CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050609	A. BUILDING _____ B. WING _____	02/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kaiser Foundation Hospital - Orange County - Anaheim	3440 E La Palma Ave, Anaheim, CA 92806-2020 ORANGE COUNTY

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	The following reflects the findings of the Department of Public Health during an inspection visit: Complaint Intake Number: CA00571227 - Substantiated Representing the Department of Public Health: Surveyor ID # 2882, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. Health and Safety Code Section 1280.3(g): 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. Health and Safety Code Section 1279.1(c): The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made. The CDPH verified that the facility informed the patient or the party responsible for the patient of the adverse event by the time the report was made. Health and Safety Code Section 1279.1 (b)(4)(A): (b) For purposes of this section, "adverse event" includes any of the following:		Preparation and submission of this Plan of Correction does not constitute an admission or agreement by Kaiser Foundation Hospital – Orange County Anahiem Medical Center ("KFH-OCA") of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies. KFH-OCA is submitting this Plan of Correction as required by state regulations. This Plan of Correction documents the actions by KFH-OCA to address the alleged deficiencies. This Plan of Correction constitutes credible evidence of compliance with the cited regulation: Tittle 22, Division 5, Chapter 1, Article 3 - 70213(a) Tittle 22, Division 5, Chapter 1, Article 3 - 70214(a)(1)(2)(c) Tittle 22, Division 5, Chapter 1, Article 3 - 70215(a)(b) Tittle 22, Division 5, Chapter 1, Article 3 - 70263(g)(2) The administration, staff and physicians of Kaiser Foundation Hospital Orange County – Anaheim Medical Center take our responsibility for safe quality care for our patients very seriously and presented a corrective action plan related to the entity reported event described herein to the CDPH surveyor on February 15th, 2018 in order to respond to the surveyor's declaration of Immediate Jeopardy. Attached in this plan of correction are the actions that the hospital presented to the surveyor.	

Event ID:MIXC11 6/6/2018 3:07:04PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Mark Costa Senior Vice President 6-24-18

By signing this document, I am acknowledging receipt of the entire citation packet. Page(s) 1 thru 19

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation

accepted
#35310

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	(4) Care management events, including the following: (A) A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose. Health & Safety Code Section 1280.3(g): 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: Title 22, Division 5, Chapter 1, Article 3 § 70213 (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. Title 22, Division 5, Chapter 1, Article 3 § 70214 (a)(1)(2)(C) (a) There shall be a written, organized in-service education program for all patient care personnel, including temporary staff as described in subsection 70217(m). The		**Plan of Correction** All ICU RNs reeducated on Safe Practices for Direct Admit Patients based on "Policy on Basic Standards of Care and Standards of Practice for Critical Care Patients". Education included: -Documentation of initial vital signs upon patients arrival to ICU -Nursing admission assessment initiated within 15 minutes of arrival to ICU -Patient receiving levophed IV Infusion will have Blood Pressure and Pulse taken and recorded every 15 minutes or more frequently as needed if the IV infusion is being titrated per physician order. -Infusion rates for levophed medication in the Alaris pump must be verified and documented mcg/kg/min (weight based) -Education started immediately after the event and 70% of ICU RN's completed the education by 2/14/2018 and 96 % of ICU RNs completed education by 4/21/2018 -Remaining ICU RNs absent during this time shall receive education upon return to work and prior to receiving a patient care assignment. - Education started immediately for all Traveller RN's and 77% of all ICU Traveler RNs completed the education by 2/14/2018 and 100% of all ICU Traveler RNs completed the education on 3/2/2018	3/15/2018

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	program shall include, but shall not be limited to, orientation and the process of competency validation as described in subsection 70213(c). (1) All patient care personnel, including temporary staff as indicated in subsection 70217(m), shall receive and complete orientation to the hospital and their assigned patient care unit before receiving patient care assignments. Orientation to a specific unit may be modified in order to meet temporary staffing emergencies as described in subsection 70213(e). (2) All patient care personnel, including temporary staff as described in subsection 70217(m), shall be subject to the process of competency validation for their assigned patient care unit or units. Prior to the completion of validation of the competency standards for a patient care unit, patient care assignments shall be subject to the following restrictions: (C) Registered nurses shall not be assigned total responsibility for patient care, including the duties and responsibilities described in subsections 70215(a) and 70217(h)(3), until all the standards of competency for that unit have been validated. Title 22, Division 5, Chapter 1, Article 3 § 70215 (a)(b) (a) A registered nurse shall directly provide: (1) Ongoing patient assessments as defined in the Business and Professions Code, section 2725(b)(4). Such assessments shall be performed, and the findings documented in the		**Plan of Correction Continues** There were no ICU and Traveler RNs assigned to Patient care prior to completing education during this time frame. Pharmacy report was created to identify all patients on levophed infusion on 2/09/2018. Nursing started monitoring the compliance with levophed administration on 2/9/2018. -Feedback is provided daily to staff by ICU nursing managers if any non compliance. Implement safety check process at initiation of all levophed Infusion on all ICU admissions starting 2/15/18 -Safety check includes 2 RNs performing a visual and verbal check of levophed infusion, pump setting and physician order Educate all ICU RN's and ICU Traveler RNs on safety check process -Education started immediately after the event and 96 % of all ICU RNs completed education by 4/21/2018 -Remaining ICU RNs absent during this time shall receive education upon return to work and prior to receiving a patient care assignment. 100 % of all ICU Traveller RNs completed education by 3/2/2018	3/15/2018

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	patient's medical record, for each shift, and upon receipt of the patient when he/she is transferred to another patient care area. (b) The planning and delivery of patient care shall reflect all elements of the nursing process: assessment, nursing diagnosis, planning, intervention, evaluation and, as circumstances require, patient advocacy, and shall be initiated by a registered nurse at the time of admission. Business and Professions Code section 2725(b)(4) (4) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (A) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures. Title 22, Division 5, Chapter 1, Article 3 § 70263 (g)(2) (g) No drugs shall be administered except by licensed personnel authorized to administer drugs and upon the order of a person lawfully authorized to prescribe or furnish. This shall not preclude the administration of aerosol drugs by respiratory therapists. The order shall include the name of the drug, the dosage and the frequency of administration, the route of		**Plan of Correction Continues** There were no ICU and Traveler RNs assigned to Patient care prior to completing education during this time frame. **Measure of Success** Audit 100% of levophed infusions daily for all ICU patients x 1 month for 95% compliance starting 2/9/2018. Then audit 100% of levophed infusions two days per week x 5 months for 95% compliance. Then audit 100% of levophed infusions for two days per month for all ICU patients x 6 months for 95% compliance. Sign in sheet shall be the evidence of compliance with education. Compliance data analysis is reported for discussion and oversight to Nursing Quality Council monthly and quarterly to Quality and Performance Oversight Committee and Executive Committee until completion. **Responsible Person** Department Administrator/Designee of Intensive Care Unit Chief Nursing Executive for Anaheim Medical Center	3/15/2018

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	administration, if other than oral, and the date, time and signature of the prescriber or furnisher. Orders for drugs should be written or transmitted by the prescriber or furnisher. Verbal orders for drugs shall be given only by a person lawfully authorized to prescribe or furnish and shall be recorded promptly in the patient's medical record, noting the name of the person giving the verbal order and the signature of the individual receiving the order. The prescriber or furnisher shall countersign the order within 48 hours. (2) Medications and treatments shall be administered as ordered. The above regulations were NOT MET as evidenced by: Based on interview, medical record review, and hospital document review, the hospital failed to ensure the RN (registered nurse) provided safe nursing care to Patient A when the RN administered the wrong dose of an IV (intravenous) medication to Patient A at the time of admission to the ICU (Intensive Care Unit) from another acute care hospital's Emergency Department causing an overdose in the medication, including but not limited to the following: * The RN failed to ensure the hospital's P&P (policy and procedure) titled "Medication Administration" was implemented. * RN 1 failed to verify the dosage calculation to		**Plan of Correction Continues** Reeducate ICU Traveler RNs and all staff ICU RNs on direct admission process from outside hospitals starting 2/15/2018 to include: -Community dosing convention for levophed infusion shall be evaluated on admission as it may be different. i.e., mcg/min vs mcg/kg/min. -Follow physician written orders from the sending hospital during handoff communication with ACLS transport RN. -Upon patient arrival to the unit, admitting physician is immediately notified and admitting orders are obtained. -Implement safety check process at initiation of all levophed infusion on all ICU admissions starting 2/15/18 -Pharmacy department will dispense the medication according to physician order. -Eduation started immediately after the event and 96 % of all ICU RNs completed education by 4/21/2018 -Remaining ICU RNs absent during this time shall receive education upon return to work and prior to receiving a patient care assignment.	3/15/2018

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	determine the correct rate the IV fluid should be administered to Patient A when converting a non-weight based dosing unit (mcg/min [microgram per minute]) to a weight-based dosing unit (mcg/kg/min [microgram per kilogram per minute]) per the hospital's protocol for vasopressor infusions (medication that causes the constriction of blood vessels) when programing the infusion on a pump (a medical device that delivers fluids, such as nutrients and medications into a patient's body in controlled amounts). During the programming, the pump displayed a soft limit alert (a hospital established limit that can be overridden by the nurse programming the pump by pressing "yes"). However, RN 1 immediately overrode the alert, resulting in the administration of an incorrect dose of the medication to the patient. The medication error was identified by RN 2, not by RN 1 (Patient A's primary nurse) 21 minutes after the infusion had begun. * The hospital failed to ensure RN 1's (a temporary agency traveler nurse) competencies to care for ICU patients were validated prior to assigning the RN to provide care independently to the patients. There was no documented evidence to show RN 1's nursing skills and competencies were validated regarding the administration and calculation of vasopressor medication IV drips. * The hospital failed to develop policies and procedures to provide guidance and safe practices to prevent the medication errors for		**Plan of Correction Continues** -Education started immediately after the event and 100 % of all ICU Traveller RNs completed education by 3/2/2018 There were no ICU and Traveler RNs assigned to Patient care prior to completing education during this time frame. **Measure of Success** Staff sign in sheets shall be the evidence of compliance. Compliance data analysis is reported for discussion and oversight to Nursing Quality Council monthly and quarterly to Quality and Performance Oversight Committee and Executive Committee until completion. All medication errors and near misses are reported to Pharmacy & Therapeutic Committee. **Responsible Person** Department Administrator/Designee of Intensive Care Unit Chief Nursing Executive for Anaheim Medical Center	3/15/2018

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	the nurses when a soft limit was displayed during the programing of the IV pumps. The cumulative effect of the hospital's deficient practices resulted in the hospital's failure to provide safe medication administration and nursing care for Patient A when a massive overdose of an IV medication was administered to Patient A, immediately leading to a significant change in the patient's condition and a code blue, resulting in the patient's death. On 1/6/18 at approximately 0118 hours, upon arrival to the ICU by ambulance transport, Patient A's IV drip of Levophed (vasopressor medication to treat low blood pressure, causes the constriction of blood vessels) was infusing at 3.5 mcg/min [equivalent to 6.6 ml/hr (hour)]. However, when Patient A's IV infusion was transferred from the ambulance's infusion pump to the hospital's infusion pump, the pump prompted RN 1 to program the IV dose using the hospital's weight based dosing system which required the RN to calculate the 3.5 mcg/min (minute) dose using the patient's weight in kg (kilogram). RN 1 calculated Patient A's IV infusion at 3.5 mcg/kg/min, which resulted in Patient A receiving the Levophed at 588 ml/hour, 89 times more than the needed dose. Patient A received a total of 168.9 ml of Levophed in a period of 21 minutes before the medication error was identified by RN 2. The pump history showed the pump was turned off at 0145 hours.		**Plan of Correction Continues** Revised current ICU nursing unit specific competency checklist for ICU Traveler RNs on 2/10/2018. Revised unit specific competency checklist to specifically address the following competencies with a return demonstration of the following: Manages administration of continuous infusions appropriately -Programs IV pump correctly for appropriate IV infusions -Titrates continuous infusions per patient condition per physician order Care for patient with hemodynamic monitoring -Non-Invasive monitoring -Assessment, management/ titration and monitoring of vasoactive continuous infusion medications which includes Norepinephrine	3/15/2018

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	The RN entered a non-weight dose from the previous hospital into a pump that required the patient's weight because the hospital's pump calculates the infusion amount by weight. The infusion rate (in ml) was changed to a weight based rate. The pump alarmed as the Smart Pump knew this was an overdose (a soft limit set by pharmacy in the pump). The other hospital's and the ambulance's pumps were programmed for non-weight dosing. The hospital's pump was programmed for weight based. The RN immediately overrode the soft stop limit. There is a hard stop limit that cannot be overridden also programmed in the pump; however, this dose was just shy of that limit. On 1/6/18 at 0155 hours, the time indicated on the pump report and 30 minutes after arrival to the ICU, Patient A developed shortness of breath and chest pain. The patient became unresponsive and went into ventricular fibrillation (a life-threatening heart rhythm that results in a rapid, inadequate heartbeat). The hospital's code blue team (a team to respond to an emergency situation in which a patient is in cardiopulmonary arrest, requiring a team of providers to rush to the specific location and begin immediate resuscitative efforts) was activated at 0155 hours. Patient A received chest compressions and was intubated [the placement of a flexible plastic tube into the trachea (windpipe) to maintain an open airway] and connected to a mechanical ventilator. Patient A returned to normal sinus rhythm (normal heart rate). However, the patient		**Plan of Correction Continues** 100% of all current ICU Traveler RNs successfully completed the revised unit specific competency validation which was revised on 2/10/18. ICU Traveler RNs onboarding process was revised on 2/9/2018 to include the following: Nursing Orientation All new ICU Traveler RN's shall complete 4 days of Nursing Orientation before independent patient assignment starting with the next nursing orientation beginning March 2018. All new ICU Traveler RN's shall complete ICU RN new hire Nursing Orientation prior to providing patient care. Unit specific Orientation All new ICU Traveler RNs Unit Specific Orientation form was revised on 2/14/2018 to include employee and Clinical Nurse Specialist and/or designee attestation. New hire ICU Traveler RNs will complete unit specific orientation with Clinical Nurse Specialist/designee to cover ICU specific policies and procedures before independent patient assignment beginning March 2018. All new ICU Traveler RN's shall complete ICU Traveler RN Unit specific Orientation prior to providing patient care	3/15/2018

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	experienced a significant change in condition 11 minutes later and a second code blue was activated. Patient A expired one hour and 26 minutes after arriving in the hospital's ICU. Findings: On 1/18/17, the hospital reported to the Department an event of an unexpected death of a patient associated with a medication error on 1/6/18. On 1/22/18, an unannounced visit was conducted at the hospital. According to the Lexicomp.com (an online professional drug reference), the drug Levophed is used to treat severe hypotension. Adverse reactions to Levophed include bradycardia (abnormally slow heart beat), anxiety, and dyspnea (difficulty breathing). These adverse reactions can include bradycardia, possibly as a result of a reflex response to increased blood pressure, as well as potentially fatal cardiac arrhythmias, including ventricular tachycardia and ventricular fibrillation Review of the hospital's P&P titled Medication Administration: Bar Coding revised 5/16 showed the medications will be administered according to the eight rights of medication administration: * Right patient * Right medication		**Plan of Correction Continues** Unit specific Competency Validation ICU Traveler RNs will be assigned to preceptor for a minimum of 3 days to complete unit specific competency validation checklist beginning March 2018 No new ICU Traveler RN's shall be assigned to patient care prior to completing ICU Traveler RN Unit specific Competency Validation. Only nurses who are deemed competent will provide patient care. **Measure of Success** Signed competency validation forms and staff sign in sheets for Nursing Orientation shall be the evidence of compliance. Compliance data analysis is reported for discussion and oversight to Nursing Quality Council monthly and quarterly to Quality and Performance Oversight Committee and Executive Committee until completion. **Responsible Person** Department Administrator/Designee of Intensive Care Unit Chief Nursing Executive for Anaheim Medical Center	3/15/2018

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	* Right dose * Right time * Right route * Right reason * Right documentation * Right response The Vasoactive Infusion ICU IP (inpatient) SCAL (Southern California) NATL (national) protocol was provided for review by the hospital's Director of Inpatient Pharmacy. The protocol showed staff is to call the physician to reassess if the Levophed requirement is greater than 0.15 mcg/kg/min. Review of the hospital's P&P titled Basic Standards of Care and Standards of Practice for Critical Care Patients revised 8/17 showed the following: "All patients will receive the following interventions by the nurse to ensure appropriate assessment of health status: Vital signs, Heart rate, respiration, and BP will be recorded every 1 hour or more frequently as indicated by hemodynamic instability." Section 1.15 states" Patients receiving vasoactive medication drips will have BP and pulse taken and recorded every 15 minutes or more frequently as needed if the drip is being titrated." Under section 6.2 "Initial vital signs and placement on monitor will be done upon arrival to the unit." On 1/22/18, Patient A's medical record review was initiated. Patient A was admitted to the hospital on 1/6/18, and expired on the same		**Plan of Correction Continues** 100% of all ICU Traveler RNs completed and passed the Alaris pump competency on 2/9/2018. Competency included definition of Soft and Hard Limit and staff were able to articulate the difference between Hard stop (Hard limit) and Soft stop (Soft limit). Education includes override procedures for Soft limits and Hard limits to all ICU Traveler RNs and ICU staff RNs: Soft Limit: Prior to any override, double-check the dose, dosage calculations, and infusion pump settings with the MAR/infusion record and/ or physician's order. If there is still a concern contact a pharmacist to review the order, who will then contact the physician as needed. Hard Limit: There is no override. Double-check the dose, dosage calculations, and infusion pump settings with the MAR/infusion record and/ or physician's order. Contact a pharmacist to review the order, who will then contact the physician as needed	3/15/2018

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	day. Patient A's medical record indicated the patient had chronic renal failure, history of congestive heart failure, diabetes, chronic respiratory failure and possible sepsis. Review of the hospital's documentation titled Telephone Call Documentation dated 1/5/18, showed at 1826 hours, the hospital's physician received a report Patient A presented to another hospital's ED due to low BP, between SBP (systolic blood pressure - the top number of a blood pressure measurement) 50 to 60 mm Hg (millimeter of mercury), after an uneventful dialysis (method of treating kidney failure by using a machine to remove waste material from the kidneys) treatment. A Levophed IV infusion was initiated for Patient A at 3 mcg/min. On 1/5/18 at 2219 hours, Patient A was accepted for a transfer from the ED by the hospital's physician after another hour of monitoring. Documentation showed the patient's BP was 104/53 and heart rate was 85 at 2200 hours, at the sending hospital. Review of Patient A's transport ambulance report showed on 1/6/18 at 0042 hours, Patient A departed by critical care ambulance from the other hospital's ED. During the transport, at 0055 hours, Patient A's BP was 94/57 mmHg (normal BP: 120/80 mmHg), HR (heart rate) was 65 bpm [normal HR: 60 to 100 bpm (beats a minute)] and RR (respiratory rate) was 20 bpm [normal respiration rate ranges from 12 to 20 bpm (breaths per minute)]. At 0057 hours, the Levophed infusion rate was increased by the		**Plan of Correction Continues** Education started immediately after the event for all ICU Traveler RNs currently assigned to ICU. 44% of ICU Traveler RNs completed the education regarding override procedures for Soft limit and Hard limit on 2/14/2018 and 100% completed on 2/18/18. Education was also provided to ICU RNs currently assigned to ICU after the event. 100% of ICU RNs completed the education regarding override procedures for Soft limit and Hard limit on 5/19/18 There were no ICU and Traveler RNs assigned to Patient care prior to completing education during this time frame.	3/15/2018

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	ambulance transport RN to 3.5 mcg/min. The ambulance report documentation showed at 0100 hours, Patient A was alert and oriented to name, time, place, and event. At 0112 hours, Patient A's BP was 98/58 mmHg and the HR was 88 bpm. On 1/6/18 at 0118 hours, RN 1 received Patient A in the hospital's ICU and signed off on the ambulance report. However, review of the medical record failed to show documentation Patient A's VS (including BP, HR, RR, temperature) was monitored after arriving at the hospital. Review of a late entry nurse's note by RN 1 dated 1/6/18 at 0445 hours, showed Patient A arrived to the ICU around 0130 hours. The documentation showed within minutes of getting Patient A on the monitor, Patient A's HR rapidly increased into the 160s and sustained. Patient A also complained of chest pain and shortness of breath. The documentation showed RN 1 administered 9 liters of oxygen via nasal cannula (a device used to deliver supplemental oxygen) and called an RT (respiratory therapist) for assistance. The RT placed Patient A on a non-rebreather mask (a device used to deliver high concentrations of oxygen) due to the symptoms of respiratory distress. RN 1 administered sublingual nitroglycerin (a medicine that opens the blood vessels to improve blood flow) twice to address Patient A's		**Plan of Correction Continues** **Measure of Success** Signed competency validation forms and staff sign in sheets shall be the evidence of compliance. Compliance data analysis is reported for discussion and oversight to Nursing Quality Council monthly and quarterly to Quality and Performance Oversight Committee and Executive Committee until completion. **Responsible Person** Department Administrator/Designee of Intensive Care Unit Chief Nursing Executive for Anaheim Medical Center	3/15/2018

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	chest pain. The documentation showed Patient A was on a Levophed infusion due to the low BP. However, RN 1 documented the Levophed infusion was stopped within five minutes of starting the infusion due to high HR and maintained BP. The documentation showed Patient A became unresponsive just as RN 1 received a phone call from the physician who had been notified of Patient A's change in condition. Patient A's infusion pump report dated 1/6/18, was provided for review to show the sequence of events following the patient's admission to the ICU. The report showed the following: * At 0121 hours, RN 1 programmed the infusion pump to infuse the Levophed at a concentration of 8 mg/250 ml, with a dosing unit of 3.5 mcg/kg/min dose. The RN calculated the patient's weight as 89.6 kg when programming the pump. With this data, the infusion pump automatically calculated the Levophed to infuse at 588 ml/hr rate, which was far greater than the 6.6 ml/hr that was infusing to Patient A upon admission to the ICU. The report showed the soft limit alert prompted and alerted the user that the dosing unit (3.5 mcg/kg/min) exceeded the maximum recommended dose (0.5 mcg/kg/min). However, the documentation from the pump report monitoring data showed RN 1 immediately overrode the soft limit warning display to continue the infusion as programmed. Further documentation review failed to show RN 1 verified the Levophed dosage calculation			

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	from mcg/min (non-weight-based dosing unit) to mcg/kg/min (weight-based dosing unit) was correct before proceeding with the infusion. * At 0124 hours, the programmed infusion of Levophed was started for Patient A. * At 0145 hours (21 minutes later), the documentation showed the infusion pump was turned off. The report showed Patient A received 168.9 ml of Levophed during the 21 minutes, not "within five minutes" as documented by RN 1 in a late entry nurses' note dated 1/6/18 at 0445 hours. Review of the Adult/Pediatric Cardiopulmonary Code Report dated 1/6/18, showed the following: * At 0155 hours, the code blue was initiated. * At 0224 hours, the code blue ended. During the code blue, Patient A received chest compressions and was intubated. Upon ending the code blue, Patient A returned to NSR (normal sinus rhythm). * At 0235 hours (11 minutes after first code blue finished), another code blue was initiated. * At 0247 hours, Patient A was pronounced dead. On 2/6/18 at 0800 hours, the Informatics Practice Specialist was interviewed. When			

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	asked why there was no documentation of the vital signs in the EMR (electronic medical record) from Patient A's cardiac monitor, the Specialist stated the data on the patient's monitor automatically populated to the EMR; however, the data would not be maintained in the EMR until the nurse reviewed and saved the data. The data could be retrieved any time. However, the Specialist stated the data could not be retrieved once the patient was discharged out of the system. In this case, after Patient A expired, the patient was discharged out of the system before the data on the monitor was reviewed and saved by RN 1. On 2/6/18 at 0700 hours, the ICU Charge Nurse was interviewed. When asked about Patient A's arrival to the ICU on 1/6/18, the Charge Nurse stated she remembered Patient A was awake upon arriving to the unit because she saw the patient as she passed by the room. The Charge Nurse stated she entered Patient A's room when the monitor alarm sounded. The Charge Nurse stated at that time, Patient A's HR was around 170 bpm on the monitor. Patient A was short of breath, restless, and attempted to get out of bed. RN 2, who was also in the room at the time, told the Charge Nurse to turn off the Levophed. The Charge Nurse then noted the infusion pump for the Levophed was running at 588 ml/hr. The Charge Nurse immediately turned off the infusion pump. Patient A then became unresponsive and the monitor showed ventricular fibrillation (rapid, inadequate			

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	heartbeat). When asked about the process on the night shift of receiving a patient directly to the ICU from another hospital, the Charge Nurse stated a patient would remain on the same treatment regimen as ordered by the sending hospital's physician until their hospital's physician was notified of the patient's arrival and new orders were in place. On 2/6/18 at 0720 hours, RN 2 was interviewed. When asked about the incident, RN 2 stated he heard RN 1 had asked for help to call an RT. Upon entering Patient A's room, RN 2 stated the patient's HR was in the 130's and the patient was fully alert, but was anxious. When RN 2 returned to Patient A's room five minutes later, the patient's HR had increased to 180 to 190 bpm. Patient A complained of chest pain, had severe shortness of breath and had started to panic. RN 2 stated at that time he noted the infusion pump for the Levophed showed it was infusing at 588 ml/ hr. RN 2 stated he immediately told the Charge Nurse, who was now in the room, to stop the infusion pump as she was standing right next to the pump. Review of the hospital's Skills/Knowledge/Behavior Validation Orientation Checklist for RNs new to the ICU showed there were 27 pages of competencies to be validated, including the administration of Levophed for hemodynamic instability.			

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	Review of the personnel file for RN 1 showed the RN was a nursing agency traveler contracted to work in the hospital's ICU for 22 weeks, from 11/7/17 to 3/3/18. Review of the Critical Care/ICU Skills Checklist for RN 1 from the nursing agency dated 1/10/17, showed RN 1 self-evaluated her competency levels as "experienced/minimal support needed" in order to administer the IV vasopressors (such as Levophed drips). There was no documentation to show the hospital determined whether RN 1 was competent to use the continuous IV infusion pump. Review of the hospital's Orientation Checklist: Agency RN (a one page document) showed a checklist of topics were signed off for RN 1 by a preceptor nurse [an ICU experienced RN who would work alongside a new RN and verify the RN had the knowledge and skill sets required for the unit and would document on a hospital form] from 11/8 through 11/13/17. However, the topic list did not include the specific ICU skill competencies such as IV vasopressors. On 2/6/18 at 0700 hours, during an interview with the ICU Charge Nurse, the RN was asked how she ensured RN 1 was competent to take care of a directly admitted patient. The Charge Nurse stated it was not her responsibility to check RN 1's competencies as RN 1 should have met all the requirements when she was assigned to the ICU to work independently.			

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	On 2/6/18 at 0750 hours, the CNS (Clinical Nurse Specialist) for the ICU and the Informatics Practice Specialist were interviewed. When asked, the CNS stated only ICU RNs were competent to infuse the Levophed IV drips. The CNS stated she was involved in developing the orientation checklist for the hospital's ICU RNs' skills validation, including vasoactive IV drips. When asked about a checklist for temporary agency nursing staff, the CNS stated she was not involved in developing a checklist for these staff. When asked, the CNS stated she was not familiar with the one page orientation checklist used for the temporary nursing staff. The CNS stated her responsibilities for the temporary nursing staff during orientation were to make sure the temporary nursing staff were given access to the Pyxis (automated medication dispensing system). When asked if RN 1 had previously cared for a directly admitted ICU patient prior to this incident, the Informatics Practice Specialist confirmed Patient A was RN 1's first direct admit patient to the ICU at the hospital. On 2/6/18 at 0950 hours, the Assistant Department Administrator for OC (Orange County) Staff and the Manager Accreditation, Regulation and Licensing were interviewed. When asked, the Assistant Administrator stated the hospital had a condensed version of the ICU orientation checklist for temporary nursing staff. However, it was unknown when the checklist was created.			

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	When asked to provide an orientation checklist for another nursing unit that was used by the hospital to validate a temporary agency nursing staff's competencies, the same orientation checklist used for RN 1 was provided. The Manager Accreditation, Regulation and Licensing verified the ICU orientation checklist used for temporary nursing staff was not specific to the ICU standard care. Review of RN 1's educational file showed RN 1 received online education regarding the infusion pump. However, the online education did not provide information as to what to do if a hard or soft limit occurred on an infusion pump, there were no questions on the test regarding infusion pumps, and no hands on instructions. Review of the infusion pump teaching material for RNs provided by the hospital showed the infusion pump soft limit was defined as a hospital established limit that could be overridden by the nurse by pressing "yes" when prompted to proceed. However, there was no documentation to show RNs were educated on the appropriate steps to take in order to prevent medication errors when the infusion pump's soft limit alerted. This facility failed to prevent the deficiency(ies) as described above that caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code Section 1280.3(g).			