**AMENDED**

The following reflects the findings of the California Department of Public Health, during the investigation of COMPLAINT NO: CA00168546.

Inspection was limited to the specific complaint(s) investigated and does not represent the findings of a full inspection of the hospital.

Representing the California Department of Public Health, HFEN

DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY

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 staff interview, review of policies/procedures, and medical record review, the hospital failed to ensure implementation of written policies and procedures addressing sponge counts resulting in five sponges retained in the surgical operating suite for removal of retained sponges. The responsible circulating nurse was provided 1:1 education regarding the correct sponge count process as identified in the organization’s policy and procedure.

A. The patient was returned to the operating suite for removal of retained sponges. The responsible circulating nurse was provided 1:1 education regarding the correct sponge count process as identified in the organization’s policy and procedure.

B. All patients undergoing operative procedures were identified at risk. The operating room staff received additional inservices related to the organization’s policy and procedure pertaining to sponge counts, including the process for communication hand-off during break relief.

C. The OR sponge count boards in all the OR suites were relocated to ensure maximum visibility by the entire team. The Director of Surgery incorporated inservices related to the sponge count policy and procedure into the new hire and annual reorientation/competency validation process.

D. A PI indicator was added to the surgery department’s PI plan to assess compliance with the sponge count policy and procedure, and results were reported to the PI Committee, minimum of quarterly, beginning 3rd Q, 2007
Continued From page 1

wound of Patient #1. Patient #1 required another major surgery and the risks of general anesthesia to remove the retained sponges.

Findings:

On 1/27/09, review of the policy, "Sponge, Needle, and Instrument Counts," revealed the statement "When additional sponges, needles/sharps are added, they are counted and the number is added to the count documentation."

Medical record review for Patient #1 revealed an operative report dated 6/8/07 documenting Patient #1 had undergone a laparoscopic, converted to open, appendectomy. Review of the operating room record revealed the documentation that the sponge counts were correct.

Medical record review revealed an operative report dated 6/8/07 documenting that Patient #1 had undergone an exploratory laparotomy with control of bleeding and evacuation of hemoperitoneum. Review of the operating room record revealed the nurse documented that the sponge counts were correct.

Medical record review revealed an operative report dated 6/13/07 documenting Patient #1 had undergone a re-exploration with removal of foreign bodies under general anesthesia. In the operative report, the surgeon documented that there were five laparotomy sponges that were seen on x-ray. All five laparotomy sponges were removed.

Event ID: JJZZ11 4/8/2009 8:56:30AM
Continued From page 2

On 1/27/09, during interview, staff disclosed that the hospital, upon investigating the incident, had discovered that during the operative procedure on 6/8/07, one of the circulating nurses had introduced a five-pack of laparotomy sponges into the sterile field and had failed to enter the count on the worksheet or grease board. Staff stated, and the operating room record reflected, that other operating room staff had relieved the original operating room staff for breaks during the procedure. Staff explained that since other team members were not aware of the extra five sponges, when the subsequent counts were performed, the count appeared correct.

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