Pennsylvania Department of Health

ALLENTOWN MEDICAL SERVICES
Health Inspection Results

ALLENTOWN MEDICAL SERVICES
Health Inspection Results For:

This is the only survey for this facility

5/26/2011

Surveys don't appear on this website until at least 41 days have elapsed since the exit date of the survey.

Initial Comments:

This report is the result of an initial registration survey conducted on May 26, 2011, at the Allentown Medical Services. It was determined that the facility was in compliance with the requirements of the Pennsylvania Department of Health Regulations 28 Pa Code, Chapter 29, Subchapter D, Ambulatory Gynecological Surgery in Hospitals and Clinics.

It was identified that The Allentown Medical Services was not in compliance with the following state law: Act 13 of 2002, Medical Care Availability and Reduction of Error (MCARE) Act 40 P.S. Medical facility reports and notifications. The specifics are located in Tag 9999 - Recommendations. A response for the this citation is required from the facility.

Safe and Sanitary recommendations were provided to the facility in Tag 9999 - Recommendations. The facility is encouraged to provide a plan of correction.

Plan of Correction:

No POC Required STANDARD Recommendation
Name - Component - 00

Observations:

Based on a review of facility documents and staff interview (EMP), it was determined that the facility failed to conform to all applicable State Laws.

The Allentown Medical Services was not in compliance with the following state law: Act 13 of 2002, Medical Care Availability and Reduction of Error (MCARE) Act 40 P.S. Medical facility reports and notifications.

Section 301. Scope. This chapter relates to the reduction of medical errors for the purpose of ensuring patient safety.

Section 309. Patient safety officer.
A patient safety officer of a medical facility shall do all of the following: (1) Serve on the patient safety committee. (2) Ensure the investigation of all reports of serious events and incidents. (3) Take such action as is immediately necessary to ensure patient safety as a result of any investigation. (4) Report to the patient safety committee regarding any action taken to promote patient safety as a result of investigations commenced pursuant to this section.

Section 310. Patient safety committee. (a) Composition.-- ... (2) An ambulatory surgical facility's or birth center's patient safety committee shall be composed of the medical facility's patient safety officer and at least one health care worker of the medical facility and one resident of the community served by the ambulatory surgical facility or birth center who is not an agent, employee or contractor of the ambulatory surgical facility or birth center. No more than one member of the patient safety committee shall be a member of the medical facility's board of governance. The committee shall include members of the medical facility's medical and nursing staff. The committee shall meet at least quarterly. (b) Responsibilities.--A patient safety committee of a medical facility shall do all of the following: (1) Receive reports from the patient safety officer pursuant to section 309. (2) Evaluate investigations and actions of the patient safety officer on all reports. (3) Review and evaluate the quality of patient safety measures utilized by the medical facility. A review shall include the consideration of reports made under sections 304(a)(5) and (b), 307(b)(3) and 308(a). (4) Make recommendations to eliminate future serious events and incidents. (5) Report to the administrative officer and governing body of the medical facility on a quarterly basis regarding the number of serious events and incidents and its recommendations to eliminate future serious events and incidents.

This is not met as evidenced by:

Based on a review of the facility's Patient Safety Plan, Patient Safety Committee meeting minutes and staff interview (EMP), it was determined that the facility failed to ensure the Patient Safety Officer was an employee working in the Allentown facility; failed to conduct patient safety meetings with all committee members present in the Allentown facility; failed to ensure the patient safety meeting was held specifically for Allentown Medical Services; and failed to document acceptable meeting minutes.

Findings include:

The facility was contacted on June 2, 2011, and a request made for a copy of the facility's patient safety plan. EMP1 noted that they would have to request a copy from the corporate office in Voorhees, New Jersey. The plan was provided to the Department on June 2, 2011. Review of the plan revealed the following: "American Women's Services - Patient Safety Plan American Women's Services is deeply committed to providing our patients with the highest quality of safe, effective medical care. Prevention of death, complications, or other serious adverse medical events is our highest priority. Toward that end, and to comply with Pennsylvania regulations, American Women's Services (AWS) has developed this Patient Safety Plan to cover AWS offices in Pittsburgh and Allentown, Pennsylvania. ... 2. Patient Safety Officer. [EMP3's name], AWS Operations Coordinator, has been designated to serve as the AWS patient safety officer (PSO). ... The patient safety committee shall meet at least quarterly ... "

Interview with EMP1 on May 26, 2011, at approximately 2:30 PM revealed the Patient Safety Officer for the Allentown Medical Services was EMP2. EMP2 worked in the corporate office in Voorhees, New Jersey. EMP2 did not work onsite on a routine basis in the Allentown facility.

Review of the patient safety meeting minutes revealed the following individuals in "Attendance" at the 1st Quarterly Meeting: March 16, 2011 - 4:30 PM: The Patient Safety Officer, AWS District Manager (EMP1), Medical and Nursing staff (EMP3), Community Resident - Allentown, Community Resident - Pittsburgh, Asst. Manager - Pittsburgh and Governing Body and Administrative Officer.

Interview with EMP1 on May 26, 2011, at approximately 2:30 PM revealed that the "Attendance" indicated these individuals were attending the Patient Safety Meeting on a telephone conference call. The individuals present in the Allentown facility for the conference call were the EMP1 and EMP3. The Patient Safety Officer, Community Resident - Allentown, Community Resident - Pittsburgh, Asst. Manager - Pittsburgh and Governing Body and Administrative Officer participated via the telephone and were not onsite in the Allentown facility.

Continued interview with EMP1 confirmed that the Patient Safety Meetings were conducted quarterly. The Patient Safety meetings were conducted for both the Allentown facility and the Pittsburgh facility. The meetings were not conducted specifically for Allentown Medical Services. The meeting minutes provided were for the Allentown and Pittsburgh facilities.

Review of the Patient Safety Meeting minutes for the March 16, 2011, meeting consisted of the following: "There is no report of an incident or event at this time. No investigations and actions needed at this time. Upon review, the quality of patient safety is fine at this time. None at this time (regarding recommendations to eliminate future incidents and serious events). No incidents or serious events at this time." The minutes provided were inadequate to ensure the reduction of medical errors for the purpose of ensuring patient safety was addressed for the Allentown Medical Services.

Based on a tour of the facility on May 26, 2011, and interview with staff, it was determined that the Allentown Medical Center failed to maintain a safe and sanitary

environment.

Findings include:

A tour of the facility was initiated at 10:00 AM on May 26, 2011, with facility staff.

Procedure Room 1 - 15 metal vaginal speculums were stored, unwrapped in three separate drawers in Procedure Room 1 on top of an incontinence blue pad. In one of the drawers, there was a sterile wrapped instrument. EMP1 stated this was a weighted speculum. EMP1 confirmed that these speculums were for patient use. EMP1 stated the metal speculums had been sterilized and confirmed that they were not wrapped to maintain sterility. In the cabinet, there was a plastic box which contained six metal extenders. EMP1 confirmed these were extenders for use during procedures. EMP1 confirmed they were sterilized and then placed together in the plastic open box and not wrapped to maintain sterility. In a drawer located at the foot of the procedure table, there were five metal vaginal speculums stored, unwrapped on a blue paper pad. Underneath the blue pad, there was a heating pad, warming the vaginal speculums. At the head of the procedure table, there was an outside window. The window had a crack in it, measuring approximately 24" in length. There was a vial in the emergency drug kit of Naloxone HCl 1 ml. that expired April 1, 2011. In the closet, there were patient care items stored directly on the floor, four boxes of ultrasound gel and one box of curettes.

Procedure Room 2 - There was a sterile blue wrapped packet with two holes in the blue wrapping. When opened, this contained nine dilators ready for patient use. There were two Clonidine 0.1 mg. tablets which expired May 1, 2011. There were nine packages containing surgical instruments. These surgical instruments had an of accumulation brown debris in the hinge areas and brown staining on the inside of the packages. Interview with EMP1 at the time of the observation confirmed the brown debris in the hinges of the surgical instruments and the brown stains on the inside of the surgical packages. EMP1 also confirmed that these surgical instruments were considered sterile and ready for patient use.

There were three sterile packages of instruments that contained the following dates: 8/22/2009, 2/4/2010 and 9/25/2010. The instruments were ready for patient use. Interview with EMP1 revealed that these dates represent the expiration of the sterility of the surgical instruments and that these instruments were no longer considered sterile.

There were two disposable uterine sound catheters which expired 3/15/2003 and three urethral catheters which expired 9/2005. There was a blue wrapped sterile instrument package with the instrument protruding through. EMP1 identified this instrument as a weighted speculum.

There were 13 metal vaginal speculums stored, unwrapped in a three drawer plastic cabinet. These speculums were stored on an incontinence pad. Both drawers containing these speculums contained dust, dirt and debris in the corners of the drawer, and one drawer had a visible hair measuring approximately one inch. EMP1 confirmed that these speculums were sterilized, wiped dry and placed in the drawers. EMP1 also confirmed that these speculums were ready for patient use.

Interview with EMP1 revealed that facility staff utilizes a disinfectant to wash the tubing on the suction canister. Further interview with EMP1 revealed that facility staff

does not utilize personal protective equipment (PPE). The PPE would include a protective gown and face mask when washing and rinsing the tubing. EMP1 confirmed there was a potential for facility staff to come into contact with blood and bodily fluids when washing and rinsing the tubing.

Recovery Area - The Recovery Area was an open room containing three black vinyl recliners for patients. There were no curtains between the chairs to provide patient privacy during recovery. The seat of the middle recliner and the left arm of the chair were were repaired with black duct tape. The chair immediately to the right had three areas on the seat of the chair where the white stuffing underneath was showing thru. A stack of patient care emesis basins was stored under the hand washing sink in the Recovery Area. There were blankets and pillows in the Recovery Area for patient use. Each of the patient recovery chairs had a heating pad covered with a removable blue covering. EMP1 confirmed that laundry of these patient care items, the pillows, blankets and heating pad covers, was completed by staff who took them home to launder "every once in awhile".

Laboratory Room - In the storage closet in the laboratory room, the following patient care items were stored directly on the floor: In excess of 50 sleeves of patient pill cups, two one-gallon jugs of Betadine solution, 10 boxes of examination gloves, 10 sleeves of paper hand towels, one case of condoms. This was confirmed with EMP2. There was a red box for used needles and syringes in the Laboratory Room. The box was full. On the floor beside the red box, was a used needle syringe. This was confirmed with EMP2.

Scrub room - There was a freezer in the scrub room which was identified by EMP1 and by signage as "Infectious Waste". EMP1 opened the freezer. There was multiple areas of a brown red frozen splatter and smear marks on the inside door of the freezer, on the rubber gasket (seal) between the freezer door and the freezer and on all sides of the interior of the freezer. There was also a thick layer of this brown red frozen material on the bottom of the freezer. EMP1 identified this brown red frozen material as frozen blood.
There was a suitcase stored under the counter. EMP1 opened the suitcase. There was a musty odor. Review of the contents of the suitcase revealed instruments wrapped in blue sterile packages with parts of the surgical instruments protruding through the wrap. EMP1 confirmed the musty odor of the suitcase and that the instruments were protruding through the blue wrap. EMP1 also confirmed that these instruments are considered sterile.

Plan of Correction:

An approved Plan of Correction is not on file.