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PRINTED: 12/11/2008
FORM APPROVED

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
	CA930000065	A. BUILDING _____ B. WING _____	11/03/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOLLYWOOD PRESBYTERIAN MEDICAL CENTER	1300 N VERMONT AVE LOS ANGELES, CA 90028

(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 The following reflects the findings of the Department of Public Health during a Complaint visit: Complaint Intake Number: CA00168152 The inspection was limited to the specific complaints investigated and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: [redacted], RN-HFEN [redacted], RN-HFEN 1280.1(c) Health & Safety Code Section 1280 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. DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY	E 000		
E 264	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 interview and record review, the facility staff failed to implement their Blood and Blood Product Administration policy and procedure (CPM.PC.015), in that two licensed nurses (Staff B and Staff C)) did not verify Patient 2's name,	E 264	The Chief Clinical Officer and the Director of Laboratory Services reviewed the Blood and Blood Product Administration policy and procedure. No revisions were indicated. The Chief Clinical Officer and the Director of Laboratory Services reviewed and revised the transfusion slip. Nurse B and C were immediately suspended. Upon completion of the investigation, both nurses received a final written counseling. Both nurses subsequently resigned.	10/28/08 11/17/08 11/05/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathy Wynn, MSN, RN, CCRN | TITLE: Chief Clinical Officer | (X6) DATE: January 9, 2009

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E 264	Continued From Page 1 date of birth, hospital identification number on the wristband and on the transfusion tag attached on the blood bag in accordance with the hospital's policy and procedure. The failure of facility staff to implement the hospital's Blood and Blood Product Administration policy resulted in Patient 2 receiving blood intended for Patient 1 with a subsequent blood transfusion reaction. Findings: On November 3, 2008, a review of Patient 2's Admission Record, disclosed the patient was admitted to the facility on October 2, 2008 with diagnoses that included sepsis and end stage renal disease. According to the clinical record, Patient 2 had a history of diabetes mellitus, hypertension and psychiatric disorder. A review of the Outcome Notes, dated October 29, 2008, disclosed the following: At 3:45 p.m., transfusion started (06LF96200) indicating the blood unit number, blood pressure (BP) 90/59 heart rate (HR) 66. At 4 p.m., the documentation indicated "stop transfusion, BP 103/62, HR - 80, patient confused, oxygen saturation 96%." At 5:10 p.m., the documentation indicated the BP 88/45 HR 86. At 5:20 p.m., notified house MD BP 86/46, MD visited, patient lethargic." A review of Patient 2's clinical record revealed no physician order for blood transfusion. There was no documented crossmatch tag/transfusion record for Patient 2 on October 29, 2008. A review of the physician progress notes, dated October 29, 2008, disclosed "patient inadvertently received wrong blood approximately 50 cc before transfusion stopped." The note further indicated Patient 2 had respiratory stridor and wheezing. Patient 2	E 264	All registered nurses were required to review the Blood and Blood Product Administration policy and procedure and take a test to demonstrate their understanding of the policy and procedure. All currently working registered nurses (94%) have successfully completed this test. Remaining registered nurses will demonstrate their knowledge of the Blood and Blood Product Administration policy and procedure by successfully completing the test prior to administering blood or blood products. A minimum of 50 transfusions are being concurrently observed for compliance with policy and procedure. Findings are reported to the Chief Clinical Officer and reported to the Quality Management Committee, the Medical Executive Committee and the Governing Board. Concurrent observations will continue until such time as 100% compliance with policy and procedure is demonstrated. Additionally, a blood product administration competency will be performed annually.	12/22/08 01/21/09 ongoing

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E 264	Continued From Page 2 received Benadryl (antihistamine), epinephrine (bronchodilator) and solumedrol (steroid). Another physician progress note, dated October 29, 2008 at 8:10 p.m., indicated rule out blood transfusion reaction, keep in the intensive care unit and consult an intensivist. At 9:10 p.m., the documentation indicated the patient expired after a code blue was called. According to the Blood Bank: Transfusion Reaction Worksheet signed and dated October 29, 2008 by blood bank tech and signed and dated by pathologist on October 30, 2008, indicated the post transfusion sample had hemolysis, was "O Positive" and the blood unit number "06LF96200 was A Positive." The conclusion indicated acute hemolytic reaction. (Transfusion reaction due to transfusion of incompatible blood). A review of the Expiration Summary dated October 31, 2008 indicated, Patient 2 had a "Hemolytic reaction secondary to inadvertent blood transfusion with blood which was meant for another patient." During an interview on November 3, 2008 at 2:45 p.m., Staff D (Administrative Staff) stated that on October 29, 2008, Patient 1 had a physician's order for blood transfusion and Patient 2 had no order for blood transfusion. Staff D stated the licensed vocational nurse (Staff A) went to the laboratory and picked up the blood, returned to the unit and handed the blood to the registered nurse (Staff B). Staff B and the charge nurse (Staff C) double-checked the unit and compared the blood with Patient 1's chart at the nurses' station. Staff B went to Patient 2's room, and hung the blood to Patient 2 at 3:45 p.m., instead of patient 1's room, "without verifying the ID of	E 264		

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E 264	Continued From Page 3 the patient against the blood." Staff D stated Staff B did the 15 minute check, then suddenly realized it was the wrong patient. Staff D stated there "were no issues" within the first 15 minutes and Staff B discontinued the blood transfusion. Staff D was questioned about the remainder of the unit of blood and she stated Staff B changed the blood transfusion tubing and started transfusing Patient 1 with the same unit of blood. When asked if Staff B notified the physician and reported the error, Staff D stated Staff B did not call the physician and did not report the error. Staff D stated that on October 29, 2008, at about 5 p.m., Staff A noticed Patient 2 was cyanotic and having difficulty breathing and notified Staff C, who in turn, notified a Medical Doctor (MD) via telephone at 5:20 p.m., Staff D stated that shortly thereafter, Staff B told the nursing director about the transfusion error. A review of Patient 1's clinical record revealed a physician's order dated October 28, 2008 at 10 a.m.; for a type and cross and transfuse 2 units of packed red blood cells (PRBC), if hemoglobin less than 10, transfuse 1 unit PRBC as needed. A review of the Crossmatch Tag for Patient 1 revealed Patient 1's name and medical record number, the blood type was AB Positive and the Donor type was A positive. The transfusion record section disclosed signatures by Staff B and Staff C dated October 29, 2008 at 3:45 p.m. indicating statement of verification that they had "matched patient name and number on the transfusion tag with the name and number on the patient's band and the donor number on the form with the donor number on the unit of blood." A review of the Outcome Notes documentation dated October 29, 2008 at 6 p.m., indicated,	E 264		

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E 264	Continued From Page 4 "Notified MD transfusion given amount of 200 ml." There was no documentation when the blood was started, the blood unit number and Patient 1's pre transfusion vital signs and vital signs fifteen minutes after the blood transfusion was started. A review of the Blood and Blood Product Administration policy and procedure (CPM.PC.015 dated as revised on August 2007): "Patient Identification Checks" section disclosed that the person who would transfuse the blood plus another RN or MD must confirm that all the following information agrees - Patient's name, date of birth and hospital identification number on his wristband and on the transfusion tag attached to the blood bag, unit number, unit ABO RH type and type of component on the bag and on attached transfusion tag. This policy and procedure failure resulted in a preventable blood transfusion error for patient 2. Patient 2, who did not have a physician order for a blood transfusion, received a blood transfusion with the wrong blood type, had a documented hemolytic reaction and expired.	E 264		