

**DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES
CORRECTIVE ACTION PLAN**

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License #: 142-04-005

Organization Name: Virginia Commonwealth University Health System Authority

Date of Inspection: 07-18-2022

Program Type/Facility Name: 04-005 VTCC Inpatient Unit

<u>Standard(s) Cited</u>	<u>Comp</u>	<u>Description of Noncompliance</u>	<u>Actions to be Taken</u>	<u>Planned Comp. Date</u>
12VAC35-105-150. (4) - The provider including its employees, contractors, students, and volunteers shall comply with: 4. Section 37.2-400 of the Code of Virginia and related human rights regulations adopted by the state board;	N	VTCC Inpatient Unit This regulation was NOT MET as evidenced by: See OHR citation below.	PR) 07/22/2022 Provide a statement of the issue that led to non-compliance and state how you corrected/will correct the deficient practice in this specific violation. PR). Staff failed to prescribe and ensure safe medication management services resulted in Medication Error as outlined in VCUHS Medication Error Document PH.MS. 003- any preventable event that may cause inappropriate medication use or endanger patient safety. PR). There is an order in Epic to continue home medication. The Physician Assistant did not "unclick" the medication from the whole list due to getting distracted by multiple emergencies. PR). Patient was admitted 6/3/2022 after overdosing on approximately 200 mg of medication- Prozac (9-10 pills). Patient was then prescribed and given Prozac 20mg on 6/4/2022 at 09:21am. Medication was given by Registered Nurse/ordered by Physician Assistant. The order was held after it was given. Later medication was discontinued by the Primary Attending. PR). The Physician Assistant was given verbal counseling on July 6, 2022 by the Division Chief, Child and Adolescent Psychiatry, reviewed different medication classes and ways to respond to overdoses (some medications need to be held, while others have to be weaned off). The Physician Assistant was reminded to reach out to on- call attending with questions regarding overdoses.	8/1/2022

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			Include a plan of action to address systematic changes (process/protocols, etc.) that have been or will be implemented to ensure you remain in compliance of the regulation. PR). The Physician Assistant was reminded to review Epic orders prior to signing them to prevent automatic prescription of home medications at the hospital, follow evidence-based practice for medication prescription, and adhere to current policy and procedure following guidelines under VCUHS Medication Administration Policy PH.AD.009 to ensure proper efforts are utilized to improve safe prescribing of patients' medications. PR). Currently there are no specific rules to follow in treating drug overdoses. Treatment is based on Medical Providers' judgment and knowledge. Subsequently, in this case, there is no deviation of practice identified as there were no known protocol in place suggesting medication should be held when treating drug (Prozac) overdose. Medication choice is a clinical decision and is to be reviewed individually on all patients. Include Staff by Title who will monitor the procedures implemented to ensure you stay in compliance with the regulation. Indicate the frequency for monitoring the plan including how it will be monitored (Ex: monthly audits, weekly chart reviews, daily checklist). PR). Every day, every admission is reviewed by the Primary Attending and/or the Attending on-call and if there are any concerns the Division	

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			Chief is notified and make recommendations. Additionally, the Division Chief for Child and Adolescent Psychiatry reviews select charts weekly. OLR) Accepted 07/28/2022	
12VAC35-115-50. B. (2) - In receiving all services, each individual has the right to: 2. Be protected from harm including abuse, neglect, and exploitation.	N	VTCC Inpatient Unit This regulation was NOT MET as evidenced by: "Neglect" means failure by a person, program, or facility operated, licensed, or funded by the department, excluding those operated by the Department of Corrections, responsible for providing services to do so, including nourishment, treatment, care, goods, or services necessary to the health, safety, or welfare of an individual receiving care or treatment for mental illness, intellectual disability, or substance abuse. Upon review of CHRIS entry A-20220044, the provider's investigation determined Employee #1 admitted to prescribing the medication in error and neglect was found. Based on preponderance of evidence, Employee #1 failed to ensure the health and safety of Individual #1.	PR) 07/22/2022 Provide a statement of the issue that led to non-compliance and state how you corrected/will correct the deficient practice in this specific violation. PR). Staff failed to prescribe and ensure safe medication management services resulted in Medication Error as outlined in VCUHS Medication Error Document PH.MS. 003- any preventable event that may cause inappropriate medication use or endanger patient safety. PR). There is an order in Epic to continue home medication. The Physician Assistant did not "unclick" the medication from the whole list due to getting distracted by multiple emergencies. PR). Patient was admitted 6/3/2022 after overdosing on approximately 200 mg of medication- Prozac (9-10 pills). Patient was then prescribed and given Prozac 20mg on 6/4/2022 at 09:21am. Medication was given by Registered Nurse/ordered by Physician Assistant. The order was held after it was given. Later medication was discontinued by the Primary Attending. PR). The Physician Assistant was given verbal counseling on July 6, 2022 by the Division Chief, Child and Adolescent Psychiatry, reviewed	8/1/2022

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			different medication classes and ways to respond to overdoses (some medications need to be held, while others have to be weaned off). The Physician Assistant was reminded to reach out to on- call attending with questions regarding overdoses. Include a plan of action to address systematic changes (process/protocols, etc.) that have been or will be implemented to ensure you remain in compliance of the regulation. PR). The Physician Assistant was reminded to review Epic orders prior to signing them to prevent automatic prescription of home medications at the hospital, follow evidence-based practice for medication prescription, and adhere to current policy and procedure following guidelines under VCUHS Medication Administration Policy PH.AD.009 to ensure proper efforts are utilized to improve safe prescribing of patients' medications. PR). Currently there are no specific rules to follow in treating drug overdoses. Treatment is based on Medical Providers' judgment and knowledge. Subsequently, in this case, there is no deviation of practice identified as there were no known protocol in place suggesting medication should be held when treating drug (Prozac) overdose. Medication choice is a clinical decision and is to be reviewed individually on all patients. Include Staff by Title who will monitor the	

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			procedures implemented to ensure you stay in compliance with the regulation. Indicate the frequency for monitoring the plan including how it will be monitored (Ex: monthly audits, weekly chart reviews, daily checklist). PR). Every day, every admission is reviewed by the Primary Attending and/or the Attending on-call and if there are any concerns the Division Chief is notified and make recommendations. Additionally, the Division Chief for Child and Adolescent Psychiatry reviews select charts weekly. OHR/OLR) Accepted 07/22/2022	

General Comments / Recommendations:

I understand it is my right to request a conference with the reviewer and the reviewer's supervisor should I desire further discussion of these findings. By my signature on the Corrective Action Plan, I pledge that the actions to be taken will be completed as identified by the date indicated.

Tonya Carr, Legal Operations Manager

(Signature of Organization Representative)

Date

C = Substantial Compliance, N = Non Compliance, NS = Non Compliance Systemic, ND = Non Determined