PHYSICAL HEALTH TREATMENT

LAW

Each patient shall... "Have a right to receive **prompt and adequate treatment**... **appropriate** for his or her condition..."

§ 51.61(1)(f), Wis. Stats. [Emphasis added.]

"Each patient shall be **treated with respect** and with recognition of the patient's **dignity** by ... all licensed, certified, registered or permitted **providers of health care** with whom the patient comes in contact."

DHS 94.24(2)(b), Wis. Admin. Code [Emphasis added.]

DECISIONS

1. An inpatient at a county hospital had a pre-existing **blood clotting condition** for which she was taking a **blood thinning medication**, coumadin. She felt staff delayed a medical assessment by not promptly arranging for a pro-thrombin time test (PT) reported as International Normalized Ratio (INR) that shows the blood level of the blood thinning medication. It is necessary that **blood tests** be done at **regular intervals** to **monitor** the level of this medication within one's system. It must remain within a certain therapeutic range in order to ease the risk of blood clotting (if the medication level is too low) or the risk of undue bleeding (if it is too high). She was given the PT/INR test **four days after her admission**. It was noted that her coumadin level was much higher than the recommended therapeutic level. Once levels are stabilized, the PT/INR tests should be done up to a month apart. Here, staff had no reason to believe a PT/INR had not been done for as long as a month, so they could justifiably have believed that waiting several days was not a major medical concern. Given these facts, **failure to conduct the blood tests** sooner than four days after admission does **not constitute a violation** of "prompt and adequate" treatment. The fact that the results were very high in this situation does not automatically make it a rights violation. (Level III decision in Case No. 99-SGE-08 on 3/23/01.)

2. An RN **assessed** a patient and **denied** his **request for a PRN for Xanax**, which he requested to help him sleep. The records indicate he was asleep within an hour, which supported the RN's decision. The patient, on appeal to Level IV, **stated he was faking being asleep**. However, the decision to deny him the medications was appropriately **based on the facts available** to them at the time. **No violation** of his rights was found. (Level IV decision in Case No. 99-SGE-05 on 3/29/02, upholding the Level III.)

3. The **county** is **ultimately responsible** for the **health** and safety of a client to whom they provide services. **Even though they have a contract** for an

independent service provider to do the hands-on services, the contracted agency's failure to perform its duties is also the county's failure. The **county must monitor** the providers it contracts with in order to ensure that vital services are provided for their clients. (Level III Decision in Case No. 03-SGE-04 on 6/15/04.)

4. The **sister/guardian** of a woman filed a grievance about the **care** the woman had received while she was living in her own apartment. She had been receiving supportive home care services from an independent service provider under a general **contract with the county**. The guardian alleged lack of care causing deterioration in health to the point of needing immediate medical attention. Staff's tasks included providing "acu-checks," monitoring her bathing three times a week and providing medical treatment for her hands and legs with sores. It was found that the **woman's rights were violated** when the **contract agency** did **not complete the assigned tasks** during a period of time and the woman's **health deteriorated** as a result. (Level III Decision in Case No. 03-SGE-04 on 6/15/04)

5. **Following an incident of restraint and seclusion**, a **prompt medical assessment** of the patient should always occur. (Level III Decision in Case No. 08-SGE-11 on 2/23/10)

[Document last updated: 02/15/12]