

Emergency Treatment Orders

(See also Express & Informed Consent)

(See also Guardian Advocates and Other Substitute Decision-Makers)

(See also Rights of Persons in Mental Health Facilities)

General

Q. How does the Baker Act control what our facility can do in applying behavioral controls on all clients as a result of the behavior of one?

The Florida Administrative Code addresses these issues as follows:

65E-5.1601 General Management of the Treatment Environment.

- (1) Management and personnel of the facility's treatment environment shall use positive incentives in assisting persons to acquire and maintain socially positive behaviors as determined by the person's age and developmental level.
- (2) Each designated receiving and treatment facility shall develop a schedule of daily activities listing the times for specific events, which shall be posted in a common area and provided to all persons.
- (3) Interventions such as the loss of personal freedoms, loss of earned privileges or denial of activities otherwise available to other persons shall be minimized and utilized only after the documented failure of the unit's positive incentives for the individuals involved.
- (4) Facilities shall ensure that any verbal or written information provided to persons must be accessible in the language and terminology

65E-5.1602 Individual Behavioral Management Programs.

When an individualized treatment plan requires interventions beyond the existing unit rules of conduct, the person shall be included, and the person's treatment plan shall reflect:

- (1) Documentation, signed by the physician that the person's medical condition does not exclude the proposed interventions;
- (2) Consent for the treatment to be provided;
- (3) A general description of the behaviors requiring the intervention, which may include previous emergency interventions;
- (4) Antecedents of that behavior;
- (5) The events immediately following the behavior;
- (6) Objective definition of the target behaviors, such as specific acts, level of aggression, encroachment on others' space, self- injurious behavior or excessive withdrawal;
- (7) Arrangements for the consistent collection and recording of data;
- (8) Analysis of data;
- (9) Based on data analysis, development of intervention strategies, if necessary;
- (10) Development of a written intervention strategy that includes criteria for starting and stopping specific staff interventions and the process by which they are to occur;
- (11) Continued data collection, if interventions are implemented; and
- (12) Periodic review and revision of the plan based upon data collected and analyzed.

Restraints

Q. I have a concern regarding assessment during a seclusion/restraint episode. On the issue of vital signs (pulse and respiratory rate at a minimum) during assessment, must it be done during the initial 15 minutes? Every hour thereafter? Respiratory rate, circulatory status, signs of injury and skin integrity could be performed with minimum stimuli to secluded/restrained patients, however, pulse rate and blood pressure require touching a patient that is trying to remain calm. Taking the blood pressure could definitely exacerbate previous out-of-control behavior. Please, advise on procedure to follow regarding vital signs during seclusion/restrain episodes.

JCAHO, federal Conditions of Participation, and your own hospital policies and procedures may have more specific requirements than those in the Baker Act rules – you would have to comply with the most stringent requirements that apply to your hospital. However the Baker Act rules state the following:

65E-5.180 Right to Quality Treatment.

(7) Seclusion and Restraint for Behavior Management Purposes. All

(e) During Seclusion or Restraint Use.

1. When restraint is initiated, nursing staff shall see and assess the person as soon as possible but no later than 15 minutes after initiation and at least every hour thereafter. The assessment shall include checking the person's circulation and respiration, including necessary vital signs (pulse and respiratory rate at a minimum).
2. The person over age 12 who is secluded shall be observed by trained staff every 15 minutes. At least one observation an hour will be conducted by a nurse. Restrained persons must have continuous observation by trained staff. Secluded children age 12 and under must be monitored continuously by face-to-face observation or by direct observation through the seclusion window for the first hour and then at least every 15 minutes thereafter.
3. Monitoring the physical and psychological well-being of the person who is secluded or restrained shall include but is not limited to: respiratory and circulatory status; signs of injury; vital signs; skin integrity; and any special requirements specified by facility policies. This monitoring shall be conducted by trained staff as required in paragraph (7)(b).
4. During each period of seclusion or restraint, the person must be offered reasonable opportunities to drink and toilet as requested. In addition, the person who is restrained must be offered opportunities to have range of motion at least every two hours to promote comfort. Each facility shall have written policies and procedures specifying the frequency of providing drink, toileting, and check of bodily positioning to avoid traumatizing a person and retaining the person's maximum degree of dignity and comfort during the use of bodily control and physical management techniques.
5. Documentation of the observations and the staff person's name shall be recorded at the time the observation takes place.

As you can see above, the rules require pulse and respiration within the first 15 minutes and at least hourly after that -- blood pressure is not required by rule. The intent of the pulse rate and blood pressure is to make sure the person is medically stable and remains medically stable throughout the event. However, if staff feel that the risk of performing these tasks outweigh the need to assess medical stability, staff should justify/document their rationale. These tasks are required to ensure the health of the individual, but if staff feel that they cannot perform them due to the potential of exacerbating the crisis, then their rationale for not following the requirement needs to be documented. Your concern about not further traumatizing an individual in restraints and using non-intrusive methods are desirable

Q. If a person has met criteria for a chemical ETO given via injection and staff has to manually hold the person while the injection is being given, are there any guidelines regarding timeframes for how long staff can restrict the person's movement in the process of medicating the person? In other words at what point, if at all, does this become a restraint?

The holding of the person to administer the medications is a restraint and it must be documented the same as any other restraint use. The Baker Act defines restraint as follows:

394.455(28)(a) "Restraint" means a physical device, method, or drug used to control behavior. A physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the individual's body so that he or she cannot easily remove the restraint and which restricts freedom of movement or normal access to one's body.

(b) A drug used as a restraint is a medication used to control the person's behavior or to restrict his or her freedom of movement and is not part of the standard treatment regimen of a person with a diagnosed mental illness who is a client of the department. Physically holding a person during a procedure to forcibly administer psychotropic medication is a physical restraint.

Q. Do you think that having police or our own security person or a trained sitter in place would constitute a restraint and thus fall under the purview of our restraint policies?

Having close observation of the person wouldn't necessarily constitute restraint under Baker Act law or rules. You need to check to see that it wouldn't be a restraint under JCAHO or CMS standards either.

Q. The term "brief isolation" remains in the Baker Act – is this different than "seclusion"? I don't feel that either the FAC nor the intent of the 394 was to dictate specific treatment modalities especially if it encourages a less restrictive option when someone is escalating. Is this correct?

It is important that any psychiatric hospital or CSU comply with any regulatory standards applying to that facility, which might include JCAHO, CARF, federal conditions of participation, and the Baker Act. The most stringent and protective of patient rights of

each of these would apply when in conflict with each other pertaining to any aspect of seclusion or other interventions. Further, if the facility has a policy/procedure that is more stringent than any of the above, that policy would prevail. The federal CoP's have been strengthened in recent years as has the Baker Act rules governing this issue, so the Centers as a licensed hospital would need to determine how this practice complied with JCAHO and CMS.

The previous rules governing "isolation" were based on a statutory reference, as follows:

394.459(4) QUALITY OF TREATMENT.--

(b) Facilities shall develop and maintain, in a form accessible to and readily understandable by patients and consistent with rules adopted by the department, the following:

1. Criteria, procedures, and required staff training for any use of close or elevated levels of supervision, of restraint, seclusion, or isolation, or of emergency treatment orders, and for the use of bodily control and physical management techniques.

Rules that were promulgated in 1998 to implement the statute identified the following:

(8) Isolation.

(a) Isolation means involuntarily imposed segregation of the person from others for a period of up to 15 minutes per event. A person in isolation shall not be behind closed doors. Isolation does not require a physician's order.

(b) When a person requires more than a total of 60 minutes of segregation in a 24-hour period, a physician's order for seclusion is required.

(c) Each use of isolation shall be documented in the person's clinical record.

(9)(b) Isolation shall be attempted prior to imposing seclusion, whenever possible.

While the reference to "isolation" remains in the statute, the term "Brief Isolation" was removed from the rules in 2008 because it could potentially be considered "seclusion". A new definition was added to Baker Act statutory definitions, as follows:

394.455(29) "Seclusion" means the physical segregation of a person in any fashion or involuntary isolation of a person in a room or area from which the person is prevented from leaving. The prevention may be by physical barrier or by a staff member who is acting in a manner, or who is physically situated, so as to prevent the person from leaving the room or area. For purposes of this chapter, the term does not mean isolation due to a person's medical condition or symptoms.

If a person chose to go to a specifically designed "safe room" seeking a quieter space or staff suggested a short "time out" from which the patient wasn't required to comply, it might not be considered "seclusion". However, if the patient had no choice as to whether he/she went to the room or stayed in the room, it would be considered seclusion per the above statutory definition. If seclusion, the rules governing seclusion have been promulgated for this intervention:

Q. The Baker Act states that physically holding a patient during a procedure to forcibly administer medication is physical restraint. The Baker Act also requires that an independent practitioner conducts a face to face evaluation within one hour of restraint event. Does the face to face evaluation applies to a situation where a patient is only being restrained to forcibly administer a medication?

Yes - the face to face is required within an hour for an physical restraint associated with involuntary medication administration. If the RN is the one administering the medication, he/she can do the face to face assessment if he/she is authorized by the facility and trained in seclusion and restraint procedures. He/she would need to complete the activities associated with the one hour face to face and the attending physician who is responsible for the care of the person must be consulted as soon as possible after the evaluation is completed.

It would constitute a face to face if they do the required assessments and document that they did.

Q. If we need to physically hold a patient to forcibly administer psychotropic medication while on the medical floor, would this be considered a restraint, requiring all the process including the physician order for restraint and the face to face within the hour?

Restraints are governed by the definitions in 394.455(28), FS as follows:

(a)“Restraint” means a physical device, method, or drug used to control behavior. A physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the individual’s body so that he or she cannot easily remove the restraint and which restricts freedom of movement or normal access to one’s body.

(b)A drug used as a restraint is a medication used to control the person’s behavior or to restrict his or her freedom of movement and is not part of the standard treatment regimen of a person with a diagnosed mental illness who is a client of the department. **Physically holding a person during a procedure to forcibly administer psychotropic medication is a physical restraint.**

(c)Restraint does not include physical devices, such as orthopedically prescribed appliances, surgical dressings and bandages, supportive body bands, or other physical holding when necessary for routine physical examinations and tests; or for purposes of orthopedic, surgical, or other similar medical treatment; when used to provide support for the achievement of functional body position or proper balance; or when used to protect a person from falling out of bed.

Physical holding to forcibly administer psychiatric medication is a physical restraint and all requirements in the Baker Act law and rule governing restraints would apply.

However, If the person is voluntarily/willingly receiving an injection and staff are merely stabilizing the arm for the injection, then the stabilizing the arm part would not be considered manual restraint. This is consistent with CMS guidelines.

Chemical Restraints

Q. Would the administration of Geodon and Ativan for a person with major depression as an emergency treatment order after attempting to hurt staff be a chemical restraint?

The federal Centers for Medicare and Medicaid would refer to any “drug used as a restraint” to include one that is used to control behavior or to restrict the person’s movement, and is not a standard treatment for the person’s medical or psychiatric condition.” Treatment medications are those therapeutic doses of psychotropic medications that help improve persons’ functioning so they can more actively participate in their treatment. If the drug is used to restrain negative behaviors instead of being part of a continuing treatment plan, it would be considered a “restraint”. Restraint is not defined so much by what device or medication is used as much as it determined by the purpose the device or medication is used. If used for behavior, it is restraint.

Q. Recently, a Joint Commission consultant has advised us that ETO’s are considered to be chemical restraints. What do the other Psychiatric Hospitals in our area and around the state doing with this standard?

A chemical restraint restricts the person's ability to move and usually results in the person going to sleep. Generally, medications that work to calm a person's behavior or stabilize their mood to help them function better in their environment and benefits the person and is a standard medication used for the person would not be considered a chemical restraint.

Per Chapter 394.455 (28)(b) F.S.: A drug used as a restraint is a medication used to control the person's behavior or to restrict his or her freedom of movement and is not part of the standard treatment regimen of a person with a diagnosed mental illness who is a client of the department.

The concept of chemical restraint centers on whether a medication is given as a part of the treatment for an individual's condition or simply to control the individual's behavior. HCFA suggests that it is the process of prescribing rather than the medication prescribed that distinguishes treatment from restraint. If a medication is prescribed as part of an assessment and plan of care, whether on a routine or as needed basis, it is a treatment. If the medication is prescribed as a reaction to an individual's inappropriate and dangerous behaviors, it is a restraint. Therefore the same medication administered to the same person could be a treatment in some circumstances and a restraint in others.

Why this is sometimes confusing is because documentation of assessment and rationale for the medication intervention can be weak in explanation of the situation and the discussion with the physician. Also, maladaptive behaviors versus targeted behavioral symptoms may need to be more clearly defined by the prescribing practitioner. Inappropriate /maladaptive behaviors should be referred to a facility psychologist for a functional analysis and behavioral management interventions if needed.

Not all ETOs are chemical restraints. Orders for psychotherapeutic medication intervention in emergency situations are typically for symptoms of the person's mental illness. You will find medication orders in medical records that have been

written as an "emergency treatment order". I have never seen an order written for a chemical restraint or documentation that the ETO is a chemical restraint and have never found a medication intervention accompanied by the required restraint monitoring and follow-up.

The Medicare Conditions of Participation Standard is below:

A-0160

482.12(e)(1)(i)(B) A restraint is - a drug or medication when it is used as a restrict to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

Interpretive Guidelines 482.13(e)(1)(i)(B)

Drugs or medications that are used as part of a patient's standard medical or psychiatric treatment, and are administered within the standard dosage for the patient's condition, would not be subject to the requirement of the standard(e). These regulations are not intended to interfere with the clinical treatment of patients who are suffering from serious mental illness and who need therapeutic doses of medication to improve their level of functioning so that they can more actively participate in their treatment. Similarly, these regulations are not intended to interfere with appropriate doses of sleeping medication prescribed for patients with insomnia, anti-anxiety medication prescribed to calm a patient who is anxious, or analgesics prescribed for pain management. The regulatory language is intended to provide flexibility and recognize the variations in patient condition.

Whether or not an order for a drug or medications is PRN; as circumstances require, or a standing-order does not determine whether or not the use of that drug or medication is considered a restraint. The use of PRN or standing-order drugs or medications is only prohibited if the drug or medication meets the definition of a drug or medication used as a restraint.

Criteria used to determine whether the use of a drug or medication, or combination of drugs or medications is a standard treatment or dosage for the patient's condition includes all of the following:

- The drug or medication is used within the pharmaceutical parameters approved by the FDA and the manufacturer for the indications that it is manufactured and labeled to address, including listed dosage and parameters;
- The use of the drug or medication follows national practice standards established or recognized by the medical community, or professional medical associations or organizations; and
- The use of the drug or medication to treat a specific patient's clinical condition is based on that patient's symptoms, overall clinical situation, and on the physician's or other LIP's knowledge or that patient's expected and actual response to the medication.

Another component of "standard treatment or dosage" for a drug or medication is the expectation that the standard use of a drug or medication to treat the patient's condition

enables the patient to more effectively or appropriately function in the world around them than would be possible without the use of the drug or medication.

Seclusion

Q. When the hospital has a patient being assessed and awaiting transfer to another facility, can we keep the patient in a supervised group room behind our locked doors? We want to keep the patient in a safe area and the unlocked lobby is not necessarily the best spot. Also, the doctor sometimes feels strongly that it is in patient's best interest to receive a treatment medicine. Is that within guidelines? If the patient requires hands-on support / restraint, is that ok?

Since the person has been "accepted" to your receiving facility, it is irrelevant whether the person has been formally admitted or not. Your obligation is to meet the persons' needs while you have them, especially since you don't know how long it will take to accomplish the transfer.

The first obligation is for safety which certainly involves avoidance of elopement or other high-risk behavior while in your care. If this means holding the person in a locked area of one of your hospitals without a formal admission, this wouldn't violate the Baker Act law or rules, assuming you aren't mixing adults with minors.

Medications can only be administered with the consent of a competent adult (competent to make well-reasoned, willful, and knowing treatment decisions) or by a legally authorized substitute decision-maker (guardian or health care surrogate / proxy) after full disclosure. The only alternative is an emergency treatment order after a physician documents the nature and extent of imminent danger. However, if informed consent or circumstances supporting an ETO are fully documented, treatment in advance of admission is fine and often takes place in ERs prior to admission or transfer.

With regard to use of restraints or seclusion in a pre-admission period, these interventions are also fully acceptable if they meet the most restrictive of JCAHO standards, federal Conditions of Participation behavioral health restraint standards, hospital policy and procedures, and Baker Act standards. Pre-admission or post-admission status is not a deciding factor.

All rights of the patient and responsibilities of the receiving facility apply when the person is on your premises, regardless of their legal status.

Initiation of Emergency Treatment

Q. What conditions must exist before a physician can order emergency treatment?

The person must be demonstrating an inability to exercise voluntary control over his or her own symptomatic behavior and that these uncontrolled symptoms and behavior are an imminent danger to the person or to others in the facility. The nature and extent of imminent danger posed must be documented in the clinical record, the emergency treatment must be the least intrusive method, and only rapid response medications are

permitted unless a detailed and complete justification for using other medications is documented by the physician. A statement of “agitation” or “disruption” wouldn’t be sufficient; actual description of dangerous behavior would be required.

Q. I was unable to find a form for executing an Emergency Treatment Order. Does the attending psychiatrist just write an order in the patient’s chart as an ETO?

A. There isn’t a model form for the purpose of writing an ETO. This is left to the physician to justify in the chart that the nature and extent of immediate danger is sufficient to warrant forced intervention. This is considered “chemical restraint” under the behavioral restraint standards governed by CMH Conditions of Participation, as well as JCAHO and the Baker Act.

Q. Does a one-hour face to face evaluation have to be conducted for all ETO’s? If a face to face within an hour has to be done, can it be done by an RN as well as by a physician, PA, or ARNP? Is this correct as long as a physician signs the order within the 24 hour period?

The face to face is typically done by a registered nurse, not a physician or other licensed independent practitioner. The RN consults with a physician following implementation of a restraint.

Q. Is an ETO is limited to a single administration or can it can include multiple administrations during a 24-hour period?

A single order can contain multiple interventions and multiple administrations, for a period of up to 24 hours. It must be specific and not include any PRN’s. If a second order is required, a petition for involuntary placement and adjudication of incompetence to consent to treatment must be filed with the court within one working day following the issuance of the second order. This is governed under chapter 65E-5.1703, FAC (pages 33-35 in the 2008 Handbook):.

65E-5.1703 Emergency Treatment Orders.

(1) An emergency treatment order shall be consistent with the least restrictive treatment interventions, including the emergency administration of psychotropic medications or the emergency use of restraints or seclusion.

(a) The issuance of an emergency treatment order requires a physician’s review of the person’s condition for causal medical factors, such as insufficiency of psychotropic medication blood levels, as determined by drawing a blood sample; medication interactions with psychotropic or other medications; side effects or adverse reactions to medications; organic, disease or medication based metabolic imbalances or toxicity; or other biologically based or influenced symptoms.

(b) All emergency treatment orders may only be written by a physician licensed under the authority of Chapter 458 or 459, F.S.

(c) The physician must review, integrate and address such metabolic imbalances in the issuance of an emergency treatment order. The use of an emergency

treatment order, consistent with the least restrictive treatment requirements, for persons must include:

1. Absent more appropriate interventions, an emergency treatment order for immediate administration of rapid response psychotropic medications to a person to expeditiously treat symptoms, that if left untreated, present an immediate danger to the safety of the person or others.

2. Absent more appropriate medical interventions, an emergency treatment order for restraint or seclusion of a person to expeditiously treat symptoms that if left untreated, present an imminent danger to the safety of the person or others.

(d) An emergency treatment order, as used in this chapter, excludes the implementation of individualized behavior management programs as described and authorized in Rule 65E-5.1602, F.A.C., of this rule chapter.

(2) An emergency treatment order for psychotropic medication supersedes the person's right to refuse psychotropic medication if based upon the physician's assessment that the individual is not capable of exercising voluntary control over his or her own symptomatic behavior and that these uncontrolled symptoms and behavior are an imminent danger to the person or to others in the facility. When emergency treatment with psychotropic medication is ordered for a minor or an incapacitated or incompetent adult, facility staff shall document attempts to promptly contact the guardian, guardian advocate, or health care surrogate or proxy to obtain express and informed consent for the treatment in advance of administration where possible and if not possible, as soon thereafter as practical.

(3) The physician's initial order for emergency treatment may be by telephone but such a verbal order must be reduced to writing upon receipt and signed by a physician within 24 hours.

(4) Each emergency treatment order shall only be valid and shall be authority for emergency treatment only for a period not to exceed 24 hours.

(5) The need for each emergency treatment order must be documented in the person's clinical record in the progress notes and in the section used for physician's orders and must describe the specific behavior which constitutes a danger to the person or to others in the facility, and the nature and extent of the danger posed.

(6) Upon the initiation of an emergency treatment order the facility shall, within two court working days, petition the court for the appointment of a guardian advocate pursuant to the provisions of Section 394.4598, F.S., to provide express and informed consent, unless the person voluntarily withdraws a revocation of consent or requires only a single emergency treatment order for emergency treatment.

(7) If a second emergency treatment order is issued for the same person within any 7 day period, the petition for the appointment of a guardian advocate pursuant to the provisions of Section 394.4598, F.S., to provide express and informed consent shall be filed with the court within 1 court working day.

(8) While awaiting court action, treatment may be continued without the consent of the person, but only upon the daily written emergency treatment order of a physician who has determined that the person's behavior each day during the wait for court action continues to present an immediate danger to the safety of the person or others and who documents the nature and extent of the emergency each day of the specific danger posed. Such orders may not be written in advance of the demonstrated need for same.

(9) To assure the safety and rights of the person, and since emergency treatment orders by a physician absent express and informed consent are permitted only in an emergency, any use of psychotropic medications other than rapid response psychotropic medications requires a detailed and complete justification for the use of such medication. Both the nature and extent of the imminent emergency and any orders for the continuation of that medication must be clearly documented daily as required above.

If your JCAHO standards, federal Conditions of Participation, or your own hospital policies and procedures are more stringent than those in the Baker Act rules, you must follow the most stringent that apply to your facility.

Q. What is the interpretation of the Baker Act and the general practices throughout the state on Intramuscular treatment when oral medications are refused by a client who is determined by the physician to be unable to provide express and informed consent. When a hearing for involuntary placement and appointment of guardian advocate has been requested, but the hearing has not been held, can a proxy or surrogate give consent to provide the medication Intramuscularly if the patient refuses to take it orally? This may place the staff in the position to hold the client to give the medication IM. What criteria should be documented to support such a practice, if appropriate?

The least restrictive available intervention should always be used. However, once a physician has documented that a person is incompetent to consent to treatment, that person is also incompetent to refuse. When the physician has documented in the chart the nature and extent of imminent danger, an emergency treatment order can be written. If this emergency treatment requires holding the person in order to administer it safely, that is acceptable.

However, the statutory definition of "restraint" includes the following:

394.455(28)(a) "Restraint" means a physical device, method, or drug used to control behavior.

(b) A drug used as a restraint is a medication used to control the person's behavior or to restrict his or her freedom of movement and is not part of the standard treatment regimen of a person with a diagnosed mental illness who is a client of the department. **Physically holding a person during a procedure to forcibly administer psychotropic medication is a physical restraint.**

If the person has a health care surrogate (designated in an advance directive when he/she was competent to do so) or a health care proxy (relative or close personal friend), that substitute decision-maker can provide consent to any and all health care that the person would have consented to if competent. The mere fact that the person is currently refusing consent may be due to his/her illness rather than belief system. A substitute decision-maker must speak with the physician and patient and must receive all disclosures required by law and code prior to giving consent.

If the medication, dosage and route are included in the person's treatment plan that the substitute decision-maker has signed and the medication is a standard treatment for the person's condition and not being used just to control the person's behavior or to restrict

his/her freedom of movement, you may avoid the label of “emergency treatment order”. However, what you describe in your message would still be considered “restraint” as defined above. You would need to provide the documentation for restraint required by the Baker Act as well as JCAHO, federal Conditions of Participation, or other regulatory/credentialing bodies that apply to DLC.

Q. Does anything prohibit our Receiving Facility physician from ordering an ETO as the least restrictive intervention for an individual Baker Acted that is not admitted to our Receiving Facility, but is being evaluated to be transferred to another facility? Can we administer a rapid response psychotropic medication to a person not admitted to the unit to expeditiously treat symptoms, that if left untreated, present an immediate danger to the safety of the person served and others? Same question for an ETO for seclusion and restraints? It appears it would be the right and lawful thing to do as the last resort if the situation escalated to this level of need to protect the safety of the person served, staff, and others. It is the responsibility of the facility to reduce the risk to staff, self, and others in situations of danger. Please verify my interpretation of the material on ETOs and Restraints.

1. Does anything prohibit our Receiving Facility to have a physician order an ETO as the least restrictive intervention for an individual Baker Acted that is not admitted to our Receiving Facility, but is being evaluated to be transferred to another facility?

There is no distinction made in the Baker Act law or rule between patient rights or facility responsibilities for persons held on evaluation status vs. those following admission. If the physician has documented in the person's clinical record the nature and extent of imminent danger, he/she can order the least restrictive intervention, including an ETO for medications. This would be considered a chemical restraint and would have to meet all federal and state requirements as a restraint.

2. Can we administer a rapid response psychotropic medication to a person not admitted to the unit to expeditiously treat symptoms, that if left untreated, present an immediate danger to the safety of the person served and others?

Use of emergency treatment orders in general and rapid response medications specifically are governed by the following:

394.453 Legislative intent. It is the policy of this state that the use of restraint and seclusion on clients is justified only as an emergency safety measure to be used in response to imminent danger to the client or others. It is, therefore, the intent of the Legislature to achieve an ongoing reduction in the use of restraint and seclusion in programs and facilities serving persons with mental illness.

65E-5.170 Right to Express and Informed Consent.

(2) Authorization for Treatment.

(d) No facility or service provider shall initiate any mental health treatment, including psychotropic medication, until express and informed consent for

psychiatric treatment is sought from a person legally qualified to give it, except in instances where emergency treatment is ordered by a physician to preserve the immediate safety of the person or others.

65E-5.1703 Emergency Treatment Orders.

(1)(c) The physician must review, integrate and address such metabolic imbalances in the issuance of an emergency treatment order. The use of an emergency treatment order, consistent with the least restrictive treatment requirements, for persons must include:

1. Absent more appropriate interventions, an emergency treatment order for immediate administration of rapid response psychotropic medications to a person to expeditiously treat symptoms, that if left untreated, present an immediate danger to the safety of the person or others.

(9) To assure the safety and rights of the person, and since emergency treatment orders by a physician absent express and informed consent are permitted only in an emergency, any use of psychotropic medications other than rapid response psychotropic medications requires a detailed and complete justification for the use of such medication. Both the nature and extent of the imminent emergency and any orders for the continuation of that medication must be clearly documented daily as required above.

Again, there is no difference in the requirements for use on those persons being evaluated as for those post-admission.

3. Same question for an ETO for seclusion and restraints.

The same response as above.

Q. Would our facility still need to get ETO orders every 24 hours if we had an authorization for treatment form completed?

In all cases, express and informed consent must be obtained (after full disclosure) by a legally authorized decision-maker before any treatment can be rendered, except in cases of imminent danger in which an ETO may be considered. If informed consent from the guardian, guardian advocate, or health care surrogate/proxy, in accordance with the Baker Act law/rules for the necessary treatment, no ETO for such authorized treatment would be needed.

A competent adult can provide or refuse consent to one's own treatment. At any time "a person's judgment is so affected by his or her mental illness that the person lacks the capacity to make well-reasoned, willful, and knowing decisions concerning his or her medical or mental health treatment", he or she is incompetent to consent to treatment. In such cases, a legally authorized substitute decision-maker must be sought to make such decisions on behalf of the person.

Q. If we have a patient that has a court petition filed with no known relatives or proxy and is refusing to take medications, can the doctor issue a one time ETO

(even if the patient is not a danger to himself or others at that time) before the courts have appointed a guardian advocate.

The Baker Act prohibits the provision of any psychiatric treatment without the express and informed consent of the person or legally authorized substitute decision-maker, except when conditions exist for an emergency treatment order. An ETO can only be administered in cases of documented imminent danger. CMS Conditions of Participation and JCAHO standards would also apply to the situation you describe. The Baker Act rules give a facility's physician the ability to order emergency treatment once in a seven day period without petitioning the court for a guardian advocate, but only in cases where the ETO has been justified due to imminent danger.

A better alternative is to seek a "close personal friend" or independent LCSW permitted as proxies when a person has no known relatives. If it is person who is likely to come back to your facility at some future time, you should assist him at the time of discharge (assuming he is then competent to do so) to execute a mental health advance directive that names a surrogate to make such decisions during periods of incapacity. A surrogate isn't limited to relatives, friends, or a LCSW.

Q. If a person has a guardian advocate but no consent has been given for the person to be given Geodon I/M, does the nurse need to seek consent from the guardian advocate or does an ETO need to be written due to the person's escalation and agitation?

An ETO can be ordered by a physician in cases of imminent danger without waiting for express and informed consent. However, Chapter 65E-5.1703, FAC states that "When emergency treatment with psychotropic medication is ordered for a minor or an incapacitated or incompetent person, facility shall document attempts to promptly contact the guardian, guardian advocate, or health care surrogate or proxy to obtain express and informed consent for the treatment in advance of administration where possible and if not possible, as soon thereafter as practical."

The purpose of this rule is to attempt to get express and informed consent from the substitute decision-maker so you don't have to consider this an ETO. If the facility is a hospital or JCAHO accredited facility, a physician would have to see the person within one hour due to use of chemical restraints. If a legally authorized person has provided express and informed consent prior to it administration, it probably wouldn't be considered a chemical restraint.

Q. The Baker Act rules states "each emergency treatment order is only valid and is authority for emergency treatment for a period not to exceed 24 hours." If staff has documented that the person is posing an imminent danger, can a physician issue an order for a rapid response medication to be given every 6 hours to address the imminent danger or does this mean that an ETO for medication can be given now and again, if the same imminent danger behavior presents again, within the 24 hour timeframe without having to obtain a new physician's order?

If a physician orders a medication to address an imminent danger situation to be administered every four hours for a 24-hour period, this is considered one ETO. A nurse

doesn't have discretion as to whether or not to administer the doses called for in the order. However, if the nurse calls the physician after one or two administrations of the medications and to say the person is calm, is sleeping, or the dangerous behavior has ceased, the physician can then discontinue his or her order. This would not be considered a PRN since the medications would be administered only as directly ordered by the physician.

Guardian Advocates & Other Substitute Decision-Makers

Q. If a person has a guardian advocate but no consent has been given for the person to be given Geodon I/M, does the nurse need to seek consent from the guardian advocate or does an ETO need to be written due to the person's escalation and agitation?

An ETO can be ordered by a physician in cases of imminent danger without waiting for express and informed consent. However, Chapter 65E-5.1703, FAC states that "When emergency treatment with psychotropic medication is ordered for a minor or an incapacitated or incompetent person, facility shall document attempts to promptly contact the guardian, guardian advocate, or health care surrogate or proxy to obtain express and informed consent for the treatment in advance of administration where possible and if not possible, as soon thereafter as practical."

The purpose of this rule is to attempt to get express and informed consent from the substitute decision-maker so you don't have to consider this an ETO. If the facility is a hospital or JCAHO accredited facility, a physician would have to see the person within one hour due to use of chemical restraints. If a legally authorized person has provided express and informed consent prior to its administration, it probably wouldn't be considered a chemical restraint.

Q. If a person who is on involuntary status and has a guardian advocate refuses oral medications, resulting in an injection of which the guardian advocate has provided consent. The person has merely refused medications but has not posed an imminent danger to self or others. Would this constitute an ETO?

If a person has been found incompetent to consent to treatment by a court, resulting in the appointment of a guardian advocate, the person is incompetent to refuse medication. However, the Baker Act law/rules prohibit a facility from administering psychotropic medications without the express and informed consent from someone who is legally authorized to consent on behalf of the person, unless the physician has documented the nature and extent of an emergency justifying an ETO. It would be necessary to get the guardian advocate's consent to a change in the medication or its method of administration. In an emergency, most facilities get this by telephone with 2 witnesses, having the guardian advocate sign a modified consent form later.

In the above scenario, this would not constitute an ETO because it is limited to treatment contained in the person's treatment plan and disclosure has been fully provided to the guardian advocate.

The federal conditions of participation for hospitals also govern "chemical restraints". There should be no inconsistency between the federal regulations and the Baker Act, given that the medications in this scenario are not being ordered for a person's behavior but are consistent with his/her treatment plan as a standard treatment for the diagnosis.

Q. One of our group homes is providing treatment for a person under an involuntary outpatient commitment order. The person has a guardian advocate appointed who approves the course of treatment, including medication (injections). The person is verbally refusing the injections. Can they give the injection or is an ETO required?

Regardless of whether the person is on involuntary inpatient or involuntary outpatient placement order, if he/she has been found by the court to be incompetent to consent to treatment, the person is also incompetent to refuse consent to treatment.

If the guardian advocate has been provided full disclosure so express and informed consent has been obtained and the GA has spoken directly to the doctor and the person about the proposed treatment, the GA can provide the consent and no ETO is necessary. An ETO is only needed when no legally authorized consent can be obtained.

Logistically this can be a problem in that the person may actually fight against the injection. However, this would happen whether it was a result of an ETO or not. Efforts need to be made to prevent any physical harm to the person or others in the process.

Q. If a patient is on involuntary status and awaiting appointment of guardian advocate, ETOs are used for emergency orders. But can the patient be given his/her routine daily psych meds if a medical proxy is assigned?

Yes, a health care surrogate or proxy is authorized by chapter 765 to make any and all health care decisions the person would have made if capable of making them (substitute judgment standard). If the proxy doesn't know what decision the person would have made, a best interest standard can be used. As you probably know, a proxy named by a facility is limited to a relative or close personal friend (LCSW under extraordinary circumstances).

Q. We have a patient on a BA52 who needs ETO treatment repeatedly. What recourse do we have in obtaining a guardian advocate since no family or friends can be located?

If a second ETO is ordered, the facility has to petition the court within one working day thereafter for adjudication of the person as incompetent to consent to treatment and appointing a guardian advocate. If no family or friend is available to serve, an adult trained and willing to serve can be appointed. Receiving facilities around the state have found volunteers to serve in this role, if there is not an organization that is willing to take on this duty. You can request the court to provide an expedited hearing on the matter.

On an interim basis, a health care proxy can serve in this capacity until a guardian advocate is appointed.

765.401 The proxy.--

(1) If an incapacitated or developmentally disabled patient has not executed an advance directive, or designated a surrogate to execute an advance directive, or the designated or alternate surrogate is no longer available to make health care decisions, health care decisions may be made for the patient by any of the following individuals, in the following order of priority, if no individual in a prior class is reasonably available, willing, or competent to act:

(h) A clinical social worker licensed pursuant to chapter 491, or who is a graduate of a court-approved guardianship program. Such a proxy must be selected by the provider's bioethics committee and must not be employed by the provider. If the provider does not have a bioethics committee, then such a proxy may be chosen through an arrangement with the bioethics committee of another provider. ...Documentation of efforts to locate proxies from prior classes must be recorded in the patient record

If your hospital has a relationship with another organization that uses LCSW's, you may be able to have a reciprocal agreement for their use. These may be a hospice, nursing home, or the local CSU.

You can also ask the court for "Expedited Judicial Intervention Concerning Medical Treatment Procedures" governed by Rule 5.900 of the Rules of Probate Procedures. This allows you to file a petition with the court for a hearing to occur within 72 hours of filing at which the court can either rule on the relief requested immediately after the preliminary hearing or conduct an evidentiary hearing not later than 4 days after the preliminary hearing and rule at that time. The contents of the petition are specified -- in your case would include the name and address of the petitioner, the name and location of the patient, the relationship between the petitioner to the patient, and the name of the patient's principal treating physician, in addition to facts sufficient to establish the need for the relief requested, including facts to support the allegation that the patient lacks the capacity to make the medical treatment decision. Notice of the petition and the preliminary hearing have to be served on specified persons -- in your case it would be the patient, the hospital administrator, the principal treating physician.

Finally, if there is a public guardianship organization in your region, you may want to contact them. However, guardianship is not a quick proceeding and may only be useful as a long-term goal.

In summary, without statutory revision to the Baker Act, treatment cannot be given without consent from a legal authorized decision-maker, except when conditions supporting an ETO are documented in the patient's record.

PRN & Standing Orders Prohibited

Q. If a person is posing an imminent danger to self or others, can a physician issue an order for a rapid response medication to be given every 4 hours for 24 hours (6 administrations) within a single ETO without having to obtain a new physician's order? Would this be considered a PRN?

If a physician orders a medication to address an imminent danger situation to be administered every four hours for a 24-hour period, this is considered under the Baker

Act as a single ETO. A nurse doesn't have discretion as to whether or not to administer the doses called for in the order. However, if the nurse calls the physician after one or two administrations of the medications to say the person is sleeping or the dangerous behavior has ceased, the physician can then discontinue his or her order. This would not be considered a PRN since the meds would be administered only as directly ordered by the physician.

Q. Can receiving facilities (CSU's and hospitals) use standing orders for new admissions? These are written orders to be followed by nursing staff based on their judgment for persons presented to the units, with no input by a physician. They include psychotropic medications from a pre-determined list as well as non-psychiatric medications and over-the-counter medications. Use of these PRN standing orders are to avoid calling a physician at night, although the physician may or may not be paid on-call fees.

The Baker Act requires a physical exam within 24 hours of arrival by an authorized health care practitioner, in addition to a nursing assessment required by rule. The CSU rules clearly prohibit standing orders for psychiatric medications. The Baker Act rules define an Emergency treatment order (ETO) to mean the written emergency order for psychotropic medications, seclusion, and restraints order by a physician in response to a person presenting an imminent danger to self or others, and as described in Rule 65E-5.1703, F.A.C., of this rule chapter. This must be based on a direct order of a physician and cannot be done on a PRN or standing order basis. Some other statutory and regulatory requirements are at the bottom of this message.

65E-5.100 Definitions

(11) PRN means an individualized order for the care of an individual person which is written after the person has been seen by the practitioner, which order sets parameters for attending staff to implement according to the circumstances set out in the order.

(15) Standing order means a broad protocol or delegation of medical authority that is generally applicable to a group of persons, hence not individualized. As limited by this chapter, it prohibits improper delegations of authority to staff that are not authorized by the facility, or not permitted by practice licensing laws, to independently make such medical decisions; such as decisions involving determination of need, medication, routes, dosages for psychotropic medication, or use of restraints or seclusion upon a person.

65E-5.170 Right to Express and Informed Consent.

(2) Authorization for Treatment.

(a) Express and informed consent, including the right to ask questions about the proposed treatment, to receive complete and accurate answers to those questions, and to negotiate treatment options, shall be obtained from a person who is competent to consent to treatment. If the person is incompetent to consent to treatment, such express and informed consent shall be obtained from the duly authorized substitute decision-maker for the person before any treatment is rendered, except where emergency treatment is ordered by a physician for the safety of the person or others.

(d) No facility or service provider shall initiate any mental health treatment, including psychotropic medication, until express and informed consent for

psychiatric treatment is sought from a person legally qualified to give it, except in instances where emergency treatment is ordered by a physician to preserve the immediate safety of the person or others.

65E-12.106

(17)(c) Medication Orders. All orders for medications shall be issued by a Florida licensed physician.

(18)(a)3. The use of standing or routine orders for emergency treatment orders is prohibited.

(20) Nursing Services.

(a) Medical Prescription. Registered nurses shall ensure that each physician's or psychiatrist's orders are followed. When a determination is made that the orders have not been followed or were refused by the person being served pursuant to section 394.459(3), F.S., the physician or psychiatrist shall be notified within 24 hours. The registered nurse or nursing service shall substantiate this action through documentation in the individual's clinical record.

(b) Nursing Standards. Each CSU and SRT shall develop and maintain a standard manual of nursing services which shall address medications, treatments, diet, personal hygiene care and grooming, clean bed linens and environment, and protection from infection.

65E-12.107 Minimum Standards for Crisis Stabilization Units (CSUs).

In addition to sections 65E-12.104, 65E-12.105, and 65E-12.106, F.A.C., above, these standards apply to CSU programs.

(3) Medical Care.

(a) The development of medical care policies and procedures shall be the responsibility of the psychiatrist or physician. The policies and procedures for medical care shall include the procedures that may be initiated by a registered nurse in order to alleviate a life threatening situation. Medication or medical treatment shall be administered upon direct order from a physician or psychiatrist, and orders for medications and treatments shall be written and signed by the physician or psychiatrist.

(b) There shall be no standing orders for any medication used primarily for the treatment of mental illness.

(c) Every order given by telephone shall be received and recorded immediately only by a registered nurse with the physician's or psychiatrist's name, and signed by the physician or psychiatrist within 24 hours. Such telephone orders shall include a progress note that an order was made by telephone, the content of the order, justification, time and date.

Q. If a person is posing an imminent danger to self or others, can a physician issue an order for a rapid response medication to be given every 4 hours for 24 hours (6 administrations) within a single ETO without having to obtain a new physician's order? Would this be considered a PRN?

If a physician orders a medication to address an imminent danger situation to be administered every four hours for a 24-hour period, this is considered under the Baker Act as a single ETO. A nurse doesn't have discretion as to whether or not to administer the doses called for in the order. However, if the nurse calls the physician after one or two administrations of the medications to say the person is sleeping or the dangerous

behavior has ceased, the physician can then discontinue his or her order. This would not be considered a PRN since the meds would be administered only as directly ordered by the physician.

Q. Some questions have come up at our facility regarding emergency treatment orders (ETO's) and how they are to be written. Chapter 65-E5.1703 (8), FAC states "...upon the daily written ETO of a physician or ARNP who has determined that the person's behavior each day....." It then goes on to say: "Such orders may not be written in advance of the demonstrated need for same." Some of our doctors are writing as PRN order +/- or with "may repeat..." phrasing. Can orders be written to cover the upcoming 24 hour period in PRN format or with the "may repeat" phrasing or is it to be written EACH time a medication administration is required, determined by the behavior?

The Baker Act regulations prohibit an ETO from lasting for more than 24 hours and it can only be issued by a physician. While it can initially be ordered over the telephone by the physician, he/she has up to 24 hours to actually sign the order. The Baker Act limits the authority to issue ETO's to physicians – this can't be extended to other professionals even under protocols.

An ETO can't be ordered in advance of a documentation of the nature and extent of specific behaviors presenting an imminent danger by the person. It can only be ordered once sufficient documentation exists to support this finding of imminent danger. It must specify the actual medication, dosage, and frequency of administration during the ETO period – a period of up to 24 hours. If nursing staff observe that the person has responded positively to the ETO prior to the end of the ETO period, staff can inform the physician of this and the physician can discontinue his/her order. It can't be ordered "as needed" or "may repeat", as this is a PRN which is prohibited.

For example, the physician can order x mg of a particular medication immediately and every 4 hours for 24 hours. Nursing staff would administer as ordered. If the patient responded to the emergency medication, the nurse can ask the physician to discontinue the order. Should the person require another ETO, the physician should again be contacted for such an order. This is not a PRN because the physician is directly ordering the start and stop of the ETO.

Only a physician can issue subsequent ETO's as long as imminent danger is documented. If more than one ETO is issued within a seven day period, a petition for involuntary placement and appointment of a guardian advocate must be filed with the circuit court.

An ETO is limited to rapid response medications – other medications require a detailed and complete justification. Medications, other than in emergency situations, require express and informed consent of the patient or his/her substitute decision-maker. If your facility is JCAHO accredited or subject to the federal conditions of participation, other standards will apply. ETO's would be considered chemical restraint under federal definitions. The most strict standard of JCAHO, CMS, and the Baker Act will apply.

Involuntary Placement Petition

Q. if a competent voluntary patient requires mechanical restraints twice in a one-week period, would the individual have to be converted to involuntary status?

It is clear that if emergency treatment orders (chemical restraints) are used more than once in a 7-day period, chapter 65E-5.1703 requires the facility to petition the court for involuntary placement and the appointment of a substitute decision-maker (guardian advocate). However, neither the Baker Act law nor the rules require such a petition in the use of mechanical restraints or seclusion.

However, voluntary status relies on the continuous willingness and competence of a person to remain on your unit – any request for release by a person on voluntary status must be acted upon within 24 hours to ensure his/her due process rights are protected. Competence is defined as being able to make well-reasoned, willful and knowing medical and mental health decisions. If a person's psychiatric condition is so fragile as to require restraints twice in one week, you need to be sure that the person's clinical record reflects continuous ability to make such well-reasoned decision making – otherwise the person would have to be converted to involuntary status, no matter how "willing" the person may be to stay at your hospital. A "window of lucidity" would not be sufficient to document competence if there are multiple acts or statement reflecting the person's lack of well-reasoned decision-making.

Since restraints are an emergency psychiatric measure used only for the immediate physical protection of the person or others, the Baker Act rules require that you investigate the circumstances preceding their imposition and review the person's treatment plan to determine whether changes to the person's treatment plan are advisable in order to prevent the further use of restraint. The chart must contain documentation of these steps.

The 2006 Florida Legislature mandated a higher level of protection for persons served in public and private receiving facilities. Finally, all aspects of JCAHO and federal Conditions of Participation must be followed as well as the Baker Act law and rules.

Q. A person on involuntary status was admitted to the hospital and became agitated, resulting in an emergency treatment order for medication on two occasions prior to being seen by the physician for assessment of capacity to provide express and informed consent. A physician then assessed the person and determined that the person did have capacity to make his own decisions regarding treatment. Does the receiving facility still need to petition the court for involuntary placement and adjudication of incapacity and appointment of a guardian advocate as required by the Baker Act law and rules?

If the person has capacity to consent or refuse consent to his or her own treatment decisions, the facility should determine if the person should remain on an involuntary basis in the facility or even if a discharge from the facility would be in order.

With regard to emergency treatment orders for psychotropic medications, it wouldn't be sufficient for the person to just be agitated. The physician would have to describe the nature and extent of imminent danger for such ETO's to be employed. This is consistent with federal and JCAHO standards as well as the Baker Act.

The Florida Administrative Code states that an emergency treatment order is valid for a period of up to 24 hours. If a physician has chosen to make the order for a shorter period of time and then does a second order, this would constitute a second ETO within a 7 day period, which requires a petition to be filed with the court. However, if the physician orders emergency treatment under the permitted circumstances for administration every 4 hours for 24-hours, he/she can discontinue the order at any time during the 24-hour period and it would be considered a single order.

A physician must see the person within 24 hours of his/her arrival on voluntary status at the hospital to establish and document "competence to provide express and informed consent in the person's clinical record. This same certification is required prior to the approval of a person's transfer from involuntary to voluntary status or prior to permitting a person to consent to his or her own treatment if that person had been previously determined to be incompetent to consent to treatment.

Q. My understanding is that when a person presents voluntarily and is examined, but refuses prescribed medication, he/she must be transferred to involuntary status via court proceedings in order for medication to be administered. Is this correct? I also understand that the only time a person is able to receive medication against his/her will is in the form of an ETO, in which case the person would not be able to be on voluntary status. Is this correct?

If the person is on voluntary status but refuses consent to treatment, the law requires that he/she be released or be transferred to involuntary status.[394,4625((2)(b), FS]. A person can't be medicated without consent of a legally authorized decision-maker, except under conditions of imminent danger when an ETO is written by a physician. If the adult patient isn't competent to consent to his/her own treatment, consent would have to be sought instead from a guardian, guardian advocate or health care surrogate/proxy.

Q. When a patient receives 2 ETO's we file for involuntary placement and document the person's incapacity. This occurred for two patients here last weekend and the psychiatrists protested because they felt on seeing the patients on Monday that these patients did have capacity. They did not want to go forward with petition filing. We filed and also presented a withdrawal of petition. Is this correct? Should we have not filed?

Your staff fully complied with the law and rules when they filed the petitions for involuntary inpatient placement after two days of ETO's. The rule is quite clear that ETO's cannot be continued after a single ETO without such filing. If the effect of the treatment stabilizes the person and he/she then regains the capacity to provide or refuse to provide consent to treatment, the petition can be withdrawn. This process is intended to prevent continued forced treatment of a person without due process.

ETO's for Medical Treatment

Q. If a person under involuntary examination status is on a medical floor, does the person have the right to refuse medications/treatment, including life saving treatment?

The Baker Act is Florida's Mental Health Act -- nothing more or less than that. It doesn't address issues of medical care and can not be used as the basis for providing medical examination or treatment. Other laws must be used instead, such as 395 that governs hospitals or 415 that governs the abuse, neglect, or exploitation of vulnerable adults (self neglect by a person who lacks capacity). If a person has a life threatening condition and is unable (not the same as refusing) to provide informed consent to necessary treatment, one can usually presume the person would have consented to such treatment if able to do so. However, a person who is competent to make such decisions but refuses the treatment has this right to do so. If the medical treatment needed by a person who isn't competent to consent isn't related to a life threatening condition, one needs to obtain a substitute decision-maker such as a health care surrogate or proxy to obtain the necessary authorization. The hospital's attorney and/or risk manager may need to consult on issues such as this.

Q. ETOs are used for psychotropic meds in an emergency situation. But if that patient needs non-psych meds, and refuses to take them, can an ETO be used to order that, say for example, insulin for a very elevated blood sugar?

The Baker Act is the state's Mental Health Act and it only governs psychiatric examination and psychiatric treatment. It doesn't govern any aspect of medical examination or treatment (other than a physical examination within 24 hours of arrival). Issues related to medical treatment must be handled the same as any other medical patient in your hospital. If you believe the person lacks capacity to make an informed refusal of such medications, you should be seeking a health care proxy if the person hadn't already named a health care surrogate in an advance directive. If no surrogate, relative, or close friend exist to serve as a substitute decision-maker, you would have to consider petitioning the court under Probate Rule 5.900 that governs Expedited Judicial Intervention Concerning Medical Treatment Procedures or by making a report of self-neglect to the Florida Abuse Registry. In any emergency situation like you mentioned, failure to medically treat such a person could be considered medical neglect.