STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150056	A. BUILDING _____ B. WING _____	C 08/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS This visit was for the investigation of a Federal complaint. Complaint Number: IN00177776 Substantiated; Federal deficiency related to the allegation is cited. Facility Number: 005051 Date of Survey: 08/20/15 QA: cjl 08/25/15	A 000		
A 438	482.24(b) FORM AND RETENTION OF RECORDS The hospital must maintain a medical record for each inpatient and outpatient. Medical records must be accurately written, promptly completed, properly filed and retained, and accessible. The hospital must use a system of author identification and record maintenance that ensures the integrity of the authentication and protects the security of all record entries. This STANDARD is not met as evidenced by: Based on document review and interview, nursing staff failed to accurately document the care and treatment of IV (intravenous) attempts and lab specimen draws for 1 of 10 pediatric patient medical records reviewed (#2). Findings included: 1. The facility policy "Peripheral Venous Access Device: Insertion, Assessment and Management", last reviewed January 2015,	A 438		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150056	A. BUILDING _____ B. WING _____	C 08/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 438	Continued From page 1	A 438		

indicated, "H. Limit the number of peripheral IV attempts to no more than two people attempting two times each, unless the situation is emergent. ... F. Documentation: ... a. Date and time b. Site of insertion."

2. Medical record #2 indicated the patient, a 4-year old, was brought to the ED (Emergency Department) by ambulance at 1312 hours on 07/04/15 after experiencing a seizure at home. The history indicated the child fell yesterday and hit the right side of his/her head, but did not lose consciousness and appeared fine today. A note by staff member #9 at 1530 hours on 07/04/15 indicated, "Butterfly attempted x6 to obtain blood cultures. Dr. [MD1] at bedside, butterfly right foot obtained for cultures and sent to lab." The record lacked documentation of the site of the six butterfly attempts or whether or not they were performed by more than one staff member. The record also lacked documentation of any other IV punctures.
The physician history and physical indicated the skin was warm, dry, and intact with no rashes. Nursing documentation from 2000 hours on 07/04/15 indicated the IV was infusing in the left arm and there was bruising noted on the upper medial right arm that the family member indicated was from a previous IV start. The record lacked documentation of any previous IV starts other than the blood culture attempts. The record also lacked any measurements or additional description of the bruising on the arm of patient #2.

3. At 2:15 PM on 08/20/15, staff member #4, the ED Charge Nurse, indicated nurses start IVs and draw labs on their patients. He/she indicated one nurse should only attempt the sticks twice before

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150056	A. BUILDING _____ B. WING _____	C 08/20/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 438	Continued From page 2	A 438		

getting another nurse, then another, with a total of 6 attempts. He/she indicated this should all be documented in the medical record.

4. At 2:30 PM on 08/20/15, staff member #5, a nurse in the ED, indicated a nurse should only attempt two needle sticks before requesting someone else to try and this should be documented. He/she indicated they have an ultrasound machine to help with vein location.

5. At 2:40 PM on 08/20/15, staff member #7, a nurse in the PICU (Pediatric Intensive Care Unit), indicated he/she was not sure if there was something written, but the rule of thumb was that one nurse would try only 2 or 3 times for a needle stick or blood draw before requesting assistance and it should be documented.

6. At 3:20 PM on 08/20/15, staff members #1 and #2, the Accreditation and Regulatory Specialists assisting with document review, confirmed the medical record findings and lack of an actual policy regarding lab stick attempts. They indicated that although the IV policy indicated only two attempts by two people, it also indicated unless the situation was emergent, which they indicated was the case for patient #2 since the blood cultures needed done for antibiotic administration. They confirmed it could not be determined whether the 6 attempts at a blood draw caused the bruising on the right arm because the site of the attempts was not documented.