

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150006	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/15/2014
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NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH LA PORTE HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 1007 LINCOLNWAY LA PORTE, IN 46350
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S000000	<p>This visit was for investigation of a State hospital complaint.</p> <p>Complaint Number: IN00148239</p> <p>Substantiated: deficiency related to allegations is cited.</p> <p>Date: 5/15/14</p> <p>Facility Number: 005006</p> <p>Surveyor: Jacqueline Brown, R.N., Public Health Nurse Surveyor</p> <p>QA: cloughlin 05/27/14</p>	S000000		
S000930	<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 policy and procedure review, medical record review, and personnel interview, nursing staff failed to</p>	S000930	1. How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction. Policy,	06/27/2014

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>supervise and evaluate the nursing care for each patient related to lack of initiation or updating of a plan of care and lack of following physician's orders for manual disimpaction bowel program for 1 of 5 (N1) closed patient medical records reviewed.</p> <p>Findings:</p> <p>1. Policy No.: ASSESS-011 titled "Patient Care Plans/Pathways", revised/reapproved 4/2012, was reviewed on 5/15/14 at approximately 4:22 PM, indicated under:</p> <p>A. General Information section, "Care Plans/Clinical Pathways are to be initiated on admission and reviewed/revised daily and PRN (as needed) to reflect significant changes in the patient's status."</p> <p>B. Admitting New Patients section, "When admitting a patient the RN (Registered Nurse) shall: 1.A. Pathway - use a pre printed clinical pathway as appropriate for the patient diagnosis and individualize for the patient. Date, time and sign the pathway. 1. B. Care Plan - Initiate the electronic Patient Care Plan Power form. Complete the mandatory education section and the appropriate sections to reflect the patient's diagnosis/needs. Sign the form. 2. Client centered outcomes that are reasonable</p>		<p>LP-PCD-ASSESS-011 Patient Care Pathways, was reviewed and revisions were completed to reflect current nursing practice by the Clinical & Professional Development Coordinator on 06/04/2014. It was approved by The Chief Quality Nursing Officer on 06/09/2014. Policy implementation occurred on 06/12/2014. Colleague education occurred by 06/12/2014 for all nursing colleagues through the use of a policy read and sign, and inclusion of client centered outcomes within the Electronic Care Plan documentation. The new policy was presented and discussed at daily change of shift huddles on 06/11/2014 and 06/12/2014. The policy was also featured in the 06/13/2014 edition of "Team Talk". The Director of Med/Surg/Oncology also identified where pre-printed clinical pathways exist on 06/03/2014 and placed a request that they be reviewed at the 07/02/2014 Superuser meeting for the conversion of all paper documents to be replaced with Electronic Patient Care Plan*.</p> <p>This change request standardized the use of the Electronic Patient Care Plan to include mandatory sections for Clinicians to address on all patients including elimination patterns. Through a Rapid Improvement Event (RIE) project, a process revision of ED to floor nursing report was done to</p>				

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	<p>and measurable are to be provided for each patient on their care plan/clinical pathway."</p> <p>2. Review of closed patient medical records on 5/15/14 at approximately 1:00 PM, indicated Patient:</p> <p>A. N1 was a 68-year-old who was admitted to the 3rd Floor Med-Surg Telemetry Unit on 3/2/14 for further medical management:</p> <p>a. per ED Notes dated 3/2/14 at 1310 PM, "Spoke to patient's [family] by phone, confirms desire for admission. Wants to remind us to order fecal disimpaction."</p> <p>c. per Physician's Orders dated:</p> <p>i. 3/2/14 at 1723, initiate plan of care.</p> <p>ii. 3/4/14 at 1659, "Tuesdays and Fridays, patient is to be digitally disimpacted."</p> <p>d. Plan of Care dated 5/2/14 through 5/7/14 lacked documentation of initiation or updating of a plan of care related to bowel program for manual disimpaction.</p> <p>e. Nurses Notes lacked documentation of manual disimpaction on Tuesday 3/4/14 and Friday 3/7/14.</p> <p>3. Personnel P1, RN, was interviewed on 5/15/14 at approximately 3:06 PM via phone and confirmed failed to update the plan of care for patient N1 on 3/4/14.</p>		<p>provide consistent verbal hand-off between the giving and receiving patient care providers. The process change was completed on 05/19/2014. All colleagues were educated by 03/31/2014 on the care of patients with decreased or absent sensation, along with implications for care related to paralyzed patients in order to enhance clinical staff learning and awareness. This education was completed by the Wound Care nurses during March unit meetings. Education and enforcement of the mandatory use of the Nursing Task List was communicated to nursing colleagues through daily Change of Shift Huddles on 06/10/2014 and 06/11/2014, an email to all nursing units by the Director of Med/Surg/Oncology on 06/10/2014, and the placement in the 06/13/2014 edition of "Team Talk". Placement of new communication boards, "What's Most Important to Me", for patients and families to use as an additional means to communication with physicians and caregivers was completed on 05/23/2014. 2. How are you going to prevent the deficiency from recurring in the future? The night Charge Nurses monitor the initiation and daily update of the patient's plan of care as documented in the electronic medical record in compliance with the existing hospital policy, LP-PCD-ASSESS-011 Patient</p>				

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	4. Personnel P7, Director of Quality, was interviewed on 5/15/14 at approximately 4:40 PM and confirmed, patient's plan of care lacked daily documentation of initiation or updating of a plan of care related to bowel program for manual disimpaction by nursing staff 5/2/14 through 5/7/14 and is a nursing standard, as well as required by facility policy and procedure. Physician's Orders for digital disimpaction on Tuesdays and Fridays was also not followed.		Care Plans, beginning 06/12/2014. On 05/23/2014 during daily nurse leader and physician rounding the appropriate use of patient/family to caregiver communication boards, "What's Most Important to Me" is evaluated and followed-up on when appropriate to ensure that consistent communication regarding patient needs are addressed and responded to in a timely manner. On 06/03/2014 a team was developed by bedside caregivers to standardize work related to the change of shift hand-off report to include the review of patient care orders received and work completed during the previous shift. This process will be completed by 06/20/2014. Education on the new process will begin on 06/23/2014 by use of a read and sign sheet by the charge nurses of all inpatient units and will be completed by 06/27/2014. Education of the new process will be communicated to nursing colleagues through daily Change of Shift Huddles on 06/23/2014 through 06/27/2014, and highlighted in the 06/27/2014 edition of "Team Talk". Bedside shift auditing will include the review of the standardized process to ensure all orders received during the designated shift have been noted and communicated to the appropriate oncoming caregivers beginning		

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			06/27/2014**. 3. Who is going to be responsible for numbers 1 and 2 above;i.e., director, supervisor, etc.? The Director of Med/Surg/Oncology *Due to the current schedule of our Clinical Informatics department in completing a conversion to our electronic medical records system, the next scheduled Superuser meeting is 07/02/2014. ** Due to the scope of the work needed to ensure the change was adopted house wide the inclusion of all nursing units needed to be represented to create the new standardized workflow. Work began on 06/03/2014 and due to the complexity of changes needed to complete plan of correction and educate employees on the new nurse to nurse order verification process the team felt extra time was needed to complete plan of correction. Plan of correction will be completed by 6/27/14.	