Survey Findings/Facility Response

Facility : CAMELBACK FAMILY PLANNING

Survey Date - 3/6/2014 - Citation4

Survey Findings

Based on a review of clinic policy and procedure, medical records, and staff interviews, the Department determined the medical director failed to follow the abortion clinic policy when performing the abortion procedure on 2 of 2 patients (# 8 and 9).

Findings include:

Review of clinic policy and procedure "PROCEDURE ROOM LAMINARIA INSERTION" revealed: "...DAY FOR D&E (dilatation and evacuation)...Cytotec 600 mcg (microgram) buccally given with pain meds per dr's order 90 min (minutes) before Lam (laminaria) removed...."

Patient # 8

Review of the medical record dated 11/5/13 revealed: "...Cytotec 600 mcg...By:...buccally...At: 8:24...Time started: 930...."

RN # 2 verified, during an interview conducted on 3/6/14, that the D&E procedure was

started at 66 minutes post Cytotec instead of 90 minutes per clinic policy and procedure.

Patient # 9

Review of the medical record dated 1/9/14 revealed: "...Cytotec 600 mcg...By:...buccally...At: 8:50...Time Started: 09:55...."

RN # 2 verified, during an interview conducted on 3/6/14, that the D&E procedure was

started at 65 minutes post Cytotec instead of 90 minutes per clinic policy and procedure.

The Licensee/Medical Director verified, during an interview conducted on 3/6/14, that there is no additional documentation why the abortion procedures were started before 90 minutes per clinic policy and procedure on 2 of 2 patients (# 8 and 9). The Medical Director, during a discussion after the survey explained that based on her clinical judgement she will deviate from the policy and procedure. There were no adverse outcomes identified only a failure to follow the policy and procedure.

sa200

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slmult1

Rule/Statute

R9-10-1508. Abortion Procedures

F. A medical director shall ensure that an abortion is performed according to the abortion clinic"s policies and procedures and this Article.

Facility Response

The date (08/27/2014) represents when the facility corrected the citation and was confirmed by the Department to be back in compliance. A facility is required to submit a Plan of Correction (POC) for each citation identified during a survey. This Plan of Correction describes how the facility is going to make corrections, the facility representative responsible for making the corrections, and what systems are in place to prevent recurrence. Once the facility has submitted an acceptable Plan of Correction, the Department confirms that the citation is corrected.

For a copy of the Plan of Correction, please contact the facility or the Department of Health Services.

Survey Findings/Facility Response

Facility : CAMELBACK FAMILY PLANNING

Survey Date - 3/6/2014 - Citation5

Survey Findings

Based on a review of clinic policy and procedures, medical records, and staff interviews, the Department determined the medical director failed to ensure a physical examination was performed during the follow-up visit for 5 of 5 surgical abortion patients

(# 1, 2, 4, 8, and 9).

Findings include:

The Surveyors requested the clinic policy and procedure delineating care to be provided to the post surgical patient during the follow-up visit, none was provided during the survey process.

Review of the clinics documentation contained in the medical records provided during the survey process revealed: "...S.O.A.P. (sign with title at all entries)...Date...24 hour Post Procedure Phone Call...HCG Slide...Cramps...Bleeding...Spotting...Birth Control...Sexual Activity...Diminished S/S (signs/symptoms) of Pregnancy...PE/Pap (pelvic examination/Papanicolaou)...Morning After Pill:...."

The S.O.A.P. note is defined as: S ubjective, O bjective, A ssessment, and P lan. The S.O.A.P. note is a method of documentation used by health care providers. Subjective describes the patient's current condition; Objective describes results of testing, physical examinations, and measurements; Assessment describes the physician's medical diagnosis for that visit; and Plan describes what the health care providers is going to do to treat the patient such as ordering additional testing, referrals, and/or procedures.

Review of the medical records for patients' # 1, 2, 4, 8, and 9 revealed:

Patient # 1

Review of the follow-up visit documentation revealed: "...S.O.A.P...11/22/13...HCG card negative...PE/Pap...0...."

The number "0" has a diagonal line drawn through it.

The S.O.A.P. note documentation was created by an RN # 8.

There is no documentation that a physical examination was performed based on the medical records provided during the survey process.

Patient # 2

Review of the follow-up visit documentation revealed: "...S.O.A.P...8/28/13...HCG Slide: Negative...PE/Pap___...."

There was no documentation for the PE/Pap entry.

The S.O.A.P. note documentation was created by an RN # 8.

There is no documentation that a physical examination was performed based on the medical records provided during the survey process.

Patient # 4

Review of the follow-up visit documentation revealed: "...S.O.A.P...8/7/13...HCG Slide: negative...PE/Pap___...."

There was no documentation for the PE/Pap entry.

The S.O.A.P. note documentation was created by an RN # 3.

There is no documentation that a physical examination was performed based on the medical records provided during the survey process.

Patient # 8

Review of the follow-up visit documentation revealed: "...S.O.A.P...11/19/13...HCG Slide: neg...PE/Pap...has PCP...."

The PE/Pap entry states the patient has a primary care physician.

There are no staff initials associated with the 11/19/13 follow-up visit entries on the S.O.A.P. note.

There is no documentation that a physical examination was performed based on the medical records provided during the survey process.

Patient # 9

Review of the follow-up visit documentation revealed: "...S.O.A.P...1/23/14...HCG Slide: 0...PE/Pap...PCP...."

The number "0" has a horizontal line drawn through it.

The PE/Pap entry states the patient has a primary care physician.

The S.O.A.P. note documentation was created by an RN # 6.

There is no documentation that a physical examination was performed based on the medical records provided during the survey process.

The Licensee/Medical Director verified, during an interview conducted on 3/6/14, that the follow-up visit includes a pregnancy test and ultrasound.

Rule/Statute

R9-10-1508. Abortion Procedures

I. A medical director shall ensure that follow-up care includes:

1. With a patient"s consent, a telephone call to the patient by a member of the patient care staff, except a surgical assistant, within 24 hours of the patient"s discharge to assess the patient"s recovery. If the patient care staff is unable to speak with the patient, for any reason, the attempt to contact the patient is documented in the patient"s medical record; and

2. A follow-up visit offered and scheduled, if requested, no more than 21 days after the abortion. The follow-up visit shall include:

a. A physical examination;

b. A review of all laboratory tests as required in R9-10-1508(A)(3); and

c. A urine pregnancy test.

Facility Response

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