State of California [ ] Fatality

DEPARTMENT OF INDUSTRIAL RELATIONS
DIVISION OF OCCUPATIONAL SAFETY AND HEALTH *W.C. Carrier : Self-Insured

NARRATIVE SUMMARY

Establishment Name: Stanford Health Care	**Inspection Number:** 1389056
Management Contacted:	**Title(s):**
1. Teri Ard	1. Environmental Health and Safety
2. Maureen Doherty	2. Manager Accreditation and Regulatory Affairs
3. Catherine Sun	3. Senior Quality Consultant
4. Patrice Duhon	4. Manager Nursing Quality
5. Christi Decena (CRONA)	5. CRONA
6. Kathy Stromberg (CRONA VP)	6. CRONA VP
7. Lisa Ledone	7. Patient Care Manager (Psych Unit)
8. Hirut Truneh	8. Director of Clinical Operations

Information on Injured **Covered by Workers' Compensation: Yes ☒ No ☐**

Name, Address and Phone Number	**Occupation**
1. Catherine Kennedy [redacted] (EE#1)	Nurse

Witness Name(s) and Title *Check Box Preceding Name if Confidentiality is Given.

*	Name and Title	Address	Phone No.	Signed Statement?			
	Sampaguita M. Pino, Nurse (EE#2)	[redacted]		Yes	x	No	
	Suja Varkey, Unit Secretary (EE#3)	[redacted]		Yes	x	No	
	Rachel Ramos, LVN (EE#4)	[redacted]		Yes	x	No	
	Leilani A. Luis, Nurse (EE#5)	[redacted]		Yes	x	No	
	Matthew L. Edwards, Jr. Resident Physician (EE#6)	[redacted]		Yes		No	x
	Tim Ando, Resident Physician (EE#7)	[redacted]	[redacted]	Yes		No	

Summary:

On March 13, 2019, the Cal/OSHA DOSH Foster City District Office received a call from the Employer, Stanford Hospital, of an employee injury. The incident occurred at 300 Pasteur Drive, Palo Alto. EE#1 was performing her normal assigned duties and attending to a patient in the locked H2 Psych Unit. The patient became agitated and attacked EE#1. Employees and Security restrained the patient while EE#1 was transported to the Emergency Department at Stanford Hospital where she was treated for her injuries.

On March 15, 2019, the District Manager assigned the undersigned Associate Safety Engineer (AE) to conduct an investigation. On March 28, 2019, CSHO and SSE reported to 300 Pasteur Drive, Palo Alto. An Opening Conference was conducted with the Environmental Health and Safety Program Manager, Department Management, and CRONA (nurses union).

On May 22, 2019, the CSHO met with EE#1 and EE#2 at EE#1's residence.

On May 29, 2019, the CSHO met with EE#3 and EE#4 at their place of employment.

On June 24, 2019, the CSHO met with EE#5, EE#6, and EE#3 at their place of employment.

THE EMPLOYER

Stanford Health Care comprises of outpatient clinics, inpatient clinics, and hospital care servicing the San Francisco Bay Area.

Within the Stanford Medical Center there is the Inpatient Psychiatry Clinic which consists of a locked unit (G2) and locked unit (H2). The Psychiatry Unit offers consultation and therapy from psychiatrists, psychologists, nurses and various other professions.

THE INJURED EMPLOYEE

The injured employee (EE#1), is a 70 year old female who had been employed with Stanford Health Care for 17 years. EE#1 has 30 years in psychiatry experience and receives annual Crisis Prevention Training. Due to EE#1's extensive background in psychiatry experience, EE#1 was assigned the patient involved in the incident on March 12, 2019.

THE ACCIDENT

On March 12, 2019, EE#1 started her shift at 1845hrs with "Report". "Report" is when information is passed during shift change. Report took about 50 minutes. During shift change there is also visiting hours. On this day there were 14 patients. When EE#1 entered H2, the locked Acute Psychiatric Unit, it was chaotic and disorganized with visitor congregating around the nurses station. The nurses station is where the visitors' belongings are kept. EE#1 was briefed on the patient's behavior earlier in the day. The patient's girlfriend was one of the visitors. The staff within the unit felt the girlfriend's appearance and behavior may have provoked the patients agitated manner. The patient was pacing back and forth within the unit and took off his shirt. At one point EE#4 retreated to the nurses station due to the patients behavior. EE#4 felt the nurses station was a safe place because patients are not allowed inside. The patient disregarded EE#4's statement as to not enter nurses station. The patient walked through the nurses station and confronted EE#2 who was blocking the exit door that leads to G2. EE#3 pulled the panic alarm and picked up the phone with security to call for help due to the patient's behavior. EE#1 administered medication to the patient as to calm him down and gave him his shirt to put back on. EE#1 did not feel threatened in any way as the patient was walking loose but tense and then started flailing on the ground in front of the nurses station. EE#1 was sitting on the floor after the medication was administered to him by EE#1. There was no security present in the unit, 1 charge nurse on shift for both G2 and H2. As EE#3 was on the phone with security, the patient

lunged at EE#1 with a scissor kick and began striking her. EE#2 tried to restrain the patient and was struck as well. Security and staff entered the unit and restrained the patient.

EE#1 was taken to the Emergency Room where she was treated for a fractured tibial plateau and a detached posterior vitreous.

SITE EVALUATION

On March 28, 2019, the CSHO and SSE inspected the locked Acute Psychiatry Unit (H2). There are 14 rooms in unit plus one seclusion room. The seclusion room is located directly across from the nursing station. The unit consists of one long hallway perpendicular to the entrance way from G2. Rooms are located on each side of the hallway. The patients are free to walk about within the unit. If a patient has security assigned to them, the patient remains in their room with the security sitting in a chair at the door.

The night of the incident, there was 1 secretary, 2 registered nurses, 1 nursing assistant, 1 licensed vocation nurse, 14 patients, and visitors. Security was not in the unit and the charge nurse was next door. Each nurse had approximately 4 patients that evening.

FINDINGS

As per management, the patient brought himself in and was admitted on Sunday, March 10, 2019. The incident occurred on March 12, 2019. On March 11, 2019 at 2200hrs there was an order to have a security with the patient.

The Stanford protocol is for security to remain with a patient until the charge nurse or physician releases security. On March 12, 2019 at 0200 the patient's medical records stated due to staff shortage the security supervisor needed to pull the security officer assigned to the patient.

Incidents are more likely to happen when change of shift is during visiting hours due to too many people present which causes disorder. The incident on March 12, 2019 occurred when change of shift overlapped with visiting hours. Prior to the incident the patient's girlfriend visited the patient which agitated the patient. During the Opening Conference it was stated the patient becomes agitated during the visits by his girlfriend.

CONCLUSION

The employer failed to maintain a 2 to 1 monitoring order for the patient, failed to identify triggers by the patients visitor, failed to identify hazard posed by overlap of guest visitation and clinician rounds, failed to identify risk factors associated with patients transferred into the psychiatric unit, failed to maintain sufficient number of staffing in psychiatric unit, and failed to make the availability of security staff. As a result an employee suffered a serious injury resulting in hospitalization greater than 24 hrs.

REGULATORY ACTION

Serious Accident Related – T8 CCR Section §3342(c).

1. The employer failed to effectively implement employee communication procedures regarding workplace violence matters, including how employees will document and communicate information to other employees between shifts and units regarding conditions that may increase the potential for workplace violence incidents in the following ways:

a. The physician's 2 to 1 monitoring order for the patient, which was recorded in the medical record, was not followed; and

b. The emergency department's assessment and patient history were not conveyed to the nursing staff in the psychiatric unit. [Ref: 3342 (c)(7)(A)]

2. The employer's implementation of the patient-specific risk assessment procedures failed to;

a. Identify the trigger initiated by the patient's visitor during visits to the psychiatric unit. [Ref: 3342(c)(10)(A) &(c)(10)(D)]

b. Identify and correct the hazard posed by scheduling overlap of guest visitation and clinician rounds in the psychiatric unit. [Ref: 3342(c)(10)(A) &(c)(10)(D)]

c. Ensure that the psychiatric unit identify risk factors associated with the patient who was transferred to the psychiatric unit. 3342(c)(10)(A) &(c)(10)(D)]

3. The employer's workplace violence prevention plan correction procedures were not effectively implemented due to failure to maintain sufficient security staffing in the psychiatric unit:

a. The employer failed to maintain sufficient numbers of security staff in the psychiatric unit. [REF:3342(c)(11)(A), (c)(11)(F), & (c)(11)(J)]

b. The security staff were not available due to other assignments preventing them from immediately responding to an alarm. [REF:3342(c)(11)(A), (c)(11)(F), (c)(11)(I) & (c)(11)(J)]

c. The employer failed to maintain order in the H2 psychiatric unit. [REF:3342(c)(11)(A), (c)(11)(F), & (c)(11)(J)]

d. The employer and security staff failed to effectively implement its security plan stand-by assessment procedures. [REF:3342(c)(11)(A), (c)(11)(F), & (c)(11)(J)]

e. The employer failed to following its corrective security procedures for a patient designated as 5150. [REF:3342(c)(11)(A), (c)(11)(F), & (c)(11)(J)]

Use additional sheet(s) as needed.

		Signature	Date
Prepared by:	**CSE, IH**	[signature]	9/12/19
Reviewed by:	**DM/SR. IH**	[signature]	9/13/19
	Regional Manager		
	Deputy Chief		