FOR IMMEDIATE RELEASE

HUMAN RIGHTS AUTHORITY-SPRINGFIELD REGION

REPORT 15-050-9016
ST. JOHN'S HOSPITAL

INTRODUCTION

The Human Rights Authority (HRA) of the Illinois Guardianship and Advocacy Commission opened an investigation after receiving complaints of the care provided to a patient within St. John's behavioral health program in Springfield. Allegations were that the patient was admitted with dementia and his due process for prescribed medications, voluntary and involuntary, was violated. Mental Health and Developmental Disabilities Code protections apply (405 ILCS 5).

An affiliate of the Hospital Sisters Health System, St. John's behavioral health program has fifteen geriatric beds. Treating psychiatrists come from the Southern Illinois University School of Medicine. The matter was discussed with staff involved in this patient's care and their attorneys. Relevant policies were reviewed as were sections of the patient's record with authorization.

The complaint states that the patient was admitted from another hospital unit with a dementia diagnosis and not a mental illness. He was reportedly given emergency forced medications without appropriate need or the ability to have a person or agency of his choice notified and given non-emergent medications without informed consent.

FINDINGS

Admission and dementia

The attending psychiatrist explained that generally, he does not admit patients with dementia. He does admit however when a patient has a need like a safety issue or a behavioral disturbance; Lewy body dementia for example and where dementia itself is a presentation. He would admit people with dementia, Alzheimer's type since it is a psychoactive illness.

Asked about program admission policies, the hospital's nursing director said they meet the Code on permissible diagnoses and that psychiatrists from the School of Medicine are to

follow their policies. The physician agreed and verified his evaluation of the patient as documented in the record.

According to the record, this patient came from another department in the hospital where his secondary diagnoses included Suicidal Ideation and Dementia, unspecified, and where he was noted to be confused, paranoid and physically aggressive with the staff. He was seen by a resident shortly after admission to behavioral health whose history and physical report stated that the man was there to stabilize psychiatric symptoms. He was diagnosed with Psychosis, not otherwise specified; rule out delirium from general medical condition. The attending visited the patient that morning as well and agreed with the evaluation and pursued involuntary commitment.

CONCLUSION

Program admission policies state that a primary psychiatric diagnosis is required and that patients with dementia must have co-occurring psychiatric symptoms. Behavioral problems alone do not qualify a patient with dementia for admission.

Under the Mental Health Code,

A person may be admitted as an inpatient to a mental health facility for treatment of mental illness only as provided in this Chapter…. (405 ILCS 5/3-200).

'Mental illness' means a mental, or emotional disorder that substantially impairs a person's thought, perception of reality, emotional process, judgment, behavior, or ability to cope with the ordinary demands of life, but does not include a developmental disability, dementia or Alzheimer's disease absent psychosis, a substance abuse disorder, or an abnormality manifested only by repeated criminal or otherwise antisocial conduct. (405 ILCS 5/1-129).

Records leave no question that this patient was admitted to behavioral health for a mental illness, Psychosis, NOS, and not dementia on its own. A violation in this instance is not substantiated.

SUGGESTION

St. John's is encouraged to review several commitment petitions that were dismissed for dementia/Alzheimer's diagnoses in recent months.

Prescribed medications

In describing how they manage informed consent for psychotropic medications within the program, a nursing manager said they provide written drug information only to those who are capable of understanding. Not everyone gets these materials since many of their patients cannot

understand; they are older and have serious conditions. She and the nursing director were unsure of whether guardians or other legal representatives get the written information and said it was probably not clearly spelled out in policy. The psychiatrist added that he will discuss medications, their benefits and risks, if patients have good cognition and can understand and decide, otherwise he orders as needed medications if they cannot, if they disagree with taking them or become high risks to others.

No one was able to say who provided informed consent for this patient or where his decisional capacity for prescribed psychotropic treatment was documented. They recalled him having a Power of Attorney for Health Care that may have excluded psychiatric admission but they were uncertain if it excluded psychiatric treatment as well. The patient's wife served as his POA agent. The psychiatrist explained that in family meetings she would agree with psychotropics and then change her mind, saying no to them. He said he continued treating with the medications as the wife objected to them but that she agreed at some point. He believed she was mentally ill and lacked capacity herself, and they pursued POA invalidation and guardianship before his discharge.

Regarding forced medication use, the psychiatrist described scenarios where patients might act out or put others in danger which would require emergency orders. He said it depends whether patients are given a chance to refuse medications but that typically they are offered pills or shots. No one was able to say with certainty where they document patient emergency preferences. A nurse suggested that it could be in nursing notes and the psychiatrist suggested that it could be in progress or admission notes but that in any case they tend to rely on that information from patient families. The staff said they usually do not complete restriction notices for emergency/forced injections although they do for restraints. They were unsure what this particular record would include.

The record showed that the patient arrived on the behavioral health unit at 3:15 p.m. on May 26 confused, agitated and disoriented. At about midnight he punched a technician and scratched a nurse. Security was called for help and he continued to physically struggle and had to be restrained. A restraint order, corresponding nursing entries and a restriction notice referenced the incident and noted that his emergency preference was used and that his wife was notified. Ativan and Zyprexa injections were given minutes into the restraint but were not included in a restriction notice. Restraints were discontinued a few hours later. The master treatment plan did not list his emergency treatment preference, if any, or whether he was asked.

A history and physical was completed that morning, Wednesday, May 27. The incident from the night before was referenced and the patient was described as less agitated, confused and unable to verbalize any complaints but awake, alert and able to follow simple commands. Zyprexa, by mouth, twice per day was scheduled and if the patient refused he was to be given injections as emergency medication for the next seventy-two hours. Zyprexa was given by mouth twice that day as ordered. A restriction notice of the right to refuse medication was not completed. The report included comments that the patient had been taken off medications by his wife who believed antipsychotics were not good for his heart or dementia and was firmly against using them. She was assured they would be used for agitation and confusion short term and as needed, outweighing the risks.

Scheduled Zyprexa was continued on May 28, and if the patient refused he was to be administered emergency injections for the next forty-eight hours. He was said to have slept well, was calmer and displayed no agitation or aggression in the meantime. Two oral doses were given that day and there was no restriction notice completed. An additional Zyprexa order, PRN or as needed, appeared without the restriction warning and an oral dose was given the next morning. There is no documented indication that the patient or any legal representative gave informed consent for the PRN or of a statement by the physician as to whether the patient had the capacity to make a reasoned decision about the treatment. It was also stated that elder abuse would be contacted as the wife's decisions including stopping medications had not been in the patient's best interest.

Scheduled Zyprexa was continued on May 29. Again, if the patient refused he was to be given injections as emergency medication for the next twenty-four hours. The psychiatric progress note stated that he needed to be on the medication to control agitated behavior since he had been a threat to others days before while at the same time saying he was doing well, having no recollection of earlier events. He was given two oral doses without written restriction notice. Zoloft, by mouth, once per day was introduced and given but without the restriction warning. There is no documented indication that the patient or any legal representative gave informed consent or statement by the physician as to whether the patient had the capacity to make a reasoned decision about the new treatment.

Scheduled Zyprexa was continued on Saturday, May 30 along with the directive to administer emergency injections if refused over the next twenty-four hours; the physician wrote, "No agitation or irritation noted." He was given two oral doses and there were no written restriction notices. Zoloft was also given that day as scheduled, without any trace of informed consent or physician's statement of the patient's decisional capacity for the treatment.

Orders for Zyprexa and Zoloft were continued on May 31 without restricting the patient's right to refuse. He was described as confused and disoriented with poor judgement. His wife, as the POA, submitted a notarized letter to the physician on June 2 prohibiting antipsychotic medication in any form. The medications were given daily through June 5 when it was noted that given the wife's attitude and opinions towards medication, discharge was unsafe and that seeking guardianship was in progress; his treatment continued. A court order from June 10 revoked the POA status and appointed the state temporary guardian. There was still no documented informed consent for the treatment given every day through discharge on June 12 according to administration records. There were no medication petitions filed during his stay.

The POA form in the record was reviewed. Completed in February 2014, the patient elected his wife as his healthcare agent and stipulated under the mental health preferences section that he never wanted to be admitted to a mental health facility; there was nothing about mental health treatment.

There was also a St. John's Ethics Committee report provided. It stated in summary that they were consulted on May 28 regarding the wife's strong opposition to psychotropic medications and concern for the patient's deterioration in result, the physician preferring a

nephew to serve as the POA. A committee representative met with the patient and his wife as well as treatment team members to investigate and with the risk manager to discuss risk points. It was noted that the case was referred to legal and that the Committee understood the treatment team's position. The Committee submitted recommendations on June 6. Among them was to honor the wife's status as the POA, her requests to provide alternative medical treatments versus psychotropic medications and both of their rights to refuse treatment. The writer commented that it seemed the staff was clearly avoiding the wife as POA and in the Committee's opinion she was not a patient, that the hospital had no jurisdiction or right to assess her decisional capacity and competence and that it was up to the courts to assess and nullify POA status. The writer added that seemingly the patient's advance directive and his preference for his wife to make decisions was not honored and that informed consent was necessary.

We asked the risk manager about the hospital ethics team's visit with him, their input on proceeding with non-emergency treatment without the patient's or the POA's informed consent, the POA's objections, the impact that their recommendations had and to what extent they were to be considered. He did not recall. The others interviewed said the same. We also inquired about training, particularly training on the Mental Health Code and any cooperative efforts with School of Medicine physicians and residents. The nursing director said that they meet every two weeks and can go over a lot of different things.

CONCLUSION

Program policy states that patients have the legal right to refuse treatment. The staff and physician are responsible for providing patient teaching and promoting treatment compliance. A patient is determined to have decisional capacity unless a physician documents otherwise in the medical record. Consent from a substitute decision maker must be obtained when a patient lacks capacity. Treatment may be given against a patient's will on emergency basis only if necessary to prevent serious harm. Substitute decision makers are to be informed of restricted rights.

Pursuant to the Mental Health Code,

If the services include the administration of electroconvulsive therapy or psychotropic medication, 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 shall determine and state in writing whether the recipient has the capacity to make a reasoned decision about the treatment. 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. If the recipient lacks the capacity to make a reasoned decision about the treatment, the treatment may be administered only (i) pursuant to the provisions of Section 2-107 or 2-107.1 or (ii) pursuant to a power of attorney for health care under the Powers of Attorney for Health Care Law[1] or a declaration for mental health treatment under the Mental Health Treatment Preference Declaration Act.[2] A surrogate decision maker, other than a court appointed guardian, under the Health Care Surrogate Act[3] may not consent to the administration of electroconvulsive therapy or

psychotropic medication. A surrogate may, however, petition for administration of such treatment pursuant to this Act. (405 ILCS 5/2-102 a-5).

(a) An adult recipient of services or the recipient's guardian, if the recipient is under guardianship, and the recipient's substitute decision maker, if any, must be informed of the recipient's right to refuse medication or electroconvulsive therapy. The recipient and the recipient's guardian or substitute decision maker shall be given the opportunity to refuse generally accepted mental health or developmental disability services, including but not limited to medication or electroconvulsive therapy. If such services are refused, they shall not be given unless such services are necessary to prevent the recipient from causing serious and imminent physical harm to the recipient or others and no less restrictive alternative is available. The facility director shall inform a recipient, guardian, or substitute decision maker, if any, who refuses such services of alternate services available and the risks of such alternate services, as well as the possible consequences to the recipient of refusal of such services.
(b) Psychotropic medication or electroconvulsive therapy may be administered 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.
(c) Administration of medication or electroconvulsive therapy may not be continued unless the need for such treatment is redetermined at least every 24 hours based upon a personal examination of the recipient by a physician or a nurse under the supervision of a physician and the circumstances demonstrating that need are set forth in writing in the recipient's record.
(d) Neither psychotropic medication nor electroconvulsive therapy may be administered under this Section for a period in excess of 72 hours, excluding Saturdays, Sundays, and holidays, unless a petition is filed under Section 2-107.1 and the treatment continues to be necessary under subsection (a) of this Section. Once the petition has been filed, treatment may continue in compliance with subsections (a), (b), and (c) of this Section until the final outcome of the hearing on the petition. (405 ILCS 5/2-107).

Whenever any rights of a recipient of services that are specified in this Chapter are restricted, the professional responsible for overseeing the implementation of the recipient's services plan shall be responsible for promptly giving notice of the restriction or use of restraint or seclusion and the reason therefor to:
(1) the recipient and, if such recipient is a minor or under guardianship, his parent or guardian;
(2) a person designated under subsection (b) of Section 2-200 upon commencement of services or at any later time to receive such notice;
(3) the facility director;
(4) the Guardianship and Advocacy Commission, or the agency designated under "An Act in relation to the protection and advocacy of the rights of persons with developmental disabilities, and amending Acts therein named", approved September 20, 1985,[1] *if either is so designated; and*
(5) the recipient's substitute decision maker, if any.

The professional shall also be responsible for promptly recording such restriction or use of restraint or seclusion and the reason therefor in the recipient's record. (405 ILCS 5/2-201).

The question is not whether this patient needed treatment but if his due process for the treatment under the Mental Health Code was respected. Regarding involuntary medications, in the first approach he was appropriately restrained and given injections after being physically harmful to staff, the documentation for which cited the need to prevent further serious and imminent physical harm when less restrictive alternatives were unavailable. Missing was a restriction notice for the injections, which follows the nurse manager's statement that they only complete them for restraints but which does not follow the Code's requirement to notify the patient, a substitute decision maker and anyone else so designated by the patient in writing of all rights that were restricted. An order restricting his right to refuse medications for a full seventy-two hours was written and carried out the next morning, forecasting a long emergency without giving him the opportunity to refuse, without twenty-four-hour redeterminations of the need to prevent serious and imminent physical harm, without apparent consideration of less restrictive alternatives and without clear consideration for use of his emergency treatment preference, if any. Meanwhile, on May 27 he was described as less agitated, alert and able to follow simple commands; on May 28: calmer, displaying no agitation or aggression; on May 29: needing to be on the medication to control agitated behavior since he had been a threat to others days before but, doing well, having no recollection of earlier events, and on May 30 (an excluded Saturday): having no agitation or irritation. The need to control agitated behavior was contained when restraints were removed days before, and descriptors over the next days like less agitated, able to follow commands, calmer, no agitation or aggression and doing well run in the opposite direction of the need to prevent serious and imminent physical harm. And, emergency administrations were further unjustified without written notification either to the patient, his POA agent or anyone he may have desired, all <u>substantiated</u> Code and policy violations.

Regarding voluntary medications, staff and the psychiatrist stated that not all patients get written drug education materials and they were unsure if substitute decision makers did. The Code however, states that consent from patients is based on written information and that the same information must be shared with decision makers, so the practice falls short of the standard. The psychiatrist stated that he will discuss medications, their benefits and risks, if patients have good cognition and can understand and decide, otherwise he orders as needed medications if they cannot or if they disagree, which under such circumstances the Code prohibits. Orders for a non-emergent psychotropic appeared on May 28, another appeared on May 29 and both were given that day. Orders with restrictions were lifted but continued as scheduled on May 31 and were given that day and in each of the next twelve days through discharge on June 12. Absent from staff statements and the record is evidence at any time of first obtaining informed consent via written information either from the patient or his POA agent and absent any written physician determination of the patient's capacity to make reasoned decisions about the treatments when they were proposed. The POA agent exercised her right to refuse treatment, in writing, and regardless of her opinions of treatment or of her alleged capacity, her status was valid at the time and St. John's continued treatment daily, never filing a petition for court-ordered treatment and not securing POA revocation and temporary guardianship until June 10, after which there is still no evidence of informed consent for the treatment that continued two more days to discharge. The HRA agrees with the Ethics Committee's Code-supported findings of the need for informed consent, respect of the POA agent's decisions and pursuing court intervention sooner. Code and consent policy violations are <u>substantiated</u>.

Also under the Code,

Upon commencement of services, or as soon thereafter as the condition of the recipient permits, the facility shall advise the recipient as to the circumstances under which the law permits the use of emergency forced medication or electroconvulsive therapy under subsection (a) of Section 2-107, restraint under Section 2-108, or seclusion under Section 2-109. At the same time, the facility shall inquire of the recipient which form of intervention the recipient would prefer if any of these circumstances should arise. The recipient's preference shall be noted in the recipient's record and communicated by the facility to the recipient's guardian or substitute decision maker, if any, and any other individual designated by the recipient. If any such circumstances subsequently do arise, the facility shall give due consideration to the preferences of the recipient regarding which form of intervention to use as communicated to the facility by the recipient or as stated in the recipient's advance directive. (405 ILCS 5/2-200 d).

The recipient's preferences regarding emergency interventions under subsection (d) of Section 2-200 shall be noted in the recipient's treatment plan. (405 ILCS 5/2-102a).

The restraint restriction notice marked that the patient’s preference was used but it is unclear he was actually asked and clear that if restraints were indeed his preference their use was not given due consideration during the seventy-two-hour emergency. In any case the master treatment plan makes no notation as required. A violation is substantiated.

RECOMMENDATIONS

1. Educate and instruct staff to complete restriction notices whenever any patient’s right to refuse medication is restricted. (405 ILCS 5/2-201).
2. Stop allowing physicians, as hospital agents, to write seventy-two-hour emergency orders and instruct them to make daily redeterminations of the need to prevent serious and imminent physical harm when no less restrictive alternative is available before administering. (405 ILCS 5/2-107).
3. Educate staff and physicians on the Code’s intention that patients and substitute decision makers must be given the opportunity to refuse and that emergency intervention preferences must be considered. (405 ILCS 5/2-107; 2-200).
4. Provide written drug information to patients *and* substitute decision makers in all instances so they may make informed decisions when providing consent or refusing. (405 ILCS 5/2-102a-5; 2-107).
5. Educate and instruct physicians to enter decisional capacity statements *whenever* psychotropic medications are proposed. (405 ILCS 5/2-102a-5).
6. Educate and instruct staff, including physicians, to honor a substitute decision maker’s right to refuse treatment, including but not limited to medications and to otherwise pursue court intervention as soon as appropriate. (405 ILCS 5/2-107; 107.1).
7. Note patient emergency treatment preferences in treatment plans. (405 ILCS 5/2-102a).
8. The Code requires all facilities to adopt written policies and procedures necessary to implement Chapter II, patient rights (405 ILCS 5/2-202). To ensure appropriate training

and compliance, broaden program policy to specifically outline Code consent and emergency treatment requirements under Sections 5/2-102, 5/2-107, and 5/2-200.

SUGGESTIONS

1. The psychiatrist said they tend to rely on the family for information about a patient's emergency intervention preferences. While we appreciate the spirit of engaging families, St. John's should be sure that patients themselves are asked for *their* preferences and that any responses are communicated to their substitute decision makers as required under the Code. (405 ILCS 5/2-200 d).

2. **The HRA implores St. John's to formalize cooperative training with SIU physicians to ensure Code and hospital policy compliance.**

RESPONSE

Notice: The following page(s) contain the provider response. Due to technical requirements, some provider responses appear verbatim in retyped format.

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March 23, 2016

Mr. James Bakunas, Chair
Human Rights Authority
Springfield Region
Guardianship & Advocacy Commission
401 South Spring Street
521 Stratton Building
Springfield, Illinois 62706

Re: #15-050-9016
Response to Human Rights Authority of the Illinois Guardianship & Advocacy Commission's Recommendations Contained in the Human Rights Authority/Springfield Regional Report
St. John's Hospital
G & G File No. M-13350

Dear Mr. Bakunas:

Please consider this St. John's Hospital's response to the recommendations in the above described report.

1. **Recommendation:** Educate and instruct staff to complete restriction notices whenever any patient's right to refuse medication is restricted. (405 ILCS 5/2-201).

   Response: St. John's Hospital's Geriatric Behavioral Health Unit staff will be instructed to complete restriction notices whenever any patient's right to refuse medication is restricted. Notices will be included in the patient medical record.

2. **Recommendation:** Stop allowing physicians, as hospital agents, to write seventy-two-hour emergency orders and instruct them to make daily redeterminations of the need to prevent serious and imminent physical harm when no less restrictive alternative is available before administering. (405 ILCS 5/2-107).

   Response: The psychiatric physicians are **NOT** agents of St. John's Hospital. The physicians are employees of Southern Illinois University School of Medicine. Pursuant to the Medical Practice Act (225 ILCS 60/1 et seq) only licensed physicians are authorized to practice medicine. (225 ILCS 60/3). Additionally, the Hospital Licensing Act (210 ILCS 85 et seq) specifically, 210 ILCS 85/10.8, provides that even in the situation of employed physicians (the psychiatrists at St. John's are not employed) Hospitals have

very limited control over physicians, and "that the employing entity and the employed physician shall sign a statement acknowledging that the employer shall not unreasonably exercise control, direct, or interfere with the employed physicians exercise and execution of his or her professional judgement in a manner that adversely affects the employed physicians ability to provide quality care to patients." Professional judgment is defined to mean "the exercises of a physician's independent clinical judgment in providing medically appropriate diagnoses, care, and treatment to a particular patient at a particular time". Thus, a hospital's ability to dictate physicians' practices is very limited.

The Guardianship and Advocacy Commission is also limited in its ability to make Recommendations "which interfere with the proper practice of medical or other professions". (20 ILCS 3955/6).

Notwithstanding the foregoing limitations on a hospital's ability to control the medical practice of physicians, St. John's Hospital will use its best efforts to educate physicians on appropriate orders for medications and to make daily redeterminations of the need to prevent serious and immanent physical harm when no less restrictive alternative is available prior to administration of medications.

3. **Recommendation:** Educate staff and physicians on the Code's intention that patients and substitute decision makers must be given the opportunity to refuse and that emergency intervention preference must be considered. (405 ILCS 5/2-107; 2-200).

   Response: St. John's Hospital will use its best efforts to educate staff and physicians on the Mental Health Code's positions regarding patients and substitute decision makers being given the opportunity to refuse and that emergency intervention preferences should be considered.

4. **Recommendation:** Provide written drug information to patients *and* substitute decision makers in all instances so they may make informed decisions when providing consent or refusing. (405 ILCS 5/2-102z-5; 2-107).

   Response: The Behavioral Health Unit of St. John's will use its best efforts to provide drug information to patients and substitute decision makers so that they may be able to make informed decisions when providing consent or refusing medications.

5. **Recommendation:** Educate and instruct physicians to enter decisional capacity statements *whenever* psychotropic medications are proposed. (405 ILCS 5/2-102a-5).

   Response: St. John's will use its best efforts to educate and advise physicians to enter decisional capacity statements in the patient's record whenever psychotropic medications are proposed.

6. **Recommendation:** Educated and instruct staff, including physicians, to honor a substitute decision maker's right to refuse treatment, including but not limited to

medications and to otherwise pursue court intervention as soon as appropriate. (405 ILCS 5/2-107; 107.1).

Response: St. John's will use its best efforts to educate and instruct staff, including physicians, to honor a substitute decision maker's right to refuse treatment, including but not limited to medications and to otherwise pursue court intervention as soon as appropriate.

7. **Recommendation:** Note patient emergency treatment preferences in treatment plans. (405 ILCS 5/2-102a).

   Response: The Behavioral Health Unit staff will make every effort to note patient emergency treatment preferences in treatment plans.

8. **Recommendation:** The Code requires all facilities to adopt written policies and procedures necessary to implement Chapter II, patient rights (405 ILCS 5/2-202). To ensure appropriate training and compliance, broaden program policy to specifically outline Code consent and emergency treatment requirements under Sections 5/2-102, 5/2-107, and 5/2-200.

   Response: St. John's Hospital Behavioral Health Unit will review and revise as necessary its written policies and procedures regarding patient rights (405 ILCS 5/2-202) and will implement appropriate training and implement policies to outline Mental Health Code consent and emergency treatment requirements under Sections 5/2-102, 5/2-107 and 5/2-200.

Regarding the Authority's suggestions, St. John's will use its best effort to ensure that patients themselves may state their preferences and that responses be communicated to their substitute decision makers pursuant to the Mental Health Code.

St. John's Hospital will endeavor to engage in cooperative training with SIU Physicians regarding Code and hospital policy compliance.

St. John's Hospital endeavors to comply with all health related statutes, regulations, policies, and procedures and shall continue to do so for the future.

Thank you for your attention to this matter.

Sincerely yours,

Richard J. Wilderson

RJW/cmb
cc: Jon Burnett, Randy Obert, Amy Bulpitt, Sandra Carter