California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA140000034	A. BUILDING _____ B. WING _____	C 06/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOSPITAL	1411 E 31ST STREET OAKLAND, CA 94602

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E 000	Initial Comments The following reflects the findings of the California Department of Public Health during the investigation of a complaint. Complaint Intake Number: CA00507065 Representing the California Department of Public Health: HFEN 25205 and 32501 The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Two deficiencies were issued for complaint number CA00507065.	E 000	This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Alameda Health System does not admit that the deficiency listed on this form exist, nor does the medical center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. Alameda Health System reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.	
E1900	T22 DIV5 CH1 ART7-70701(a)(5) Governing Body (a) The governing body shall: (5) Take all reasonable steps to conform to all applicable federal, state and local laws and regulations, including those relating to licensure, fire inspection and other safety measures. This Statute is not met as evidenced by: Based on interview and record review the hospital failed to assure that the emergency department Psychiatrist exercised "reasonable efforts to communicate the threat" of bodily harm made by Patient A to his brother (Patient B), pursuant to California Civil Code §43.92. (California Civil Code §43.92 "(a) There shall be no monetary liability on the part of, and no cause of action shall arise against, any person who is a psychotherapist...in failing to protect from a patient's threatened violent behavior or failing to	E1900	T22 DIV5 ART7-70701(a)(5) Governing Body Immediate Corrective Action: Patient A has been discharged Corrective Action: Moving forward discharge instructions must be signed by the patient and provider or rationale for non-signature must be documented in the medical record. Email communication was sent to staff and provider as well as disseminated in huddles regarding the above expectation. Monitoring: 30 medical records per month will be reviewed to ensure compliance is met and maintained for 90 days. Responsible Person(s): ED Nurse Manager	7/7/17

Licensing & Certification
East Bay District Office
AUG 25 2017
RECEIVED

Licensing and Certification Division

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

A. SMITH, VICE PRESIDENT (INTERIM) QUALITY — 8/25/17

acceptable POC 9/5/17 Nancy Cabanyo HFE II Supervisor

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E1900	Continued From page 1 predict and protect from a patient's violent behavior except if the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims. (b) There shall be no monetary liability on the part of, and no cause of action shall arise against, a psychotherapist who,...discharges his or her duty to protect by making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency...") This failure had the potential to cause Patient A to become a danger to his brother (Patient B). Findings: On 5/16/17, review of Patient B's emergency department's (ED) record showed Patient B was brought by ambulance to the ED, on 5/15/15 at 2:06 p.m., with penetrating trauma to the left chest. At 2:19 p.m., Medical Doctor (MD) 1 wrote "I performed a bedside limited ultrasound. The heart was scanned...no cardiac activity, clot in chambers" [of the heart]. MSW (medical social worker) wrote that Patient B was in his mid twenties and arrived to ED with no signs of life, no pulse. Patient B expired at 2:05 p.m. MSW also wrote, "Mother informed this writer Pt's brother [Patient A]...may be involved in incident..." On 5/18/17, review of Patient B's coroner's report, dated 5/18/15, showed cause of death was a stab wound of the chest. Eight days earlier, Patient A was brought to the ED. Review of the note, dated 5/7/15, written by a paramedic enroute to the hospital, showed that Patient A was in his late twenties and: "...on a 5150 hold in hand cuffs and very combative. [Police officer] stated pt appears to have taken	E1900	This page left blank intentionally	

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E1900	Continued From page 2 unknown amount of Abilify [medication used to treat the symptoms of psychotic conditions] and threatening to harm everyone...Pt was transported to [hospital] ER for med eval/clearance." (Section 5150 is a section of a California law which authorizes a qualified officer or clinician to involuntarily confine a person suspected to have a mental disorder that makes him/her a danger to themselves and/or a danger to others.) Review of the 5150 form, dated 5/7/15 at 1:15 a.m., and signed by a police officer had the following: "While on scene [Patient A] threatened to kill brother for calling 911." Review of the Nursing Triage note, dated 5/7/15 at 2:57 a.m., included that Patient A had a suicide attempt by overdose and the 5150 had a report that Patient A threatened to kill his brother. On 5/7/15 at 5:43 a.m., ED Physician Resident 1 conducted the medical screening exam and entered into the electronic record, "Pt. states he is depressed, has been through a lot and has a lot of things going on in his life. Did not really want to harm self, hoping to get help. Pt's girlfriend and brother called 911, he threatened to kill them after this (another reason why placed on 5150.) On 5/7/15 at 11:16 a.m., ED Physician Resident 2 wrote Psychiatrist 1 discontinued the 5150 hold and to discharge patient home. During an interview, on 3/27/17 at 2:10 p.m., ED Physician Resident 2 stated the discharge process was based on Psychiatrist 1's order and also based on Patient A's behavior in the ED. ED Physician Resident 2 said there was no need for	E1900	This page left blank intentionally	

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E1900	Continued From page 3 further evaluation at the time of discharge: "I would not go back and re-consult the patient. There was no reason to start a new evaluation." On 5/7/15 at 11:33 a.m., Psychiatrist 1 entered into the electronic medical record Patient A had a "...history of bipolar disorder with psychiatric treatment dating to his teens... Pt [Patient A] often becomes agitated and threatening when on cocaine and once tried to strangle his mother...Pt also threatened the brother as pt did not want to be brought to [the hospital]. Pt had been drinking and had used cocaine. BA [blood alcohol] was 0.63 [8 times the legal limit of 0.08 % concentration]... Pt says he was not trying to kill himself and that his brother over reacted...Pt no longer wishes to hurt anyone." (Bipolar disorder is a mental health condition that causes extreme mood swings from emotional highs or mania, and emotional lows or depression.) Review of ED Physician Resident 2's discharge instructions, with a print date and time of 5/7/15 at 11:16 a.m. included: "Please return to the ED if you feel your symptoms are worsening, if you feel like hurting yourself, or if you are otherwise concerned. Please refrain from drugs and alcohol." There were no prescriptions and no clinic or physician for follow-up, listed on the discharge instructions. Patient A did not verify, by signature, that he received and understood the instructions. There was no documentation that Psychiatrist 1 communicated to Patient A's brother (Patient B), and the brother's girlfriend, regarding Patient A's threat of violence and propensity for violence while under the influence of alcohol and cocaine,	E1900	This page left blank intentionally	

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E1900	Continued From page 4 pursuant to California Civil Code §43.92. Psychiatrist 1 was unavailable for an interview.	E1900		
E1956	T22 DIV5 CH1 ART7-70707(b)(11) Patients' Rights (b) A list of these patients' rights shall be posted in both Spanish and English in appropriate places within the hospital so that such rights may be read by patients. This list shall include but not be limited to the patients' rights to: (11) Reasonable continuity of care and to know in advance the time and location of appointment as well as the identity of persons providing the care. This Statute is not met as evidenced by: Based on interview and record review the hospital failed to assure reasonable continuity of care when emergency department (ED) staff failed to ensure a follow-up psychiatric appointment was made for one patient, Patient A, after he presented to the hospital for attempted suicide and threatening harm to a family member and friend. Patient A, who had a psychiatric history of bipolar disorder and other suicide attempts, and asked ED staff for help, was discharged to his own care with the instruction to return to the ED for worsening symptoms. The failure of the ED staff to assure Patient A had follow-up psychiatric care had the potential that Patient A would attempt another suicide or harm others. Findings: Review of the note, dated 5/7/15, written by the	E1956	T22 DIV5 CH1 ART7-70707(b)(11) Patient's Rights Immediate Corrective Action: Patient A has been discharged. Corrective Action: Moving forward a list of community resources has been developed and will be provided to patients with mental health diagnosis upon discharge. Email communication was sent to staff and provider as well as disseminated in huddles regarding the above expectation. Monitoring: 30 medical records per month will be reviewed to ensure compliance is met and maintained for 90 days. Person(s) Responsible: ED manager	7/7/17

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E1956	Continued From page 5 paramedic enroute to the hospital, showed that Patient A was in his late twenties and: "...on a 5150 hold in hand cuffs and very combative. [Police] stated pt [Patient A] appears to have taken unknown amount of Abilify [medication used to treat the symptoms of psychotic conditions] and threatening to harm everyone. Pt was moved to a gurney and placed in four points restraints [each extremity being restrained usually by locked leather straps] and also was given Versed [used for sedation] 5 mg IM [a shot into the muscle.] Pt was transported to [hospital] ER for med eval/clearance." The paramedic wrote that the "described complaint" by Patient A was: "I want to die." (Section 5150 is a section of a California law which authorizes a qualified officer or clinician to involuntarily confine a person suspected to have a mental disorder that makes him/her a danger to themselves and/or a danger to others.) Review of the 5150 form, dated 5/7/15 at 1:15 a.m., and signed by the police officer, showed Patient A's family member called the police department regarding Patient A who took an unknown amount of antidepressant pills along with alcohol. Patient A suffered from depression and attempted suicide about a year ago by overdosing on pills. The police officer also wrote: "While on scene [Patient A] threatened to kill brother for calling 911." On 5/7/15 at 5:43 a.m., ED Physician Resident 1 conducted the medical screening exam and entered into the electronic record, "Pt. [Patient A] states he is depressed, has been through a lot and has a lot of things going on in his life. Did not really want to harm self, hoping to get help. Pt's girlfriend and brother called 911, he threatened to	E1956	This page is left blank intentionally	

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E1956	Continued From page 6 kill them after this (another reason why placed on 5150.) Suicide attempt-overdose a year ago is asking for psych resources, but does not want to go to [the medical center's psych hospital.] Also drank 1.5 water bottles full of ETOH [alcohol] and used cocaine...suspect patient needs more outpatient psych support than actual inpatient admission..." Also Psychiatrist 1 will evaluate the patient. On 5/7/15 at 6:50 a.m., ED Physician 3 wrote the following note: "Attestation (Resident no Procedure) - I saw and evaluated the patient. I reviewed the resident's note and agree with the findings and the plan of care." On 5/7/15 at 11:16 a.m., ED Physician Resident 2 wrote Psychiatrist 1 "...dropped 5150 given patient is normal...will d/c [discharge] patient home." On 5/7/15 at 11:33 a.m., Psychiatrist 1 entered into the electronic record that Patient A "...has a history of bipolar disorder with some form of psychiatric treatment dating to his teens. Pt also has a history of using marijuana and cocaine. Pt often becomes agitated and threatening when on cocaine and once tried to strangle his mother. Pt also has a history of once trying to run in front of a bus and of overdosing...Pt is followed by [community clinic]...no thoughts or plans to hurt self or others...thinking somewhat pressured when asked too many questions judgment and insight are fair..." Psychiatrist 1's treatment recommendations were to discontinue 5150 hold and follow up at the community clinic. Psychiatrist 1 was unavailable for interview. On 5/7/15 at 11:37 a.m., Registered Nurse (RN) 1	E1956	This page left blank intentionally	

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E1956	Continued From page 7 entered the following into the electronic record: "Plan of care was discussed with patient. Patient discharged by RN. (-) Patient received printed prescriptions and review of medication use, potential interactions with other substances, and side effects were discussed with the patient. Patient verbalized understanding of all discharge instructions. Left ED with a steady gait." RN 1 was unavailable for interview. Review of ED Physician Resident 2's, computerized discharge instructions, dated 5/7/15 with a print time of 11:16 a.m., included the following: "Please return to the ED if you feel your symptoms are worsening, if you feel like hurting yourself, or if you are otherwise concerned. Please refrain from drugs and alcohol." There were no prescriptions and no clinic or physician for follow-up, listed on the discharge instructions document. The discharge instructions had an attached page entitled "My Signature Below Indicates:" ">I have received and understood the oral instructions regarding my current medical problem. >I will arrange follow-up care as instructed above. >I acknowledge receipt of the written instructions as outlined on this and any previous page(s). I will read and review these instructions. >I authorize [hospital]to disclose information...to (initial all that apply). ___the follow-up physician listed above.____my primary care physician_____..." No follow-up physician and no primary care physician were listed on the discharge instructions. The signature lines for Patient A and a witness to sign were left blank.	E1956	This page left blank intentionally	

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E1956	Continued From page 8 In an interview on 3/27/17 at 2 p.m., ED Physician 4 stated she had oversight of the residents (ED Physician Residents 1 and 2). ED Physician 4 said, "Unfortunately we are unable to make an appointment for patients with clinics," and Patient A was discharged based on the psychiatrist's order. ED Physician 4 said she did not see any hint of a behavioral issue in Patient A to justify reestablishment of the 5150 hold and to reevaluate Patient A before discharge. By review of the ED electronic medical record, ED Physician 4 was listed on Patient A's "Disposition Summary" document as an ED physician. There was no documentation in the medical record by ED physician 4. During an interview, on 3/27/17 at 2:10 p.m., ED Physician Resident 2 stated the discharge process was based on Psychiatrist 1's order and also based on Patient A's behavior in the ED. ED Physician Resident 2 said there was no need for further evaluation at the time of discharge: "I would not go back and re-consult the patient. There was no reason to start a new evaluation." Review of the Policy and Procedure entitled "ED-Evaluation and Care of Psychiatric Patients", last revision of 6/2014, had the following directions: the "...Emergency department provides urgent medical screening for patients experiencing acute psychiatric complaints. Focused medical examination is performed in order to provide medical stabilization. The ED works collaboratively with our Psychiatric services at_____Psychiatric Hospital in a manner to safely facilitate transfer of care for patient to Psychiatric services after medical stabilization..."	E1956	This page left blank intentionally	

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E1969	Continued From page 9	E1969	This page left blank intentionally	
E1969	T22 DIV5 CH1 ART7-70707(d) Patients' Rights (d) All hospital personnel shall observe these patients' rights. This Statute is not met as evidenced by: See tag E 1956.	E1969		