

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050129	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2009
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NAME OF PROVIDER OR SUPPLIER ST BERNARDINE MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2101 N. WATERMAN AVE, SAN BERNARDINO, CA 92404 SAN BERNARDINO COUNTY
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The following reflects the findings of the California Department of Public Health during a complaint/adverse event visit.

Complaint Intake Number: CA00181368

Representing the California Department of Public Health: [REDACTED], HFEN

The inspection of the facility was limited to the specific entity-reported incident investigated and does not reflect the findings of a full inspection of the facility.

Health & Safety Code Section 1280.1 (c): For the purpose 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.

Based on observation, interview and record review the facility failed to ensure that Patient 1 did not retain a foreign object in her pharynx (throat) after being intubated prior to receiving anesthesia while in the operating room. For Patient 1 the Anesthesiologist (Physician A) failed to ensure that the blade extender tip for an adult Bullard laryngoscope (a rigid fiber optic laryngoscope that allows for rapid visualization of the larynx which reduces the amount of positioning and manipulation necessary for inserting an oral airway), that was put on by the Anesthesia Technician, was securely attached to the blade before inserting the Bullard laryngoscope into the oral airway of Patient 1,

Report Clarification:
① The patient's anatomy was unusual which was discovered once the intubation process was started. The Anesthesiologist could not intubate this patient with the routine laryngoscope and blades. The Anesthesiologist then asked for the Bullard laryngoscope which had the snap-on extender to better facilitate this difficult intubation.

Immediate Action:
① Bullard laryngoscope and an extender was reviewed for possible malfunction. Equipment was determined to be functioning properly.

3/10/09

Event ID:9WXJ11

12/9/2009

12:02:44PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Suzanne Morril, Director of Quality/Risk

TITLE

(X6) DATE

12/21/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Continued From page 1
which resulted in the blade extender tip being retained in the throat of Patient 1 after the Bullard blade was extracted. The retention of the blade extender tip in Patient 1's airway had the potential to result in imminent danger due to occlusion of the airway, as a result of aspiration of the blade extender tip.

REGULATION VIOLATION:
T22DIV5 CH1 ART3-70237 Anesthesia Service Equipment and Supplies
(a) There shall be adequate and appropriate equipment for the delivery of anesthesia and postanesthesia recovery care.
(1) The anesthetist shall check the readiness, availability, and cleanliness of all equipment used prior to the administration to the anesthetic agents.

FINDINGS:
During an interview with the Director of Quality Risk Services (DQRS), on 3/26/09 at 9:35 AM, the DQRS stated that Patient 1 had under gone an outpatient laparoscopic cholecystectomy (removal of the gallbladder from the abdominal cavity by making several small incisions in the abdomen to allow the use of a camera and other instruments used to excise and remove the gallbladder) on [REDACTED], and during a routine follow-up phone call to the patient on [REDACTED] 9, Patient 1 informed the hospital staff that she had "coughed up a piece of white plastic." The DQRS stated that Patient 1 brought in the piece of white plastic to the facility, and photographs were taken. The DQRS stated that the Anesthesiologist (Physician A) identified the white plastic, in the photograph, as the

② Anesthesiologist involved in the incident and the Division Chair for the Anesthesia Division of the Medical Staff reviewed the case and discussed difficult intubation techniques.

③ Anesthesiologist involved in the incident took responsibility to provide education to the Anesthesia technicians who could be asked to assist in assembling equipment during a "difficult" intubation.

3/10/09

3/11/09

Event ID:9WXJ11 12/9/2009 12:02:44PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Stephanie Mowll, Director of Quality/Risk</i>	TITLE <i>12/21/09</i>	(X6) DATE
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extender tip of the Bullard laryngoscope that he used to intubate Patient 1. During the interview the DQRS stated that it was the Anesthesia Technician who attached the extender tip on the blade of the Bullard laryngoscope before Physician A used the Bullard laryngoscope to intubate Patient 1 prior to receiving anesthesia. During the interview the DQRS, an observation of an extender tip revealed that the extender tip was a white, firm plastic approximately 5 cm (centimeters) in length, approximately 3.5 cm in width at the base, approximately 1.5 cm in width at the tip, and .5 to .75 cm in depth.

The clinical record for Patient 1 was reviewed on 3/26/09. The clinical record indicated that Patient 1 was a [redacted] year old [redacted] admitted to the facility on [redacted] with diagnosis of [redacted] with [redacted].

Review of the "Operative Report "dated [redacted] indicated that Patient 1 had a laparoscopic cholecystectomy under general endotracheal anesthesia that had been administered by Physician A.

Review of the "Intraoperative Anesthesia Record" dated [redacted], indicated that Physician A used the Bullard laryngoscope to intubate (insertion of a tube through the mouth used to maintain an open airway) Patient 1 in the operating room prior to receiving anesthesia.

During an interview with Anesthesia Technician 1 (AT 1) on 3/26/09 at 9:50 AM, AT 1 stated that he

④ Anesthesia Division of the Medical Staff discussed the use of this piece of equipment. The decision was to keep the Bullard laryngoscope and extenders in the "Emergency" Airway cart for difficult intubations. 3/31/09

⑤ Competencies will be developed for use during the Annual Skills evaluation of the Anesthesia technicians. 12/31/09

Monitoring:

① Anesthesia Division of the Medical Staff will monitor cases/techniques that require the use of the "Emergency" airway cart for difficult intubations. Ongoing

Event ID:9WXJ11 12/9/2009 12:02:44PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Suzanne Mowell Director of Quality/Resid* TITLE *12/21/09* (X6) DATE

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	<p>Continued From page 3</p> <p>had attached the extender tip to the Bullard laryngoscope used by Physician A on Patient 1. During the interview, AT 1 presented a Bullard laryngoscope and demonstrated how the white plastic extender tip is attached to the end of the blade. During the demonstration, AT 1 stated that when the extender is properly attached, it snaps in place, and requires the use of forceps to remove it from the blade. During the interview AT 1 stated, "It (the white plastic extender tip) probably came off because I did not put it on properly, it is suppose to snap in place."</p> <p>During a telephone interview with Physician A on 3/26/09 at 3:15 PM, during the interview Physician A stated that he did not notice that the extender tip was no longer attached to the Bullard blade after he extracted the blade from the throat and mouth of Patient 1. Physician A stated that he had been working at the facility for a few months, and was told that the staff was familiar with the Bullard laryngoscope, but stated that after the incident that he did not think the staff was knowledgeable about the assembly of Bullard laryngoscope. During the interview, Physician A stated that AT 1 attached the extender tip to the blade of the Bullard laryngoscope, but stated that he (Physician A) took full responsibility for the extender tip blade being retained in the throat of Patient 1.</p> <p>The facility's failure to ensure that Patient 1 did not retain a foreign object in her pharynx (throat) after being intubated prior to receiving anesthesia while in the operating room, is a deficiency that has caused, or is likely to cause, serious injury or</p>		<p><u>Monitoring - Cont.</u></p> <p>② Facility Administrative staff and Facility Risk Management/designee will be notified of the use of the "Emergency" Airway cart via the internal variance process. This will allow for further evaluation of the patient outcome and equipment utilization.</p> <p style="text-align: right;"><i>ongoing</i></p>	
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12/9/2009

12:02:44PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Suzanne Monell</i>	TITLE <i>Director of Quality/Risk</i>	(X6) DATE <i>12/21/09</i>
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death to the patient, and therefore constitutes an immediate jeopardy within the meaning of the Health and Safety Code section 1280.1 (c).

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12/9/2009

12:02:44PM

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Suzanne A. Mowell Director of Quality/Risk

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