Patients Without Capacity Leaving Non-Mental Health Acute Care and Emergency Units

Inpatient treatment teams are commonly challenged with managing patients with neurocognitive disorders like dementia and delirium who lack decision-making capacity (DMC) to consent to the treatment plan. In some cases, these patients do not want to remain in the hospital to complete the episode of care and may not be able to safely care for themselves in the community. This guidance specifically addresses these patients (either with or without a surrogate decision-maker) for whom VA hospitalization on an acute non-mental health inpatient unit is indicated, and who wish to leave prior to a clinically specified and physician-recommended endpoint. This guidance does not apply to patients who no longer have a medical indication for hospitalization (i.e., they no longer require ongoing inpatient treatment), and are awaiting disposition but are unsafe to return home.

Clinicians may experience an ethical conflict between their professional obligation to promote the patient's well-being and prevent harm from an unsafe discharge, and their obligation to follow applicable laws and respect a patient's right to self-determination and to not be held against their will. In these situations, treatment teams should provide care consistent with VA standards established in VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures[2] and as described in the 3 separate clinical scenarios and flowchart below.

In contrast to the scenarios described in this guidance, situations when the patient may meet state-based criteria for either a mental health hold or commitment should be managed by licensed mental health professionals. District Counsel can provide support to clinical staff as needed.

NOTE: Some facilities have attempted to address the subject of this guidance by following recommendations in the literature and the practice at their academic affiliate by implementing "medical hold" processes whereby the patient may be held against their will in a medical hospital to promote their health and well-being.[3-4] For facilities that are using, or plan to use such "medical hold" practices, we are not aware of any authority that exists for such processes. We advise facilities consult with their District Chief Counsel to ensure their local practice is supported by existing Federal law.

This guidance does not address the general clinical and ethical challenges of caring for inpatient Veterans with distressing and dangerous behaviors that can undermine the safety of other patients and staff and that may require co-management with mental health professionals. Further guidance about these challenges can be obtained from your facility Disruptive Behavior Committee[5] and/or your mental health professional staff.

Scenario #1: When the patient does NOT require emergency medical care, lacks DMC to provide informed consent for the episode of further needed inpatient treatment, but HAS a surrogate: The practitioner must obtain informed consent from the surrogate for the treatment plan of continued hospitalization over the patient's objection, and document it in the patient's health record (see VHA Handbook 1004.01, paragraph 14). The informed consent discussion with the patient's surrogate (and including the patient if feasible) should address what strategies may be required to safely manage the patient in the hospital and prevent the patient from leaving using non-restrictive or the least restrictive means possible. For example, this could include any combination of the following: an observer/attendant or 1:1, use of a crisis team for patient distress, and/or temporary physical or chemical restraints. (See VHA

Handbook 1160.06, Inpatient Mental Health Services, September 16, 2013,[6] 38 CFR 17.33(d) and The Joint Commission Hospital accreditation standards for further guidance). If after the informed consent discussion, the surrogate prefers and consents to the patient leaving the hospital, the practitioner should document this discussion in the health record including the risks and likely consequences of that decision along with any measures designed to mitigate potential harms (e.g., home health aides, life alert devices, etc.). This discussion should also include a discharge plan that will enable the patient to be safely cared for in a less restrictive environment as soon as feasible and facilitate the return to medical care if desired.

Scenario #2: When the patient does NOT require emergency medical care, lacks DMC to provide informed consent for the episode of further needed inpatient treatment, and does NOT HAVE an authorized or available surrogate: Detaining the patient in the hospital under these circumstances has neither legal nor VA policy grounding and is not within VA's current authority. Although a longer-term VA-wide solution to this challenge is not yet available, there are short-term interventions staff can implement that may help to protect these patients from harm in accord with accepted ethical and legal standards of practice.

For some patients, particularly those with significant cognitive impairment, redirection and other Veteran-centered activities may be effective in addressing the patient's desire to leave the hospital. These strategies may include providing a favorite snack or meal for the patient, distracting the patient with known conversation topics of interest, or redirecting the patient away from hospital exits. Geriatric and/or mental health professionals can provide evidence-based recommendations and assist the treatment team with managing the patient's behaviors.

Additionally, calling for immediate clinical support from mental health and social work is frequently helpful in deescalating a challenging situation and for identifying available safety net resources in the community that may reduce harm. For several reasons, summoning and directly involving VA police in these situations should generally be avoided with few exceptions. VA police lack the legal authority to detain or physically intervene with patients in this clinical scenario. Although clinicians may believe that VA police presence may be both calming and deterring for some patients, police may not be able to effectively de-escalate the situation and justice-involved Veterans may react negatively to having police involved in their clinical care. Police presence should ideally be commensurate with the potential for serious or imminent harm whether the patient remains in the facility or attempts to leave. Facilities should proactively collaborate with their police services leadership so that there is a consistent approach that addresses these concerns.

Finally, for these patients without an authorized surrogate and whose capacity is unlikely to be restored, the facility should as soon as feasible, consult with their District Counsel regarding legal guardianship proceedings in order to facilitate a longer-term solution for the patient's health care decision-making. Also, when the patient's clinical status changes, (e.g., the patient no longer requires inpatient care or their DMC is restored) the process specified in this section may no longer apply.

Scenario #3: When the patient requires emergency medical care, is unable to provide informed consent and does NOT HAVE a surrogate (or the surrogate is not available within a clinically indicated timeframe to prevent hazard to the life or health of the patient): In these situations, when the practitioner must provide a treatment or procedure to preserve life or avert serious impairment of their health that can only be provided in the hospital, the patient's consent is implied by law (see 38 C.F.R. 17.32(c)(7) and VHA Handbook 1004.01, paragraph 15a.). The ethical basis for this practice derives from the presumption that reasonable people would consent to the emergency treatment if they were able

to. When significant patient restraint is needed to render emergency care, VA Police may and should provide clinical assistance at the direction of the responsible practitioner, but the police do so as VA employees, not as VA police officers acting in a law enforcement role. The responsible practitioner should document in the health record the clinical rationale for emergency treatment as soon as possible. Once the patient no longer requires emergency medical care, the process specified in this section no longer applies.

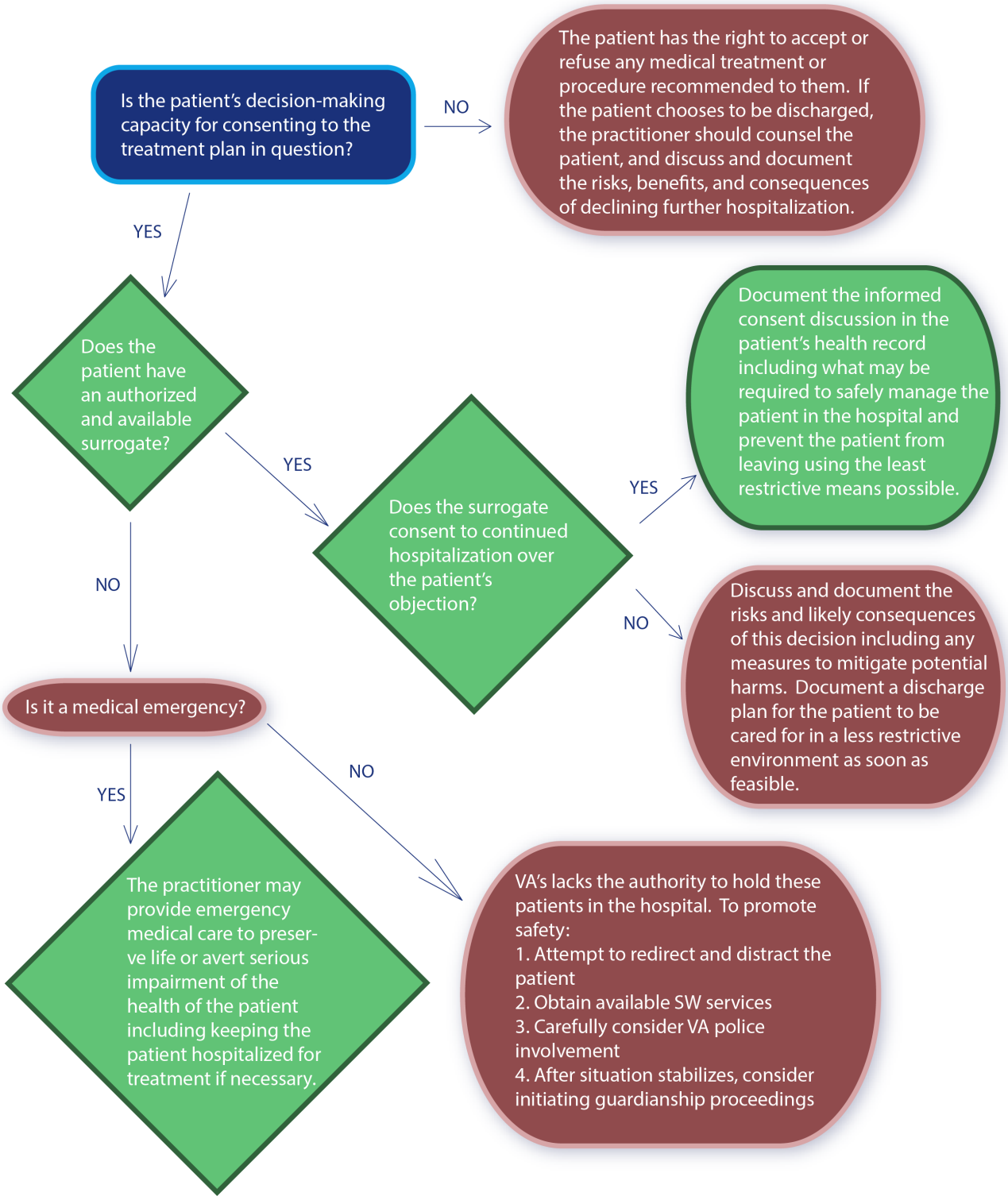
Questions about this guidance should be addressed to the VHA National Hospital Medicine Program at vha11spec11hospitalmedicine@va.gov or the VA National Center for Ethics in Health Care (10ETH) at vhaethics@va.gov.

Please see the Frequently Asked Questions (FAQ) for questions related to this guidance.

References:

1. VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures Amended September 17, 2021
2. Cheung EH, Heldt J, Strouse T, Schneider P. The Medical Incapacity Hold: A Policy on the Involuntary Medical Hospitalization of Patients Who Lack Decisional Capacity. Psychosomatics. 2018 Mar-Apr;59(2):169-176.
3. Heldt JP, Zito MF, Seroussi A, Wilson SP, Schneider PL, Strouse TB, Cheung EH. A Medical Incapacity Hold Policy Reduces Inappropriate Use of Involuntary Psychiatric Holds While Protecting Patients From Harm. Psychosomatics. 2019 Jan-Feb;60(1):37-46.
4. VHA Directive 5019.01, VHA Workplace Violence Prevention Program, Amended February 22, 2022
5. VHA Handbook 1160.06, Inpatient Mental Health Services, September 16, 2013

Patients Without Capacity Leaving Non-Mental Health Acute Care and Emergency Units



VA | U.S. Department of Veterans Affairs
Veterans Health Administration
National Center for Ethics in Health Care

VHAEthics@va.gov