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California Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000088	A. BUILDING _____ B. WING _____	4/13/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMISE HOSP OF EAST LOS ANGELES	443 South Soto Street Los Angeles, CA 90033

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E000	Initial Comments The following reflects the findings of the Department of Public Health during an investigation of an entity reported incident. Complaint: Intake/Entity/Reported Incident: CA00223727 – Substantiated Representing the Department of Public Health: [redacted] – Senior Health Facilities Evaluator Nurse [redacted] – Health Facilities Evaluator Nurse The inspection was limited to the specific entity reported incident and does not represent the findings of a full inspection of the facility. 1280.1 (c) Health and Safety Code Section For purposes of this section, "Immediate Jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or likely to	E000		
E264	cause, serious injury or death to the patient." T22 DIV5 CH1 ART3-70213(a) Nursing Service Policies and Procedures. (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. This RULE: is not met as evidenced by: Based on review of Patient 1's clinical record, review of facility documents, and interviews with the facility staff, the facility failed to implement their policies and procedures to ensure Patient 1		E264 Immediately upon receiving the report of medication errors on March 26, 2010, an investigation was initiated and action plans were instituted to prevent an re-occurrence of the incident. Administration, nursing services leadership, pharmacy leadership and quality management met to discuss and investigate the incident.	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLER REPRESENTATIVE'S SIGNATURE | TITLE CEO | (X6) DATE 10/7/2010

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E264	Continued From Page 1 received the correct medication dosage and correct medication as ordered by the physician. On March 22, 2010 at 12:15 p.m., the physician ordered to discontinue the medication Cardizem CD (controlled release form of Cardizem) 180 milligrams (mg) daily dose and ordered Cardizem (a drug used to treat abnormal heart rhythm and also used to treat high blood pressure). 60 mg via gastrostomy tube (surgical opening into the stomach used for feeing and administration of medication). However, four doses of 600 mg (ten times more than prescribed amount per dose) Cardizem CD were administered to Patient 1. This failure resulted in severe bradycardia (very slow heartbeat), heart rate of 29 beats per minute and an inability by the licensed nurse to obtain a blood pressure reading on the patient for nine (9) minutes. Subsequently, Patient 1 required intubation (insertion of breathing tube in the windpipe), mechanical ventilation (a machine that helps a person breathe), and administration of emergency medications. Findings: On April 13, 2010, an unannounced visit was made to the facility to investigate a facility reported incident regarding a medication error which lead to patient intubation, mechanical ventilation, administration of emergency medications and transfer to the Intensive Care Unit (ICU) for seven days. Cardizem is a Class IV antiarrythmic (a drug used to treat an abnormal heart rhythm) agent and Calcium Channel Blocker. It works by slowing the electrical conduction in the heart, slowing heart rate, and/or normalizing heart rhythm. It slows the movement of calcium into	E264	Continued From Page 1 An In-service on Over-Riding Medications was given to staff pharmacists and nursing leadership that included instructions that over-riding medications is to be performed only by the Nursing Supervisor on duty and only on an emergency basis. The Director of Pharmacy will continue to monitor through daily over-ride reports. The policy and procedure on Medication Administration was reviewed by nursing and pharmacy to ensure that it contained all practices and standards of Medication Administration. The managers of the Medical Surgical Department and ICU Departments gave inservices to all staff that contained the following information: • Drug administration procedures and the steps in medication administration. Copies of handouts and policies and procedures were distributed to all attendees • Review the 5 Rights of Medication Administration • Steps in medication administration as follows: o Practices, control, hand-hygiene o Patient identifiers o Check orders of physician including completeness of the order o Check the medication, side effects and expiration date o Read the drug label at least 3 times-when picking up the drug – just prior to administration and just after administration	4/30/2010

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E264	Continued From Page 2 the cells of the heart and blood vessels, thereby relaxing blood vessels, increasing the supply of oxygen-rich blood to the heart, and reduces the heart's workload. The clinical report for Patient 1 was reviewed on April 13, 2010. The Admission Face Sheet indicated Patient 1 was admitted to the facility on January 26, 2010. Patient 1 had a history of chronic obstructive pulmonary disease, pneumonia, aspiration pneumonia, and respiratory failure. According to the Physician Order Sheet dated March 22, 2010, at 12:15 p.m., the physician ordered to discontinue the medication Cardizem CD (180 mg daily dose). The second physician order was Cardizen 60 milligrams (mg) via Gastrostomy tube every 8 hours. A review of the Medication Administration Record (MAR) dated March 22, 2010, 7 a.m. to March 23, 2010, 6:59 a.m., revealed a handwritten Cardizem 600 mg via G-tube every 8 hours. The documentation indicated this dosage of medication was administered at 2 p.m., 10 p.m. and 6 a.m. The MAR dated March 23, 2010, 7 a.m. to March 24, 2010, at 6:59 a.m., revealed a preprinted dilitazem HCl (Cardizem 60 mg tablet per G-Turb every 8 hours. This entry had a large triangle written over it (indicating changed) and a handwritten notation stating "see new order". Below this was a hand-written entry of Cardizem 600 mg q8/gt (every 8 hours per G-Tube). The documentation on the MAR indicated this dosage of medication was administered at 2 p.m., 10 p.m. and 6 a.m. During an interview with Pharmacist 1 on April 13, 2010, at 10:55 a.m., he stated that	E264	Continued from Page 2 • Before administering any drug, mentally review the Five Rights: o Right PATIENT o Right DRUG o Right DOSE o Right ROUTE o Right TIME, REASON and Documentation • The Nursing Supervisor on duty for a particular shift is the only person who is mandated to initiate/witness all over-rides and must have another licensed nurse as a witness • Over-Rides should only occur AFTER normal pharmacy hours of operation and only for EMERGENCY medications • Any over-ride that is initiated by un-authorized personnel or occurs DURING pharmacy hours will be subject to disciplinary action up to and including termination In addition to the above; the action plan also included the following: The CNO/Designee inserviced all nursing staff on the following: • Policy and procedure on Administration of Medication **and 12 hour and 24 hour check of orders.** • Policy and procedure on Transcribing Physician Orders • Policy and procedure on Over-Ride Authorization **and automated dispensing.** • Utilization of available resources related to medications (i.e. Pharmacy Department, PDR's) The Director of Pharmacy did: • The Director of Pharmacy removed Cardizem 300 mg in the Med DISPENSE • The Director of Pharmacy re-inserviced the Pharmacy staff on the policy and procedure regarding Over-Rides	4/30/2010 4/30/2010 4/30/2010 4/25/2010 4/25/2010

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E264	Continued From Page 3 medications were taken from the "med DISPENSE", not the medication cart. Licensed Nurses transcribe the physician's medication order on the Medication Administration Record (MAR) if the medication or dose is initially ordered. The facility has an automated medication dispense system in place called the "med DISPENSE". The med DISPENSE report of drug transactions for Cardizem 60 mg for Patient 1 for dates March 18, 2010 to March 25, 2010, indicated LVN 1 had taken out one 60 mg tablet on March 22, 2010 at 1:25 p.m. and one 60 mg tablet on March 23, 2010, at 2:10 p.m. Further review of the med DISPENSE reports revealed drug transactions for Cardizem CD 300 mg for dates March 18, 2010 to March 25, 2010. The report indicated two 300 mg capsules of Cardizem CD dispensed to LVN 2, with an override authorization by RN 2, on March 22, 2010 at 8:41 p.m. There were also three entries with tow 300 mg capsules of Cardizem CD dispensed to LVN 2, with an override authorization by RN 1, on March 23, 2010 at 4:48 a.m., March 23, 2010 at 7:58 p.m. and March 24, 2010 at 4:39 p.m. The physician's orders were to discontinue Cardizem CD and start Cardizem 60 mg. A review of the 24 Hour Care Record-1 dated March 22, 2010 indicated the patient's heart rate and blood pressure readings at 8 a.m. were 71 beats per minute (bpm) and 154/83, respectively. At 12 p.m. the heart rate was 62 and the blood pressure was 137/85. On March 23, 2010, at 12 a.m. the patient's heart rate was 109 beats per minute and blood pressure was 164/86. At 4 p.m. the heart rate was 60 bpm and the blood pressure was 90/63.	E264	Continued from Page 3 The Chief Nursing Officer also gave inservices to all Nursing Supervisors The Medical Surgical Nursing Manager completed all Inservices to nursing staff The ICU Manager completed all inservices to ICU staff and Surgical Staff The Hospital Leadership has also a monitoring system in place to ensure that there is no recurrence of this deficiency as follows: Medication Administration: (Pharmacy/Nursing Leadership) – Completeness and accuracy of medication orders / the number of medications administered. The results will be reported on a monthly basis to Quality Management and P&T Committee and reported up through Quality Council, the Medical Executive Committee and the Board of Governors. Over-riding of Medications: (Director of Pharmacy or Designee): Appropriate over-riding of medications / total number of override medications. The results will be reported on a monthly basis to Quality Management and P&T Committee, and reported up through Quality Council, the Medical Executive Committee, and the Board of Governors.	4/30/2010 4/30/2010 4/30/2010 On-Going On-Going

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E264	Continued From Page 4 On March 24, 2010, at 4 a.m., the heart rate was 56 and the blood pressure reading was 110/65. At 8 a.m. the heart rate was 55 bpm and the blood pressure was 90/54. A review of the CPR Record dated March 24, 2010, at 12:08 p.m., indicated Patient 1's heart rate was 29 and no blood pressure readings. "Code Blue" was called and Advanced Cardiac Life Support (ACLS) protocol was initiated. Initially, Patient 1 was ventilated with bag and mask ventilation. Patient 1 also received on does of Atropine and 2 doses of Epinephrine. At 12:20 p.m. Patient 1 was intubated (inserted a tube in the windpipe) and was transferred to the ICU at 12:28 p.m. During an interview with LVN 1, on April 13, 2010, at 11:15 a.m., LVN 1 stated "I transcribed it wrong. I meant to write 60 (mg). In the med DISPENSE, it (Cardizem 60 mg) is there already – the 60 mg, no need to override." When asked why she signed off on the Cardizem 600 mg entry in the MAR for March 23 to March 24, 2010, she replied "I thought it was the 60 (mg)." The facility policy and procedure number 10.NUR.15.13.21, titled "Transcribing Physician Orders" dated November 1, 2004, indicated "Nurses are responsible for checking all medication orders and for checking transcription orders done by the monitor technicians and initialing the MAR after checking. Nurses are responsible for checking that physician's orders are transcribed accurately and sent to the appropriate department in a timely manner." The facility policy and procedure, titled, "12 Hour Chart Check" dated November 1, 2004, with a revision date of February 2010, stipulated, "Every 12 hours the physician's order sheet is checked	E264	Continued From Page 4 As a result of the investigation done by Administration, Nursing Leadership, Pharmacy Leadership and Quality Management, it was determined that, due to their failure to follow hospital policies and procedures, and the adverse outcome of their actions, the following personnel had their employment relationship with Promise terminated: LVN 2 RN 1 RN 2 LVN 1 received a written warning and was re-inserviced on Medication Administration and Transcribing Physician Orders.	4/9/2010 4/9/2010 4/9/2010 4/21/2010

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E264	Continued From Page 5 to ensure that all orders have been noted correctly. This is the responsibility of the NOC (night) shift. All orders written in the past 12 hours hare checked to see if they have been transcribed correctly. The orders are verified against the patient kardex and the medication records". The facility policy and procedure number 10.NUR.5.12.7 titled "Medication Administration Of" dated November 1, 2004, stipulated, "Verify drugs to be administered with the prescriber's order. Refer to the MAR and ensure that the dose is correct...Before administering any drug, mentally review the five rights: right patient, right drug, right dose, right route, right time" A memorandum to all licensed nursing personnel dated October 9, 2008, indicated "effective IMMEDIATELY, any licensed personnel witnessing an over-ride must be provided with a copy of the order to verify that the medication being obtained has the documentation to support the over-ride. Both nurses will be held accountable for the over-ride discrepancies." The facility policy and procedure titled "Automated Dispensing" dated November 1, 2004, with a revision date of October, 2008, indicated, "Only drugs for which a written order exists may be removed from the cabinet" The facility's failure to implement its policies and procedures to ensure a patient received the correct medication and correct does of medication, as ordered by the physician, is an deficiency that has caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an Immediate jeopardy within the meaning of Health and Safety Code Section 1280.1.	E264		

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