TREATMENT - - EVALUATION AND MONITORING OF

THE LAW

“(6) 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.

(d) Documentation that is specific and objective and that adequately explains the reasons for any conclusions or decisions made regarding the patient.”

(7) 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.

(8) 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.]

DECISIONS

1. A patient in an **outpatient methadone treatment program** was observed “**splitting his dose**” in a bathroom at the clinic. The clinic subsequently **increased** his “**monitoring level**” for a six-month probationary period. This did **not violate** his right to the least restrictive treatment. (Level IV decision in Case No. 99-SGE-02 on 5/24/00, upholding the Level III.)

2. An **inpatient**, admitted to county hospital via an “**Emergency Detention**” due to **suicidal ideation**, felt staff did not provide her enough time and attention in dealing with her concerns - especially, **why she was not eating meals**. She was depressed during much of her six days there. She refused several meals.

She wanted her meals served to her in her own room so she would not have to sit near a certain male peer. There was considerable charting as to the staff's plan to encourage the patient to eat meals and have proper nutrition and food intake. But two days passed with the patient not coming out for meals, and staff seemed to not be doing anything more to explore why she was not eating, and/or in what circumstances she would be able or willing to eat meals. Patients have a right to refuse meals. But, in this instance there were medical reasons why proper food intake was important, and the charting also stressed that eating meals was to be encouraged. That being the case, one might reasonably expect staff to do more than simply observe that a patient was not coming out to eat. They let her eat one meal in her room, then gave her a "take it or leave it" ultimatum. What really was the goal? Was it to encourage nutritional intake? Or to try to force compliance with the unit expectation that patients come out of their rooms to eat in the congregate setting? There was **no documentation** as to why they took that stance. No other approaches to encourage her to eat were made. Under these circumstances, the **lack of any documented team discussion** or decision was a **violation** of the patient's right to specific and objective documentation of the reasons and rationale for the decision that was made. (Level III decision in Case No. 99-SGE-08 on 3/23/01.)

3. 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.)

4. 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.)

5. 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.)

6. A father/guardian wanted to **choose** a different county **case manager** for his son. He noted that the Medical Assistance Waivers Manual emphasizes a choice of providers. The father wanted to choose a specific case manager who worked for the county. The county had only five case managers and had a solid rationale for why they were not willing to reassign the son to the case manager the father requested. They gave him the option of choosing either the county as a provider or an outside agency. Thus, the **county** was **providing** him with a **choice of provider**. The county was **not mandated** to provide him with a **choice amongst their own case managers**. The counties still maintain final decision-making authority in how they manage their staff and the workload that is assigned to those staff. No rights violation occurred. (Level III Decision in Case No. 03-SGE-06 on 2/18/04.)

7. The **county** is **ultimately responsible** for the health and safety of a client to whom they provide services. Even though they may 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.)

8. An independent agency working on a contract with the county did not have any documentation regarding services they provided because they moved offices and, apparently, those **files were lost during the move**. The missing files should have been retained for a minimum of seven years. Offices and agencies move locations or may close one of their offices over time, but their records must be retained. The **loss of these records is inexcusable**. The rights of the client were violated because the agency did not retain documentation as to the care and treatment of the client. (Level III Decision in Case No. 03-SGE-04 on 6/15/04.)

9. The **contract** between an independent service agency and a county **should have also been more precise**. The treatment plan and the expectations of care protocols should have been as specific as possible to reflect the client's individual needs and the tasks required in the contracted agreement with the agency. **Documentation** of the expectations, and their **implementation**, is **essential**. (Level III Decision in Case No. 03-SGE-04 on 6/15/04.)

10. 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.)

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