STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

June 16, 2015

Jane Yousman, Administrator
Planned Parenthood Of Connecticut Inc - Hilda Stan
1030 New Britain Avenue
West Hartford, CT 06133

Dear Ms. Yousman:

An unannounced visit was made to Planned Parenthood Of Connecticut Inc - Hilda Stan on June 12, 2015 by representatives of the Facility Licensing and Investigations Section of the Department of Public Health for the purpose of conducting a monitoring visit.

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 visits.

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 June 30, 2015 or if a request for a meeting is not made by the stipulated date, the violations shall be deemed admitted.

Please address each violation with a prospective plan of correction which includes the following components within fourteen days of the date of this letter:

1. Measures to prevent the recurrence of the identified violation, (e.g., policy/procedure, inservice program, repairs, etc.).
2. Date corrective measure will be effected.
3. Identify the staff member, by title, who has been designated the responsibility for monitoring the individual plan of correction submitted for each violation.

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.

Respectfully,

Donna Ortelle, RN, MSN

Donna Ortelle, RN, PHSM
Public Health Services Mananger
Facility Licensing and Investigations Section

DMO:mb

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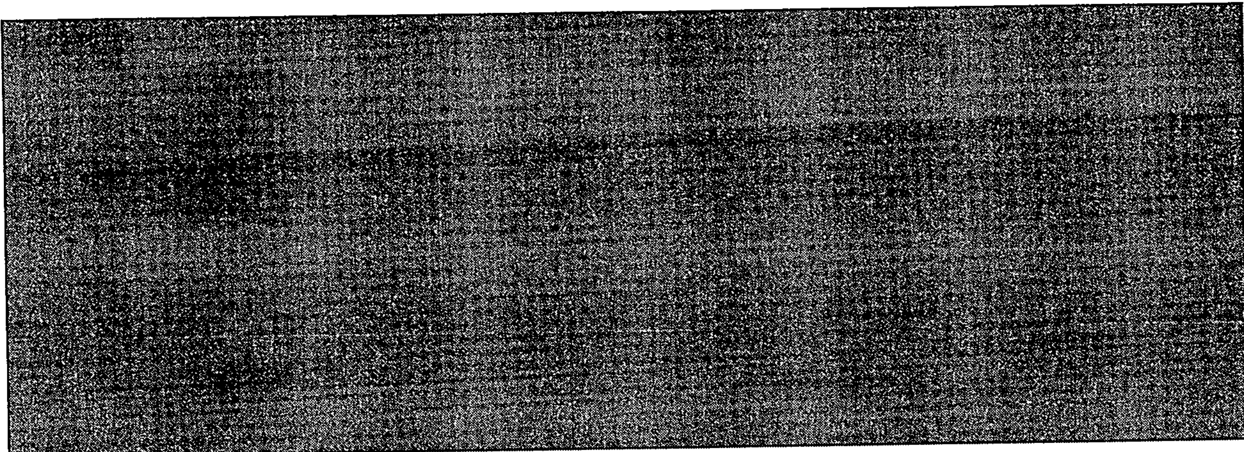


DATE(S) OF VISIT: June 12, 2015

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

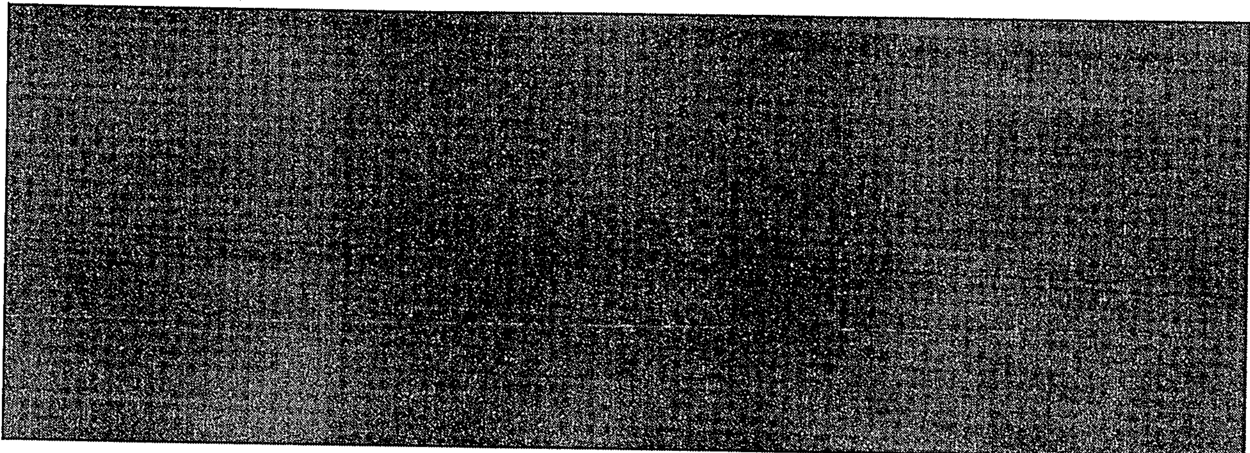
The following is a violation of the Regulations of Connecticut State Agencies Section 19-13-D47 Governing Board. Administration (b) and/or 19-13-D51 Pharmaceutical and/or 19-13-D52 Maintenance.

1. Based on observation and interview, the facility failed to ensure that medications were secured at all times. The finding includes:
   a. Observation of one of the two procedure rooms on 6/12/15 at approximately 10:30am identified that the narcotic cabinet containing fentanyl, versed and other medications including atropine, and lidocaine were in an unlocked cabinet without licensed staff in attendance. The Certified Registered Nurse Anesthetist (CRNA) was observed to complete a procedure in this room and went into another procedure room. Interview with the Clinical Manager on 6/12/15 at 11am identified that the medication cabinets should be locked when licensed staff is not in attendance. And/or

2. Based on observation and interview for one of two pregnancy terminations observed, staff failed to ensure that single patient intravenous (IV) fluids were not used on more than one patient. The finding includes:
   a. Observation of Patient #6's termination of pregnancy procedure on 6/12/15 at approximately 10:40am identified a 500cc bag of normal saline IV fluid with a needle and 3-way stopcock attached. Certified Registered Nurse Anesthetist (CRNA) #1 was observed to withdraw 10cc of fluid from the 500cc bag of normal saline and flushed the patient's IV after administering IV fentanyl, versed and atropine prior to the procedure. Interview with CRNA #1 on 6/12/15 identified that he uses the 500 cc bag for flush solution for all the procedures scheduled in that room for the day and that vials of normal saline are more expensive. Review of the label on the 500ccIV bag identified it was for single patient use.

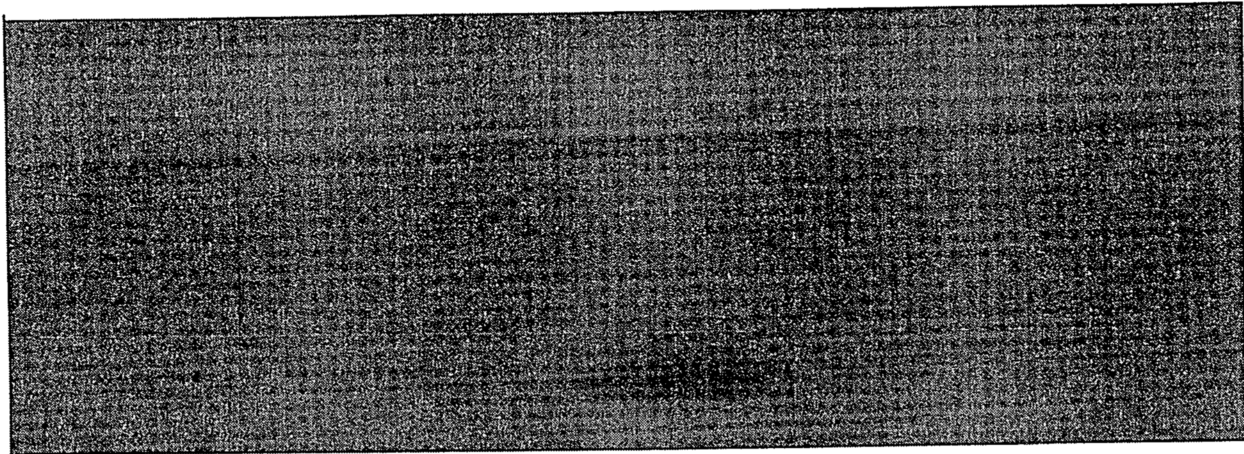
The following are violations of the Regulations of Connecticut State Agencies Section 19-13-D49 Records.

3. Based on review of the medical record and interview, the facility failed to ensure that the printed medical record was completed and accurate when printed. The finding includes:
   a. Review of Patient #1 - 6's printed medical record on 6/12/15 identified that they received medications including, versed, fentanyl, atropine, metronidazole, ibuprofen, Rhophylac, and/or misoprostol. The printed medical record failed to identify the time of administration of the medication and the staff who administered the medication. Review of the electronic medical record with the Clinical Manager on 6/12/15 identified that the time of medication administration and staff who administered the medication was identified in the electronic medical record view but there must be a glitch with the computerized program when the medical record was printed. The Clinical manager further identified that the facility is in the planning phase of getting a new electronic health record program.
   b. Patient #3 underwent an induced termination of pregnancy on 6/12/15. Review of the medical record identified that the patient received intravenous moderation sedation and



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

Monitored Anesthesia Care (MAC) by Certified Registered Nurse Anesthetist (CRNA) #2. The medical record failed to identify the medications received for sedation during the procedure. Review of the Controlled Drug Log dated 6/2/15 identified that Fentanyl 100mcg and Versed 2mg was signed out for Patient #6. Interview with the Clinical Manager on 6/12/15 failed to explain the discrepancy.



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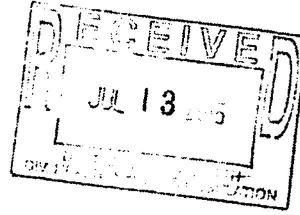
7/13/15 POC Accepted - DO



June 30, 2015

Donna Ortelle, RN, PHSM
Public Health Services Manager
Facility Licensing and Investigations Section
State of Connecticut
Department of Public Health
410 Capitol Avenue MS # 12HSR
Hartford, Connecticut 06134

Dear Ms. Ortelle,

Please find a response and corrective action plan for violations found during the monitoring visit conducted by you on June 12, 2015 at the Planned Parenthood of Sothern New England - Hilda Standish Center located in West Hartford.

Violation of the Regulations of Connecticut State Agencies Section 19-13-D47 Governing Board, Administration (b) and/or 19-13-D51 Pharmaceutical and/or 19-13-D52

1. Based on the observation and interview, the facility failed to ensure that medications were secured at all times. The finding includes:
   a. Observation of one of the two exam rooms on 6/12/15 at approximately 10:30 am identified that the narcotic cabinet containing fentanyl, versed and other medications including atropine, and lidocaine were in an unlocked cabinet without licensed staff in attendance.

Response
PPSNE's policy clearly states all medications should be stored in locked medication cabinets when licensed staff is not in attendance. The policy for storing narcotic medications was reviewed with both CRNAs on 6/12/15 and 6/16/15. The CRNA and another licensed staff person are responsible for the day end count and the sign off of the narcotic log. This staff is responsible for ensuring all medication is stored properly and the medication cabinets are locked. Jane Yousman, Center Manager is responsible for checking that this policy is followed.

2. Based on observation and interview for the two pregnancy terminations observed, staff failed to ensure the single patient intravenous (IV) fluids were not used on more than one patient.

Response

Single dose Saline 10cc syringes were ordered and have been in use since 6/26/15. The Abortion Services Coordinator, Getzina Nieves is responsible for ordering and maintaining this stock.

Violations of the Regulations of Connecticut State Agencies Section 19-13-D49 Records

3. Based on the review of the medical record and interview, the facility failed to ensure that printed medical record was completed and accurate when printed.
    a. Review of Patient #1 – The printed record failed to identify the time of administration of the medications and staff who administered the medication.

    Response

    The electronic health record currently in use does not print this information in the visit summary but the manager did show the reviewers where the information is recorded in the patient record. PPSNE has submitted a ticket on 6/15.15 to the vendor for the EHR system requesting this information be printed on the visit summary for each patient. Additionally, PPSNE is scheduled to migrate to a different EHR system in September of this year.

    b. Patient #3 underwent an induced termination of pregnancy on 6/12/15. The medical record failed to identify the medications received for sedation during the procedure.

    Response

    An addendum to this chart was created to document the patient did in fact receive sedation on 6/12/15. A chart audit of 20 charts was conducted of this CRNA over a three week period and all sedations patient has the medication documented correctly.

    Additionally, a staff meeting was held on 6/25/15 where all these violations and corrective actions were reviewed with all staff.

I hope this response to the violations cited form the June 12, 2015 visit to the Hilda Standish Center. Please do not hesitate to contact me of you have further questions.

Thank you,

Jane Yousman
Center Manager

cc: Mary Bawza
COO