PRINTED: 04/28/2010
FORM APPROVED

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA060000060	A. BUILDING _____ B. WING _____	08/05/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MISSION HOSPITAL REGIONAL MED CENTER	27700 MEDICAL CENTER RD MISSION VIEJO, CA 92691

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 000	Initial Comments	E 000		

The following reflects the findings of the Department of Public Health during the investigation of COMPLAINT NO: CA00186058.

Inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility.

HSC Section 1280.1(a). If a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an administrative penalty in an amount not to exceed twenty-five thousand dollars ($25,000) per violation.

c) For the 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.

Representing the Department of Public Health: [redacted], HFEN

DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY

T22 DIV 5 CH1 ART3 - 70213 (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service.

The above regulation was NOT met as evidenced by:

Based on medical record review, staff interview, and review of policies, the facility failed to ensure

E000

a) HOW THE CORRECTION WILL BE ACCOMPLISHED, both temporarily and permanently.

- Medication administration to patients from the Postpartum Unit of Mission Hospital Mission Viejo who go to see their children on the NICU (CHOC Children's Hospital at Mission – CHM) was stopped immediately.
- The policy and procedure was changed to reflect that any Mission patient going to see their children who are patients in CHM would not have any medications administered by the Mission staff while they were in the CHM units.
- This requirement was added to the Unit Specific Orientation for new RNs in the Women's and Infants' (W and I) service.
- The five rights of medication administration were reviewed with the Staff of the W and I units.

b) TITLE OR POSITION OF THE PERSON RESPONSIBLE FOR THE CORRECTION

- Executive Nursing Director of the Women's and Infants' Service.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Director Quality Improvement		MAY 14, 2010

Approved 5.18.10 JW

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E 000	Continued From Page 1 implementation of established policies addressing medication administration causing serious injury to a patient. Findings: On 7/24/09, review of the policy "Medication Administration" revealed the directive "2. All medications must be administered according to the "Five Rights: 2.1 Right Patient 2.2 Right medication 2.3 Right dose 2.4 Right route 2.5 Right time." During interview on 7/24/09, staff stated Patient 1 had given birth to triplets on 4/5/09 at 0500 hours and spent a lot of time in the Neonatal Intensive Care Unit (NICU) where the infants were being cared for. Staff disclosed that on 4/4/09 at 2215 hours, the post-partum nurse had taken morphine sulfate (MS) from the post-partum unit on the second floor to the NICU on the fifth floor to medicate Patient 1. Patient 1 was skin-to-skin bonding with one of the triplets (Baby A) when the nurse administered the MS intravenously (IV). Both Patient 1 and Baby A had IV lines in place. Soon after the administration of the MS, Baby A became dusky, exhibited respiratory depression, and required intubation. Staff disclosed that during interview, the post-partum nurse stated she thought she gave the medication to Patient 1 but was not certain. During interview, staff stated "It is thought the nurse might have injected the MS into the baby's running IV instead of the mother's." During the interview on 7/24/09, staff disclosed that on 4/6/09 urine samples from all three babies were sent out to another laboratory for analysis and only Baby A was positive for MS.	E 000	c) DESCRIPTION OF THE MONITORING PROCESS • The CHM staff will stop any Mission RN who comes to the CHM units to administer medications, and will immediately notify the Executive Nursing Director of W and I/ designee of any such incident. This is ongoing in the protocol and remains in effect. To date (Sept 09 – current), no attempts to administer medications to a Mission patient who came to see a patient on the CHM units have occurred. • Any violation/near violation of the above will be discussed at the monthly collaborative meeting of the Maternal Infant Continuum of Care. Staff from W and I and the CHM meet for this meeting. • Through the QRE system (incident reporting process), any medication variation from the five rights is reported and responded to immediately by the Executive Director/designee. This is an ongoing monitoring methodology for the five rights of drug administration. d) DATE OF CORRECTION COMPLETION All actions were completed on or before September 5, 2009. Monitoring is ongoing.	

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E 000	Continued From Page 2 Medical record review for Baby A revealed the discharge summary for discharge dated 4/20/09. In the discharge summary, the physician documented "The baby recovered without any obvious sequelae on physical examination. In further investigation, it was noted this infant had a positive urine for opiates which turned out to be morphine...Entertained in the differential diagnosis was also an inadvertent administration of morphine to the infant that was intended for the mother who was skin to skin with the infant at a time just shortly prior to first symptoms." This information failed to show evidence the "Five Rights" of medication administration were followed prior to administration of the pain medication as per facility policy, in that the nurse failed to ensure the right patient received the medication.	E 000		