

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>050197</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/10/2016</b>
NAME OF PROVIDER OR SUPPLIER <b>SEQUOIA HOSPITAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>170 Alameda De Las Pulgas, Redwood City, CA 94062-2751 SAN MATEO COUNTY</b>		
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	<p>The following reflects the findings of the Department of Public Health during an inspection visit:</p> <p>Complaint Intake Number: CA00477434 - Substantiated</p> <p>Representing the Department of Public Health: Surveyor ID # 33819</p> <p>The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility.</p> <p>Health and Safety Code Section 1280.3(g): 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.</p> <p>Glossary of Definitions:</p> <p>Hysterectomy: Surgical removal of the uterus.</p> <p>Salpingectomy: Surgical removal of the Fallopian tubes, the tubes through which an egg travels from the ovary to the uterus.</p> <p>Oophorectomy: Surgical removal of the ovaries, the part of a woman's reproductive system that stores and releases eggs for fertilization and produces female hormones.</p> <p>Appendectomy: Surgical removal of the appendix, a small tube connected to the digestive system and</p>			

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

TITLE

(X6) DATE

*Mary Christensen* Director - Quality 11/10/16

By signing this document, I am acknowledging receipt of the entire citation packet, Page(s) 1 thru 15

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.

*POC Accepted. Acting HFES. 11/22/16*

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	<p>located at the junction of the small and large intestines.</p> <p>Symptomatic leiomyomata uteri: benign muscle tumors of the uterus.</p> <p>Universal protocol: a procedure requiring a time out prior to beginning surgery, a practice that has been shown to improve teamwork and decrease the overall risk of wrong-site surgery.</p> <p>Time Out: The pause right before surgery begins and is intended to make everyone slow down and check what they are about to do. The Time Out confirms site, patient, and procedure.</p> <p>OR: Operating Room</p> <p>RN: Registered Nurse</p> <p>Circulator RN: a registered nurse whose function is to monitor the procedures in operating rooms during surgery. During operations and other surgical procedures, the circulator assists by acting as an intermediary between the operating room staff and the rest of the hospital.</p> <p>H &amp; P: Called a "history and physical", is part of a medical record that documents the patient's status,</p>			

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	<p>reasons why the patient is being admitted for to a hospital or other facility, and the initial instructions for that patient's care.</p> <p>Operative Report: A document produced by a surgeon or other physicians who have participated in a surgical intervention, which contains a detailed account of the findings, the procedure used, the specimens removed, the preoperative and postoperative diagnoses.</p> <p>Pathology Report: the document that contains results of the examination of tissue removed during a biopsy or surgery.</p> <p>Health and Safety Code 1279.1(c)</p> <p>"The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made."</p> <p>The CDPH verified that the facility informed the patient or the party responsible for the patient of the adverse event by the time the report was made.</p> <p>Health and Safety Code 1280.1(c)</p> <p>(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.</p> <p>Health and Safety Code 1279.1(b)(1)(A)</p>		<p><b>T22 DIV5 CH1 ART3-70223(d)</b> <b>Corrective action(s) accomplished for patient identified by the deficient practice:</b></p> <p>Attending surgeon and Sequoia Hospital's Risk and Patient Safety Manager met with affected patient following surgical event on 2/19/2016 and agreements were reached with the patient regarding appropriate clinical monitoring and provision of appropriate medication therapy.</p>	

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	<p>(b) For purposes of this section, "adverse event" includes any of the following: (1) Surgical events, including the following: (A) Surgery performed on a wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.</p> <p>T22 DIV5 CH1 ART3-70223(d) Surgical Service General Requirements (d) Prior to commencing surgery the person responsible for administering anesthesia, or the surgeon if a general anesthetic is not to be administered, shall verify the patient's identity, the site and side of the body to be operated on, and ascertain that a record of the following appears in the patient's medical record:</p> <p>This RULE: is not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to perform the correct surgery for one sampled patient (Patient 1), when:</p> <p>1. There was no verification of the correct procedure and site/side/level, with the physician or physician's office staff when the scheduling request was received. Therefore, the surgical procedure was not entered correctly in the surgical schedule according to the History &amp; Physical (H &amp; P), and consent.</p> <p>2. The admitting Registered Nurse (RN 1), did not</p>		<p>Issue 1- No verification of correct procedure and site/side/level, at the time of procedure scheduling.</p> <p>Corrective Action Plan: Verification of the correct patient and procedure at the time of scheduling by the physician's office staff is not considered a reliable process for procedural verification. Therefore, Sequoia Hospital's Universal Protocol for Surgical and Invasive Procedures policy does not all use of the Procedural Schedule to conduct the final verification of patient, procedure, and site/side/level</p> <p>100% of medical staff members and surgical staff members involved in the wrong surgical procedure were counseled and re-educated about requirement to use the signed consent form and H&amp;P to correctly verify the patient, surgical procedure, and site/side/level, on the day of the error was known.</p> <p>100% of Operating Room RNs, Cardiac Cath Lab RN's, Labor and Delivery RNs, Procedure Room RNs, and Endoscopy RNs were re-educated never to rely on the surgical/procedural schedule to verify the patient, surgical procedure, and site/side/level. Instead, the Hospital's policy requires use of the signed consent form and H&amp;P to correctly verify the patient, surgical procedure, and site/side/level</p>	<p>02/19/16</p> <p>04/01/16</p>

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	<p>document the procedure verification based on H &amp; P and consent; and did not document the same prior to moving Patient 1 to the procedure area.</p> <p>3. A Registered Nurse (RN 2), who received Patient 1 into the procedural area, did not verify correct patient, correct procedure based on H &amp; P and consent.</p> <p>4. The facility did not follow their policy and procedure when the surgeon was allowed to lead the Time Out procedure instead of the circulator nurse.</p> <p>This adverse event constituted an immediate jeopardy which placed the health and safety of Patient 1 at risk when Patient 1's ovaries were mistakenly removed during surgery, and as a result she will need to be on estrogen replacement therapy for life.</p> <p>Findings:</p> <p>Patient 1 was admitted on 2/18/16 with diagnosis of symptomatic leiomyomata uteri (benign muscle tumors of the uterus), for surgery to remove the uterus, fallopian tubes and appendectomy. Record review of a facility form titled "Consent to Surgery or Special Procedure" showed Patient 1 signed on 2/17/16 at 4:30 PM for the indicated handwritten procedure: "Laparoscopic hysterectomy- removal of both fallopian tubes - appendectomy".</p>		<p>Our Universal Protocol for Surgical and Invasive Procedures policy was revised and approved by the Medical Staff to indicate that when the physician or physician office staff contacts the Hospital's surgical scheduling staff, the correct patient name, the date of the intended procedure, and the name of the intended procedure is obtained from the physician or physician staff in order to schedule the appropriate date, time, surgical supplies and equipment. Per Universal Protocol for Surgical and Invasive Procedures policy revision, the surgical/procedural schedule will never be relied on to verify the procedure, patient, and site/side/level during the procedural "Time Out".</p> <p>Education regarding requirement to use the signed consent form and H&amp;P to correctly verify the patient, surgical procedure, and site/side/level was provided to anesthesiologists and surgeons at multiple meetings of the Departments of Anesthesia, Surgery,</p> <p>100% of Operating Room RNs, Cardiac Cath Lab RN's, Labor and Delivery RNs, Procedure Room RNs, and Endoscopy RNs (not on leave of absence) were required to review and attest to understanding the revised Universal Protocol for Surgical and Invasive Procedures policy. RN's working in these procedural areas that have not reviewed the revised policy, because they are on LOA or otherwise not working, will review and attest to understanding the revised Universal Protocol for Surgical and Invasive Procedures policy prior to returning to work.</p> <p>100% of surgical and anesthesiologist members of the Medical Staff received written notification of the requirement to use the signed consent form and H&amp;P to correctly verify the patient, surgical procedure, and site/side/level.</p> <p>Person Monitoring Corrective Action: Director of Surgical Services</p>	<p>08/17/16</p> <p>09/08/16</p> <p>09/30/16</p> <p>09/30/16</p>

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	Record review of a form titled "Request for Surgery Booking" dated 1/27/16 3:06 PM, identifying Patient 1 medical record number, name and date of birth, indicated under "Surgery date: 2/18/16..." and under "Procedure with laterality: TCH (total complete hysterectomy), BSO (bilateral salpingo oophorectomy), appy (appendectomy)...".		Issue 2 – The admitting nurse (RN 1) did not verify the correct patient and procedure based on the written informed consent and the H&P when the patient came into her unit and when moving the patient to the procedure room.  Corrective Action:  The admitting nurse involved (RN 1) was immediately counseled and re-educated to verify the patient, surgical procedure, and site/site/level based on the written informed consent and the H&P.	02/19/16
	Record review of a document titled: "Surgery Case Statistics" dated 02/18/16 containing the roster of surgeries for the day, indicated Patient 1 was scheduled for "Procedure: Laparoscopic hysterectomy, BSO (bilateral salpingo oophorectomy, appendectomy)".		100% of Operating Room RNs, Cardiac Cath Lab RN's, Labor and Delivery RNs, Procedure Room RNs, and Endoscopy RNs (not on leave of absence) were re-educated to correctly verify the patient, procedure and side/site/level based on the written informed consent and the H&P. RN's working in these procedural areas that have not received the education, because they are on LOA or otherwise not working, will receive this education prior to returning to work.	04/01/16
	Record review of a printed copy of the electronic record titled "Preop H&P" signed by the surgeon (MD) on 02/18/16 at 12:11 PM indicated under "Plan: A total laparoscopic hysterectomy with bilateral salpingectomy is planned. We will save the ovaries and incidental appendectomy will be performed...She (Patient 1) has decided on the above plan...".		100% of Operating Room RNs, Cardiac Cath Lab RN's, Labor and Delivery RNs, Procedure Room RNs, and Endoscopy RNs (not on leave of absence) were required to review and attest to understanding the revised Universal Protocol for Surgical and Invasive Procedures policy. RN's working in these procedural areas that have not reviewed the revised policy, because they are on LOA or otherwise not working, will review and attest to understanding the revised Universal Protocol for Surgical and Invasive Procedures policy prior to returning to work.	09/30/16
	Record review of a printed copy of the electronic record titled "Operative Report" signed by the MD on 02/19/16 at 17:08 PM, indicated under "Title of Operation: Total laparoscopic hysterectomy, bilateral salpingo-oophorectomy, ....and incidental appendectomy...".			

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	<p>Record review of a facility policy titled: "Universal Protocol Policy and Procedure" dated "3/2014" indicated under "Purpose: ...is to promote patient safety by ensuring that processes are defined and followed to ensure the correct surgical or invasive procedure is performed for the correct patient at the correct side/site/level...". Under "Verification Process:...A. At the time the procedure is scheduled... C. At the time of admission or entry into the facility for a procedure D. Before patient leaves the pre-procedure area E. Upon arrival to the procedure area E. Immediately prior to the procedure..."</p> <p>During a 4/27/16 at 12:45 PM interview with Director of Quality Services(DQS), Risk Manager(RM), and Director of Perioperative Services (DPS), DQS acknowledged from the moment of scheduling the procedure the documentation had the wrong procedure: "...BSO (bilateral salpingo oophorectomy) was written and that was the wrong procedure...". Asked about the verification of the procedure from the time the "Request for Surgery Booking" facility form was faxed to the scheduling office from the physicians office, DQS stated: "That was just a request for a time slot from the doctor's office...". RM stated: "The documentation is less than optimal...we need to change the language in our Universal Protocol Policy..."</p>		<p>Immediately following the event, a checklist/tracer tool was developed and ten (10) surgical cases per month are observed and monitored by the Peri-operative Director or Manager using the tracer tool/checklist to ensure 100% compliance with the verification process of utilizing the written informed consent and H&amp;P to correctly verify the patient, procedure and side/site/level at the time of patient admission to the pre-operative area, patient entry into the surgical area, prior to administration of anesthesia, and prior to commencing the procedure.</p> <p>In June 2016, the checklist/tracer tool was revised and implemented as a checklist for O.R. staff to utilize for validation of all elements of the Universal Protocol. The checklist/tracer is used for all patients undergoing procedures in the Operating Room.</p> <p>The Peri-operative Director audits a minimum of 50% of the checklists (randomly selected) to ensure documentation of appropriate verification of the patient, procedure and side/site/level based on the written informed consent and the H&amp;P at the time of patient admission to the pre-operative area, patient entry into the surgical area, prior to administration of anesthesia, and prior to commencing the procedure. Audits will continue until 100% compliance is achieved for four (4) months.</p> <p>Person Monitoring Corrective Action: Director of Surgical Services.</p>	<p>On-going</p> <p>06/30/16</p> <p>On-going</p>

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	<p>During a concurrent interview with DQS, RM and the Director of Perioperative Services (DPS), on 4/27/16 at 12:45 PM while reviewing a 7 pages facility copy of the electronic Patient 1 Pre-Operative Nursing Assessment form dated "02/18/16 7:21", completed by a Registered Nurse (RN 1); DQS acknowledged RN 1 "...was the RN admitting Patient 1...".</p> <p>The same document failed to indicate the verification of the correct patient, correct procedure and correct site/site/level using the H &amp; P and the procedure consent during admission and prior to moving Patient 1 to the procedural area. The document indicated on page 4, under "Pre-Op/Procedure Checklist: Report Given to:" a Registered Nurse (RN 2) in the OR, dated "02/18/16 at 8:25". DPS stated: "Yes, RN 2 received that report". Both DQS and DPS acknowledged the document did not contain a verification of H&amp;P and consent.</p> <p>During a 4/27/16 at 12:45 PM interview with DQS, RM and DPS, while reviewing a 8 pages facility copy of the Intra-Operative nursing assessment; DQS and DPS acknowledged the record indicated in page 2 under "Surgical Procedures/ Procedure Detail: Hysterectomy, BSO, Appendectomy", and failed to document a review of Patient 1 H&amp;P and consent upon arrival in the procedural area and immediately prior to the procedure; and that the same document indicated RN 2, RN 3 and RN 4 were present in the procedural area.</p> <p>Record review of a facility policy titled: "Universal</p>		<p>Issue 3: A Registered Nurse (RN 2), who received Patient 1 into the procedural area, did not verify correct patient, correct procedure based on H &amp; P and consent.</p> <p>Corrective Action: The nurse (RN 2) receiving the patient in the OR was immediately counseled and re-educated to verify the correct patient, procedure based on the written informed consent and the H&amp;P.</p> <p>100% of Operating Room RNs, Cardiac Cath Lab RN's, Labor and Delivery RNs, Procedure Room RNs, and Endoscopy RNs (not on leave of absence) were re-educated to correctly verify the patient, procedure and side/site/level based on the written informed consent and the H&amp;P. RN's working in these procedural areas that have not received the education, because they are on LOA or otherwise not working, will receive this education prior to returning to work</p> <p>100% of Operating Room RNs, Cardiac Cath Lab RN's, Labor and Delivery RNs, Procedure Room RNs, and Endoscopy RNs (not on leave of absence) were required to review and attest to understanding the revised Universal Protocol for Surgical and Invasive Procedures policy. RN's working in these procedural areas that have not reviewed the revised policy, because they are on LOA or otherwise not working, will review and attest to understanding the revised Universal Protocol for Surgical and Invasive Procedures policy prior to returning to work.</p>	<p>02/19/16</p> <p>04/01/16</p> <p>09/30/16</p>

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	<p>Protocol Policy and Procedure" dated "3/2014" indicated, "...Verification immediately prior to moving the patient to the procedural area:...Pre-Procedure Checklist:...B. Accurately completed, signed, procedure consent form...</p> <p>Under "Verification at the time of arrival in the procedural area: The nurse receiving the patient will verify the correct patient, correct procedure and correct site: a. Using..b. The history and physical c. The procedure consent..</p> <p>Under "Verification Immediately prior to the procedure (aka time out)...the time out has the following characteristics: A. All team members will stop al other activities to complete the verification process. B. The circulating or procedure nurse will lead the time out...D. The basic elements of the time out/procedural pause are: ...c. Correct procedure is verified..."</p> <p>During an interview with an operating room Registered Nurse (RN 3) on 04/27/16 at 12:05 PM, RN 3 stated she was a circulator nurse "as a resource..." on 02/18/16 for Patient 1's scheduled surgery. Asked how and who lead the time out, RN 3 stated: "the surgeon is the only one that leads the time out..., I did not see any documents...I never had Patient 1's medical record..."</p> <p>RN 3 was shown a facility form signed by her on 2/18/16 and titled: "World Health Organization Surgical Safety Check" that described in three</p>		<p>Immediately following the event, a checklist/tracer tool was developed and ten (10) surgical cases per month are observed and monitored by the Peri-operative Director or Manager using the tracer tool/checklist to ensure 100% compliance with the verification process of utilizing the written informed consent and H&amp;P to correctly verify the patient, procedure and side/site/level at the time of patient admission to the pre-operative area, patient entry into the surgical area, prior to administration of anesthesia, and prior to commencing the procedure.</p> <p>In June 2016, the checklist/tracer tool was revised and implemented as a checklist for OR staff to utilize for validation of all elements of Universal Protocol. The checklist/tracer is used for all surgical patients undergoing procedures in the Operating Room. .</p> <p>The Peri-operative Director audits a minimum of 50% of the checklists (randomly selected) to ensure documentation of appropriate verification of the patient, procedure and side/site/level based on the written informed consent and the H&amp;P at the time of patient admission to the pre-operative area, patient entry into the surgical area, prior to administration of anesthesia, and prior to commencing the procedure. Audits will continue until 100% compliance is achieved for four (4) months.</p> <p>Person Monitoring Corrective Action: Director of Surgical Services</p>	<p>On-going</p> <p>06/30/16</p> <p>On-going</p>
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NAME OF PROVIDER OR SUPPLIER <b>SEQUOIA HOSPITAL</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>170 Alameda De Las Pulgas, Redwood City, CA 94062-2751 SAN MATEO COUNTY</b>
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	<p>columns: "Before Induction of Anesthesia /Sign In-Circulator Leads, After Draping/ Before Skin Incision Time Out- Circulator Leads, Before Patient Leaves Operating Room Team Debriefing-Circulator Leads", at in each column steps to follow; RN 3 acknowledged her signature on the form and stated: "My signature only means I was part of identifying the correct patient and date of birth, not the right procedure", as she pointed to the first column initial step. RN 3 said, "...I did not read the consent or other document...".</p> <p>During an interview with an operating room Registered Nurse (RN 4) on 04/27/16 at 12:25 PM, RN 4 stated she was "A circulator nurse having finished orientation and my training was not finished...", present on 02/18/16 for Patient 1 scheduled surgery. RN 4 stated "The time out was lead by the Dr.[surgeon] MD. The MD stated the name of the patient, the procedure and asked for questions...". Asked if she saw Patient 1 signed consent, or H &amp; P, RN 4 stated: "No, I never saw the consent or the H&amp;P...".</p> <p>RN 4 was shown the "World Health Organization Surgical Safety Check" form used at the facility and signed by her on 2/18/16. RN 4 acknowledged her signature on the form and stated: "My signature was for the patient identification only, the doctor MD lead the time out...".</p> <p>(At <a href="http://www.who.int/patientsafety/safesurgery/ss_ch">http://www.who.int/patientsafety/safesurgery/ss_ch</a></p>		<p>Issue 4: The facility did not follow their policy and procedure when the surgeon was allowed to lead the Time-Out procedure instead of the circulator nurse.</p> <p>Corrective Action: The attending surgeon and surgical staff involved in this event were immediately counseled that per Hospital policy, surgeons cannot lead the final Time-Out procedure immediately prior to commencing the surgical case. The attending surgeon and surgical staff involved in this event were immediately informed that per Hospital policy, the Circulating Nurse is accountable to lead the Time-Out procedure immediately prior to commencing the surgical case. Further, the Circulating Nurse is required to visually review the written informed consent with the attending surgeon during the final Time-Out procedure immediately prior to commencing the surgical case.</p> <p>Education was provided to anesthesiologists and surgeons at multiple meetings of the Departments of Anesthesia, Surgery, Orthopedics, Obstetrics and Gynecology, Internal Medicine and Cardiovascular regarding requirement that per Hospital policy, surgeons cannot lead the final Time-Out procedure immediately prior to commencing the surgical case; that the Circulating Nurse is accountable to lead the Time-Out procedure immediately prior to commencing the surgical case; and that the Circulating Nurse is required to visually review the written informed consent with the attending surgeon during the final Time-Out procedure immediately prior to commencing the surgical case</p>	<p>02/19/16</p> <p>09/08/16</p>

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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
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	<p>ecklist/en/ World Health Organization website and according to a publication titled "Implementation Manual Surgical Safety Checklist", the Checklist divides the operation into three phases, each corresponding to a specific time period in the normal flow of a procedure - the period before induction of anesthesia (Sign In), the period after induction and before surgical incision (Time Out), and the period during or immediately after wound closure but before removing the patient from the operating room (Sign Out). In each phase, the Checklist coordinator must be permitted to confirm that the team has completed its tasks before it proceeds further).</p> <p>During a concurrent interview with the Director of Quality Services (DQS) and the Patient Safety Risk Manager (RM) on 04/01/16 beginning at 11 AM, DQS stated: "There were many misses on this event...There was a new Operating Room circulator nurse in charge of the time out.... Dr.[name of physician] (MD), is a doctor who leads her own time out. We interviewed the MD and she said she is not perfect and she forgot the correct procedure...". RM added: "Our Policy was not followed, it has been revised..., the consent was correct but it was entered incorrectly by a clerk doing the surgical schedule..., the documentation brought in to perform the time out was wrong...".</p> <p>During an interview with the Director of Perioperative Services (DPS) on 04/27/16 at 1 PM, DPS stated: "I would expect that each RN reviews the patient's</p>		<p>100% of surgical and anesthesiologist members of the Medical Staff received written notification of the requirement that Circulating Nurses are accountable to lead the Time-Out procedure immediately prior to commencing the surgical case, and that the Circulating Nurses are required to visually review the written informed consent with the attending surgeon during the final Time-Out procedure immediately prior to commencing the surgical case.</p> <p>100% of Operating Room RNs, Cardiac Cath Lab RN's, Labor and Delivery RNs, Procedure Room RNs, and Endoscopy RNs (not on leave of absence) were re-educated that surgeons cannot lead the final Time-Out procedure immediately prior to commencing the procedure; that the Circulating Nurse is accountable to lead the Time-Out procedure immediately prior to commencing the procedure; and that the Circulating Nurse is required to visually review the written informed consent with the attending surgeon during the final Time-Out procedure immediately prior to commencing the procedure. RN's working in these procedural areas that have not received the education, because they are on LOA or otherwise not working, will receive this education prior to returning to work.</p>	<p>09/30/16</p> <p>09/30/16</p>

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	<p>H &amp; P and the consent for surgical procedure, from the moment of patient admission and every hand off time in the process...", and added: "The circulator nurse has to lead the time out and reads from the patient's consent and obtains a verbal agreement from all present in the operating room, as it is in the policy...".</p> <p>Record review of a printed copy of the electronic record titled "Progress Note" signed by the surgeon MD on 02/19/16 at 5:08 PM indicated, "This morning I visited the patient for my postsurgical rounds....At that very point, she (Patient 1) reminded me that the ovaries were not supposed to come out. I recalled immediately that she was actually quite correct...and told her that I had wrongfully removed her ovaries...I mistakenly conducted the surgical pause and said that I would remove the uterus, tubes, and ovaries, and proceeded to do so".</p> <p>Record review of a facility policy titled: "Universal Protocol Policy and Procedure" dated "3/2014" indicated under "Verification at time of Procedure Scheduling: ...the person responsible for scheduling the procedure will verify the correct patient, correct procedure and site/site/ level with the physician or physician's office staff or nursing staff scheduling the procedure...". Under "Verification at Admission or Entry into the Facility:....A. The nurse admitting the patient will verify the correct patient, correct procedure and correct site/site/level using the</p>		<p>Immediately following the event, a checklist/tracer tool was developed and ten (10) surgical cases per month are observed and monitored by the Peri-operative Director or Manager using the tracer tool/checklist to ensure 100% compliance with the verification process of utilizing the written informed consent and H&amp;P to correctly verify the patient, procedure and side/site/level at the time of patient admission to the pre-operative area, patient entry into the surgical area, prior to administration of anesthesia, and prior to commencing the procedure.</p> <p>In June 2016, the checklist/tracer tool was revised and implemented as a checklist for OR staff to utilize for validation of all elements of Universal Protocol. The checklist/tracer is used for all surgical patients undergoing procedures in the Operating Room. .</p> <p>The Peri-operative Director audits a minimum of 50% of the checklists (randomly selected) to ensure documentation of appropriate verification of the patient, procedure and side/site/level based on the written informed consent and the H&amp;P at the time of patient admission to the pre-operative area, patient entry into the surgical area, prior to administration of anesthesia, and prior to commencing the procedure. Audits will continue until 100% compliance is achieved for four (4) months.</p> <p>Person Monitoring Corrective Action: Director of Surgical Services</p>	<p>On-going</p> <p>06/30/16</p> <p>On-going</p>

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	<p>...b. The history and physical c. The procedure consent..."</p> <p>The policy's last page indicated under "Approval Bodies: Department Manager/Director, Medical Executive Committee, Board..."</p> <p>At <a href="http://www.who.int/patientsafety/safesurgery/ss_checklist/en/">http://www.who.int/patientsafety/safesurgery/ss_checklist/en/</a> World Health Organization website and according to a publication titled "Implementation Manual Surgical Safety Checklist: The ultimate goal of the WHO Surgical Safety Checklist is to help ensure that teams consistently follow a few critical safety steps and thereby minimize the most common and avoidable risks endangering the lives and well-being of surgical patients.</p> <p>In this manual, the "operating team" is understood to comprise the surgeons, anesthesia professionals, nurses, technicians and other operating room personnel involved in surgery. In order to implement the Checklist during surgery, a single person must be made responsible for checking the boxes on the list. This designated Checklist coordinator will often be a circulating nurse, but it can be any clinician or healthcare professional participating in the operation.</p> <p>The Checklist divided the operation into three phases, each corresponding to a specific time period in the normal flow of a procedure - the period before induction of anesthesia (Sign In), the period</p>			

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	<p>after induction and before surgical incision (Time Out), and the period during or immediately after wound closure but before removing the patient from the operating room (Sign Out). In each phase, the Checklist coordinator must be permitted to confirm that the team has completed its tasks before it proceeds further.</p> <p>Therefore, during "Sign In" before induction of anesthesia, the person coordinating the Checklist will verbally review with the patient (when possible) that his or her identity has been confirmed, that the procedure and site are correct and that consent for surgery has been given.</p> <p>The team will pause immediately prior to the skin incision to confirm out loud that they are performing the correct operation on the correct patient and site and then verbally review with one another, in turn, the critical elements of their plans for the operation using the Checklist questions for guidance.</p> <p>Having a single person lead the Checklist process is essential for its success. In the complex setting of an operating room, any of the steps may be overlooked during the fast-paced preoperative, intraoperative, or postoperative preparations. Designating a single person to confirm completion of each step of the Checklist can ensure that safety steps are not omitted in the rush to move forward with the next phase of the operation. Until team members are familiar with the steps involved, the Checklist coordinator will likely have to guide the team through this Checklist process."</p>			
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	<p>The hospital's failure to perform the correct surgery for Patient 1 constitutes an immediate jeopardy within the meaning of Health and Safety Code Section 1280.1(c).</p> <p>This facility failed to prevent the deficiency(ies) as described above that 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 1280.3(g).</p>			

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