OR - pink is for you

PRINTED: 08/17/2012
FORM APPROVED

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FTAF-0017	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 07/26/2012
NAME OF PROVIDER OR SUPPLIER NOVA WOMEN'S HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 10400 EATON PLACE, SUITE 515 FAIRFAX, VA 22030		

(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
T 000	12 VAC 5- 412 Initial comments An unannounced Licensure Initial survey was conducted July 24, 2012 through July 26, 2012 by three Medical Facilities Inspectors from the Office of Licensure and Certification, Virginia Department of Health. Two complaints were investigated in conjunction with the initial survey. The agency was not in compliance with 12 VAC-412 Regulations for the Licensure of Abortion Clinics. (Effective 12/29/2011). Deficient practice was cited and follow in this report.	T 000	usually announced but unannounced because of complaints	
T 010	12 VAC 5-412-140 A Organization and management A. Each abortion facility shall have a governing body responsible for the management and control of the operation of the facility. This RULE: is not met as evidenced by: Based on observation, record review and interview the governing body failed to monitor and ensure policies/procedures and processes were implemented related to : 1. Delineation of privileges for two of four physicians. (Staff # 3 and Staff #9) 2. Physicians signing with date and time orders for medications and discharge orders. 3. The completion of a history and physician's physical prior to the termination procedure. 4. Staff training and competency for identifying anatomy associated with the products of conception. The findings included:	T 010	policy in place but not followed, After VDH survey, our Medical Executive Committee (MEC) that reports to the governing board, held a meeting that addressed issues found in the survey. New policies and procedures have been implemented to avoid future occurrence.	07/31/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE ADMINISTRATOR (X6) DATE 9/13/12

STATE FORM 021199 WQRK11 If continuation sheet 1 of 38

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T 010	Continued From Page 2 These credentials shall be reviewed by the credentialing Committee [sic] and specific practice privileges identified and recorded before presentation to the Board of Managers ... The application and Committee's recommendation are given to the Governing Board. Final approval rests with the Governing Board ...7.2 Privileging Procedure: The practitioner must complete the appropriate Delineation of Privileges Form and supply the requested documentation to allow the Medical Director to accurately assess the practitioner's qualifications. The completely verified credentialing documentation, along with the practitioner-completed requested Delineation of Privileges, will be presented to the Governing Board for recommendation and approval for privileges ..." 2. Review of Patients #1 - #20's medical records did not provide evidence of consistent physicians signing with date and time orders for medications. Patient #1 - #20's medical records did not have a physician's order for discharge or transfer to a higher level of care (Patients #5 and #8). An interview conducted on July 25, 2012 at 11:47 a.m., with Staff #4 revealed that verbal orders were given when a patient needed transfer to a higher level of care. Staff #4 acknowledged the verbal orders need to written plus signed, dated and timed by the physician. Review of the facility's policy titled "Verbal Orders" read "Orders for drugs and biologicals that are transmitted by the physician verbally should be followed by a written order that is signed by the prescribing physician ... The prescribing physician must sign, date, and time written orders in the patient's medical record confirming the verbal order. This shall be done as soon as possible ..."	T 010	Review of patient #1-#20's medical records did not provide evidence of consistent physicians signing with date and time orders for medications. New forms have been created and have been used for physicians to provide signature, date and time when the order is given. The same form also contains instructions that prompt nurse to obtain physician order for specific actions such as to obtain discharge order or to transfer patient to a higher level of care. The nurse is responsible to review chart for completion prior to patient discharge.	08/20/12

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T 010	Continued From Page 3 3. The physician failed to complete a history and physical prior to the abortion procedure. Review of medical records on July 24 and 25, 2012 revealed the following patient that underwent first trimester pregnancy terminations did not have a history and physical performed by a physician: Patient #5: date of procedure March 29, 2012; Patient #8: date of procedure March 3, 2012; Patient #15: date of procedure March 3, 2012; Patient #18: date of procedure March 3, 2012; Patient #19: date of procedure March 3, 2012; and Patient #20: date of procedure March 3, 2012. An interview and record review was conducted on July 25, 2012 at 3:38 p.m., with Staff #2. Staff #2 acknowledged the physician had failed to complete the history and physical portion of the form. Staff #2 acknowledged the six patient did not received a history and physical prior to the termination of their pregnancy.	T 010	New procedure was implemented to ensure physician's compliance in documenting all services rendered including a history and physical assessment prior to procedure. Forms for physician to complete were edited and simplified to remind physician to document their finding before proceeding to the next step. The nurse is responsible to review chart completion, especially for history and physical before letting patient to proceed with the next step. This addition to the manual is approved by and shall be reviewed annually by the Governing Board.	07/31/12 08/20/12
	4. Staff training and competency for identifying anatomy associated with the products of conception. Observations were conducted July 24 and 25, 2012 as Staff #8 processed the products of conception (poc) after the procedures. Staff #8 identified whether the tissue removed during the abortion process contained the villi or fetal parts. On two observations, Staff #8 verbally informed the physician the results were "Okay". The physician documented in the patient's medical record that the gross pathology had been completed and verified per his/her signature. Review of Staff #8's employee record did not reveal documented training or competencies related to identifying components of the products of conception.		On 07/31/12 physician held staff training for identifying anatomy associated with products of conception. Staff #8 received formal documented training on that day. This training will be held every 6 months by the physician in the future to ensure competency. The Governing Board has approved it and the Director of Nursing will be responsible to review and check medical staff's ongoing training and competency. Documentation copy of staff training is available for review.	07/31/12

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T 195	Continued From Page 18 This RULE: is not met as evidenced by: Based on record review and staff interview the facility failed to ensure each patient, who received an abortion had a history and physical performed by a physician for six of twenty patients. (Patients #5, #8, #15, #18, #19, and #20) The findings included: Review of medical records on July 24 and 25, 2012 revealed the following patient that underwent first trimester pregnancy terminations did not have a history and physical performed by a physician: Patient #5: date of procedure March 29, 2012; Patient #8: date of procedure March 3, 2012; Patient #15: date of procedure March 3, 2012; Patient #18: date of procedure March 3, 2012; Patient #19: date of procedure March 3, 2012; and Patient #20: date of procedure March 3, 2012. An interview and record review was conducted on July 25, 2012 at 3:38 p.m., with Staff #2. Staff #2 acknowledged the physician had failed to complete the history and physical portion of the form. Staff #2 acknowledged the six patient did not received a history and physical prior to the termination of their pregnancy.	T 195	New procedure was implemented to ensure physician's compliance in documenting all services rendered including a history and physical assessment prior to procedure. Forms for physician to complete were edited and simplified to remind physician to document their finding before proceeding to the next step. The nurse is responsible to review chart completion, especially for history and physical before letting patient to proceed with the next step.	07/31/12 08/20/12
T 200	12 VAC 5-412-240 B Medical testing, patient counseling and labor B. The abortion facility shall offer each patient, in a language or manner they understand, appropriate counseling and instruction in the abortion procedure and shall develop, implement and maintain policies and procedures for the provision of family planning and post-abortion counseling to its patients.	T 200		

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T 200	Continued From Page 20 An interview and review of Patient #1 - #20's medical records was conducted on July 25, 2012 at 4:42 p.m., with Staff #1 and Staff #2. Staff #2 verified the facility staff had failed to document pre-op and family counseling for patient whether they did or did not returned to the facility for follow-up visits. ? not documented if they returned	T 200		
T 220	12 VAC 5-412-250 A Anesthesia service A. The anesthesia service shall be managed in accordance with the Office-Based Anesthesia provisions of the Regulations Governing the Practice of Medicine, Osteopathic Medicine, Podiatry and Chiropractic (18 VAC 85-20-310 et seq.). This RULE: is not met as evidenced by: Based on record review and interview the facility's anesthesiologist incorrectly documented the level of sedation as general anesthesia for fourteen of fifteen patients that received conscious sedation. (Patients #1, #3, #5, #6, #8, #9, #10, #12, #13, #14, #15, #18, #19, and #20) The findings included: The review of the medical records for Patients #1, #3, #5, #6, #8, #9, #10, #12, #13, #14, #15, #18, #19 and #20 was performed on July 24 and 25, 2012, by three surveyors. The review revealed the "Anesthesia Record" documented the patients received "GA (general anesthesia)." The "Anesthesia Record" provided a check box for "Conscious sedation", which for fourteen of the fifteen records had not been checked. [According to the Virginia Department of Health Professionals "The Board of Medicine Regulations Part III: Office-Based Anesthesia 18 VAC	T 220	Our facility's anesthesiologist incorrectly documented the level of sedation as general anesthesia. Our facility has never provided general anesthesia service to patients. To prevent future reoccurrence we have edited all of our anesthesia forms to change the term "general anesthesia" into "intravenous sedation (IV sedation)". During an MEC meeting on July 314, 2012 it was addressed to all employees to refrain from using the term "general anesthesia" to prevent confusion. Anesthesiologist has agreed to not use the term "general anesthesia" in the future and to use correct terminology in writing and speaking.	08/06/12

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T 220	Continued From Page 21	T 220		

85-20-310 Definitions: "General anesthesia" means a drug-induced loss of consciousness during which patients are not arousable even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive-pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired." The definition for "Moderate sedation/conscious sedation" means a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are usually required to maintain a patent airway, and spontaneous ventilation is usually adequate. Cardiovascular function is usually maintained." The regulations defined "Local anesthesia" means a transient and reversible loss of sensation in a circumscribed portion of the body produced by a local anesthetic agent."

An interview conducted on July 25, 2012 from 10:05 a.m. to 10:35 a.m., with Staff #3 revealed the facility did not employ general anesthesia. Staff #3 reported the facility employed local anesthesia and conscious sedation.

physician

An interview was conducted on July 25, 2012 at approximately 11:42 a.m., with the Medical Director (Staff #4). Staff #4 reviewed the medical records for Patients #5 and #8. Staff #3 acknowledged the facility did not utilize general anesthesia. Staff #4 stated' "We get in the habit of saying general anesthesia when we really mean conscious sedation." Staff #4 acknowledged the anesthesia records did not correctly reflect the level of sedation provided to the patients. Staff #4

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T 220	Continued From Page 22 reported any medical record that documented the "level of sedation, as general anesthesia is incorrect." An interview and review of medical records (Patients #1, #3, #5, #6, #8, #9, #10, #12, #13, #14, #15, #18, #19 and #20) was conducted on July 25, 2012 at 3:32 p.m. with Staff #1 and Staff #2. Staff #2 verified the facility did not utilize general anesthesia and the physician had incorrectly checked general anesthesia rather than checking conscious sedation listed on the anesthesia record. According to the American Society of Anesthesiologist's "Documentation of Anesthesia Care" revised 2008: "Documentation is a factor in the provision of quality care and is the responsibility of an anesthesiologist. While anesthesia care is a continuum, it is usually viewed as consisting of preanesthesia, intraoperative/procedural anesthesia and postanesthesia components. Anesthesia care should be documented to reflect these components and to facilitate review. The record should include documentation of: ... C. Doses of drugs and agents used, times and routes of administration and any adverse reactions. D. The type and amounts of intravenous fluids used, including blood and blood products, and times of administration. E. The technique(s) used and patient position(s). <http://www.asahq.org/For-Members/Standards-Guidelines-and-Statements.aspx> " T 265 12 VAC 5-412-260 A Administration, storage and dispensing of dru A. Controlled substances, as defined in 54.1-3401 of the Drug Control Act of the Code of	T 220 no CRNA?			
		T 265		

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T 335	Continued From Page 25	T 335		
	July 25, 2012, approximately at 10:21 a.m.			
T 340	12 VAC 5-412-310 Medical records	T 340		
	An accurate and complete clinical record or chart shall be maintained on each patient. The record or chart shall contain sufficient information to satisfy the diagnosis or need for the medical or surgical service. It shall include, but not limited to the following: 1. Patient identification; 2. Admitting information, including a patient history and physical examination; 3 Signed consent; 4. Confirmation of pregnancy; and 5. Procedure report to include: a. Physician orders; b. Laboratory tests, pathologist's report of tissue, and radiologist's report of x-rays; c. Anesthesia record; d. Operative record; e. Surgical medication and medical treatments; f. Recovery room notes; g. Physician and nurses' progress notes, h. Condition at time of discharge, i. Patient instructions, preoperative and postoperative; and j. Names of referral physicians or agencies.			
	This RULE: is not met as evidenced by: Based on record review and interviews the facility failed to maintain complete and accurate clinical records for twenty of twenty patients in the survey sample. (Patients #1 - #20) 1. The medical records failed to include physician orders for discharge (Patients #1 - #20), orders for transfer to a higher level of care (Patients #5 and			

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T 340	Continued From Page 26 #8), and did not consistently document medications ordered (Patients #1 - #20). 2. Twenty of twenty medical records did not have physician progress notes. (Patients #1 - #20) 3. Three of fifteen medical records for patients that received surgical termination of a first trimester pregnancy had post anesthesia care documented on the intra-operative record. (Patients #5, #7, and #8) 4. Two of fifteen medical records for patients that received surgical termination of first trimester pregnancy did not have recovery room notes. (Patient #6 and #12) 5. Fourteen of fifteen medical records for patients that received surgical termination of a first trimester pregnancy had the incorrect level of sedation documented. (Patients #1, #3, #5, #6, #8, #9, #12, #13, #14, #15, #18, #19 and #20) 6. Six of twenty medical records for patients that had a first trimester termination of pregnancy did not have a physician's history and physical documented. (Patients #5, #8, #15, #18, #19, and #20) The findings included: 1. The medical records failed to include physician orders for (a) discharge (Patients #1 - #20), (b) transfer to a higher level of care (Patients #5 and #8) and (c) did not consistently document medications ordered, notation by nursing staff or dates and times (Patients #1 - #20). (a) A review of twenty medical records were conducted on July 24 and 25, 2012 by three	T 340	? complications – physician followed then from OR & Rept unity or intraprocedural instead of PAR (RR) but the are time conflicts. ? Routine check ? The medical records failed to include physician orders for discharge and orders for transfer to a higher level of care. Forms have been created and edited and have been used by physicians to provide signature, date and time when orders are given. The same form also contains instructions that prompt nurse to obtain physician order for medications and other specific actions such as to obtain discharge order or to obtain order to transfer the patient to a higher level of care. The nurse is responsible to review the chart for completion prior to patient discharge.	08/20/12

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surveyors. The review of Patients #1- #20's medical records did not reveal a documented physician's order for discharge.

An interview conducted on July 24, 2012 at 3:14 p.m., with Staff #1 and Staff #2 revealed the physician did not write discharge orders. Staff #2 acknowledged patients admitted to the facility were admitted under the care of a physician and the physician was responsible for discharging the patient.

(b) Review of Patient #5's medical record revealed a complication during surgery. The medical record documented the patient was stabilized and the physician recommended transfer to a local hospital's Emergency Department (ED) for further work-up. The patient's medical record documented emergency transport was called and the patient was transported from the facility. Patient #5's medical record did not contain a physician's order for transfer to a higher level of care.

OR doesn't know about

Review of Patient #8's medical record revealed a complication during surgery. The medical record documented the patient was stabilized for transfer to a local hospital's Emergency Department (ED) for further work-up. The patient's medical record documented emergency transport was called and the patient was transported from the facility. Patient #8's medical record did not contain a physician's order for transfer to a higher level of care.

OR knows about

medical director

An interview was conducted on July 25, 2012 at 11:55 a.m. with Staff #4. Staff #4 reviewed the medical records for Patient #5 and Patient #8. Staff #4 verbalized awareness of Patient #5 and Patient #8's condition at transfer. Staff #4

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reported he/she had given verbal orders to the nursing staff for emergency transport. Staff #4 stated, "I did not write the order." Staff #4 reported the nursing staff did not write a verbal order to transfer the patients from the facility to the local hospital's ED. Staff #4 acknowledged the medical records did not contain a documented physician's order to transfer the patient to a higher level of care.

(c) A review of twenty medical records were conducted on July 24 and 25, 2012 by three surveyors. The review of Patients #1- #20's medical records did not reveal consistent documentation of physician ordered medications or nursing documentation of noting the medications orders with a time and date. The medical records for Patients #1 - #20 documented nursing administration of medications without a documented medication order within the medical record.

An interview and review of medical records was conducted on July 25, 2012 at approximately 3:32 p.m., with Staff #1 and Staff #2. Staff #1 and Staff #2 verified the physicians did not consistently document orders for medications. Staff #2 reported the forms utilized had changed from not listing the medications to a standing order document. Staff #2 acknowledged before the change to the standing order document the nursing staff listed the medications administered, but the medical chart did not contain physician orders for the medications. Staff #2 acknowledged the standing order document was not consistently signed by the physician for medications, which were designated to be administered pre-procedure, intra-procedure and post-procedure. Staff #2 verified the medication orders that had been signed by the physician did not include a date and time. Staff #2

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T 340	Continued From Page 29 acknowledged nursing staff did not authenticate the physician's orders as to when they were received by date and time.	T 340		
	2. A review of the medical records for Patients #1 - #20 did not reveal physician progress notes. An interview and review of medical records was conducted on July 25, 2012 at approximately 3:32 p.m., with Staff #1 and Staff #2. Staff #2 verified the medical records for Patient #1 - #20 did not have physician progress notes. Staff #2 reported the physicians are not documenting in the progress notes. Staff 32 reported he/she had not been aware of the requirement for physicians to document in the progress notes. Staff #2		Physician progress notes. A new form was created to allow physicians a separate section to document their patient assessment and findings. And a section was provided for physicians to document their progress notes.	08/20/12
	3. Three of fifteen medical records for patients that received surgical termination of a first trimester pregnancy had post anesthesia care documented on the intra-operative record. (Patients #5, #7, and #8) Review of Patient #5's medical record revealed a complication during surgery. The documentation suggested the care and treatment received occurred intra-operatively. The time documented for the patient's stabilization and transport to the ED conflicted with the procedure ending time and discharge from the procedure room. Review of Patient #7's medical record revealed a complication during surgery. The documentation suggested the care and medication received occurred intra-operatively. The documentation did not specify date and times nor indicate which staff administered medications to the patient. Review of Patient #8's medical record revealed a		Three of fifteen medical records for patients who received first trimester termination had post anesthesia care documented on the intra-operative record. We have edited and updated our surgical forms to separate the documentation into pre, intra, and post procedure. Each phase has its own section for physicians or nurses to document findings and/or assessment. Director of Nursing will maintain and update the forms periodically and report to the Governing Board of any changes.	08/20/12

we have no date for Pt's #7's abortion & it appears she was not transferred (only make an order for it).

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FTAF-0017	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 07/26/2012
NAME OF PROVIDER OR SUPPLIER NOVA WOMEN'S HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 10400 EATON PLACE, SUITE 515 FAIRFAX, VA 22030		

(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
T 340	Continued From Page 30 complication during surgery. The documentation suggested the care and treatment received occurred intra-operatively. The time documented for the patient's stabilization and transport to the ED conflicted with the procedure ending time and discharge from the procedure room. An interview was conducted on July 25, 2012 from 10:05 a.m. to 10:35 a.m., with Staff #3. Staff #3 reviewed the medical record for Patient #7. Staff #3 stated, "I continue to write on the OR (Operation Room) record when the patient moves to the PACU (post anesthesia care unit)." Staff #3 agreed he/she did not document the date and time for his/her medical record entries. Staff #3 acknowledged Patient #7's medical record did not document, which staff had administered the medications. Staff #3 reported he/she follows patients in the "PACU" if there are complications. Staff #3 reported he/she will generally "just continue to document on the intra-operative form." Staff #3 acknowledged the care provided post operative documented on the intra-operative form creates time conflicts. 4. Two of fifteen medical records for patients that received surgical termination of first a trimester pregnancy did not have recovery room notes. (Patient #6 and #12) Review of Patient #6 and Patient #12's medical records revealed the "Recovery" section of the nursing documentation was incomplete. An interview was conducted on July 25, 2012 at 4:42 p.m. with Staff #1 and Staff #2. Staff #2 reviewed the medical records for Patient #6 and Patient #12. Staff #2 reported the nurse failed to complete the documentation related to recovery.	T 340	Two of fifteen medical records for patients did not have recovery room notes. With the edited forms, recovery room note is part of the surgical form. In the past, a nurse must obtain a separate form to document recovery room notes, which left many opportunities for documentation failure. Nurses are also expected to complete the entire form prior to patient discharge. Director of Nursing will ensure nurses comply with the practice.	08/20/12

physician

to this an improvement see above