CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY DEPARTMENT OF PUBLIC HEALTH

STREET ADDRESS, CITY, STATE, ZIP CODE NESTERN MEDICAL CENTER SANTA ANA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL The following reflects the findings of the Department of Public Health during the investigation of COMPLAINT NO: CA00182943. Inspection of the facility. Representing the Department of Public Health DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY T22 DIVS 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 staff interview, review of policies/procedures, review of facility failed to ensure implementation of written policies and procedures in consultation with order appropriate health professionals and 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, review of facility records, and medical record review, the facility failed to ensure implementation of written policies and procedures addressing sponge/instrument/needle counts, resulting in a laparotomy sponge retained in the EVENT ID 200911	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLI AND PLAN OF CORRECTION IDENTIFICATION NO. 050746			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED - 04/14/2009			
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Jacqueline Herd, RN, MSN, Chief Nursing Officer 6/3/09

Astement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined ther safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are disclosable 90 days following the date er 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.

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE AND PLAN OF CORRECTION IDENTIFICATION NU		A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	050746	B. WING		04/14/2009	
NAME OF PROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STATE,	ZIP CODE		
WESTERN MEDICAL CENTER SAN	TA ANA 1001 I	NORTH TUSTIN AVENU	JE, SANTA ANA, CA 92705 ORANGE	COUNTY	
PREFIX (EACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPRIATE D	BE CROSS- COMPLETE	
Continued From pag	e 1				
undergo the risks	Patient #1. Patient #1 of another major surger remove the retained spong	y and	Responsible Persons: Director Perinatal Services and Director Education	or of	
Sharps, Instrument directives: Sponges and sharps surgical procedures establish a baseline added to the sterile cavity within a cavit	s/needles will be counted s; before the procedur e; when additional spong e field; before the closure; y; before wound closure; nent relief of either the	on all res to ses are se of a and at	Policy and procedure for cour sharps, instruments was revise All pieces of an instrume counted X-ray requirement to be a section in policy Mandatory staff in-services w completed regarding policy ar procedure for:	ed to add: Int to be a separate Fere and	
Instruments will be counted on all cases in which a cavity is entered or might be entered. Instrument counts will be taken before a procedure to establish a baseline, before wound closure begins, when additional instruments are added to the field, and the outcome of the instrument count will be recorded by the circulator on the nursing Intraoperative Record. The policy stated the results of all sponge, sharp and instrument counts would be documented on the patient's intraoperative or delivery record and documentation would include the rationale when the count was not performed or completed as dictated by policy.			1) Counting sponges, slinstruments practices documentation of coordone as per policy are procedure. 2) Completion of the numerous procedure. 2) Completion of the numerous procedure record cases. 3) Documentation of rance counts being done as per policy are procedure. 4) Process for requiring counts being done and counts being done are process for requiring to communication with x-ray and documentate declination, if indicate In-services conducted 3/25/09 with 100% of staff attending conservice.	arsing for all tionale for e. g.x-ray a surgeon for ation of ted. 0 - 4/8/09	
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ABORATORY OF ECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Jacqueline Herd, RN, MSN

Chief Nursing Officer

6/3/09

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CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY DEPARTMENT OF PUBLIC HEALTH

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050746		B WING		04/14	/2009			
			ĺ	SS, CITY, STATE, ZIP CODE FUSTIN AVENUE, SANTA ANA, CA 92705 ORANGE COUNTY				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE CROSS- CO			
	Continued From page The policy stated sponge, sharp and forfeited and the phymust be made to a on these cases. An suite, prior to woo declines an x-ray, refusal and document on the intraoperative refusal and document on the intraoperative refusal and hystered ovary and fallopian tub. Review of the Intraoperative refusal and hystered ovary and fallopian tub. Review of the Intraoperative refusal and hystered ovary and fallopian tub. Review of the Intraoperative refusal and the instrument oriculating nurse are stated sponge counts circulating nurse as stated sponge counts. Record. During interview on and the instrument were not counted before the performed, but a final instrumed, but a final instrumed instrument, but a final instrument, b	"In an extreme instrument count visician informed. Extended the count laps in x-ray will be taker und closure. If it is will be noted ited. This must be ecord." The revealed that regone an emergen extomy with removal ite. The perative Nursing Reshow documented for instrument country in the surgical proced in the surgical proceding the surgical procedure on the surgical procedure on the surgical procedure or after the procedure on 4/15/09, the an initial needle	ts may be very attempt and needles in the OR he surgeon as an MD documented on 3/18/09, cy cesarean of the left ecord, dated evidence of ints prior to, ure. hospital, the inician both however, the ise of the documented tive Nursing ulating nurse instruments dure. instrument count was		 Tool developed, "Rem for STAT C-section" OR suites as a referent Implement C-section – with critique of drill opportunities to improcompleted 4/16/09. For July and October. Staff counseled on proof forms – completed 	to be posted in ce for staff. drills quarterly s to identify ove. First drill ollow-up drills oper completion		
Event ID:	2N0911/7		5/19/2009	9:04:	15AM			

BORATORY DIFFECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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Jacqueline Herd, RN, MSN, Chief Nursing Officer 6/3/09

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	DVIDER OR SUPPLIER MEDICAL CENTER SANT	TA ANA	STREET ADDRESS, (CODE E, SANTA ANA, CA 92705 O	PRANGE COUNTY		
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	Continued From page 3 procedure was not performed. Review of the documentation failed to contain the rationale as to why sponge/needle and instrument counts were not performed and documented in accordance with policy and that the physician was notified. The documentation failed to show evidence that during this emergency procedure, an x-ray was taken as per policy or that the surgeon had declined the x-ray. Medical record review revealed that over the next several days, Patient #1 developed progressive leukocytosis, continued abdominal pain, and low grade fever. On 3/23/09 at 1620 hours, an abdominal/pelvic CT scan was performed and the report stated a "foreign body appreciated within the lower pelvis." An operative report dated 3/24/09 documented Patient #1 had undergone an exploratory laparotomy under general anesthesia with removal of a retained laparotomy sponge. The violation(s) has caused or is likely to cause, serious injury or death to the patient(s).		d instrument umented in eysician was to show ocedure, and the surgeon were the next progressive in, and low whours, and ed and the d within the ted 3/24/09 ergone and anesthesial ge.				7mo -5 PM : 24	
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ABOURTORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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