STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050224	A. BUILDING _____ B. WING _____	04/28/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOAG MEMORIAL HOSPITAL PRESBYTERIAN	ONE HOAG DRIVE, NEWPORT BEACH, CA 92663 ORANGE COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
	The following reflects the findings of the Department of Public Health during the investigation of COMPLAINT NO: CA00147573 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], MD 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 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) § 70223. 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			

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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 interviews and a review of the closed medical record for Patient A, the medical staff failed to ensure that policies for surgical instrument counts had been implemented. This resulted in a second general anesthetic requiring re-intubation (insertion of an assistive breathing tube) and a second abdominal surgery for Patient A. Findings: On 4/28/08 Hospital Policy and Procedure #1.354, dated 3/21/08, identified that surgical instruments used on the sterile field were to be counted during surgery "whenever the depth and location of the wound is such that the item could be lost or left in a patient. Only in the event of extreme patient emergency will the count be waived. Instrument counts are done...before wound closure begins. All parts of all instruments must be accounted for. Counts are done audibly. The start of the closing count should be announced to the entire surgical team. Counting logs must be visible in the room." This policy was not implemented for Patient A as follows: A review of the closed medical record on 4/28/08			

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	Continued From page 2 revealed that Patient A came to the hospital on 4/14/08 for surgical services. Admitting diagnoses included: renal mass, horseshoe kidney, diabetes mellitus, lung cancer, thyroid cancer and a pelvic mass. At 1307 hours on 4/14/08 Patient A was induced with general anesthesia and the surgical procedure started at 1330 hours. A right renal mass was removed and then the patient had an exploration of the right lower abdomen. At 1215 hours on 4/28/08, a review of the anesthesia record with the Director of Anesthesia, interviews with RN 1 and RN 2 and a review of the closed medical record for Patient A revealed that Patient A had been fully extubated (assistive breathing tube for anesthesia removed) despite the fact that the surgical instrument and sponge counts for Patient A had not been completed. Patient A was retained in the operating room, with the anesthesiologist in attendance, at the time that the surgical instrument count was being completed. RN 2 stated that the instrument count was determined to be incorrect. She stated that she then notified the surgeons, who had left the operating room that a malleable retractor blade and handle were missing and absent from the final instrument count. RN 2 stated that MD X and MD Y requested radiographs of the abdomen to document that the malleable retractor had been retained in Patient A. According to the anesthesia record, at 1655 hours,			

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the retractor was identified as being retained within the abdomen of Patient A. The anesthesia record revealed that general anesthesia was again induced and Patient A re-intubated (breathing tube re-inserted) without difficulty. The perioperative nursing record revealed that a "Bookwalter retractor blade was identified by the operating surgeon, patient re-draped for exploration and retrieval for foreign body."

At 1930 hours, the nursing notes revealed that Patient A remained intubated while in the Post Anesthesia Care Unit, but was then extubated by the attending anesthesiologist after blood gases were obtained.

During the interviews conducted on 4/28/08, at 1300 hours, the nursing director of perioperative services stated that interviews with nursing staff had been conducted as part of the hospital's internal investigation. These interviews revealed that the instrument, sharps and sponge counts were ongoing and required additional staff because of the fact that five surgical packs had been opened.

The director of perioperative services stated that combined surgical procedures, such as that for Patient A, required additional nursing staff to be summoned to the operating room to assist in the counts. She stated that surgeons frequently closed the abdomen, to avoid unnecessary prolonged anesthesia time, while the instrument counts were being completed. This is in violation of the policy of the hospital. For Patient A, the skin

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	Continued From page 4 had been closed and the surgeons had left the operating room prior to the time the instrument count had been completed. Subsequently the missing retractor was identified as being absent and presumably in the abdomen of Patient A. Interviews with RN 1 and RN 2 at 1300 hours on 4/28/08 indicated that the initial count was started during the surgical procedure but not completed until after the operating surgeons had left the room and the patient had been extubated by the anesthesiologist. RN 2 stated that she summoned the surgeons to inform them that the instrument was missing. A portable x-ray of the abdomen for Patient A revealed that the retractor had been retained in the abdomen of Patient A. RN 2 stated that Patient A was re-draped and re-prepared for a second procedure. Patient A was re-intubated by the attending anesthesiologist without difficulty and the procedure performed. The violation(s) has caused or is likely to cause, serious injury or death to the patient(s).			

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