**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**DEPARTMENT OF PUBLIC HEALTH**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER IDENTIFICATION NUMBER:**

050112

**(X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER:**

A. BUILDING

B. VING

01/14/2010

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1250 16th St, Santa Monica, CA 90404-1249 LOS ANGELES COUNTY

**SANTA MONICA · UCLA MEDICAL CENTER AND ORTHOPEDIC HOSPITAL**

**NAME OF PROVIDER OR SUPPLIER**

**SUMMARY STATEMENT OF DEFICIENCIES**

**PREFIX TAG**

**PROVIDER'S PLAN OF CORRECTION**

**(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)**

**DATE COMPLETED**

**RECEIVED**

**PREFIX TAG**

**DATE COMPLETED**

2/26/2013

**HOSPITAL MUL TIPLE CONSTRUCTION BUILDING**

The following reflects the findings of the Department of Public Health during an inspection visit:

Complaint Intake Number:

CA00185841 - Substantiated

Representing the Department of Public Health:

Surveyor ID # 17030, 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.

**T22 DIV5 CH1 ART 3- 70213 (a) Nursing Service Policies and Procedures:**

(a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service.

**T22 DIV5 CH1 ART 3- 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

Since this incident in 2009, our facility has taken many measures to ensure the safety of our patients. Our plans of action include:

a) Purchasing devices to assist with equipment count. Our facility purchased sponge count hanging bags that were to be used in every procedure. Responsible Party: Dir. of Peri Op Services

b) Policy Review & Revision

Our leadership reviewed and revised the policy to reflect the use of new hanging bags, proper sponge counting process, & requirement that hand offs during a case involve 2 RNs counting all sharps, needles, & sponges. Responsible Party: Dir. of Peri Op Services

Completed on:

6/10/09

8/12/09

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 disclosed 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 disclosed 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.
Event ID:7PQR11

2/12/2013 11:46:09AM

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

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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 implement its written policy and procedure for counting sponges used for Patient B's surgical procedure which resulted in the retention of a foreign object (surgical sponge) in the patient's abdomen. As a result, Patient B had to undergo a second surgical procedure under general anesthesia for the removal of the lap sponge and was placed at risk for possible additional complications (e.g., bleeding, infection, shock, adhesions, ileus (paralysis of the bowel), changes in blood pressure, heart rate or heart rhythm and allergic reaction to general anesthetic medicine).

Findings:

On January 13, 2010, an unannounced visit was conducted to investigate an entity reported incident on a retained foreign object (lap sponge) after a surgical procedure on Patient B.

A review of the clinical record for Patient B disclosed the patient was admitted to the facility on 8/17/2009, with a diagnosis of gastric tumor. According to the Operative Record dated 8/19/09, Patient B underwent a partial gastrectomy (partial surgical removal of the stomach) with complex gastric reconstruction and pyloroplasty.
The Operating Room Nursing Record dated 2009 disclosed that three lap sponge counts were conducted and all three were correct.

A review of Patient B’s CT (computed tomography) Abd-Pelvis scan without contrast preliminary report dated 2009, revealed a foreign object (a surgical sponge) was retained in the patient’s left upper quadrant of the abdomen.

A review of the Operative Report dated 2009, disclosed Patient B had an exploratory laparotomy (an incision made into the abdomen and abdominal exploration performed under general anesthesia) to remove a lap sponge.

During an interview on January 13, 2010 at 10:45 a.m., Employee 4 stated, Employee 5 (Circulating Nurse) might have failed to separate each sponge to visually conduct a correct count with Employee 6 and 7.

In a telephone interview on January 14, 2010 at 3:38 p.m., Employee 5 stated that she had conducted three lap sponge counts with Employee 6 (Scrub Technician) and Employees 7 (Scrub Technician) during the surgical procedure on Patient B on 2009. Employee 5 stated she had placed all lap...
Continued From page 3

sponges on the floor and conducted a count with Employee 6 and Employee 7.

A review of the facility's policy and procedure (Policy #C4) titled, "Counts, Sponges and Sharps" dated as last revised in April 2008, stipulated the mandatory count are performed audibly and visually by the scrub person and circulating nurse.

According to The Recommended Practices for Sponge, Sharp and Instrument Counts by the Association of perioperative Registered Nurses (AORN Standards, Recommended Practices, and Guidelines): Sponges should be separated, counted audibly and concurrently viewed during the count procedure by two individuals, one of which should be a nurse.

The facility's failure to implement its policy and procedure to prevent retention of a lap sponge during a surgical procedure for Patient B is a deficiency that has caused, or 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).