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
	050077	A. BUILDING _____ B. WING _____	05/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scripps Mercy Hospital	**4077 5th Ave, San Diego, CA 92103-2105 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: CA00397967 - Substantiated Representing the Department of Public Health: Surveyor ID # 22930, 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: 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. The hospital was comprised of two campuses, Hospital A refers to the central campus and Hospital B refers to the north campus. Health and Safety Code Adverse Event: 1279.1. (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, 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.		RECEIVED NOV 2 2015 SAN DIEGO DISTRICT OFFICE SOUTH **70213 Nursing Service Policies and Procedures** **70215 Planning and Implementing Patient Care** **Plan of Correction:** Patient Care Process Responsible Person: Chief Nurse & Operations Executive Action: On 05/27/2014, utilizing a rapid cycle improvement methodology, a task force was formed and met to develop corrective action plans. Members included patient care directors, director of Psychiatric Liaison Team (PLT), Chief Nurse and Operations Executive, clinical informatics nurse specialist, psychiatric clinical nurse specialist, clinical nurse educator, the director of patient safety and the director of quality. The findings addressed included initial assessment and reassessment processes for suicidal patients (and relevant documentation requirements) admitted to the medical surgical units from the ED.	

Event ID:T9ZQ11 9/28/2015 7:54:10AM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Kathy Seny TITLE Director, Risk (X6) DATE 10-29-15

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 22

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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	(b) For purposes of this section, "adverse event" includes any of the following: (3) Patient protection events including the following: (C) A patient suicide or attempted suicide resulting in serious disability while being cared for in a health facility due to patient actions after admission to the health facility, excluding deaths resulting from self-inflicted injuries that were the reason for admission to the health facility. 1279.1 (c) The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made. 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 and Safety Code Section 1280.3 (a) Commencing on the effective date of the regulations adopted pursuant to this section, the director may assess an administrative penalty against a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 for a deficiency constituting an immediate jeopardy violation as determined by the department up to a maximum of seventy-five thousand dollars ($75,000) for the first administrative penalty, up to one hundred thousand dollars ($100,00) for the second subsequent administrative penalty, and up to one hundred twenty-five thousand dollars ($125,000) for the third and every subsequent violation. (g) For purposes of this section, "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of		The task force reviewed and revised the then current policy titled Suicidal Patients in the Acute Care Setting. A literature search along with assessment of the community hospital practices was the framework used for revision. In addition, Supplemental Standards of Practice for the Suicide Patient in the acute care setting were developed to assist the RN staff in performing assessments, reassessments and development of a care plan. The PLT developed a template for the RN to use when a suicidal patient is first admitted to the acute care hospital setting to assist with the initial suicide assessment process. The RN will use the template to assist in the initial suicide assessment and involve the patient in answering the identified questions. The RN will place a telephone call to the PLT. PLT will respond within thirty minutes with a return telephone call and review the patient responses. The PLT will provide guidance to the RN in implementing the Suicidal Patient, Supplemental Standards of Practice; individualizing the plan of care; and/or communicating pertinent information to the psychiatrist/ attending physician. These documents were reviewed and approved by the Chief Nurse Operations Executive and the Chief of the Medical staff on 06/17/2014.	

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	licensure has caused, or is likely to cause, serious injury or death to the patient. California Code of Regulations: 70954. Determining the Initial Penalty for Each Violation (a) An initial penalty shall be determined for each deficiency, considering the nature, scope and severity of the deficiency by using the matrix set forth in subdivision (d). (b) Severity of the deficiency. (c) Scope of the noncompliance. (d) The matrix set forth in this subdivision shall be used to determine the initial penalty for a deficiency by selecting a penalty percentage from the range provided in the matrix cell that corresponds to the appropriate scope of noncompliance and the severity of harm categories. The percentages in each cell of the following matrix shall be applied to the maximum administrative penalty as set forth in Health and Safety Code section 1280.3: (1) $25,000 for any deficiency that does not constitute an immediate jeopardy, (2) $75,000 for the first deficiency constituting an immediate jeopardy, (3) $100,000 for the second deficiency constituting an immediate jeopardy, and (4) $125,000 for the third deficiency and every subsequent deficiency constituting an immediate jeopardy. An immediate jeopardy penalty shall be considered a first administrative penalty if the date the violation occurred is over three years from the date of violation of the last issued immediate jeopardy penalty, the hospital has not received additional immediate jeopardy violations, and the department		On 06/18/2014 the Medical Executive Committee approved the Policy: Suicidal Patients in the Acute Care Setting, Suicidal Patient, Supplemental Standards of Practice, and the PLT – RN Telephone Triage Consultation Template. On 06/18/2014, the task force met and determined that the revised process would be implemented on 06/23/2014. On 06/19/2014 the mandatory education for RNs and PLTs was finalized. On 06/22/2014, in-service education on the revised assessment/reassessment process was shared with the Charge Nurses. Formal, mandatory education was distributed to all Registered Nurses and Psychiatric Liaison Team staff via the Learning Management System. Staff have 30 days to complete the mandatory LMS. Completion rates of the mandatory education will be reported to nursing leadership on a weekly basis. Monitoring: Scripps Mercy Hospitals Quality Department will continue to monitor the care provided to SI patients and the elements of this plan of correction by auditing a minimum of 30 SI medical/ surgical patients per month using the attached modified audit tool.	

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	finds that the hospital has been in substantial compliance for over the three years prior to the date of the violation that is the subject of the penalty calculation. Title 22 Regulation 70213 Nursing Service Policies and Procedures (d) Policies and procedures that require consistency and continuity in patient care, incorporating the nursing process and the medical treatment plan, shall be developed and implemented in cooperation with the medical treatment staff. 70215 Planning and Implementing Patient Care (b) The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission. The above regulation was NOT MET as evidenced by: Based on observation, interview, record and document review, Hospital A failed to ensure that its policies and procedures pertaining to their patient care process, critical clinical and team communication, chain of command, risk assessments, and patient's rights were implemented. There was no documented evidence to demonstrate that necessary interventions were implemented to address immediate safety needs		Compliance rates will be reported monthly to the Quality Assurance and Performance Improvement Committee (QAPIC), where data trends will be tracked and analyzed. Ongoing process or performance improvements will be monitored and/or revised to ensure compliance with stated action plan. Adjustments to the frequency and scope of audits will be made under the direction of QAPIC. **Critical Communication/Chain of Command** Responsible Person: Chief Nursing & Operations Executive Action: On 06/19/2014, the task force was re- formed and met to develop corrective action plans. Members included patient care directors, Chief Nurse and Operations Executive, clinical informatics nurse specialist, psychiatric clinical nurse specialist, clinical nurse educator, the director of patient safety and the director of quality. The task force reviewed and revised the then current policy titled "Critical Clinical and Team Communication" This policy was approved by the Chief Nurse Operations Executive on 06/20/2014. On 06/20/2014 the revised policy would be implemented on 06/23/2014.	

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	for Patient 1, who was admitted after an attempted suicide, upon the identification of the patient's auditory hallucinations (a profound distortion in a person's perception of reality, hearing voices or sounds) during an initial admission nursing assessment. Registered Nurses (RNs) also failed to ensure that the attending physician was informed of Patient 1's active auditory hallucinations, use of psychotropic (used to treat psychiatric conditions) medications prior to the admission and psychiatrist information. In addition, there was no documented evidence to demonstrate that consistent room and environmental risk assessments had been performed in the medical-surgical units for the care and management of psychiatric patients who required medical clearance prior to their admission to the Behavioral Health Unit (BHU- a locked unit that cared for patients with a mental illness). As a result of these failures, Patient 1 jumped off his bed, through a 1/4 inch glass pane window, falling approximately sixty feet down to his death onto the fourth floor rooftop. Findings: On 5/12/14 at 12:15 P.M., a record review and investigation was initiated at Hospital A after the hospital reported a Sentinel Event (SE, an unexpected occurrence involving death or serious physical disability, or the risk thereof, not related to the natural course of the patient's illness or underlying condition) to the CDPH. Per the report dated 5/12/14, a patient (Patient 1) with self-inflicted stab wounds to the chest was brought in as a major trauma on 5/11/14. Per the same		On 06/20/2014, the mandatory education for RNs and PLTs was amended to include a review of the handoff process. On 06/22/2014, in-service education on the revised "Critical Clinical and Team Communication policy was shared with the Charge Nurses. Formal, mandatory education was distributed to all Registered Nurses and Psychiatric Liaison Team staff via the Learning Management System. Staff has 30 days to complete the mandatory LMS. Completion rates of the mandatory education will be reported to nursing leadership on a weekly basis. Monitoring: Scripps Mercy Hospitals Quality Department will continue to monitor the care provided to SI patients and the elements of this plan of correction by auditing a minimum of 30 SI medical/ surgical patients per month using the attached modified audit tool. Compliance rates will be reported monthly to the Quality Assurance and Performance Improvement Committee (QAPIC), where data trends will be tracked and analyzed. Ongoing process or performance improvements will be monitored and/or revised to ensure compliance with stated action plan. Adjustments to the frequency and scope of audits will be made under the direction of QAPIC.	

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	report, Patient 1 had a left-sided hemothorax (a collection of blood in the space between the chest wall and the lung; common cause is chest trauma) and required a chest tube (is a hollow, flexible tube in the chest; it acts like a drain; to drain blood, fluid or air from around the lungs to allow the lungs to fully expand) placement. Patient 1 was admitted to the hospital's 10th floor (trauma/medical-surgical unit) under 1:1 (one-to-one) constant observation (staff member physically placed in room with patient to provide continuous observation). According to the same report, at approximately 9:15 P.M., Patient 1 was noted to suddenly launch himself off his bed, through and out the window, landing approximately sixty feet down on the fourth floor rooftop. Patient 1 was pronounced dead at 9:25 P.M. on the rooftop. Patient 1 was admitted to Hospital A's trauma bay on 5/11/14 at 3:02 P.M. per the Face sheet. According to a History and Physical (H&P) dated 5/11/14, Patient 1 was admitted due to self-inflicted stab wounds to the chest and a superficial neck laceration (cut). According to the same H&P, Patient 1 had been having psychiatric issues (mental health conditions or disorders that affect mood, thinking and behavior) all day. Per the Trauma Resuscitation Flow Sheet Nurse's Notes, dated 5/11/14 at 4:45 P.M., Patient 1 contracted for safety and denied desires to harm self. Per the same Notes, Patient 1 "... states he was hearing voices that told him his mother was killed" and that he did not want to live by himself. On 5/11/14 at 5:30 P.M., Patient 1 was transferred to the 10th		**Environmental Risk Assessment** Responsible Person: VP, Chief Operations Executive Action: On 05/12/2014, immediate mitigation strategies were put in place, which included an evaluation of floors, rooms, and bed locations. Evaluation criteria used were identifying the lowest floors possible, rooms furthest from the elevators/ stairwells, bed locations furthest from the window (bed #1 position) and foot of the bed closer to the door than the head of bed due to the positioning of the Constant Observer. The determination was made that the CO is to be positioned at the foot of the bed to provide maximum ability to intervene with a patient attempting to breach the window or the door. The determination was also made to place portable privacy curtains in front of the windows to provide a visual and actual deterrent to easy access through the window. Operations Supervisors, Charge Nurses and Patient Logistics Center were educated on the immediate changes put in place. On 05/20/2014, the hospital initiated a further environmental safety analysis of existing medical- surgical patient rooms utilizing the behavioral health environmental standards to identify possible room safety enhancements for the SI or attempted suicide patient population.	

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	floor with stable vital signs and on oxygen therapy via nasal cannula. Per the H&P dated 5/11/14, Patient 1 required a left chest tube, daily chest x-rays, a suicide watch (continuous monitoring of a patient for any signs and symptoms of hurting oneself) placement and a psychiatric evaluation to be conducted by the psychiatrist (Physician 1) on 5/12/14. The H&P also documented that Patient 1 was previously seen at Hospital B's Emergency Department (ED) in January 2014 for auditory hallucinations. A review of Patient 1's ED Record at Hospital B in January 2014 was conducted. Patient 1 arrived to the ED with a chief complaint of "hearing voices". According to the ED Record, dated 1/19/14, Patient 1's mother expressed that she was worried about Patient 1. Patient 1's mother stated that the patient was "paranoid" (paranoia - being suspicious, having illusions about being followed or persecuted, or about being afraid or distrustful of others) and was hearing voices. Patient 1's mother also stated that the patient "sometimes runs out of the house in a dangerous fashion" and that was why she was concerned for Patient 1's safety. Patient 1 was evaluated by the PET (psychiatric emergency treatment - a hospital service that provides immediate initial evaluation and treatment to mentally ill patients) team for medications at Hospital B. Per the Psychiatric Liaison (PLT - is a hospital-based psychiatric assessment team with clinicians providing onsite consultation and evaluation services) Note, dated 1/19/14 at 9:05 A.M., it was unclear at that time whether Patient 1 was exhibiting prodromal psychotic (to describe a		These enhancements would be implemented in designated rooms on designated units, based on the most appropriate placement of suicidal patients requiring medical- surgical care. An analysis of which units should be utilized for attempted suicide and SI patients was made, based on patient acuity, level of care and clinical needs, along with the total # of rooms needed. The environmental assessment included the Safety Officer, Sr. Director Facilities/ Support Operations, Director Risk Management, Advance Practice Nurse Behavioral Health, Chief of Staff, VP Chief Operations Executive, and Medical-Surgical Unit Directors. The team utilized a set of eighty six environmental safety elements to be evaluated for applicability to a medical- surgical unit and risk scoring of likelihood of occurrence X consequence of occurrence. The hospital is in the process of safety product evaluation. Cost estimates, purchase orders, implementation and ongoing monitoring of room modifications are beyond the time scope of this plan of correction, however are being tracked through Quality Council. On 05/27/2014, utilizing a rapid cycle improvement methodology, a task force was formed and met to develop corrective	

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	specific group of symptoms that may precede the onset of a mental illness) symptoms or if his symptoms were related to his sleep deprivation. Patient 1 was given a prescription to help him sleep. Patient 1 denied suicidal or homicidal ideation (SI - thoughts/plans to kill self and HI - thoughts/plans to kill others) and visual hallucinations (a sensory experience involving sight of something that does not exist). Patient 1's mother was given an outpatient referral and encouraged to follow up if the paranoia and psychosis (an abnormal condition of the mind) were present after the patient was rested. Patient 1 was discharged home with 5 capsules of Trazadone (a medication that causes sleepiness and can help with anxiety) 50 mg (milligrams) to use for sleep as needed. A list of clinics for psychiatric follow up was discussed with Patient 1's mother. During an interview with the Director of Quality and Risk Management (DQRM) on 5/12/14 at 2:30 P.M., the DQRM acknowledged that Patient 1 was placed in a semi-private room with two beds. She acknowledged that, in hindsight, keeping an unoccupied bed in the room had not been necessary. Per the DQRM, because there were two beds in the room and the available space in the room, Patient 1's bed was placed closer to the window. On 5/13/14 at 4:07 P.M., an observation of Patient 1's room located on a medical-surgical unit was conducted with the DQRM, 10th floor Nurse Manager (RN 5) and the Nursing Director of Trauma (NDOT). Per the DQRM, Patient 1's room was		action plans. Members included patient care directors, director of Psychiatric Liaison Team (PLT), Chief Nurse and Operations Executive, clinical informatics nurse specialist, psychiatric clinical nurse specialist, clinical nurse educator, the director of patient safety and the director of quality. The findings addressed included the role the RN has in ensuring the patient care rooms that suicidal patients occupied in the medical surgical areas met specified safety requirements. The task force reviewed and revised the then current policy titled Suicidal Patients in the Acute Care Setting, specifically "Room Preparation for Placement of the Suicidal Patient- Attachment A was developed. This policy was reviewed and approved by the Chief Nurse Operations Executive and the Chief of the Medical staff on 06/17/2014. On 06/18/2014, the Medical Executive Committee approved the Policy: Suicidal Patients in the Acute Care Setting. On 06/18/2014, the task force met and determined that the revised process would be implemented on June 23, 2014. On 06/19/2014, the mandatory education modules for RNs and PLTs and Constant Observers were finalized.	

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	untouched since the patient's suicide. There was an unoccupied bed in the room. Patient 1's bed was placed 2 1/2 feet from four breakable windowpanes. The broken windowpane was made of glass that was 1/4 inch thick. In addition, the room was also 15 feet away from a stairway exit. The stairway exit had an unlocked door that was accessible to any patient who wanted to evade or leave the hospital to hurt oneself. The following medical device and tubing were noted in the room: a nasal cannula tubing that was partially coiled and hanging on an oxygen flowmeter. An interview with Registered Nurse (RN 1) was conducted on 5/14/14 at 8:55 A.M. RN 1 stated that she was Patient 1's primary nurse on 5/11/14 day shift (7:00 A.M. to 7:30 P.M.). She stated that Patient 1 arrived and was admitted to the 10th floor with oxygen therapy via nasal cannula. Per RN 1's medical record entry, Patient 1 arrived to the unit at 5:30 P.M. RN 1 stated that during the handoff report (the transfer of patient information between two RNs during transitions in care across the continuum) on 5/11/14 (shortly after the patient's arrival to the unit), in the presence of the trauma nurse (RN 2), Patient 1 informed them both that, on that morning when he woke up, he heard voices telling him that his mother was dead. Per RN 1, Patient 1 shared that since he was the only child, he did not want to live without his mother. RN 1 explained that RN 2 at that point was able to contact Patient 1's mother who was alive and on her way to the hospital. Patient 1 was informed and was able to speak with his mother. After RN 2 left, RN 1 proceeded to perform Patient 1's initial		On 06/22/2014 in-service education on the revised assessment/reassessment process was shared with the Charge Nurses. Formal, mandatory education was distributed to all Registered Nurses and Psychiatric Liaison Team staff via the Learning Management System. Staff have 30 days to complete the mandatory LMS. Completion rates of the mandatory education will be reported to nursing leadership on a weekly basis. Monitoring: Scripps Mercy Hospitals Quality Department will continue to monitor the care provided to SI patients and the elements of this plan of correction by auditing a minimum of 30 SI medical/ surgical patients per month using the attached modified audit tool. Compliance rates will be reported monthly to the Quality Assurance and Performance Improvement Committee (QAPIC), where data trends will be tracked and analyzed. Ongoing process or performance improvements will be monitored and/or revised to ensure compliance with stated action plan. Adjustments to the frequency and scope of audits will be made under the direction of QAPIC. On 05/16/2014, Scripps Mercy Hospitals Quality Department developed a CO Process Error Reduction Plan to measure	

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	admission assessment. She asked Patient 1 if he was still hearing voices and he replied "yes". Patient 1 reported that the voices were telling him the same thing, that his mom was dead. RN 1 stated that she reminded Patient 1 that he had just spoken to his mother, who was well and on her way to the hospital. RN 1 explained that she asked Patient 1 again, if he wanted to hurt himself and he replied no, because he knew that his mom was okay. Per RN 1, Patient 1's mother arrived to the hospital on 5/11/14 at 6:45 P.M. Patient 1's mother expressed her concerns and provided additional information about Patient 1 to RN 1. According to Patient 1's mother, Patient 1 needed to stay in the hospital for 2-3 months, she expressed that three days was not enough. Patient 1's mother provided RN 1 with a business card of Patient 1's psychiatrist. Per the patient's mother, Patient 1 was taking psychotropic (any medication capable of affecting the mind, emotions, and behavior) medications, Zyprexa (an antipsychotic medication used to treat conditions when the patient's grasp of reality is distorted, limited or lost) and Trazodone to treat his psychiatric illness. RN 1 stated that she completed the hospital's medication reconciliation (a process of comparing a patient's medication orders to all the medication that the patient has been taking; this reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or drug interactions) form and faxed it to the pharmacy. She did not report the following to Patient 1's attending physician (Physician 2): the patient's self-report of actively hearing voices during the initial admission assessment, the new		compliance with the immediate mitigation strategies. The CO Process Error Reduction Plan consists of three levels of QA to ensure all elements are in place. Level 1 is managing the SI patient at the unit level and as close to the bedside, by having the charge RN manage each element of the plan. Level 2 is a twice a day check by the Operations Supervisor (OS) who checks that the SI patient has a trained CO and was placed in a designated room. The OS emails out this list of SI/ Legal Hold patients to nursing leadership at approximately 7am and 7pm. Level 3 involves nursing leadership rounding to monitor both Level 1 and Level 2 are occurring. Additionally, environmental safety rounds are completed semiannually to include elements of room and unit safety for suicidal patients. Summary findings will be reported to the Safety Committee up through the Medical Staff Quality Council. **Patient Right to Care in a Safe Setting** Responsible Person: VP, Chief Operations Executive Action: On 05/12/2014, immediate mitigation strategies were put in place, which included an evaluation of floors, rooms, and bed locations. Evaluation criteria used were identifying the lowest floors possible, rooms furthest from the	

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	050077	A. BUILDING _____ B. WING _____	05/23/2014

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	information received from the patient's mother regarding the patient's psychiatrist; and the psychotropic medications (Zyprexa and Trazodone) that the patient was on (his last dose taken on 5/10/14 at bedtime). According to Patient 1's medical record, written plans of care pertaining to patient safety and psychosocial needs were not developed until 14 hours after the patient's suicide. Written plans of care contained and described necessary interventions to address the safety and psychosocial needs of a suicidal patient with a psychiatric illness. The primary nurse (RN 1) did not determine the urgency or importance of developing a plan of care to address Patient 1's psychiatric status and safety needs; therefore, preventative actions and interventions were not in place. An interview with Physician 2 was conducted on 5/14/14 at 11:07 A.M. Physician 2 was Patient 1's trauma attending. Physician 2 conducted Patient 1's initial medical assessment in the trauma unit on 5/11/14. Physician 2 stated that he had received report from the paramedics who brought Patient 1 into the trauma unit. Per the paramedic report, Patient 1 had "psychiatric issues all day". Physician 2 explained that Patient 1 had a history. He reviewed a record of Patient 1's ED admission at Hospital B in January 2014. He stated that he was aware that Patient 1 had a new onset of auditory hallucinations and had an outpatient follow up 4 months ago. Physician 2 stated that he spoke with Physician 1 (the psychiatrist consulted		elevators/ stairwells, bed locations furthest from the window (bed #1 position) and foot of the bed closer to the door than the head of bed due to the positioning of the Constant Observer. The determination was made that the CO is to be positioned at the foot of the bed to provide maximum ability to intervene with a patient attempting to breach the window or the door. The determination was also made to place portable privacy curtains in front of the windows to provide a visual and actual deterrent to easy access through the window. Operations Supervisors, Charge Nurses and Patient Logistics Center were educated on the immediate changes put in place. On 05/20/2014, the hospital initiated a further environmental safety analysis of existing medical- surgical patient rooms utilizing the behavioral health environmental standards to identify possible room safety enhancements for the SI or attempted suicide patient population. These enhancements would be implemented in designated rooms on designated units, based on the most appropriate placement of suicidal patients requiring medical- surgical care. An analysis of which units should be utilized for attempted suicide and SI patients was made, based on patient acuity, level of care and clinical needs, along with the total # of rooms needed.	

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	in the care of Patient 1) on 5/11/14, who agreed to place the patient on a 5150 hold (a means by which someone who is in serious need of mental health treatment can be transported to a designated psychiatric inpatient facility for evaluation and treatment for up to 72 hours against their will), a psychiatric evaluation by Physician 1 in the morning, and the placement of sitter for Patient 1. Physician 2 stated that he was unaware that Patient 1 had actively heard voices (auditory hallucinations) during the hospitalization. He also stated that he did not know that Patient 1 had been on Zyprexa and Trazodone. He also was not made aware that Patient 1 had been seeing a psychiatrist. He stated that Patient 1's nurses had not communicated any of these new assessment findings to him. He acknowledged that there was room for improvement in terms of communication. During this interview, Physician 2 described his own "personal frustrations" that the medical-surgical unit was not as equipped as the BHU to address the needs of patients with "florid psychological problems". He stated that the physical environment on the medical-surgical unit did not have the same safety adaptations as the BHU. The BHU's physical environment and safety features were discussed during an initial meeting with the administrative staff on 5/13/14 at 2:30 P.M. The administrative staff explained that in the BHU, the windows had a metal mesh. The BHU was a locked unit to the outside. BHU patients had no access to elevators or stairwells. During an earlier observation of Patient 1's room with the DQRM on		The environmental assessment included the Safety Officer, Sr. Director Facilities/ Support Operations, Director Risk Management, Advance Practice Nurse Behavioral Health, Chief of Staff, VP Chief Operations Executive, and Medical-Surgical Unit Directors. The team utilized a set of eighty six environmental safety elements to be evaluated for applicability to a medical- surgical unit and risk scoring of likelihood of occurrence X consequence of occurrence. The hospital is in the process of safety product evaluation. Cost estimates, purchase orders, implementation and ongoing monitoring of room modifications are beyond the time scope of this plan of correction, however are being tracked through Quality Council. On 05/27/2014, utilizing a rapid cycle improvement methodology, a task force was formed and met to develop corrective action plans. Members included patient care directors, director of Psychiatric Liaison Team (PLT), Chief Nurse and Operations Executive, clinical informatics nurse specialist, psychiatric clinical nurse specialist, clinical nurse educator, the director of patient safety and the director of quality. The findings addressed included the role the RN has in ensuring the patient care	

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	5/13/14, Patient 1's room was on a medical-surgical unit that was not a locked unit. On the medical-surgical unit, patients had access to elevators and stairwells. The windows were breakable and had no metal mesh. An interview with a psychiatric liaison team (PLT) member (RN 4) was conducted on 5/15/14 at 2:00 P.M. RN 4 explained that the admission of a psychiatric patient with active psychosis meant placement in the hospital's Behavioral Health Unit (BHU) unless the patient required medical clearance. Depending on the medical needs of the patient, the patient may be placed in the Emergency Department or another unit of the hospital such as the medical-surgical unit until medical clearance was obtained per RN 4. An interview with Physician 1, the psychiatrist consulted in the care of Patient 1, was conducted on 5/14/14 at 1:02 P.M. Physician 1 stated that his initial discussion with Physician 2 about Patient 1 did not include the patient's psychiatric history. He explained that he was scheduled to perform the patient's psychiatric evaluation on 5/12/14. He also stated that he expected to be notified by Physician 2 and his team (the nurses) if there was any new information or changes to Patient 1's psychiatric status. He explained that typically if the nurses identified or came across new information or changes to a patient's psychiatric status or condition, they would have informed Physician 2. He said that Physician 2 would make the decision to inform him.		rooms that suicidal patients occupied in the medical surgical areas met specified safety requirements. The task force reviewed and revised the then current policy titled Suicidal Patients in the Acute Care Setting, specifically "Room Preparation for Placement of the Suicidal Patient- Attachment A was developed. This policy was reviewed and approved by the Chief Nurse Operations Executive and the Chief of the Medical staff on 06/17/2014. On 06/18/2014, the Medical Executive Committee approved the Policy: Suicidal Patients in the Acute Care Setting. On 06/18/2014, the task force met and determined that the revised process would be implemented on June 23, 2014. On 06/19/2014, the mandatory education modules for RNs and PLTs and Constant Observers were finalized. On 06/22/2014 in-service education on the revised assessment/reassessment process was shared with the Charge Nurses. Formal, mandatory education was distributed to all Registered Nurses and Psychiatric Liaison Team staff via the Learning Management System. Staff have 30 days to complete the mandatory LMS. Completion rates of the mandatory	

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	An interview was conducted with RN 3 on 5/14/14 at 1:55 P.M. RN 3 stated that she was Patient 1's primary nurse for the night shift (7:00 P.M. to 7:30 A.M.) on 5/11/14. RN 3 stated that Patient 1 did not require oxygen therapy on her shift. She explained that at the beginning of her shift, she assessed Patient 1's room for "hazards" to ensure that only medically necessary items were left in the room to meet the patient's medical and safety needs. She defined "hazards" as items that can be used by the patient to hurt or harm oneself. RN 3 stated that she knew the following information about Patient 1: She stated that Patient 1 was on a 72 hour hold (also known as a 5150) because of his suicide attempt. She stated that Patient 1's suicide attempt was related to hearing voices. Per RN 3, a constant observer was placed in Patient 1's room. Patient 1 reported actively hearing voices during RN 1's initial admission assessment. Patient 1 was taking psychotropic medications, Zyprexa and Trazodone. Patient 1 had taken his last dose of both medications at home on 5/10/14. The nursing staff had received a business card of Patient 1's psychiatrist. Patient 1 had a physician's order for psychiatric evaluation. RN 3 stated that when she conducted her initial assessment of Patient 1, he denied having auditory hallucinations at that time. She stated that she had planned on providing Physician 2 (trauma/attending physician) with a status update on Patient 1 when the physician conducted his patient rounds on the unit that night. She stated that based on her initial assessment findings, all the patient information received from RN 1 during their shift handoff report on 5/11/14 from 7:00 P.M. -		education will be reported to nursing leadership on a weekly basis. Monitoring: Scripps Mercy Hospitals Quality Department will continue to monitor the care provided to SI patients and the elements of this plan of correction by auditing a minimum of 30 SI medical/ surgical patients per month using the attached modified audit tool. Compliance rates will be reported monthly to the Quality Assurance and Performance Improvement Committee (QAPIC), where data trends will be tracked and analyzed. Ongoing process or performance improvements will be monitored and/or revised to ensure compliance with stated action plan. Adjustments to the frequency and scope of audits will be made under the direction of QAPIC. On 05/16/2014, Scripps Mercy Hospitals Quality Department developed a CO Process Error Reduction Plan to measure compliance with the immediate mitigation strategies. The CO Process Error Reduction Plan consists of three levels of QA to ensure all elements are in place. Level 1 is managing the SI patient at the unit level and as close to the bedside, by having the charge RN manage each element of the plan. Level 2 is a twice a day check by the Operations Supervisor (OS) who checks that the SI patient has a	

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	7:30 P.M., and her nursing judgment, she did not determine an urgent need to call Patient 1's attending physician (Physician 2) to inform him of the patient's active auditory hallucinations during RN 1's initial admission assessment, the discovery of Patient 1's psychotropic medications, and information about the patient's psychiatrist. According to the hospital's policy titled "Patient Care Process: Assessment, Planning, Intervention and Evaluation", dated 9/9/13, the policy's purpose was to describe the components of, and identify responsibility for the implementation and documentation of the "Interdisciplinary Patient Care Process". Per the policy, the components of the care process include: assessment, planning, intervention, and evaluation of the identified care goals. Under procedures of the policy, an initial admission nursing assessment, as defined in standards for a specific setting, or patient population, was completed by the RN within established timeframes. Components of the initial admission assessment include a focused assessment, clinical examination, data collection and risk screens. Per the policy's focused assessment, "The RN assesses the immediate needs and safety of the patient and intervenes as necessary. Aspects of a focused assessment include but are not limited to: a. Introductions and patient verification process using two patient identifiers with identification armband in place b. Chief complaint/presentation c. Orientation of patient/family to environment and immediate safety needs.		trained CO and was placed in a designated room. The OS emails out this list of SI/ Legal Hold patients to nursing leadership at approximately 7am and 7pm. Level 3 involves nursing leadership rounding to monitor both Level 1 and Level 2 are occurring. Additionally, environmental safety rounds are completed semiannually to include elements of room and unit safety for suicidal patients. Summary findings will be reported to the Safety Committee up through the Medical Staff Quality Council.	

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	d. Hurting self or others (suicide/violence)" Per the same policy, on the medical-surgical unit, a focused assessment was to be completed within 1 hour of admission. Patient 1 was admitted to the medical-surgical unit at 5:30 P.M. There was no documented evidence to demonstrate that at 6:30 P.M. (one hour after admission) the nursing staff had implemented any necessary safety interventions when Patient 1's auditory hallucinations were identified. Per the policy's focused assessment, "The RN assesses the immediate needs and safety of the patient and intervenes as necessary...." Patient 1 was admitted after an attempted suicide and was actively hearing voices during an initial admission assessment (focused assessment). There was no documented evidence that immediate safety needs were addressed, safety interventions implemented and communication with Physician 2, Patient 1's attending physician was conducted, in an effort to ensure that a safe environment was provided to Patient 1. According to the hospital's policy titled "Critical Clinical and Team Communication", dated 2/2013, the policy's purpose was to identify and communicate expectations used for critical clinical and team communication. Per the policy, a hand off report was required "...When critical communication is required to update another care provider about a patient situation/condition." In addition, the policy indicated that "Staff are encouraged to use the critical communication interventions outlined" within the policy. The policy			

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	defined communication as "the exchange of information between a sender and a receiver." Per the same policy under timely (a critical communication intervention), it indicated that "Information sharing is prompt, especially when there is potential to compromise a patient's situation...." Per the hospital's policy titled "Chain of Command", dated 7/2013, the policy's purpose was to provide the hospital and medical staff with a framework for communication and issue resolution. Under the "Chain of Command Flow Chart - For Medical Management" of the policy, it indicated for patient issues, call the physician. An interview with certified nursing assistant (CNA 1), who was the constant observer assigned to Patient 1, was conducted on 5/14/14 at 3:10 P.M. CNA 1 stated that he was Patient 1's constant observer on 5/11/14 from 7:00 P.M. to 7:00 A.M. He stated that he was sitting on the left side of the patient towards the head of the bed and about an arm's length from Patient 1 (his chair placed between the patient and the door). He recalled that the patient's mother was sitting in a chair on the right side of Patient 1's bed by the window, holding the patient's hand. The mother's chair was between Patient 1's bed and the breakable windows. According to CNA 1, the patient's mother was in the room at the start of his shift and had left the room three times. Per CNA 1, shortly after Patient 1's mother had left the room (third time, exact time unknown), Patient 1 was observed using his cellular phone when he suddenly, and without			

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	warning, said "hey man", stood up on his bed, jumped up (shoulder first), hit and went through the glass window. CNA 1 immediately ran out of the room to call for help. He stated that he went to the nurse's station and informed RN 3 of what had happened to Patient 1. He explained that he was responsible for ensuring that the patient was safe, constantly observing the patient and reporting to the patient's primary nurse any patient concerns or needs. According to the hospital's policy titled "Risk Assessment Program, Environment of Care", dated 9/2012, the policy's purpose was to outline the environment of care risk assessment program which entailed the following: A) "To routinely evaluate the impact of the buildings, grounds, equipment, occupants, and internal physical systems on patient and public safety. B) This program is designed to reduce the likelihood of an event detrimental to the hospital through determining areas at risk and taking action to minimize the potential for the event happening. C) The level of safety compliance will be monitored to identify situations that detract from the goal of providing a safe and secure environment for patients, employees, medical staff and visitors. Inherent in our monitoring is the obligation to take corrective action when a problem is detected and to provide follow-up to corrective actions taken."			

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	Per the same policy, the Safety Officer and the Environmental Health and Safety Committee had overall responsibility for maintaining the risk assessment program and conducting the risk assessments. An interview and joint document review with the Safety Officer was conducted on 5/22/14 at 10:45 A.M. The Safety Officer stated that the hospital-wide risk assessment was performed every fiscal year, usually in October. The hospital-wide risk assessment for the fiscal year 2014 was completed in October 2013. There was no documented evidence to demonstrate that room and environmental risk assessments had been performed for the care and management of attempted suicide or SI patients on the medical-surgical units. The Safety Officer stated that, prior to the suicide on 5/11/14, the hospital had not conducted a comprehensive risk assessment of the rooms and physical environment on the medical-surgical units which mirrored what they assessed for in the care and management of BHU patients in the BHU. There was no documented evidence to demonstrate that consistent room and environmental risk assessments had been performed in the medical-surgical units for the care and management of psychiatric patients who required medical clearance prior to their admission to the BHU. The Safety Officer stated that he was one of many who performed and completed the hospital-wide risk assessment which helped the hospital identify safety concerns in effort to mitigate risks and provide a safe environment for all.			

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	An interview and joint record review with the 10th floor Nurse Manager (RN 5) was conducted on 5/22/14 at 2:30 P.M. She stated that her nursing judgment would have been to call Patient 1's physician (Physician 2) to inform him of the assessment findings related to the auditory hallucinations, the discovery of antipsychotic medications used at home, Zyprexa and Trazodone (the last dose was taken on 5/10/14), and the information about the patient's psychiatrist. She stated that she would have notified the physician as soon as the findings were discovered. She stated that by communicating the findings to the physician, it allowed the physician an opportunity to determine whether or not he wanted to continue the administration of the antipsychotic medications, and/or make changes to the plan of care. She acknowledged that the nursing staff did not communicate their new assessment findings related to Patient 1's psychiatric history and status to the physician, in an effort to ensure that all members of Patient 1's interdisciplinary team were informed to meet all his medical and psychosocial needs. Per RN 4, the nursing staff was expected to include in their initial and shift assessments that a safety check of the patient's room had been performed to ensure that a safe environment was provided to the patient. RN 4 stated that when Patient 1's nasal cannula and need for oxygen therapy was discontinued, the nasal cannula and all its tubing attachments should have been removed from Patient 1's room. Failure to consistently perform room and			

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	comprehensive physical environment risk assessments impeded the hospital's ability to identify safety concerns to mitigate risks in an effort to provide care in a safe setting. Unnecessary medical furniture and tubing were found in Patient 1's room. The lack of removing unnecessary medical furniture prevented the hospital from determining optimal placement of an attempted suicide or a suicide ideation patient. Unnecessary medical tubing can be hazardous for attempted suicide or SI patients, as this item could potentially be used as a weapon or an opportunity to hurt oneself. According to the hospital's policy titled "Access to [Hospital name] Care and Services, Patient Rights and Responsibilities", dated 8/1/13, its purpose was "To establish a policy addressing non-discrimination and the rights and responsibilities of all patients receiving care and services at a [Hospital name] facility." Per the policy, the hospital recognized that each patient was an individual with unique healthcare needs. The hospital was committed to observing and promoting Patient Rights and Responsibilities. According to Attachment A of this policy with a title that read "Patient Rights and Responsibilities, Approved Model Content", dated 5/2013, it stipulated that "As a patient, you have the right to: ...13. Receive care in a safe setting...." On 5/23/14 at 4:15 P.M., the Corporate Senior Director of Patient Safety (SDPS), the DQRM, Interim CNOE, the DOPS, Physician 1, the CMD and the CEO were informed of the potential for an			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Scripps Mercy Hospital	**4077 5th Ave, San Diego, CA 92103-2105 SAN DIEGO COUNTY**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
	Administrative Penalty to be issued as a result of these violations. 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).			