

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 12/15/2011
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 the investigation of a State complaint.</p> <p>Complaint: IN00092045 Substantiated, State deficiency related to allegation cited.</p> <p>Date of Survey: 12-15-11</p> <p>Facility number: 005051</p> <p>Surveyor: John Lee, R.N. Public Health Nurse Surveyor</p> <p>QA: claughlin 01/03/12</p>	S0000			

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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S1510	<p>410 IAC 15-1.6-2(b)(2)(A)(B)(C)</p> <p>(b) The emergency service shall have the following:</p> <p>(2) Written policies and procedures governing medical care provided in the emergency service are established by and are a continuing responsibility of the medical staff. The policies shall include, but not be limited to, the following:</p> <p>(A) Provision for the care of the disturbed patient.</p> <p>(B) Provision for immediate assessment of all patients presenting for emergency and obstetrical care.</p> <p>(C) Provision for transfer of patients when care is needed which cannot be provided.</p> <p>Based on document review and interview the facility failed to ensure that Emergency Service staff follow established policy/procedures for Peripheral Venous Access Device; Insertion, Assessment and Management and Pain Management for 1 of 5 medical records (MR) reviewed (Patient #1).</p> <p>Findings include:</p> <p>1. Review of policy/procedure IV 3.01 AP, Peripheral Venous Access Device; Insertion, Assessment and Management, indicated the following; " R. Promptly remove any peripheral venous catheter no</p>	S1510	<p>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 and/or executed solely because it is required by the provisions of state and federal law. <u>Credible Allegation of Correction and Compliance:</u> 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</p>	01/13/2012	

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	<p>longer essential to patient treatment." This policy/procedure was last reviewed/revised on August 2009.</p> <p>2. Review of patient #1's MR indicated the patient presented to the Emergency Department on 04-22-11 at 2130 hours for complaint of Epistaxis post operative. The patient's MR indicated that a Peripheral Venous Access Device was placed in the right antecubital on 04-22-11 at 2142 hours. The patient was discharged to home on 04-23-11 at 0046 hours. The patient's MR lacked documentation that the Peripheral Venous Access Device was discontinued prior to the patient being discharged to home.</p> <p>3. Review of policy/procedure CP 1.04 AP, Pain Management, indicated the following; "V. Policy Statements E. If it is anticipated that the patient will have pain with a procedure, such as ambulation or dressing change, pharmacological intervention is appropriate even if patient is at goal." This policy/procedure was last reviewed/revised on September 2010.</p> <p>4. On 12-15-11 at 1450 hours via the telephone, MD #1 confirmed that when placing a rhinorocket and Foley catheter in nasal area, it is normal to apply some</p>		<p>correction and compliance. S 1510 410 IAC 15-1.6-2 Emergency Services Corrective Action(s): 1. The University Hospital Director of Clinical Operations reviewed organization policies IV 3.01 Peripheral Venous Access Device: Insertion, Assessment and Management and CP 1.04 AP Pain Management. A plan was implemented to provide re-education/ and reemphasis on policy expectations to nursing. The objective of the plan was to ensure removal of any peripheral venous catheter no longer essential to patient treatment; also review and re-educate the ED staff on the management of painful procedures. By January 13, 2012, a concurrent review process was put in place to ensure all elements of policies IV 3.01 AP and CP 1.04 AP are being met. Each patient will be assessed prior to discharge to ensure removal of all peripheral access devices. All charts will be reviewed at the point of discharge to ensure intravenous lines have been documented as removed. Nursing Staff will assess patients for the presence or absence of pain and will provide interventions to reduce or eliminate pain associated with their diagnosis, procedure or treatment. The patients will be reassessed for the effectiveness of the intervention. To ensure ongoing compliance, by January</p>		

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	<p>type of topical anesthetic medication prior to placing the rhinorocket and Foley catheter.</p> <p>5. Review of patient #1's MR indicated the patient presented to the Emergency Department on 04-24-11 at 1912 hours for complaint of Epistaxis. The patient's pain level was a 0 on a scale of 1 to 10. Review of the Physician Notes dated 04-24-11 at 2108 hours indicated the following; "NC (nasal cavity) with bright red blood bilaterally. bivalve splints in place. oc (oral cavity) clear, OP (oral pharynx) had large clot, once swallowed there was active bright red bleeding. Floseal did not control, large posterior rhinorocket placed on right followed by left posterior pack with Foley catheter placed with anterior Vaseline gauze." The patient's MR lacked documentation that the patient received a topical anesthetic or pain medication prior to placing of the rhinorocket and Foley catheter in the nasal area.</p> <p>Review of the Nurses Notes dated 04-24-11 at 2301 hours indicated the patient's pain level was a 10. Review of the medication administration records (MAR) indicated the patient received Morphine 4 mg IV push on 04-24-11 at 2301 hours. Review of the Physician Notes dated 04-24-11 at 2308 hours indicated the following; "After inspecting</p>		<p>13, 2012, all registered nurses will have received educational review of peripheral venous access including insertion, assessment and management; and pain management.</p> <p>Monitoring: Beginning with care provided January 13, 2012; weekly audits have been conducted to determine if the peripheral access devices have been removed prior to discharge. All charts will be reviewed at the point of discharge to ensure IV has been documented as removed. Pain levels will be monitored upon admission and prior to discharge. All charts will be audited to ensure compliance for a period of three consecutive months. The audit process will be complete when 100% 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 100% or greater compliance. Results of the audits will be communicated to the University Hospital Director of Nursing Practice and Quality. Data and will be shared with units throughout the hospital and at monthly Clinical Practice Council Meetings. Responsible Person(s): The University Hospital Director of Nursing Practice and Quality, Clinical</p>				

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	patient again, there was breakthrough posterior bleeding on the right. Rhinorocket removed and Foley catheter placed with anterior Vaseline gauze." The patient's MR lacked documentation when the Rhinorocket was removed and the second Foley Catheter was placed in the patient's nose. Therefore, it could not be determined that pain medication was given prior to placing of Foley catheters in nose.		Nurse Managers, and Clinical Nurse Specialists		