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HUMAN RIGHTS AUTHORITY-NORTH SUBURBAN REGION

REPORT 20-100-9013
CHICAGO BEHAVIORAL HOSPITAL

INTRODUCTION

The Human Rights Authority (HRA) opened an investigation after receiving complaints of potential rights violations in the care provided to a patient at Chicago Behavioral Hospital in Des Plaines. Allegations were that the patient was given psychotropic medication that caused a decline in her condition and emergency medication without justification. Substantiated findings would violate protections under the Mental Health and Developmental Disabilities Code (405 ILCS 5).

The hospital has a one hundred-forty-four bed capacity for adult and adolescent inpatient treatment and provides intensive outpatient treatment as well. The HRA held interviews with representatives from administration and those involved in direct care. Relevant policies were reviewed as was the patient's record with authorization.

COMPLAINT SUMMARY

The patient was allegedly given Abilify which caused side effects and an overall worsening of her condition. Her husband reportedly spoke with the staff about medications and said that the patient had a previous adverse reaction to the drug and not to give it. She was also reportedly given emergency Haldol when there was no reason to force it on her.

FINDINGS

Abilify:

The patient signed a voluntary application on October 9 which stated she was suitable for admission and had the capacity to consent to the admission. Assessments described her as alert and oriented but with manic behavior and suicidal ideations. Ativan, Haldol and Zyprexa were ordered on the first day, and the patient signed a consent form verifying that oral education about the medications was provided. None of the medications came with written education materials

or a physician's statement regarding the patient's decisional capacity. Abilify was offered and refused on October 13, and according to the physician's note the next day, the patient had an injection on the previous evening for inappropriate comments and behaviors towards staff and peers. He described her as hyperverbal, labile, anxious, agitated, preoccupied, disorganized and that she had racing thoughts, poor concentration and insight and made little progress toward treatment goals. He offered Abilify again, a long acting form, and this time the patient was agreeable. She signed a consent form that day and an oral explanation of the drug was provided but without printed materials or a statement from the physician about the patient's decisional capacity.

The physician's note from the 15th referenced a call from the patient's family who said that she previously did not respond well to Abilify and that she appeared to be decompensating when they visited the night before. He told the family that the patient asked to take the medication and she reported no adverse effects or symptoms. He met with the patient and found her appearing tired, lethargic, isolative, she was rambling and hyperverbal with racing thoughts. Abilify was discontinued. According to a subsequent entry on the 16th, the physician was informed of a medication error when the patient was given the Abilify dose after it was discontinued. The family was notified, and the patient was sent to the emergency department for medical evaluation. Nursing notes showed a second visit to the emergency department two days later after the patient complained of muscle stiffness; she returned from both visits without noted medical concerns. Another psychotropic medication was ordered in the meantime to which the patient consented following oral education. Again, no printed materials were shared with her and there was no physician's statement of her capacity to consent. She was discharged on October 19 with no additional documented medication-related issues.

The physician explained during our interviews that he covers all medication benefits, side effects and alternatives with patients as he proposes them. Nurses typically cover the information again and ask patients to sign consent forms, which was the case here. Printed drug materials are provided on request, and physicians do not enter decisional capacity statements in the records. Patients are presumed to have decisional capacity unless they present otherwise. The social worker/therapist recalled talking with the family on the 15th about their worries over the patient's history with Abilify and then alerting the physician who in turn addressed it directly with them. The physician said he told the husband about how the patient asked for Abilify, that she was agreeable with it and did not raise concerns about adverse side effects. He discussed an alternative medication with the husband and the patient's mother, and both agreed with the option. He then met with the patient who was also agreeable, and Abilify was discontinued. Regarding the medication error, nursing staff and the physician assured the HRA that the patient was monitored closely. She was taken for evaluation and displayed no reactions to the medication. The physician said that in his medical opinion, in no way did the patient condition decline from the Abilify dose.

CONCLUSION

Chicago Behavioral policy calls for informed consent when prescribing psychotropic medications for all patients regardless of admission status, via explanation of the drug's purpose, risks, benefits and alternatives, primarily by the physician but by a nurse when the physician is

unavailable. The physician in that case must confirm the explanation with the patient within two working days. Neither written drug materials nor decisional capacity are mentioned, however "legal capacity" is defined in the policy as an adult having no "adjudicated incompetence".

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 or a declaration for mental health treatment under the Mental Health Treatment Preference Declaration Act.*
> (405 ILCS 5/2-102a-5).

The primary issue is informed consent, the patient's right to choose her treatments in other words, which she did for Abilify per the documentation. But informed consent for psychotropics must be based on oral *and* written information and the patient's physician-determined capacity to decide, which was failed by Chicago Behavioral Hospital along with the medication error in this case. When the error was discovered and when the patient complained of stiffness, she was immediately evaluated by medical professionals who found no related effects, and the clinical symptoms the patient presented on the unit were the same before and after the Abilify dose according to all psychiatric evaluations. There is no evidence of a decline in her condition. A rights violation is <u>substantiated</u> in the failure to provide written Ability information and to determine the patient's decisional capacity.

<u>RECOMMENDATIONS</u>

-Policy strays from Code requirements and must be revised to include written education materials and the physician's written capacity statements at the time psychotropics are proposed, not within two working days. (405 ILCS 5/2-102a-5).

-Physician and nursing staff must be trained on the Code's complete informed consent requirements and the revised policy.

SUGGESTION

-The informed consent policy identifies "legal capacity" as not having been adjudicated incompetent, implying that such patients are free to "manage their affairs", i.e., make treatment decisions. Competence is often thought of as a legal determination while capacity is a medical determination that can change with a person's condition. The Code only refers to capacity, regardless of legal status, and Chicago Behavioral is encouraged to revise the policy's language.

Emergency Haldol:

The record held several questionable incidents where the patient was given injections, and one was unclear if it was given willingly or forced. On her first day, October 9, Haldol and Ativan injections were given for anxiety and there were no further documented explanations. The physician's October 13 note referred to the patient getting an injection the previous evening for inappropriate behavior toward staff. Nursing notes from that evening state that the patient was yelling, screaming and was verbally aggressive but no indication of an injection, however a psychiatry note added that the patient was "highly agitated, making threats, got PRN (as needed)". There was no corresponding restriction notice. According to a PRN administration note on the 14th, the patient had an altercation with peers, used a lot of profanity and was belligerent. Her behavior continued to escalate despite attempts to redirect; she was offered by mouth medication, which she refused and was given an injection. There was no accompanying restriction notice. On the 17th at 10:05 a.m. she was given a Haldol injection because "I need something to calm down." She was quoted later at 3:30 p.m. to say that the staff lied to her, that she asked for Invega and not Haldol. The note further stated that the social worker had called the patient's husband and he refused to allow the patient to have Invega. There was no accompanying restriction notice. At 5:30 p.m. on the 17th she received Haldol and Benadryl injections for being physically and verbally aggressive. "Pt. loud, bizarre behavior, argumentative, pacing…verbally aggressive, 'you lied to me' repeatedly. Pt. escorted to her room, started to hit staff…[injection] given…." This incident carried a restriction notice that stated she was agitated and yelled at staff, "You lied to me"; she postured toward a nurse and threw objects at the staff. There was no indication of whether the patient had an emergency intervention preference and whether it was used. No one was to be notified of the restriction according to the notice. The patient's designated emergency treatment preference, if any, is not documented on her treatment plan.

The staff we interviewed were unable to explain why there was only one rights restriction notice completed. Regarding emergency interventions, the nursing director informed us that they use a crisis care plan sheet, separate from the treatment plan to list any designated emergency treatment preferences. He said that according to this patient's crisis plan, she preferred medications, time out and seclusion in that order.

CONCLUSION

The hospital's emergency medication policy states that adult patients have the right to refuse medication and if refused, it shall not be given unless necessary to prevent serious and

imminent physical harm to themselves or others. A patient rights restrictions policy states that justification for any restriction will be reflected in the record. Neither require the completion of restriction notices.

The Mental Health Code states that patients and their substitute decision makers must be given opportunities to refuse medications. If refused, they shall not be given unless it is necessary to prevent serious and imminent physical harm and no less restrictive alternative is available. (405 ILCS 5/2-107). Whenever a right under Chapter II is restricted, including the right to refuse medications, a written notice of the restriction and the reasons therefor must be entered in the record and be provided to the patient and any person or agency he or she so designates. (405 ILCS 5/2-201).

The question is whether emergency injections were necessary under Code standards. Incidents on the 12th, 14th and the first one on the 17th were no doubt given without choice. Yelling, screaming, being verbally aggressive, agitated and threatening on the 12th without further explanation does not meet the need to prevent *serious and imminent physical harm* and there was no completed restriction notice to further justify. Likewise, on the 14th: having an altercation with peers, using profanity, being belligerent and continuing to escalate without further supportive language and no restriction form. On the first incident of the 17th, the documentation states that the patient asked for something to calm down and that she later found out she was given Haldol without her knowledge when she asked for Invega. She had no opportunity to refuse the Haldol. More concerning is the staffs' reliance on the husband's treatment directives about the Invega, refusing her to have it when he was not her substitute decision maker. That scenario likely caused the second incident later that evening. The complaint is a <u>substantiated</u> rights violation.

<u>RECOMMENDATIONS</u>

-Require appropriate staff to only give emergency medications with supportive documentation to prevent serious and imminent physical harm when no less restrictive alternative is available. (405 ILCS 5/2-102a).

-Revise policy to include the completed restriction notices every time a right under Chapter II including the right to refuse medication is restricted.

-Physicians and nursing staff must be trained on the Code's right to refuse medication and notification requirements and the revised policy.

<u>SUGGESTION</u>

-Ensure that all designated emergency intervention preferences are noted on respective treatment plans. (405 ILCS 5/2-200; 2-102a).

-While the HRA acknowledges the importance of family input with treatment planning, we caution the hospital against relying on medication directives from them when the adult patient who maintains her rights is the one to consent or refuse.

RESPONSE

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