P.O.C accepted SC. 5/13/11

PRINTED: 04/29/2011
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
	CA830000127	A. BUILDING _____ B. WING _____	C 07/23/2010

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 investigation. Complaint Intake Number: CA00212417 - Substantiated Representing the Department of Public Health: [redacted], RN, HFEN 1280.1(c) Health and Safety Code Section 1280 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 likely to cause, serious injury or death to the patient. T22 DIV CH1 ART 3-70223 (b)(2) Surgical service 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.	E 000		
E 264	T22 DIV5 CH1 ART3-70213(a) Nursing Service Policies and Procedures. (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the nursing service. This Statute is not met as evidenced by:	E 264	The citation is based upon the following; "the facility failed to implement their written "Counts: Instruments, Sponges, Sharps and Miscellaneous Items" policy and procedure which resulted in the retention of a lap sponge in the patient's abdominal cavity. A thorough root cause analysis (RCA) was conducted and it was determined that the staff followed the policy however, a miscount did occur due to human factors despite built in redundancy and the fact that three counts were performed per policy.	1/15/2010

PRINTED: 04/29/2011
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 07/23/2010

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 264	Continued From page 1 Based on interview and record review, the facility surgical staff failed to implement their "Counts; Instruments, Sponges, Sharps and Miscellaneous Items" policy and procedure during Patient A's surgical procedure. This failure resulted in the retention of a lap sponge in the patient's abdominal cavity and subsequently subjected Patient A to an additional surgical procedure under general anesthesia for the removal of the foreign object and was placed at risk for possible additional complication like 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 July 21, 2010, an unannounced visit was conducted at the facility to investigate an entity-reported incident of a retained foreign object after a surgical procedure on Patient A. A review of the clinical record for Patient A disclosed the patient was admitted to the facility on [redacted] 2009, with a diagnosis of esophageal cancer. According to the Operative Record dated [redacted], 2009, Patient A underwent a resection of the proximal esophagus. A review of the Operating Room Nursing Record dated [redacted] 2009, disclosed three lap sponge counts were conducted and all three were documented as being correct. A review of Patient A's Chest X-ray report dated [redacted], 2009, disclosed a foreign object (a surgical sponge) was retained in the patient's abdominal cavity.	E 264	As a result of the RCA, the following Plan of Correction has been initiated: A new practice was implemented and added to the existing Policy and Procedure #N.E.67 titled "Counts: Instruments, Sponges, Sharps and Miscellaneous Items". This new practice is the use of the "Bag It" Sponge Counting System, which allows sponges to be separated during the count process with each sponge being placed in a clear pocket so that they are easily viewed and accurately counted. Full implementation of this new process, including installation of the Bag It Sponge Counting System in all operating rooms, was completed 1/16/2010. A Copy of the revised policy N.E.67 titled "Counts: Instruments, Sponges, Sharps and Miscellaneous Items" is attached. 100% of the OR staff (RNs and OR Techs) were educated to the new policy and procedure at staff meetings and one-on-one sessions. This education included review of the aforementioned policy and procedure changes, demonstration of the correct use of the Bag It Sponge Counting System, and a DVD presentation on the correct and incorrect way to count sponges. 100% of staff signed an Accountability Commitment Form to acknowledge their understanding of how to use the Bag It Sponge Counting System, how to count correctly, and their commitment to patient safety. All new OR personnel are educated and sign this Commitment Form upon orientation into the OR. The policy change and process was monitored for six months via direct observation of the use of the Bag It system during surgical procedures. Observations were conducted by the OR leadership team which consisted of managers	1/16/2010 1/14/2010 to 2/14/2010 and ongoing 3/2010 to 8/2010

PRINTED: 04/29/2011
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 07/23/2010

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 264	Continued From page 2 A review of the Operative Report dated [redacted] 2009, disclosed Patient A had an exploratory laparotomy (an incision made into the abdomen and abdominal exploration performed under general anesthesia) to remove a lap sponge. During a telephone interview at the facility on July 23, 2010 at 9:50 a.m., in the presence of Employee 2 (Operating Room Manager), Employee 4 (Scrub tech) stated he had conducted three lap sponge counts with Employee 3 (Registered Nurse) during the surgical procedure on Patient A on [redacted] 2009. Employee 4 stated Employee 3 had placed all lap sponges in a basket and conducted a count with him. According to Employee 2, Employee 3 might have failed to separate each sponge to visually conduct a correct count with Employee 4. Employee 3 (Registered Nurse) was not interviewed. Multiple attempts to interview Employee 3, were unsuccessful. A review of the facility's policy and procedure titled, "Counts; Instruments, Sponges, Sharps and Miscellaneous Items" dated as last revised in November 2007, stipulated the count shall be audibly and visually performed by two (2) persons, one of whom is a registered nurse. The facility's failure to implement its policy and procedure to prevent retention of a lap sponge during a surgical procedure for Patient A 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 the Health and Safety Code Section 1280.1.	E 264	and the educator on both day shift and evening shift to ensure the Bag It system was being utilized correctly and sponge counts were accurate. The counting process was observed in a total of 163 procedures with compliance at 100%. In addition to the aforementioned policy change, a practice change was introduced to encourage staff to call for extra help when counting during procedures that were complex to ensure correct counts were confirmed prior to incision close. This was facilitated via the "Hall Nurse" monitoring activity in OR's and prioritizing the need for additional resources. Persons responsible for this Plan of Correction include the Director Perioperative Services, Clinical Educator Perioperative Services, and the Sr. VP Patient Services/CNO.	2/2010 and ongoing