

Patient Rights Case

Objective	Given a scenario, the surveyor will identify areas of concern, potential citations, and related regulatory requirements.
Prior to Class	Print copies of the scenario. Have the hospice regulations available. Have flip charts and markers available.
Total Time for Activity	60 minutes* (The time given is approximate.)
Set-up	Set class up for small groups as appropriate.*

Step	Preceptor Instructions	Activity Time
1.	Divide the class into groups.*	5 min.
2.	Each group should select someone to take notes on the flip charts and be prepared to report to class. Groups must answer the questions provided.	5 min.
3.	Give the teams time to read and discuss the scenario. As the groups are completing this task, walk around the room and listen to the conversations. Provide direction where appropriate. Warn the class when the time available is down to the last five minutes.	25 min.
4.	Debrief each scenario by discussing key points contained in the Preceptor Answer Sheet.	25 min.

*For individual assignment, provide the worksheet and support where appropriate during the completion of the activity. Once completed, review answers against the answer sheet, and discuss the key points together from the scenario.

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Directions: Read the scenario and document your answers on the flip chart provided. Work as a team, if able.

Complaint Pain Management Scenario

A complaint was received on 12/03/12 by a hospital social worker that alleged a hospice patient (#3) complained that they had spent several days in a hospice inpatient unit where nurses failed to control pain. The complaint stated that the nurses used peripheral intravenous (IV) sites to administer medications instead of the available new Peripherally Inserted Central Catheter (PICC) line (central IV site), and left the patient lying in feces for two days. The patient requested transfer from the inpatient hospice back to the hospital palliative care unit.

Survey Team Questions:

1. What would be the next step to take to investigate this complaint?

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Directions: Read the scenario and document your answers on the flip chart provided. Work as a team, if able.

Complaint Pain Management: On-Site Visit Scenario

On-site investigation began on 12/21/12 at the inpatient hospice (a deemed agency that required direction from a Federal Regional Office (RO) to send state surveyors on a complaint investigation). On arrival, a tour of the inpatient hospice unit and review of the list of patients and diagnoses showed no current patients identified for nursing care of bowel incontinence. The available patients, who were bed-bound, had bowel continence, and either had catheters for urine and/or could get to the bathroom with minimal assistance. The unit had no odors of incontinence, and no patient could be found that was able to verbalize, or who complained of similar problems (lack of pain control or lack of incontinence care).

Survey Team Questions:

1. Do we go home now? Or should we investigate further, and if so, how?
2. At a minimum, how many clinical records should you review following a complaint per the State Operations Manual (SOM)?

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Directions: Read the scenario and document your answers on the flip chart provided. Work as a team, if able.

Complaint Pain Management: Records Scenario

Review of the clinical records of five patients (open and closed records, including the patient named in the complaint) showed Patient #3 had a record of grievance filed on 12/03/12 by a hospital Social Worker (SW) after the patient was already transferred to the hospital palliative care unit in November. The inpatient hospice agency's grievance file showed it failed to describe an investigation of the complaint (no discussion with the nursing staff, and no phone call to talk with the patient or his/her family members, but had one note of incomplete information from the nurse practitioner who worked with the Medical Director, and a discharge summary from the Medical Director). Clinical record review showed nursing documentation for two patients (number one and number three) revealed the patients complained of severe pain and/or nausea symptoms. Patient #3, a young adult with colon cancer and abdominal metastasis, had a blocked bowel and a nephrostomy tube (very small lumen) for a gastrostomy tube (g-tube), which drained fecal material. The patient vomited fecal material and fecal material leaked around the g-tube. For Patient #3 and Patient #1, nursing documentation failed to show if the pain or nausea medication was effective after medications were given. Patient #3's clinical record revealed there were periods of over four hours between assessments for pain or symptom management. Some of the nursing documentation showed Patient #3 refused to allow nurses to change the dressing around the g-tube, while one nurse was able to obtain the patient's permission to assist the patient to change the dressing and cleanse the patient of fecal incontinence that constantly oozed. Interview of the nurse revealed the patient was afraid when nurses removed the abdominal dressing around the long, dangling g-tube, that they would cause increased pain by manipulation of the tube, which had been a problem in the past. The nurse allowed the patient to help remove the dressing, and to assist while the nurse changed the dressing and cleansed the g-tube area of feces. Both patients (number one and number three) were admitted to inpatient hospice care for acute symptom management.

Survey Team Questions:

1. What questions do we have now that we may need to investigate further or verify through interview?

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Directions: Read the scenario and document your answers on the flip chart provided. Work as a team, if able.

Complaint Pain Management: Interviews Scenario

Interviews with nurses who cared for Patient #1 and Patient #3 showed no explanation for the lack of documentation of pain/symptom management for long periods of time, except that the nurses also document follow-ups in the Medication Administration Record (MAR). Review of the MAR also showed no pain level re-evaluation after pain medication was given to Patient #3 for over four hours on at least two of the five days the patient spent in the hospice inpatient unit. Several times, Patient #3 had pain levels of nine to 10 on a scale of one to 10, for over six hours, including the night he or she was first admitted to the inpatient unit when documentation failed to show interventions or re-evaluations for over four hours. Interviews of nursing staff and record review failed to show why nurses started two peripheral subcutaneous IVs for nausea and pain symptom control instead of using the available and patent PICC central IV line. Interviews with nursing staff and clinical record review showed the PICC line was kept flushed, and used intermittently by some nurses for intravenous push medications and for some of the pain and/or anxiety medications. Nurses did not use the PICC line for small volume infusions of patient-controlled analgesia medications, which they infused in pumps per the subcutaneous route in two separate peripheral IV sites.

Survey Team Questions:

1. Cite or not cite?

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Preceptor Answer Sheet

Complaint Pain Management Scenario

1. What would be the next step to take to investigate this complaint?
 - An on-site investigation with observation of patients: A hospital social worker called this in; obtain the phone number of the patient or family that complained.

Complaint Pain Management: On-Site Visit Scenario

1. Do we go home now? Or should we investigate further, and if so, how?
 - Review clinical records of the complainant and hospice inpatient grievance file.
2. At a minimum how many clinical records should you review following a complaint per the State Operations Manual (SOM)?
 - In the SOM investigative procedures, Part 1, review a minimum of three clinical records, Appendix M—Part 1 and follow investigative guidelines of Part 2 of Appendix M.

Complaint Pain Management: Records Scenario

1. What questions do we have now that we may need to investigate further or verify through interview?
 - The lack of documentation of pain and/or symptom management of Patient #1 and Patient #3

Complaint Pain Management: Interviews Scenario

1. Cite or not cite?
 - We cited both L512 and L509 for failure to meet the patient's pain and/or symptom management needs and lack of investigation by the inpatient hospice when they learned of a complaint filed by the patient regarding poor symptom management and possible neglect by nursing staff.