Complaint Summary for Public Viewing Reports for:
ST MARY'S HOSPITAL AND MEDICAL CENTER

Intake ID: CO00007938
Facility: ST MARY'S HOSPITAL AND MEDICAL CENTER
Date of Complaint: 3/29/2006
Date of Investigation: 6/5/2006
Total Number of Allegations for Complaint: 1

Allegation: 1

Type: Resident/Patient/Client Rights

Findings: Substantiated

Allegation Detail: The Health Facilities and Emergency Medical Services Division received a complaint on 3/14/06. The complainant alleges that the facility failed to follow the patient's directives --- ---- when they resuscitated him and placed him on a respirator and inserted a nasogastric tube after the patient aspirated emesis.

Findings Detail: An unannounced on-site survey, authorized by Centers for Medicare and Medicaid (CMS), was conducted by four surveyors from 6/5/06 through 6/7/06. Interviews were conducted, policies, procedures, and medical records were reviewed. Observations included tours of patient care units throughout the facility. Area of survey included: Patient Rights.

The medical record of --- ---- was reviewed. On 4/26/04, the patient, a 79-year old living at an assisted living facility was somewhat confused and agitated. The patient's daughter --- ---- was contacted --- ----. EMS (emergency medical services) was contacted and the patient arrived at --- ---- per ambulance.

The patient presented to the ED (emergency department) at 12:53 p.m., with known diagnoses including --- ---- which required continuous oxygen needs. At the time of admission to the ED it was unclear if the patient had been wearing oxygen prior to and when he was found to be more confused that morning. It was documented by the ED physician, --- ----, the complete assessment and review of systems was "somewhat challenging to obtain secondary to some baseline agitation" --- ----. The patient only described "fatigue" as a presenting complaint. A medical work up was initiated and it was determined the patient was experiencing an --- ---- and was treated for --- ----. The patient was also found to have a --- ---- and was treated with --- ----.

During the patient's treatment in the ED, the physician documented a discussion with the patient and his/her daughter and conveyed a DNR (do not resuscitate) status. The emergency department orders stated "DNR disc. pt. & daughter" and this was placed in the ED chart. The physician documented in the
dictation notes, " this (DNR status) will warrant to be further clarified and made official while the patient is an inpatient".

An interview was conducted with the Director of Resource Management, --- ----, on 6/6/06. It was determined the ED physician had intended the DNR order to be in effect while the patient was in the emergency room. Once admitted to an inpatient status, the primary care physician would then assess the patient and complete new medical orders to meet patient care needs. The admitting physician, --- ----, was covering for the patient's primary care provider, --- ----, and had written admission orders on 4/24/06. Upon review of the patient medical record, there was no documentation of a cor status addressed in the physician's progress notes and there was no indication of this addressed within the physician's orders on the inpatient medical record.

On 4/27/06 at 11:00 p.m., it was documented in the nurses narrative notes, "pt heard coughing, upon entering the room witnessed --- ----.

An emergency response (Cor Zero) was called for the patient by the nurse. According to the physician response note dictated by --- ----, the patient was --- ---- by the time of his/her arrival. It was documented the patient had --- ----. The physician intubated the patient, and documented "neurologic status did seem to improve somewhat with adequate ventilation", and --- ----. The endotracheal tube was left in place. The patient was ventilated by ambu bag and then on a ventilator when h/she was admitted to the ICU (intensive care unit) and an NG (nasogastric tube) was placed to assist with drainage removal from the patient's stomach.

The emergency response physician, --- ----, had contacted the patient's primary care physician on call --- ---- about this occurrence, and during the phone conversation was handed a pink emergency room sheet which indicated a hand written note "patient is DNR". The physician documented --- ----.

The "Patient and Family Education Record" documented standards of care. One section included Advance Directives. This checklist included: "discussed advance directives as appropriate", "advance directive pamphlet offered and reviewed", and "consult spiritual care as needed". All three were initialed, dated 4/27, and it was written under the column who /present: "daughter/pt". However there was no evidence in the patient medical record of a copy of the patient's written advance directive provided by the patient's daughter or that this document was requested by staff. --- ----.

At approximately 1:00 a.m., the patient's daughter arrived and spoke with --- ----. Documentation in the progress notes revealed --- ----. Written orders were obtained to "extubate, discontinue the Dopamine drip, discontinue blood draws, and in the event of cardiopulmonary arrest or respiratory failure DNR/DNI (do not resuscitate; do not intubate)". At 1:25 a.m., a morphine PCA (patient controlled analgesic pump) was initiated for comfort measures and the endotracheal tube was removed. Pastoral care was present to provide emotional support for the patient's daughter. On 4/28/04 at 3:52 a.m., the patient was in asystole (without pulse) and expired at 4:15 a.m.

At the time of the survey the facility had revised their Advance Directives policy and procedures. The date of the revision was 4/2005; Communication Hand-Off for all patient care providers (approved 4/2006) and included a new form (color coded blue) and titled "Cardio/Pulmonary Resuscitation Status Order Sheet" implemented in 10/2005. This checklist form indicated "Do Not Resuscitate" or "Limited Resuscitation" with stated

guidelines in writing and included options for ambu and suction, intubation, external cardiac massage, electroshock, chemical cor only, and exceptions and additions to provide guidelines for individualized resuscitative efforts.

In summary, the allegation was substantiated regarding the DNR status, however there was no evidence of the patient's advance directive in the patient medical record. The nursing staff responded timely to a patient found unconscious and in respiratory distress secondary to aspiration of emesis. A DNR order was written in the emergency department and was not addressed by the admitting inpatient physician who was covering for the patient's primary physician. The physician, --- ----, discussed medical care treatments with the patient's daughter upon her arrival to the ICU and honored the daughter's last wishes for the patient.