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
	050047	A. BUILDING _____ B. WING _____	01/08/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PACIFIC CAMPUS HOSPITAL	2333 BUCHANAN STREET, SAN FRANCISCO, CA 94115 SAN FRANCISCO COUNTY

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	The following reflects the findings of the Department of Public Health during a Complaint Investigation visit. Representing the California Department of Public Health: [redacted] R.N. Health Facilities Evaluator Nurse Health and Safety Code Section 1280.1(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. Title 22 70213 (b) Nursing Service Policies and Procedures (b) Policies and procedures shall be based on current standards of nursing practice and shall be consistent with the nursing process which includes: assessment, nursing diagnosis, planning, intervention, evaluation, and, as circumstances require, patient advocacy. 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		Please accept this Plan of Correction as our allegation of compliance. State of California CDPH – L&C NOV 16 2009 Daly City Dist. Office **The correction is accomplished by:** 1. The physician's performance has been addressed by the Medical Staff leadership. **Responsible person:** Department Chair, Orthopedic Surgery **Monitoring Process:** 1. All surgical cases performed at CPMC by Surgeon 1 from 10/01/08 to 2/28/09 were reviewed. Compliance with the timeout / verification process was documented at 100%.	10/08 2/09

Event ID:6LE511 10/30/2009 1:44:15PM

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Teresa Carney RN, Director Risk Management		11/12/09

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

11/17/09

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	Continued From page 1 staff where such is appropriate. Based on interview and' record review, the surgeon failed to implement the facility's Process for Verification of Operative or Invasive Procedure (Time Out) policy and procedure prior to beginning Patient 1's surgery. The circulating nurse failed to advocate for the safety and positive surgical outcome for Patient 1 when she failed to tell the surgeon that a time out was required prior to beginning the procedure. These failures resulted in Patient 1 having surgery on the wrong knee, the surgeon proceeded to do the surgery on the correct knee (left) after. Findings: Patient 1 was admitted to the hospital on 9/24/08 for a left knee arthroscopy (examination of the interior of a joint with an endoscope). On 9/26/09, the facility notified the Department that the surgeon performed an arthroscopy of the right knee. During an interview on10/1/08 at 3:05 p.m., the Risk Manager stated "They should have done a time out but they didn't do one, they went straight into the procedure." She stated when the surgeon realized the mistake, he proceeded to do an arthroscopy of both knees even though the consent form was for the left knee only. Review of Patient 1's record on 10/1/08 at 3:15		**The correction is accomplished by:** 1. Nursing staff were re-educated to their responsibility to speak up and stop the process if they believe patient safety may be compromised. 2. Concurrent monitoring of the Pre-Procedure Verification process with focus on Time-out, Site-marking and the completion of the pre-procedure checklist is done routinely in the operating rooms and the procedure areas on all campuses. 3. Monitoring results reveal 100% compliance for the 3rd and 4th quarters of 2008 and the 1st and 2nd quarters of 2009. (audit results are attached) 4. Develop and implement an enhanced Universal Protocol / Verification process that includes the Joint Commission 2009 NPSG standards and recommendations for the World Health Organization (WHO) Surgical Safety Checklist. The revised policy and Procedure for *Universal Protocol* was presented to the Surgery and Operating Room committee (Surgical Service Chiefs) for their input and approval in January and February 2009. (CPMC Administrative Policy 2.98, *Universal Protocol* is attached) 5. Inservice education regarding the policy changes and the Procedure Safety checklist was provided to the Surgical Services team in person and via video-conference on February 26 and 27, 2009. (agenda is attached)	11/08 On-going Ongoing 1/09 to 3/09 2/09

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	Continued From page 2 p.m. indicated a consent to surgery form which listed the following procedure: " Left arthroscopy, possible menisectomy (excision of a part of the knee joint), possible repair, possible chondroplasty (plastic repair of cartilage)." The authorization was signed by Patient 1 on 9/24/09 at 12:40 p.m. Patient 1's intraoperative record was reviewed and showed that no time out was performed prior to the beginning of Patient 1's surgery. The facility's Process for Verification of Operative or Invasive Procedure (Time Out) policy and procedure indicated the following: General Information: Verifying the operative site is a team effort that begins with the physician's assessment and formulation of the surgical/procedural plan and ends at the completion of the procedure or surgical operation. The physician performing the procedure is responsible for ensuring that the patient, the procedure, the site/side or level are identified, the correct patient position, and if required, marked. Additionally other members of the procedure/operative team are responsible to perform checks to ensure the correct patient has the correct procedure performed at the correct site. Procedure: The following steps are to be taken prior to beginning the procedure/operation. prior to "Time Out"		**Responsible persons:** Medical Director, Surgical Services Director, Surgical Services Clinical Manager, Surgical Services **Monitoring Process:** Concurrent monitoring for compliance is completed each month. Audit results are reported quarterly to the Procedure Area Committee and then to the hospital Quality Improvement Committee which is a committee of the CPMC Medical Staff. Reports and minutes of the Quality Improvement Committee are reported to the Board.	

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	Continued From page 3 1." Time Out" or immediate preoperative pause, must occur in the location where the procedure will be done. The "timeout" may precede induction of anesthesia or may occur after the patient is anesthetized but before starting the procedure. 2. The "timeout" must involve at a minimum participation by the surgeon/procedure physician, anesthesia provider, and circulating/procedure nurse. The physician performing the procedure using active communication, will verbally confirm the patient, procedure, site/side and marking (if required), correct patient position and if applicable implants, special equipment and requirements. The patient's signed consent is present and referenced during this process. The physician uses active communication and involves the entire team. 3. Any unresolved differences or failure to identify patient, site/side or procedure must be reconciled utilizing the Administrative Policy, Chain of Command 2.01. On 10/29/09 at 2:25 p.m., Circulating Nurse 1 was interviewed and stated she went to the preoperative holding area to bring Patient 1 to the operating room. She stated she checked the surgical consent which indicated that Patient 1 was scheduled for a left knee arthroscopy. She said the surgical site was marked on Patient 1's left upper thigh. After she brought Patient 1 to the operating room,			

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	Continued From page 4 Surgeon 1 proceeded to position Patient 1's right leg, she prepped the patient's right knee and the surgeon draped Patient 1's right knee. She said that shortly after the surgeon started the procedure, the anesthesiologist checked Patient 1's consent form and told Surgeon 1 he was operating on the wrong knee. When asked if a time out was done prior to Patient 1's surgery, Circulating Nurse 1 responded "No." She stated the time out was not done because everything was "rushed" and she was intimidated by Surgeon 1. She said Patient 1's surgery was running late because of the previous surgery, that it was changed to a different operating room at the last minute and it was her first time working with Surgeon 1. She said she was intimidated by Surgeon 1 so she did not feel comfortable telling him a time out had to be done prior to beginning Patient 1's procedure. She stated "If it was a different surgeon, I would have felt more comfortable saying' wait, time out needs to be done' " She acknowledged that she failed to act as an advocate for Patient 1 when she allowed herself to be intimidated by Surgeon 1 and failed to tell him that a time out had to be done prior to beginning Patient 1 's procedure. On 10/29/08 at 2:35 p.m. ST 1 was interviewed. He stated he set up the operating room for Patient 1's procedure, took a break and when he returned, the patient's knee was positioned, prepped and draped and Surgeon 1 has scrubbed to begin surgery. ST 1 said			

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	Continued From page 5 Surgeon 1 began the procedure and after a while he heard the anesthesiologist ask "What leg are you doing?" Surgeon 1 responded "The right one." At this point the anesthesiologist informed the surgeon that Patient 1 's consent was for the left knee. ST 1 stated he asked if a time out was done but got no response. Surgeon 1 finished the patient's right knee and then proceeded to do the left knee. During an interview on 10/29/08 at 2:45 p.m., the Surgical Services Manager stated the time out procedure is a team process, She said the facility's policy and procedure specifies the physician performing the procedure is responsible for initiating the time out but that any team member can act as a patient advocate and initiate the time out. She also said that nurses and surgical technicians are expected to call the physicians attention to the fact that a time out was not done. The Surgical Services Manager stated that there is a process that the nurses and surgical technicians should follow if a physician refuses to do a time out. Patient 1 had surgery on both knees instead of the left knee which had the potential to affect his post operative recovery. Having surgery on both knees can cause increased pain and decreased ability to ambulate after the surgery. The facility's failure to ensure that Surgeon 1 initiate and implement its Process for			

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	Continued From page 6 Verification of Operative or Invasive Procedure (Time Out) and Circulating Nurse 1's failure to act as an advocate for Patient 1 is a deficiency that has caused, or is likely to cause, serious injury or death to the patient, and therefore constitutes an immediate jeopardy within the meaning of Health and Safety Code section 1280.1			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Teresa Carney RN, TITLE: Director Risk Management, (X6) DATE: 11/12/09

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