

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050476	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/09/2008
NAME OF PROVIDER OR SUPPLIER SUTTER LAKESIDE HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 5176 HILL ROAD EAST, LAKEPORT, CA 95453 LAKE COUNTY		
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	<p>The following reflects the findings of the California Department of Public Health during the investigation of an Entity Reported Incident.</p> <p>Representing the California Department of Public Health: Health Facilities Evaluator Nurse (HFEN) 1872.</p> <p>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.</p> <p>Incident/Complaint Number CA00152420</p> <p>T22 DIV5 CH1 ART9-70223(b)(2) Surgical Service General Requirements</p> <p>(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.</p> <p>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</p>		<p>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.</p> <p><u>Action Plan for 70223 (b) (2)</u></p> <p>Sutter Lakeside Hospital has in place Medical Staff Committees with assigned responsibilities in the development, maintenance, and implementation of written policies and procedures.</p> <p>A Root Cause Analysis was conducted on 6/3/08. As a result, the following five action plans were developed and implemented.</p> <p>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").</p>	

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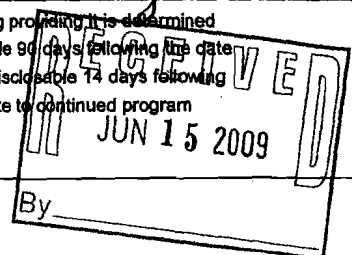
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(X6) DATE

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

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	<p>Review of the Report of Operation, dated 5/28/08, revealed, "...There was a retained mini laparotomy sponge which was removed without difficulty."</p> <p>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.</p> <p>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</p>		<p>5) The RN Director of Surgery will review and assess available sponge count assist devices for the Main OR suites.</p> <p><u>Implementation:</u> 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.</p>	9/12/08

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	<p>Continued From page 3</p> <p>asked, the Surgical Tech stated that he was not in the room the entire time of the procedure, but had informally performed a count with his relief before and after his break. The surgical tech stated that he did not know how they had missed the retained sponge.</p> <p>Review of the Authorization For and Consent to Surgery or Special Diagnostic or Therapeutic Procedures, dated 5/28/08, demonstrated that Patient 1 was notified of a need to remove a foreign body.</p> <p>Patient 1 stated, in an interview on 8/14/08 at 11:36 a.m., that the surgeon informed her prior to the second surgery that a sponge had probably been left in her abdomen.</p> <p>The Director of Surgical Services, stated during an interview on 10/9/08, that the facility had performed a Root Cause Analysis and the Surgical Services Committee would be informed of the report during the October meeting. The Director of Surgical Services stated that competency validation performed with the surgical nursing staff is done on initial orientation and that the annual validations are not operating room specific with the exception of conscious sedation. Competency is reviewed by reported errors and that the charge nurses and managers observe tasks performed by staff.</p> <p>The hospital failed to implement the sponge count policy, resulting in the requirement for</p>		<p>The Root Cause Analysis report was reviewed by the Surgery Sub-Committee on 11/28/08. The Sub-Committee recommended that the Sharps and Sponge Count Policy be revised to require a sponge count during any rest breaks, lunch breaks, and shift change. The surgery staff were in-serviced on the revised Policy by RN Director of Surgery in December, 2008.</p> <p><u>Monitoring Process:</u></p> <p>The Clinical Coordinator and RN Director of Surgery will conduct observational audits for compliance with the Sharps and Sponge Count Policy for one quarter, from April 2009 through June 2009.</p> <p>The RN Director of Surgery, Clinical Coordinator, or designee will audit 20 charts a month for one quarter in the Main OR and all surgical charts in the Family Birth Center beginning April 2009 through June 2009 for compliance with the Policy.</p> <p>There have been no reported incidents of retained sponges or foreign objects in the Surgery Department since 5/21/08.</p>	11/28/08
				6/30/09

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