



CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY  
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  050168	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/04/2010
NAME OF PROVIDER OR SUPPLIER ST. JUDE MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 101 E. VALENCIA MESA DRIVE, FULLERTON, CA 92835 ORANGE COUNTY		
(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
	<p><b>Continued From page 1</b></p> <p>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.</p> <p>DEFICIENCY CONSTITUTING IMMEDIATE JEOPARDY</p> <p>T22 DIV5 ART3-70223(b)(2) Surgical Service General Requirements</p> <p>(b) A committee of the medical staff shall be assigned responsibility for:</p> <p>(2) Development, maintenance and implementation of written policies and procedures in consultation with other appropriate health professionals and administration. Polices shall be approved by the governing body. Procedures shall be approved by the administration and medical staff where such is appropriate.</p> <p>This regulation is NOT MET as evidenced by:</p> <p>Based on interview and record review, the hospital failed to ensure implementation of its written policy and procedure and current standards of practice in that it did not perform a thorough follow-up after a surgical count identified a surgical sponge was missing with the result that a sponge was retained for two and one half months with delayed wound healing and the increased risk of infection.</p> <p>Findings:</p> <p>On 9/7/10, the hospital notified the Department of a</p>		<p><b>T22 DIV5 Surgical Service General Requirements</b></p> <p>a) <b>How the correction will be accomplished, both temporarily and permanently.</b></p> <p>The following process changes and standard work were implemented to both temporarily and permanently eliminate the reoccurrence of this type of event.</p> <p>Standard work was developed for the count process that includes the missing sponge count, critical thinking processes and reasons why certain actions are taken in the sequence required.</p> <p>The process changes include addressing what to do at the end of a case where the count is not resolved, how to escalate the potential event, what script to use to communicate, what follow up processes are required to occur once the sponge cannot be accounted for.</p> <p>A script was developed for staff and surgeons to clearly communicate the count issues.</p> <p>The final count process is completed when all sponges are removed from the patient.</p> <p>The count policy was updated to include the following items: final stitch announcement from surgeon to surgical team; two procedure cases where there is no closure, but packing is utilized; a two table set up for a two procedure case as well as counting for the final</p>	<p>2/28/2012</p> <p>2012 FEB 1 PM 11 25</p>

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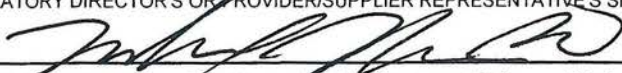
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. Except for nursing homes, the findings above are 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.

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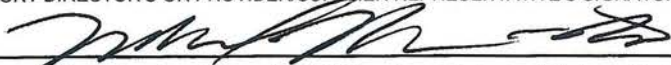
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