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
	050476	A. BUILDING _____ B. WING _____	10/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUTTER LAKESIDE HOSPITAL	5176 HILL ROAD EAST, LAKEPORT, CA 95453 LAKE COUNTY

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	The following reflects the findings of the California Department of Public Health during the investigation of an Entity Reported Incident. Representing the California Department of Public Health: Health Facilities Evaluator Nurse (HFEN) 1872. The inspection was limited to the specific complaints/entity reported incidents investigated and does not represent the findings of a full inspection of the facility. Incident/Complaint Number CA00152420 T22 DIV5 CH1 ART9-70223(b)(2) Surgical Service General Requirements (b) A committee of the medical staff shall be assigned responsibility for: (2) Development, maintenance and implementation of written policies and procedures in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate. Based on clinical record review, policy and procedure review, and staff interview, the hospital failed to ensure that the Surgical Service nursing staff implemented the policy and procedure titled, "Sponge and Sharps Count," resulting in a surgical lap pad (sponge)being retained in Patient 1's abdominal cavity		**Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by Health and Safety Code Section 1280.** **Action Plan for 70223 (b) (2)** **Sutter Lakeside Hospital has in place Medical Staff Committees with assigned responsibilities in the development, maintenance, and implementation of written policies and procedures.** **A Root Cause Analysis was conducted on 6/3/08. As a result, the following five action plans were developed and implemented.** **1) All surgery staff will review and demonstrate understanding of Policy and Procedure #PC 35-044, entitled "Sharps and Sponge Count" (the "Sharps and Sponge Count Policy").**	

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

Susan Meyers RN BSN Clinical Effectiveness Manager 3/30/09

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	Continued From page 1 following surgery. Patient 1 had to undergo another surgical procedure to remove the lap sponge, placing the patient at increased risk for complications due to the additional surgery and anesthesia. THE FOLLOWING EVENT CONSTITUTED AN IMMEDIATE JEOPARDY (IJ), WHICH PUT THE HEALTH AND SAFETY OF SURGICAL PATIENTS AT RISK WHEN NURSING STAFF FAILED TO IMPLEMENT THE HOSPITAL'S WRITTEN POLICY AND PROCEDURE TITLED, "SPONGE AND SHARP COUNT," AND IDENTIFY PRIOR TO SURGICAL CLOSURE THAT A LAP SPONGE WAS RETAINED IN THE PATIENT'S ABDOMEN. THIS FAILURE PLACED THE PATIENT AT RISK FOR INFECTION AND COMPLICATIONS FROM A SECOND SURGICAL PROCEDURE TO REMOVE THE LAP SPONGE. Findings: Review of Patient 1's clinical record on 6/13/08, indicated that Patient 1 was admitted to the hospital on 5/21/08 for a paraesophageal hernia repair and graft surgery on 5/21/08 at 7:30 a.m. Review of the Intraoperative Record dated 5/21/08, indicated that sponge counts were performed prior to the surgical procedure and prior to closing, and that both counts were correct. Review of the Report of Operation dated 5/21/08 revealed, "...Sponges placed to		Implementation: On 5/30/08, 6/13/08, and 7/11/08, all surgery staff reviewed the Sharps and Sponge Count Policy and demonstrated correct sharps and sponge counting technique to the RN Director of Surgery and/or Surgery Clinical Coordinator. 2) Association Operating Room Nurse (AORN) guidelines will be reviewed by the RN Director of Surgery to ensure the Sharps and Sponge Count Policy represents the current AORN standards. Implementation: In 6/08, the RN Director of Surgery reviewed the Sharps and Sponge Count Policy and determined that it met the current AORN guidelines. 3) The RN Director of Surgery will ensure preceptors for new employees are competent in the sponge count process by return demonstration. Implementation: In June, 2008, the RN Director of Surgery assessed all preceptors' competency in the sponge count process by observing the preceptors return demonstration.	7/11/08 6/30/08 6/30/08

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	Continued From page 2 facilitate exposure were also removed. Instruments and sponges were counted and confirmed times two ..." Review of the Imagining Report, dated 5/28/08, revealed, "Curvilinear density in the left upper abdomen concerning for a intra-abdominal foreign body, possibly a surgical sponge. Correlate clinically ...The findings of this study was discussed with [Patient 1's surgeon] on 5/28/08 at 12 p.m." Review of the Report of Operation, dated 5/28/08, revealed, "...There was a retained mini laparotomy sponge which was removed without difficulty." Review of the hospital's policy and procedure titled, "Sponge and Sharps Count", PC 35-044, review date 1/2008, demonstrated that the count protocol requires that sponges are counted audibly and viewed concurrently as they are separated and counted by two individuals, one of whom should be an RN, prior to the procedure, prior to wound closure, and at skin closure or end of procedure. The Surgical Tech stated in an interview on 6/13/08 at 1:55 p.m., that he performed a sponge count with a Registered Nurse prior to the procedure. The count was five large sponges, five small lap sponges, 10 Raytec sponges. The Surgical Tech stated that two sponges were inserted into the abdomen by the surgeon and two were removed. When		4) The RN Director of Surgery or designee will review the Intra-operative Record form for appropriateness and in-service surgery staff on the form and documentation process. Implementation: The Surgery Department's Unit Base Council revised the Intra-operative Record form to improve clarity and ease of use. The Risk and Quality Manager and the RN Director of Surgery conducted a documentation in-service for surgery staff on 9/4/08. 5) The RN Director of Surgery will review and assess available sponge count assist devices for the Main OR suites. Implementation: In 9/08, the Surgery Department purchased sponge count bags to support accuracy in large intra-abdominal cases. The Sharps and Sponge Count Policy was revised to include the addition of the sponge count bags to our procedure. The surgery department staff were in-serviced on the use of the sponge count bags and on the revised policy by the RN Clinical Coordinator.	9/4/08 9/12/08

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