California Department of Public Health STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING CA930000063 04/22/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 23845 W MCBEAN PKWY HENRY MAYO NEWHALL MEMORIAL HOSPITAL VALENCIA, CA 91355 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION Ю (X4) ID COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY** E 000 E 000 initial Comments E 000 SUMMARY The following reflects the findings of the California The corrective actions taken are Department of Public Health, Licensing and summarized below. For more information Certification Program during a Medication Error on each action, please see response to Tag Reduction Plan (Health and Safety Code Section E485, below. 1339,63) survey. Adjusted Hospital computer system 1/19/10 The survey was conducted April 6-8, 12-14, and ("Meditech") setting dose range alert to 20-22, 2010, "All". The "All" setting includes all toxic drugs in the computer data base Representing the Department of Public Health: including Colistimethate and alerts the pharmacist if the dose ordered is outside Surveyor ID #27873, Pharmaceutical Consultant of the clinically appropriate range. Meditech renal notification parameters 1/19/10 for Colistimethate were adjusted to 1280.1 (c) Health and Safety Code Section For purpose of this section, "Immediate Jeopardy notify the user during order entry of the patient's renal status. The ordering means a situation in which the licensee's noncompliance with one or more requirements of physician is then contacted as necessary. licensure has caused, or likely to cause, serious Colistimethate was added to the 1/20/10 injury or death to the patient. Pharmacy's Daily Clinical Reminder report. This report alerts the F 485 E 485 T22 DIV5 CH1 ART3-70263(g)(2) pharmacist that review is needed. Pharmaceutical Service General Requirements Colistimethate was added to the Daily 1/20/10 Renal Monitoring report. This report (g) No drugs shall be administered except by alerts the pharmacist of changes in licensed personnel authorized to administer values that may need dose adjustments. drugs and upon the order of a person lawfully authorized to prescribe or furnish. This shall not Colistimethate has been included on the 1/20/10 preclude the administration of aerosol drugs by Daily Communication Log, indicating to respiratory therapists. The order shall include the the pharmacist when patients are name of the drug, the dosage and the frequency receiving the drug. of administration, the route of administration, if A Multidisciplinary Medication Safety 6/30/10 other than oral, and the date, time and signature Team ("Team") was formed. Under the of the prescriber or furnisher. Orders for drugs direction of a physician and the Director should be written or transmitted by the prescriber of Pharmacy, the Team analyzes all or furnisher. Verbal orders for drugs shall be medication incidents for unusual given only by a person lawfully authorized to prescribe or furnish and shall be recorded occurrences and trends. promptly in the patient's medical record, noting Licensing and Certification Division

California Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING CA930000063 04/22/2010 STREET ADORESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 23845 W MCBEAN PKWY HENRY MAYO NEWHALL MEMORIAL HOSPITAL VALENCIA, CA 91355 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) The Chair of the Department of Medicine 10/1/10 E 485 Continued From page 1 E 485 reviews all Medication Incident Reports the name of the person giving the verbal order on an ongoing basis for timely action and and the signature of the individual receiving the to follow up. The Chair forwards any order. The prescriber or furnisher shall recommendations to the Director of countersign the order within 48 hours. Quality, Director of Pharmacy and to the (2) Medications and treatments shall be The policy "Medication – Orders" No. 6/20/11 administered as ordered. MM.414 has been revised to clarify when pharmacists must contact a physician for clarification. In response to the findings of non-compliance This Statute is not met as evidenced by: discovered during the MERP survey the Based on review of Patient 1's medical record, following comprehensive corrective action review of facility documents, and interviews with plans have been instituted: the facility staff, the hospital failed to ensure that Patient 1 received the correct medication dosage 1. HOSPITAL/PHARMACY ALERTS, as ordered by the physician. Patient 1 was prescribed Colistin (Colistimethate) **NOTIFICATIONS AND REPORTS** Methanesulfonate, (an antibiotic used to treat Action: Meditech Alert Settings Adjusted 1/19/10 infections), 5 milligrams (mg) per kilogram (kg), in The Hospital uses Meditech software as its "divided doses," intravenously (IV), every 8 electronic medical record and information hours. Based on the patient's weight, 70.3 kg, management system, and First Data Bank the physician's order for Colistin required the ("FDB") as its Formulary Service Provider. The patient to receive 5 mg per kg, every 8 hours, in divided doses, which would have been 117 mg Meditech Dose Range Checking default every 8 hours (a total dose of 350 mg per day). identified in the Hospital's Meditech However, six (6) doses of 350 mg (three times Customer Defined Parameters were revised more than the prescribed amount per dose) of to "ALL". The "ALL" setting will ensure dose Colistin were administered to Patient 1. range checking for all ranges provided by FDB and any ranges entered manually by Hospital The facility's failure resulted in Patient 1 staff. This setting includes the drug developing acute renal failure (a sudden loss of Colistimethate and all other drugs in the kidney function characterized by decreased urine production and elevated blood urea nitrogen computer data base. (BUN) and creatinine. As a result of the facility's failure, Patient 1 required hemodialysis treatments (a procedure which directs the patient's blood flow externally through a special

California Department of Public Health STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A BUILDING B. WING CA930000063 04/22/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 23845 W MCBEAN PKWY HENRY MAYO NEWHALL MEMORIAL HOSPITAL VALENCIA, CA 91355 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY Education: All Clinical Pharmacists were E 485 E 485 Continued From page 2 educated regarding the new alert settings in machine which helps the body remove wastes. late January 2010. before returning the blood to the patient). Responsible Person: Director of Pharmacy. Findings: Monitoring: The Director of Pharmacy reviews updates to the Meditech Information On April 7, 2010, during the Medication Error system on at least a monthly basis. This Reduction Plan (MERP) survey, a review of the review ensures that the most up to date facility's medication error reports revealed that an information in regards to Dose Range overdose of Colistin Methanesulfonate was given to Patient 1. Checking is available within Meditech and for review by the Hospital's Clinical Pharmacists. Colistin (Colistimethate) is an antibiotic No incidents of incorrect medication doses medication used to treat infections. The side for Colistimethate have been reported effects of this drug include tingling or numbness through the monitoring process since the in the extremities and mouth, weakness of the Meditech Customer Defined parameters lower limb, increase BUN and creatinine levels, were set to "ALL". nephrotoxicity (poisonous effects of toxic chemicals and medications on the kidneys), Action: Adjust Renal Notification dizziness, headache, slurred speech, respiratory 1/19/10 Parameters for Colistimethate arrest, rash, and itching. The dose for adults is based on the patient's ideal body weight. The Within the Meditech drug dictionary set up dosing for intravenous was 2.5 milligram for Colstimethate, a specific alert was set up (mg)/kilogram (kg)/per day in 2 - 4 divided doses. to notify the user during order entry of the patient's renal status. According to the facility's policy and procedure on If a patient has an alert for altered renal Medication Administration, Preparation, Control, Distribution, and Documentation dated January status during Colistimethate order entry, the 27, 2009, medications would be administered pharmacist will contact the physician to safely to the patients as prescribed by the request any adjustments to the ordered physician. The primary goal in medication dose, as necessary, and will note this in the administration included administering the correct intervention log in Meditech. dose of the drug. Education: The Pharmacy Staff was On April 7, 2010, a review of Patient 1's medical educated in person in January 2010. record was conducted. The History and Physical Responsible Person: Pharmacy Clinical report dated 2010, indicated Patient 1 Coordinator. was admitted to the facility with diagnoses that included pneumonia, chest pain and abdominal pain.

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E 485	Report dated physician's assessme obstructive pulmonary multi-drug resistant or bronchitts/pneumonia recommendations incomedication intravenous. A review of the Physic Orders dated indicated an order, "Colevery 8 hours) in dividence of the Medic (MAR) dated handwritten Colistime 100 ml sodium chlorid 8 hours IV. The MAR weight was 70.3 kg ar Colistin required the pkg every 8 hours in directly a colistin required the pkg every 8 hours in directly a colistin required the pkg every 8 hours in directly and per day). Further review of the licensed nurses admiring IV to Patient 1 on times: 20 2010, at 4 a.m., at 12 2010, at 4 MAR revealed the over Patient 1 every 8 hours being discovered and 2010. The Progress notes (I dated 2010).	ctious Disease Consults 2010, at 2:25 p.m. ont included severe chruy disease exacerbation rganisms as well as . The physician's luded to administer Cously to Patient 1. cian Progress Notes &	the onic with with distin	E 485	Monitoring: The Pharmacy Clinic Coordinator will monitor the Medi intervention log weekly for 90 days July 1, 2011 for appropriate contact ordering physician as needed. Act monitoring will be performed as ne based on the results of the 90 day Action: Daily Clinical Reminder F. Colistimethate was added to the P. Daily Clinical Reminder Report. Thi generated on a daily basis and lists identified as needing Clinical Pharm review. After review, the Clinical Pharmacist communicates any conthe physician requesting dosage act or discontinuation of drug. Education: The Pharmacy Staff was in person in January 2010. Responsible person: Pharmacy Clin Coordinator Monitoring: Clinical Pharmacists the Daily Clinical Reminder Report basis to ensure that patients who a identified drugs, including Colistim have their medical records reviewed ensure that the drugs are being use and effectively. The Hospital note effectiveness of the Daily Clinical Report is evident, in that no error in of Colistimethate has been reported this drug was added to the Daily Cl. Reminder report on 01/20/2010.	tech s starting st with ditional eeded review. Report harmacy's s report is drugs nacist cerns to djustments s educated nical monitor on a daily are on the ethate, ed to ed safely es that the eminder n dosage d since	1/20/10	
		the patient complained dry mouth, and saying					}	

"the artibiotics are killing me." At 11 a.m., the physician was notified. At 12:15 p.m., Patient 1 stated again, "the antibiotics are killing me." had severe dry mouth and complaining of "loss of motor ability." The Physician Progress Notes & Orders dated 20:10 at 1:30 p.m., indicated to hold Colistin until further orders. The Physician Progress Notes & Orders dated 20:10 at 5:30 p.m., revealed the patient developed acute renal failure secondary to (caused by) Colistin. The Renal Consultation Note dated 20:10, indicated the nephrologists (Nephrologist A) initial impression was the acute renal failure was caused by hypersensitivity to radiocontrast material (medication used to highlight body organ functions during a special x-ray procedure). The CT (computed tomography) Scan report dated 20:10, indicated the patient received radiocontrast medium at 4 p.m. In an interview with Nephrologist A on April 8, 20:10, at 12 p.m., he stated that the consultation was based upon the information he had at the time of the incident. Nephrologist A stated the acute renal failure was caused by the overdose of Colistin. Nephrologist A stated that the consultation was based upon the information he had at the time of the incident. Nephrologist A stated the acute renal failure was caused by the overdose of Colistin. Nephrologist A stated that the consultation was based upon the information he had at the time of the incident. Nephrologist A stated the acute renal failure was caused by the overdose of Colistin. Nephrologist A stated that the consultation was beased upon the information he had at the important received only one (1) dose of Colistin. The Physician Progress Notes & Orders dated 20:10, disclosed the patient was 20:10, discl	California Department of Public Health							
### STREET ADDRESS, CITY. STATE, JIP CODE ### SASK WINGEAN PRWY ### ANYO NEWHALL MEMORIAL HOSPITAL ### ORDINARY SYATEMENT OF DEPTICEMENTS ### CAND DEPTIC	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING		COMPLETED		
ACTION Computed to more propress Notes & Orders dated 2010, indicated the nephrologist A) initial impression was the acute renal failure was caused by hypersensitivity to reduce that the consultation was based upon the information he had at the time of the incident. Nephrologist A stated the acute renal failure was caused by the overclose of Colistin. Action: Daily Renal Monitoring Report 1/20/10 2	NAME OF CO	OVER OR SUPPLIED		STREET ADD	PESS CITY ST	ATE 7/P CODE		52010
VALENCIA, CA 91355 VALENCIA, CA 91355	NAME OF PR	OVIDER OR SUPPLIER						
E 485 Continued From page 4 "the artibiotics are killing me." At 11 a.m., the physician was notified. At 12:15 p.m., Patient 1 stated again, "the antibiotics are killing me." had severe dry mouth and complaining of "loss of motor ability." The Physician Progress Notes & Orders dated 2010 at 1:30 p.m., indicated to hold Colistin until further orders. The Physician Progress Notes & Orders dated 2010 at 5:30 p.m., revaled the patient developed acute renal failure secondary to (caused by) Colistin. The Renal Consultation Note dated 2010, indicated the nephrologist's (Nephrologist A) initial impression was the acute renal failure was caused by thypraensitivity to radiocontrast material (medication used to highlight body organ functions during a special x-ray procedure). The CT (computed tomography) Scan report dated 2010, at 12 p.m., he stated that the consultation was based upon the information he had at the time of the incident. Nephrologist A stated the acute renal failure was caused by the overdose of Colistin. Nephrologist A stated the acute renal failure was caused by the overdose of Colistin. The Physician Progress Notes & Orders dated 2010, indicated the patient received radiocontrast medium at 4 p.m. In an interview with Nephrologist A on April 8, 2010, at 12 p.m., he stated that the consultation was based upon the information he had at the time of the incident. Nephrologist A stated the acute renal failure was caused by the overdose of Colistin. Nephrologist A stated the acute renal failure was caused by the overdose of Colistin. The Physician Progress Notes & Orders dated 2010, disclosed the patient received radiocontrast medium at 4 p.m. In an interview with Nephrologist A stated the mine of the incident. Nephrologist A stated the acute renal failure was caused by the overdose of Colistin. Nephrologist A stated the acute renal failure was caused by the overdose of Colistin. The Physician Progress Notes & Orders dated	UEMDV MAVO MEMUATI MEMODIAT DOCDITAL				-	Y		
"the artibiotics are killing me." At 11 a.m., the physician was notified. At 12:15 p.m., Patient 1 stated again, "the antibiotics are killing me." had severe dry mouth and complaining of "loss of motor ability." The Physician Progress Notes & Orders dated 20:10 at 1:30 p.m., indicated to hold Colistin until further orders. The Physician Progress Notes & Orders dated 20:10 at 5:30 p.m., revealed the patient developed acute renal failure secondary to (caused by) Colistin. The Renal Consultation Note dated 20:10, indicated the nephrologists (Nephrologist A) initial impression was the acute renal failure was caused by hypersensitivity to radiocontrast material (medication used to highlight body organ functions during a special x-ray procedure). The CT (computed tomography) Scan report dated 20:10, indicated the patient received radiocontrast medium at 4 p.m. In an interview with Nephrologist A on April 8, 20:10, at 12 p.m., he stated that the consultation was based upon the information he had at the time of the incident. Nephrologist A stated the acute renal failure was caused by the overdose of Colistin. Nephrologist A stated that the consultation was based upon the information he had at the time of the incident. Nephrologist A stated the acute renal failure was caused by the overdose of Colistin. Nephrologist A stated that the consultation was based upon the information he had at the time of the incident. Nephrologist A stated the acute renal failure was caused by the overdose of Colistin. Nephrologist A stated that the consultation was beased upon the information he had at the important received only one (1) dose of Colistin. The Physician Progress Notes & Orders dated 20:10, disclosed the patient was 20:10, discl	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
suffering "from acute renal failure likely due to Colistin and IV contrast." The progress notes documented the pharmacy "mis-dosed" Colistin and the patient was given 5 mg/kg IV, every 8 hours, which was not in divided doses as ordered.	E 485	"the antibiotics are kill physician was notified stated again, "the amsevere dry mouth and motor ability." The Product dated indicated to hold Colist patient developed act (caused by) Colistin. The Physician Progre 2010 at 5 patient developed act (caused by) Colistin. The Renal Consultating 2010, indicated the new A) initial impression was caused by hypermaterial (medication of functions during a spectro of the computed tomograph of the computed tomograph of the incident. In an interview with N 2010, at 12 p.m., he swas based upon the intime of the incident. In misdiagnosed the situ patient received only the Nephrologist A stated caused by the overdo. The Physician Progrematerial in an interview with N 2010, dissuffering "from acute colistin and IV contradocumented the phant and the patient was ghours, which was not	ling me." At 11 a.m., the distribution of "loss of hysician Progress Note 2010 at 1:30 p.m., etin until further orders. It is sometiment of the progress of the patient of the progress of the patient of	nt 1 had of s & s & dary to dary to gist ure rast organ The ed ived s, tion ne se s to ss stin	E 485	Colistimethate was added to the Pl Daily Renal Monitoring Report. This generated on a daily basis and lists that may need adjustment based of function. If a patient's serum creation 1.3 or above, a creatinine clearance calculated. The pharmacist will indict the report has been reviewed by sidely log. Education: On 01/20/2010 Clinical Pharmacists were educated in person Director of Pharmacy regarding the of Colistimethate to the Daily Renal Monitoring Report. Responsible Person: Pharmacy Clinical Pharmacists the report on a daily basis to ensure drugs requiring possible dosing adjubased on current renal function are identified and that the ordering phonotified if necessary. The pharmacy reviewing the report will indicate the report has been reviewed by signing The Pharmacy Clinical Coordinator monitor for completeness of reviewed as beginning 07/01/2011. Addit monitoring will be performed as near the content of the part of the	narmacy's sereport is drugs in renal inine is existed is is is icate that gning the exaddition is existed in a the grant is existed in a the grant in a	1/20/10

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NAME OF PROVIDER OR SUPPLIER HENRY MAYO NEWHALL MEMORIAL HOSPITAL (X4) ID PREFIX TAG PREFIX TAG E 485 Continued From page 5 According to the facility's Medication Errors form dated According to the facility's Medication Errors form dated E 485 PREFIX TAG STREET ADDRESS, CITY, STATE, ZIP CODE 23845 W MCBEAN PKWY VALENCIA, CA 91365 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COME CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) E 485 Action: Daily "Off Service" Notes Pharmacists assigned to clinical shift(s) utilize an electronic log to communicate important issues between off-going and	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				A BUILDING			COMPLETED	
CACORDING TO THE APPROPRIATE COMMENTAL CA 91365 CACORDING TO THE APPROPRIATE CACORD	AME OF PRO	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	ATE, ZIP CODE			
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According to the facility's Medication Errors form dated 2010 at 1:45 p.m., on Pharmacists assigned to clinical shift(s) utilize an electronic log to communicate important issues between off-going and	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	(XS) COMPLETE DATE	
an unclear order. The order was written for "Collistin 5 mg/kg IV every 8 hours in divided doses". Order entered as 350 mg IV every 8 hours, should have been 117 mg every 8 hours. Serum creatinine increased from 0.8 on to 8.4 on the serum creatinine increased from 0.8 on to 8.4 on the serum creatinine increased from 0.8 on the serum creatinine is middle doses before the order was discontinued. There was no evidence that the pharmacy clinical Collistimethate are specifically noted in the Daily "Off Service" Notes. Education: A memorandum was sent to pharmacy staff on 01/20/10 reminding pharmacists to include Collistimethate in the Off-going pharmacists. Patients receiving colistimethate are specifically noted in the Daily "Off Service" Notes. Education: A memorandum was sent to pharmacy staff on 01/20/10 reminding pharmacists to include Collistimethate in the Off-going pharmacists to include Collistimethate in the Off-going pharmacists to include Collistimethate are specifically noted in the Daily "Off Service" Notes. Education: A memorandum was sent to pharmacy staff on 01/20/10 reminding pharmacists to include Collistimethate in the Off-going pharmacists to include Collistimethate in the Off-going pharmacists of include Collistimethate in the Off-going/on-coming communication log located in pharmacy clinical Coordinator. Responsible Person: Pharmacy Clinical Coordinator. Monitoring: The pharmacist assigned to the clinical shift will review the Daily "Off Service" Notes on a daily basis and perform follow up monitoring. Monitoring to date has revealed that all pharmacy staff are aware		According to the facility 2010 at 4:15 p.m. an unclear order. The "Colistin 5 mg/kg IV e doses". Order entere hours, should have be Serum creatinine increase to 8.4 on before the order was evidence that the phanurse called the physiunclear order. A review of the facility 2010, dis level elevated to 32 m (reference interval 6-1 level increase to 4.9 n 0.7-1.3 mg/dL). Urea the fiver and removed kidneys. Creathnine is found in a person's ble by the kidneys. If kidneys. If kidneys. If kidneys. 2010, Parmg/dL and creatinine was a considerable and c	ity's Medication Errors 10 at 1:45 p.m., on 1, the physician prescrit e order was written for every 8 hours in divided d as 350 mg IV every 8 een 117 mg every 8 ho eased from 0.8 on 20 Patient received 6 discontinued. There we example and/or the licen ician to clarify the pres decised the patient's Black and creatinin mg/dL (reference intervise a byproduct secrete 19 mg/dl) and creatinin mg/dL (reference intervise a byproduct of creatin codstream that is remoney function is abnorm will increase in the blood tharge Summary dated tient 1's BUN level was level was 1 mg/dL on wever, the BUN level 1 and creatinine level may 2010, and cont 2010, and cont 2010, Patient 1's set 3 mg/dL. ss Notes & Orders dat	doses as no sed cribed ted JN e ral d by nine oved al, the d. s 5 ose inued level inum	E 485	Pharmacists assigned to clinical shi utilize an electronic log to communimportant issues between off-goin on-coming staff. The on-coming phwill follow up on any concerns ider the off-going pharmacist. Patient receiving Colistimethate are specific noted in the Daily "Off Service" Noted in collection of the Colistimeth the off-going/on-coming communicated located in pharmacy folder on the shared drive. Responsible Person: Pharmacy Clin Coordinator. Monitoring: The pharmacist assist the clinical shift will review the Dail Service" Notes on a daily basis and follow up monitoring. Monitoring has revealed that all pharmacy staff aware of the Daily "Off Service" Noted utilize them appropriately. The repharmacist will sign the log indicate been reviewed. The Pharmacy Clin Coordinator will monitor the log for signature for 90 days starting 07/01 Additional monitoring will be performeded based on the results of the	ift(s) nicate g and narmacist ntified by its nically ites. sent to ding ate in on log network nical gned to liy "Off perform g to date iff are otes and eviewing ing it has inical or 1/11. ormed as	1/20/10	

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E 485	Continued From page	6		E 485	2. FORMATION OF MULTIDISCII MEDICATION SAFETY TEAM	PLINARY	
	acute renal failure was acute hemodialysis after a dialysis catheter placement. The Physician Progress Notes & Orders dated 2010, revealed the catheter placement was completed for hemodialysis treatment. The Physician Progress Notes & Orders dated 2010, disclosed the patient was to receive hemodialysis on that day. On 2010, with the patient still requiring hemodialysis, Patient 1 was transferred to Hospital #2. The Discharge Summary dated 2010, disclosed that due to elevated BUN and creatinine levels, the patient underwent hemodialysis. The patient's final discharge diagnoses included acute renal failure. A review of the History and Physical Examination Record dated 2010, from Hospital #2 disclosed Patient 1 was transferred to Hospital #2		to ation tal #2 tal #2		Action: Formation of Multidisci Medication Safety Team A Multidisciplinary Medication Safety Team") was formed in June 2010 promptly review all medication er Team is chaired by the Chair of the Pharmacy and Therapeutics Commithe membership is made up by representatives from nursing, pharespiratory therapy, imaging and of management. The first meeting on June 30, 2010. The Team cate medication errors by severity, reviunusual occurrences, harm to patitrends by unit or practitioner and errors. The Team also formulates action plans to avoid similar errors evaluates the effectiveness of the	fety Team) to rors. The e nittee and rmacy, quality took place egorizes iews ients, type of corrective s and	6/30/10
	with diagnoses that included renal failure, likely chronic, and in need outpatient hemodialysis treatment. The Discharge Summary dated 2010, from Hospital #2, disclosed the patient received hemodialysis treatments and his last treatment was on 2010. The plan was to discharge the patient to home and to arrange with a dialysis center for continued hemodialysis treatments. A review of the Physician's Orders dated 2010, from the dialysis center, indicated hemodialysis treatment every Monday and Friday for three weeks. The Progress Record dated 2010, disclosed that the patient had received 4 hemodialysis as of that date. On 2010, the hemodialysis				taken. Education: The Pharmacy and Therapeutics Committee was educative formation of the Multidisciplin Medication Safety Team in August Responsible Person: Director of Pharmacy will undertain review of the effectiveness of the taken by the Team over a period of Additional monitoring will be performeded based on the results of the review. Monitoring will be conditived of the errors identified and breakdown of the error severity and the severit	nary 2010. harmacy. the ke a actions of 90 days. ormed as e 90 day ucted via a	

Licensing and Certification Division

California Department of Public Health STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A RUILDING B. WNG CA930000063 04/22/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 23845 W MCBEAN PKWY HENRY MAYO NEWHALL MEMORIAL HOSPITAL VALENCIA CA 91355 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY The Team reports to the Pharmacy and E 485 Continued From page 7 E 485 Therapeutics Committee, which is a medical was discontinued when the patient's creatinine staff committee, and the information is level had improved to 2.0 mg/dL. reported to the Board of Governors by the Medical Executive Committee. The facility's failure to ensure that a patient received the correct doses of medication as 3. POLICY AND PROCEDURES ordered by the physician, which resulted in the Action: Revision of Hospital Policy 6/20/11 patient receiving an overdose of an antibiotic with "Medication - Orders" Policy No. MM.414 side effects that included renal toxicity. The house-wide policy, "Medication -developing acute renal failure, and undergoing Orders" No. MM.414 will be revised to hemodialysis treatment, is a deficiency that has caused, or is likely to cause, serious injury or include the following verbiage: Orders death to the patient, and therefore, constitutes an that state "give in divided doses" must be immediate leopardy within the meaning of Health clarified with the practitioner as to the total and Safety Code Section 1280.1 daily dose and the exact dose and frequency of the dose(s) to be administered. This change requires pharmacy staff to clarify with the ordering physician all orders written in this manner. This policy change will help safeguard against errors when calculating the medication dosage for a patient. Education: A draft revision of policy "Medication - Orders" policy No. MM.414 will be presented at Senior Leadersip attended by Nursing directors on June 23. 2011. The revised policy will be reviewed at the Pharmacy and Therapeutics Committee meeting on June 29, 2011. On June 30, 2011 the Director of Pharmacy will educate Hospital directors including Nursing directors on the policy changes via electronic mail. The pharmacy staff will be educated in person on June 30, 2011. Medical Staff will be educated on the updated policy via memorandum and a copy of the revised policy will be distributed to all physicians on staff on July 1, 2011.

California Department of Public Health STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING_ CA930000063 04/22/2010 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 23845 W MCBEAN PKWY HENRY MAYO NEWHALL MEMORIAL HOSPITAL VALENCIA, CA 91355 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) JD (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E 485 E 485 Responsible Person: Director of Pharmacy. Monitoring: Starting July 1, 2011, the effectiveness of the policy change will be monitored for 90 days by reviewing the Pharmacy Intervention Log where all the physician contacts are documented. Additional monitoring will be performed as needed based on the results of the 90 day review. Detailed reports for Colistimethate will be analyzed by the Pharmacy Clinical Coordinator to ensure that proper contact with the prescriber has been initiated in cases where contact has been deemed necessary. The outcome of the monitoring will be reported to the Multidisciplinary Medication Safety Team as part of the Hospital's quality reporting process. Action: Medication Event Dashboard 07/20/10 In order to analyze and trend errors, the Pharmacy has developed an aggregate medication event dashboard. The dashboard presents overall errors broken down by node(medication administration, prescribing, dispensing, and transcription) as well as an overall error run chart. This dashboard was presented at the Hospital's Quality Performance Council ("QPC") in July 2010 and is now a standing agenda item at the quarterly QPC meeting chaired by the Hospital's Deputy Chief of Staff. The report is also presented at the Pharmacy and Therapeutics Committee every 2 months. (The QPC functions as the Hospital's Quality Improvement Committee.) Education: The change in error reporting format was presented at Quality Performance Council on July 2010.

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