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
	050093	A. BUILDING _____ B. WING _____	01/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Agnes Medical Center	1303 E Herndon Ave, Fresno, CA 93720-3309 FRESNO COUNTY

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00525763 - Substantiated Representing the Department of Public Health: 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. DEFICIENCY CONSTITUES IMMEDIATE JEOPARDY Title 22, Division 5, Chapter 1, Article 7, Section 70213 (a) - Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. Title 22, Division 5, Chapter 1, Article 7, Section 70413(a) Written policies and procedures shall be developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and		POC ACCEPTABLE YES ☒ NO ☐ Reviewed By: Gloria Nelson Name Fax _____ Original ✓ Facility Notified Name: Janine Shaed, RN Date: 3/9/18 Time: 11:06 AM Notified By: Gloria Nelson Name RECEIVED MAR 2 2018 CA DEPT OF PUBLIC HEALTH LICENSING & CERTIFICATION - FRESNO RECEIVED MAR 2 2018 CA DEPT OF PUBLIC HEALTH LICENSING & CERTIFICATION - FRESNO	

Event ID: 5L5Y11 2/5/2018 4:27:53PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

W. Eugene Egerton, MD, FAAP Chief Medical Officer 3/2/18

By signing this document, I am acknowledging receipt of the entire citation pac[illegible]e.

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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	administration. Polices shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate. Based on interviews, clinical record, administrative document and video recording review, the hospital failed to protect the rights of Patient (Pt) 1 and failed to ensure staff followed hospital policies and procedures when: 1. Registered Nurse (RN) 3 did not follow the hospital's "Against Medical Advice (AMA): Left Without Being Seen (LWBS)" policy (AMA means when a patient leaves a hospital against the advice of their doctor) and wheeled Pt 1 out to the bus stop without first informing the risks of leaving prior to discharge and without a discharge order from the provider. 2. RN 3 and RN 4 did not consider alternate means of transportation when Pt 1 requested to be sent home. 3. RN 3 and RN 4 did not consider to consult other resources such as social services prior to wheeling Pt 1 out of the emergency department (ED). These failures resulted in the potential for serious disability or injury by wheeling Pt 1 out to the bus stop without first obtaining a safe discharge order from the ED provider. These failures may have contributed to Pt 1's eventual death.			

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	Findings: Patient 1's clinical record indicated he was a 40-year-old male who was brought to the hospital's Emergency Department (ED) at 10:02 p.m., on 3/8/17. The ambulance Emergency Medical Service (EMS) report indicated Patient 1 had complained of heart palpitations and that he appeared moderately intoxicated. The EMS report indicated Patient 1 would not answer questions but kept repeating, "Just take me to the hospital". The EMS report indicated Patient 1's heart rate (HR) was 124 (normal is 60 to 100 beats per minute) and respiratory rate (how many times you breath in and out per minute, RR) was 28 (normal is 12 to 20). Patients 1's clinical record indicated his blood alcohol level was 454 mg/dl-milligrams per deciliter (normal is below 80 mg/dl). The hospital's security video of the lobby and exterior of the building was viewed. The video runs from 10:03 p.m. on 3/8/17, when Patient 1 was brought into the hospital by EMS, and then starts again at 11:36 p.m. on 3/8/17 through 1:10 a.m. on 3/9/17. There was no audio. Patient 1 was identified as the patient with a cap on and a jean jacket and pants. At the 12:41:13 reading on the video file identified as 0028 to 0050 Patient 1 had his head down on the arm of the chair while in the waiting area of the main ED lobby. Security Guard (SG) 1 was seen approaching Patient 1. At 12:41:18 SG 1 stopped talking to Patient 1 and left. At 12:43:58 Registered Nurse (RN) 4 was seen			

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	approaching Patient 1. Patient 1 had his head down on the arm of the chair and appeared to be sleeping. At 12:44:03 RN 4 tapped and then grabbed hold of Patient 1 on the shoulder and shook his shoulder back and forth a couple of times. Patient 1 stood up with an unsteady stance, was very wobbly and appeared to attempt to follow RN 4. Patient 1 then bent over at the waist, straightened up slightly and turned around and sat back down. RN 4 walked back and spoke to Patient 1. Patient 1 didn't lift his head but had it face down. He leaned over and appeared to put his head on the arm of the chair. At 12:45:22, RN 4 left Patient 1. At 12:48:40 RN 3 was seen approaching Patient 1. RN 4 was a short distance from Patient 1 and RN 3. At 12:48:51 RN 3 was seen walking away from Patient 1 headed in the direction of the security desk. Patient 1 was still sitting in the chair. At 12:49:14 SG 1 and RN 3 approached Patient 1 with a wheelchair. At 12:49:52 Patient 1 was seen standing. He stood briefly at the chair, wobbly. He got into the wheelchair and SG 1 and RN 3 wheeled him out. On video labeled 0057 - 0112 ED Drive, SG 1 was seen returning to the hospital with the empty wheelchair at 12:57:06. At 12:57:31 Patient 1 was seen entering the image on the left corner walking into the intersection. At 12:57:38 Patient 1 was seen putting his belongings on the street in front of a vehicle and then laying down. At 12:57:59 the vehicle was seen running over Patient 1. The ED clinical record for Patient 1 dated			

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	3/8/17 indicated under "History of Present Illness ...Patient [1] was found face down on the ground at the bus stop at the front of the hospital. CPR was started and the patient was brought to the ED. Patient had two rounds of CPR with no palpable pulse noted or cardiac activity noted on the US [ultrasound]. Another round of CPR was done on the patient. Upon pulse check there was cardiac activity noted on the US but there was no palpable pulse so CPR was re-started. After the fourth round of CPR there was no palpable pulses or cardiac activity noted on the US. Patient was then pronounced expired [1:23 a.m. on 3/9/17]". On 5/10/17 at 07:54 a.m., during an interview, RN 3 stated Patient 1 arrived to the ED that evening, and was seen briefly by the triage nurse. Patient 1 was considered stable, so he was sent to the waiting room to wait to be assessed by a qualified medical provider (QMP). RN 3 stated he received a call from RN 4 informing him that Patient 1 was cursing and being disruptive in the waiting room. RN 3 stated he asked SG 1 to speak with Patient 1 to see if SG 1 could calm him down, but SG 1 was unsuccessful. RN 3 stated he knew Patient 1 from a previous visit the night before when Patient 1 displayed similar disruptive behaviors. RN 3 stated the previous night, he was able to calm Patient 1 down, but on this night, Patient 1 continued to curse and be disruptive in front of women and children. RN 3 stated Patient 1 kept repeating that he wanted to go home. RN 3 was asked why it shows on the video that he			

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	tapped Patient 1 on shoulder and made him get up, when it appeared Patient 1 was falling asleep. RN 3 stated Patient 1 wasn't sleeping, he had his head down but continued to curse. RN 3 stated he was concerned Patient 1's behavior would "escalate" so he made the decision to put Patient 1 in a wheelchair and take him to the bus stop. RN 3 stated he did not inform the QMP of this decision. RN 3 stated he did not discharge Patient 1 from the hospital, nor did he have him sign AMA papers. RN 3 stated the normal process would have been for him to have Patient 1 be evaluated by the QMP before leaving the hospital. RN 3 stated he did not follow this process. RN 3 also stated the normal process for any patient that wants to leave the hospital before they have been medically cleared to do so, would be to have the patient sign AMA papers. RN 3 stated he did not follow this process. RN 3 stated he felt he had built a rapport with Patient 1 so he and SG 1 wheeled him outside and thought they would be able to calm him down while walking him outside. RN 3 stated at one point, while being wheeled outside, Patient 1 apologized for cursing in the waiting room and he considered bringing Patient 1 back in to the waiting room, but then he started cursing again. RN 3 stated he and SG 1 continued wheeling Patient 1 to the bus stop. RN 3 stated when they arrived at the bus stop, Patient 1 got out of the wheel chair and they left him at the bus stop. RN 3 stated he knew the buses were not running at that time of night (01:00 a.m.). RN 3 stated he did not consider offering Patient 1 a			

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	taxi voucher, or another way home. RN 3 was asked if he would do the same thing if this situation occurred again. RN 3 stated, "No. I would notify the QMP and let them make the decision to let the patient go." RN 3 also stated he would have patient sign AMA papers before leaving. On 5/10/17 at 09:12 a.m., during an interview, RN 4 stated he was the triage (the sorting of patients-as in an emergency room, according to the urgency of their need for care.) nurse the night of 3/8/17 when Patient 1 was brought into the ED. RN 4 stated Patient 1 kept going in and out of the department to smoke, was cursing, and was just being "difficult." RN 4 stated Patient 1 was yelling and cursing, demanding the hospital staff provide with him transportation home, and being generally disruptive to the department. RN 4 stated he called his charge nurse (RN 3) to come assess the situation. RN 4 stated RN 3 and SG 1 came to the waiting room to talk to Patient 1, but he continued cursing. RN 4 stated RN 3 and SG 1 asked Patient 1 to get into a wheelchair and they wheeled him outside. RN 4 was asked what the normal process would be if a patient wanted to go home. RN 4 stated he would try to put them in a room and notify the QMP. RN 4 was asked if it was normal process to take a patient to the bus stop at 01:00 a.m., when the buses aren't running. RN 4 stated, "I don't know, but the homeless are manipulative, they are resourceful and resilient, so I wasn't really worried."			

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	On 5/10/17 at 09:28 a.m., during an interview, SG 1 stated he was working the night of 3/8/17 when Patient 1 was brought into the ED. SG 1 stated Patient 1 was in the waiting room and was very disruptive. SG 1 stated, "This guy was being disruptive, wanting to go home, cursing. There was a family with kids across from him. He kept going in and out (of the ED) smoking. I told him there was no smoking on the property. He kept saying he wanted a ride home by ambulance." SG 1 stated RN 3 was called to the waiting room. RN 3 tried to talk to Patient 1, but he wasn't cooperating, so RN 3 said to, "Get him out of here." SG 1 stated he and RN 3 got Patient 1 a wheelchair and escorted him to the bus stop. SG 1 was asked if it is a normal practice to take a patient to the bus stop in the middle of the night when no buses were running, SG 1 stated, "Yes, it is not an unusual practice." SG 1 was asked if this practice is still going on. SG 1 stated, "Yes, not every night, but it still happens." 5/11/17 at 10:47 a.m., during a concurrent interview with the Medical Director of the ED (EDMD), the Director of the ED (ED Dir), and Risk Manager (RM), EDMD stated his expectation in his department is that there is collaboration between staff and medical providers with every patient. When asked specifically about patients that say they want to leave, EDMD stated there should be communication between nursing staff and medical providers. It should be discussed at			

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	length to make sure patient is safe to leave, and if they aren't safe to leave they should consider doing something else like possibly getting social services involved. EDMD stated there needs to be better documentation by nursing staff. EDMD stated he thinks the mistake made in the case of Patient 1 was an error in judgement by RN 3, because RN 3 did not discuss the situation with the medical provider before escorting him outside. When asked if it is still acceptable to discharge a patient to the bus stop at 01:00 a.m. when buses aren't running, EDMD stated it would be ok on a "case by case basis." The hospital's Policy and Procedure titled "Against Medical Advice (AMA): Left Without Being Seen (LWBS)" dated April 2015, indicated, "...Policy: 1. Reasonable efforts will be made to avoid having patient leave the hospital AMA or LWBS 2. The risks and consequences of leaving the hospital will be explained to the patient. 3. Every effort will be made by nursing personnel to have the patient sign the "Leaving Hospital against Medical Advice" form (see Appendix A) prior to leaving the hospital. Procedure: 1. Assess the patient's ability to understand their condition and the risks of leaving the hospital (vital signs, mental status, language. etc.). 2. Notify the attending physician, the manager/designee and/or Administrative Director of Nursing immediately of patient's intent to leave the hospital. 3. Inform the patient their physician is aware of their desire to leave. 4. Explain the patient's			

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diagnosis/condition to the patient. 5. Explain the risks and consequences of leaving the hospital to the patient and family...7. Involve available resources in an attempt to dissuade the patient from leaving, including the physician, social worker, chaplain, family or friends, etc. 8. Complete "Leaving Hospital Against Medical Advice" form (see Appendix 1) when the patient (or responsible person) persists in wanting to leave the hospital prior to completion of treatment by the attending physician... 12. If requested, assist the patient in arranging transportation..."

The hospital's "Patient Bill of Rights and Responsibilities," undated, indicated, "As a patient, you have the right to... 2. Considerate and respectful care, and to be made comfortable...9. Make decisions regarding medical care, and receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse a course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved, alternate courses of treatment or nontreatment and the risks involved with each... 17. Receive care in a safe setting..."

The hospital's failure as described above that resulted in Patient 1 being left unattended near the hospital which resulted in preventable events that may have contributed to Patient 1's death directly led to the licensee's

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	non-compliance with one or more requirements of licensure, Title 22, Division 5, Chapter 1 Article 7, Section 70413(a) and Health & Safety Code 1280.3 (g) 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).			

SAINT AGNES MEDICAL CENTER
Complaint Intake Number: CA00525763 – Substantiated

Plan of correction	Completion date
The following constitutes Saint Agnes Medical Center's amended credible allegation of correction for the cited EMTALA deficiency. Saint Agnes Medical Center is a faith based organization and as such our core values center around reverence, integrity, compassion, and a commitment to excellence. Our Mission is to serve as a compassionate and transforming healing presence within our communities. Every effort is being made to ensure we are true to that mission. This event prompted us to reexamine how we can ensure our patients' safety and fundamental rights are honored and supported. DEFICIENCY CONSTITUTES IMMEDIATE JEOPARDY Title 22, Division 5, Chapter 1, Article 7, Section 70213 (a) – Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. Title 22, Division 5, Chapter 1, Article 7, Section 70413(a) Written policies and procedures shall be developed and maintained by the person 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. **Actions taken:**	
The initial response to the incident included targeted debriefs with Senior Leadership, Emergency Room Leaders, Quality & Risk Management, and Employee Relations. This lead to an immediate and thorough investigation of the event.	3/9/17
1) Director of Employee Relations and Nursing Director of the Emergency Department met with the staff closely involved in the care of Patient 1 to get an accurate account of the event. Follow up occurred directly with RN 3 using the Just Culture Management process in response to wheeling Patient 1 off property at 1am prior to completion of his assessment and without signing out against medical advice or being discharged.	3/9/17
2) Quality & Risk Management completed a clinical review of the case with ED leadership to establish a time line of events and to analyze factors that may have contributed to the event. A quality and performance improvement work group was then convened to address the issues identified and develop actions to mitigate future risk. The workgroup included Quality & Risk Management, ED Medical and Nursing Director, Chief Nursing Officer, Chief Medical Officer, and Director of Case Management and Social Services.	4/13/17
3) Immediate discussion with ED staff and physicians regarding this event began at ED staff huddles, at physician, ED and Security staff meetings as well as communication via electronic mail. Emphasis was placed on the following areas:	6/16/17

a) Patients' right to be fully assessed by a provider to determine if an emergency medical condition is present. b) Patients will not be discharged and/or escorted off property before a full assessment is completed c) Patients will be discharged in a safe manner, considering alternate means of transportation if necessary d) If a patient wishes to leave AMA, the hospital's policy must be adhered to. The AMA policy requires staff to: ▪ "Notify the provider... of the patient's intent to leave the hospital." ▪ "Involve available resources in an attempt to dissuade the patient from leaving." ▪ "Explain the risks and consequences of leaving before a medical screening exam and/or treatment has been completed." ▪ Make "every effort...to obtain his/her (patient's) signature on the "Leaving against Medial Advice" form.	
4) Mandatory education via an e-learning module was assigned to all ED staff, ED Case Managers, Social Workers, ED Physicians, Security Officers, ED Registration staff and House Supervisors, with completion achieved on 6/16/17. The education focused on items 3a)-d) and the requirements of EMTALA regulations in the Emergency Department. The e-learning module education is required annually for all ED RNs, Security staff and ED providers (MD, NP, PA).	5/10/17-6/16/17
5) The Emergency Services Policy Index E-3 titled "Discharge from Emergency Department" was revised to include the following changes: "Patients will not be discharged from the Emergency Department until a medical screening exam is completed... The exception to this is if a patient chooses to leave against medical advice... Every attempt will be made to ensure that patients have a safe mode of transportation for discharge. The nurse will involve other resources deemed necessary to facilitate a safe patient discharge, including assisting patient with notification to family and/or friends, or initiating referral to a Social Worker. When no transportation by a family or friend is available, options include offering a bus token or a taxi voucher ... If a patient chooses to leave the ED prior to completion of screening and treatment, or before a safe discharge can be arranged, refer to the hospital's AMA policy."	6/22/17
6) Education on the above policy revisions were provided to RNs, Social Workers and Security staff via staff meetings, huddles and e-mail. Ongoing reminders occur in ED staff huddles to maintain staff awareness around the aforementioned AMA policy and Discharge from Emergency Department policy.	6/26/17-7/14/17
Compliance and Monitoring: The Director of Quality & Risk Management was responsible at this time for ensuring a concurrent and retrospective audit process was conducted to monitor compliance to the plan of correction.	

1) A concurrent audit tool was developed to track any patient that is escorted off hospital property to ensure that:
   - A full assessment was completed to rule out an EMC
   - The patient posed a clear danger or threat to the safety of others
   - Team collaboration occurred for an appropriate plan for the patient
   - All appropriate resources were exhausted first

2) A retrospective audit tool was developed that tracked AMA patients that leave the ED before the care episode is completed to ensure that the hospital's AMA policy was followed.

3) An RN was designated by the Director of Quality & Risk Management to review a list of AMA patients obtained from the EMTALA log. Every other patient was selected up to a maximum of 30 patients per month for the next 3 months to review for the following:
   - Documentation in the record reflects that risks and consequences of leaving before evaluation and treatment were completed was discussed.
   - The provider was notified and every effort made to intercede in a case where a patient chooses to leave before a full assessment can be completed.
   - Other available resources were used in an attempt to dissuade a patient from leaving, and to assist in providing a safe discharge for the patient.
   - Every effort was made to have the patient sign the AMA form.

4) The audit process continued for 90 days after which there was a re-evaluation to determine overall compliance and the need for continued monitoring. The decision was made to continue monitoring a sample of 30 cases per month to maintain staff awareness and to track ongoing compliance to our policies, with the goal of consistently achieving ≥95% compliance.

5) If areas of non-compliance are identified during the audit process, the ED Nursing Director and/or Medical Director, or their designee, are responsible for following up directly with their staff / providers using the Just Culture Management Process by 1:1 reeducation, coaching / counseling, or further corrective action as necessary.

6) Audit results are reported to the ED staff and physician monthly at the ED Value Stream Steering Committee. This team has oversight of the LEAN process improvement work currently focused on reducing ED wait times, reducing incidence of patients leaving before completing treatment, and improving throughput. Audit results are also reported to the hospital's leadership, Board members and physician leaders at the Medical Affairs Council on a monthly basis.

Responsible persons:
Chief Nursing Officer
Chief Medical Officer
Director of Quality and Risk Management