FOR IMMEDIATE RELEASE

REPORT OF FINDINGS
METROSOUTH MEDICAL CENTER--- 15-040-9003
HUMAN RIGHTS AUTHORITY—South Suburban Region

[Case Summary— The Authority made corrective recommendations that were accepted by the service provider. The public record on this case is recorded below; the provider did not request that its response be part of the public record.]

INTRODUCTION

The South Suburban Regional Human Rights Authority (HRA) has completed its investigation into an allegation concerning MetroSouth Medical Center. The complaint stated that an elderly recipient was given psychotropic medication without her informed consent and in the absence of an emergency. If substantiated, this allegation would violate the Mental Health and Developmental Disabilities Code (the Code) (405 ILCS 5/100 et seq.) and the Illinois Power of Attorney Act (755 ILCS 45/4-7 [a]).

METHODOLOGY

To pursue the investigation, MetroSouth Medical Center's Chief Quality Officer, the Risk Manager, the Director of Senior Behavioral Health, the Attending Physician, the Chief Nursing Officer and a Registered Nurse were interviewed. The complaint was discussed with the recipient's agent for health care. Sections of the recipient's record and a copy of her Durable Power of Attorney for Health Care (POA), dated March 17th, 2010, were reviewed with consent. This document appoints the resident's granddaughter, who lives in a nearby state, to make health care decisions for the individual if she is unable to make them. Relevant policies were also reviewed.

The HRA was unable to interview the nurse who completed the Voluntary Application because she is no longer employed with the medical center. The Attending Emergency Department physician did not attend the meeting when the complaint was discussed with the staff.

COMPLAINT STATEMENT

The complaint stated that Haldol and Risperdal were administered without her informed consent and justification. It was reported that a copy of the recipient's Durable Power of Attorney for Health Care was provided to the hospital. However, the hospital staff did not involve the recipient's designated health care agent in treatment decisions, which includes medication.

FINDINGS

According to MetroSouth Medical Center Emergency Department Record, the recipient was accompanied by family members upon her arrival on August 27th, 2014 at 11:35 a.m. Her family told the triage nurse that the recipient has Dementia and was exhibiting aggressive behaviors. They reported that the recipient had allegedly pulled a knife on a staff person at her residential facility. And, she was discharged from her residential placement after she was

evaluated at a nearby hospital. The triage nurse wrote that the recipient and her family were informed about the initial plan of care was when she was escorted to a treatment room. The record contained a general consent for treatment form signed by a family member. It is unclear why her family member signed the form. We note that the individual in question is not the recipient's health care agent. Blood was drawn. The recipient was seen by a physician who documented altered mental status; the onset was acute, symptoms of aggression and a history of aggressive behaviors. The recipient was diagnosed with psychosis and a urinary tract infection.

At 1:00 p.m., a nursing entry stated that the recipient was cooperative and was watching television with her family at her bedside. A petition and certificate were prepared on that same day at 2:20 pm. The Attending Psychiatrist was notified. The recipient and her family were informed about the plan to admit her to the hospital's geriatric behavioral health unit. The nurse wrote that the recipient verbalized that she understood her plan of care. Cipro 500 mg orally was given around 3:30 p.m. Ativan 2 mg Intramuscular (IM) stat was ordered and cancelled by the physician. Her record lacked indication concerning why the medication was cancelled. The recipient was medically cleared for admission to the behavioral health unit and was discharged from the Emergency Department around 3:31 p.m.

According to MetroSouth Medical Center Behavioral Health Record, the recipient signed a Voluntary Application on that same day at 4:00 p.m., which was also signed by a Registered Nurse who affirmed that rights under this status were admonished and that she gave the recipient or designee a copy of the form. The voluntary application does not indicate whether or not the recipient wanted someone to be notified about her hospital admission or whenever her rights were restricted. The recipient and the nurse also signed a copy of the "Rights of Individuals Receiving Mental Health and Developmental Disabilities Services." indicating that rights were orally explained and given in writing. A second general consent for treatment form was completed during the admission process and signed by the recipient. The form recorded that the recipient has a designated health care agent and that a copy of her Durable Power of Attorney for Health Care document would be provided to the hospital.

According to the admitting nursing note, the recipient was oriented to person, place, and time upon her arrival to the behavioral health unit. She was cooperative with the admission process and she verbalized an understanding about information shared with her. Her family told the nurse that the recipient is a wanderer, confused, and aggressive. The recipient told the nurse that she did not want to be in the hospital because there was nothing wrong with her. She said that she had been mistreated at her residential facility. And, her treatment goal was to get out of the hospital. Later on that same day, the recipient was described as being somewhat confused, but she did not exhibit any physical or aggressive behaviors at the time. She was compliant with scheduled medications and fluids were encouraged.

A history and physical assessment, completed on the admission day, stated that the recipient was admitted to the hospital's behavioral health unit because of confusion and alteration of her mental status. She was described as being alert during the assessment and oriented times two. She denied having any pain, except for some mild distress. Per the assessment report, the recipient's medical condition was discussed in details with her. And, the plan was to continue administering the recipient's previous and current medications during her hospital stay. A psychiatric evaluation report documented aphasia, apraxia, amnesia and increased agitation. She was alert, oriented to self, and confused. Her insight and judgement were very poor. She reportedly believed that people were out to get her. She was diagnosed with Psychotic Disorder and rule out Dementia with delusions.

On the admission day, the medication records indicated that Amlodipine 10 mg, Donepezil 15 mg, Oxybutnin Chloride Extended Release 15 mg orally daily, and Cipro 500 mg and Naprosyn 500 mg orally twice daily for her physical problems were ordered. These medications reportedly had been prescribed prior to the recipient's admission to the behavioral health unit with the exception of Cipro. Oxybutnin Extended Release was changed to Oxybutnin Immediate Release 2.5 mg twice daily, and Cipro was changed to Levaquin 250 mg daily. Seroquel, 25 mg orally twice daily, Ativan 2 mg orally or IM and Haldol 1 mg orally or IM every six hours PRN (as needed) for her psychiatric problems were ordered.

A psychotropic medication consent form indicated the physician discussed with the recipient the risks, benefits and side effects and other alternatives to the medications ordered. The kind of medications, frequency, dosages, length of time, and the method of administration were explained. The form documented that the recipient was informed of the right to refuse medication except in an emergency. The physician and the recipient signed the form on the admission day indicating that she had agreed to accept the medications. However, there were no specific medications, recommended dosages, or frequency listed on the document. The medication form lacked space for the information above. Also, we found no indication during the record review that written psychotropic medication information was provided.

The medication records indicated that the recipient was compliant with schedules dosages of medications overall. She was allowed to refuse medication, and there were no indications that the medications were given over her objections. For example, the recipient reportedly had refused medication and swung her hand at the nurse when medication was offered on August 29th. It was recorded that the recipient would be monitored and that her behaviors would be recorded. There was no mention that medication was given over her refusal. The HRA noticed that a copy of her health care document was faxed to the hospital on the second admission day at 12:29 p.m. We found no documentation of any phone calls or communication between the treating psychiatrist and the recipient's designated health care agent in her record. And, there was no clear statement concerning her capacity to give consent for treatment in her record.

The medication records further documented that as needed medication was given on several occasions. For example, Haldol and Ativan IM were administered On August 31st, 2014. A patient care note stated that the recipient was angry and barricaded herself in her room. She was uncooperative, hitting at the staff, and she was not redirectable. On September 1st, 2014, Haldol and Ativan IM were given because the recipient was disruptive, disoriented, and aggressive. Also, it was recorded that the staff had attempted to reorient the recipient, but she refused to leave another patient's room. On that next day, the recipient told a nurse that she wanted to go home. Also, the nurse entry indicted that the recipient would be monitored for aggressive behaviors.

On September 3rd, 2014, Haldol and Ativan IM were administered. According to a patient care note, the recipient's POA agent was informed that she was physically and verbally aggressive towards staff and family members on the above day. She seemed "withdrawn" while visiting with her family and had refused to get up off the floor. Her family had observed her punching a staff person. Also, the recipient reportedly was verbally abusive towards the, nurse while she was talking to her health care agent. She refused to talk to her substitute decision maker until she heard her agent say that she was coming to get her.

The medication records indicated that the administration of Zoloft 25 mg orally daily, and Saphris 5 mg and Namenda 5 mg orally twice daily were started on September 3rd and the 5th 2014, respectively. Again, we found no consent for the medication in her record. The

medication record does not reflect that Risperdal was ordered and administered as stated in the complaint. A "Psychiatric Discharge Summary" stated that the recipient was stable and that she had obtained the maximum benefit from inpatient care. According to a progress note, the recipient was accompanied by her health care agent when she left the behavioral unit on September 6th, 2014.

MetroSouth Chief Quality Officer first responded to the complaint by letter stating that the recipient is an Illinois resident but her POA and Certificate of Incapacity documents prepared in another state did not appear to be consistent with Illinois forms. She wrote that the recipient was cooperative, her admission to the unit was voluntary, and medication was administered with consent. When the complaint was discussed with the staff, the HRA was informed that the hospital's geriatric behavioral health unit has fourteen beds and that there were three recipients on the unit on the site visit day. The criteria for admission to the unit includes: 1) immediate danger to self or others, 2) dementia, and, 3) psychosis. We were told that many recipients admitted to geriatric unit have a history of mental illness. The treating psychiatrist said the recipient had the capacity to make a reasoned decision about treatment, although she might have been confused sometimes. He said that people, who present with mental illness, "go in and out of reality" or have some decisional capacity at certain times.

At the site visit, the staff interviewed said that medication was administered with the recipient's consent. There was a lot of discussion about informed consent for psychotropic medication. We talked about the hospital's psychotropic medication form that does require information about specific medications, dosages, route, and frequency. The HRA requested documentation showing that the recipient had agreed to the psychotropic medications administered during her hospital visit. The staff referenced the medication consent form affirming that the physician had discussed the kind of medications, frequency, dosages, length of time, and the method of administration with the recipient. Also, the investigation team was informed that the consent form is used at the provider's other health centers.

According to MetroSouth Medical Center's "Procedure for Voluntary and Involuntary Admissions" policy, all individuals who request treatment and are considered to be clinically suitable for care may be admitted to the hospital's behavioral health units as a voluntary patient. It states that the Medical Director or designee shall evaluate a person's suitability for voluntary admission based on the following criteria: 1) the person has a psychiatric condition, which can benefit from inpatient treatment and is consistent with the admission criteria of the unit.

The Medical Center's "Overview of Multidisciplinary Treatment Planning Process" policy states that an individualized treatment plan shall be developed for each patient admitted to the program. A meeting will be held within 72 hours of admission to the unit at which time a Master/Interdisciplinary Treatment Plan will be written. A treatment meeting will held weekly after the initial staffing and more frequently if clinically indicated. The patient and/or family should attend the meeting as clinically appropriate and should sign the treatment plan to document their participation and understanding of its contents.

The Medical Center's "Informed Consent/Medication/Psychoactive" policy states that the physician or designee will discuss the use of medication, reason for treatment, symptoms, the risk of not using the medication, and possible alternative to medication with the patient and/or guardian. The right to refuse medication will be provided. The physician or designee will document on the consent form the completion of the above. The patient and/or guardian will be given the opportunity to ask questions. They will sign the consent form after reading about

possible side effects. The policy lacks mention of other possible surrogates such as health care agents. Also, we found no requirement of a physician's determination of decisional capacity.

The Medical Center's patient rights statement includes as follows: 1) to refuse certain services, unless such services are necessary to prevent serious harm to self or others, and, 2) to have the nature, reason and possible side effects of all prescribed medications explained and other treatments.

CONCLUSION

The Illinois Power of Attorney for Health Care Act (755 ILCS 45/4-7 [a] states,

> A health care provider furnished with a copy of a health care agency shall make it a part of the patient's medical records…. Whenever a provider believes a patient may lack capacity to give informed consent to health care which the provider deems necessary, the provider shall consult with any available health care agent known to the provider who then has power to act for the patient under a health care agency.

Section 45/2-7.5 of the Illinois Power of Attorney for Health Care Act states, that a principal shall be considered incapacitated if a physician determines after examination that the principal lacks decision making capacity.

Section 5/2-102 of the Code states,

> (a) A recipient of services shall be provided with adequate and humane care and services in the least restrictive environment, pursuant to individual services plans. The plan shall be formulated and periodically reviewed with the participation of the recipient to the extent feasible and the recipient's guardian, the recipient's substitute decision maker, if any, or any other individual designated in writing by the recipient….
>
> (a-5) If the services include the administration of psychotropic medication and electroconvulsive therapy, the physician or the physician's designee shall advise the recipient, in writing, of the side effects, risks, and benefits of the treatment, as well as alternatives to the proposed treatment, to the extent such advice is consistent with the recipient's ability to understand the information communicated… The physician or the physician's designee shall provide to the recipient's substitute decision maker, if any, the same written information that is required to be presented to the recipient in writing…. The physician shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment …. If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only (i) pursuant to Section 5/2-107 ….

And, Section 5/2-107 (a) of the Mental Health Code states,

> An adult recipient of services…must be informed of the recipient's right to refuse medication ….If such services are refused, they

> shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent harm to the recipient or others and no less restrictive alternative is available….psychotropic medication or electroconvulsive therapy may be given under this Section for up to 24 hours only if the circumstances leading up to the need for emergency treatment are set forth in writing in the recipient's record.

The complaint stated that an elderly recipient was given psychotropic medication without her informed consent and in the absence of an emergency. Under Illinois law, an advance directive such as a Durable Power of Attorney for Health Care allows the recipient to provide directions for substitute decision making concerning his/her medical treatment when the person lacks decisional capacity. In this particular case, the hospital relied on her capacity to complete her Voluntary Application. And, according to the psychiatrist, the recipient had decisional capacity to make give consent for treatment although a general consent for emergency room treatment was signed by a family member. However, there was no evidence that the recipient's informed consent was actually obtained for psychotropic medications before they were administered. Although the record contained a signed psychotropic medication consent form, there were no specific medications, dosages, etc. listed on the document. There was no written physician's statement in the record as to whether the recipient had the capacity to make a reasoned decision about them. Also, we found no evidence that written drug information was provided as required. This violates Section 5/2-102 (a-5) of the Code.

The nursing documentation indicated that the recipient was given Haldol and Ativan PRN medication intramuscular twice. Also, the medications above were given orally on September 1st, 2014. The hospital said that the recipient accepted medication. The Code requires informed consent, based upon documented decisional capacity, whenever a recipient accepts the medication, all of which was missing for the dosages that the recipient was said to have accepted.

The Authority substantiates the complaint only in regard to informed consent for psychotropic medication. We found no clear violations of Section 5/2-102 (a) of the Code, the hospital policies or rights statement.

RECOMMENDATIONS

1. Follow Code requirements and document whether a recipient has the capacity to give inform consent about the proposed treatment and ensure that informed consent is obtained before administering psychotropic medication under Section 5/2-102 (a-5). Ensure that the policy on informed consent for psychoactive medication includes this Code requirement.
2. Follow the Code's Section 5/2-102 (a-5) and provide written psychotropic medication information to recipients or substitute decision makers.

SUGGESTIONS

1. Consider revising the psychotropic medication consent form and include space to document the specific medication, dosage ranges, route and frequency discussed.

2. The Authority must caution MetroSouth Medical Center because the voluntary application lacked indication that the recipient was asked whether or not she wanted someone or an agency to be notified of her admission to the medical center under the Code's Section 5/2-113 (a).
3. Ensure that the informed consent policy for psychoactive medication includes reference to other potential surrogates such as health care agents.

COMMENT

The HRA acknowledges that the recipient's Durable Power of Attorney for Health did not need to be invoked in this case. However, we disagree with the hospital that her document was very different from a standard Illinois form. We noticed that the recipient signed the document and defined her designated agent powers effective when she was no longer able health care decisions. She allowed her agent to withhold or withdraw a feeding tube unless this would cause her pain or additional discomfort. She allowed access and disclosure of her medical records. She declined anatomical gifts. All of the above are consistent with an Illinois form.