STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH

Raul Pino, M.D., M.P.H.
Commissioner

Dannel P. Malloy
Governor
Nancy Wyman
Lt. Governor

Healthcare Quality And Safety Branch

February 21, 2018

Ms. Sally Helleman, Administrator
Planned Parenthood Of Southern New England
345 Whitney Avenue
New Haven, CT 06511

Dear Ms. Hellerman:

An unannounced visit was made to Planned Parenthood Of Southern New England on January 26, 2018 by a representative of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a licensing inspection with additional information received through January 26, 2018.

Attached are the violations of the Regulations of Connecticut State Agencies and/or General Statutes of Connecticut which were noted during the course of the visit.

You may wish to dispute the violations and you may be provided with the opportunity to be heard. If the violations are not responded to by March 7, 2018 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

In accordance with Connecticut General Statutes, section 19a-496, upon a finding of noncompliance with such statutes or regulations, the Department shall issue a written notice of noncompliance to the institution. Not later than ten days after such institution receives a notice of noncompliance, the institution shall submit a plan of correction to the Department in response to the items of noncompliance identified in such notice. The plan of correction shall include:

(1) The measures that the institution intends to implement or systemic changes that the institution intends to make to prevent a recurrence of each identified issue of noncompliance;

(2) the date each such corrective measure or change by the institution is effective;

(3) the institution's plan to monitor its quality assessment and performance improvement functions to ensure that the corrective measure or systemic change is sustained; and

(4) the title of the institution's staff member that is responsible for ensuring the institution's compliance with its plan of correction.

The plan of correction shall be deemed to be the institution's representation of compliance with the identified state statutes or regulations identified in the department's notice of noncompliance. Any institution that fails to submit a plan of correction may be subject to disciplinary action.

We do not anticipate making any practitioner referrals at this time.

If there are any questions, please do not hesitate to contact this office at (860) 509-7400.

Keeping Connecticut Healthy
DPH
Connecticut Department of Public Health

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Public Health Accreditation Board

DATE(S) OF VISIT: January 26, 2018

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

Respectfully,

Heidi Caron RN

Heidi Caron, MSN, RN, BC, CLNC
Supervising Nurse Consultant
Facility Licensing and Investigations Section

HAC:mb

DATE(S) OF VISIT: January 26, 2018

THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D49 (b) Records.

1. Based on review of the clinical record and interviews with facility personnel, the facility failed to ensure that 1 0f 4 clinical records were accurate. The findings include:
   a. Review of Patient #1's clinical record on 1/26/18 at 11:30 AM with the Manager and Director of Medical Services indicated that on 1/3/18 the patient had a surgical procedure completed. The record indicated that the patient's anesthesia completion time was documented as 10:02 AM and the patient was transferred to the recovery area. Review of the recovery documentation indicated that the patient arrived at 9:55 AM. Review with the Director of Medical Services indicated that the discrepancy regarding the documented transfer to recovery would be reviewed with anesthesia. Review of facility policy identified that whether on paper or in the electronic medical record, the time entered into the chart must be accurate.
   b. Review of Patient #1's clinical record with the Director of Medical Services on 1/26/18 at 11:30 AM indicated that on the nursing admission information prior to the procedure indicated that the patient had no known drug allergies (NKDA). However, review of the anesthesia assessment indicated that the patient was allergic to Keflex. Review of facility policy identified that a target medical history would include special attention to patient allergies.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D52 Maintenance.

2. Based on observations and interviews with facility personnel, the facility failed to ensure that infection control practices were maintained. The findings include:
   a. Review of the sterilization logs for the period of 11/1/2017-1/26/2018 failed to identify results of the steam indicator placed in each load on 11/15/17, 11/18/17, 12/7/17, 1/18/18, 1/19/18, and 1/24/18. Interview with the Manager on 1/26/18 at 12:00 PM indicated that the results of the steam indicator should be circled. Review of facility policy identified that documentation of the sterilization logs includes sterilization indicator results, load number and pack number.
   b. Review of the autoclave monthly cleaning log for the period of 1/1/17 through 12/31/17 for the large autoclave failed to reflect that cleaning had been completed for the months of May 2017, June 2017 and July 2017. Review of the logs for the small autoclave for the dame period failed to reflect monthly cleaning had been completed for June 2017 and July 2017. Interview with the Manager on 1/26/18 at 12:15 PM indicated that the facility policy is to perform monthly cleaning however, there was a change in management during that time and she in not sure why the cleaning had not been completed. Review of facility policy identified that autoclaves are to be cleaned, drained and have the water replaced at least once a month.
   c. Tour of the recovery area on 1/26/18 at 10:20 AM indicated that patient chairs were cloth

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covered, rendering them unable to be fully sanitized after patient use. Review of facility policy identified that disinfectant of chairs would be achieved on a vinyl surface.

The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D50 Nursing Personnel.

3. Based on tour, observation, interview and policy review the facility failed to ensure that medications were labeled with the date, time, medication, amount and person drawing up the medication. The finding includes the following:
   a. Tour of the procedure room on 1/26/18 at 10:00 AM identified five (5) syringes in the top drawer of the anesthesia cart that were labeled as Versed. The label failed to reflect the date and time the medication was drawn up, the initials of the staff member and the amount of medication in the syringe. Interview with the RN on 1/26/18 at 10:10 AM indicated that the syringe contained Fentanyl and Versed and had been drawn up that morning. Interview with the Director of Medical Services on 1/26/18 at 10:30 AM indicated that facility policy is that staff should have labeled the syringe with date and time the medication was drawn up, the initials of the staff member and the amount of medication in the syringe. Review of facility policy identified that medication solution labels will include the following; medication name, strength, quantity, diluent, volume and expiration time.

The following are violations of the Regulations of Connecticut State Agencies Section 19a-116-1(f) Emergency preparedness (B).

4. Based on facility document review and interview the facility failed to ensure that fire drills were completed per policy. The findings include the following:
   a. Review of the fire drill documentation with the Nurse Manager on 1/26/18 at 12:30 PM indicated that a fire drill was conducted October 10, 2017. The facility was unable to provide fire drills prior to that date. Interview with the Nurse Manager indicated that fire drills are to be completed quarterly, but when she started the job in August she was unable to locate any previous documentation that fire drills had been completed. Review of facility policy identified that fire drills are to be completed quarterly.

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4/3/18 OK HAC

Planned Parenthood of Southern New England
New Haven Health Center

Plan of Correction

March 1, 2018

1. **Plan of correction for the violation of the Regulations of Connecticut State Agencies Section 19-13-D49(b) Records:**

   a. An investigation into clinical record time documentation regarding surgical procedures revealed that the time in our computer system differed from the time displayed on the analog clock mounted in the procedure room. We have removed this clock because it does not seem to be working properly. I have ordered a digital clock to replace the analog so that there will not be a differing in interpretation. We will also check the time on the clock for accuracy before the start of each surgical clinic which will be 3 times per week. The sedation provider who is scheduled in the procedure room during any surgical clinic will be responsible for ensuring that the time displayed on the clock is accurate and matches the time displayed in our electronic health records system, Athena Health. This corrective action will go into effect on March 2, 2018. In order to ensure that the new clock system is accurate, charts will be audited after clinic session ends on March 7th by the Center Manager to ensure that the times documented in the EHR and on the sedation record correlate appropriately. Additionally, the Director of Quality Management will include this in her annual surgical abortion audit.

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   Addendum:

   The original plan was to audit charts on March 7th but clinic was cancelled that day due to a snowstorm. Charts were audited on March 14th instead. All charts showed that the patient arrived in the recovery room after the abortion was completed. Five charts will be audited once a month for the remainder of 2018.
   The person responsible for this corrective action plan is Lisa Marvinsmith, Director of Quality Management. She will ensure that the audits are completed and corrective actions taken as indicated

   b. Staff received an in-service on February 2, 2018 on the importance of accurate and thorough documentation for all patient visits with an emphasis on surgical procedures and known allergies. We discussed the importance of updating medical records should the patient disclose something different to the CRNA than what was previously charted in the EHR. Charts will be audited after clinic on March 7th by the Center Manager to ensure that

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the sedation record correlates with the EHR. Additionally, the Director of Quality Management will include this in her annual surgical abortion audit.

Addendum:
Five charts were audited on March 14th to ensure that the charting of the sedation provider correlated with the charting of the other health center staff. Five charts will be audited once a month for the remainder of 2018.
The person responsible for this corrective action plan is Lisa Marvinsmith, Director of Quality Management. She will ensure that the audits are completed and corrective actions taken as indicated.

2. **2) Plan of correction for the violation of the Regulations of Connecticut State Agencies Section 19-13-D52 Maintenance:**

   a. The sterilization log that we had been using during the timeframe of this violation was found to be poorly structured and unclear to the staff which led to lack of documentation compliance. A new log form was implemented 2/16/2108 to reflect an accurate and readable documentation of indicator results. The sterilization process was also reviewed with staff at the February 2nd staff meeting. The Clinic Assistants will be responsible for completion of the sterilization log and the Health Center Manager will monitor compliance. In addition, the Director of Quality Management will monitor compliance across the agency annually.

   b. Due to a change in management, the autoclave cleaning had not been documented consistently. Autoclave cleaning documentation has been consistently cleaned and maintained since August 2017 and will continue to be cleaned monthly by Clinic Assistants and monitored by the Health Center Manager. The policy was reviewed with the clinic staff at the February 2, 2018 at a staff meeting.

   Addendum: *The Director of Quality Management, Lisa Marvinsmith is responsible for this corrective action.*

   c. We are looking into purchasing new chairs for our recovery room. Currently, we do clean each chair with purple PDI wipes after patient use and we put down a disposable paper chuck for each patient to sit on to maintain cleanliness. We also have the chairs deep-cleaned several times per year and additionally as needed. The Health Center Manager will pursue the purchase of new chairs and will monitor the status of the chairs.

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Addendum: The Regional Director, Shira Revzen is responsible for this corrective action.

3. **Plan of correction for the violation of the Regulations of Connecticut State Agencies Section 19-13-D50 Nursing Personnel:**

   a. The policy for labeling syringes was reviewed on January 26, 2018 with all staff that perform sedation. The anesthetists will now adhere to the policy of labeling medications with the medication name, strength, quantity, diluent, volume, expiration time and the initials of the person who drew it up. The labeling of syringes has been added to the sedation provider privileging checklist. The Health Center Manager will ensure each sedation provider remains compliant through periodic spot checks.

4. **Plan of correction for the violation of the Regulations of Connecticut State Agencies Section 19a-116-1(f) Emergency preparedness (B):**

   a. Due to a change in management, fire drills had not been consistently documented. However, quarterly fire drills have been consistently done since October 2017 and will continue to be facilitated and documented by the Health Center Manager. Fire drills are done quarterly and the policy was reviewed with the clinic staff on February 27, 2018. The Regional Director will monitor the fire drill log for compliance.

   Addendum: The Regional Director will audit the fire drill log every quarter.

Sincerely,

Lauren Perriera
Health Center Manager

Sally Hellerman MS, APRN
Sally Hellerman, MS, FNP-BC
Director of Medical Services