

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150056	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/20/2011
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NAME OF PROVIDER OR SUPPLIER  INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN46206
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S0000	<p>This visit was for investigation of two hospital licensure complaints.</p> <p>Complaint Numbers: IN00086139: Substantiated with deficiencies cited related to the complaint</p> <p>IN00088105: Unsubstantiated with deficiencies cited not related to the complaint</p> <p>Date: 12/19/11 and 12/20/11</p> <p>Facility Number: 005051</p> <p>Surveyor: Linda Plummer, R.N., Public Health Nurse Surveyor</p> <p>QA: claughlin 12/29/11</p>	S0000		
S0744	<p>410 IAC 15-1.5-4 (e)(1)</p> <p>(e) All entries in the medical record shall be:</p> <p>(1) legible and complete; Based on policy and procedure review, patient medical record review, and staff interview, the emergency department manager failed to ensure the completeness of medical records for 5 of 5 patients. (pts N1 through N5)</p>	S0744	<p><b>Preparation and execution of this response and plan of correction do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared</b></p>	01/20/2012

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Findings:</p> <p>1. at 1:25 PM on 12/19/11, review of the policy and procedure "Documentation Standards: Adult", NADM 1.30 A, indicated:</p> <p>a. in section V. "Policy Statements", it reads: "A. General Documentation Standards...2...All entries must be legible, complete, dated, timed and signed..."</p> <p>2. review of patient medical records at 12:10 PM on 12/19/11 indicated:</p> <p>a. pt. N1 was lacking complete documentation on page 4 of the "Emergency Nursing Patient Care Record" in regards to: Discharge Disposition time; who the patient was released to; the mode of transportation; and the pain level at the time of release</p> <p>b. pt. N2 was lacking documentation of the "time seen by provider" on the "Emergency Physician Patient Care Record" form</p> <p>c. pts. N3 and N4 were lacking complete documentation on page 4 of the "Emergency Nursing Patient Care Record" in regards to: Discharge Disposition time, who the patient was released to; the mode of transportation; whether the patient was sent home/admitted/transferred, etc.; and the pain level at the time of release</p> <p>d. pt. N4 was also lacking a date and</p>		<p><b>and/or executed solely because it is required by the provisions of state and federal law.</b></p> <p><b><u>Credible Allegation of Correction and Compliance:</u></b> For the purpose of any allegation that IU Health, Inc. is not in substantial compliance with the regulations set forth, this plan of correction constitutes IU Health's credible allegation of correction and compliance.</p> <p><b>S 744 410 IAC 15-1.5-4 Medical Record</b> <b>Corrective Action(s):</b> The IU Health Methodist Hospital Director of Clinical Operations and the Clinical Educator reviewed organization policies NADM 1.30 AP Documentation Standards: Inpatient and 678.91081 MH EMTC Vital Signs to ensure they met the required standards of practice. A plan was implemented to provide education on the necessary criteria each patient must meet prior to being discharged and documentation of such in the patient's record. The objective of the plan was to ensure safe patient discharge from the ED with a completed record of care.</p> <p>On January 12, 2012 the Vital Sign policy was revised. The new policy provides specific parameters which the patient must meet during a final assessment including pulse, respiratory rate, blood pressure, and pain. The assessment will be completed within 60 minutes prior to the patient leaving the facility and documented in the patient's record. If the patient fails to meet the criteria a licensed independent practitioner</p>		

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	<p>time of authentication of the patient discharge instructions</p> <p>e. pt. N5 was lacking complete documentation on page 4 of the "Emergency Nursing Patient Care Record" in regards to: pain level at the time of release</p> <p>3. interview with staff members NB and NC at 1:30 PM on 12/19/11 indicated:</p> <p>a. all medical records listed in 2. above were lacking completeness of documentation on the ED forms as stated</p>		<p>(LIP) will be notified.</p> <p>By January 20, 2012, mandatory education was provided to each Emergency Department Registered Nurse (RN) on documentation standards consistent with revised Emergency Room Vital Sign Policy guidelines. New nurses attend Central Nursing orientation which includes education on accurate and timely documentation in patient records.</p> <p><b>Monitoring:</b> Beginning with care provided January 13, 2012 daily audits are being conducted of patient records to determine if discharge documentation has been appropriately and timely recorded. One-on-one re-education occurred with individual nurses when discharge documentation was found to be incomplete or lacking. Data from weekly audits was submitted to the Director of Clinical Operations.</p> <p>A minimum of 10 patient's records audits per day are performed. The audits review the completeness of triage, orders, assessments, history, and discharge/disposition. The audits will be conducted to ensure compliance for a period of three consecutive months. The audit process will be complete when 90% or greater compliance is achieved for three consecutive months. At that time, audits will continue on a random basis. If the required threshold is not met on random audit, consistent auditing will resume until such time that data for a consecutive three months reflects achievement of 90% or greater compliance. Results</p>		

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S0912	<p>410 IAC 15-15-6 (a)(2)(B)(i)(ii)(iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on policy and procedure review,</p>	S0912	<p>of the audits will be communicated to the IU Health Methodist Hospital Director of Clinical Operations.</p> <p><b>Responsible Person(s):</b> The IU Health Methodist Hospital Director of Clinical Operations.</p> <p><b>S 912 410 IAC 15-15-6 Nursing Service</b></p>	01/20/2012	

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	<p>patient medical record review, and staff interview, the nurse manager failed to ensure the implementation of physician orders for 4 of 5 patients. (N11 to N14)</p> <p>Findings:</p> <p>1. at 12:15 PM on 12/20/11, review of the policy and procedure "Chart Checks" (NADM 1.21 AP) indicated:</p> <p>a. in section V. "Policy Statement", it reads: "A. RNs are responsible for ensuring all orders are entered for all patients assigned to their care...F. Regardless of when the chart check is performed, the RN responsible for the patient will verify the following prior to leaving at the end of the shift: 1. All orders have been entered into Cerner..."</p> <p>b. in section VI. "Procedure", it reads: "C. If there are orders that have not been processed in the appropriate manner, one or both nurses will take action to rectify the situation as soon as it is possible to do so."</p> <p>2. at 12:15 PM on 12/20/11, review of the policy and procedure ""Processing Orders for Patient Care", (NADM 2.07 AP), indicated:</p> <p>a. in section I. "Purpose", it reads: "The purpose of this policy is to outline the process for the timely and accurate processing of orders written by physicians..."</p>		<p><b>Corrective Action(s):</b></p> <p>The IU Health Methodist Hospital Director of Surgical Services and the Clinical Nurse Managers reviewed organization policies NADM 1.30 AP Documentation Standards: Inpatient, NADM 1.21 AP Chart Checks, and NADM 2.07 Processing Orders for Patients to ensure they met the required standards of practice. A plan was implemented to ensure all orders were reviewed and implemented in a timely manner. Nursing staff was provided re-education/re-emphasis on policy expectations for timely and accurate completion of orders written by physicians/licensed independent practitioners.</p> <p>By January 19, 2012, mandatory education created by the Clinical Educator was provided to each Registered Nurse (RN) which also included hospital guidelines for documentation of vital signs. New nurses attend Central Nursing orientation which includes education on processing orders for patient care and timely documentation of vital signs.</p> <p><b>Monitoring:</b></p> <p>Beginning with care provided January 8, 2012; weekly audits have been conducted to determine if the Physician/LIP orders are being processed appropriately, in a timely manner and the minimum expectations for documentation have been met. One-on-one re-education has occurred with individual nurses when orders were found to be incomplete or documentation was lacking. Data from weekly audits was submitted to the Director of Surgical Services.</p>		

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	<p>b. in section VI. "Procedure", it reads: "C. Carry out any ordered interventions as appropriate to the situation."</p> <p>3. review of patient medical records on 12/20/11 indicated:</p> <p>a. pt. N11 had physician orders for Vital Signs every 4 hours. The medical record indicated vital signs were taken greater than every four hours as follows:</p> <p>A. on 2/8/11 between 0700 hours and 1200 hours</p> <p>B. on 2/8/11 from 1530 hours and 2035 hours</p> <p>b. pt. N12 had physician orders for: "Vital Signs (TPR BP) [temperature, pulse, respirations, blood pressure] Q2, 02/09/11 4:55:00, Until discharge" (the every two hours of vital signs was ordered on 2/8/11 post operatively and was continued on 2/9/11 with transfer to 4 South) Documentation of vital signs not taken every 2 hours, as per orders, in the medical record indicated:</p> <p>A. 2/8/11 between 1600 hours and 2000 hours</p> <p>B. 2/9/11 between 0225 hours and 0700 hours</p> <p>C. 2/9/11 between 0700 hours and 1200 hours</p> <p>D. 2/9/11 between 1417 hours and 1945 hours</p> <p>E. 2/10/11 between 0600 hours and</p>		<p>A minimum of two chart audits per day are being performed by a unit designated RN assigned by the Clinical Manager. The chart audits review the completeness of orders and vital sign documentation. Chart audits will be conducted to ensure compliance for a period of three consecutive months. The audit process will be complete when 90% or greater compliance is achieved for three consecutive months. At that time, audits will continue on a random basis. If the required threshold is not met on random audit, consistent auditing will resume until such time that data for a consecutive three months reflects achievement of 90% or greater compliance. Results of the audits will be communicated to the Methodist Hospital Director of Surgical Services and the Clinical Nurse Managers. Data and will be submitted to the Methodist Hospital Director of Surgical Services and the Clinical Nurse Managers for review.</p> <p><b>Responsible Person(s):</b> I U Health Methodist Hospital Director of Surgical Services.</p>		

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	<p>0851 hours</p> <p>F. 2/10/11 between 0851 hours and 1230 hours</p> <p>G. 2/10/11 between 1500 hours and 2000 hours</p> <p>c. pt. N13 had physician orders on 2/7/11 at 1433 hours that included "Vital Signs Q8". Documentation of vital signs not taken every 8 hours, as per orders in the medical record, indicated:</p> <p>A. on 2/8/11 between 0800 hours and 1759 hours</p> <p>B. on 2/10/11 between 0800 hours and 2000 hours</p> <p>d. pt. N14 had an order entered 2/7/11 in the electronic system at 2101 hours (after the patient was admitted to the 6 South nursing unit from the post op area) for vital signs every 4 hours, with a "requested start date/time of 02/08/2011 5:53". The "Discontinue" order was entered electronically on 2/9/11 at 1448 hours and reads "Automatically discontinued on 02/09/2011 at 14:48 due to discharge...". Documentation of vital signs not taken every 4 hours, as per orders, in the medical record indicated:</p> <p>A. on 2/8/11 between 0719 and 1200</p> <p>B. on 2/8/11 between 1545 and 2155</p> <p>C. on 2/9/11 between 0338 and 0700</p> <p>D. on 2/9/11 between 0700 and 1448 ( per nursing staff, the patient did not</p>				

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	<p>actually leave the facility until the evening of 2/9/11 and no vital signs were taken after 0700 hours on that day)</p> <p>4. interview with staff members NE, NF and NG during the medical record review indicated that nursing failed to follow physician orders for vital signs for patients N11 to N14 as stated in 3. above.</p>				