

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 150023	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/10/2014
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NAME OF PROVIDER OR SUPPLIER UNION HOSPITAL INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1606 N SEVENTH ST TERRE HAUTE, IN 47804
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S000000	<p>This visit was for the investigation of a State complaint.</p> <p>Complaint: #IN00139688 Substantiated: State deficiency related to the allegations is cited.</p> <p>Facility Number: 005022</p> <p>Survey Dates: 06/10/2014</p> <p>Surveyor: Saundra Nolfi, RN Public Health Nurse Surveyor</p> <p>QA: cloughlin 06/18/14</p>	S000000		
S000912	<p>410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii)(iii)(iv)(v)</p> <p>(a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following:</p> <p>(2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary</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>to provide care for all patient care areas of the hospital.</p> <p>(ii) Maintaining a current nursing service organization chart.</p> <p>(iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions.</p> <p>(iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements.</p> <p>(v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.</p> <p>Based on medical record review, policy and procedure review, and interview, the nurse executive failed to ensure gastrointestinal assessments and elimination documentation were done according to physician orders and policies for 1 of 5 patients reviewed (N1).</p> <p>Findings included:</p> <p>1. The facility policy "Assessment" for Critical Care, last reviewed 05/13, indicated, "Assessments: Assessments will include evaluation with appropriate documentation on permanent record of all patient systems, including psychosocial, neurological, cardiovascular, respiratory, genitourinary, gastrointestinal, and integumentary.</p>	S000912	1, 2, and 3. Assessment of I & O and policy compliance a. Since the date of this patients visit (July 2013) revisions have been made to the electronic medical record system in relation to I&O documentation and totals (Fall 2013). The system allows for a running I&O total as well as daily eight (8) hour and 24 hour totals. Staff and practitioners are also able to view individual entry times. The final review record displays an eight (8) hour span of time which includes individual entries; cumulative eight (8) hour totals, and 24 hour totals are also available. (Attachment 1& 2) b. Staff education as well as monthly reviews related to I & O documentation have been ongoing since September 2013. Those results are reported and monitored at NCM meetings as	07/20/2014

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	<p>...Intake and Output: Intake and output will be done on all patients every twelve (12) hours or as ordered. Twenty-four (24) hour fluid balance will be calculated and recorded in computer documentation at 0600 daily."</p> <p>2. The facility policy "Nursing Assessment", last reviewed 04/13, indicated, "2. A full body assessment will be completed every 12 hours on inpatients and outpatients and upon arrival from another unit that provides a different level of care."</p> <p>3. The medical record for patient N1 indicated a hospitalization for triple bypass surgery on 07/08/13 with an extended stay in ICU (Intensive Care Unit) and the foley catheter was left in to monitor I&O (intake and output) until 07/14/13. Physician's orders were to monitor I&O every 8 hours while in ICU and changed to every 12 hours when the patient was transferred to the telemetry unit on 07/19/13. The total output documentation was as follows:</p> <p>From 0700 on 07/14/13 to 0700 on 07/15/13- 4350 cc. (cubic centimeters) From 0700 on 07/15/13 to 0700 on 07/16/13- 3875 cc. From 0700 on 07/16/13 to 0700 on 07/17/13- 2961 cc.</p>		<p>well as the Clinical Advisory group. This review process is ongoing at this time. (Attachment 3) c. I&O information was added to the CCU nursing report sheet in December 2013 (Attachment 4) d. Mandatory education to CCU nursing staff on I&O completed February 2014 (Attachment 5) e. Clinical documentation redesign education included information specific to I&O. (June 2014) f. Two policies reviewed during visit (Critical Care Assessment and Nursing Assessment)have been revised to reflect the current practice and process in which documentation is captured related to assessment of I&O in our electronic medical record system as well as the final record file-HPF. The CNO/Vice President of Clinical Services has approved the changes (July 2, 2014) to both policies and the Critical Care Assessment policy will be forwarded onto the Medical Executive Committee on July 7, 2014 for review and recommendation for approval. (Attachment 6 and Attachment 7) Corrective Action: a. Policy revision to match current documentation practice (July 7, 2014) b. Storytelling at daily CCU team huddles specific to importance of accurate elimination assessment, follow-up, and documentation. (July 2 through July 9, 2014) c. Continue ongoing monitoring related I& O documentation and</p>				

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	<p>From 0700 on 07/17/13 to 0700 on 07/18/13- 1501 cc. with no amount listed for the night shift</p> <p>From 0700 on 07/18/13 to 0700 on 07/19/13- 0 cc. with no amount listed for any of the shifts</p> <p>From 0700 on 07/19/13 to 0700 on 07/20/13- 0 cc. with BRP (bathroom privileges) noted at 0900</p> <p>From 0700 on 07/20/13 to 0700 on 07/21/13- 0 cc. with no amount listed for any of the shifts</p> <p>From 0700 on 07/21/13 to 0700 on 07/22/13- 404 cc. with 400 cc. at 1700 and voided x4 noted</p> <p>From 0700 on 07/22/13 to 1800 on 07/22/13- 0 cc. with voided x3 noted</p> <p>The patient was alert and oriented, was eating a regular diet, and was working with cardiac rehab to increase his/her activity level. The record lacked any documentation of the patient being incontinent or noncompliant with requests.</p> <p>Gastrointestinal assessments were documented by nursing each shift and indicated the patient had hypoactive bowel sounds on 07/14/13 and 07/17/13, but otherwise, the box "active bowel sounds in all 4 quadrants" was checked. Description of the patient's bowel movements was "small, brown, watery"</p>		<p>report to NCM and Clinical Advisory Group. (ongoing) Final Process Owner VP Pt Care Services/CNO 3 & 4</p> <p>Gastrointestinal (GI) Assessment and follow up a. Since the date of this patients visit (July 2013) revisions have been made to the electronic medical record system in relation to GI& documentation options (June 17,2014). The system now has mandatory documentation of bowel sounds in all four quadrants by the staff. (Attachment 8 & Attachment 9)</p> <p>b. Staff education as well as monthly reviews related to BM documentation has been ongoing since September 2013. Those results are reported and monitored at NCM meetings as well as the Clinical Advisory group. This review process is ongoing at this time. (Attachment 10 & Attachment 11) Corrective Action: a. Addition of education specific elimination (assessment, treatment, documentation) to the GI segment of the CCU and Telemetry unit specific orientation curriculum (August 20, 2014) b. Storytelling at daily CCU/2EB team huddles specific to importance of accurate elimination assessment, follow-up, and documentation. (July 2 through July 9, 2014) c. Continue ongoing monitoring related BM documentation and report to NCM and Clinical Advisory Group. (ongoing) d. Care of the critically ill post-op</p>				

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	<p>on 07/14/13, 07/17/13, and 07/19/13 with no documentation of any bowel movements on 07/20/13, 07/21/13, and 07/22/13.</p> <p>The physician Daily Note forms from 07/19/13, 07/20/13, and 07/21/13 indicated there was 0 output, but the record lacked any documentation that this was addressed or questioned. On 07/22/13 at 5:43 PM, shortly before the patient was discharged, MD3 documented that the patient complained of weakness and urinating frequently. The note lacked any further documentation regarding this.</p> <p>4. At 2:20 PM on 06/10/14, staff member A3 indicated nurses were to assess patients daily regarding elimination and although there was nothing written, they should notify the physician if a patient had not had a bowel movement in 3 days.</p> <p>5. At 4:45 PM on 06/10/14, staff member A1 confirmed the medical record findings and acknowledged staff did not follow physician orders regarding intake and output for patient N1 and the description of the small, watery bowel movements and hypoactive bowel sounds could have been investigated. He/she also confirmed the lack of documentation</p>		<p>patient mandatory competency to be completed with CCU/2EB nursing staff (this will include GI system and elimination). (Competencies scheduled from August 1 through September 30, 2014). e. Clinical Informatics to add electronic documentation requirement for nursing on discharge assessment regarding last documented BM and urination. Anticipated completion by October 1, 2014, will reassess progress of project every 30 days. f. Clinical Informatics to add auto "alert" within our clinical documentation system to notify nursing and physician if patient has not had a documented BM in three (3) days. Anticipated completion October 1, 2014 -will reassess progress of project every 30 days. Final Process Owner VP Pt Care Services/CNO</p>	

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	regarding abdominal assessments and lack of output on the physician daily note forms.				