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
	050234	A. BUILDING _____ B. WING _____	10/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sharp Coronado Hospital and Healthcare Center	250 Prospect Pl, Coronado, CA 92118-1943 SAN DIEGO COUNTY

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00459867 - Substantiated Representing the Department of Public Health: Surveyor ID # 29499, 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(g): 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. Title 22 Regulation: 70415 Nursing Service Staff (a) A physician trained and experienced in emergency medical services shall have overall responsibility for the service. He or his designee shall be responsible for: (1) Implementation of established policies and procedures. 70413 Basic Emergency Medical Service, Physician on Duty, General Requirements (a) Written policies and procedures shall be developed and maintained by the person		Received 2567 on February 13, 2017. RECEIVED FEB 22 2017 LICENSING AND CERTIFICATION SAN DIEGO DISTRICT OFFICE SOUTH	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ken Mueller TITLE: Director Quality/Regulatory (X6) DATE: 2/20/17

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate. The above regulations were NOT MET as evidenced by: Based on observation, interview, record and document review, the hospital failed to ensure that its Emergency Department (ED) triage policy was implemented when Patient 1 was not triaged (the principle or practice of sorting emergency patients into categories of priority for treatment) by a Registered Nurse (RN) upon his arrival to the ED. Approximately one hour after arrival to the ED, when Patient 1 was called for triage, staff found him in the locked ED waiting room restroom. Patient 1 had attempted suicide. He was found with a belt around his neck and suspended from a hook on the wall. In addition, ED RN 1, who was trained on how to unlock the ED restroom door, was unable to unlock the door in an attempt to gain access to Patient 1 when he did not respond to requests by RN 1 to open the door. This resulted in a two minute delay in providing care and emergency interventions to the patient. The patient was transferred to the Intensive Care Unit (ICU), and was subsequently diagnosed with anoxic encephalopathy (lack of oxygen to the brain) according to an MD progress note dated, 10/3/15. The patient was without		SharpHealth Care (SHC) Triage Policy (35024) was reviewed with ED staff during daily shift huddles X 17 days to ensure all staff received the information. The education highlighted the requirement that each patient will be evaluated at the time of arrival by a Registered Nurse (RN). The RN has been established/identified as the first contact for intake and screening for those identified as patients coming for treatment in the Emergency Department (ED). This was communicated during daily shift huddles X 17 days to ensure all staff were aware of leadership expectations. Monitoring: Random audits X 10 for one month to assure RN evaluation at the time of patient arrival. Responsible party: ED Manager	9/25/15 9/25/15 10/25/15

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	capacity, or the ability to understand. The patient required ventilator support (a mechanical device that moves breathable air into and out of the lungs) and received nutrition via a tube placed into the stomach. Findings: An investigation was initiated on 9/29/15 at 10:00 A.M., as a result of an Entity Reported Incident (ERI) reported to California Department of Public Health (CDPH) on 9/24/15, which indicated that Patient 1 attempted suicide in the hospital's ED waiting room restroom. A video from three surveillance cameras located in the hospital's ED waiting room, dated and time stamped on 9/24/15, was observed and reviewed on 10/1/15 at 7:30 A.M. The following events were observed via the ED surveillance video: Patient 1 entered the ED waiting room on 9/24/15 at 6:39 P.M. Security Guard (SG) 1, and several other people, were observed in the ED waiting room. At 6:41 P.M., RN 3 entered the ED waiting room and took a patient into the ED. At 6:54 P.M., RN 3 reentered the ED waiting room and took a second patient into the ED. At 7:05 P.M., RN 1 reentered the ED waiting room and took a third patient into the ED. Patient 1 remained in the ED waiting room. At 7:16 P.M., Patient 1 entered the ED waiting room restroom. At 7:36 P.M., approximately 57 minutes after Patient 1's arrival to the ED, RN 1		CPR was started on Patient 1 upon finding him unconscious in the Emergency Department lobby's public restroom. He was transferred to ICU where he was stabilized. Emergency Department(ED) RNs received Re-education, related to ED restrooms, on the process of unlocking the doors. This required re-demonstration on unlocking ED restroom door. Monitoring: Two ED RNs will be randomly selected monthly (X6 months= 50%), to demonstrate proficiency in unlocking ED restroom door. Results of monitoring will be incorporated into the ED Dashboard and reported to the Quality & Patient Safety Council quarterly. Re-education is given to staff that do not demonstrate proficiency. Results of monitoring will incorporated into the ED dashboard and is reported to Quality & Patient Council quarterly. Responsible party: ED Manager	9/25/15 9/25/15-10/7/15 11/1/15 11/1/15 11/1/15-5/1/16

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	entered the ED waiting room. SG 1 pointed to the ED waiting room restroom. SG 1 knocked on the ED waiting room restroom door. The door remained closed. At 7:36 P.M., when there was no response from the person locked in the ED waiting room restroom, RN 1 left the ED waiting room. At 7:38 P.M., RN 2 entered the ED waiting room and opened the ED restroom door. When the door was opened, RN 2 found Patient 1. On 9/29/15 at 2:15 P.M., an interview was conducted with SG 1 and the Director of Quality and Regulatory (DQR). SG 1 stated that when Patient 1 entered the ED waiting room, SG 1 asked Patient 1 the following questions: name, reason for visit to the ED and the name of the patient's primary physician. According to SG 1, Patient 1 stated that the reason for his visit to the ED was that, he would only talk to a doctor. SG 1 stated that he opened the waiting room door and verbalized the information which he obtained from Patient 1 to Patient Access Staff (PAS) 1, who was on the other side of the door in the ED. SG 1 stated that "while the Patient 1 was in the ED waiting room, he sat down, breathed heavily, stood up and went to the ED restroom, and was in the restroom approximately 15-20 minutes." During an interview with SG 1 on 9/30/15 at 4:20 P.M., SG 1 stated that, he did not receive education and training related to collecting patient information and that, he obtained Patient 1's information in the ED waiting room because PAS 1 asked him to ask Patient 1 those questions. He acknowledged that he asked Patient 1 those			

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	questions and then, relayed the information to PAS 1. On 9/30/15 at 3:00 P.M., an interview was conducted with PAS 1 and the DQR. PAS 1 stated that his responsibilities included obtaining a patient's name, reason for visit to the ED, and the name of the patient's primary care physician. After obtaining that information, the PAS would enter it into a computer, then inform the nurses that a patient arrived at the ED. PAS 1 stated that SG 1 informed him of Patient 1's first name and that the reason for the visit to the ED was that Patient 1 only wanted to talk to a doctor. PAS 1 stated that SG 1 opened the ED waiting room door and relayed Patient 1's information to him. Per PAS 1 he did not physically go into the waiting room to speak with Patient 1. He asked Patient 1 through the open door to the waiting room what his name was. Per PAS 1, Patient 1 only stated his first name. PAS 1 stated he entered the information collected from SG 1 into the computer and informed the nurses that Patient 1 arrived at the ED. On 9/29/15 at 1:30 P.M., an interview was conducted with RN 1 and the DQR. RN 1 stated that on 9/24/15, she was assigned as the triage nurse, for the evening shift, from 7 P.M until 7 A.M. She stated that as the triage nurse, she screened patients coming in to the ED according to priority. She stated that the reasons for patients' visits were obtained during a handoff report from the day triage nurse, RN 3. She stated that she was busy with other patients and did not triage Patient 1 when the patient first arrived. She stated that when she went to the ED waiting room to call Patient 1 for triage,		The Patient Access Services (PAS) was coached on ED through-put process. The revised process was reviewed with all PAS staff by the Patient Access Manager. This process will be included in the department's training orientation packet. The RN is at the front window checking patients in, while the PAS completes initial registration from paper work generated by the nurse. Responsible Parties: ED Manager and Business Office and Admitting (PAS) Manager	10/8/15 11/23/15

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	SG 1 informed her that Patient 1 went into the ED waiting room restroom. She stated that SG 1 knocked on the restroom door. When there was no answer, RN 1 stated that she only had a pen and was not sure how to open the door, so she asked RN 2 to unlock the ED restroom door. In addition, RN 1 stated that staff usually opened the ED restroom doors with scissors or a dime. On 10/5/15 at 9:00 A.M., an interview was conducted with RN 1 and the DQR. RN 1 stated that in February 2015, staff received an email related to opening the locked ED restroom doors and that staff used a coin or a screwdriver that was placed on the white board in the ED (staff communication board). However, RN 1 stated the communication board was not visible on 9/24/15 due to a construction project in the ED waiting room. On 10/5/15 at 9:23 A.M., an interview and review of the ED document titled "Bathroom Lock Access" dated 2/9/15, was conducted with the ED Manager (EDM). The document indicated "The recommended tool to open the bathroom lock is the ED RN or HCP's (Health Care Partners) trauma shears... just put in the rounded part of your shears and turn." "A second method is to use a small coin (such as a penny or dime) to insert in the rounded part of the lock hole and turn." "Or there is always the flat head screwdriver tool in the nursing station (kept with other pens in the holder facing rooms 1-4, just insert and turn." On 9/29/15 at 5:17 P.M., an interview was			

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	conducted with RN 3, the day triage nurse, and the DQR. RN 3 stated that Patient 1 was the next patient waiting to be triaged at the shift change. However, RN 3 stated that she did not triage Patient 1 next, but instead triaged Patient 2 due to that patient's chief complaint of head trauma and vomiting. On 10/2/15 at 7:21 A.M., an interview was conducted with RN 2. RN 2 stated that he was assigned on 9/24/15 as the Expediter nurse (additional triage and resource for nursing staff). RN 2 stated he was able to view Patient 1 (in the waiting room) via the monitor at the nursing station, and was aware that the patient would only talk with a doctor. He stated that Patient 1 was not a priority acuity from what he saw via the monitor and that he appeared stoic. RN 2 stated that he did not triage Patient 1 and RN 2 was not aware that the other triage nurses had not triaged Patient 1. He stated that RN 1 came back from the ED waiting room and informed him that she had called Patient 1 back for triage and that the patient was locked in the ED waiting room restroom. RN 1 asked RN 2 to help unlock the restroom door. RN 2 stated he went to the ED waiting room and unlocked the ED waiting room restroom. RN 2 found Patient 1 with a belt buckle around his neck, and the belt was tied around a wall hook. He stated that he lifted Patient 1 off the wall hook, untied the belt and began cardiopulmonary resuscitation (CPR - emergency medical procedures for restoring normal heartbeat and breathing). He stated that he continued CPR and a code (alert to staff for life sustaining treatment) was called. Patient 1 was transferred			

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	back to the ED and later transferred to the intensive care unit (ICU). On 10/2/15 at 8:37 A.M., an interview and review of the hospital's policy titled "Triage, dated 8/2014," was conducted with the Medical Director (MD) 1. The policy indicated "Each patient is evaluated at the time of arrival by a RN." The policy also indicated, "the triage nurse will obtain information needed to determine urgency of each patient's care needs." MD 1 stated that the hospital's expectation was that a patient would be immediately screened for triage in the waiting room by an RN, in accordance with the hospital's triage policy and procedure. MD 1 acknowledged that this was not implemented in accordance with the hospital's ED triage policy and procedure. On 10/5/15 at 9:00 A.M., an interview and review of the hospital's policy titled "Triage, dated 8/2014," was conducted with RN 1 and the DQR. The policy indicated "Each patient is evaluated at the time of arrival by a RN." The policy also indicated "the triage nurse will: obtain information needed to determine urgency of each patient's care needs." The Triage Nurse will obtain information needed to determine priority, I. Obvious Emergent Patient - The patient is taken directly to the treatment area." Under section III. Procedure, "Other patient care should be initiated in accordance with the Emergency Guidelines of Care." According to the hospital's "Emergency Guidelines of Care" dated 2/20/15, Under reassessment of lobby patients, page 11,"Patients in the lobby are		Prerarrival documentation is now limited to incoming Emergency Medical Services (EMS), online reservations, and referrals from outside providers. As such, once the patient arrives in the ED, the RN will complete the patient evaluation. The tracking board now shows real-time patient log documenting arrival (check in), reason for visit, and acuity. The ED log is reviewed/monitored daily, real time, by the ED charge nurse with ED manager oversight. Monitoring: Log reports are run on demand for retrospective review of through-out (arrival, acuity, triage, and discharge). Length of stay may be tracked and a report run on demand. Results of monitoring are incorporated into the ED dashboard and reported to the Quality & Patient Safety Council quarterly. Responsible Parties: ED Manager Director of Acute and Critical Care	9/25/15

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	reassessed, as needed, according to their chief complaint." In addition, the guidelines indicated, under "Suicidal Behavior - pt management", "A screening is performed on all patients upon entry to the Emergency Department as part of the Triage assessment, with regard to "Does the patient have a psychological or behavioral complaint?" If "Yes" is answered, a suicide risk assessment is performed using the RSQ (Risk for Suicide Questionnaire) scale where points are calculated when risk is identified & initial interventions noted with the final calculation." The policy and guidelines were not implemented when Patient 1 was not triaged upon his arrival to the ED on 9/24/15 at 6:39 P.M. According to a consultation note dated 9/24/15, Patient 1 had to be resuscitated in the ED with ACLS (Advanced Cardiac Life Support) protocol and was intubated, on ventilator support and transferred to the ICU with an overall prognosis of poor. Twenty one days later, following Patient 1's attempted suicide, a Discharge Summary, dated 10/14/15, indicated that Patient 1 remained in the ICU and was subsequently diagnosed with anoxic encephalopathy (lack of oxygen to the brain) and without capacity, or the ability to understand. The patient required ventilator support and received nutrition via a tube placed into the stomach and his prognosis remained "guarded".			

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	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).			