

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MDKXC2	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 09/17/2008
NAME OF PROVIDER OR SUPPLIER HOLY CROSS HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 FOREST GLEN ROAD SILVER SPRING, MD 20910		
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{A 000}	<p>Initial Comments</p> <p>On September 17, 2008 a survey was conducted to follow-up on deficiencies related to Maryland's Health Care Decisions Act that were cited at Holy Cross Hospital on April 4, 2007. Survey activities included a review of the medical records of ten (10) patients, interview of staff and review of hospital policies. Deficiencies which resulted from this survey are contained in this report.</p> <p>§5-605 Health Care Decisions Act (c) (1) Any person authorized to make health care decisions for another under this section shall base those decisions on the wishes of the patient and, if the wishes of the patient are unknown or unclear, on the patient ' s best interest. (2) In determining the wishes of the patient, a surrogate shall consider the patient ' s: (i) Current diagnosis and prognosis with and without the treatment at issue; (ii) Expressed preferences regarding the provision of, or the withholding or withdrawal of, the specific treatment at issue or of similar treatments;</p> <p>This segment of the Health General Article is not met as evidenced by:</p> <p>Patient #7 is a 60-year-old man who presented to the Emergency Room on August 15th with worsening shortness of breath and hemoptysis (blood in the sputum). The Emergency Room physician did not have any evidence of the patient's wishes regarding intubation. Given his worsening respiratory status and no information to the contrary, the physician appropriately intubated the patient in the Emergency Room.</p>	{A 000}		

OHcq

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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{A 000}	<p>Continued From page 1</p> <p>The patient's diagnoses during the hospital stay included acute on chronic respiratory failure, chronic obstructive pulmonary disease, hemoptysis, ventilator-dependent, pulmonary fibrosis, pulmonary hypertension, cor pulmonale (right sided heart failure), acute on chronic kidney disease, systemic inflammatory response syndrome, sepsis, Clostridium difficile diarrhea, hypertension, hyperlipidemia, congestive liver failure, hypokalemia, obesity, failure to thrive, depression, and confusion. The procedures he received included placement of a central venous catheter placement, PICC line, tracheostomy, and percutaneous endoscopic gastrostomy. The patient's community pulmonologist also cared for the patient in the hospital.</p> <p>On 8/15/08, a physician transfer summary notes that the patient is known to have "refused intubation in the past." On 8/16/08, the pulmonologist's progress note states "Patient never wanted to be intubated. Probably was unable to vocalize that in the ED."</p> <p>On 8/22/08, the doctor ' s progress note states "Dr. T. mentioned trach to patient and he indicated that he was not interested in trach." On 8/22/08, a pulmonary progress note states "Family meeting with brother, sister, son about tracheostomy. Spoke to patient. He understood but doesn't quite get that the alternative is terminal weaning. Will await family decision as they may decide for him."</p> <p>On 8/23/08, a medicine progress note states that the patient is refusing a trach. On 8/23/08, a doctor's progress note states "Dr. I. met with family and patient. Unclear if patient is able to comprehend and make decisions. Family to make decision regarding trach." On 8/24/08, the</p>	{A 000}			

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{A 000}	Continued From page 2 pulmonologist's note states "Tracheostomy of next week hopefully. Patient not weanable at this point. Family likely to decide for him. I seriously doubt terminal weaning as much as patient was against intubation." On 8/25/08, a progress note states "Today patient is agreeable to trach." This is the only indication in the chart that the patient agrees to a tracheostomy, but multiple prior notes indicate the patient lacks the capacity to make this decision. On 8/25/08, there is a Post-it note on the progress sheet that states "MD, Please consider palliative care consult prior to trach decision as patient did not want intubation (assist family). Tx." On 8/25/08, a doctor's progress note says that they will discuss with patient and family about trach. On 9/1/08, the patient's brother signed a consent for a tracheostomy. On 9/4/08, a tracheostomy was done. On 9/5/08, a percutaneous endoscopic gastrostomy was done. From August 15th to September 4th, no ethics committee was convened and no palliative care consult was done to address this issue. Throughout the chart it is repeatedly stated that the patient did not want to be intubated or get a tracheostomy. Surrogate decision makers were allowed to make decisions that were in contrast to the patient's stated wishes regarding no intubation or tracheostomy. §5-606 Health Care Decisions Act (a) (1) Prior to providing, withholding, or withdrawing treatment for which authorization has been obtained or will be sought under this subtitle, the	{A 000}		

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{A 000}	<p>Continued From page 3</p> <p>attending physician and a second physician, one of whom shall have examined the patient within 2 hours before making the certification, shall certify in writing that the patient is incapable of making an informed decision regarding the treatment. The certification shall be based on a personal examination of the patient.</p> <p>This segment of the Health General Article is not met as evidenced by:</p> <p>Review of the medical records of Patient # 6 and Patient # 2 revealed that the hospital staff sought treatment decisions from family members rather than the patients but did not first certify that the patients were incapable of making informed decisions regarding such treatments. The decisions centered on significant issues such as consent for major surgery and the withholding of resuscitative measures.</p> <p>§Health-General 4-304 Copies of Records, changes in records.</p> <p>(b) Changes in records - (1) A health care provider shall establish procedures for a person in interest to request an addition to or correction of a medical record (5) If the final determination of the health care provider is a refusal to change the medical records, the provider: (i) shall permit a person in interest to insert in the medical record a concise statement of the reason that the person in interest disagrees with the record.</p> <p>This segment of the Health General Article is not met as evidenced by:</p> <p>Patient #11 died at Holy Cross Hospital on March</p>	{A 000}		

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{A 000}	<p>Continued From page 4</p> <p>27, 2003. On May 12, 2006 the patient ' s son, a person in interest, wrote to the president and chief executive officer of the hospital requesting changes to his father ' s medical record. In that correspondence the son concisely summarized what he believed to be erroneous entries in his father ' s medical record and requested that those entries be addressed.</p> <p>On May 18, 2006 the hospital ' s director of medical records wrote to the patient #11 ' s son and instructed him to complete a form entitled " Request to Amend/Correct Health Information Held by Holy Cross Hospital " . The son complied and on June 5, 2006 sent the completed form and additional information which concisely addressed which part of the medical record the son disputed to the director of medical records.</p> <p>On September 7, 2006 privileged correspondence was generated between an attorney representing Holy Cross Hospital and an attorney representing patient #11 ' s son. Ultimately no changes were made to the medical record nor was the concise statement which the son had presented to the hospital on two occasions ever inserted into the medical record.</p> <p>§5-606 Health Care Decisions Act (a) (1) Prior to providing, withholding, or withdrawing treatment for which authorization has been obtained or will be sought under this subtitle, the attending physician and a second physician, one of whom shall have examined the patient within 2 hours before making the certification, shall certify in writing that the patient is incapable of making an informed</p>	{A 000}		

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{A 000}	Continued From page 5 decision regarding the treatment. The certification shall be based on a personal examination of the patient. This segment of the Health General Article is not met as evidenced by: Review of the medical records of Patient # 6 and Patient # 2 revealed that the hospital staff sought treatment decisions from family members rather than the patients but did not first certify that the patients were incapable of making informed decisions regarding such treatments. The decisions centered on significant issues such as consent for major surgery and the withholding of resuscitative measures. §Health-General 4-304 Copies of Records, changes in records. (b) Changes in records - (1) A health care provider shall establish procedures for a person in interest to request an addition to or correction of a medical record (5) If the final determination of the health care provider is a refusal to change the medical records, the provider: (i) shall permit a person in interest to insert in the medical record a concise statement of the reason that the person in interest disagrees with the record. This segment of the Health General Article is not met as evidenced by: Patient #11 died at Holy Cross Hospital on March 27, 2003. On May 12, 2006 the patient's son, a person in interest, wrote to the president and chief executive officer of the hospital requesting	{A 000}		

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{A 000}	Continued From page 6 changes to his father's medical record. In that correspondence, the son concisely summarized what he believed to be erroneous entries in his father's medical record and requested that those entries be addressed. On May 18, 2006 the hospital's director of medical records wrote to the patient #11's son and instructed him to complete a form entitled "Request to Amend/Correct Health Information Held by Holy Cross Hospital." The son complied and on June 5, 2006 sent the completed form and additional information which concisely addressed which part of the medical record the son disputed to the director of medical records. On September 7, 2006 privileged correspondence was generated between an attorney representing Holy Cross Hospital and an attorney representing patient #11's son. Ultimately no changes were made to the medical record nor was the concise statement which the son had presented to the hospital on two occasions ever inserted into the medical record.	{A 000}		
{A 142}	10.07.01.08 B (3) (a) Complaints Investigations .08 Complaint Investigations. B. Complaints. (3) If the Department determines that the hospital or residential treatment center has not satisfactorily addressed the referred complaint or if the complaint alleges the existence of a life-threatening deficiency, the Department shall conduct an independent investigation. When conducting its independent investigation, the Department shall use:	{A 142}		

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{A 142}	<p>Continued From page 7</p> <p>(a) For an accredited hospital, the standards of review of the Joint Commission on Accreditation of Healthcare Organizations;</p> <p>This Regulation is not met as evidenced by: Based on review of medical records it was determined that the hospital staff did not meet the following standard of The Joint Commission in the care of patient # 6:</p> <p>RI. 2.80 The hospital fails to address the wishes of the patient related to end of life decisions.</p> <p>Based on review of patient #6's medical records, it was determined that the hospital failed to address the patient's end of life wishes as soon as possible after admission as evidenced by:</p> <p>Patient #6 is a 95-year-old woman who was transferred from an assisted living facility to the Emergency Room on August 6, 2008. The patient was admitted to the hospital for management of pneumonia, probable Clostridium difficile diarrhea, acute renal failure, dehydration, leukocytosis, and hypernatremia.</p> <p>The assisted living facility sent the patient's Maryland Emergency Medical Systems Do Not Resuscitate form to the Emergency Room. Option B was checked off, indicating that the patient did not want resuscitation to be attempted in the event of a cardiac or pulmonary arrest.</p> <p>The physician's history and physical that was completed on August 7th does not mention code status. Contrary to the patient's wishes to not be resuscitated, she was a full code from her arrival to the hospital until August 8th. A progress note</p>	{A 142}		

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{A 142}	Continued From page 8 on August 8th noted the doctor clarified the patient's wishes regarding resuscitation with her son. The physician wrote a "do not resuscitate" order and completed a second Maryland Emergency Medical Systems form indicating Option B. The facility failed to properly document the patient's code status in a timely manner. If the patient had coded prior to August 8th when the DNR order was written, she would have been resuscitated despite her clearly documented wishes for no resuscitation.	{A 142}		