

## **Kaiser Permanente Complaint 6-23-06 thru 7-28-06**

To Whom It May Concern:

I found a full bag of "Vancomycin" hanging on my wife "Debra Moretta's" IV tree on (Thursday 7-20-06), while preparing to move her to the operating room. I immediately asked her nurse "Mario" what he knew about it. He said it was hanging there when he took over @ 7:00 A.M. He then showed me the bag that he had given to Debi @ 1:00 P.M. He also said that he had looked at the med sheet to see who had hung it, but all of Debi's meds were signed as if they had been given. From there he went to the refrigerator and found extra bags of Vancomycin with Debi's name on them.

At that point Mario and I walked over to "Helen Newman's" office. Helen is the Department Administrator, but was unfortunately away from her desk. From there I called "Linda Bodell". Linda is Helen's supervisor, and she told me to give the bag to "Martha" (The Charge Nurse). She also said she'd investigate the situation and get back to me.

A short time later I went back to Helen's office. I asked Helen for a copy of the med sheet, but she said they were in the middle of the investigation and would therefore not be willing to give me a copy. I then asked if all the meds had been signed for. She said that they had been, but that it was "not uncommon" for a nurse to sign the drugs off before they were actually given. She then told me to come back in the morning (Friday 7-21-06) and she'd give me the results of her investigation.

The following morning (Friday 7-21-06) I spoke with Helen Newman, but she said they were still investigating our Vancomycin mishap. She said they had one more nurse to interview before she could give me an answer. I asked her how many Vancomycin bags were found in the refrigerator with Debi's name on them, and she said two. She also said it was possible that the extra bags had been missing, or placed on someone else's refrigerator shelf and therefore the nurse(s) may have requested replacement bags from the pharmacy. Once again she told me that it was "not uncommon" for nurses to sign the med sheet before the drugs were actually given.

I waited for Helen Newman's answer until (Thursday 7-27-06). At that point I went back to her office. Helen had the bag that I found on Debi's IV tree in a plastic zip-lock type bag. She told me that she had questioned all of Debi's nurses, but every one of them claimed they had given Debi her Vancomycin. She also said she spoke to the pharmacy, but was told they do not keep records for Vancomycin. In other words, if a nurse requested a replacement bag from the pharmacy, the pharmacy would simply replace it without any type of record showing the request or replacement. Once again during our conversation, Helen acknowledged telling me that it was "not uncommon" for nurses to sign the med sheet before the drugs were actually given.

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At that point I thanked Helen for her efforts, but felt it was necessary for me to file a formal complaint with "Member Services". I also told her that I was going to speak with her supervisor "Linda Bodell" & contact "The Joint Commission".

From there I met with Member Services "Laurie Walsh" and filed a formal complaint. Afterwards I called "Linda Bodell". I told Linda what Helen had said with regards to nurses signing for drugs before they were actually given. I also told her I was going to contact "The Joint Commission". Linda said she would investigate the situation herself and asked me to wait until she had finished before calling "The Joint Commission"...I agreed.

The following day (Friday 7-28-06), Linda came to Debi's room to give us the results of her investigation. She said that all of Debi's nurses had been questioned, but each of them had said they gave Debi her Vancomycin. She also said that she contacted the pharmacy, but was told that no additional labels had been printed for Debi. Therefore no replacement Vancomycin had ever been ordered for her. As to Helen Newman's comment regarding nurses signing for drugs before they were actually given. Linda said that Helen denied ever telling me that. Linda did however acknowledged that there were extra bags, but said she did not know why.

Here's our dilemma: Debi was scheduled to receive Vancomycin @ 1:00 P.M. & 1:00 A.M. daily for treatment of "Staphylococcus Aureus". Given the fact that "Mario" gave Debi her 1:00 P.M. dose, there should have only been one bag left in the refrigerator, but "Helen Newman" said there were two. That coupled with the one hanging on her IV tree means there were two bags that Kaiser cannot account for.

As part of the Vancomycin complaint, it's important to note that I found the bag on (Thursday 7-20-06), yet the bag was spiked with tubing that was labeled in green "Change by Tuesday". Given the fact that the tubing is only good for four days, the bag was clearly spiked with outdated tubing. It's also important to note that the tubing was not connected to Debi's IV. It looked as though someone had hung it, but forgot to finish the job. See attached photo.

My second complaint is that during Debi's five-week stay at Kaiser Fontana, the vast majority of her nurses were not using the "Identi-Hide" labels. These labels are supposed to be affixed over the top of the patient's IV label before discarding. I personally witnessed nearly all of Debi's nurses simply tossing her infused IV bags in the trash without using these labels. At one point I actually removed a bag from the trash and asked her nurse why she would throw it away without covering Debi's medical information. She said she had done it because there were no labels in her room. I asked her to please get some and make sure they were used in the future. It's important to note that I spoke to both Linda Bodell & Helen Newman about these labels and the nurse's failure to use them. I also included it as part of my complaint with Member Services. See attached photo.

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I'd also like to mention that Debi suffered a horrific brain injury resulting from bacterial meningitis she contracted while undergoing chemotherapy for acute leukemia in March 2002. At that time Debi was under the care of the very same nurses station that cannot account of the extra Vancomycin we discovered. Also "Sunil J Patel M.D." was Debi's oncologist at that time. He is currently serving a seven-year probation period for the death of two of patients, yet he is also in charge of the Fontana Kaiser Oncology Department...why?

As a side note, the Fontana Kaiser Neonatal Ward was closed in March 2002 as a result of "Staphylococcus Aureus". Debi contracted bacterial meningitis at the very same time. <http://www.DebraMoretta.com>

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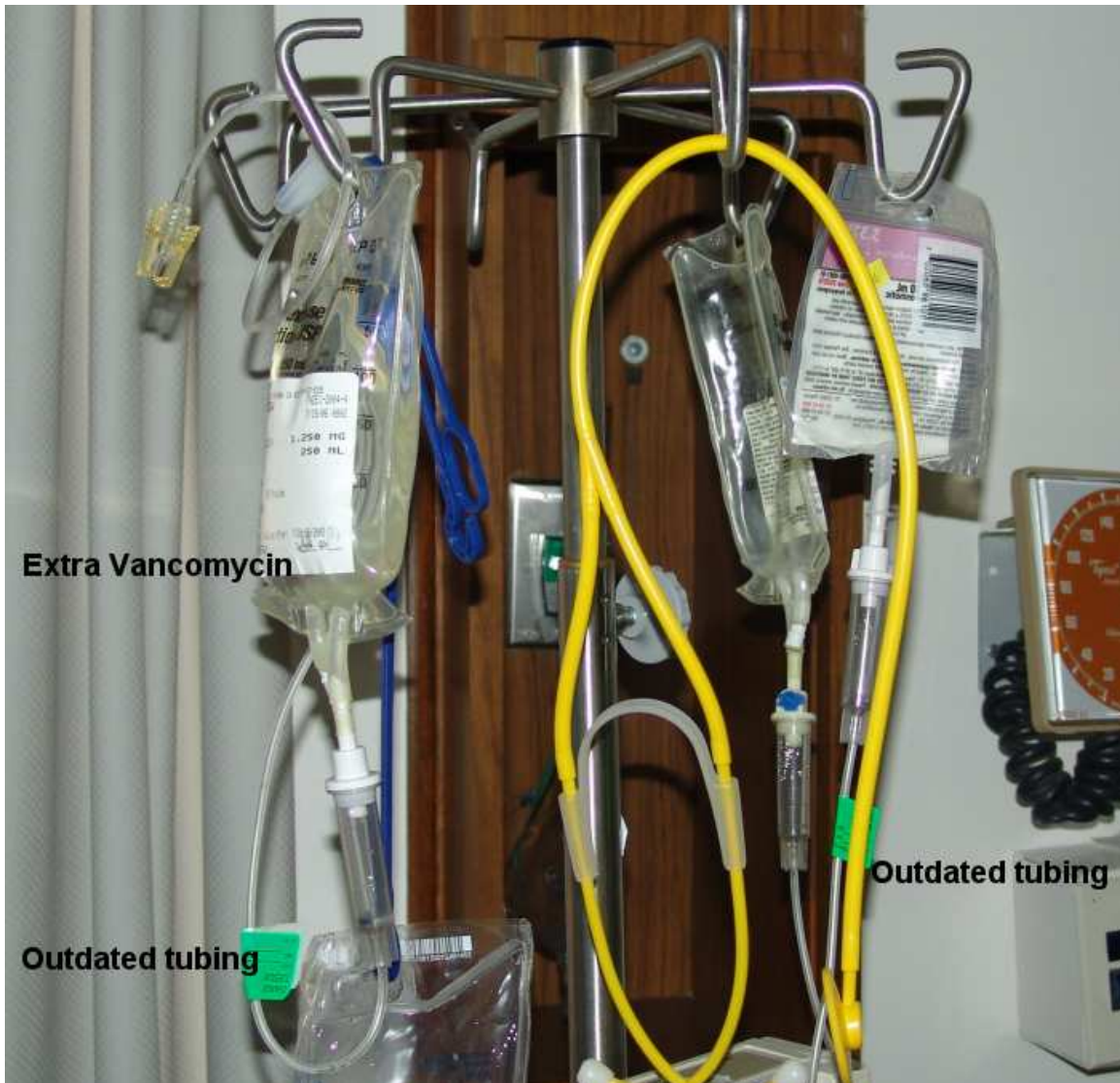
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Please help us get some more conclusive answers to these very troubling questions.

Thank you,

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