The following reflects the findings of the California Department of Public Health during the investigation of complaint # 141559.

Representing the California Department of Public Health: [Redacted], HFEN

1280.1(a)(c) Health and Safety Code Section 1280(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 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.

Title 22 Nursing Staff Development 70214 (a) (2) (B)

A registered nurse who has demonstrated competency for the patient care unit shall be responsible for nursing care as described in subsections 70215 (a) and 70217 (h)(3), and shall be assigned as a resource nurse for those registered nurses and licensed vocational nurses who have not completed competency validation for that unit.

Title 22 Nursing Service Staff 70217 (n)
All registered and licensed vocational nurses utilized in the hospital shall have current licenses. A method to document current licensure shall be established.

Based on interview and record review, the hospital failed to ensure that a staff member assigned as a resource person for the management and care of patients’ central venous access devices, in the intensive care and medical surgical units, was a licensed and competent Registered Nurse (RN). As a result, a staff member (SM), whose RN license was revoked, taught, trained and provided oversight to licensed nurses at the bedside for the process of dissolving a blood clot (declotting) in peripherally inserted central catheters (PICC) lines utilizing the high risk medication, Alteplase. The unlicensed SM implemented a declotting procedure with Alteplase, used by staff members on patients, without approval from any appropriate committee. In addition, the unlicensed SM taught and trained licensed nurses, either on a patient at the bedside, or in other areas on the clinical unit, general nursing care related to PICC line management which included: how to draw blood, change dressings, and flush PICC lines with Heparin (blood thinner), another high risk medication. The Administrative staff at the hospital was aware that the SM did not have a current California Registered Nurse’s license when she was hired. Continued implementation of the above practices by the hospital was likely to place other patients in a situation of immediate jeopardy with the potential to
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cause serious injury, harm, impairment, or death.

Findings:

On 3/20/08 at 10:20 A.M., an investigation was initiated as a result of a complaint which alleged that the SM with a revoked California Registered Nurse’s license was providing patient care and training nurses in the clinical setting. Per the Board of Registered Nurses’ (BRN) website, the California Registered Nurses’ license of the SM was revoked on 8/18/05, and to date, had not been reinstated.

On 3/20/08 at 4:45 P.M., an interview was conducted with Licensed Nurse (LN) 1 who worked in the intensive care unit (ICU). LN 1 stated that if a PICC line needed to be declotted, the unlicensed SM was one of the persons to call to declot the line.

On 3/20/08 at 5:00 P.M., an interview was conducted with LN 2 who also worked in the ICU. LN 2 stated that the hospital utilized an outside contract person to insert the PICC lines, but if a PICC line needed to be declotted, staff were to call either the unlicensed SM, or LN 3 to declot the line. LN 2 stated that the phone numbers of the unlicensed SM and LN 3 were kept in the rolodex file in the ICU for this purpose.

On 3/20/08 at 5:20 P.M., an interview was conducted with LN 4 who worked on the medical surgical unit. LN 4 stated that the unlicensed SM taught her how to declot a PICC line with Alteplase.
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LN 4 described the process she was taught by the unlicensed SM in order to declot the PICC line. LN 4 stated that the unlicensed SM demonstrated the procedure on a patient, and then told LN 4 to find another patient, so that she could actually perform the procedure. LN 4 stated that she also observed the unlicensed SM train another nurse, (LN 5) on the declotting procedure using Alteplase.

The manufacturer's package insert for Alteplase documented that the drug initiated local fibrinolysis (destroyed a substance in a blood clot). A review of the hospital's policy pertaining to high risk medications revealed that fibrinolytic medications were deemed high risk/high alert medications. The policy also documented that Heparin was a high risk/high alert medication.

On 3/20/08 at 5:40 P.M., an interview was conducted with LN 5. LN 5 confirmed that the unlicensed SM taught her how to declot a PICC line with Alteplase on a patient.

On 3/21/08 at 12:40 P.M., an interview was conducted with the Chief Nursing Officer (CNO). The CNO stated that the unlicensed SM received specific training on the management of PICC lines, including the declotting procedure, from a contracted vendor for PICC lines. The CNO stated that the unlicensed SM was trained for the "educational component" of PICC line management from an outside vendor. The CNO stated that staff were to call the unlicensed SM for education-related questions such as: how to take care of a PICC line, how often to change the
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dressing, how to flush the line and with what medication, and how to draw blood from the PICC line. The CNO stated that such training was performed either on a one to one basis, or via a group inservice.

On 3/21/08, an interview was conducted with the unlicensed SM. The unlicensed SM stated that she "stepped in" and trained some nurses on how to declot PICC lines. She stated she began doing this in the ICU because they were "receptive." She named LN 5 and LN 6 who worked in the ICU, as two nurses that she had provided direct training and oversight to, during the declotting procedure of a patient's PICC line with Alteplase. The unlicensed SM stated that she "stood over" LN 6, directed him on how to write the order for Alteplase, call the MD, and obtain the drug from the pharmacy. She stated that then she "walked him through the procedure." The unlicensed SM stated that she had "instructed others" on the declotting procedure. The unlicensed SM presented a document entitled "Declot PICC Line Competency," and stated that she had implemented this procedure at the hospital for staff to use when declotting a PICC line. She stated that she got this procedure from a nurse who worked at another hospital and from the PICC line vendor. She stated that this procedure for staff use had not gone through the Pharmacy and Therapeutics or the Medical Executive Committees for approval. The unlicensed SM stated that she was "going to try it out first."

A review of the unlicensed SM's "inservice...
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education" records on 3/21/08 at 1:15 P.M., revealed that at 6:30 A.M. and 1:00 P.M. on 12/31/07, 1/2/08, and 1/3/08, the unlicensed SM had taught registered and licensed vocational nurses specific nursing care functions related to the management of PICC lines. The specific nursing care functions included: blood drawing, dressing changes, and flushing the line with heparin.

On 3/20/08 at 3:00 P.M., a review was conducted of the unlicensed SM's employee file. Her job description documented that her job duties included the role of "Education Coordinator." There was no evidence in the unlicensed SM's file that she possessed the qualifications and competencies to function as a resource registered nurse for licensed personnel in the intensive care or medical-surgical units, who had not yet achieved competency requirements related to any aspect of PICC line management, including a declotting procedure with a high risk medication.

The hospital's policy and procedure related to PICC lines was reviewed on 3/21/08. The policy documented that "PICC care management is provided by licensed nursing staff that are competent in venipuncture and central line care. Licensed nurses competent in central line dressing change, perform ongoing dressing care management."

On 3/25/08 at 11:30 A.M., a telephone interview was conducted with a Nurse Education Consultant from the California Board of Registered Nurses. She stated that if a patient procedure required...
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nurse licensure to perform, then only an individual with a nursing license could train or teach other licensed personnel how to perform the procedure.

On 3/25/08 at 1:30 P.M., an Immediate Jeopardy was called related to Nursing Staff Development. The Chief Executive Officer (CEO) and the Chief Nursing Officer (CNO) were present. Both the CEO and the CNO confirmed that they were aware of the revoked status of the SM's California Registered Nurse's license when they hired her for the position of "Education Coordinator." The violations were likely to cause serious injury, harm, impairment, or death to future patients when a staff member (SM) with a revoked California Registered Nurses' license taught, trained, and provided oversight to licensed nurses on patients at the bedside, or in other areas on the clinical unit, general nursing care related to PICC line management, which included the process of flushing the line and dissolving blood clots utilizing the high risk medications, Heparin and Alteplase. In addition, the unlicensed SM independently developed and implemented a procedure utilizing a high risk medication to be used by licensed nurses at the bedside without any oversight or approval from the Pharmacy and Therapeutics or Medical Staff Executive Committees.

On 3/25/08 at 4:00 P.M., a credible plan of correction was received from the hospital and the Immediate Jeopardy was abated.

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