Association of Health Care Journalists

IMPROVING PUBLIC UNDERSTANDING OF HEALTH AND HEALTH CARE

The information below comes from the statement of deficiencies compiled by health inspectors and provided to AHCJ by the Centers for Medicare and Medicaid Services. It does not include the steps the hospital plans to take to fix the problem, known as a plan of correction. For that information, you should contact the hospital, your state health department or CMS. Accessing the document may require you to file a Freedom of Information Request. Information on doing so is available here.

CASCADE BEHAVIORAL HOSPITAL	12844 MILITARY ROAD SOUTH TUKWILA, WA	April 21, 2014
VIOLATION: *NURSING CARE PLAN*		**Tag No:** A0396

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interviews, review of medical records, review of hospital policy and procedures and review of internal hospital documents, it was determined that the requirement for nursing care planning and assessments and reassessments for each patient is not performed consistently and accurately. Policies and procedures are not in compliance with a psychiatric patient population. The discharge instructions/information is incomplete including the physician transfer form and the nursing discharge instructions. The physician dictated discharge summary is not available at the time of discharge making the completion of the above forms necessary. The hospital's failure to develop and follow the nursing plan of care, provide complete discharge information to skilled nursing facilities/adult family homes/home health agencies, consistently perform assessments/reassessments and provide employees with appropriate policies and procedures places patients at risk of harm.

Findings include:

Patient #1 is an [AGE] year old patient admitted with a psychiatric diagnosis and a history of [DIAGNOSES REDACTED]. On admission from the acute care hospital, bruises and abrasions were noted on the patient's forearms. No other skin conditions noted. Patient #5 is a [AGE] year old admitted with a psychiatric diagnosis, dementia and incontinence. Skin issues from the acute care hospital were documented on all extremities. The facility's policy on Pressure Ulcer Risk Assessment & Prevention indicated interventions to be put in place for patients assessed with a Braden Scale less than 18. A Braden score less than 18 is indicative of the potential risk of skin breakdown.

Patient #1 was assessed with a Braden Score of 16. Patient #5 was assessed with a Braden Score of 16. The two records did not indicate the policy was followed in regards to implementing all components of the interventions associated with the patient's skin assessment. The policy on Pressure Ulcer Risk Assessment and Prevention states to elevate heels off the bed, utilize a foot pressure device PRN if heel integrity is impaired and apply bed cradle as needed (These are 3 of the 14 interventions

listed in the policy). These interventions were not put in place for Patient #1 or Patient #5. The skin assessment (Braden Score) and interventions were not included on either of the two patient's discharge instructions for the receiving facilities/agencies to continue treatment and monitoring of the patient's condition to prevent further skin issues.

The nursing staff assessed Patient #8, a [AGE] year old patient, as a moderate fall-risk secondary to the patient having a history of falls. The assessment was completed on admission and not repeated throughout the 4/3/14-4/9/14 stay. The documentation of the fall prevention interventions, as in personal alarm and increase frequency of monitoring, was incomplete on all shifts as required per the Fall Prevention policy. In addition, this information was not included on the patient's discharge instructions alerting the receiving agencies of the patient's safety issues and eliminating the risk of a fall with injury.

Two of the eight patients experienced bladder conditions requiring intervention during their hospitalization . Patient #1 required a Foley (urinary) catheter during the hospitalization . On 4/2/14, the physician ordered the catheter to be removed. No documentation was found as to when the Foley catheter was removed. A bladder scan was performed on 4/3/14 at 2300 with documentation of 275 ml of fluid and the patient stating "he will urinate soon". On 4/4/14, the nursing documentation states "Foley removed 4/3/14 at 0630, bladder scan 700 ml, catheterized for 340 ml." No urine output was documented prior to the patient's discharge the afternoon of 4/4/14 (no exact time was found in the patient record).

The physician orders on Patient #4 state to perform a bladder scan on the patient every shift to assess the patient's ability to void without intervention. The order included to catheterize the patient if the scan identified over 275 cc of urine in the bladder. The patient record lacked documentation of this procedure and had missing and/or incomplete entries from 1/17/14 through 1/21/14. Documentation of the time of the scan and results of the scan were not consistently completed and there was no policy on the requirements of bladder scanning documentation available for the nursing staff.

The investigator interviewed Nurse #1 on the documentation requirements related to bladder scanning and Foley catheter discontinuation. RN #1 referred to a Bladder Scan Protocol. RN #1 also stated that the discontinuation of the catheter should be documented on the patient record progress notes. During an interview, the Chief Nursing Officer stated that no protocol exists for Cascade Behavioral Hospital and explained that protocol referred to by RN #1 was in place prior to the change in facility ownership.

Based on review of the Pressure Ulcer Risk Assessment policy and the Fall Risk Assessment policy, interventions listed were not appropriate for use by the psychiatric patient population. The interventions included the use of an over bed trapeze and patient bed alarm with a cord which may provide a mechanism for a patient to hang him/herself. On interview with nursing leadership, the Chief Nursing Officer acknowledged the policy was based on an acute care population and not revised to meet the psychiatric population. Although the patients are screened for suicidal ideation, the potential for harm in this population remains a safety issue.

VIOLATION: *DISCHARGE PLANNING NEEDS ASSESSMENT*	**Tag No:** A0806

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY

Based on interviews, review of medical records and review of hospital documents, including policies and procedures, it was determined that the hospital failed to provide a timely, complete, multidisciplinary evaluation of the patient needs for safe discharge planning. The clinical needs post-discharge are not clearly identified by the nurse and/or physician during the discharge planning process.

There is a lack of communication among members of the health care team regarding the discharge needs of the patient's. There is a draft policy outlining the necessary requirements for an effective discharge process but compliance with the policy is

not found in the medical record.
On interview with the discharge planners, they could not state that there was a formal policy on the discharge process. The Social Work/Discharge Planning manager produced the policy and stated the facility was in the process of total implementation of the policy but only partially compliant at this time.

Based on review of the draft policy and interviews with SW #1 and #2, it was determined there is a lack of information available during the discharge planning process regarding the clinical needs post discharge. The discharge instructions and transfer form are completed immediately prior to discharge and therefore are not always available to provide to the receiving facilities/agencies. The lack of information for the receiving facilities may place the patient at risk for injury.

Findings include:

The investigator reviewed eight patient records on April 21, 2014. All eight patients had been transferred to a skilled nursing facility or adult family home with home health services on discharge.

Two of the eight medical records reviewed documented skin issues during the inpatient stay as described below. The inpatient skin assessment and interventions are not documented on either of the two patient's discharge instructions or physician's discharge summary.

Patient #1 was admitted to Cascade Behavioral hospital on [DATE] from an acute care hospital. The transfer documents from the acute care facility included a description of current skin issues. The acute care hospital identified abrasions and bruising on the patient's forearms. Patient #1 had an inpatient stay at Cascade of 18 days. This patient required continuation of medical treatment after discharge to the adult family home setting on 4/4/14. The discharge information on the skin condition was limited to the left heel location and one elbow location however the nursing documentation during the inpatient stay included a right foot lesion starting on 3/26/14 and continuing until the day of discharge. The receiving facility's home health nurse assessed the patient on arrival to the facility noting abrasions on the forearms, stage 2 pressure sore on the coccyx, and heal blisters on both feet. The discharge instructions contained no treatment or current interventions on the skin issues as described above.

Patient #5 was admitted from an acute care hospital on [DATE]. The transfer information from the acute care facility indicated abrasions and blisters on the patient's forearms. The skin issues were documented during the inpatient stay by the nursing staff. The patient was discharged to a skilled nursing facility on 4/14/14. The discharge instructions on "skin conditions" were left blank.

Two of the eight patients experienced bladder conditions requiring intervention during their hospitalization . Patient #1 required a Foley (urinary) catheter during the hospitalization . On 4/2/14, the physician ordered the catheter to be removed. No documentation was found as to when the Foley catheter was removed. A bladder scan was performed on 4/3/14 at 2300 with documentation of 275 ml of fluid and the patient stating "he will urinate soon". On 4/4/14, the nursing documentation states "Foley removed 4/3/14 at 0630, bladder scan 700 ml, catheterized for 340 ml." No urine output was documented prior to the patient's discharge the afternoon of 4/4/14 (no exact time was found in the patient record). Patient #1's discharge instructions did not include the bladder condition, treatment plan or current status. The receiving facility/home health nurse did not receive a verbal report prior to transfer.

Patient #4 was admitted on [DATE] and discharged on [DATE]. The patient was treated for chronic bladder issues during hospitalization and interventions were ordered and performed by the nursing staff. This condition and the necessary interventions were not included on the discharge instructions.

On April 3, 2014, the nursing staff assessed Patient #8 as a moderate fall-risk secondary to the patient having a history of falls. No additional assessment of the patient's fall risk was found during the 4/3/14 - 4/9/14 admission and was kept on fall

prevention interventions throughout the entire admission. This information was not included on the patient's discharge instructions for the receiving facility to continue the safety precautions placing the patient at risk for injury.

Five of the eight medical records reviewed (patients #1, 3, 4, 5 and 8) had incomplete discharge instructions and transfer forms (areas left blank as in bladder control, dietary information, skin condition, etc.).

On April 21, 2014, the investigator interviewed one registered nurse (RN #1) and three discharge planners/social workers (SW #1,2, & 3) on the discharge process. Prior to hospitalization , Patient #1 was treated by the VA system. The discharge planners indicated VA has a unique process for their patients, in which only the VA can arrange home health services. The hospital had no formal process documented and no follow-up procedure to assure the patient received services planned on by the VA.

The discharge planners explained that they fax portions of the medical record to the receiving agencies and encourage an on-site assessment of the patient. The physician discharge summary is not available at time of discharge. The physician completes a patient transfer form immediately prior to discharge. The nursing staff completes the discharge instructions immediately prior to discharge. As stated above, five of the eight medical records reviewed contained incomplete patient transfer forms and discharge instructions post discharge. The respondent facility's discharge planners explained that these were the forms faxed to the agencies.