CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	050243	A. BUILDING _____ B. WING _____	08/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESERT REGIONAL MEDICAL CENTER	1150 N Indian Canyon Dr, Palm Springs, CA 92262-4872 RIVERSIDE COUNTY

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	The following reflects the findings of the Department of Public Health during an inspection visit Complaint Intake Number: CA00309249 - Substantiated Representing the Department of Public Health Surveyor ID # 18930, HFEN The inspection was limited to the specific facility event investigated and does not represent the findings of a full inspection of the facility. Health and Safety Code Section 1280.1(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. The Department was able to substantiate a violation of the regulations. Health and Safety Code Section 1279.1 (b) For purposes of this section, "adverse event" includes any of the following (1) Surgical events, including the following: (D) Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained		**The plan of correction is prepared in compliance with federal regulations and is intended as Desert Regional Medical Center's credible evidence of compliance. The submission of the plan of correction is not an admission by the facility that it agrees that the citations are correct or that it violated the law.** **Organization Minutes:** The confidential and privileged minutes are being retained at the facility for agency review and verification if required. **Exhibits:** All exhibits including revisions to Medical staff Bylaws, reviewed/revised or promulgated policies and procedures, documentation of staff and medical staff training/education are retained at the facility for agency review and verification upon request. **Tag:** Health and Safety Code Section 1289.1(c) **Policy & Procedures:** The Risk Manager, Chair of OB/GYN Medical Staff Department, Chief Nursing Officer and Nursing Director reviewed the Perinatal policy for operating room counts as well as the Tenet wide policy "Prevention of Retained Surgical Invasive Items". It was determined to implement approved Tenet wide policy. **Training:** Perinatal educator and Clinical Managers conducted education to perinatal nursing staff and perinatal techs on the	05/31/2012 05/19/2012 and ongoing

Event ID: EGKN11 5/13/2014 4:55:23PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

5/30/2014

By signing this statement, I am acknowledging receipt of the entire citation packet. Page(s) 1 of 5

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 stated 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.

05/2012

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	Health and Safety Code Section 1279.1(c) "The facility shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made." 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 Title 22, California Code of Regulations, Section 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 Based on record review and interview, the facility failed to follow their policy and procedure entitled, "Prevention of Retained Surgical/Invasive Procedure Items," when all surgical counts were not performed accurately, resulting in a retained surgical sponge in the abdomen of one patient (Patient A) and		changes regarding counts and processes in the OR for the prevention of retained foreign items as described in the "Prevention of Retained Surgical Invasive Items" policy. Review of this policy and required procedures is a component of initial OB staff orientation. Every new RN to Perinatal L/D OR receives 1 week training, equivalent to three 12 hour shifts, to the main OR. Competencies are validated by OR staff. A mandatory staff meeting was conducted to present the issue of retained foreign item in OR. All changes were reviewed with staff regarding OR processes, appropriate communication and counts of laps, sharps, and instruments. Those not in attendances were in-serviced individually. 100% of staff were in-serviced. A Special meeting of the OB/GYN Medical Staff Committee was convened where the Chair of the Department reviewed the practices that would be required to prevent retained foreign bodies. The Department Rules and Regulations were revised to include the practices and criteria for surgical counts.	5/23/2012 5/23/2012 5/16/2012 5/10/2012

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	second surgery for Patient A to remove the retained surgical sponge six weeks later, which caused the patient pain and infection, and placed her at risk for trauma and death. Findings: The facility's policy and procedure entitled, "Prevention of Retained Surgical / Invasive Procedure Items," was reviewed. The purpose of the policy and procedure is set forth as to provide for the following: "guidelines for ensuring that foreign objects are not retained in a patient after surgical / invasive procedures," and "accurately accounting for sponges, sharps and instruments throughout the surgical / invasive procedures to minimize the risk of a retained object." The facility's procedure for surgical counts indicated that "sponges should be counted, before the procedure has begun to establish a baseline count, before the closure of a cavity, before wound closure begins which includes any level of fascia, at skin closure or end of procedure." The facilitys procedure for surgical counts also indicated the surgical staff should "separate the sponges, count audibly, and concurrently view during the count procedure by two individuals, one of whom should be a registered nurse circulator." On [redacted] 2012, at 10:45 a.m., a visit was made to the facility for the purpose of investigating a facility reported incident. Patient A was a 38 year old female admitted to the facility on [redacted]		Monitoring: A minimum of 10 audits per month for 3 months to insure OR/count practice is consistently followed with 100% compliance expected; After which 3-5 random observational audits will be conducted by the Director of Surgery (main OR) or designee for 3 additional months. The results of the audits are reported to the Quality Council, the Medical Executive Committee and the Governing Board at their regularly scheduled meetings for review and action as required. Perinatal techs will demonstrate competency In OR procedures. Quarterly audits are conducted for 1 year and annually The scrub tech and the circulating RN involved in the case were proctored for a total of 5 cases each. A proctor tool was designed for the monitoring of these employees.	9/10/2012 9/16/2012 and ongoing 9/21/2012

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	2012, for a Primary Cesarean Section for a Breech (the baby was in a feet first position) Review of the Intraoperative Nursing Record, dated [redacted] 2012, revealed that three surgical counts were completed during the procedure and all were checked off as accurate. According to the medical records, the patient and the baby were discharged home on [redacted] 2012. Record review indicated Patient A presented to the physician's office (MD1), on [redacted] 2012, for her six week follow up appointment. At that time the patient had complaints that she was able to feel a mass in her abdomen. . A CT (Computerized Tomography) Scan confirmed the presence of a retained foreign object, on [redacted] 2012. On [redacted] 2012, Patient A was admitted to the facility for an exploratory laparotomy (a surgical incision into the abdominal cavity) and removal of retained foreign object. Review of the History and Physical, dated [redacted] 2012 at 11:00 a.m., revealed that the patient "described yellow vaginal discharge." The Laparotomy Operative Report by MD1 dated [redacted] 2012, revealed the following findings: an "Encapsulated laparotomy sponge that was surrounded by serous (body) fluid and severe and bowel adhesions (bands of scar tissue that attach to organs). The left adnexa (part of the uterus) also		**Other Corrective Actions:** A memorandum was sent to all members of the OB/GYN department with the following: "Effective immediately and until further notice, it will be that any physician performing a C-section must order a post-operative x-ray to rule out foreign body prior to the patient leaving the operating room. The circulating RN and the Perinatal tech will remain in the room until the results are obtained." A special OB/GYN meeting was held to discuss concerns regarding retained foreign bodies and a way to prevent this from happening. Consideration was given to ordering micro chipped laps but they are currently unavailable. Therefore criteria were placed into the Rules and Regulations of the OB/GYN department for prevention of retained foreign bodies to include: announcing when laps are left in and when removed, attaching a clamp on the tails of laps left in and not placing sponges in the cavity Also discussed at the staff meeting was the mandate that inappropriate conversations would stop immediately. Staff was instructed to intervene in such situations and if the parties were not compliant, notify the Department Director A trial for using microchip lap sponges was conducted.	3/10/2012 3/16/2012 5/24/2012 5/25/2012

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	incorporated into this mass." Under, "Procedure in Detail," the physician noted: "At this time, inspection of the abdomen revealed the mass and collection to be adhesed to the left pelvic side wall. There were dense bowel adhesions of bowel loops, which were covering the laparotomy sponge, and it also incorporated the left fallopian tube and broad ligament... I opted to consult general surgery (MD2) secondary to the extensive bowel involvement in this retained foreign body, and (MD2) scrubbed in just minutes after he was called." Review of the Operative report authored by MD2, dated [redacted] 2012, revealed the following notes: "was asked by (MD1) from the operating room to come and assist with removal of a retained foreign body, it has (sic) been a lap pad that was left in place from a C-section 6 weeks prior...Using significant amount of blunt finger fracture technique, was able to free off both small bowel and sigmoid colon from the lap pad. Once the cavity was entered, non-smelling purulent fluid was encountered." Review of the Discharge Summary, dated [redacted] 2012, revealed the following: "She (Patient A) was treated with triple antibiotics with ampicillin, gentamycin, and clindamycin for 48 hours throughout her hospital stay." The patient was discharged home on [redacted] 2012 On May 14, 2012, at 12:50 p.m., an interview was conducted with the Operating Room Director. She stated, "A lap sponge is 18 by 18 inches square		Joint meetings between Perinatal and the Main OR are conducted quarterly and then twice yearly with the purpose of evaluating count and other processes used in both OR's against AORN guidelines, identify discrepancies, standardized count procedures and other workflow items as appropriate. White boards were re-positioned for ease of use and ability for all in OR to see counts, laps in/out. Staff and physicians were in-serviced regarding location. Terminal cleaning of the OR suites is conducted nightly. Annual review of C-section packs were completed to monitor that they are of the same content and quality that is required. Any changes to packs will be posted in writing, shared at staff meetings and staff will be in-serviced on the changes. Responsible Person(s): Chief Department of OB/GYN Chief Nursing Officer, Perinatal Nursing Director, Director of Surgical Services, Director of Risk Management, Director of Clinical Quality Improvement.	5/24/2012 and ongoing 12/19/2012 05/19/2012

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	and thin as gauze. The count came out correct four times, 20 to start, 20 at finish. It was not clear how it happened." The facility's failure to follow their policy and procedure, to ensure all surgical counts were performed, is a deficiency that has 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. 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 1280.1(c)		Disciplinary Action: Non-compliance with corrective action by hospital staff will result in immediate remediation and appropriate disciplinary action in accordance with the hospital's Human Resources policies and procedures. Medical Staff members demonstrating non-compliance with corrective action will be referred for peer review in accordance with Medical Staff bylaws, as appropriate.	