The following reflects the findings of the Department of Public Health during a Complaint Investigation visit.

The following reflects the findings of the Department of Public Health during the investigation of COMPLAINT NO: CA00172310.

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: [红acted], HFEN

DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY

CCR, Title 22 DIV5 CH1 ART3- 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 staff where such is appropriate.

The above regulation was NOT MET as evidenced by:

Based on record review and staff interview, the hospital failed to implement the existing

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perioperative policy and procedure (P&P) for surgical sponge counts and to utilize x-rays instead of fluoroscopy to locate foreign bodies unintentionally retained inside the patient's abdomen. The failure resulted in Patient Z having repeat abdominal surgery under general anesthesia to retrieve 2 laparotomy towels and 3 laparotomy sponges that were left inside the patient's abdomen.

Findings:

On 2/10/09, in the hospital's perioperative P&P, policy #108, the "supportive data" stated that surgical procedures had the potential for retention of sponges and sharps. Unintended retention of a foreign body might result in physical injury to the patient.

Other supportive data stated that x-ray detectable elements facilitated locating any item presumed lost or left in the cavity when a sponge/needle/instrument count discrepancy occurred. Towels with radiopaque markers were to be used in open wounds. The scrub person was expected to keep track of all countable items (i.e., sponges, instruments) additionally placed on the sterile field to assure accuracy while the circulating nurse was expected to electronically document the final count.

On intraoperative counts, all countable items should be counted at the time of change of nursing personnel. The nursing personnel would record and electronically sign the perioperative documentation.
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On “Incorrect closing count - Intentional & Non-intentional,” it stated that surgeons should be notified of missing items and should be asked to search the wound. A physician’s order should be requested for x-rays and the x-ray department should be notified for the x-ray films to be read by a radiologist. The circulating nurse would communicate to the Radiology Department the immediate need for the films to be read.

Per clinical record review on 2/10/09, Patient Z was admitted to the hospital on 12/12/08 via ambulance due to a gunshot wound to the abdomen. Patient Z was taken to the operating room on an emergency basis due to low blood pressure attributed to losing blood.

Review of the record of operation on 12/12/08 revealed that Patient Z entered the operating room (OR) at 2225 hours and left the OR area at 0549 hours on 12/13/08. The initial sponge/sharp/instrument count was performed at 2225 hours by Circulating Nurse #3 and Scrub #1. By 2300 hours, a shift change of OR nursing personnel occurred. A shift sponge/needle/instrument count was noted at 2325 hours on the record of operation; however, it was electronically entered late at a different date on 12/13/08, instead of 12/12/08, by Circulating Nurse #4 and Scrub #2. There was no other documentation presented that Circulating Nurse #3 and Scrub #1 were present during the shift count. The next count, recorded as the first closing count, was executed at 0400 hours, dated 12/13/08, by

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(A) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
050373

(B) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:

(C) DATE SURVEY COMPLETED:
05/06/2009

NAME OF PROVIDER OR SUPPLIER
LAC+USC MEDICAL CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1200 NORTH STATE STREET, ROOM 1110, LOS ANGELES, CA 90033 LOS ANGELES COUNTY

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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Circulating Nurse #4 and Scrub #2 who both performed the final closing count at 0456 hours. Moreover, it was stated on “count comments” that the staff were “unable to clarify count due to lap sponges in abdomen at change of shift. X-rays were taken after surgical procedure. X-ray result negative.”

Per the report of operation on 12/12/08, the patient underwent exploratory laparotomy/celiotomy (surgical incision of the abdomen) with wound packing temporarily while repairing the major vein, pancreas and small bowel lacerations. The patient also underwent further exploration to rule out injury to the stomach, liver and spleen. At the end of the case, the sponge/sharp/instrument counts were reported by the nurse as all correct and there was no complication noted. But, “prior to leaving the operating room and extubating the patient (removing the assistive breathing tube), the abdominal and pelvic cavities were examined using fluoroscopy, to again rule out the possibility of any retained surgical foreign bodies present in the abdomen. No evidence of retained foreign bodies was noted.” Patient Z was transferred to the intensive care unit (ICU) on 12/13/08 at 0610 hours for further care and recovery. The use of fluoroscopy instead of the standard x-ray failed to detect 2 laparotomy towels and 3 laparotomy sponges left in Patient Z’s abdomen. There was no documented evidence a radiologist read the fluoroscopy films as per the hospital’s P&P.

On 12/13/08, Patient Z was noted to have a fever and was slightly tachycardic (having fast heart...


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rate). Further evaluation for a retained bullet ensued, a possible reason for fever and resulting fast heart rate.

The trauma team's progress notes stated that by 1800 hours on 12/13/08, multiple plain abdominal x-rays were taken to locate the bullet without confirmation. However, foreign bodies were detected in the right and left upper abdomen. The concern was that the foreign bodies were laparotomy sponges. It was noted on the progress notes that it was discussed with the wife that the foreign bodies identified on the x-ray should be removed though they were not likely to be the bullet. A CT (computerized tomography) scan was requested by the patient's family to be expedited to confirm the location of the foreign bodies.

By 2016 hours on 12/13/08, Patient Z entered the OR again for the second time for removal of foreign bodies in the abdomen. The second report of operation stated that the trauma surgeon's attention was first turned to the right upper quadrant where 2 radiopaque laparotomy towels were identified and removed. Subsequently, the surgeon's attention was focused to the left upper quadrant where 3 laparotomy sponges were removed. Further review of the record of operation showed that x-ray films as described in the P&P, and not fluoroscopy, were obtained to ensure no further laparotomy sponge was left in the abdomen. Patient Z was transferred back to ICU after confirmation of the final x-ray film.

On 3/5/09 at 1315 hours, the OR nurse manager was asked regarding the shift count. She stated...
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that the sponge/needle/instrument count at change of shift was a must. She was unable to explain why it was documented late on the day following Patient Z's first surgery and without the presence of the staff being relieved of duty.

In an interview with the attending trauma surgeon on 3/5/09 at 0935 hours, she was unable to explain how the abdominal towels and sponges were missed during the first surgery. She stated that she obtained numerous x-rays to confirm no foreign object was left in Patient Z's abdominal surgery before leaving the OR area after the second surgery.

The violation(s) has caused or is likely to cause, serious injury or death to the patient.

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