

UWMC PRON: PSYCHIATRY RESIDENT ON-CALL NOTEBOOK

Revised 7/12/2017

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UWMC CHEAT SHEET

GENERAL INFORMATION

Call Shifts: 8AM-6PM, 6PM-8AM
Weekend Nursing Rounds: 8AM

PHONE NUMBERS

Long Distance: 9, 1, #

UW:

7N: 598-4720
7N FAX: 598-6111
Short Call: 559-1264
C/L: 598-7140 (VM), 986-1734(pg)

UW ER:

ER SW: 598-4222
ER Attending: 598-0105
Main ER: 598-2000

HMC:

HMC PES: 206-744-3076
HMC PES res: 206-744-3979
Call Pager: 206-663-9595

DMHP:

206-263-9202

Other:

DESC 464-1570
Crisis Clinic 461-3222

Chief Resident:

Stephanie Chang
Pager: 206-314-8801
Cell: 971-533-9934
E-mail: schang10@uw.edu

ROOMS

C/L Room: 7121, code 7732*
Crow's Nest: B650, code 325
7N workroom: CC702
UW ER back door code: 2001#

MUST SEE PATIENT

- New onset SI
- AMA Discharge (inpatient or CL)
- Code Gray
- Medical issues on 7N

7N ADMIT

- Obtain 7N nurse approval
- Pre-Authorization
- Consent for admission
- Confirm safety screen/search
- Med Reconciliation
- Admission orders
- Antipsychotic consent (Paper)
- Physical examination
- Write "Admit Note"
- Update CORES

CONSULTS

- Examine Pt
- Call Attending/Primary Team
- Write "Consultation – Inpt" or "Psychiatry Emergency Svcs Note"
- Update CORES
- Leave message at 598-7140

DISCHARGE

- Discuss AMA D/C w/ attending
- Med Reconciliation
- Fax D/C Meds
- Place Discharge Order
- Write Brief Discharge Note

TRIAGE ORDER

1. Urgent inpt psychiatry issues
2. Urgent consults
 - a. Attempted suicide
 - b. Urgent safety eval
 - b. Threatening violence
 - c. Just placed in restraints
 - e. AMA evaluation
 - f. Other emergent issues
3. ED consults

4. Non-urgent psychiatry cross-cover issues
5. Non-urgent consults (during day call)

DMHP RULES

- Brought in by Police
- Seen by MH provider within 3 hours
 - Detained within 12 hours
- Not brought in by Police
- Seen by DMHP within 6 hours after decision to refer.
- Inpatient
- Must detain by end of next judicial day
 - 180 day order
 - Pt on 180 day hold needs court order to compel antipsychotics.

DOCUMENTATION

- Consults (non-ED)
"Consultation – Inpt"
Consults (ED)
"Psychiatry Emergency Svcs Note"
Inpatient Admission
"Admit Note"
Inpatient Notes
"Psychiatry Record – Inpt"

MUST CALL ATTENDING

- Unplanned discharges
- New consults (including ED)
- Clinical decision making regarding SI/HI
- Discharging an ED pt with a deteriorating clinical course
- If a DMHP contacts you about taking an ITA'd patient on 7N
- Transferring a C/L pt to 7N
- ED admits/transfers you do not feel are "medically clear"

<u>FLOW CHART:</u>	Writes orders	Initiates orders	Admit Note	Physical exam	Auth.
PES ● UW Inpt	PES provider	UW resident	PES provider	PES provider	PES SW
HMC CL ● UW inpt	HMC C/L Resident	UW resident	UW resident	UW resident	HMC SW

UW ED ●HMC inpt	UW Resident	HMC RN	UW resident	UW resident	UW ED SW
UW CL ●HMC inpt	UW C/L Resident	HMC RN	HMC Inpt	HMC resident	UW SW UW Res

GENERAL ON-CALL INFORMATION

HOURS

Night Call (every night)	6PM to 8AM
Day Call (Sat, Sun and Holidays)	8AM to 6PM
Short Call (weekdays)	Until 6PM

WEEKEND/HOLIDAY DAY CALL

At UWMC the call is "home call." However weekend day call residents are expected to be in-house at the start of their shift. Please arrive for nursing rounds on 7N at 8:00am.

To Start Your Day Call

- 1) Sign-in to CORES as the Primary Contact for inpatient and consult teams.
- 2) Page the resident on call to get sign out. Make sure to leave enough time to get to the UW by 8am.
- 3) Be at 7N at 8am for nursing rounds.

Day Call Responsibilities

- 1) Complete floor work: Review labs from overnight, call consults, follow-up on anything listed in CORES. You are not expected to round on the patients with the attending.
- 2) See follow up consults.
- 3) See ALL new consults—do not postpone until Monday.
- 4) Complete all admissions that come to the floor (unless admitted from HMC PES).
- 5) Update CORES

NIGHT CALL

You are not required to be in-house for your call shift, but are available by pager and are expected to come in to the hospital when needed.

To Start Your Night Call

- 1) Sign-in to CORES as the Primary Contact for inpatient and consult teams.
- 2) Page the resident on call to get sign out. Be sure to leave enough time to get to the UW when your shift starts if necessary (usually around 30 minutes before you shift starts).
- 3) Check in with 7N. Call the front desk at 206-598-4720.

Night Call General Responsibilities

- 1) See Urgent Consults, including consultation to the ED. See [Triage](#) (pg.)
- 2) Address all 7N cross-cover issues
- 3) Complete all admissions that come to the floor (unless admitted from HMC PES)
- 4) Field telephone calls from UW outpatients (rare)

5) Update CORES

WHEN TO COME INTO THE HOSPITAL (MUST SEE PATIENT)

The basic answer is—**whenever you are requested to come in** or if you have to perform any patient care related duties. Here are some common scenarios in which you would be required to be present (**not an exhaustive list**):

- Admissions (except for transfers from HMC PES ONLY)
- ED evaluations (you'll be asked by the SW or the ED attending)
- Requests for new consults or follow-up of consult patients
- Patient safety concerns
- Behavioral issues or concerns
- Serious or acute medical concerns that need in person evaluation
- Any time you are going to prescribe medications to someone in the ED that is not going to be admitted

If you are ever unsure, you should always err on the side of coming in.

There is no "time" at which to pass on any emergent issues that require our evaluation (including but not limited to the following)

- New onset SI/HI
 - Although starting a 1:1 is an important first step, thorough psychiatric evaluation that allows for the relief of a staff member at the bedside, or escalation of safety measures (e.g. removal of dangerous objects, initiating restraints) is an **emergent** issue that requires our attention as psychiatrists.
- AMA Discharge
 - All fields can evaluate for decisional capacity, yet, if a primary team is requesting assistance, and the patient is insistent on discharge, it is within our purview to help guide the primary team and assist with a bedside decisional capacity evaluation. We want to ensure the **best** patient care, and without our assistance, a patient may be inappropriately discharged, or inappropriately detained, both of which are problems we can assist teams to avoid.
- Code Gray
 - Code Grays are called across the hospital, and may not always require psychiatry intervention. If a code gray is called, and psychiatry is consulted, please ensure prompt assistance as psychiatrist's training in communication and assessment of the patient can be of immense assistance for a primary team that is largely focused on the medical and surgical issues the patient is struggling with.
- Medical Issues on 7N
 - We are the *only* physicians that care for the patients on 7N. If a medical issue emerges, this is an important situation that should be assessed. If the medical issue is emergent, please ensure your presence to assist in evaluation. If you are concerned for the patient's medical status prior to your arrival, you can call nursing and have a rapid response initiated while you make your way to unit.

CONTACTING THE ATTENDING

The on-call attending should check in with you at the beginning of your call shift.

They should be your co-signer on all of your notes, though you should CC any related parties (inpatient or consult attendings/residents, outpatient providers, etc.).

At UWMC you must call your attending for:

- Unplanned discharges
- New consults
- Clinical decision making regarding SI/HI
- When discharging an ED patient with a rapidly deteriorating clinical course
- If a DMHP contacts you about taking an ITA'd patient on 7N
- When transferring a patient from a medical unit to 7N
- If the ED is requesting you to admit a patient that you do not believe is "medically clear"
- Before referral to DMHPs

In addition to the explicit occasions noted above, you should discuss with your attending ANY scenarios in which you are not comfortable, or have questions/concerns. It's strongly encouraged to also discuss prioritization and triage decisions when the consult and admission volume is high.

At UWMC, you are not *required* to call the attending for new admissions to 7N. If you have any questions, especially about starting new medications or other issues, please call the attending.

What if I cannot reach my attending?

First try their home and/or cell phone (which you may get from the UWMC paging operator). If you still cannot get a hold of your attending by pager or phone, call the following people in this order (the paging operator also has their numbers):

- 1) HMC on-call attending (not the PES attending) – if different than the UWMC attending
- 2) Dr. Ryan Kimmel (cell phone: 206-554-1347)
- 3) Dr. Thomas Soeprono (cell phone: 909-709-0447)
- 4) Dr. Rebecca Engelberg (cell phone: 206-465-5230)

SIGN-OUT

Weekday sign-out

- On the weekdays each day team (inpatient and C/L) should verbally sign out with the resident on short call, even if this is to say, "nothing to do, I'm leaving the hospital." Sign out should consist of any pertinent clinical information about patients on each of the teams.
- The incoming night call resident should page the short call pager (559-1264) to get sign-out from the short call resident. Incoming on-call residents should call early enough to get sign out from the short call resident so that they can be at the hospital by 6pm if needed, so usually between 5:00-5:30pm.
- The night call resident during the weekdays will verbally sign out to the inpatient residents in the morning, this is done by the incoming day residents calling the night call resident **by 7:45am** each weekday (except when the service only has R1s then on Thursdays AMs the night call resident should call the attendings directly for sign out).
- The sign out procedure for the consult team includes the on-call resident updating CORES and signing out directly with the consult team with any urgent/important issues from overnight.
- For any ED related issues, the on-call resident will sign out to the daytime ED social worker or ED attending as appropriate, and contact the consult service if this is indicated.

BE SURE TO SIGN-IN YOURSELF IN ON CORES SO OTHERS WILL KNOW YOU'RE THE PRIMARY CONTACT

Weekend/holiday sign-out

- On the weekends and holidays, the incoming day resident will call the off-going night resident to receive sign out. The incoming day resident needs to account for the fact that they have to be on the unit and ready for the weekend nursing rounds that start at 8:00am, so sign-out needs to be completed early enough to allow for enough time to get to the hospital by the start of rounds.
- The night call resident should call the day call resident early enough to get sign out so that they can be at the hospital by 6pm if needed, so usually between 5:00-5:30pm.

What if the on-coming resident does not call me for sign out?

If you do not hear from the on-coming resident, you should determine who the resident is and attempt to contact them, both by pager and by phone (look it up on https://psychres.washington.edu/WebApp/Uwnetid/resident_homelist.asp , or ask the operator for this info). If the on-coming resident has not been reached after 30 minutes, then you should call the first back-up resident. Remember, you are still the person covering until you have identified who will be taking over—you remain on-call until the back-up resident takes over. If the first back-up resident doesn't respond, call the second back-up resident.

TRIAGE: PRIORITIZING PATIENTS AND TIME MANAGEMENT

Some helpful guidelines in triaging patients

- Prioritize the patients for whom you are the primary physician responsible for their care.
 - *Examples:* All the patients on the inpatient unit
- The more acute and dangerous the situation sounds, the sooner you should see them.
 - *Examples:* In-hospital suicide attempts, violent or agitated patients (especially if they are necessitating security), or anyone with new concern for SI or self-harm.
- Any other patients that are waiting on you for a decision
 - *Examples:* Patient waiting to be discharged from a medical/surgical unit but needs to be cleared by psychiatry, someone in the ED waiting for a medication, or decisional capacity questions where you are asked to weigh in before they can make treatment decisions. These scenarios are more time sensitive and take precedence over requests that can wait, i.e. someone on the medical unit who wants to start an antidepressant.
- You can always call your attending for any challenging triage decisions or if you are feeling overwhelmed!

Triage Order

- 1) Urgent behavioral or medical issues for patients admitted to inpatient psychiatry
- 2) Urgent Consults:
 - a) Patient attempted suicide in-house or is threatening imminent suicide
 - b) Patient admitted after suicide attempt and requires safety assessment
 - c) Patient has or is threatening to assault staff or other patients
 - d) Patient is in restraints for behavioral issues and requires evaluation
 - e) Patient is asking to leave AMA and the team does not feel they have capacity

- f) Any other issue that seems emergent
- 3) ED consults
- 4) Non-urgent cross-cover issues
- 5) Non-urgent consults (during day call)

What If There Isn't Time For A Full Admission?

It is understood that there will be times that the on-call resident is unable to immediately perform the full admission work-up and documentation for patients transferred/admitted to the inpatient unit. This is most likely to occur near the end of a shift. In these situations, involve the 7N charge nurse and your on-call attending. Until your shift is over, it is expected that you come in to see the patient and do as much of the following as you can:

- Assess for urgent psychiatric or medical issues
- Place admission orders
- Review medications and continue home medications as indicated
- Complete a physical exam/ROS

Please briefly document any work you are able to complete in a free text note. Be sure to include:

- Medical issues and stability
- Primary psychiatric issues and stability
- Evaluation and treatment that needs to be initiated right away
- Physical exam/ROS, if completed.

Residents are encouraged to stay in communication with the 7N charge nurse, as the 7N staff will try to support the on call resident in the challenge of meeting multiple clinical demands. Based on the resident's workload, the charge nurse may be able to take this into account when making decisions about accepting new transfer patients, or at least may try to stagger the timing of the admissions.

DOCUMENTATION

Templates

UWMC psychiatry does its charting based on pasted templates. These notes exist in this format both as an impetus to record critical clinical information but also for billing. **If you are comfortable with Power Note you may continue to generate your notes this way as the relevant categories are included.**

These templates are available on the Psychiatry Residency web site, and can be found under 'Clinical Tools,' then 'UWMC ORCA Note Templates'. Or you can copy and paste this link: <http://psychres.washington.edu/clinicaltools/uworca.asp>

There are 4 templates available on the web site and the note templates are titled:

- Psychiatry Consultation Service Initial Evaluation Note
- Psychiatry Consultation Liaison Progress Note
- Inpatient Psychiatry Admission Note
- Inpatient Psychiatry Progress Note

Here is how to use them:

1. Open a new document in ORCA by going to 'Documents' and then choosing 'Add' from the list.
2. Copy the template text into your note
3. From here you can select note type and designate cosigners. See the chart below for guidelines on which note type to use and which corresponding template to choose.

Notably, for **falls**, there is a different template, found in a different location.

- In ORCA, click on "IVIEW & PowerNote" and click the "Open" button, and click on the tab "Encounter Pathway."
- Search "fall" and a note type "Provider Post Fall Assessment" will appear.
- Click the button "Add to Favorites" (so you don't have to do this every time).
- There are a number of preset boxes you can go through to document your physical exam findings and your plan.
- There is also a fall PowerPlan that can be found in Orders on ORCA.

Scenario	ORCA Note Type	Template
Admission to 7N	Type: "Admit Note" Subject: "Psychiatry Admission Note"	Inpatient Psychiatry Admission Note
Inpatient progress notes	Type: "Psychiatry Record - Inpt"	Inpatient Psychiatry Progress Note
ED evaluation (non-admission or transfer to HMC)	Type: "Psychiatry Emergency Svcs Note"	Psychiatry Consultation Service Initial Evaluation Note
Consults	Type: "Consultation - Inpt" Subject: "Psychiatry Consultation Initial Note" or "Psychiatry Consult Progress Note"	Psychiatry Consultation Service Initial Evaluation Note OR Psychiatry Consultation Liaison Progress Note
Fall	N/A	Provider Post Fall Assessment

Compliance Requirements

Admit Notes

To bill at the appropriate level, admission notes must have all of the following:

- Chief Complaint
- HPI
- ROS
 - o List all positives
 - o Write "ALL OTHER SYSTEMS NEGATIVE" (caps added for emphasis!)
- MSE
 - o All eleven elements
 - o List Attention/Concentration, Memory and Orientation as 3 separate items
- Medical Decision Making
 - o Give specific Assessment and Plan for each diagnosis
 - o Diagnosis

- List all psychiatric as well as medical diagnoses
- Note: Primary diagnosis cannot just be “Substance Use Disorder, as we are not accredited to treat chemical dependency and then the hospital stay will not be paid for. It is ok to use “Substance Induced” mood disorder or psychotic disorder or use abuse/dependence as secondary diagnosis.
- Note: in 2017, CMS is tracking active substance use, substance use in remission, and the associated treatments provided by the hospital. Be sure to include specific diagnoses (e.g. opiate use disorder, in early remission) and detailed information about recent and current substance use.

Discharge Summaries

To meet compliance requirements, Discharge Summaries must have the following:

- If the patient is on >1 antipsychotic, justification must be provided
- All discharge medications must have an indication
- Follow-up provider information
 - o Name of the provider
 - o Name of the Clinic
 - o Fax number of the clinic (we fax all D/C summaries)
- Forward to “UWMC 7N discharge summary pool”
- Medical students *can* complete discharge summaries **BUT**
 - o Residents must add an **addendum** with the daily Interval History, MSE, and Plan

Additional information

- Send all notes to the on-call attending, even if you do not discuss the patient with them.
 - o Also CC all related parties (eg. inpatient attendings for admits)
- You may want to write free text notes for less common scenarios such as telephone interactions or focused cross cover (please use appropriate ORCA note types for these).
- Update CORES with new patients for the inpatient psychiatric team, consult team, and for ongoing evaluations in the ED (add to consult team list). If you have referred a patient to the DMHPs in the ED, please update the CORES consult list so this patient can be followed by the consult service the next day.
- To comply with ITA laws, the UWMC templates contain a checkbox at the bottom for ITA patients. This is to certify that the psychiatry team has determined that the patient requires involuntary treatment and that that the patient has been discussed in a multidisciplinary fashion. These statements are required by law and must be included in each note for ITA patients.

TELEPHONE CALLS (UW OPC – OUTPATIENT CARE)

You may be called by patients associated with UWMC or other patients from the community. Before engaging in any conversation **get the phone number and address of the patient**, this is so you can reach the person if disconnected or send emergency help if necessary. If the patient will not give you this info you should end the call.

Document the phone call in ORCA and if the patient has a UWMC outpatient provider make sure to CC them on the note. In addition, send the provider an email asking them to check their ORCA inbox. Assuming the patient you talk to isn't in crisis, you can call your attending to ask for guidance about what to do and then call the patient back (for example, if an outpatient is requesting a medication refill). If the patient is in crisis, you need to decide whether or not to send the police/ambulance to their location or help the patient make arrangements to get to the nearest ED.

Requirements:

1. Take the call
2. Ask for the patient's full name and birth date
3. Enter telephone note in ORCA
4. CC the attending
5. Email the attending and ask them to check ORCA inbox

SAFETY

If you at any time would like the assistance of UWMC Public Safety please do not hesitate to call them via the UWMC operator, at their phone number 598-5555 or find them 24/7 at the desk outside the front entrance to the ED (on the other side of the wall from the ED SW offices). You may want to do this regarding patients you encounter in the ED, on 7N, for a walk to/from your vehicle, or for any other concerns.

RESTRAINTS

The resident needs to come in to do a face-to-face assessment with an associated note within one hour when a patient is initially placed in restraints. Every four hours the nurse will call to renew the restraint. This can be done over the phone, and no new note is needed. Every twenty four hours after the patient is placed in restraints, there needs to be a new face-to-face assessment with a paper note (although this "24 hr" time point can be reset by the day team, i.e. from 3 AM to 8 AM so that the night float resident does not need to come in the middle of the night)

MEDICAL STUDENTS ON-CALL

The medical students will sign up for various call shifts. For night shifts they will contact you by pager at the start of the shift if it is an evening shift. For weekend day shifts you should plan to meet the medical student on the unit by 8:00am. If you are at home and go in to see a patient, please remember to call the medical student if one is scheduled with you.

Medical student call shift hours are: Weeknights until 11pm and Weekend days 8am to 4pm or 4pm to 11pm.

CALL TRADES

If you are trading any call shifts, you must notify the chief resident, the call chief, and Athena Wong (aswong@uw.edu).

CONSULTS ON CALL

INPATIENT CONSULTS

Days

- On weekend days, the psychiatry on call resident is responsible for any psychiatric consults during their shift including non-urgent consults.

Nights

- On nights, the psychiatry on call resident is only responsible for urgent consults—non-urgent consults can be passed on to the next day.

Consult Requests

- All consult requests should originate from physicians/residents, not from other staff members.

Sign-Out

- If you are passing a consult on to the team in the morning, be sure to leave a voicemail for the consult service (598-7140) and put the patient on the Consult team's CORES roster.

Outpatient Consults

- We can only do consults on inpatients. Rarely, you may get a call from 4S or 8SE, which are outpatient/procedural clinics. Please direct them to the ER if they desire an urgent consult.
- This link contains more information if you receive an urgent consult regarding a suicidal outpatient: <https://uwmc.uwmedicine.org/sites/PoliciesProcedures/apop/Pages/85-38.aspx>
- If there are safety concerns, instruct the primary team to initiate the suicide safety protocol, and they or security will escort the patient to the ED.

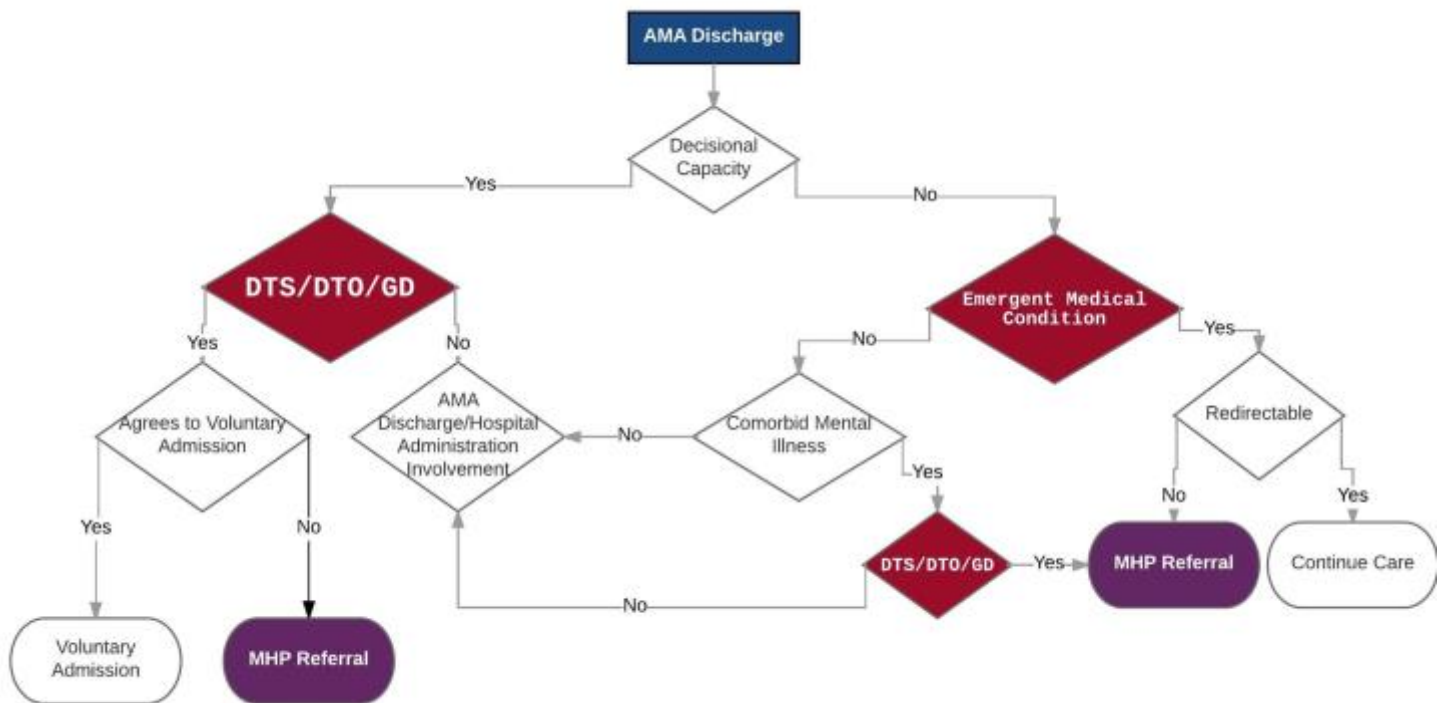
Suicidal Ideation

- New inpatient consults with suicidal ideation are to be seen within 3 hours by psychiatry and placed on the **Suicide Prevention Protocol** by the primary team.
- If you are very busy, you can do an initial quick 15min check/chart review, ask the team to put the patient on suicide protocol, and document a brief note explaining your safety recommendations and that you will be back to complete a full evaluation.
- After you see the patient, call your attending, then call the team back with your recommendations, then do your note.

AMA Discharge

- See flowchart below for AMA Discharges on consults
- Utilize this flowchart alongside your attending's knowledge base to make the best decision for the patient
- Important definitions include:

- Redirectable: If the patient can be reasoned with (regarding his/her desire to leave), can be appeased by various behavioral measures
 - o Patient is considered *not* redirectable: If the patient is demanding to leave or trying to leave, and requiring restraints to keep them from leaving; for the patient who despite their medical condition is able to get out of their room and head for the elevator, and needs hands-on/restraints to keep them in place.
 - o Medical restraints: Restraints that are placed clearly for medical (i.e. not behavioral) reasons, including but not limited to falls, pulling out their IV lines, and others. The rationale for restraints for medical reasons must be clearly documented, and if so, the patient can fall in the category of “redirectable” with such measures in place



CONSULTATION TO THE ED

Responsiveness to Emergency Department psychiatric consults is a priority on call. Although our social work colleagues evaluate and arrange disposition for the vast majority of patients presenting to the ED with psychiatric issues we may be consulted by EDSW or by the ED attending directly. Of note, resources in the EDSW office include a plastic bin with useful forms you may need when admitting a patient to UW or HMC.

Complete ED psychiatry evaluations when requested by the ED social worker or ED attending/resident. Please let the ED resident/attending know “face-to-face” when you start and finish your evaluation and tell them your recommendations. The UW ED does NOT have capacity to observe patients for extended periods of time. Please conduct a timely evaluation and make recommendations to ED physicians, admit as a voluntary patient or initiate MHP-Referral. If a patient is MHP’d in the ED, please see the patient and do an initial consultation-liaison note. The SW should call to let you know when a patient has been referred to the MHP in the ED.

See [Consultation to the ED](#) (pg.) section for more details.

Consultation and Discharge Only

If you’ve staffed a patient with your attending and you are not going to admit that patient whom you have seen in the ED, then type a “Psychiatry Emergency Svcs Note” into ORCA.

Consultation and Admission

If you are admitting a patient, follow directions under “Admission Checklist” listed below and document an admission note in ORCA.

Children

If you are consulted on a patient younger than 18 years old, complete assessment as usual. It may be helpful to involve Children’s Crisis Outreach Response System through Crisis Clinic at 206-461-3222 or 1-866-4CRISIS. See [If A Minor Presents to the ED](#) (pg.) for more information.

DMHP Referral

A patient who is being referred for MHP evaluation should be discussed with your on-call attending and the ED attending and staff. Patient’s safety should be assessed and you should review how the patient will be monitored while awaiting the arrival of the MHP. This includes an assessment of whether or not the patient needs a 1:1 sitter or if they need seclusion and/or restraints. After discussing with the ED staff about what staffing is available to provide a 1:1 sitter, the patient may need to be secluded if there is no staff to monitor the patient. **Choosing the appropriate level of monitoring is an important safety concern and this decision should be made as a team, including both ED staff and your attending.**

Restraint Documentation

Restraint documentation is necessary for either seclusion or physical restraints. If you need to have a patient restrained or secluded, communicate with the ED Attending, Charge RN, and/or the RN working with the patient. The nursing staff is responsible for implementing the restraint protocols & completing the paperwork required for restraints. You are responsible for providing any info about the reason for restraints. Please note that locking the room door is a form of restraint (SECLUSION) and complete documentation is required.

Writing an Affidavit

If you act as an affiant in the involuntary detention of a patient while on call, **you need to be available to testify in 3 business days.** For night float residents, if there is a training call resident, this person should be the affiant. If the night float resident is solo, **you should recruit the SW or other staff to be an affiant if appropriate.** See [MHP REFERRALS AND AFFIDAVITS](#) (pg.) and [ITA PROXY](#) (pg.)

Boarding

Voluntary patients boarding in the ED

- With bed capacity down, there have been situations where voluntary patients are waiting for a bed to open up (sometimes for a day or two). If residents are called by the ED or find out about a boarded voluntary patient, then please see the patient and do a new consult note, and staff with the attending. The attending may or may not see the patient depending on acuity. (i.e. The attending does not need to see the patient daily like with an involuntary patient).
- The resident should see the patient every day, and do a f/u consult note daily while the patient is boarded in the ED.

Involuntarily detained patients boarding in the ED

Detained patients may end up boarding in the ED until placement is found. The length of stay of these detained patients in our ED may be up to 72hrs (these refer to business days, so there is a theoretical possibility of 5 day boarding time if the 72 hrs begins over a weekend). *Before seeing an ITA patient, please check with security (RN, and SW as well) to see if they have any concerns about you interviewing the person alone or if they feel they or security should be on standby.*

- The DMHP will fax a 'one bed certification' to the ED to be placed in the patient's chart.
- These patients will be seen by the UWMC Consultation-Liaison service as consultations.
- The ED staff has **primary responsibility** for these patients with the C/L service providing recommendations and input regarding treatment.
 - The consulting resident **can and should** write the order for the antipsychotic medication and associated compel order
 - **ANY** emergent indications for psychiatric medications will still be ordered by the ED staff
 - For example, although the ED may call for assistance with an acutely agitated patient, you should instruct the ED staff to proceed as clinically indicated as it may take you time to see and evaluate the patient and provide recommendations
 - All other medical issues will be managed by the ED staff
- Whenever a patient is detained to the UWMC ED, information about the patient should be **entered into CORES on the CL Team.**
- After hours and on weekends, these patients will be seen by the on-call resident. Per ED staff, these patients all receive one-to-one observation and q 15min checks.
- ED staff will write all orders and complete all physical examinations and medical work ups.
- If the patient is suicidal, the Suicide Prevention Protocol should be instituted.
- All clinical documentation should be entered in ORCA as a Consultation Liaison follow up.
- Attending psychiatrists will need to see these patients daily, including on weekends/holidays.
- Patients already detained to the UW ED should NOT be accepted onto 7N for boarding by the on call resident. This is a decision which should be made only by the 7N medical director or nursing manager.

When is a patient considered boarding?

Finding beds for both voluntary and involuntary patients can take a significant amount of time—it can often take several hours to find placement. You are not required to see every psychiatric patient waiting in the ED for placement. You are required to see patients when they are boarding. For involuntary patients, this is when the UW has obtained a single bed certification from Western State Hospital. When this occurs, the UWMC ED social worker will contact you. Other detained patients may benefit from psychiatric consultation while waiting placement—for example to receive compelled medications. In this case, it is the ED social worker or ED medical provider's responsibility to seek your assistance. If you have any questions about whether a patient in the ED needs to be seen, contact the UWMC ED social worker.

ED SOCIAL WORK

UWMC has 24-hour social work coverage, but there may be instances when a SW is unavailable. If this happens please refer to "Resources if there is no ED SW" in the appendix. **You are not expected to do SW tasks for the ED if there is no SW coverage**, i.e. find dispo for medical patients/bus tickets. If you get a call from the ED asking you to do SW tasks, you can help them out by giving them some numbers to call in the appendix. There is also a 24 hr SW coverage by pager which you may access through the operator. If that SW does not know the answer to your question, our ED SW Maggie Yamanakahas graciously offered to help us and you can access her by paging her at 206-986-1021 day or night.

Social Work Assistance

If you complete an assessment of a patient and the patient needs transfer to detox or an outside hospital or needs assistance with other community resources. You are expected to work collaboratively with social work staff in problem solving and accessing these resources. You must clearly document in your note what resources you are recommending, including an assessment that supports that level of care.

Gaps in Social Work Coverage

If you are on call when there is a gap in SW coverage, please email the chief resident and explain when it happened, how much notice you were given, and a brief description of any work you had to do as a result and the amount of time it took you to do it (e.g. "Saw two patients, admitted one, discharged one, 3.5 hours of work")

If a social worker is leaving shift with no follow-up coverage, then please have them sign the case back to the ED attending and request that the ED attending consult as needed.

If there is no social work staff on shift, then the ED may consult with you directly. You may sign out your recommendations back to the ED staff once you have made your assessment. If patient needs admission and there are no beds at HMC and UWMC, you may be asked to help find a placement.

Assisting the social worker

You may be asked to consult with social work in the following cases:

Medication assistance

- If the social work evaluation indicates that medication or change in medication may be helpful. See the patient, consult with attending as needed and write Psychiatry

Consultation Service Initial Evaluation Note. In general, we try to avoid starting new medications or making med adjustments in the ED as it's often not clear who the patient will follow up with, call if they have a med reaction, etc.

Detained patient in the ED

- Before seeing an ITA patient, please check with security (RN, and SW as well) to see if they have any concerns about you interviewing the person alone or if they feel they or security should be on standby.
- Please see newly detained patients in the ED and complete an initial psychiatric consultation-liaison note. If the SW initiated and completed the MHP referral, they should call you to let you know that there is a patient in the ED who is now detained.
- There is no legal obligation to see a patient immediately after they are detained, but there is usually a clinical reason to, so we ask that this be done unless there is a compelling reason not to (keep reading). Please assess the patient to see whether psychiatric medications are indicated overnight or over the weekend and let the ED attending know your plan (i.e. a psychotic/manic patient can now be given antipsychotics, or you are going to give a catatonic patient benzodiazepines, etc).
- You can obtain an antipsychotic compel by getting signatures from the ED attending, and your attending (via phone). See [Antipsychotic Consent/Compel](#)
- If you feel strongly that there is no clinical reason to see a patient in the ED that has just been detained and you feel that it would be counter-therapeutic to see the patient then (e.g. suicidal patient who has been awake for 3 days just fell asleep and it's 3 AM), you need to confer with your attending about this decision, and WRITE A NOTE to at least document when you were informed that the patient has been detained, and explain why you felt it was better not to see the patient at that time (if the patient was ill enough to be detained, this will be uncommon). Additionally, **you must ADD THAT PT TO CORES** and call the consult voicemail (598-7140) and alert them that the patient is there, is now detained, and will need to be seen in the AM.

Diagnostic/Medical Or Disposition Question

- You may be asked to consult when there is a question of diagnosis, if acute medical issues are part of the presentation, when there is concern that symptoms are result of medication reaction, or for an additional opinion about disposition options for a patient, etc. It is important to have clear communication about the question you are being asked to evaluate and to have clear documentation of your assessment and recommendations.

Patient BIB police

- If a patient is BIB police, they need to be evaluated by a mental health professional within 3 hours. If the patient was not seen within 3 hours, this can be used as grounds for a dismissal. If a social worker asks you to see someone because they're worried about missing this 3 hour window, you should go in and see the patient.

Transfers to Harborview's inpatient unit:

- see [Admission to HMC checklist](#) (pg.)

Back-up

- If there are 3 patients or more waiting to be seen in the ED, you may be asked by the social work staff to perform an evaluation/consultation. You can discuss with the social work staff/ED staff which patient is most likely to need medications/admission and see that patient.
- We are always working together as a team. At times this may necessitate good communication about what roles each person will perform. For example, it may make most sense for the psychiatry resident to evaluate a new patient that will likely need admission and ask for social work assistance in accessing community resources for a patient that has been seen.

PHONE CONSULTS

- Rarely, you may be called by an outside hospital for input on patient care, or for a transfer (these pages may be labelled "MedCon")
- For all medical questions from outside hospitals:
 - Page the attending on call
 - Provide the contact information for the individual asking for medical input to the attending
 - FYI: MedCon is a consult service where UW specialists provide relevant clinical information for situations in which the community provider is requesting additional guidance
- For transfers:
 - Contact the 7N charge
 - Provide the contact information for the individual requesting a transfer

ADMISSIONS/DISCHARGES

ADMISSIONS TO 7N

Screening/Insurance Authorization

- During business hours: Central Intake screens and arranges admissions
- Nights/Weekends: 7N charge nurse screens and arranges admissions.
- The charge nurse may accept patients without consulting psychiatry on-call resident.
- **If you are seeing a patient in the ED you would like to admit, be sure to contact the 7N screener prior to moving forward with an admission**
- The On-call attending should also be involved in the process of deciding to accept any transfers of medically complex patients.
- Occasionally, insurance authorization cannot be confirmed. In this case the patient is often denied admission. UWMC hospital charges are significantly higher than other Seattle psychiatric hospitals. UWMC is often not an in-network provider, especially for out-of-state insurances. To spare the patient thousands of dollars of hospital bills, UWMC often will deny admission and advise seeking admission at other Seattle psychiatric hospitals. This decision often involves the nurse manager.
- The following patient characteristics are generally not compatible with 7N voluntary admission:
 - Inability to understand voluntary treatment agreement.

- o Unable or unwilling to provide informed consent for psychiatric admission.
- o Refusing or ambivalent or vacillating about voluntary admit.
- o Unwilling to comply with treatment planning or participate in recommended treatment modalities (including groups and medications).
- o Suicidal or self-destructive patients who cannot or are assessed to be unable to refrain from self-harm.
- o Homicidal or threatening patients who are assessed to be unable to refrain from harming or threatening others.
- o Recent assaultive or threatening behavior toward others.
- o Recent fire setting or destruction of property.
- o Involuntary patients referred from outside 7N by MHPs.
- o Patients with primary addiction problems without a concurrent psychiatric illness.
- o Medical instability (the patient is not medically stable for transfer).
- o A primary diagnosis of a severe eating disorder.

Admission to 7N From UWMC ED (seen by SW) or Outside Hospital

- Outside hospitals or ED SW will call the screener to present patient for admission
- The charge nurse is responsible for ensuring that hospital authorization was obtained
- If accepted, the charge nurse will page the resident to inform them of the accepted patient and will page the resident again when the patient has arrived on the unit.
- UW resident will:
 - o Enters admission orders on UWMC encounter (Resident also initiates orders)
 - o Writes admit note
 - o Completes physical exam

Admission to 7N From UWMC ED (seen by psychiatry)

- Occasionally, a resident will want to admit a patient they are seeing in the UWMC ED.
 - o This could be a patient seen earlier by a resident or a patient the resident was called in to evaluate.
- The UW resident will:
 - o Discuss the case with the on-call attending
 - o Call the 7N screener (the charge nurse afterhours) to screen the admission
 - o If the patient is accepted for admission, the resident will
 - Enters admission orders on UWMC encounter (Resident also initiates orders)
 - Writes admit note
 - The patient should have a new admit note, even if a PES or C/L note has already been written.
 - To save yourself from writing two notes, write only an admit note if you know the patient will be admitted.
 - Completes physical exam
- The UW charge nurse is responsible for ensuring authorization was obtained

Admission to 7N from HMC PES

- HMC PES contacts the UWMC screener to screen patient for admission
 - o If UW resident is inadvertently contacted first, please refer them to charge nurse for screening
- If patient is accepted, the charge nurse will page the UW resident so that they are aware of newly admitted patient.

- HMC PES provider will:
 - Obtain preauthorization
 - Enter admission orders on UWMC encounter (Do not initiate)
 - Write admission note
 - Add the patient to UWMC CORES (if PES provider is a resident)
 - Verbally sign-out to UWMC resident
- UW Resident will:
 - Initiate orders
 - Add the patient to UWMC CORES
 - Does not need to see the patient or write a note
- The patient will be seen by the primary team or on-call attending the next day
- Patient should be brought to admitting office (before midnight) or ED (after midnight). Patients are taken to the ED registration desk to sign consents, not for an ED evaluation!

Admission to 7N of a Patient Seen by the HMC Consult Team

- HMC SW or HMC resident will:
 - Contact UWMC screener
 - Obtain preauthorization.
- HMC C/L resident will:
 - Write admission orders on UWMC encounter (Do not initiate)
 - Add the patient to UWMC CORES
 - Verbal sign out to UWMC resident
- UWMC resident will:
 - Do an in person evaluation
 - Completes physical exam
 - Writes admit note
- If UWMC resident does not receive word about a pending transfer from HMC and nurses on 7N call to inform you about the patient's arrival, call the HMC consult team (989-9863 from 8am-5pm) or the PES resident (744-3076) to discuss the patient.

Admission (transfer) To 7N of a Patient seen by UWMC Consult Team

- UWMC C/L resident will:
 - Contact UWMC screener
 - Obtain preauthorization
- Primary team will:
 - Discharge the Patient
 - Place a discharge order
 - Complete the Discharge Medication Reconciliation
 - Submit a discharge summary
 - The discharging team will probably not know this because psychiatry and rehab are the only two inpatient services that function this way.
- UWMC C/L resident will:
 - Write admission orders on UWMC encounter (Do not initiate). See [Transfer Orders](#).
 - Add the patient to UWMC 7N CORES
 - Verbally sign out to UWMC resident
- UWMC 7N resident will:
 - Do an in-person evaluation
 - Complete a physical exam
 - Write a complete admit note

- On Call C/L team to 7N Admissions:
 - C/L to 7N admission do not typically occur after hours, but there may be clinical scenarios in which it would be appropriate to have the patient transfer to psychiatry.
 - If the on-call resident gets a request for “transfer” in the evening or on a weekend/holiday (that was not already coordinated by the C/L service), the resident should evaluate the patient and discuss the case with the on-call attending.

ADMISSIONS TO HMC INPATIENT

Sending UW ED Patients To HMC Psychiatry

- After business hours, the UWMC ED SW (or resident) will contact the PES attending regarding bed availability.
- The UW resident completes the entire admission:
 - Obtains authorization (ED SW can help if available)
 - Enters admission orders on HMC encounter (do not initiate!)
 - Writes admit note
 - Add to HMC CORES
 - Gives verbal sign out to HMC PES resident
- HMC nurse will initiate orders
- HMC resident does not need to see the patient (same as coming up from HMC PES)

Sending UWMC Medical Patient (Psych C/L Patient) to HMC Psychiatry

- During business hours, the primary team SW or C/L resident will call HMC screener (989-4845) to get patient approved for transfer.
- SW to arrange transportation
- UW C/L team Will:
 - Obtain authorization (primary team SW can do if privately insured)
 - Write daily note
 - Enters admission orders on HMC encounter (do not initiate!)
 - Give verbal sign out to HMC resident
 - Add to HMC CORES
- HMC nurse will initiate orders
- HMC resident will:
 - Do in-person check-in
 - Complete physical exam
- Admit note will be done by HMC inpatient team the next day

Sending 7N Patient To HMC Psychiatry

- 7N SW will call HMC screener (989-4845) to get patient approved for transfer
- UWMC resident will:
 - Obtain authorizations (possibly with assistance from 7N SW)
 - Enter admission orders on HMC encounter (do not initiate!)
 - Give verbal sign out to HMC resident
 - Add to HMC CORES
- HMC nurse will initiate orders

- HMC resident will:
 - o Do in-person check-in
 - o Complete physical exam
- Admit note will be done by HMC inpatient team the next day

ADMISSION ORDERS

Orders

- 1) Select the correct encounter by clicking "Selected Encntr:" at top of screen
 - a) Double click on the encounter for the current admission. This will state "Inpatient" under Visit Type, "UWMC" under Facility, "Psychiatry" under Medical Service, and the admit date under Admit//Arrival.
- 2) Click on the Orders tab on the left pane
- 3) Click on "Document Medication by Hx" at the top left
 - a) Enter home medications by clicking the "+Add" button on the top left
- 4) Click on "Reconciliation," then click on "Admission" from the drop down box
 - a) Continue (green triangle) or Discontinue (red square) home medications
 - b) Click on "Reconcile And Sign" at bottom right
- 5) Add Psych Admit Power plan
 - a) Click "+Add" on top left
 - b) Search for "psych admit" then click on "PSYCH Admit"
- 6) Complete Power Plan
 - a) Click on drop down for "Admit/Place Psychiatry INPATIENT"
 1. Select team, attending, and admitting diagnosis
 - b) Click on drop down under "Psych Precautions" and select precautions
 - c) Select Diet
 - d) Add home medications by clicking on button at the upper left that looks like an eye looking forward or a triangle
 - e) Add additional medications by either clicking on available options or using "+Add to Phase" then "Add Order..." from the drop down
 1. Be sure to add PRNs
 - f) Add labs by either clicking on available options or using "+Add to Phase" then "Add Order..." from the drop down
 - g) Add antipsychotic consent or compel
 1. Click "+Add to Phase" then "Add Order..."
 2. Search for "psych precautions" and click
 3. Click on "*Psych Alert(s):" drop down
 4. Select "Consent for antipsychotic meds signed" OR
 5. Select "Signed Compel Order in place"
 - h) Click "Sign"
- 7) Initiate orders per site policy
 - a) Initiate button is found on the bottom right
 - b) You can also right click on the power plan in the left pane and select "Initiate"

*****If you do not do in this way (add meds first while you go through your power plan) then you will have to add them all in again when you do med reconciliation*****

Encounters

Orders must be entered under the encounter for the current inpatient psychiatry admission (either at HMC or UWMC). If entered under the incorrect encounter, orders will be dropped.

ADMISSION CHECKLISTS

Admission to UWMC Checklist

- Pre-Authorization (see [Pre-authorization](#) (pg.)—usually already done by ED SW or OSH)
- Consent for psychiatric admission (usually done by ED SW or nursing)
- Make sure patient has had safety screen/search
- Medication Reconciliation form needs to be filled out electronically
- Enter Admission orders
- Antipsychotic consent form signed by patient and electronic order
- Treatment Partnership Agreement if appropriate (based on clinical scenario)
- Physical examination (cannot link to ED physical exam)
- Document note and physical exam in ORCA (see [Documentation](#) (pg.) for details on note types and templates).
- Update CORES
- DO NOT TRANSPORT ALONE! If you will be transporting the patient from the ED to 7N, ALWAYS ask security or another staff member to accompany you.

Admission to HMC Checklist

- UWMC SW (or resident) calls PES attending, if bed is available and PES attending accepts patient then PES attending coordinates with HMC charge nurse
- PES attending provides contact information for unit charge nurse to UWMC ED SW (or resident)
- Consent for admission and preauthorization needs to be obtained (usually done by SW)
- Complete admission forms. You can find these forms in a plastic bin in the ED SW office:
 - Consent for admission
 - Antipsychotic consent form signed and electronic order
 - Compel order if needed. See [Compel Orders](#) (pg.)
- UWMC (or MHP) arranges transportation
- UWMC resident gives sign-out report to charge nurse at HMC and HMC resident.
- Send with the patient any paper orders, along with ITA detention order if applicable
- UWMC resident updates CORES
- UWMC resident places admission orders
- UWMC resident calls PES attending if patient's condition changes between time of admission acceptance and transfer to HMC

TRANSFERS

Transfer From Psychiatry To Medical/Surgical Service

- UWMC resident will:
 - o Coordinate transfer with consulting medical/surgical team
 - o Discuss transfer with the psychiatry attending
 - o Place a discharge order
 - o Complete the Discharge Medication Reconciliation
 - o Submit a discharge summary (primary team)

- o Usually place the patient on C/L CORES and sign-out to the C/L team (or leave VM at 598-7140)
- Transfers on-Call
 - o In lieu of full discharge summary can write a brief discharge note with:
 - Basic information about the patient, the diagnosis and reasons for psychiatric admission
 - Detailed account of events leading up to their transfer, i.e. chest pain, fall, lab abnormalities, etc.
 - Rationale for transfer, i.e. admit to medicine for rule out MI, etc.
 - Psychiatric treatment recommendations while they are on the medical/surgical service, i.e. medication recommendations, safety concerns such as need for sitter/restraints or not, etc.
 - At the end of the note write "Full discharge summary to follow on Monday by the primary team"
 - CC your note to the primary team

TRANSFER ORDERS

Tell the primary service (med/surg/neuro, etc.) that the transfer has to be completed as a discharge from their service and a new admission to psychiatry. This is a billing issue, and it has to be done this way. That means that they will need to put in a DISCHARGE ORDER, and DISCHARGE MEDICATION RECONCILIATION, and a DISCHARGE SUMMARY. They will be used to using transfer orders in these situations because that's what would be used for movement from one service to another except when patients go to inpatient psych or rehab. Once you decide to move the pt to 7N and the charge nurse has okay'd it, page the primary team's resident to explain this to them (the orders will get messed up if they don't do it correctly).

To write orders for these patients (this will mostly be the psych consult resident doing this), you will need to select the encounter for the 7N inpatient psychiatry admission. To do this, open the patient's chart and click on "Selected Encntr" on the top menu bar. Select the encounter that lists "Inpatient" under Visit Type, "UWMC" under Facility, "Psychiatry" under Medical Service, and the correct admit date under Admit/Arrival. If you do not see this listed, 7N nursing staff may not have posted the new encounter yet. Please be patient; you may also ask them to page you once they have added the encounter.

1. Once you're on the correct encounter, you can then enter a Power Plan the same as you would for any other admission (ie. Add-> psychiatry-> psych admit-> Psych admit power plan).
 - Any additional med, lab, etc you want to add to this power plan you have to add using the "**add to phase**" button with blue cross, and not use the usual "add" button. If you don't use the "add to phase" button, those orders will get dropped when the Power Plan is initiated.
 - Do not do an admission medication reconciliation because these medications will not be available to nursing. Follow the instructions above to add medications.
2. Sign the orders by clicking "orders for signature" then "sign." **DO NOT INITIATE.** If you initiate, your orders will not be able to be transferred to the new encounter and you will have to re-enter them.

3. The MD responsible for admissions at the time the patient arrives on 7N will initiate the orders when the patient arrives (this will be the resident on that team if the pt arrives prior to 3PM, the short call resident if the patient arrives between 3-6PM, or the on-call resident if the pt arrives after 6PM). The floor is supposed to page the resident within a few minutes of the patient arriving. **If you find out that you were not paged in a timely fashion (i.e. within minutes of the pt's arrival), please try to find out why and explain that the MD needs to know as soon as the patient arrives so that orders can be initiated and the admission completed. Please email the chief resident with details if this happens so that we can provide specific feedback to the relevant parties.** In the past, 7N nurses would initiate orders in these scenarios (as is done at HMC), but there were significant problems with this (i.e. delays, confusion) that could have caused patient harm, so the policy was changed—some of the RNs are still confused about this so you may need to gently remind them.

ADMISSION CHART

UW ⑥⑦ HMC	Writes orders	Initiates orders	Admit Note	Physical exam	Authorizatio n
PES ⑦ UW inpt	PES provider writes orders, calls verbal signout to UW resident, UW resident updates CORES	UW resident	PES provider	PES provider the UW resident does NOT have to do a face-to- face eval in this scenario	PES SW PES provider if SW unavailable
HMC Consult ⑦ UW inpt	HMC Consult resident writes orders, calls verbal sign out to UW resident, and updates CORES	UW resident	UW resident	UW resident	HMC SW HMC provider if SW unavailable

UW ED ⑦ HMC inpt	UW resident writes orders, calls verbal sign out to HMC resident, and updates CORES	HMC RN	UW resident	UW resident (the HMC resident does not need to do a face- to-face)	UW ED SW UW resident if SW unavailable
UW Consult ⑦ HMC inpt	UW Consult resident writes orders, calls verbal sign out to HMC resident, and updates CORES	HMC RN	HMC inpatient team (Often the following AM)	HMC resident	Depends: primary team SW if pt has private ins; UW resident if gov't funded

DISCHARGES

AMA Discharge

- You must discuss any AMA discharges with your on-call attending.
 - If the patient is on a medical or surgical floor, and the primary team is concerned about the patient's welfare, complete an evaluation
- If discharge occurs afterhours or on a weekend/holiday:
 - If the patient was seen by the primary team: you can write a brief note in lieu of a full discharge summary, which would include the following information:
 - Basic information about the patient, the diagnosis and reasons for psychiatric admission
 - Detailed account of events leading up to their discharge
 - If MHPs were called, discuss details of this assessment and the decision made
 - Provide any psychiatric treatment recommendations if appropriate, i.e. any recommended follow-up, if medications were given on discharge, etc.
 - Be sure to include in the note any re-admission criteria, i.e. patient should not be considered a good faith voluntary for future admissions, patient may be considered for voluntary admission if _____, etc.
 - At the end of the note write "Full discharge summary to follow on Monday by the primary team"
 - CC your note to the primary team
 - If the patient was not seen by the primary team (i.e. the patient was admitted over the weekend), submit a full discharge summary. Please submit the completed summary to the [UWMC 7N discharge summary pool](#).

- You will need to write discharge orders. Typically discharge meds are not given for AMA discharges, but this will depend on the scenario and your clinical judgment.
- Complete the inpatient discharge form:
 - Select the Discharge Readiness menu tab, then “Enter new inpatient discharge form,” then “Psych transition record”
 - Complete all fields and select the green checkmark on the upper left to sign
 - Patient’s discharge paperwork will autopopulate with information from this form.

Discharge Orders

- 1) Click Discharge Readiness (one of the left tabs)
- 2) Med Recon (add tab)
 - a. continue or discontinue meds, middle button if you want to write a prescription
 - b. to print meds, go to “medication list” (one of the left tabs). Right click on the med
 - **click resend** (not print—it will print a pamphlet instead). Can also highlight multiple meds by holding down on CTRL button.
- 3) Diagnosis: click on correct diagnosis, then change diagnosis from “working’ to “discharge”
- 4) Discharge order: little light blue triangle by add button: “discharge patient – inpatient”

NO ECT

The UWMC does not practice ECT. If you anticipate a need for ECT please notify Clemen Katiraie at Central Intake or email her directly at katiraie@u.washington.edu . This can start the process of hospital preauthorization evaluation for a bed at another hospital where the patient can receive ECT.

ITA PATIENTS ON 7N

Infrequently, a DMHP may request UWMC to accept a detained patient under the One-Bed Certification procedure. This is just that, a REQUEST for 7N to accept this patient. The on-call resident should talk to the DMHP and hear about the case and try to determine if the patient is appropriate for the UWMC inpatient unit.

Points to consider in making this decision:

- Can the patient be cared for in a safe/effective manner on our unit?
- Are there medical treatment needs that cannot be accommodated at other facilities like HMC (i.e. patient is pregnant and obstetrical care is not available)?

After hearing about the patient case, the on call resident is required to discuss the case with the on-call attending.

- If the decision is to NOT admit ---then you may decline to accept this patient. If problems arise (e.g. The MHP is unhappy with this), then again contact your attending and/or the medical director (Ryan Kimmel) for reinforcement.
- If the decision is to ADMIT ---then confer with the nursing manager (Chris Larson) or medical director (Ryan Kimmel) BEFORE accepting the patient, even if it is in the middle of the night. Contact information for Chris Larson and Ryan Kimmel is available on the unit.

PRE-AUTHORIZATION

Pre-authorization means that you are getting approval from the insurance company that the patient is sick enough to be admitted. Usually the ED SW will do this, but on some occasions you may have to do this. This is important to do so that the patient does not get billed later because of failure to try and call for pre-auth.

Who to call

Depends on what kind of insurance (or lack of insurance) they have. One way to find out what their insurance is, is to look under EPIC -> patient profile -> benefits or eligibility

- For private insurance: call the number on patient's insurance card. If they don't have their card, Google their insurance company.
- For Medicaid clients: call the King County Authorization line (461-4858)
- For Medicare clients: no preauthorization is required
- For Group Health clients: call Group Health central operator 206-326-3342 and they will page the psychiatrist on call for pre-authorization after hours
 - Group Health patients cannot self-refer to UW or be admitted through the UW ED without Group Health approval. UW has a contract with Group Health, but we are only allowed to admit and be paid for their patients after individual authorization is obtained. Under usual circumstances UWMC would not treat Group Health patients, as they would be out of their covered system.
 - Group Health Medicare patients need to be referred by Group Health and need to be authorized for admission by Group Health. Patients who have not assigned their Medicare to Group Health do not require preauthorization for admission.
- **UWMC Hospital Tax ID# 916001537**

Different Outcomes Of Preauthorization

- Accept: Great! admit the patient to UW or OSH
- Can't reach anyone: usually the case on weekends, especially weekend nights. Leave a message if you are able to. Usually, OSH will still accept the patient if you tell them you tried to do pre-auth but couldn't reach anyone.
- Reject: This will be a clinical decision. Talk to your attending about whether or not this would change your plan. Can usually talk to the preauthorization person's supervisor to appeal especially if patient is unfunded or has Medicaid.

Document Preauthorization In Your Admit Note

- 1) If you obtain preauthorization:
 - a. Include the number you called
 - b. To whom you spoke, or if you left a message.
 - c. Document the number of days the authorization is good for if this is given.
- 2) If you are unable to reach someone:
 - a. Include the number you called,
 - b. How you obtained that number, (i.e. Patient didn't have their insurance card so I did a Google search and found their website),
 - c. Whether or not you were able to leave a voice mail.
- 3) The more information you document means the less likely the insurance company can withhold paying the hospital/ billing the patient.

INPATIENT AND CONSULTS

HOURS

On Mondays, Tuesdays, Wednesdays, and Fridays, residents on inpatient psychiatry rotations are expected to arrive on their clinical service by 7:45am for sign-out, and to work until 5pm (6pm if on short call).

ABSENCES/COVERAGE

- If a resident is ill and cannot come to work, he/she (or someone on his/her behalf) must page, email, and/or call the attending and chief resident as soon as possible that morning.
 - Please page the attending and send a confirmatory email to the attending and CC Athena Wong (aswong@uw.edu)
 - If you do not receive a reply from the attending, call/text and page the Chief Resident and await reply.
 - Residents may arrange with their attending in advance to be absent from their inpatient service on a weekday afternoon (e.g. for medical appointments, supervision). PGY-2 residents must attend scheduled continuity clinic.
 - When a resident must be absent from his/her inpatient service for didactics, clinic, supervision, or appointments, there should be a clearly designated covering physician for the service (e.g. the attending during didactics, the short call resident for afternoon absences).
 - The covering physician should be contacted with any patient care questions during the resident's absence. However, if the resident is paged during these times, he or she should answer the page, if only to direct the caller to the appropriate covering physician for the service.
 - Residents are required to request approval from the attending and chief resident for vacation at least 30 days in advance. Educational leave must also be approved by the program director.
-

CHARTING/PATIENT NOTES

- See above for more information about [Documentation](#) (pg.) in ORCA. Progress notes are written by the resident (at least) three times per week.
- Your attending also writes progress notes and they generally "link" to yours. So, if you are not writing notes on the 'usual' M-W-F schedule, be sure you discuss this with you attending.
- All daily notes must be completed before 6pm and before leaving the unit. Discharge summaries need to be completed within 24 hours of discharge.
- All notes from which billing is done (admit, daily progress, and d/c summaries done on the day of discharge) need to be entirely generated by the resident (not medical student) for billing purposes.
- Medical student notes: while they are welcome to write notes, these notes do not count as official documents!
 - When students are rotating on the consult service they can write daily SOAP notes that can be co-signed, but the notes need to have a full addendum by the resident, fellow or attending.
 - While on the inpatient rotation, the students are encouraged to write discharge summaries for the patients they follow. They may do this by either:

- Writing the discharge summary in a Word document and then sending it to the resident for review/edits and then this document can be entered into ORCA
- The resident and student can co-write a discharge note directly into ORCA, with the resident being the listed author and signer (not the medical student)
- If there is already a daily progress note in the ORCA (written by the resident or attending) on the day of discharge, then the medical student may write an independent discharge summary in ORCA and send it to the resident to co-sign. The residents will then review and edit the note before signing.

SIGN-OUT

- Inpatient residents should arrive early enough in the morning to receive sign out by 7:45am. Consult residents will check CORES for updates. If any urgent/important issues occurred overnight, they **should** receive a verbal sign-out in the morning.
- All residents (inpatient and consults) should sign out in the afternoon/evening to the short call resident, who then signs out to the overnight resident at the end of their shift. Sign out should ALWAYS be verbalized to the short call resident prior to other residents leaving, even if this is just to communicate that a resident is leaving the hospital and there is nothing to be aware of or to be done. Short call residents will pass on any information received from the Psychiatry Central Intake office to night call residents.
- CORES should be updated each night for each patient, being as specific as necessary to guide covering physicians what to do or not to do over the night/weekend. For the weekends, the consult team's sign-out should indicate which patients need follow up over the weekend and specific instructions on what should be evaluated.
- Sign out instructions should include context and 'if, then' instructions, instead of just 'check on' instructions. For example, lab follow-ups for patients should include context about why a lab was being done and what to do with the results.
- Please see the attached section below for details on CORES signout, and the importance of verbal sign out for medically active patients.

DISCHARGING A PATIENT

General Information

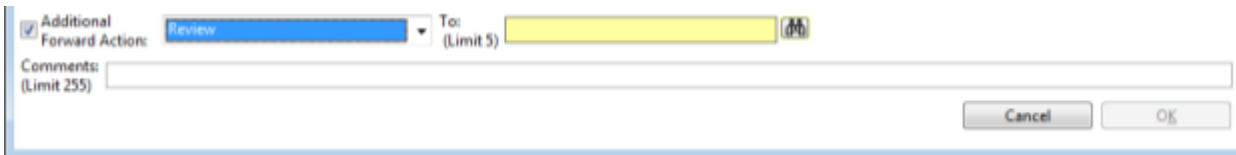
- Write and submit all discharge orders (w/ pharmacy orders) to the 7N front desk by 4:00pm of day PRIOR to discharge.
- Complete inpatient discharge form:
 - Select the Discharge Readiness menu tab, then "Enter new inpatient discharge form," then "Psych transition record"
 - Complete all fields and select the green checkmark on the upper left to sign
 - Patient's discharge paperwork will autopopulate with information from this form
- NOTE: If discharge the next day is probable, but not final, go ahead and submit discharge orders so that medications can be prepared.


Discharge Summaries

- Complete within PowerNote
- Must submit within 24 hours of discharge
- Include indications for all discharge medications
- Include fax numbers for outpatient providers not within the UW Medicine system
- **Please forward all summaries to the UWMC 7N discharge summary pool**

Once you've completed and signed your discharge summary to your attending within PowerNote, go to the "Clinical Notes" tab. Find and open your discharge summary from that tab. Within the discharge summary, right click and select "Forward."

The following box will appear. Select "Review" from the drop-down menu and then click on the binocular icon.

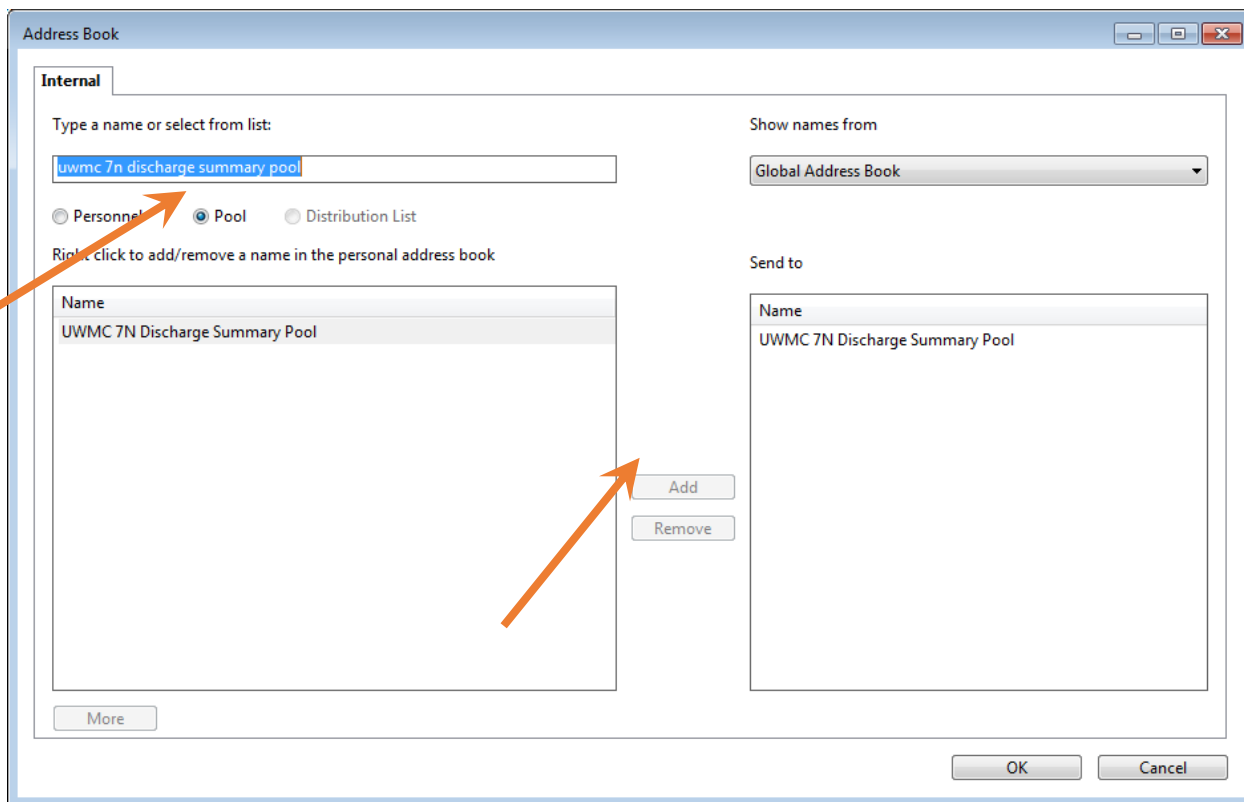


Additional Forward Action: Review To: (Limit 5) 

Comments (Limit 255)

Cancel OK

The following menu will appear. Type "UWMC 7N discharge summary pool" in the search field, press "Enter" on your keyboard, and then select the "Pool" radio button. This pool will appear in the box below the search field. Select the pool, click "Add," and then click "OK." You're done!



Address Book

Internal

Type a name or select from list:

Show names from: Global Address Book

Personnel Pool Distribution List

Right click to add/remove a name in the personal address book

Name
UWMC 7N Discharge Summary Pool

Add Remove

Send to

Name
UWMC 7N Discharge Summary Pool

More

OK Cancel

Discharge To Skilled Nursing Facility

- Stat d/c summary—CODE 55 "transfer to nursing home".
- Call transcription services to alert them.
- This must be completed before the patient can be discharged.

Short Stay (<24 Hour Admission)

- DO NOT NEED A DISCHARGE SUMMARY
- Complete a Discharge Note

SHORT CALL

SHORT CALL HOURS

Monday – Friday

Both Inpatient Residents Present

3pm-6pm

One Inpatient Resident Absent (Vacation, Clinic, Didactics)

1pm-6pm

Short call pager #: 559-1264

RESPONSIBILITIES

Admissions

- Both inpatient residents present
 - Short call admits **one** patient from 3:00pm-4:30pm
- One inpatient resident absent (Vacation, Clinic, Didactics)
 - Short call admits **two** patients from 1:00-4:30pm
- Things you can do if a patient comes after 4:30pm
 - Document a physical exam
 - Complete the ROS
 - Input basic orders

Cross-cover

Anytime you are called to see a patient, you should document with a cross-cover note in ORCA (S.O.A.P. note format) and update CORES accordingly. Please send notes to both the patient's attending and resident.

Consults

The short call resident is responsible for consults from 5:00pm-6:00pm. Most consults can usually be triaged to the night resident or the consult service the next day. Emergency or urgent consult may need to be seen.

Who to call

- Until 5:00pm: Daytime team attending
- 5:00pm-6:00pm: Consult attending (see consult schedule)

Sign-out

Each team (Blue, Purple, C/L) should verbal sign out with the resident on short call EVERY DAY even if this is to say, "nothing to do, I'm leaving the hospital." The night call resident pages the short call resident at around 5:30pm for sign out. If the incoming resident does not contact the short call resident, it is the responsibility of the short call resident to contact the on-call resident by pager and then by phone. If you do not hear from the resident within 30 minutes, call the

backup resident—but remember you are still the person covering until you have identified who will be taking over.

APPENDIX

TRAINING CALL AT UWMC

- Trainee and trainer should plan a time to meet during every training call. It is very important to meet and review training call issues even if there are no active issues because each resident has a limited number of training calls and call can be quite variable at UWMC.
- Remember training resident and trainer should work TOGETHER for entire shift. The trainee should call the trainer about ALL the work that comes up. It is helpful for the trainer to model all aspects of patient care on call, including interviews, formulation, notes, interacting with the attending etc. It is helpful for the trainer to think “out loud” and discuss their clinical decision making process. It is also helpful for the trainee to ask lots of questions during each training call!
- The following topics should be covered. Even if one training resident has covered these topics it may be useful to review them with additional training residents as each person develops their own approach to call.

- Shift times when on call
- How To's of Sign-Out (start and ends of shift)
- Checking in with charge nurses
- Checking in with ED social worker
- When to come in if called by floor or ER
- How to triage multiple issues
- 30 minute expectation
- inclement weather expectation
- Medical Students on Call
- Where things are: workspace, Crow's nest, eating, sleeping, night float key
- Parking
- When and who to call
- Safety Levels, Restraint Rules, Codes
- How to Admit a Patient, including orders and documentation requirements
- Discharging a pt from ED, including documentation requirements
- Tips on working as a consultant in the ER
- Who accepts patients
- Do you want to be notified by nursing once a patient has been accepted for admission, or only after they arrive on the unit?
- Outpatient telephone calls
- When/how to call the attending
- What to do if you are sick

- Discussing cases you have seen (both typical and difficult) may be useful training tools if there are no patients to see as examples. The Trainer can go through all aspects of the case

from medical decision making to practical details like which forms and notes you would use for that type of patient. Possible cases:

- Patient presents to ED with suicidal ideation and BAL of 150.
 - Patient in ICU post OD and team with concern for SI.
 - Patient refusing to cooperate with nursing staff on unit and concern for SI.
 - Pregnant patient goes into labor (or has chest pain) on 7N.
 - Patient falls on the unit
 - Psychotic patient presents to ED and psychiatry resident consulted to evaluate for voluntary admission to 7N.
 - Any case you have recently seen!
- Remember if you have questions that your trainer cannot answer, you can ask your attending or send an e-mail to the chief resident! This will allow the chief resident to either get back to you with an answer or clarify a point in the PRON!

MHP REFERRALS AND AFFIDAVITS

Who Should Be Referred for Involuntary Treatment?

Patients who are being referred need to fulfill all of the following criteria:

1. Patient has a mental disorder (substance use disorder by itself is not sufficient)
2. Patient poses an imminent risk AND is either
 - a. A danger to themselves
 - b. A danger to others
 - c. Gravely disabled due to their mental illness
3. The patient is either:
 - a. Unwilling to be admitted voluntarily
 - b. Unable to consent to voluntary hospitalization
 - c. Has shown from past behaviors that they cannot be considered voluntary

If You Are Going to Refer a Patient

- Do NOT give any psychiatric medications, unless for urgent or emergent reasons
- If patient is tied with an agency and has a case manager, make sure the patient is evaluated by the on-call case manager (if one is available) prior to the referral. They will come to the hospital to evaluate the patient, consider any other less restrictive options and assess if they agree with the MHP referral.

Timing Scenarios for Assessments

- NOTE: MHP = psychiatrist, psychologist, psych ARNP, psych nurse, social worker, or licensed mental health counselor ; D-MHP are County Designated MHPs who have the power to detain our patients.
- If patient is detained by police and sent/brought in for evaluation, then patient must be seen by MHP (not DMHP) within 3h from medical clearance and detained by D-MHP within 12h from medical clearance.
- If patient presents for observation and treatment (not detained by police) the MHP does NOT have to see the patient within 3h. Once the MHP has determined to refer patient to D-MHP for evaluation, then patient must be seen by DMHP within 6h. The clock starts once you have determined to refer the patient.

- If patient is already admitted voluntary and requests to leave but you think they are a danger and want to refer them, then D-MHP must evaluate and detain the patient by the end of the next judicial day after the patient asked to leave the hospital.
- If patient is a Juvenile, whether or not they have been detained by police, then once MHP has decided to refer patient, the D-MHP must detain within 12h.

General Points

- Affidavit must be written on the specific affidavit form template, which can be found electronically on the residency website, under Clinical Tools, or at <http://psychres.washington.edu/clinicaltools/clinicaltools.asp>.
- There are also paper copies of the template in the ED SW office.
- Statements and examples used in the affidavit should be EXACTLY the same as in your clinical note. This means absolutely IDENTICAL, carbon copy of what you said in your clinical note.
- Limit the use of any medical jargon or acronyms
- Use as many exact quotes from the patient as possible

What Should Be Included in the Affidavit?

- 1) Identification of who you are and the nature of your interaction with the “respondent” (aka the patient)

I, Julius Cesar, MD, am a University of Washington psychiatry resident physician. I evaluated patient X on January 1, 2014 at University of Washington Medical Center, while in my capacity as the on-call psychiatry resident.

- 2) State that the respondent has a mental disorder

Mr. X has a mental disorder characterized by delusional beliefs, violent and threatening behavior, impulsive behavior, and disorganized thinking.

- 3) Summary of the patient’s presenting problem, symptoms, and relevant past history

Mr. Mr. X was brought into the emergency department by the police this evening after being found threatening passengers on the bus. While in the emergency room he said to me “I believe aliens are taking over the bus system” and was noted to be talking to himself frequently. He has a prior diagnosis of schizophrenia from his medical record. He was also arrested last year after he was found making a disturbance on a bus and waving a gun at other passengers.

- 4) Reasons why patient should be considered for involuntary detention—this is where you want to make your case so don’t be afraid to use some of your best convincing arguments and dramatic flair! For Grave Disability, make sure to explain the imminent medical consequences if not treated (often relating to loss of life or limb).

Mr. X appears to be a danger to others and has a history of being violent and threatening in the past. He is currently displaying psychotic symptoms and is impulsive and lacks insight and judgment. He is at a high risk for harming others given his recent behavior and this poses an imminent danger to the public.

- 5) What other lesser restrictive options you have considered and why they are not an option

I have offered Mr. X voluntary admission to our psychiatric unit, but he refused. He was also not willing to discuss any other outpatient follow-up.

6) Summary Statement

In summary, I believe Mr. X suffers from schizophrenia and should be detained involuntarily as he is a danger to others.

7) Signature, date and location

You must be able to use objective evidence to demonstrate imminent risk. This can include any recent statements by the patient, recent behaviors, or can be based on other collateral information gathered. You can also refer to any past psychiatric history that would be relevant, including past suicide attempts, or past violent or dangerous behavior. For patients that are gravely disabled, you can use any recent dangerous or disorganized behaviors (i.e. walking out into traffic because patient was so disorganized) or any evidence that they might be at imminent risk for significant injury, medical illness or even death (infection requiring antibiotics, dehydration or electrolyte imbalance).

Sample Affidavits for Involuntary Treatment

The clinician who has requested that a patient be committed may need to write an affidavit, which documents the reasons why s/he believes the patient should be committed. Below are several examples of affidavits:

I, Anna Able, am a University of Washington psychiatry resident and have evaluated Mr. Joe Delta at Harborview Medical Center on January 2, 2013. Mr. Delta has a mental disorder meeting criteria for major depressive disorder, characterized by hopelessness, severe insomnia, poor appetite, psychomotor retardation and suicidal ideation. Mr. Delta overdosed on 10 tablets of alprazolam, a sedative medication, earlier today, and states that he plans on doing so again if he leaves the hospital. The respondent has a history of three suicide attempts prior to this one and has required involuntary treatment once before. He currently refuses voluntary psychiatric hospitalization. Because of his mental disorder and persistent suicidal ideation, Mr. Delta should be detained involuntarily as a danger to self. I would be willing to testify to the above in court.

Anna Able, M.D.
Harborview Medical Center
Seattle, Washington
January 2, 2013

My name is Billy Bobb, a University of Washington psychiatry resident, and I have evaluated Mrs. Winona Willy in my capacity as on-call resident at Harborview Medical Center. Mrs. Winona was referred to Harborview by her nursing home due to her refusal to eat and her 20-pound weight loss over the last 2 weeks. Due to her poor intake of fluids, her blood pressure is abnormally low and the patient is at risk for stroke, heart attack, kidney failure and death. Mrs. Winona has also refused to take Coumadin, a blood thinner required to prevent a clot from forming in her heart; this may result in stroke and death. The respondent has a mental disorder characterized by severe memory loss, inability to recognize relatives, inability to care for herself and paranoid delusions regarding her food. She likely meets criteria for Alzheimer's disease with psychotic features. I believe that, due to her mental disorder, Mrs. Winona is unable to adequately care for herself, is at risk for serious medical consequences, and should be detained involuntarily as gravely disabled. I would be willing to testify to the above in court.

Billy Bobb, M.D.
Harborview Medical Center
Seattle, Washington
August 22, 2012

I, Carol Channing, in my capacity as on-call psychiatry resident at Harborview Medical Center, have evaluated Mr. Lou Prole on October 10, 2011. Mr. Prole was brought to Harborview by the Seattle Police Department today because of threats he made to kill his girlfriend. Mr. Prole has a mental disorder characterized by extreme paranoia, command auditory hallucinations telling him to kill his girlfriend and homicidal ideation with the intent to kill her should he leave the hospital. He has a long history of schizophrenia requiring four hospitalizations, but also has three Against-Medical Advice discharges and a history of assaultive behavior towards hospital staff. Mr. Prole is willing to be admitted to the hospital but must be considered a poor-faith voluntary due to his history and his current refusal to contract for safety. I believe that due to his mental illness, Mr. Prole presents a danger to others and should be detained involuntarily. I would be willing to testify to the above in court.

Carol Channing, M.D.
Harborview Medical Center
Seattle, Washington
December 31, 2011

ITA PROXY

While on night float you will occasionally need to refer patients for involuntary treatment. If you receive a subpoena you may request proxy, which allows a different provider to testify in your place. In all cases, remember that a proxy can only be used if the clinical note has appropriate documentation, including:

- Opening statement such as "All statements in the following evaluation were made directly to me by the patient unless otherwise noted and I observed the following:"
- Quoted patient words
- "I" statements ("I heard the patient say", "I saw the patient do...") and a clear description of the patient's actionable behaviors.
- It is VITAL that all the statements in your affidavit are IDENTICAL to those in your clinical note.
- If you were threatened or harmed by the patient, unfortunately, it is not possible to utilize proxy

To request proxy do the following:

1. Place a copy of the clinical note, supporting clinical evidence, and the declaration (affidavit) in ED social work office.
2. Fax the clinical note, supporting clinical evidence, and the affidavit to 206-368-1852 (the office of Dr. Janice Edwards). Ensure you utilize a cover sheet briefly describing your REQUEST for proxy and the included documents.

3. Email the the UWMC ED social work supervisor, Margaret Yamanaka (myama@u.washington.edu) and Dr. Janice Edwards (Janice.Edwards@nwhsea.org) to REQUEST proxy. Ms. Yamanaka will assess the possibility of proxy. You should expect to hear back at least 24 hours prior to the court date via the contact information you provided as to whether or not you will be required to testify. Be sure to ASK for a proxy and not simply state that you will be using a proxy.
 - a. IF proxy is not available through Dr. Janice Edwards, a different proxy will be searched for. In the meantime, fax the clinical note, supporting clinical evidence, and the affidavit to 206-296-8720 and email (paoita@kingcounty.gov) detailing your REQUEST for proxy.
4. In cases of grave disability, the prosecutor may require an MD to serve as proxy. If this is the case, please write another email to the prosecutor's office (paoita@kingcounty.gov) and cc the following HMC CL attendings:
DeMers (sdemers@uw.edu), Dubovsky (ameliand@uw.edu), Croicu (croicu@u.washington.edu), Bentley (sbentley@uw.edu), Poeschla (bpoeschl@uw.edu), and Zatzick (dzatzick@uw.edu).
5. If proxy is approved, the resident will discuss the case with the proxy provider at 7 am PRIOR to the resident going off shift. The notes on the case will be in the file for the attending to reference prior to court, if they are called.
6. Finally, after vetting the testimony with the daytime attending at 7AM the day of the hearing, leave voice mails at both the court (744-7774) and the prosecutor's office (296-8936) and give them the ED social work office phone number (598-7149) [or if using a HMC attending as proxy, the HMC consult phone number (744-5927)]. Give them the name of the covering provider, and the provider's pager number so the court can call them when needed.

If no one can be found to be proxy, or proxy is not approved, you will end up having to testify. If you are not able comply with the 10-hours-between-shifts ACGME rule when giving testimony, then you will be pulled from call that night and the back-up resident will have to take call. The back-up resident will have to cancel their clinic the next day and you will owe a call in the next call cycle. To prevent proxy issues, do what you can to have someone else write the affidavit.

RESOURCES IF THERE IS NO EDSW

There is a social work administrator on call that is available via the paging operator (598-6190). Our UW ED SW Maggie has also graciously offered to help us out 24/7 if you have questions. Her pager number is 986-1021.

Payment/Authorization

If there is a question about SW authorizing payment of medications, contact the social work administrator on call, they can help with requesting authorization or assist in problem solving. If you need to do pre-authorization for voluntary hospitalization, refer to the [Preauthorization](#) (pg.) section above for details on how to do this.

How To Find A Bed For Your Patient If UW Is Full

Call the list of outside hospitals below and ask "Do you have a voluntary ____ (male or female) bed available?" Try all Seattle area beds first before going out-of-county. There will be a screener at the outside hospital that will then ask you questions about the patient to make sure that they are appropriate for their unit. Then you can call pre-auth because usually pre-auth will want to know which hospital the patient is going to.

If A Minor Presents To The ED

We cannot admit anyone under 18 to UW or HMC. First, by law, we must give the child and the parent a "mental health treatment option for minor children" form which is located in the hanging file by the SW door. Call CCORES for further assistance and dispo options. CCORES can come to the ED to help with assessments, provide next day appts, and crisis stabilization beds. Call the crisis clinic 1-866-4CRISIS to be connected with CCORES. Also, if discharging a minor from the ED, the child must go home with the legal guardian.

Outside Hospitals

This is the list of hospitals with inpatient psychiatric services.

- In the Seattle area:
 - Harborview Medical Center PES phone: 744-3076, resident pager: 663-9595
 - Swedish (Cherry Hill Campus) day phone: 320-5073, night pager: 991-9156
 - Overlake Hospital (Bellevue) 425-688-5175
 - Navos Psychiatric Hospital 206-933-7299 (voluntary only under rare circumstances)
 - Fairfax Hospital (Kirkland) 425-820-3533
 - VA (if veteran) 206-764-2600
 - Childrens (if < 17) 206-987-2222 and ask for MH provider
- Looking further:
 - Swedish (Edmonds Campus) 425-640-4981 or 425-640-4000
 - St. Francis Hospital (Federal Way) 253-944-7975
 - St. Joseph's Medical Center (Tacoma) 253-426-4101 or 253-426-6691
 - St. Peter's Hospital (Olympia) 360-493-7064 or 360-493-7080
 - Skagit Valley Hospital (Mt. Vernon) inpatient psychiatry is called the Care Center 360-428-2422
 - St. Joseph's Hospital (Bellingham) 360-715-6526 or 360-715-6413
 - Swedish Edmonds 425-640-4981
- Geriatric Psychiatry units:
 - Northwest Hospital (Seattle) 206-364-0400 or 206-368-1823 or 206-368-1823 or 206-368-1747
 - Highline Medical Center (Burien) 206-248-4713
 - United General Hospital (Sedro Woolley) 360-856-7421, admission pager 360-336-6927
 - Auburn Regional Center (age > 50) 253-804-2813
- If you cannot find a voluntary hospital and the patient cannot be safe without hospitalization, you can consider voluntary boarding.

Outpatient Options

The Crisis Clinic database for community resources (www.crisisclinic.org) is the best way to sort out available options and resources in Washington. You can also call the Crisis Clinic Supervisor at 206-461-3210, press 1. In the middle of the night, you may not be able to make an appointment but you can give patient resources. There are also brochures for shelters and other resources in the SW office, in plastic holders on the wall.

- Low cost options in our local area:
 - Fremont Community Therapy Project
 - Samaritan Center of Puget Sound (used to be Presbyterian Counseling Services)
 - Jewish Family Services
 - Lutheran Counseling Network
 - WellSpring Family Services
- Outpatient Medical Clinics with short term behavioral health/counseling services:
 - Country Doctor
 - 45th Street Clinic
 - HMC Pioneer Square
 - 3rd Ave Center
- Drug and Alcohol resources: Call 866-789-1511 (24/7 hotline to help find resources)
- Students: can often access counseling services at most colleges they attend
- Employees: many businesses offer Employee Assistance Programs (EAP's) for counseling
- Specialty clinics that have some support for psychiatric services:
 - HMC Madison Clinic (HIV clinic)
 - UWMC Seattle Cancer Care Alliance (SCCA)

How To Make A Referral To UW Outpatient Psychiatry Clinic

Please be aware that the UW outpatient clinic operates under a consultation model, meaning that most referrals are seen for 1-2 consultation visits ONLY. Most referrals will not be seen for ongoing care, unless they are referred to a wait list after their initial consultation visit. The average wait is between 4-6 weeks and some people are never chosen off the wait list. If you are looking for a 100% assurance that your patient will be seen, please contact the chief resident and/or other faculty working at the clinic to enquire about possible options.

To make a referral to the UW Outpatient Psychiatry Clinic, please contact the UW outpatient chief resident for direction. Pt's can also call the UW contact center (206.598.7792) and ask for a psychiatry appointment.

Other Disposition Options

- If the patient is able to go home, you can request the SW on the next day to do a follow-up call to assist with identifying resources. To notify the SW leave a note on the top of the SW communication log book, which is located on the desk of the first SW office, found usually on the left hand side.
- SHELTER: DESC: 206-464-1570 (If full, call Operation Nightwatch 329-2099 for help finding a shelter)
- DETOX: Recovery Center of King County (RCKC) 206-325-5000. The Detox van does not travel to UWMC so the patient will need a cab or can go by private vehicle if patient can identify a support who can take them. Detox can take patients at night if they are straight forward (no benzo abuse, no medical complications and no heroin abuse higher than 3 grams/day). Note: we no longer have to send any medications with the patient.

Transportation

- CAB VOUCHERS: Cab vouchers can be obtained from the after-hours emergency fund cash box kept on 5SE. You can access these by calling the charge RN for that unit or communicating with the STAT RN.
- BUS TICKETS: There is a supply of bus tickets which can be accessed by the ED Charge RN.
- The social work administrator on call may also be able to assist with some transportation issues

ORDERS

Antipsychotic Consent/Compel

- Have the patient sign the paper antipsychotic consent form
- Alternatively, fill out the paper Compel Antipsychotics form
 - The UWMC ED attending will sign the compel order with the UWMC Psychiatry attending as the second physician via telephone order
 - Ask the on call attending to write a note in ORCA stating their agreement with the compel order
 - On the compel order write out "Verbal authorization given by Dr. _____, see ORCA note"
- For ordered antipsychotic medications, write for PRN doses with a note "if patient refuses scheduled medication, please administer this medication as per compel form"

Hints For Lab Orders

- If a QAM order is placed before 0600, order will be for that day.
- If order is placed after 0600, order will be for the next day. If order is needed for today, a one time order must be entered.
- Do not set a time for AM labs
- Routine phlebotomy labs are draw within two hours (STAT orders should be placed for draws needed before two hour timeframe)
- Type in N for time "now"
- Type in T for date "today"

Power Plans

When you discontinue a power plan, make sure you know which medications you are discontinuing. Some medications are managed through power plans (e.g. insulin orders). When a power plan is discontinued, ALL medications in the plan are stopped. This has led to medications being discontinued inadvertently. Always double check when stopping a power plan!

CORES SIGN OUT (SAME AS HMC SIGN OUT)

Under the cross cover section please use the following standardized format for sign out. Please note we have now added medical history and medical FYIs as a required part of the sign-out (in red).

Unit**	Problems	Medications	Other:	Comments/Tasks	Notes:
Name H# DOB Attending Room# CODE STATUS Allergy Days inpt **This whole column autopopulates	Diagnosis and Problems (should be kept up-to-date but is not always accurate – you can edit via Prob & Diag tab in ORCA)	**This whole column autopopulates	ITA status (auto-populates) Patient Summary (few sentences) Medical history: Other team notes	XC: FYI: - H/o or c/f violence: - Vital sign parameters, blood glucose parameters, etc - Medication compels Medically active: Yes/No Consulting services: If/then: - Pain: - Anxiety/Agitation: - Insomnia: - Tries to leave (if voluntary) Legal status: court date/length of hold	Left blank

OTHER:

ITA STATUS (autopopulated)

- CORES now has ITA status auto-populated from the patient admit orders.
- If the patient status changes (came in voluntary and now is detained vs. converted from involuntary to voluntary patient), you will need to modify the bed type.
 - o How to modify bed type:
 - In ORCA, click on Orders -> in the left hand bar click on "Psych Admit (Initiated)" -> right click the top order "Admit/Place Psychiatry INPATIENT" -> click 'Modify' -> modify the bed type, re-enter the attending name and sign the order
 - NOTE: DO NOT click 'Cancel/Reorder,' if you do you will be asked for a discontinue reason. Just refresh without signing and go back to modify the order.
- Patients on the consults team do not currently have their status or bed type, so this does not need to be done for patients on the consult team.

PATIENT SUMMARY: Brief summary paragraph of psychiatric history, reason for presentation (can be adapted from initial assessment)

MEDICAL HISTORY: Look at your admit note and update with any new problems. If unable to obtain or suspect the pt may be a poor historian, please indicate. Even if some of it is mixed into the summary blurb above, please also list it here.

TEAM: This section is optional and is used for your own purposes; you can include major events in the hospital course so you can write the D/C summary with more ease and accuracy later. You can also include a "to do list" for yourself.

Example:

[] family meeting Monday

[] check depakote level on Tuesday

--increased risperdal to 4 mg on 3rd hospital day

--family meeting focused on importance of med compliance and behavioral activation

COMMENTS/TASKS:

XC:

- Note that this should only say XC or "to do" items...save any FYIs for below so the on-call resident can quickly scan
- For weekend, only critical labs that would be a problem if not followed up on by the attending (can list other routine labs in the FYI section, but clearly state that the attending will be following up so the weekend resident will know).
- put "NTD" if there is nothing to do

FYIs:

Always include:

- H/o or concern for violence?

And if they have:

- Any poorly controlled medical conditions
- Atypical VS parameters
- If a patient on insulin and inconsistently eating, what you'd like done if they're not eating; or any other insulin issues you can anticipate (atypical hold parameters)
- Instructions on when to give a compel if you think this is likely (and ensure the form is done/order is in)
- And anything else you think is important.
- Daily med changes do not need to be noted unless you think it would be valuable to night resident

COMPEL antipsychotic medications:

- If patient has a compel order signed, a document that two attendings have to sign, (this cannot be signed by a resident), which specifies the need for compelling antipsychotic medication please be sure that you have a backup IM medication on the PRN list in case the patient refuses the PO med.
 - o Example: "antipsychotic compel signed, if pt refuses olanzapine 10mg PO, instruct nurse to give olanzapine 10mg IM."
 - o Note a compel order can only be used for compelling antipsychotic meds. If you are compelling other medications like insulin, please include these instructions in the FYI section.

MEDICALLY ACTIVE? Yes/No

- if YES = you are actively monitoring a medical condition or symptoms that might require the MD to do something, or you are worried that something is brewing for this patient.
- If yes, should be verbally signed out each night. Includes people with medical issues that are requiring significant time to manage, or potential for decompensation

CONSULTING SERVICES: write down the names of any consulting services and what they are consulting for

IF/THEN:

Pain- please include instructions for pain if PRN's are ineffective such as, "use NSAID's for back pain, instruct nurse to use hot and cold pack if NSAIDS are ineffective."

Insomnia- please include instructions for insomnia if PRN's are ineffective, please be sure to check that your ambien orders have not expired as they will expire 3 days after admit.

Example—" If two doses of ambient are ineffective can use Trazadone"

Anxiety/agitation- please include instructions for anxiety if PRN's are ineffective such as, "Pt. may not have extra benzodiazapenes if PRN's are ineffective, instruct nurse to use encourage patient to engage in distress tolerance skills, such as progressive relaxation technique." Or "Pt is very psychotic, ok to use extra benzos to achieve calm, hold if patient is sedated or somnolent" or "Please renew restraints as indicated by nursing, pt has history of assault"

LEGAL STATUS (with court date/length of hold):

- Include information about ITA status: voluntary vs. 72 hour hold vs 14 day hold. If patient is voluntary please include instructions for the resident if the patient demands to leave AMA such as, "If pt demands to leave, please refer to MHP for detainment, see affidavit, a copy is in patient's paper chart." OR "If pt wants to leave overnight, he/she can leave AMA if they do not have new SI/HI on your evaluation, please give 1 week of antipsychotic medication"
- Make sure you talk to your attending on what your overnight/weekend plan is for voluntary patients, if patient has been talking about leaving all day be sure to leave a signed and dated affidavit in the patient's paper chart or in the affidavit box in the resident room (specify which in signout). Affidavits are only good for 24 hours after signature, however, you can update these as necessary. The on call resident will still need to see the patient and evaluate them and write their own affidavit if required to do so by the MHP (most MHP's will require that the referring physician write their own affidavit as well, your affidavit will help the on-call resident write an accurate and compelling affidavit).

ON-CALL/UWMC INFO

PARKING

The parking office is in T-wing, 4th floor.

INCLEMENT WEATHER POLICY (As per residency-wide policy)

In cases of inclement weather (e.g. snow or icy road conditions), residents are expected to fulfill all patient care responsibilities, or to ensure appropriate coverage.

Specifically, residents are expected to:

- Make appropriate travel arrangements (e.g. chains, 4WD, bus), and allow appropriate travel time, to ensure they can be present at the clinical site for

patient care. This can include the hospital's emergency transportation system, where available.

- Stay in house if there is no guarantee of returning to the clinical site within 30 minutes (e.g. stay in-house if unable to walk safely to the clinical site within 30 minutes during home call or night float).
- Remain on-site as needed for patient care, until the next resident or other appropriate provider arrives.
- Attempt to make a voluntary call/night float trade, or find appropriate daytime coverage of patient care responsibilities, if they anticipate difficulty getting to the clinical site.
- In case of emergent inability to travel to the clinical site, despite having attempted the measures listed above, notify the attending, and/or (as appropriate) clinic staff, Chief Resident, Assistant Training Director, and/or Chief of Service, and (for call/night float), utilize the backup call system for coverage and notify the resident(s) currently on-site of the need to remain on-site until a backup resident can get there. Please note that backup call residents may have similar difficulty getting to the site. The backup system should only be used when absolutely necessary, and the backup resident should be alerted as soon as possible, to maximize the chances that he/she will be able to get to the clinical site in time for call.

Nights

- Residents working at night may use spaces on the bottom level of the Triangle parking garage from 5:30pm until the conclusion of their overnight work. Residents will be charged for their time if they enter prior to 5:30pm. Please make every effort to leave the garage before 8am, i.e. do verbal sign out with oncoming resident early enough to leave by 8am and complete any note writing at home if necessary.
- If you leave past 8am you may be charged, unless you were in the hospital for direct patient care responsibilities (i.e. writing orders, managing a transfer, acute consult, etc.).
 - If this is the case, tell the parking staff that you were in the hospital for "emergent patient care needs" and show them your badge. You do NOT need to explain the exact situation to them. You may have to sign a log sheet to obtain a card to exit the garage, they should not charge you for this extra time and the GME office should be billed directly. The log sheet will be checked by the GME office, and residents using this log for parking not related to the completion of overnight work will face sanction.
- If you leave past 8am because you were writing notes and not doing direct patient care, you have to pay for the extended time. Up until 8:30am you will only be charged \$3, but after that you will pay regular rates.

Weekends

- On Saturday AM residents may park in S1 for \$5.00, or in the West Campus Garage on the pay per use plan. S1 is free for in/out usage after noon on Saturdays. Residents should park in the Triangle Garage on Sundays as the kiosk is not manned on this day.

Garage Locations

Portage Bay/PPU Garage

- o Portage Bay Garage between Brooklyn and University south of Pacific Street. This is the parking garage available for residents under the Universal Parking/Pay Per Use program, which you need to set up with the parking office in advance. Park here anytime. Your Husky Card opens the garage gate.

Triangle Garage

- o Across Pacific Ave from the front of UW Hospital entrance.

S1 Garage

- o Behind UW hospital at South Campus Center; from Pacific Ave, turn south on 15th Ave. Residents may park in the S-1 parking garage from 9:00pm -6:00am from Monday through Friday, and without charge on the weekends from noon Saturday through 6:00am Monday. The fee for Saturday parking before noon is \$5.00.

Lactation Stations

ROOM #	LOCATIO N	Designate d Lactation Station?	Private?	Door Lock?	Sink in room or close?	Power?	Pump?	NOT in bathroo m	COMMENT S
NN537	5North	YES	Y	Y	Y	Y	2	Y	Ready for USE - Call HR 8-6116 for code
SA7440	7th floor MLT Quiet Room	YES	Y	Y	Y	Y	Y	Y	Ready for USE - Prox acces required, call HR for access.
SE4317	4SE Lactation Station	YES	Y	Y	Y	Y	Y	Y	Ready for USE - Call HR 8-6116 for code
EE112	1st Floor Pacific Women's Lounge	YES	N	N	Y	Y	Y	Y	Pump added and tethered 2/24/17 - No code needed!
SP1111	1st floor Pavillion Ladies Locker room	YES	N	N	Y	Y	Y	Y	Pump added and tethered 2/24/17 Access limited to OR providers & staff
SW300	3rd Floor MICC Lobby	YES	Y	Y	N	Y	Y	Y	Pump added and tethered 2/24/17 - No code needed!

ON-CALL ROOM—THE CROW’S NEST

The Crow’s nest is in the 6th floor B wing, B 650

1. Go to the 3rd floor and head towards the T-wing
2. Walk until you see the sign for “B WING STAIRS↘”
3. Turn left; WITHIN SEVERAL STEPS, there is a stairwell on your left (stairwell B1)
4. Take the stairs to the 6th floor
5. Door code: 3-2-5
6. Two rooms have Psychiatry nameplates and should be available for on-call residents. (The ‘occupied’ signs are not necessarily accurate; knock first).

UWMC ON-CALL MEAL PROGRAM

At UWMC and HMC, residents and fellows are reimbursed for meals when on-call, in- house for 24-hours or working a 14-hour shift or longer. Residents/fellows may choose to eat in the hospital cafeterias or go elsewhere to purchase food.

Locations

The Plaza Café is open from 6:30 a.m. – 7 p.m. seven days per week. On-call meals may be purchased during the following hours.

- Dinner: 3 p.m. – 7 p.m.
- Breakfast: 6:30 a.m. – 11 a.m. (may be purchased either on the day you are coming on-call or on your post-call morning (but not both).
- Lunch (weekends only): 11 a.m. – 4 p.m.

The **evening food cart** is available for meals after the Plaza Cafe closes. The cart is open on weekdays from 7 p.m. – 3:30 a.m., and on weekends/holidays from 7:30 p.m. – 3:30 a.m. Page operator for location of cart.

Reimbursement Rate and Process

- On-call, in-house 24-hour shift - \$15 (weekdays) and \$22.50 (weekends/holidays)
- In-house 14-hour shift or longer - \$7.50
- On home-call, returned for patient care - \$7.50

On the 15th of each month (or after the two-week reporting window in MedHub has closed) the GME Office will run a Meals Report from MedHub to pull duty hour data reported by housestaff to identify appropriate reimbursement rates. The report will be sent to the Husky Card Office, and the reimbursement amounts will be posted to the trainees’ Husky Card Account. Funds posted to the account may be used for future meal purchases and at campus retailers that accept the Husky Card debit account.

PHONE NUMBERS AND OTHER INFO

UWMC

Long Distance Code: 9, 1, #
7N Phone: 598-4720, 7N FAX: 598-6111
UW Short call pager: 559-1264
UW C/L Service: 598-7140 (voicemail) or
986-1734 (pager)
UW C/L workroom: 598-7386 / 598-7140
Resident 7N workroom: 598-3534 / 598-
4496 / 598-5723 / 598-4792 / 598-9317
Chief Resident Contact: 206-314-8801 (pg)
971-533-9934 (call or text)

UW Paging Operator: 598-6190
UW Main Number: 598-3300
UW Inpatient Pharmacy: 598-4088
UW Discharge Pharmacy: 598-5441
UW Lab: 598-6224
UW ER SW: 598-4222
UW Main ER: 598-4000
UW ER Attending: 598-0105
UW Admitting: 598-4310
UW Central Intake (screener): 598-6195
Public Safety: 598-5555 (or 598-4082)
Phlebotomy: 598-1343
Environmental Services: 598-6181
IT Help Desk: 543-7012
7N Utilization services: 598-7240
7N SW Blue Team: 598-4723
7N SW Purple Team: 598-4713
Erica (pharmacy): 598-1949, (p)994-5881
UW Occupational Therapy: 598-4738
HIPAA Bin removal: 598-9507
Inpatient Chief Resident office: 598-4106
UW Outpatient Chief Resident: 598-2401
UPOC backline: 598-1571

UWMC ATTENDINGS

Margie Cashman: 683-7464, (p) 314-1491
Ryan Kimmel: 598-7541, (p) 560-0076
Suzanne Murray: 598-7055, (p) 215-0390
Joseph Cerimele: 221-4928, (p) 314-1349
Jürgen Unützer: 543-3128, (p) 541-3457
Richard Veith: 543-3752, (p) 405-9719

Deborah Cowley: 543-6577, (p) 680-9493
Mitch Levy: 598-7792, (p) 663-0139
Donna Davis: 598-0556, (p) 559-7613

HMC

HMC Main Line: 744-3000
HMC PES: 744-3076
HMC PES Resident: 744-3979
HMC Short Call Pager 663-9595
HMC 5WA: 744-3565
HMC 5WB: 744-3119
HMC 5MB: 744-5856
Resident room: 744-3779 / 744-8765 / 744-
4970
HMC C/L room: 744-5927
Chelsea: (p) 540-2409

VA

VA Main Line: 762-1010, enter "0"
VA "MD only line" 764-2333
VA inpatient unit: 764-2101
Evening ER SW (till 11pm): 764-2610
AOD: 764-2810

OTHER NUMBERS

King County DMHP:
206-263-9202
Next Day Appointment: 206-461-3210, ext 1
King County Hospital Authorization:
206-461-4858
DESC: 464-1570, CRP: ext 3057
Crisis Clinic: 206-461-3222
KC Drug/Alcohol help line: 206-722-3700
ITA Court: 206-744-7774

LOCATIONS

C/L Room: 7121, code 7732*
Crow's Nest: B650, code 325
Inpt Resident workroom: CC702
UW ER back door code: 2001#

UWMC Hospital Tax ID# 916001537