Clarification re: *The Rights of Psychiatric Patients and Intramuscular Medications*

In discussing the May 2015 clinical alert *The Rights of Psychiatric Patients and Intramuscular Medications* with hospitals, the following concerns have arisen:

1. Because the practice in many hospitals has been for providers to write orders for medications "PRN (often for agitation) PO or IM," hospital surveyors have found multiple patients who have received upwards of 20 IMs given during a four or five day hospital stay. This practice circumvents the patient's right to refuse medications, is likely traumatic, and puts the onus of decision-making and behavioral assessment on the nursing staff who are medicating without physician input or notification.

2. The focus of the clinical alert was on the involuntary nature of intramuscular (IM) medications that are given when the patient refuses PO medications in non-emergency situations. The patient has the right to refuse medications except in a few narrow circumstances: During a violent behavioral emergency, under the direction of a clinical review panel, under a court order, or when authorized by a court-appointed guardian, if permitted by the guardianship order.

3. Medications given during a violent behavioral emergency must be given with an order written, or provided verbally, by a prescriber (MD, CRNP, or PA-C) authorized by the hospital. Just like physical restraints or seclusion, the order must be obtained at the time the medications are given.

4. In order to make things as safe as possible for their staff and patients while still adhering to regulation, some hospitals have implemented the following procedures:

a. During the initial risk assessment, staff will identify what medication regimen (as well as other calming or self-soothing techniques) has worked for the patient in the past, and what doesn't work to control his or her behavior. The provider will then write a note in the H&P or the care plan indicating that XX is the regimen that works best for controlling the patient's behavior. When the nurses have to call in the middle of the night, they can tell the hospitalist or mid-level what the psychiatrist recommends and get an order.

b. Even though it requires two patient encounters, it is probably safer to place the violent patient in a seclusion room than to put hands-on and hold him or her while the nurse prepares the medication. Once the patient is in the seclusion room, staff have time to get an order and provide medications in a controlled manner.

c. One hospital plans to request patient consent for IM medications at the time the patient signs voluntary admission papers. This practice may, for some patients, reduce the involuntary nature of receiving IM medication, but just like advance directives, consent can be verbally withdrawn by the patient at any time. Getting consent from the patient, whether in advance or in the moment, does not eliminate the prohibition against PRN IM orders.

In 2010, the New York State Office of Mental Health (OMH) released their own guidance regarding the use of PRN medications in behavioral health settings.[1] Their recommendations include:

a. Agitation, in and of itself, is not an emergency behavior and giving PRN medications for "agitation" is only appropriate if agitation is defined and identified as a targeted symptom in the patient's care plan.

b. Every PRN order for agitation must specify that administration is voluntary. OMH presumes that all orders for IM medication are by their nature involuntary since few patients voluntarily agree to take IM medications.

c. OMH calls for no PRNs (PO or IM) at all, saying that any behavior that rises to the level requiring PRN intervention also requires physician input and a STAT order.

d. Early identification of anxiety and stress and the use of non-pharmacologic coping mechanisms in partnership with patients will reduce the need for emergency behavioral intervention.

The Office of Health Care Quality appreciates that eliminating PRN IM orders for behavioral health patients represents a paradigm shift for many hospitals and providers. But if we are serious about maintaining patient autonomy and respecting patient rights, we need to look critically at long-standing patient rights issues like PRNs.

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[1] https://www.omh.ny.gov/omhweb/advisories/prn_meds.pdf