# CENTERS FOR MEDICARE & MEDICAID SERVICES

# INVESTIGATION

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| GUAM MEMORIAL HOSPITAL AUTHORITY | 850 GOV CARLOS G CAMACHO ROAD TAMUNING, GU 96913 |

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| {A 395} | RN SUPERVISION OF NURSING CARE<br>CFR(s): 482.23(b)(3)<br><br>A registered nurse must supervise and evaluate the nursing care for each patient.<br><br>This STANDARD is not met as evidenced by:<br>Based on record reviews and interviews the hospital failed to provide adequate nursing supervision to evaluate the nursing care for 2 of 12 sampled patients (Patient 4 and 6). This failure was evident when the nurse failed to adequately monitor Patient 4 during a routine hemodialysis treatment and he expired. In addition the nurses failed to adequately monitor and use all available hospital resources for Patient 6. Patient 6 had changes in respiratory status and vital signs over a period of time and he subsequently expired.<br><br>Findings include:<br><br>1). During a record reviews on 4/29/19 at 11:00 a.m., of Patient 6 a 5 year old child reveals that he arrived at the Emergency Room (ER) of the | {A 395} | **A395**<br>**RN SUPERVISION OF NURSING CARE**<br>**CFR(s): 482.23(b)(3)**<br><br>**Finding 1:**<br><br>**Details of the actions taken that resulted in the alleged correction of each alleged deficiency:** | 06/14/2019 |

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| {A 395} | Continued From page 6<br>hospital on 10/30/18 at 11:30 AM with complains of fever for 2 days, shortness of breath (SOB). Patient 6 also arrived from outside of the country 2 days prior and was seen by another clinic outside of the hospital. Patient 6 was evaluated by the ER MD (Medical Doctor) and his physical assessment revealed that the patient was ill-appearing, not alert, not playful, not smiling, not well appearing, lethargic, dyspnea, nasal congestion, cough, chills and decrease in activity, positive for confusion, sore throat, positive for grunting, left lung with rales, chest was positive for accessory muscle use and retractions.<br>Nursing ER assessment revealed chief complaint of fever for 2 days and SOB with associated symptom of chills, decrease activity, cough, dyspnea, nausea and vomiting, left and right lungs were positive for rhonchi (low pitched, rattling lung sounds), tachypnea (abnormal rapid breathing) and high fever, non-productive cough.<br>MD conducted various diagnostic test and provided medical treatment to Patient #6. He was admitted at 1:30 PM to the Pediatric unit with the diagnosis of Febrile Illness, Viral Pneumonia, Bacteremia, Rule out Dengue Fever, physical symptoms and abnormal labs. According to Pediaric Advance Life Support Guidelines Age 3-6 years old normal vital signs parameters Heart Rate (70-120), Blood Pressure (SBP 95-110 and DPB 60-75), Respiratory rate (20-24), Oxygen Saturation (95-100%). Further direct quotes from the record review revealed:<br><br>a). Chest X-ray (CXR)"<br>- 10/30/18 at 12:44 PM - Impression: Peribronchial Opacities are seen with Viral Infections<br><br>b). "Throat / Blood Culture (CX)" | {A 395} | Continued from page 6<br>This case was immediately reviewed by the Administrator of Clinical Services, the Administrator of Nursing Services, and the Pediatric Unit Supervisor on May 1, 2019. On May 2, 2019, a case overview was presented at a special Pediatric Unit staff meeting by the Administrator of Clinical Services and Administrator of Nursing Services as a learning opportunity. A Power-Point presentation and discussion covered an overview of the case; assessment of the pediatric patient population with special focus on vital signs and respiratory assessment; recognizing and communicating abnormal findings to the medical provider; using available hospital resources; and nursing documentation of communication in the medical record. (Power-Point presentation attached)<br>At this meeting, the Pediatric Unit Supervisor and the Administrator of Nursing Services presented the Pediatric Early Warning Score (PEWS). The Pediatric Unit Supervisor provided a resource article of PEWS to all pediatric staff. (Minutes and PEWS article attached)<br>Using the Lippincott educational information, the Pediatric Unit Supervisor conducted a unit in-service on respiratory assessment of the pediatric patient. This was completed on May 30, 2019. (Lippincott educational material and training record attached)<br>The Pediatric Unit Supervisor created an identification card attachment. This is an easy to access tool for all pediatric unit staff to reference the PEWS scoring tool and normal vital sign values for the pediatric population. All staff can wear this as an attachment to their work identification card. Cards were distributed to all pediatric staff on May 15, 2019. (PEWS/VS ID Card attached)<br>A policy was created on the use of PEWS in the Pediatric Unit. This was approved by Nursing Management on May 20, 2019 and approved by the Pediatric Physician Department on June 13, 2019. (Policy attached)<br>The PEWS scoring system was built in to the General Assessment section of the hospital's Electronic Health Record. The PEWS scoring system Flow Sheet was built into the hospital's Electronic Health Record. Training was conducted to the Pediatric Nursing Staff on June 10, 2019. (Printed General Assessment and printed Flow Sheet of PEWS. Training on PEWS in the EHR attached) | |

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| {A 395} | Continued From page 7<br>- 10/30/18 at 1:35 PM - resulted on 10/31/18 at 11:38 AM - Heavy growth Streptococcus Pyogenes (Group A)<br><br>c). "History and Physical (H&P)"<br>- 10/30/18 at 7:00 PM - 5 year old febrile illness and viral pneumonia /bacteremia and presumptive Dengue Fever. Case discussed with MD because of concern with elevated Liver Function Test and Coagulation (process in which blood forms clots); Respiratory coarse breath sounds, congestion, scattered rales (sounds you will hear in the lung field that has fluid in the small airways, abnormal rattling lung sounds), rhonchi, occasional wheezing.<br><br>- 10/31/18 6:44 PM - late entry note by the on call MD - called by RN at 3:00 AM patient increase work of breathing ordered albuterol TX, Lasix, Solumedrol and CBG and result showed no acidosis or CO2 retention. After 7:00 AM received another call that patient was coding, came in and patient already pronounced by ER MD. Post Mortem care done, spoke to father.<br><br>d). "Nurses Notes (NN)"<br>- 10/30/18 - 2:24 PM - Patient (Pt.) being transferred to the pediatric unit awake, alert oriented, denies pain, nausea and vomiting (NV).<br><br>- 3:04 PM - Received by pediatric nurse patient breathing easy, chest coarse breath sound congested, lips dry, pale pink, father at bedside. Patient 6 was not on oxygen (O2) at this time.<br><br>- 8:10 PM - Audible Rhonchi, oxygen saturation (O2 Sat.) at = 91 % on room air with retractions (reduced air pressure inside the chest, signs of someone having a hard time breathing), lips dry, | {A 395} | Continued from page 7<br>**Title of the position of the person responsible for the correction:**<br><br>Pediatric Unit Supervisor, Administrator of Nursing Services, Administrator of Clinical Services<br><br>**Description of the monitoring process established to prevent recurrence of the alleged deficiency:**<br><br>The Pediatric Unit QAPI representative is tracking and trending the use of PEWS in all admissions (100%) to the Pediatric Unit. The sample size is being audited each month as part of the Pediatric Nursing Unit's QAPI plan. The Pediatric Nursing Unit Supervisor is reviewing and analyzing monthly QAPI data to identify any areas requiring improvement. Any challenges and/or opportunities to improve assessment and the recognition of changes in patient condition, documentation, and communicating appropriate level of care with providers in the Pediatric Unit are being identified. Any instances of noncompliant QAPI data will be reported, analyzed, and addressed at the Nursing Department's QAPI meeting. This will be reported to the Performance Improvement Committee and the Governing Body's Quality and Safety Committee on a quarterly basis. | |

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skin pale pinkish, oxygen started on 1 Liter Per Minute (LPM) with nasal cannula (NC) and O2 Sat. was 93 %, charge nurse increased O2 to 2L and Saturation was 95%, coarse and crackles, MD increased intravenous fluids (IVF) rate to 100 Mililiter per hour (ML/Hr).

- 9:34 PM - Minimal rash noted to chin, breath sount (BS) coarse crackles with chest retractions noted with occasional cough.

- 10:24 PM - Patient refusing O2 via NC, Respiratory Therapist (RT) sets up O2 mist 28% on 6 Liter (L)

- 11:38 PM - Chest retractions, nasal Flaring, coarse crackles (an abnormal breath sound), head of bed elevated (HOB), face mask at 6L

- 11:46 PM - Temperature (Temp.) 102.8, Tylenol given per order and cooling measures implemented

- 10/31/18 - 12:57 AM - HOB 45 degrees breathing with mild retractions nasal flaring, coarse and crackles at 7L via simple mask, lips pale, pinkish slightly dry, petechial rash chin/neck area

- 3:00 AM to 3:33 AM - restless, uncooperative, O2 at 8L with Sat. at 80%, Respiration (Resp.) 48, complaint of chest pain, back pain, BS coarse crackles, retractions, color pale, increased O2 to 10 L with Sat. at 90-93%, Informed MD of Patients condition, new order recieved for Respiratory Treatment (TX), Lasix 20 mg IV, Capillary Blood Gas (CBG) after TX.

- 4:00 AM to 5:26 AM - Pt irritable, Hallucinating,

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Breathing with retraction and nasal flaring, chest coarse, O2 via 10 L mask, lips pale pinkish slightly dry, minimal blood tinge secretions to nares, rash to chin, neck area, Temp. 100.9, Resp. 60, heart rate (HR) 180, MD called and gave new orders, at 5:00 AM Intravenous (IV) Solumedrol 5 mg given, Tylenol given, O2 via mask, and Temp. 101.5.

- 6:50 AM - Febrile with Temp. 102.8, HR 180, Resp. 60's, at rest Resp. in the 40s, HR 140, episode of irritable and agitated, on/off hallucination continues, breathing with mod retractions and nasal flaring, blood tinge to nares, petechial rash to chin and neck, O2 98% at 10 LPM Albuterol RTX given by RT.

- 6:53 AM - Nurse checked patient noted and he is unresponsive with faint pulses. CPR initiated and code blue called - refer to code sheet:

- 7:00 AM - Pulseless patient (Pt).

- 7:01 AM - Pt. intubated by ER MD, advance cardiac life support (ACLS) protocol followed, primary care physician (PCP) informed, intensive care unit (ICU) nurse and nursing supervisor present during code.

- 7:15 AM - Patient Asystole

- 7:16 AM - Time of death called by ER Doctor

e). "Respiratory Care Flow Sheets by Respiratory Therapist (RT)"
- 1st Treatment (TX) - 10/30/18 at 10:00 PM - Albuterol 2.5 mg administered Heart Rate (HR) 128/132, Respiration (Resp.) 34/36; Oxygen (O2) via BLOWBY MIST (type of oxygen deliver

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methord) 28%/5L, Patient breath sound (BS) with crackles pre and post treatment (TX), (Via mask and changed to BLOWBY) Patient is crying, tachypnea, congestion and cough.

- 2nd Treatment - 10/31/18 at 1:15 AM - Administered Albuterol 2.5 mg, HR 142/148, Resp. 48/50, O2 at 100%, coarse, crackles BS pre and post TX via mask.

- 3rd Treatment at 3:00 AM - Administered Albuterol 2.5 mg, HR 156/164, Resp. 56/58, O2 at 100%, BS coarse with crackles pre and post TX via mask;

f). "Vital Signs (VS) Flow Sheet"
- 10/30/18 at 2:00 PM - Temp. 101.5, HR 147, Resp. 32 room air (RA), oxygen saturation (O2 - Sat.) at 95%

- 4:40 PM - O2 at E liter (L) via nasal cannula (NC) O2 -Sat. at 95 %

- 12:00 AM- blood pressure (BP) 108/68, Temp. 102.8, HR 148, Resp. 56, O2 via mask 7 L, O2 Sat. at 95 %

- 4:00 AM - BP 105/74, Temp 100.9, HR 180, Resp. 60, O2 via mask 10 L o2 Sat. at 96 %

- 5:00 AM - Temp. 100.5

During an interview concurrent with a record review on 4/30/19 at 9:00 a.m., with Staff #5 She acknowledged that Patient 6 expired on the pediatric unit and indicated that the staff did everything they could. She verbalized that Rapid Response Team (RRT) was not available for the pediatric unit. When asked if there were any

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| {A 395} | Continued From page 11<br>initiative implemented for improvements for other future patients who may be admitted with similar conditions, she indicated "No". "The staff did everything right". When asked if she considered that the VS and respiratory status of Patient 6 were abnormal she indicated "Yes". When asked if the staff should have considered calling the ER MD or nursing supervisor for assistance with assessing Patient 6 further she stated, "They are the pediatric experts, usually they do not call for a RRT, because there is a charge nurse on the unit".<br><br>During an interview concurrent with a record review on 4/30/19 at 9:30 a.m., with Staff #6 acknowledged according to her documentation in the notes for patient 6, he was having continued changes in physical symptoms along with difficulty breathing during the entire shift (7:00 PM -7:00 AM). She validated that the physician was called 2 times because of the ongoing changes in his medical status and received order for treatments and medications. Staff #6 also acknowledged the vital signs (HR, Resp. and O2 Sat %) were within an abnormal range but expected for the patient status to improve with medications. When asked if she considered using other available resources such as the nursing supervisor, ER MD and asking the on call MD to come in to evaluate patient since the conditions was not improving and continues to worsen she stated "No". When asked if she considered calling a rapid response for an evaluation for the respiratory distress she indicated that "There are no Rapid Response Team (RRT) for pediatrics, only for adults and we are the pediatric experts at the hospital". When asked since she is the pediatric expert why Patient 6 was not transferred / Upgrade the level of care to a Pediatric | {A 395} | Continued from page 11 | |

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Intensive Care Unit (ICU) Bed for closer monitoring with cardiac monitors and initiate critical care protocols for ICU, she indicated "Patient 6 was moved closer to the nursing station for close monitoring". When Staff #6 was asked if she knew that she could call for a code prior the patient becoming unresponsive, not responding positively to all treatments/medications and experiencing worsening of the respiratory status she indicated that, "I have taken care of patients who are sicker than Patient 6".

During an interview concurrent with a record review on 4/30/19 at 9:40 a.m., with Staff #7 from (11:00 PM - 7:00 AM shift) she acknowledged that Patient 6 respiratory status progressively worsened during the shift and VS were with abnormal parameters. When asked if she considered calling a rapid response to support or help improve patient 6 medical status she stated "No, there are no Rapid Response Team for the Pediatric Unit". When asked if she considered calling for additional resources such as the nursing supervisor, ER MD for additional support with assessing Patient 6 decline in respiratory status she indicated "NO". When asked if she considered changing the level of care to a higher level of care such as Pediatric ICU she stated "NO".

During an interview on 4/30/19 at 1:00 p.m., with Staff #4 from (7:00 AM - 3:00 PM shift) she acknowledged that the respiratory status and VS were abnormal for a 5 year old according to the Electronic Health Record (EHR) documentation and it would be concerning if it was during her shift. Staff #4 further explained that nasal flaring and retractions are signs of respiratory distress

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and could have possibly considered placing a breathing tube in Patient 6 to decrease the work of breathing and give him rest. Staff #4 validated that the hospital does not have a pediatric Rapid Response Team and only calls the pediatric physicians when there are concerns with patients. She also confirmed that the ED MD and nursing supervisor are always available if they are called.

During an interview concurrent with a record review on 4/30/19 at 4:30 p.m., with Respiratory Staff #9 she acknowledged that the respiratory status and VS documented in the flow sheets for Patient 6 were abnormal and not within the normal parameters. In addition Staff #9 further explained that continuous chest retractions, nasal flaring, coarse, crackles, upgrading to various oxygen devices with no improvements post treatments and medications are serious signs of worsening of the respiratory distress status. When asked what would she considered for Patient 6 she stated "placement of a breathing tube for the child would have been the best option".

During an interview on 4/30/19 at 9:00 a.m., with Respiratory Staff #8 she acknowledged that Patient 6 was experiencing respiratory distress and the VS were abnormal. She indicated that she reported every assessments and treatments to nursing. When asked if she considered calling the ED MD for an evaluation of Patient 6 respiratory status, since he was not responding to treatment she stated "No".

During an interview on 4/30/19 at 3:05 p.m., with Administrative Staff #3 she acknowledged that based on the written vital signs and symptoms Patient 6 was experiencing respiratory distress. In

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| {A 395} | Continued From page 14<br>addition she indicated the expectation is for staff to use all available resources such as calling the nursing supervisor and ER MD if necessary. Staff #3 confirmed that the RRT is available for the entire hospital and not sure why the pediatric staff did not call for back up help. Reviewed the hospital policy for the RRT with Staff #3 and there are no written indications for adults use only. Staff #3 states "This RRT policy is a hospital wide standard policy which is available for every staff". Staff #3 also agreed that based on the clinical status documented in the notes of ongoing respiratory depression and no improvements from medications and treatments for Patient 6 the pediatric staff should have considered elevating the level of care to higher level of care like ICU.<br><br>During an interview on 5/1/19 at 8:30 a.m., with Administrative Staff #2 she acknowledged that after Patient #6 death the hospital took no actions and the Risk Management Team did not do a Root Cause Analysis (RCA) to investigate the concerns for possible process improvements initiatives. In addition Staff #2 confirmed that Patient #6 death should have been evaluated because it is the hospital policy to investigate all death that occurs during the 1st 24 hours of admission.<br><br>During an interview on 5/1/19 at 8:30 a.m., with Administrative Staff #12 she acknowledged that after she reviewed the clinical record for Patient 6, she identified opportunities for improvements. She also stated that she only became aware of Patient 6's incident during this weeks survey. Staff #12 further explained that moving forward the hospital will have process improvement initiatives to prevent any reoccurrences of this type of incident. She indicated that she already | {A 395} | Continued from page14 | |

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| {A 395} | Continued From page 15<br>started education sessions with the pediatric staff in regards to available resources in the hospital and educating staff on assessment / parameters of vital signs and symptoms.<br><br>During an interview on 5/1/19 at 8:30 a.m., with Administrative Staff # 13 she acknowledged having heard of the incident involving Patient 6 during a meeting, but had not taken any action for process improvements in the hospital. Staff # 13 also indicated that that Patient 6 was not prioritized appropriately.<br><br>During an interview on 5/1/19 at 8:30 a.m., with Administrative Staff #11 she acknowledged having heard about the incident during meetings but took no actions to elevate the concerns and follow through for any improvements initiatives. She also explained that processes would be reevaluated for improvement with the communication and the improvement of care for the patients.<br><br>During an interview on 5/2/19 at 2:00 p.m., with Medical Staff #16 acknowledged that he conducted the Medical Peer Review and did take a quick look at the nursing notes and VS but identified no concerns with the medical care given to Patient 6.<br><br>During an interview on 5/2/19 at 2:30 p.m., with Medical Staff #14 indicated that when he admitted Patient 6 he was stable after the ER treatments and endorsed the care to the primary physician. He also explained that Patient 6 was talking and watching TV and he spoke to the father about the plan of care. Staff #14 states Patient 6 respiratory distress worsening during the night was an unexpected conclusion. He | {A 395} | Continued from page 15 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 650001 | A. BUILDING ______ B. WING ______ | R-C 05/03/2019 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| GUAM MEMORIAL HOSPITAL AUTHORITY | 850 GOV CARLOS G CAMACHO ROAD TAMUNING, GU 96913 |

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| {A 395} | Continued From page 16<br>further explained that the nursing staff should have convey the physical symptoms urgency to the primary MD in order for other actions to be taken. When asked if calling the ER doctor would have been a consideration to call for an evaluation of Patient 6 he indicated "Absolutely, we call the ER DR. all the time".<br><br>During an interview on 5/2/19 at 2:30 p.m., with Medical Staff #15 he validated that he was the MD on call and spoke to the nurse 2 times and gave orders. Staff #15 further explained that "The last report he received was the CBG results and no further called indicating that the respiratory status continued to worsen and patient not responding to treatments and medications. The nurse did not communicate the urgency of physical symptoms or else he would have come in to assess the patient or call the ER Dr. to go and evaluate the patient. The expected plan was to come in the morning to see the Patient 6".<br><br>Hospital Policies reviewed on 5/1/19 Titled:<br>-"Rapid Response Team" revised on 1/2013 reveals that it is a team of experts clinicians that can provide effective communication with the primary physician on the patient's status and work collaboratively with primary nurse clinician to continue to improve early recognition and response to changes in patient's condition. The goal is the reduction of Code 72 (Code Blue Activation) events through early interventions.<br><br>-Assessing Vital Signs" revised on 5/2018 reveals<br>- The purpose: to provide guidelines in how to properly obtain vital signs on a pediatric patient as well as to follow the set parameters given. Assess respiratory for retractions, use of accessory muscles, nasal flaring, grunting, | {A 395} | Continued from page 16 | |

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| {A 395} | Continued From page 17<br>stridor, and pursing lips. Heart rate: bradycardia (slow) less than 80, tachycardia (fast) 140-160 in a child.<br><br>- "Lippincott Nursing Skills and procedures" revised on 3/2019 reveals normal respiratory rate for preschooler is 22-34 and school age child is 18-30. Respiratory patterns with Tachypnea- rapid respirations; the rate increase corresponds to increases in body temperature - possible causes are compensatory respiratory alkalosis, pneumonia, respiratory insufficiency, lesions in the brain's respiratory center and salicylate poisoning.<br><br>- "Charge Nurse Duties and Responsibilities, for Pediatrics Department" revised 5/2018 disclosed that the charge nurse will lead nursing staff to ensure patient safety and quality of care in a given shift. Assesses acuity level of each patient and assigns patient accordingly to each scheduled staff member depending on their level of training. Make round and assess patients' needs. Supervises, direct and guides the care provided by members of the overall nursing personnel working in the unit. Ensure that quality of care is being rendered by nursing. Supports and promotes the philosophy and policies of the hospital and nursing services and makes decisions based on them.<br><br>- "Hospital Nurse Supervisor, Description of Duty" revised 4/2018 and it disclosed Makes patient rounds to coordinate patient care services and to evaluate adherence to nursing care standards and policies and procedures. Assist to assignment of patients to rooms. Respond to all code 72 if threatening and act as team captain. | {A 395} | Continued from page 17 | |

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| GUAM MEMORIAL HOSPITAL AUTHORITY | 85O GOV CARLOS G CAMACHO ROAD<br>TAMUNING, GU 96913 |

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| {A 395} | Continued From page 18<br>- "Medical Examiner Case" revised on 4/2018 and it indicated that these type of deaths will be investigated:<br>Deaths without medical attendance including death at home<br>All hospitals death on arrival whether civilian or military<br>death within 24 hours of hospital admission and all fetal deaths unattended by a physician. | {A 395} | Continued from page 18 | |