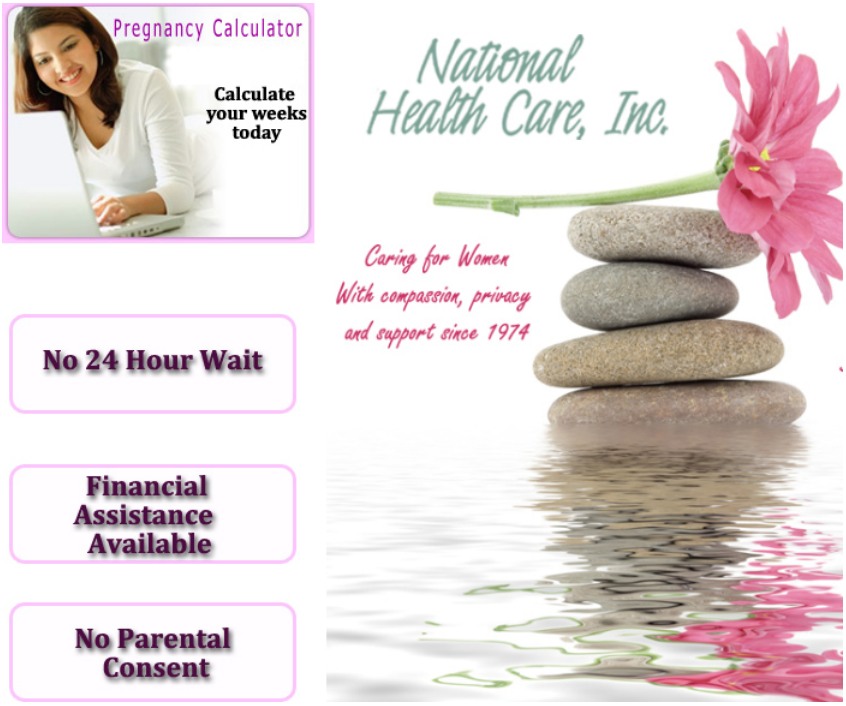
McHenry County Blog

Illinois Abortion Facility Inspection Update – Part 5

Posted on **03/04/2012** by **Cal Skinner**

This is the fifth of a series of posts written by a friend of McHenry County Blog summarizing Illinois Department of Public Health Inspections of abortion clinics.

National Health Care, Peoria



This is by far the most difficult clinic to write about. Of all the PTSCs that remain open it had the most violations. It is impossible to be brief in this summary.

On 6/16/11 a nursing survey was done. Here are the results listed according to survey category:

Under Organizational Plan- there was a chart to delineate lines of authority that was conflicting. Another flow chart was proposed.

Under Standards of Professional Work- There was no documentation that the consulting committee had met in 2008, 2009, 2010, or 2011. They are required to meet quarterly. This is very important because the consulting

committee is the heart of how a clinic operates. It writes and updates policies and procedures for the P&P manual; it sets criteria for who can work there, qualifications, job descriptions, the granting of privileges; it serves as the tissue committee to make sure the pathology reports are read, filed, and responded to if they come back abnormal; because it consists of at least 3 qualified consulting physicians it encourages an interaction between professionals that improves the quality of care. By not meeting quarterly they did not oversee the things which are required for safe practice, which will be demonstrated below.

The P&P manual lacked a procedure for granting privileges. But there were doctors hired and working there. Credentials were to be reviewed by the credentials committee (which did not meet) so that specific practice privileges could be requested (which they were not) and could be granted (which they were not). All 4 doctors had no documentation in their files to indicate whether privileges were granted and what the scope of those privileges were. There were no requests for privileges in the files. One of the doctors didn't even have a job application in his file. When a doctor is granted specific practice privileges he is to provide a motorized statement indicating the name of the Illinois' licensed hospital(s) where he has skilled-equivalent practice privileges. None of the files contained this. Two doctors had hospital letters on file, but it turned out that one of them was no longer on the staff of the hospital. That means that of the four physicians only one had current hospital privileges.

Since the consulting committee did not meet, the tissue committee did not meet. The pathology reports were said to have been handled by the RN. There was no collaboration on the findings, which could improve care. There was also an unwillingness to change the procedure, expressed by the clinic administrator. The Medical Director is responsible for securing compliance with the policies and procedures pertaining to the medical and surgical procedures. First off, the P&P manual was to be reviewed semi-annually by the consulting committee (which was not meeting). But even without updating, the Medical Director allowed many violations of the current Nurse Practice Act to occur. IV moderate sedation is to be administered only by physicians and RNs. In about 1/2 of the cases it was being given by an LPN. This is unsafe, unlawful, and totally not allowed. Because the staff nurse job description had no delineation between the requirements and duties of an RN and an LPN, they ended up overlapping duties. Also, it was found that a CNA was mixing up medications for IV usage. There was no documentation that she had ever been trained to do this. This also is not allowed and is dangerous. There was also questionable training of the ultrasound techs. According to the tech, she had been trained by the administrator, but the administrator claimed that all sonographers have been under the direction of an x-ray technologist who specializes in ultrasound. There was no documentation in the tech's file to indicate any training or demonstrated competency in perfoming ultrasounds.

Under Personnel Policies-each employee's file is to contain documentation of orientation and/or demonstrated competency to their work. Of the 12 employees, 9 failed to have this documentation while the other 3 employees HAD NO FILE AT ALL. What kind of a place is this? How does ANY place of business not have file records on their employees? There was a dispute between the nurse surveyor and the administrator over the scope of one of the employee's work, but since she was one of the employees without a file, it's hard to say if she was doing things she was allowed to or not!

Under Presence of Qualified Physician-"a qualified physician is required to remain until all patients are medically discharged. The discharge criteria shall be defined by the qualified consulting committee." There was no discharge criteria in the P&P manual. And since the consulting committee wasn't meeting…

Under Nursing Personnel-3 of 3 LPN personnel files failed to include documentation of training in observation and emergency techniques for preoperative and postoperative care of surgical patients. It appears that they were simply hired and told, "go to work".

Under Laboratory Services-There was no written agreement with a CLIA certified lab. They later produced a written agreement with the lab they have been working with for what they said was 30+ years.

Under Equipment-There was no evidence of any preventative maintenance program or log for the equipment utilized in the provision of patient care. This includes the sterilizers (3), the suction machines used for the abortions (3), the sonogram machine, the centrifuge, the blood pressure machine, special lights, and an oxygen tank which was last checked 10/16/2000 and was empty. All the equipment was sent out to be maintained and a yearly recheck is now set up.

Also in terms of equipment management is the safety in storage and use of all narcotics and medications in accordance with state and federal law. There were many violations of procedural discipline found. There were medications stacked in unlabeled medication cups, open and unopened medications in unlocked drawers, open vials with no indication of when they were opened (once open they rapidly expire). Open and unopen vials placed on the procedure stand in the procedure rooms by the door included Fentanyl, a narcotic. It is to be kept under lock and key.

Under Sanitary Facility-The sterilizers are to be cleaned monthly. They hadn't been. Also, they are to be tested weekly. According to the log they were only being tested monthly, and I notified the IDPH about that. A broader explaination of the purpose and importance of this will be found under Northern Illinois Women's Center.

Also under Sanitary Facility-the laundry was processed on site, but there was no documentation that the water temperature was monitored so as to prevent cross-contamination. There was food found on the crash cart (snack nuts and cookies), open 2×2 gauze squares in the medication closet, open packages of bandaids stored in emesis basins in all three procedure rooms, and various patient care items stored on the floor.

Under Emergency Care-While there were policies related to emergency preparedness in the P&P manual, there was nothing to indicate the staff had received any training in handling emergencies.

Under Pre-operative Care -a complete history and physical is to be done and a pre-anesthetic evaluation. In 20 out of 20 patients there was no documentation to indicate the history (completed by the patient) nor the physical examination (lab work, pelvic and sonogram completed by the nurse, lab, and/or sonographer) were reviewed by the physician prior to their procedure. Nor was there documentation to indicate a pre-anesthetic evaluation was conducted prior to the the administration of IV moderate sedation. This is so dangerous. (See the death at the Woman's Aid Clinic below.) This is part of the definition of "abortion mill"- doing the procedure without a concern for the individual patient, her individual needs, her particulars regarding her body. Yes, the tests may have been done, but someone must READ and INTERPRET them. And histories need to be done interactively, or at least discussed. Not just filled out without scrutiny. Also, the examination completed was only a pelvic exam, a sonogram, and lab work-up. There were no other systems examined like the respiratory system (lungs) or the circulatory system (heart). This is extremely dangerous for someone undergoing IV sedation and surgery.

Under Operative Care-This is where it gets particularly scary. This relates to the actual procedures. The code states, " Surgical procedures shall be performed only by a qualified physician within the limits of the defined specific practice privileges that have been granted". Since there was no way of granting privileges, there are no limits on the scope of practice on doctors who were never qualified to operate. No physician had defined specific privileges granted, or even requested.

The IV sedation given by LPNs was totally outside their scope of practice. LPNs are allowed to start IVs after certification. There was no evidence that any of the 3 LPNs were even IV certified, yet they administered IV push medications, including narcotics.

Regarding the registered nurses giving IV moderate sedation- the RN must have no other responsibilities during the procedure in order to monitor the patient's response to the medication (breathing, heartrate, etc.). She must maintain current Advanced Cardiac Life Support (ACLS) certification. The supervising physician must have training and experience in delivering and monitoring moderate sedation and possess clinical privileges at the ASTC to

administer moderate sedation or analgesia. The supervising physician must maintain current ACLS certification… These RNs had multiple clinical responsibilities. NONE were ACLS certified. The physicians were not privileged to administer moderate sedation. Only 1 of the 4 physicians had ACLS certification in their professional file.

Regarding RNs in the operating room- an RN must be present in the operating room and function as the circulating nurse during all invasive or operative procedures. This was not so. If the RN is giving the IV sedation, she cannot circulate. If she is circulating, she cannot be giving IV sedation or leave the room. At some times the only person in the room, besides the physician and the patient, was an LPN. This is not safe practice. But it was their standard procedure, as voiced by the administrator.

Under Statistical Data- There is specific statistical data to be kept at the clinic regarding procedures done, complications, deaths, and transfers. There was no data compiled nor presented. There was only an oral reassurance that the clinic has never had a death or a serious life-threatening issue in the last 36 years. I find it hard to believe.

On 9/6/11 the nurse surveyor returned. The clinic had corrected many of the problems, but significant problems remained.

Under Standards of Professional Work- there was still no procedure for granting privileges. It had been written, but had not been reviewed and approved by the consulting committee. However, privileges had been granted to physician(s?), but it was discovered that at least one of the physicians had no admitting privileges at an Illinois hospital. (Because some documents were reviewed on site I can't tell exactly what was going on). The P&P manual had not been reviewed and approved at this time (3 months after the initial survey). The new discharge form was being implemented, although it had not been approved.

Under Pre-operative Care- There was in 14 of 14 charts no documentation to indicate that the history, lab work, or pelvic exam were reviewed by the physician prior to the procedure and there was no documentation to indicate a pre-anesthetic evaluation was conducted prior to IV moderate sedation. Again, this is after 3 months to initiate change.

The clinic had to make some drastic changes. Since only one physician had hospital privileges and ACLS certification, the others stopped practicing there. One was able, later, to get privileges at a hospital and become ACLS certified. The other two have left permanently. However, that leaves only 2 qualified physicians at the clinic, and 3 are required for a Qualified Consulting Committee, so something needs to change for compliance. Allowing them to operate without the 3rd physician will not raise the standard of care, and as you can see, it's already pretty low.

Unfortunately, the changes that the clinic made were not always improvements. Because an RN was required to devote full attention to administer IV moderate sedation, the clinic opted for the physician route. Now the physician administers the IV moderate sedation and no nurse is involved. This is legal, but clearly less safe. He may believe that he can multitask, but the physician is split between doing the abortion and being responsible for the sedation. If he has a complication with one, how is he to monitor the other? Clearly a dangerous move, but one that is considered legal. While his license is at stake the patient risks her very life.

On 10/7/11 the IDPH did another onsite visit. Since there was only 1 physician working there and doing the IV moderate sedation himself, and since the policy and procedure manual was reviewed and approved on 9/15/11 by the (not exactly qualified) consulting committee, and since there were medical history, physical exam and discharge criteria present in 15 of 15 charts examined, the clinic was deemed compliant. Let's hope it's safer.

On 7/6/11 a Life Safety Survey was done. Multiple violations were found.

Under Hazardous Areas- walls did not extend through to the roof, there were areas without drywall leaving the metal studs exposed, and there were fire doors needed in some areas and needing documentation in other areas. This involved 4 different rooms of storage areas. All are fire hazards.

Under Emergency Illumination- there was no documentation of any testing of the emergency lighting. When tested by the surveyor the battery operated light for the back fire exit did not function.

Under Written Fire Plan-there was a plan, but it was neither complete, direct, explicit, nor gave proper procedures. It was rewritten. There was no documentation as to how the facility conducts an “in-service” of fire safety for their existing and new staff.

Under Fire Drills- there was no documentation of fire drills occuring. In the P&P manual they were required yearly, but the standard is quarterly and requires documentation.

Under Fire Alarm System-there were an insufficient number of smoke detectors; no documentation of testing system components; the door hardware had magnetic locks that did not allow for quick and easy egress in the event of a fire; the electric panel was not marked “Fire Alarm Circuit” and lacked a lock on devise.

Under Fire Extinguishers- there was no documentation of any testing or inspection as required. (It was later provided).

Under Electrical Wiring- They needed GFI on outlets near sinks in the procedure rooms. Multiprong adaptors were being used in 2 areas. The electrical work was corrected.

Under Support Services Areas-the corridor contained a gurney, a wheelchair, and a table all obstructing egress. They were cleared out and properly stored.

On 9/12/11 a follow-up survey was conducted. There were uncorrected deficiencies remaining.

On 10/14/11 another follow-up survey was conducted. There were still uncorrected deficiencies remaining.

Under Hazardous Areas- the rating on the existing fire doors still had not been verified.

Under Emergency Illumination- there was still no documentation of testing, even though they had submitted a form in July. The form had not been used (documenting monthly testing).

Under Fire Alarm System-they were still missing a smoke detector. The hardware for the exit door was not installed by 9/12/11. There was no sign on that door by 10/14/11 to indicate the location of the “red button” that allowed an override of the system.

On 11/1/11 a desk audit was done. The clinic had sent in pictures of the 2 fire door ratings and of the exit sign. I could find no documentation that the emergency lighting was tested. The surveyor found that all deficiencies previously identified have now been corrected.

I am sure that these surveyors had a hard time with this clinic. In a newspaper article in the Peoria Journal Star the clinic administrator says as much. Having gone for so long without inspection, and being unaware of many changes in the code made for a very large task of coming up to date. The clinic made a lot of substantial changes to come up to the standards. Except for their having the physician do the IV Sedation himself, rather than hire additional RNs to do it, I think these changes will result in a safer enviroment for the patients and the staff, particularly in

cases of emergency. By tightening up on their medication standards they should make it more difficult for drug abuse to occur, which has been seen to be a problem in many clinical settings.

More tomorrow.

Posted in **Abortion**, **Abortion Clinic**, **National Health Care**
permalink [http://mchenrycountyblog.com/2012/03/04/illinois-abortion-facility-inspection-update-part-5/]