



Complaint Summary for Public Viewing Reports for:
DENVER HEALTH MEDICAL CENTER

Intake ID: CO00007935
Facility: DENVER HEALTH MEDICAL CENTER
Date of Complaint: 3/29/2006
Date of Investigation: 6/12/2006
Total Number of Allegations for Complaint: 2

Allegation: 1

Type: Physician Services

Findings: Substantiated

Allegation Detail: The Health Facilities and Emergency Medical Services Division received a complaint on 2/7/06. The complainant alleges that staff physicians failed to removed the guide wire when a femoral line was placed in the patient during a procedure on 1/9/06. The guide wire was detected at a long term hospital, --- ----, on the day he was transferred there, 1/24/06. The patient was taken to another facility, --- ----, on 2/2/06, where a foreign body retrieval --- ---- was done. The patient was then returned to the long term hospital, --- ----.

Findings Detail: On 6/12/06 through 6/14/06 an unannounced on-site complaint investigation authorized by CMS (Centers for Medicare and Medicaid) was conducted by four surveyors. Conditions of Participation surveyed were Nursing, Medical Staff, Quality Assurance and Medical Records. Tours/observations of patient care, and staff interviews were conducted. Medical records, credential/personnel files and policies and procedures were reviewed. The findings were:

On 6/12/06 the record of the patient in the complaint was reviewed. According to a Clinic Note dictated by --- ---- the patient was a male in his forties who was involved in a motorcycle accident on 12/24/05. The patient was on his motorcycle, wearing a helmet, when he was struck by a driver of a truck. Upon arrival to --- ----.

According to the Discharge Summary from --- ---- dictated by --- ----, the patient was admitted to the hospital on 12/24/05 and discharged on 1/24/06. Principal diagnosis was Motorcycle Collision. Secondary Diagnoses: --- ---- Principal Procedure: --- ---- Hospital course by systems in pertinent part revealed --- ----

The Interventional Radiology Report from --- ----. Indications: --- ----

On 6/12/06 an interview was conducted with the Director of Regulatory Compliance, --- -- of the --- ----. He stated the facility was made aware --- ----.

According to documentation in the --- ----.

On 6/12/06 an interview with the Patient Safety/Quality Manager, --- ---- was conducted regarding what steps the facility had taken to prevent this from happening again. They stated a --- ----.

On 6/13/06 a tour of the SICU was conducted. It was observed the Central Line Cart was in SICU. Interview at that time with --- ---- revealed the cart is shared with the MICU (Medical Intensive Care Unit). The cart is kept locked, similarly to the crash cart, and is restocked when the seal is broken. A tour/observation of MICU and the SDU (Step Down Unit) revealed the new forms were available to staff. All other departments including the ED have instituted the form.

In summary, the allegation that staff physicians failed to remove the guide wire when a femoral line was placed in a patient during a procedure of 1/9/06 was substantiated. The facility had identified, investigated and had an action plan in place to prevent this from occurring again. No Federal deficiencies cited.

Allegation: 2

Type: Nursing Services

Findings: Unsubstantiated

Allegation Detail: The complainant alleges that facility nursing staff failed to follow all of the steps for verification to match the correct patient with the correct blood products.

Findings Detail: On 6/12/06 review of the patient's medical record revealed the allegation was unsubstantiated due to lack of sufficient evidence. The --- ---- The blood unit transfusion records for "Massive Transfusion" in the patient's record revealed blood transfusion policies were followed. No Federal deficient practice was cited.