**California Department of Public Health**

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The following reflects the findings of the California Department of Public Health during the investigation of complaint #CA00318590.

Representing the Department of Public Health, HFEN 1700/17334

The inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility.

**E 1944** T22 DIV5 CH1 ART7-70707(a) Patients' Rights

(a) Hospitals and medical staffs shall adopt a written policy on patients' rights.

This statute is not met as evidenced by based on interviews, medical record and policies and procedures (P&P) review the facility failed to follow policy and procedure (P&P) for patients' rights. The hospital staff failed to communicate health care decisions affecting Patient 1's care with the patient/patient's representative.

**Findings:**

The record review showed that Patient 1, age 89 years old, was admitted to the hospital on 2/18/12 for gastrointestinal bleeding. The 2/21/12 Discharge Summary documented that during the hospitalization, Patient 1 developed hospital acquired delirium.

Delirium or acute confusional state is a transient global disorder of cognition. The condition is a

**Kaiser Foundation Hospital Roseville takes all complaints very seriously as a way to the quality of care and services to patients.**

Upon being informed of these concerns an immediate and thorough investigation was conducted. The results and corrective actions of the investigation described below.

**E 1944 Immediate Action:**

- Education was provided to the involved staff members in the care of the patient.

**Systemic Action:**

- Physicians and nursing staff will be educated regarding patient informed consent related to medication/treatment with antipsychotic and benzodiazepine in patients with dementia related psychosis prior to receiving treatments.

**Accountable Party:**

- Adult Service Director
- Pharmacy Director

**Monitoring:**

- Medical records of patients with dementia related psychosis on antipsychotic (Haldol) and benzodiazepine (Restoril) medications will be monitored to ensure patient/family have been informed as a proposed treatment.

Monitoring will continue for a period of 3 months. Results of the monitoring activities will be reported to Quality Council which reports to the Medical Executive Committee (MEC). Monitoring will be completed after determination by the MEC that a sustained acceptable threshold of performance has been reached.
medical emergency associated with increased morbidity and mortality rates. Early diagnosis and resolution of symptoms are correlated with the most favorable outcomes. Therefore, it must be treated as a medical emergency. Delirium is not a disease but a syndrome with multiple causes that result in a similar constellation of symptoms. Delirium is defined as a transient, usually reversible, cause of cerebral dysfunction and manifests clinically with a wide range of neuropsychiatric abnormalities. The clinical hallmarks are decreased attention span and a waxing and waning type of confusion. [http://emedicine.medscape.com/article/286890-overview]

The review of Patient 1's medical record showed a Procedure Note on 2/18/12 at 5:09 p.m. by a Registered Nurse (RN) indicating that Patient 1 was admitted to ICU (Intensive Care Unit) due to (gastrointestinal) bleeding. The Procedure Note by the physician on 2/18/12 at 5:28 p.m. showed that Patient 1 had an upper endoscopic surgical procedure (EGD) performed under sedation to repair gastrointestinal bleeding.

Review of flowsheets showed that on 2/19/12 at 6 p.m. and 8 p.m., a registered nurse (RN 1) documented that Patient 1 was increasingly restless. On 2/19/12 at 9:20 p.m., the nursing flowsheets showed that an order for non-behavioral restraint was obtained for "pulling lines, pulling tubes, removal of equipment, climbing. Patient 1 pulled out intravenous (IV) line and urinary catheter and had increase in confusion and that Physician 1 was notified.

On 2/19/12 at 9:50 p.m., RN 1 documented that Patient 1 was being transferred from ICU to a Medical/Surgical floor. On "transport" Patient 1
was noted “disoriented” at 10 p.m. RN 1 documented that Patient 1 changed from “periodic confusion” at 8 p.m. to “confused at all times” at 10 p.m. On 2/19/12 RN 1 further noted that at 10:15 p.m. Patient 1 requested “something for sleep” and that Physician 1 ordered Restoriol (Temazepam, a benzodiazepine sedation medication).

The review of medication orders and administration record showed that on 2/19/12 at 10:24 p.m. Patient 1 received Restoriol 15 mg by mouth, administered by RN 1, per order from Physician 1.

The medical record for Patient 1 showed no physician progress notes associated with the patient condition prior to the order of Restoriol. There was no documentation to indicate that the physician was aware of the patient’s sudden changes in mental status (confused and disoriented as documented in the nursing flowsheets: at 4 p.m. the patient was restless, at 8 p.m. the patient noted with periodic confusion and patient confused at 10 p.m.) prior to ordering Restoriol.

The medical record for Patient 1 showed no documentation that the patient’s representative (spouse per medical record) was informed of the changes in Patient 1’s mental status and the proposed treatments (Restoriol).

In an interview on 10/1/12 at 2:30 p.m., RN 1 stated that Patient 1 complained of trouble sleeping so he called Physician 1 who ordered Restoriol to help the patient sleep. RN 1 stated he did not call family to inform them of Patient 1’s change in mentation (increasing confusion), order for Restoriol and later treatments with restraints.
California Department of Public Health

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/COLA IDENTIFICATION NUMBER**

CA030001370

**(X2) MULTIPLE CONSTRUCTION**

A BUILDING
B WING

**(X3) DATE SURVEY COMPLETED**

C 10/03/2012

**NAME OF PROVIDER OR SUPPLIER**

KAISER FOUNDATION HOSPITAL - ROSEVILLE

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1600 EUREKA ROAD
ROSEVILLE, CA 95661

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and psychotropic medications

In an interview on 10/3/12 at 10:50 a.m., after reviewing the medical record, Physician 1 confirmed that he ordered Restoril for Patient 1 to help the patient sleep. Physician 1 stated that he did not recall talking with the patient/family prior to ordering Restoril but the patient probably requested it because Restoril is usually not his first choice for sleep medication.

Review of physician progress notes showed that on 2/20/12 at 2:55 a.m., the hospitalist, Physician 2, documented that he was called in because of Patient 1 was confused and agitated. The physician assessed the patient with delirium and ordered Haldol 1 mg (psychotropic medication) intravenously as part of the emergency treatment for delirium. The physician noted that according to nurses the patient was agitated, confused and in restraints since ICU. Physician 1 also noted that Patient 1 was given temazepam (Restoril, a sedative benzodiazepine medication) but the patient was confused prior to receiving the medication, therefore it was not the cause of delirium.

In a telephone interview on 10/3/12 at 7 a.m., Physician 2 confirmed the information in the above progress note. Physician 2 stated that he did not call the family to discuss the care because he assumed the family was aware since the care issues were ongoing. The physician stated that the usual practice was to discuss care with the patient and/or family.

In a collaborative telephone interview on 9/28/12 at 3 p.m. with Patient 1 and Patient 1’s representative (spouse), the spouse stated that on 2/20/12 in the late evening/night, a few hours
after he left Patient 1 at hospital in good
condition, he was called by Patient 1 in distress
telling him that she was being abused. Patient 1
confirmed that after receiving what she
understood was "something for sleep," she woke
up confused in restraints and requested to call
her husband. The spouse stated that upon
returning to the hospital, he found Patient 1 in
restraints and confused and found out that
Patient 1 was given Restoris and Haldol without
the patient or his consent. The spouse stated that
he was not notified by the hospital staff about
Patient 1's change in mental status, that Restoris
was given for sleep and later Patient 1 had to be
restrained and treated with Haldol.

Review of the hospital policy titled "Patient Rights
and Responsibilities" (reviewed 9/8/11) in part
indicated, "The patient has the right, in
collaboration with his/her primary physician, to be
involved in the health care decisions affecting
him/her... The patient's legally authorized
responsible person has the right to exercise, to
the extent permitted by law, the rights delineated
on behalf of the patient if the patient... is unable
to communicate his/her wishes regarding
treatment."