' '		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME	BER.	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR COMPLETE	
		050168		B. WING		02/23	/2010
NAME OF PR	OVIDER OR SUPPLIER	s	TREET ADDRESS, CIT	Y, STATE, ZIP (	CODE	•	
ST. JUDE	MEDICAL CENTER	10	01 E. VALENCIA M	ESA DRIVE,	FULLERTON, CA 92835 ORAN	IGE COUNTY	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FU SC IDENTIFYING INFORMATIC		ID REFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SHOU REFERENCED TO THE APPROPRIA	JLD BE CROSS-	(X5) COMPLETE DATE
	The following reflects to Department of Public Finspection visit:				1279.1 (a)		
	Complaint Intake Numl CA00212243 - Substar				A: How the correct accomplished, both and permanently.	oth temporarily	,
		artment of Public Health eutical Consultant II	n:		The St. Jude Med (SJMC) Sentinel Event Reporting a	Event/Adverse	e
	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 1280.1(c): 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.				policy is in compl reporting timefrar "immediate and w as it relates to the	ne of vithin five days	
			jeopardy" licensee's quirements		regulation. In the this event and the of Dec. 9, 2009 it the original coron not available until at which time a resubsequent revie	investigation e reporting dat is noted that er's report wa l Oct. 14, 2009 equest for a	e s
	DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY				was made with fu provided to the co process took ove	irther evidence proner. This	
1279.1(a) HSC Section 1279 (a) A health facility licensed pursuant to subdivision (a), (b) or (f) of Section 1250 shall report an adverse event to the department no later than five days after the adverse event has					and the final repo on Nov. 18, 2009		
			event has		Based on the sub toxicology report	of Morphine	
		if that event is a			toxicity there was		
urgent or emergent threat to the welfare, health or safety of patients, personnel or				review of the sma programming by			
	visitors, not later	·	after the		question. Upon c		
	adverse event has	been detected.	Disclosure		this review the ca		
	of individually ide shall be consistent with	•	information		reported on Dec.		
Event ID:	MRC011		12/29/2010	8:40:20		_	
	RY DIRECTOR OR PROVID	ER/SUPPLIER REPRESEN		_	TITLE		(X6) DATE

IDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU			PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		050168		A. BUILDING B. WING		- _ 02/23	3/2010
'	OVIDER OR SUPPLIER MEDICAL CENTER		STREET ADDRESS 101 E. VALENCI		IP CODE /E, FULLERTON, CA 92835 O	RANGE COUNTY	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTION ) REFERENCED TO THE APPROI	SHOULD BE CROSS-	(X5) COMPLETE DATE
Event ID:	following:  (A) A patient of associated with a but not limited to, drug, the wrong of wrong time, the preparation or administration, differences in old selection and dose.  70213(a) Nursing Procedures  (a) Written policies care shall be implemented by the nursing procedures (b) Written policies care shall be implemented by the nursing procedure of a committee of equipmentative of equipmentative and representative and representative.  (1) The committee and procedures for effective systems distribution, dispensing	ation Error  of this section the following: ment events, ince death or serious medication error an error involving lose, the wrong wrong rate, the wrong excluding re inical judgment  Service Policand procedures developed, maint ursing service.  Pharmaceutical ind therapeutics couvalent composition committee shall co- ian, one pharm irsing service the administrate shall develop writ- establishment of for procurement	cluding the s disability including, the wrong patient, the the wrong route of easonable on drug dicies and for patient ained and service ommittee, or n, shall be noist of at nacist, the or her or or his tten policies f safe and t, storage,	) 8:40:2	reported in ad SB1301 regulatimeline monit to the Patient Performance Committee.  1279.1 (b) 4 A: How the consecutive accomplished and permaner  A comprehensiand review of practices was following area review:  1. The smart pure the Morphine parameters with a "hard stop order sets with were updated changes. This in a redundant pump programent that will prevent contradiction corder.	epartment  Events that are herence to the ation will have thored and reporte Safety Improvement  Exercision will be hoth temporarily of the policies and completed. The swere part of the administration ere programmed of Morphine order to reflect these change will resuct to the PCA ming by nursing nt a programmin	d at
	RY DIRECTOR'S OF PROVID	ER/SUPPLIER REPRESE			TITLE		(X6) DATE

LABORATORY DIRECTOR'S OF PROVIDER/SOPPLIER REPRESENTATIVE'S SIGNATURE

no

TATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	050168	B WING		02/23/2010		
ME OF PROVIDER OR SUPPLIER  T. JUDE MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  101 E. VALENCIA MESA DRIVE, FULLERTON, CA 92835 ORANGE COUNTY				
REFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTION REFERENCED TO THE APPRO	SHOULD BE CROSS- COMPLETE		
other appropriate administration shall development are procedures. Policies governing body. Property of the administration such is appropriate.  (g) No drugs shall licensed personnel drugs and upon the authorized to present preclude the drugs by respirator include the name of the frequency of administration, if other time and signature furnisher. Orders for transmitted by the Verbal orders for a person lawfully furnish and shall patient's medical rethe person giving signature of the interest of the order within 48 hours.  The above regulate evidenced by:  Based on interview.	armacist in consultation with health professionals and be responsible for the noted implementations of shall be approved by the rocedures shall be approved on and medical staff where on any medical staff where authorized to administer elementary of a person lawfully cribe or furnish. This shall administration of aerosol of the drug, the dosage and administration, the route of the prescriber or drugs should be written or the prescriber or furnisher. The given only by authorized to prescribe or be recorded promptly in the ecord, noting the name of the verbal order and the individual receiving the order. The furnisher shall countersignars.  The constant of the prescribe or the prescriber or furnisher and the individual receiving the order. The furnisher shall countersignars.  The constant of the prescribe or the verbal order and the individual receiving the order. The prescriber of the prescriber or the verbal order and the individual receiving the order. The prescriber of the prescriber or the verbal order and the individual receiving the order. The prescriber of the prescriber or the prescriber of the prescriber or the prescriber		infusion policy with respect to process and or responsibility. While the nurnot follow est policy by dou PCA pump programment the plant with another or check the ent found to be a other nursing to the policy of warranted. Doubt all nursing stareview of the "Lessons Leathe double charted the safety me patients was another nursing of preceptor proto include an verification of including critical thinking review.	to the process. se in question did ablished hospital ble checking the rogramming hysician order and nurse to double try, this was not practice among staff and changes were not respite this finding aff received a policy and arned" regarding neck process and reasures it provides completed. Intation and annual were updated to CA pump changes orientation gram was updated improved if the skills program; cal skills and w. Preceptors d criteria to ensure		
Event ID:MRC011	12/29/20	10 8:40:2	20AM			
BORATORY DIRECTOR'S OR PROVID	ER/SUBPLIER REPRESENTATIVE'S SIGN	NATURE	l mo	(X6) DATE		

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.

State-2567

Oct.   Inc.	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		1 ' '	(X3) DATE SURVEY COMPLETED	
TO ALLENCIA MESA DRIVE, FULLERTON, CA 92835 ORANGE COUNTY    CALID   PROVIDERS RIAN OF CORRECTION (EACH OERRECTION SECULD PREEK REGILATORY OR LSC OEMTFYING IN-COMMTON)   PREEK TAG			050168			02/23	3/2010
Continued From page 3 order prior to increasing the dose of morphine (a potent narcotic medication to treat pain) for Patient 1. The unordered increase in dosage resulted in Patient 1 receiving 10 times the dose of morphine ordered by her physician. According to the coroner's report, Patient 1 died of "Acute Morphine Intoxication." The hospital also failed to ensure Staff 2 compiled with their policy and procedure (P&P) entitled, "Patient Controlled Analgesia Infusion" which required confirming a dosage change on the Patient Controlled Analgesia (PCA) pump with a second nurse. Staff 2 did not obtain a second nurse. Staff 2 did not obtain a second nurse confirmation. This safeguard in the P & P is set to prevent the administration of excessive amounts of pain medication.  Findings:  On 2/23/10 at 1301 hours, during an interview with Staff 1 (the Registered Nurse risk manager) stated Patient 1 was brought to the Emergency Department on 99 after an accidental overdose of ditilizarem (medication)  100 Staff 3, (a physician) explained to Staff 2 (the Registered Nurse who cared for Patient 1 and resigned from her job 12/16/09) that during palliative care some patients require morphine doses up to 20 mg (milligrams) per hour intravenously. Staff 1  Event IDMRC011  PREFEX TAG  REFERENCED TO THE APPROPRIATE DEFICIENCY)  4. thinking processes are evaluated as well as basic skill levels.  B: Chief Nursing Officer and the Director of Pharmacy  C: Monitoring process  B: Chief Nursing Officer and the Director of Pharmacy  C: Monitoring process  B: Chief Nursing Officer and the Director of Pharmacy  C: Monitoring process  B: Chief Nursing Officer and the Director of Pharmacy  C: Monitoring process  B: Chief Nursing Officer and the Director of Pharmacy  C: Monitoring process  B: Chief Nursing Officer and the Director of Pharmacy  C: Monitoring process  B: Chief Nursing Officer and the Director of Pharmacy  C: Monitoring process  B: Chief Nursing Officer and  Director of Pharmacy  C: Monitoring of the PCA  Smart pump data is pe						RANGE COUNTY	
order prior to increasing the dose of morphine (a potent narcotic medication to treat pain) for Patient 1. The unordered increase in dosage resulted in Patient 1 receiving 10 times the dose of morphine ordered by her physician. According to the coroner's report, Patient 1 died of "Acute Morphine Intoxication." The hospital also failed to ensure Staff 2 complied with their policy and procedure (P&P) entitled, "Patient Controlled Analgesia Infusion" which required confirming a dosage change on the Patient Controlled Analgesia (PCA) pump with a second nurse. Staff 2 did not obtain a second nurse sconfirmation. This safeguard in the P & P is set to prevent the administration of excessive amounts of pain medication.  Findings:  On 2/23/10 at 1301 hours, during an interview with Staff 1 (the Registered Nurse risk manager) stated Patient 1 was brought to the Emergency Department on 90 after an accidental overdose of dilitiazem (medication indicated for high blood pressure and to stabilize abnormal heart beats). Patient 1 was admitted to the ICU (Intensive Care Unit) where she was treated for low heart rate and low blood pressure. According to Staff 1, on 10,9, Staff 3, (a physician) explained to Staff 2 (the Registered Nurse who cared for Patient 1 and resigned from her job 12/16/09) that during palliative care some patients require morphine doses up to 20 mg (milligrams) per hour intravenously. Staff 1  Event IDMRC011  4. thinking processes are evaluated as well as basic skill levels.  B: Chief Nursing Officer and the Director of Pharmacy  C: Monitoring process  B: Chief Nursing Officer and the Director of Pharmacy  C: Monitoring process  B: Chief Nursing Officer and the Director of Pharmacy  C: Monitoring process  B: Chief Nursing Officer and the Director of Pharmacy  C: Monitoring process  B: Chief Nursing Officer and the Director of Pharmacy  C: Monitoring process  B: Chief Nursing Officer and the Director of Pharmacy  C: Monitoring process  B: Chief Nursing Officer and the Director of Pharmacy  C: Monitoring proc	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S	HOULD BE CROSS-	COMPLETE
Findings:  On 2/23/10 at 1301 hours, during an interview with Staff 1 (the Registered Nurse risk manager) stated Patient 1 was brought to the Emergency Department on 99 after an accidental overdose of diltiazem (medication indicated for high blood pressure and to stabilize abnormal heart beats). Patient 1 was admitted to the ICU (Intensive Care Unit) where she was treated for low heart rate and low blood pressure. According to Staff 1, on Staff 2 (the Registered Nurse who cared for Patient 1 and resigned from her job 12/16/09) that during palliative care some patients require morphine doses up to 20 mg (milligrams) per hour intravenously. Staff 1  Event ID:MRC011  to the drug library.  2. Proactive audits of the PCA process were conducted and continue to be completed to account for both the programming of the pump, use of correct drug profile and adherence to the double check process.  3. The education department oversees the orientation program and the annual skills review process that includes the process.  4. The drug library.  2. Proactive audits of the PCA process were conducted and continue to be completed to account for both the programming of the pump, use of correct drug profile and adherence to the double check process.  3. The education department oversees the orientation program and the annual skills review process that includes the process used to the drug library.		Patient 1. The resulted in Patie dose of morphine According to the died of "Acute hospital also faile with their policy "Patient Controlled required confirming Patient Controlled a second nurse second nurse's cothe P & P is set	unordered increase in dosage ent 1 receiving 10 times the e ordered by her physician. coroner's report, Patient 1 Morphine Intoxication." The d to ensure Staff 2 complied and procedure (P&P) entitled, d Analgesia Infusion" which g a dosage change on the Analgesia (PCA) pump with Staff 2 did not obtain a onfirmation. This safeguard in to prevent the administration of		levels.  B: Chief Nurs Director of Ph  C: Monitoring  1. Weekly monit smart pump of for any deviate parameters. Teported to the Committee are and Theraper	ing Officer and the process toring of the PC/data is performed in from the Finis information and the Pharmacy tics Committee	the  A March  B A  B A  B A  B A  B A  B A  B A  B
		Findings:  On 2/23/10 at 13 with Staff 1 (to manager) stated Emergency Department overdown indicated for his stabilize abnormal admitted to the 10 she was treated blood pressure.  109, Staff 3, Staff 2 (the Registrant 1 and resisted that during palarequire morphing (milligrams) per hour	B01 hours, during an interview he Registered Nurse risk Patient 1 was brought to the rtment on 709 after an se of diltiazem (medication gh blood pressure and to heart beats). Patient 1 was CU (Intensive Care Unit) where for low heart rate and low According to Staff 1, on (a physician) explained to stered Nurse who cared for igned from her job 12/16/09) liative care some patients e doses up to 20 mg intravenously. Staff 1		to the drug lib 2. Proactive aud process were continue to be account for be programming of correct dru adherence to process. 3. The education oversees the program and review proces preceptor pro	orary.  lits of the PCA conducted and e completed to oth the of the pump, us g profile and the double chec n department orientation the annual skills as that includes t	e :k
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE						<u></u>	

050168 A. BUILDING  B. WING	02/23/2010
NAME OF PROVIDER OR SUPPLIER ST. JUDE MEDICAL CENTER ST. JUDE MEDICAL CENTER ST. JUDE MEDICAL CENTER ST. JUDE MEDICAL CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 101 E. VALENCIA MESA DRIVE, FULLERTON, CA 92835 ORANGI	E COUNTY
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH DEFICIENCY MUST BE PRECEEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REFERENCED TO THE APPROPRIATE IN	BE CROSS- COMPLETE
Continued From page 4 stated that Staff 2 misinterpreted Staff 3 and considered this a verbal order.  On 2/23/10 at 1322 hours, Staff 1 stated on 1/99 at 1730 hours, the PCA (Patient Controlled Analgesia pump that delivered the morphine) dose setting was changed from morphine 2 mg per hour to morphine 20 mg per hour by Staff 2. This was determined by reviewing the PCA pumps' memory of events.  Staff 1 stated there was no order by a physician to increase Patient 1's dose of morphine to 20 mg per hour. Patient 1's respiration rate (number a breaths a person takes per minute) was running low at between 99-12 breaths per minute (normal 15-20 breaths per minute) and the patient died within an hour of the morphine dose increase, at 1808 hours. Staff 1 stated the hospital requested an autopsy to determine the cause of death. The coroner's autopsy report revealed a blood level of morphine of 4.1 milligrams/Liter and the coroner determined the cause of death was due to "Acute Morphine Intoxication."  On 2/23/10 at 1420 hours, Staff 1 stated that Staff 2 was completing the last week of her 3 month orientation when Staff 2 administered the overdose of morphine to Patient 1. According to the hospital's administrative document, Staff 2 admitted she did not know how to program a PCA pump but did so anyway and thought Staff 3 increased the dose of Morphine to 20 mg.	to provide ack to new date the tion of the  Service dures  Ition will be the temporarily  der/Verbal eviewed for the nurse in wing the policy and pect to rders for all the swere cies. Both raing were to on the use emergent raing was ed information order trelates to the
Event ID:MRC011 12/29/2010 8:40:20AM	

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DS0168  STREET ADDRESS, CITY, STATE, 2P CODE  SUMMARY STATEMENT OF DEFICIENCIES  (AA-0 ID (AA-0 ID (AA-0 ID AB))  SUMMARY STATEMENT OF DEFICIENCIES  (AA-0 ID (AA-0 ID (AA-0 ID AB))  SUMMARY STATEMENT OF DEFICIENCIES  (AA-0 ID (AA-0 ID AB)  SUMMARY STATEMENT OF DEFICIENCIES  (AA-0 ID (AA-0 ID AB)  SUMMARY STATEMENT OF DEFICIENCIES  (AA-0 ID (AA-0 ID AB)  SUMMARY STATEMENT OF DEFICIENCIES  (AA-0 ID (AA-0 ID AB)  SUMMARY STATEMENT OF DEFICIENCIES  (AA-0 ID (AA-0 ID AB)  SUMMARY STATEMENT OF DEFICIENCIES  (AA-0 ID (AA-0 ID AB)  SUMMARY STATEMENT OF DEFICIENCIES  (AA-0 ID AB)  SUMMARY STATEMENT OF DEFICENCES  (AA-0 ID AB)  SUMMARY STATEMENT ON FORMATION  (AA-0 ID AB)  SUMMARY STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(x2) MULTIPLE CONSTRUCTION  A, BUILDING			(X3) DATE SURVEY COMPLETED		
10 E. VALENCIA MESA DRIVE, FULLERTON, CA 92835 ORANGE COUNTY  (XA) ID PROVIDERS PLAN OF CORRECTION (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION)  Continued From page 5  The hospital's P&P (Policy & Procedures) entitled, "Patient Controlled Analgesia Infusion" states before changing a prescription, "A second registered nurse must verify that the parameters are correct and co-sign the E-MAR (electronic medication administration record) or PCA flow sheel." Staff 2 changed the dose of morphine without following the hospital's P&P which required verification and documentation of dosage changes by a second nurse.  The hospital failed to prevent this overdose of morphine by failing to ensure that Patient 1 received the dose of morphine ordered by her physician. The hospital slos failed to nesure that Staff 2 followed the hospital's P&P entitled, "Patient Controlled Analgesia Infusion" which required a second nurse to double check and verify the programming of the PCA pump. The hospital failed to follow the policies and procedures for programming a pump for Patient Controlled Analgesia resulting in the death of Patient 1 by morphine overdose.  The hospital's PAP (Policy & Procedures) and nursing representatives on the committee failed to ensure that the pharmacy and nursing representatives on the committee failed to ensure that the pharmacy and nursing representatives on the committee failed to ensure that the pharmacy and nursing representatives on the committee forwided adequate training and oversight for their staff so patients were administered morphine accurately, safely, and according to hospital policies and procedures.			050168					02/23	/2010
Continued From page 5   The hospital's P&P (Policy & Procedures) entitled, "Patient Controlled Analgesia Infusion" states before changing a prescription, "A second registered nurse must verify that the parameters are correct and co-sign the E-MAR (electronic medication administration record) or PCA flow sheet." Staff 2 changed the dose of morphine without following the hospital's P&P which required verification and documentation of dosage changes by a second nurse.  The hospital failed to prevent this overdose of morphine by failing to ensure that Staff 2 followed the hospital's P&P entitled, "Patient Controlled Analgesia Infusion" which required a second nurse to double check and verify the programming of the PCA pump infusion and medication administration that emphasize the double check process were reviewed Despite the nurse in question not following the existing policies was completed no changes were made. The development of "Lessons Learned" regarding the patient safety mechanism of the double check process was completed and distributed to all nursing staff.  B: Chief Nursing Officer  C: Monitoring  1. Verbal order process is monitored on a monthly basis with any occurrences reviewed for reason and education.  2. Proactive audits of the PCA pump. The hospital's PAP entitled, "Patient Controlled Analgesia resulting in the death of Patient 1 by morphine overdose.  The hospital's Pharmacy and Therapeutics Committee failed to ensure that the pharmacy and nursing representatives on the committee provided adequate training and oversight for their staff so patients were administered morphine accurately, safely, and according to hospital policies and procedures.							TON, CA 92835 ORAN	GE COUNTY	
The hospital's P&P (Policy & Procedures) entitled, "Patient Controlled Analgesia Infusion" states before changing a prescription, "A second registered nurse must verify that the parameters are correct and co-sign the E-MAR (electronic medication administration record) or PCA flow sheet." Staff 2 changed the dose of morphine without following the hospital's P&P which required verification and documentation of dosage changes by a second nurse.  The hospital failed to prevent this overdose of morphine by failing to ensure that Patient 1 received the dose of morphine ordered by her physician. The hospital also failed to ensure that Staff 2 followed the hospital's P&P entitled, "Patient Controlled Analgesia Infusion" which required a second nurse to double check and verify the programming of the PCA pump. The hospital failed to follow the policies and procedures for programming a pump for Patient Controlled Analgesia resulting in the death of Patient I by morphine overdose.  The hospital's Pharmacy and Therapeutics Committee failed to ensure that the pharmacy and nursing representatives on the committee provided adequate training and oversight for their staff so patients so patients so patients were administered morphine accurately, safely, and according to hospital policies and procedures.	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEEDED BY	FULL	PREFIX	(EACH (	CORRECTIVE ACTION SHOU	LD BE CROSS-	COMPLETE
Event ID:MRC011 12/29/2010 8:40:20AM		The hospital's entitled, "Patient states before of second registered parameters are of (electronic medica PCA flow sheet." morphine without which required of dosage changes to the hospital failed morphine by failing received the dose physician. The hospital required a second verify the program hospital failed procedures for Patient Controlled death of Patient 1 by The hospital's Committee failed and nursing repprovided adequat their staff so morphine accurate	P&P (Policy & Controlled Analges changing a preson nurse must verification administration Staff 2 changed to following the host verification and doy a second nurse.  If the property of the property of the PCA to follow the programming and analgesia result to ensure that the programming and	tia Infusion" cription, "A fy that the the E-MAR record) or the dose of spital's P&P documentation  overdose of t Patient 1 ered by her to ensure P&P entitled, sision' which check and pump. The bolicies and pump for ting in the  Therapeutics he pharmacy e committee oversight for administered		1.	pump infusion an administration that the double check reviewed. Despite question not follo existing policy aff was completed in were made. The "Lessons Learne the patient safety the double check completed and displayed in the patient safety the double check completed and displayed in the patient safety the double check completed and displayed in the patient safety the double check completed and displayed in the patient safety the double check completed and displayed in the patient safety the patient safety the patient safety in the patient safe	d medication at emphasize process were the nurse in wing the ter the review o changes development mechanism process was istributed to a Officer  Cess is monthly basis nces reviewed ducation.  of the PCA anducted to the the pump, us rofile and	e of of sall March S, 2011 d
C 40/11/10/11/10/11/11	Event IF	:MRC011		12/29/201	0 8·40·2				

AND PLAN OF CORRECTION IDEN		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050168	(X2) MULTIPLE  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 02/23/2010	
		<u> </u>					
	OVIDER OR SUPPLIER		SS, CITY, STATE, ZIP C		ANCE COUNTY		
ST. JUDE	MEDICAL CENTER	101 E. VALEN	CIA MESA DRIVE,	FULLERTON, CA 92835 OF	RANGE COUNTY		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PREFIX TAG	,	Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S REFERENCED TO THE APPROP		COMPLETÉ DATE	
	Continued From page	e 5		70000 ( ) DI		<del>-</del>	
	The hospital's P	&P (Policy & Procedures)		70263(c) Pha Services Gen	rmaceutical eral Requiremei	nts	
	· ·	Controlled Analgesia Infusion" anging a prescription, "A		A: How the co	prrection will be		
		nurse must verify that the			l, both temporari	ily	
		rrect and co-sign the E-MAR		and permane	•		
		on administration record) or		The Pharmac			
		Staff 2 changed the dose of		•	Therapeutics Committee chair was immediately made aware of		
	1 '	following the hospital's P&P		the event. The		OI	
	which required v				d Therapeutics		
	of dosage changes by	a second nurse.			ructure supports		
	The hospital failed	to prevent this overdose of			all medication	•	
	*	g to ensure that Patient 1		****	ctual and potential.		
	1 '	of morphine ordered by her			the smart pump		
		spital also failed to ensure			therence is a portion		
	1' '	d the hospital's P&P entitled,		of the overall	review of the		
	"Patient Controlled	·		medication pr	ogram.		
	required a second	nurse to double check and			ently an increase		
	verify the programn	ning of the PCA pump. The	•	emphasis on	the smart pump		
	hospital failed to	o follow the policies and		alerts and cor	mprehensive		
	I *	programming a pump for Analgesia resulting in the		review.			
	death of Patient 1 by	morphine overdose.		B: Director of	Pharmacy		
	The hospital's I	Pharmacy and Therapeutics to ensure that the pharmacy		C: Monitoring		Max 1 8,201	
and nursing representatives on t		esentatives on the committee	,	At each Phar	macy and	01000	
	provided adequate	training and oversight for	-		Committee meet	ing	
	their staff so	patients were administered	ı		a review of the smart		
	morphine accuratel	• • • • • • • • • • • • • • • • • • • •		pump data fo	r adherence to t	he	
	hospital policies and p	procedures.		formulary libra	ary. This provide	es	
				members of t	he committee ar	n	
					provide oversig		
				•	s. This occurs o	ρh	
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