Inappropriate use of psychotropic drugs lands former DON in prison

The use of psychotropic drugs in long-term care is a significant issue that every facility deals with. This article examines a highly unusual case and also suggests what nursing facilities can expect from government regulators.

On January 9, Gwen Hughes, a former Director of Nursing (DON) at a skilled nursing facility, was sentenced to three years in state prison, according to the California Attorney General (AG). Hughes pled no contest to a felony count of elder abuse with an added allegation that the abuse contributed to the death of a nursing home resident. She was also charged with “assault with a deadly weapon, to wit, Risperdal, a psychotropic medicine.” Because of their complicity in the “convenience drugging,” the facility’s former medical director and a former pharmacist also were charged with elder abuse, resulting in death; and assault with a deadly weapon (psychotropic medications). Additionally, the facility’s former chief executive officer was charged with eight felony counts of elder abuse. According to the AG, she “allowed the staff to forcibly administer psychotropic medications to patients for their own convenience, rather than for their patients’ therapeutic interests.” [1]

In a gross deviation from accepted standards of care, Hughes, as DON, would initiate Interdisciplinary Team (IDT) meetings where she directed the pharmacist to write prescriptions for antipsychotic drugs for residents she considered “troublesome.” Apart from the obvious problem with a nurse ordering drugs, Hughes ordered those drugs “not for therapeutic reasons, but instead to control and quiet them for the convenience of the staff.” But Hughes had willing accomplices. The pharmacist wrote the orders and the nurses administered the medication to the residents. For his part, Dr. Hoshang Pormir, the former medical director, signed the orders after the IDT meeting—sometimes, three weeks after the medication was given. Moreover, he neglected to examine the residents to determine if the psychotropic medications were medically necessary, according to the AG.

Astonishingly, when a resident refused the medications, she was “held down and injected with the psychotropic medicine by force.” According to a state investigator, “it took 4 or 5 staff to hold [the resident] down to administer the injection [Risperdal] against her will.” Three residents died as a result of the “convenience drugging,” while the others suffered serious adverse effects such as weight loss, lethargy, confusion and dehydration, according to official documents.

Former Attorney General Edmund G. Brown, Jr., stated, “As [nursing home] administrator, Pamela Ott was ultimately responsible for safeguarding the welfare of her patients. Instead, Ott abdicated her responsibility and allowed the staff at the Kern Valley Hospital to forcibly sedate patients who questioned their care.” Ott was charged with conspiracy to commit an act injurious to the public health based on her failure to adequately supervise the DON, whom she had hired. After pleading no contest, she was sentenced to three years formal probation and 300 hours of volunteer service. Dr. Pormir was also sentenced to 300 hours of volunteer service and was placed on probation by the California Medical Board. As a condition of probation, he is prohibited from practicing medicine in skilled nursing facilities, convalescent homes and assisted living facilities during his probation. The former pharmacist, Debbi Hayes, also pleaded no contest to a felony charge and was a cooperating witness for the State.

WHAT PROVIDERS CAN EXPECT

The actions described above represent a disturbing and highly unusual aberration. However, LTC providers need to continuously examine their use of antipsychotic drugs. In May 2011, the HHS Office of Inspector General (OIG) released a report, Medicare Atypical Antipsychotic Drugs Claims for Elderly Nursing Home Residents, in which it noted that in 22 percent of the atypical antipsychotic claims it reviewed, the medications “were not administered in
accordance with CMS standards regarding unnecessary drug use in nursing homes.” [2] The OIG launched a new initiative for nursing facilities that began in 2013. It will assess antipsychotic drug use in LTC facilities and will pay particular attention to both the percentage of residents who receive these drugs as well as which drugs are most commonly administered.

Providers can also expect heightened scrutiny by state survey teams. The Centers for Medicare & Medicaid Services (CMS) has intensified its efforts to reduce inappropriate antipsychotic drug use. As such, surveyors will focus on whether facilities are using the lowest possible dose of an antipsychotic for the shortest duration. They will ascertain whether the facility sought input from the resident (if possible) and/or the family or responsible party as well as from the interdisciplinary team members. Providers can anticipate that surveyors will also ask how the facility manages residents with dementia. Additionally, surveyors will examine whether the comprehensive assessment and care planning considered reducing or eliminating antipsychotic drug use.

Facilities’ staff are familiar with the federal requirements dealing with both chemical restraints and unnecessary drugs (42 C.F.R. §§ 483.13(a), 483.25(l), respectively). Adequate documentation should demonstrate that antipsychotropic drugs are being given for clinically justifiable reasons and not as chemical restraints. Residents without a history of antipsychotic drug use should not receive these drugs unless necessary to treat a specific condition as diagnosed and documented in the clinical record. For those residents with a history of antipsychotic drug use, the regulations require gradual dose reductions and behavior interventions, unless contraindicated. Facilities can expect surveyors to look even more closely at how well they comply with these requirements.

There are a number of state and national initiatives currently under way that offer a wealth of information and resources to providers. For example, the American Medical Directors Association (AMDA) recently sent a letter to medical directors of nursing facilities asking them “to join with AMDA and CMS in the nationwide effort to reduce the unnecessary use of antipsychotic agents by refocusing the interdisciplinary team on a better understanding of the root cause of dementia related behaviors.” [3] CMS has instituted a National Partnership to Improve Dementia Care in Nursing Homes, which offers free webinars and other resources. Organizations such as the American Health Care Association (AHCA) and initiatives such as Advancing Excellence in America’s Nursing Homes, offer useful techniques, sample policies and clinical practice guidelines aimed at reducing antipsychotic medication usage.

Prudent providers will undertake all reasonable measures to decrease and/or eliminate inappropriate antipsychotropic drug use. Not only are such measures required by the regulatory scheme, they lie at the heart of resident-focused quality care.

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