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
	050279	A. BUILDING _____ B. WING _____	06/10/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HI-DESERT MEDICAL CENTER	6601 WHITE FEATHER RD, JOSHUA TREE, CA 92252 SAN BERNARDINO COUNTY

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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
	The following reflects the findings of the California Department of Public Health during the investigation of a complaint. Complaint numbers: CA00190039 and CA00189824. Representing the California Department of Public Health: [redacted], RN, MS, HFEN. The inspection was limited to the specific complaint investigated and does not represent the findings of a full inspection of the facility. One deficiency was written as a result of complaint numbers CA00190039 and CA00189824. REGULATION VIOLATION: 70213 Nursing Service Policies and Procedures (a) Written policies and procedures for patient care shall be developed, maintained and implemented by the Nursing Service. Based on interview and record review, the facility failed to implement their policy and procedures for ensuring the safe use of an electric cautery machine and its grounding system prior to a surgical case which resulted in a 2nd degree burn on the lower back of Patient A on 5/22/09. FINDINGS: On 6/10/09, a self-reported facility incident was investigated regarding a 4 year old female who underwent an uneventful tonsillectomy & adenoidectomy on 5/22/09, however, prior to being		**PLAN OF CORRECTION** **1.** The gel pad utilized for the grounding of the patient was removed from service until the equipment was evaluated by an outside company (**temporary**) **Person Responsible** : Stephanie Eigner OR Director **Monitoring Process**: Individual grounding patches were utilized while the grounding gel pad was removed from use. **2.**-On Sept. 3, 2009 An educational session on the electrical hazards involved in the use of cautery and the grounding gel pad system was provided to all the operating room staff. **Person Responsible**: Stephanie Eigner OR Director (**Temporary**) **Monitoring Process**: All the employees were individually observed during a "Hands on" practice in the use of the cautery and grounding gel pad to ensure that the correct technique was used.	**May 22, 2009** **Sept. 3. 2009**

Event ID:7NZN11 11/24/2009 2:18:57PM

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lionel "Chad" Chadwick	Chief Executive Officer	12/2/09

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	Continued From page 1 discharged to home; a 4x7 centimeter, 2nd degree burn was discovered to her lower back. According to a facility letter to the California Department of Public Health received on 7/1/09 at 4:42 PM, the facility confirmed on 5/22/09, a 4x7 centimeter burn was identified to the lower back area on Patient A, and that "interference" of Patient A's cautery machine's grounding system was possibly due to Patient A urinating while on the operating room table. Review on 7/6/09 of the nurse's progress notes dated 5/22/09 (not timed) indicated that after receiving general inhalation by mask, the Anesthesiologist placed Patient A on the operating room table when she urinated on the table. Documentation indicated that Staff Nurse 1 folded a cotton blanket and placed the blanket underneath the patient, covering the area where she had urinated. Review on 7/6/09 of the nurses' progress notes dated 5/22/09 and timed at 8:29 AM, indicated while in the recovery room, the nurse anesthetist discovered a 4x7 centimeter burn to Patient A's lower back. In addition, documentation indicated that Patient A's primary physician had been notified and had requested a surgical consult to evaluate the burn on Patient A. Review on 7/6/09 of the surgical consult's progress notes dated 5/22/09 and timed at 11:00 AM, indicated that a deep, 2nd degree burn had occurred during surgery and was described as		**3.** - A new process has been designed to ensure all staff is educated on new/revised policies and procedures especially when such P&Ps are related to critical functions performed by the employees regardless of their category (Full Time, Part Time, Per Diem). **a)** The term "Mandatory Educational in-service" will be used for essential education such as: New/revised Policies and Procedures, implementation of new devices, high risk equipment, or new techniques needed by the employees to perform critical functions/activities inherent to their jobs and scope of practice. **b)** All "Mandatory Educational In-services" will include a component to verify the employee understanding of the educational materials. The verification of the understanding may be through testing, return demonstration, or other acceptable methods determined by the course's instructor **c)** Any employees who missed a "Mandatory Educational In-service" will be allowed 2 weeks to complete a recommended alternative training module(s) and/or competencies. **d)** Employees who failed to take the recommended alternative training in the 2(two) weeks allowed, will be suspended from performing their jobs until such requirement is satisfied.	**Dec. 29, 2009**

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Lionel "Chad" Chadwick | Chief Executive Officer | 12/10/09

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	Continued From page 2 being "... a vesicular formation surrounded by a ring of erythema." Further documentation indicated the following treatment regiment for Patient A's burn: a. Silver sulfadiazine cream to burn site (medication used to prevent and treat sepsis in 2nd and 3rd degree burns). b. Tylenol with codeine, 1 teaspoon by mouth every 4 hours as necessary for pain. c. Unasyn antibiotic, 1.5 grams intravenous piggy back drip every 6 hours. Review on 7/6/09 of the facility's Adverse Event Report dated 6/1/09 indicated in its' conclusion that "...the burn occurred at the surgery site due to the inability of the ground pad to provide adequate capacitance (hold of electric charge) relative to the limited surface area. Heat in the presence or absence of acidic urine resulted in partial thickness chemical burns." During an interview with Surgery Staff Nurse 1 on 7/6/09 at 12:40 PM, she stated that when she saw that Patient A had urinated on the operating room table she went to get a folded cotton blanket from the self and placed the folded cotton blanket underneath the patient's bottom, covering the wet spot. Review on 7/6/09 of the facility's policy and procedure titled: "Patient Safety With The Cautery Machine" dated 7/2006 indicated in section 6: "...Do not place excessive linens or excessive amounts of other materials between the patient and the electrode ground pad. The use of excessive		**e)** The new Policy and Procedure on the attendance to mandatory In-services was approved by the Board of Directors on Dec. 8, 2009 **f)** All hospital staff will be educated on the new Policy & Procedure on attendance to mandatory in-services. **g)** The new Policy and Procedure on Attendance to Mandatory In-services will be fully implemented hospital-wide **Person Responsible**: Jackie Combs -Chief Nursing Officer, Kathy Alkire Staff Educator **Monitoring Process**: After the completion of every "Mandatory Educational In-service" the attendance list and training Materials will be provided to the Educational Dept., they will identify the employees who failed to attend the in-service and notify the Department Director responsible to follow up on the completion of such in-service by all the required employees.	**Dec. 29, 2009**

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material between the patient and ground pad assemble may result in a diminished electrosurgical effect."

Review on 7/6/09 of the facility's Biomedical Consulting Services report (an independent analysis report) dated 5/30/09 indicated in its' conclusion that "...the cautery unit was within clinical engineering standards, and the burn sustained was due to interference with the electrical coupling between the patient and the ground pad surface. This may have been due to the presence of the damp towel or the small area of contact that was created between the patient and the ground pad."

During an interview with the Operating Room Manager on 7/6/09 at 1:10 PM, she confirmed that Surgical Staff Nurse 1 should not have placed a folded towel underneath Patient A when she urinated on the operating room table and agreed that it was against policy to do so. In addition, she stated that Surgical Staff Nurse 1 had not attended the in-service training session given by the manufacturer's representative on 2/9/09 regarding the safe use of the cautery machine (Megadyne 1000) and its grounding system (Mega 2000 Grounding Pad).

Review of the department of surgery's policy and procedures titled: "Safety In The Operating Room" dated 4/2007, indicated that all personnel"...shall be instructed in the proper use of all equipment used in the Operating Room and the Recovery Room."

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Review on 7/6/09 of Patient A's physicians' progress notes dated 5/22/09 and timed at 1:50 PM indicated that after discussion with Patient A's physicians', the family decided to transfer their daughter (Patient A) for further treatment to the burn unit at Acute Hospital B pending Patient A's acceptance.

Review on 7/8/09 of Acute Hospital B's inpatient progress notes dated 5/22/09 and timed at 5:15 PM indicated that Patient A was a "direct admit" to the pediatric floor by her accepting physician and was tentatively scheduled for surgery, the following day, on 5/23/09.

Review on 7/8/09 of Acute Hospital B's inpatient progress notes dated 5/23/09 and timed at 3:00 AM indicated that Patient A's physician assessed Patient A as having a 2nd or 3rd degree burn to her left lower back area which required surgery.
Review on 7/8/09 of Acute Hospital B's surgery notes and post surgical inpatient progress notes dated 5/23/09 indicated Patient A underwent a surgical "irrigation and debridement" procedure with "closure of left flank wound" on 5/23/09, and was discharged home, on 5/24/09.

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