

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 03/12/2013
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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46206
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S000000	<p>This visit was for the investigation of one (1) State hospital complaint.</p> <p>Complaint Number: IN00114253 Substantiated; no deficiencies related to allegations are cited. Deficiency unrelated to allegations is cited.</p> <p>Survey Date: 3-12-2013</p> <p>Facility Number: 005051</p> <p>Surveyor: Deborah Franco, RN Public Health Nurse Surveyor</p> <p>QA: clauglin 04/17/13</p>	S000000		

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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S000784	<p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(i)(5)</p> <p>(i) Emergency service records shall document and contain, but not be limited to, the following:</p> <p>(5)Description of treatment given or prescribed, clinical observations, including the results of treatment, and the reports of procedures and test results, if applicable.</p> <p>Based on document review and interview, the registered nurse failed to document clinical observations in relation to a positive response to a depression screening question, the time and volume of intravenous fluids (IV) infused, the refusal of a blood test, refusal of insulin, and the time the IV was discontinued for 1 of 5 Emergency Room medical records reviewed (N2).</p> <p>Findings included:</p> <p>1. Review of medical records on 3-12-13 indicated:</p> <p>a. N2 was an Emergency Room patient who presented 8-6-12 at 12:46 with presenting complaint of right flank pain and high blood sugar. N2 was a diagnosed insulin dependent diabetic.</p> <p>b. N2 reported at home medications of Prozac for depression and one other</p>	S000784	<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 correction and compliance. S 784 410 IAC 15-1.5-4 Medical Record Corrective Action(s): The IU Health Methodist Hospital Director of Clinical Operations and the Clinical Educator reviewed organization policies NADM 1.30 AP Documentation Standards: Inpatient. At the time</p>	03/31/2013			

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	<p>depression medication which N2 could not name or describe.</p> <p>c. N2's medical record lacked documentation of a Clinical Note of an assessment of N2's "Yes" response to the depression screening question conducted at time of triage- " In the past 90 days have you had thoughts about harming yourself?" .</p> <p>d. Physician's orders at 15:00 included "1 Liter Normal Saline Intravenous IV Bolus".</p> <p>e. Initiation of Intravenous infusion of 1 Liter of Normal Saline at 15:18.</p> <p>f. N2's "Medication & IV Administration Documentation & Orders" contained an area under "Infusion Bolus/Fluids/IVPB" to document the volume of IV fluids infused and time and these areas were blank.</p> <p>2. Facility policy "Documentation Standards: Adults" last reviewed/revised November 2010 provided on page 1 under Exceptions "This policy does not apply to patients classified as outpatients..." and on page 11, 18 Narrative Notes. "A narrative note is used whenever the electronic or paper forms do not support the level of documentation required to accurately capture a patient event, situation, or care episode".</p>		<p>of the survey it was recognized there were gaps in patient care related to the required Emergency Room (ED) documentation of patient care. Also, it was recognized the policy, Documentation Standards: Inpatient, did not meet the needs of the Emergency Medical Trauma Center (EMTC). On May 2, 2013, the EMTC policy Emergency Treatment Record was reviewed and revised. The policy was renamed Documentation in the Emergency Treatment Record. This policy includes documentation requirements related to: i. Requirements for IV infusion (intake) to include times and volumes in the record ii. Nursing process to document positive suicide/depression screening and notification of physician/provider to determine risk and interventions iii. Documentation standards related to any refusal of treatment/interventions This revised policy will serve to guide the practice in the EMTC. Staff Education and Feedback: May 1, 2013 EMTC is providing continuous/ongoing mandatory education to each EMTC Registered Nurse (RN) on the policy revision and the documentation guidelines to meet the required standards of practice. One-on-one re-education will occur with individual nurses if missing documentation is observed during</p>				

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	<p>3. During interview with P2 on 3-12-13 at 12:35 PM, P2 indicated:</p> <p>a. 1 liter of the intravenous fluids ordered had infused at approximately 16:30, N2's IV was discontinued at that time; P2 did not document the results/completion of the order by noting the time, amount of the IV fluids infused in the medical record in the area provided on N2's "Medication & IV Administration Documentation & Orders" form.</p> <p>b. N2's positive response to the depression screening question " In the past 90 days have you had thoughts about harming yourself?" should have been followed up with nursing assessments to determine if N2 had a suicide plan with N2's responses documented in the medical record.</p> <p>c. N2 refused to allow P2 to draw a blood specimen for lab testing of glucose following an accu-chek result at approximately 16:30 of greater than 500. P2 did not document this refusal of testing in the medical record.</p> <p>d. When approached by P2 and MD1, an Emergency Room physician, to develop a plan of care, N2 refused to participate in diabetes education regarding the monitoring and management of N2's blood glucose. MD1 told N2 that Emergency Department treatment would include insulin injection but N2 also</p>		<p>audits. The objective of the plan was to ensure quality, safe patient care in the ED with a completed record of care at the time of discharge. Ongoing mandatory education was provided to each Emergency Department Registered Nurse (RN) on documentation standards consistent with revised Emergency Room documentation policy guidelines. New nurses attend Central Nursing orientation which includes education on accurate and timely documentation in patient records.</p> <p>Monitoring: March 31, 2013 The EMTC will continue the daily audits that are being conducted of patient records to determine if 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. A minimum of 10 record audits will be performed per day. 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</p>				

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	<p>refused insulin at this time. This refusal of treatment was not documented in the medical record.</p> <p>e. N2 refused to stay in the ER to complete treatment and left against medical advice at 18:10. N2 refused to stay to listen to the risks of leaving against medical advice; refused to sign the facility form "Release on Unauthorized Dismissals"; and refused to wait for discharge instructions to be prepared and explained.</p> <p>4. During interview with S3, Emergency Room electronic medical record specialist, on 3-12-13 at 2:00 PM, S3:</p> <p>a. confirmed the findings in N2's medical record.</p> <p>b. indicated the electronic medical record screen which contains the depression screening question " In the past 90 days have you had thoughts about harming yourself?" does not provide an area to assess/evaluate positive responses. However, a Narrative Note/Clinical Note can be added to any patient's electronic medical record to describe pertinent patient observations to include follow-up assessment to a positive response to a depression screening.</p> <p>c. N2's medical record should have included documentation of:</p>		<p>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 IU Health Methodist Hospital Director of Clinical Operations.</p> <p>Responsible Person(s): The IU Health Methodist Hospital Director of Clinical Operations.</p>	

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	<p>i. time and volume of IV fluids infused;</p> <p>ii. nursing assessments based on N2's positive response to the depression screening to determine if N2 had a suicide plan and was a risk to self;</p> <p>iii. refusal of tests and treatment.</p> <p>d. No policy could be located which identified the standards of documentation in the Emergency Room. The facility expectation is that ER staff use the facility's in-patient documentation standards policy and generally accepted standards of nursing care documentation as guidance for documentation in the ER.</p>			

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