POC- acceptable 1/9/09 [illegible]

California Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 050735	(X2) MULTIPLE CONSTRUCTION A.BUILDING ______ B.WING ______	(X3) DATE SURVEY COMPLETED C 10/30/2008
NAME OF PROVIDER OR SUPPLIER WHITTIER HOSPTIAL MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 9080 COLIMA RD WHITTIER, CA 90605	

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E000	Initial Comments The following reflects the findings of the Department of Public Health during a Complaint Investigation. Complaint Intake Number: CA00166431 - Substantiated The inspection was limited to the specific facility adverse event investigated and does not represent the findings of a full inspection of the facility. Representing the Department of Public Health: [redacted], RN-HFEN [redacted], RN, Sr. HFEN 1280.1(c) Health & Safety Code Section 1280 For purpose 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. Deficiency Constituting Immediate Jeopardy	E000	Corrective Action Plan: **Temporary Compliance:** The Items listed below were implemented immediately to correct our processes. Each corrective action is also part of the resolution and compliance with the regulations. 1. Policy & procedure revision: Immediately following the event the policies listed below were reviewed and/or revised. On 10/30/08, substantial revisions were made to meet the Standards and intent of the regulations. • Identification Policy • Universal Protocol, Team Time Out • Hand Off Communication • Out Patient Process • Communication for Impaired Individuals **Responsible Person:** CNO	1. 10/15/08 10/31/08 11/04/08 approved by Governing Board
E347	T22 DIV5 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.	E347	2. Form Revisions: The following Forms were reviewed and/or revised. On 10/30/08 further for revisions were implemented to coincide with policy revisions. • Pre Procedure Check List • Pre Anesthesia Questionnaire • Patient Identification Form • Pre Anesthesia Assessment. **Responsible Person:** CNO 3. An Ad Hoc Committee of Hospital Administration and Medical Staff Leadership met regarding the OR incident for a plan of action regarding the physicians' involvement. Focus of Education, Policy changes and expectations. **Responsible Person:** CEO AdHoc meeting held 10-30-08 with medical staff and key leaders to establish policy & procedure for compliance with regulations. **Responsible Person:** CEO, CNO	2. 10/15/08 10/31/08 11/04/08 approve by Governing Board 3.10/15/08 10/30/08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE CEO (X8) DATE 1/9/09

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E347	Continued From page 1 This Statute is not met as evidenced by: Based on review of facility documents, a review of patient's clinical records and interviews with staff, the facility failed to ensure policies and procedure were implemented for patient safety by accurately identifying a patient prior to implementation of a treatment, medication and/or procedure which resulted in a wrong surgical procedure being performed on Patient 1. The facility failed to endure the "Hand-off Communication" policy and procedure was implemented when Patient 1 was transferred to the operating room (OR) without exchange of accurate information about the patient's care and treatment which resulted in RN 1 transporting the wrong patient to the OR. RN 1 failed to identify Patient 1 by checking the patient's identification arm band prior to transporting the patient to the OR as stipulated in the Identification of Patient policy and procedure and Standards of Care For The Operating Room. The surgical team failed to check Patient 1's identification band with the chart prior to induction of anesthesia and prior to start of the surgical procedure. Patient 1 was scheduled for a Port-a-Cath placement, however, according to the documentation in the medial record "Because of mistaken identiy was given general anesthesia and dilatation and curettage was attempted." (Removal of contents of the uterus, after stretching, by means of an instrument.) On October 30, 2008 at 4:40 p.m., an immediate jeopardy (IJ) was identified due to the facility's failure to consistently implement policies and procedures for accurately identifying patient prior to the initiation of a surgical procedure and failure to implement the "Hand-off Communication" policy and procedure by exchanging accurate information about the patient's care and treatment. In addition, approximately two weeks after the adverse surgical incident involving Patient, 1 the facility continued to fail to safely protect patients from the wrong surgical procedure being performed on them by incomplete implementation of policies/procedures relating to

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E347	4. Medical staff meetings were held for all divisions who conduct surgery, special procedures, or other invasive procedures. Education was provided regarding the event, actions taken, policy & form revisions. A. Anesthesia Committee met 11/3/08 B. Surgery Committee met 11/12/08 C. OB Committee met 11/11/08 D. Medicine Committee met 11/17/08	4.see below A. 11/03/08 B. 11/12/08 C. 11/11/08 D. 11/17/08
	5. Education: a. Conducted Perioperative Update course for nursing staff to educate to policy revision, form revision and implementation expectations. **Responsible Person:** OR Director, Directors where procedures are performed.	5. a. Initiated 10/29/08 and is on-going
	b. Written Notification of policy changes and expectations mailed directly to all physicians. **Responsible Person:** CEO	b. 10/14/08
	c. General Staff Meeting for all physicians was held. Policy changes and expectations were reviewed and discussed. Compliance, with suggested policy changes were discussed by Medical Staff/Hospital Leadership. Changes approved. **Responsible Person:** Hospital CNO	c. 11/18/08
	6. Signage posted in prominent places throughout the facility including the Pre-op, OR, OR suites, physician lounges, dining room, dictation areas and scrub areas. Further revision of the posted signage done to coincide with policy & form revision. **Responsible Person:** Director of OR	6. 10/29/08 10/31/08

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E347	Continued From page 2 properly identifying patients prior to the initiation of a surgical procedure. Findings: On October 21, 2008 at 8:40 a.m., an unannounced complaint investigation was conducted to investigate a facility reported incident regarding a wrong surgical procedure performed on Patient 1. A review of Patient 1's clinical record on October 21, 2008, disclosed the patient was a 63 years old with diagnosis of colon cancer and was admitted to the Outpatient Surgery (OPS) area on October 14, 2008 for placement of a Port-a-Cath device for chemotherapy. A review of MD 1's (Medical Doctor) progress notes, dated October 15, 2008, documented that, "Because of mistaken identity the patient was given general anesthetic and dilatation and curettage was attempted, which was terminated when found that the patient did not have a uterus. Some biopsies apparently curetting of the vaginal cuff were taken." A review of MD 2's progress notes dated October 15, 2008 at 1:40 p.m., indicated the patient was already asleep when MD 2 entered the operating room. After the patient was prepped, there was some bleeding from the vagina. A pelvic exam was performed and MD 2 "Did not feel the cervix and uterus." MD 2 placed a weigh speculum and retractor and "could not see the cervix." MD 2 "used medium sized curette to collect the blood, did not do curettage and finished the procedure." During an interview on October 21, 2008 at 10:35 a.m., RN 1 stated she went to pick up the patient and there was no nurse available in the Outpatient Surgery area. RN 1 stated she "grabbed the chart, called out the patient's name and Patient 1 nodded her head. RN 1 brought the patient to the operating room and the anesthesiologist started putting the leads on the patient while he was "busy looking at the chart." RN 1 stated the patient was already asleep		***Permanent Compliance**:* Permanent Compliance is achieved by integrating the above changes into orientation, training and competency process. Ongoing monitoring is being conducted to assure adherence to standards. ***Hospital Staff:*** All temporary changes were implemented. Further corrective actions were implemented based on application into practice. 1. General and nursing orientation modified to include revised policy and procedure requirements. **Responsible Person:** CNO and Flex Education 2. Department specific competencies revised and implemented in the OPS, PACU, OR departments. **Responsible Person:**OR Director 3. Human Resources Process changed to require completed competencies to be sent to Human Resources within the first 90 days of employment. **Responsible Person:** Director of Human Resources. 4. Annual Competency Assessment revised to include Team Time out & universal protocol elements for all nurses. OR, OPS, PACU Unit specific competencies revised to include dept specific process elements. **Responsible Person:** CNO, OR Director, Directors where procedures take place. 5. Annual Safety Update to be revised to include current requirements **Responsible Person:** DCPI and Director Support Services	1. 11/08 2. 10/29/08 and on-going 3. 11/08 and on-going 4. 2009 5. March 2009

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	Continued From Page 4 when the surgeon entered the room. When asked if the surgical team had done the "Time-Out," RN 1 stated they "did a quick time-out with the patient's chart by checking consent for the patient's name and procedure." When asked if the identification arm band was checked, RN 1 stated he did not check the arm band during the "Time-Out." When asked if she checked Patient 1's identification arm band in the pre-op area, prior to transporting the patient to the operating room, RN 1 stated she "did not check the patient's arm band." A review of Patient 1's Intraoperative Nursing Record dated October 14, 2008, disclosed Patient 1 was in Operating Room 5 at 12:20 p.m., anesthesia was started at 12:35 p.m. and the surgery ended at 12:40 p.m. There was no documented evidence in Patient 1's clinical record that the Correct Side/Site and Time-Out Verification Checklist was completed prior to the procedure. A review of the facility's "Hand-Off Communication" policy and procedure (H.107.0) dated 06/20/06, indicated the objective was, "To provide accurate information about a patient's care, treatment or services when responsibilities are "handed off" from one care provider to another." The policy and procedures stipulate the hand off communication would occur when, "transferring a patient from one internal level of care to another or nursing unit." A review of the facility's Identification of Patient policy and procedure (I.108.1) dated, as revised 02/28/08 disclosed, "Before any procedure begins on a patient, the identification of the patient will be verified by the health care professional providing the care." The policy and procedure stipulate to, "Verify information on the patient armband on conscious/alert adult/child." The policy also indicated that all patients in the facility being		***Physicians:*** The items listed below were implemented to achieve permanent compliance with our processes involving Universal Protocol. 1. All temporary compliance measures were implemented with changes as required secondary to clinical application, as indicated above. 2. New Physician Orientation was revised to include expectations for patient identification as per "Identification Policy", Universal Protocol and Team Time Out, Hand Off Communication, and Communication expectations for translator use. **Responsible Person:** Director Medical Staff 3. Monitoring of Team Time Out compliance with drill down by MD. Report findings to Medical Staff Committees, MEC and Governing Board for action. **Responsible Person:** Quality Manager and Director of Medical Staff 4. Notification to Physicians that fallouts from these policy changes and expectations will be filed in their Credentialing Packet and appropriate action taken. **Responsible Person:** Director Medical Staff	1. 12/02/08 2. 12/02/08 and on-going 3. Initiated 12/02/08 and on-going 4. On-going

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	Continued From Page 5 provided care would be given a wristband at the time of registration and stipulated that, "Before any interaction or procedure begins on the patient, the identification will be verified by the healthcare professional providing care. The patient will be asked to verbally provide his/her name when possible." A review of the Universal Protocol – Surgical/Procedural Site/Side Identification and Verification For Invasive Procedures policy and procedure (S.118.3) dated as revised 03/07/07, disclosed that, "The surgical/procedural site/side will be verified by the patient and/or legal representative and the physician performing the procedure, prior to entering the operating/procedural room." The policy stipulate that, "Prior to the start of any non-emergent invasive procedure, there will be a final verification process that will identify the patient, procedure, physician performing the procedure and procedure side/site. "The policy indicated that the information would be documented in the medical record, "utilizing the Time-Out Verification Form." A review of the Standards of Care For The Operating Room (OR) policy and procedure (291) dated as revised 09/03, included proper identification of patient on transportation of patient to OR, Identification (ID) band checked with chart on initial patient interaction by RN. A review of the facility's action plan in response to the incident involving Patient 1, dated October 21, 2008, disclosed risk reduction strategies to include the following: "Surgeon must lead the Time-Out procedure. Patients are not put to sleep until Time-Out had been completed. Revise Universal Protocol Policy. Reinforce identification of Patient policy to ensure armbands are checked before a procedure."		**Education:** 1. Mandatory Hospital staff education was conducted for all the surgery and pre operative staff post incident regarding the Identification Policy, Universal Protocol, Team Time Out, Hand Off Communication, Communication of Impaired Individuals and the Out Patient Process. (Competencies) To date, ____% of surgery staff have completed. **Responsible Person:** OR Director and Directors where procedures take place. 2. Unit Specific orientation/competencies were revised and implemented. **Responsible Person:** OR Director 3. Medical Staff was re- educated regarding the importance of the Universal Protocol through one to one meetings with quality manager, medical staff meetings and communication from administration. Medical Staff Committee education A. Anesthesia Committee B. Surgery Committee C. OB Committee D. Medicine Committee **Responsible Person:** CEO, CNO, Director of Surgery, Quality Manager 4. Expectations redefined by the CEO of the facility . **Responsible Person:** CEO 5. Quality Manager sent follow up letter to physicians for expectations. **Responsible Person:** Quality Manager 6. 1 to 1 Education to Anesthesia regarding Team Time Out Policy and their responsibilities and expectations. **Responsible Person:** Quality Manager	1. On-going 2. 10/31/08 3. A. 11/03/08 B. 11/12/08 C. 11/11/08 D. 11/17/08 4. 10/14/08 5. 12/08/08 6. 10/31/08 and on-going

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	Continued From page 6 On October 30, 2008, a review of the facility's action plan, dated October 30, 2008, revealed the following: "Surgeon must lead the Time Out procedure. Patients are not to be put to sleep until Surgeon and Circulator Nurse have completed the Time Out. Policy Revisions – Identification of a Patient, Universal Protocol – Team Time-Out, Hand-Off Communication." In addition, the Anesthesia Documentation requirement disclosed that, "A patient is not to be put to sleep until after the surgeon has completed the Team Time-Out." On October 30, 2008 at 10:58 a.m., during observation in the operating room prior to a surgical procedure, the OR staff was observed conduction a Time-Out procedure, the surgeon led the Time-Out and all members of the team participated. The patient was sedated during Time-Out observation. In an interview at 11 a.m., RN 2 stated a Time-Out had been done then the surgeon had to go the bathroom. RN 2 stated the Evaluators observed a second Time-Out. At 1:35 p.m., the same day, during an interview, Scrub Tech 1 stated that after Time-Out was called the surgeon left for about 15 minutes. On October 30, 2008, a review of 6 closed clinical records, of patient admitted since the incident involving Patient 1 on October 14, 2008, revealed that 5 of the 6 records identified the patients had received anesthesia prior to the Time Out procedure. For example: a. A review of Patient 3's clinical record indicated the patient presented to the Emergency Room with acute pelvic pain on October 29, 2008.		**On-Going Monitoring:** 100% audit of all surgery cases until hospital is able to demonstrate a four - month sustained performance of 90% compliance. **Responsible Person:** Quality Manager, OR Director, Directors where procedures are done, Medical Staff, CNO, CEO	Initiated 10/31/08 and on-going **Current Compliance** Nov. 2008 99.6% Dec. 1-16, 2008 compliance 100%

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	Continued From page 7 The Pre-Procedure Surgery Checklist Section, designated for the Surgery/Procedure Unit was not completed. The Anesthesia Documentation Record dated October 29, 2008, indicated the anesthesia started at 1:45p.m., surgery started at 1:57 p.m. and ended at 2:06 p.m. The Correct Side/Site and Time-Out Verification Checklist documentation for Patient 3 indicated the Time-Out was done on October 29, 2008 at 2:55 p.m., one (1) hour and ten (10) minutes after the anesthesia was started and forty-nine (49) minutes after the surgical procedure ended which was not in accordance with the Time-Out policy and procedure. The record indicated Patient 3 had a dilatation and curettage procedure under general anesthesia. During an interview, on October 30, 2008 at 3:15 p.m., Administrative Staff B stated the Pre-Procedure Surgery Checklist must be completed. Administrative Staff B acknowledged the time of "Time-Out" and was not able to explain the discrepancy with the time. b. A review of Patient 4's Anesthesia Documentation Record dated October 28, 2008, revealed anesthesia started at 10:46 a.m., and surgery started at 11:26 a.m., and Time-Out Verification Checklist documentation indicated Time-Out was done on October 28, 2008 at 11:25 a.m., thirty-nine (39) minutes after anesthesia was started. The record indicated Patient 4 had dilatation and curettage procedure under general anesthesia. In an interview at 4 p.m., RN 2 was not able to explain why the Time-Out documentation for Patient 3 indicated 2:55 p.m. when the surgery started at 1:57 p.m. RN 2 acknowledged the time of "Time-Out" verification for Patient 4. c. A review of Patient 5's Anesthesia Documentation Record dated October 28, 2008, indicated anesthesia			

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	Continued From page 8 started at 8:34 a.m., and surgery started at 9:09 a.m. The Correct Side/Site and Time-Out Verification Checklist documentation indicated the Time-Out was done on October 28, 2009 at 9 a.m., twenty six (26) minutes after anesthesia was started. d. A review of Patient 6's Anesthesia Documentation Record dated October 28, 2008, revealed anesthesia was started at 8:20 a.m., and surgery started at 8:51 a.m. The Correct Side/Site and Time-Out Verification Checklist documentation indicated the Time-Out was done at 8:50 a.m., thirty (30) minutes after anesthesia was started. The record indicated Patient 6 had general anesthesia. e. A review of Patient 8's Anesthesia Documentation Record dated October 29, 2008, indicated anesthesia was started at 1:05 p.m. and surgery started at 1:25 p.m. The Correct Side/Site and Time-Out Verification Checklist documentation indicated the Time-Out was done at 1:24 p.m., nineteen (19) minutes after anesthesia was started. The record indicated Patient 8 had general anesthesia. These policy and procedure failures resulted in Patient 1 having the wrong surgical procedure performed on her and subjected the patient to unnecessary use of general anesthesia.			