
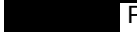
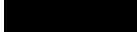


CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>050324</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>11/27/2007</b>
NAME OF PROVIDER OR SUPPLIER <b>SCRIPPS MEMORIAL HOSPITAL - LA JOLLA</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>9888 GENESEE AVENUE, LA JOLLA, CA 92037 SAN DIEGO COUNTY</b>		
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	<p>The following reflects the findings of the CA Department of Public Health during a complaint investigation of COMPLAINT # 133082.</p> <p>Representing the Department of Public Health (formerly Department of Health Services):</p> <p> Pharmaceutical Consultant  Pharmaceutical Consultant , Pharmaceutical Consultant</p> <p>HSC 1280.1(a)(c) 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.</p> <p>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.</p> <p><b>DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY</b></p> <p>70265 A pharmacist shall have overall responsibility for the pharmaceutical service. He shall be responsible for the procurement, storage, and distribution of all drugs as well as the development, coordination,</p>			

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5/8/2008

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	<p><b>Continued From page 1</b></p> <p>supervision and review of pharmaceutical services in the hospital. Hospitals with a limited permit shall employ a pharmacist on at least a consulting basis. Responsibilities shall be set forth in a job description or agreement between the pharmacist and the hospital. The pharmacist shall be responsible to the administrator and shall furnish him written reports and recommendations regarding the pharmaceutical services within the hospital. Such reports shall be provided no less often than quarterly.</p> <p>Based on interview, clinical record review and policy review, the hospital failed to ensure that pharmacists responding to medical emergencies (code blue) were trained and competent before recommending doses of all medications used in a medical emergency.</p> <p>Findings: On 11/27/07 at 11:15 a.m., review of Patient 1's clinical record revealed that on 11/9/07 at 11:45 a.m., the nurse reported the patient was found in bed with labored breathing, respiratory rate = 24 and placed on oxygen at 2 liters/minute. At 11:50 a.m., the SP02 (measure of oxygen in the blood - normal 95) fell to 80 and the oxygen was increased to 4 liters/minute. At 11:55 a.m., the SP02 decreased to the 60's and at 12:02 p.m. the patient was found to be non responsive. A code blue was called by the nursing staff at 12:02 p.m. According to the patient's Discharge Summary dated 11/11/07, the patient was noted to be hypoxic (condition in which the body as a whole is deprived of adequate oxygen supply) with</p>			
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	<p><b>Continued From page 2</b></p> <p>depressed respirations when the code blue was called. She was administered naloxone (a medication to reverse the effects of an overdose of narcotic medication) to reverse the depressed respirations from the overdose of narcotics and required emergency intubation (a procedure performed when a patient cannot breathe on their own and a tube is inserted through the mouth into the trachea, the airway from the mouth to the lungs).</p> <p>On 11/27/07 at 08:45 a.m., review of Patient 1's Emergency Record dictated by Physician J on 11/9/07 at 12:56 p.m., revealed that he arrived to the code blue finding "the patient to be hypoxic and completely unresponsive with an oxygen saturation of 32%. He described immediately giving the patient 2 mg (milligrams) of naloxone (Narcan). (. There was no effect or change in Patient 1's physical status after naloxone. The patient required rapid sequence induction and intubation for airway protection and oxygenation. She was subsequently transferred to the intensive care unit in critical condition."</p> <p>On 11/27/07 at 9:04 a.m., during a telephone interview with Physician J, the emergency department physician who lead Patient 1's code blue, he stated that when he arrived to the code, Patient 1 was near apneic (breathing has stopped) and hypoxic and unresponsive. He ordered naloxone (Narcan) 2 mg but when asked if he was sure the 2 mg dose was given, he responded that he was not sure the dose was given as ordered. He did not administer the dose of naloxone, a nurse</p>			
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	<p><b>Continued From page 3</b></p> <p>administered the dose, but wanted 2 mg given. Following intubation, vital signs and oxygen saturation improved to near normal.</p> <p>On 11/27/07 at 9:17 a.m., Pharmacist B who responded to Patient 1's code blue on 11/9/07 was interviewed. She stated when she arrived to the code the nurse told her she turned a rapid response team alert into a code blue. Physician J arrived at the code and ordered "Narcan 2" and Pharmacist B asked if he meant 0.2 mg and Physician J said yes. Naloxone (Narcan) 0.2 mg was given at 12:07 p.m. and documented on the code blue resuscitation record. There was no response of narcotic reversal after the dose was given. No further naloxone was ordered. During the interview, Pharmacist B was asked about recommending a dose of naloxone 0.2 mg in a hypoxic and unresponsive patient and whether it was an adequate dose. She responded that the standard dose of naloxone was 0.4 mg but she had seen 0.2 mg given in a code blue. In an interview with Pharmacist A, she stated Pharmacist B was ACLS (Advanced Cardiac Life Support) certified, and because of this certification was authorized to participate in code blues. Pharmacist A stated pharmacists needed to complete certification in ACLS during their first three months of hire.</p> <p>On 11/27/07 at 10:17 a.m., during a second telephone interview with Physician J, he stated the smallest dose of naloxone (Narcan) is 0.4 mg and that would be for mild narcotic reversal. He gives 2 mg to patients in distress as was the case with Patient 1. If he would have known 0.2 mg of</p>			
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	<p><b>Continued From page 4</b></p> <p>naloxone (Narcan) was administered, he would have ordered a total dose of 2 mg for this patient. He relied on the pharmacist to draw up the dose he ordered and the nurse to administer it.</p> <p>On 11/27/07 at 10:26 a.m., Pharmacist A stated Pharmacist B drew up the dose of naloxone (Narcan) to be given during the code blue; and pharmacists responding to code blues received a medication dosing guideline on "adult code blue medications" which included medications stored in the emergency crash cart (contains necessary supply of medications for the management of medical emergencies). Naloxone was included in the medication dosing guideline. The guideline stated to give naloxone as follows, "in non-opiate addicted patients the dose is 0.4 mg to 2 mg every 2 minutes up to 10 mg in 10 minutes." Pharmacist B did not follow this guideline when recommending naloxone 0.2 mg. Pharmacist A stated Pharmacist B had this medication guideline in her possession during the code blue.</p> <p>On 11/27/07 at 10:34 a.m. a review of the ACLS competency training manual was conducted, and naloxone was not a medication covered in training along with several other medications located in the emergency crash cart. Pharmacist A stated there was no education or competency testing on those medications not covered in the ACLS training manual. There were 10 medications stored in the crash cart that were not covered in ACLS training, i.e., naloxone, calcium chloride, dextrose 50%, diphenhydramine, flumazenil, phenylephrine, sodium bicarbonate, succinylcholine, vercuronium,</p>			
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	<p><b>Continued From page 5</b></p> <p>verapamil.</p> <p>On 11/27/07 at 1:39 p.m., review of policy entitled: Adult and Pediatric Emergency Response / Code Blue in Main Hospital or on Campus and dated 8/7/06, stated code blue responsibilities of the clinical pharmacists were to assist physicians with medication dosing and prepare medications for administration. The clinical pharmacist was considered the expert on medications during a code blue and relied on to recommend the appropriate dose and draw up that dose for administration. Pharmacist B was not adequately trained on the appropriate dose of naloxone and drew up a dose that was too low to be effective.</p> <p>On 11/27/07 at 2:56 p.m., the hospital administration staff including the CEO was informed that Immediate Jeopardy (IJ) had been identified based on the hospital's failure to protect patients from potential undue adverse medication consequences after a pharmacist, the expert with code blue medications, recommended an ineffective dose of naloxone. It was later discovered that Pharmacist B was only trained on certain ACLS medications and not adequately trained on all code blue medications located in the emergency crash cart. Pharmacists were chosen to respond to code blues because of their knowledge and expertise with those medications.</p> <p>Pharmacist B had the pharmacy's dosing guideline in her pocket which she could have referred to, but did not ,she instead recommended a subtherapeutic dose (below the dosage level to adequately treat medical conditions) of naloxone</p>			
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	<p><b>Continued From page 6</b></p> <p>(Narcan) during a code blue which resulted in failure to reverse the effects of the narcotic and required rapid intubation of the patient. The hospital was asked to address the IJ by providing a plan of correction pertaining to the training and competency testing of pharmacists on crash cart medications not covered in the ACLS training manual. On 11/27/07 at 9:05 p.m., a plan of correction was submitted and accepted.</p> <p>The violation(s) has caused or is likely to cause serious injury or death to the patient(s).</p>				

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