| **Statement of Deficiencies** | **(X1) Provider/Supplier/CLIA Identification Number** | **(X3) Date Survey Completed** |
|---|---|---|
| | 530015 | 04/05/2012 |
| **Name of Provider or Supplier** | **Street Address, City, State** | |
| St Johns Medical Center | 625 East Broadway, Jackson, WY | |

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

| **(X4) ID Prefix Tag** | **Summary Statement of Deficiencies**<br>(Each deficiency should be preceded by full regulatory or LSC identifying information) |
|---|---|
| **A0404** | ADMINISTRATION OF DRUGS<br>CFR(s): 482.23(c)<br><br>Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under 482.12(c), and accepted standards of practice.<br><br>This STANDARD is not met as evidenced by:<br>Based on medical record review and staff interview, the facility failed to ensure medications were administered as specifically ordered for 5 of 7 patients (#3, #4, #6, #10, #11) who received Versed as a pre-operative sedation medication. In addition, the facility failed to ensure the accuracy of post anesthesia care unit (PACU) transcribed orders, and/or staff corrected pre-printed order sets on medication administration records (MARs), to reflect orders written for 5 of 5 patients (#3, #4, #5, #6, #11) reviewed. The findings were: 1. Medical record review of the sedative, Versed, administered to pre-operative patients showed it was ordered as a single dose with permission to repeat the dose as needed to achieve the desired effect. Review of medical records from August of 2010 to current practice showed in some medical records, staff failed to follow orders for Versed administration. Although the physician ordered dosing administered in a smaller quantity with a second dose if needed, findings in 5 of 7 records showed staff document administration of the two doses together at one time. Interview with the chief nursing officer (CNO) on 4/3/12 at 2:53 PM confirmed the practice was to give the total dose ordered at one time instead of the ordered divided dose. She said staff usually gave the total dose stating the physicians wanted the total given. She confirmed the practice did not match the pre-printed orders nor was the order changed by the physician. Review of the following medical records showed problems related to dosage administration contrary to physician orders, and lack of assessment between doses for Versed: a. Review of the medical record for patient #3 showed the patient's surgical date was 4/2/12. |

A pre-operative order, dated 4/2/12 and signed off at 7:30 AM, included "Versed 1 mg [milligram] IV [intravenous route], repeat x [times] one PRN [as needed] anxiety for patients [symbol for greater than] 12 yo [years old], and [symbol for greater than] 40 kg [kilograms]". Review of the MAR showed the patient received the maximum total dose ordered, 2 mg, as administered at 7:30 AM rather than the 1 mg dose followed by documentation indicating the need for administration of the second, 1 mg dose. b. According to the medical record for patient #10, on surgery date 4/2/12, orders included "Versed 1 mg IV, repeat x [times] one PRN for anxiety for patients [symbol for greater than] 12 yo, and [symbol for greater than] 40 kg." Review of the patient's MAR showed s/he received 2 mg at 7:35 AM, and not the divided dose as ordered by the physician. c. Review of the medical record for patient #11 showed s/he had surgery on 8/8/11. Pre-operative orders included "Versed 1 mg IV, repeat x [times] one prn anxiety for patients [symbol for greater than] 12 yo, and [symbol for greater than] 40 kg [up to] 4 mg total." The patient received 2 mg at 7:25 AM and an additional 2 mg at 7:28 AM. d. The medical record for patient #4 showed a pre-operative order (dated on 8/30/11 and timed for 7:10 AM) for "Versed 1 mg IV, repeat x [times] one PRN for anxiety for patients [symbol for greater than] 12 yo, and [symbol for greater than] 40 kg." Review of the patient's MAR showed the nurse transcribed the order as "Versed 2 mg IV" and signed that 2 mg was given at 7: 30 AM. e. Review of the medical record for patient #6 showed the patient had surgeries on two separate dates, 8/13/10 and 8/25/10. Each time the preoperative medication ordered was "Versed 1 mg IV, repeat x [times] one prn anxiety for patients [symbol for greater than] 12 yo, and [symbol for greater than] 40 kg". Review of the patient's MAR for 8/13/10 showed it transcribed as "Versed 2 mg IV pre-op" and that 2 mg was given at 9:55 AM. The MAR dated 8/25/10 also showed the Versed transcribed as "Versed 2 mg IV x [times] 1 pre-op anxiety" and that 2 mg given as a single dose at 8:18 AM. 2. Review of medical records from August 2010 to current practice revealed the PACU area used preprinted orders sets with preprinted MARs which transcribed most of the medication orders found on the order set. Comparison of the order sets with the MARs during record review showed no deletion of medications not ordered, and in some cases, additional medications hand written on the order set, were not always transferred over to the MAR. Interview with the chief nursing officer (CNO) on 4/3/12 at 2:53 PM revealed that PACU nurses worked off the orders and when they gave a medication from the order set, it was then documented on the MAR. She confirmed that the MAR was not corrected to reflect the actual orders from the physician as was the standard within the rest of the facility. Review of medical records identified the following issues related to transcription accuracy: a. Review of the medical record for patient #3 showed in PACU on 4/2/12, preprinted order sets and preprinted MARs were used. Of the multiple medications on the order set, the physician ordered the patient to receive Fentanyl and Phenergan. Review of the patients MAR also dated 4/2/12, showed no corrections for the medication which were not ordered. Morphine, Dilaudid, Toradol, and Demerol, remained on the MAR despite no orders for administration. b. Review of the medical record for patient #5 revealed preprinted order sets and preprinted MARs were used for the PACU area on surgery date, 4/3/12. Although the orders set contained multiple medication orders, the only order chosen by the physician was Dilaudid for pain. Yet, review of the MAR showed it was not corrected to reflect that Dilaudid as the only order. The MAR contained orders for Morphine, Fentanyl, Toradol, Demerol, and Phenergan even though the physician had not ordered these. c. The medical record for patient #4 showed a pre-operative order (dated on 8/30/11 and timed for 7:10 AM) for "Versed 1 mg IV, repeat x [times] one PRN for anxiety for patients [symbol for greater than] 12 yo, and [symbol for greater than] 40 kg." Review of the patient' s MAR showed the nurse transcribed the order as "Versed 2 mg IV". Interview and

| | |
|---|---|
| | record review with the CNO on 4/3/12 at 2:53 PM confirmed the medication was not transcribed accurately. In addition, the PACU order set contained multiple medication orders. Yet, review of the MAR showed it lacked correction to reflect that Morphine was not ordered for this patient. d. Review of the medical record for patient #11 showed s/he had surgery on 8/8/11. Review of the PACU order set showed the physician ordered Dilaudid and Demerol for the patient. In addition, the physician wrote an order for the anti-nausea drug, Zofran. Review of the MAR failed to reflect deletions of the medications not ordered, and the addition of the Zofran order. e. Review of the medical record for patient #6 showed the patient had surgeries on two separate dates, 8/13/10 and 8/25/10. Each time the preoperative medication ordered was "Versed 1 mg IV, repeat x [times] one prn anxiety for patients [symbol for greater than] 12 yo, and [symbol for greater than] 40 kg". Review of the patient's MAR for 8/13/10 showed it transcribed as "Versed 2 mg IV pre-op" and that 2 mg was given at 9:55 AM. The MAR dated 8/25/10 showed the Versed transcribed as "Versed 2 mg IV x [times] 1 pre-op anxiety". The nurse documented 2 mg given as a single dose at 8:18 AM on 8/25/10. Review of the medical record and interview at 9: 45 AM on 4/5/12 with the CNO confirmed the transcription inaccuracy. The record review also revealed other transcriptions issues: I. Review of the preprinted order set for frequently used PACU medications showed staff did not individualized the PACU MARs to match the medication ordered by the physician. During the patient's 8 /13/10 surgery, the only preprinted medications ordered were for the the medications Fentanyl and Dilaudid. Yet, the pre-printed MAR was not corrected to reflect the deletion of medications not ordered such as the Morphine, Toradol, Demerol, and Phenergan. II. Review of the PACU MARs for the patient's second surgery on 8 /25/10 showed the medical record documentation showed the patient as oversensitive to the effects of Phenergan. It showed the physician crossed out the Phenergan on the order set, but the medication was never deleted even though it now was listed under allergies by nursing staff. III. Medications ordered on 8/25/10 on the PACU order set, such as Benadryl, Versed, and Zofran, were never added to the PACU MAR. Yet, Morphine was never ordered by the physician, but it remained on the MAR and not deleted. IV. On 8/25/10, when the patient returned to the one day surgery center after his/her recovery in PACU, a pain medication, Lortab, was ordered 1 to 2 tablets every six hours. However, the order was transcribed to be given every four to six hours, a time range sooner than ordered. Although other medications were ordered to be given as needed, such as Ibuprofen, and Benadryl, these were not transcribed onto the MAR and were not listed as available choices for this patient. According to "Nursing Interventions and Clinical Skills," fourth edition, copyright 2007, the form used to verify that the right medications are administered at the correct times is the medication administration record, MAR. The nurse who checks all transcribed orders is responsible for the MAR accuracy. The nurse must also ensure the MAR is up-to-date and accurate by comparing the MAR to the physician orders. The authors teach that adding new hand written orders includes ensuring that they are accurately transcribed to the MAR. |