

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  050373	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2010
NAME OF PROVIDER OR SUPPLIER <b>LAC+USC MEDICAL CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1200 NORTH STATE STREET, ROOM 1110, LOS ANGELES, CA 90033 LOS ANGELES COUNTY</b>		
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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: CA00204312 - Substantiated</p> <p>Representing the Department of Public Health: Surveyor ID # 17108, MEDICAL CONSULTANT</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>Deficiency Constituting Immediate Jeopardy:</p> <p>70233(a) Anesthesia Service General Requirements (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. The policies and procedures shall include provision for at least:</p> <p>The above regulation was NOT MET as evidenced by:</p>		<p>[Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusion set forth on the statement of deficiencies.]</p> <p>In response to the deficiencies identified by the California Department of Public Health during their visit to LAC+USC Medical Center on April 8, 2010, the following actions have been carried out to ensure the highest level of patient care that meets the expectations of Health and Safety Code Section 70233 (a) Anesthesia Service General Requirements.</p> <p>Action: To address the observed deficiency outlined in the finding regarding lack of supervision and failure to meet standard of practice in the case of patient A, the following has been done:</p> <p>To determine if the CRNA, Attending</p>	10/30/10

Event ID:KEE811

3/25/2011

3:48:40PM

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

TITLE

(X6) DATE

*PETE DELGADO*

CEO, LAC+USC Healthcare Network

04/11/11

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State-2567

*Accepted  
4/12/11  
S. Wainstein  
B. Mellor, HFES*



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	<p><b>Continued From page 2</b></p> <p>undergo "split thickness skin graft to the right leg." CRNA X wrote: the "Medical History" revealed that Patient A had consumed 1/2 a pack of cigarettes per day for 40 years and he was a "heavy drinker" (patient with a significant alcohol abuse history could have impaired liver function and vitamin deficiencies that could impact wound healing and impaired general health.)</p> <p>The physical examination performed and entered into the medical record by CRNA X revealed that Patient had "increased secretions" (noises in the upper airway bronchial tubes that may reflect inflammation in the airway), and breath sounds "clear to auscultation on both sides", this finding reflects that the lungs and lower airways are clear of secretions or pneumonia. CRNA noted that a "NG" (nasogastric tube, tube placed with its tip in the stomach, inserted through the nose), was in place. The vital signs revealed a blood pressure of 104/58 mm Hg (millimeters of mercury) normal is in the range of 120/80. This reduced value may reflect dehydration, a condition that commonly occurs in patients with burns, a pulse of 122 bpm (beats per minute-this heart rate is above the normal heart rate of approximately 70-90 bpm) and a temperature of 100.3 F (Fahrenheit).</p> <p>The laboratory work for Patient A was assessed and reviewed by CRNA X and entered into the hospital's Pre-Anesthetic evaluation form revealed 21,200 microliters of WBC (white blood cell), 7.9 gm (grams) Hgb (hemoglobin), and Albumin of 2.1. (These values reflect that Patient A had an elevated white blood cell count, low hemoglobin and low</p>		<p>To facilitate communication between the CRNA, residents and supervising attending staff, the Department of Anesthesia has issued portable phones to all supervising Anesthesiologist and contact numbers are made available to all care team members and OR staff daily.</p> <p><b>Policy:</b> The Department of Anesthesiology maintains policies of CRNA Supervision and Pre-operative Assessment. Both policies were reviewed by the Anesthesia Chief of Service and found to meet Title 22 expectations for safe patient care.</p> <p><b>Education:</b> The Anesthesia Departmental policy of CRNA Supervision was emailed to all anesthesia providers with a transmittal placing specific emphasis on required supervision/ documentation of the pre-anesthesia assessment and induction of anesthesia.</p> <p>In addition, the importance of communicating and documenting such communication was discussed</p>	<p>10/08/10</p> <p>07/27/10</p> <p>12/16/09</p>

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	<p><b>Continued From page 4</b></p> <p>Patient A, the laboratory values, or the planned surgery and anesthesia procedures had been presented to Physician R for consultation or discussion. There was no written documentation that either the supervising anesthesiologist or the surgical team had been made aware of these laboratory values, for this elective procedure.</p> <p>When interviewed at approximately 1015 hours on 5/10/10, both Physician R and CRNA X agreed that there was no documentation in the medical record to indicate that CRNA X had been authorized to begin anesthesia induction, as is required by the policy and procedure for CRNA supervision that states "All CRNAs must have an anesthesiologist present for induction for all anesthesia". "If the faculty is busy with another case, permission for a CRNA to begin induction with a resident or alone is needed". "This permission should be documented on the anesthesia record." The anesthesia record revealed no written documentation of such authorization from MD R to CRNA X to begin anesthesia induction.</p> <p>Anesthesia induction occurred at 1143 hours with 100 mg of Propofol (a drug widely used by anesthesia providers to induce general anesthesia.) There was no documentation that the hospital policy, to document that CRNA X had been given authorization to proceed with induction by Physician R, had been obtained or entered into the medical record, as is required by the policy and procedure from the hospital.</p> <p>Interviews with Physician R at 1115 on 5/10/10</p>				

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	<p>Continued From page 5</p> <p>revealed that Physician R was in another room providing anesthesia services. Physician R stated that she was in transit to the operating room for the procedure to be done on Patient A when she received a telephone call from CRNA X. MD R stated that she was informed by CRNA X: "I am going ahead with the case".</p> <p>When interviewed on 5/10/10, at approximately 1015 hours, CRNA X stated that Physician R was not in the operating room at the time that induction of anesthesia, as is required in the policy and procedure from the hospital.</p> <p>However, during an interview conducted with Physician R on 5/10/10 at approximately 1115 hours, she stated that she was in the operating room at the time the laryngeal mask anesthesia was placed for Patient A, but then left the room, to attend to another case.</p> <p>At 1148 hours Laryngeal mask anesthesia was placed.</p> <p>A review of the anesthesia record revealed that the blood pressure changed from 88/48 mm. Hg. to 77/38 mm. Hg.</p> <p>At 1148 hours Phenylephrine 80mcg (micrograms) was given IVP (intravenous push) and again at 1149 hours. Phenylephrine is a medication used to raise blood pressure in a patient whose blood pressure becomes dangerously low. IVP is rapid intravenous administration of the medication, usually in an emergency situation. 1000 cc of intravenous fluid</p>			

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	<p><b>Continued From page 6</b></p> <p>was also rapidly infused (this is done in an attempt to raise a dangerously low blood pressure, during anesthesia).</p> <p>There was no documentation in the medical record that CRNA X discussed or informed the surgical team of the medications being administered to maintain the blood pressure for the patient.</p> <ul style="list-style-type: none"> <li>- At 1150 hours, surgery started.</li> <li>- At 1151 hours Phenylephrine and Ephedrine were administered by CRNA X.</li> <li>- At 1152 hours 400 cc Lactated ringers was administered</li> <li>- At 1200 Phenynelephrine 40 mcg was given by IV push</li> <li>- At 1204 Lactated ringers 300 cc was administered</li> <li>- At 1204 Hetastarch 500 ml was administered. (Hetastarch is a plasma volume expander).</li> <li>- At 1215 a time out was completed.</li> <li>- At 1228 CRNA X left the operating room for lunch and was relieved by Physician S.</li> <li>- At 1230 the surgical incision was made.</li> <li>- At 1237 Physician S removed the laryngeal mask anesthesia device to intubate the airway of Patient A (place a breathing tube). At 1237 the blood pressure was recorded as 40/25 mm. Hg.</li> <li>- At 1245 chest compressions were initiated by the surgeon.</li> <li>- At 1320 hours bilateral chest tubes were placed by the surgeon.</li> </ul> <p>According to the medical record and interviews with Physician S at approximately 1130 hours on 5/10/10, Physician S provided anesthesia services</p>			

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	<p><b>Continued From page 7</b></p> <p>for Patient A, to relieve CRNA X. Physician S stated that Patient A became very difficult to ventilate, using the laryngeal mask anesthesia (LMA). Physician S stated that he thought that Patient A developed severe bronchospasm (narrowing of the airway as a result of spasm of the resulting in severe hypoxia (not enough oxygen getting to the tissues or organs, particularly the brain). Physician S withdrew the Laryngeal Mask Anesthesia (a device used to administer anesthesia without inserting a tube into the airway). and intubated the airway of Patient A at 1237 hours on 8/25/09. At that point, the heart rate was recorded as 40 beats per minute and the oxygen saturation at 40. At that point, CPR (Cardio-Pulmonary Resuscitation) was initiated for presumed pulseless electrical activity of the heart and low blood pressure.</p> <p>Post-procedure notes indicated that Patient A has suffered severe anoxic brain injury.</p> <p>Patient A remains an inpatient at a rehabilitation facility.</p> <p>The facility failed to ensure that its surgical staff implemented the policy and procedure for Physician Supervision of CRNAs, that allow CRNAs to perform anesthesia procedures under the supervision of an anesthesiologist and require</p> <p>(1) the supervising physician co-sign the pre-anesthetic assessment for a patient, and</p> <p>(2) CRNAs have an anesthesiologist present for induction of all anesthesia or have a written permission to begin induction. This deficiency has</p>			
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APR 17 2011

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