Tragedy Brings Safer Care:

Lessons Learned from a Patient Stairwell Death

San Francisco General Hospital and Trauma Center

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My Pager 10/8/2013…



"Dead Body Found in Stairwell – Please Come to the 5th Floor Right Away"


MSNBC


FOX
NEWS
Channel


SFGate
San Francisco Chronicle


BBC
WORLD
NEWS


CNN


KTVU 2 NEWS


KRON 4
The Bay Area's News Station


NBC
BAY AREA


5


The Joint Commission

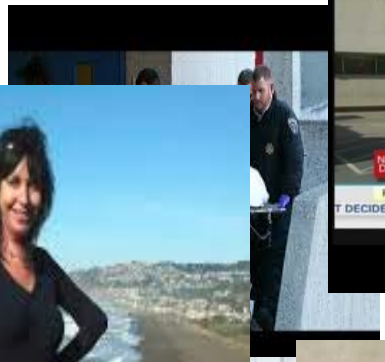

SAN FRANCISCO
POLICE
ORO EN PAZ
FIERRO
EN GUERRA


California Department of
Public Health
CDPH

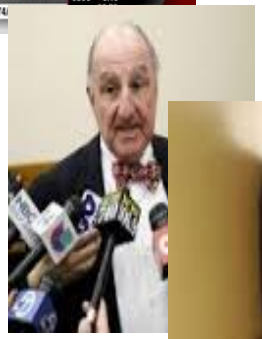

SAN FRANCISCO
SHERIFF'S DEPT.


CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES


BODY IN STAIRWELL
POLICE WORKING TO ESTABLISH TIMELINE
September 21
Patient Disappears
September 23
Hospital Meeting
October 4
Man Reports Person
in Stairwell
KRON 4
6:05
CHARGES FOR ALLEGED PROWLING INCIDENT
STANFORD
CSCO
POINT REYES 63/49
ROHNERT PARK




DEBT CEILING DEADLINE
184:38:28
GOVERNMENT SHUTDOWN
DAY 9
NEW DAY
FAMILY WANTS ANSWERS
HOW DID PATIENT END UP DEAD IN STAIRWELL
LIVE
CNN
RIGHT NOW
T DECIDED ABOUT THE AFTERNOON," SCHOOL SYSTEM TWEETS
7:21 AM ET




TODD MAY
CHIEF MEDICAL OFFICER
NBC
#WEINVESTIGATE


DEBT CEILING DEADLINE
172:35:00
GOVERNMENT SHUTDOWN
DAY 9
DEAD BODY IN STAIRWELL MAY BE MISSING WOMAN
Lynne Spalding disappeared from the hospital 17 days ago
LIVE
CNN


URGENT: MOM MISSING 17 DAYS
HLN
NANCY GRACE
MOM IN HOSPITAL W/URINARY INFECTION VANISHES; FOUND DEAD IN STAIRWELL
MOM CHECKS INTO HOSPITAL FOR BLADDER INFECTION; FOUND DEAD IN STAIRS

Briefly What Happened

54 year old woman admitted to hospital for progressive physical and cognitive decline. On the 3rd day of hospitalization she went AWOL. Her nurses called our security service (we contract with the San Francisco Sheriff's Department) requesting assistance locating and returning her to the floor. Listening to the taped phone calls we learned her description was grossly incorrect and security had a limited response since she was not on a legal hold. She was not found that day.

Over the subsequent 5-7 days the family initiated a missing persons campaign in the neighborhood. Meeting with our security regularly we noted the need to be certain the whole campus was searched so we could work with family to focus search efforts in the community.

Briefly What Happened

On day 13 following Ms. Spalding's AWOL a person reported to a senior nurse they saw a person sleeping in a stairwell. The senior nurse concerned about an unsafe situation in the stairwell called security. On the taped phone calls we learned security confirmed they would secure the stairwell.

On day 17 following her AWOL, on a standard quarterly patrol of the service stairwell a building engineer found Ms. Spalding's remains.

The San Francisco Medical Examiner reported she had no traumatic injuries. Presumed death from metabolic or infectious cause.

What Did We Learn?

1. Assessment and Care of “At Risk” Patients

2. A well-coordinated significant event plan is critical

3. Clear leadership oversight of security

4. Importance of Transparency

Assessment and Care of "At Risk" patients

- Definition
- Monitoring/Interventions
- Code Green



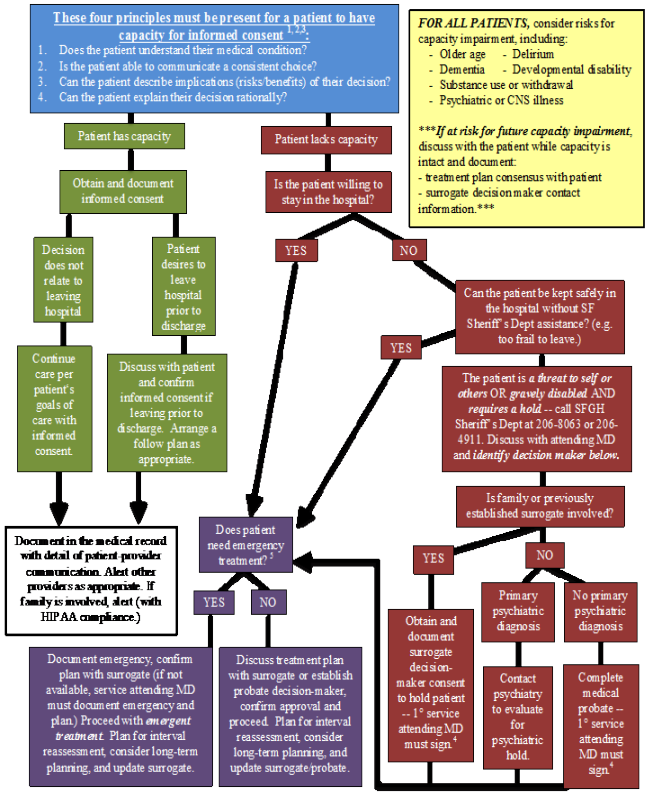
Assessment and Care of "At Risk" patients

Definition:

A patient who (1) exhibits behavior indicating a compromised mental status that may put him/her in danger and requires further assessment, *or* (2) is on a legal psychiatric hold, *or* (3) has a surrogate decision-maker.

Assessment and Care of "At Risk" patients

CLINICAL DECISION ALGORITHM FOR PATIENTS WITH IMPAIRED OR AT-RISK DECISION MAKING CAPACITY
FOR QUESTIONS, CALL LEGAL/RISK MANAGEMENT (OFFICE 206-6600, 24 HOUR PAGER 327-9543.)



[1] If capacity determination is unclear, discuss with psychiatry consult service (pager 327-9058, 24 hours/day). See teaching handout for detailed discussion.
[2] For assistance with detailed cognitive testing, consider neuropsychology referral (and obligatory for standard capacity determination.) 206-5666.
[3] For assistance with complex cases consider SFGH Ethics Committee review (email request to ethicsconsult@u.washington.edu or eric.nunn@emergency.ucsf.edu.)
[4] Probate paperwork and surrogate decision-maker hold consent form are available from Legal/Risk Management Department 327-9543 or via CHN intranet.
[5] "Emergency" defined here as: without treatment the patient is at risk for serious harm or death.

When signed by attending provider, fax all consent/probate forms to Legal/Risk Management Dept SFGH Risk Management at 206-4150 and place a copy in the front of the chart. If probate paperwork needs overnight signature, please call FIX Attending at 443-3002 after completing paperwork by phone with service attending. Primary service attending must take responsibility for probate ASAP upon return to the hospital.

CAPACITY TO MAKE MEDICAL DECISIONS
Lee Rawitscher, MD – Psychiatry C/L Service, SFGH

This guideline can be used to evaluate a patient's capacity to consent to the work-up or treatment of a specific medical problem.

1. Does the patient understand the nature of the medical illness?
- Typically, a basic understanding of the illness is adequate, but when subtleties are of critical importance, a deeper understanding may be necessary.
- Examples of a patient having problems in this area.
  a) Patient is too confused or demented to understand the illness
  b) Patient understands your explanation, but forgets by the next day
  c) Patient is paranoid and believes you are lying
  d) Patient has delusions about the medical illness

2. Can the patient communicate a consistent choice?
- Examples of a patient having problems in this area.
  a) Patient is comatose
  b) Patient refuses to speak about the issue
  c) Patient is too ambivalent to decide
  d) Patient expresses one choice verbally but behavior indicates another choice.
  (e.g. an NPO patient tells you he will not eat, but he continues to eat.)

3. Does the patient understand the risks/benefits of the recommended treatment and the risks/benefits of alternatives treatments (including doing nothing)?
- Examples of a patient having problems in this area.
  a) Patient is too confused or demented to understand the risks/benefits
  b) Patient understands your explanation, but forgets by the next day
  c) Patient can state risks but clearly minimizes them

4. In making a decision, can the patient manipulate the information rationally?
- This applies to all patients, whether refusing or accepting the recommended treatment.
- Cultural, religious and philosophical issues should be taken into consideration.
  (e.g. religious beliefs about blood transfusion)
- Examples of a patient having problems in this area.
  a) Patient is too confused or demented to weigh risks/benefits
  b) Patient's reasoning is affected by delusions or other forms of psychosis
  c) Patient's reasoning is affected by severe depression
  d) Patient's reasoning is affected by extreme emotions (e.g. anger, fear)

Additional Considerations When Evaluating Capacity
1) A patient must fulfill all 4 of the above criteria to retain capacity.
2) Capacity is evaluated for a specific medical problem. An individual might lack capacity regarding one issue but retain capacity for another issue. (e.g. a patient might understand the need for antibiotics to treat a pneumonia, but the same patient might not understand the risks/benefits of cardiac catheterization.)
3) Capacity can change over time (e.g. a patient's delirium resolves)
4) If the benefits are very high and the risks are very low (e.g. antibiotics for sepsis), then a patient refusing treatment needs to demonstrate an excellent grasp of all 4 steps listed above.
5) A psychiatric evaluation is not required to determine a patient's capacity, but a psychiatric consultation can be helpful in ambiguous situations.

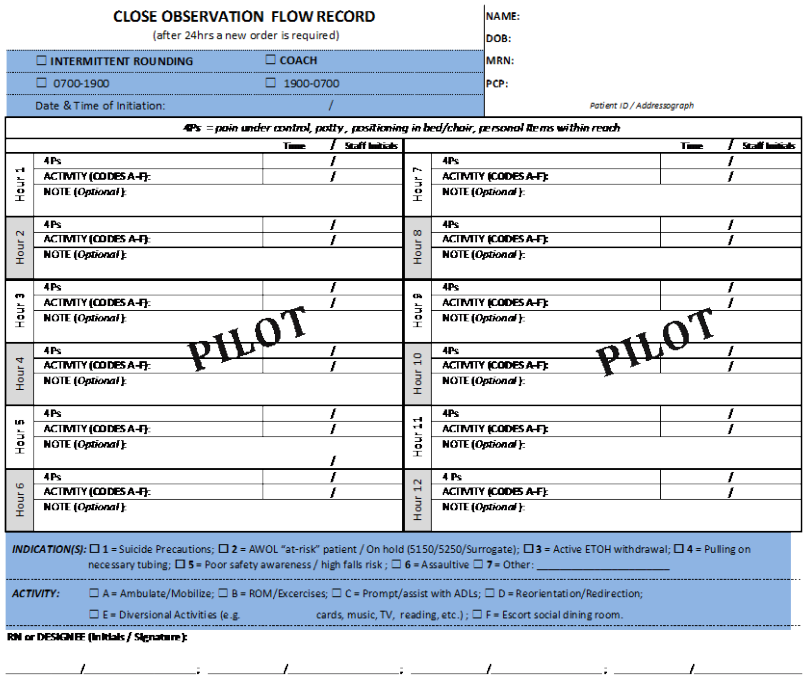
Assessment and Care of "At Risk" patients

Environment of Care Policy: 13.09
TITLE: CODE GREEN - MISSING "AT RISK" PATIENT ALERT RESPONSE & SEARCH PROCEDURES

Administrative Policy Number: 18.02
TITLE: CLOSE OBSERVATION OF THE HOSPITALIZED PATIENT

Administrative Policy Number: 1.10
TITLE: AMA, AWOL & AWOL "AT-RISK": ADULT PATIENTS LEAVING SFGH PRIOR TO COMPLETION OF THEIR EVALUATION OR TREATMENT

Administrative Policy Number: 1.09
TITLE: PATIENT TRACKING SYSTEM



CLOSE OBSERVATION FLOW RECORD

(after 24hrs a new order is required)

NAME:
DOB:
MRN:
PCP:

☐ INTERMITTENT ROUNDING ☐ COACH

☐ 0700-1900 ☐ 1900-0700

Date & Time of Initiation: /

Patient ID / Addressograph

4Ps = pain under control, potty, positioning in bed/chair, personal items within reach

		Time / Staff Initials
Hour 1	4Ps	/
	ACTIVITY (CODES A-F):	/
	NOTE (*Optional*):	
Hour 2	4Ps	/
	ACTIVITY (CODES A-F):	/
	NOTE (*Optional*):	
Hour 3	4Ps	/
	ACTIVITY (CODES A-F):	/
	NOTE (*Optional*):	
Hour 4	4Ps	/
	ACTIVITY (CODES A-F):	/
	NOTE (*Optional*):	
Hour 5	4Ps	/
	ACTIVITY (CODES A-F):	/
	NOTE (*Optional*):	/
Hour 6	4Ps	/
	ACTIVITY (CODES A-F):	/
	NOTE (*Optional*):	

		Time / Staff Initials
Hour 7	4Ps	/
	ACTIVITY (CODES A-F):	/
	NOTE (*Optional*):	
Hour 8	4Ps	/
	ACTIVITY (CODES A-F):	/
	NOTE (*Optional*):	
Hour 9	4Ps	/
	ACTIVITY (CODES A-F):	/
	NOTE (*Optional*):	
Hour 10	4Ps	/
	ACTIVITY (CODES A-F):	/
	NOTE (*Optional*):	
Hour 11	4Ps	/
	ACTIVITY (CODES A-F):	/
	NOTE (*Optional*):	
Hour 12	4 Ps	/
	ACTIVITY (CODES A-F):	/
	NOTE (*Optional*):	

PILOT

PILOT

INDICATION(S): ☐ **1** = Suicide Precautions; ☐ **2** = AWOL "at-risk" patient / On hold (5150/5250/Surrogate); ☐ **3** = Active ETOH withdrawal; ☐ **4** = Pulling on necessary tubing; ☐ **5** = Poor safety awareness / high falls risk ; ☐ **6** = Assaultive ☐ **7** = Other: _____

ACTIVITY: ☐ A = Ambulate/Mobilize; ☐ B = ROM/Excercises; ☐ C = Prompt/assist with ADLs; ☐ D = Reorientation/Redirection; ☐ E = Diversional Activities (e.g. cards, music, TV, reading, etc.) ; ☐ F = Escort social dining room.

RN or DESIGNEE (Initials / Signature):

_____/_____; _____/_____; _____/_____; _____/_____

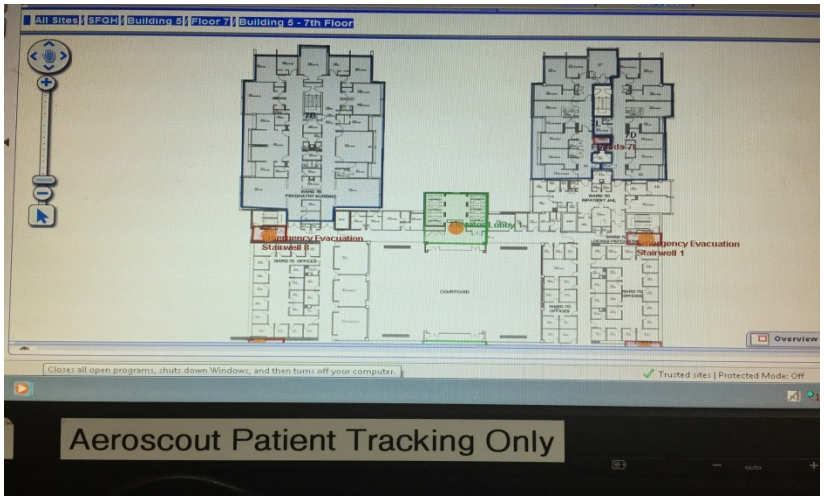
Monitoring/Interventions

Administrative Policy Number: 18.02

TITLE: CLOSE OBSERVATION OF THE HOSPITALIZED PATIENT

e:

Monitoring/Interventions





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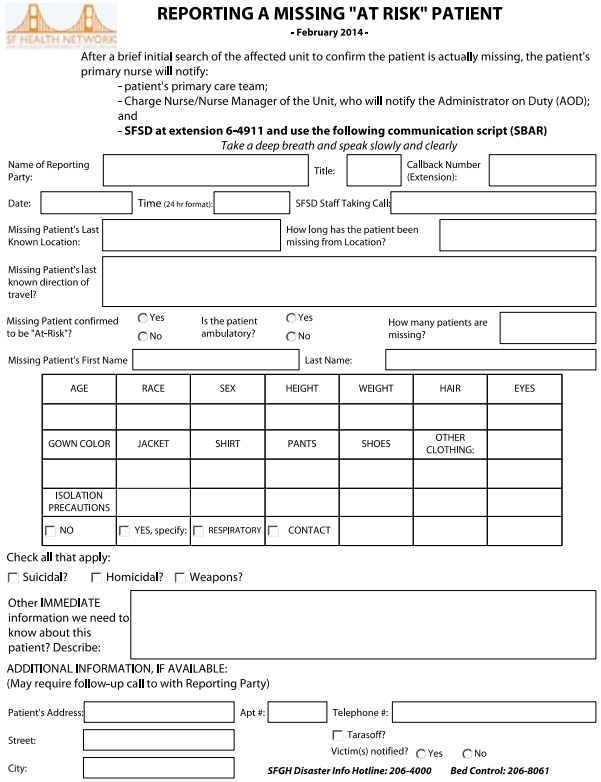
"CODE GREEN"



REPORTING A MISSING "AT RISK" PATIENT

- February 2014 -

After a brief initial search of the affected unit to confirm the patient is actually missing, the patient's primary nurse will notify:

- patient's primary care team;
- Charge Nurse/Nurse Manager of the Unit, who will notify the Administrator on Duty (AOD); and
- **SFSD at extension 6-4911 and use the following communication script (SBAR)**

Take a deep breath and speak slowly and clearly

Name of Reporting Party: _____ Title: _____ Callback Number (Extension): _____

Date: _____ Time (24 hr format): _____ SFSD Staff Taking Call: _____

Missing Patient's Last Known Location: _____ How long has the patient been missing from Location? _____

Missing Patient's last known direction of travel? _____

Missing Patient confirmed to be "At-Risk"? ○ Yes ○ No Is the patient ambulatory? ○ Yes ○ No How many patients are missing? _____

Missing Patient's First Name _____ Last Name: _____

AGE	RACE	SEX	HEIGHT	WEIGHT	HAIR	EYES
GOWN COLOR	JACKET	SHIRT	PANTS	SHOES	OTHER CLOTHING:	
ISOLATION PRECAUTIONS						
☐ NO	☐ YES, specify:	☐ RESPIRATORY	☐ CONTACT			

Check all that apply:

☐ Suicidal? ☐ Homicidal? ☐ Weapons?

Other IMMEDIATE information we need to know about this patient? Describe: _____

ADDITIONAL INFORMATION, IF AVAILABLE:
(May require follow-up call to with Reporting Party)

Patient's Address: _____ Apt #: _____ Telephone #: _____

Street: _____ ☐ Tarasoff?

Victim(s) notified? ○ Yes ○ No

City: _____

SFGH Disaster Info Hotline: 206-4000 *Bed Control: 206-8061*



SAN FRANCISCO GENERAL HOSPITAL AND TRAUMA CENTER

NAME

DOB

MRN

PCP

Patient ID / Addressograph

AWOL "AT RISK" CHECKLIST / REPORTING A MISSING "AT-RISK" PATIENT FORM

Use the AWOL At Risk checklist if the missing patient exhibits behavior indicating a compromised mental status, is on any type of legal hold or has a surrogate decision maker. The patient has been deemed "At-Risk" and is missing and can't be found after a brief search of the immediate area including outside the patient care area.

Note: This checklist is intended to be completed to assist the clinical staff with completing all steps assuring proper care is provided and documented.

Date: _____ Time: _____ Unit: _____

Nursing Staff

- Primary Nurse will notify the Charge Nurse or Nurse Manager, together they will notify the: Administrator-on-Duty (AOD), The San Francisco Sheriff's Department at 6-4911, and the primary team.
- Complete the description on the back of this check list to provide a description of the missing at risk patient to the SFSD.
- Charge Nurse will assign staff to conduct a search of common areas (main and outpatient lobbies, cafeteria, 2nd floor vending machines, and Emergency Department lobby);
- Document in the end of shift nursing notes the time the patient was last seen, the measures taken to find the patient (code green activated), were they found and returned along with any other important information;
- Complete an Unusual Occurrence Report
- Provide this check list to the primary team provider to complete the next section.
- Once the complete checklist is returned submit completed checklist to the AOD

Primary Team/MD/LIP

- Immediately respond to patient unit when called about an AWOL "AT RISK" patient. Participate in Code Green activities as needed
- Document an "AWOL Note" in the LCR, include the circumstances and the measures taken to find the patient (ie: code green activated), were they found and returned along with any other important information. If they are not returned describe the measures that continue or the resolution of the code green, i.e., located with responsible party, arrested located in jail, etc.
- Place a clinical alert in the LCR
- Return completed check list to the primary nurse to submit to the AOD

Reporting a Missing "At-Risk Patient Form (see other side)

NOT PART OF THE MEDICAL RECORD

Rev. 1/15

Environment of Care Policy: 13.09

TITLE: CODE GREEN - MISSING "AT RISK" PATIENT ALERT RESPONSE & SEARCH PROCEDURES

A well-coordinated significant event plan is critical



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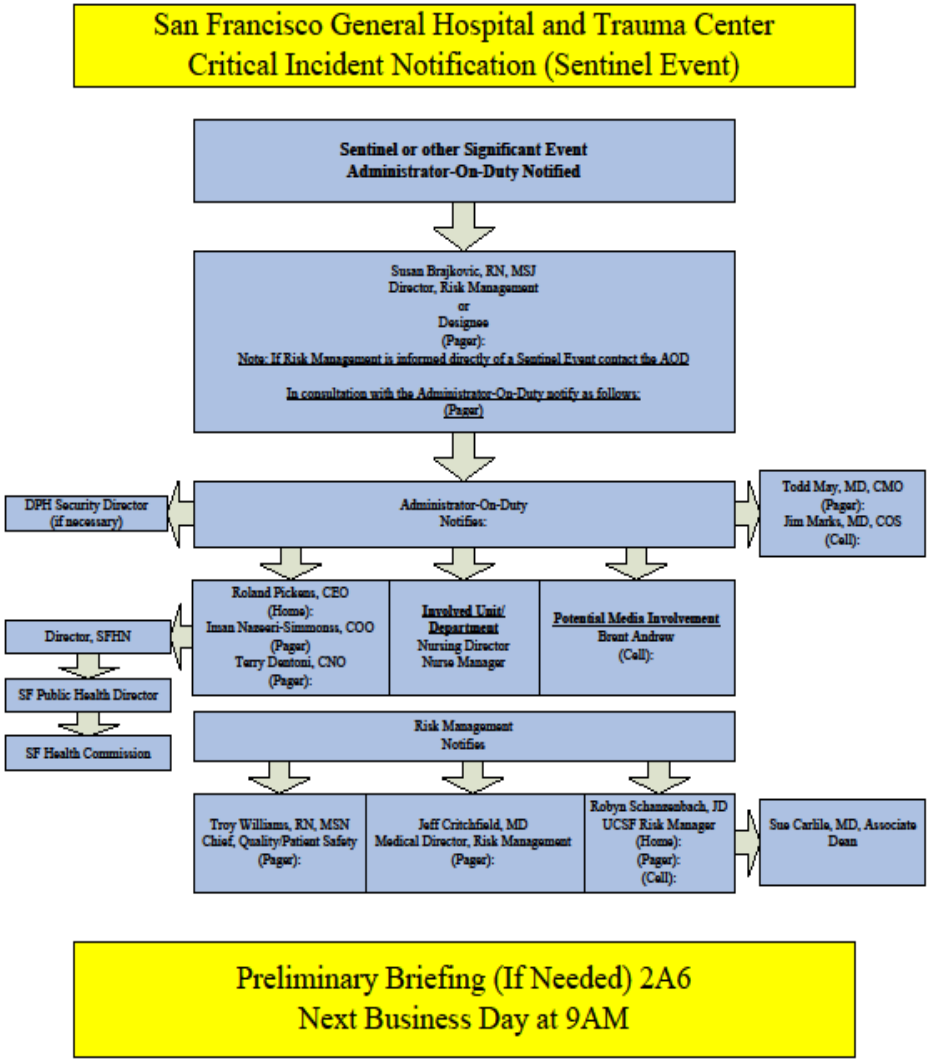
Communication Tools and Strategies-

1. Internal
    a. Staff
    b. Foundation
    c. Governing Body
2. External
    a. Media
    b. Regulatory Agencies
    c. Family Attorney
    d. Law Enforcement

Significant Event Notification



Clear Leadership Oversight of Security (Sheriff's Dept.)

- Coordinated search plan
- Assistance with "At Risk" patients
- Performance metrics



Importance of Transparency

- Open dialogue with family spokesperson and their lawyer
- Regulatory agencies
- The media
- Our staff



Supporting Staff Emotional Impact





Discussion and Questions