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HUMAN RIGHTS AUTHORITY-SPRINGFIELD REGION

REPORT 15-050-9017
HSHS ST. JOHN'S HOSPITAL

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving complaints of the care and services provided to patients within St. John's behavioral health program, Generations. Allegations are that the program admits people with dementia and provides medications and electroconvulsive therapies without informed consent or emergency.

Substantiated findings would represent violations of patient rights. Patients admitted and treated in mental health facilities are protected under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

An affiliate of the Hospital Sisters Health System, St. John's Generations serves older adults only with fifteen beds in Springfield. Treating psychiatrists come from the nearby Southern Illinois University School of Medicine. Issues were discussed with administrative, nursing and medical staff and their attorneys in April, 2016. Policies were reviewed as were three of six masked records of all patients who underwent electroconvulsive therapies in May and June 2015. Attorneys involved in commitment hearings for St. John's were also consulted.

Complaints say that the program routinely admits patients with dementia or Alzheimer's and no co-existing psychosis which, since they are not mental illnesses, is prohibited under the Mental Health Code. It was also said that some of these patients are prescribed and administered mental health treatments like psychotropic medications and electroconvulsive therapy, or ECT, without informed consent, based on the capacity to give informed consent and otherwise no emergent need in violation of the Code's processes.

FINDINGS

Admissions with dementia

Records:

Patient A of the sample was hospitalized at Generations for eleven weeks. History and physical reports stated that the patient was admitted for agitated behavior. Axis 1 diagnoses at that time were vascular dementia with behavioral disturbances, rule out delirium. A certificate completed by the attending psychiatrist stated that the patient was subject to involuntary hospitalization for dementia and agitation, prior to accepting a voluntary application. Axis 1 diagnoses nine weeks in were dementia with behavioral changes and major depressive disorder. Discharge summaries included chronic dementia with behavior problems and senile with depression diagnoses.

Patient D was hospitalized for eleven days. A history and physical report and the clinical resume listed depression and suicidal ideation as the patient's chief complaints. Admission and discharge diagnoses were major depressive disorder and generalized anxiety disorder.

Patient F was hospitalized for twelve weeks for dementia with agitated behavior and depression per Axis 1 diagnoses on the history and physical report. A petitioner wrote of the patient's history with Alzheimer's, increasing agitation, disorientation and attacks on caregivers. The attending psychiatrist's certificate stated that the patient was subject to involuntary admission for dementia, agitation, aggression, confusion and disorientation, prior to accepting a voluntary application. The patient developed pneumonia and passed away while there according to the clinical resume.

Interviews:

Attorneys who manage area commitment hearings were consulted on the number of petitions for involuntary/judicial admission they had seen from St. John's between September 2015 and February 2016 on patients with dementia or Alzheimer's. A Legal Advocacy Service attorney said that approximately fifteen such petitions were filed in that time and an Assistant State's Attorney said that five or six were what they call "go-on" petitions, meaning the provider insisted on proceeding with hearings but failed because of dementia or Alzheimer's diagnoses. Both agreed that all petitions with these diagnoses, absent psychoses, will be rejected or dismissed.

A notable decrease in these numbers has since been reported.

Hospital staff explained that their admissions practices have changed since the issue was raised. All pertinent staff have been educated on the subject. Charge nurses now serve as gatekeepers and a checklist to identify appropriate admissions is under development, which will promote communication between the nursing and the medical staff. According to the psychiatrist, there must be an existing, primary psychosis diagnosis for a patient to be admitted. He also verified that although he is not a St. John's employee, he is expected to follow the hospital's policies.

CONCLUSION

Hospital admission policy states 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'…does not include…dementia or Alzheimer's disease absent psychosis… (405 ILCS 5/1-129).

Patient D was admitted for a mental illness, which satisfies St. John's policy and the Code. Patients A and F were admitted with dementia and no psychosis diagnoses for lengthy stays according to their charts. A violation of policy and the Code is substantiated. But as indicated by court players and the hospital team, St. John's is already addressing the practice by reducing the number of petitions for those with dementia/Alzheimer's absent psychosis, by educating related personnel and by creating a form to enhance communications between the right staff, all to further protect people without mental illness from being admitted to the mental health program. Their efforts are respected and no recommendations are needed.

Medications and ECT without informed consent or emergency

Records:

Patient A was administered psychotropic medications and ECT during an eleven-week hospitalization according to the chart. Seroquel, Haldol, Zyprexa, Zoloft, Ativan, Desyrel, Prolixin and Remeron were ordered and given periodically or daily through discharge per the medication discharge summaries, without apparent emergencies or court orders. The History and Physical reports completed at admission and again several weeks in describe the patient as irritable, difficult to understand and illogical, with poor insight and judgement. There is no physician's statement regarding the patient's decisional capacity to consent to the medications in the materials provided. There is also no indication the patient was educated in writing about the prescribed medications to any extent or that the same written drug information was shared with the agent under a Power of Attorney, or POA, only that the agent would be contacted for more social history. The POA document gave broad authority and made no stipulations toward mental health treatment.

ECT was ordered four weeks into the hospitalization and thirteen sessions followed. There is no physician's statement about the patient's decisional capacity, but an ECT consent form with the agent's signature entered prior to the start date was included. The form noted that the patient was unable to sign because of dementia and that the agent had been educated on the proposed treatment; the patient was educated on the start date. The consent covered a series of treatments as ordered or for a maximum of six months and the accompanying anesthesia.

Patient D was administered psychotropic medications and ECT during an eleven-day stay. Buspar, Klonopin, Desyrel, Effexor and Zyprexa were given almost daily through discharge according to the medication discharge summaries, without apparent emergencies or court orders. The History and Physical completed at admission described the patient as depressed, with suicidal ideation; alert and oriented with impaired insight but good judgement. There is no physician's statement regarding the patient's decisional capacity to consent to the medications and no indication the patient was informed in writing of the medications' side effects, risks, benefits and alternatives in the record provided. There were no substitute decision makers.

ECT was ordered the day after admission and four sessions followed. There is no physician's statement determining the patient's capacity to consent to the treatment, but an ECT consent form with the patient's signature entered before the start date was in the chart. The form noted that the patient had been educated on the treatment at that time and that the information was repeated by the psychiatrist on the start date.

Patient F was administered psychotropic medications and ECT during a twelve-week hospitalization. Desyrel, Zoloft, Zyprexa, Prolixin, Haldol, Depakote and Ativan were given, Prolixin, Haldol and Ativan at times by injection for apparent emergencies. There are a few notices restricting the right to refuse for hitting, kicking and the inability to redirect for some, but not all, over a span of days. The History and Physical from admission described the patient as alert and calm, but irritable, with poor memory and insight, while the admission certificate from the same day had him more confused, disorganized and disoriented. There is no written physician's statement of the patient's decisional capacity or whether drug information was shared in writing before the medications were started. Family members were involved but there were no formal substitute decision makers.

By the patient's second day he was described in psychiatric progress notes as severely confused and that he required forced medications for agitation. Over the next few days he was increasingly aggressive, attacking the staff and throwing objects at them and had to be restrained and forced medicated after failing to be redirected. Emergency ECT was being discussed with the family if the medications were not effective. On his seventh day in he struggled physically again and was restrained and given an injection. An ECT consent form was completed shortly after, without patient signature, noting the treatment would be an emergency. The psychiatrist's progress note referenced the session that occurred immediately and that it was necessary to prevent significant danger after the patient's physicals attacks on family and staff. A petition for the involuntary administration of ECT was completed and filed with the circuit clerk about two hours after the session; it asked for eight treatments over thirty days. There is no subsequent court order. There was no ECT treatment the next morning when the psychiatrist described the patient as slightly better and calm, but not yet "back to baseline"; moans, keep eyes closed, gets agitated. A second session took place the following day when the psychiatrist noted the patient to be less agitated on the progress record, continuing to need PRN, or emergency injections, which was only once the day before according to the chart. A third emergency ECT session occurred two days later, during which time the patient received no injections. The psychiatrist wrote that the patient was overall calmer, less agitated and remained very somnolent. A corresponding psychiatric progress note described him before the session as showing

improvement and no agitation or irritation. Five emergency ECT treatments were carried out over the next week. All entries meanwhile portrayed the patient's significant improvement, easy redirection and cooperation, increased interaction and coherence without episodes of aggression or agitation, during which time there was one emergency injection charted. There were no restriction notices for the eight emergency ECT sessions.

Interviews:

Hospital staff explained that they have addressed their consent and capacity related practices since the issues were raised. They are now using state medication consent forms and capacity statements for proposed treatments, medications and ECT alike, are being entered on either the History and Physical or in progress notes. The psychiatrist agreed. They share written education materials and get consent from substitutes as soon as they can and nurses are typically the ones to cover the written information. ECT is more involved where videos on the treatment are played for patients, family and substitute decision makers.

Regarding the continuation of Patient F's emergency ECT treatments, it was offered that at the time their practice was to carry on with sessions beyond seventy-two hours on the filing of a petition alone. The Code's redetermination requirements in conjunction with petitions are now being followed.

On Mental Health Code training, the hospital staff said that they have no specific class but employee training is ongoing as they work and they have access to the Code on the unit. The psychiatrist added that he tries to go over hospital policies as often as he can or whenever something comes up. He also has people he can call and said that Code training is ongoing with residents; they cover commitment, read articles and go over it in orientation at the hospital and at SIU.

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.

Under 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. (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).

All three patients from the sample were prescribed multiple psychotropic medications which were given throughout their hospitalizations on voluntary bases according to their records. That means patient teaching was required under St. John's policy and the Code and written capacity statements were required under the Code, both of which were missing in each case. Violations are substantiated. All three patients were prescribed various numbers of ECT sessions, which means the same was required: teaching and capacity statements. Patient A's POA agent consented in writing to the proposed treatment and the consent form showed evidence of prior teaching to both; Patient D consented in writing with evidence of prior teaching as well, and Patient F was started on emergency sessions, where, if indeed necessary to prevent

serious and imminent physical harm, prior teaching and capacity determination was unlikely and not evidenced on the form. But, decisional capacities were not documented for Patients A and D, so violations of that part are substantiated. Patient F's emergency ECT treatments were started for what seemed to be well supported reasons, following bouts of physical attacks on others and after other attempts to calm the patient including medications failed. A petition to authorize the treatment was filed on the same day and treatment continued for two weeks but without a court order and without the redetermined need to prevent serious and imminent physical harm when no less restrictive alternatives were available. Instead, the patient was said to have improved at each step, was overall better, calm, somnolent, cooperative and coherent and that he displayed no agitation. While the petition may have been appropriate to treat the patient's condition, an emergency did not coexist for the duration. A violation is substantiated.

Reforms in St. John's practice are already underway as we are told that all related nursing and medical staff have been informed of the Code's information and capacity based consent and emergency redetermination processes.

RECOMMENDATION

1. Train all appropriate staff that restriction notices must be completed whenever a patient's right to refuse treatment, including ECT, is restricted (405 ILCS 5/2-201).
2. St. John's policy (Involuntary treatment, Behavioral Services) states that a patient is determined to have capacity unless the physician documents the lack of, which fails to meet the Code's requirement to document decisional capacities regardless. The policy must be revised accordingly (405 ILCS 5/2-102a-5; 2-202). Provide a copy of the revisions in the required response.

SUGGESTIONS

Patient F's chart showed instances where it appeared necessary to force injections, some accompanied by required restriction notices, some not, but because the record is dated and masked, it is not certain whether every instance was in fact emergent. Staff should nonetheless be sure that restriction notices are completed every time a patient's right to refuse is restricted, that any emergency intervention preference of the patient's is relayed to guardians/substitutes and considered, that anyone designated is notified (405 ILCS 5/2-201; 2-200d) and that any emergency treatment exceeding seventy-two hours must be accompanied by a filed petition (2-107).

Train staff to document each patient's emergency treatment preference, if any, in his or her treatment plan (405 ILCS 5/2-102a).

Formalize Mental Health Code training and explore ways to combine it with SIU physicians.

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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Mr. James Bakunas, Chair
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Re: #15-050-9017
HSHS St. John's Hospital, Springfield
Response to Report and Recommendations
G & G File No. M-13350

Dear Mr. Bakunas:

HSHS St. John's Hospital responds to the Human Rights Authority report and recommendation as follows:

1. Train all appropriate staff that restriction notices must be completed whenever a patient's right to refuse treatment, including ECT, is restricted (405 ILCS 5/2-201).

RESPONSE: HSHS St. John's Hospital has undertaken a program to train all appropriate staff that restriction notices must be completed whenever a patient's right to refuse treatment, including ECT, is restricted in accordance with the Mental Health Code.

2. St. John's policy (Involuntary treatment, Behavioral Services) states that a patient is determined to have capacity unless the physician documents the lack of, which fails to meet the Code's requirement to document decisional capacities regardless. The Policy must be revise accordingly (405 ILCS 5/2-102a-5; 2-202). Provide a copy of the revisions in the required response.

RESPONSE: Attached is St. John's Hospital's revised policy regarding patients' decisional capacity. (Note: added Sect. E.1.f).

HSHS St. John's will also use its best efforts to utilize restriction notices each time a patient's right to refuse is restricted and to relay such information to guardians/substitutes.

HSHS St. John's will also use its best efforts to train staff to document each patient's emergency treatment preference, if any, in his or her treatment plan. The Hospital will also work to formalize Mental Health Code training and explore ways to coordinate it with the SIU Psychiatrists.

As always, HSHS St. John's Hospital endeavors to comply with all aspects of the Mental Health Code and regulations and will continue to do so for the future. Thank you for your attention to this matter.

Sincerely yours,

Richard J. Wilderson

RJW/cmb
Encl.
cc: Charles Lucore, M.D., President, CEO HSHS St. John's
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