# Patient Rights, Patient Risks, and Patient Advocacy

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# Disclaimer

Nothing in this presentation should be construed as legal advice.

Please consult with your risk department and legal counsel.

# Course Outline

**Patients' Rights – Who, What, Where, When and Why**

- General Patient Rights, the ED, and Specific Rights in LPS Designated Facilities
- The Denial of Rights Process: Rationale, Required Documentation and Impact on Patients
- The Right to Refuse Medication
- The Right to Liberty, Consent, 5150 Issues, and the Clock

**Risks for EDs to Consider**

- Elopement and Risk of Harm
- Consent: Refusal of Diagnostic Medical Screening
- EMTALA
- Confidentiality Barriers & Treatment Needs: Exceptions that Allow Disclosures
- **Rights vs. Risks**

# Patients' Rights

Individuals receiving behavioral health services have the same legal rights afforded to every American citizen.

In **general acute care settings**, patients have many rights, for example, the right to:

- enjoy freedom from discrimination
- considerate, respectful care, and safe care
- know the names of licensed healthcare providers
- information about their illness
- informed consent
- non-consent
- the right to leave "AMA"
- have personal privacy respected
- confidentiality
- have visitors of their choice
- execute an advance directive, name an agent

# The Lanterman-Petris-Short (LPS) Act

- To end the inappropriate, indefinite, and involuntary commitment of mentally disordered persons;
- To provide prompt evaluation and treatment of persons with serious mental disorders or impaired by chronic alcoholism;
- To guarantee and protect public safety;
- To safeguard individual rights through judicial review;
- To provide individualized treatment, supervision, and placement services by a conservatorship program for gravely disabled persons;
- To protect mentally disordered persons and developmentally disabled persons from criminal acts

# Welfare and Institutions Code (W&I) 5325.1

**It is the intent of the legislature that persons with mental illness shall have rights including, but not limited to, the following:**

- (a) A right to treatment services which promote the potential of the person to function independently. Treatment should be provided in ways that are least restrictive of the personal liberty of the individual.
- (b) A right to dignity, privacy, and humane care.
- (c) A right to be free from harm, including unnecessary or excessive physical restraint, isolation, medication, abuse, or neglect. Medication shall not be used as punishment, for the convenience of staff, as a substitute for program, or in quantities that interfere with the treatment program.
- (d) A right to prompt medical care and treatment.

# W&I 5325.1 (continued)

- (e) A right to religious freedom and practice.
- (f) A right to participate in appropriate programs of publicly supported education.
- (g) A right to social interaction and participation in community activities.
- (h) A right to physical exercise and recreational opportunities.
- (i) A right to be free from hazardous procedures.

# Rights in LPS Designated Facilities

- Upon admission to an LPS facility for evaluation or treatment, every patient (both voluntary and involuntary patients), shall immediately be given a copy of a State Department of Health Care Services prepared patients' rights handbook according to WIC §  5325 (i)
- Handbooks can be requested through your local Patient Advocate or through DHCS: https://www.dhcs.ca.gov/services/pages/office-of-patients-rights.aspx

# Notification of Rights (W&I 5331)

A patient who leaves a public or private mental health facility following evaluation or treatment (both voluntary and involuntary) must be given this statement:

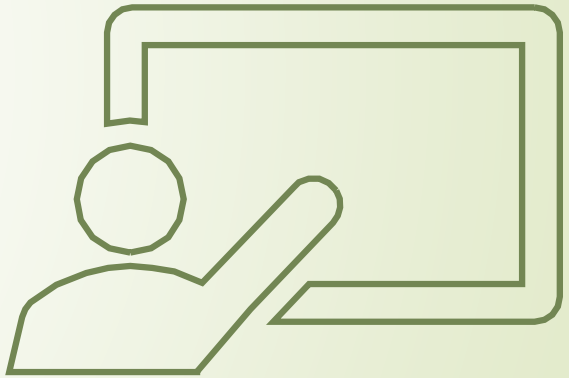
**No person may be presumed to be incompetent because he or she has been evaluated or treated for mental disorder or chronic alcoholism, regardless of whether such evaluation or treatment was voluntarily or involuntarily received.**

This explains why a patient can refuse medication, regardless of the setting.

Persons with serious mental illness and persons detained pursuant to LPS procedures are legally presumed to have capacity.

# Rights that Cannot be Denied: W&I 5325, 5325.1

- Humane care
- Be free from abuse or neglect
- Social activities and recreation
- Education
- Religious freedom and practice
- Access to services free from discrimination
- To see and receive services of a patient advocate



# Rights that Can be Denied with Good Cause in an LPS Facility

The right to:

- Wear one's own clothes and keep personal items
- Keep and spend a reasonable sum of money
- Access to personal storage space for private use
- Have visitors, each day
- Access to telephones to make and receive confidential calls or have calls made on your behalf
- Have ready access to letter-writing materials, stamps, and mail
- Receive mail unopened

# Denial of Rights, continued

- Patient rights may not be waived by parent, guardian or conservator
- Rights may be denied only when “good cause” exists to deny the rights granted to patients under W&I 5325
- Good cause is legally defined as a situation when the professional person in charge of the facility, or his or her designee has good reason to believe any of the following:
  - 1.Exercise of the specific right would be injurious to the patient, or
  - 2.There is evidence that the right, if exercised, would seriously infringe on the rights of other patients, or
  - 3.The institution or facility would suffer serious damage if the specific right was not denied; AND
  - **there is no less restrictive way of protecting the interest specified in the reason for denial.** (9 CCR 865.2)

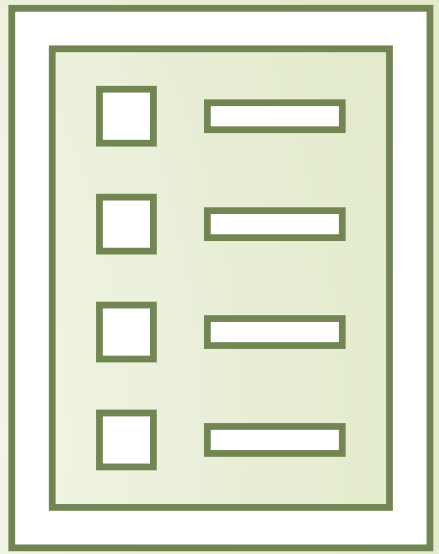
# Good Cause for Denial of Rights

1. Must have clear relationship to right denied.
2. Rights may not be denied as a condition of admission, as part of a treatment plan, or for the convenience of staff members
3. Rights cannot be treated as a privilege to be “earned”

Consider Different Scenarios:

- A patient continuously calling 911; a patient actively attempting to self-harm with clothing; a specific visitor causes the patient distress to the point of harmful behaviors
- Do all of these meet the criteria for Good Cause? What are some possible less restrictive ways of promoting safety? Were all efforts of less restrictive measures documented in the medical record?

# Analysis of Denial of Rights



1. Is there a right?
2. Is that a right that can be denied?
3. Is it an absolute denial or a restriction?

   If it is a restriction, is it within reasonable limits (*e.g.*, coffee in the morning and meals, regular visiting hours)?
4. Have all lesser restrictive measures failed?  Are these documented?
5. Is there good cause for the denial?

   Remember: injury to the person, infringing on another's rights, or serious damage to the facility
6. Is the right restored as soon as possible?

# Documentation for Denial of Rights

Clients are entitled to an explanation for each denial.

Each denial must be noted in the patient's treatment record "immediately." (9 C.C.R. 865.3).

The documentation must include:

1. The specific right being denied
2. The date and time of denial
3. A specific and clear statement of good cause
4. Less restrictive alternatives tried
5. Additional legal requirements (signatures, time limits)

# Restoration of Rights and Reporting

Once the good cause for denial of a right is no longer present, the right must be restored immediately (9 C.C.R. 865.5).

- The date of the restoration of the right must be documented in the chart.
- All denials of rights must be reported each quarter to the local County Mental Health Director, who then submits a quarterly report to the Patients' Rights Specialist, CA Department of Health (9 C.C.R. 866).

# W&I 5325.2 The Right to Refuse Medication

Any person subject to detention pursuant to Section 5150, 5250, 5260, or 5270.15 shall have the right to refuse antipsychotic medication.

# Right to Refuse Medication

Patients may refuse psychotropic medications unless:

1. It is an emergency
(Note specific legal definitions)

2. A court has determined that the person lacks capacity to make this decision (Riese vs. St. Mary's Hospital)

3. Assent: if a patient accepts medication after being verbally informed of risks, benefits and alternatives, and of their right to refuse, it is not required that they then sign an informed consent form or verbally agree (W&I 5332(a))

# Voluntary Patients in the ED

It is frustrating for providers when a patient accepts a EMTALA medical screening exam, but refuses recommended care

- If the provider is concerned about the patient's safety, the provider may wish to seek out a surrogate decisionmaker for physical healthcare decisions

- Is threatening to put someone on a 5150 hold in order to force medical care a violation of their rights? Is it legal? Is it appropriate?  NO.

# Right to be Free from Seclusion and Restraints

- Patients have a right to be free from seclusion and restraints that are placed as a means of coercion, discipline, convenience, or retaliation by staff members
- This includes medication when that drug is not standard treatment for the person's medical or psychiatric condition (H&S Code 1180.4(k))
- Restraints may be physical, chemical, or mechanical

# Risks vs. Rights

Situations to Consider

- Self-harm
  - Suicide attempt
- Compliance violations
  - Failure to address “ligature risk”
- Harm to self, staff members, other patients, visitors due to inappropriate behavior
- Elopement: does this lead to dangerousness or harm via inability to care for basic needs?
- But what about patient’s rights?

# Rights vs. Risks continued
## What Would you Do?

1. Check with legal counsel and/or risk?  “Pick your lawsuit”
2. Consider using the denial of rights process, if appropriate
3. Is 1:1 staffing available?

# Risks vs. Rights continued

Competing interests:

- Compliance issues
- Possible lawsuit
- Harm to patient/staff/others
- If you do / if you don't

# What are Some Options to Consider?

1. Always check with legal counsel and/or risk
2. Restrain the patient and hope the person remains safe, does not get injured, and/or file a grievance or lawsuit?
3. Let the patient go, and call 911 if they walk out the door?

# Patients have the Right to be Free Once 72 Hours have Passed

- Unless the doctor has clinically determined that the individual meets the criteria to continue to be held on an involuntarily basis via W&I “5250” (this is also known as the “two week cert” or the “14 day hold”)
- After the 72-hour period, the law explicitly states that a third party review (Certification Review Hearing) is necessary in order to continue detaining someone against their will
- The involuntary hold process does not give authority or consent to treat the patient

# After 72 Hours, and the Patient is Still in the ED

- First, why do you think that 72 hours have passed?
  - When did the clock start?
    - W&I Code 5150 indicates that this is when the person is first taken into custody
    - W&I Code 5151 indicates that this is when the person is admitted into designated facility
- Counties handle this differently

# What Would you Do?

- Scenario: Sixty hours have passed, and you have finally found a bed for the patient stuck in your ED. The designated facility now tells you they start the clock at §5150 and will not accept the patient unless you initiate one of the following:
  - “Fresh hold”
  - “Serial hold”
  - “Parking lot hold”
- **What would you do? What does the law say?**

# What Would you Do? (continued)

- Scenario: You have located a bed, but are waiting for transportation. The 72 hours have passed.
  - Do you/can you prevent the patient from leaving your facility?
  - Are restraints appropriate?
  - Allow your patient to leave?
  - Other…

# What Would you Do? (continued)

- What if you discover a medical emergency during the initial exam that requires admission to an acute care unit?
- If you admit to an acute care unit, what happens to the involuntary hold placed in the community?
- Is it void?  Paused?  Still in effect?
  - No one knows: the law is silent about this event!

# Privacy Issues and Challenges

Your patient has told mental health providers they do NOT have permission to talk to other providers

(can they talk anyway, as it is permitted for “treatment purposes?”)

This is important because the patient has been brought to your ED on a hold, and you want as much information as possible

# Privacy Issues

- **AB 1119** explicitly permits communication of patient information during the provision of emergency services between mental health professionals and emergency medical personnel at the scene of an emergency, or in an emergency transport vehicle, or other professional person or emergency personnel at a health facility
- Note that this bill changed the numbering of subsections under W&I 5328

# Privacy Issues, continued

- How do you legally and ethically get the information that you need and/or want in order to provide good care?
  - Do your providers, or providers in the community that you work with, need additional training state and federal confidentiality laws?
- HIPAA allows sharing information for “treatment purposes” (45 CFR 164.506)
- “Treatment” is defined broadly:
  - 45 CFR 164.501: *Treatment* means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.

# Privacy Issues: Substance Use Disorder

- 42 CFR Part 2 Section 2.51: Medical emergencies.
  - (a) General rule. Under the procedures required by paragraph (c) of this section, patient identifying information may be disclosed to medical personnel to the extent necessary to meet a bona fide medical emergency in which the patient's prior informed consent cannot be obtained.

# Making Things Better when Balancing Risks and Rights

- Identify problem areas
- Develop policy and community standards where the law is silent
- Invite everyone: Patients' Rights Advocates, NAMI, law enforcement, County Mental Health, CBO's, transport, designated facilities, psychiatric hospitals, etc.
- Meet on a regular basis on a friendly basis to make difficult conversations easier

# Things to Consider

- Research whether law, regulation, CMS Condition of Participation, or Joint Commission standard addresses the issue
- Consult compliance, risk, and legal counsel
- Consult with other, similar facilities in your community
  - Consider establishing a “standard of care” to address issues that are not already guided by the above
- Re-evaluate internal Policies and Procedures (the following topics may be useful)

# How do you Handle Non-Consent?

- Force treatment and accept risk?
- Work with patient to get laboratory testing done?
- Discharge patient?
- Forego non-psychiatric evaluation and treatment?
  - Hope the designated hospital will accept the patient

# How do you Prevent Self-Harm?

- Deny rights to certain belongings with good cause
  - Shoelaces, jewelry, other ligature risk
- Provide one-to-one staffing/ sitters?
- Are restraints clinically and legally appropriate?
  - Physical
  - Chemical – sedative medications
  - Safe room/safety cell environment?

# How do you Protect Staff?

- Panic buttons to call law enforcement or security
- Code phrases
- Use of restraints
- Seclusion
- Safe room (e.g., with lock) for patient
- Safe room (fish bowl) for staff

# How do you Avoid Regulatory and Enforcement Citations?

- While still providing care in a legal manner
- While still providing care in an ethical manner
- What is an appropriate transfer of an unstable patient with a psychiatric emergency
  - Is it an EMTALA issue if the patient refuses the transfer

## Rights vs. Risks

No Easy Answers, and Likely no one Answer Works all of the Time

- Identify risks
- Identify rights
- Identify competing interests
- Try to find a balance

# Questions? Thank you!

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