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HUMAN RIGHTS AUTHORITY - NORTHWEST REGION

REPORT 13-080-9002
H. DOUGLAS SINGER MENTAL HEALTH CENTER

Case Summary: the Authority found violations of the patient's right to provide informed consent. The program's response is not included in the public record.

INTRODUCTION

The Human Rights Authority opened an investigation of potential rights violations in the services provided at Singer Mental Health Center. Allegations state that a patient was not provided with adequate and humane care in that he rarely saw his psychiatrist and was not given the opportunity to discuss a particular medication's side effects and provide informed consent. Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5), the Administrative Code for state-operated programs (59 Ill. Admin. Code 112) and Illinois Department of Human Services (DHS) policies and procedures (PPD 02.06.01.02).

Singer was a state-operated hospital located in Rockford that provided civil and forensic based treatment for adults. At the time of our visit in early October 2012 there were about twenty patients remaining. The hospital closed its doors on October 31, 2012. This report will be shared with DHS administrators given our findings and relevance to existing state-run hospitals and the nursing/medical staff from Singer who may have moved on to them.

This review includes access to the patient's record with written authorization. Singer's quality manager and the patient's attending psychiatrist were interviewed.

COMPLAINT SUMMARY

The complaint states that the patient's psychiatrist visited him only twice since the patient arrived at the hospital almost a month earlier. The patient reportedly had problems with a prescribed medication, Asenapine, was concerned about seizure contraindications and asked to see the psychiatrist several times without success. A nurse allegedly gave him written education

materials on the medication but did not ask for his consent or his signature and if he had any questions.

FINDINGS

According to the patient's record, he was admitted on June 29th under the care of a specified attending psychiatrist. But a different psychiatrist visited him just a couple hours after admission for a "brief assessment and medication needs". Phenytoin and Ziprasidone were ordered and administered upon written informed consent from the patient and the physician's statement that the patient had decisional capacity. Entries showed that yet another psychiatrist met with him a day later, this time to do a more complete psychiatric evaluation. The corresponding report notes the patient's seizure history, the last occurring about one month prior. Lurasidone and Sertraline were subsequently ordered and administered upon written informed consent from the patient and the physician's statement that the patient had decisional capacity. The psychiatrist who made first contact with the patient on the 29th followed up with him three more times on July 2nd, 3rd and 5th, one for a treatment plan meeting and the others for routine assessments. Lorazepam, Haldol and Hydroxyzine were ordered PRN, or as needed, in the meantime and were administered numerous times unforced throughout his stay. Missing however was documentation that written informed consent from the patient based on a physician's written capacity determination was completed for any of these beforehand. Notes from the 5th state that the patient complained of not seeing his doctor since being there.

Progress notes revealed that the attending psychiatrist saw his patient the next day on July 6th; his notes stated that the medication regimen was discussed and that the patient was likely drug seeking. The patient had no complaints. The attending followed up from there five more times on July 9th, 10th, 13th, 16th and 20th, either for general assessments, dosage increases for two psychotropics, and treatment planning updates; the last visit on the 20th to file court documents after the patient requested discharge. On the 17th the attending wrote about his visit with a social worker to talk about the patient's excessive demands including a change of antipsychotics. The note stated that Fanapt would be started although the medication administration record showed that Asenapine was ordered instead. Again, there was no documented evidence of getting the patient's informed consent along with the physician's statement of decisional capacity. The record also showed that Asenapine was offered daily as ordered but was refused by the patient each time. A progress note from the 20th stated that the patient refused to take Asenapine and wanted to talk to his doctor. His doctor saw him a few hours later during a special treatment team meeting and wrote that various medication options and their side effects were discussed with the patient on several occasions. Seizure contraindications with Asenapine were not specifically noted as a discussion topic.

The attending psychiatrist clarified during our interviews that indeed, he had discussed Asenapine with the patient. The potential side effect of seizures was brought up and he explained how seizures were not a necessary problem for him, at least as a cause from the drug. He mentioned to us that all psychotropics needed to be used with caution considering seizure activity. We pointed out that per the patient's record, there was no documented informed consent for the three PRN medications, the scheduled Asenapine and two scheduled medication increases

outside consented doses. We pressed about the need for informed consent and that the law prohibits administering medications without consent absent an emergency, to which he responded, "I know what the law says, but it's not practical in real life. I will order the medication anyway as opposed to allowing the patient to continue declining." We asked how the facility as a whole goes about the consent process and where his responsibility comes in. The psychiatrist described how nurses primarily complete consents and should have done so with the PRN phone orders. He said that pros and cons of medications including capacity are discussed when they are ordered, but there are blank consent forms where spaces for medications and capacity statements are to be added and that he usually gets these later during treatment team meetings where the information is covered while the patient is present. We suggested here that treatment team meetings usually take place a considerable time after medications have started.

CONCLUSION

Under the Mental Health Code, all recipients are to be provided with adequate and humane care and services, which are defined as those reasonably calculated to improve and avoid further decline in one's clinical condition (405 ILCS 5/2-102 a; 1-102.2). To ensure informed consent, facilities are required to provide patients with written information on proposed psychotropic medications. Physicians must determine and state in writing whether patients have decisional capacity to provide informed consent and can only proceed with giving the medications if they do (405 ILCS 5/2-102 a-5). The Administrative Code and DHS policies provide for the same, except that DHS policies and procedures fail to mention required written capacity statements; both add that informed consent from patients must be in writing (59 Ill. Admin. Code 112.90; PPD 02.06.01.02 B).

Here the patient was seen five times by two psychiatrists during his first week in the hospital. His attending psychiatrist visited him six days into his admission and followed up with him six times after that until his discharge for a total of eleven psychiatry visits during his one-month stay. Although he might have thought he should have seen his attending psychiatrist earlier, the complaint that he was not provided with adequate and humane care in that regard is not substantiated.

Medications as were prescribed in his care however, provide a different outcome. First, there were no informed consents for three PRN psychotropics, each administered from time to time without emergencies. Second, Asenapine was ordered and offered numerous times without getting the patient's informed consent; fortunately he refused each offer. Third, two psychotropics were increased and administered which exceeded consented doses, and, fourth, as described by this psychiatrist, his responsibility to complete the capacity determination in writing comes during treatment team meetings, well after medications are proposed and started. Finally, add the psychiatrist's proclamation about the informed consent requirement being impractical and bypassed and collectively there is a certain violation of the patient's guaranteed right to provide informed consent. The complaint is substantiated.

RECOMMENDATIONS

1. The Department psychiatrist in this case admitted that he ignores informed consent laws whenever he finds them impractical for treating his patients. This kind of blatant misconduct is not only illegal but a flagrant disregard and violation of a patient's right to control his personal healthcare when able. The Department **must** denounce such practice and ensure that all physicians currently under its employ conform.
2. The Department should revise existing hospital policies to include Code-required written capacity statements whenever physicians propose psychotropic medications (405 ILCS 5/2-102 a-5; 59 Ill. Admin. Code 112.90).
3. Ensure that all Department psychiatrists document a patient's decisional capacity whenever psychotropics are proposed, whether scheduled or PRN and that physicians and nurses complete the informed consent process by covering written information about proposed medications with them, not later during treatment team meetings after meds have already been started (405 ILCS 5/2-102 a-5; 59 Ill. Admin. Code 112.90).
4. Seek written informed consent from clinically competent patients (59 Ill. Admin. Code 112.90; PPD 02.06.01.02 B).
5. Seek additional informed consent whenever doses for previously prescribed medications are increased.

SUGGESTIONS

1. According to the documentation, this patient requested discharge in writing on Monday, July 16 and was not seen by his treating psychiatrist until Friday, July 20; he remained there pending a court hearing and without seeing any psychiatrist again for nine more days. When questioned about the delays, the psychiatrist said he worked part time which was likely the reason for not seeing his patient sooner regarding his discharge request, not that he intentionally uses the full five-day allotment to evaluate. He did not know why the patient was not seen for nine days after that.

   We stress that any patient who requests discharge must be discharged at the *earliest appropriate time* not to exceed five days unless court documents are filed (405 ILCS 5/3-403). Regardless of the outcome, we cannot understand how a patient's right to be discharged at the earliest appropriate time can be honored if he is not evaluated each day after his request. While the psychiatrist denied the practice of intentionally waiting five days, we encourage the Department to ensure this is not the case in all of its hospitals as well. Perhaps other psychiatrists can evaluate patients for potential discharge in the absence of the attending. We have no answers as to why the patient spent his last nine days without a psychiatrist's visit, but best practice would suggest at least a periodic check in the meantime.

2. This patient's discharge summary states that he was prescribed Phenobarbital for seizures when actually he was never prescribed that medication according to his records. The inaccuracy should be corrected since this kind of information travels with the patient for future care.

3. Discuss the risky practice of using PRN telephone orders without consent and without a prescribing physician's ability to personally see and determine a patient's decisional capacity.