STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150056	A. BUILDING 00 B. WING	09/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
INDIANA UNIVERSITY HEALTH	1701 N SENATE BLVD INDIANAPOLIS, IN 46202

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S 0000 Bldg. 00	This visit was for an investigation of a State Licensure Hospital Complaint. Complaint IN00416951 - State deficiency related to the allegations is cited at S1504. Survey Date: September 18, 2023 Facility Number: 005051 QA: 9/27/2023 & 10/3/2023 & 10/5/2023	S 0000		
S 1504 Bldg. 00	410 IAC 15-1.6-2 EMERGENCY SERVICES 410 IAC 15-1.6-2(a) (a) If a hospital provides a community emergency service, the service shall meet the emergency needs of the patients served, within the scope of the service offered, in accordance with acceptable standards of practice, and be under the direction of a physician qualified by education or experience. Based on document review and interview, the facility failed to provide emergency services according to acceptable standards of practice in 2 out of 5 (patients 4 and 5) medical records reviewed related to communication of wait times, lab draws, and medication administration; failed to provide access to a call light for non-behavioral health patients in 1 out of 5 (patient 4) medical records reviewed; and failed to reassess patient vital signs per policy/procedure in 1 out of 5 (patient 4) medical records reviewed.	S 1504	S1504 Thank you for the opportunity to review care provided to patients in MH ED. For S1504 here are the steps IU Health ED has initiated to meet standards as per the IDH findings: **How are you going to correct the deficiency? If already corrected, include the steps taken and the date of correction.** *Date of Correction*	11/15/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Heidi Coffey	Accreditation and Regulatory Manager	10/20/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	Findings include: 1. Review of document titled, "Review of document titled, "Emergency Severity Index Handbook Fifth Edition", copyright 2023, the focus of 5-level acuity scale is on identification of unstable and high-risk patient situations and quick sorting of patients in the setting of constrained resources. The document indicated that ESI level-3 are non-emergent and need two or more resources, such as lab tests, radiograph, and computed tomography scan. 2. Review of document titled, "Triage, emergency department", revised August 21, 2023, stated documentation for emergency department triage includes timelines relating to care and reevaluation performed. Review of patient's 4 and 5 medical records lacked documentation regarding communication of wait times and delayed lab work and tests. 3. Review of policy titled, "Triage - Methodist Emergency Department", approved 03/04/2022, indicated that patients will be triaged, the acuity of patient determined by Emergency Severity Index, and that all patients will be reassessed depending on patient presenting condition and pertinent finding. 4. Review of policy titled, "Guideline for Vital Signs in the Adult and Pediatric Emergency Medicine and Trauma Centers", approved 03/08/2023, stated that vital signs and pain levels are assessed at the time of initial assessment, and should be reassessed at a minimum of every 4 hours. 5. Review of patient 4's medical record indicated patient arrived on 09/05/2023, at 7:56 pm, in the		*begins 10/17/2023 for all the following below.* The thorough review was completed and identified some gaps and opportunities to improve the overall care and outcomes of the patients. An internal review of patient's 1-5 records identified all 5 patients as a level 3, 4, and 5 and received an individualized plan of care for their needs based on the triage and provider assessments. An opportunity was identified to improve communication with patients and families regarding lab work, tests, room boarding/transfer. Additionally, the opportunity related to reassessment of vital sign and pain documentation, medication administration, and communication at minimum every 4 hours per policy. ED Leadership provided re-education for reassessment and documentation standards via email and Tier 1 huddle (Shift huddle) for a two-week time period. The ED leadership team created rounding documentation standards for ED team members to non-licensed team members, including talking points on how to address patient wait times. ED leadership provided team members (medics, ED RNs, ED Resource Pool RNs, support staff, and Patient liaisons) on how to document discussion of wait times. Educated all team members on rounding process,	

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	Emergency room (ER), was triaged and placed in ER waiting room; patient waited in ER waiting room for 8 hours and 56 minutes until transferred to a patient room on 09/06/2023 at 4:52 am; medication and lab tests were ordered at 8:05 pm on 09/05/2023; medication was given at 2:33 am, 6 hours and 28 minutes after order was documented; labs were drawn at 3:34 am, 7 hours and 29 minutes after order was documented; initial vital signs were documented at 7:59 pm on 09/05/2023 and were reassessed 7 hours and 32 minutes later at 3:31 am on 09/06/2023; patient was placed in ER patient room 34 but was not a behavioral health patient and room lacked a call light. 6. Review of patient 5's medical record indicated patient arrived on 09/05/2023, at 9:48 pm, in the Emergency room (ER), was triaged and placed in ER waiting room; patient waited in ER waiting room for 10 hours and 6 minutes until transferred to a patient room on 09/06/2023 at 7:54 am; EKG (electrocardiogram) was ordered at 11:16 pm on 09/05/2023 and completed at 9:54 am on 09/06/2023, 10 hours and 38 minutes after initial order was documented. 7. Interview with A8 (Interim Director of ER and Registered Nurse), on 09/18/2023, at approximately 10:21 am and 12:45 pm, confirmed staff should keep patients informed of extended wait times, but ER did not have a rounding policy. Designated behavioral health rooms do not have call lights for safety reasons and room 34 was a behavioral health room and staff should acquire a call light for non-behavioral health patients placed in these rooms.		documentation of rounding process, and escalation of findings in rounding process. Trained Patient Liaison in ED on rounding documentation in "ED Special Charting" section to include notes from rounding and patient/family updates. Provided education regarding triage reassessment and vital sign at the 4-hour mark, including documentation requirements per policy. An opportunity was identified related to a non-behavioral health patient being placed in a room used for behavioral health patients and did not have a call light in the room after arrival. Leadership confirmed expectation checklist for support staff when preparing a room for patient. The ED leadership is re-educating all ED team members of room standards specifically to the to behavior health room to Tier 1 Huddle (shift huddle) for a two-week time period. Provided information on process to obtain call light to resource team members, contract staff, support staff, and patient liaison. **How are you going to prevent the deficiency from recurring in the future**? Beginning 10/17/2023 ED leadership and team will begin multiple surveillance audits in areas of deficiency will be completed on a daily or weekly basis with an expectation of 90%	

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			compliance or greater. 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 ED Learning Center/Huddle Room and trended through the unit's Professional Practice Council. Leadership team will complete 10 daily chart audits for ED patients greater than 5 hours to reach 90% compliance or greater. Complete 10 audits/week on non-behavior health patient in behavior health ED room until compliance with process is 90% or greater compliance within 30 days. Continual education for current team members and newly hired team member including contract staff will be provided by leadership. **Who is going to be responsible for numbers 1 and 2 above; i.e., director, supervisor, etc**.? ED leadership including Manager, Clinical Nurse Specialist, Nursing Professional Development. All	

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			education is also provided to Resource Pool Team through Resource Pool Leadership in partnership with ED leadership. **By what date are you going to have the deficiency corrected**? Date of Correction started education and surveillance 10/17/2023 with correction to be completed within 30 days on 11/15/2023.	