COMPLAINT INVESTIGATION FINDINGS

COMPLAINT #: 149848
STATE SHELL #: KO9011
MEDICARE SHELL #: KO9011
FACILITY: Seattle Children's Hospital and Regional Medical Center
MEDICARE PROVIDER NUMBER: 503300
DATE (S) OF INVESTIGATION: 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.
DATE REPORT WRITTEN: December 15, 2010
INVESTIGATOR(S) NAME AND TITLE: Mary Wood, MN, BSN, RN
Complaint Investigator

STATEMENT OF DEFICIENCY:
Yes, deficiencies were identified

ISSUE(S):
-Nursing Services
-Quality Assessment Process Improvement

PROCESS:
Interviews:
On 10/7 and 11/8/2010, unsuccessful attempts were made to interview Registered Nurse (RN) #1, who was identified in the complaint.

I interviewed the Senior Vice President/ Chief Nursing Officer (SVP/CNO) throughout the investigation. We discussed hospital policies, procedures and usual processes around multiple hospital operations. We also discussed the hospital's awareness of the complaint allegation, how the hospital had conducted its own internal investigation and the actions taken by the hospital as a result of the internal investigation.

On 10/4/2010, I interviewed staff from the sending/referring hospital, including board-certified Neonatologist #1 and a Neonatal Intensive Care Nurse, regarding their participation in the care of Patient #1, the patient identified in the complaint. We also discussed their understanding of the role of the transport team, including at which point the transport team assumed responsibility for the patient, and how that transition point was determined, as well as their observations of the Seattle Children's Hospital (SCH) transport team during the transport effort.

On 10/13/2010, a joint interview was conducted with personnel from SCH. The interview included the SVP/CNO; the Medical Director of Emergency Department Services/Chief of the Division of Emergency Medicine; the Medical Director for the Neonatal Transport Team; the acting Neonatal Intensive Care Unit (NICU) nurse educator; the Transport Services Program Manager who was a respiratory therapist and a NICU nurse, RN #9, whose duties included NICU staff RN and transport team RN.

The joint interview discussion included the process for how the team contacted the Medical Consultation (Med Con) physician regarding the patient; how the MedCon communication line conversations are recorded and utilized to confirm accuracy of orders; how the plan of care for the transport was developed; the role of the Emergency Medical Technician (EMT) in the transport; availability of backup ambulances and equipment; who was responsible for recording team activities and what each team member's signature on the medical record signified; the qualifications of team members; physician signatures on the transport records for orders given to the transport team; scope of the program and when responsibility for the patient was assumed by the SCH team; team members roles and responsibilities while in the sending hospital; orientation and supervision of team members; post-transport record review of care provided and the quality assessment plan and process for transport services.

On November 12th, I interviewed Neonatologist #2, who was from a second sending/referring hospital which had previously utilized the services of the SCH transport team. We discussed her/his interactions with, and observations of, the team, and what s/he believed to be areas that needed improvement.

On December 1, 2010, I reviewed the Med Con tapes which had recorded conversations between RNs on transport service and the Med Con physicians. The tapes were reviewed in the company of RN #9 and the Transport Services Program Manager.

Twelve (12) tapes were reviewed. The 12 tapes pertained to conversations regarding 12 patients (of 28 total) who received transport services in September, 2010. All tapes were reviewed for evidence of physician orders for continuation of medications, fluids, lipids and other treatments already begun by the sending/referring hospital, as well as for orders for new fluids,

medications and treatments. Tapes were also reviewed for evidence that the verbal orders were read back and verified by the RN to the physician, as directed in the hospital's policy "Telephone/Verbal/Electronic Messaging Orders". In addition, tapes were reviewed for evidence that physician orders had been received for respiratory medications and treatments, and that those orders had also been read back and verified. The tapes were also reviewed for evidence that all orders were accurate and complete.

On December 2 and 3, I interviewed RNs numbers 2 through 8. We discussed the training received by the RNs for their role on the transport team; how they assure that they had correct verbal orders while on the transport team; who they believed to be their supervisor while performing transport duties; their understanding of, and participation in, the transport services quality assurance/process improvement plan; whether or not they administered medications while in the field, without, or before, receiving physician orders to dos o; and how orders for respiratory drugs and treatments were conveyed to the respiratory therapist. We also discussed the role of the EMTs on the transport team; the nurses understanding of the role of the transport team while in a sending/referring hospital, i.e., who was responsible for the patient while the team was in the sending/referring hospital and how that was determined; and the nurses' familiarity with the hospital policies "Transport Team Patient Care Guidelines" and "Telephone/Verbal/Electronic Messaging Orders".

On December 2 and 3, I also interviewed Registered Respiratory Therapists (RRT) numbers 1 through 7. We discussed the training each RRT had received, including their continuing education and competencies; who the RRTs believed to be their supervisor while in the field on transports; their understanding of, and participation in, the transport services quality assurance/process improvement plan; their observation of RNs in the field on the transport team, specifically related to the administration of medications or treatments without a physician's order; and how they received orders for respiratory medications and treatments while in the field.

On December 6, I interviewed 4 of 6 physicians who were identified as having been Med Con physicians involved in the 12 (of 28 total) transport cases under review for the month of September, 2010. We discussed the physicians' qualifications, including board certifications and their training, experience and orientation to the Med Con role and process. We also discussed how they assured that their verbal orders had been taken correctly

by the RN in the field. We discussed whether or not the physicians were aware of any RN on the transport team had given medications without a physician's order; the physicians' awareness of, and participation in, a quality assurance/process improvement plan for Transport Services and what their understanding was of the role of the transport team in the field, including when and how the transport team assumed care of the patient. In addition, we discussed whether the physicians were aware of the hospital policy "Transport Team Patient Care Guidelines" and how those guidelines were to be utilized.

On December 6 and 7, 2010 I interviewed 4 of 4 EMTs who were dedicated to the transport team. We discussed the qualifications and background of the EMTs; their role on the transport team, including documentation; their observations of the RNs and the RT, specifically whether or not the RNs had been observed to administer medications or treatments without physician orders; their impressions of care delivered by the transport team and whether or not their input or opinions had ever been solicited by hospital leadership.

Medical Record Review:
I reviewed 12 of 28 transport records from a list of patient transports identified by the hospital as performed by the SCH transport team in the month of September, 2010. Included in the review was the transport record for Patient #1. In addition, I reviewed the medical record for Patient #1 that was developed by the referring/sending hospital.

The SCH transport records were reviewed for evidence that the transport team had contacted the Medical Consultation (MedCon) physician to develop a plan of care in situations where the plan of care was unknown; that the sending hospital had been contacted regarding an anticipated time of arrival of the transport team; a nursing assessment of the patient by a RN; documentation of medications administered by the transport team; evidence of a physicians order and signature for medications administered by the transport team; and a RN reassessment or statement of status at the end of the transport.

Document Review:
I also reviewed the following, or portions of the following:

-Position description for the Senior Vice President and Chief Nursing Officer
-Organizational chart for nursing services
-Position description for Registered Nurse – Transport Team
-Position description for respiratory therapist II
-Scope of Practice of Respiratory Therapists
-Position description for American Medical Response Emergency Medical Technician

The following policies and procedures were reviewed:

-Assessment and Plan of Care for Inpatient and Ambulatory Settings
- Verification of Licensure, Certification, Registration or Permit
-P&P "Telephone/Verbal/Electronic Messaging Orders
-P&P-s "Blood Component Ordering and Administration"

-Neonatal Emergency Patient Transport
-Medical Control for Infant Ground Transport Team
-Guidelines for Care of the Premature Infant
-Transport Team Patient Care Guidelines
-Infant Transport Nurse, Respiratory Therapist Annual Skills Competency Verification Record
-Patient Expiration Prior to or During Transport
-Passive Hypothermia during Neonatal Transport
-Placental Tissue Transfer
-Controlled Drugs: Handling and Documentation of Medications for the Neonatal Transport Team

-Ambulance Accident or Fire: Evacuation Procedure
-Use of Long Range Pager for Transport On-Call Shifts
-Dispatching an Infant Ground Transport Team
-Cellular Telephone Use
-Storage and Use of Refrigerated Medications
-Restocking Transport Equipment: Neonatal Transport Team
-Incubator Cleaning and Assembly
-Restocking Infant Car Seat After use on patient Transport

-Seattle Children's Hospital Patient Safety Program
-Seattle Children's Patient Safety Leadership Training: Serious and Sentinel Event Management, dated July 17, 2009

-P&P "Serious or Sentinel Events
-Event Review Process (a algorithm for decision-making)
-Form used to perform Medication Error Mini RCA reviews

I reviewed internal hospital documents which detailed the hospital's investigation into the alleged events, and included statements from RN #1 regarding the alleged event.

I also reviewed the employee file for RN #1, which included her/his last performance evaluation which was dated 6/25/2009. The file also contained documentation that a competencies and skills check had been completed on in 2010.

CONCLUSION:
This investigation substantiated the allegation that RN #1 administered medications to Patient #1 without a physician's orders to do so.

ACTION TAKEN:
This investigation did substantiate the complaint allegation and deficiencies were identified. A Statement of Deficiencies was written.