Arkansas Department of Health

5800 West Tenth Street, Suite 400 • Little Rock, Arkansas 72204 • Telephone (501) 661-2201
Governor Asa Hutchinson
Nathaniel Smith, MD, MPH, Director and State Health Officer

November 22, 2016

[redacted]
Planned Parenthood Of AR & Eastern OK
5921 West 12th Street, Suite C
Little Rock, AR 72204

Dear Administrator:

The Arkansas Department of Health completed a survey of your agency on 10/19/2016, to determine whether or not it was in compliance with the Rules and Regulations for Abortion Facilities in Arkansas.

In a letter dated 11/01/2016, we informed you that an acceptable Plan of Correction (POC) would be required in order for us to complete the survey process. The POC that we received from you dated 11/21/2016, is not acceptable. Please resubmit a POC that answers the following questions:

1. What specific action will be taken to correct the deficient practice including systemic changes made to ensure the deficient practice does not recur? 6M10 Please address what discipline can administer medications in your policy and procedure.
2. How will you evaluate or monitor the corrective action to prevent the recurrence of the deficient practice? 8E3 and 10A2.

The instructions for the submission of the Plan of Correction follow:

Arkansas Department of Health
Health Facility Services
5800 West 10th Street, Suite 400
Little Rock, AR 72204

If you have any questions, feel free to call me at (501)661-2201

Sincerely,

Liz Davis

Liz Davis, Program Manager
Health Facility Services

LR Response Verbiage

(Memo for additional info requested on letter dated 11/22/16 should be attached to original POC and submitted via email and USPS.)

1. What specific action will be taken to correct the deficient practice, including systemic changes made to ensure the deficient practice does not recur? **6M10 – What discipline can administer medications in your policy and procedure?**
    a. For item 6M10, the Planned Parenthood Arkansas abortion facility in Little Rock has submitted a written medication administration policy that promotes patient safety.
        i. See attached document for medication administration policy and procedure

2. How will you evaluate or monitor the corrective action to prevent recurrences of the deficient practice? **8E3 (Health center employees with expired CPR) and 10A2 (Health center employees with expired TB).**
    a. For item 8E3, responsibility for monitoring CPR licenses will fall on the Health Center Manager (HCM) with additional supervision provided by the Regional Director of Health Services. The center managers know which employees in their centers need CPR. They will maintain copies of CPR licenses on-site, along with a master list of who has CPR and when an employee's CPR license expires. CPR licenses are also submitted to PPGP's Director of Compliance and Risk and Quality Management every January, which is deemed "Safety Month" at the PPGP affiliate.
        i. See attached document for master list example

    b. For item 10A2, Planned Parenthood Great Plains' Human Resources department will take on responsibility for monitoring all employee health items, including annual TB skin testing. TB skin testing is performed upon hire, but then the Director of Human Resources will work directly with the Arkansas HCM's and regional director to coordinate annual testing (≤ 365 days). Similar to monitoring of CPR licenses, the HCM's will maintain copies of all employees' TB screenings on-site, along with a master list of each employee's most recent TB evaluation.
        i. See same attached document for master list example

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Planned Parenthood Great Plains

Policy: Medication Administration/ Dispensing

Originator: [redacted]

Approval Date: 12/1/16

Policy: **Medication Administration/ Dispensing as indicated in Medical Standards and Guidelines Administrative section Chapter 7 section 1**

General information
Orders for all prescriptions are documented in the medical record. Dispensation and/or administration of all medications are documented in the medical record by the staff person who dispenses/administers the medication.

Dispensed/dispensation refers to medications that the patient will take at home.

Administered/administration refers to medications that the patient will take while in the center.

7.1.1 Administering/ Dispensing Medications within the health center

1. Whenever clients are given a parenteral injection at the affiliate, they **must** be observed on site for at least 20 minutes before being allowed to leave
2. If a client is beyond the date of expected menses, a pregnancy test must be performed and documented before prescribing any antibiotic that is contraindicated in pregnancy.
3. Antibiotics should not be withheld during the luteal phase (before the expected menses), even if the client did not use effective contraception earlier in the cycle.
4. All clients receiving medications **must** also receive written or verbal instructions including the name, purpose and appropriate administration technique for each drug.
5. Following current State Medical and Nurse Practice Acts only trained and/or licensed medical staff are authorized to administer or dispense medication to clients with a current prescription. Qualified staff include the following: Physicians, Advance Practice Registered Nurses (APRN), Physician Assistants (PA), Registered Nurses (RN), Licensed Practical Nurses (LPN) and Medical Assistants. Medical staff with this privilege are

trained upon hire and medication handling policies are reviewed annually upon evaluation.

6. All patients must be appropriately identified by checking identification (ask patients name and date of birth, check ID band) before administering or dispensing medication.
7. Medication may not be administered without an active or current prescription.

7.1.2 Perioperative or other Procedural Settings

1. Must label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings. (Note: Medication containers include syringes, medicine cups, and basins.)[8]

Procedure:

1. Upon hire licensed medical staff and support medical staff will be trained on medication handling, dispensing and administration.
2. These staff members will be directly observed performing medication handling, dispensing and administration prior to being given privileges to perform skills independently.
3. A privileging form will be signed by medical staff supervising the new staff member and will be kept within the employee records.
4. Privileged medical staff will be evaluated annually with direct observation and documentation review.

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Health Center CPR / TB List

Center_____ Month_____

EMPLOYEE NAME	EMPLOYMENT DATE	TYPE OF CPR LICENSE *(BLS, ACLS, ETC.)*	COPY OF CPR CARD SENT TO QA	CPR EXPIRE DATE	CPR CLASS NEEDED or SCHEDULED?	MOST RECENT TB EVALUATION
1.			Yes No			
2.						
3.						
4.						

PRINTED: 11/01/2016
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Health Facility Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	ABOR00002	A. BUILDING: ______ B. WING ______	10/19/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PLANNED PARENTHOOD OF AR & EASTERN !	5921 WEST 12TH STREET, SUITE C LITTLE ROCK, AR 72204

(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
4A000	Memo An entrance conference was conducted with Facility Representatives at 0915 on 10/18/16. The Representatives were informed the purpose of the visit was to conduct a State Re-Licensure survey. An exit conference was conducted with Facility Representatives at 1545 on 10/19/16. The findings of the survey were discussed. The Representatives were given an opportunity to present additional findings. None were presented at the exit conference. 6.D. General Administration. Each facility shall develop and maintain a written disaster plan which includes provisions for complete evacuation of the facility. The plan shall provide for widespread disasters as well as for a disaster occurring within the local community or the facility. The disaster plan shall be rehearsed at least twice a year. One (1) drill shall simulate a disaster of internal nature and the other external. Written reports and evaluation of all drills shall be maintained. Based on interview, it was determined the Facility failed to develop, implement or rehearse a disaster plan that provided for widespread disasters as well as local community disasters. This failure did not assure staff were knowledgeable of actions to take or had practiced the Facility's developed protocols in the event of a disaster. The failed practice had the potential to affect patients, visitors and staff in the event of a widespread local or community disaster. Findings follow: During an interview with Clinical Staff #1 at 1640 on 10/19/16, she stated the Facility did not have a	4A000 6D	Planned Parenthood of Arkansas and Eastern Oklahoma has a disaster/contingency plan that focuses on role definition, designates areas of responsibility and provides a framework for decision making (see document 1). Planned Parenthood of Arkansas and Eastern Oklahoma leadership has created a plan for semi-annual rehersal of said disaster/contingency plan. This plan will be rehearsed beginning Jan 2017 and will continue semi-annually in July 2017, etc. The Director of COPM will monitor for compliance and coordinate drills.	1/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [redacted] TITLE President & CEO (X6) DATE 11/17/16

Health Facility Services

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4A000	Continued From page 1 disaster plan. 6.E. General Administration. There shall be posted a list of names, telephone numbers, and addresses available for emergency use. The list shall include the key facility personnel and staff, the local police department, the fire department, ambulance service, Red Cross, and other available emergency units. The list shall be reviewed and updated at least every six (6) months. Based on document review and interview, it was determined the Facility failed to update the list of names, telephone numbers and addresses as well as emergency contact numbers available for emergency use at least every six months. Failure to update the list had the potential to delay contacting the appropriate emergency contact. The failed practice had the potential to affect any patient, staff or visitor who experienced an emergency or was in the Facility in the event of a disaster or untoward event. Findings follow: 1. Review of the emergency telephone number list received from Clinical Staff #1 at 1230 on 10/18/16 revealed a date of 2014. 2. During an interview with Clinical Staff #3 at 0905 on 10/19/16, she verified the employee telephone roster and the emergency number list had not been updated since 2014. 6.M.10. General Administration. Policies and procedures shall include, but not be limited to the following: medication administration; Based on interview, it was determined the Facility failed to develop and implement a policy and procedure defining the medication administration	4A000 6.E.	The Health Center Manager has reviewed and updated the emergency contact list that is posted in the health center. It will be reviewed/ updated by the Health Center Manager on a semi-annual basis and then reprinted/reposted with the current revision date. (See document 2.) for the most current, updated emergency contact list.	11/7/16

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PLANNED PARENTHOOD OF AR & EASTERN I	6921 WEST 12TH STREET, SUITE C LITTLE ROCK, AR 72204

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4A000	Continued From page 2 practices for the Facility. Failure to develop and implement a medication administration policy and procedure did not allow employee guidance for who, when and how medications would be administered. The failed practice affected all patients in the Facility who received medications from facility personnel. Findings follow: During an interview with Clinical Staff #1 at 1540 on 10/19/16 she stated the Facility did not have a medication administration policy. 8.E.3. Program Requirements. Complications. General Abortion Facilities shall have emergency drugs, oxygen and intravenous fluids available to stabilize the patient's condition, when necessary. An ambu bag, suction equipment and endotracheal equipment shall be located in the clinical area for immediate access. All clinical staff shall have documented current competency in cardiopulmonary resuscitation (CPR). Based on interview and document review, it was determined 3 (#2, #4 and #5) of 4 (#2, #3, #4 and #5) Clinical Staff did not have current Cardiopulmonary Resuscitation (CPR) certification. Failure to ensure all Clinical Staff were CPR certified did not ensure the availability of Clinical Staff who were certified and competent in the event of a life threatening event. The failed practice had the potential to affect all patients, visitors and staff. Findings follow: 1. Review of employee documents which included licensure, CPR, and skin tests revealed no CPR certification for Clinical Staff #2, #4 and #5. 2. By the exit at 1545 on 10/19/16 no additional CPR certification had been received from the	4A000 6.M.10 (Cont'd) 8.E.3	In Arkansas Health Centers only physicians may dispense mifepristone and misoprostol per State law. Provision of pharmaceuticals in accordance with all State/local laws (see document: The Regional Director of Health's) Center Operations is currently working with the Health Center Manager to schedule a CPR class for both the physician and PRN which will be completed by the end of 2016. The center's RN has a valid CPR certification. Please see attached document 4.	11/14/16 12/16

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4A000	Continued From page 3 Facility. 10.A.2. The facility shall follow standard Center for Disease Control and Prevention (CDC) precautions. Based on review of employee Tuberculosis (TB) records, Policy and Procedure review, and interview it was determined 5 (#1, #2, #3, #4 and #6) of 6 (#1 – #6) did not have current TB skin tests or screening for TB. Failure to ensure staff received current TB tests or were screened for TB exposure potential did not allow the facility to be proactive in monitoring and surveillance of possible staff conversion and to be in compliance with the Center for Disease Control and Prevention "Guidelines for Preventing Transmission of Mycobacterium Tuberculosis in Health-Care Settings, 2005". The failed practice affected all patients and staff who came in contact with the five employees. Findings follow: 1. Review of employee documents which included licensure, CPR, and skin tests revealed the following: A. Clinical Staff #1 last TB skin test was dated [redacted] B. Clinical Staff #2 last TB skin test was dated [redacted] C. Clinical Staff #3 last TB skin test was dated [redacted] D. Clinical Staff #4 last TB skin test was dated [redacted] E. Clinical Staff #6 last TB skin test was dated [redacted] 2. Review of the Policy and Procedure received from Facility Representative #1 at 1100 on 10/19/16 revealed the following under Policy, Tuberculin Skin Testing; ...Annual Employee	4A000 10.A.2	Planned Parenthood of Arkansas and Eastern Oklahoma will continue to adhere to Centers for Disease Control and Prevention (CDC) recommendations regarding the types of immunizations required for staff. All of the Little Rock Health Center employees are now current on their TB skin testing. Moving forward, the annual TB testing process for staff will be monitored to ensure that tests are always performed within a precise time frame. (see documents 5.1 - 5.5)	11/3/16

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4A000	Continued From page 4 Screening. Employees with a negative skin test history will have, at minimum, an annual PPD skin test and, depending on the test results, will be followed as above if necessary per local DOH (Department of Health) ... " 3. The above findings were verified by Clinical Staff #1 at 1535 on 10/19/16. 10.A.3.(a). Infection Control for Abortion Facilities, General. There shall be policies and procedures establishing and defining the Infection Control Program, including: definitions of nosocomial infections which conform to the current CDC definitions; Based on review of Policy and Procedures and interview, it was determined the Facility failed to develop definitions of nosocomial infections. Failure to develop definitions of nosocomial infections did not allow the Facility the opportunity to define what it considered an infection, define at what point in time the Facility would take ownership of an infection, and to track and trend infections related to care received at the Facility. The failed practice affected any patient receiving care at the Facility. Findings follow: 1. Review of Chapter 13A, Occupation Health received from Clinical Staff #1 at 1100 on 10/18/16, revealed no policy and procedure which defined nosocomial infections. 2. During an interview with Clinical Staff #3 at 1016 on 10/19/16 she stated the Facility did not have a policy and procedure which defined what the Facility deemed nosocomial infections. 10.A.3.(g).(11). Infection Control for Abortion Facilities, General. There shall be policies and	4A000 10.A.3(a)	Please see the attached document 6.1 which defines what is considered a healthcare associated infection, defines at what point CHPPGP should take ownership of the infection, describes how CHPPGP would track and trend infections related to care it provides and describes how CHPPGP would respond to a potential HAI outbreak. The Director of Compliance, Quality and Risk Management is responsible for the tracking/trending of infections. Staff in the health center will be re-educated to this policy by the CQRM Director. 1 Dec 2016.	12/16

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4A000	Continued From page 5 procedures establishing and defining the Infection Control Program, including: techniques for separation of clean from dirty processes; Based on observations and interview, it was determined the Facility failed to store patient care items that were available for use in a clean environment in that the Emergency Box and a case of white drapes were sitting on the floor of the storage room which is considered a dirty area. Failure to ensure patient care supplies were not sitting on the floor had the potential to allow contamination of patient care equipment. The failed practice had the potential to affect all patients whose care involved the use of drapes and the Emergency Box. Findings follow: 1. Observations made during the tour conducted at 0730 on 10/19/16 revealed a case of white patient drapes and the Emergency Box sitting on the floor of the storage room. 2. The above findings were verified by Clinical Staff #3 at 0745 on 10/19/16. 12.C.3. Physical Facilities, Abortion Facilities. General Considerations. The building and equipment shall be maintained in a state of good repair at all times. Based on observations and interview, it was determined the Facility failed to ensure equipment was kept in good repair in that one stool in the Ultrasound Room had a cloth covering and the covering had a one half inch hole in the top. The failed practice had the potential to allow cross contamination in that the cloth top has an absorbent nature and cannot be disinfected. The failed practice had the potential to affect anyone who sat on the stool. Findings	4A000	12.C.3 Planned Parenthood of Arkansas and Eastern Oklahoma will follow the Infection Prevention Policy on clean and dirty equipment and supplies. (See documents 6.2.T.6.5) The white drapes and emergency box were removed from the floor. The staff was reeducated on clean / dirty supply / equipment storage by the Health Center Manager. The Health Center Manager will audit using the ARMS HP Manual environment of care tool monthly. (See attached)	11/16

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4A000	Continued From page 6 follow: 1. Observations made during the tour conducted at 0730 on 10/19/16 revealed the cloth covered stool in the Ultrasound Room. Closer inspection of the stool revealed a one half inch wide hole which extended down into the cushion. 2. The above findings were verified by Clinical Staff #3 at 0750 on 10/19/16.	4A000 12.C.3 (cont'd)	the stool on the ultrasound room has been replaced with a stool that has vinyl covering. the Health Center manager will do monthly audits to ensure that all equipment is in good condition starting 12/1/16. These audits are turned into the Director of Compliance, Quality and Risk Management on a monthly basis.	11/16 12/16

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Planned Parenthood Great Plains

Policy: CONTINGENCY PLAN

Originator: [redacted]

Approval Date: November 14, 2016

Policy: CONTINGENCY PLANS

INTRODUCTION:
Planned Parenthood Great Plains (PPGP) takes staff, patient and other visitors' safety and security very seriously. Our established risk management program has enabled us over the years to identify and prevent actual as well as potential sources of loss that confront us as an affiliate. Our risk management program is meant to be proactive whenever possible. It is not synonymous with *crisis management*, which this document addresses.
PPGP has a variety of experiences to draw from when creating an emergency response plan. We have always taken the time to debrief after incidents, and have therefore learned quite a bit about what works well and what doesn't when handling crisis situations. One of the most important things to acknowledge is that no two emergency situations are ever exactly alike, and often cannot be predicted. Thus, our plan that follows is flexible and broad enough to cover all types of scenarios. This document focuses on role definition, designates areas of responsibility and provides a framework for decision-making. It is divided into two sections – *administrative framework (incident, group and role definition)* and *response framework (communications and direction to take with each type of incident.)*.

ADMINISTRATIVE FRAMEWORK:
Levels of Emergency Response:

[redacted]

Phases of an Emergency:
Most emergency incidents (except some Level 1 incidents) have four distinct phases that require special management skills. These phases are described below.

1.) Crisis Phase: This phase is characterized by some degree of confusion, panic and mixed messages. The goal of the first arriving PPGP "official" in this phase is to:
- ensure the safety of staff and other first responders as much as possible
- try to stabilize the scene
- limit the growth of the incident

The PPGP "official" could be different depending on the situation and the location. At the health center level, that person will most likely be the Health Center Manager or other senior staff member. At our PPGP Administrative offices it will most likely be a Security Officer or a member of the Senior Management Team that has been alerted to the incident. These are the people who would most commonly be called to the scene of a developing incident.

There are a few types of incidents that fall outside of this due to their impending nature. In those cases any staff person who encounters them will initiate the crisis phase response. For instance, anyone who notices a large, involved fire in any of our facilities would not necessarily take the time to notify a manager of its whereabouts. Instead, that staff person would announce (page, shout, etc.) the evacuation.

In most other situations, the first arriving PPGP "official" should consider the following items their priority tasks until he/she is relieved by a supervisor or other more appropriate staff person:

- establish a level of communication and control – make yourself known as the leader, start gathering details and notes about what has unfolded thus far.
- identify any "danger zone"
- secure the "danger zone" as much as possible
- establish an outer perimeter to control access to the entire scene – start delegating tasks to others, limit "milling round" scene as much as possible
- request needed resources – put first round of calls in to PPGP Administration, vendors, police, etc.

(Level 1 incidents may end here. Most other incidents will move on to the following 3 stages.)

2) Scene Management Phase:

3.) Executive Management Phase:

4.) Termination Phase:

[redacted]

Definitions:
Executive Authority –

[redacted]

Crisis Response Team –

[redacted]

Conference call information for Crisis Response Team [redacted]

The Crisis Response Team includes:

[redacted]

Emergency Operations Center -

[redacted]

[redacted]

Key Responsibilities:

[redacted]

Task/Responsibility

[redacted]

2

Little Rock Contacts List November 2016

External

Little Rock Police Department (501) 371-4829

MEMS Ambulance Service (501) 301-1407

UAMS on-call Physicians (501) 686-7000

Little Rock Fire Department (501) 918-3736

American Red Cross Disaster Relief (501)748-1000

Internal

Facilities:

[redacted]

Physicians:

[redacted]

Nurse Practitioners:

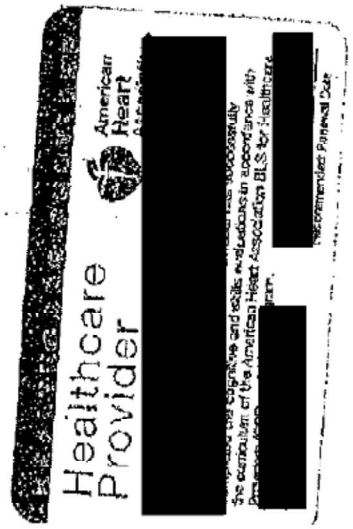
[redacted]

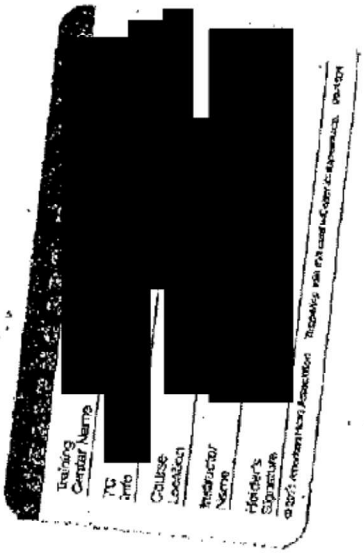
Support Staff:

[redacted]

3

[redacted]


Healthcare
Provider
American
Heart


Training Center Name
Course Location
Instructor Name
Holder's Signature

4

5.1

Planned Parenthood® of the Heartland

Annual Employee Health Screening for Staff / Interns / Volunteers With Direct Patient Contact

SECTION 1 (To be filled out by employee)

[redacted]

SECTION 2 (To be filled out by staff)

Tuberculin Skin Test (Mantoux)

[redacted]

5. 2

Planned Parenthood® of the Heartland

Annual Employee Health Screening for Staff/Interns/Volunteers With Direct Patient Contact

SECTION A (To be completed by employee)

[redacted]

Tuberculin Skin Test Injection

[redacted]

5.3

Planned Parenthood® of the Heartland

Annual Employee Health Screening for Staff/Interns/Volunteers with Direct Patient Contact

SECTION 1: (To be completed by employee)

[redacted]

SECTION 2: (To be completed by staff)

Tuberculin Skin Test Injection [redacted]

[redacted]

5.4

Planned Parenthood® of the Heartland

Annual Employee Health Screening for Staff/Interns/Volunteers with Direct Patient Contact

SECTION 1 (To be completed by employee):

[redacted]

SECTION 2 (To be completed by staff):

Tuberculin Skin Test Infection [redacted]

[redacted]

5.5

Planned Parenthood® of the Heartland

Annual Employee Health Screening for Staff/Interns/Volunteers with Direct Patient Contact

SECTION 1 (To be completed by employee)

[redacted]

Tuberculin Skin Test Injection [redacted]

[redacted]

6.1

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Planned Parenthood Great Plains

Policy: Healthcare Associated Infection (HAI) Policy (Nosocomial Infection Policy)[1][2]

Originator: Director of Compliance, Quality & Risk Management

Approval Date: 11/14/16

Policy: It is the policy of Comprehensive Health of Planned Parenthood Great Plains (CHPPGP) to comply with all state laws controlling the delivery of health care, including state laws that require abortion providers to date pregnancies by means of transvaginal ultrasound. The transvaginal ultrasound transducer sheath comes into contact with the patient's mucous membranes, creating a risk of introducing pathogens that can lead to a healthcare associated infection. This policy defines what is considered a healthcare associated infection, defines at what point CHPPGP would take ownership of the infection, describes how CHPPGP would track and trend infections related to care it provides, and describes how CHPPGP would respond to a potential HAI outbreak.

Centers for Disease Control/ National Healthcare Safety Network surveillance definition of healthcare associated infection (HAI): "a healthcare-associated infection is a localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s) that was not present on admission."[3]

There are three points at which CHPPGP patients are vulnerable to HAIs.

1. The transvaginal ultrasound transducer has the potential to introduce exogenous microbes that could cause an HAI.
2. The technique and instruments used for pelvic examinations have the potential to cause HAIs
3. Instruments used for surgical abortions have the potential to introduce exogenous microbes that could cause an HAI.

HAI prevention

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[1] The Arkansas Department of Health requires abortion facilities to have infection control policies and procedures that define nosocomial infections, specifically, the potential of transvaginal ultrasound transducers to act as fomites.
[2] The CDC began using the term "nosocomial" in 1989 but has since updated it with the more descriptive term "healthcare associated infection," which is used in this policy.
[3] http://www.cdph.ca.gov/programs/hai/Documents/Slide-Set-20-Infection-Definitions-NHSN-2013.pdf

- It is the policy of CHPPGP to disinfect all semi-critical instruments, including transvaginal ultrasound transducers, using the high-level disinfection procedure described in CHPPGP's ARMS Infection Prevention Manual.
- It is the policy of CHPPGP to observe meticulous hand hygiene and gloving protocol described in CHPPGP's ARMS Infection Prevention Manual.
- The transvaginal ultrasound procedure requires the additional infection prevention measure of covering the transducer with a condom (ARMS Infection Prevention Manual).
- There are also infection prevention measures to prevent ultrasound coupling gel contamination.

HAI surveillance in the ambulatory care clinic

- Patients who receive abortion care receive verbal and written discharge instructions describing signs and symptoms of infection to watch for, report, and seek immediate treatment. Discharged patients are given the written phone number of the after-hours on-call nurse to call 24 hours a day, 7 days a week.
- Patients who have a medical abortion follow up in the clinic where they are screened for signs and symptoms of infection.
- CHPPGP conducts monthly infection prevention chart audits by the health center manager
- CHPPGP conducts monthly infection prevention monitoring, observation, and environment of care rounds by the health center manager
- CHPPGP conducts at least annual infection prevention monitoring by the Director of Compliance and Quality Risk Management
- CHPPGP conducts monthly chart audits of on-call nurse utilization and documentation by the Director of Compliance and Quality Risk Management
- CHPPGP maintains records of infection rates
- The CHPPGP medical staff Peer Review Committee examines every patient complication, including infections, to determine the quality of care that was provided to the patient
- The incident reporting system captures data on patient infections, which is tracked and trended by the CHPPGP Infection Preventionist and reviewed by an infection prevention consultant at the ARMS risk management service

HAI diagnosis in the ambulatory care clinic

CHPPGP adopts the CDC/NHSN surveillance definitions of HAI, which states that evidence of HAI may be derived from: [3]

- Direct observation of the infection site or review of information in the patient chart or other clinical records.
- For certain types of infection, a physician diagnosis of infection derived from direct observation from pelvic examination is an acceptable criterion for a HAI, unless there is compelling evidence to the contrary.

The CDC/NHSN definition of "other infections of the female reproductive tract (vagina, ovaries, uterus, or other deep pelvic tissues, excluding endometritis or vaginal cuff infections)" requires the presence of at least 1 of the following criteria:[3]

1. Patient has organisms cultured from tissue or fluid from affected site
2. Patient has an abscess or other evidence of infection of affected site seen during a surgical operation or histopathologic examination.
3. Patient has:
    a. 2 of the following signs or symptoms with no other recognized cause:
        i. Fever (> 38 degrees C)
        ii. Nausea
        iii. Vomiting
        iv. Pain
        v. Tenderness
        vi. Or dysuria
    b. and at least 1 of the following
        i. Organisms cultured from blood
        ii. Physician diagnosis

The CDC/NHSN does not define the following infections as HAI:[3]

- Infections associated with complications of extensions of infections already present, unless a change in pathogen or symptoms strongly suggests the acquisition of a new infection
- Colonization, which means the presence of microorganisms on skin, on mucous membranes, in open wounds, or in excretions or secretions but are not causing adverse clinical signs or symptoms;
    - For this reason, CHPPGP does not consider a vaginal yeast infection following the administration of antibiotics to be an HAI since the vagina is typically colonized with yeast that is present on admission and is not introduced by healthcare equipment or providers.
- Inflammation that results from tissue response to injury or stimulation by noninfectious agents, such as chemicals.
- The presence of (skin) commensal flora in cultures (this indicates culture contamination, not infection).

HAI ownership in the ambulatory care clinic

CHPPGP will take ownership of an infection that meets the CHC/NHSN surveillance definitions when the patient meets the diagnostic criteria of a HAI without evidence of having the infection at the time health care was provided by CHPPGP (diagnosis must occur on or after the third day following the procedure).

The main pathogens of concern with transvaginal ultrasound transducers[4]

- Human immunodeficiency virus (HIV)
- Cytomegalovirus (CMV)
- Human papilloma virus (HPV)
- Enteric Gram-negative pathogens (E.g. Escherichia coli, Klebsiella spp.)

[4] Leroy S. Infectious risk of endovaginal and transrectal ultrasonography: systematic review and meta-analysis, Journal of Hospital Infection(2012) http://dx.doi.org/10.1016/j.jhin.2012.07.014 and M'Zali F. Persistence of microbial contamination on transvaginal ultrasound probes despite low-level disinfection procedure, PLOS One (2014) at www.ncbi.nlm.nih.gov/pmc/articles/PMC3973690

- *Staphylococcus aureus*
- *Chlamydia trachomatis*, mycoplasmas, Gonorrhoa, Syphilis, and other sexually transmitted infections

Response to a diagnosed HAI in the ambulatory care clinic

If a CHPPGP patient is diagnosed with an HAI, the provider will notify the Infection Preventionist, who will consult ARMS for guidance in investigating whether the HAI is part of an outbreak. If an outbreak is suspected, all patients with potential exposure will be contacted and offered testing and treatment. CHPPGP will comply with all state public health authority reporting laws.

1. The patient will be evaluated for the presence of infection and if one is diagnosed, the patient will receive appropriate treatment.
2. All cleaning procedures will be reviewed including reviewing the autoclave logs and interviewing involved staff to identify possible breaks in procedure.
3. If it is possible that the HAI was caused by the transvaginal ultrasound transducer, all patients who received transvaginal ultrasounds that day will be contacted and asked to be tested for infection.
4. All reportable pathogens will be reported to the county or state public health department (E.g. Chlamydia, gonorrhea, syphilis, HIV) in compliance with state law.

6.2

Safe Injection, Infusion and Medication Vial Practices

Injection safety, or safe injection practices, is a set of measures taken to perform injections in an optimally safe manner for patients, health personnel, and others. A safe injection does not harm the recipient, does not expose the provider to any avoidable risks, and does not result in waste that is dangerous for the community. Injection safety includes practices intended to prevent transmission of infectious diseases between one patient and another, or between a patient and healthcare provider.

The transmission of bloodborne viruses and other microbial pathogens to patients during routine healthcare procedures can occur due to unsafe and improper injection, infusion, and medication vial practices. The transmission of infection is preventable if proper infection prevention and aseptic techniques are used by staff during the handling and preparation of parenteral medications, administration of infections and procurement and sampling of blood. Use of safe injection practices is critical to prevent microbial contamination of products administered to patients. All staff must adhere to the following safe injection, infusion and medication vial practices.

Aseptic Technique

A. Parenteral medications should be accessed in an aseptic manner

B. Perform hand hygiene prior to accessing supplies, handling vials and IV solutions, and preparing or administering medications

C. Use aseptic technique in all aspects of parental medication administration, medication vial use, injections and glucose monitoring procedures.

D. Store medications and supplies in a clean area on a clean surface. Never store needles and syringes unwrapped as sterility cannot be assured

medication Box

3. Clients are increasingly immune-compromised and require diligent protection from microorganisms due to increased risk and susceptibility.
4. Separation of clean and dirty procedures is paramount to the prevention of the spread of microorganisms. Policy

O. Questions/discussion

1. OSHA Post-test: see Chapter 7: Compliance.

AED Review

Proof and Documentation of Proficiency in Infection Prevention Practices

Initial orientation of a new staff member should include all the above elements, plus a time period after the delivery of the information and before independent functioning in the clinic setting, when proficiency must be established and documented. For example, after a didactic session on infection prevention concepts and a practical ("lab") on setting up a sterile tray, the employee should be observed in the clinic three to five times setting up the tray. These observations will help the staff member learn the new skills by having an opportunity to make mistakes and ask questions while the safety of the client is not at risk. At the conclusion of this period, proficiency will be documented. This verification must also be available in the employee's personnel file.

The Infection Prevention Series located on the CAL at theCAL.org contains recommended proficiency requirements.

6.4

PROCESS

Table 4. Infection-Free Environmental Health Center Checklist