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
	050373	A. BUILDING _____ B. WING _____	03/04/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAC+USC MEDICAL CENTER	1200 NORTH STATE STREET, LOS ANGELES, CA 90033 LOS ANGELES COUNTY

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	The following reflects the findings of the Department of Public Health during the investigation of COMPLAINT NO. CA00140041. Inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: [redacted] HFEN. HSC Section 1280.1(a) If a licensee of a health facility licensed under subdivision (a), (b) or (f) of Section 1250 receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an administrative penalty in an amount not to exceed twenty-five thousand dollars ($25,000.) per violation. c) For the purposes of this section "immediate jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to the patient. DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY T22 DIV5 CH1 ART3-70223(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		LAC+USC Healthcare Network maintains Operating Room Policies and Protocols to prevent the inadvertent retention of any foreign body during surgery. To address this incident, the Operating Room Nursing Management Team (Clinical Nursing Director, Nurse Managers and Supervising Surgery Nurse II's) convened a group to investigate the factors contributing to the event and to develop targeted corrective actions to prevent recurrence. **Policy/Procedures** To assure that LAC+USC Operating Room Policies meet Title 22 standards and effectively address the prevention of retained foreign body the Operating Room Nursing Management Team conducted a thorough review and analysis of the 'Sponge and Needle Count Policy' and the corresponding Protocol for documentation in the 'Perioperative Care Plan'. This review identified a lack of clarity in the policy regarding where and how the sponge and needle counts should be documented. It was this ambiguity that contributed to the failure to document, and therefore, complete the final sponge count. Additionally, staff had variable understanding of the policy contributing to confusion and potential for recurrence.	4/3/08 & Ongoing

Event ID:LCK011 7/21/2008 9:30:16AM

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Pete Delgado, Chief Executive Officer, LAC+USC Healthcare Network CEO 8/6/08

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	Continued From page 1 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 The above regulation was NOT MET as evidenced by: Based on clinical record review and staff interview, the hospital's operating room team for Patient B failed to implement the hospital's policy and procedure on sponge and sharp counting. As a result, Patient B had a repeat surgery to re-open his abdomen to retrieve the retained laparotomy sponge in the patient's right lower quadrant. Findings: On 2/13/08, review of the hospital's policy and procedure (P&P) on Perioperative Services Unit Specific Procedures, under supportive data, states that, "Surgical procedures have the potential for retention of sponges & sharps because of the nature of the proposed procedure or additional procedures necessitated by changes in the patient's condition. Unintended retention of a foreign body may result in physical injury to the patient." Further review of the P&P showed there should be three counts; the initial, intraoperative, and closing counts. Under closing counts, the P&P states that: 1. The circulating nurse and scrub person count together, audibly & in view of both; and sign on the perioperative patient care plan form #HS-1008.		OR Nursing Policy 'Sponge and Sharp Count' was updated and clarified to require three sponge and needle counts (initial, intraoperative and closing) and are now required to be documented by the circulating nurse in the new electronic perioperative care plan documentation system (ORSOS). Documenting the sponge and needle count in ORSOS significantly reduces the risk of missing forms or accidental oversight of any part of the count. Documentation cues in ORSOS provide consistent, predictable fields regarding sponge and needle counts that must be completed for every indicated surgical case. The new policies are scheduled for final Nursing Executive Council approval. **Education** In response to the deviation in protocol by the individual staff and the resulting change in protocol the following educational interventions were conducted: 1. The involved nurse was counseled specifically about the importance of the sponge and needle count and the need to adhere to specific documentation standards. 2. In-service to educate the OR staff on the new 'Sponge and Sharp Count' policy was conducted and all identified questions or issues were answered.	

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	Continued From page 2 2. The circulating nurse records count correct or incorrect on the perioperative patient care plan form HS#-1008. 3. Count needles (opened needles and unopened packages) at closure on every case/procedure without exception. 4. Count sponges at closure on every case or procedure except skin grafts, stereotaxic biopsy with no additional procedures, closed urology procedures, sigmoidoscopies/colonoscopies and percutaneous pinning. An additional procedure on incorrect closing count states that the surgeon should be notified of missing items so the surgeon can search the wound, the sterile and un-sterile fields. The incorrect count should be reported to the nurse-in-charge and appropriate forms should be filled out to report that the count was incorrect. Per record review on 2/13/08, Patient B was examined in the hospital's emergency room (ER) on [redacted]/08 due to generalized abdominal pain without a bowel movement and not passing any gas since the day before. It was noted by the ER physician that Patient B had undergone an open appendectomy on [redacted]/07. Patient B was diagnosed as having small bowel obstruction secondary to adhesions from the open appendectomy. Per the perioperative patient care plan, Patient B entered the operating room (OR) on [redacted]/08 at 0201 hours. It was recorded on the anesthesia record that surgery ended at 0325 hours of the same		3. The OR nursing staff was oriented to the new electronic perioperative care plan to assure their familiarity with the new documentation process. 4. Implementation of the new policy was initiated. **Quality Monitoring** To ensure the effectiveness of the implemented corrections the electronic perioperative record will be independently monitored for staff compliance with the new policy and procedure. The results of the monitoring will be tracked, trended and reported on a monthly basis to the Nursing Clinical Council for review and action as indicated. Additionally, Nurse Managers or designee will conduct unannounced, random, weekly visual quality control checks for compliance with the policy and procedure. These results will also be report to Nursing Clinical Council on a monthly basis. Individual counseling for non-compliance will be done by the Nurse Manager.	Ongoing

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	Continued From page 3 night. Patient B had an exploratory laparotomy operation with lysis of adhesions that caused his distal small bowel obstruction. Per report of the operation by the primary surgeon, dated [redacted]/08 at 0657 hours, the attending physician was present throughout the second portion of the procedure and all sponge, needle and instrument counts were correct at the end of the case. On [redacted]/08, a routine postoperative abdominal radiograph was obtained to assess the progress of the operation. The film revealed a drain in the right lower quadrant which upon further review was diagnosed as a retained foreign body. Patient B had to be taken back to the OR, general anesthesia was again induced, and his abdomen re-opened. The retained foreign body in the right lower quadrant and pelvis was identified to be a laparotomy sponge. Review of the perioperative care plan, dated [redacted]/08, revealed that on the first and second count of the sponges and sharps, only the initial of the circulating nurse was evident without the counter-initial of the scrub person. On the second count, only the sponges and sharps were counted but the instruments were not included. The document did not show that a third count was performed. The OR director was asked on 2/13/08 at 1520 hours about the case. She submitted a copy of a written statement of the circulating nurse which stated that correct sponge, needle and instrument counts were done before and after surgery with the		<u>Leadership</u> This event and the corrective action planning were presented and discussed at the quarterly Governing Body meeting. Follow-up pending actions and outcomes will be reported at future quarterly Governing Body meetings. **<u>Responsibility</u>** Chief Nursing Officer	

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	Continued From page 4 scrub person. When the OR director was asked how many counts should be done in abdominal surgeries, she stated that the circulating nurse and the scrub person should count sponges and "sharps" (needles and instruments) three times. These times were before surgery, in the middle of the surgery and during the closing of the surgery. When the record of operation was shown with only two of the three required counts and without the counter-initial, she made no comment. On 2/13/08 at 1545 hours, the scrub person was interviewed. He stated that the sponge count was correct before, in the middle and after the surgery. When the record of operation was shown, he could not remember why he had not initialed/signed the form and why the count was done only twice. In failing to implement its policy and procedure requiring three sponge counts during surgery, the hospital caused serious injury to the patient by subjecting him to another surgical procedure to remove the foreign body. The violation(s) has caused or is likely to cause, serious injury or death to the patient(s).			

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