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
	250000507	A. BUILDING _____ B. WING _____	C 10/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST HEALTHCARE SYSTEM	25500 MEDICAL CENTER DRIVE MURRIETA, CA 92562

(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 California Department of Public Health during a complaint visit. Complaint # CA00151535 Inspection does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: [redacted], HFEN The Department was able to substantiate a violation of the regulations Abbreviation List: CT - Computerized Tomography OR - Operating Room ORM - Operating Room Manager POD - Peri Operative Director Stat - Immediately X - Times	E 000		
E 264	T22 DIV5 CH1 ART3-70213(a) Nursing Service Policies and Procedures. (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to follow their policy and procedures by failing to ensure all surgical counts were performed resulting in a retained surgical	E 264	Response to Complaint # CA00151535 T22 DIV5 CH1 ART3-70213(a) Nursing Service Policies and Procedures A. What corrective action will be accomplished for the patient(s) identified to have been affected by the deficient practice? The patient identified to have been affected by the deficient practice was returned to surgery for removal of the instrument.	05/22/08

09 JUL 31 PM 3:35
CA DEPT OF PUBLIC HEALTH
LICENSING & CERTIFICATION
RIVERSIDE COUNTY

Licensing and Certification Division

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CNO — (X6) DATE: 7/29/09

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E 264	Continued From page 1 instrument in one patient (Patient A). Findings: The facility's policy and procedure titled, "Sponge, Sharp and Instrument Count" was reviewed and stipulated the purpose was to provide quality patient care, to ensure perioperative patient safety by accounting for sponges, sharps and instruments used during a surgical procedure and preventing those items from being retained in a surgical wound. The policy and procedure defined instruments as surgical tools or devices designed to perform a specific function such as dissecting, cutting, grasping, retracting, holding or suturing. The facility's policy further indicated the circulating registered nurse will ensure that all surgical counts are performed to account according to unit specific standards and may request additional counts at any time, the circulating registered nurse must participate in and document all counts performed during a surgical procedure and the primary responsibility for initiating all surgical counts lies with the circulating registered nurse, all personnel participating in the operative procedure are responsible for correct counts. The facility's procedure for surgical counts indicated the scrub nurse and the circulating nurse should count consecutively and the initial sponge, sharp, instrument and miscellaneous item count will be taken on all abdominal, thoracic and retroperitoneal procedures, or any procedure in which the depth and location of the would presents a significant risk for retained foreign bodies.	E 264	Continued from page 1 B. How other patients having the potential to be affected by the same deficient practice be identified, and what corrective action will be taken. All patients having surgery in which the peritoneum is being closed are identified as a potential to be affected. As the peritoneum is being closed the staff will account for anything that is touching the patient. Before the surgeon leaves the room, the circulator and scrub tech will reconcile all instruments touching the patient. C. What immediate measures and systemic changes will be put in place to ensure that the deficient practice does not recur. Staff education done at the daily Board Rounds, Director and/or Manager reviewed surgical count policy to re-emphasis this aspect of care. During the instrument count that begins as the peritoneum is being closed, the staff will account for anything that is touching the patient. - Using a white board, the circulator will note as "IN" any instrument touching the patient or in use by the surgeon. - At the conclusion of the case, before the surgeon leaves the room, the circulator and scrub tech will reconcile all instruments of the type noted on the "IN" Board. For example, if the board indicates that a malleable retractor is "IN" during closing, at the conclusion of the case, the Circ & Tech will recount all of the malleable retractors for a full reconciliation. This will be done for each instrument on the "IN" Board.	06/04/08 06/04/08

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In addition, the facility's policy and procedure indicated the scrub person and the circulating nurse will take counts concurrently and if there was any uncertainty about a count, it will be repeated. Sponges, sharps and instruments added to the sterile field during the procedure will be counted.

On June 10, 2008, at 11:50 a.m. and October 21, 2008, at 11:45 a.m., visits were made to the facility for the purpose of investigating a self reported event regarding a retained surgical instrument. An interview was conducted with the POD at that time. She stated, "An instrument count is done prior to closing. Once the wound is closed, a sponge count is done, but not instrument (count). If any trays are added, that is accounted for." The POD also stated the facility identified the instrument was retained because there were two surgeons that were not familiar with each other's technique.

A review of Patient A's record was conducted on June 10, 2008, at 12:10 p.m. Patient A was a 22-year-old female admitted to the facility on May 20, 2008, with uterine contractions. The patient had a vaginal delivery of a female infant on May 21, 2008. On post delivery day one, the patient began to complain of increasing left upper abdominal pain. The physician wrote orders for stat blood draw, that showed the patient's hemoglobin (a component in the blood that carries oxygen to the cells from the lungs and carbondioxide away from the cells to the lungs) dropped from the initial admission value of 12.4 down to 7.8. After a CT scan showed free fluid in the abdomen and the patient's heart rate increased, the patient was taken to the OR for emergency and exploratory surgery When the

D. A description of the monitoring process and positions of persons responsible for monitoring. How the facility plans to monitor its performance to ensure corrections are achieved and sustained.

The Perioperative Services Director will be responsible for monitoring the process for success. The perioperative nursing leaders will directly observe the process to ensure compliance. An update will be provided at the Department of Surgery meeting on 07/10/08. 09/04/08

E. Dates when the corrective action will be completed.

09/04/08 complete. 09/04/08

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surgeon found the bleeding was coming from the splenic area, a vascular surgeon was consulted intraoperatively and the surgical repairs were made.

A review of the first surgical report failed to show documentation indicating an instrument count was performed.

According to the record, postoperatively, on May 22, 2008, a CT angiogram was ordered to rule out any further bleeding or aneurysm and a foreign body was found left in the abdomen after surgery The patient was taken back to surgery and a malleable retractor (A surgical instrument made of flexible metal which can be molded to different shapes to assist in holding back tissues) was removed. The Postoperative Diagnosis was, "...Foreign body in abdomen...."

On October 21, 2008, at 11:45 a.m. an interview with the ORM was conducted. She stated, during surgery there were two surgeons that usually did not work together. The ORM stated both physicians turned to look at the x-rays. The ORM stated, "In the count the technician and the circulating nurse were present...It was the technician's duty to watch where the instruments were." She was unable to state the reason the technician was not watching the surgical field to prevent the retractor from being left in the patient. The ORM stated, "The malleable that was used was about 10 inches long by two inches wide"

A review of Patient A's Discharge Summary revealed, ".. Vaginal delivery of a 34 viable female infant. Exploratory laparotomy and splenectomy for a ruptured splenic aneuryxm...Return to OR for exploratory laparotomy on the same day of splenectomy

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E 264	Continued From page 4 secondary to retained foreign body.. Postoperatively, a CT angiogram was ordered to rule out any other possible aneurysm and was noted that a foreign body was left after the surgery and the patient was taken back to the OR on the same day and a malleable retractor was removed from her abdomen...." The facility failed to ensure their policy and procedure for Sponge, Sharp and Instrument Count was followed by failing to ensure an instrument count was performed as per policy resulting in the failure to provide quality of patient care The facility failed to ensure perioperative patient safety by failing to account for a 10 inch by two inch surgical instrument used during surgery which was retained in the surgical wound.	E 264			