

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150074	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/22/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL EAST			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 N RITTER AVE INDIANAPOLIS, IN 46219		
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S000000	<p>This visit was for the investigation of one (1) State hospital complaint.</p> <p>Date of survey: 5-22-13</p> <p>Facility number: 005068</p> <p>Complaint number: IN00123971 Substantiated: Deficiency cited under Pharmacy services.</p> <p>Surveyor: Jennifer Hembree, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 06/12/13</p>	S000000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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. (see instructions.) Except for nursing homes, the findings stated 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.

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S001014	<p>410 IAC 15-1.5-7 PHARMACEUTICAL SERVICES 410 IAC 15-1.5-7(c)</p> <p>(c) In order to provide patient safety, the director of pharmacy shall develop and implement written policies and procedures for the appropriate selection, control, labeling, storage, use, monitoring, and quality assurance of all drugs and biologicals.</p> <p>Based on document review and staff interview, the pharmacy director failed to ensure facility policy related to patient allergies was followed and failed to ensure quality monitoring was ongoing related to patient safety alerts.</p> <p>Findings include:</p> <p>1. Review of patient #1 medical record indicated the following: (A) The patient's record documented an allergy to Penicillin. (B) An order was written on 1/23/13 for Kefzol 2 gms, however per the medication administration record (MAR), the Kefzol was held. The reason the medication had been dispensed and then held was not documented. There was no indication that the facility followed policy titled "Management of Patient Drug Allergies".</p> <p>2. Facility policy titled "Management of</p>	S001014	<p>Re: Deficiency S1014 401 IAC 15.1.5-7 PHARMACEUTICAL SERVICES Rule was not met as evidenced by: 1. Pharmacy Director failed to ensure facility policy related to patient allergies was followed 2. Pharmacy Director failed to ensure quality monitoring was ongoing related to patient safety alerts Response to #1 The pharmacy department is expected to adhere to all policies related to patient allergies and medication dispensing. Any actions taken as a response to a patient allergy and a drug order need to be documented in the patient chart. While policies were followed in this situation there was no documentation of a conversation occurring between the nurse, physician and pharmacist. 1. The individual pharmacist responsible for dispensing the medication has been counseled regarding proper documentation practices on June 19th, 2013. 2. Education regarding how to document these conversations was dispersed via</p>	07/03/2013	

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	<p>Patient Drug Allergies" with an effective date of 8/30/11 states on page 1: "For patients who have a history of allergy to medications as well as other substances (eg iodine, peanuts), the healthcare team will obtain and document any known allergies and evaluate the appropriateness of medication therapy based on the patient ' s allergy history. <u>Procedure:</u> Allergies are documented on the admission orders by the admitting physician or in the admission database by licensed nursing personnel. The allergy and the type of reaction, if known, are documented.8. After consideration of alternative medications, a physician may determine that the potential benefits of a medication outweigh the risk of a possible allergic reaction. In these cases, the physician should complete a brief note documenting this information for inclusion in the progress notes of the medical record (Notice of Reported Potential Drug Allergy), general process being:</p> <ol style="list-style-type: none"> 1. Determine the nature of the reaction... 2. Determine if a structurally-unrelated alternative medication, that is safe and effective, may be used... 3. Determine if an alternative medication with potential for less cross-reactivity may be used... 4. Determine is the patient is a candidate for drug desensitization... <p>3. Review of pharmacy override history for patient #1 indicated that an override occurred at 1928 on 1/23/13 for Kefzol with no reason indicated for the override related to the patient allergy. The</p>		<p>email in March of 2013 to all pharmacy personnel. This educational document was updated to reflect the importance of documentation and redistributed to pharmacy personnel on June 19th , 2013 3. Pharmacy provides education to new nurses during their orientation class. The importance of reviewing allergies with the patient and/or their family was presented on June 19th and will be presented every two weeks to new nurses. 4. The importance of documentation as well as step-by-step instructions will be distributed during new pharmacist training. Training material updated, June 19th, 2013. 5. Proper documentation of conversations will be reviewed in the June pharmacist staff meetings scheduled for July 1st and July 3, 2013. Response to #2 Historically, monitoring of alerts was completed on a weekly basis by the Network Medication Safety Officer. The person in that position left the network in April and, while the reports continued to be published, no documented review of the reports was occurring. In response to this citation the responsibility for the monitoring of the alerts report has been assigned to the Epic Pharmacy Steering Committee. This group is comprised of Pharmacy Directors, the Network Clinical Director, the Chief Pharmacy Officer and members</p>		

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	<p>document stated "1. PENICILLINS [level: CROSS-SENSITIVE CLASS MATCH] [Reason: Dose appropriate].</p> <p>4 Staff member #4 indicated the following in interview beginning at 1:10 p.m. on 5/22/13: (A) After reviewing the medical record for patient #1, he/she was unable to determine why the Kefzol was dispensed to patient #1 or why it was discontinued.</p> <p>5. Staff member #7 indicated the following in interview at 3:35 p.m. on 5/22/13: (A) Kefzol has a potential interaction if a patient is allergic to Penicillin. (B) If there is a direct contraindication, the pharmacist will contact the nurse and request they find out what the reaction to the medication is. (C) The pharmacist will check the medical record to see if the medication had been prescribed/administered in the past. (D) The pharmacy started a QA study in December or January to reduce " alert fatigue ". When the study started, the pharmacy found that in a 1 week period of time, the system had 19,000 alerts at all 4 campuses. They began eliminating unnecessary alerts. Currently there are no printed reports of the study and no interventions in place. The safety officer</p>		<p>of the Pharmacy Informatics teams. This group will review the data twice a month. Based on the number of alerts and quality of response to the alerts the group will decide and implement steps to reduce alerts or make them more effective. It was also identified that physicians need to participate in the monitoring of this report. The Chief Pharmacy Officer has implemented a process whereby physicians on the Epic team will begin reviewing alerts seen by providers when entering medications. Based on the type and quality of alerts that group will make suggestions regarding changes, etc. The Pharmacy Informatics team will be responsible for implementing those changes.</p>				

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	<p>who was in charge of the study left the facility 5 weeks ago.</p> <p>(E) He/she verified that the record did not explain a reason the Kefzol was dispensed for patient #1 despite the documented allergy to Penicillin.</p>			