



Complaint Summary for Public Viewing Reports for:
SKY RIDGE MEDICAL CENTER

Intake ID: CO00007837
Facility: SKY RIDGE MEDICAL CENTER
Date of Complaint: 2/23/2006
Date of Investigation: 5/8/2006
Total Number of Allegations for Complaint: 8

Allegation: 5

Type: Pharmaceutical Services

Findings: Unsubstantiated

Allegation Detail: The complainant alleges that the facility failed to ensure that the patient's medication for an ear infection was available and administered timely on 12/30/05. Allegedly a dose of the IV medication was "lost" and the pharmacy would not release a replacement dose. During this delay, the patient's IV became "clogged" and had to be removed, so the patient eventually had to receive the medication by injection after an additional delay.

Findings Detail: The patient had recently been hospitalized at another facility --- ---- for a respiratory and ear infection and presented to the emergency room at --- ---- on 12/29/05, with listlessness, vomiting, and a fever. Review of the patient's medical record revealed a physician order for Auralgan ear drops, oral Tylenol and Childrens Advil.

An interview with the Director of Pharmacy --- ---- was conducted on 5/9/06. He stated that the pharmacy has a "two hour turn around time to deliver medications," and that "pharmacists are encouraged to respond to patient care needs." However, the pharmacist explained that medications ordered prn or "as needed," are based on patient request and then communicated to the pharmacy by nursing staff. The eardrops were in the pharmacy formulary and available upon request. The physician ordered medications which included Auralgan ear drops, Tylenol drops and Childrens Advil/Ibuprofen. The pharmacist explained that oral Tylenol and Childrens Advil were effective for the treatment of earaches and generalized discomfort. The nurses use their professional judgment in administering medications and base this on patient care needs and specific patient requests.

In the clinical documentation record dated 12/29/05 at 9:30 P.M., there was an entry which stated "ear drops ordered prn (as needed) for pain." However, no documentation on the MAR (medication administration record) indicated that Auralgan ear drops had been administered by the nursing staff. The child had received one dose of Tylenol drops --- ---- and one dose of Advil suspension --- ----. On 12/30/05 at 11 minutes past midnight, it was documented, "pt (patient) resting quietly, appears comfortable." At 8:00 A.M., there was documentation patient "content in Mom's arms drinking pedialyte." No further dosings of Tylenol drops, Children's Advil or eardrops were documented on the MAR for 12/30/05. The child was discharged later that day.

To summarize, the allegation was unsubstantiated due to lack of sufficient evidence. No evidence was found in the medical record that the parents had requested additional medications on 12/30/05. No federal deficiencies were cited.

Policies and procedures were reviewed and a tour of the Pharmacy was conducted. Medications are sent via a pneumatic tube system to specific units. The Director of Pharmacy explained that replacement doses are prioritized. Medications are always sent immediately upon the request of a nurse or physician in an emergency. If medication has been sent and the nurse cannot find the medication, the RN (registered nurse) was advised to check the medication room again as several tubes can arrive at any time. If the medication cannot be located, the medication will be replaced as soon as possible. The Director explained that the turnaround time for filling new orders or modifying existing orders can take up to two hours from the actual time the written order was received in the central pharmacy. Nursing staff has a one hour time frame to administer the medication upon receipt of the dose on the unit. All medication distributions are recorded within the medication computer --- ---- system from the centrally located pharmacy to the patient care units.

On 12/30/05, at 11:30 A.M. the patient's IV (intravenous) site did infiltrate. The RN --- - --- consulted the physician --- ----. On 12/30/05, an order was obtained at 11:50 A.M. to change the same antibiotic --- ---- from the intravenous route to be administered IM (intramuscularly) at 1:00 P.M. The physician orders upon admission stated that the medication --- ---- was to be administered twice throughout the child's hospitalization. The antibiotic was to be given once every 24 hours. The initial dose was given on 12/29/05 at 9:10 P.M., and the second dose was administered before discharge on 12/30/05 at 3:46 P.M. The MAR indicated that the antibiotic injection was mixed with Xylocaine 1% for patient comfort and tolerance. The child was discharged with the parents at 4:15 P.M.

To summarize, the allegation was unsubstantiated. While the IV infiltrated earlier in the day, this incident did not affect the timing of the medication, only the route of administration. The parents received discharge instructions and the child was given the second dose of medication per physician order.