Lakeside Medical Center
Glades Rural Area Support Board
Patient Safety and Quality Committee Meeting Minutes
September 15, 2014
Board Room, Lakeside Medical Center

I. Roll Call

Janet Moreland called the meeting to order at 10:42 a.m.

A. Roll Call

Committee members present: Janet Moreland, Chair/LMC Director of Quality and Patient Safety; Dr. Alina Alonso, Board Member; Gilberto Alvarez, Board Member; Sandra Chamblee, Board Member; Mary Weeks, Board Member; Thomas Leach, Administrator, Lakeside Medical Center; Elizabeth Fiegel, Director of Nursing, Lakeside Medical Center; Shelley Nesbitt, Director of Clinical Support/Pharmacy, Lakeside Medical Center; David Jamison, Director of Support Services, Lakeside Medical Center; Jonathan Immordino, Director of Hospital Finance; Terri Calsetta, Patient Advocate, Lakeside Medical Center; Nicholas Romanello, Chief Legal Counsel; Tina Luque, Director of Corporate Risk and Insurance, Health Care District.

Committee members absent: Heidi Denton, DO Resident; Nathan Kaller, DO Resident; Dr. Daniel Kairys; Darcy Davis, Chief Institutional Officer, Health Care District; Morgan Means, Interim Compliance Officer; Dr. Ronald Wiewora, Chief Executive Officer, Health Care District.

Guest: Lisa Wade, Risk Manager, Lakeside Medical Center

Recording Secretary: Tara Harn

Transcribing Secretary: Katie Person

B. Introductions

None.

II. Meeting Minutes Approval

A. August 18, 2014 Patient Safety and Quality Committee Meeting Minutes

CONCLUSION/ACTION: Ms. Chamblee made a motion to approve the August 18, 2014 Patient Safety and Quality Committee meeting minutes as presented. The motion was duly seconded by Dr. Alonso. A vote was called, and the motion passed unanimously.

III. Agenda Approval

A. Additions/Deletions/Substitutions

None.

B. Approval of the Consent Agenda.

C. Approval of the Regular Agenda.

CONCLUSION/ACTION: Dr. Alonso made a motion to approve the Consent Agenda and the Regular Agenda as presented. The motion was duly seconded by Ms. Weeks. A vote was called, and the motion passed unanimously.

IV. Consent Agenda

A. **RECEIVE AND FILE:**
Legal Notice of Patient Safety and Quality Committee meeting posted at www.lakesidemedical.org.

V. Regular Agenda

CLOSED

1. **RECEIVE AND FILE:**
Patient Safety and Quality Report

Ms. Moreland stated that she would like to share with you on the first report for the months of July and August there were 17 occurrence reports submitted. There were 13 with no injury, three with minor, and one with significant. The next page provides a brief description of each incident that occurred in the month of August. She would like to go through that with you.

Ms. Moreland stated that on August 1 we had a miscellaneous that we categorized in the OB Department. The category was minor. What we found was the patient communicated that she was allergic to latex. A latex Foley catheter was replaced

with a latex-free. There was no harm or injury to the patient, but we what we wanted to do in terms of prevention strategy is reinforce the handoff communication to the OB nursing staff. What we have also done is consider latex-free Foley catheters hospital-wide. We have scheduled a meeting with the managers in material management to see what the cost effectiveness of that would be. That is an ongoing process we are looking at. With this very same patient there was an IV that was not primed, which means the solution was not run through the line. That means there was some air in the line. The CRNA, a staff member, provided in-service on August 4 with our staff in terms of IV fluids via pressure bag. The nurse will remain at the bedside to monitor the condition and status during that process. There was no major harm to the patient, but we did need to note that.

Ms. Moreland stated that the next incident occurred on August 11 and was against medical advice that occurred in PCU. The patient refused Ativan by mouth. He wanted it by IV. The patient left against medical advice. He was first provided education by the physician and the director of nursing in regards to the risks and benefits of signing out of the hospital against medical advice. We provided ongoing patient education. In addition, for this particular patient, pain management education and counseling was provided.

Mr. Alvarez asked if we did not provide the Ativan by IV.

Ms. Moreland affirmed.

Mr. Alvarez asked if he signed out and went someplace else.

Ms. Moreland stated that she is not sure if he went someplace else.

Ms. Fiegel stated that he comes in about once a week.

Dr. Alonso asked what he was being treated for.

Ms. Fiegel stated that he comes in with chest pain. He is well known to us. We try to do education about his pain medications, but he insisted having the Ativan IV. The hospitalist had to talk to him. We have tried other modalities. He is in about once a week. We met with his primary care doctor and suggested a pain management doctor. Ernesto, our nurse navigator, is working on his case trying to see if he can get him set up with a pain management doctor. He has a lot of anxiety as well. He does have social support, a significant other who comes with him. However, he has some personal anxieties.

Dr. Alonso asked if the Ativan has worked in the past.

Ms. Fiegel replied not IV.

Dr. Alonso referred to just the Ativan.

Ms. Fiegel referred to P.O.

Dr. Alonso stated that it is because it calms him down, so Valium would work, too.

Ms. Fiegel expressed agreement.

Ms. Moreland stated that the next incident to report occurred on August 11 and was against medical advice in PCU. Patient and family requested to leave to seek treatment with their personal physician at Good Samaritan Hospital. Once again, risks and benefits were discussed with the family.

Mr. Alvarez asked for clarification.

Ms. Moreland stated that they came in through the emergency room and got admitted. During the course of their treatment, they decided they wanted to leave. Both of these patients were inpatient admissions.

Mr. Alvarez asked if they get charged for that if they have insurance.

Mr. Leach said he does not know if they had insurance or not. If they need to be admitted, they are admitted regardless.

Mr. Alvarez expressed understanding.

Mr. Leach stated that for the time that they have been here, they get charged for their care.

Ms. Moreland stated that the patient had been here for a number of hours in our care and decided to seek treatment with their personal physician at Good Samaritan Hospital.

Dr. Alonso stated that this one sounds to her as though his doctor does not come here for whatever reason, and he wanted to see his doctor. Once they feel a little stable that they are not dying, they may decide to go somewhere else.

Mr. Alvarez said, as long as we can charge him.

Ms. Moreland stated that the next incident occurred on August 16 and was categorized as miscellaneous in PCU. There was no injury. The patient could not remember where he left his wallet. The patient admission belonging list did not indicate that he had a wallet, but the wallet was found under the mattress and returned to the patient.

Ms. Moreland stated that the next one was laboratory OB. There was a blood test, a PKU, that was ordered on a newborn. It was placed on the wrong patient card. The test was redrawn. What occurred with this employee was a review of the policy because the patient identifying policy should have been utilized in this case. There will be ongoing monitoring, and she is sure some type of documentation will be implemented.

Ms. Moreland stated that the next case was August 18 and a medication variance ICU. Due to other extenuating circumstances with this patient, the patient coded four times en route to the hospital, in the ED, and ICU. There was regular insulin that was delayed. There was no injury in regard to the insulin occurrence. The patient came in with elevated potassium that was the focus of attention for the provider. Blood sugar at that time was within normal limits. However, the patient needed to receive regular insulin, and there was a delay in receiving that insulin. Once again, the patient coded four times, one en route to us, one in the ED, and a couple of times in the ICU. The recommendation is to have some type of education by an endocrinologist, so we are looking to set that up. A long term goal is to have a diabetic nurse educator.

Dr. Alonso asked if that would even come into play if you are coding. The regular insulin usually is after meals.

Ms. Moreland stated that based on the chart review and the orders of the physician, that was an order of the physician.

Dr. Alonso expressed understanding. She thought the patient was arguing that.

Ms. Moreland said the patient was coding. Because of the delay in the insulin and some other things, we are going to route this to peer review which will occur on September 19.

Ms. Moreland stated that the next incident was a late entry. This occurred on May 13, but we got a report because we needed to find out exactly what happened. It was reported on 8/21 but the incident occurred on May 13. A visitor was walking down the hall and looking for a room number when he tripped over his own feet. He did not get hurt. He declined medical treatment. There was no obstruction in terms of the environment that contributed to it, and he was not harmed at all. Follow-up has been provided with him. He is fine.

Ms. Weeks asked if he came back and said this happened.

Ms. Moreland responded negatively, stating that we had a couple of staff members who were out, and we needed to get witnesses and some other things. By the time that occurred, it was late. It was reported the day it occurred, but the investigation part took a little bit longer in terms of witness statements.

Ms. Moreland stated that the next incident was on 8/22 and was inpatient miscellaneous. A patient pulled out the tube after being weaned off sedation for five hours. Respiratory therapy and the nurse were at bedside. There was no respiratory distress. The chest x-ray and lab were performed as per protocol. The patient was later transferred to PCU on telemetry. What is being recommended, and she thinks it will be sometime very soon, is gradual approach to weaning off sedation will be discussed at the critical care line meeting. That is an agenda item to look at that.

Ms. Moreland stated that the last incident is an IV infiltration and a minor injury. The site was infiltrated, which means it was a little red and a little swelling was there. The prevention strategy is to consider use of PICC line to be discussed also at the critical care service line meeting. There will be ongoing monitoring of this process, but there was minor harm to the patient that related to redness and swelling.

Ms. Moreland stated that for the months of July and August there was a total of 17 incidents. She asked if there were any questions on any of those. There being none, she stated that the next one she would like to share with you is the hospital acquired, and she showed the dashboard. For the months of July and August we have some pending cases. For the month of August there were five cases, four of which were pneumonia. We would like to involve the respiratory department as well as nursing and others to look at this, as well as the infection control nurse. That is why she put pending review. Right now there are five, but we do need to look at each case to see how we can do things a little better.

Mr. Alvarez stated that he has very small grandchildren, and the mothers are all concerned about this infection of the kids that are up north.

Dr. Alonso stated that it is a variation of the common cold. She asked if the kids have asthma.

Mr. Alvarez asked if we are aware of it here in case somebody comes in. He asked if we will be able to determine that is what it is.

Dr. Alonso said we would have to test for it, but she is asking if his kids have asthma.

Mr. Alvarez stated that they do.

Dr. Alonso stated that they are the ones at a higher risk. This is affecting the kids with asthma. If they start with a cold, just get them in right away.

Mr. Alvarez stated that he is concerned hospital-wide; if people do not go to get care they will come into the hospital. He just wants to make sure they will be aware that it is out there.

Ms. Fiegel stated that we have done staff education. They talked about it at huddle on Friday.

Ms. Moreland stated that in relation to the hospital acquired, if you will bear with us, we will have a meeting within the next week to look at those four cases that were pneumonia diagnosed. The patients all originated in the ICU and then transferred. We will need to look at those cases specifically.

Mr. Leach asked if the pneumonias were VAPs.

Ms. Fiegel stated that they were not. We have to look at them, but what we think is maybe we have an opportunity to get some sputums on arrival and culture them. They probably had the bacteria but not present on chest x-ray.

Mr. Leach stated when it comes to pneumonia, the only thing he has to put on here are VAPs when it comes to hospital acquired infections, but the team has taken an approach where they are researching all of them. He has no problem going high and explaining it later. This is our approach to how we practice out here, and he appreciates that we are looking at all of them. Again, these documents you are looking at are what go up on our communication boards each and every month. Our staff will be able to explain it to anyone as well.

Ms. Moreland stated that is exactly what we want to do. We want to take a look at each case. Our infection control nurse, respiratory nurse, she, and others will be to the table to look at each case.

Mr. Leach stated that is part of our goal of chasing zero. One infection is too many for a hospital. We are going to have them, but we need to research and look at each and every one of them. He applauds the efforts.

Ms. Moreland stated that next is catheter associated, and we had none for the month of August. For central line we had none for the month of August. We had one surgical site infection. We had a patient who had a surgical procedure, and the area started to open up just a little bit. The patient has since been followed by the primary care clinic, first at the Health Department, primary care, OB, and then also followed by the nurse navigator. The patient is doing much better. It was a self-pay patient whom we need to help get medication and antibiotics to get her moving. She is doing fine.

Ms. Weeks asked what surgery it was.

Ms. Fiegel stated that it was post c-section. She had a lot of folds. What we have done on that is OB is giving the patients an antimicrobial scrub to take home, and before they come in they are supposed to shower and use that antimicrobial. If they come in all of a sudden and have not showered, then we are going to try to shower

them here with that antimicrobial. On the clipping in OB, we are making sure the clipping happens in OB and not in the OR because those hairs can cause infection. The biggest part is patient education about how to keep it clean and take care of it.

Ms. Moreland stated that for the month of August we had no inpatient falls at all. She then stated that before we open the session, she wants to report that with very limited information right now that she has, there is a code 15 that we will be reporting. A two-day old male infant expired here at the hospital. It is very hard for the staff and everyone here who has been dealing with this case. We are doing everything we can do to move things along. The first step will be within the next two days Lisa the risk manager and she will be completing a code 15 reporting this to AHCA. The next will be self reporting to the Joint Commission as a sentinel event. We have since, on that very same day, had a debriefing. This occurred on 9/2 with nursing staff, quality, risk, as well as the physicians. We have had a root cause analysis that was done on 9/18. We have lots of things that came out of that. We are utilizing the framework of the Joint Commission in terms of the root cause questions. We are also looking at everything related to that.

This was not a case for the M.E. She spoke with the M.E. He was very nice. He sent her a 21-page document as to why it was not a case. There was no criminal intent. The patient was under the care of a physician. She had to secure an autopsy service, which was University of Miami. We used them in 2009 thinking that everything was in place still, but they had lots of staff turnover and could not locate the document, so we started from square one with getting everything secured as a client of University of Miami. She then tried to facilitate getting the transport back and forth. The number of the company we used in 2009 was not a working number, so we secured a local funeral home company here. We were expecting to hear something back within 24 hours. Every day she has talked to probably 10 people within that department at University of Miami. She will be making a call as soon as she gets out of here because we have not received any preliminary information. She has been working closely with Tina Luque, Mr. Romanello, and others to make sure we sequester the record, medical equipment, and everything we are aware of. She does not have any answers at this point. Once again, it is very hard for all staff involved.

Dr. Alonso said perhaps after you work on the case itself you can share a little bit more with her because we have had problems with the M.E. not taking cases. She does not see how this cannot be a case for the M.E. She is sure they have their reasons, and she would like to explore that. If we have to take it up further, we will.

Ms. Moreland stated that she can share with you his name. He did send her the document as well as a webinar to go on and take a look at. He said this communication went out to physicians in general within the state of Florida. According to what he told her, when Janet Reno was in office, she clearly defined what would be an M.E. case. He quoted the Florida Statute and provided a copy to

her. However, he said the patient was under physician care, and she will be more than happy to share after that.

Dr. Alonso stated that physicians cannot do autopsies. Basically it falls on the family then having to do the autopsy if they want to know why the death occurred.

Ms. Moreland stated that she wanted to bring that to your attention. When we receive the autopsy report, she will certainly share whatever is within our rights to do so.

OPEN

Ms. Moreland stated that Lisa Wade is our risk manager as well as herself. We both completed our risk licenses and received them. Right now she is the person listed for Lakeside. Ellen is no longer the risk manager here listed for Lakeside. We will be working on Lisa's paperwork this week to also have her, so there will be two risk managers listed for Lakeside Medical Center. We are happy, and we had our first risk management survey, a three-day process. Thankfully we had everything in order. There were three minor things, two of which have already been taken care of. We just have to appoint a representative who is not a practicing physician or nurse to our hospital safety meeting. We will be working on that very quickly. Our next meeting is scheduled in October for patient safety, so we will have a representative at that meeting.

Mr. Leach stated that with an AHCA survey, once we receive the official findings, which is normally 10 days to two weeks after the survey is completed, then we will have 30 days to respond. You have about a month and a half, give or take, from the time they walk out the door to really get things straightened up. After those 30 days you are eligible for a re-inspection. That is for any AHCA survey. Already having two of the three taken care of before we even get the official survey in writing back to us is just being one step ahead of the game. He referred to the three findings, basically some documentation errors in our recordkeeping, the community member on one of our boards, and our annual risk training. They found one person out of the records they reviewed who had a 45-minute documented risk training instead of the hour required risk training. All of that is very correctible, and we will ensure the processes get in place to have that fixed. He cannot express how proud he is of the entire team.

2. **MOTION TO APPROVE:**
Medical Staff Report

None.

3. **RECEIVE AND FILE:**
Customer Service Update
Customer Service Education Committee

Ms. Calsetta stated that we do not have a new report because it came in Friday afternoon after she left. We will get that next month. Nothing has changed from last month.

4. **RECEIVE AND FILE:**
Regulatory Visits

Ms. Moreland advised to stay tuned for the final report.

5. **RECEIVE AND FILE:**
Resident Update

Ms. Moreland noted that the resident report was provided at the previous meeting.

VI. Comments

Dr. Alonso asked if we are going to make suggestions as to how we report to the main committee. She does not have the name yet.

Mr. Romanello stated that in November he is hoping the Health Care District Board appoints members to the Patient Safety Committee. He guesses that committee will have a formative meeting sometime toward the end of this calendar year. Then we can start talking about process.

Mr. Leach stated that one of the processes he knows they are looking at is an electronic reporting format for the whole District organization. That is something he is extremely supportive of. If we are able to get that in place this year or next year, he thinks overall it will help out tremendously.

Mr. Romanello stated that what Dr. Alonso is talking about is kind of central to the whole creation of that committee. The whole purpose of that is to have a system-wide view of risk without drilling down into the facts and circumstances of each fall at the Healey Center or the hospital.

Dr. Alonso stated that it is not to do what we are doing here in detail. It will be very general. Her suggestion is we do something like what Healthy Palm Beaches used to report to the board.

Mr. Alvarez asked if legal got involved immediately in the case of the two year old.

Mr. Romanello stated that we were notified immediately of the incident. The system worked flawlessly. It came up through risk from the hospital to the corporate office and to legal. There was good communication.

Mr. Leach stated that he has to commend Mr. Romanello and Ms. Luque and their team because the support has been tremendous. He is very happy with the communication effort.

Mr. Alvarez stated that it is so hard especially in a smaller hospital where nothing hardly ever happens like that. He can imagine how hard it is for the family.

Mr. Leach stated that it is tremendously devastating both for the family and the staff involved. Our staff live in this community also, and they have to face this family sometimes. That is a very hard thing for them to do. This has been a challenge for the organization, but we have to maintain our professionalism. We have to maintain our empathy and sympathy with the family and provide them what we can provide them. We still have an operation to run, and we have to put the right processes in place. Whenever there is a tragedy, you usually develop processes to help prevent that tragedy from happening again. We have done everything he thinks we possibly could to help that process along. There definitely is a healing process that goes with it.

Mr. Alvarez stated that he understands everything we say here stays here, but being a small community, people will start talking. They will approach us as members of the other board. He is assuming all we say is it is being worked on.

Mr. Leach stated that he just encourages you all, if you are approached in the community, to be empathetic and sympathetic, and what tends to be presented out there are not necessarily the facts of the case. You just lend an ear and let them know the organization is doing everything in our power to move forward.

Mr. Alvarez asked if we will know the results in one of those committees eventually of what happened.

Dr. Alonso stated that all we can know is what the M.E. tells us. With these things, sometimes you never know what happened.

Mr. Leach stated that we will come back with what we can.

VII. Upcoming Meetings

2014 Patient Safety and Quality Committee Meeting Schedule:

October 20
November 17
December 15

2015 Patient Safety and Quality Committee Meeting Schedule

January 19
February 16
March 16
April 20
May 18
June 15
July 20
August 17
September 21
October 19
November 16
December 21

VIII. Adjournment

There being no further business, the meeting was adjourned at 11:14 a.m.

Janet Moreland, Chair
Patient Safety and Quality Committee

10/2014
Date Approved