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PRINTED: 12/21/2011
FORM APPROVED

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000912	A. BUILDING _____ B. WING _____	02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KECK HOSPITAL OF USC	1500 SAN PABLO ST LOS ANGELES, CA 90033

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 000	Initial Comments The following reflects the findings of the Department of Public Health during an investigation of an entity reported incident. Intake Number: CA00230939 - Substantiated Representing the Department of Public Health: [redacted], RN, HFEN 1280.1(c) Health and Safety Code Section 1280 For 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 likely to cause, serious injury or death to the patient.	E 000	Keck Hospital of USC maintains Operating Room policies and protocols to prevent the inadvertent retention of any foreign body during surgery. To address this incident, the hospital undertook several measures, including, but not limited to, to convening a multidisciplinary performance improvement group on June 15, 2010 to investigate the factors contributing to the event and identify opportunities to improve care and outcomes in order to prevent subsequent recurrence.	June 15, 2010 & Ongoing
E 347	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 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. This Statute is not met as evidenced by: Based on record review and interview, the facility surgical staff failed to implement their "Counts: Sharps and Sponges/Instruments policy and procedure during Patient A's surgical procedure. This failure resulted in retention of an electrocautery tip in the patient's chest cavity and subsequently subjected Patient A to an additional	E 347	This review identified a lack of clarity within the Surgery Department and associated Operating Room staff regarding the counting of cautery tips as required by the Keck Hospital policy, "Counts: Sharps and Sponges/Instruments."	

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E 347	Continued From page 1 surgical procedure under general anesthesia for the removal of the foreign object and who was placed at risk for additional complication such as bleeding, infection, shock, and changes in blood pressure, heart rate or heart rhythm. Findings: On February 22, 2011, an unannounced visit was conducted at the facility to investigate an entity-reported incident of a retained foreign object after a surgical procedure on Patient A. A review of the facility letter to the Department dated May 25, 2010, indicated Patient A was admitted to the facility on [redacted] 2010 for " redo of an aortic valve repair. " During the post-operative period in the intensive care unit (ICU), a chest X-ray was completed and revealed a retained foreign object overlying the patient ' s right hemidiaphragm. The retained foreign object was a tip from an electrosurgical pencil cautery (a device used to cauterize the tissue following a surgical incision and provide hemostasis{a process which causes bleeding to stop}). On February 22, 2011, a review of the clinical record of Patient A disclosed the patient was admitted to the facility on [redacted] 2010, with a diagnosis of aortic insufficiency. According to the Operative Record dated [redacted] 2010, Patient A underwent a redo of a sternotomy and aortic valve replacement. After the surgery, the patient was transferred to the Intensive Care Unit (ICU). A review of the Intraoperative Nursing Record dated [redacted], 2010, disclosed three counts of "sponge, needle and instrument " were conducted and all three counts were documented	E 347	**Actions Taken** The following education and interventions were conducted by the group: 1. The involved Operating Room staff were counseled by perioperative management specifically about the importance of counting cautery tips and the need to adhere to the requirements of the policy.	May 19, 2010
			2. An in-service was conducted for the entire Operating Room Staff regarding counting cautery tips and all questions and issues were answered.	July 23, 2010
			3. All new employees receive orientation to and a copy of the "Counts: Sharps and Sponges/Instruments" policy upon hire.	Ongoing
			4. Annual performance appraisal and competencies for all employers will now include a review of the "Counts: Sharps and Sponges/Instruments."	January 3, 2012

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E 347	Continued From page 2 as being correct. A review of Patient A's Chest X-ray report dated [redacted] 2010, at 3:05 p.m. disclosed a " foreign density " (approximately 5 millimeters (mm) x 2 mm) was noted over the right inferior chest. According to the Computer Tomography report dated [redacted], 2011, at 6:52 a.m., a 6 centimeters " linear metallic foreign body" was seen in the right anterior mediastinum. A review of the Operative Report dated [redacted], 2009, dictated at 10:30 a.m., disclosed Patient A had a video-assisted thoracoscopic procedure under general anesthesia to remove a retained foreign body. According to the operative report, the electrocautery tip was removed from Patient A's right chest. During an interview with Employee 3 (Registered Nurse) at the facility on February 25, 2011 at 8:38 a.m., she stated she had failed to conduct the count of the electrocautery tip with Employee 4 (Surgical Technician) during the surgical procedure on Patient A on [redacted], 2010. An interview was conducted with Employee 2 (Perioperative Director) on February 25, 2011 at 9:30 a.m. She stated Employee 3 and 4 counted sponges and needles but not the electrocautery tip. According to Employee 2, both Employee 3 and 4 failed to follow the facility's policy and procedure titled,"Counts: Sharps and Sponges/Instruments." A review of the facility's policy and procedure titled,"Counts: Sharps and Sponges/Instruments" dated as last revised in February 26, 2008, stipulated "the sharp counts includes, but are not	E 347	**Actions Taken Continued** 5. Ongoing evaluation of potential like events have been continuously monitored since this event, with no similar cases reported. **Quality Monitoring** To ensure the effectiveness of the implemented education and interventions, specifically, compliance with Keck Hospital of USC counting policy, unannounced, random quality control checks will occur for 300 cases between January 1, 2012 and December 31, 2012. Results will be reported to the Performance Improvement Committee and the Surgery Committee. **Responsibility** Associate Administrator, Perioperative Services	May 19, 2010 & Ongoing Ongoing

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E 347	Continued From page 3 limited to, suture needles, scalpel blades, and cautery tips." The facility's failure to implement its policy and procedure to prevent retention of an electrocautery tip during a surgical procedure for Patient A is a deficiency that has caused, or likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of the Health and Safety Code Section 1280.1.	E 347		