Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HL100256	A. BUILDING: ______ B. WING ______	09/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HCA FLORIDA BAYONET POINT HOSPITAL	14000 FIVAY RD HUDSON, FL 34667

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CZ824 SS=D	408.811 FS; 59A-35.120 FAC Right of Inspection; Inspection Reports 408.811 Right of inspection; copies; inspection reports; plan for correction of deficiencies.- (1) An authorized officer or employee of the agency may make or cause to be made any inspection or investigation deemed necessary by the agency to determine the state of compliance with this part, authorizing statutes, and applicable rules. The right of inspection extends to any business that the agency has reason to believe is being operated as a provider without a license, but inspection of any business suspected of being operated without the appropriate license may not be made without the permission of the owner or person in charge unless a warrant is first obtained from a circuit court. Any application for a license issued under this part, authorizing statutes, or applicable rules constitutes permission for an appropriate inspection to verify the information submitted on or in connection with the application. (a) All inspections shall be unannounced, except as specified in s. 408.806. (b) Inspections for relicensure shall be conducted biennially unless otherwise specified by this section, authorizing statutes, or applicable rules. (c) The agency may exempt a low-risk provider from a licensure inspection if the provider or a controlling interest has an excellent regulatory history with regard to deficiencies, sanctions, complaints, or other regulatory actions as defined in agency rule. The agency must conduct unannounced licensure inspections on at least 10 percent of the exempt low-risk providers to verify regulatory compliance. (d) The agency may adopt rules to waive any inspection, including a relicensure inspection, or grant an extended time period between relicensure	CZ824		

AHCA Form 3020-0001
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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CZ824	Continued From page 1 inspections based upon: 1. An excellent regulatory history with regard to deficiencies, sanctions, complaints, or other regulatory measures. 2. Outcome measures that demonstrate quality performance. 3. Successful participation in a recognized, quality program. 4. Accreditation status. 5. Other measures reflective of quality and safety. 6. The length of time between inspections. The agency shall continue to conduct unannounced licensure inspections on at least 10 percent of providers that qualify for an exemption or extended period between relicensure inspections. The agency may conduct an inspection of any provider at any time to verify regulatory compliance. (2) Inspections conducted in conjunction with certification, comparable licensure requirements, or a recognized or approved accreditation organization may be accepted in lieu of a complete licensure inspection. However, a licensure inspection may also be conducted to review any licensure requirements that are not also requirements for certification. (3) The agency shall have access to and the licensee shall provide, or if requested send, copies of all provider records required during an inspection or other review at no cost to the agency, including records requested during an offsite review. (4) A deficiency must be corrected within 30 calendar days after the provider is notified of inspection results unless an alternative timeframe is required or approved by the agency. (5) The agency may require an applicant or licensee to submit a plan of correction for	CZ824		

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CZ824	Continued From page 2 deficiencies. If required, the plan of correction must be filed with the agency within 10 calendar days after notification unless an alternative timeframe is required. (6)(a) Each licensee shall maintain as public information, available upon request, records of all inspection reports pertaining to that provider that have been filed by the agency unless those reports are exempt from or contain information that is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution or is otherwise made confidential by law. Copies of such reports shall be retained in the records of the provider for at least 3 years following the date the reports are filed and issued, regardless of a change of ownership. (b) A licensee shall, upon the request of any person who has completed a written application with intent to be admitted by such provider, any person who is a client of such provider, or any relative, spouse, or guardian of any such person, furnish to the requester a copy of the last inspection report pertaining to the licensed provider that was issued by the agency or by an accrediting organization if such report is used in lieu of a licensure inspection. 59A-35.120 Inspections. (1) When regulatory violations are identified by the Agency: (a) Deficiencies must be corrected within 30 days of the date the Agency sends the deficiency notice to the provider, unless an alternative timeframe is required or approved by the Agency. (b) The Agency may conduct an unannounced follow-up inspection or off-site review to verify correction of deficiencies at any time.	CZ824		

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CZ824	Continued From page 3	CZ824		

(2) If an inspection is completed through off-site record review, any records requested by the Agency in conjunction with the review, must be received within 7 days of request and provided at no cost to the Agency. Each licensee shall maintain the records including medical and treatment records of a client and provide access to the Agency.
(3) Providers that are exempt from Agency inspections due to accreditation oversight as prescribed in authorizing statutes must provide:
(a) Documentation from the accrediting agency including the name of the accrediting agency, the beginning and expiration dates of the provider's accreditation, accreditation status and type must be submitted at the time of license application, or within 21 days of accreditation.
(b) Documentation of each accreditation inspection including the accreditation organization's report of findings, the provider's response and the final determination must be submitted within 21 days of final determination or the provider is no longer exempt from Agency inspection.

This Statute or Rule is not met as evidenced by:
Based on staffing sheets, staffing grid, and interview, facility failed to provide accurate staffing sheets for the Progressive Care Unit (PCU) on 7PM to7AM night shift.

Findings included:

Staffing sheets for PCU provided by PCU Manager on , reflected a charge RN (Registered Nurse) without a patient care assignment and floor RNs with a nurse to patient ratio of 1:4.
Assignment sheets provided by the unit reflected a

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CZ824	Continued From page 4 charge RN with 6 patients and floor RNs with 6 patients each, contradicting the previous staffing information given. Review of the staffing grid for PCU, the facility staffing ratio for PCU should be 1 nurse for 4 patients, and a charge nurse with no patient assignment. On at 11:20 AM an interview with Staff T,Charge Nurse revealed staffing on night shift, the charge nurse cared for six patients and the other three RNs also cared for six patients each. Class III	CZ824		

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H 000	INITIAL COMMENTS	H 000		

A complaint survey for complaint numbers 2023012393, 2023010951, 2023022940, 2023012631, 20230123518 was conducted on - at HCA Florida Bayonet Point Hospital. Deficiencies were identified at the time of survey.

Class I violations were identified at H0121, H0206 beginning on . Class "I " violations are those conditions or occurrences related to the operation and maintenance of a provider or to the care of clients which the agency determines present an imminent danger to the clients of the provider or a substantial probability that or serious physical or emotional harm would result therefrom. The condition or practice constituting a class I violation shall be abated or eliminated within 24 hours, unless a fixed period, as determined by the agency, is required for correction.
The Vice-President of Quality was notified of Class I violations on at 09:30AM.

The facility failed to:

1. Ensure sufficient staffing on the Surgical (SICU)/ Unit , and Progressive Care Unit (PCU), for the immediate availability of a Registered Nurse for the needs of the patients, and the ability to respond to a change of condition immediately, for one patient (#1) of 117 patients on telemetry monitoring.

2. Provide appropriate telemetry monitoring for 2 patients (#1, #5) of 3 sampled patients.

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H 000	Continued From page 1	H 000		

The hospital failed to implement an effective Quality Assurance and Performance Improvement (QAPI) plan, with reassessment of corrective action.

The effect of these systemic failures resulted in the identification of Class I violations for all patients hospitalized.

H 121 SS=K | 59A-3.243(4)(c), FAC NURSING SERVICE - Sufficient Staffing | H 121

(c) The registered nurse shall be responsible for determining the number of qualified registered nurses to be on duty at all times. The number of qualified nurses shall be sufficient to ensure immediate availability of a registered nurse for bedside care of any patient when needed, to assure prompt recognition of an untoward change in a patient's condition, and to facilitate appropriate intervention by nursing, medical or other hospital staff members.

This Statute or Rule is not met as evidenced by:
Based on the ICUs ( ) and PCU (Progressive Care Unit) staffing schedules, interviews, facility staffing grids, record review, and policy review, it was determined:

1. The facility failed to ensure sufficient staffing on the Surgical / Unit (SICU), and Progressive Care Unit (PCU), for the immediate availability of a Registered Nurse (RN) for the needs of the patients in 2 of 3 units reviewed for staffing.

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H 121	Continued From page 2 2. The facility failed to provide appropriate monitoring for two patients (#1, #5) of 3 patients reviewed for telemetry monitoring, putting patients at risk for unrecognized rhythms, and contributing to the of Patient #1. The facility's actions resulted in a Class I violation. Findings included: Review of the facility ICUs staffing grid revealed the SICU ratio was one RN to two patients with the Clinical Nurse Coordinator/Charge Nurse (CN) having no patients. The facility PCU staffing grid revealed the PCU ratio is one RN to four patients with the CN having no patients. a) Review of the facility staffing schedules for SICU from to , revealed the following: On at 7AM, CN with 2 patient assignment; On at 7AM, CN with 3 patient assignment; On at 7PM, CN with 1 patient assignment; On at 7PM, CN with 1 patient assignment, and 1 RN with 3 patient assignment; On at 7PM, CN with 1 patient assignment; On at 7AM, CN with 1 patient assignment;	H 121		

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H 121	Continued From page 3	H 121		

On at 7PM, CN with 2 patient assignment, and 3 RNs with 3 patient assignment;

On at 7PM, CN with 2 patient assignment, and 6 RNs with 3 patient assignment;

On at 7AM, CN with 1 patient assignment, and 1 RN with 3 patient assignment;

On at 7PM, CN with 2 patient assignment, and 1 RN with 4 patient assignment;

On at 7AM, CN with 2 patient assignment, and 1 RN with 3 patient assignment.

b.) On at 10:36 AM an interview with Staff H revealed he is Charge Nurse for the unit, caring for 2 patients and acting as the unit secretary. He also stated two RNs are caring for 4 PCU patients each. "Night shift is extremely short; the staff is talking about unsafe working conditions and are refusing to pick up extra shifts. One night shift RN will look at the schedule and if its short staffed, he refuses to work, he will purposely call out, that is how unsafe it is. The last 45 days have been horrible with staffing; we are to charge RNs taking assignments along with acting as unit secretary for the unit. Staff H revealed the Chief Nursing Officer (CNO) said its ok for the ICUs to triple their RNs if the patients are not . patients. It's also ok for the charge RNs to take assignments now."

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H 121	Continued From page 4 c.) Review of the facility staffing schedules for Progressive Care Unit (PCU) from - , revealed the following: On at 7AM, CN with 4 patient assignment; On at 7PM, CN with 4 patient assignment; On at 7AM, CN with 4 patient assignment; On at 7AM, CN with 4 patient assignment; On at 7PM, CN with 4 patient assignment; On at 7AM, CN with 4 patient assignment; On at 7PM, CN with 4 patient assignment; On at 7AM, CN with 4 patient assignment; On at 7PM, CN with 4 patient assignment; On at 7AM, CN with 4 patient assignment; On at 7PM, CN with 4 patient assignment; On at 7AM, CN with 4 patient	H 121		

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H 121	Continued From page 5 assignment; On at 7PM, CN with 6 patient assignment, and all RN assignments are 6 to 1 nurse. d.) On at 11:20 AM an interview with Staff T, CN was conducted. Staff T disclosed that on nightshift, the Charge Nurse cared for six patients and the other three RNs also cared for six patients each. Staff T, CN stated the charge RN frequently has an assignment caring for patients. Staff T said they do what they can to make it work. There is no leadership higher than my manager that seems to care. The nurses ask if they can rooms and they say no. The nurses must go up to 6 patients, if need be. When a patient must leave the floor for a test, the nurse must go with the patient. When the charge RN has an assignment, she/he can't monitor/care for any other nurse's patients. The nurses must team up and help each other. Staffing has definitely been a challenge this last month and appears to be worse now. e.) Review of Patient #1' s medical record was completed. The patient arrived at the facility ED (Emergency Department) via (Emergency Medical Services) on at 3:32 PM with chief complaint of increased and . The patient stated he was feeling achy and had a positive COVID-19 (Corona 2019) test. Vital signs were stable on arrival. Patient #1 had a medical history of Type 2	H 121		

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H 121	Continued From page 6 (a , involving inappropriately elevated levels), (high (the doesn't make enough hormones to meet your body's needs), (medical device that sends electrical pulses to your to help it beat at a normal rate and rhythm), (removal of), and (a type of , or abnormal heartbeat). Patient #1 received an admit order at at 8:18 PM. At 10:46 PM, a nurse's note reflected Patient #1 had a temperature of 101.8 [degrees Fahrenheit] and had no treatment orders. To treat the , Staff B, RN (registered nurse) called the admitting physician for orders and was unable to contact anyone. Registration personnel admitted the patient in the medical computer system into an incorrect room at 9:25PM, resulting in the medical computer system showing him in a different room. Telemetry monitoring was applied by the Charge Nurse in the emergency room with no documentation of the exact time this occurred. A review of the monitoring strips showed that on at 10:52 PM, right arm fail, leads off. At 11:17 PM, Patient #1's rhythm was noted to be (fatal). On 11:37 PM, a Code Blue ( ) was called after Staff B, RN went into the patient's room to administer medication, and noted Patient #1 lying across the bed, open, and out of his nares (nostrils). Staff B called the patient's name, performed a sternal rub, and noticed no rise and . Staff B did not feel a , and called a Code Blue and began ( ). Ultimately on 12:00 AM Patient expired.	H 121		

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H 121	Continued From page 7 f.) In a telephone interview on 7:21 PM with Staff A, monitor technician (MT), Staff A stated that Patient #1 was supposed to be in 2 West. Staff A was monitoring [telemetry] 2 West and Central. Patient #1 started to have a lethal rhythm. Only one lead was on, and it looked like artifact (not a rhythm) or . I called the nurse on the floor [2 West] and she said the patient wasn't there yet. I didn't know what to do at that time. It didn't seem reasonable to call a Code Blue to an empty room. Staff D, House Supervisor was there, and I asked her what to do. We tried to locate the patient. He was supposed to be in ER [Room] X according to the electronic medical system. I called the ER and no one answered. "Me and the house [supervisor] didn't know what to do. I didn't know where the patient was. I knew he needed help. There was only one lead on." Staff A stated she was trying to find information in the computer to locate the patient. About minutes later she saw the (fatal ,). She stated she called the nursing unit again, because her monitor showed the patient was on the unit. The nurse said the patient still hadn't arrived. She stated she then called the ED and there was no answer, so she asked the supervisor what to do. She called the ED again and spoke to Staff C, ED CN who said the patient had a nurse in the room with him. About 7 minutes later she heard a Code Blue ( ) called and figured out it was for Patient #1. It was flat line (,) before they called the code. We do have a policy to call a code to the patient' s bedside. But there wasn't a patient in the location the monitor showed he was in. Staff A said she also had 55 patients she was monitoring.	H 121		

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H 121	Continued From page 8 g.) In a telephone interview on 7:47 PM with Staff B, RN ED, she said she was on a different assignment and switched with one of the nurses and took over the assignment at around 9:00 PM. She did a set of vitals on Patient #1 right after report. He was awake, alert, oriented. She checked his temperature, and it was 101.2 degrees Fahrenheit. She called the attending doctor and did not get an answer. She then sent a text and didn't get an answer. Then she attempted to contact the on- call physician and his phone was off. She went to the ED doctor and told them he had been "admitted for hours and didn't have one prn" (as needed) order. The practitioner gave orders for , and , . Staff B stated that it took about 15 minutes for the orders to be processed. So around 11:00PM, Staff B pulled the medication from the dispensing system and went into the room and called Patient #1' s name. He didn't respond, so she did a sternal rub. He still didn't respond. Staff B called a Code Blue ( ) and started (, ,). "He was down for 20 minutes before was started." h.) In an interview with Staff C, ED Charge Nurse (CN) on at 5:40 AM she stated Patient #1 was on a monitor and his information was faxed to the telemetry monitoring room, however, Staff C had to attend to an emergency and could not bring Patient #1 upstairs right away. Staff C remembered the monitor technician was trying to find the patient. When Staff C received the call,	H 121		

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H 121	Continued From page 9 the monitor technician said Patient #1 was in room X, but there was not a patient in that room. We then found the patient in room Y in . A code was called. Staff C stated she was the assigned charge and acting as secretary that night. Staff C stated she is often playing a dual role. "They have been saying since last . that we are getting a monitor technician for the ED, and we still don't have one." Staff C stated the ED "gets extremely busy, and we can't always bring them upstairs right away. The other night we had 8 . . holds and 4 of them were vent patients. There were no ( ) beds, so the nurses down here had at least 1 patient along with their other case load. We have no staff. Take last night. We had 24 ER holds with 7 nurses after 1 AM. I am in charge, have patients, and the ED secretary. The 2 nurses have assigned patients as well and they should only float, so they are available for ." She further stated the ED Manager does his best to help us out, but the Director doesn't answer his phone and is very difficult to get a hold of. i.) In an interview on 5:53 AM with Staff P, MT she stated Patient #1 was on the ER screen [the ER screen in the telemetry unit] and being transferred to his room. She stated that when they receive a text message, they are to transfer the patient to the tree [the unit's monitoring screen]. After Patient #1 was transferred to the tree (2 West), the monitor was showing only 1 lead in use and Staff A, MT (monitoring technician) knew something was wrong, and it needed attention. She called the ER, and they told her the patient went upstairs.	H 121		

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H 121	Continued From page 10 She called the floor, but the floor said the patient was not there either. She called the ED again to tell them the patient was not on the floor and the leads needed to be fixed. But the ED said they could not find the patient. Later, the ED called and said they found the patient and an RN was with him. She stated they realized after the fact; our screen showed the patient was in room Y in the (charting system) but the patient was actually in room X; that's why no one could find him. Then a Code Blue was called. The house supervisor was in the telemetry monitoring unit with us during that entire time. The telemetry policy came out in , , and it stated the patient stays on the ER tree until the patient goes to the floor to the bed they are assigned to, and the bedside nurse confirms the patient made it to the floor. She stated they were taught a different process. They were taught that when they receive a picture from the ED, they move the patient to the room that was assigned to them. "But now we must follow the policy. We had emails sent out regarding reviewing the policy and education. The policy is also printed out and placed in our tele monitor unit for us to review and we need to sign a sign in sheet stating we reviewed it. Then our manager did come to us and ask us if we had any questions regarding the policy. I mentioned, in the policy on page #4 and 5, it is confusing and vague. I pointed out in the policy it does not specify what room or which they are referring to. When I started, I do not recall even seeing or being given a copy of the policy; so, I've been working the way they taught us which is the wrong way. " j.) In a telephone interview with Staff D, nursing	H 121		

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H 121	Continued From page 11 supervisor (NS) on at 10:05 AM she stated she was in the monitor room rounding. She looked at the logs and the trees. She looked at Staff A, MT's screen and saw Patient #1 was in distress and asked Staff A, MT about it. Staff A said Patient #1 has been doing that [questionable irregular rhythm] for a while and Staff A was unable to contact the nurse because she didn't know where Patient#1 was. Staff A told Staff D, nursing supervisor, that she had called the floor and the ED and spoke to Staff C, Charge Nurse who stated the patient wasn't there. Staff A said she called the floor again and they said Patient #1 was not there. "So, we were talking, and I said maybe he is in transit. I wasn't sure what was going on, I didn't like it [rhythm on the screen]. Staff A said it was just artifact. When the patients move around a lot it can cause artifact." Staff D stated she asked Staff A what she had done to find the patient. "The rhythm was changing. I was not sure what was going on. I wasn't there from the onset. I didn't know if he was moving while he was in transit. She said she was following what she was supposed to do. I thought well ok, if you're following what your protocol is. The protocol is to call a rapid or a code. According to her it wasn't a lethal rhythm. I am ok with rhythm strips. Not like I was a few years ago. I would reach out to an nurse or if necessary, a doctor or resident. No code was called, no. The patient was registered into the wrong room, and they moved the patient to the room upstairs prior to the patient leaving the ER. " k.) Review of Patient #5' s medical record, showed Patient #5 was admitted to the facility on for postop medical management of total right , , (surgical procedure to	H 121		

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H 121	Continued From page 12 restore function of a ,). Patient #5 has a past medical history of , , , hyperlipemia, , , , . A telemetry order was placed for Patient #5 on at 1:30 PM. l.) Review of the telemetry event log dated revealed a notation that Patient #5 was received to the nursing unit at 3:17 PM, not put on monitor until 10:01 PM, approximately 7 hours later. m.) In an interview on at 3:22PM with Staff S, nurse manager she revealed Patient #5 came from PACU (Post Care Unit) on at 9:35 PM with the telemetry monitoring on. The monitor tech got and thought the patient had discharge orders. She asked another monitor technician to go take the telemetry box off Patient #5. Then later in the shift the monitor tech realized she made a mistake; Patient #5, did not have discharge orders. She told the other monitor technician to put the telemetry box on the Patient #5. After that incident happened, she educated the monitor technicians on the process of double checking the patients' name and room number with the orders that are printed out. Also, before taking the box off the patient, they must ask the PCT (patient care technician) working the nursing unit, and then the RN if the telemetry box can be removed from the patient. n.) Review of the policy, Telemetry Monitoring, effective , revealed Patients on telemetry will have their rhythm	H 121		

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H 121	Continued From page 13 continuously monitored by a telemetry technician or nurse who is competent in rhythm interpretation. The rhythm will be documented at predetermined intervals as per applicable facility standards. . .Staff will respond immediately to any significant rhythm change or loss of signal. A defined notification and escalation pathway is used to reliably ensure timely communication and treatment. . .All changes in telemetry monitoring (e.g., room changes, patient transfers, telemetry box changes) must be verified by nursing and should be immediately communicated to the telemetry technician. . .Procedure: If during transport (including transfer from the emergency department) the patient is monitored on a portable monitor, then a nurse must accompany the patient. If, however, central monitoring continues during transport, then there is no telemetry related requirement for a nurse to accompany the patient. All patient transfers must be timely communicated to the telemetry technician. . .Rhythm Changes: The telemetry technician must immediately notify the nurse of any significant change in rhythm. Telemetry technician will record the notification on the telemetry notification log. . .Telemetry notification and escalation process: Life-threatening , -In the event of a potentially life-threatening , the telemetry technician will initiate the following procedure: immediately activate 'Code Blue' response to the patient 's bedside, notify the patient 's nurse, document the event on the facility log, print strip with interpretation and send to unit. Class I	H 121		

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H 206	Continued From page 14	H 206		
H 206 SS=K	59A-3.271(3), FAC QUALITY IMPROVEMENT - Data Assessment Process (3) Each hospital shall have a process to assess data collected to determine: (a) The level and performance of existing activities and procedures, (b) Priorities for improvement, and, (c) Actions to improve performance. This Statute or Rule is not met as evidenced by: Based on review of previous plan of correction dated for an Class I/Imminent Danger cited for H0020, H121, H205, H206, H416, H419(refer to the State3020 Statement of Deficiencies for Event ID FRZJ11, dated , facility document review, and interviews the facility failed to ensure that actions for identified concerns with telemetry monitoring were effective and sustained in preventing serious harm or likely serious harm to patients on monitoring for 2 (#1, #5) of 3 patients reviewed. The facility's actions resulted in a Class I violation. Review of the Plan of Correction, submitted to the Agency for Healthcare Administration (AHCA) on . revealed Performance indicators which included timely telemetry response and staffing safety. It reveals measure including targeted education regarding Telemetry Workflow to be within the expected standards of practice for safe care of all telemetry patients on telemetry monitoring completed by . During an interview conducted with the Director of Patient Safety/Risk Manager on at 1:39 PM regarding Patient #1, he revealed they	H 206		

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identified human factor, policy and procedure, training and competency as issues in telemetry monitoring incidents. Factors noted were Staff A, MT inattention to detail, and the registrar who registered the patient into the wrong room, and lack of , thinking by Staff D. An action plan was developed, and education was done with a read and sign escalation protocol of lethal rhythms, equals code blues immediately, as well as MT Staff must document all notification on logs as they occur. Education was completed on .

Audits of the telemetry logs for any deviation from policy for the registrars began. We did a read and sign specifically about admission bed placement making sure that it's accurate where they're placing the patient. He disclosed that weekly tests of the system are performed. We disconnect the patient from telemetry and wait to see how the escalation goes.

During an interview conducted at 2:25 PM regarding QAPI, with Vice President of Quality (VPQ), ED Manager, Staff S, PCU (progressive care unit) manager, ACNO (assistant chief nursing officer), and the VP of operations. The staff presented a power point. The VPQ stated that the facility continued to track and trend our telemetry logs, stating that they have been at 95% from the date of the event to present. The VPQ stated that after Patient #1's , immediate education began for the ED nursing supervisor, registration, monitor technicians and transport personnel. On they began additional education to all the inpatient units.

The ED Manager stated there has been a

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decrease in ER hold hours of about 30 minutes (How long the patient waits in the ED prior to room placement), and a decrease in length of stay.

The ED Manager stated that 91% of ED staff have completed the education.

Staff S, Manager of telemetry, PCU and Float pool stated according to the current telemetry algorithm, if a life threatening , is detected, they call a code blue overhead immediately, and then the notifications they have made including the code blues, rapid responses or the tele alerts (overhead paging notification) are written on the telemetry notification log and they do not call a unit or the nurse. Monitor Technicians are to immediately call a code blue (overhead paging) for a lethal rhythm for life threatening conditions of , , , , or 3 or more consecutive (, /ineffective occurring before the ventricle has refilled with) that are rate 142- 150, , severe , (low rate) and severe , (fast rate). That's currently our policy. They are familiar with our escalation, and the managers tested them and all of them received 100% on the test.

During an interview conducted with Staff I, MT (Monitoring Technician) at 11:19 AM on , Staff I said "if the patient is having a serious rhythm, call the nurse, then the charge. If they don't answer call a code overhead." This is contrary to the policy and management interviews.

In an interview on at 3:22PM with Staff S, Nurse Manager she revealed Patient #5 came

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H 206	Continued From page 17 from PACU (post care unit) on at 9:35 PM with the telemetry monitoring on. The monitor tech got and thought the patient has discharge orders. She asked another monitor technician to go take the telemetry box off Patient #5. Then later in the shift the monitor tech realized she made a mistake; Patient #5, did not have discharge orders. She told the other monitor technician to put the telemetry box on the Patient #5. After that incident happened, Staff S/Nurse Manager educated the monitor technicians on the process of double checking the patients' name and room number with the orders that are printed out. Also, before taking the tele box off the patient, they must ask the PCT (patient care technician) working the nursing unit, then the RN if the telemetry box can be taken off the patient. Class I	H 206		