The following reflects the findings of the Department of Public Health during the investigation of COMPLAINT NO: CA00141168

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: [Redacted], HFEN.

HSC 1280.1 (a) HSC Section 1280

1280.1 (a) If a licensee of a health facility licensed under subdivision (a), (b), or (f) of Section 1250 receives a notice of deficiency constituting an immediate jeopardy to the health or safety of a patient and is required to submit a plan of correction, the department may assess the licensee an administrative penalty in an amount not to exceed twenty-five thousand dollars ($25,000) per violation.

(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.

DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY

T22 DIV5 ART3-70223(b)(2) Surgical Service General Requirements

(b) A committee of the medical staff shall be
## Corrective Action Plan

(A) 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. Policies shall be approved by the administration and medical staff where such is appropriate.

This REGULATION: is not met as evidenced by:

Based on interview and record review, the nurse and anesthesiologist did not verify the surgery site with Patient #1 in the OR, the surgical procedure was written on the surgical count board prior to the time out, and the patient's history and physical were not reviewed during the time out. The hospital failed to follow their universal policy and procedure to prevent wrong site surgery being performed on the wrong knee for Patient #1.

### Findings:

On 3/3/08, review of the hospital's policy and procedure named "Universal Protocol to Prevent Wrong Person, Procedure, Site Operations And/or Procedures" showed the nurse and anesthesiologist would verify the correct person, procedure and site and this would occur with the patient's involvement in the OR suite if possible. The policy and procedure also showed the nurse confirms the consent, history and physical, and surgery schedule for accuracy during the time out. Additionally, the policy and procedure showed the
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operative site/side will be written on the surgical count board after the time out has taken place and correct site/side verified.

During interview, on 3/3/08 at 1250 hours, pre-operative RN A stated that the surgery schedule for Patient #1's surgery showed the patient was to have a right knee arthroscopy on 2/15/08. However, when the preoperative RN interviewed the patient, he stated the surgery was for the left knee. According to pre-operative RN A, she then notified the surgery desk charge RN, in person, about the need to change the surgery schedule to designate the left knee as the operative site. She also stated she called into the OR (operating room) suite and spoke with the anesthesiologist about the correction. Pre-operative RN A stated she also went into the operating suite and spoke with the surgeon about the change on the surgical consent from the right to the left knee.

Review of the facility's records on 3/3/08, showed a surgery schedule listing Patient A as scheduled for "arthroscopy/chondroplasty/debridement/synovectomy knee, right." The word right had been crossed out and the word left was hand-written in.

Review of the patient's medical record showed an authorization for surgery form with the operation as "arthroscopic debridement chondroplasty meniscectomy medial left knee."

On 3/3/08 at 1135 hours, OR technician B was interviewed. The OR technician stated the patient...
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was awake upon arrival in the OR suite. The OR technician stated there was no mark on the patient's right leg. The OR technician stated the procedure was written as right leg on the board located in the OR suite.

At 1200 hours on 3/3/08, Circulating Nurse C was interviewed. The nurse stated she had spoken with Patient #1 in the preoperative area and saw that the left knee was marked when she went to bring the patient to the surgery suite. Nurse C stated when she went to set up the patient for the surgery; she set up for a right knee surgery. She also stated she wrote right knee on the count board next to the word "procedure." As she was preparing the patient for the surgery she noted the absence of a "mark" on the right knee and also that no surgical prep had been done on the right knee. The nurse stated she and the anesthesiologist used two patient identifiers (for example, ID bracelet and stating patient name to patient) to identify the patient, however a procedural verification was not done with the patient.

Nurse C also stated a time out was done prior to the surgery and the surgeon read the consent out loud as right knee. The nurse stated the history and physical was not reviewed during the time out prior to the surgery.

Nurse C stated the error was discovered when the patient woke up in the recovery room and became aware of the error.

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