POC accepted Nov. 15, 2010 A. Williams RN, RN.

PRINTED: 10/26/2010
FORM APPROVED

California Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	CA930000127	A. BUILDING _____ B. WING _____	C 07/07/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TORRANCE MEMORIAL MEDICAL CENTER	3330 LOMITA BLVD TORRANCE, CA 90509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 000	Initial Comments The following reflects the findings of the Department of Public Health during a Complaint visit. Complaint Intake Number: CA 00224338 - Substantiated The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: [redacted] RN, HFEN 1280.1(c) Health and Safety Code Section For purposes to this section, "Immediate Jeopardy" means a situation in which the licensee's noncompliance with one or more requirements of licensure has caused or likely to cause, serious injury or death to the patient.	E 000		
E 264	Nursing Service Policies and Procedures. (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. This Statute is not met as evidenced by: Based on record review and interviews, the facility failed to implement their written policy and procedure on counting miscellaneous items used for Patient 1's surgical procedure. The facility staff failed to account for a miscellaneous item (endoscopic anti-fog solution bottle) used during Patient 1's surgical procedure, which resulted in	E 264		

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E 264	Continued From page 1 the retention of a foreign object in Patient 1. Findings: On July 7, 2010, an investigation was conducted following an entity reported event regarding retention of a foreign object in Patient 1. The face sheet indicated Patient 1 was admitted to the facility on [redacted] 2009 with diagnoses which included malignant neoplasm urethra. A review of the Operative Report dated [redacted] 2009, indicated Patient 1 underwent a laparoscopic left nephroureterectomy (removal of the left kidney and left ureter) on [redacted] 2009 under general anesthesia. The Operating Room (OR) Nursing Record dated [redacted], 2009, at 12:18 p.m., indicated the initial, second and final counts verification were done. The OR Nursing Record also indicated the miscellaneous count was correct. However, the miscellaneous items used in Patient 1's surgery were not specified. A review of the facility's analysis summary indicated Patient 1 had another surgery on [redacted], 2009 [redacted] months later), at a different facility, where they found and removed a foreign object from Patient 1's abdomen. The analysis summary indicated the foreign object was a "FRED" bottle (fog reduction endoscopic device), 2 inches x ¾ inches, which was used during the laparoscopic nephroureterectomy procedure on June [redacted] 2009. A review of the Operative Report dated August 24, 2009, from the second general acute care hospital, disclosed Patient 1 had an exploratory laparotomy (incision through abdominal wall) surgery. The pre-operative diagnoses included an intra-abdominal mass of unknown etiology,	E 264	The policy that existed at the time did not call for a counting of the FRED bottle as a miscellaneous item. The OR staff conducted 3 counts as indicated per policy and all three counts were correct. Additionally, the surgeon, per his practice, conducted an inspection of the patient's cavity with his hands and did not detect anything unusual. The policy as written at the time was followed.(attached) Regardless, the following Plan of Correction has been initiated: 1. A revision to our existing Policy and Procedure entitled "Counts; Instruments, Sponges, Sharps and Miscellaneous Items." continued on page 3...	2/2010; and 11/10

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E 264	Continued From page 2 possibly abscess. The plan was to proceed with an exploration for this mass, resect the mass, and possibly reposition the gastrostomy tube. The postoperative diagnoses included intra-abdominal abscess between the duodenum (the first and shortest segment of the small intestine and the transverse colon (is a part of the large intestine, which is of a diameter larger than the small intestine) and a foreign body in the patient's pelvis. The Operative Report dated August 24, 2009, further disclosed that during exploration, the surgeon found an eyedrop sized, closed bottle of "Fred" laparoscopic defogging solution, in the left lower quadrant of the pelvis, between the loops of Patient 1's small bowel. The surgeon removed the "Fred" bottle from the pelvis. During an interview with Employee A, the director of surgical services, on July 7, 2010 at 10:30 a.m., she stated the staff used custom packs (which contained specific surgery supplies) during the surgeries to prevent opening various little packages. Employee A stated the "Fred" bottle which came in the custom packs, was used to keep the lens of the telescope from fogging. Employee A further stated, "Not all the items inside the custom packs were counted." A review of the facility's analysis summary indicated the "FRED" sponge was counted, but not the "FRED" bottle, even though they were contained in the same package from the distributing company. During an interview with Employee B, the surgery manager, on July 7, 2009 at 10:45 a.m., he stated the green sponge that came inside the	E 264	...continued from page 2 More specifically, the policy was revised to include the FRED bottle on the list of miscellaneous items to be counted. 2. The procedure was standardized as to the removal and disposal of certain items. Items, such as the FRED bottle, would be placed in a basin while in use and immediately discarded in a plastic trash receptacle once used. 3. The OR staff, including all RNs and OR techs, signed an Accountability Commitment Form. The purpose of this form was to raise awareness and commitment to patient safety and to further clarify how items, such as FRED bottles, are to be handled in the OR and surgical field. All new OR staff sign this Accountability Commitment Form upon orientation into the OR. 4. Verification that 100% of the OR staff (RNs and OR techs) sign the above mentioned form was conducted. 5. Education to staff was conducted at Staff meetings and one to one meetings for all OR staff (RNs and OR techs). continued on page 4...	2/10 9/10/09 9/10/09 and continuing 9/14/09 to 9/18/09

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E 264	Continued From page 3 "FRED" bottle package was counted but not the bottle, due to the radiopaque marker, which the "FRED" bottle did not have. Employee B stated the radiopaque marker (is a marker used with catheters to enable the catheter to be visualized during x-ray and fluoroscopic procedures) made items easier to locate inside a body cavity during the x-ray. A review of the facility's policy and procedure titled, "Counts; Instruments, Sponges, Sharps and Miscellaneous Items," stipulated the instruments, sponges, sharps and miscellaneous items would be accounted for during a surgical procedure to ensure the patient is not injured as a result of a retained foreign object. The facility's policy defined the miscellaneous items as penrose, acorn adapter, safety pin, umbilical tapes, "Fred" sponge, however, it did not include the "Fred" bottle. Because Patient 1 had a retained foreign object removed during a second surgery, the patient was placed at risk for possible additional complications to include peritonitis (an inflamation of the lining of the patient's body cavity and the tissue covering the patient's internal organs), potential obstructions of the small/large intestine and the need for repetive surgery. The facility's failure to implement its policy/procedure to prevent the retention of the endoscopic anti-fog solution bottle used during a surgical procedure is a deficiency 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 1280.1	E 264	...continued from page 3 6. The policy change and process was monitored for 5 months. Monitoring was conducted via a sampling of cases and the method of sampling included cases from all shifts. During this time, 718 cases were monitored for 100% compliance with the standardization of the method of disposal of the FRED bottle. 7. All OR custom packs were reviewed and a plastic trash receptacle for standardized disposal of FRED bottles and similar items were included with the custom packs. It is our understanding that the finding of the FRED bottle was an incidental finding (the abscess found in the subsequent surgery was situated in a different location than that of the FRED bottle) and the patient experienced no residual injury or harm. Persons responsible for this Plan of Correction include the Sr. VP, Patient Services/CNO and Clinical Director, Perioperative Services.	9/09 to 1/10 9/18/09