



IDAHO DEPARTMENT OF
HEALTH & WELFARE

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October 29, 2013

Doug Crabtree, Administrator
Eastern Idaho Regional Medical Center
PO Box 2077
Idaho Falls, ID 83403-2077

RE: Eastern Idaho Regional Medical Center, Provider #130018

Dear Mr. Crabtree:

On **October 22, 2013**, a complaint survey was conducted at Eastern Idaho Regional Medical Center. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00006031

Allegation #1: The facility failed to respond to a patient in a timely manner when tracheostomy tube became dislodged. The facility did not know how long the tube was dislodged and the patient suffered a respiratory and cardiac arrest as a result of the delay.

Findings # 1: An unannounced, on-site complaint survey was conducted from 8/19/13 to 8/20/13. Facility policies were reviewed and staff interviews were conducted. Incident report logs and Code Blue incidents from January 2013 to April 2013 were reviewed. Medical records of 7 patients who experienced a significant cardiac or respiratory event were reviewed.

One patient record was that of a patient who had a tracheostomy performed approximately 24 days before a Code Blue incident. The patient record also indicated the patient was preparing for discharge to a rehabilitation facility. The record noted the patient was transferred from the ICU to the telemetry unit earlier that shift. On 3/18/13 at 3:30 AM, while she was receiving personal care, the patient experienced shortness of breath and difficulty breathing. The nurse documented the patient was repositioned, the inner cannula of the tracheostomy was changed, and the patient was suctioned. The patient's oxygen saturations improved, and the patient was noted to be resting quietly with her call light within reach. Towards the end of the shift, the patient experienced another episode of oxygen desaturation.

A Cardiopulmonary Resuscitation Flow Sheet documented the telemetry monitor alarmed when the patient experienced bradycardia (decreased/slow heart rate) at 5:27 AM. The flow sheet documented staff arrived in the patient's room at 5:28 AM. When the staff arrived in the room it was noted the patient had removed the inner cannula of her tracheostomy tube and had no heart rate. The staff initiated cardiac compressions immediately and replaced the inner cannula of the tracheostomy tube. The patient was transferred back to the ICU at 5:45 AM.

A Code Blue Critique form was completed by the House Supervisor at the time of the event . The form contained information such as "OBSERVATION OF PROPER CPR TECHNIQUES, EFFICIENCY OF PERSONNEL and EQUIPMENT & SUPPLIES." The form was completed and indicated there were no problems noted by the House Supervisor during the event.

During an interview on 8/20/13 beginning at 9:00 AM, the Manager of the Intensive Care Unit (ICU) stated the House Supervisor responded to all "Code Blue" calls and would complete a critique form after the event. The form was to be attached to the Cardiopulmonary Resuscitation Flow Sheet, and sent to him for review. The Manager of the ICU stated he met with the members of the code review team each month and discussed all cardiac and respiratory arrests that had occurred.

The Manager of the Critical Care Unit (CCU) was also interviewed. After reviewing the medical record, she stated that at the time of the event the technician that monitored telemetry patients had been relieved by the charge nurse for a break. The charge nurse was watching the monitors from the nurse's station. The Manager of the CCU stated the charge nurse had initially disregarded the patient's oximeter (a noninvasive devise, usually attached to a finger or earlobe, used to measure oxygen saturation level) alarms when they triggered. The Manager of the CCU explained that patient movement may cause an oximeter alarm to go off and the alarms did not always indicate a patient was in distress. She stated the staff did respond immediately when the patient's bradycardia alarm went off.

The Manager of the CCU stated after the event occurred the facility made the following changes:

- Patient and nursing staff ratio is adjusted so nurses have fewer patients when assigned to care for a patient with a tracheostomy.
- Patients with a tracheostomy are placed close to the nursing station.

The other 6 records showed appropriate and timely staff response to critical events.

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It was determined the facility failed to respond to an alarm indicating a patient's oxygen saturation level was low. The patient subsequently experienced cardiac and respiratory arrest requiring resuscitation. While the complaint was substantiated, no deficiencies were cited, as the facility initiated corrective actions prior to the survey.

Conclusion #1: Substantiated. No deficiencies related to the allegation are cited.

Allegation #2: A patient was forced to do physical therapy despite her protests.

Findings #2: An unannounced, on-site complaint survey was conducted from 8/19/13 to 8/20/13. Seven clinical records and facility policies were reviewed and staff interviews were conducted.

One patient record was that of a patient who had a tracheostomy. The patient record also indicated the patient was preparing for discharge to a rehabilitation facility. No evidence was found that this patient, or the 6 other patients reviewed, were forced to perform physical therapy.

While the events may have occurred, it could not be verified through the investigative process.

Conclusion #2: Unsubstantiated. Lack of sufficient evidence.

As only one of the allegations was substantiated, but was not cited, no response is necessary.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,



SUSAN COSTA
Health Facility Surveyor
Non-Long Term Care



SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

SC/pt