HMC PRON
Revised 10/12/17

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Updates:

10/12/17 –Elopement protocol
7/26/17 -10.77 Patients
6/20/17 -Proxy requests
-MHP referrals and restraints
2/10/17 - Procedures for covering consults on weekends and when to ask for back up assistance seeing patients from attending
- Entering sign off notes for consults

HMC PRON cheat sheet:

PHONE NUMBERS :
Operator: 744 3000
Short call pager: 663-9595
Voicemail pin code: 3291
5WA: 3565
5WB: 3119
Maleng: 5856
Medical Maleng: 1208
PES: 3076
PES resident number: 3979
Consult Voicemail: 744-5927
Pharmacy inpt: 3220 Pharmacy d/c: 7966
MHP(professionals only): 461-3210 or 263-9202
Crisis Clinic: 461-3222
Medicine Consult Pager: 997-8045
DESC: 464-1570, CRP: ext 3057
IT help: 543-7012
Psychiatry C/L Resident 663-9595 pager
C/L social worker (M-F) 744-2170
PES social worker (24/7):744-2649
Saturday Inpt Psych SW (8-4:40): 680-8737 pager
Med/Surg social worker (eve & wkds) 986-2576 pager
HMC Inpatient Psych RN screener:744-4464/ 898-4845
Pt. Placement Coordinator (PPC): 204-0370

DOOR CODES:

room 502 Call room 60136013; ED lounge 70347034
Skybridge bathroom 325325; Resident lounge on 5W 755159
MB111/112 noon conference: 1133

Places to get scrubs :

1CT 91: door code 911911
2WH 91: door code 206206

CL office:
-walkthrough the center tower through the 5east clinic, past the elevators; office is on the right (west):
-code for CL office: 111333

Residency website

Training call guide

Call schedule: **https://psychres.washington.edu/WebApp/uwnetid/calendar.asp**.

Who is my attending on weekend days (Friday after 5pm-Sunday 6pm)?

Trouble figuring out who your attending is:

1. **The operator at HMC will always have the correct on call attending.**
2. **Check the email sent to you from Susan Taubenack about your call shift that lists the attendings and their pager numbers.**
3. **On Sundays after 6pm your attending is the UWMC/HMC on call attending.**

General On Call information

- All call at HMC is in house call meaning that the resident on call is always at the hospital
- If you are on a day call you will *mostly* be doing consults and taking care of floor issues
- If you are night call you will *mostly* be doing PES work

Start/Finish Times:

- Night float/Night call: 8:00pm to 8:00am
- Weekend days and holiday call: 8:00am to 8:00pm

Sign-out:

Weeknight (nightfloat):

- You should be in the PES ready to get sign-out from the PES resident at 7:45 pm.
- Morning sign-out takes place at 7:45 am in the resident workrooms where the day team residents (or attendings) will be present to get sign-out.
- Leave message for the consult service (x5927) with any new referrals and update CORES as appropriate

Weekend day/night call and holidays:

- The oncoming resident will meet the off going resident in the PES at 7:45 to get sign out.
- Leave message for the consult service (x5927) with any new referrals and update CORES as appropriate
- Don't forget to hand off the pager and the keys to the oncoming resident

What if the next resident has not shown up?

- If the next resident has not arrived by the end of your shift, page the resident.
- If no response, call the resident at home.
- Call schedules and resident contact information are available on the psychiatry residency website.
- If you cannot contact the next resident by ½ hour after the end of your shift, start by paging the 1st backup resident.
- **Do not leave Harborview** until the next resident – either the scheduled on-call resident or one of the backup residents – has arrived.

****Report all such situations to the HMC Inpatient Chief Resident!****

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Short Call and the PES resident hand-off:

- The short call resident is responsible for floor coverage of all teams that have signed out to him or her until 5pm.
- The short call resident does not do any inpatient admission except for rare ECT direct admission.
- The short call resident will sign-out to the PES resident at 5pm in the resident workroom
- The PES resident provides coverage from 5pm to 8pm. Triage during this time consists of floor matters coming first, emergent consults (do what you can, refer the rest to the Night Res), followed by normal PES work.
- After 5 pm on weekdays, staff non PES patients with on call attending
- **FYI, if the PES resident calls in sick, then the short call resident is expected to either remain in house to provide cross coverage until the night resident arrives at 8pm, or to find someone else who is willing to do this**
- On M-F, evening sign-out should occur in the PES unless active floor or consult issues require the resident to be upstairs.

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On-Call Pager and Keys

- At the start of your shift, please make sure to pick up the On-Call Pager and On-Call Keys from the prior resident.
- The On-Call Pager (663-9595) has numeric paging and voicemail capabilities.
- **Remember it is O.K. to interrupt patient interviews to answer pages.**
- Voicemail should be checked at least within 15 minutes of the page.

- Sometimes there are problems with the pager – there might be some "dead zones" within the hospital. **Periodically check voice mail** to make sure you haven't missed a message

To retrieve voice mails, dial 9-663-9595, enter 0, then 3291 (the PIN) and 6 to listen to messages, 2 to delete each message

Triage and On-Call Duties

The on-call resident is responsible for:

- Performing "cross-cover" evaluations of inpatients on 5WA, 5WB and 5MB
- Answering phone calls from HMC psychiatric outpatients and outside providers
- Consulting to other services on patients with urgent or emergent psychiatric problems (weeknights and weekends) or with routine psychiatric problems (weekend days) if time permits
- Evaluating patients in the PES and admitting them if necessary

Triage of responsibilities follows these general guidelines:

Day call:

1. Emergent and urgent cross cover issues i.e. medical or psychiatric emergency on the floor take precedence over all other issues, you are the only physician taking care of these patients.
2. Emergent Consults
   - Emergent consults= patient who has just attempted suicide in house, or is threatening to do so, patient admitted for suicide attempt patient or who has assaulted staff or other patients, and is now in restraints, pt without capacity is asking to leave AMA.
   - If you have several emergent consults to do at once, please do a focused assessment/interview and focus recommendations on reducing risk of injury, i.e. restraints, 1:1 sitter, medication management of agitation.
3. Non-urgent C/L issues, such as disposition, or social admit type questions
4. PES work

Night call:

1. Emergent and urgent cross cover issues i.e. medical or psychiatric emergency on the floor take precedence over all other issues, you are the only physician taking care of these patients.
2. Emergent consults
   - Emergent consults= patient who has just attempted suicide in house, or is threatening to do so, patient admitted for suicide attempt patient or who has assaulted staff or other patients, and is now in restraints, pt without capacity is asking to leave AMA.
   - If you have several emergent consults to do at once, please do a focused assessment/interview and focus recommendations on reducing risk of injury, i.e. restraints, 1:1 sitter, medication management of agitation.
3. PES work
4. Non-urgent C/L issues, such as disposition, or social admit type questions

Things to remember when on call:

- There will be times when you will not be entirely sure how to triage the work in front of you. In these events, contact your on-call attending to discuss how to proceed.
- If there are consults you are not able to get to during a weekend day, the night resident can always help out.
- You are not required to see patients with 1:1 sitters or who are involuntarily detained unless it is psychiatrically necessary (ie acute concerns for safety)
- While you have many responsibilities as the on-call resident, remember that you are only human. This means you need to stay hydrated and well nourished.
- You cannot:
  - Be in two places at the same time
  - Make everybody happy all the time.
- If you have an unprofessional interaction with a consulting team, staff, MHP, admission authorization person, or anyone else, please debrief with your attending and email one of the chief residents at HMC.

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How and when do I contact the On-Call Attending?

- The PES attending will supervise your work in the PES as well as the occasional consult in the medical side of the ED. Your on-Call Attending backs you up on ALL OTHER consult issues and floor matters and will co-sign your consult and inpatient notes (unless you forget to identify them as a co-signer, which would make them feel left out and sort of useless). The on-call attending's shift starts at 6 pm on weekdays. If you need to staff any non-PES patients after 6 pm on weekdays call on call attending.

You MUST contact the On-Call Attending for:

- Every new consult
- Clearance for unplanned discharges, whether AMA or not
- Any clinical decision-making related to suicidal/homicidal ideation
- Any physical assault and any sexual activity on the unit
- If you receive a page indicating an internal or external disaster (see "disaster preparedness")

Its highly recommend that you contact the on call attending for:

- **Assistance with triaging consults,** particularly on the weekend. It's recommended to check in with the attending covering consults (5WA attending) in the morning to let them know who you are planning on seeing that day and any urgent issues on consults**. If at any time you are feeling like you are not sure how to triage consults or feel like there may be more patients that need to be seen than you can physically see, contact the attending covering consults. If after triaging with the attending there are more patients that need to be seen urgently than you can see during your shift, the 5WA attending will contact the 5 MB attending who is responsible for seeing patients on consults if needed.**

You may also wake them up to chat about:

- Psychopharmacology issues on consult or inpatient cases
- Disposition issues
- Any other issue for which you would like attending supervision / consultation (seriously, this is the one thing that junior residents don't tend to do enough- this is your education!)
- Attendings need/want to know about patient care issues for which they are liable as the attending of record. Think MI or ICU transfer, but basically anything worth knowing.
  +
  A good rule of thumb is to discuss with each new attending when and how to contact them for each shift. Different attending have different styles and different ways they like things to be done. Being proactive and learning what your attending wants for each shift saves headaches/heartaches later.

When to call IN the attending*:*

When any of the following situations arise, you must absolutely call the attending to discuss the case. In some of these situations, you and the attending may decide that it is most appropriate for them to come in to the hospital to assist you.

- Patient suicide
- Patient death
- Serious assault on unit
- Serious conflict with other service or staff regarding delivery of care to patient
- Internal or external disaster
- ON WEEKENDS: After triaging with attending on call it is determined there are more urgent consults that need to be seen than can be seen by one resident. The 5WA attending covers consults and will assist with triaging. The 5 MB attending is in charge of seeing patients on consults if needed.

***If you have a scenario where you called in your attending (or thought hard about calling them in but decided not to), please email the chief resident with the email title "QI Confidential" and notify her/him of the incident.

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Who is my on-call attending?

Weekday Evenings (5-8pm shift):

- Your on-call attending is assigned by the department for each call night and covers both UW and HMC.

- The back up attending does not page the HMC PES resident at 6 pm. However, they are aware that their shift starts at 6 pm and therefore if the PES resident needs to communicate with them they should be available by pager. Call the operator and ask to have the on-call psychiatry attending paged.

Nights (after 8pm):

- Your on-call attending is assigned by the department for each call night and covers both UW and HMC. The back up attending will page the UW nightfloat resident between 6pm-7pm with their contact info and will page the HMC nightfloat resident with their contact info between 8-9pm.

Weekends

- The on-call attending covering consults on weekends is the attending covering 5 WA
- If after triaging consults with 5 WA attending there are more patients that need to be urgently seen than you can see during that day, the 5 MB attending is responsible for helping see patients

If you cannot reach the on-call attending:

- In the event that the on-call attending cannot be reached by pager, the resident will need to ask the HMC operator to call the attending at home (they should have the home or cell phone number). If the attending still does not respond, residents should then use the PES attending for supervision (PLEASE notify the HMC inpatient chief resident via email if you are unable to reach your on-call attending as this is monitored closely).
- If you cannot reach the on-call attending or the PES attending (this should be very rare), use the HMC Operator or the numbers below to page the following attendings in this specific order. Page first and if no answer then use the cell phone number. If they do not answer, then use the home number. If they still do not answer, go down to the next attending on the list: (all 206 area codes)

1) Mark Snowden, MD HMC Chief of Psychiatry
   Pager: 663-2336, cell: 388-8311, home: 368-8027
2) Paul Borghesani, MD PhD, PES Medical Director
   Pager: 340-3082, cell 206-380-2563
3) Heidi Combs, MD Inpatient Medical Director
   Pager: 540-3484 cell: 909-0234, home: 829-8271
4) Kathy Chen, Asst Training Director
   Pager: 416-5119, cell: 608-469-3649

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Weekend and Holiday Days:
During the day the backup attending issue is more complicated. During weekend days and holidays, there are 3 attendings responsible for interviewing all new and follow-up patients on each of the inpatient units.

If you have trouble figuring out who your attending is:

1. **The operator at HMC will always have the correct on-call attending.**
2. **Check the email sent to you from Susan Taubenack about your call shift that lists the attendings and their pager numbers.**

In general, attendings will handle most daytime cross-cover issues on the units, but they may occasionally ask you to follow up on something. If you are extremely busy, you may need to negotiate division of workload. Occasionally, the attendings may shuffle duties (e.g. the 5WB attending take overnight calls), in which case you should be notified.

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What if there is no PES Attending while I'm on call?

1. First, remember that you can always run things by the On-Call Attending, and should notify them that there is no PES attending available – that way they are primed to expect more than the usual number of pages!

2. Secondly, remember that the PES nursing staff, social workers, and ARNPs have a vast amount of experience – so use their expertise.
3. When there is no PES Attending, you may need to see and evaluate patients that were seen by the ARNP or the Social Worker.

If you are an R1, it is considered a violation of ACGME rules for you to be in-house alone. In the emergent event that a PES attending is unavailable, backup residents will provide R1s with in-house supervision. You will therefore need to call the first back-up resident and ask them to come in. In the event that the back-up resident is called in, the called in resident will be given a call break in the following call cycle.

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What should I do if I become ill or can't continue to work during call?

If you become ill or for any reason cannot carry on your duties, (i.e. fatigue so you cannot work, family emergency during a call/night float shift) you should:

- Seek medical attention, if necessary, in Urgent Care or the ER.
- If you are being trained on training call, let your TC resident know, and s/he will take over your call. Hand her/him your on-call pager, keys (If you are the trainer, call in the 1st backup resident immediately to take over training).
- If you are not on training call, notify the 1st backup resident immediately. You can figure out who this is by referring to the on-line call schedule at **https://psychres.washington.edu/WebApp/uwnetid/calendar.asp**. If the 1st backup resident has been on call within the last 3 days, s/he will let you know that you need to call the 2nd backup resident.
- Wait for the backup resident to arrive; backup residents are allowed up to one hour to get in to the hospital. Hand off the on-call pager, keys and on-call log. Sign-out any pending issues.
- Try to arrange for a ride home, if possible. Harborview's Parking Office operates a sick employee ride home service, which you can access by calling 744-3193

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Training Call

Each resident who is new to a clinical site receives Training Call with an R3/R4. Details of training call are covered in the **training call guide**

Medical Students:

You may well have a medical student (or two) on call with you at HMC. Their weekend call shift times are 8am to 4pm and 4pm to 11pm. Weeknight shift times are from when the student finishes his/her day work until 10pm. It is the student's responsibility to find you at the start of his/her shift. This is an excellent learning opportunity for the students, so please teach freely as time allows. Please contact the inpatient chief resident or Dr. Heidi Combs with any difficulties/problems/questions you have about students while on call.

On call Amenities, where to eat, sleep and get scrubs

- **Food** is available at the following places:
  - HMC cafeteria (in the basement; open from about 6:30am to 7pm)- breakfast is quite good (if you like saturated fats and simple carbs after a long night's work) and cheap too.
  - After hours, the coffee stand in the cafeteria sells some sandwiches, Uwajimaya's finest microwavable entrees, and soup.
  - Vending machines are located near the main patient entrance to the ER.
  - While there is also food available in the PES, this is primarily for patients. You should check with the PES nurse before eating or drinking anything in the PES refrigerator or cupboards.
- **Sleeping** is available in:
  - A new call room in the Maleng Building, RM 502 (on sky bridge) with the latest secret code of: 6013, 6013
  - Please keep in mind that the expectation for the Night Float Resident is that s/he will sleep during the day and stay up at night for call. However, you should still take breaks as needed.
- **Scrubs:**

- 1CT 91: door code 911911
  2WH 91: door code 206206

Where is the CL office?

- Located in the 5 East Clinc area, 5EC 29 through 5EC 38, Consultation liaison suite
  - Directions from the 5th floor resident work room:
  - Make a right out of the resident work room walking toward Maleng. After about 30 feet the center tower is located on your right, walk through the center tower (the old psychiatric ICU ward), you will then walk past the clinical education area and walk through large double doors into the 5 east clinic, continue to walk through the 5 east clinic until you get to the East clinic elevators, right past the elevators you will see a door with a glass window on your right hand side and a sign that says “Consultation Liaison Office”, the code is 111333.

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The PES

The majority of your time while on night float/night call will be spent evaluating patients in the PES. The following section details information you may need while in the PES. For more details (i.e. admission procedures, referring patients for involuntary detention, etc…), see other sections and appendices as needed.

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Don't forget **to check Epic and/or Mindscape** when chart reviewing patients in the PES. Most outpatient mental health notes are in Epic!

Initial Meet & Greet:

1. **All patients must be at least superficially evaluated by a provider** (MD, mid-level or social worker) **within 30 minutes** of arrival. This is to avoid missing critical emergencies and to better establish rapport.
2. The PES attending will delegate who is responsible for doing the patient drive-by (aka Provider Initial Contact). If the attending asks you to do this, introduce yourself to the patient and quickly make sure he/she isn't planning or already doing something dangerous while in the PES. Also obtain contact numbers so that someone can start getting collateral info ASAP.
3. If, on your Meet &Greet, the patient is out of control, seems medically ill, or is threatening/attempting suicide and violence while in the PES, then tell the attending and staff. Tell the patient they will be seen for a more in-depth visit as soon as possible and try to give a ballpark time estimate (keeping in mind that things always run slower than expected, it could be many hours).
4. Then order standing orders on CPOE see instruction to the right.

PES Initial Contact (Meet&Greet) for new PES arrival

- Briefly (5 minutes) check in with patient within 30 minutes of arrival to PES
- Introduce yourself
- State the approximate wait time for full intake
- Ask about immediate SI/HI
- Assess for medical emergency (resp distress/severe withdrawal)
- Check in with attending/staff about pt status
- Go to CPOE and order standing orders
  - Under Orders "Psychiatry"
    - PSYCH PES EVAL
    - Check off appropriate labs, withdrawal protocols, PRN meds, etc.
  - Sign orders

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PES sign-out rounds:

These occur at 7 a.m. every day of the week. These rounds are attended by the PES Attending for the day, the Social Workers ending and starting their shifts, and Nurses ending and starting their shifts. Unless you are called away for floor duties or emergent consults, if you have a patient left on the PES board, please present during morning rounds.

Signing up for patients and using first net:

1. Look at the patient board in the nurses' station in the PES, each patient needs to be seen in order that they have arrived to the PES, if there BAL is above 100, then you must wait to do a full evaluation until it is below 100, calculation=BAL decreases 50points/hour.
2. Ask your attending if there are two patients that came at around the same time to determine which patient would most appropriate to see first.
3. Sign up with your initials on the track shell under PES comments.
4. Sign up for the patient on First net by right clicking on their name and clicking "Assign Provider"

Discharging patients and using first net:

1. If you have decided to discharge the patient to anywhere other than the inpatient unit you will need to right click on their name and start the "discharge process"
2. Indicate dispo, diagnosis, and follow-up
3. Fill out medications on discharge as indicated, print on tamper proof paper and sign. Then give this Rx to the nurse.
4. Print out the discharge form and have the patient sign it, if they refuse to sign that is okay, just document this.
5. Let the nurse know that you have finished your discharge process and they will facilitate the discharge.

PES Notes:

1. PES notes should be done using the *Psych Emergency Services MD ARNP SW* in ORCA PowerNote.
2. Remember, you MUST check the title when *signing the note.* Note that whenever you sign a note, it will default to the last type of note you wrote and will ignore the template title you selected.
3. Fill out admit (how pt looked on admit) and discharge rating scale (how pt looked after your intervention)
4. Remember to forward the PES note to the attending for review/signature.
5. When entering a diagnosis, do not free text. Click on the problems and diagnoses link in the Powernote to search for and add the right diagnosis. This will help with billing, help with insurance authorizations for voluntary admits (because ICD-10 code will auto-populate), and help with discharges (because d/c diagnosis will auto-populate on d/c paperwork).

PES Note

- Go to IView/Powernote
- Use the title "*Psychiatric Emergency Services MD ARNP SW"*
- This will auto-populate the template
- Enter time of evaluation as the time of your full evaluation
- Write note
- Fill out admit and discharge rating scale
- Sign note and have your PES attending co-sign

*****If you accidentally sign it with a different title, please forward to HMC FIX and ask that they change the title.**

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Community Call for a transfer or admit to HMC psychiatry

If you receive a call about a person who may need psychiatric care but is not yet at a hospital, tell the caller to take the person to the **CLOSEST ED, unless this is an MHP (See #2 below).** It does not matter if the closest hospital has a psych unit or not: the person can always be safely transferred by ambulance if need be.

1. A sample response would be "I understand your desire to have them admitted to our facility, but please take them to the nearest ED, since we do not know what will happen to the patient between his current location and the hospital."
2. **The exception to this is that an MHP can require us to take a patient at any time**. If we don't have a bed, the patient simply takes up residence in our ED until something more permanent opens up.

STAY COOL w/ agitated patients

S–Stand at a safe distance, not looking straight at the patient

T–Talk w/ even, concerned voice tone; consider timing of questions, directives

A–Ask simple questions; avoid being provocative; agree to disagree; know where alarms are

Y–Be a **yellowbelly!** Walk away if unsafe.

C–Be **concise** and unambiguous

.

O–Observe surroundings and patient. Warning signs include being demanding, belligerent, not following directions, pacing, raised voice, motor agitation.

O–Options . Give choices: food v no food; IM v PO meds; lights on v off. Having choices is empowering.

L–Look(eye contact but no staring contest); **-Listen** (What does patient want?); Be neutral and remember that you control the situation –**Lay down the law**

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Hillard/Zitek
(2003) Emergency Psychiatry, p182

Medical ED to PES transfer

1. In order for the patient to be transferred from the ER to the PES be sure they have been medically cleared:
2. Complete medical work up for altered mental status with labs (serum medication levels, BMP, CBC, etc), EKG, and possibly head CT if indicated
3. Medically cleared in the ED to us means: the ED attending would discharge the patient home if they had no psychiatric issues

PES to Medical ED:

1. Contact the ED provider and explain why you think the patient needs to be on their side, reasons can be needs heart monitoring, is medically destabilizing, severe benzo/etoh withdrawal, is delirious etc.
2. Then provide suggestions for how they can treat their psychiatric problems
3. If your attending now approves the transfer and everyone else agrees with the transfer ask the PES nurse to contact the medical ED nurse to facilitate the transfer

Medical ED to PES transfer

- Confirm that pt is medically cleared
- Complete medical work up for altered mental status with labs (serum medication levels, BMP, CBC, etc), EKG, and possibly head CT if indicated
- Medically cleared in the ED = the ED attending would discharge the patient home if they had no psychiatric issues

PES to Medical ED transfer

- Contact ED provider and explain why they need to be transferred
- Provide recommendations for psych issues
- If your attending approves this transfer, ask the PES to facilitate the transfer

10.77 Patients:

A 10.77 refers to a patient who is brought from the jail for assessment and psychiatric placement. The following steps occur with these patients.

1. The patient is medically cleared in the main ED
2. The patient is seen by an attending (not a resident) who writes an affidavit (but does not write an eval note)
3. Placement is found for the patient. This involves one of two scenarios:
   a) If this is at an outside hospital, the resident is not involved.
   b) If the patient is placed at HMC, the process is just the same as with a patient detained in the field. The PES attending, ARNP, or resident will need to write a PES evaluation note, fill out standard admission paperwork and put in admit orders. The patient goes through the regular PES process and is not directly admitted to the floor (i.e. staff with PES attending as per usual)

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Safety

Safety features in the PES include:

- Four "panic buttons" are distributed around the PES: two in the east hallway of the PES, one under the Nurses' station, and one under the Social Worker's desk. Activate and stand clear of the doors—security doesn't knock.
- A "panic telephone" is located under the video monitors at the Nurses' station. Pick up the receiver and say, "Code Gray in the PES, Code Gray in the PES"
- **The most important safety feature is the generous staffing allotment: if you are EVER concerned, ask another staff member or security to accompany you and standby while you interview the patient.**

Violence and Assault Prevention:

1. **Prior to any psychiatric interview, you should try to assess the potential dangerousness of the patient** by checking in with other staff that is familiar with the patient.

2. **You should also carefully review the patient's medical record- THE BEST PREDICTOR OF FUTURE BEHAVIOR IS PAST BEHAVIOR!**

   a. **Some predictors of violence:** High degree of intent to harm, frequent and open threats, concrete plan, history of loss of control, history of chronic anger, hostility, or resentment, history of

childhood brutality or deprivation, history of fire-setting, cruelty to animals, history of prior violent acts and history of reckless driving

b. **Some diagnoses and syndromes associated with violence:** Antisocial and borderline PD, mania, psychosis, intoxication, impulse control disorders, dementia

3. When interviewing a patient, position your chair so that you have unobstructed access to the door. You may wish to leave the door open for easier egress from the room. If you feel unsafe, trust your intuition! Get out of the room immediately, and call for help by yelling, "Staff!", or pull one of the panic buttons.

4. There are three general ways to acutely manage aggression:
   a. Verbal de-escalation
   b. Medications
   c. Seclusion and restraint

5. You should never perform any of these on your own. You may be asked by staff to order medications, e.g., lorazepam, to reduce aggression and agitation. You should not be asked and will never need to participate in seclusion and restraint of patients because adequate staff is always immediately available.

6. **Always debrief with staff and security after a code gray or after a patient was physically touched involuntarily, i.e put into restraints**

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Dispo from the PES other than inpatient psychiatry

Social work can help, if there is no social worker on duty or available, dispositions include:

- next-day appointment (NDA)
- psychiatry resident continuity clinic (PRCC)
- detox or sobering center
- WASBIRT referral
- crisis respite
- DESC Crisis Solutions Center
- hospital diversion bed
- homeless shelter
- a bus ticket out of town

Each dispo is explained in detail below:

- **Next-Day Appointments (NDA's)**
  - If a patient doesn't require hospitalization but needs immediate outpatient follow-up, refer them to a Next-Day Appointment (actually within 72 hrs) at a Community Mental Health Center, which you can arrange through our pals at the Crisis Clinic. Be prepared with patient's address, DOB, and a pithy HPI, and remember to fax your ER note to the treatment agency.
  - As a last resort, we have some NDAs available through HMHS, but you should go through the Crisis Clinic first before you fill up our appointments.

- **Private Pay Next-Day Appointments**
  - In the rare event that you get someone with gilt-edged insurance, call their agency and see if they will cover an acute evaluation. If you can get Blue Cross or Primera to say 'yes,' our Bellevue friends at Overlake offer a deluxe NDA Service. Before 5 pm call the Overlake Behavioral Switchboard at 425-688-5691, and be sure you have an insurance authorization in-hand.

- After working hours? Just call the 24 Hour Triage Nurse Pager at 206-645-6554. (They will also take cash, of course.) Naturally, most insurance agencies don't work after-hours, so you may not be able to get their preauthorization, but please document that your tried to contact the insurance agency.

- **PRCC (Harborview Psychiatry Resident Continuity Clinic)**
  - This may be an option for very stable, low-risk patients needing psychotherapy and/or medication management without social work/case management needs or treatment-interferring substance use that are able to wait up to several months for to their initial appointment. A link to the PRCC referral form is located at: http://psychres.washington.edu/

- **Detox and Sobering Centers**
  - Patients with a history of mild or moderate withdrawal and NO current suicidality may be referred to one of the local detox facilities. To arrange, contact a detox facility and ask to speak to the intake supervisor. Typically, the detox facility will arrange for transportation from the PES, and most patients will be sent away with pre-packaged med.
    - Complete discharge medication through first net, print on tamper-proof paper and then hand this to the nurse who will decide to either have it filled in house or give it directly to the patient. See PES Discharge meds
  - **Detox is NOT an appropriate disposition for patients with a history of severe withdrawal or seizures**.

  - The Sobering Center is a room with a rubber mat that takes in the chemically-dependent without significant withdrawal history or suicidality. Case managers are available to assist with psychosocial issues, but medical support is not available.

- **WASBIRT Program (Washington State Screening, Brief Intervention, Referral, and Treatment Project)**
  - A Washington State pilot study whose initial success has resulted in ongoing funding. WASBIRT referrals are generally available first thing in the morning or as late as midnight if counselors are present. As the name suggests, a WABIRT counselor will do a screening and brief intervention with the patient in the PES. They may then qualify for outpatient follow-up of several motivational interviewing type sessions with possible referral to additional chemical dependency treatment as needed.

- **Crisis Respite and Hospital Diversion Beds**
  - If a patient has a non-substance related Axis I disorder, requires more intensive monitoring than can be provided at a shelter, and needs temporary accommodation, they may be admitted to Crisis Respite at the Downtown Emergency Service Center (DESC).

- **DESC Crisis Solutions Center**
  - DESC now has the Crisis Solutions Center (206-682-2371). They provide housing (for up to 17 days, 72 hours acutely with a second, 14 day stabilization stay) designed to help with acute psychiatric decompensation and referral to community mental health resources. Patients should not require detox, not be acutely dangerous to themselves or others (ie, requiring hospitalization), and not require special nursing needs. This level of care is meant to be similar to crisis respite.

- **Homeless shelters**
  - There are a number of homeless shelters in Seattle; phone numbers are listed in PES. DESC is a shelter that also provides some case management and psychiatric services.

- **Bus ticket- the Greyhound Cure**
  - Social Workers have a small slush fund for 'therapeutic travel.' If you have a patient who has been taking up a lot of services and says they would feel so much better if only they could get back home to Nashville where they just *know* there's a cousin who will help them get a job at the salvage yard and be their AA sponsor, you can ask social work to buy them a bus ticket right out of town. The ticket is pre-paid and left at the Will-Call desk at the depot, so no cash changes hands. This happens about twice a year, when an attending decides it would be cheaper to ship a patient rather than triage them yet again. Be sure and give the newly departed a few sandwiches to eat on the way, because, brother, it's a LONG bus ride to Nashville.

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Consultation-Liaison On Call

- Saturday and Sunday day shifts are generally dominated by C/L work. Urgent consults come at all hours, however, and when you're on call, the C/L list remains your responsibility. Below are procedures for managing your consult life.

Weekend/Holiday Day CL work and triage

1. Triage rules apply: see Triage, general rules of triage while on call still apply even when you are six consults deep on a Saturday.
2. See numerous new consults along with follow-up work that needs to be done on existing consult patients. Prioritization of consult work should follow the general thinking of the most emergent/urgent need gets tended to first. Follow these guidelines:
   A. Emergent new consults - think "SAFETY 1ST!!!" (i.e. **attempted suicide, patient verbalized SI, combative patient, decisional capacity/safety eval for a medical patient demanding to leave AMA**).
      ****If safety is in any way a question or concern, seeing the pt and communicating recs to the consulting team in a timely manner is a priority. Assessing patient within an hour is ideal although not always possible. Be sure to recommend restraints and / or 1:1 sitter if necessary until you can evaluate them. Your consult (assessment, reasoning and recs) should be communicated verbally to the consulting team and then documented in an ORCA note, in CORES, and verbally on sign-out to the oncoming psych resident.****
   B. Urgent revisits (the weekday consult team will sign-out which patients they would like seen)
   C. New, urgent to non-urgent, but pressing consults (i.e. safety evals, delirium causing trouble)
   D. Other revisits and C/L patient dispo (i.e. patient gets medically cleared and needs a voluntary bed in the community)
   E. Interesting, but not pressing new consults (i.e. primary service is "curious," but willing to wait on the consult if needed)

It's recommended that you check in with the attending covering consults (5WA attending) in the morning and let them know who you are planning to see and any urgent issues. Attendings can offer sage advice as well as back you up if another service feels we can't see their patient as quickly as they would like. **If at any time you are feeling like you are not sure how to triage consults or feel like there may be more patients that urgently need to be seen than you can physically see, contact the attending covering consult s (5 WA attending). If after triaging with the attending there are more patients that need to be seen urgently than you can see during your shift, the 5WA attending will contact the 5 MB attending who is responsible for seeing patients on consults if needed. Please let the chief resident know if this happens.**

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Notes / Documentation

- When completing consult notes, you should use Power Note with a note type of **"Consultation-Inpt"** and titles of "Psychiatry Consultation Initial Note" or "Psychiatry Consult Progress Note." (Please do ***NOT*** use the "psychiatry – inpt" note type.) The Power Notes have nice templates to make your work easier. Remember to select the appropriate note type for each note as ORCA will default to your most recent note type, not based on the title you select when opening your Power Note
  - Forward to HMC FIX if you need to correct a title.

- Send your notes to your on-call attending for signature when you are finished (See who is my attending –Days)
- Please document that you discussed the patient with your attending
- Make sure to write a brief (1-2 sentence) note, if contacted by an MHP about a patient on consults. The note should state whether the patient was detained or not.
  - Consider including verbiage such as the following in your note for the benefit of the consulting team: "The patient has been involuntarily detained on a psychiatric hold and the psychiatry consult service will continue to follow the patient. The patient is to remain in-hospital until the hold is lifted. The patient remains under the care of the [name of service] service until transferred to an inpatient psychiatry bed. Do not hesitate to contact our service or on-call resident with any questions or concerns."

Admissions/Transfers:

You will likely have to admit patients from the C/L to inpatient psychiatry either at HMC, UWMC, or some outside hospital. See the "Admissions/Transfers" section of the PRON for details on the type of admission you are trying to do. HMC

CL/med surg →HMC INPT, HMC CL MED/SURG→UWMC INPT and here for options regarding assistance from social workers.

Speaking To Other Services, Being a *Liaison* :

- Doing C/L work often means speaking/working/laughing with physicians and nurses from other services. It is important to remember when doing this kind of work that we are providing a service to other physicians, much as they provide a service to us when we call them for consults. So put on your best customer service hat and play nice in the sandbox. Provide empathy, validation to the staff and providers.
- Often, however, other services want things that we cannot give them. If this is the case, try to determine the primary team's perceived priority of their request to make sure it is in keeping with your perception of when you can meet their needs.
- If you cannot see/admit/diagnose a patient as soon as a primary service would like you to be able to for whatever reason, it makes the best sense to be honest and discuss with them your thoughts. Sometimes other services think things are more or less important than we do. Coming to mutual understanding of the needs of the other service, what we can provide, and what is in the best needs of the patient, can end lots of potential conflicts before they start.
- When in doubt, discuss any management issues you may have with your on-call attending.
- If you are called by a team or a nurse about doing a "two physician override:" The two physician override is an idea that if two doctors think a patient needs something, they can override the patient's wishes and implement the treatment, surgery, etc. It does not exist in our practice (at least in the state of WA). Inform the team that a two physician override cannot be done, but that you can evaluate the patient for decisional capacity, then approach the case as you would for a standard capacity evaluation.

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Completing a consultation:

- During your phone call with the requestor, get an understanding of the reason for the consult. If this is a weeknight consult, you may need to triage the issue until the following day. Let the requestor know when you or someone else from Psychiatry will be able to see the patient. Keep in mind that patients with suicidal ideation or following a suicide attempt should be seen within 90 minutes of the consult being placed.

- Given the high volume of new consults during the day time, it might be reasonable to see a consult over night, even if it is not urgent. This decision should be made based on the work load in the PES.

- Go to the ward, review the chart for 5-10 minutes, and ask nurses for their observations. You might also want to speak to some collateral sources to see if they drop any clues.

- Your patient interview should be no longer than 30-45 minutes**.** Focus on: HPI; past psychiatric history; current medications; social situation; drugs & alcohol; and the mental status examination.

- **Write a succinct note** – Using the C/L Initial Consult form for new consults or the C/L Progress note for follow-ups.

- **Recommendations should be numbered, worded explicitly, and listed by priority**
  - Things of particular note are dosages and titrations of meds, and whether restraints are needed (or can be discontinued).

- **Do *NOT* place orders on CL patients** – we make recommendations to the primary team, which is responsible for entering orders (this helps to delineate roles and ensures no duplicate orders or a tragedy of the commons phenomenon.)

- **Page the primary team's resident and briefly review the case with them** and leave a brief message on the Consult Service voice mail (x5927); including the patient's name, location, diagnosis, current psychiatric recommendations and contact person and ***place the patient in CORES***

- Transfers to Inpt Psychiatry are possible on the weekend; transfers at night are not, absent exigent circumstances (review with your attending). Review bed availability with the PES Social Workers & the inpatient charge nurses.

- For the voluntary transfers, authorization is needed. Call the PES Social Workers (x42649) who are happy to help us coordinate authorizations to point of providing the clinical information to the clinician from the authorizing

agency. The Social Worker would expect us to provide the clinical information directly to the authorizer once they do the preliminary assessment of insurance and initial phone calls to reach the authorizer.

- Call the on-call Attending after each consult, no matter how trivial it may seem, and make sure you put the On-Call Attending as the co-signer.

- Prior to any transfers to the Psychiatry Inpatient Unit, an interim or a discharge summary by the primary team must be completed with appropriate recommendations for any ongoing med/surg issues. This *CAN* be waived for a compelling reason (I can't think of any right now), but the referring team should explain what the reason is. If they feel the patient is simply unmanageable, you can suggest ways Mr. Difficult be kept safe (medications, sitter) while the team finishes its summary, or if this is not practical, you can quiz them on the medical issues and get them to provide you with a verbal plan to manage any foreseeable problems.

Med/Surg Pt. is requesting to leave AMA

1. Patient is demanding to leave AMA defined as, patient has asked two times or more and is not redirectable, or tries to leave.
    a. If redirectable then please document that the patient is willing to voluntarily stay in the hospital
2. **Restraints in patients attempting to leave AMA:** In many situations, if a patient is in restraints to keep them from eloping from the hospital, they will need to be referred to MHPs for evaluation. This is determined by whether or not they have capacity and whether or not they are delirious:
        i. **If patient does not have capacity**:
            1. And is delirious: We can hold them without detaining them while we work to restore their capacity.
            2. And is not delirious: Need to refer to MHPS for evaluation
        ii. **If patient does have capacity**: Can only use restraints if you are referring them to MHPs for involuntary detainment otherwise they will need to be release
        iii. Okay to have patient in restraints without referring them, if they are at risk of eloping the hospital before you have an opportunity to complete evaluation.
3. Medical restraints: Restraints that are placed clearly for medical reasons (i.e. not behavioral issues such as patient attempting to elope) include but not limited to falls or pulling out their IV lines or other lines. The rationale for restraints must be clearly documented.
4. Additional information regarding when to refer in decision algorithm in the Appendix

The Floors 5WA,5WB, 5Maleng

- While on call, floor issues remain your primary responsibility.

Notes

- There will be times when you make interventions for floor patients and you must decide how to document such an intervention.
- General practice is that extremely simple medication changes or interventions (i.e. renewing an Ambien order) can be documented in CORES alone without formal ORCA documentation.
- Anything beyond simple medication adjustments or PRN's require a formal note in ORCA. This includes any time you go see a patient, especially if you examine the patient and/or address a specific concern.
    - Notes can be free text notes in ORCA with the type being "Psychiatric Inpatient Note." Following a SOAP format ensures that you will not forget important parts. All notes need to be co-signed by the on-call attending and should be forwarded to appropriate daytime attendings and residents so they see what you have done.
- Generally, significant interventions should generate a call to the on-call attending as well as they usually hate learning about significant issues after the fact. These can include having a rapid response called, a fall with an injury that required a significant workup.

Medical Issues

- You will get called for ALL medical issues that floor patients have. These can range from the very simple to the very complex. When in doubt about what to do, speak with your attending and a consulting medical service if necessary.
- For complicated and/or serious medical/surgical cross-cover issues, it is often prudent to consult other services.

- If it becomes necessary to emergently transfer a patient to a different service, remember to complete a Discharge Summary as soon as possible. (It can be brief.) Its content should especially highlight behavioral recommendations, discharge medications, and any other relevant details, which will smooth the transition to a different service.
- See HMC inpt → HMC medicine in the transfer admit section

- Rapid Response (RR): Any staff member can call a rapid response; they are most often initiated by nursing staff. A RR triggers a stat nurse to come to the unit . There are (frequently changing) restrictions for what can be medically accomplished on the inpatient psych units and often the stat nurse has the most uptodate information.

Rapid Response Criteria:

Any intuitive sense that something is going wrong with a patient

OR (one of the following):

Acute change in:
-mental status
-respiratory status
-CV status:
-HR <55 or > 120
-SBP <90 or >170
-decrease in HCT by 6 pts /24 hrs
New onset chest pain, agitation or restlessness
Acute change in temperature <35C or >39.5C

Medical Issues that require your in-person assessment

- If a **rapid response** is called you should immediately go see the patient and decide whether they need a consult. You should enter a SOAP note documenting the event.
- **Falls** always need to be assessed, perform a physical exam and work up any trauma (xray or head ct if indicated), consider placing on Q neuro checks if patient has head trauma.
  - **A fall note must be entered for every patient who has a fall.**
    - Click on "IVIEW & PowerNote" and click the "Open" button, and click on the tab "Encounter Pathway."
    - Search "fall" select "Provider Post Fall Assessment."
    - 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.
  - **For falls that require a change in management, initiate the fall PowerPlan (NOT REQUIRED).**
    - Click on "Orders" and click on "Add," search "fall" and you will find "Fall, MED Fall Prevention HMC"
    - This provides a few options on VS monitoring, nursing care, activity level, medication options, and workup options all in one place.

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EKG Guidelines:

- All EKGS must be reviewed in person, signed and dated by either a resident or attending & then placed in "to be scanned" basket
- If the EKG machine reads out an EKG as "abnormal" the nurse is expected to page the resident and the resident is expected to review the EKG in person within several hours.
- If there is a concerning read out i.e. acute infarct OR if the patient has any concerning cardiac signs/symptoms the resident is expected to review the EKG as soon as possible.
- If an EKG is ordered and has not been done by the time the primary team is signing out, the pending EKG should be written in CORES and the primary team should advise the on-call resident what they are monitoring for.
- If you are reviewing an abnormal EKG and are not sure what to make of the result: call medicine consults for assistance or bring the EKG to the ED and have an ED provider assist you in reading it.

How to Deal with AMA discharges/requests

- Often, residents are called because a voluntary patient on the inpatient unit is requesting to leave AMA. The management of such events is case dependent and should always be addressed with your attending, but here is a general algorithm:
- Check CORES and progress notes to see if there is a contingency plan in place for AMA requests
- Discuss case with nursing staff, charge nurse
- Evaluate patient at bedside, determine if redirection possible
- If redirection not possible, ALWAYS call attending!
- See if primary team left an affidavit
- Assess patient for MHP referral
- Discuss with on call attending to determine if you should proceed with referral
- If patient not detained by MHPs, call attending first before releasing, could consider re-referral if very concerned

- **ALWAYS, ALWAYS call attending before discharging a patient**

- If you and the attending decide to discharge the patient AMA, generally we do not provide discharge medications. The most common exception to this would be if there is a risk of withdrawal from meds (i.e. benzos). If you decide that it is crucial to write for discharge meds, make sure that you write a short prescription (2 weeks supply or less). Then tell patient to either f/u with their current outpatient provider or call crisis line/ go to ER if needed. Make sure you document all of this!

Safety of Vulnerable patients on our units:

The policy identifies **geriatric (age 60 and older) female patients with dementia** to be in a high risk vulnerable category that require a specific placement guideline.

- If a patient needs a psychiatric admission, the team will attempt to place a patient to an appropriate inpatient geriatric unit (e.g. NWH), but if no beds are available, the patient should be **screened for the West units**
- If the patient does not meet criteria for admission to the West units, The patient would need to be **placed on boarding status in the PES or medical unit.**
- The AAA (Liz McNamara), the Medical Director of the service and the Chief of Psychiatry should be notified that there is a female geriatric patient with dementia requiring an IP bed
- The AAA and the Chief of psychiatry will work with the Medical Director on appropriate placement
- **If for behavioral reasons the patient needs to be admitted to 5MB,** the patient would need to be **given a one-to-one monitor** until transfer to the West units is clinically appropriate.

Sexual Activity on the Ward Procedure:

All allegations of sexual abuse/assault by patients are taken seriously. Any sexual activity on the inpatient psychiatry ward may be considered "nonconsensual" as our patients may not have capacity to consent when hospitalized. Therefore, we recommend following this procedure whenever any sexual activity occurs on the unit:

- Nursing staff will either contact the attending or the resident to alert them of the occurrence or the allegation
- The resident should immediately evaluate the patient to assess need for urgent medical care and then contact attending. You are NOT expected to perform a gynecologic exam.
- If the patient does not have capacity and has a surrogate decision-maker OR requests to have family contacted—the resident should discuss with the attending who is the most appropriate person to alert the surrogate/family.
- The attending should coordinate with the Administrator on Call (the AOC) and receive further instructions from them. (Feel free to remind your attending of this, particularly if they are an outpatient attending.)
- The attending OR resident OR nurse will notify the ED Social Worker ASAP and coordinate for the SANE nurse to meet with the patient ASAP. It is appropriate to request the charge nurse do this but it is the MD's responsibility to ensure this happens quickly.
- The resident will then complete a cross-cover note to document the incident and to document what interventions were taken afterwards (ie: SANE nurse has been contacted, etc)
- If this occurs while you are on call, PLEASE EMAIL the chief resident with the email title “QI Confidential” and alert her/him of the incident.

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Physical Assault on the Ward Procedure:

All allegations of physical assault by patients are taken seriously. We recommend following this procedure whenever an assault occurs on the unit:

- Nursing staff will either contact the attending or the resident to alert them of the occurrence or the allegation.
- The resident should immediately evaluate the patient to assess need for urgent medical care and then contact attending.
- If the patient does not have capacity and has a surrogate decision-maker OR requests to have family contacted—the resident should discuss with the attending who is the most appropriate person to alert the surrogate/family.
- The attending should coordinate with the Administrator on Call (the AOC) and receive further instructions from them. (Feel free to remind your attending of this, particularly if they are an outpatient attending.)

- The resident will then complete a cross-cover note to document the incident and to document what interventions were taken afterwards.
- If this occurs while you are on call, PLEASE EMAIL the chief resident with the email title "QI Confidential" and alert her/him of the incident.

Patient Elopement:

In the event of patient elopement, the following actions should be taken:

- Contact the on-call attending to inform them of the elopement.
- Check whether the patient is voluntary or involuntary.
- If the patient is involuntary:
  - Call the Crisis Clinic to inform them of elopement.
  - Call 911 to inform the SPD; inform HMC security – note that nursing may have already done this; ask them first.
  - Check whether there is a duty to warn and take appropriate steps to warn target.
- If the patient is voluntary:
  - Look at recent notes and CORES to assess level of risk – consider contacting 911 if the patient is considered high risk.
- Write a brief cross-cover note indicating the steps you took. Primary team will be responsible for the discharge summary.

Transfers/Admissions

HMC PES to HMC inpatient admit, procedure and CPOE:

PROCEDURE

HMC PES→HMC INPT

- Most admissions to inpatient psychiatry at HMC come through the PES. If a patient is detained in the field and brought to HMC for admission they will go through the PES and still need a standard admission work-up.
- If a patient is assessed to need admission:
  1. Call the charge nurse on each unit to see if they will accept the patient
  2. Once you have a bed for the patient obtain insurance authorization (through private insurance or county auth. - see appendix) – not needed for involuntary patients

Then make sure you…

- ❑ Admission write-up (PES note).
- ❑ Physical Exam and ROS
- ❑ Completed insurance pre-authorization form (not for involuntary patients).
- ❑ Admission orders in CPOE
- ❑ Be sure to select correctly select if patient is voluntary vs. involuntary under 'bed type' in admit orders.
- ❑ Admission/transfer request form—the BLUE sheet
- ❑ Sign Admission form
- ❑ Admission medication reconciliation
- ❑ Antipsychotic compel form if needed
- ❑ **Antipsychotic consent form if needed**
- ❑ Update CORES

FOR PES BOARDERS:

- ❑ You still need to get insurance authorization for voluntary patients – when you call tell them no beds in the community.
- ❑ On the BLUE sheet – instead of selecting a unit, write in "PES"
- ❑ **In admit orders,** select voluntary or involuntary, then put Jagoda Pasic as the attending and select PES as the service.
- ❑ **Otherwise the procedure is the same!**

CPOE ORDERS

HMC PES→HMC INPT (& for Direct Admissions)

Admit orders:

1. It is most efficient to enter meds by:
   a. Entering home meds into document medication by history (top left corner button)
   b. Continuing or discontinuing home meds by clicking button reconciliation → admission (top left corner button)

2. Then do psych admit power plan (Add, Psychiatry, PSYCH ADMIT, done), and while in powerplan, pull in meds by clicking on button which looks like an eye looking forward/triangle.

If you do not do in this way, ie. 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

3. Once you know the unit and team, please enter the attending and team in the admit orders. On WEEKENDS ONLY enter the attending of service as the attending on weekend call for that particular unit (5WA, 5WB, or 5Maleng). The attending will be listed in the email "On call weekend reminder" sent by Susan Taubenack.
   a. This applies for Friday 5pm until Sunday 6 pm. Any admits after Sunday 6pm through the rest of the weekdays, would be admitted to the attending of the team they are actually being admitted to.

(team I,II, III etc, the charge nurse of the unit usually tells us who this is)

4. EKG: fill it out as prompted in CPOE, no need to fill out separate paper EKG form

5. You will still need patient to sign paper antipsychotic form

HMC PES boarders to HMC inpatient *Return to table of contents*

CPOE ORDERS:

Transfering PES Boarders To HMC Inpatient:

- These patients already have inpatient admission orders (done when they become a boarder)
- To admit them to the floor (when a bed is available):
  1. Go to the Add icon (you will be able to see "Admin/trans/disch") → click on "Transfer patient (psychiatry)" then "order reviewed - ok for transfer".
  2. Refresh and double left click on the "Admit" field to change the patient location, type and attending.
  3. Make the appropriate changes to the location, attending etc…
  4. Sign and refresh.
  5. You will not need to do med recon. In the special information box, you can type "Transfer of patient from PES to 5MB. Admission orders to be continued"

UWMC ED to HMC inpatient admit, procedure and UWMC CL to HMC inpatient psychiatry admit procedure:

PROCEDURE

UWMC ED→HMC INPT

- In these cases, the admission workup and paperwork will be done by the UW on-call resident and ED SW at UWMC
  - This includes admission orders, all authorizations and other paperwork, and updating CORES
- The resident from UWMC will contact you to give you sign-out about the patient
- You should go see the patients when they arrive as they may have active medical issues that you should be aware of to provide the best care.

Then make sure you…

- ❑ Receive sign-out from UWMC resident
- ❑ You do not need to do an admission note, this will be done by the day team the next day
- ❑ Once patient has arrived, see pt, evaluate as needed given sign-out
- ❑ Leave a SOAP note about your brief interaction with the patient.

PROCEDURE

UWMC CL/med surg→HMC INPT

- Admissions from the UWMC C/L service are largely completed by the UW C/L or UW on-call resident.
  - This includes admission orders, all authorizations and other paperwork, and updating CORES
- The resident from UWMC will contact you to give you verbal sign-out about the patient
- You should go see the patients when they arrive as they will often have active medical issues that you should be aware of to provide the best care.

Then make sure you…

- ❑ Receive verbal sign-out from UWMC resident
- ❑ You do not need to do an admission note, this will be done by the day team the next day
- ❑ Once patient has arrived, physically evaluate patient to assure care hand-off
- ❑ Leave a SOAP note about your brief interaction with the patient.

PROCEDURE

UWMC INPT→HMC INPT

- Typically happens for cases of ECT and happens during the day.
- Inpatient resident at UW will arrange most of the admission.
  - This includes admission orders, all authorizations and other paperwork, and updating CORES
- The resident from UWMC will contact you to give you sign-out about the patient
- You should go see the patients when they arrive as they may have active medical issues that you should be aware of to provide the best care.

Then make sure you…

- ❑ Receive sign-out from UWMC resident.
- ❑ Confirm any arrangements and orders needed if the patient is going to ECT the next morning. **Remember, no benzos unless otherwise stated.
- ❑ Once patient has arrived, see pt, evaluate as needed given sign-out.
- ❑ If you are on short-call, then you should do an admission PAF. Night float can just leave a SOAP note about your brief interaction with the patient.

HMC CL/med surg service to HMC psychiatry inpatient procedure:

NOTE: daytime CL resident is responsible for CL→Inpt Psychiatry Admission between 8:00AM-5:00PM; If admission procedure is not completed prior to leaving shift, CL resident will complete as much of this process as possible and sign-out remaining admission elements to the on-call resident.

The inpatient psychiatry resident is NOT expected to write a note on the patient on the day of transfer EXCEPT in the following two scenarios:

- ***If the patient was NOT seen by psychiatry consults on the day of transfer***
- ***If the transfer happens on a Friday and the patient gets to the floor before 4pm (to ease the burden for the weekend attending).***

Note: In this case, correct note type for inpatient resident to use would be 'Psychiatry Assessment Form – Inpt'

PROCEDURE

HMC CL/med surg →HMC INPT

- The HMC consult OR on-call resident at HMC completes all of the admission work for these admits
  1. Call the charge nurse on each unit to see if they will accept the patient
  2. Once you have a bed for the patient obtain insurance authorization (through private insurance or county auth. - see appendix) – not needed for involuntary patients

Then make sure you…

- ❑ Page accepting psychiatry resident to inform of transfer; accepting resident is to page the medicine team for verbal hand-off. If weekend/after hours, on call resident should page medicine team for verbal sign out.
- ❑ Addend/write daily consult note reflecting admission
- ❑ Completed insurance pre-authorization (not for involuntary patients)
- ❑ Call admitting and request pre-admit encounter created for the patient so that admission orders can be written in CPOE
- ❑ Confirm discharging service writes discharge orders and discharge summary
- ❑ Admission orders in CPOE (see special section in CPOE orders on admissions from other services)
- ❑ Admission medication reconciliation form
- ❑ Ensure that all medications and precautions for medical/surgical problems are entered – check for ortho precautions, diet precautions, wound care, mobility precautions/needs, anti-coagulation (make sure they don't need to continue this after surgery or for other reasons prior to dc anti-coags)
- ❑ Antipsychotic compel form if needed
- ❑ **Antipsychotic consent form if needed**
- ❑ Update CORES

CPOE ORDERS

HMC CL/med surg →HMC INPT

To be completed by HMC consult resident or on-call resident:

1. Wait for a preadmit to be completed
   a. This is done by admitting and can take a while although they try to be as speedy as possible. This is initiated once a request is sent to admitting by the inpatient psychiatry screener.
   b. To see if this is done, you can click on the patient encounter and see if you can change the encounter to a "preadmit" for inpatient psychiatry
2. Once a preadmit has been completed, select this encounter and enter all of your admission orders under this encounter. LEAVE ALL ORDERS IN A "PLANNED" STATE for nursing to initiate once the patient has been transferred
3. In the admit power plan on WEEKENDS ONLY enter the attending of service as the attending on weekend call for that particular unit (5WA, 5WB, or 5Maleng). The attending will be listed in the email "On call weekend reminder" sent by Susan Taubenack.
4. Do not complete the admission medication reconciliation until the discharging service has completed their discharge medication reconciliation (you may need to remind that service to do this, although other services are usually highly motivated to get their patient transferred to us). This will allow you to carry over discharge orders into admission orders and will prevent possible duplicate orders.
5. Nursing will then initiate all of the orders once the patient has been physically transferred.

If you want to transfer a specific medicine (or other service) power plan for a particular patient:

1. Find the medicine power plan you want. Click on the plan and select "save to my favorites"
2. Switch to the new preadmit encounter, click on add orders, select favorites, and add that particular power plan
3. Once you have done this, delete the specific power plan from your favorites as it is patient specific and you don't want to re-use it on another patient.
4. Leave all orders in a planned state for nursing to initiate upon physical transfer.

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After Hours transfers from HMC CL/Med Surg to Inpatient Psychiatry

After Hours, Evenings, and Weekends
On-call **Resident** coordinates transfers from HMC inpatient medical units to inpatient psychiatry (at HMC & outside facilities.) The PES social worker (744-2649) is available 24/7 and the inpatient psychiatric social worker is available Saturdays 8:00AM-4:30PM *to consult* on specific cases (pgr: 680-8737).

How to Transfer a Voluntary Patient:

- **Check insurance coverage:**
  - Private insurance & Managed Medicare: programs limit coverage to "in-network" facilities. Check the "cheat sheet" in the PES for further information about specific insurance carriers.
  - For patients on Medicaid or who are uninsured: determine the county of residence. Medicaid and uninsured patients are pre-authorized for voluntary inpatient psychiatric admission through their county of residence. (King County Authorization Line: 206-461-4858.)
  - Veterans: can be referred to the VA. Consult with PES or Inpt Psych SW.
- **Find an appropriate bed:**
  - Determine if the patient needs to stay at HMC due to medical acuity
  - Check bed status at HMC by calling the charges nurses on 5MB, 5WB, 5WA.
  - Call Facility: Fairfax, Overlake, UWMC, Northwest, Cascade, Swedish CH.
  - Check the patient placement guidelines for what medical conditions are acceptable for each facility, eg Fairfax is not able to do wound care with packing.
- **If there is an available bed**, provide a brief clinical description, and fax a clinical packet (demographic sheet, H&P/admit note, most recent MD notes, labs, OT/PT note or other consult notes if present). HMC and UWMC have access to Orca and no clinical packet is necessary.
- **Referral Outcome:** The screener will review and call back with an acceptance or denial. If you don't hear back and are going off shift, call the screener to provide a new contact name/number.
- **If accepted:**
  - Find out the name of the accepting provider and the number for the RN to RN report.
  - Ask what time the facility can accept the patient.
  - Call the insurance company or the county authorization line for pre-authorization. Ask the PES social worker if you are unsure who to call.
  - Contact the Med/Surg social worker or the Inpatient Psych social worker (Saturdays) for help with the logistics of the transfer (packet, AMR, etc).
- **If denied, continue to look for a bed.**

Involuntary Patients:

- **Check insurance coverage:**
  - Private insurance & Managed Medicare restrict psychiatric admissions to "in network" or "preferred" facilities.
- **Determine if patient should stay at HMC due to medical acuity.**
- **Call the King County Patient Placement Coordinator (PPC)** to locate open ITA beds (206-204-0370.)
- **Make referral** by calling the facility, then fax clinical information (demographic sheet, H&P/admit note, most recent MD notes, labs, RN notes, OT/PT notes or other consult notes if present).
- **If accepted:**
  - Review ITA paperwork:
    - ***If on a 72 hour hold***, make sure the IT-10 (Custody Authorization form) has the accepting facility checked. If not, call the DMHP for a new IT-10.
    - ***If on a 14 day or 90/180 day hold***, check court order to make sure the accepting facility is listed.
    - ***If it is not listed***, it must be amended by the ITA court (during normal court, M-F).
  - Obtain contact info: name of the accepting provider & phone # for RN-to-RN report. Ask outside facility for preferred ETA.
  - Insurance authorization: required for private insurance.
  - Contact Social Worker: the Med/Surg social worker (pgr 986-2576) or the Inpatient Psych social worker (Saturdays , pgr 680-8737) for help with the transfer (AMR, packet, etc).
  - Notify PPC (206-204-0370) that patient has been accepted at the outside facility.
- **If denied:**
  - Document the reason for denial.
  - Call PPC, ask if there is an open bed at a different facility.

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HMC PES to UWMC inpatient psychiatry procedure and CPOE orders:

PROCEDURE

HMC PES→UWMC INPT

- As these admissions are coming from the PES, the PES provider/resident will complete the bulk of the admission paperwork.
- If a patient is assessed to need admission:
  1. Call the charge nurse on each unit to see if they will accept the patient
  2. Once you have a bed for the patient obtain insurance authorization (through private insurance or county auth. - see appendix) – not needed for involuntary patients
  3. Then give sign-out to the UWMC resident:
  4. If it is before 3pm on a weekday, then call 7N (598-4720) to determine who the resident will be for the team to which the patient is going
  5. If it is b/w 3-6pm on a weekday then call the UW Short-call pager (559-1264).
  6. If it is after 6pm or on the weekend, then page the UW night float, or night call resident

Then make sure you …

- ❑ Admission write-up (ER note).
- ❑ Physical Exam Form (embedded in ORCA template, do not simply reference medical ED physical)
- ❑ Completed insurance pre-authorization (not for involuntary patients)
- ❑ Have patient sign Consent for Voluntary Psychiatric Treatment (if pt. is voluntary)
- ❑ Complete Hospital Authorization /Medicaid Release of Information

CPOE ORDERS:

HMC PES → UWMC INPT

- This applies for putting in orders before patient is actually on 7N (HMC PES to UW, or any pre-admit situation when a 7N encounter has not been set up yet.

1. Change the encounter in the top yellow bar where it says selected encounter to "UWMC lifetime encounter" (left click on "lifetime encounter UWMC", click change encounter button.)
2. To write orders pre-admit, they have to be in a power plan (ie. Add-> psychiatry-> psych admit-> done for the Psych admit power plan). This means that any med, lab, etc you add to the power plan you have to add using the "add to phase" button with blue cross, and not use the typical "add" button.
3. Sign 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)
4. UW nurses will initiate the orders when the patient arrives.
5. If the orders do not look right, sometimes you need to log out, and back into ORCA for the encounter info to display the updated information.

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HMC CL/med surge service to UWMC inpatient admit/transfer procedure and CPOE orders:

PROCEDURE

HMC CL MED/SURG→UWMC INPT

- Patients admitted from the HMC C/L service will have the admission completed by the HMC C/L service whenever possible
- If the C/L team is unable to complete the admission:

1. Call the charge nurse on each unit to see if they will accept the patient
2. Once you have a bed for the patient obtain insurance authorization (through private insurance or county auth. - see appendix) – not needed for involuntary patients
3. Next call the charge nurse on 7N to see if he/she will accept the patient
4. Once UWMC will accept the patient and payment for admission has been secured, complete the **admission checklist** BELOW
5. This will include giving verbal sign-out to the UWMC resident:

   -If it is before 3pm on a weekday, then call 7N (598-4720) to determine who the resident will be for the team to which the patient is going

   -If it is b/w 3-6pm on a weekday then call the UW Short-call pager (559-1264).

   -If it is after 6pm or on the weekend, then page the UW night float or night call resident Complete Hospital Authorization /Medicaid Release of Information

Admission Checklist:

Then make sure you…

- ❑ Addend/write daily consult note reflecting admission
- ❑ Completed insurance pre-authorization (not for involuntary patients)
- ❑ Call admitting and request pre-admit encounter created for the patient so that admission orders can be written in CPOE
- ❑ Confirm discharging service writes discharge orders and discharge summary
- ❑ Have patient sign Consent for Voluntary Psychiatric Treatment (if pt. is voluntary)
- ❑ Complete Hospital Authorization /Medicaid Release of Information Forms
- ❑ Admission orders in CPOE (see special section in CPOE orders on admissions from other services)
- ❑ Admission medication reconciliation form
- ❑ Antipsychotic compel form if needed
- ❑ **Antipsychotic consent form if needed**
- ❑ Give sign-out to UWMC resident
- ❑ Update CORES

CPOE ORDERS

HMC CL/med surg →UWMC INPT

1. Wait for a preadmit to be completed
   a. This is done by admitting and can take a while although they try to be as speedy as possible. This is initiated once a request is sent to admitting by the inpatient psychiatry screener.
   b. To see if this is done, you can click on the patient encounter and see if you can change the encounter to a "preadmit" for inpatient psychiatry
2. Once a preadmit has been completed, select this encounter and enter all of your admission orders under this encounter. LEAVE ALL ORDERS IN A "PLANNED" STATE for nursing to initiate once the patient has been transferred
3. Do not complete the admission medication reconciliation until the discharging service has completed their discharge medication reconciliation (you may need to remind that service to do this, although other services are usually highly motivated to get their patient transferred to us). This will allow you to carry over discharge orders into admission orders and will prevent possible duplicate orders.
4. Nursing will then initiate all of the orders once the patient has been physically transferred.

If you want to transfer a specific medicine (or other service) power plan for a particular patient:

1. Find the medicine power plan you want. Click on the plan and select "save to my favorites"
2. Switch to the new preadmit encounter, click on add orders, select favorites, and add that particular power plan
3. Once you have done this, delete the specific power plan from your favorites as it is patient specific and you don't want to re-use it on another patient.
4. Leave all orders in a planned state for nursing to initiate upon physical transfer.

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HMC PES to Seattle VA and HMC PES to outside hospital procedure:

PROCEDURE

HMC PES→SEATTLE VA INPT

- ➢ Verify VA eligibility through the VA Administrator On Duty (AOD): 762-1010.
- ➢ Call the resident on-call at the VA (either directly or via VA paging operator: 762-1010) to check bed availability and present the patient.
- ➢ If the VA on-call resident agrees to accept the patient in transfer, complete the admission checklist…

- ❑ Complete and copy the following forms:
  - ER notes
  - Physical Exam (or make sure the electronic version prints with the note)
  - Complete and have the patient sign the **Consent for Patient Transfer**
- ❑ Put the following forms into the AMR Envelope:
  - Copy of ER notes
  - Copy of Physical Exam
  - Yellow Copy of Consent for Patient Transfer
- ❑ Put the AMR Envelope on the back desk (by the stamping machine) and call AMR (444-4444) to take the patient to the VA ER.
- ❑ Turn in the remaining forms into the PES basket.
- ❑ Be SURE and tell the patient you *cannot guarantee* that they will be admitted: the VA Resident may decide they are a poor faith voluntary, that they aren't as sick as you thought they were, or god only knows what else. Don't be surprised if they take a cab right back to you a few hours later.

PROCEDURE

HMC PES→OUTSIDE HOPSITAL

- ➢ Call the operator at your desired hospital and request an audience with the Psychiatric Admissions Screener
- ➢ Check for bed availability and present the patient
  - o If they are willing to accept the patient, complete the admission checklist for transfer to an outside hospital…

- ❑ Addend/write daily consult note reflecting admission
- ❑ Complete and copy the following forms:
  - ▪ ER notes
  - ▪ Physical Exam form
  - ▪ Insurance pre-authorization form
  - ▪ Consent for Patient Transfer
- ❑ Put the following forms into the AMR Envelope:
  - ▪ Copy of ER notes
  - ▪ Copy of Physical Exam (which may be in the electronic note you print out)
  - ▪ Original Hospital Authorization /private insurance Authorization
  - ▪ Yellow Copy of Consent for Patient Transfer
- ❑ Put the AMR Envelope on the back desk (by the stamping machine) and call AMR (444-4444) to take the patient to the accepting hospital.
- ❑ Turn in the remaining forms into the PES basket.

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Direct Admission

HMC can accept direct admits from UWMC, WSH, Northwest hospital and Valley Cities Hospital. You will be contacted by the HMC Psychiatry Screening nurse if a direct admission is arriving to your team.

Generally, the short call resident is only responsible for direct admissions from 3-5pm**.** Rarely, the short call resident may be asked to do a direct admission between 1 and 3pm when an inpatient team does not have a resident and the attending is unavailable for the afternoon.

- If you receive info that a direct admission is coming, then confirm that the unit's charge nurse (5WA, 5WB, or 5MB) is aware of the patient, knows any necessary patient information, including the patient's medical problems and their ETA.

- If the direct admission arrives from UWMC: the UWMC resident does the admission note, physical exam, admit orders & antipsychotic consent. The HMC resident should see the patient immediately after they arrive and make sure there are not any outstanding care issues (such as patient in alcohol withdrawal).

- If the patient arrives from another other hospital: the HMC resident will perform the full admission (psychiatry assessment form (the admit note), physical exam, admit orders (see page 18) & antipsychotic consent).

- To admit a patient to a team with an attending and PA only, the Short-call resident is required to…
  - **i.** interview the patient
  - **ii.** write a brief Psychiatry Assessment Form (PAF) (PAs cannot write PAFs)
  - **iii.** the PA will assist in completing the physical exam, writing orders and generally helping out with any other admission duties
- **If the patient is a direct admit for ECT:** Speak with the ECT Attending (Neumaier) in person or on the phone to get all of the details on this patient's care plan, which meds should be continued or d/c'd and order the ECT powerplan.

Residents do not facilitate direct admissions. If you receive a call from another hospital requesting admission to HMC: advise them "I am not authorized to accept direct admissions." They should be advised to contact the HMC Psychiatry screening nurse. (Screening nurse pager: 989-4845).

HMC inpatient psychiatry to HMC medicine service:

PROCEDURE

HMC psych inpt→HMC medicine

- If it becomes necessary to emergently transfer a patient to a different service i.e. medicine or surgery you will need to discharge the patient from psychiatry and the medicine admitting team will need to admit the patient to their team
- THERE IS NO SUCH THING AS A TRANSFER IN THIS CASE, it is a DISCHARGE FROM PSYCHIATY AND ADMIT TO MEDICINE, be sure the medical team is aware of this.
- Make the charge nurse on the psychiatry unit aware that you are planning to discharge your patient to a medicine service.
- Give the psych nurse sign-out about the discharge as he/she will then need to communicate this information to the medicine nurse taking over.
- Remember to complete a Discharge Summary. Its content should especially highlight behavioral recommendations, discharge medications, and any other relevant details, which will smooth the transition to a different service
- Complete discharge orders as you would for any other discharge on CPOE, making sure to reconcile medications and include indications on each medication.

Then make sure you…

- ❑ Write a brief discharge summary including the medical course that lead to transfer
- ❑ Write specific behavioral and psychiatric medication recommendations to function as consult recommendations to accepting medical team
- ❑ Discharge orders in CPOE
- ❑ Discharge medication reconciliation with "zero" quantity for the meds since they are not leaving the hospital
- ❑ Update CORES

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Other CPOE orders

CPOE ORDERS:

CPOE 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"

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Appendix

If disaster strikes (emergency preparedness): If an event occurs that's categorized as a "disaster" you will receive a page/text and/or hear an overhead announcement stating "internal disaster" or "external disaster." If it is after-hours & you are the on-call resident you are therefore the "psych inpatient unit captain." Immediately proceed to room 506 on the Maleng skybridge. Call your attending as soon as able to discuss the situation with them. Likely they will need to come into the hospital and will then take over as the "psych inpatient unit captain."

ITA proxy information during *Night Float*

Undoubtedly, there will be times during your night-float that you will refer patients to the MHPs and they will be detained. In order to keep you out of court during prime sleep time later that week, an ITA proxy protocol has been developed that allows the daytime PES attending to testify on your behalf.

Times where you responsible for requesting proxy:

- Typically the ED Social Worker will take care of proxy requests on your behalf, but if they are not available, you will have to complete the proxy requests
- If the outcome of DMHPs evaluation is not known by the end of your shift, you can request that the PES social worker or your daytime counterpart request proxy for you

How to request proxy:

1) Place a copy of the clinical note, supporting clinical evidence, and the declaration (affidavit) in the clear rack above the resident work space in the PES as well as the front of the file cabinet by the attending desk , AND

2) **Fax the affidavit, PES note, supporting clinical evidence, and to Marsha Luiz's office at 206-296-8720**. Also include your contact information so they can get a hold of you, either via your pager, cell phone, or email, to let you know if you will be required to testify or not. When possible, you may consider staying late in the morning to call the prosecutor's office to make sure that they really do have all of the paperwork. Sometime fax machines malfunction, etc, and you could find yourself answering prosecutors' pages later in the AM.

3) **Please email the prosecutor's office** (paoita@kingcounty.gov**) to REQUEST proxy and cc the daytime attendings**: Pasic (jpasic@uw.edu), Klunk (k8klunk@uw.edu), Strope (mstrope@uw.edu). If the patient is admitted to the

hospital and on the consult list, please **add to the email the consult attendings**: DeMers <sdemers@uw.edu>,Dubovsky <ameliand@uw.edu>, Croicu"<croicu@u.washington.edu>, Bentley <sbentley@uw.edu>, Poeschla <bpoeschl@uw.edu>, Black <macblack@u.washington.edu>, and Zatzick dzatzick@uw.edu. Be sure to ASK for a proxy and not simply state that you will be using a proxy.

4) **Check to make sure proxy was approved.** Proxy must be approved by the prosecutors. You should expect to hear back from the prosecutor 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. If you do not hear from them within that time frame, call them (296-8936).

4) **If proxy is approved, on the court date:**

- Discuss the case with the daytime attending at 7 am PRIOR to the resident going off shift so that the attending is clear that they will be acting as proxy. The notes on the case will be in the file for the attending to reference prior to court, if they are called.
- Leave voice mails at both the court (744-7774) and the prosecutor's office (296-8936) and give them the PES phone number (731-3076), name of the covering attending, and the attending's pager number so the court can call them when it's show time.

In all cases, remember that a proxy can *only* be used if the clinical note has **appropriate documentation.** This includes:

- 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

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Further notes on the ITA-Proxy System

A. Please keep in mind that a subpoena (summons) REQUIRES you to come to court, UNLESS the ITA prosecutors determine that a proxy will be sufficient.

B. Whether a proxy will be sufficient can only be determined on a case-by-case basis. When the proxy guidelines are followed, the ITA prosecutors will make their best efforts to try to use a proxy and also to tell you in a timely manner whether a proxy will or will not suffice

C. Proxy testimony is more likely to be usable with patients who are gravely disabled or with SI, and less likely in case of DTO.

D. In order for the initial 72 hour to start, a DECLARATION (affidavit) written by a professional person who has been involved in patient care is needed. The best statement is one using quotes from the patient and "I…" statements from the clinician- "I saw, I observed, I heard" – and describing the behavior or what the patient said. For GD, obviously, we need to elaborate on any pertinent medical issues, such as electrolyte abnormalities, metabolic panel, glucose and HbA1C, etc.

E. At the hearing for 14 days of treatment beyond the 72 hours, the declaration CANNOT be used as evidence. However, part or all of the CLINICAL NOTE may be useable as evidence. So the CLINICAL NOTE should be structured in the same way as the declaration, with lots of direct quotes and "I…" statement from the clinician. Also, the court does not recognize statements such as "psychotic," but understands descriptions of psychosis, such as "looking suspiciously around, talking to himself, talking to the vent, picking on his arm." The court also does not recognize statement such as "confused, disorganized," but does understand statements describing how that state is manifested. The clinical notes must be SIGNED and DATED (including time). Only with a STRONG CLINICAL NOTE can the prosecutors evaluate if they will use the proxy process. If there is information in the DECLARATION which IS NOT in the CLINICAL NOTE, it is unlikely the proxy process will work.

F. Lab results or other medical findings should be documented in both CLINICAL NOTE and DECLARATION, with a description of what they mean.

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Phone Calls from Outside HMC

What should I do if an outpatient calls?

1. Ask for the patient's full name, call back phone number, and where he or she is right now (get the exact address). You never know what direction a phone call will take and you'll need this information to call the patient back or send someone over (like the police).

2. If a patient won't give you this information, be prepared to give them the hard sell, with "I need to have this information before I can talk with you. If you can't give me this information, I'll have to end this call. The crisis line number is (206) 461-3222.

3. Once you have the patient's phone number and address, identify the reason for the call. Most calls are:
   - medication request/re-fill request;
   - medication question;
   - patient is trying to reach their primary provider; or,
   - patient is in crisis/request for hospitalization.

In *all* of the above cases, **it is extremely important to assess for crisis, i.e., suicidal or violent ideation.** For dealing with specific situations, see below:

Medication request/re-fill request

- **NEVER prescribe any medication or re-fill a patient's medications without first seeing the patient**. Tell the patient that you cannot prescribe them any medications over the phone, but if they need to be seen they should present to the closest emergency room. Otherwise, they should contact their primary provider on the next business day.

Medication question

- Patients often call with questions about side effects they may be experiencing. If the side-effects sound serious, document that you insisted that patient report to the nearest emergency room (assuming of course, that you DID insist). If the side-effects do not sound serious, say yes, that *is* a possible side-effect (no matter how unlikely or bizarre) and refer them to their provider.

- Do not suggest any change in dose or medication unless and until you are prepared to explain to a medical board why you felt comfortable changing meds on an unknown patient at 2 in the morning over the phone. Just saying it aloud makes is seem like a bad idea, doesn't it? If you're not sure what to do, call your attending, then call the patient back. You might also call the pharmacist at HMC, then call the patient, but document the name and rank of every upper-level you consult and their exact recommendations: the last thing you want is to be the only name the grieving widow finds in the medical charts when she reads them with her attorney.

- Occasionally, patients will call to ask about taking more or less of their medications. If this happens, do not chat about the fascinating article you read in the *Lancet* last week, opine on your pet theories, or give the slightest hint that you have heard a word they said. Refer them to their prescriber and get out. Anything you say can only get you in trouble, so helicopter out of there, soldier: your mission is now to evade and escape.

Patient is trying to reach the primary provider

- Assuming the provider is at HMC, inform the patient that this person is currently unavailable and give him or her, the phone number for the clinic in which the provider works. And no, we do not call individual providers or take messages after hours.

Patient is in crisis/request for hospitalization

- Be sure you have the information discussed above (patient's name, number, and location). Many of these calls go to the ER social workers, but occasionally a call will get through to you. Generally you're too busy

to provide telephone crisis support, so your primary goal should be determining if the patient needs to seen right away and what must be done to ensure patient safety.

- If the patient is suicidal, do a brief suicide evaluation (for plan, means, and intent). Determine if the patient is with someone who can support/supervise them.

- If it sounds as though the patient may be in imminent danger, tell them you think they need to be seen right away and encourage them to call 911. Then hang-up and call 911 yourself, telling the dispatcher all the details, starting with who you are and ending with where the caller can be found.

- If the situation seems less exciting, you can offer the patient several options: the crisis line phone number, presenting to an ED for evaluation, or contracting for safety until they see their primary provider.

***In all of the above, **write a brief note detailing the conversation with the patient and have a low threshold for calling the attending**.

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Legal Guardianship and Patient Admission

Patients who have a legal guardian and need inpatient psychiatric hospitalization **MUST be referred to the D-MHPs**. This is specific to PSYCHIATRIC hospitalization.

Patients who have a guardian have been deemed incompetent by the court, as a result they cannot make a decision to agree to psychiatric admission. In WA state legal guardians cannot determine placement and therefore cannot consent to psychiatric admission.

This is an unusual case when it comes up and if the D-MHP you make the referral to does not understand the situation please involve your attending and the D-MHP's supervisor if necessary.

How do I refer a patient for involuntary treatment?

You should refer a patient to the D-MHP's if:

(1) They have an "Axis I" disorder that is directly related to their current high-risk status, AND

(2) One or more of the following is true:

(a) They pose a **danger to themselves**, with an *imminent* risk of suicide, as evidenced by statements made during the interview, recent behaviors, collateral information and/or past history, OR

(b) They are an imminent **danger to others**, as evidenced by statements made during the interview, recent behaviors, collateral information and/or past history, OR

(c) Due to mental illness, they are **gravely disabled** and are at *imminent* risk of significant injury or even death, as evidenced by recent dangerous or disorganized behaviors (e.g., walking in traffic) or medical issues requiring on-going attention (e.g., infection requiring antibiotics, dehydration, electrolyte imbalance).

(3) AND, one of the following is true:

(a) The patient is unwilling to be admitted voluntarily, OR

(b) They are unable to consent to voluntary hospitalization, OR

(c) You believe they are a "gravely disabled" (see separate section below.)

*Based on discussion/agreement between HMC and DMHP leadership, we no longer use the term "poor faith voluntary" in our affidavit or other related documentation and instead simply make the case for detainment based on the above criteria, including evidence of difficulty adhering to treatment as a risk factor in favor or involuntary treatment.

If your patient meets these criteria, do NOT give any psychiatric meds (unless cleared by your attending in the case of intractable dangerous behavior) and:

- ensure the patient does not have a significant medical issue that needs attention prior to psychiatric hospitalization;
- Determine who will be the "affiant," that is, who will write the affidavit . Affadavit template The affiant must have first-hand knowledge of the patient's threats or behaviors; There can be multiple affiants. Residents almost always write an affidavit. If the patient has a case manager, the case manager will also write an affidavit. Additionally, if a patient specifically said something threatening or regarding self-harm to a nurse, family member, etc, that person should also complete an affidavit. If you get collateral from a family member that is important in determining that someone is a threat to themselves, others or gravely disabled, ask that person to serve as an affiant and collect their name and telephone number. When you write your affidavit, include the following sentence. I spoke with XXX, phone number XXX, and they told me the patient said/did XXX. He/she would be willing to serve as an affiant.

NOTE there is a difference b/w D-MHP and MHP; MHP = psychiatrist, psychologist, psych ARNP, psych nurse, social worker, or licensed mental health counselor ; D-MHP are County Designated MHPs and are the folks who detain patients

· If patient is detained by police and sent/brought in for evaluation, then patient must be seen by MHP (not DMHP) within 3h and detained by D-MHP within 12h of arrival to ED.

· If patient is presents for observation and treatment (not detained by police) an MHP does NOT have to see the patient within 3h BUT once 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.

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How to refer a patient to the D-MHP:

If you decide you need to refer a patient to the D-MHP, first tell the patient and tell the primary team. The patient may already have a 1:1 sitter. Determine if the patient needs a sitter during the referral process to help keep them from leaving the hospital/self-harming/harming others. Unless they are immobilized and incapable of leaving or causing harm, they likely need a sitter.

1. If the patient has a case manager (i.e. "tiered", meaning enrolled, with HMC, sound mental health, DESC etc): call the case-manager on call to request that they evaluate the patient. All tiered patients MUST be seen by a case manager prior to the referral. If you don't know if the patient has a case manager, the SW in the PES (24/7) or consults (8-5 weekdays) can help you find that information. You can also call the crisis clinic (number below) and ask if your patient has a case manager.

IF not tiered and/or case manager has completed their eval...go to step 2.

2. Complete your affidavit, including direct quotes from the patient and your statement about your concern for serious harm to the patient (or someone else). For grave disability, include potential medical consequences. Include any information from affiants as well (see previous page regarding affiants). **Please note: Medical students should NOT write affidavits. This is the resident or attending's responsibility.** See example affidavits below.

3. Call the crisis clinic at 206-263-9202 (M-F 8a-5p) or 461-3222 (after hours) and say that you would like to refer a patient for detainment. They will likely need to take a message and call you back. Give your cell phone number if you are going to be moving around the hospital.

- The D-MHP will collect information from you about the patient, demographics (including DOB, address, SSN), diagnosis and current symptoms that are prompting the referral. Be prepared to describe the medical consequences if the patient is gravely disabled (i.e. low sodium is risk for seizure and death, etc).
- The D-MHP will ask for a callback number to notify you of the outcome. It is typically best to leave a callback number of the PES or the overnight pager in case you sign-out before the D-MHP visits the patient.

4. Complete your note, including identical quotes in your note and your affidavit.DO NOT copy/paste your entire affidavit in the note - this can lead to case dismissal by the court! Include the time that you completed the referral to the MHP in the plan of your note and in CORES.

5. Place both the affidavit and a print-out of your note in the patient's chart on the unit. Sometimes the MHPs surprise us and arrive to evaluate the patient within 30 minutes of getting our call, so please be speedy in completing your documentation and placing it in the chart.

**If you complete your note and affidavit and it is the end of your shift, you can sign out calling the crisis clinic to the next resident. You CANNOT sign out writing the affidavit or note.

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How do I write an affidavit?

Affadavit template
If the above link doesn't work, go to the Psych Residency Website → Click Clinical Tools (http://psychres.washington.edu/clinicaltools/clinicaltools.asp) → Click CD-MHP Form and the form can be downloaded to your computer.

Your affidavit should include the following:

- identification:

  My name is Dr. Erasmus St. James, University of Washington psychiatry resident.

- the nature of your interaction with the "respondent" (a.k.a., the patient):

  I evaluated the respondent, Mr. Justin Case, in my capacity as on-call resident at Harborview Medical Center.

- summary of the respondent's presenting problem, psychiatric symptoms and relevant past history, using *as many quotes as possible*:

  Mr. Case was brought to Harborview after waving a knife in front of the Seattle Police Department, and says "Suicide by cop, man, why didn't those bastards just f-----g shoot me?" He has a mental disorder characterized by depressed mood, suicidal ideation, command auditory hallucinations . . . He has a history of six suicide attempts . . .

- reason(s) why respondent should be detained involuntarily
  The respondent has a long history of serious suicide attempts, continues to endorse suicidal ideation with a plan and the intent to carry it out, is psychotic and impulsive, and is at very high risk of suicide given his recent behavior whereby he placed himself in significant danger of death with the intention of ending his life.

- summary statement:
  In summary, I believe Mr. Case should be detained involuntarily as a danger to self.

  I would be willing to testify to the above in court.

- signature, date, location ("Harborview Medical Center, Seattle.")

General points:

- the quotes and examples in the affidavit should be *IDENTICAL* to those in your clinical note. However, you should NOT copy and paste your affidavit into your clinical note and your clinical note can contain information that your affidavit does not contain.
- limit the use of jargon and avoid diagnostic acronyms like SIMD w/BPD and AVHs
- write the affidavit on a special affidavit form
- if you are not using the affidavit form, write "In lieu of affidavit" at the top of the page and list the patient's full name and DOB at the top: be sure and conclude with the "I would be willing to testify. . ." and write "Seattle, Washington" and the date under your signature.
- do *not* stamp the form with the patient's HMC identification card.

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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, 2000. 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, 2000

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.
Etc.

I, Carol Channing, in my capacity as on-call psychiatry resident at Harborview Medical Center, have evaluated Mr. Lou Prole on October 10, 2000. 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., etc.

Please note that you should avoid abbreviations and overly-technical terminology. Be prepared to be subpoenaed to appear in court if you write an affidavit.

What does "poor faith voluntary" mean?

If a patient requests/agrees to voluntary hospitalization, but you suspect they are unlikely to abide by the rules or may attempt to leave against medical advice, then the patient is considered a "poor faith voluntary." You can offer them outpt treatment in lieu of a stint at the Harborview Hilton or, if you feel they actually require a stay behind the locked doors, refer them to the MHPs and explain why you are unwilling to simply admit them as a voluntary patient. The MHP will want a good story that includes a stiff mix of some of the following elements:

- **Non-adherence to recommended psychiatric treatment.**
  - history of AMA discharge from hospital;
  - protracted failure to follow through with outpatient tx;

- **Inability to give informed consent.**
  - A patient who is unable to understand or unwilling to sign the voluntary treatment agreement cannot be admitted voluntarily. As with any informed consent procedure, a potential voluntary patient must be able to appreciate the procedures, risks and benefits involved in hospitalization. This potentially excludes certain demented, delirious and severely manic or psychotic patients.

- **Ambivalence about entering the hospital**, e.g., the patient who repeatedly changes their mind about being admitted. These patients are likely to elope or request AMA discharge long before we fix their considerable problems.

- **Assaultive behavior.** This includes:
  - recent violent behavior;
  - history of assault in treatment settings; or,
  - inability of patient to agree to not harm others.

- **Inability to stay safe on the unit.**
  - self-harm behavior in the PES (banging head on wall, eating soap);
  - history of getting into dangerous spots while hospitalized; or,
  - inability to follow staff re-direction.

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Hospital Pre-Authorization (i.e. getting your patient paid for)

Involuntary Admissions:

- We generally don't need to worry about this as unfunded or Medicaid patients do not need pre-authorization for involuntary admissions and CDMHPs are responsible for disposition of detained patients (meaning that they will take care of making sure a patient goes to a hospital that an insured patient's panel will cover).

Voluntary Admissions:

- **Unfunded/Medicaid Patients:**
  - King County residents: call UBH 24/7, 206-461-4858, for hospital authorization
  - Other Washington state counties: pre-authorization is needed from county of residence

- Out of state: pre-authorization through King County-call UBH 206-461-4858
- Residency status is not clear: pre-authorize through King County call UBH 206-461-4858
- For patients who have not met the criterion of duration of living in King County and they come from a county where they do not have funding for mental health, we need to go back to King County authorization to ask that they approve for emergency hospitalization of an out of county resident without funding. This may need to involve hospital authorization supervisors.

- **Managed Medicaid:** Some patients will look like they have private insurance when they actually have managed Medicaid. Sometimes this will come up on their record as United Healthcare Medicaid, and other times it is trickier (i.e. Molina, Healthy Options and CHPW). These plans do not have a separate behavioral health plan and **the patient needs to be authorized through the Crisis Clinic.**

- **Medicare:** If a patient only has Medicare, he or she can be admitted without pre-authorization. If the patient has secondary coverage through Medicaid, he or she needs to be pre-authorized through King County or the patient's county of residence. If the patient has Managed Medicare, see below

- **Managed Medicare:** If a patient has Managed Medicare, you will need to contact the management company to determine if HMC is a preferred provider. If this is the case, the patient will need to get pre-authorized through the management company. If not, then the patient will need to be admitted to another hospital that is preferred.

- **Private/commercial insurance:** Determine if HMC is a preferred provider. If this is the case, obtain authorization for admission. If not, then the patient will need to be admitted to another hospital that is preferred.

- **Private/commercial insurance** with exhausted benefits (i.e. several hospitalizations in one year) or limited/no mental health coverage: These patients need to be authorized through King County, or the patient's county of residence.

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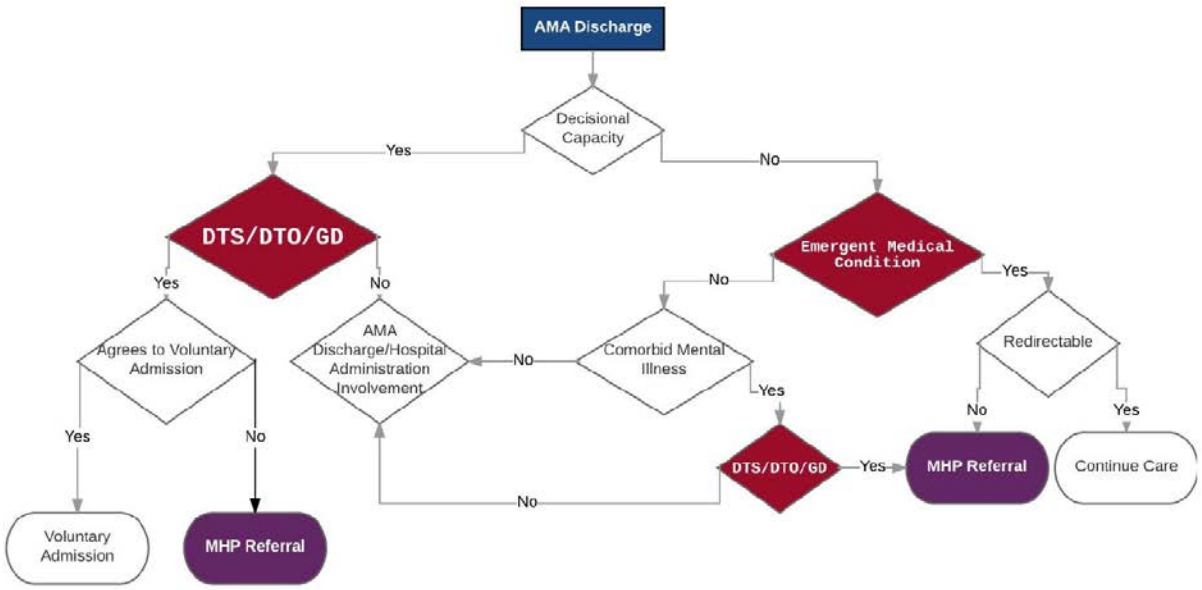
Algorithm for patients who demands to leave AMA on med/surg: *Return to table of contents*



Sign out on CORES Guidelines: *Return to table of contents*

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	Meds	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)	Auto-populated	**Illness severity:** WATCHER /STABLE Legal/ITA status (auto-populates) **Patient Summary** (few sentences) •Age, gender, primary diagnosis, + major comorbidities, reason for admission • Key 24 hour events with big picture plan History of Violence? DNR/DNI? Medical History Consults: Contacts: Other team notes	**Action list:** the "to dos" for the cross-covering resident **Situational awareness** "If/thens" - Pain: - Anxiety/Agitation: - Insomnia: - AMA/Tries to leave (if voluntary) - Vital sign or glucose parameter if/thens - Medication compel if/thens Legal status: court date/length of hold	Left blank for note taking and **synthesis**

IN OTHER:

ILLNESS SEVERITY:

• **'Watcher'**: all patient assigned watcher status need to be signed out verbally

- medically active patients that may need interventions
- psychiatrically active patients that nursing is likely to call regarding

• **'Stable'**: no major interventions anticipated

•**'Discharge'**: use this label if discharge is occurring during the cross-covering resident's shift. Remember, it is primary team's responsibility to do all discharge planning and medications.

PATIENT SUMMARY:

*Patient Summary – brief (*should not be copy and pasted PES or admission assessment). The summary should be updated daily and reflect:

• Age, gender, primary diagnosis, + major comorbidities, reason for admission

• Key 24 hour events with big picture plan (do not need minor daily med changes – include only what is relevant to cross-covering resident).

Every patient requires the following information:

• Legal Status: Invol. vs. Vol. (this is typically auto-populated, but can be wrong so please double check) ; court date; length of hold

• History of violence? Yes or No

• DNR/DNI? Yes or No

• Past 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 that. Even if some of it is mixed into the summary blurb above, please also list it here. Indicate if any particular condition is poorly controlled.

• Consults: include current, signed off, and curb-sided

• Important Contacts? i.e. DPOA, legal guardian, family member who could help if AMA?

Team: The primary team can use this is a checklist/note section for non-urgent items.

IN COMMENTS/TASKS:

ACTION LIST: This is the plan or the "to-dos" for the cross-covering resident.

• This section should indicate:

- Who does it and when?
- Include dates for wknd cross-cover

• Over weekend, only list critical lab follow up and provide if/then instructions to the resident about what to do with the results.

- Note that this should only say XC or "to do" items. No "FYIs" in this space for ease of reading for cross-covering resident.

SITUATIONAL AWARENESS

• What are anticipated problems that could occur over the next 24 hours? Plan for these with "if / then" statements.

• Every patient requires "if/thens" for:

- Anxiety/agitation
- Insomnia
- Pain
- AMA (if voluntary) – if patient likely to leave AMA, please have an updated affidavit available (affidavits only good for 24hrs); if there are conditions under which it would be ok for a patient to leave AMA, please explain (i.e. "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")
- Compel medications

• Include atypical VS parameters and plan for management

• If a patient on insulin and inconsistently eating, include what you'd like done if they're not eating; or any other insulin issues you can anticipate (atypical hold parameters)
• Include instructions on any complex situations where compelled meds are being given (or not given)

IN NOTES:

SYNTHESIS: blank as a space for accepting resident to take notes. *Remember: All "watcher" patients must be verbally signed out*