

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150056	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/11/2016
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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202
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S 0000 Bldg. 00	<p>This visit was for investigation of a state licensure hospital complaint.</p> <p>Complaint Number: IN00206516</p> <p>Substantiated: deficiency related to the allegations is cited.</p> <p>Date: 8/11/16</p> <p>Facility Number: 005051</p> <p>QA: 8/25/16 jlh</p>	S 0000		
S 0930 Bldg. 00	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-1.5-6 (b)(3)</p> <p>(b) The nursing service shall have the following:</p> <p>(3) A registered nurse shall supervise and evaluate the care planned for and provided to each patient.</p> <p>Based on document review and staff interview, nursing staff failed to supervise and evaluate the nursing care for each patient related to lack of documentation in the EMR (electronic medical record) by nursing staff every shift and/or daily of how patient toilets, I&O (intake & output), peri-care, underpad/linen change, and/or bath</p>	S 0930	S930 Nursing Service 15-1.5-6 Nursing staff failed to supervise and evaluate the nursing care for each patient related to lack of documentation in the EMR (electronic medical record) by nursing staff every shift and/or daily of how patient toilets, I&O (intake & output), peri-care, underpad/linen change, and/or bath completed. Corrective	10/13/2016

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>completed for 1 of 10 (patient 1) medical records reviewed.</p> <p>Findings:</p> <p>1. Policy #NADM 1.30 AP, Documentation Standards: Inpatient, revised/reapproved 4/12/16, indicated the expectation for documentation of the patient assessment process or reviewing the documentation and validating this review with nursing staff signature is a minimum of once per the RN's (Registered Nurse's) shift. This policy states to refer to the Daily Assessment and Care Standards, which indicates what should be documented by the RN under the: Physical Assessment section, frequency is per unit standard for all systems including gastrointestinal and genitourinary; Routine Care section, linen changes and personal hygiene as it occurs; Nutrition/All Intake and Output (I&O) section, I&O that occurs episodically (i.e. intermittent feedings, incontinence, voiding or intravenous boluses) in real time; and Plan of Care section, completed nursing interventions on each shift.</p> <p>2. Review of patient 1's medical record on 8/11/16 at approximately 1152 hours indicated there was no documentation of whether or not nursing staff assisted the</p>		<p>Action(s): The IUH Clinical Manager of A4 North unit and the Shift Coordinator (s) of the A4 North unit will share the deficiency findings with all unit staff during daily shift huddles, the weekly email update, and leader rounding on September 13, 2016. Additionally, leaders will share the plans for correction and monitoring. The IUH Clinical Manager of A4 North unit and the Shift Coordinator (s) of the A4 North unit will meet one on one with each the A4 North unit staff Registered Nurses, Tech Unit Secretaries, and Patient Care Assistants beginning on September 12, 2016. All one on ones with the aforementioned staff will be completed by October 13, 2016. During the one on ones the staff will be educated on documentation standards for the following:</p> <ol style="list-style-type: none"> 1.Modality of toileting as it occurs 2.Peri care and bedpad linen changes as instances of incontinence occur 3.Daily hygiene 4.Intake and output daily per order 5.Output as it occurs and totaled for the day <p>The clinical manager and shift coordinators will use an education flyer as a guide during the educational one on one with staff. Staff members will sign off on the education flyer to acknowledge that they have</p>	

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	<p>patient with toileting. Documentation was lacking for toileting method on 6/2/16 through 6/10/16, 6/14/16 and 6/16/16. The patient was incontinent of urine and I&O documentation was lacking on 6/8/16 and 6/9/16. Patient did not have a Foley catheter. Documentation of peri-care was lacking on 6/5/16 and 6/7/16. Documentation of underpad and/or linen change was lacking on 6/5/16, 6/7/16 and 6/9/16. Documentation of bath (including CHG wipes) was lacking on 6/2/16, 6/7/16, 6/13/16 and 6/15/16.</p> <p>3. Staff 7 (Shift Coordinator) was interviewed on 8/11/16 at approximately 1440 hours and confirmed the expectation for documentation in the patient EMR, as far as peri-care and baths (including CHG wipes), is for nursing staff to document the completion of these tasks daily. Patients who are incontinent may have peri-care, baths, I&O, or underpad/linen changes documented several times a day. Toileting is documented either when it is done or every shift. Diapers are not used and patients have an underpad on their bed that is changed when it becomes soiled or as needed. The above-mentioned patient EMR lacked documentation by nursing staff every shift and/or daily of how the patient toileted, I&O, peri-care,</p>		<p>received and understand the education. Any staff required to complete the outlined education that is presently on an approved leave will be required to receive the education during a one on one with the unit clinical manager or a unit shift coordinator upon returning to work. Monitoring: To ensure compliance, beginning October 13, 2016, IUH Methodist Clinical Manager on A4 North will initiate a monthly audit of thirty (30) patient records in total. The audit will include monitoring of documentation related to daily hygiene, modality of toileting, documentation of output as it occurs and totaled for the day, daily intake and output as per order, and peri care and bedpad linen changes as instances of incontinence occur. Any identified gaps will immediately be discussed with the staff on an individual basis for performance improvement. This audit will be completed for three months, with expectations for 90% compliance or greater. If this threshold is achieved, then the auditing process will be transitioned to a periodic spot audit. If the referenced threshold is not met, then consistent auditing will continue until such time that data for a consecutive three month period reflects achievement of the 90% threshold. Results of audits will be included in unit quality display boards and analyzed and trended through the unit's</p>	

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	underpad/linen change, and/or bath completed as required per facility policy and procedure.		Professional Practice Council, Unit Charge Nurse Meetings, and Unit Support Staff Meetings. Responsible Person(s): Vice President and Chief Nursing Officer for IU Health Academic Health Center Adult Hospitals, IU Health Methodist Associate Chief Nursing Officer, and the IU Health Director Clinical Operations of the Surgical Division will be responsible for oversight. IU Health Director Clinical Operations of the Surgical Care Division along with the Clinical Manager of the unit will be responsible for ensuring that staff has a clear understanding of monitoring of these corrective actions to ensure the deficiency is corrected and will not recur.	