MEDICATIONS - - FREE FROM UNNECESSARY OR EXCESSIVE

THE LAW

Each patient shall..."Have a right to be **free from unnecessary or excessive medication** at any time. No medication may be administered to a patient except at the **written order of a physician**. The **attending physician** is responsible for all medication which is administered to a patient. A **record of the medication** which is administered to each patient shall be kept in his or her medical records. Medication may not be used as **punishment**, for the **convenience of staff**, as a **substitute for a treatment program**, or in quantities that **interfere** with a patient's **treatment** program..."

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

“(5) The treatment facility shall maintain a patient **treatment record** for each patient which shall **include**:

(a) A specific statement of the **diagnosis** and an explicit description of the **behaviors** and **other signs or symptoms** exhibited by the patient;
(b) **Documentation of the emergency** when emergency treatment is provided to the patient; and
(c) Clear documentation of the **reasons and justifications** for the **initial use** of medications and for **any changes** in the prescribed medication regimen.

(6) A **physician** ordering or changing a patient's medication shall ensure that **other members of the patient's treatment staff are informed about the new medication** prescribed for the patient and the expected **benefits and potential adverse side effects** which may affect the patient's overall treatment.
(7) A **physician** ordering or changing a patient's medication shall routinely **review the patient's prescription medication**, including the beneficial or adverse effects of the medication and the need to continue or discontinue the medication, and shall **document that review** in the patient's treatment record."

DHS 94.09, Wis. Admin. Code [Emphasis added.]

"Each **inpatient and residential treatment facility** that administers medications shall have a **peer review committee or other medical oversight mechanism** reporting to the facility's **governing body** to ensure proper utilization of medications."

DHS 94.09(8), Wis. Admin. Code [Emphasis added.]

DECISIONS

1. Where a hospital patient complained about an **error in medication administration**, the State Grievance Examiner **referred** the matter to the **Bureau of Quality**

Assurance for investigation. [BQA subsequently issued the hospital a citation for violation of state and federal regulations.] (Level III referral in Case No. 00-SGE-07 on 4/17/00.)

2. A client was **deprived of one of her medications** just prior to taking a long trip, due to a series of **errors and omissions** on the service provider's part. This was a **violation** of her right to prompt and adequate treatment. (Level III decision in Case No. 00-SGE-02 on 6/17/00, upheld at Level IV.)

3. A mother complained that her **son's condition was worsening** since his medications were discontinued. Her son's **doctor was on maternity leave** and the service provider would not temporarily assign him to another doctor. She was instructed to call back the next month when the doctor was scheduled to return. The **desperate mother** put her son back on the discontinued medication, without any medical assistance. The service provider **violated** the son's right to prompt and adequate treatment. (Level III decision in Case No. 00-SGE-08 on 7/28/00, upheld at Level IV.)

4. A doctor filed a **late entry** in a patient's chart **clearing up some confusion** over when a specific medication was given to a patient. While this **entry was not timely**, it **did not** mean the original **records were falsified**. (Level IV decision in Case No. 01-SGE-01 on 5/25/01, upholding the Level III.)

5. A woman complained about her doctor, alleging that the **medications he prescribed** for her may have **caused an adverse heart reaction** leading to an emergency visit to the hospital. This allegation was reviewed by the **Bureau of Regulation and Licensing** (BRL), which reviews medical allegations of malpractice or injury to others. BRL did not find that the heart reaction and emergency room visit were necessarily caused by the medication. The **grievance process defers to BRL's medical expertise** on such issues and thus there was **no finding** of any rights violation. (Level III decision in Case No. 00-SGE-03 on 9/12/01.)

6. A **PRN** ("as indicated") **order** does **not mean** the patient will receive the medication **upon demand**. A qualified medical professional, such as an RN, must make the **clinical decision** as to whether or not it is appropriate for the patient, based on an **assessment** of the **patient's condition** at the time. (Level IV decision in Case No. 99-SGE-05 on 3/29/02, upholding the Level III.)

7. 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.)

8. Where a patient received medications in dosages that made her **over-sedated** and caused her **blood pressure and pulse rate to drop** substantially, her right to be free from unnecessary or excessive medication was **violated**. However, the facility **mitigated** this violation by **recognizing the over sedation** and **taking steps** to reduce her medications. (Level IV decision in Case No. 01-SGE-08 on 8/27/02.)

9. There must be **sufficient evidence** to show it was **more probable than not** that a doctor **departed from professional judgment** in his prescribing medication to a patient **after a phone call** with her. Such evidence would have to come in the form of a **second opinion** from a **professional of equal or greater standing** than the doctor. Where there was no such evidence presented during the Level III review, the **finding of a rights** violation will be **overturned**. (Level IV decision in Case No. 02-SGE-04 on 9/19/03, overturning the Level III.)

10. In a situation where a **suicidal patient** has been **put on a new medication**, then **cancels her next appointment** with the doctor, the **clinic has a duty** to at least have someone **review** the situation to **see if follow-up contact** with the patient is necessary. There was **no evidence** that this was done here. While it could be assumed that, as a voluntary patient, she was exercising her right to discontinue treatment, there should have been **some determination** made as to whether or not to contact her. The **clinic** thus **violated the patient's right** to prompt and adequate treatment by not making that determination. (Level IV decision in Case No. 02-SGE-04 on 9/19/03.)

11. Patients have the **right** to have their **care and treatment coordinated** with **other treatment staff** who are involved in their care and treatment. A **doctor** ordering a change in a patient's medication **must ensure** that other members of the patient's **treatment team** are **informed** about the **new medication** and the **expected benefits** and **potential adverse side effects** which may affect the patient's overall treatment. (Level IV decision in Case No. 02-SGE-04 on 9/19/03.)

12. Where a **doctor knew** or should have known that his patient was seeing other professionals involved in her care, the doctor has a **duty** to at least **attempt to inform** the **other therapist** involved of a **change in medication**. If the patient's consent is required, the doctor should ask for it. Where no such attempt was made here, the doctor violated the patient's rights. (Level IV decision in Case No. 02-SGE-04 on 9/19/03.)

13. A **court decision** to **order medications cannot be challenged** in the **grievance process.** (Level III decision in Case No. 03-SGE-10 on 10/23/03.)

14. A **service provider** where the individual picked up his medications has **inadequate parking**, making it inconvenient for him at times. The service provider attempted to resolve this by offering him alternative times in which he could pick up his medication when the parking lot would be less crowded. These accommodations included: a) suggesting he pick up his medication on a Friday when the parking lot is

less busy; b) picking up his medication in the afternoon when the staff parking lot is less full; or c) speaking with his case manager to arrange picking up his medication at a different time than the set times. They were also willing to arrange for him to pick up his medication when he meets with his psychiatrist every three months for his psychiatric medication check up, thus saving him four trips a year. These **accommodations were reasonable** and **sufficient**. (Level III Decision in Case No. 03-SGE-08 on 7/14/04.)

15. The service recipient wanted to **receive his medications** in the **exact form** the pharmaceutical company sends it and as soon as they send it. However, his service provider had the **need to double-check all medications** being given to patients through a Patient Assistance Program (PAP). They do so through a local pharmacy. When they receive medications from any drug company they immediately send it to the pharmacy where it is checked, repackaged and dispensed. The pharmacy does not mix lot numbers or expiration dates, therefore each patient receives the same medication (with regards to freshness and lot number) as was sent from the drug company. The individual's desire to receive his medication just as it was sent from the drug company is understandable; however, so is the service provider's liability to make sure that he is getting exactly what medication he was prescribed from the drug company. The service provider agreed to have their professional staff open the medication, check its content, and dispense the medication as prescribed by his psychiatrist in order to avoid his medications having to go through the pharmacy, as requested. This **resolved** his complaint. (Level III Decision in Case No. 03-SGE-08 on 7/14/04.)

16. The service provider was concerned that a patient did not have a strong family/friend support network that would report unusual behavior. So they **required** him to come in to **pick up his medications** every **28 days**. This was required **in order to assess** him for abnormal psychiatric symptoms, adverse side effects, and the effectiveness of the medications he was receiving. While this assessment may seem very basic or even inadequate to the recipient, the **nurse** who dispenses the medication is **qualified** to be conducting this assessment and, if unusual behavior were present, they would extend the assessment. Since he was clear and present when he came to pick up his medications, the assessment was very brief. However, if he were not well, the assessment would be much more thorough and he would be asked to come into another room to speak privately with nursing staff for a more thorough interview. This issue was **referred to his psychiatric**. His psychiatrist can decide if they have developed a reliable history with him, sufficient to extend the amount of medication given to him at one time and thus lengthen the time between pick-ups. (Level III Decision in Case No. 03-SGE-08 on 7/14/04.)

17. The **psychiatrist prescribing** the medications has the **ultimate authority** to make **individualized decisions** for each patient. Individualized decision-making is a key element for providing prompt and adequate treatment services appropriate to each individual patient's condition. While the majority of patients may not be suitable for a full disbursement of their medications, psychiatrists and treatment providers need to

recognize individuals who are stable and consistent with their treatment programs and accommodate their request for dispensing increased amounts of medications at one time accordingly. (Level III Decision in Case No. 03-SGE-08 on 7/14/04.)

18. A client objected to the **medications she was given** during an **Emergency Detention**. Patients have a **right to refuse** medications in most situations. There is an **exception**, however, that **allows medications to be administered in an "emergency"** situation without the patient's consent. The hospital was relying on that exception when they gave her medications without her consent. (Level IV decision in Case No. 06-SGE-10 on 3/20/07)

19. It was **not a patient rights violation** to have an **internal medicine specialist** rather than a psychiatrist **provide a patient her prescriptions**, particularly since a psychiatrist initially evaluated her and provided a diagnosis and prescription recommendations. (Level III decision in Case No. 11-SGE-01 on 6/28/11)

[Document last updated: 02/15/12]