UPDATED: December 4, 2024
November 13, 2024

United Methodist Children's Home
2002 S Fillmore St
Little Rock, AR 72204-4909

The Division of Provider Services and Quality Assurance (DPSQA) of the Arkansas Department of Human Services has contracted with Arkansas Foundation for Medical Care (AFMC) to perform Inspections of Care (IOC) for Inpatient Psychiatric Services for Under 21. The Medicaid Manual for Inpatient Psychiatric Services for Under Age 21 was used in the completion of this report.

Observations and any deficiencies noted are listed below for the inspection conducted at the following service site on the following date:

United Methodist Children's Home
Provider Medicaid ID: [redacted]
Onsite Inspection Date: November 12, 2024
Onsite Inspection Time: 8:46 AM

A summary of the policies reviewed, and finds are noted below:

Inspection of Care Summary

Health and Safety-Policy Review

This inspection was triggered by a complaint against United Methodist Children's Home. Based on the nature of the incident, the following were requested for review:

- Policies and Procedures
- Facility Documentation

Health and Safety Deficiencies:
Upon review of the site's policies, procedures, and certification requirements, no deficiencies were noted.

Observations:
Upon arrival at the facility, AFMC staff were promptly greeted at the entrance by a United Methodist Children's Home receptionist in the main lobby. AFMC staff spoke briefly in the lobby with the Compliance Director and the Chief Executive Officer who stated they had a board meeting and would be unavailable to assist with the Inspection of Care. The Compliance Director stated that the Corporate Compliance Specialist would be the point of contact and the facility's Nurse Manager would be available for a couple of hours to assist via telephone only due to having a car accident that morning. AFMC was taken to a conference room where they were met by the Corporate Compliance Specialist. AFMC staff were given the completed and signed consent form listing approval for access to the AFMC portal. AFMC staff discussed the Document Request Form and the requirements for the Additionally Ordered Inspection of Care with facility staff.

Additional Health and Safety Policy Review:
Based on the nature of the incident, the following additional policies, procedures, and facility documents were requested for review:

- Medication Administration Policy
- Medication Error Policy
- Medication Errors for the previous three months
- Quality Assurance Meeting Minutes
- Incident Reporting Policy
- Chart Audit Policy
- Chart Audit Tool

Summary of Findings and Resolution:

Below are findings based on a review of the facility's policies, procedures, and documents and an extensive conversation with the Corporate Compliance Specialist and a telephone conversation with the Nurse Manager. No deficiencies were noted during the reviews.

- Medication Errors are reported to the Nurse Manager via a medication error form. That information is then submitted to be reviewed at each quarter's Quality Assurance Meeting.
- Upon review of the Quality Assurance Meeting Minutes for the prior year it was determined that there has only been one medication error in the last year on November 29, 2023, at 11:00 a.m. [redacted] was ordered by the physician. The nurse accepting the order did not transcribe the medication orders to the Medication Administration Record, so the client did not receive either medication for a total of twenty-seven doses.
- The following is the process verbalized by the Nurse Manager that the nursing staff follow with all new physician orders:
    - The physician gives the new order to the staff via verbal order, telephone order, or by email. The physician does not enter any of their orders in the electronic health record. The nurse manager states that the physician must sign the orders within 48 hours of the original order time which is per the Documentation of Time Frames Policy.
    - The nursing staff have a nursing group email that is utilized to share the physician orders as well as any other information regarding the clients' care and behaviors. If the order is not received by email from the physician, the nurse will email the order in a nursing group email which includes the Nurse Manager as well as the staff nurses. There was an agency nurse working on one of the units who AFMC staff spoke to regarding this process. They stated they did not have access to this nursing group email therefore, they rely on another nurse to give them the updates regarding each client.
    - The nurse who receives the order or a nurse who has access to the nursing group email enters the order into the electronic health record system.
    - If the order includes a medication that is new, changed, or discontinued the order is entered into a different computer system that houses the Medication Administration Record. The Medication Administration Record is printed for each day and the nursing staff document on the printed Medication Administration Record when administering medications. If medication orders are received after the Medication Administration Record is printed, then all new medication orders are handwritten on the Medication Administration Record.
    - After the orders are transcribed onto the Medication Administration Record the outsource Pharmacy (Omnicare) is called by the nurse and those orders are relayed to the pharmacist to fill for each client. AFMC staff asked if the orders were only called via telephone or were they also faxed since the order that is entered into the computer can be printed. The Nurse Manager stated that they only "call in" the medication orders to the pharmacy. Omnicare fills the medication order in a 30-day blister pack for each single medication with the client's information as well as the prescribed medication information labeled on each blister pack. If the medications are discontinued before the 30-day blister pack is completed, then the pack is disposed.
    - Once the client is discharged, the Medication Administration Records are scanned into the actual health record.
    - The above steps are not reflected in the facility's Medication Administration Policy.

- AFMC staff asked the Nurse Manager how the staff verified that each medication order was completed. The Nurse Manager stated that they have a 1530 Form that is completed on the 15th and 30th of each month and they have implemented a chart audit process that is done every 30 days on each chart.
    - Upon review of the 1530 Form, AFMC noted this is a medication reconciliation form. This form is utilized to suffice Regulation CFR 42 456.610(b)(1) which states the attending physician reviews prescribed medications at least every 30 days in psychiatric facilities.
    - Upon review of the new chart audit process, AFMC staff were informed that this process has a form that is placed in the front of each chart. The Nurse Manager stated that chart audit tool also has instructions for completion in the front of each chart. AFMC staff were unable to find the instructions for the chart audit tool. Facility staff emailed the instructions the following day to AFMC staff.
    - AFMC staff reviewed several active client charts for this form and found that the Nurse Manager is the one who is completing the chart audit process monthly. This form is a checklist to ensure that the chart contains all the required forms upon admission as well as documentation is completed as per the regulation requirements. There is one check box that states "Orders" and the instructions state to "verify that orders in the computer have been noted properly."
    - AFMC staff asked the Nurse Manager and nursing staff that were on duty the day of the IOC if there were any type of audits that were occurring every shift or every 24 hours to verify that all orders were completed and all nursing staff answered that there were no other checks and balances completed on charts to verify that all orders are completed, and all medications are given as ordered.

Summary of Findings and Resolution:

- AFMC staff discussed with the facility's Corporate Compliance Specialist the lack of evidence of any type of daily chart check to ensure that all orders received from the physician were completed each day. Daily chart checks are not only a nursing standard of care but considered the best practice. These chart checks should be performed daily and noted in the chart once each chart check is completed. Auditing charts daily ensure that all orders have been completed correctly and will prevent medication errors from not only occurring but also continuing for days and even weeks before being found.
- Prevention of medication errors should include double check/triple check procedures. Nurses must ensure that not only are the orders reviewed every shift but also communicate new orders to incoming shift staff.
- Unsafe medication practices and errors are the leading cause of injury and avoidable harm in the health care system. Safe medication administration involves the implementation of safe medication procedures to bridge critical communication gaps from the time the order is given until the order is carried out. The facility is encouraged to review all steps of the medication administration process and bridge any gaps in their process of ordering, transcribing, dispensing, administering, and monitoring medications for their clients.
- The more steps in prescribing medications will equal more risk of error. Ensuring the five rights of medications as well as institutional policies related to medication transcription are followed will help prevent medication errors. This facility is encouraged to review all steps they are currently utilizing for medication administration and update their policy to reflect their current practice.

Respectfully,

Inspection of Care Team
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