aamended 2/15/13 KC/gp

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050128	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 04/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRI CITY MEDICAL CENTER	**4002 Vista Way, Oceanside, CA 92056-4506 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: CA00271149, CA00265925 - Substantiated Representing the Department of Public Health: Surveyor ID # 22363, 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 1280.1(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. Informed Adverse Event Notification Health and Safety Code Section 1279.1 (c). The CDPH verified that the facility informed the patient or the party responsible for the patient of the adverse event by the time the report was made. Health & Safety 1279.1 (a) HSC Section 1279 (a) A health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250 shall report an adverse event to the department no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients,		CA00265925 & CA00271149 Penalty Number 080008720 Health & Safety Code § 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 Health & Safety Code § 1280.1 (c) 1 Temporary corrective actions taken a. The Manager for the Radiology & the Director for Radiology were notified of the fall b The Manager for Radiology immediately notified Director of Regulatory c Immediately conducted an investigation into incident. Interviewed staff, involved physicians, rapid response nurse, and involved technician. d Determined that "hand-off" communication/report between RN-Transporter-Technician required review, education, and process change for individual units e. The Manager for Radiology immediately sent out reminders to all Patient Transporters to make sure that the patients who are transferred via the cardiac chair are secured with the belt attached to the chair. f All cardiac chairs were assessed for belts readiness & to assure they were in good working order g The chairs with frayed belts were sent to engineering for repair h The involved staff received education on fall risk & securing patients in cardiac chairs i Completion Date: 4/22/2011 j Responsible Party: The Manager for Radiology	

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

Jamie Bleanson Director Regulatory Compliance 2/15/13

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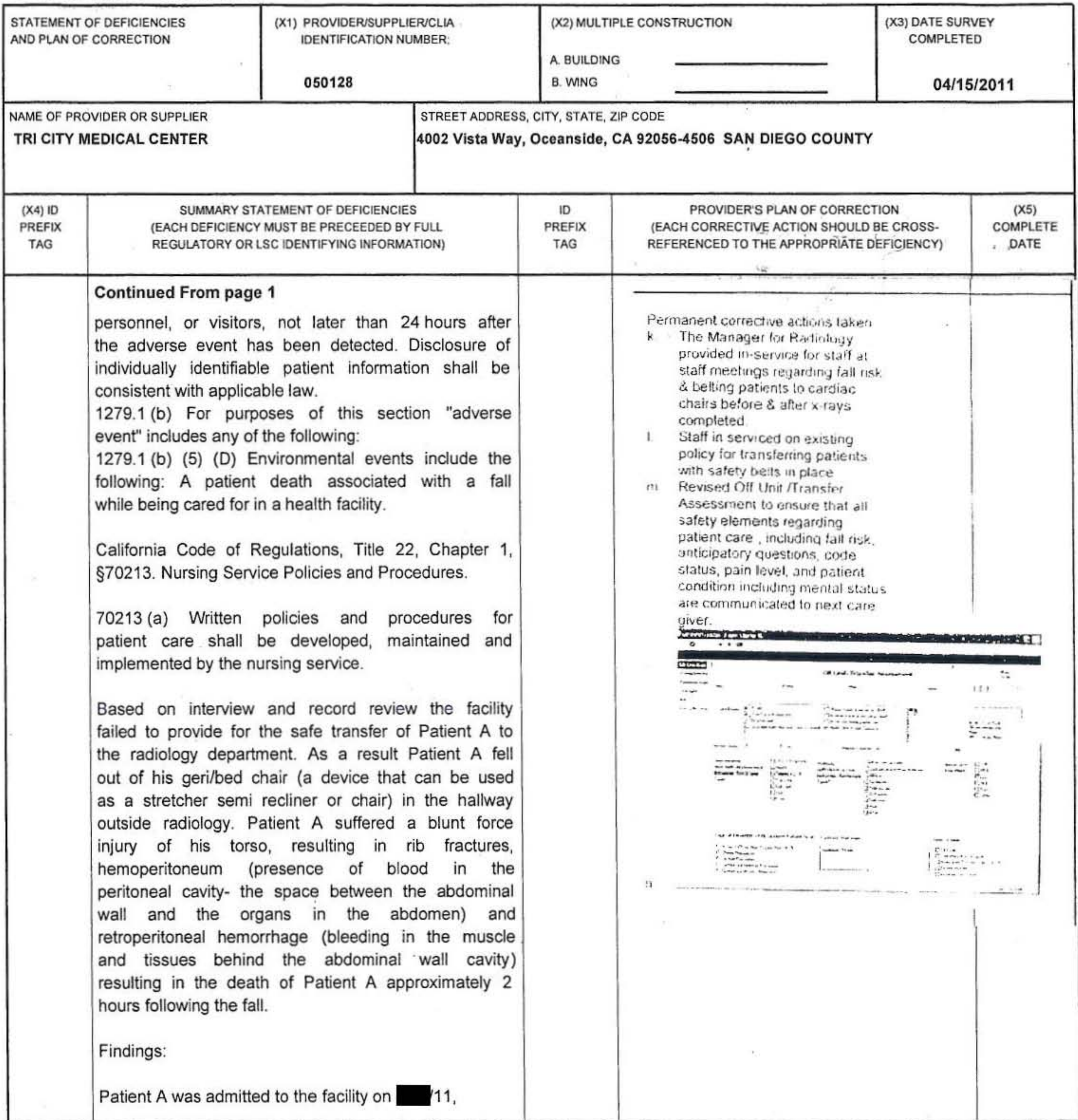

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personnel, or visitors, not later than 24 hours after the adverse event has been detected. Disclosure of individually identifiable patient information shall be consistent with applicable law.

1279.1 (b) For purposes of this section "adverse event" includes any of the following:

1279.1 (b) (5) (D) Environmental events include the following: A patient death associated with a fall while being cared for in a health facility.

California Code of Regulations, Title 22, Chapter 1, §70213. Nursing Service Policies and Procedures.

70213 (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service.

Based on interview and record review the facility failed to provide for the safe transfer of Patient A to the radiology department. As a result Patient A fell out of his geri/bed chair (a device that can be used as a stretcher semi recliner or chair) in the hallway outside radiology. Patient A suffered a blunt force injury of his torso, resulting in rib fractures, hemoperitoneum (presence of blood in the peritoneal cavity- the space between the abdominal wall and the organs in the abdomen) and retroperitoneal hemorrhage (bleeding in the muscle and tissues behind the abdominal wall cavity) resulting in the death of Patient A approximately 2 hours following the fall.

Findings:

Patient A was admitted to the facility on [redacted]/11,

Permanent corrective actions taken

k. The Manager for Radiology provided in-service for staff at staff meetings regarding fall risk & belting patients to cardiac chairs before & after x-rays completed.

l. Staff in serviced on existing policy for transferring patients with safety belts in place

m. Revised Off Unit /Transfer Assessment to ensure that all safety elements regarding patient care, including fall risk, anticipatory questions, code status, pain level, and patient condition including mental status are communicated to next care giver.

n.

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with diagnoses that included general weakness and cancer.

Upon admission and throughout his stay Patient A was assessed to be at high risk for falls. On [redacted]1, the physician ordered a shoulder X-Ray because Patient A was complaining of shoulder pain. According to administrative staff (interviewed on 4/15/11) the facility utilized either the transport team or the radiology staff to transport patients to and from radiology. On [redacted]11 the transport team was called for the transport of Patient A to radiology. According to administrative staff, nursing gives the transport team a report prior to leaving the floor. The transfer form utilized by nursing was reviewed. There was no documentation on the transfer form to indicate nursing staff gave report to the transport team. The transport team placed Patient A in a geri/bed chair. According to administrative staff the geri/bed chairs are supposed to have straps to support the patients, but this particular chair was strapless.

The radiologist technician (R 1) performing the shoulder X-Ray was interviewed on 4/15/11. According to R 1, he received Patient A in a seated position, without straps. Following the X-Ray, R 1 placed Patient A in the hallway for pickup by the transport team, with the back of the chair facing toward R1, making only the top of Patient A's head visible to R 1. R 1 stated that Patient A was restless, but R 1 assumed the patient was too weak to get out of the chair. A few moments later R 1 heard Patient A fall to the floor.

o. The process for patients waiting to be returned to their rooms following x-ray was re-educated. The patients are secured in cardiac chairs or gurneys, side rails up, and positioned so that staff can closely monitor to protect from falls.
p. The techs will document on transfer form "other" belt secured and side rails up.
q. The restraint policy was reviewed & revised to include "A restraint does not include devices, such as orthopedically prescribed devises, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm."
r. Responsible Person: Manager for Radiology
s. Completion Date: Implementation of revised policy on 4/29/2011. Board approval pending for May 2011.

2. Monitoring process to prevent recurrence:
   a. Random chart audit to review the transfer forms completed monthly.
   b. Completion Date: Ongoing & reported to Radiology Unit Specific monthly
   c. Responsible Person: Manager for Radiology
   d. Completion Date: Ongoing review.

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The PA (physician's assistant) responded to the fall, placed a neck brace on Patient A and ordered a stat (urgent or rush) CAT scan (Computerized Axial Tomography, a specialized X-Ray procedure) of the head, neck face and chest. The order was timed [redacted]11 at 3:35 p.m. The PA was interviewed on 6/15/11 at 2:00 p.m. According to the PA, she assessed Patient A following the fall. The PA stated Patient A complained of chest pain and was having a hard and painful time with breathing. The PA palpated Patient A's chest but did not view the chest because Patient A was wearing a gown. According to the PA, she reviewed the chart and noted that Patient A had thrombocytopenia (a disorder in which there is an abnormally low amount of platelets. Platelets are parts of the blood that help blood to clot. This condition is sometimes associated with abnormal bleeding), and ordered the cat scans. The PA stated that generally in these cases she does call the physician but could not recall specifically in this case if she had spoken with Patient A's physician (Physician X).

RN 1 obtained a verbal order from Physician X on [redacted]11 at 3:50 p.m., cancelling the CAT scan of the face and chest and proceeding with the head and neck cat scans. RN 1 was the RRT (rapid response team) nurse responding to the fall on [redacted]11. RN 1 was interviewed on 6/15/11 at 3:00 p.m. According to RN 1 she could not recall much of the incident, or why the CAT scan of the chest was cancelled. RN 1 stated she did not recall speaking to Physician X but knows she must have if she wrote a verbal order from him. RN 1's documentation of the fall was reviewed with

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administrative staff on 6/15/11. According to RN 1's documentation, Patient A was complaining of left chest and shoulder pain. RN 1 noted bruising to the anterior/inferior chest that did not appear fresh. The vital signs recorded at 3:35 p.m. were as follows: blood pressure of 72/51, heart rate of 110, respiratory rate of 24 and 99 % oxygen saturations on 3 liters of nasal cannula oxygen. RN 1 noted Patient A to be confused and very restless.

RN 2 (the nurse assuming care of Patient A following the CAT scan) was unavailable for interview. RN 2's documentation on [redacted]/11 and timed at 6:13 p.m. was reviewed with administrative staff on 6/15/11. According to RN 2's documentation, Patient A returned from radiology and Physician X was made aware of Patient A's condition at 1635 (4:35 p.m.), with a blood pressure of 81/63. The RRT nurse (RN 1) remained at bedside monitoring the patient. According to the documentation, Patient A's wife was at the bedside and realized her husband was weak and had a low blood pressure. According to the nurses notes, a narcotic was given in order to "ease his discomfort with respirations of 24 and periods of apnea (cessation of breathing), patient is a no code (do not resuscitate) with history of ca (cancer) of prostate with mets (metastatic/spreading cancer)".

At 5:30 p.m. on [redacted]11, RN 2 documented that Patient A appeared terminal, had agonal respirations (an abnormal pattern of breathing characterized by shallow, slow, irregular inspirations followed by irregular pauses and may also be characterized by gasping, labored

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breathing) pale color and "seems to be passing now".

Patient A was pronounced dead on [redacted]11 at 6:14 p.m.

Patient A's family requested an autopsy following Patient A's demise. According to the medical examiner's autopsy report dated [redacted]11 the cause of death was noted to be "Rib fractures, hemoperitoneum and retroperitoneal hemorrhage due to "Blunt force injury of torso" with a contributing factor being advanced metastatic prostate cancer. The manner of death was listed on the autopsy report as "accident".

The facility policy entitled Hand-Off Communication (last revised 9/9/11) was reviewed with administrative staff on 4/15/11. According to the policy, "A consistent method for patient hand-off communication shall be conducted throughout the organization during the following: Prior to and after transfer of care to another department for a procedure/test i.e. radiology..." The policy further stipulates, "...Nurse shall provide hand-off to the transporter". The policy entitled General Hospital Safety & Patient Management was also reviewed with administrative staff. According to the policy; "...Every patient should be secured with a belt while on a wheelchair, gurney or exam table..." The facility's policy and procedure related to falls also noted that even in low risk to fall patients the facility staff is to "Use safety measures in chairs and wheelchairs..."

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Patient A was assessed at a high risk to fall. Patient A was, transferred to radiology unsecured in a geri-bed chair. Following the x-ray, Patient A was left in the radiology hallway in a geri-bed chair, unsecured and unattended. Patient A fell out of the geri-bed chair onto the floor. Following the fall the PA documented that Patient A complained of trouble breathing and chest pain. The PA also recognized that Patient A had a history of thrombocytopenia making the patient at risk for bleeding. The PA ordered a CAT scan of the patient's chest which was cancelled. Patient A continued to complain of chest pain, displayed signs of respiratory distress, hypotension and finally agonal breathing. Patient A died at 6:14 p.m., just 2 hours after the fall.

The facility failed to ensure that staff followed their policy and procedures: 1. No evidence that nursing staff conducted a communication handoff to the transport team prior the Patient A's transfer from the floor to the radiology department which would have reinforced that Patient A was at high risk for falls, 2. Transporting of Patient A, in a geri-bed chair that did not have the straps to secure the patient to the chair. The facility's failure to follow their policy and procedures by not implementing fall precautions for a patient with high risk for falling is a deficiency that has caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of the Health and Safety code Section 1280.1 (c).

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