



STATE OF WASHINGTON  
DEPARTMENT OF HEALTH  
Olympia, Washington 98504

RE: **Seattle Children's Hospital**  
Investigation #: **K09011**  
Document: **Statement of Deficiencies and Plan of Correction**

Regarding your request for information about the above-named facility, certain information may have been withheld pursuant to Washington state laws. While those laws require that most records be disclosed on request, they also state that certain information should not be disclosed.

The following information has been withheld: **NONE**

You may appeal the decision to withhold any information by writing to the Privacy Officer, Department of Health, P.O. Box 47890, Olympia, WA 98504-7890.

If you have any questions or need an additional Public Disclosure request, please contact:

Public Disclosure & Records Center  
P.O. Box 47865  
Olympia, WA 98504-7865  
Phone: (360) 236-4836  
Fax: (360) 586-2171  
EMAIL: [PDRC@DOH.WA.GOV](mailto:PDRC@DOH.WA.GOV)



January 20, 2011

Mary Wood, MN, BSN, RN  
Department of Health  
20435 72<sup>nd</sup> Ave. South, Suite 200  
Kent, Washington 98032

**Re: SCH Statement of Deficiencies (SOD)**

Dear Ms. Wood:

Thank you for the opportunity to respond to your letter and the Department of Health (DOH) Statement of Deficiencies (SOD) dated January 10, 2011. As explained in the attached Plan of Correction (POC), Seattle Children's Hospital (SCH) has taken a number of actions designed to address the DOH's concerns. These actions include policy review and revision, as needed, education, improvements in the supervisory structure and process, and monitoring to ensure continued compliance with DOH requirements.

While we have implemented, and will continue to implement, our plan of correction, we disagree with several of the DOH surveyors' findings. Specifically:

1. The SOD appears to imply, perhaps inadvertently, that SCH was responsible for the care of patients at sending/referring hospitals. As DOH knows, this is not correct. While SCH operates a transport service, Medicare Conditions of Participation and other applicable laws place the responsibility for the patient's care and treatment on the hospital where the patient is located.
2. The hospital disagrees with DOH's statement that the lack of clear written guidelines describing the SCH's transport team's processes and responsibilities may have contributed to Patient #1's death, and the statement that lack of a clearly defined RN supervisory structure led to confusion with negative outcomes for patients. The King County medical examiner has determined that this patient died of natural causes. Neither SCH transport guidelines nor our supervisory structure contributed to this patient's death.
3. The hospital has a supervisory structure in place for its ground transport nurses. These nurses are evaluated and supervised by SCH's NICU nurse manager, not a respiratory therapist, as alleged in the SOD.

Mary Wood, MN, BSN, RN

January 20, 2011

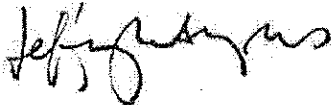
Page 2

4. SCH acknowledges that transport service policies, procedures, supervision, training and education require improvement consistent with the SOD. However, we want to note for the record that many of the surveyors' primary concerns resulted from the actions of a single SCH nurse, who acted inappropriately and failed to comply with the hospital's established policies and procedures. This nurse's actions are not in any way indicative of the care that we normally provide. To the contrary, SCH is committed to compliance with applicable laws, regulations, and administrative standards.

While we do not intend to formally appeal the above findings at this time, we do wish to document our disagreement as part of the hospital's plan of correction.

Thank you for your review of the hospital's submission. If you have any questions regarding the hospital's plan of correction, please contact me or Susan Heath, RN, MN, Chief Nursing Officer.

Sincerely,



Jeffrey M. Sconyers  
Senior Vice President and General Counsel

Enclosure: Plan of Correction

Washington State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>000008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/19/2010</b>
NAME OF PROVIDER OR SUPPLIER <b>SEATTLE CHILDREN'S HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>4800 SAND POINT WAY NE/BOX C-5371 SEATTLE, WA 98105</b>		
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B 000	WAC 246-320-111 Initial Comments  This State hospital complaint investigation survey was conducted on September 30 and October 1, 4, 5, 7, 13, and 21; November 4, 12 and 19; December 1, 2, 3, 6, 7 and 8, 2010, by Mary Wood, MN, BSN, RN, in response to complaint #149848.  Shell #K09011	B 000		
B 160	WAC 246-320-131 Governance-Authenticated Orders  The governing authority must: (4) Require written or electronic orders, authenticated by a legally authorized practitioner, for all drugs, intravenous solutions, blood, medical treatments, and nutrition;  This WAC is not met as evidenced by: Based on review of medical records and interviews with hospital personnel, it was determined that the hospital failed to ensure that drugs and biologicals were administered upon the documented and signed order of a legally authorized practitioner, for all drugs, intravenous solutions, blood, medical treatments, nutrition and respiratory therapy for 12 of 12 patient records reviewed.  The hospital's failure to ensure authentication of physician orders placed all patients at risk for receiving care and services which were not what the ordering physician had intended, or not receiving care and services which were what the ordering physician intended, with the potential for harm as a consequence.  Findings include:	B 160	Tag B160  How:  1. The hospital reviewed and revised its verbal and telephone order policy to improve ease, clarity and efficiency of use.  2. The hospital re-educated ground transport staff and physicians on its verbal and telephone order policy. Following education each of these individuals signed an attestation that they had read, understood and agreed to comply with the policy. In addition, the hospital will provide targeted education on the hospital's requirement to authenticate physician orders and the clarification process for unclear or incomplete physician orders.	

By signing, I understand these findings and agree to correct as noted:

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

*Jeffrey S. [Signature]*

TITLE

Senior Vice President

(X6) DATE

Jan. 20 2011

Washington State Department of Health

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B 160	<p>Continued From Page 1</p> <p>Records of 12 patients who had received services from the Seattle Children's Hospital (SCH) transport service in September, 2010. The records were selected for review from a list of 28 patients who the hospital reported as having received transport services in September, 2010. Included in the review was the medical record of Patient #1, who was identified in the complaint.</p> <p>All 12 records were reviewed for evidence that a physician had authenticated the orders, as evidenced by her/his signature on the medical record. Medical records were also reviewed for evidence that medications and biologicals were administered per physicians' orders. The review revealed that 12 of 12 records reviewed did not have authenticated physician orders, as evidenced by the signature of the ordering physician, as required by Washington State Law and by the hospital's own policy "Telephone/Verbal/Electronic Messaging Orders".</p> <p>Patient #1: Nursing notes documented that the patient received epinephrine [a drug used to regulate heart rate], morphine [a pain reliever], ativan [an anti-anxiety medication] and vecuronium [a paralytic] while still at the sending hospital. An internal investigation by SCH had determined, prior to the Department of Health investigation, that the RN #1 had administered the morphine, ativan and vecuronium without a physician's order.</p> <p>The RN documented that epinephrine was administered. No physician orders were evident in the medical record for the administration of the epinephrine, and it is not clear from the medical record if a physician at the sending hospital or a physician from SCH ordered the epinephrine.</p>	B 160	<p>3. The Ground Transport Team has redesigned the transport documentation forms to improve ease of authentication by:</p> <ol style="list-style-type: none"> <li>providing visual cues about where the physician is to authenticate; and</li> <li>creating a section for physician orders that is distinct from the plan of care, assessment or intervention sections of the documentation.</li> </ol> <p>4. Physicians will receive education on the proper use of new documentation/ authentication tools.</p> <p><b>Who:</b></p> <p>Medical Director of Ground Transport for new documentation tools and physician education; Transport Program Manager for staff education and monitoring process.</p> <p><b>What:</b></p> <ol style="list-style-type: none"> <li>The hospital will monitor 100% of charts for physician authentication for three months. At the end of three months, the results will be provided to the hospital's Quality Improvement Steering Committee, which will increase or decrease monitoring as needed.</li> </ol>	

By signing, I understand these findings and agree to correct as noted:

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B 160	<p>Continued From Page 2</p> <p>Intravenous (IV) fluids were also documented as given to the patient.</p> <p>In addition, the medical record documented that Patient #1 was on a ventilator and had received manual "bagging" during the resuscitation throughout the transfer process and subsequent resuscitation effort.</p> <p>No verbal orders were authenticated for the medications, the IV fluids or the ventilator settings.</p> <p>Patient #2: The patient's medical record revealed that IV fluids were established at the sending hospital and reportedly continued while under the care of the SCH teammate medical record also documented that the patient received phenobarbital while under the care of the SCH team.</p> <p>No physician verbal orders were authenticated.</p> <p>Patient #3: The patient's medical record documented that IV fluids, with added trophamine [an amino acid] had been established by the sending hospital. The established IV fluids and medication additive were reportedly continued while the patient was under the care of the SCH transport team.</p> <p>No authenticated physician verbal orders were evident.</p> <p>Patient #4: Review of the patient's medical record indicated that the patient had IV fluids established at the sending hospital. The SCH plan of care indicated that the patient was to receive the same IV fluids,</p>	B 160	<p>2. The hospital will identify charts that have not been signed within 48 hours and follow-up with the ordering physician to obtain the necessary authentication in accordance with hospital policy.</p> <p>When:</p> <ol style="list-style-type: none"> <li>1. Policy revision 11/10/10.</li> <li>2. Re-education and attestation completed in October, 2010. Targeted education will be completed by 1/31/11.</li> <li>3. As of 1/13/11, the new transport documentation tools have been designed and piloted, with suggestions from staff for improvement incorporated. Final version of new documentation tool to be completed 1/31/11.</li> <li>4. Physician education to occur week of 2/5/11 with full implementation of new documentation /authentication tools to occur week of 2/14/11.</li> <li>5. Chart audits for MD authentication initiated 1/17/11.</li> <li>6. 48 hour identification process initiated 1/31/11.</li> </ol>	

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B 160	<p>Continued From Page 3</p> <p>with an additive of trophamine [an amino acid].</p> <p>No authenticated physician verbal orders were evident in the medical record.</p> <p><b>Patient #5:</b> The patient's medical record revealed that the patient had had IV fluids established at the sending hospital. The SCH plan of care indicated that the patient was to receive the same IV fluids, at the rate of "80 cc/kg/D".</p> <p>The plan of care also stated that the SCH team was to "cont. amp &amp; gent" [ampicillin and gentamicin, both antibiotics], the dosage was not specified.</p> <p>The medical record documented that both antibiotics had been given at the sending hospital on the previous day; however, there was no documentation that the antibiotics had been administered at the sending hospital since the previous day.</p> <p>No authenticated physician verbal orders were in the medical record.</p> <p><b>Patient #6</b> Review of the patient's medical record revealed that IV fluids, with trophamine, had been established at the sending hospital. The dose was continued, and increased, while the patient was under the care of the SCH transport team. The medical record also documented that the patient received "PGE 0.03 mcg/kg/min (mcg/ml)" [unknown drug/nutrient] while under the care of the SCH transport team.</p> <p>No authenticated physician verbal orders were in the medical record.</p> <p><b>Patient #7:</b></p>	B 160		

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B 160	<p>Continued From Page 4</p> <p>The patient's medical record documented that the patient had IV fluids established at the sending hospital. While under the care of the SCH transport team, the IV fluids were continued, along with dopamine [a medication used to regulate heart rate and blood pressure]. The patient also received "NS" [normal saline] and "all" [unknown].</p> <p>The SCH plan of care revealed that the physician had ordered "TF = 80cal/Kg/D [tube feeding] as well as "continue amp &amp; gent". The medical record documented that the patient had received ampicillin and gentamycin [antibiotics] at the sending hospital. Documentation indicated that the antibiotics had been administered as one-time doses, and were not being administered as a continuing dose.</p> <p>No authenticated physician orders were evident for the IV fluids, the dopamine, the tube feeding or the 2 antibiotics.</p> <p>Patient #8: The medical record documented that the sending hospital established IV fluids, and indicated that the fluids had been continued while under the care of the SCH transport team.</p> <p>The medical record also documented the administration of ampicillin and gentamycin, both antibiotics, both administered while the patient was under the care of the SCH transport team. The medical record also documented that the patient received sodium acetate [a salt solution] and Survanta [a surfactant administered intra-tracheally] at the time the SCH transport team arrived. It is not clear who administered the sodium acetate or Survanta, or whether those were one-time doses.</p>	B 160		

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B 160	<p>Continued From Page 5</p> <p>The physician's verbal order was for "ampicillin, gentamicin...0.1mg/kg morphine, PRN, agitation".</p> <p>No clarification of the incomplete orders was found on the record, and no authenticated physician verbal orders were on the medical record.</p> <p>The patient was also on a ventilator during the transport process. No authenticated physician's verbal orders were found on the record for the ventilator settings.</p> <p>Patient #9: The patient had IV fluids and parenteral nutrition established at the sending hospital and reportedly continued while under the care of the SCH transport team. The patient also received insulin intravenously. The physician's orders on the plan of care noted that the patient had received ampicillin, gentamicin, and flagyl [an antibiotic] while at the sending hospital, but the medication record did not document that those medications had been administered by the sending hospital.</p> <p>No authenticated physician's verbal orders were on the medical record relative to the fluids and parenteral nutrition which were administered while the patient was under the care of the SCH transport team.</p> <p>Patient #10: Review of the medical record revealed that the patient had IV fluids established at the sending hospital. The fluids were reportedly continued while the patient was under the care of the SCH transport team.</p> <p>No authenticated physician verbal orders were</p>	B 160		

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B 160	<p>Continued From Page 6</p> <p>on the medical record.</p> <p><b>Patient #11:</b> Review of the patient's medical record revealed that the patient had IV fluids and lipids [fat for nutrition] established at the sending hospital, both reportedly continued while under the care of the SCH transport team. The patient also received heparin [used to prevent blood clots] and fentanyl [pain medication] while under the care of the SCH transport team.</p> <p>No authenticated physician verbal orders were found for any of the fluids, the lipids or for the heparin and fentanyl.</p> <p><b>Patient #12:</b> The patient's medical record revealed that the patient had IV fluids established at the sending hospital. The medical record also documented that the patient had received clindamycin [antibiotic] IV while under the care of the SCH transport team. The physician's orders, as documented on the plan of care, stated that clindamycin was given at the sending hospital, and the patient was to receive ampicillin and gentamicin. No documentation was found in the record that the patient received ampicillin or gentamicin.</p> <p>No authenticated physician verbal orders were found in the record.</p> <p>The Senior Vice President/ Chief Nursing Officer (SVP/CNO) and the Registered Nurse (RN) liaison for transport services were interviewed and the issue of authentication was discussed. The SVP/CNO and the RN reviewed each of the 12 transport patient medical records and confirmed that none of the records contained evidence that the physician's verbal orders had</p>	B 160		

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B 160	Continued From Page 7  been authenticated.	B 160		
B 180	<p>WAC 246-320-136 Leadership-Patient Care Service</p> <p>The hospital leaders must: (2) Establish hospital-wide patient care services appropriate for the patients served and available resources which includes: (a) Approving department specific scope of services;</p> <p>This WAC is not met as evidenced by: Based on interview and review of hospital documents, it was determined that hospital leadership failed to establish hospital-wide patient care services appropriate for the patients served, including an approved department-specific scope of service for transport services. The hospital's failure to do so resulted in lack of clear, written guidelines for staff to ensure consistent and appropriate patient care processes, may have contributed to confusion around care and services for Patient #1, and potentially placed all patients of the transport team at risk for incomplete/inappropriate/inaccurate care and services.</p> <p>Findings include:  On 10/13/2010, a joint interview was held with the Senior Vice President for Patient Care Services/Chief Nursing Officer (SVP/CNO); the Medical Director of Emergency Department Services and Chief of Emergency Medicine; the acting NICU Nurse Educator; the Respiratory Therapist who was the Program Manager for transport services and the Medical Director for</p>	B 180	<p>Tag B 180</p> <p>How:</p> <ol style="list-style-type: none"> <li>The hospital disciplined the RN involved in the Ground Transport Case #1 and reported her to the State Board of Nursing. The nurse no longer provides care at the hospital.</li> <li>The hospital will implement a Ground Transport Scope of Services document that will:             <ol style="list-style-type: none"> <li>Define when the patient ceases to be the responsibility of the sending hospital and becomes the responsibility of the receiving hospital; and</li> <li>Define principles for roles during emergencies at referring hospitals.</li> </ol> </li> <li>The hospital will implement guidelines of care to accompany the Ground Transport Scope of Services that will address the issues identified by the surveyors for inclusion in written guidelines.</li> <li>The hospital will educate referring hospitals regarding its Scope of Services.</li> </ol>	

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B 180	<p>Continued From Page 8</p> <p>Transport Services. The group discussed multiple issues, including what practices and expectations were, and were not, in writing.</p> <p>Identified during the DOH investigation was a lack of written guidelines for transport staff to include:</p> <ul style="list-style-type: none"> <li>-At what time did the patient cease to be the responsibility of the sending hospital and become the responsibility of the transport team</li> <li>-While at the sending hospital, did the transport team communicate about patient care with the sending hospital physicians or the Medical Consultation (MedCon) physician at Seattle Children's Hospital (SCH) or both</li> <li>-How were communications between the MedCon physicians and the transport team staff members communicated to the physicians and staff at the sending hospital</li> <li>-In the event of an emergency while still at the sending hospital, what were the expectations around how, or if, the transport team would participate in the care of the patient</li> <li>-Were the transport team members allowed to accept orders, verbal or otherwise from the sending hospital's physicians and if so, how were those orders documented and authenticated</li> <li>-At what time, or under what circumstances, was the patient switched from the sending hospital's equipment to SCH equipment, such as ventilators, and how was that decision made and by whom</li> </ul> <p>The hospital's "Neonatal Emergency Patient Transport" document, which included the scope of practice, was reviewed as were the policies and procedures pertaining to transport services, which were provided by SCH. None of the documents addressed the above-noted issues and no other documents provided addressed the</p>	B 180	<p>5. The hospital will educate its ground transport staff and physicians on the new Scope of Service and guidelines and order sets.</p> <p>6. The hospital will seek referring hospital feedback on the effectiveness of the implementation of Scope of Services.</p> <p><b>Who:</b></p> <p>Medical Director of Ground Transport; Transport Program Manager accountable for Scope of Services and protocols; Director of ICU and Transport accountable to assure staff understanding and implementation of these tools. The Program Manager of Transport will provide oversight to the process of gathering referring hospital feedback.</p> <p><b>What:</b></p> <p>The hospital will measure effectiveness of implementation of the new Scope of Services tools as follows:</p> <p>1. The hospital has established a debrief process for staff to be completed after each transport. The hospital will add questions to obtain qualitative staff feedback on effectiveness of Scope of</p>	

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B 180	<p>Continued From Page 9</p> <p>above-identified issues.</p> <p>Patient #1</p> <p>Review of the medical record for Patient #1 revealed that on 9/17/2010, during the transport effort, RN #1 documented that s/he had administered epinephrine [a drug used to regulate heart rate], morphine [a pain reliever], ativan [an anti-anxiety medication] and vecuronium [a paralytic]. The medications were documented as administered to the patient while the patient and transport team were still at the sending hospital.</p> <p>Intravenous (IV) fluids were also documented as given to the patient, no authenticated physician's verbal orders were documented and it was not clear from the medical record who had given those orders.</p> <p>(An internal investigation by SCH, prior to the Department of Health investigation, had determined that RN #1 administered the morphine, ativan and vecuronium without a physician's order and falsified the medical record to indicate that such verbal orders had been received).</p> <p>The SCH RN #1 documented on the code sheet, which is a written record of events during a resuscitation effort, that s/he had also administered epinephrine. No physician orders were evident for the administration of the epinephrine, and it is not clear from the medical record if a physician at the sending hospital or a physician from SCH ordered the epinephrine; however, during the interview of 10/4/2010, the neonatologist at the sending hospital confirmed that s/he gave the orders for epinephrine.</p>	B 180	<p>Service and protocols to guide their interactions and services at referring hospitals.</p> <p>2. The hospital will create a process to survey referring hospitals on the services provided by Ground Transport Team, with specific questions focused on the clarity of roles.</p> <p>3. The feedback from these constituencies will be regularly reviewed, trended and used to improve education of staff and as part of our customer service outreach programs. These findings will also be incorporated into the Ground Transport QAPI program and reported through the hospital's QI structure.</p> <p><b>When:</b></p> <p>1. RN discipline and report actions completed 10/1/10.</p> <p>2. Scope of Services to be completed 2/28/11.</p> <p>3. Protocols to be completed 2/28/11.</p> <p>4. Referring hospital and transport staff education to be completed 2/28/11.</p>	

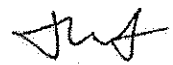
By signing, I understand these findings and agree to correct as noted:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>000008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/19/2010</b>
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B 180	<p>Continued From Page 10</p> <p>During the 10/4/2010 interview, the neonatologist at the sending/referring hospital stated that after the second dose of epinephrine was administered to the patient, s/he asked if the patient had received additional medications. The neonatologist stated that the SCH RN reported that s/he had administered 3 medications including vecuronium [a drug used to paralyze patients], and the neonatologist was "shocked".</p> <p>The neonatologist stated that the RN reported that s/he had administered vecuronium because the patient was agitated and s/he needed to re-tape the endotracheal tube. The physician stated that s/he asked the RN why s/he had given the vecuronium and the RN replied "it's in my power to give these meds".</p> <p>The sending neonatologist stated that s/he had stated to the SCH transport team that the endotracheal tube had been difficult to place and specifically directed that the tube should not be re-taped; however, the respiratory therapist reportedly told the neonatologist "that's our decision".</p> <p>The sending/referring neonatologist also stated that at one point, the SCH transport RN was on the phone with the MedCon physician; s/he asked for the phone to speak to the Med Con physician, but the RN was reluctant to relinquish the phone and finished her/his own conversation with the Med Con physician before allowing Neonatologist# 1 speak to the Med Con physician.</p> <p>Review of the medical record for Patient #1 revealed that RN#1 administered 4 medications to the patient. Three (3) medications were administered without an authenticated physician's order, and the fourth medication was</p>	B 180	<p>5. Debriefing process implemented 01/11. Questions added to debrief process by 2/28/11.</p> <p>6. Referring hospital survey process implemented by 2/28/11.</p>	

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B-180	<p>Continued From Page 11</p> <p>administered under the order of a physician from the sending/referring hospital. The code sheet also documented that the RN had contacted the SCH Med Con physician at least twice during the resuscitation effort.</p> <p>The SCH medical record documented other interventions, including ventilator adjustments and the initiation of cardiopulmonary resuscitation by the SCH transport team, while the patient and the SCH transport team were at the sending hospital.</p> <p>On 10/4/2010, a board-certified neonatologist, Neonatologist #1, and a Neonatal Intensive Care Nurse, both from the sending/referring hospital, were interviewed. Both stated that they had participated in the care of Patient #1, the patient who was identified in the complaint. The physician and the nurse both stated that they understood the patient to be the responsibility of the sending hospital, until the patient was removed from the premises by the transport team.</p> <p>On 11/4/2010, the SCH Therapist (RT) involved in the care of Patient #1 during the transport effort of 9/17/2010 was interviewed. The interview was conducted via telephone, and included in the call was the RT supervisor and the SVP/CNO. The RT was asked who had responsibility for care of the patient while the transport team was still in the sending/referring hospital. The RT stated that s/he was "...not 100% clear on that" and that "they've gone back and forth" regarding the issue.</p> <p>The RT was also asked how the SCH transport team knew when they were to assume care of the patient. The RT responded that s/he was "not real clear on that", but the team did communicate</p>	B 180		

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B 180	<p>Continued From Page 12</p> <p>with the sending hospital to try to "keep consistent with care" and that the Med Con physician was also contacted while the team was in the hospital.</p> <p>The RT was asked why the SCH transport team performed resuscitation efforts on the patient if the patient was supposed to be under the care of the sending hospital. S/he stated that, with the exception of the RN, the physician and staff of the sending hospital had left the room and had to be summoned back when the patient coded.</p> <p>S/he stated that RN and RT from the transport team began resuscitation and the sending/referring hospital physician had to be summoned back into the unit. When asked if the staff and physicians from the sending hospitals typically left during a transport effort, the RT stated that it differed with each hospital.</p> <p>On November 2, Neonatologist #2, was interviewed. The neonatologist stated that, although s/he had not been involved in the care of Patient #1, s/he had been told about the case. The neonatologist stated that s/he had concerns about "communications" between sending hospitals and the SCH transport team, but had not discussed her/his concerns with SCH leadership because up until the present, s/he had not believed that the issues rose to the level of being unsafe.</p> <p>When asked to describe what her/his concerns with the SCH transport team were, Neonatologist #2 stated that there seemed to be confusion about who could issue orders to the transport team, how the Med Con physician communicated with whatever physician was at the sending hospital and when the patient became the responsibility of the transport team.</p>	B 180		

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B 180	Continued From Page 13  Neonatologist #2 also stated that it was important to remember that not every sending/referring hospital had a neonatologist present, and that in some cases the care might be best managed by the Med Con physician who had the clinical expertise to manage the care, instead of by the physician who was physically present at the sending/referring hospital.  Neonatologist #2 stated that it was important that sending/referring hospitals and the transport team understand how to work collaboratively.  During the group discussion/interview of 10/13/2010 with SCH physicians and staff, it was also stated that the patient was the responsibility of the sending hospital until the patient was removed from the sending hospital by the SCH transport team.  Medical Consultation Physician Interviews On December 6, 2010, Med Con physician #1 was interviewed regarding who was responsible for care of patients while the patient was still at the sending/referring hospital, including giving orders for care and services. The physician stated that there was a "progressive assumption of care...collaboration..." and that the responsibility for care "may go back and forth".  On December 6, 2010, Med Con physician #2 was interviewed regarding who was responsible for care of patients while the patient was still at the sending/referring hospital, including giving orders for care and services. The physician stated that the process of defining who is responsible for patient care during the transport process was "evolving"; while the patient was still "their [SCH] patient" the Med Con physicians "can't override the onsite physician" and the SCH	B 180		

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B 180	<p>Continued From Page 14</p> <p>Med Con physician "wouldn't openly defy the local doc".</p> <p>S/he also stated that there was not conflict between the Med Con physician and the sending/referring physician if the sending/referring physician was a Neonatologist, with the exception of one Seattle Medical Center who was very competitive and "they do not defer to anyone".</p> <p>On December 6, 2010, Med Con physician #3 was interviewed regarding who was responsible for care of patients while the patient was still at the sending/referring hospital, including giving orders for care and services. When asked when and how it was determined that the patient became the responsibility of the transport team, the physician stated "once they're hooked up to our equipment, we should assume care". The physician stated that s/he had not seen written guidelines pertaining to the issue.</p> <p>On December 6, 2010, Med Con physician #4 was interviewed regarding who was responsible for care of patients while the patient was still at the sending/referring hospital, including giving orders for care and services. The physician stated "practically, it depends on the hospital...when the transport team arrives it's their baby practically speaking". The physician stated that the responsibility for care of the baby at various points in the transport process was not in writing.</p> <p>Medical Record Review Patient #1: Nursing notes documented that the patient received epinephrine [a drug used to regulate heart rate], morphine [a pain reliever], ativan [an anti-anxiety medication] and</p>	B 180		

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B 180	<p>Continued From Page 15</p> <p>vecuronium [a paralytic] while still at the sending hospital. An internal investigation by SCH had determined, prior to the Department of Health investigation, that the RN #1 had administered the morphine, ativan and vecuronium without a physician's order.</p> <p>The RN documented that epinephrine was administered. No physician orders were evident in the medical record for the administration of the epinephrine, and it is not clear from the medical record if a physician at the sending hospital or a physician from SCH ordered the epinephrine. Intravenous (IV) fluids were also documented as given to the patient.</p> <p>In addition, the medical record documented that Patient #1 was on a ventilator and had received manual "bagging" during the resuscitation throughout the transfer process and subsequent resuscitation effort.</p> <p>No verbal orders were authenticated for the medications or the IV fluids.</p> <p><b>Patient #2:</b> The patient's medical record revealed that IV fluids were established at the sending hospital and reportedly continued while under the care of the SCH teammate medical record also documented that the patient received phenobarbital while under the care of the SCH team.</p> <p>No physician verbal orders were authenticated.</p> <p><b>Patient #3:</b> The patient's medical record documented that IV fluids, with added trophamine [an amino acid] had been established by the sending hospital. The established IV fluids and medication additive</p>	B 180		

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B 180	<p><b>Continued From Page 16</b></p> <p>were reportedly continued while the patient was under the care of the SCH transport team.</p> <p>No authenticated physician verbal orders were evident.</p> <p><b>Patient #4:</b> Review of the patient's medical record indicated that the patient had IV fluids established at the sending hospital. The SCH plan of care indicated that the patient was to receive the same IV fluids, with an additive of trophamine [an amino acid].</p> <p>No authenticated physician verbal orders were evident in the medical record.</p> <p><b>Patient #5:</b> The patient's medical record revealed that the patient had had IV fluids established at the sending hospital. The SCH plan of care indicated that the patient was to receive the same IV fluids, at the rate of "80 cc/kg/D".</p> <p>The plan of care also stated that the SCH team was to "cont. amp &amp; gent" [ampicillin and gentamicin, both antibiotics], the dosage was not specified.</p> <p>The medical record documented that both antibiotics had been given at the sending hospital on the previous day; however, there was no documentation that the antibiotics had been administered at the sending hospital since the previous day.</p> <p>No authenticated physician verbal orders were in the medical record.</p> <p><b>Patient #6</b> Review of the patient's medical record revealed that IV fluids, with trophamine, had been established at the sending hospital. The dose</p>	B 180		

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B 180	<p>Continued From Page 17</p> <p>was continued, and increased, while the patient was under the care of the SCH transport team. The medical record also documented that the patient received "PGE 0.03 mcg/kg/min (mcg/ml)" [unknown drug/nutrient] while under the care of the SCH transport team.</p> <p>No authenticated physician verbal orders were in the medical record.</p> <p>Patient #7: The patient's medical record documented that the patient had IV fluids established at the sending hospital. While under the care of the SCH transport team, the IV fluids were continued, along with dopamine [a medication used to regulate heart rate and blood pressure]. The patient also received "NS" [normal saline] and "alt" [unknown].</p> <p>The SCH plan of care revealed that the physician had ordered "TF = 80cal/Kg/D [tube feeding] as well as "continue amp &amp; gent". The medical record documented that the patient had received ampicillin and gentamycin [antibiotics] at the sending hospital. Documentation indicated that the antibiotics had been administered as one-time doses, and were not being administered as a continuing dose.</p> <p>No authenticated physician orders were evident for the IV fluids, the dopamine, the tube feeding or the 2 antibiotics.</p> <p>Patient #8: The medical record documented that the sending hospital established IV fluids, and indicated that the fluids had been continued while under the care of the SCH transport team.</p> <p>The medical record also documented the</p>	B 180		

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B 180	<p>Continued From Page 18</p> <p>administration of ampicillin and gentamicin, both antibiotics, both administered while the patient was under the care of the SCH transport team. The medical record also documented that the patient received sodium acetate [a salt solution] and Survanta [a surfactant administered intra-tracheally] at the time the SCH transport team arrived. It is not clear who administered the sodium acetate or Survanta, or whether those were one-time doses.</p> <p>The physician's verbal order was for "ampicillin, gentamicin...0.1mg/kg morphine, PRN, agitation".</p> <p>No clarification of the incomplete orders was found on the record, and no authenticated physician verbal orders were on the medical record.</p> <p>Patient #9: The patient had IV fluids and parenteral nutrition established at the sending hospital and reportedly continued while under the care of the SCH transport team. The patient also received insulin intravenously. The physician's orders on the plan of care noted that the patient had received ampicillin, gentamicin, and flagyl [an antibiotic] while at the sending hospital, but the medication record did not document that those medications had been administered by the sending hospital.</p> <p>No authenticated physician's verbal orders were on the medical record relative to the fluids and parenteral nutrition which were administered while the patient was under the care of the SCH transport team.</p> <p>Patient #10:</p>	B 180		

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B 180	<p>Continued From Page 19</p> <p>Review of the medical record revealed that the patient had IV fluids established at the sending hospital. The fluids were reportedly continued while the patient was under the care of the SCH transport team.</p> <p>No authenticated physician verbal orders were on the medical record.</p> <p>Patient #11: Review of the patient's medical record revealed that the patient had IV fluids and lipids [fat for nutrition] established at the sending hospital, both reportedly continued while under the care of the SCH transport team. The patient also received heparin [used to prevent blood clots] and fentanyl [pain medication] while under the care of the SCH transport team.</p> <p>No authenticated physician verbal orders were found for any of the fluids, the lipids or for the heparin and fentanyl.</p> <p>Patient #12: The patient's medical record revealed that the patient had IV fluids established at the sending hospital. The medical record also documented that the patient had received clindamycin [antibiotic] IV while under the care of the SCH transport team. The physician's orders, as documented on the plan of care, stated that clindamycin was given at the sending hospital, and the patient was to receive ampicillin and gentamicin. No documentation was found in the record that the patient received ampicillin or gentamicin.</p> <p>No authenticated physician verbal orders were found in the record.</p> <p>The Senior Vice President/ Chief Nursing Officer</p>	B 180		

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B 180	Continued From Page 20  (SVP/CNO) and the Registered Nurse (RN#9) liaison for transport services were interviewed and the issue of authentication was discussed. The SVP/CNO and the RN reviewed each of the 12 transport patient medical records and confirmed that none of the records contained evidence that the physician's verbal orders had been authenticated.  Documentation of the transport effort of 9/17/2010 illustrated a lack of clarity regarding scope of responsibility, scope of care, lines of communication and how teams from both hospitals were supposed to interact during an emergency.  The lack of clear written guidelines describing SCH transport team processes and responsibilities may have contributed to confusion regarding the care of Patient #1, while the patient was still at the sending hospital, which may potentially have contributed to the death of the patient.  Reference citation written under Tag 0160 - Governance, Authenticated Orders Reference citation written under Tag 0620 - Human Resource Management, Staff Supervision Reference citation written under Tag 0750 - Information Management, Patient Records Accuracy	B 180		
B 620	WAC 246-320-156 Human Resource Mgmt-Staff Supervision  Hospitals must (4) Assure supervision of staff;	B 620	Tag B 620  How:  1. The hospital has always had a reporting structure in which the NICU Nurse Manager supervises all ground transport RNs. However, the hospital	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>000008</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/19/2010</b>
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B 620	<p>Continued From Page 21</p> <p>This WAC is not met as evidenced by: Based on interview and review of hospital documents, it was determined that the hospital failed to ensure that a registered nurse (RN) provided supervision to all RNs who provided transport services. The hospital's failure to provide direct observation or supervision to RNs who provided transport services, while the RNs were providing transport services, resulted in confusion for the transport nurses and in the potential for RN practice that was not consistent with hospital policy, procedure and expectations, with subsequent negative outcomes for patients.</p> <p>Findings include:</p> <p><b>Patient #1</b> Neonatologist #1, a physician at the sending/referring hospital, stated on 10/4/2010 that s/he had provided medical care to Patient #1. The physician stated that s/he was called to the "code" [cardiopulmonary arrest] by the Neonatal Nurse at the sending/referring hospital. At that time, the patient had been under the care of the transport team for approximately 70 minutes.</p> <p>Neonatologist #1 stated that the patient had a good airway, but it had been a difficult intubation; s/he stated that s/he gave explicit instructions to the transport team to not lose the airway [let the endotracheal tube become dislodged] and to not attempt to re-tape the airway tube.</p> <p>The after the second dose of epinephrine [a drug to regulate heart rate] had been given, Neonatologist #1 stated that s/he asked the SCH transport nurse if the baby had received any medications other than the epinephrine. The physician stated that the RN reported that s/he had administered 3 medications, including ativan</p>	B 620	<p>will improve its supervisory structure by hiring a Ground Transport Nurse Manager who will serve as the new supervisor for the ground transport RNs. The Ground Transport Nurse Manager will be responsible for initial and ongoing ground transport RN competency and supervision. The Ground Transport Nurse Manager will be accountable, in partnership with the Ground Transport Medical Director, in assuring accurate administration of the Scope of Services and the associated protocols. The Ground Transport Nurse Manager will partner with other ground transport leaders to lead quality assurance and performance improvement activities in ground transport.</p> <p><b>Who:</b></p> <p>Director of ICU/Transport for hiring of new Ground Transport Nurse Manager; Nurse Manager of Ground Transport responsible for monitoring of competencies and audits.</p> <p><b>What:</b></p> <p>1. Audit will be conducted to assess staff ability to identify their RN supervisor and the role of this individual.</p>	

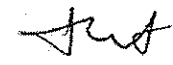
By signing, I understand these findings and agree to correct as noted:

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B 620	<p>Continued From Page 22</p> <p>[an anti-anxiety medication], morphine [a pain reliever] and vecuronium [ a paralytic].</p> <p>The physician stated that s/he was "shocked", and clarified with the transport RN that the patient had been given vecuronium. When asked why the patient had been given the vecuronium, the transport RN reportedly stated "it's within my power to give these meds". The RN reportedly stated that the patient had been agitated and s/he retaped the airway to prevent the airway from being dislodged.</p> <p>The Neonatal Nurse at the sending/referring hospital also was interviewed on 10/4/2010 and stated that s/he had also observed the patient. The Nurse stated that s/he had not observed any thrashing of the patient, and believed that the airway tube was secure. The Nurse stated that s/he questioned the transport nurse about what medications s/he was giving and why, and the transport RN reportedly stated "because it's in my power to do so..."</p> <p>On 11/4, a phone interview was conducted with respiratory therapist (RT) #1, who was on the transport team that cared for Patient #1. The RT stated that Neonatologist #2 "made it clear" that it was a difficult intubation and clearly said "do not lose the airway". The RT stated that s/he was not comfortable with how secure the airway was taped, and that while the tube may have been secure in the eyes of the sending/referring hospital team, s/he was not sure the tube would be secure with transport "in a bumpy ambulance". The RT stated that s/he did not re-tape the airway tube, but held the tube in place by hand.</p> <p>RT# 1 stated that s/he knew RN# 1 was going to administered medications but did not observe the</p>	B 620	<p>2. Regular trending of ground transport staff competencies will occur. Results of these assessments, in addition to feedback from referring hospitals and staff debrief information, will be used to improve the ground transport educational programs.</p> <p>3. The results will be reviewed as part of the hospital's QAPI program.</p> <p>When:</p> <p>1. Ground Transport Nurse Manager position has been posted. Nurse Manager will be hired or interim manager appointed by 2/28/11.</p> <p>2. Audits and related trending initiated 2/28/11.</p>	

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B 620	Continued From Page 23  administration of the medications. The RT stated that RN #1 said the patient needed to be sedated because the patient was agitated, and the RT stated s/he also observed the patient to be agitated.  Emergency Medical Technician (EMT) #1 was also interviewed about her/his observations during the transport team's efforts at the sending/referring hospital. The EMT stated that s/he retrieved the medications and needles from the "box" for the RN to administer. The EMT stated that the RN appeared to feel that administering the medications was within her/his scope of practice and s/he believed that the RN had "standing orders". The EMT stated that the RN told Neonatologist #2 that giving the medications was within her/his scope of practice.  Review of the patient's medical record and interview with physicians and staff at the sending/referring and receiving hospitals revealed that the resuscitation efforts were eventually discontinued and the patient died while still at the sending/referring hospital.  Neonatologist #1 stated that her/his main concerns with the actions of the transport team RN were: -the advice of the physician at the sending/referring hospital "was not respected" -the RN was on the phone with the Med Con physician during the code and would not relinquish the phone to the Neonatologist at the sending/referring hospital -disregarded the orders of Neonatologist #1  Neonatologist #1 stated that whenever possible, s/he chose to use a transport team other than that of SCH because the other transport team had medical personnel on the team and that	B 620		

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B 620	<p>Continued From Page 24</p> <p>team worked quickly and collaboratively with the sending/referring hospital and the SCH team "just is not as professional".</p> <p>The Neonatologist also stated that the events that occurred with Patient #1 "wouldn't have happened with a more experienced and better trained staff"...and that, while the team was adequate in some circumstances, it was not comparable to those transport teams which had a fellow or attending physician on the team.</p> <p>Training and Supervision of Transport Team RNs</p> <p>On 10/13/2010, the Senior Vice President/Chief Nursing Officer (SVP/CNO) was interviewed about the supervision process for the RNs who worked on the hospital's transport team. The SVP/CNO stated that the RNs who provided transport services worked in the hospital's Neonatal Intensive Care Unit (NICU), and each shift had specific, specially-trained RNs assigned to transport services.</p> <p>S/he stated that the RNs were required to pass the NICU competencies as well as additional competencies for transport services. The SVP/CNO also stated that direct supervision of the RNs was accomplished by the supervision of practice that occurred in the NICU, as well as by observing the nurses during the verification of the nurse's skills, for example, performing intubations. The SVP/CNO confirmed that after the initial orientation period, direct supervision did not occur during actual transport services.</p> <p>On 10/13/2010, a joint interview was held with the SVP/CNO; the Medical Director of Emergency Department Services and Chief of Emergency Medicine; the acting NICU Nurse</p>	B 620		

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B 620	<p>Continued From Page 25</p> <p>Educator; the Respiratory Therapist who was the Program Manager for transport services and the Medical Director for Transport Services. Discussion involved multiple issues, and included how RNs who provide transport services are supervised in the field.</p> <p>When asked to describe how supervision of transport RNs was accomplished, the Program Manager, a Respiratory Therapist, stated that s/he provided first-line supervision to the RNs. Upon further discussion, the Program Manager acknowledged that supervising RN nursing practice was not within the scope of practice of a respiratory therapist and discussion was held regarding the Washington State Nurse Practice Act.</p> <p>During the conversation, the acting Nurse Educator stated that during the orientation process for the RNs, a "ride along" was done. When the RN felt able, and competencies had been verified, the RN then practiced independently without direct observation, including no supervision on an intermittent basis, while performing transport duties.</p> <p>The Medical Director for Transport Services stated that the hospital also provided continuing education and verification of competencies to assure nurse competency in the field. S/he also stated that the RNs had direct observation during orientation, as well as during their regularly-assigned work in the NICU.</p> <p>During the conversation, the investigator noted that RN practice in an unfamiliar environment, such as that of the sending/referring hospital, could be a different experience for the NICU RNs than practicing in the NICU in which the RN usually worked. Also noted was that practice</p>	B 620		

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B 620	<p>Continued From Page 26</p> <p>under what could be stressful and urgent conditions, such as an emergency during a transfer, might not necessarily reflect practice that was observed during observation of the RN in the NICU or in a skills laboratory setting.</p> <p>On 12/7/2010, an Emergency Medical Technician, who was one of the dedicated EMTs assigned to the transport team, stated that the nurses seemed to be out in the field without support and they "...don't have anyone to bounce things off of except the RTs [respiratory therapists]".</p> <p>Transport Nurse Interviews</p> <p>On December 2 and 3, 2010, transport team RNs #2 through #8 were interviewed and asked who their supervisor was while they were on the transport team and out in the field.</p> <p>The responses were:</p> <p>RN #2 stated that the Transport Program Services Manager (a respiratory therapist) was her/his supervisor, and that the NICU [Neonatal Intensive Care Unit] manager was her/his full-time supervisor.</p> <p>RN #3 stated that [the Director of the Intensive Care Units] was her/his supervisor while s/he was in the field on transports.</p> <p>RN #4 stated that Med Con was the supervisor for transport, but that there was no nursing supervisor.</p> <p>RN #5 stated that Med Con was the supervisor, but the nursing supervisor was [the Director of the Intensive Care Units].</p>	B 620		

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B 620	<p>Continued From Page 27</p> <p>RN #6 stated that Med Con was the supervisor. When asked who the nursing supervisor/contact was, the RN stated that there was no nursing supervisor for the RNs on transport, and that s/he followed the Med Con directions.</p> <p>RN #7 state that while on transports, s/he was accountable to Med Con, but there was no nursing supervisor.</p> <p>RN #8 stated that Med Con "directs care", and also named two other physicians who were on the "supervisor team". When asked who the nursing supervisor was, the RN stated that s/he did not know.</p> <p>Hospital Failure to Supervise Practice of Transport Team RNs Field Practice, Including Medication Administration</p> <p>All of the above RNs were also asked if it was their practice to administer medications and/or deliver treatments while in the field on transport, without a physician's order for same.</p> <p>The responses were: RN #2 stated that s/he did not administer medications without an order.</p> <p>RN #3 also stated that s/he did not administer medications without an order.</p> <p>RN #4 stated that s/he did not administer medications without an order, but had heard of other transport RNs who did so.</p> <p>RN #5 stated that s/he did not administer medications without an order.</p> <p>RN #6 stated that on 3 occasions s/he had given medications without an order, but believed that</p>	B 620		

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B 620	<p>Continued From Page 28</p> <p>under the conditions that were present, her/his actions had been appropriate. RN #6 stated that s/he had been told in orientation, that if a life-threatening situation was present, it was acceptable to give medications and get an order later.</p> <p>RN #7 stated that s/he had not given medications without an order. The RN, who was also identified as a transport team preceptor and as the preceptor for RN #1, stated that s/he did not know how any RN could have gotten the impression that it was acceptable for RNs to give medications without an order.</p> <p>RN #8 stated that s/he always called Med Con for orders, and did not know what other RNs did. S/he also stated that it "could be okay in emergency situations" to give medications without an order, and that it was "a given" that nurses could give medications in an emergency without orders. The RN stated that s/he thought it was written "in the guidelines", but was not sure where to find those guidelines.</p> <p>Washington State Nurse Practice Act</p> <p>The Washington State Nurse Practice states in part:</p> <p>WAC 246-840-700 Agency filings affecting this section &lt;registerfilling.aspx?cite=246-840-700&gt; Standards of nursing conduct or practice. (1) The purpose of defining standards of nursing conduct or practice through WAC 246-840-700 &lt;http://apps.leg.wa.gov/wac/default.aspx?cite=246-840-700&gt; and 246-840-710 &lt;http://apps.leg.wa.gov/wac/default.aspx?cite=246-840-710&gt; is to identify responsibilities of the professional registered nurse and the licensed</p>	B 620		

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B 620	Continued From Page 29  practical nurse in health care settings and as provided in the Nursing Practice Act, chapter 18.79 < <a href="http://apps.leg.wa.gov/RCW/default.aspx?cite=18.79">http://apps.leg.wa.gov/RCW/default.aspx?cite=18.79</a> > RCW. Violation of these standards may be grounds for disciplinary action under chapter 18.130 < <a href="http://apps.leg.wa.gov/RCW/default.aspx?cite=18.130">http://apps.leg.wa.gov/RCW/default.aspx?cite=18.130</a> > RCW. Each individual, upon entering the practice of nursing, assumes a measure of responsibility and public trust and the corresponding obligation to adhere to the professional and ethical standards of nursing practice. The nurse shall be responsible and accountable for the quality of nursing care given to clients. This responsibility cannot be avoided by accepting the orders or directions of another person. The standards of nursing conduct or practice include, but are not limited to the following;  (2) The nursing process is defined as a systematic problem solving approach to nursing care which has the goal of facilitating an optimal level of functioning and health for the client, recognizing diversity. It consists of a series of phases: Assessment and planning, Intervention and evaluation with each phase building upon the preceding phases.  (a) Registered Nurse: Minimum standards for registered nurses include the following: Minimum standards for licensed practical nurses include the following; (D) Implementation: The registered nurse implements the plan of care by initiating nursing interventions through giving direct care and supervising other members of the care team; and (ii) Standard II Delegation and Supervision: The registered nurse is accountable for the safety of	B 620		

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B 620	Continued From Page 30  clients receiving nursing service by: (A) Delegating selected nursing functions to others in accordance with their education, credentials, and demonstrated competence as defined in WAC 246-840-010 < <a href="http://apps.leg.wa.gov/wac/default.aspx?cite=246-840-010">http://apps.leg.wa.gov/wac/default.aspx?cite=246-840-010</a> >(10); (B) Supervising others to whom he/she has delegated nursing functions as defined in WAC 246-840-010 < <a href="http://apps.leg.wa.gov/wac/default.aspx?cite=246-840-010">http://apps.leg.wa.gov/wac/default.aspx?cite=246-840-010</a> >(10); (B) The licensed practical nurse in delegating functions shall supervise the persons to whom the functions have been delegated; (C) Evaluating the outcomes of care provided by licensed and other paraprofessional staff;  (4) Other responsibilities:  (a) The registered nurse... shall have knowledge and understanding of the laws and rules regulating nursing and shall function within the legal scope of nursing practice;  (b) The registered nurse and the licensed practical nurse shall be responsible and accountable for his or her practice based upon and limited to the scope of his/her education, demonstrated competence, and nursing experience consistent with the scope of practice set forth in this document; and  (c) The registered nurse...shall obtain instruction, supervision, and consultation as necessary before implementing new or unfamiliar techniques or procedures which are in his/her scope of practice.  (d) The registered nurse ...shall be responsible for maintaining current knowledge in his/her field	B 620		

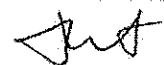
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B 620	Continued From Page 31  of practice...  Nursing leadership failed to adequately educate transport RNs to their scope of practice and responsibility when acting as transport nurses, and subsequently failed to supervise the RNs while the RNs performed their duties as transport nurses.	B 620		
B 750	WAC 246-320-166 Information Mgmt-Patient Records Accuracy  Hospitals must: (4) Create medical records that: (e) Have accurately written, signed, dated, and timed entries;  This WAC is not met as evidenced by: Based on interviews and review of medical records, it was determined that the hospital failed to ensure that medical records for 12 of 12 transport patients were complete, accurately written, signed, dated and timed. The hospital's failure to do so created medical records for transport patients that were incomplete and inaccurate, with the potential to deliver misleading information to practitioners.  Findings include:  Twelve (12) records were reviewed for patients who had received services from the Seattle Children's Hospital (SCH) transport service. The records were selected for review from a list of patients who the hospital reported as having received transport services in September, 2010. Included in the review was the medical record of Patient #1, who was identified in the complaint.	B 750	Tag B 750  How:  1. New documentation tools were designed during November and trialed during December and January. Team members have provided feedback on efficiency, ease of use and clarity of the tools and changes are being incorporated. These new tools will: a. separate MD orders in their own section with associated authentication (see Tag B160); b. match RT and RN signatures with their discipline specific components of care; and c. separate RN plan of care in its own section with clear RN signature line.  2. The hospital will provide 1:1 staff education on the new tools.  3. See Tag B160 for additional corrections related to the authentication of physician orders.	

By signing, I understand these findings and agree to correct as noted:

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If continuation sheet 32 of 42

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  000008	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/19/2010
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B 750	<p>Continued From Page 32</p> <p>All 12 records were reviewed for evidence that a physician had authenticated the orders, as evidenced by her/his signature on the medical record. Medical records were also reviewed for evidence that medications, biologicals (including intravenous fluids and lipids) as well as respiratory therapy, were administered per physicians' orders. The records were also reviewed for evidence that the other members of the Seattle Children's Hospital transport team, the Registered Nurse and the Respiratory Therapist, had created complete and accurate records.</p> <p><b>Physician Order Authentication</b></p> <p>Twelve (12) records were reviewed for patients who had received services from the Seattle Children's Hospital (SCH) transport service. The records were selected for review from a list of patients who the hospital reported as having received transport services in September, 2010. Included in the review was the medical record of Patient #1, who was identified in the complaint.</p> <p>All 12 records were reviewed for evidence that a physician had authenticated the orders, as evidenced by her/his signature on the medical record. Medical records were also reviewed for evidence that medications and biologicals were administered per physicians' orders. The review revealed that 12 of 12 records reviewed did not have authenticated physician orders, as evidenced by the signature of the ordering physician.</p> <p>Twelve (12) of 12 records reviewed did not contain authenticated physician verbal orders for drugs and/or biologicals and/or respiratory therapy which the medical records documented as administered to the patients. The lack of</p>	B 750	<p><b>Who:</b></p> <p>Medical Director of Ground Transport accountable for development of these tools; Director of ICU/Transport accountable for implementation and compliance in use of these tools. The Program Manager will be responsible for the monitoring.</p> <p><b>What:</b></p> <ol style="list-style-type: none"> <li>The hospital will monitor 100% of charts for 3 months to confirm that:             <ol style="list-style-type: none"> <li>RN and RT signatures are associated only with care provided that is within their scope of practice;</li> <li>care provided is covered by MD orders either initiated by order sets or individual orders, including where care is a continuation of what started in referral hospital;</li> <li>the nursing plan of care is clear;</li> <li>contact with physicians is clear;</li> <li>all signatures have time and date.</li> </ol> </li> <li>The hospital's QISC committee will review audit results after 3 months and increase or decrease monitoring as needed.</li> </ol>	

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B 750	<p>Continued From Page 33</p> <p>authenticated physical orders resulted in an incomplete and inaccurate medical record.</p> <p>Patient #1: Nursing notes documented that the patient received epinephrine [a drug used to regulate heart rate], morphine [a pain reliever], ativan [an anti-anxiety medication] and vecuronium [a paralytic] while still at the sending hospital. An internal investigation by SCH had determined, prior to the Department of Health investigation, that the RN #1 had administered the morphine, ativan and vecuronium without a physician's order.</p> <p>The RN documented that epinephrine was administered. No physician orders were evident in the medical record for the administration of the epinephrine, and it is not clear from the medical record if a physician at the sending hospital or a physician from SCH ordered the epinephrine. Intravenous (IV) fluids were also documented as given to the patient.</p> <p>Interview with Neonatologist #1, on 10/4/2010, revealed that s/he had ordered that the epinephrine be given, but that the SCH transport RN was on the phone with the Med Con physician; therefore, the medication was administered by the sending/referring hospital staff.</p> <p>In addition, the medical record documented that Patient #1 was on a ventilator and had received manual "bagging" during the resuscitation throughout the transfer process and subsequent resuscitation effort.</p> <p>No verbal orders were authenticated for the medications, the IV fluids or the ventilator settings.</p>	B 750	<p>When:</p> <ol style="list-style-type: none"> <li>1. New documentation tools to go to printer on 1/31/11.</li> <li>2. Implementation date of new tools on 2/14/11.</li> <li>3. Staff education will be completed by 2/14/11.</li> <li>4. Audits of use of new tools initiated 2/14/11.</li> </ol>	

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B 750	Continued From Page 34  Patient #2: The patient's medical record revealed that IV fluids were established at the sending hospital and reportedly continued while under the care of the SCH teammate medical record also documented that the patient received phenobarbital while under the care of the SCH team.  No physician verbal orders were authenticated.  Patient #3: The patient's medical record documented that IV fluids, with added trophamine [an amino acid] had been established by the sending hospital. The established IV fluids and medication additive were reportedly continued while the patient was under the care of the SCH transport team.  No authenticated physician verbal orders were evident.  Patient #4: Review of the patient's medical record indicated that the patient had IV fluids established at the sending hospital. The SCH plan of care indicated that the patient was to receive the same IV fluids, with an additive of trophamine [an amino acid].  No authenticated physician verbal orders were evident in the medical record.  Patient #5: The patient's medical record revealed that the patient had had IV fluids established at the sending hospital. The SCH plan of care indicated that the patient was to receive the same IV fluids, at the rate of "80 cc/kg/D".  The plan of care also stated that the SCH team	B 750		

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B 750	<p>Continued From Page 35</p> <p>was to "cont. amp &amp; gent" [ampicillin and gentamicin, both antibiotics], the dosage was not specified.</p> <p>The medical record documented that both antibiotics had been given at the sending hospital on the previous day; however, there was no documentation that the antibiotics had been administered at the sending hospital since the previous day.</p> <p>No authenticated physician verbal orders were in the medical record.</p> <p>Patient #6 Review of the patient's medical record revealed that IV fluids, with trophamine, had been established at the sending hospital. The dose was continued, and increased, while the patient was under the care of the SCH transport team. The medical record also documented that the patient received "PGE 0.03 mcg/kg/min (mcg/ml)" [unknown drug/nutrient] while under the care of the SCH transport team.</p> <p>No authenticated physician verbal orders were in the medical record.</p> <p>Patient #7: The patient's medical record documented that the patient had IV fluids established at the sending hospital. While under the care of the SCH transport team, the IV fluids were continued, along with dopamine [a medication used to regulate heart rate and blood pressure]. The patient also received "NS" [normal saline] and "alt" [unknown].</p> <p>The SCH plan of care revealed that the physician had ordered "TF = 80cal/Kg/D [tube feeding] as well as "continue amp &amp; gent". The medical record documented that the patient had received</p>	B 750		

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B 750	<p>Continued From Page 36</p> <p>ampicillin and gentamycin [antibiotics] at the sending hospital. Documentation indicated that the antibiotics had been administered as one-time doses, and were not being administered as a continuing dose.</p> <p>No authenticated physician orders were evident for the IV fluids, the dopamine, the tube feeding or the 2 antibiotics.</p> <p>Patient #8: The medical record documented that the sending hospital established IV fluids, and indicated that the fluids had been continued while under the care of the SCH transport team.</p> <p>The medical record also documented the administration of ampicillin and gentamicin, both antibiotics, both administered while the patient was under the care of the SCH transport team. The medical record also documented that the patient received sodium acetate [a salt solution] and Survanta [a surfactant administered intra-tracheally] at the time the SCH transport team arrived. It is not clear who administered the sodium acetate or Survanta, or whether those were one-time doses.</p> <p>The physician's verbal order was for "ampicillin, gentamicin...0.1 mg/kg morphine, PRN, agitation".</p> <p>No clarification of the incomplete orders was found on the record, and no authenticated physician verbal orders were on the medical record.</p> <p>The patient was also on a ventilator during the transport process. No authenticated physician's verbal orders were found on the record for the ventilator settings.</p>	B 750		

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B 750	<p>Continued From Page 37</p> <p><b>Patient #9:</b> The patient had IV fluids and parenteral nutrition established at the sending hospital and reportedly continued while under the care of the SCH transport team. The patient also received insulin intravenously. The physician's orders on the plan of care noted that the patient had received ampicillin, gentamicin, and flagyl [an antibiotic] while at the sending hospital, but the medication record did not document that those medications had been administered by the sending hospital.</p> <p>No authenticated physician's verbal orders were on the medical record relative to the fluids and parenteral nutrition which were administered while the patient was under the care of the SCH transport team.</p> <p><b>Patient #10:</b> Review of the medical record revealed that the patient had IV fluids established at the sending hospital. The fluids were reportedly continued while the patient was under the care of the SCH transport team.</p> <p>No authenticated physician verbal orders were on the medical record.</p> <p><b>Patient #11:</b> Review of the patient's medical record revealed that the patient had IV fluids and lipids [fat for nutrition] established at the sending hospital, both reportedly continued while under the care of the SCH transport team. The patient also received heparin [used to prevent blood clots] and fentanyl [pain medication] while under the care of the SCH transport team.</p> <p>No authenticated physician verbal orders were</p>	B 750		

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B 750	<p>Continued From Page 38</p> <p>found for any of the fluids, the lipids or for the heparin and fentanyl.</p> <p><b>Patient #12:</b> The patient's medical record revealed that the patient had IV fluids established at the sending hospital. The medical record also documented that the patient had received clindamycin [antibiotic] IV while under the care of the SCH transport team. The physician's orders, as documented on the plan of care, stated that clindamycin was given at the sending hospital, and the patient was to receive ampicillin and gentamicin. No documentation was found in the record that the patient received ampicillin or gentamicin.</p> <p>No authenticated physician verbal orders were found in the record.</p> <p>Reference deficiency written under Tag 0160 Governance - Authenticated Orders</p> <p>Registered Nurse Documentation Patients 1 - 12, Incomplete documentation regarding IV fluids and/or medications</p> <p><b>Patient #1</b> Review of the transport record for Patient #1 revealed that, while at the sending hospital, Patient #1 had "coded" [suffered a cardiopulmonary arrest] and required resuscitation efforts, including the administration of epinephrine, a medication used to increase heart rate. There was no RN signature on the Seattle Children's Hospital (SCH) "code sheet" to support that SCH RN#1, had actually participated in the resuscitation effort or administered the medications listed on the sheet. The RN documentation did not note how, or from whom,</p>	B 750		

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B 750	<p>Continued From Page 39</p> <p>the order to administer epinephrine had been received.</p> <p>Further review of the medical record revealed that RN #1 had documented that s/he had administered morphine, a pain reliever; ativan, an anxiety-relieving medication and vecuronium, a paralytic drug, to the patient. The RN had documented that verbal orders for those medications had been received from the Seattle Children's Hospital consulting physician. Review of internal hospital documents, and interviews with hospital leadership, revealed that the hospital's internal investigation had revealed that although RN #1 had administered the medications documented, s/he had not received verbal orders for those medications and had falsified the medical record to indicate that s/he had received the orders.</p> <p>Review of the transport records revealed that all 12 of 12 patients whose records were reviewed, had IV fluids and/or medications that were initiated with the sending hospital. Hospital leadership stated that the IV fluids and the medications initiated in the sending hospital had been continued by the SCH transport team. For 12 of 12 patients, documentation did not clearly indicate which IV fluids and/or medications had been initiated with the sending hospital and given as one-time doses, which IV fluids and/or medications had been initiated with the sending hospital and continued by the SCH transport team and which IV fluids and/or medications had been initiated in the field by the SCH transport team.</p> <p>Registered Nurse Documentation Patients #4 and #7 Incomplete documentation regarding Patient history</p>	B 750		

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B 750	<p>Continued From Page 40</p> <p>The patient history was not documented for 2 of 12 patients. Under the field for "nursery history" the RN had documented "Please refer to discharge summary from [sending hospital]"; however, the discharge summary was not included with the records. The lack of a patient history resulted in an incomplete medical records.</p> <p>Patients #1 through #12 - RN signature for respiratory assessments/treatment</p> <p>Discussion with the Program Manager and Medical Director for Transport Services confirmed that the RNs did not provide respiratory therapy services during transport, and their signatures did not indicate that they had, but was intended to signify their participation in the plan of care.</p> <p>The RN signature for respiratory assessments/treatments that the RN did not perform or supervise resulted in inaccurate medical records.</p> <p>Respiratory Therapy Documentation Respiratory therapist signature for nursing assessments, receipt of physician verbal orders and administration of medications</p> <p>Patients #1 through 12 Review of the medical records revealed each patient record contained a sheet entitled "Patient Transport Records". The Patient Transport record sheet included fields for the physical examination of the patients, as well as the Plan of Care which included physicians orders for IV fluids and/or multiple medications, as well as a field for the reporting of laboratory values.</p>	B 750			

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B 750	<p>Continued From Page 41</p> <p>For 12 of 12 records, the RN and the respiratory therapist had both signed the sheet, although the physical examination of the patient, excluding the respiratory system, was outside of the scope of practice for the respiratory therapists. Also outside of the scope of practice for the respiratory therapists was the acceptance of orders for medications, excepting specific medications for respiratory therapy, and some aspects of the laboratory values.</p> <p>The respiratory therapists signature for processes not performed by the respiratory therapists, and for actions outside of the scope of practice of the respiratory therapists, resulted in inaccurate medical records.</p> <p>Discussion with the Program Manager and Medical Director for Transport Services confirmed that the respiratory therapists provided only respiratory therapy services during transport, and their signatures did not indicate that they had participated in other aspects of care, but was intended to signify their participation in their segment of the plan of care.</p>	B 750		

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No redactions applied