PATIENT DEATH UNDER ANESTHESIA

CMS declares "Immediate Jeopardy" to patient safety

"Based on the review of medical records, documents, policies and procedures and interviews, it was determined that the facility failed to ensure that patient care services are provided in a manner that protects the health and safety of all patients."

- Centers for Medicare & Medicaid Services (CMS) report

1 Problem

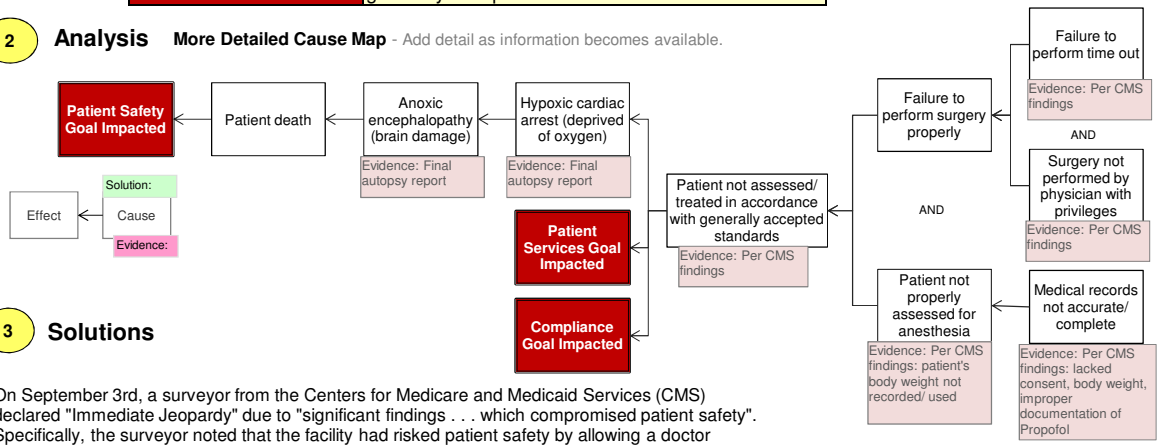
What	Problem(s)	Patient cardiac arrest, death under anesthesia
When	Date	August 28, 2014
	Time	See timeline
	Different, unusual, unique	History of chronic reflux disease
Where	Facility, site	Manhattan, NY
	Unit, area, equipment	Endoscopy center
	Task being performed	Patient undergoing endoscopy

Impact to the Goals

Patient Safety	Patient death
Compliance	"Never event"
Patient Services	Patient not assessed/ treated in accordance with generally accepted standards

2 Analysis

More Detailed Cause Map - Add detail as information becomes available.



3 Solutions

On September 3rd, a surveyor from the Centers for Medicare and Medicaid Services (CMS) declared "Immediate Jeopardy" due to "significant findings . . . which compromised patient safety". Specifically, the surveyor noted that the facility had risked patient safety by allowing a doctor without privileges to be allowed in the operating room and perform a procedure, and not obtaining consent or performing a time out for a procedure that was performed.

The facility quickly submitted a corrective action plan that revised procedures allowing visitors to the facility, ensuring informed consent and time out procedures are used before every procedure, and providing training on these updated procedures to staff. Immediate jeopardy was removed on September 5th.

Cause Mapping is a Root Cause Analysis method that captures basic cause-and-effect relationships supported with evidence.

CAUSE MAPPING

Problem Solving • Incident Investigation • Root Cause Analysis

Step 1	Problem	What's the Problem?
Step 2	Analysis	Why did it happen?
Step 3	Solutions	What will be done?

For a free copy of our Root Cause Analysis Template in Microsoft Excel, used to create this page, visit our web site.

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Timeline

Date	Time	Description
August 28, 2014		Patient arrives at endoscopy center for esophagogastroduouudenoscopy (EGD)
		Patient notifies staff her personal doctor will be joining her
	8:44:00 AM	Pre procedure vital signs taken: BP 118/80, pulse 62, regular respirations 16, temperature 97.2 F, SpO2 100%
	8:50:00 AM	Patient signs anesthesia consent
	9:04:36 AM	Time out announced for EGD by endoscopy technician
	9:21:45 AM	Medical Administration Record notes 100 mg Propofol administered to patient
	9:12:49 AM	BL 117/60, pulse 71, SpO2 92%
	9:16:13 AM	BP 92/54, pulse 54, respirations 16, SpO2 94%, ETCO2 26
	9:21:42 AM	BP 89/44, pulse 54, respirations 17, SpO2 97% ETCO2 19
	9:21:46 AM	Medical Administration Record notes 100 mg Propofol administered to patient
	9:21:48 AM	Medical Administration Record notes 50 mg Propofol administered to patient
	9:21:50 AM	Medical Administration Record notes 50 mg Propofol administered to patient
	9:26:36:AM	BP 84/40, pulse 47, SpO2 92@
		Patient's personal ENT begins nasolaryngoscopy
		Patient undergoes EGD performed by endoscopist
	9:28:00 AM	Patient undergoes second nasolaryngoscopy performed by ENT
		Cardiac Arrest Record indicates patient went into cardiac arrest
		Endoscopy Code Blue Record noted patient in ventricular tachycardia
		Endoscopy Code Blue Record documents assisted ventilation and chest compression initiated
		Endoscopy Code Blue Record notes Epinephrine 1 mg and Atropine 1 mg administered
	9:30:00 AM	Laryngoscope withdrawn
		Cardiac Arrest record indicates cardiopulmonary resuscitation initiated
		BP 85/49, SpO2 92%
	9:38:00 AM	Cardiac Arrest Record notes Epinephrine 1 mg and Atropine 1 mg administered
	10:00:00 AM	Patient successfully resuscitated
	10:04:00 AM	Patient transferred to hospital
	2:36:37 PM	Note added to medical record indicating the presence of the personal ENT and noting that there was a mistake in the Propofol log - only 120 mg was given (not 300 mg)
September 2, 2014	3:00:00 PM	Interview with second anesthesiologist says she gave only 120 mg of Propofol (double clicked on the Propofol 100 mg, so it indicated twice, and gave one additional dose of 20 mg, not two doses of 50 mg as indicated)
	3:50:00 PM	Interim Medical Director states ENT not privileged at the facility
September 3, 2014	1:00:00 PM	Staff confirms there was no informed consent for laryngoscopy
	3:15:00 PM	Immediate Jeopardy declared by CMS
	6:30:00 PM	Facility submitted corrective action plan
September 4, 2014	1:15:00 PM	Patient death
	1:30:00 PM	Surveyor observed newly implemented staff training
September 5, 2014	6:30:00 AM	Surveyor validated attendance records of staff receiving training (66% of credentialed physicians; 92% of remaining staff)
	12:45:00 PM	Surveyor observed implementation of revised time-out
	1:10:00 PM	Surveyor observed implementation of revised time-out
	4:20:00 PM	New/ revised policies accepted by surveyor
	6:10:00 PM	Immediate Jeopardy removed