

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  050373	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  08/13/2008
NAME OF PROVIDER OR SUPPLIER LAC+USC MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 NORTH STATE STREET, LOS ANGELES, CA 90033. LOS ANGELES COUNTY		
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	<p>The following reflects the findings of the Department of Public Health during the investigation of COMPLAINT NO: CA00157362.</p> <p>Inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the facility.</p> <p>Representing the Department of Public Health: [REDACTED]</p> <p><b>DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY</b></p> <p>CCR, Title 22 DIV5 CH1 ART3- 70223(b)(2) - Surgical Service General Requirements</p> <p>(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.</p> <p>The above regulations were NOT MET as evidenced by:</p> <p>Based on record review and staff interview, the hospital failed to implement existing policy and procedures thereby failing to ensure accurate</p>		<p>LAC+USC Healthcare Network maintains policies and procedures to provide for the planning and delivery of patient care in compliance with Title 22 Div 5, Article 3 regarding Surgical Services.</p> <p>In response to the self reported retained surgical sponge, LAC+USC initiated an intensive review of the sponge count process and how it is documented in the medical record.</p> <p><u>Action</u> In review of the case it was determined that the nursing staff involved failed to adhere to LAC+USC OR policy and procedure regarding the documentation of sponge counts. The Nurse Manager of the OR verbally counseled each staff involved with an emphasis on compliance with the sponge and needle count documentation.</p>	<p>6/30/08</p> <p>7/1/08</p> <p style="writing-mode: vertical-rl; transform: rotate(180deg);">2009 APR 27 PM 4:27</p>

Event ID: Z17311

3/12/2009

9:14:04AM

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

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4/29/09

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	<p><b>Continued From page 4</b></p> <p>binding) and Quikclot was applied on the pelvis to control the bleeding. The previous bowel connections were reexamined and were proven to be intact. Again, the pelvis was repacked using 1 single laparotomy pad "to achieve meticulous hemostasis (the arrest of bleeding)." Attempt was made to close the abdomen but was found difficult secondary to severe swelling of the abdomen. Temporary closure of the abdomen was again achieved by placement of a wound V.A.C. abdominal dressing. Toward the end of the report of operation, it was noted that, "All sponge, needle and instrument counts were correct at the end of the case."</p> <p>On 6/25/08, Patient X went back to OR for removal of a laparotomy pack and closure of the abdominal cavity. The pack was removed with no additional bleeding noted. The abdominal cavity was closed with no documented evidence by the nursing staff that the intra-operative count and the closing count was initiated before the skin closure, as required by the P&amp;P. The surgeon documented "The sponge, lap, needle and instrument counts were correct."</p> <p>Per the record of operation on 7/13/08, Patient X returned to the hospital on 7/13/08 with a fever of 102 degrees Fahrenheit as well as worsening abdominal pain. A C.T. (computed tomography) scan demonstrated a retained foreign body, most likely a laparotomy sponge. Patient X was taken to the OR again for</p>			<p>709 APR 27 PM 4: 27</p>

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	<p>Continued From page 5</p> <p>abdominal exploration and removal of the foreign body. "The peritoneal cavity was entered and immediately upon entering the peritoneum, a copious amount of pus was encountered. The abscess cavity was irrigated with two liters of warm sterile saline."</p> <p>On 7/24/08 review of the Record of Operation and Perioperative Patient Care Plan revealed that the sponge and sharp count recorded on the three surgical procedures, dated 6/22/08, 6/23/08 and 6/25/08, were executed only once during each OR procedure instead of the minimum three counts as required by the hospital's P&amp;P.</p> <p>On the first surgical procedure performed on 6/22/08, the Perioperative Patient Care Plan form revealed that there was no intraoperative and closing sponge and sharp count recorded. A laparotomy sponge pad was intentionally left by the surgeon that rendered the sponge count incorrect, as stated in the P&amp;P, yet there was no indication on the form that the count was incorrect.</p> <p>Per report of operation on 6/23/08, it was documented by the surgeon that all sponge, needle and instrument counts were correct at the end of the case. However, the review of the Perioperative Patient Care Plan of 6/23/08 demonstrated again that only an initial count was recorded without the required intraoperative and final closing sponge and sharp count.</p>			2009 APR 27 PM 4:27	

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	<p>Continued From page 6</p> <p>The sponge pad applied to help control the bleeding during the first surgery on 6/22/08 was removed during the second surgery, 6/23/08. However, continuous bleeding was noted and again, a sponge pad was purposefully left by the surgeon rendering the sponge count incorrect, yet no staff initial was found on the respective slots to denote that the sponge and sharp count was incorrect. Instead, both circulating nurse and scrub technician documented their initials on the correct slots of the sponge count.</p> <p>On 6/25/08, Patient X went back to surgery for removal of the laparotomy pad and closure of the abdominal cavity. Per report of the operation, it was documented that the sponge, needle and instrument counts were correct at the end of the case. However, only an initial count was done without the required intraoperative and closing counts.</p> <p>On 7/24/08 at 0945 hours, the Chief of the Trauma Surgery was interviewed. He stated that a "damage control" approach was used to save the patient's life during the first surgery. Severe use of packing was done to temporarily stop the bleeding then care for the patient further in ICU. The patient, once stabilized, was taken back to OR for more repairs and possibly more packing until the bleeding was corrected. He stated that there was a good possibility that one of the operating surgical residents forgot to tie the multiple packing</p>			2009 APR 27 PM 4:27	

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	<p>Continued From page 7</p> <p>together during the first surgery wherein some sponges may have been lost in the abdominal cavity.</p> <p>On 7/24/08 at 1100 hours, the Director of OR declared that she did not know exactly what happened. It was either they counted wrong from the very beginning or they added extra sponges and did not account for it. She made no comment when the Perioperative Patient Care Plan forms were shown containing only the initial count with no middle or final count on three surgical procedures.</p> <p>The violation(s) has caused or is likely to cause, serious injury or death to the patient.</p>			7:19 APR 27 PM 4:27

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