CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050009	A. BUILDING _____ B. WING _____	02/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Queen of the Valley Medical Center	1000 Trancas St, Napa, CA 94558-2906 NAPA COUNTY

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00363220 - Substantiated Representing the Department of Public Health: Surveyor ID # 27294, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. Health and Safety Code Section 1280.3: 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 is likely to cause, serious injury or death to the patient. Penalty Number: 110011422 E 264 T22 DIV5 CH1 ART3 - 70213(a) Nursing Service Policies & Procedures (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. Based on interview, clinical record and hospital document review, the hospital failed to ensure that Licensed Staff G followed physician orders to administer epinephrine (a lifesaving medication used to treat allergic reactions) subcutaneously (injection under the skin) and gave the epinephrine		Abbreviations: CNO – Chief Nursing Officer CMO – Chief Medical Officer COO – Chief Operating Officer ED – Emergency Department MSQC – Medical Staff Quality Council MSEC – Medical Staff Executive Committee BOT – Board of Trustees ** This finding was previously corrected following a Federal Complaint Validation Survey. E 264 T22 – 70213 Nursing Service Policies & Procedures **Immediate / Follow Up Actions:** Debriefing of all involved medical staff and nursing staff commenced on 5/25/13. The hospital's policy titled "Medication Administration", pg. 2, E.6 indicates that prior to administration, the healthcare provider administering the medication will "verify that the medication is being administered at the proper time, in the prescribed dose, and by the correct route". This policy was approved on 07/2012 and was in effect at the time of this event. In this event, this element of the hospital policy was not followed. Corrective actions: 1. Following the recognized intravenous administration of Epinephrine that was ordered to be given subcutaneously, the following actions: a. The ED nurse involved in the care of the patient, ED manager, and ED educator, debriefed regarding this event and discussed measures to prevent future occurrences. b. The involved ED nurse gave a presentation	10/1/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jenny Stratton RN, Vice President Patient Care/CNO | TITLE | (X6) DATE: 8/6/15

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s). 1 thru 5

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Plan of Correction Reviewed & Accepted
Mary Fidler RN, Compliance manager informed. 1/19/16
1:45pm JB Nelson, HFEN

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	intravenously (into a vein), which resulted in Patient 101 developing chest pain, and cardiac arrhythmias. Patient 101 was admitted to the hospital for observation. This failure was a violation of Section 70213(a) of Title 22 of the California Code of Regulations and was a deficiency that caused or was likely to cause serious injury or death to the patient and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code 1280.1(a). Findings: Patient 101, a 46 year old male, was admitted to the Emergency Department on 05/24/13, at 10:15 p.m., with itching, swelling of his lips, and a tingling sensation in his throat (symptoms of a life threatening allergic reaction). The Emergency Department Records, dated 05/24/13, for Patient 101, indicated the following medications were ordered by the Emergency physician at 10:35 p.m., for an allergic reaction: 1. Benadryl (Diphenhydramine) 50mg. /1 ml/one/IV-25mg. (antihistamine used to treat allergy). 2. Epinephrine 1 mg/1 ml/one/subcut - 0.3mg; (used to ease breathing by opening airways and narrows the blood vessels to maintain blood pressure). 3. Methylprednisolone 125 mg/2 ml/ one/IV-125 mg (anti-inflammatory which reduces swelling). During an interview on 09/09/13 at 11:45 a.m., Licensed Staff G stated she was working the night shift (6 p.m. - 6 a.m.) in the emergency department		regarding "this medication error and medication safety" at an ED staff meeting on 6/20/13. Minutes from this meeting were distributed to all ED registered nurses. Topics included: • Review of hospital's medication administration policy • Details of this event / medication error • Indications, use, and side effects of epinephrine • Discussion: hospital policy indicates that the MAR or other prescriber order must accompany the healthcare provider to the cassette, Pyxis, or other designated medication storage area and throughout the medication administration process; thereby, utilizing a printed copy of the physician order when floor space for the workstation on wheels (WOW) becomes limited (i.e, due to equipment or number of persons in the room) should reduce the risk of medication errors. c. A process change was implemented to ensure that when the Electronic Medication Administration Record (EMAR) is not at the patient's bedside in close proximity allowing the nurse to view the physician orders during the medication administration process, the nurse will print a copy of the EMAR to bring to the patient's bedside. 2. Mandatory education titled, "Medication Management in ED" commenced for ED nursing staff on 7/1/13 and was completed on 8/29/13 with 100% documented compliance. Education topics included: a. Requirement to verify physician orders with a printed order or the open EMAR.	

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	on 05/24/13. She stated this was her normal shift and stated she was really busy that night. Patient 101 was admitted with an allergic reaction. She stated she went into Meditech, (the facility's electronic charting system) to check the new Physician's orders for Patient 101 saw the new orders and went to the Pyxis (facility's medication storage system) to retrieve the medications. She stated two of the medications, (Methylprednisolone and Benadryl) were ordered to be given intravenously, and she inadvertently gave the Epinephrine intravenously also. The Emergency Department Medication record, dated 05/24/13, indicated Licensed Staff G gave all three medications intravenously between 10:50 and 10:55 p.m. Emergency Room Nursing treatment notes, dated 05/24/13 at 10:57 p.m., indicated Patient 101 complained of chest pain, his heart rate was up to 140s (sinus tachycardia) with frequent PVC's (Premature ventricular contractions: abnormal heart rhythm). Patient 101's heart rate on admission was 73 and Patient 101 had no history of heart problems. Patient 101 was placed on oxygen, cardiac monitoring and lab tests were checked for elevated Troponin levels (Troponin is a protein released into the blood by a damaged heart muscle and is a specific indicator that there has been injury to the heart muscle - called a myocardial infarction). Patient 101 was admitted to the telemetry unit at 1:35 a.m., for observation; the diagnosis was acute		b. RN responsibility for documentation and practice. c. Back-to-Basics – 5 rights 3. Completion of mandatory staff education is monitored and tracked via department specific reports and/or via HealthStream, the hospital's electronic Learning Center system. Elements of the above mandatory education have been added to the annual competency requirements for ED nursing staff and have been included in new hire orientation for all new staff working in the ED. Monitoring Process: 1. Designated ED staff commenced an audit of medical records of all ED patients having a physician order(s) to administer Epinephrine (1:1000) 1 mg / 1 ml). This monthly audit commenced on 6/1/13 and concluded on 10/31/13. All doses were given as ordered, including the proper time, the prescribed dose, and the correct route; resulting in 100% compliance. Additional audits were completed February 2014 through April 2014 resulting in Feb 2014 = 9/9; Mar 2014 = 12/12; April 2014 = 7/7 for 100% continued compliance. Responsible Person(s): ED Director or designee Actions for the above Plan of Correction were evaluated for effectiveness. Audit data and analysis was reported to involved staff, Patient Safety Council, Administration, Nursing Leadership, MSQC, MSEC, CQC, and the BOT for tracking, education & improvements as needed, and integration into the hospital's quality assurance program.	10/31/13

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	chest pain and ventricular arrhythmias due to inadvertent administration of intravenous epinephrine. Epinephrine given intravenously can have an adverse reaction to the cardio/vascular system causing ventricular arrhythmias, chest pain, and tachycardia (rapid heart rate). Preferred route for Epinephrine is by subcutaneous injection except in cases of cardiac arrest or anaphylactic shock. Lippincott 8th Edition I.V. Drug Handbook - published 2004; pages 310 - 312; Lippincott - Nursing 2009 Drug Handbook; Pages 844-847. Hospital policy titled Medication Administration, last reviewed 7/2012, indicated prior to administration of a medication, the healthcare provider administering the medication verifies that the medication is being administered at the proper time, in the prescribed dose and by the correct route. This failure to ensure that Licensed Staff G followed physician orders to administer Epinephrine (a lifesaving medication used to treat allergic reactions) subcutaneously (injection under the skin) and gave the Epinephrine intravenously (into the vein), which resulted in Patient 101 developing chest pain, and cardiac arrhythmias. Patient 101 was admitted to the hospital for observation was a violation of Section 70213(a) of Title 22 of the California Code of Regulations and was a deficiency that caused or was likely to cause serious injury or death to the patient and therefore constitutes an immediate jeopardy within the meaning of Health			

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	and Safety Code 1280.1(a). This facility failed to prevent the deficiency(ies) as described above that 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(c).			