

CALIFORNIA HEALTH AND HUMAN SERVICES AGENCY
DEPARTMENT OF PUBLIC HEALTH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 050228	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/09/2010	
NAME OF PROVIDER OR SUPPLIER SAN FRANCISCO GENERAL HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 1001 POTRERO AVENUE, SAN FRANCISCO, CA 94110 SAN FRANCISCO COUNTY		
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	<p>Continued From page 1</p> <p>Based on interview and record review, the surgeon failed to implement the facility's Consent to Medical and Surgical Procedures and the Surgicenter staff, surgical resident, and operating room staff failed to implement the facility's Universal Protocol for Verification of Surgical and/or Invasive Procedures. These failures resulted in Patient 1 having the wrong surgical procedure. Patient 1 had a left partial mastectomy (removes breast tissue containing the tumor/lump) on [REDACTED]/09 instead of the left total mastectomy (removes the whole breast) she had requested and signed a consent for.</p> <p>Findings:</p> <p>Patient 1 was admitted to hospital on [REDACTED]/09 for a left mastectomy with sentinel node biopsy (helps to determine if cancer has spread outside the breast tissue). On [REDACTED]/09, the facility notified the Department that the surgeon performed a left partial mastectomy instead of a left mastectomy (full mastectomy).</p> <p>On 10/29/09 at 12:25 p.m., the Director of Risk Management, the Director of Regulatory Affairs, the Director of Perioperative Services and the Nurse Manager of Perioperative Services were interviewed. The Director of Risk Management stated that Patient 1 was seen in the breast clinic on [REDACTED]/09 to discuss surgical options as she had recently been diagnosed with cancer in her left breast. Patient 1 wanted time to think about her options but by the end of the appointment agreed to schedule a left partial mastectomy. The patient</p>		<p>Following the complaint validation site visit by state licensing on October 6, 2009, Hospital and Perioperative Services leadership met to review the incident and identify corrective actions.</p> <p>The SurgiCenter Nurse Manager immediately implemented frequent observation of SurgiCenter patients awaiting surgery through rounds conducted at least every 30 minutes by SurgiCenter staff (see Attachment 2).</p> <p>The Attending Surgeon was counseled by the Chief of the Medical Staff and the Chief Medical Officer regarding consent procedures and patient disclosure procedures.</p> <p>The nurse staffs of the surgical clinic, Operating Room, and SurgiCenter involved in the incident were counseled by the Nurse Managers of their units.</p> <p>The incident was reviewed in OR Committee.</p> <p>The Co-Chairs of the Operating Room (OR) Committee implemented the following changes to the OR case scheduling procedures for elective and emergency surgeries of both inpatients and outpatients in order to improve patient safety in the perioperative setting effective immediately:</p>	<p>Initiated October 16, 2009 and ongoing</p> <p>October 2009</p> <p>October 2009</p> <p>October 13, 2009</p> <p>Initiated October 22, 2009 and ongoing</p>

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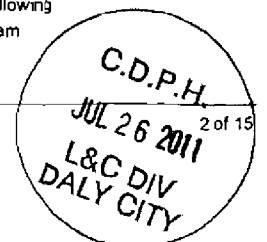
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	<p>Continued From page 2</p> <p>signed a consent for a left partial mastectomy and a form was faxed to the operating room scheduler requesting Patient 1 be scheduled for the procedure. On [REDACTED]/09, Patient 1 had a preoperative appointment in the breast clinic and at that time she stated she wanted a full mastectomy not a partial. The Director of Risk Management said the nurse practitioner who saw the patient documented that the surgeon was notified that Patient 1 wanted a mastectomy not a partial mastectomy. Consent for a mastectomy was signed by Patient 1 and a form was faxed to the operating room scheduler requesting Patient 1 be scheduled for a mastectomy not a partial mastectomy. The Director of Risk Management stated the only consent in Patient 1's record now was the one for a left mastectomy. He said "The consent for the partial mastectomy has disappeared."</p> <p>The Director of Perioperative Services stated that SurgiCenter RN 1 who prepared Patient 1 for surgery on [REDACTED]/09 failed to confirm the procedure with the patient per the facility's policy. She stated that Patient 1 spoke to Surgicenter RN 2 regarding her concern about the consents and that she wanted a mastectomy not a partial mastectomy. However, Surgicenter RN 2 told the patient to talk to her surgeon about her concerns. Even though SurgiCenter RN 2 saw two consents in Patient 1's medical record (one for a left mastectomy and one for a left partial mastectomy) she did not follow up on the discrepancy or notify the patient's primary nurse or surgeon about the patient's concerns.</p> <p>The Director of Perioperative Services said when</p>		<p>*Cases are now scheduled by hand-delivering a completed OR scheduling form to the OR front desk. Faxed scheduling requests are no longer accepted.</p> <p>*Scheduling forms that are faxed to the OR are not scheduled and the OR front desk contacts the scheduling clinic or physician.</p> <p>*Changes in the surgical procedure require completion of a new scheduling form which must be hand-delivered to the OR front desk as described above. At that time, the prior procedure is cancelled out and the new procedure entered.</p> <p>* Effective November 2, 2009, cases can only be scheduled by delivering a completed OR scheduling form AND a completed and signed surgical consent form to the OR front desk. The scheduling form and consent must match.</p> <p>* Effective November 2, 2009, cases can only be scheduled when the consent form is properly completed and the surgical procedure on the consent matches the procedure on the scheduling form. This is verified by OR front desk personnel.</p> <p>* Effective November 2, 2009, discrepant forms are returned to the person scheduling for correction (see Attachment 3).</p> <p>The SurgiCenter Nurse Manager met with the SurgiCenter staff to review the incident and implement corrective actions including but not limited to:</p>	October 22, 2009

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	<p>Continued From page 3</p> <p>Circulating RN 2 conducted the time out prior to the beginning of Patient 1's surgery she did not use the consent form to confirm the correct procedure. The Director of Perioperative Services said the expectation was that the circulating nurse would use the consent form during the time out to verify the correct patient, procedure etc. She said the OR schedule for 09 listed Patient 1's procedure as a left partial mastectomy, left sentinel node biopsy. She stated when the operating room staff received the form scheduling Patient 1 for a mastectomy, they must have seen she was already scheduled for a procedure and assumed it was the same procedure. She said "They didn't check the procedure; a mastectomy means the whole breast is removed, a partial means only a part of the breast is removed."</p> <p>The facility's Universal Protocol for Verification of Surgical and /or Invasive Procedures with revised date of 11/2004, was reviewed and indicated the following: Statement of Policy: It is the policy of (name of facility) that prior to the start of any invasive/surgical procedure that may place the patient at risk, a verification process is completed and documented. The verification process identifies and confirms the correct site, procedure and patient and the availability of the correct radiological films, implants, special equipment or requirements (when applicable). Scope: 1. Verification for invasive /surgical procedures is required for all procedures that may place a patient at risk.</p>		<p>*rounding on preoperative patients at least every 30 minutes,</p> <p>*customer service and communication,</p> <p>*documentation of comfort measures, patient concerns, communication with family, and other issues identified during preop rounds in the Operating Room Management Information System (ORMIS),</p> <p>*documentation in the medical record about communication regarding discrepancies, omissions, and/or changes in the patient's condition to a member of the patient's surgical team in real time,</p> <p>*reassessment of patients upon return from diagnostic tests, imaging, etc.</p> <p>*notification of SurgiCenter Nurse Manager or covering manager when the patient is required to wait longer than two hours after their scheduled surgery time to ensure that a member of the surgical team speak with the patient regarding the reason for the surgical delay (see Attachment 4).</p> <p>The SurgiCenter Nurse Manager created new SurgiCenter Policy X: Preoperative Patient Care and Documentation to codify the management of pre-operative patients including frequent observation (at least every 30 minutes), re-assessment of patients returning from diagnostic tests/imaging, etc., preop chart audits, and guidelines for</p>	October 23, 2009
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	<p>Continued From page 4</p> <p>4. The verification process includes positive patient identification and comparing the patient's response to their wrist band and consent.</p> <p>5. A "Time Out" occurs immediately prior to incision or other invasive action and must be conducted in the location where the procedure will be done.</p> <p>6. The "Time Out" must include verification of: correct patient, correct site, correct procedure, correct patient position, correct radiological exam (when applicable) and correct implants or any special equipment or requirements (when applicable).</p> <p>Procedure</p> <p>I. Scheduling and Consenting</p> <p>A. The verification process for invasive/surgical procedures begins with consenting the patient and scheduling him/her for the procedure.</p> <p>D. All discrepancies or questions must be verified with the attending surgeon/provider and resolved prior to the procedure.</p> <p>II. Pre-procedural/Preoperative Verification</p> <p>A. Hospital personnel processing the patient must verify the patient's identity by asking him/her to state their full name and date of birth and the procedure/surgery to be performed and ensure that the information is the same on the wrist band, consent form, radiographic films, site mark and required documentation in the medical record (e.g. MD note, OR scheduling form).</p> <p>III. Marking of the Operative /Procedural Site.</p> <p>A. Prior to marking the site(s), the consent(s), history and physical and radiological exam(s) (if</p>		<p>documenting in the medical record (see Attachment 5).</p> <p>The SurgiCenter Nurse Manager in-serviced the SurgiCenter staff on the new SurgiCenter Policy: Preoperative Patient Care and Documentation (see Attachments 4, 5).</p> <p>The OR Leadership approved implementation of a revised format for universal protocol called a "rolling time-out" with ongoing monitoring and process improvement.</p> <p>Risk Management staff in-serviced the SurgiCenter staff regarding the requirements of Admin Policy 3.9 /Consent to Medical and Surgical Procedures (see Attachment 6).</p> <p>The incident was reviewed at the OR staff meeting (see Attachment 7).</p> <p>The SurgiCenter Nurse Manager developed a Perioperative Patient Satisfaction Survey tool in response to concerns about the customer service aspect of patient care in the SurgiCenter (see Attachment 8)..</p> <p>The Surgicenter Nurse Manager initiated a patient satisfaction survey of perioperative patients using the new survey tool to establish patient satisfaction with care.</p>	<p>October 2009</p> <p>October 26, 2009</p> <p>October 27, 2009</p> <p>October 28, 2009</p> <p>October 29, 2009</p> <p>Initiated October 2009 and ongoing</p>

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	<p>Continued From page 5</p> <p>applicable) are completed and verified for accuracy by the performing physician/provider.</p> <p>B. The physician/provider to perform the procedure or a provider on his/her team/service that will be involved with the case asks the patient or decision-making surrogate to state their name, date of birth, the intended procedure(s) and the site(s)/side(s) of the procedure.</p> <p>IV. Active Final Verification ("Time Out")</p> <p>A. A verbal "Time Out" must be done immediately before the start of the case.</p> <p>C. The "Time Out" verbally verifies the correct:</p> <ul style="list-style-type: none"> patient procedure site/side position Radiological film (if applicable) Implants (if applicable) special equipment and/or requirements (if applicable) <p>E. The physician/provider ensures the completion of the "Time Out" and its documentation in the medical record.</p> <p>Surgicenter RN 1 was interviewed on 10/29/09 at 1:25 p.m. and stated she took care of Patient 1 in the pre operative area. She said it was the practice in the Surgicenter to verbally confirm the procedure with the patient and check the consent form. She said she couldn't remember if she confirmed Patient 1's procedure with her or if she checked the patient's consent form to verify the procedure. Surgicenter RN 1 stated " I should have documented I did it, but I didn't that time." She said Patient 1 had to go to another hospital to have her</p>		<p>The 5C Nurse Manager reviewed Admin Policy 20.04/Transport of Medical-Surgical Patients To Clinical Diagnostic Departments/Clinics with 5C nursing staff reminding them of the policy requirements around transport of patients to outpatient clinical areas (see Attachment 9).</p> <p>The SurgiCenter Nurse Manager reviewed the revised OR case scheduling procedures for elective and emergency surgeries of both inpatients and outpatients practice changes with the PACU & SurgiCenter staff (see Attachment 10).</p> <p>The OR Committee approved implementation of new OR Policy 30.0/ Operating Room Rolling Time-Out Policy which included the latest versions of the rolling time-out form, surgical site marking guidelines and time-out checklist (see Attachment 11)</p> <p>The Medical Director of Perioperative Services/Clinical Director of Anesthesia Services disseminated notice via email about the new OR Policy 30.0/ Operating Room Rolling Time-Out Policy, which included the latest versions of the rolling time-out protocol form, surgical site marking rules, and time-out checklist to be implemented effective January 4, 2010 to the Department of Anesthesia faculty and to the OR Committee members (see Attachment 12).</p>	<p>November 2009</p> <p>November 4, 2009</p> <p>December 15, 2009</p> <p>December 20, 2010</p>

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	<p>Continued From page 7</p> <p>operative staff had reviewed the paperwork and the patient was ready for surgery. Circulating RN 1 stated she was "flipping " through the chart and noticed the two consents, one for a left partial mastectomy and one for left mastectomy. She said because Patient 1 had a bandaid on her left breast from nuclear medicine and the consent for the left partial mastectomy was on top, "it all pointed to a partial." She said "We normally go with the top consent." She said she returned to the operating room to finish setting up for the case and the anesthesia staff brought Patient 1 to the operating room.</p> <p>A review of the facility's operating room schedule dated [REDACTED]/09 listed Patient 1's surgical procedure as "Left Partial Mastectomy, Left Sentinel Node Biopsy."</p> <p>Surgeon 1 was interviewed on 10/29/09 at 2:20 PM and stated Patient 1's consent for surgery was obtained by a nurse practitioner in the clinic two to three weeks prior to her surgery. When asked if she was notified by the nurse practitioner that Patient 1 wanted a full mastectomy she responded "I don't remember that." She said she had not seen Patient 1 since her initial clinic appointment on [REDACTED]/09. She stated she did not see Patient 1 the day of her surgery until the patient was in the operating room and had already received general anesthesia. She said a member of the surgical team, a resident or intern will see the patient before the procedure to complete the pre-surgical history and physical which would include looking at the consent and confirming the procedure with the</p>		<p>The Perioperative Management Executive Team (PEMT) was established as a result of process improvement recommendation made by the Risk Management Committee. The PEMT reports to the OR Committee and is responsible for strategic planning, performance improvement, and the day-today operations of the perioperative area (see Attachment 14).</p> <p>Final revisions to Admin Policy 3.9/Consent to Medical and Surgical Procedures, including the addition of the Addendum for Surgical Consent for Breast Cancer Surgery form, were approved by the Nursing Executive Committee (NEC), the Medical Executive Committee (MEC) and the Quality Council (QC) (see Attachment 15).</p> <p>The Director of Perioperative Nursing Services instructed the staff of the OR, the SurgiCenter, and the Surgical Specialty Clinic (3M) via memo regarding the new requirement that all surgical patients scheduled for a breast surgery must have both a Consent For A Treatment or Procedure form and an Addendum for Surgical Consent for Breast Cancer Surgery form signed by the patient and attending surgeon in order for the surgery to proceed (see Attachment 16).</p>	<p>April 2010</p> <p>Approved by: NEC August 3, 2010 MEC August 5, 2010 QC August 17, 2010</p> <p>September 28, 2010</p>

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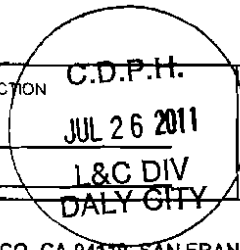
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	<p>Continued From page 8</p> <p>patient. She stated "He (the surgical resident) was in the OR during the time out; he did not say anything about a full mastectomy." Surgeon 1 stated a time out was done but she couldn't recall if the circulating nurse used Patient 1's consent form. When asked if she checked Patient 1's consent prior to the procedure, she responded "I don't usually look at the patient's consent." Surgeon 1 was asked how she knows which procedure to perform and she said "I look at my own pre-op note and what the OR (operating room) schedule is."</p> <p>Review of Patient 1's Pre-Surgical Interval History and Physical dated [REDACTED]/09 at 9 a.m. indicated the following: Procedure Planned: L Mastectomy with SLN biopsy</p> <p>Attestation Statement: I have verified the identity of the patient and the site and side of the surgery. The informed consent for the procedure has been completed per hospital policy. The surgical procedure remains as indicated above.</p> <p>Surgical Resident 1 had printed and signed his name below the attestation statement.</p> <p>During an interview on 10/29/09 at 3:20 p.m., Circulating RN 2 stated she initiated the time out prior to Patient 1's surgery because Circulating RN 1 was on break. She said prior to going on break, Circulating RN 1 gave her report and told her Patient 1 was scheduled for a left partial mastectomy. She said she verified Patient 1's surgical procedure based on what Circulating RN 1</p>		<p>Hospital and Perioperative Services leadership mandated use of the new Addendum to Surgical Consent for Breast Cancer Surgery form developed by the Chief of Surgical Services as an appendix to Admin Policy 3.9/Consent to Medical and Surgical Procedures. This addendum lists descriptions of the breast procedures with fields for the patient's initials documenting which breast procedure they are consenting to (see Attachment 17).</p> <p>The OR and 3M Breast Clinic staff conduct audits of 100% of Addendum to Surgical Consent for Breast Cancer Surgery forms to ensure compliance with policy expectations that consents are complete and that the</p> <p>Attending Physician name matched the name written on the hospital Consent to Medical and Surgical Procedures form. Audit results indicate 100% compliance and results are reported monthly to the OR Committee (see Attachment 18).</p> <p>The OR Committee approved revisions to the SFGH Perioperative Patient & Procedure Verification "Rolling Time-Out" form (see Attachment 19).</p> <p>Hospital leadership reviewed Admin Policy 21.7 /Universal Protocol for Verification for Surgical and/or Invasive Procedures and approved addition of language from the OR "Rolling Time-Out" protocol to the hospital</p>	<p>Initiated September 29, 2010 and ongoing</p> <p>Initiated October 2010 and ongoing</p> <p>November 2010</p> <p>Approved by: NEC Feb 1, 2011</p>
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	<p>Continued From page 9</p> <p>told her and what was on the operating room schedule. She said everyone present during the time out agreed on what the procedure was and the surgery proceeded. When asked if she had checked Patient 1's consent form or had it in her hand during the time out, she responded "No, I did not."</p> <p>Review of Patient 1's record on 10/29/09 showed an Outpatient Progress Record dated [REDACTED]09 which indicated the following: "Pt offered lumpectomy, sentinel node bx (biopsy) and radiation vs mastectomy only. Pt wishes to think about but ok with scheduling lumpectomy and sentinel node bx in next 2 weeks." There was a note from Surgeon 1 which consisted of the following: "Pt seen and examined." There was a Peri-Operative Case Preparation Form dated [REDACTED]09 which listed Patient 1's procedure as left partial mastectomy and left sentinel node biopsy.</p> <p>There was a Pre-Surgical Complete History and Physical form dated [REDACTED]09 which indicated the following under plan: " Pt desires mastectomy, reviewed with (name of Surgeon 1) OR papers changed to reflect new plan." A Peri-Operative Preparation Form dated [REDACTED]09 listed Patient 1's procedure as left mastectomy with sentinel node biopsy. The form was stamped that it was faxed to the operating room on [REDACTED]09. There was Consent for a Treatment or Procedure form which listed Patient 1's procedure as "Left Mastectomy with Sentinel Node biopsy." The authorization was signed by Patient 1 on [REDACTED]09 at 5:15 p.m. The Physician/Provider portion of the consent form was</p>		<p>policy. The additions were approved by SFGH Medical Executive Committee (MEC), Nursing Executive Committee (NEC), and Quality Council (QC) (see Attachment 20).</p> <p>Facilities staff completed preoperative waiting room renovations funded by grant monies: new furniture, new flooring, and new paint.</p> <p>Following receipt of this 2567, the Chief of Staff and Chiefs of Surgical Services met and agreed to implement the following additional actions to ensure patient safety during perioperative care:</p> <p>1. Health Stream – effective July 22, 2011, a revised module (incorporating #2 below) has been uploaded to the Health Stream system and all surgical fellows, residents and faculty rotating through the OR will be required to complete the module prior to performing OR cases.</p> <p>2 A Licensed Independent Practitioner (NP, resident, or faculty member) involved in the case (including in the Time Out) will perform the interval H&P and site marking for all scheduled OR cases. Note: this means that the attending physician or surgeon will be required to personally complete the interval H&P and the site marking for all cases where</p>	<p>MEC Feb 3, 2011</p> <p>QC Feb 15, 2011</p> <p>May 2011</p> <p>July 19, 2011</p> <p>Anticipate completion by August 1, 2011</p> <p>To begin August 1, 2011 and ongoing</p>

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	<p>Continued From page 10</p> <p>completed by NP (nurse practitioner) 1.</p> <p>There was a preoperative note written by Surgeon 1 on [REDACTED]/09 at 4 p.m., which included the following: "Consented for partial mastectomy + (and) sentinel node bx."</p> <p>During a telephone interview on 2/01/10 at 10:50 AM, Surgical Resident 1 stated he saw Patient 1 prior to her surgery but did not look at the consent or check it prior to marking the surgical site. He stated the first time he met Patient 1 was the day of her surgery and he wished he had been more thorough at the time. He acknowledged he was present during the time out but could not remember who initiated the time out or if the nursing staff referred to Patient 1's consent during the time out. He stated he didn't say anything during the time out because Patient 1 had consented for a mastectomy but the consent did not specify a "full or total mastectomy."</p> <p>During a telephone interview on 2/2/10 at 5:05 p.m., Patient 1 stated she remembered signing two consents. She said at her first clinic visit she meet Surgeon 1 for "about one minute." She said "I really wanted a mastectomy but she (Surgeon 1) was pushing for a lumpectomy so I said I would think about it." She said she signed the consent for a partial mastectomy but a couple of days later she called the clinic and told a nurse she wanted a mastectomy not a partial mastectomy. She said "I wanted my whole breast removed." Patient 1 stated she was not seen by Surgeon 1 during her pre operative visit at the clinic. She said a staff member</p>		<p>an intern or non-licensed PGY-2 is the only other practitioner involved with assisting the attending physician with the procedure (see Attachment 21).</p> <p>The Surgical Services Chiefs disseminated these changes to their respective staff via email.</p> <p>A formal case review of this incident and the corrective actions taken to ensure patient safety in the perioperative setting will be conducted with the nursing and medical staff of the medical surgical units, the Operating Room, the SurgiCenter, and the surgical clinics.</p> <p>Monitoring: Quality Management staff will conduct weekly random direct observation audits of rolling timeouts conducted in the operative setting for two weeks and then monthly for two quarters. Results will be reported monthly to Quality Council for two quarters.</p> <p>Responsible Person(s): Director of Quality Management</p>	<p>July 20, 2011</p> <p>To begin August 2011 and anticipate completion by October 2011</p> <p>To begin week of July 25, 2011 and anticipate completion by February 2012</p>
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	<p>Continued From page 11</p> <p>("I think it was a resident") reviewed the consent with her and she signed a consent for a mastectomy.</p> <p>She said the day of her procedure she was left lying on a gurney in a hallway. A few staff members came by to check her name and date of birth and said to her "You're having a lumpectomy." She said she told them "No, I'm having a mastectomy." Patient 1 said the staff would then go through her paperwork until they found the consent for mastectomy. Patient 1 said "You would think the paper for the procedure would be on top."</p> <p>She said anesthesia staff came by and started an IV (intravenous) line in her foot but didn't discuss the procedure with her. She said "Some guy came by and marked my left breast. They marked the right side but did the wrong thing." Patient 1 stated "The surgeon never spoke to me before the procedure so how would she know what to do?" She said she realized she hadn't had a mastectomy later that night after she was admitted to the nursing unit. She said she told the surgical resident who "seemed surprised."</p> <p>Patient 1 stated she told the nurse taking care of her the next day that she wanted to see her surgeon. She said she also asked the surgical residents if she could talk with Surgeon 1 and was told she could talk to her in the Breast Clinic that afternoon. She stated "She (Surgeon 1) didn't even come to see me; I had to go to the clinic." She said she went to the clinic and after waiting to see Surgeon 1 was told by staff she couldn't be seen</p>			



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	<p>Continued From page 12</p> <p>because she was an in patient and would have to be discharged from the hospital before she could be seen. She said she returned to the nursing unit and after she was discharged returned to the Breast Clinic where she was seen by Surgeon 1 at 4 p.m.</p> <p>Patient 1 stated Surgeon 1 apologized by saying "At least we didn't do a mastectomy instead of a lumpectomy." Patient 1 said she felt Surgeon 1's comment was inappropriate considering what had happened. She said "I felt so neglected, I was left on a gurney in a hallway for four hours, and I never saw her (Surgeon 1) she never spoke to me. I had to go to the clinic to see her after surgery, she wouldn't see me the first time, and I had to go back to the hospital, get dressed and go back to the clinic before she finally spoke to me." Patient 1 said she no longer felt safe receiving care at the facility and had not returned there since [REDACTED]/09 when she was told she needed chemotherapy and radiation treatment to treat her breast cancer. She stated "I'm not going back there, I don't trust them." She said she had an appointment at another hospital next week to begin treatment.</p> <p>RN 1 was interviewed on 10/29/10 at 4 PM and stated she took care of Patient 1 on [REDACTED]/09. She said the night nurse told her Patient 1 had "an issue" regarding the result of the surgery and was questioning why all of her breast was not removed. RN 1 stated it was "pretty clear" that Patient 1 wanted to talk to her surgeon. RN 1 said she told Patient 1 the surgeon would be doing rounds soon and should be coming to see her "but she didn't." She said she asked some of the surgical doctors</p>				
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	<p>Continued From page 13</p> <p>doing rounds to talk with Patient 1 but they told Patient 1 they had not been involved in her case and were trying to get hold of the attending physician (Surgeon 1). RN 1 said Patient 1 asked several times between 10 a.m. and 11 a.m. to talk to Surgeon 1 and she (RN 1) paged the surgical team several times but was told they were "working on it." She said somebody from the surgical team eventually told Patient 1 to go to the Breast Clinic to see Surgeon 1. RN 1 stated she thought this was "an odd plan" but Patient 1 was anxious to speak with Surgeon 1.</p> <p>RN 1 stated Patient 1 went to the Breast Clinic wearing a dressing gown and slippers and was accompanied by her daughter. However, she said Patient 1 returned to the nursing unit after lunch without seeing Surgeon 1. She said the Breast Clinic staff sent Patient 1 back to the nursing unit because she was an inpatient and could not be seen in an out patient area. RN 1 stated the Breast Clinic staff called her and told her it was not appropriate to send Patient 1 to the clinic and that they would page Surgeon 1. She said the surgical team got an order to discharge Patient 1 who went back to the Breast Clinic where she was finally seen by Surgeon 1. RN 1 stated "Her goal was to talk to her Attending, she was focused on it."</p> <p>A review of Patient 1's Inpatient Progress Record dated [REDACTED] 09 at 6 a.m. indicated the following: "Doing well at post op check, except pt upset because she thought she was having total mastectomy."</p>			
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	<p>Continued From page 14</p> <p>On [REDACTED]/09, Surgeon 1 documented the following during Patient 1's visit to the Breast Clinic: "Pt one day s/p (status post) L partial mastectomy/axillary node dissection for + (positive) sentinel node. No complications.... May opt for total mastectomy to avoid Rad Rx (radiation treatment)." There was no documentation regarding the fact that Patient 1 had the wrong surgical procedure performed on [REDACTED]/09.</p> <p>Patient 1 had the wrong surgery performed on [REDACTED]/09 which caused her anxiety, and resulted in a delay in her receiving treatment for breast cancer as she no longer felt safe receiving care at the facility and had to wait until February 2010 to be seen at another hospital.</p> <p>The facility's failure to ensure that Surgeon 1 implement the facility's Consent to Medical and Surgical Procedures, that the Surgicenter staff, surgical resident, and operating room staff implement the facility's Universal Protocol for Verification of Surgical and/or Invasive Procedures, is a deficiency that has 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.</p> <p>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).</p>			
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