0908

(717) 783-1379

November 16, 2010

[redacted]
Planned Parenthood Association of Bucks County
610 Louis Drive Suite 303
Warminster, Pennsylvania 18974

RE: Facility ID #00188701

Dear [redacted]

On November 9, 2010, an on-site survey was conducted at Planned Parenthood Association of Bucks County. The survey findings revealed that the clinic failed to provide services in accordance with 28 PA. Code Chapter 29, Subchapter D, Ambulatory Gynecological Surgery in Hospitals and Clinics. Specifically, the clinic did not meet the following requirement:

29.33(13) Requirements for Abortion. Each patient shall be supervised constantly while recovering from surgery or anesthesia, until she is released from recovery by a registered nurse or a licensed practical nurse under the direction of a registered nurse or a physician. The nurse shall evaluate the condition of the patient and enter a report of the evaluation and orders in the medical record of the patient.

On November 9, 2010 approximately 2:30 PM, onsite survey review of the agency's policy for Post-Procedure Recovery Room Monitoring revealed "Vital signs must be taken: at initiation of recovery and then every 15 minutes during the recovery process until discharge".

Onsite survey review of medical records, facility's policies and procedures, and interviews with the Facility Director and Director of Health Center Operations revealed the facility was not following it's policy for recovery room monitoring. Per the facility's policy for recovery room monitoring, "Vital signs must be taken: at initiation of recovery and then every 15 minutes during the recovery process until discharge". Two (2) of the three (3) patients receiving Intravenous sedation were not monitored every fifteen minutes.

Medical records reviewed on November 9, 2010 between 1:00 PM and 2:30 PM revealed the following:

Medical record# 4022890: According to the patient's "Recovery Room Note" of September 17, 2010, the patient arrived in the recovery room at "10:26 AM", and vital signs (blood pressure, pulse, cramps, bleeding, oxygen saturation) were initiated at "10:30 AM". No further vital signs were taken until the time of discharge at 11:10 AM when only the patient's blood pressure and bleeding were monitored. The "Recovery Room Note" was signed by a physician on 9/17/2010.

Medical record# 4045779: According to the patient's "Recovery room note" of July 30, 2010, the patient arrived in the recovery room at "11:40 AM", and vital signs (blood pressure, pulse, cramps, bleeding, oxygen saturation) were initiated "11:42 AM". No further vital signs were taken until the time of discharge 12:45 PM when only the patient's blood pressure and bleeding were monitored. The facility failed to document the patient's level of consciousness at discharge and verify if the patient was "accompanied" upon leaving. The "Recovery Room Note" was signed by a physician on July 30, 2010.

Interviews conducted on November 9, 2010 at approximately 3:00 PM with the Facility Director and Director of Health Center Operations confirmed the above identified findings.

The facility needs to develop and implement a corrective action plan. Please submit your written corrective action plan to the Department of Health, Division of Home Health 132 Kline Plaza, Suite A, Harrisburg, PA 17104, along with evidence for a mechanism for monitoring. You have 10 calendar days from the date of this letter to submit a corrective action plan. Thank you and your staff for the consideration shown at the time of the survey. If you have questions, please feel free to contact at (717) 783-1379.

Sincerely,

cc: File

PLANNED PARENTHOOD®
ASSOCIATION OF BUCKS COUNTY
Warminster, PA

CORRECTIVE ACTION PLAN

PROBLEM NOTED

Audit of abortion services by Pennsylvania Department of Health on November 9, 2010 revealed that monitoring of patients' vital signs was not being documented per policy, specifically, "[For patients receiving IV sedation], vital signs must be taken at initiation of recovery and then every 15 minutes during the recovery process until discharge."

Of 3 charts reviewed, 2 patients receiving IV sedation were noted not to have had vital signs monitored every 15 minutes.

ACTION PLAN

ACTION ITEM	RESPONSIBILITY	DUE BY
1) **Revise Recovery Room form** to add additional space for more frequent monitoring and to prompt staff of need for monitoring at arrival into recovery and at 15 minute intervals	[redacted]	Completed 11/22/2010
2) **Staff in-service training** on monitoring vital signs in Recovery Room & on new Recovery Room documentation form. Submit documentation to RQM Coordinator.	[redacted]	Nov. 30, 2010
3) **Immediate monitoring**: When signing patient discharge from Recovery, vital sign monitoring should be reviewed to assure that vitals have been documented at least every 15 minutes for patients having received IV sedation. Any non-compliance should be immediately addressed with Recovery room staff and reported to the Health Center Manager.	Abortion Services Physician	Nov. 30, 2010 & ongoing
4) **Ongoing assurance of compliance:** On at least a monthly basis, 10% of charts for patients who receive IV sedation (or minimum of 4 in month) will be reviewed to assure that monitoring of vital signs every 15 minutes is being maintained. Minimum acceptable level of compliance = 85%		
▪ An audit form will be developed to document the review of vital signs	▪ [redacted]	▪ Completed 11/24/2010
▪ Chart review & documentation of vital sign monitoring will be completed and submitted to the RQM Manager by the 2nd Friday of each month.	▪ [redacted]	▪ Dec. 10, 2010 and ongoing
▪ Chart review reports will be reviewed and monitored at quarterly Patient Safety Committee meetings. If further action is indicated, this will be decided upon by Committee membership	▪ [redacted]	▪ Next PSC meeting scheduled 12/17.2010

Plan completed by _____ **Date** _____

[redacted]

Review & approval by Patient Safety Committee - pending next meeting

PLANNED PARENTHOOD®
ASSOCIATION OF BUCKS COUNTY
→Warminster Health Center←

RECOVERY RECORD

Name_____
Acct #_____ DOB _____
Or Place Label Here

DATE: _____ ALLERGIES: _____

RH STATUS: ☐ Positive ☐ Negative _____ ANESTHESIA: ☐ Local ☐ IV Sedation

TIME ADMITTED: _____AM/PM ☐ Ambulatory w/assistance ☐ via wheelchair ☐ OPERATIVE REPORT reviewed.

IV in place: ☐ No ☐ Yes_____. IV discontinued @_____ am / pm by _____.

	VITAL SIGNS q 15 minutes			CONDITION				REMARKS	INIT
Time	BP	Pulse	SpO_2	Bleeding	Cramps	N/V	LOC		
Arrival									
Discharge									

Bleeding/Cramping (0 none 1 light/mild 2 moderate 3 heavy/severe)
Level of Consciousness (5-awake, alert & oriented; 4-Drowsy, easily aroused; 3-Drowsy, eyes open to verbal stimuli; 2-Drowsy, hard to arouse-needs tactile stimuli; 1-Responds to pain only; 0-Unresponsive)

Signature	Init

MEDICATIONS Given in RR (as ordered by MD on Form AB-16 Op Note):

☐ Acetaminophen 1000 mg po @ _____ by (init) _____ Lot #_____
☐ Ibuprofen 400 mg po @ _____ by (init) _____ Lot #_____ ☐ #641 Med factsheet given
☐ Methergine 0.2 mg po @ _____ by (init) _____ Lot #_____ ☐ #642 Med factsheet given
☐ Other:_____
☐ DMPA 150 mg IM @ _____ by (init) _____ in ☐ Deltoid: R / L ☐ Hip: R / L Lot #_____ ☐ #300 CIIC given
☐ MicRhogam 50 mcg IM @ _____ by (init) _____ in ☐ Deltoid: R / L ☐ Hip: R / L Lot #_____ ☐ Form AB-10 given
☐ Rhogam 300 mcg IM @ _____ by (init) _____ in ☐ Deltoid: R / L ☐ Hip: R / L Lot #_____ ☐ Form AB-10 given

DISCHARGE MEDICATIONS (as ordered by MD on Form AB-16 Op Note):

☐ Doxycycline 100 mg po #14 given by (init) _____ Lot #_____ ☐ #660 Med factsheet given
☐ OCP_____ x #1pack given by (init) _____ Lot #_____ ☐ #320 CIIC given
☐ Methergine 0.2 mg po #_____ given by (init) _____ Lot #_____ ☐ #642 form given
☐ Amoxicillin 500 mg po #_____ given by (init) _____ Lot #_____ ☐ #660 Med factsheet given
☐ Next Choice ECP given by (init) _____ Lot #_____ ☐ #310 CIIC given
☐ Other_____ given by (init) _____ Lot #_____ ☐ _____ given

NOTES (as needed)

PT STABLE & CLEARED FOR DISCHARGE BY _____MD/DO/CRNP @_____ (See Discharge Vitals above)

☐ #AB-07 Post Abortion instructions given & verbally reviewed by (init) _____
☐ AB Feedback questionnaire #AB-32 given by (init) _____
☐ #AB-31 F/U Form given & impt. of F/U appt stressed by (init) _____. Plans F/U @ _____

☐ To leave accompanied
☐ To leave unaccompanied

Birth Control Plans: _____

SPECIAL INSTRUCTIONS:
☐ Ectopic Precautions ☐ Form # AB-09 given & reviewed verbally ☐ Pt verbalized understanding of same Init
☐ Return in one week for F/U U/S ☐ Instruc provided verbally & in writing ☐ Pt verbalized understanding of same Init

☐ _____ ☐ Instruc provided verbally & in writing ☐ Pt verbalized understanding of same Init

PLANNED PARENTHOOD®
ASSOCIATION OF BUCKS COUNTY

RQM DOCUMENT
CONFIDENTIAL

AUDIT TOPIC: ABORTION SERVICES – MONITORING OF VITAL SIGNS IN RECOVERY

PURPOSE: To assure that patients having received IV sedation are having their vital signs monitored and documented on arrival to recovery and at least every 15 minutes until discharge

SAMPLE: 10% of patients receiving IV sedation during review period or minimum of 4 charts

FREQUENCY: Monthly

# of patients receiving IV sedation during review period: _____ **# CHARTS REVIEWED:** _____ **AUDIT TIME FRAME:** _____

REVIEWER: _____ **DATE OF REVIEW:** _____

ACCT # / CRITERIA: There is documentation of:						Level of Compliance	
						# / # of charts	%
1. time of admission to recovery.							
2. BP, pulse, oxygen saturation, nausea/vomiting & level of consciousness at admission to recovery, i.e. within 5 minutes of time of admission							
3. BP, pulse, oxygen saturation at least every 15 minutes until discharge from recovery							
4. BP, pulse, oxygen saturation, bleeding/cramping and level of consciousness at discharge							
5. time of discharge from recovery							

Remarks:

- Completed Audit to be submitted to RQM Coordinator by the 2nd Friday of each month.
- Reports to be reviewed at quarterly Patient Safety Committee meetings

Planned Parenthood®
Association of Bucks County

RECEIVED

NOV 2 9 2010

PA DEPT OF HEALTH
DIVISION OF HOME HEALTH

November 24, 2010

Department of Health
Division of Home Health

Harrisburg, PA 17104

Enclosed please find Planned Parenthood® Association of Bucks County's Corrective Action Plan, along with some substantiating documentation.

At this time, it is my belief that we have submitted all outstanding documentation. If there is any further information that you are awaiting, or you have any questions about the materials that have been submitted, please do not hesitate to contact me. You can contact me at or via email at

Thank You for your Assistance through this audit process!

Sincerely,

[redacted]

Enc. 3

Being needed is cause enough.

610 Louis Drive, Warminster, PA 18974-2828 • 215.957.7981 • Fax: 215.957.9668 • www.ppbucks.org

A copy of PPABC's official registration and financial information may be obtained from the Pennsylvania Department of State by calling toll-free, within Pennsylvania, 1-800-732-0999. Registration does not imply endorsement.

PLANNED PARENTHOOD®
ASSOCIATION OF BUCKS COUNTY
Warminster, PA

CORRECTIVE ACTION PLAN

PROBLEM NOTED

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Plan completed by _____ **ate** 11/24/10

[redacted]

Review & approval by Patient Safety Committee - pending next meeting

PLANNED PARENTHOOD®
ASSOCIATION OF BUCKS COUNTY
→Warminster Health Center←

RECOVERY RECORD

Name_____
Acct #_____ DOB _____
Or Place Label Here

DATE: _____ ALLERGIES: _____

RH STATUS: ☐ Positive ☐ Negative _____ ANESTHESIA: ☐ Local ☐ IV Sedation

TIME ADMITTED: _____AM/PM ☐ Ambulatory w/assistance ☐ via wheelchair ☐ OPERATIVE REPORT reviewed.

IV in place: ☐ No ☐ Yes_____. IV discontinued @_____ am / pm by _____.

	VITAL SIGNS q 15 minutes			CONDITION				REMARKS	INIT
Time	BP	Pulse	SpO_2	Bleeding	Cramps	N/V	LOC		
Arrival									
Discharge									

Bleeding/Cramping (0 none 1 light/mild 2 moderate 3 heavy/severe)
Level of Consciousness (5-awake, alert & oriented; 4-Drowsy, easily aroused; 3-Drowsy, eyes open to verbal stimuli; 2-Drowsy, hard to arouse-needs tactile stimuli; 1-Responds to pain only; 0-Unresponsive)

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ASSOCIATION OF BUCKS COUNTY

RQM DOCUMENT
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						# / # of charts	%
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5. time of discharge from recovery							

Remarks:

- Completed Audit to be submitted to RQM Coordinator by the 2nd Friday of each month.
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Planned Parenthood®
Association of Bucks County
610 Louis Drive, Warminster, PA 18974-2846
Tel: 215-957-7981 / Fax: 215-957-9668

FAX COVER SHEET

TO:

FROM:

COMPANY: PA DOH

DATE: Nov 22, 2010

FAX#:

OF PAGES: 10 (including cover sheet)

☐ URGENT ☒ FOR REVIEW ☐ PLEASE COMMENT ☐ PLEASE REPLY ☐ PLEASE RECYCLE

Attached please find:

① Revised Recovery Record (Form AB-18) that clearly notes medications ordered by MD while given out by staff

NOTE: Revised form now clearly indicates need for vital signs every 15 minutes.

② IV Removal
- Training module
- Training Checklist (completed for
- Lab Test Performance (form 129) - completed for

This message is intended only for the use of the individual or entity to which it is addressed, and may contain information that is privileged, confidential exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone, and return the original message to us at the above address via the U.S. Postal Service. Thank you.

A copy of PPABC's official registration and financial information may be obtained from the Pennsylvania Department of State by calling toll-free, within Pennsylvania, 1-800-732-0999. Registration does not imply endorsement.

PLANNED PARENTHOOD®
ASSOCIATION OF BUCKS COUNTY
→Warminster Health Center←

RECOVERY RECORD

Name_____
Acct #_____ DOB _____
Or Place Label Here

DATE: _____ ALLERGIES: _____

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Birth Control Plans: _____

SPECIAL INSTRUCTIONS:

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☐ Return in one week for F/U U/S ☐ Instruc provided verbally & in writing ☐ Pt verbalized understanding of same. Init_____
☐ _____ ☐ Instruc provided verbally & in writing ☐ Pt verbalized understanding of same. Init_____

F-1: IV REMOVAL – TRAINING & PROFICIENCY

I. OBJECTIVE

A. **To assure that staff removing IVs will be able to:**
   1. perform the removal correctly and effectively
   2. select appropriate Personal Protective Equipment (PPE) materials needed for the removal and perform the procedure safely to reduce the incidence of bloodborne exposure to the healthcare worker and injury to the patient
   3. identify any problems associated with IV removal & manage common problems
   4. document the removal properly in the medical record

B. **To assure consistency** in the training provided to personnel performing IV removal

C. **To provide documentation** of training & proficiency in the skill of venipuncture

II. PERSONNEL

A. **Personnel Eligible for Training to remove IVs,** include:
   1. Medical Assistant Externs
   2. Medical Assistants (MAs)
   3. Health Care Assistants
   4. Licensed medical staff (RN, LPN, PA, CRNP, CNM, MD/DO)

B. **Personnel Eligible to Proctor New Trainees**
   1. Licensed medical staff, i.e., MD, DO, NP, PA, RN, LPN, CNM

III. REQUIREMENTS PRIOR TO HANDS-ON TRAINING

A. **Before proceeding with this Training Module, the trainee must have:**
   1. Participated in an OSHA Bloodborne Pathogens Training within the past year
   2. Completed a Hepatitis B Refusal Form or have begun/ completed the Hepatitis B vaccination series
   3. Read PPABC's Infection Control/Exposure Control Plan policies (See *Medical Manual*, Section III-A)
   4. Reviewed the content and requirements included in this Training Module

B. **The proctor must confirm that the trainee has fulfilled all requirements in "A" above and should reinforce the following material:**
   1. OSHA's Bloodborne Pathogens Standard, and other Infection Control issues, especially the following:
      a. the selection and use of appropriate Personal Protective Equipment
      b. proper hand sanitizing procedures
      c. SHARPS care, including proper disposal
      d. disposal of biohazardous materials
      e. procedure in event of a bloodborne exposure incident
   2. Patient Preparation

3. Technique
4. Problem Management
5. Documentation of removal procedure in patient medical record

III. SUPERVISED SKILL TRAINING & PRACTICE

A. The trainee must have observed at least 3 successful IV removals (these may be observed at PPABC or elsewhere) ***before*** skill practice on a patient may be initiated.

B. The clinician or approved proctor MUST *directly supervise* all IV removals during the proctoring period.

C. The proctor (or clinician) must:
   1. be directly available and prepared to provide technical assistance as necessary
   2. review the completion of all required documentation
   3. cosign the medical record for all IV removals performed during the proctoring period

D. An approved proctor (or clinician) must observe a minimum of 5 successful IV removals by the trainee. If any of these removals are performed incorrectly in any way, the trainee must be observed for a total of at least 5 additional removals.

   NOTE: Staff with previous experience in IV removal are only required to perform 2 successful removals under observation

IV. PROFICIENCY VERIFICATION REQUIREMENTS

A. A clinician must assure that all requirements stated in this Training Module have been completed successfully, including:
   - direct observation of a minimum of 5 (2 for staff with previous experience) completed and successful IV removals, documented on the IV Removal Training Checklist

B. **Documentation of Proficiency** -- A clinician must:
   1. Sign the *"Statement of Competency"* found at the end of the IV Removal Training Checklist
   2. Make a copy of the IV Removal Training checklist for the trainee, which must be maintained in the Control Binder in each health center in which the employee will be performing IV removals
   3. Forward the original of the completed Checklist to Human Resources for inclusion in the employee's personnel file.

C. **Continued Proficiency** -- The clinician should observe at least one additional IV removal procedure within the next 6 months, and then at least one observation yearly for verification of continued proficiency. (This monitoring of proficiency should be documented on Form 129.)

D. **Additional training /skill proctoring** may be requested at any time by the staff person or the clinician.

PLANNED PARENTHOOD BUCKS COUNTY

POLICIES & PROCEDURES
XVI. LABORATORY
F-2. IV Removal; Training Checklist

F-2. IV REMOVAL: TRAINING CHECKLIST

TRAINEE NAME _____

I have read PPABC's Infection Control Policies & Procedures and PPABC's Exposure Control Plan.
I have observed at least 3 successful IV removals.
I know that I should ask questions about anything that I do not understand.

Trainee Signature _____ Date 11·19·10

I have verified that the above named trainee has participated in an OSHA Blood-borne Pathogen training within the past 12 months, and has been offered Hepatitis B vaccination.

Proctor Signature _____ Date 11/19/10

√ = Achieved
⊘ = Not Achieved

CRITERIA:	Account #	4198338	4124163			
	Date	11/19/10	11/19/10			
	Proctor Initials	[redacted]				
1. Verified patient identity with patient & medical record		√	√			
2. Hands sanitized appropriately.		√	√			
3. Gathered all needed supplies & PPE. (gloves, bandage, disposal container)		√	√			
4. Explained the procedure to the patient accurately, and in a manner to ensure cooperation and ease anxiety.		√	√			
5. A gauze pad or cotton ball was placed over the puncture site and the IV removed from the vein slowly and gently.		√	√			
6. Gentle pressure was applied to the site for 3 minutes or the patient was asked to apply pressure to the site with the arm in the appropriate position. (If bleeding did not stop after the first 3 minutes, the patient was asked to elevate the arm while continuing to apply pressure.)		√	√			
7. A bandage strip was applied over the gauze.		√	√			
8. Immediately upon removal, the IV tubing, gloves & other items were disposed of appropriately.		√	√			
9. Hands sanitized appropriately.		√	√			
10. The procedure was documented accurately & completely in the medical record		√	√			

COMMENTS: _____

STATEMENT OF COMPETENCY – IV REMOVAL: The above employee has successfully completed the IV Removal Training and Proficiency Module, demonstrating safe and effective IV removal procedure. S/he is competent to perform IV removal independently.

Clinician Signature _____

Trainee Signature _____ Date _____

PLANNED PARENTHOOD BUCKS COUNTY

POLICIES & PROCEDURES
XVI. LABORATORY
F-2. IV Removal: Training Checklist

F-2. IV REMOVAL: TRAINING CHECKLIST

TRAINEE NAME [redacted]

I have read PPABC's Infection Control Policies & Procedures and PPABC's Exposure Control Plan.
I have observed at least 3 successful IV removals.
I know that I should ask questions about anything that I do not [illegible]

Trainee Signature [illegible] Date 11-19-10

I have verified that the above named trainee has participated in an OSHA Blood-borne Pathogen training within the past 12 months, and has been offered Hepatitis B vaccination:

Proctor Signature [illegible] Date 11/19/10

	Account #	45 46138	45 86 94			
√ = Achieved ⊘ = Not Achieved	Date	11/19/10	11/19/10			
CRITERIA:	Proctor Initials	[redacted]				
1. Verified patient identity with patient & medical record		√	√			
2. Hands sanitized appropriately.		√	√			
3. Gathered all needed supplies & PPE. (gloves, bandage, disposal container)		√	√			
4. Explained the procedure to the patient accurately, and in a manner to ensure cooperation and ease anxiety.		√	√			
5. A gauze pad or cotton ball was placed over the puncture site and the IV removed from the vein slowly and gently.		√	√			
6. Gentle pressure was applied to the site for 3 minutes or the patient was asked to apply pressure to the site with the arm in the appropriate position. (If bleeding did not stop after the first 3 minutes, the patient was asked to elevate the arm while continuing to apply pressure.)		√	√			
7. A bandage strip was applied over the gauze.		√	√			
8. Immediately upon removal, the IV tubing, gloves & other items were disposed of appropriately.		√	√			
9. Hands sanitized appropriately.		√	√			
10. The procedure was documented accurately & completely in the medical record		√	√			

COMMENTS: _____

STATEMENT OF COMPETENCY – IV REMOVAL: The above employee has successfully completed the IV Removal Training and Proficiency Module, demonstrating safe and effective IV removal procedure. S/he is competent to perform IV removal independently.

[illegible] 11/19/10
Clinical Site Date

[illegible] 11-19-10
Trainee Signature Date

Planned Parenthood® Bucks County

LAB TEST PERFORMANCE / EVALUATION SHEET for STAFF NAME [redacted] Title_____

Prior to independently performing any lab test on a patient, the staff member must have:

- attended an OSHA Bloodborne Pathogens Training within the past year
- initiated the Hepatitis B vaccination series or signed a Refusal
- read PPABC's General Laboratory Policies, Infection Control policies and the lab test procedure for each lab test to be performed
- read any instructions provided by the manufacturer for lab reagents and equipment.

By signing and dating below, the Technical Laboratory Supervisor acknowledges that the staff member has demonstrated proper knowledge and skill technique.

LAB TEST PROCEDURE:	DATE	Technical Lab Supervisor Signature	DATE	Technical Lab Supervisor Signature	DATE	Technical Lab Supervisor Signature
1. **Height / weight** measurement						
2. **Temperature** measurement						
3. **Blood Pressure** measurement ▪ Aware of alert value/management						
4. **Hemoglobin using HemoPoint H2™** ▪ Wore gloves/washed hands ▪ Wiped off 1st blood drop ▪ Uses cuvette correctly ▪ Reads result correctly ▪ Disposes of materials correctly						
5. **HemoPoint H2 control** (run & document)						
6. **Urine Dipsticks:** Name of Tests: _____/_____ ▪ Wore gloves/washed hands ▪ Read dipstick at proper time ▪ Read accurately ▪ Logged in Lab Log appropriately ▪ Disposed of materials correctly						
7. **Urine dipstick control:** Name of Control: _____ ▪ Can run & document						
8. **Urine Pregnancy Test:** Name of Test: _____ ▪ Wore gloves/wash hands ▪ Followed test instructions ▪ Read & logged test correctly ▪ Disposed of materials properly						

Planned Parenthood® Bucks County [redacted]

LAB TEST PROCEDURE:	DATE	Technical Lab Supervisor Signature	DATE	Technical Lab Supervisor Signature	DATE	Technical Lab Supervisor Signature
9. Pregnancy Test control Name of control: _____ ▪ Can run & document						
10. Venipuncture/Use of Centrifuge ▪ Wore gloves ▪ Used proper technique ▪ Disposed of SHARPS / other materials correctly ▪ Properly labeled specimen ▪ Properly completed lab slip						
11. IM Injections ▪ Washed hands / Wore gloves ▪ Proper technique ▪ Disposed of materials properly ▪ Documented procedure properly						
12. Use of Autoclave ▪ Pre cleaned instruments ▪ Wore gloves ▪ Loaded properly / not overloaded ▪ Used proper indicators ▪ Completed autoclave log						
13. Run biological indicator: Attest						
14. Rh Factor						
15. Rapid HIV Test with Control Name of Test: _____						
16. Products of Conception- management						
17. Removal of IV (See P&P XVI-F1-2, for training Checklist& Statement of Competency	11/19/10	[redacted]				
17. Review of lab results ▪ Can sort positive from negative						

Laboratory Director Review:

[redacted] Date [redacted] Date [redacted] Date

129 11/19/2010

RETAIN THIS RECORD IN OFFICE FOR 5 YEARS & THEN FORWARD TO PERSONNEL FILE

Planned Parenthood® Bucks County

LAB TEST PERFORMANCE / EVALUATION SHEET for STAFF NAME [redacted] Title_____

Prior to independently performing any lab test on a patient, the staff member must have:

- attended an OSHA Bloodborne Pathogens Training within the past year
- initiated the Hepatitis B vaccination series or signed a Refusal
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- read any instructions provided by the manufacturer for lab reagents and equipment.

By signing and dating below, the Technical Laboratory Supervisor acknowledges that the staff member has demonstrated proper knowledge and skill technique.

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2. **Temperature** measurement						
3. **Blood Pressure** measurement ▪ Aware of alert value/management						
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5. **HemoPoint H2 control** (run & document)						
6. **Urine Dipsticks:** Name of Tests: _____ / _____ ▪ Wore gloves/washed hands ▪ Read dipstick at proper time ▪ Read accurately ▪ Logged in Lab Log appropriately ▪ Disposed of materials correctly						
7. **Urine dipstick control:** Name of Control: _____ ▪ Can run & document						
8. **Urine Pregnancy Test:** Name of Test: _____ ▪ Wore gloves/wash hands ▪ Followed test instructions ▪ Read & logged test correctly ▪ Disposed of materials properly						

Planned Parenthood® Bucks County [redacted]

LAB TEST PROCEDURE:	DATE	Technical Lab Supervisor Signature	DATE	Technical Lab Supervisor Signature	DATE	Technical Lab Supervisor Signature
9. Pregnancy Test control Name of control: _____ ▪ Can run & document						
10. Venipuncture/Use of Centrifuge ▪ Wore gloves ▪ Used proper technique ▪ Disposed of SHARPS / other materials correctly ▪ Properly labeled specimen ▪ Properly completed lab slip						
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12. Use of Autoclave ▪ Pre cleaned instruments ▪ Wore gloves ▪ Loaded properly / not overloaded ▪ Used proper indicators ▪ Completed autoclave log						
13. Run biological indicator: Attest						
14. Rh Factor						
15. Rapid HIV Test with Control Name of Test: _____						
16. Products of Conception- management						
17. Removal of IV (See P&P XVI-F1-2, for training Checklist& Statement of Competency	11/19/10	[redacted]				
17. Review of lab results ▪ Can sort positive from negative						

Laboratory Director Review:

[redacted] Date [redacted] Date [redacted] Date

RETAIN THIS RECORD IN OFFICE FOR 5 YEARS & THEN FORWARD TO PERSONNEL FILE

Planned Parenthood®
Association of Bucks County
610 Louis Drive
Warminster, PA 18974-2828
215-957-7981 – Phone
215-957-9668 – Fax

FAX COVER SHEET

TO:

FROM: [redacted]

FAX #: 215-957-9668

DATE: NOVEMBER 23, 2010

OF PAGES (INCLUDING COVER SHEET): 12

RE: PA DEPARTMENT OF HEALTH AUDIT

Attached please find revised **Emergency Drug and Equipment Logs**.

According to my records, Planned Parenthood® Association of Bucks County has now submitted all items that at the time of our Audit on November 9th we were requested to fax to the Department of Health. If you have any questions about the information that has been submitted, please do not hesitate to contact me at 215-957-7981 ext. 4120.

Also, please note that you should be receiving the form listing our current Abortion Services physicians that we were asked to have notarized via the US Postal Service.

This message is intended only for the use of the individual or entity to which it is addressed, and may contain information that is privileged, confidential exempt from disclosure under applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering the message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by telephone, and return the original message to us at the above address via the U.S. Postal Service. Thank you.

A copy of PPABC's official registration and financial information may be obtained from the Pennsylvania Department of State by calling toll-free, within Pennsylvania, 1-800-732-0999. Registration does not imply endorsement.

PLANNED PARENTHOOD®
ASSOCIATION OF BUCKS COUNTY
• Warminster Health Center •

CRASH CART & OTHER EMERGENCY DRUGS & EQUIPMENT FOR SURGICAL SERVICES

YEAR: _____

1. Emergency Drug & Equipment check must be done monthly.
2. Expiration dates must be documented for all medications. (Limit expiration dates to no more than 2 different expirations per drug type).
3. When a medication will expire in ≤ 30 days, an order to replace the expiring medications must be initiated.
4. Use a footnote (i.e. [1], [2], [3], etc) between the ***Actions Taken Log*** and the Drug Checklist to indicate lot # changes.
5. The ***actual number*** of drug vials/ampules and /or pieces of equipment at time of count must be documented.
6. When equipment operation check is indicated, a √ should also be noted to indicate that the equipment operation was checked and found to be operational.
7. Any equipment found to be non-operational must be immediately replaced and/or repaired and the Health Center Manager advised.
8. All actions taken must be documented on the ***Actions Taken Log*** below including but not limited to when replacement medications are ordered, when medications are wasted due to expiration, when medications are provided during an emergency situation, when equipment is noted to be broken/non-operational and the actions taken to replace or repair that equipment.

ACTIONS TAKEN (including Drug Use Record):

DATE	ACCOUNT # if applicable	EQUIPMENT OR DRUG (include dosage if applicable)	ACTIONS TAKEN (include medications given, expired medications removed/replaced, equipment ordered, etc.,)	SIGNATURE

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DATE	ACCOUNT # If applicable	EQUIPMENT OR DRUG (include dosage if applicable)	ACTIONS TAKEN (include medications given, expired medications removed/replaced, equipment ordered, etc.)	SIGNATURE

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CRASH CART #1054 (IV SEDATION ROOM)

		Init												
		Date												
ITEM	MIN QTY	EXP	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
ALBUTEROL INHALER 17 gm Manu:	1													
ATROPINE 0.4 mg/ml 1 ml ampules Manu:	10													
CALCIUM CHLORIDE 10% Inj IV Manu:	1													
DEXTROSE 50% IV (50 cc vial) Manu:	1													
DIPHENHYDRAMINE (Benadryl) IM (50mg/ml) Manu:	4 vial													
DIPHENHYDRAMINE PO (Benadryl) 25 mg tablets Manu:	12													
EPHEDRINE SULFATE 50 mg/ml (1 ml ampules) Manu:	5 amps													
EPINEPHRINE 1:10,000 IV Manu:	5													
EPINEPHRINE 1:1000 1mg/ml (1ml amps) Manu:	4													
FLUMAZENIL (Romazicon) 0.5mg/5ml vials Manu:	1													

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		Init												
		Date												
ITEM	MIN QTY	EXP	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Glycopyrollate 0.2 mg/ml (1 ml ampules) Manu:	5 amps													
LACTATED RINGERS 500 CC Manu:	2													
NORMAL SALINE 500 CC Manu:														
LIDOCAINE 2% Abboject 100mgm/5ml Manu:	1													
MEFOCLOPRAMIDE (Reglan) Manu:	5 amps													
METHYLPREDNISOLONE SUCCINATE (Solu-Medrol) 125 mg IV/IM 4ml/500mg vial Manu:	1													
NALOXONE (Narcan) 0.4 mg/ml ampule Manu:	1													
ONDANSETRON (Zofran) Manu:	5 amps													
PITOCIN (Oxytocin) 10 units/ml Manu:	15													
SODIUM BICARBONATE Inj 1mEq/ml Abboject 500 cc Manu:	1													
SOLU-CORTEF IV 100 mgm/2 ml vials Manu:	2													

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		INIT													
		DATE													
ITEM	MIN QTY	EXP	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
STERILE WATER	5													
ALCOHOL SWIPES	10													
AMBU BAG (adult bag valve mask with reservoir)	1													
AMMONIA INHALANTS	2													
ASEPTO CATH 22 G (may have other gauges)	5													
AUTOMATED ELECTRONIC DEFIBRILLATOR (AED) See Form #AB-106 to document Autocheck	1													
BLANKET (light weight)	1													
BUTTERFLY infusion set/winged infusion set 21g (may have other additional gauges)	3													
CUT DOWN TRAY	1													
ENDOTRACHEAL TUBES (one each size)	1													
EYE WASH & Cup	1													
FIRST AID KIT	1													
FLASHLIGHT (✓ indicates operation checked)	1													
GLOVES (pair) (Latex-free available)	10													

PLANNED PARENTHOOD®
ASSOCIATION OF BUCKS COUNTY
▪ Warminster Health Center ▪

		INIT													
		DATE													
ITEM	MIN QTY	EXP	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
HYPO ALLERGENIC TAPE	1													
ICE BAG	1													
IV POLE	1													
IV TUBING SET	2													
LARYNGOSCOPE	1													
NASAL AIRWAYS	1													
NASAL CANNULA	2													
NEEDLES -various size gauges (5 ea) 20G1" 18G1"	 5 5													
NON- REBREATHER FACEMASK	2													
ORAL AIRWAY (set)	1													
ORAL SUCTION MACHINE w/ Suction Catheters	1													
OXYGEN TANK w/ Liter Meter & Gauge √O_2 - indicates O_2 level checked & > ¾ full (O_2 level check required every 6 months)	1													
POCKET MASK	1													
STERILE 4X4 GAUZE	4													
SYRINGES – various sizes (5 each) 1cc TB (SC EPI 1:1000) 3cc with 21G needles	 5 5													
TOURNIQUET	1													
MEDICAL EMERGENCY PROTOCOLS	1													
OCCUPATIONAL EXPOSURE Folder	1													

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• Warminster Health Center •

CRASH CART 32654 (LOCAL PROCEDURE ROOM)

ITEM	MIN QTY	EXP	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
		Init												
		Date												
ALBUTEROL INHALER Manu:	1													
ATROPINE 0.4 mg/ml 1 ml ampules Manu:	10													
CALCIUM CHLORIDE 10% Inj IV Manu:	1													
DEXTROSE 50% IV (50 cc vial) Manu:	1													
DIPHENHYDRAMINE (Benadryl) IM (50mg/ml) Manu:	4 vial													
DIPHENHYDRAMINE PO (Benadryl) 25 mg tablets Manu:	12													
EPINEPHRINE 1:10,000 IV Manu:	5													
EPINEPHRINE 1:1000 1mg/ml in 1ml ampules Manu:	4													
FLUMAZENIL (Romazicon) 0.5mg/5ml vials Manu:	1													
LACTATED RINGERS 500 CC Manu:	2													

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• Warminster Health Center •

		Init													
		Date													
ITEM	MIN QTY	EXP	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
NORMAL SALINE 500 CC Manu:														
LIDOCAINE 2% Abboject 100mgm/5ml Manu:	1													
METHYLPREDNISOLONE SUCCINATE (Solu-Medrol) 125 mg IV/IM 4ml/500mg vial Manu:	1													
NALOXONE (Narcan) 0.4 mg/ml ampule Manu:	1													
PITOCIN (Oxytocin) 10 units/ml Manu:	15													
SODIUM BICARBONATE Inj 1mEq/ml Abboject 500 cc Manu:	1													
SOLU-CORTEF IV 100 mgm/2 ml vials Manu:	2													
STERILE WATER	5													
ALCOHOL SWIPES	10													
AMBU BAG (adult bag valve mask with reservoir)	1													
AMMONIA INHALANTS	2													
ASEPTO CATH 22 G (may have other gauges)	5													

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		Init												
		Date												
ITEM	MIN QTY	EXP	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
BLANKET (light weight)	1													
BUTTERFLY infusion set/winged infusion set 21g (may have other additional gauges)	3													
CUT DOWN TRAY	1													
ENDOTRACHEAL TUBES (one each size)	1													
EYE WASH & Cup	1													
FIRST AID KIT	1													
FLASHLIGHT (✓ indicates operation checked)	1													
GLOVES (pair) (Latex-free available)	10													
HYPO ALLERGENIC TAPE	1													
ICE BAG	1													
IV POLE	1													
IV TUBING SET	2													
LARYNGOSCOPE	1													
NASAL AIRWAYS														
NASAL CANNULA	2													
NEEDLES -various size gauges (5 ea)														
20G1"	5													
18G1"	5													

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		Init													
		Date													
ITEM	MIN QTY	EXP	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
NON-REBREATHER FACEMASK	2													
ORAL AIRWAY	1 set													
ORAL SUCTION MACHINE w/ Suction Catheters	1													
OXYGEN TANK w/Liter Meter & Gauge √O_2 - indicates O_2 level checked & > ¾ full (O_2 level check required every 6 months)	1													
POCKET MASK	1													
STERILE 4X4 GAUZE	4													
SYRINGES – various sizes (5 each) 1cc TB (SC EPI 1:1000) 3cc with 21G needles	 5 5													
TOURNIQUET	1													
MEDICAL EMERGENCY PROTOCOLS	1													
OCCUPATIONAL EXPOSURE Folder	1													

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▪ Warminster Health Center ▪

EMERGENCY MEDICATIONS / EQUIPMENT (OTHER LOCATIONS)

ITEM	MIN QTY	EXP	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
		Init												
		Date												
REFRIGERATOR #2406 (IN RECOVERY ROOM)														
METHERGINE 0.2 mg IM Manu:	10													
SUCCINYL CHOLINE 200 MG IN 10cc vial Manu:	1													
LOCKED SAFE (IN FRONT SUPPLY CLOSET)														
DIAZEPAM (Valium) 5mg IV / IM Manu:	1													
OTHER														
BATTERY OPERATED LAMPS (1 in cabinet in each procedure room) Place ✓ to indicate operation checked	1 1													
BLOOD SPILL KIT (FRONT LAB)	1													
EYE WASH STATION Place ✓ to indicate operation checked	1													
MERCURY SPILL KIT (FRONT LAB)	1													