

PROBLEM: HOSPITAL LIABILITY FOR NEEDLESS DEATH

THE ORANGE COUNTY BETA
REGISTER By [COURTNEY PERKES](#)
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St. Joseph Hospital of Orange has been fined \$50,000 in the death of a patient who stopped breathing after an oxygen tank ran out, the California Department of Public Health announced Tuesday.

St. Joseph was one of seven hospitals across the state to receive a fine for errors likely to cause serious harm or death to patients.

The state's investigative report gives this account of what happened at St. Joseph:

In March 2009, an unidentified patient suffering from shortness of breath and pneumonia in both lungs was transported with a portable oxygen tank to the ultrasound department for a scan.

The patient waited for an hour in the radiology room, although the oxygen tank only had a capacity to last 45 minutes. When the patient was transported back to a hospital room, the tank was empty and the patient wasn't breathing. The patient was reconnected to oxygen but was pronounced dead.

According to the report, the hospital failed to ensure transport policies were followed, advocate for patient safety or develop policy for care of transported patients who are on oxygen.

St. Joseph issued a statement Tuesday saying it had redesigned its policy to include "standard guidelines and communication expectations of staff when transporting oxygen-dependent patients." The changes include standardizing when a nurse must accompany a patient receiving oxygen.

The fine is the second for St. Joseph since 2007. In 2008, the hospital was fined \$25,000 after operating on a patient's wrong knee.

A new law took effect in 2007, and since then the state has issued 146 fines to 96 hospitals for a total of more than \$4.2 million, said Kathleen Billingsley, a deputy director. The fines started out at \$25,000, but last year increased to \$50,000 for the first violation. Fines for a second violation are \$75,000 and increase to \$100,000 for a third or more. Fines issued before 2009 are not counted toward that total.

The fines are used to improve hospital quality and safety, including a program to reduce incidents of surgical equipment left behind in patient's bodies.

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