

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  150056	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/09/2013
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NAME OF PROVIDER OR SUPPLIER  INDIANA UNIVERSITY HEALTH	STREET ADDRESS, CITY, STATE, ZIP CODE 1701 N SENATE BLVD INDIANAPOLIS, IN 46202
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S000000	<p>This visit was for one State hospital complaint investigation.</p> <p>Complaint Number: IN00130720</p> <p>Unsubstantiated; lack of sufficient evidence. Deficiency unrelated to allegations is cited.</p> <p>Facility Number: 005051</p> <p>Date: 10/9/13</p> <p>Surveyor: Linda Plummer, R.N. Public Health Nurse Surveyor</p> <p>QA: cloughlin 10/21/13</p>	S000000		

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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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 to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (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. (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 policy and procedure review, patient medical record review, and staff interview, the nursing executive failed to ensure that the facility policy related to every two hour checks of patient IV(intravenous) sites occurred for 5 of 5 patients. (pts. #1 through #5)</p>	S000912	Corrective Action(s): Tag §912 410 IAC 15-1.5-6 Nursing Service The Nursing Professional Practice Council reviewed its policy to ensure it appropriately identified the required standards	12/10/2013

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	<p>Findings:</p> <p>1. at 10:00 AM on 10/9/13, review of the policy and procedure "Peripheral Venous Access Device: Insertion, Assessment and Management", policy # IV 3.01 AP, indicated:</p> <p>a. under the section "V. Policy Statements", it reads on page two in item M.: "Catheter site assessment is performed a minimum of every 2 hours for adult patients..."</p> <p>2. review of patient medical records indicated:</p> <p>a. pt. #1 had a gap in documentation of their IV site checks from 4:00 AM to 8:00 AM on 9/24/12; from 6:00 PM on 9/25/12 to Midnight on 9/26/12; and from Midnight 9/26/12 to 8:00 AM</p> <p>b. pt. #2 had a gap in documentation of their IV site checks from 4:00 AM to 8:00 AM on 6/23/12</p> <p>c. pt. #3 had no documentation of the IV site checks from 10:00 AM 12/27/12 to the time of discharge at 3:30 PM that same day</p> <p>d. pt. #4 had a gap in IV site documentation from 4:00 AM to 8:01 AM on 6/30/12; from 8:00 PM on 6/26/12 to Midnight 7/1/12; from Midnight to 4:00 AM on 7/1/12; and from 4:00 AM to 8:00 AM on 7/1/12 for both IVs (L wrist and R hand)</p> <p>e. pt. #5 had a gap in documentation of their right hand IV site checks after 8:00 AM on 8/15/12 and no further documentation of this IV, or of discontinuation of the IV, prior to discharge on 8/16/12</p> <p>3. interview with staff members #51, a RN and Regulatory Specialist, and #52, a RN and IT (information technology) Specialist, at 1:30 PM on 10/9/13, indicated:</p> <p>a. the medical records, as listed in 2. above, were lacking the documentation of IV site checks as required per facility policy</p>		<p>of practice. Unit 3 North nurses were reeducated reemphasizing the importance of both assessing PIV sites at least every two hours and documenting the assessment in the electronic medical record per policy. Education will be completed on or before December 10, 2013 with immediate implementation. Any requisite staff members who fail to complete the education within the designated timeframe will be prohibited from working with patients until documentation of completion is provided. Any staff required to complete the outlined education that is presently on an approved leave will be required to complete this task on an individual basis upon returning to work. Monitoring: To ensure compliance, beginning in December 2013, UH Unit 3 North Nursing staff will initiate a monthly audit of the Peripheral IV section of the EMR. The audit will include 15 patient records from the 3 North unit to ensure that the PIV was assessed at least every 2 hours. Any identified gaps will immediately be discussed with the nurse on an individual basis for performance improvement. This audit process will be completed for a 3-month period with expectations for achievement of 90% or greater compliance. If the threshold is achieved, then the auditing process will be transitioned to a spot audit. If the referenced</p>				

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			threshold is not met, then consistent auditing will continue until such time that data for a consecutive 3- month period reflects the achievement of the threshold. Results of the audits will be communicated through the Clinical Manager Meeting and the Nursing Professional Practice Council. Responsible Person (s): The Director of Nursing Practice and Quality and/or her designee will be responsible for ensuring that staff has a clear understanding of what and how services are provided to UH 3 North patients and the monitoring of these corrective actions to ensure that the deficiency is corrected and will not recur.	