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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150017 | X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____ | X3) DATE SURVEY COMPLETED 05/28/2015 |
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| NAME OF PROVIDER OR SUPPLIER LUTHERAN HOSPITAL OF INDIANA | STREET ADDRESS, CITY, STATE, ZIP CODE 7950 W JEFFERSON BLVD FORT WAYNE, IN 46804 |
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| S 0000 Bldg. 00 | <p>The visit was for investigation of two State hospital complaints.</p> <p>Complaint Number: IN00165473 Substantiated: a deficiency related to the allegations is cited.</p> <p>Complaint Number: IN00169522 Substantiated: deficiencies related to the allegations are cited</p> <p>Date: 5-27/28-15</p> <p>Facility Number: 005016</p> <p>QA: cjl 06/30/15</p> | S 0000 | | |
| S 0322 Bldg. 00 | <p>410 IAC 15-1.4-1 GOVERNING BOARD 410 IAC 15-1.4-1(c)(6)(H)</p> <p>(c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following:</p> <p>(H) Requiring all services to have policies and procedures that are updated as needed and reviewed at</p> | | | |

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>least triennially. Based on document review and interview, the facility failed to implement its incident/adverse event reporting policy for 1 of 11 medical records (MR) reviewed (patient 30).</p> <p>Findings:</p> <p>1. The policy/procedure Event Reporting Policy (reviewed 5-15) indicated the following: "Events are to be reported into the Patient Safety Evaluation System (ERS) ...These reports should include those involving patients [and] visitors ...Additional Reportable Events ...Delay of Treatment, test or procedure which causes an adverse occurrence or injury either directly or indirectly. Treatment, test, or procedure ordered but not performed (omission) which causes an adverse occurrence or injury either directly or indirectly."</p> <p>2. The MR for patient 30 indicated on 3-09-15 that blood specimens were lost on two separate occasions and no documentation indicated the patient was updated and informed about the delay in treatment due to the lost lab work.</p> <p>3. In interview on 5-27-15 at 1420 hours, the laboratory services quality</p> | S 0322 | <p>1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. · The Director of Emergency Services will educate staff on the importance of completing an event report in the electronic Event Reporting System (ERS) when a patient experiences a delay of treatment (example given of specific need to report lost or missing lab specimens to ensure tracking of data). Staff will be educated via an education flyer and in the course of daily safety huddles.</p> <p>2. How are you going to prevent the deficiency from recurring in the future? · Understanding that the importance of this issue is hospital-wide, a Safety-Alert flyer was created and will be distributed throughout the hospital. The Safety-Alert flyer is our hospital template to communicate important processes and procedures that ensure best patient care practices. The alert is based on the SBAR (Situation, Background, Assessment, and Recommendation) format. The Situation narrative includes the explanation of what process failed. Background narrative gives the history of what the patient experienced. The Assessment description details the patient's outcome due to the experience.</p> | 08/02/2015 | |

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| | <p>coordinator A14 confirmed that only one set of lab specimens collected at 1935 hours were received in the lab on 3-09-15 for patient 30. The quality coordinator confirmed that no lab notes or entries indicated any blood specimens were unusable and/or mislabeled and/or discarded around the time of specimen collection for patient 30.</p> <p>4. Event reports for the period 1-01-15 through 3-31-15 failed to indicate an event report resembling the complaint allegations.</p> <p>5. In interview on 5-27-15 at 1050 hours, the quality manager A5 confirmed that no event report resembling the complaint allegations was available</p> <p>6. In interview on 5-27-15 at 1630 hours, the nursing supervisor A16 indicated they (A16) recalled being requested to speak with an emergency department (ED) patient regarding lost lab work and multiple blood draws in a hall bed on "this side". Supervisor A16 confirmed they (A16) were the evening nursing supervisor on duty 3-09-15 and was called to speak with an ED patient regarding multiple blood specimens collected and sent to lab and not received by the lab. The supervisor A16 indicated they (A16) spoke with the patient about</p> | | <p>The Recommendation narrative explains the importance of following a correct process to ensure improved patient care that is focused on safety and well-being. To prevent the deficiency from recurring and ensure compliance, the process will be monitored. 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? · The Director of Emergency Services will be responsible for the plan of correction within the Emergency Department. · The Chief Nursing Officer will be responsible for the hospital-wide education. 4. By what date are you going to have the deficiency corrected? · The deficiency will be corrected by August 2, 2015 with education and alerts communicated to all staff who required the information.</p> | |

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| S 0732 Bldg. 00 | <p>the concern and apologized. Supervisor A16 also indicated that the supervisor directed ED staff to hand-deliver the blood specimens to the lab and the supervisor confirmed that they (A16) did not complete an event report regarding the delay in treatment or document the patient contact and/or concern in the supervisor's shift report.</p> <p>7. In interview on 5-28-15 at 0935 hours, the quality manager A5 confirmed that the failure to receive blood specimens by the lab on 3-09-15 resulted in a delay in treatment for patient 30 and confirmed the facility failed to follow its policy/procedure regarding event reporting.</p> <p>410 IAC 15-1.5-4 MEDICAL RECORD SERVICES 410 IAC 15-1.5-4(d)(1)(2)(3)(4)</p> <p>(d) The medical record shall contain sufficient information to:</p> <p>(1) identify the patient; (2) support the diagnosis; (3) justify the treatment; and (4) document accurately the course of treatment and results.</p> <p>Based on document review and interview, the facility failed to implement policy/procedure and document multiple blood specimen collection events for 1 of</p> | S 0732 | 1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. · The Administrative | 09/02/2015 |

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| | <p>11 (patient 30) medical records (MR), failed to document the MR copies sent with a transferring patient for 1 of 11 (patient 31) MR, and failed to maintain a chart copy of the External Transfer Report and Transfer Form during a patient transfer for 1 of 11 (patient 31) MR reviewed.</p> <p>Findings:</p> <ol style="list-style-type: none"> The policy/procedure Medical Record Access and Documentation Guidelines (reviewed 4-15) indicated the following: "Documentation, created in the sequence of events as they occur, will be sufficiently comprehensive to support the diagnoses and outcomes and justify the course of treatment." The MR for patient 30 indicated triage nurse N17 obtained blood specimens from the patient on 3-09-15 at 1525 hours and indicated the patient's lab work was lost on two separate occasions. No MR documentation indicated that the patient was subjected to two additional venipunctures (needle sticks) to obtain replacement blood specimens and no documentation indicated the patient was informed about the delay in treatment due to the lost lab work. In interview on 5-27-15 at 1420 hours, | | <p>Director of Nursing will review and revise policy 'Transferring Patient to Another Facility and External Transfer Report # 1.01.08' to specify the procedure of how to document and verify patient records transferred/forwarded to the receiving facility. As part of the process, staff utilize the Discharge Envelope Checklist. On the front of the envelope is a checklist that includes all records that must be copied and forwarded to the receiving facility. In order to document what specific patient records are sent to the receiving facility, staff will make a copy of this checklist once it is completed and place this form into the patient's chart. Additionally, staff will be educated on the requirement that a copy of the Transfer Form or External Transfer Report must be placed into the patient's chart. Staff will be educated regarding the policy revision and discharge process improvement via email notification blast as well as education presented at department safety huddles. Based on policy # PTO3.018, 'Medical Record Access and Documentation Guidelines' The Director of Emergency Services educated staff on the importance of documenting all lab venipunctures as well as documenting any delay in treatment issues in patients' medical records. Staff were</p> | |

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| | <p>the laboratory services quality coordinator A14 confirmed that only one set of lab specimens collected at 1935 hours were received in the lab on 3-09-15 for patient 30. The quality coordinator confirmed that no lab notes or entries indicated any blood specimens were unusable and/or mislabeled and/or discarded around the time of specimen collection for patient 30.</p> <p>4. In interview on 5-28-15 at 0935 hours, the quality manager A5 confirmed the MR for patient 30 failed to indicate the patient was subjected to two additional venipunctures or was informed about the delay in treatment by a staff.</p> <p>5. The policy/procedure Transferring Patient To Another Facility And External Transfer Report (revised 11-13) indicated the following: a. Necessary Equipment: ...External Transfer Report ...Transfer Form ...Patient's Medical Record ...all information listed on Patient Transfer Envelope [Copy of Entire Chart] ...complete both transfer forms ...keep original on chart. b. Documentation: ...Forms sent with patient ...Specific medical record copies sent to accepting institution.</p> <p>6. The MR for patient 31 failed to</p> | | <p>educated on the need to document all care in a manner that will be comprehensive and justify the course of treatment. Education was presented via education flyer and at the departments safety huddle. 2. How are you going to prevent the deficiency from recurring in the future? · To prevent documentation of care and delay in treatment deficiencies, a Safety-Alert flyer was created and will be distributed throughout the hospital. The Safety-Alert flyer is our hospital template to communicate important processes and procedures that ensure best patient care practices. The alert is based on the SBAR (Situation, Background, Assessment, and Recommendation) format. The Situation narrative includes the explanation of what process failed. Background narrative gives the history of what the patient experienced. The Assessment description details the patient's outcome due to the experience. The Recommendation narrative explains the importance of following a correct process to ensure improved patient care that is focused on safety and well-being. To prevent the deficiency from recurring and ensure compliance, the process will be monitored. · The deficiency of the documentation process of patients being transferred to outside facilities will</p> | | | | |

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| | <p>indicate a Transfer Form or External Transfer Report was present at the time of a review and no documentation indicated that a copy of the patient's MR was obtained and sent with the patient at the time of transfer to another acute care facility.</p> <p>7. Documentation of requests for release of patient 31's MR indicated that many sections of MR were requested on 2-04-15 by the receiving facility after the patient had been discharged from the hospital.</p> <p>8. In interview on 6-04-15 at 1605 hours, the administrative director of nursing A3 and quality manager A5 confirmed the MR for patient 31 failed to indicate a copy of the Transfer Form or External Transfer Report was present and failed to indicate that a copy of the complete MR was sent with the patient upon transfer to the acute care facility.</p> | | <p>be prevented by ensuring staff are appropriately educated on the correct procedures and policy revisions regarding the transfer of patients to another facility. Education will include the importance of continuity of care through complete and accurate communication among health care practitioners and facilities. To prevent the deficiency from recurring and ensure compliance, the process will be monitored. 3. Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc.? • The Administrative Director of Nursing will be responsible for the plan of correction regarding patient transfer documentation process and education. • The Director of Emergency Services will be responsible for the plan of correction within the Emergency Department. 4. By what date are you going to have the deficiency corrected? • The plan of correction for the Emergency Department will be corrected by August 2, 2015, with education and alerts communicated to all staff who required the information. • The plan of correction for transfer documentation will be corrected by September 2, 2015, with education and alerts communicated to all staff who required the information.</p> | |