VA PRON: Psychiatry Resident On-Call Notebook

One Page Cheat Sheet (print just page 2; phone # page is 42)
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2018-19 PRON Updates

6/5/18:
- New food closet code: 83167

7/9/18
- Orders for ECT
- Hand-Off Tool with IPASS formatting
- AMA and unplanned discharges adjusted to VA standard operating procedures

7/16/18
- Orders clarified for consults transferring to 7W

8/15/18
- Email 7W SW staff with all new MHP referrals (they will do court paperwork)

9/26/18
- New instructions for SUICIDE RISK EVALUATION-COMPREHENSIVE note: Document as a separate note on every admission and discharge

12/10/18
- Clarification about PES role and duties
- New information about duty to protect
- Update to Emergency Medical Guardianship
- Updates to seclusion and restraints

1/18/19
- National Service Desk: (855) 673-4357

2/15/19
- Clarification about restraint procedures
- Guidelines for patients with dementia

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**PES – No Admit**

**[SEA MHS PE PSYCHIATRY IND]**

- If on 1:1, when done write EMERGENCY DEPARTMENT SAFETY ASSESSMENT NOTE before doing anything else
- PSYCHIATRY EMERGENCY DEPARTMENT NOTE, or
- PSYCHIATRY CARE NOTE if SW has documented fully
  - Add Dr Li as co-signer; Complete the suicide risk assessment portion of this note for all patients
  - If S/Hopeless at any point, SUICIDE RISK EVALUATION-COMPREHENSIVE note
  - If S/Hopeless at any point, SUICIDE SAFETY PLAN
  - If Hi/violent, VIOLENCE RISK COMPREHENSIVE ASSESSMENT NOTE
  - If attempt in last 12 mos, SUICIDE BEHAVIOR REPORT
  - Give D/c papers available in PES

**Dispo options**

- Back to MHC; doc of day 9:30-11:00, 2:30-3:30 (cc MHC providers and RNs)
- New pt: Consults -> Mental Health -> Outpatient (Seattle), they will contact pt
- Place Travel Consult, talk w/ AOD to help with bus/taxi
- More urgent/Homeless: have them return to PES in morning, cc Rachel Morgan & Ellen Li; leave contact information
- Addictions: Pt to call 764-2457 or to ATC, Bldg 24
- Shelters: DESC, AOD or 24h SW can assist

**Consult**

**[SEA MHS INPATIENT CONSULT]**

PSYCHIATRY CONSULTATION-LIASON INITIAL CONSULT REPORT
PSYCHIATRY CONSULTATION-LIASON FOLLOW-UP CONSULT REPORT

These should be associated with consult in CPRS
- Update s/o: W:\PUG_Workgroups\PsychResidents\Forms Residents\Sign-Out
- Detained pts, awaiting MHP, SI requires sitter
- There Are medical holds (unlike UW)

**Cross-cover**

**[SEA MHS 7WEST]**

- PSYCHIATRY COVERING PHYSICIAN
- Update Hand-off
- Clearly, AMA discharges need in-person assessment

**Safety Levels**

**[SEA MHS PE PSYCHIATRY IND]**

- All pts admitted on moderate if not high, changes require in-person assessment & discussion w/ attending
- SUICIDE RISK RE-ASSESSMENT NOTE
- Orders: Admission/Treatment Orders → Activity: Ward Restrict (or Suicide Obs) Admission/Treatment Orders → Risk Assessment → Moderate or (High)
- Continuous nursing obs is a 1:1 level for medical issues

**Restraint/Seclusion**

**[SEA MHS PE PSYCHIATRY IND]**

- Call Code Green to initiate restraint | Call atting
- New episode: orders in 1st hour, see pt and do note/CPRS orders within 4 hours (ideally in 1st hour)
- Order: Restraint/Seclusion → Psychiatric/Behavioral Restraint/Seclusion Note → BEHAVIORAL HEALTH CARE RESTRAINT/ SECLUSION NOTE
- #48 hours: written order, do not need to see pt
- #48 hours: SEE patient, write note and CPRS Order
- If restraint increase (eg, seclusion to restraint), process starts anew
- To do/c, discuss w/ nursing, then let orders expire

**Compel Orders**

**[SEA MHS PE PSYCHIATRY IND]**

- Tell attending, will need 2nd attending statement
- ANTIPSYCHOTIC <PSYCHIATRY INVOLUNTARY ANTI-PSYCHOTIC MEDICATION NOTE>
- Order med pm, “if refuses...COMPEL ORDER”

**Referral for Involuntary Treatment**

- Blank affs:
  - W:\PUG_Workgroups\PsychResidents\Forms
  - Leave affidavit in chart
  - Leave affidavit and note for PES SW; email 7W SWers
  - Proxy information for NF in PRON

**Outside Hospital → VA**

- Talk with atting and 7W charge prior to accept/decline
- Pt will need to sign behavioral treatment agreement (on W:\PUG_Workgroups\PsychResidents\Forms)
- More detailed instructions, tips in PRON

**NOTES**

**Update handoff! Have fun!**

**Boarders**

**[SEA MHS PE PSYCHIATRY IND]**

- Contact outside hospitals and document in your note if no beds, PES SW will take over during business hours (7am to 11pm)
- Complete Psychiatry Admission Note and Bed Request to High Intensity General Psychiatry
- Complete “Delayed Orders” as if admitting to 7W
- 1:1 for all boarders
- Give patient a rubber sleeping mat and blanket if no safety concerns
- Do daily note using “Psychiatric Care Note” on the weekends, add Ellen Li as co-signer
- Communicate with ED nurse and physician frequently to update on status of plan

**Proxy Instructions**

# Use proxy for all MHP referrals!
# Don’t fax paperwork to the court!
# Leave a copy of the affidavit the patient’s chart.
# Affidavit and note go to the PES SW
# Use patient initials in request - no full names
# Email req w/ aff attached to paoita@kingcounty.gov; johnathan.buchholz@va.gov; susan.kennelly@va.gov; edward.gignoux@va.gov; jessa.lynch@va.gov; ellen.li@va.gov
# Ask if MD will be req’d for proxy
# Follow-up if you do not hear back
VA Call Quickstart

Hours
- Weeknights: 6pm-8am
- Sat/Sun/Holidays: Day 8am-6pm, Night 6pm-8am
  - MUST COME IN TO “huddle” WITH ATTENDING and NURSES AT 8:15am on 7W

To Start your Call
- Call resident on-call to get sign-out with enough time to get to the VA when your shift would start if necessary (Short call resident & pager # listed in amion) (Resident room phone numbers are here)
- Call PES SW’er around 30min before shift to check in to see if there are any patients who need to be seen
  - Call with enough time to be able to be at VA when shift starts
  - PES SW pager: 206-416-1994
  - PES SW number: 206-764-2610
  - ED Number: 206-277-2600 (if none of the numbers above work)
- Call 7W to check in and make sure they have your correct pager number
  - 7W (277-3208 or 763-2101)
- Review Triage Tips
- Patient should be medically cleared before evaluation – the ER provider does not have to finish and sign note in CPRS before your evaluation.
- If you get called in to the floor or PES please contact staff to let them know when you arrive. If you are delayed, traffic, etc., contact staff to let them know of the delay.
- IF ASKED BY NURSING, PLEASE COME IN. The Attending cannot “ok” us to refuse to come in.
  - If afterward, you found it inappropriate for you to come in, then let the Chief know ASAP.
- NPOD keys are found in mailbox in the workroom in the ED on the green beaded keychain. 7W access card will also get you into the ED (7W code: 1379#, “swipe the card”)
  - Always return keys at the end of the shift.
- The attending schedule is emailed out to everyone by Lisa Canady. You should have a copy for the month.
- Questions about coming in due to weather? Please review the Residency Inclement Weather Policy
  Please maintain your professionalism, and if you have any problems, let the chief know ASAP.

PES R1 Training Shift Basics
- Training resident will meet trainee in the 7W workroom (or other pre-designated area) by 5:45pm
- Do a face to face sign-out with Short Call resident
- Call around to other units as above. (Give the trainer’s pager number, but have the R1 answer all pages)
- Both residents are on call together until 8:00am the next morning
- R2+ residents can hold the pager at home; R1s cannot

Abbreviations
- NPOD (Night Psychiatrist On Duty)
- UC (Urgent Care, = ER/PEC)
- AOD (Administrator On Duty, in ER)
- ATC (Addictions Treatment Clinic, BLDG 24)
- MOD (obsolete term: now ER provider)
- MHC (Mental Health Clinic, BLDG 1)
- NOD (Nurse Manager On Duty)
- POC (PTSD Outpatient Clinic, BLDG 1)
- PES (Psychiatric Emergency Services (ER))
- PCC (Primary Care Clinic Seattle)
GENERAL ON-CALL INFORMATION

Hours & Logistics:
- Weeknights: 6pm-8am; Sat/Sun/Holidays: Day 8am-6pm, Night 6pm-8am, All pages come to your personal pager
- Day Expectations
  o Join morning huddle on the unit at 815am with the nurses and your attending.
  o You do not need to round or do daily progress notes, however, you are still responsible for taking pages related to unit patients, evaluating AMA discharges, medical issues, so on. You may split these duties with your attending, at their discretion.
  o See consults, PES patients as necessary. See Triage Tips. All consults must be seen in 24 hours.
  o Answer your pager until the end of your shift -- 8AM or 6PM. You are responsible for answering pages and dealing with pages until that last minute, even if you’ve signed out. Consider getting in touch with the following resident for help so you can finish on time. Eg, you receive a call a 5:56pm but hope the next resident can take care of the issue: YOU call the next resident, not the nurse who paged you (who in fact paged the correct resident).
  o Handle outpatient phone calls
  o Sign out to next resident in time for them to be at VA by 6pm.
- Night Expectations:
  o Inpatient unit coverage, this is first priority
  o See PES patients and floor consults as necessary. PES patients have priority.
    o See consults that were received between 5-7pm if you are not otherwise busy.
    o If it is busy in the PES, the PES SW may ask you to come in to begin seeing patients.
  o Evaluate outside ED/hospital requests to transfer patient, this is your last priority
    o If you are busy in ER/ward/consults/alone, ask referring provider to begin faxing ED notes (ED medical assessment, MH/SW assessment, labs) to 206-764-2225
  o Handle outpatient phone calls
  o Sign out to next resident (or daytime teams) in time for them to be at VA by 8am.
  o Provide feedback on sign out to daytime teams.
- You can do home call, only if you can...
  o Answer pages within 5 minutes
  o Arrive to the VA within 30 minutes of a page
  o Have immediate remote computer access for charting, orders, so on. NO VERBAL ORDERS.
  o Put in orders and documentation for restraint/seclusions in a timely fashion

Sign Out
- Sign Out is done both verbally and in writing.
  o The on-call resident is responsible for patient coverage until the service is signed out.
  o The incoming resident should page for signout.
  o If the incoming resident has not contacted you by the beginning of your shift, you should page them, then call their home then contact the back-up resident and contact someone who can help you find the missing resident as per the residency "No Show for Duty Policy."

Incoming resident for all call shifts
- The incoming resident must contact VA with enough time to allow themselves to get to the VA at the start of their shift, if needed. This is critical for keeping our home call status. If you are delayed for some reason (traffic, etc) please communicate that to the person who called you.
  o Who to contact at the beginning of the shift to check in.
    ▪ Make sure they have your correct pager number.
      - Short call resident (assignment and pager in amion) during the weekdays.
      - On-call resident on weekends/holidays: personal pager
      - 7W Charge Nurse (Gen Inpt Psych): 206-277-3208, 206-764-2101

Outgoing resident for all call shifts
- Make sure Hand-Off and Consult sign-out is updated
- Should be contacted by incoming resident
- Verbally sign-out any overnight issues and things to follow-up on
- For ATC, and Consult patients during the week
  o Non-urgent issues: leave voicemails prior to the end of your shift
  o Urgent or complex: page or call the appropriate person between 7:30-8:00am to verbally relay during weekdays, otherwise sign-out to on-call resident
  o Consults: non-urgent: leave VM (797-0628)
    urgent: contact consult resident
Sign-Out documentation

- All inpatient teams use HAND-OFF within CPRS for sign-out; update Hand-Off anytime you do anything for a patient during your shift.
- You should note feedback on HAND-OFF, e.g., "PLEASE CLARIFY DOSING OF qHS MED," so on. Every Friday, night float should provide feedback on quality of sign-out during the week.
- The consult service cannot use HAND-OFF so they use a Word document that can be accessed on the W-drive. W:\PUG_Workgroups\Psych Residents\Sign-Out

### Accessing HAND-OFF Remotely

**Accessing Patient List**
1) log on to CPRS  
2) open any 7W GEN PSYCH patient chart  
   → tools  
   → HAND-OFF  
   → log in to pop-up screen  
   → ward  
   → select appropriate ward (7W)  
   → submit

**View/Print the Sign-Out (cannot print at home)**
After accessing Patient List  
→ File  
→ Print Report or PreView Report

**Updating Sign-Out** *only the yellow boxes can be edited*
→ select patient  
→ edit appropriate box by clicking in it & typing  
→ File  
→ Save Template Fields To Vista (must do to save!)

### Accessing Consult Sign-Out Remotely

**On site**
1) log on to computer  
   → my computer  
   → W:drive  
   → PUG Work Grps  
   → Psych Residents  
   → Sign-Out  
   → Psych Consult Signout (appropriate month/year)

**Remotely**
Log on: https://varwest.vpn.va.gov/vpn/index.html  
→ Click on the “Desktops” tab  
→ Open "PUG ICIP Desktop." This takes a few minutes the first time you open it.  
→ You’ll see a desktop, which you can navigate like any other, within the citrix interface.  
→ Going through “Computer,” you can find the Sign-Out folder (see above address) as well as “My Documents” from your own VA account.  
→ If remote desktop does not work, use the the old method of getting to the W:drive on the Psych Wiki [tinyurl.com/psychwiki].

Contacting On-Call Attending: When do I contact? How do I contact? Who is my attending?

**Who’s your attending?**
- Weekdays 8am-430pm: Inpatient, consult, or PES attending  
- Weekdays 430pm-8am: On-call attending  
- Weekends (430pm Friday until 8am Monday): On-call attending  
- The On-Call Attending should page you at the start of your shift. If you do not hear from them, page or call them at home. VA operators should be able to provide pager and home numbers if you do not have them on hand.

- The On-Call Attending schedule is emailed to all the residents by Lisa Canady and should be available to you. A copy is also on the W: drive under Schedules.

- You must call the On-Call Attending EVERY TIME the following occurs:
  - Admission to 7W  
  - Discharge from PES  
  - New Consults  
  - Possible transfers from outside hospitals  
  - Unexpected deterioration of patient’s condition  
  - Increased concerns for SI/HI  

See Resident Program Policy Manual regarding further details about when to contact your attending here.

**If you talk to the attending, document "Spoke with Dr. _____ who agrees with the assessment and plan.**

**If the On-Call Attending is not responding at any time,** call the following:

- 7W pts: Jonathan Buchholz p416-4161 c253-273-6122  
- C/L pts: Marcella Pascaulay p797-0627 h232-0188 c390-7431  
- ED pts/issues: Ellen Li c898-6440 p416-1875 h568-3043  
  - If you are still unable to reach someone:  
    - call Jesse Markman p416-4957 h734-239-3249  
    - then: Jonathan Buchholz p416-4161 c253-273-6122

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**General Triage Tips**
When you are on call overnight and on weekends, you are the only psychiatrist on for the entire VA.
Here is the triage priority.
1. Urgent behavioral or medical issues for patients admitted to inpatient psychiatry.
2. Safety reassessment for inpatient transfers from outside hospitals. See Transfer Safety Reassessment Documentation and Orders; if PES is less acute (see #3) can do a full Transfer Admission.
3. PES patients
   o By clinical urgency first, else time of arrival
4. Full transfer admissions
5. Consults – the exception being urgent floor consults, eg, imminent safety risk, suicide assessments, urgent capacity evaluation. If you do prioritize a consult, speak with the PES attending, your attending, so that there is no confusion as to why you aren’t seeing a PES patient.

**Working in the PES**

**Logistics**
- If a patient is in the quiet room on 1:1 with a nurse technician, consider whether you want to use a computer in the main ED (rather than in the PES workroom).
- If there are no patients in the quiet room, please use the PES workroom. The desk with one computer is reserved for the PES social worker as that phone is the main number outside providers call (206-764-2610).
- Do not let the 1:1 sitter leave when you are interviewing the patient in any location of the ED. This is for safety reasons for you and the patient, and there may be times when you need to leave urgently.
- Any patient in the PES for 4 or more hours will need to get the same level of nursing care as if they were admitted to inpatient psychiatry, including full medication orders placed by the on-call psych resident.

**ER Provider**
- The ER provider’s note does not have to be in CPRS prior to your evaluation.
- If you or the PES SW has been informed of medical clearance, you can begin your evaluation.
- **Always communicate with ED provider (and ER nurse) your assessment, treatment plan, disposition so they are aware**

**Medical Clearance**
- All patients are to be medically cleared by the ER provider prior to being seen in the PES at any time of day
- Labs will be done that the ER provider feels are clinically indicated
- Before seeing a patient, make sure they have been medically cleared first
  - If the ER provider is unable to document their note prior to you seeing them, SW should have them discuss their findings with the NPOD
  - Ask the ER provider if you have questions regarding the patient’s medical clearance. I.e. too intoxicated, delirious?

**Entering Encounter Location**
All notes need to have a location for the encounter entered before a note is started
- Create a new encounter FIRST.
  - Select the correct patient.
  - Click on “New Note” and a pop-up screen for “Location for Current Activities” appears.
  - Select “New Visit”
  - Type in “Visit Location”: SEA MHS PE PSYCHIATRY
  - Date/Time of visit should read: NOW
  - Click “ok” and choose the note template above.

**Cut-off time to see Patients**
- New admissions before 4:30pm by the short call resident. Admissions after 4:30pm are seen by the night resident.
- In general, do what you can to finish by the end of your shift and allow the incoming resident or PES staff to do the rest (e.g., just the note and plan, or as much as you can get done).

**Entering Orders in the ED/PES**
Orders for admission and discharge are covered elsewhere. This section covers orders for medications/labs to be administered while a patient is physically in the emergency department.

**Note:** Unless a patient is admitted to psychiatry and awaiting a bed, you are not required to enter orders for patients in the ED or PES. ED providers should be monitoring and provisioning care. However, there are times when you may choose to do so for efficiency and teamwork. Either way, communicate your action with ED providers and staff.
• In CPRS, choose the Orders tab
• Click “Emergency Department Orders” in the Orders menu
  o Select the current visit (as denoted by the time stamp)
• For medications, look under “Medications” and click “Medications for Administration in ER”. Choose either a pre-existing choice or “<<ALL Medications>>”. You may get a popup about Clinic Medication orders. Click Yes. Type in your medication(s) and sign as usual.

CPRS/Computer Downtime
At times CPRS and the Computer system may be down for maintenance or other reasons.
• If CPRS is down
  o Access Patient data through “Clinical Applications” folder on the desktop at the VA
    • Click on “Pug Downtime VistaWeb” icon then click on ”Northwest Network” then Puget-Sound
    • You will then need to log in as you do with CPRS
    • Enter patient’s information to see notes
  o Orders can be given verbally to the nurses, or if you are in house ask the nurses about the backup paper system
  o CPRS may open during designated downtime, do not use as this may interfere with drug dispensing/documentation by pharmacy
• If computer system is down
  o You will not be able to access patient data
  o Orders will be on paper, or verbally if not at the VA

Verbal Orders
Can only be given in the following situations
• When CPRS is down
• In an emergency
If you are not near a computer and an order needs to be placed
• Try to place it within 30min of the request
• If you suspect that it will be longer then 30min, let the nurse know when you think you will do it
If you are unable to access CPRS remotely, you will need to be in-house

Placing Orders on 7W
If you change location to SEA MHS 7West to write a note you may be asked where to associate new orders that you subsequently placed.
Associate those orders to 7West (Sea) and not SEA MHS 7West

SAFETY & CODE GREENS
All patients seen in the PES are expected to have had their belongings taken and be placed in hospital clothes by the RN. YOU SHOULD NOT check patients for weapons or contraband; if you have concerns, talk to PES/ER nursing or call security. If you feel unsafe interviewing a patient alone, you can ask the VA police to stand by while you talk with the patient. (Also, as with any problem you may have on call, please let the chief resident know!)

Safety Screens are informal verbal and visual assessments that can be done by any clinical staff member, including NPODs. These should be done by nursing or SW. However, you too can perform a Safety Screen:
• Ask the patient “Do you have any sharps, knives or anything that can be used as a weapon?”
• NOTE: you can ask a patient to empty out their pockets do not have to go through their belongings.

Safety Screen Indications:
• As long as the patient poses no threat of violence (NO SI, HI, Behavioral Flags or menacing behavior)
  o May be performed by the NPOD without police involvement.
  o This should be done prior to admission to 7W.
  o If there is any concern, but no evidence of threat, ask the police to standby during the Safety Screen.
• If a patient refuses a Safety Screen,
  o Police should be contacted. They will then determine if a Security Screening is warranted. If the officer declines to do a security screening on the patient, you may request a standby while you conduct your medical duties.

Security Screens are formal evaluations by the VA Police to assess safety risk and determine that no weapons or contraband are present. They may include a search of pockets and belongings as well as a pat-down and/or wand search. Security screens are only conducted when reasonable suspicion of a weapon or intent to use a weapon is present, which only the VA Police can determine, or if patients have behavioral flags at level 2 or 3 in CPRS.
Security Screen Indications:
- Level 2 or 3 behavioral flag in CPRS
- Patient reports or alludes to having a weapon on them or in their belongings
- Patient reports or alludes to intent to harm others in the hospital (PES, 7W, etc)

Points to Remember
1. **All patients admitted to 7W require a Safety Screen at minimum.**
   Verify that the patient was Safety or Security Screened ahead of time before taking them to 7W (don’t assume it was done already). If a patient has been Security Screened by the VA Police, then they will be given a “blue card.”

2. **“Deemed Safe by medical team.”**
   If the patient has a “threat of violence,” has not been screened, but has been already seen by the medicine team and has been acting calmly throughout the visit, then the pt will have been technically deemed “safe” by the medical team and you can only perform a Safety Screen prior to admission.

3. **Can ask for standby.**
   Police can always be asked to “standby” while you are interviewing the patient. Do not hesitate to get a standby, even if you began the interview without one.

4. Patients’ belongings can often be found in the PES lockers.

**Code Greens** are behavioral codes.
- Any staff person can call a code green – the NPOD DOES NOT HAVE TO BE INVOLVED!
  - When Code Green is called this is not to be questioned or canceled by anyone.
  - Either a nurse or the police will run the code green. NOT THE RESIDENT.
  - Relevant staff will assemble, (7W nurses, VA Police, ER staff) to prepare the gurney, restraints and manpower to initiate restraints or seclusion.
- Once the Code Green team arrives, they evaluate the patient, determine the appropriate intervention and initiate it.
  - Interventions may include attempts to verbally de-escalate the patient, placing the patient in seclusion or restraining the patient.
- Resident Role
  - Help determine if the patient should be given sedating/calming meds or not.
  - YOU ARE NOT ENCOURAGED, OR EXPECTED TO BE INVOLVED IN, THE ACTUAL RESTRAINING PROCESS. (You can do so at your own risk/discretion).
- As in any restraint situation, consider less restrictive measures first.

When to call a Code Green
- When a patient is acutely agitated or for a patient you think may elope and you need restraints.
- You always need to call a code green when starting physical restraints. Calling a Code Green is not necessary for initiating locked-door seclusion. Use your discretion for seclusion episodes.

To initiate a Code Green
- Tell the nursing staff.
- Push the panic button in the room or leave the room, dial 911, say Code Green and give your location.

**Sitters (1:1)**
When to use a 1:1 sitter:
- When a patient needs to be watched constantly for their own safety, but does not need to be physically restrained
  - i.e. delirium, SI but no active ideation or intent
- All patients awaiting MHP referral need a sitter at minimum.
- All patients detained and not on inpatient psych need a sitter- both in the ED and on medical floors.

To obtain a sitter in the ED
- Inform the nurse you would like a sitter and they will find one.
- Document: EMERGENCY DEPARTMENT SAFETY ASSESSMENT NOTE to indicate need for one
- Periodically, staffing shortages result in difficulty finding sitters. Nursing staff or NODs may ask you to be the sitter. This is not your responsibility. Politely ask to speak with the NOD to let them know you will be unable to act as the sitter. You may want to speak with your attending in this situation and s/he may speak with the NOD.
- In some cases the ER nurses may elect to call a code green to quickly provide adequate staffing to monitor the patient.

To discontinue 1:1 sitters in ED
- Inform the patient’s nurse a sitter is no longer needed –they will be happy to have the sitter available for other ED tasks!
- Order change: tell the nurse of the patient
- Documentation needed: EMERGENCY DEPARTMENT SAFETY ASSESSMENT NOTE

Safety Levels on 7 West
- All patients are admitted as moderate or high risk levels. Full description of Risk Assessment & Activity levels follow below. Generally, it is not ideal to change safety levels overnight; staffing issues should NOT be the primary concern when determining safety levels!
- Patients changing levels require an IN PERSON MD ASSESSMENT and should be discussed with the attending on call. You want to document improvements or deterioration requiring changes in level. For example, ask the patient, “What is safer now?” I feel less depressed and as though I can talk to staff.
- To discontinue 1:1 (or High Risk Level) on 7W
  - Document with: SUICIDE RISK REASSESSMENT NOTE & justify change
  - Orders: Modify the Risk Assessment and Activity Level if needed
  - ADMIT/TREATMENT ORDERS>ACTIVITY>WARD RESTRICT
  - ADMIT/TREATMENT ORDERS>RISK ASSESSMENT>MODERATE

Seclusion and Restraints

When to Use Seclusion or Restraint:
When attempts at verbal deescalation have failed AND a patient is at risk for harming themselves or others.

Restraint or Seclusion (R/S) for PES patients:
1. Restraint and seclusion are to be used only in an emergency, as a last resort, when the patient presents a risk of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff or others.
   a. Alternative interventions must have been employed (food/drink, lorazepam, haldol, olanzapine), were not effective or were judged likely to be ineffective.
   b. Restraint/seclusion should be discontinued as soon as patient no longer presents at risk of violent or self-harm behavior.
2. If a patient is behaviorally disruptive and assessed as at imminent risk of danger to self or others, initiate locked door seclusion in the Quiet Room (room 23 or 24). If patient is unable to deescalate in locked door seclusion (kicking door, banging window, self-harm/hitting head), consider initiating restraints for patient and staff safety.
   a. The ED Charge RN, ED MD, or PES provider (SW, psychiatry attending, resident) should be immediately notified when the patient has been placed in restraints and/or seclusion.
   b. The RN or MD, PES psychiatrist or resident must evaluate the patient within one hour of the patient being placed in restraint or seclusion and complete the “Initial in-person evaluation” in ”Restraint/Seclusion” template in CPRS. The RN can complete this evaluation but only a MD/ARNP/PA can place an initial order for restraint or seclusion in CPRS. Both the evaluation and order must be done within one hour of initiation of restraint/seclusion.
   c. The patient’s assigned RN initiates and monitors documentation as required by Facility Memorandum TX-05, Policy for the use of Restraint and Seclusion.
      i. Nursing staff must continually monitor a patient who is simultaneously secluded and restrained (this is rare to have a patient in locked door seclusion AND restraint)
      ii. Monitoring by a nurse or designated observer must be documented every fifteen (15) minutes (done by paper flowsheet).
   d. A registered nurse must evaluate a patient in restraint or seclusion at least every eight (8) hours.
3. **Renewal of orders:** Only a MD/ARNP/PA can order Restraint or Seclusion and each order lasts for 4 hours. Order must be renewed within 4 hours up to 24 hours.

4. **New Orders:** Every 24 hours, the MD/ARNP/PA primarily responsible for the patient’s ongoing care must evaluate the patient before completing a *new* order for restraint and seclusion. This should be done only if the patient still presents a risk of violent or self-destructive behavior. **Complete “Physician/LIP in-person review” in Restraint/Seclusion template.** You would complete this review/template if the patient is waiting for a bed on 7W/community and in restraint or seclusion >24 hours.

5. Patients in restraints or seclusion may refuse any and all non-emergent medical procedures.
   a. If the provider determines there is a medical emergency, life-saving and life-preserving medical procedures can and should be performed using the two-physician procedure.
      i. This includes drawing focused labs to evaluate for immediate life threats and treating immediate life threats.
      ii. Two providers need to document that the patient refused interventions and honoring the patient’s refusal would have immediate life-threatening consequences.
         1. One of the providers must be an attending psychiatrist (call your attending should this rare scenario occur)

### Initiate Seclusion or Restraint:

**- Call a Code Green to initiate restraints.** Optional for seclusion, based on pt behavior and RN availability. You are not trained to do these yourself.

- Immediately inform nursing staff that restraint/seclusion has been initiated. **Crucial, as nurses need to do q15 min checks!**
- Enter the order into CPRS within 1 hour from when a patient is placed in restraint or seclusion
- For restraint or seclusion **on 7W**, a 7W RN can do the initial in-person evaluation after initial restraint or seclusion placement and document the attending physician and you were notified.
  - It is your responsibility to complete order renewals, q24 hour evaluations and new orders
- Patient in restraints should be in a gurney locked to the floor for safety
- Discuss with staff ways for patient to regain control/plan for discontinuation of restraints/seclusion
- Revise plan of care as needed (additional medications for agitation, does patient need referral to MHP?)
- Call your attending, communicate change in status to the ED attending (if in the PES), and always keep nursing informed of changes to a patient’s status

### Restraint/Seclusion Rules to Remember:

- If a patient goes into a higher level of restraint (i.e. from seclusion → restraint), the process starts over from the “initial evaluation.”
  A new order for restraint is needed.
- Per JCAHO, you must complete evaluation, orders and documentation on time even if an MHP or another person is evaluating the patient. The highest priority is putting the orders in on time – 1 minute late is too late!
- Once you have completed the initial evaluation, you do not need to see the patient in person q8 hours (previously was true.) You are required to renew the order every 4 hours. Consider staying in-house given the acuity of patient and possibility of staff consulting you again.
- Sometimes, nurses will “trial release” patients out of restraint/seclusion. If the patient remains a danger to themselves or others, the original order may be used for restraints/seclusion. In other words, as long as the prior order is still active (good for 4 hours), it can be used to reapply restraints/seclusion and you do not need to do an original evaluation.

- Remember, the initial evaluation can be done by an ED MD or nurse, 7W RN, or you. As such, you may not need to be present. However, because of their acuity, you may be called to assess the patient anyway to help with self-harm or destructive behavior. If you are not immediately available (admitting a patient, elsewhere in the hospital), the ED RN or MD **can** (and needs to) complete the initial evaluation on time.
- Remember to sign out to the next resident that a patient is in restraint/seclusion.

To Discontinue Restraints/Seclusion:
- Discuss a plan with staff
- Typically involves gradually removing 1 restraint at a time over the minimal amount of time after the patient has demonstrated continuous calm, safe behavior. Consider having the patient eat a meal while partially restrained to demonstrate safe behavior.
- Orders will expire and you do not need to discontinue them.
- A MD or RN must complete the “Discontinuation” portion of Restraint/Seclusion template. You will enter time in and out of restraint/seclusion and document if the patient experienced any complications or injuries from restraint or seclusion.

Additional Restraint/Seclusion Reminders:
- Write orders for patients on whom you’ve been consulted; always be explicit with the ED about who is responsible for entering the orders. If the ED physician initiates R/S, then be clear that the ED physician should complete the initial order and “initial in-person evaluation” in Restraint/Seclusion template.
- SW and RNs are unable to place orders for R/S (even in PES)
- Remember a RN can complete the initial in-person evaluation and documents notifying the ED attending.
- Staff can place a patient in restraint or seclusion while notifying the ED physician, PES attending or you if patient is at imminent risk of violence to self or others.
- If you recommend restraint or seclusion, you should complete initial in-person evaluation, initial order and 4-hour order renewal.
- Locked-door seclusion does not require a Code Green. Notify ED MD and nursing if initiated.

Patient Care Scenarios

Consults in the ED / PES
We act as helpful ED consultants (see the policy): usually patients are referred with SI/HI/Hopelessness (for which patients must be seen by PES). We write orders/prescriptions for these patients in the ED. You will be actively involved in renewing seclusion/restraint orders for PES patients.

The VA ED will perform a triage algorithm to assess for suicidal ideation. First, ED Triage RN does a “primary screen” (“Over the past two weeks, how often have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?”) If positive, ED RN will complete a “secondary screen” (Columbia Suicide Severity Screen) unless patient specifically presented with SI. If positive, further evaluation is done by the PES.

Patients endorsing SI/HI in the ED must be seen by the PES prior to discharge. In order to prevent elopement, the patient will need a “detaining order” in CPRS. This allows the police to hold them at the hospital until seen and evaluated by the PES. The detaining order is found under “Emergency Department Orders”-> “Restraint/Seclusion”->”Police Detainment of Patient in the ER”

When patients present to triage with SI/HI/Hopelessness and no medical complaint.
• Pt sent to quiet room with 1:1 sitter if SI/HI (not hopelessness).
• Should get “medically cleared” by ER provider before being seen.
• Should have a Safety Screen before being seen; read more about safety screening on page 7.
• Someone from PES must see them (Resident, ARNP, SW, Attending) before they are discharged.
  o Prior to seeing any pt in the ED, check the ‘posting’ button in the upper right corner of the CRPS screen to look for a potential crisis plan. If one is present, click on the words ‘Crisis Plan’ and it will link you to the appropriate document.
  o Note: Just like at the UW, if the social worker in the ED is swamped with psychiatry patients, you will be called in to assist in triage, evaluation, and appropriate treatment of patients.

If a patient is in the ED for a medical problem and endorses SI/HI/Hopelessness (even if intoxicated), someone from the PES needs to see them prior to discharge. (Resident, ARNP, SW, Attending)
• Should have a 1:1 sitter, unless endorse only hopelessness.
• Should get medically cleared before being seen.
• Check for a potential Crisis Plan under Postings (button in upper Right corner of CPRS)
• HI
  o Complete “ASSESSMENT OF DANGER TO OTHERS” embedded in Psych ED Note
• If a patient has HI, you will need to talk to your attending to assess your “Duty To Warn.” If you decide to pursue a duty to warn, you must add Sean Longosky to your note as a cosigner, as he is in charge of releasing information.

Documentation
• **After interviewing an SI/HI patient on 1:1, the “EMERGENCY DEPARTMENT SAFETY ASSESSMENT NOTE” needs to be completed immediately before any other work is done.**
  o This note details whether the patient needs continued 1:1 and why/if it can be discontinued.
  o The Safety assessment note needs to be updated every four hours. ER nurses do this, not you.
• **“SUICIDE RISK EVALUATION-COMPREHENSIVE” and “SUICIDE SAFETY PLAN NOTE.”**
  o Active/Passive SI patients: RISK EVAL only for admission; both notes for discharges.
  o Hopelessness only patients: Need RISK EVAL only, unless there is an overwhelming number or risk factors-use clinical judgment.
  o If they are being admitted, the “SUICIDE SAFETY PLAN” will be done by the inpt team.
• **“SUICIDE BEHAVIOR REPORT”**
  o If the patient has had a suicide attempt or self-harm behavior within the last 12 months, this note must be completed if one is not in the chart already.
  o This can be done by SW, but the NPOD needs to ensure that it has been done or do it themselves. You do not need to know/verify all of the information on the Behavior Report, just enter the info you have.
  o Click on prompt in Psych ED Note if necessary

**Intoxicated Patients**
• The ED is supposed to estimate the decline of the patient’s BAL to <100 and recheck it.
• Once the patient’s BAL is <100 they can be referred to the NPOD to be psychiatrically evaluated.
• However, if the ER provider insists on us seeing the patient we must come in. If patient does not appear cognitively intact, then we should let the ER provider know a 2nd, full eval will be needed when patient is sober.

**Patients Seen in ED & Discharged**
• Check for a Crisis Plan via ‘Postings’ button (top Right Corner of CPRS) to make sure that if crisis plan is present, then it was adequately followed prior to ED discharge.
• Talk to On-Call Attending to notify them of the discharge.
• Documentation: see text box
• After you have completed a discharge plan and given it to the patient – the form is in the shelves in the PES or on the W: drive under forms – tell the ER provider as they will be the one responsible for discharging the patient.
• If discharging patient with a limited medication supply, then you are responsible for placing that order.
• Document contact with On-Call Attending.
• Do not hold patients in the ED for PES SW to finalize the plan. Patients can return during the day to see SW.
• You can consider a referral to the “Mental Health Same Day Access Clinic”, which is a walk-in clinic located directly behind the ED, which is open during the day M-F and will triage patients to the most appropriate outpatient care.

**Possible Dispo & F/U Options**

| Currently enrolled in an outpatient clinic (i.e. there are recent notes in the chart from ATC, POC, MHC, etc) | - CC (“add additio MHC RNs to note to help coordinate f/u (Roberta Jacobs, Sandy Sundberg, Michael Tampieri, Kirk Williams)
  - Follow up with that clinic the next day, either via:
    1. telephone (206-764-2007) to schedule follow-up
    2. in person, every clinic has a “doc of the day” who can see patients urgently
(3000 check in times are 9:30-11:30A, 2:00-4:00P)
  - ATC patients can walk in (or call 764-2457) and be seen anytime by a team member.
  - CC outpatient providers on PES note |
<p>| Currently enrolled in Mental Health Primary Care (MHPC) (recent chart notes titled “Mental Health | -Patient should self-present to STARR clinic in Primary Care Clinic, hours M-F 8:30am – 4:00pm, they will be seen the same day. Patient should check in with front desk and request a STARR appointment. |</p>
<table>
<thead>
<tr>
<th>Not enrolled &amp; have mainly substance issues but no active SI/HI.</th>
<th>ATC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients may call 764-2457 to sign up for ATC orientation group on Mondays or Thursdays at 8:30AM in BLDG 24.</td>
<td></td>
</tr>
<tr>
<td>1) If pt needs to be seen in ATC more immediately, consider an ATC Next Day Appointment (NDA); enter an ATC consult in CPRS (orders-&gt; consults-&gt; all seattle consults-&gt; addiction treatment center-&gt; outpatient) and write in the narrative space that this is for a next day appointment. Put the patient’s initials and last four on the hardcopy ATC NDA sheet in the metal mailboxes and leave for AM social work. Instruct the patient to go to building 24 at 8:30am; give the veteran an appointment card. From the NDA patient can be directed to inpatient or outpatient detoxification.</td>
<td></td>
</tr>
<tr>
<td>2) If patient needs to be seen in ATC more immediately, consider an ATC Next Day Appointment (NDA); enter an ATC consult in CPRS (orders-&gt; consults-&gt; all seattle consults-&gt; addiction treatment center-&gt; outpatient) and write in the narrative space that this is for a next day appointment. Put the patient’s initials and last four on the hardcopy ATC NDA sheet in the metal mailboxes and leave for AM social work. Instruct the patient to go to building 24 at 8:30am; give the veteran an appointment card. From the NDA patient can be directed to inpatient or outpatient detoxification.</td>
<td></td>
</tr>
<tr>
<td>3) Scheduled inpatient detox is arranged through ATC at the above number.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Not enrolled &amp; low/moderate psychiatric acuity, no drug use &amp; no active SI/HI.</th>
<th>MHC or POC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2) Complete the consult order under “Mental Health Consults” → Mental Health Service Outpatient (Seattle) for the appropriate referral clinic.</td>
<td></td>
</tr>
<tr>
<td>3) Be sure to complete the consult request completely, including getting contact information from the patient and giving patient the contact information for the triage coordinator.</td>
<td></td>
</tr>
<tr>
<td>4) Patients will be scheduled to be seen by a prescribing provider within 14 days of your consult request.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Not enrolled &amp; with more acute psychiatric care and social support needs who need to be seen sooner than 14 days.</th>
<th>PES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) If the pt has a phone and can be contacted, get the phone number and leave a note for the PES SW to call them in the morning to arrange prompt follow up.</td>
<td></td>
</tr>
<tr>
<td>2) If pt is homeless, without a phone and cannot be contacted, have them return to the PES in the morning to arrange an appointment. See also shelter options below.</td>
<td></td>
</tr>
<tr>
<td>** CC your note to Rachel Morgan &amp; Ellen Li in both of the above cases.**</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Not enrolled &amp; need substance detox (EtOH or heroin) &amp; no SI/HI.</th>
<th>Detox Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Call detox center to find a bed (325-5000); they will have a long questionnaire. If possible, give the phone to the pt and have them answer the questions directly.</td>
<td></td>
</tr>
<tr>
<td>2) You don’t need to send meds w/ the patient.</td>
<td></td>
</tr>
<tr>
<td>3) Pt needs to take taxi, bus or have friend drive them. Also consider an ATC next day appointment (see above in table); ATC can arrange inpatient versus outpatient detox. For potentially life-threatening withdrawal, consider admission.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Enrolled or not, psychiatrically decompensated in need of temporary place to stay</th>
<th>1) See social work section.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2) CC your note to Rachel Morgan, SW</td>
<td></td>
</tr>
<tr>
<td>3) (DESC Crisis Solutions no longer an option due to prolonged wait times)</td>
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</tbody>
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**Med Refill Requests in the ED**
- **See the pt if asked.**
  - Do not prescribe meds over the phone or refuse to see a pt.
  - When you see the pt, if you do not feel meds are safe or indicated, you can decline to fill the med and should document your decision clearly.
  - If you do provide meds, **only give a few days’ worth** to encourage f/u in OP clinics, not reliance on ER.
  - Keep in mind the following time tables
    - For routine f/u at MHC wait time is 2 weeks
      - Consider giving 1 week supply with 1-2 refills.
      - Patient who are already established with MHC can visit the Doc of the Day, any weekday, in that clinic without an appointment.
    - See Dispo Options on page 12 for help w/ follow-up.
  - Documentation
    - If SW has seen pt and done a PSYCH ED NOTE, you may document your visit with a PSYCHIATRY CARE TEMPLATE note or make an addendum to the SW note.
    - If you will be the only person to write a note on this visit, then you need to do to the PSYCHIATRIC EMERGENCY DEPARTMENT NOTE (I realize this may be overkill, but that is the policy. Be succinct.)
    - CC the patient’s VA provider (if they have one) on your note

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**The 3 D’s of Malingering**
- **Demanding...**
  - Eg, specific treatments, discharge
- **Divulging...**
  - Unusual, elaborate, bogus symptoms freely shared or endorsed
- **Dependent...**
  - Harm or outcomes dependent on conditions

The DSM also highlights antisocial PD; medicolegal contexts; subjective distress out of proportion to objective distress; and uncooperativeness with assessment with malingering.

• If patient is seen in MHC, CC the MHC RNs on your note to help coordinate f/u (Roberta Jacobs, Sandy Sundberg, Michael Tampieri, Kirk Williams)

• If the patient lives at BENSON HEIGHTS or CASCADE HALL, they should not be given med refills. These facilities have their own meds on site. Call these facilities if you recommend medication changes.

• Be judicious if prescribing benzos and NEVER refill narcotics; ER provider’s can refill narcotics and any other non-psych meds.

ATC Patients on Methadone
• If presents to ED looking for methadone dosing over weekend
  o Often seen in patients getting discharged from the hospital and being released from jail over the weekend
  o Should have been prearranged by ATC with pharmacy prior to the weekend
  o Will be clearly documented in the most recent ATC notes-review all of the most current notes
    ▪ If supposed to be arranged, make sure pharmacy checks the “vault”
    ▪ Attempt to contact ATC pharmacist who occasionally works on the weekends

• No documentation found in ATC notes
  o Patient may have gotten out of jail unexpectedly and will need corrections papers stating as much
  o Attempt to contact ATC pharmacist who occasionally works on weekend to see if she knows anything
  o If on Sunday consider having patient wait until Monday am
  o Consider covering patient with couple days’ worth of withdrawal meds
  o Generally the final answer is ”No” regarding dispensing any opiates.

• When to say “No”
  o Claims meds were stolen (even with police report)
  o Lost meds

• When in ED, the doctor may prescribe methadone for replacement therapy as a “backup.” Special waiver is not needed.

Geropsych Patients -- Guidelines
• For patients with dementia-related problems/behavioral disturbances presenting to the ER, proceed with usual psychiatric and medical evaluation.
  • Obtain collateral information from caregivers and living facility to determine if this is a new behavioral problem or chronic
  • Determine if patient is able to return home/care facility; offer MH outpatient treatment with clinic nurse support as alternative; emphasize to family/facility that less restrictive interventions need to be tried; complete (if needed) MHC referral and request intake with Dr. Wang or Labardi as they are our geriatric psychiatrists. GRECC Psychiatry Clinic serves as a consultation service and does not follow short or long-term.
- Evaluate for delirium. Collateral from family/facility/caregiver is very useful to establish if symptoms are new.

- If adult family home or skilled nursing facility refuse to accept patient home from ER, and hospitalization is needed due to inability to provide self-care, please call your attending to discuss the case *AND* if admission to medicine is not feasible (see guidelines below), contact Dr. Buchholz (253-273-6122) to discuss and determine best service for veteran, e.g. medicine or psychiatry. Do not offer 7W admission until speaking with Dr. Buchholz.

- If patient is **incapable** of making medical decisions, 7W is **not** appropriate as patients must agree and understand voluntary treatment agreement. A Durable Power of Attorney or guardian cannot sign a patient into 7W.
  - Consider DCR referral if patient has history of combative behavior and severe neuropsychiatric symptoms. Please discuss with your attending as involuntary detainment will negatively impact placement options.

Patients more appropriate for medicine (**This is a guideline within our service and not a formal agreement with medicine**)
- Patients with severe dementia who would not benefit from inpatient programming (groups, milieu) due to cognitive impairment
- Patients with high nursing needs or non-ambulatory, e.g., one or two-person assistance, fall risk, incontinence - 7W has fixed low beds and 7W is a no-lift unit
- Patients needing hospital bed because of medical reason (usually these are for patients also needing 2-person assist)
- Motorized wheelchair, walker and canes are not allowed on 7W due to safety concerns (wheelchair and four wheel walkers are permitted)
- Patient with isolated violence – one assault toward caregiver but no pattern or repetitive behavior disturbance
- Dementia with ongoing decline and need for higher level of care

Patients possibly appropriate for psychiatry (Main factor: Can the patient engage in groups and milieu activities? If yes, 7W is possible)
- New onset of neuropsychiatric symptoms and would benefit from further psychiatric assessment and management
- Underlying mental illness with mild/moderate cognitive impairment BUT can participate/benefit from group therapy
- Patients with recurrent/persistent behavioral disturbances (paranoia, AVH, agitation) without high nursing needs, not on any psychotropics or could benefit from medication adjustment **may** need to come to us given our locked unit. The KEY is the patient should NOT have any high nursing needs, able to consent to voluntary treatment agreement and ideally has housing to return to after discharge

For all other geriatric mental health patients, 7W is appropriate.

If you suspect adult abuse and talk to Adult Protective Services, add James Weivoda and Jeffrey Swanberg as additional cosigners to your note. They are the current privacy officers.

Active Duty Personnel in the ED
- If active duty personnel checks into VA ED in crisis, see him like any other patient.
  - If needs admission
    - Call Madigan first main number: 253-968-1110 (for additional phone numbers see Outside Hospital List) to see if they have any beds.
    - If Madigan does not have any beds we can admit them to VA inpt see: Admissions to 7W .
    - If the VA is full, the personnel can be fee-serviced out to the community.
      - Active duty persons are covered by Tri-Care and the community hospital would have to contact Madigan or Tri-Care for approval.
      - Do you think the patient needs MHP referral? (See Active Duty Service Members and ITA)
  - If patient only needs outpatient follow-up
    - Direct them to follow-up at Madigan
      - Call main number: 253-968-1110 and ask to be transferred to ED or SW or MH for specific questions about getting MH f/u.
  - If an Outside Hospital calls with a transfer request see: Transfer of Active Duty from Outside Hospital.

VA Employee in the ED
- Many employees of the VA are veterans who receive health care through the VA Puget Sound system. If a VA employee checks into VA ED in crisis, see him like any other patient.
  - If needs admission
    - The patient can be transferred to an outside hospital to preserve privacy of health information regardless of service connection. The patient can be admitted to 7W (if pt prefers) however
should be offered transfer to outside hospital. Follow instructions for transfer to outside hospital on page 23. Also discuss this with your attending. Please document in your note that you have offered them hospitalization outside of the VA, regardless of where they choose to receive their care.

- If the patient needs outpatient follow up
  - Then follow algorithm for patient being seen in the ED and discharged
  - If the vet works in VA outpatient mental health and would have been referred there per algorithm, then refer the vet to PES or STARR Doc (mental health in the primary care clinic) for next day follow up to protect privacy.

**Patient Phone Calls**

- Can use the VA Doctor’s Line (764-2333) and ask to be put thru to the patient’s number if you are calling from outside the VA. **“67” + the patient’s number will block your number from appearing on their phone, if you just want to call them back without going through the operators.**
- First get patient’s name, last 4 and exact address of calling location. If they refuse this, explain that you cannot speak with them and end the phone call.
- Consider verbalizing a “10-minute time limit” at the beginning of your call, after which time you can ask pt to come in for evaluation if the problem is not resolved.
- If patients hang up suddenly and you have concerns, consider either getting a “welfare safety check” by police or calling the MHPs. Discuss this with your On-Call Attending.
- If the patient cannot agree to be safe, call 911, identify yourself and ask to speak with the 911 dispatcher for the locale where the call is originating. 911 will transfer you to the local dispatcher. Before making this call, try to gather as much information as possible about the presence of weapons or other people (e.g. children).

**Voluntary Admissions – Are they appropriate?**

- Prior to promising admission, you’ll need to check in with
  - On-call attending
  - PES SW during the day (in case they have pending admissions)
  - 7W charge nurse (to whom you’ll need to give report as well)
  - Discuss bed availability and staffing needs depending on their risk assessment

- Voluntary admissions are meant to facilitate transition into OP mental health clinics. Veterans not interested in following up with OP treatment should consider other options.

- Check for **CRISIS PLANS (a.k.a. “triage notes”)** by clicking the POSTINGS button in the upper R hand side of CPRS. These notes are in place to deter admission for patients who have had behavioral problems, have repeatedly not followed up with outpatient care, or who have otherwise not benefited from inpatient hospitalization.
  - Patients with crisis plans may not be appropriate for voluntary admits – however, they may be MHP’d.
  - Patients with crisis plans can be asked to return to the PES during business hours or follow up with outpatient providers.
  - Beware years-old crisis plans that may no longer apply; use clinical discretion & review with your attending.
  - Pts may be admitted if they are a good-faith voluntary (non-aggressive, agree to not smoke, agree to work with staff, go to groups, and f/u with OP afterward). If this is questionable, discuss with the attending and 7W charge nurse.

- Review and complete the Voluntary Treatment Agreement sheet with every voluntary patient.
  - **If the patient has a known history of disruptive behavior on the unit but they are asking to be admitted voluntarily (and admission is clinically warranted),** admit them voluntarily with a SPECIFIC treatment plan that spells out expectations for their hospitalization, rather than refer them to the CD-MHPs as “poor faith.” These expectations may include discharge from the hospital if the patient is determined to be medically appropriate for discharge. Refer to recommendations for re-admission from the previous discharge summary, if applicable.
  - If they are unwilling to agree to the stipulations, then other options will need to be considered, such as MHP referral, discharge with outpt f/u, etc.
    - As always talk to your attending.
  - Can be found on files cubbies outside SW office or on W: drive (W:\PUG_Workgroups\Psych Residents)
  - ATC admissions are scheduled during business hours. Very rarely, the NPOD might have to do an ATC admission, should the pt arrive after 5pm. In this situation, you will be contacted by the ATC attending.
  - Please See **Admissions to 7W** (page 19) for more “how to” details and CPRS instructions.
  - Please See **Seattle VA → Outside Hospital** (page 27) if there are no beds on 7W or if the patient is a VA employee.
  - Avoid admission of VA employees to 7W as it places them at undue risk for HIPAA violations
• If no 7W or community psych beds are open, Please See Boarders – Patients Awaiting Transfer

DCR (Previously MHP) Referrals

More details on how to write affidavits, request proxy, are in Appendix One. At the VA, you may request proxy testimony for any patient you see, regardless of availability for court. (ie, you don’t have to be on night float.) Of course, proxy is granted at the court’s discretion and never guaranteed.

• Patients who need admission, but are not voluntary for the following reasons should be referred.
  o Refuse to comply with the Inpatient Mental Health Behavioral Agreement
  o Unable to consent to admission due to psychiatric illness (i.e. florid mania or psychosis)
  o Do not want to be in the hospital but are a danger to themselves, others
  o Gravely disabled

• You must call the On-Call Attending prior to making any MHP referrals!
• Check the consult section regarding MHP referrals on medical/surgical units.
• Once a decision is made to refer the patient, write your affidavit and call the MHPs (461-3210).
• Due to federal privacy laws, you cannot release ’7332’ information regarding drug abuse, alcoholism or alcohol abuse, infection with HIV, or sickle cell anemia in your affidavit. However, ‘7332’ information will be in your clinical notes that the MHP will read in the emergent context of the referral. So if alcohol/drug use is an important part of your reason for referral, MHPs will see it in the clinical note.
• Add Sean Longosky as a cosigner to your ED note for HIPAA compliance. (He is the director for Health Informatics at the VA and keeps track of this stuff.)
• Send an email to the 7W SW’s about any new referred or detained patients; they act as court evaluators.
  o Susie Kennelly (Susan.Kennelly@va.gov), Ned Gignoux (Edward.Gignoux@va.gov), Rebekah Clinger-Prince (Rebekah.ClingerPrince@va.gov)

• To prepare for the MHP
  o Print out your note (PSYCHIATRY EMERGENCY DEPARTMENT NOTE), any other pertinent clinical notes, and affidavit and give to PES SW’er or to ER provider taking care of patient
  o Other notes supporting your decision for MHPs to support the affidavit
  o Confirm the ER provider has documented the medical eval prior to referral to MHPs
  o Review Helpful Hints for Working with the MHP’s before calling

• Patients awaiting MHP need a sitter at minimum.
  o It is not necessary to call a Code Green if a patient is being referred to the MHPs as long as the patient is calm, cooperative and does not have a history of violence. Use your clinical judgment (and attending guidance) to decide whether a Code Green is needed, but have a low threshold for calling one. If there is any chance that the patient may escalate or become violent when informed that they are being referred to the MHPs, it is strongly advised to call a Code Green.

• Waiting for the MHP’s: You are not expected to stay in-house to wait for the MHP. You do need to be available to speak to the MHP via telephone, and potentially re-evaluate the patient if not detained. Give ED staff (SW, pt’s nurse) MHP paperwork to have available for MHP upon arrival. Make sure ED staff know to contact you when the MHP arrives. Patients waiting for over 4 hours will need full orders (see section on ‘PES Boarders.’)
  o Educate ED provider and nursing staff about the MHP process, and keep them abreast of developments.
  o Make sure ED staff knows to call you when the MHP has made a decision, or contact PES provider if this happens after your shift. If the pt is not detained, the NPOD will need to re-evaluate. Consider asking them to page you when the MHP arrives.
  o Can also give the MHP your pager for them to call you with their decision

• If the patient is not detained, you will need to prepare to discharge the patient:
  o Discuss the plan with attending. Do they need a re-referral?
  o Document the following as an addendum to the Psych ED Note:
    • The MHP decision
    • What changes have occurred in the patient’s risk status (i.e. why you thought they needed to be involuntarily detained, but now feel they are safe to leave).
    • Detail the measures you have taken to ensure patient safety and discuss your clinical reasoning for the discharge plan.
    • This documentation needs to be completed by the NPOD on duty at the time, even if the referral was made earlier by one of your colleagues. If you have referred a patient to the MHPs and they are not detained, the NPOD is expected to make sure that all ED discharge documentation is done. (See ED discharge documentation box).

• SW and MHP referrals
  o ER Social Workers are capable of evaluating and referring patients to the MHPs independently,
  o They have a low threshold for requesting additional consultation prior to MHP referral.
• Be ready to assist the SW in this process.
• SW are still able to write affidavits and call MHPs. If you are asked to see a patient who is awaiting a MHP, you should still write a note of your own even if the SW is taking care of the referral and affidavit.
  • If there are medical issues, the MD should be another affiant.
• May use brief version of PSYCHIATRY ADMISSION NOTE and reference SW’s initial note if SW referred the patient.

• **Active Duty Service Members and ITA**
  o MHP’s will not evaluate or detain active duty service members
  o Service members are hospitalized, voluntary or otherwise, only after getting a formal order from their command
    ▪ If the service member chooses to stay, it is considered a voluntary admission
    ▪ If they choose to leave despite orders, see below
      • Hold the patient in the hospital and contact the service member’s command (contact info should be documented in CPRS or paper chart)
      • Inform command patient is requesting to discharge against orders and that we cannot continue to hold the patient
      • Inform command of their SI/HI risk assessment and request assistance in disposition to a military facility that is equipped to manage their care and act on military orders.
        o Military command may opt to take patient into military custody until a safe disposition can be arranged.
        o If command refuses to take the patient, discuss with your attending
        o Do not discharge the pt if you do not feel safe doing so

**Detaining to 7W or Emergency Department**

• **We accept transfers of veterans on an initial 72-hour ITA hold from outside EDs in King County** (not vets on other inpatient medical or psychiatric units from outside hospitals). Go through the same screening process as you would for accepting a transfer.

• **7W social work team** should be notified of all detained patients, regardless of location in hospital.
• All detained pts (newly detained or transfer) will need to receive the **ITA list of patient rights** both verbally and in writing. You can ask a SW’er or RN to assist with this but you must still document in your note that it was done and by whom.
• Detained to 7W
  o Document detained status in PSYCHIATRY ADMISSION NOTE
    ▪ Use brief version to reference either your own initial note, or the SW’s note.
  o Write delayed “HIGH INTENSITY GEN PSYCH (SEATTLE) ADMIT” orders.
  o Assess risk and activity as clinically indicated—at least moderate risk.
  o Do not need to have patient sign voluntary treatment agreement.
  o See Admissions to Seattle VA for details.

• No beds on 7W for detained patient? See the section on “No beds on 7W.” Detained patients are to stay in a PES observation room until a bed opens up on 7W. This is the rare instance when you will have a patient “board” in the ED.
  o If waiting in a PES observation room, then plan to transfer to 7W as soon as a bed opens up. PES “boarders” need 1) daily notes from the PES attending (weekdays) and the NPOD (on-call resident) on weekends, and 2) full ED orders if in the ED for 4+ hours.
  o If waiting in an inpatient medical bed:
    ▪ The ED staff will enter consult for bed request in CPRS.
    ▪ Write delayed “HIGH INTENSITY GEN PSYCH (SEATTLE) ADMIT” orders, delayed release.
      • Choose actual unit pt will be physically on, i.e. 4E, etc
      • Enter on-call attending and yourself as resident
      • Choose “7W-Admit Orders” if needed.
      • Choose Team 1 and enter diagnosis.
      • Must place on “HIGH” suicide risk assessment with corresponding activity level of “Suicide Observation” as patient must have continuous direct observation while on med floor.
      • Write nursing text order stating: “Patient is legally detained to the VA and requires continuous observation. Do not allow the patient to leave the floor.”
      • VTE orders/risk: treat decision as if patient was going to psy floor
    ▪ Will be followed by Psych consults team
- Add to Psych Consults sign-out (W:\PUG_Workgroups\Psych Residents \Sign-Out)
- Contact consult resident in the morning if applicable. Pager: 797-0628
- If this occurs on the weekend/holiday, make sure the on call attending knows because a psych attending will need to see the patient daily during the first 72 hours of the hold, no matter where they are staying.

  - Following detained patients on medical floor
  - Needs to be seen by attending daily
  - Needs to have daily Consult follow-up Note: Psychiatry Consultation-Liaison Follow-Up Consult Report
  - Transferring detained patients on medical floor → 7W

Compel Medications

Documentation: ANTIPSYCHOTIC <PSYCHIATRY INVOLUNTARY ANTIPSYCHOTIC MEDICATION NOTE>.

- You will write the 1st Antipsychotic Note and your on-call attending will sign it.
- A brief 2nd Antipsychotic note will be needed from a 2nd attending- usually the in-house ED doc. If the ED doc is a no-go, then call Jonathan Buchholz & he will do the 2nd note.
- Director Review irrelevant unless you are told otherwise.
- You can write for and start the compel med once you have discussed with your attending & the 1st note is in (but not necessarily co-signed). Get the 2nd note in as soon as possible.

Order: write a standard prn order for the medication with the following statement in the comments section:

- Eg, haloperidol 5mg IM prn, comments: "If refuses scheduled risperidone. COMPEL ORDER."

For patients on 180-day Holds: We cannot compel antipsychotic medications unless,

1) We petition the courts, which takes about a month. During that month we cannot compel antipsychotics.
2) It is an emergent (read: dangerous) situation. Then antipsychotics can be given until the courts deem it OK vs. not OK.

So if you are cross-covering for a patient on a 180-hold, use alternatives to antipsychotics for treating symptoms, unless they are clearly warranted by an emergent situation. Then, go for it.

Admissions To Seattle VA (7W) from the VA PES

This section tells you how to admit a patient. Before doing this, you might read other sections about:

- Voluntary admissions (p16)
- MHP referrals (p17) and involuntary admissions (p18)
- Active duty patients (p15)
- Transferring from another hospital (p25)
- Transferring from consults (p28)

For patients with dementia, please first try to fee-for-service to a specialized geropsych unit.

1. Talk to attending & screen patient with 7W charge nurse. (When there is a PES SW, you will also want to talk with them to ensure no pending admissions that may take priority.)

   - Don’t promise admission until this is done!
   - Complete the voluntary treatment agreement for voluntary patients. This from is in the PES or on the W: drive (PUG_Workgroups -> Psych Residents -> Forms, etc -> > PES Forms).
   - Either you or charge nurse should call Dr. Buchholz for approval of assist devices on the unit (slings, braces, etc)

2. Before writing a note, create a new encounter.

   - Open the patient chart in CPRS>
   - Click on "New Note" and a pop-up screen for "Location for Current Activities" appears.
     - If this does not appear, be sure the current encounter is listed in the box that sits to the right of the patient’s name. You can change the encounter by clicking on that box.
     - Select “New Visit”
     - Type in “Visit Location”:
       - PES: SEA MHS PE PSYCHIATRY IND
       - Consults: SEA MHS INPATIENT CONSULT
       - Outpatient: your outpatient clinic

Admissions to 7W

Documentation

[Encounter in PES: SEA MHS PE Psychiatry Ind]
[Encounter on C/L: SEA MHS INPATIENT CONSULT]

1) H&P = PSYCHIATRY ADMISSION NOTE, brief or detailed depending on documentation
   - Primary Provider = on call attending
   - no need to complete the rest of the encounter info (after assigning)

2) Separately document
   # Always: SUICIDE RISK EVALUATION-COMPREHENSIVE note
   # If HI/violent: VIOLENCE RISK COMPREHENSIVE ASSESSMENT NOTE
   # If SA or self-harm in last 12 months: SUICIDE BEHAVIOR REPORT

3) Behavioral Agreement (paper form)
4) Fill out VA Handoff Tool for XC
• Date/Time of visit should read: NOW
• Click “ok” and start writing/ordering!

3. Use the PSYCHIATRIC ADMISSION NOTE. You can use the brief version if there is a note with much of the clinical information already completed the same visit (eg, SW note, initial c/s note). Be sure the note you reference indeed has the pertinent clinical history! Use the detailed version if you’re the first psychiatric provider or the other note is insufficiently detailed. Document substance use hx for the past year (including associated problems, amount, and frequency, even if patient is unable to specify) and violence hx for the past 6 months.
• Document contact with On-Call Attending.
• For patients admitted through the PES, you do not need to do a physical exam so long as the ER PROVIDER exam is sufficient.

4. SUICIDE RISK EVALUATION-COMPREHENSIVE note
• Complete screen in admission note
• In a separate note, also complete the “SUICIDE RISK EVALUATION-COMPREHENSIVE” note
  o If the PES SW has seen the patient, they will often document this note, which you can reference in your admit note ("Please see Suicide Risk Evaluation - Comprehensive completed by ... on ...")
  o Be sure to review theirs to confirm it is fully complete and that you agree with their assessment. If you do not agree, complete a separate SUICIDE RISK EVAL. note for yourself.
• All admissions to inpt psychiatry are Moderate Risk or higher, with some exceptions. (See Risk Assessment/Activity Level below for details)
• If the risk assessment changes at any point, you must document a complete new one in your admit note.

5. Violence Risk Screen/Assessment: All admissions must have a “Violence Risk Screen;” this is automatically part of the aforementioned psychiatry admission note template. If the screen is positive, then you will be instructed to complete a “VIOLENCE RISK COMPREHENSIVE ASSESSMENT NOTE.”

6. Inpatient Mental Health Behavioral Agreement (aka Voluntary Treatment Agreement)
• All patients (except ITA’d patients-see below) admitted to 7W need to complete this.
• Copies are available on 7W or in the W drive
• Review the document with the pt to consent them for inpatient admission.
• Pts should initial and sign the document & you take it up to the floor.
• Remind pts they will not be allowed to smoke at all during admission.
• Involuntarily/detained patients will not sign this, just document that “they declined” in your note.

7. Complete the SUICIDE BEHAVIOR REPORT if the patient has self harm behavior in the past 12 months that has not previously been documented.

8. Writing Admission Orders
• See the inset box for specific instructions about writing orders. You will be prompted for a standardized order set.
• If the patient is already on the unit and “admitted” in the system, you do not write delayed orders; rather, you write active Admit/Treatment Orders.
• The idea of delayed orders can be confusing: conceptually, when you open a “delayed” order set, you are writing a full set of orders that become active when something happens, in this case, admission to High Int Gen Psych(Seattle) aka inpatient psychiatry. The old orders, from medicine or the ER, then become obsolete. You can open, view, or change the “Delayed” set by opening the Orders tab and clicking on the “Delayed HIGH INTENSITY GEN PSYCH” line in the window in the left hand column (just above the “Write Delayed Orders” button). See example on the right.
• CPAP machines need to have settings ordered (or consult respiratory therapy)

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### Admissions to 7W

1) Bed Request
   → Admission Bed Request (Seattle)
   - if bed request is denied: Consults & Procedures
   → Seattle division: Emergent/Urgent or Observation Admission Bed Request
   → Bed request: Emergent/Urgent Admission Bed Request
   - fill in form
   - admitting specialty = High Intensity Gen Psych Inpt

2) Admission Orders
   - If Bed Request Pending, patient not yet admitted:
     → Write Delayed Orders
     → Delay Until: High Int Gen Psych (Seattle)
     → Once admitted you can “release” orders by right-clicking “Release Delayed Orders”
   - If Bed Request has Gone Thru, patient admitted:
     → Admit/Treatment Orders
Then...
   → 7W - Admit Orders
   * Meds w/ indication * Labs * EKG for all
   * Risk Assessment & matching activity level

---
• Insulin pumps are not allowed on the unit. Rule of thumb is ½ basal insulin and ½ short acting insulin. Refer to last endocrinology note and call endocrinology for questions.

9. **Risk Assessment/Activity Level Orders**:
   - **Risk Level is Assigned in the following areas:**
     - SUICIDE RISK EVALUATION-COMPREHENSIVE note
     - Admit orders
     - You must assign the same risk level for both areas
   - **Activity level Assignment**
     - Must match the risk level (see table below)
     - Part of admit orders

<table>
<thead>
<tr>
<th>Risk Assessment</th>
<th>Definition</th>
<th>Activity Level</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate</td>
<td>increase risk self/others ALL ADMITS ARE MODERATE RISK ALL PATIENTS ARE EVENTUALLY MODERATE RISK-no one is Low Risk except those admitted for social reasons (see above)</td>
<td>Ward Restrict</td>
<td>Continuous nursing rounds with q15 documentation by nurse</td>
</tr>
</tbody>
</table>

**Risk Assessment Definition**

**Activity Level Definition**

- **Moderate**: Increase risk self/others. All admits are moderate risk. All patients are eventually moderate risk—no one is low risk except those admitted for social reasons (see above).

**Activity Level**: Ward Restrict

- Continuous nursing rounds with q15 documentation by nurse.

**High**: Significantly elevated risk of harm to self/others despite hospitalization. See: **Outside Hospital to 7W Transfers**

**Activity Level**: Suicide Observation

- In a safe room at the front of the unit 1:1 with staff (staff are within arm’s reach).
- In pajamas.
- Personal Possessions are removed from Patient and stored.

Other Activity Orders

- Continuous Nursing Observation: 1:1 with staff. Used primarily for medically compromised patients, high fall risk, dementia.
- Detox Status: used for ATC patients primarily.
- Don’t use buddy or close observation.

10. **When the patient is ready to be transported to the floor, tell the ER nurse and they will arrange transport.**
    - You should not be involved in patient transportation.
    - If worried about the behavioral control of the patient or the patient has been ITA’d, inform the nurses of this and suggest that they obtain a police officer to accompany them.

11. Enter the patient info into the VA Hand-Off Tool. See **How to Use the VA Hand-Off** if you don’t know how.

12. **Releasing delayed orders**: Once the patient is on 7W, you will release delayed orders (not nursing staff). To release orders: Open the delayed orders (see step 8 above), right-click and “Released Delayed Orders.” If you get an error message that the patient is not yet admitted, then remind the nurses to ensure the patient is listed as admitted and that they may need to speak with the AOD (Administrator on Duty).

**ATC Admissions to 7W**

On the rare occasion veterans schedule for an ATC admit on 7W will be getting medically cleared in the PES delaying their admission to the NPOD.

Once medically cleared do the following:

- Submit bed request consult
- Document:
  - PSYCHIATRY ADMISSION NOTE, detailed version if necessary
- Orders: ADTP order set
- Risk: can be low risk if indicated
- Activity level order: ward restrict, if clinically indicated
- Patient can always be converted to a general psych inpatient if clinically indicated.
• If a patient is being difficult, threatening, or otherwise oppositional, review/refer the pt to the Behavioral Agreement and that such behavior is grounds for AMA discharge.
• One caveat to this is OIF/OEF vets. There is a significant pressure to keep these patients engaged in treatment.
• Discuss with on-call attending prior to any AMA discharge.

AMA, Unplanned, and Off-Hour Discharges
Need to be assessed by the NPOD in person prior to being discharged.
• Attempt to convince the patient to stay until morning to discuss it with their team and avoid an irregular (AMA) discharge which will make voluntary admission less likely in the future.
• If the pt insists upon leaving, assess for SI/HI/grave disability (i.e. MHP/DCR referral) & speak to your attending prior to letting them go.
• If you & attending feel they are safe to leave, or they are discharged by the DCR, do the following:
  • Suicide Safety Plan form: As usual
  • Appointment:
    • Patients have to be offered in-person next day appointments first, then phone if they don’t want in person, then document if patient refuses both.
      o Copy this exact text into your discharge note, with a checkmark next to the option that the vet chooses:

        ▪ The veteran was offered an in-person follow up within the next 24 hours. The veteran has chosen to:
          [ ] attend the in person appointment – time and place
          [ ] decline the in person appointment, preferring that they have a phone appointment – time and preferred phone number
          [ ] decline all next day appointments both in person or via phone

    • If veteran requests in-person appointment:
      o If before 4:30pm on work day, 7W SW will try to schedule pt with outpatient team in 24 hours. Outpt providers to be alerted by phone, email, and co-signature on D/C Summary.
      o If not possible, SW to contact Am Lake for next-day appt in AML MHS MH PACC IND for 9am or 10am slot.
      o If after 4:30pm Sun-Thurs, on-call resident to email PUG MH ALVA PACC to inform them of patient to be seen the following day. Email subject: “Next Day Appointment.” Please include veteran’s identifiers, veteran discharged in unplanned fashion, and time when pt prefers to go to PACC.
      o If on weekend or holiday, on-call resident will call Dr. Ellen Li directly for a next day appointment: 206-898-6440

    • If patient requests phone appointment
      o If before 4:30pm on work day, 7W SW will try to schedule pt with outpatient team in 24 hours. Outpt providers to be alerted by phone, email, and co-signature on D/C Summary.
      o If not possible, 7W team will contact Seattle PES and arrange phone appointment with social worker at 9am or 10am.
      o If after 4:30pm, on-call resident will contact PES social worker to arrange appointment. If SW not available, leave a message on PES line at ext. 62610 with pt identifiers, best phone number to reach veteran and preferred time (9am or 10am). Resident will also add next day’s social worker to their discharge note.
        ▪ You can find the PES SW for the next day on the calendar on the wall in the PES

• Who do I send these note to?
  o Always cc: Jonathan Buchholz and whomever is going to contact the patient the next day

    • Medications: Can be given at your discretion. Should be limited. (Typically none are given.) You can call weekend pharmacy at 277-2383, or -2382, or -1332. See also Appendix on preparing discharge medications.
    • AMA Discharge Form (if you decide the discharge is AMA)
To complete this form you need to be at a computer with a signature pad. There is one in the 7W exam room -- use extreme caution taking an uncooperative patient who wants to leave into that small room. If there is any safety concern, it is OK to forgo getting the patient’s signature. You still have to fill out the form if they don’t sign.

- **SUICIDE RISK EVALUATION-COMPREHENSIVE note**: Completed for every discharge (can be copied forward and modified from admission)

### Patient Elopement

- **From 7W/ED**: Nursing staff on the unit would guide the response for both inpatients and ED patients, per policy Memorandum PE-14 "Management of Missing, Absent, and Wandering Patients"
  - You will likely be notified to help determine if patient meets criteria for being a “Missing Patient” per the PE-14
    - **Missing Patient**: one who meets criteria for at-risk who disappears from an inpatient or outpatient treatment area on VA property, or while under control of VA
    - **At-Risk Patient**: legally committed, have court-appointed legal guardian, considered dangerous to self or others, gravely disabled secondary to mental disorder, lack cognitive ability to make relevant decisions, or has physical or mental impairments that increase risk of harm to self or others.
  - The nurses are responsible for coordinating the initial search and with the police.
  - King county crisis line should be alerted at 206-461-3210 #1.

- **From Non-psych inpatient units (Psych Consult may or may not be following)**: Primary team is responsible for the entire response and all followup. (Do not let them tell you differently.)
  - If they would like our help, they will need to get the patient back in the room, with a sitter or in restraints until we get there.

### Confidentiality and Duty To Protect (Last updated 11/28/18)

Washington has two sources of law governing a clinician’s obligations to protect third parties from the violent acts of patients:

1. Statutory Law (RCW 71.05.120): “duty to warn or to take reasonable precautions to provide protection from violent behavior where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims.” This applies in the context of ITA. The statute provides an immunity provision of you can establish that you reasonably warned the intended victim and law enforcement.

2. Case Law (Volk v. DeMeerleer): A mental health professional is under a duty of reasonable care to act consistent with the standards of the mental health profession in order to protect the foreseeable victims from his patient’s dangerous propensities. This applies when a there exists a special relationship with the patient. This applies in the context of outpatient care. Legal scholars to date interpret this as also applying in the context of voluntary hospitalization.

In fulfilling your duty to protect, you have several options. Issuing a warning to an intended victim is one option. However, there are circumstances where this may not be possible or may further exacerbate the situation. You can also take other measures, such as changing or intensifying psychiatric care in the inpatient or outpatient settings. If you take alternate measures to protect and were to be sued, you would need to establish that the measure(s) taken were reasonable under the circumstances.

For circumstances in which a warning is issued:

1. If you are issuing a warning to discharge your duty, it is recommended in most circumstances that you take reasonable measures to warn the intended victim and also notify law enforcement in the jurisdiction of the intended victim. Please consult with the VA Police for help with identifying the appropriate law enforcement agency. The VA police serve as a liaison to law enforcement in the community; however, VA Police encounter difficulties being able to report to local police as they are “secondary” parties to the information. At this time, the VA police have requested that we always notify them, but we, as the clinician, take on the primary role of notifying the local authorities or potential victim. If you are unable to contact the potential victim, document your attempt and notify the appropriate local police department and request they also try to contact the potential victim.

2. For threats/warnings towards VA staff, you should notify the VA Police in addition to the victim(s).

3. You should limit what is disclosed to the intended victim and law enforcement. You should not disclose any 7332-protected information (alcohol, substance use, HIV or sickle cell).

4. You are not breaching patient confidentiality if you get the patient’s consent to issue notifications.

5. Add Jeffery Swanberg and James Weivoda, privacy officers, to your clinical note as additional cosigners ANY time you disclose patient information (duty to warn, APS, CPS, ER disclosures)
This area can be confusing and changes with new case law. You should always discuss these issues with your attending. You can also consult in non-emergent situations with Dr. Jennifer Piel, director of the VA Disruptive Behavior Evaluation Clinic.

Consults on Medical Floors
- Urgent consults (SI, post SA, behavioral emergencies, active w/d, AMA) need to be seen within your shift, unless you have even more urgent issues.
- During the week, non-urgent consults between 5-7pm should be completed by the night float resident if you have time.
- All consults should be seen within 24 hours of initial request.
- Anytime you see a new consult, you must discuss it with your on call attending.
- Make sure the requesting team places a consult in CPRS, otherwise you will not be able to complete your note.
- Update the consult sign-out if you: receive a consult, follow-up on a consult, address consult pt questions. This helps the consult team stay informed about all consult issues.
- Add new consults to consult sign-out
  - The consult service cannot use HAND-OFF so they use a word document that can be accessed on the W-drive. W:\PUG_Workgroups\Psych Residents\Sign-Out

MHPing a medical patient? Remember that the VA does recognize medical holds, which may apply. If you do refer a patient and they are detained, email the weekday attending and SW team to let them know about the patient: susan.kennelly@va.gov, edward.gignoux@va.gov, jessa.lynch@va.gov, johnathan.buchholz@va.gov, marcella.pascualy@va.gov

To arrange follow-up for consult patients, check the list of possible disposition options.
- MHC: 62007/62037
- ATC: 62081/62457
- For new patients, you can also place a Consult for Mental Health / Outpatient Treatment / MHC via CPRS and patients will be contacted to arrange an intake.
- Some notes on clozapine in that section.

Clozapine
- Because the VA has a separate certification policy for rx-ing, you’ll probably need your attending for help.
  - All attendings should be able to order clozaril if you need help. If they have difficulty, please contact Sachi Yari-Doty 206.314.9746.
  - (Btw, register yourself: www.clozapineregistry.com .)
- Starting new patients on clozapine requires a lot of work and is best left to the primary team.
- For patients who are on clozapine and need to be taking while admitted: everyone require a new CBC and ANC on admission, regardless of when their last one was. Use the order CLOZAPINE CBC & APOLY PANEL; order it STAT.
  - Hold clozapine in patients with drops greater than WBC 3000/mm³ or ANC 1500/mm³ compared to prior CBC/ANC.
- For patients with clozapine-induced leukopenia/ granulocytopenia, follow the package insert guidelines: hospitalization with daily monitoring until WBC>3000/mm³ and ANC>1500/mm³.
- Look up the clozaril package insert online for further monitoring guidelines.

Emergency Medical Guardianship
As a federal facility, the VA Consent law CFR 17.32 (b) details guidelines for emergency medical guardianship:

- "Practitioners may provide necessary medical care in emergency situations without the patient's or surrogate's

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Does this patient have capacity?
Can this patient...
- Communicate the choice at hand
  - Ability to communicate
  - Oriented to situation
- Understand information relevant to decision
- Acknowledge medical condition and consequences of treatment options
- Engage in rational process of manipulating information
As consultant, you need to be aware of potential consequences and weigh risk/benefit in gauging decisional capacity! For standardized instrument, see Tunzi 2001 pmid: 11476275 Appelbaum 2007 pmid: 17978292

Consults

Documentation
[Encounter: SEA MHS INPATIENT CONSULT]
New: Psychiatry Consultation-Liaison Initial Consult Report
Follow Up: Psychiatry Consultation-Liaison Follow-Up Consult Report

STAR*D: Switch or Augment?
STAR*D roughly randomized depressed patients unresponsive to citalopram to augmentation vs switch strategies, and found no difference among them:
- Bupropion SR
- Sertraline
- Venlafaxine XR
- Citalopram + bupropion SR
- Citalopram + buspirone
- Citalopram + CBT
- CBT alone
With citalopram in stage 1, 36.8% of patients remitted; after switching or augmenting in stage 2, another 30.6% remitted. Rush 2006 pmid: 17074942

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express consent when immediate medical care is necessary to preserve life or prevent serious impairment of the health of the patient or others and the patient is unable to consent and the practitioner determines that the patient has no surrogate or that waiting for the patient's surrogate would increase the hazard to the life or health of the patient or others. In such circumstances consent is implied."

Therefore, if the patient does not have decisional capacity and needs imminent medical treatment to prevent serious impairment of health, they can be held for medical treatment. A MHP referral does not apply.

"Emergency medical guardianship could be invoked in a situation in which there is a dire medical condition AND the patients lacks decisional capacity around the issue of discharge, AND is ambulatory and wants to leave the hospital. For example, a patient who just had a stroke, has hemiparesis, is confused, cannot state a plan for self-care, wants to leave, and doesn't understand what is going on does not have capacity to decide to leave the hospital, and thus staff should make every effort to have him remain in the hospital under the concept of emergency medical guardianship.

Additional comments:
- Emergency medical guardianship should NOT be invoked in situations in which a patient is consenting to care but wants to leave the floor temporarily (e.g. to smoke, go to the cafeteria...).
- Emergency medical guardianship should NOT be invoked in situations in which a patient lacks decisional capacity to make healthcare decisions but is medically stable and no longer needs inpatient care and the primary care team determines that there is no imminent risk for impairment to the patient's health if they were to leave the hospital.
- In the case of a patient with severe cognitive impairment and no social support to compensate for the patient's deficits (e.g. socially isolated, demented patients that are unable to take of their ADLs) you must consider referral to the MHPs on grounds of grave disability if the patient is "insistently and consistently" demanding to leave (if you refer, do not rush the MHPs to complete their evaluation because the consult team can call it off the next morning if need be).
- As much as possible, it is preferable to delay these difficult consults (including need to refer to the MHPs) to the formal consult service the following day. Put most of your efforts and recommendations into cajoling the patient and asking nursing to use distraction techniques and making sure the patients needs are met in order to help the patient remain hospitalized. Consider sedating the patient. Remember, it is our duty to protect patients who are unable to protect themselves and from a risk management standpoint this position is easier to defend than a bad outcome.

Please see Dr. Pascualy's summary of Emergency Medical Guardianship in Appendix IX.

Cross-Coverage
- Use PSYCHIATRY COVERING PHYSICIAN NOTE [Encounter: SEA MHS 7WEST] to document all patient cross-coverage issues in person or by phone. A good rule of thumb is to leave a formal cross cover note anytime you see a patient or change treatment plans in some way.

Patient Transfers

Outside Hospital ER, medical floor or inpatient psych unit → 7W
Evaluating for Transfer – Remember, once you accept a patient, you have to admit them!
- We DO accept overnight transfers if medically stable and appropriate for voluntary admission (even if the PES SW has departed).
- We DO accept overnight transfers of veterans on an initial 72-hr ITA hold from other King County EDs who are not in restraints.
- You must discuss all transfer requests with your on call attending prior to declining or accepting the patient.
- If the patient is not appropriate (intoxicated, out of state, potentially delirious, medical stability in question, not clear they are voluntary, a VA employee, just got kicked out of a SNF & primarily need placement, etc), have the referring hospital call the PES (206-764-2610) at 7am the next morning when PES staff comes in.
  - If both you and the overnight attending both feel the patient may not be appropriate, it is ok to have them call the PES in the morning. The daytime team can more easily navigate unclear situations.
- Always talk to the patient on the phone to complete evaluation.
Know that service-connected veterans are meant to have "priority," however, in clinical practice this should not matter to you – excellent clinical care is above reproach.

If there are beds available on 7W, the patient can be accepted. Beds are not "held" for potential ED patients. That said, it is wise to think about potential space restrictions you could run into if the shift is busy. If there are policy issues, feel free to contact the 7W medical director anytime.

We do NOT accept transfers for "evaluation."
  o If you are contacted w/ this request, tell the caller you are unable to accept patients for "evaluation."
    • Instruct them that their facility will need to perform an evaluation to decide if the pt needs psychiatric admission or not, and if the pt is voluntary or should be referred (by them) to the MHPs. After they have made this determination, they can call you back to discuss a transfer for admission.

Only our service can accept pts for admission to our service.
  o If the AOD, NOD or ER PROVIDER accepts someone to inpt psychiatry, inform them of this and speak to your attending to decide how to proceed. It may be that the pt ends up being an appropriate admission, but if not – you do not have to admit them to psychiatry.

Transfers from outside ED’s and Inpatient Units will all go directly to 7W and not stop in the PES.

Transfer of Active Duty from Outside Hospital
  o We do not accept ITA’d Active Duty Personnel transfer requests.
    o Voluntary?
      • Make sure they have tried Madigan first. If they have not, they need to call and make sure they have no beds before we could consider an admission.
      • Obtain patient’s full name, SS#, Date of Birth and give to Health Plan Management Staff in the eligibility office (ask operator to tx you there) during the weekday, or to the AOD at front desk of ED during the weekend, nights, and holidays to enter into CPRS.
      • We do not need to worry about insurance coverage. Tri-Care is billed for active duty patients and we are not involved.
      • Follow Nuts and Bolts of Accepting a Transfer below to consider for admission.

Nuts and Bolts of Accepting an Outside Transfer
1. Collect the following information from the referring provider:
   a. Has the patient been assessed by the ER or inpatient physician and medically cleared (i.e. safe to discharge to home or shelter without ongoing medical treatment)? What are the vitals? Labs?
   b. What was the result of the UTOX and BAL? If pt is intoxicated, suggest they call you back once s/he is sober.
   c. Ask the referring facility to fax you the following for review – ER fax 206-764-2225 / 7W fax 206-764-2946
      • For ER patients: ER physician assessment, nursing notes & SW assessment if there is one, Labs, Meds
      • For inpatients: admit note, recent progress note, SW or psychiatry consult notes, labs
2. Talk with patient to discuss admission and inpatient behavioral agreement (can’t leave or smoke).
3. Confirm patient is eligible for care (i.e. in CPRS) with AOD & look for behavioral flags or history of poor faith voluntary
4. Confirm with 7W Charge Nurse (206-277-3208) for Bed Availability and discuss pt appropriateness.
5. Call attending to run case by them. You cannot accept a patient without attending approval.
6. If the case sounds ok, before you formally accept the patient, fax the Inpatient Mental Health Behavioral Agreement (found in PES mailboxes outside SW office and at: W:\PUG_Workgroups\Psych Residents \Forms) to the outside hospital for the patient to sign.
7. If patient signs and agrees:
   a. Inform the referring provider that you will accept the patient & tell them their nursing staff MUST call nursing report to 7W (206-277-3208).
   b. Ask AOD to arrange transportation (Patient must be transported in ambulance) if necessary, unless they are active duty patients and the referring facility is responsible for transportation.
   c. All patients from outside ED’s and outside inpatient units go directly to 7W (not through PES).

Before Arrival: Transfer Documentation
Use PSYCHIATRY COVERING PHYSICIAN NOTE template to document the following
• Accept decision
  o If denied: state what would need to be resolved before transfer could be reconsidered
• Estimated time of arrival
• Any acute issues that will need to be addressed upon arrival

Before Arrival: Transfer Orders
Orders needed for transfer
• "Admission Bed Request (Seattle)" order, details in admission section
• Can start “7W General Psychiatry Admit/Transfer Orders” under Delayed Orders; recommend waiting to put in medications until patient arrives on unit.

Before Arrival: Travel Consult
1. New note > BENEFICIARY TRAVEL note
2. Note template will open, then select the following:
   a. **Special Mode Transportation/Common Carrier**
   b. Point of Contact: enter your name and pager #
   c. Inter-facility transfer: No
   d. Medical justification: No
      i. Check “other”, then under describe write in: “suicidal (or homicidal/psychotic) patient requires transfer for safety”
      ii. Use same justification “suicidal (or homicidal/psychotic) patient requires transfer for safety” in second box explaining why other means of transportation cannot be used
   e. Type of transport: **Basic Life Support**
   f. Enter date
   g. Time frame: **One time**
   h. Select one way
3. Sign note
4. Order will automatically open upon signing note. Complete details including address of facility where veteran will be picked up, and VA Puget Sound (1660 S Columbian Way, Seattle, WA 98108) as intended destination. Specify that veteran should be transferred directly to 7W and not the ED.
5. Sign the order
6. Call the AOD (764-2810) to inform them that the request was placed, otherwise they will not be aware

**Admitting Transfer Patients**
- Admit note: PSYCHIATRY ADMISSION NOTE, detailed version.
  - Will need to do a physical exam
  - Will need to do a “SUICIDE RISK EVALUATION-COMPREHENSIVE” note
- Admit orders: Revise admission orders and add medications once verified with patient.
- Fill in patient info into the VA Handoff Tool see [How to Use the VA Hand-Off](#).

**Seattle VA → Outside Hospital**
*We DO transfer Veteran voluntary patients from our PES to other hospitals when we have no beds OR if the patient is a VA employee* regardless of service connection status. If Inpatient Psych beds are full or the patient is a VA employee, find a bed at another hospital (see outside hospital phone list on the last page in this section). The outside hospital will be covered by a Fee-For-Service payment by the VA for all veterans seen in the VA ER.

If you cannot find an outside hospital bed, and 7W is completely full, try this [No Beds section](#).

1) Do the note as you would for a patient being discharged from the ED. Document why hospitalization is necessary & that there are no beds here. Also document discussion with your attending.
   - Place Rachel Morgan, as a co-signer alerting her you have "Fee Serviced" a Vet to another facility.
2) Have SW (or yourself if no SW around) call hospitals to find out if they have an open bed. (The ER provider is not expected to help with this, but if they want to great.)
   - See [Local Hospital List](#) in Appendix for phone numbers (SW also has updated list)
   - Trouble finding a spot? HMC PES may know: 744-2367
   - Try not to use the UW and Harborview if possible as they are the most expensive
     - If pt sent to UW or HMC clearly document all other options were exhausted
   - See No Beds Open at Outside Hospital, if you have went through the entire outside hospital list and found no openings for your patient.
3) Fax ER provider, SW and NPOD notes to potential facility. (SW will do this if available)
4) Ask the AOD to type up paperwork that authorizes the VA to pay for the outside hospitalization and have them fax it to the receiving hospital.
5) **TRANSFER DOCUMENTATION IN HAS TO BE FILLED OUT BY PHYSICIAN (ER provider OR NPOD)**
   - **IMed Consent Form** found under [Tools→IMed CONSENT→SHARED→ADMINISTRATIVE→Patient Certification and Patient Consent for Transfer](#) (be patient, it will appear)
   - **VIRS Transfer Consult** needs to be completed. Located under the [Orders](#) tab -> [Consults & Procedures](#) > VIRS Consult-Interfacility > Puget Sound VA Medical Center > VIRS Transfer Consult
   - Once completed, a [hard copy of these documents need to accompany the patient](#) during transfer.
6) Order TRAVEL CONSULT (Orders Tab>Consults and Procedures>All Seattle Consults and procedures>Travel Request>Ambulance>fill out consult and sign). Let AOD know you put in a travel consult.

American Lake VA (ALVA) PACC ("Psychiatric Assessment and Clinical Care") → Seattle VA
8am-4pm: ALVA has PACC that sees walk-ins and has admitting privileges to 7W. PACC admissions are coordinated with 7W nursing. Admission note and medical clearance are completed prior to 7W arrival. 7W nursing will call to alert you of patient’s arrival to floor, but you do not have to see the patient or do a note.

Seattle VA Medical Floor → 7W
Consult Patients
• Discouraged on the weekends, unless prearranged. Talk with Attending before accepting transfer. Do not promise admission before you have spoken with the necessary parties and secured a bed. Patients with dementia should be referred to a specialized geropsych unit if possible. Patients referred from outpatient clinics should go through the PES.
  o During the day, speak with PES SW (62610) regarding bed flow; overnight, talk with the 7W charge nurse (63208).
  o Have the patient sign a Voluntary Treatment Agreement (if they’re voluntary); find this form on 7W or the W: drive.
  o Ask the medicine service enter TRANSFER SUMMARY with hospital course (in lieu of discharge summary) to ensure appropriate continuity of care
  o Psychiatry will write the transfer orders AND delayed orders for admission- Order: “HIGH INTENSITY GEN PSYCH (SEA) WARD TRANSFER” found under ADMIT/TREATMENT ORDERS [using the encounter SEA MHS Inpatient Consult]
    ▪ Transfer order
      o "Admit/Treatment Orders” > “Transfer Orders” (beneath Patient Status Orders) > Change Specialty to “High Intensity Gen Psych” + Ward “7 West (SEA)” + Diagnosis
      o Internal/Resident/Attending not necessary
    ▪ Admit orders: Also complete usual 7W General Psychiatry Admit order set
    ▪ DO NOT write delayed medication orders in the delayed transfer/admit orders- this leads to med duplications, much deleting, and potential for med errors.
    ▪ Medication orders placed on VA medicine floors remain active after transfer 7W but will need to be reviewed/edited following transfer to 7W
    ▪ Once pt is on 7W and orders have been activated, review medication list- add meds as needed and delete IVs, unneeded PRNs
    ▪ Change location of medication order to 7W to reflect change in patient’s location
    ▪ Transfer medications DO need to be renewed by the primary team on psychiatry so that med alerts go to the correct team – so give a heads up the primary team in the Hand-Off
      o Documentation: PSYCHIATRY ADMISSION NOTE, detailed version [SEA MHS Inpatient Consult].
        o If you have a recent consult note with suitable history, a brief admission note may be acceptable; however, be sure to include updated medical and psychiatric problem list and plan.
      o Documentation: also complete a full SUICIDE RISK EVALUATION-COMPREHENSIVE note
      o See Admissions to 7W section for details on placing delayed orders, safety levels, sign out, so on.

7W → Seattle VA Medical Floor
• First, discuss case with Attending.
• Then, call the medical or surgical team who may be willing to accept the patient on a med/surg floor. Place the appropriate consult as directed by the medical or surgical team as per your conversation.
• When calling a consult:
  o Review chart, see the patient and do a physical exam
  o Formulate a clear question
  o Call operator and have them page the appropriate consulting service
  o Document: “Psychiatry Covering Physician” [enc: SEA MHS 7WEST]
  o Order: ALL SEATTLE CONSULTS → MEDICINE INPATIENT (SEA) → Type in Provisional Dx
    ▪ Patient seen as: inpatient
    ▪ Place: bedside
    ▪ Write reason: brief description of problem
• Consulting team will decide if patient is appropriate to transfer to their service and give location if they accept them.
• If accepted for transfer
  o Remember that detained patients require a continuous observation (eg, 1:1 sitter) while they are on medical floors. Medical teams should also enter a text order: “Patient is legally detained to the VA and
requires continuous observation. Do not allow the patient to leave the floor.” The accepting medicine/surgery team will need to write orders in this regard!

- Let the psych nurses know so they can give report
- Write a TRANSFER SUMMARY, including recommendations for safety and management of psychiatric issues while on the unit
- Add patient to psych consult sign-out (W:\PUG_Workgroups\Psych Residents \Sign-Out) and to consult VM message (797-0628)
- Accepting team will do the orders
- Verbally sign-out to next resident

**ATC→7W or 7W→ATC**

- **Document:** Use the PSYCHIATRY COVERING PHYSICIAN NOTE [enc: SEA MHS 7WEST] note to document circumstances of the bed status change.
- **Orders:** none needed, unless the pt is on low risk, then he would need to be changed to moderate risk with ward restrict. (should already be on ward restrict)

**No Beds on 7W or in the Community**

- Once the decision has been made to admit a patient, and there are no beds on 7W or in the community, after four hours in the ER, the patient is considered boarding – but USE THE TERM “WAITING FOR A BED” with ED Nurses. Due to nursing concerns about providing inpatient psychiatric nursing care for boarding patients, we use the term waiting for a bed until this issue is resolved.

- **When a patient is waiting** for a psychiatry bed, regardless of the patient’s final psychiatric disposition (most likely 7W when a bed opens versus community bed):
  1. Complete DELAYED ORDERS and a BED REQUEST as you normally do for any 7W admission.
  2. Complete all needed medications (psychotropics and medical) through “Emergency Department Orders” and “Medications” column. Also add prn medications for anxiety, agitation or sleep.
  3. Communicate with ED provider and ER nurse about completed orders.
  4. Continue 1:1 monitoring while patient is waiting for a bed.

- **Additional comments:**
  - The VA boards patients detained by MHPs in the PES observation room with 1:1 until a 7W bed opens up. Detained patients have priority for first available bed.
  - Voluntary admissions wait for a psychiatric bed in the ED/PES, instead of admission to medicine floors
  - Is a bed being held for an ATC admit the next day?
    - Acute admissions get priority over scheduled ATC admits the following day if there are no other options (no outside hospital bed available)
  - PES Social worker will continue to contact outside hospitals for beds (but most likely, patient will wait until 7W bed opens up).
  - Sign out active ED cases/PES patients waiting for a bed to next day PES SW on weekdays or incoming psychiatry on-call resident on weekends
  - Document in your note about attempts to locate community bed – list outside hospitals you called.
  - ALL PATIENTS WAITING FOR A BED NEEDS TO BE SEEN DAILY BY PSYCHIATRY RESIDENT (WEEKENDS) and PES ATTENDING (WEEKDAYS)
    - Clinically, patient may improve and no longer needs inpatient care; consider discharge with outpatient services if appropriate (consult attending)
    - Document symptoms warranting inpatient care
    - Use Psychiatric Care Template

**Boarders in the PES – Awaiting Transfer to 7W or a Community Bed**
Any patient spending more than 4 hours in the PES will need to get the same level of nursing care as if they were admitted to inpatient psychiatry. Regardless of the patient's final psych bed location, write medication orders for the patient in the PES as if they were admitted to the hospital, including restarting the outpatient pharmaceutical regimen if indicated and PRN medications for sleep, agitation, anxiety, minor aches & pains, etc. You will also need to write a bed admission request. Once a bed on 7W becomes available, you will then write delayed admission orders.

**Involuntary patients:**

- If a patient has not been approved for admission and is involuntarily awaiting MHP evaluation, then they will need 1:1 observation. They also have priority for PES observation rooms. They will need full ED orders (inpatient level care) if waiting for 4+ hours.
- If a patient has been detained by MHPs and there is no 7W bed available and the patient has been/will clearly be in the PES for 4+ hours, treat them as a voluntary boarder who needs an obs room with 1:1.

**Voluntary patients:**

- If patient needs 1:1 observation, place the orders
- Place a diet order
- Ensure that the patient has a soft mat to sleep on if staying in an observation room
- Place medication orders as if the patient were on the inpatient unit
  - Daily medications (for DM, HTN, etc)
  - Psychiatric medications
  - Psychiatric PRNs (insomnia, agitation, anxiety)
  - Other PRNs (Tylenol, Miralax, Tums, etc)
- Daily notes are complete by the on-call resident on weekends using the 'Psychiatric Care Template.' See box ->
- After the psych resident has been unsuccessful getting a voluntary bed the for patient, the PES SW will take over calling facilities and working with 7W to get the patient placed.
- Discharge: If the ED SW or on-call psychiatry resident feel that a boarding patient may be able to discharge to outpatient f/u, this should be cleared by the on-call attending prior to PES d/c
- Keeping ED Staff in the Loop!
  - Communicate treatment recommendations to PES Social Worker and the ED Nurse and ED Provider, including any modifications to treatment plan

**Procedures for PES Boarders/Waiting for a Bed (Decision is admission and it's been > 4 hrs in PES)**

**Orders**

1. Complete bed request and delayed admission orders to 7W as you would if a bed were available
2. Order 1:1 (all patients)
3. Order all needed medications (psychiatric and medical) the patient requires while waiting. Order in ED context under Medications (see here for instructions.)

**Documentation (daily on weekends)**

1. Change encounter to SEA MHS PE PSYCHIATRY IND
2. Chose "Psychiatric Care Template" using your on-call attending as cosigner and add Ellen Li as an additional signer.
3. Document the need for acute inpatient psychiatric hospitalization or if clinically improved, consider discharge to outpatient care

**Communication**

1. Ensure ED MD and nurses know the patient is waiting for a bed (community or 7W).
2. Inform ED staff about need for seclusion or restraint. Let them know if you plan to discontinue either!
Appendix I - Involuntary Detention

In order to refer a pt for an involuntary psychiatric admission, you must feel the patient is DTS, DTO or GD as a result of their Mental disorder AND be willing to document it in a legal document (affidavit) and testify if you are asked to. Imminence is typically thought of as 24-72 hours.

Abbreviations:
ITA – involuntary treatment act  DTS – danger to self
DTO – danger to others  GD – gravely disabled
CDMHP or MHP – County Designated Mental Health Professional

Should This Person be referred for ITA?
1) Is there an Axis I condition contributing to the presentation?
2) Is one or more of the following true?
   - 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.
   - They are an imminent danger to others, as evidenced by statements made during the interview, recent behaviors, collateral information and/or past history.

Things that indicate someone is a danger to self/others:
- they make threats (document these verbatim)
- they state explicit plans and intent (document these verbatim)
- they have a history of violence or have recently threatened harm to self or others

- Due to mental illness, they are gravely disabled and are at serious risk of significant injury or death

Things that indicate someone is gravely disabled:
- unable to maintain nutrition (drastic weight loss, electrolyte imbalances, orthostatic hypotension combined with elevated BUN and Cr, dry mucous membranes on exam, can't tell you where or how they would obtain food)
- unable to maintain medical safety (untreated lethal infections, noncompliance with care that is likely to lead to death)
- unable to maintain physical safety (elder who can't fend for self, grossly disorganized behavior such that they are unable to function i.e. can't find home, can't stay out of road)
- "severe deterioration in routine functioning" evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving necessary care

3) Is one or more of the following true?
   - patient is unwilling to be admitted voluntarily
   - patient is unable to provide informed consent for a voluntary hospitalization
   - you believe they are a ‘poor-faith voluntary’ (essentially wants to be in the hospital, but a historically bad player – i.e. leaves AMA, assaults staff, repeatedly does not follow up with outpatient follow up, only wants housing)

If the answer is yes to all three questions, you should do the following:
- Do NOT give any psychiatric medications
- Ensure patient does not have any significant medical issues that need addressed prior to psychiatric hospitalization
- Call your attending to discuss the plan
- If the patient has a Case Manager (uncommon at the VA), call this person to evaluate the patient for ‘less restrictive options
- Determine who will write the affidavit – this person must have first-hand knowledge of the patient’s threats or behaviors (can be you, family members, SW, CMs, other staff)
- Call the MHP - 293-9202 or -9203 (weekdays) or 461-3210 (nights/weekends).
   - Be prepared to give the patient’s date of birth, address, and a concise yet oddly compelling story explaining why detention is necessary. Document the call in the chart (including the time) and make sure your affidavit is complete before the MHP arrives.

NEW as of July 1, 2014: “Use of recent history evidence”
1) When weighing GD, court must take into account if present symptoms are similar to or associated with past symptoms which led to past ITAs, violence, deteriorations, etc. (i.e. mania)
2) When weighing likelihood of serious harm, court will consider recent history of violent acts or recent commitments based on likelihood of serious harm.

Writing an Affidavit
- Statements & examples in the affidavit have to be IDENTICAL to those in your clinical note. But DO NOT copy and paste the entire affidavit into your note. Copy & paste only brief, notable parts of the affidavit.
- Quotes & behavioral descriptions whenever possible. Courts care about words and actions! Not diagnosis.
• Limit the use of jargon and avoid diagnostic acronyms like SIMD w/BPD and AVHs.
• Write the affidavit on a special affidavit form (you can get this from the Psychres site or find a blank copy on the W: drive.)
• At the VA, it is preferred that the inpatient SW team act as your proxy in court (if so allowed by the court), so be sure to write an appropriate clinical note and affidavit!

**An 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 Seattle VA Hospital.

**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. (PAINT IT STRONG, MATLOCK—THIS IS YOUR CLOSING ARGUMENT TO THE COURT)

**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**

**Samples**

**Danger To Self**

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.

**Danger to Others**

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 has failed other less restrictive options by demonstrating an unwillingness to follow up with his outpatient providers, and is
currently refusing 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.

Grave Disability

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.

Confidentiality of drug/alcohol abuse, HIV, sickle cell anemia (7332)

Because the VA is a Federal entity and the involuntary treatment cases go through open, Federal Courts, veterans have additional privacy rights around drug abuse, alcoholism, alcohol abuse, HIV infection, and sickle cell anemia. On the ROIs at the VA, there is even a special box to allow release of this information. **Unless a veteran agrees to sign a 7332 release of information, you cannot put that information in the affidavit, which is a legal document.**

However, you will put all of the relevant 7332 information into the clinical chart, which the MHP will have access to in the emergent situation of an MHP referral (grave disability, danger to self/others, etc). Before the clinic notes are officially released to the court after involuntary detention occurs, the VA legal team will black out the 7332 info as needed.

Though you can't directly discuss 7332 information in an affidavit, you can allude to ‘life threatening illness’ that is going untreated due to untreated mental illness or ‘patterns of behavior’ that are currently rampant and worsening the patient’s mental illness from a biochemical perspective. While this wording is vague, it is legal and will clue the MHPs into your reasoning around the referral regarding drug abuse, alcoholism, alcohol abuse, HIV, and/or sickle cell anemia.

ITALY Proxy

The daytime inpatient VA social work staff is willing to testify on your behalf if you order a proxy! (Indeed, it is easier for them to do this.) You are encouraged to use the proxy system FOR EVERY PATIENT YOU REFER from the VA. Since proxy is granted at the court’s discretion, the use of proxy testimony is never guaranteed.

CRITICALLY IMPORTANT: In all cases, remember that a proxy can only be used if the clinical note has appropriate documentation, including quoted patient words and to whom they were spoken (eg. The patient said to me, “I will…” as well as clear descriptions that you witnessed the patient’s behaviors (eg, “I then saw the patient do...”). These exact phrases and quotes MUST BE IDENTICAL to those in your clinical note, which must be similarly written and particularly thorough. You may copy and paste pertinent sections of your affidavit into the clinical note where appropriate. **If you copy and paste your entire affidavit into the note, it is viewed as ‘the affidavit’ not ‘the clinic note.’ This results in a clinic note that cannot be used for proxy!!** Note: a proxy can’t attest to your level of fear is a patient is DTO; you will get called to court if that is the crux of your affidavit.

Be particularly diligent: if you are not approved for proxy, you are required by law (and the force of your subpoena) to present to court at the appointed date and time. On night float, if you are unable to get a proxy you must go to court and have the backup resident take your call, it being a duty-hours violation to work longer than 24 hours without an adequate inter-shift break (per Deb).

After writing your note in the above fashion, initiate the proxy request process:

1) Leave completed paperwork in the PES for daytime SW.

2) Make sure a copy of your affidavit is in the patient’s paper chart and goes with them to 7W or their inpatient destination. Do not e-mail the affidavit to SW or the King County mental health court.

3) Send an e-mail to the people below. **Only use patient initials (not full name) as the identifier.** Be sure to ask whether an MD would be required to serve as proxy (critical for the daytime team):  
   paota@kingcounty.gov, johnathan.buchholz@va.gov, susan.kennelly@va.gov, jessa.lynch@va.gov, Edward.gignoux@va.gov, ellen.li@va.gov

   Return to Table of Contents
Here’s a sample email that you can copy-paste:

Mental health/ITA court—
I am [NAME], a UW psychiatry resident who requesting that proxy testimony be allowed in my place in the case of [PATIENT INITIALS], detained on [DATE DETAINED] to appear in court [TRIAL DATE on your subpoena]. I am cc’ing the VA inpatient social work team as well. Please let us know if an MD is required for proxy testimony.

Thank you for your consideration,

4) If you do not hear back from someone the next weekday, you should do the following:
• Email the entire group again
• Look at the VA SW notes and contact the SW’er on the case (email should be above)
• Call the prosecutor’s office: Marsha Luiz, Paralegal, number 206-296-8936, M-F: 730AM-330PM
• If still have no response, page the VA Chief Resident (206-314-8817)

NOTE: Do NOT fax patient records to the ITA court to request proxy, as is the practice at Harborview. The Social Work team will take care of sending necessary documents to court agents, because certain material around substance abuse, sickle cell anemia, and HIV may need to be redacted per 7332. Continue to print notes from the patient record for the MHP, as the MHP is not a court agent and a referral is indicative of an emergent situation (danger to self, danger to others, grave disability).

Helpful Hints for Working with the MHP’s
• When calling in a referral state who you are, where you are calling from (i.e. PES, 5WA, 7W), and add that you have discussed the case with you attending and they support an MHP referral.
• Try to describe the case the best you can to the screener as well as answer their questions to your ability. I have attached the screener intake sheet so that you can have an idea of what questions they might ask.
• The MHP screener CANNOT refuse your referral, no matter how much push-back they give you. The only way for them not to come is if you rescind your referral. Some of the supervisors are trying to work on less push-back/screener opinions about cases however this will not likely be resolved nor consistent in the near future.
• Speak to witnesses if you can when forming your case, however do not feel compelled that you need to find/speak to them. Apparently this is also an issue within their department as they are supposed to be responsible for finding collateral in carrying out their investigation and they do not want the providers referring to feel that this is their responsibility.
• Please do NOT use the term “poor faith” voluntary. D-MHPs have asked clinicians to move away from this term due to its frequent misuse/overuse. INSTEAD, when making a DMHP referral on these pt’s, EXPLAIN why the pt. is “[grossly] impaired” using the following pillars:
  - Risk
  - Mental Disorder
  - Cause (how is the risk is caused by or associated with the mental disorder or pt having cognitive impairment that prevents them from making this decision)
  - What less restrictive options were considered/tried/available and why these are not appropriate
• In regards to the time-limit rules. Document in the clinic note the time at which the decision to refer to MHPs was made; the 6-hour clock starts from that time for PES/ED referrals. Unfortunately due to such high volume as well as staffing issues overnight they will not always be able to make it in time. However you should continue to hold the patient until they are seen. Ideally the patient will agree to a continuance once hospitalized or will not be released on this technicality, but this is a risk that will continue with our current system. The MHPs are doing their best to triage cases (another reason to present the case the best you can to the screener) and generally the HMC PES and 5-MM are about as safe a place there is for a patient with safety concerns so often times they are elsewhere seeing more urgent cases. Things we can do to help extend the timeline would be to delay the final decision to refer to the MHPs until the medical work-up is complete (or letting the patient sober up) and document the time in the chart (i.e. Unable to evaluate patient at 0130 as his BAL is 250 and continues to present as intoxicated). Additionally the point at which the patient "consistently and persistently" asks to leave requires prompt evaluation and referral.
List of Rights for ITA Patients

You are being provided this copy of the WAC 388-865-0566 prior to being admitted to the Seattle VA Hospital as an involuntary patient:

"You have the right to:

(1) Remain silent and any statement you make may be used against you.
(2) Access to attorneys, courts and other legal redress, including the name and address of the attorney the mental health professional has designated for you.
(3) Immediately be informed of your right to speak with an attorney and a review of the legality of your detention including representation at the probable cause hearing.
(4) Have access to a qualified language interpreter in the primary language understood by you, consistent with chapter 388-03 WAC.
(5) Have a responsible member of your immediate family if possible, guardian or conservator, if any, and such person as designated by you be given written notice of your inpatient status, and your rights as an involuntary consumer.
(6) A medical and psychosocial evaluation within twenty-four hours of admission to determine whether continued detention in the facility is necessary.
(7) A judicial hearing before a superior court if you are not released within seventy-two hours (excluding Saturday, Sunday, and holidays), to decide if continued detention within the facility is necessary.
(8) Not forfeit any legal right or suffer any legal disability as a consequence of any actions taken or orders made, other than as specifically provided.
(9) Not to be denied treatment by spiritual means through prayer in accordance with the tenets and practices of a church or religious denomination.
(10) Refuse psychiatric medication, except medications ordered by the court under WAC 388-865-0570 but not any other medication previously prescribed by an authorized prescriber.
(11) Refuse treatment, but not emergency lifesaving treatment unless otherwise specified in a written advance directive provided to the facility.
(12) Be given a copy of WAC 388-865-0585 outlining limitations on the right to possess a firearm."

___________________________________________________
Patient signature date

o Patient refused to sign (check if applicable)

___________________________________________________
Staff signature date
Appendix II - NPOD as Consultant to ER

The January 2010 VAPSHCS revised policy regarding Night Time, Weekend, and Holiday Psychiatry Resident (NPOD) Coverage in the Emergency Department:

1. The Medical Officer on Duty (MOD) is the responsible physician for all Emergency Department (ED) patients.
2. Psychiatry residents provide psychiatric consultation to the ED.
3. Patients presenting to the ED will all be seen by the MOD to be medically cleared:
4. If a patient presents with suicidal or homicidal ideation, or has a behavioral flag in the system, the triage nurse will contact Police Service for a security screen which will occur in the triage area. After the security screen, the veteran will be monitored on 1:1 observation until further evaluation by a Mental Health provider occurs.
5. If Psychiatric consultation is needed, the MOD must evaluate the patient prior to psychiatric evaluation and specify a reason for the consultation.
6. The Psychiatry Resident will consult with the Psychiatry Attending regarding his/her assessment and treatment plan for the patient and will communicate the assessment and treatment plan to the MOD.
7. Psychiatry Residents are not responsible for disposition issues (e.g., arranging transportation, finding shelters/housing); the Social Worker or the Administrative Officer on Duty (AOD) should be consulted for these issues.
8. If the patient is admitted to the Psychiatry Service, the Psychiatry Resident will:
   a. Complete the admission note
   b. Give report to the staff at the admitting facility
   c. If admitted to the Seattle, write bed request and admit orders
   d. If admitted to an outside facility, the AOD or social worker will arrange transport to the outside facility
9. If the patient is admitted to the Psychiatry Service at either Division or referred to the MHP, these laboratory studies are often done, but not required. The MOD will do what is clinically indicated:
   a. Chem-7, LFTs (AST, ALT, bilirubin, alkaline phosphatase), CBC with differential
   b. Urine drug and alcohol screen
   c. Urinalysis with culture and sensitivities, if indicated (for elderly patients)
   d. Blood alcohol level
   e. Lithium level (if on lithium)
   *Note: These labs may be ordered by either the MOD or the Psychiatry Resident
10. If a patient will be admitted to the Psychiatry Service at the VA or an outside facility, the MOD evaluation must include a medical history, physical examination, indicated diagnostic studies, and assessment/recommendations for current medical problems.
11. The MOD evaluation for Psychiatric Service admissions will be documented:
   a. Prior to transport for admissions to a community hospital or MHP hold
   b. By the end of the shift for admissions to the same VA Psychiatry Service unit (i.e., admissions from the Seattle ED to Seattle 7W)
12. Placing ED orders as consultant:
   a. All orders for the ED should be placed by the MOD. (i.e. meds and labs)
   b. We can offer to place orders for the ED, but we need to let the MOD know as they are ultimately responsible.
   *Note: It is collegial to offer to place orders for ED psychiatry patients, especially if the ED is busy.

**Per edict from Psychiatry Emergency Services director, Dr. Ellen Li: Once patients are medically cleared by the MOD, the consulting psychiatry provider should assist the MOD and ED nursing staff by informing them of the assessment and plan in real time and in person, by ordering psychotropic medications for ED administration, and ordering any psychotropic medication for discharge.

**If the ED social worker is over-loaded with patient’s with psychiatric complaints, then the psychiatry resident will help out with ED triage, evaluations, and treatment if called in by the social worker.
### Appendix III - Check-list of To Dos and Documentation Requirements

#### SI, HI, Hopelessness Patient in ED

<table>
<thead>
<tr>
<th>During initial call / Before you see the patient</th>
<th>Immediately after you see patient</th>
<th>Patient Being Admitted</th>
<th>Patient Not Being Admitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Has patient been security screened?</td>
<td>o Emergency Department Safety Assessment Note</td>
<td>1) Call attending</td>
<td>1) Call attending</td>
</tr>
<tr>
<td>o 1:1 sitter or restraints (not needed for hopelessness)</td>
<td></td>
<td>2) Confirm bed availability/discuss with 7W charge nurse (6-3208)</td>
<td>2) Talk to ER provider/nurses about plan</td>
</tr>
<tr>
<td>o Has patient been seen by ER provider?</td>
<td></td>
<td>3) Talk to ER provider/nurses about plan</td>
<td>3) Complete Suicide Safety Plan, print it and give to patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4) Bed Request (if going to 7W)</td>
<td>4) Complete Inpatient Mental Health Behavioral Agreement (paper form)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5) Orders</td>
<td>5) [enc: SEA MHS PE Psychiatry Ind]</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• risk assessment must match activity level</td>
<td>6) SUICIDE RISK EVALUATION-COMPREHENSIVE note</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• labs (get drawn in ED-should be done by ER provider)</td>
<td>7) Violence Risk Screen. If positive, complete VIOLENCE COMP. ASSESSMENT Note</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• EKG for all patients-on 7W (order as on ward)</td>
<td>8) Suicide Behavior Report (if SA or self-harm in last 12 months)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• meds as indicated</td>
<td>9) Enter patient sign-out into HandOff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6) Complete Inpatient Mental Health Behavioral Agreement (paper form)</td>
<td>10) Suicde Behavior Report (if SA or self-harm in last 12 months)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7) Inform nurses pt is ready for transport to floor</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>8) PSYCHIATRIC ADMISSION NOTE, detailed version [enc: SEA MHS PE Psychiatry Ind]</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>9) SUICIDE RISK EVALUATION-COMPREHENSIVE note</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>10) Violence Risk Screen. If positive, complete VIOLENCE COMP. ASSESSMENT Note</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>11) Suicide Behavior Report (if SA or self-harm in last 12 months)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>12) Enter patient sign-out into HandOff</td>
<td></td>
</tr>
</tbody>
</table>

#### General Psychiatric Complaints in ED (without SI or HI)

<table>
<thead>
<tr>
<th>During initial call / Before you see patient</th>
<th>Patient Being Admitted</th>
<th>Patient not being admitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Is there any behavioral problem/agitation?</td>
<td>1) Call attending</td>
<td>1) Call attending</td>
</tr>
<tr>
<td>- if so, consider security screen or 1:1 sitter</td>
<td>2) Confirm bed availability/discuss with 7W charge nurse (6-3208)</td>
<td>2) Talk to ER provider/nurses about plan</td>
</tr>
<tr>
<td>o Has patient been seen by ER provider?</td>
<td>3) Talk to ER provider/nurses about plan</td>
<td>3) Fill out PES Patient Discharge Plan &amp; give to patient</td>
</tr>
<tr>
<td></td>
<td>4) Bed Request (if going to 7W)</td>
<td>4) Psychiatry Emergency Department Note</td>
</tr>
<tr>
<td></td>
<td>5) Orders</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• risk assessment must match activity level</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• labs (get drawn in ED-should be done by ER provider)</td>
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<tr>
<td></td>
<td>• EKG for all patients-on 7W (order as on ward)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• meds as indicated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• call Dr. Li for approval of assist devices</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6) Complete Inpatient Mental Health Behavioral Agreement (paper form)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7) Inform nurses pt is ready for transport to floor</td>
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<tr>
<td></td>
<td>11) Suicide Behavior Report (if SA or self-harm in last 12 months)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12) Enter patient sign-out into HandOff</td>
<td></td>
</tr>
</tbody>
</table>
### Outside ED/Hospital Patient Transfers

#### Before Accepting Patient
- Review all records from outside hospital/ED
- Confirm medically cleared
- Confirm eligible for care with AOD, review any flags
- Talk with patient to see if appropriate as voluntary pt and review MH Behavioral Agreement. Currently not accepting ITA'd pts during nights or weekends.
- Discuss case with Attending for approval
- Fax over MH Beh Agreement and have pt sign it and outside facility fax it back

#### Once Accepted
- Outside facility must call report to 7W (206-277-3208)
- Ask AOD to arrange for transport directly to 7W
- Document decision with: PSYCHIATRY COVERING PHYSICIAN NOTE [enc: SEA MHS PE tele]
- Order: “Bed Request”, can start “7W General Psychiatry Admit/Transfer Order” set under delayed orders

#### Once Arrives to VA
- Patients now arrive on default ward restrict. No longer need to take patients off of 1:1.

#### Admitting Transfer Patient
- Document: PSYCHIATRY ADMISSION NOTE, detailed version
- Do physical exam
- Do SUICIDE RISK EVALUATION-COMPREHENSIVE note
- Revise admission orders to include medications
- Enter patient sign-out into HandOff

### Seclusion/Restraints
*you must remain at the VA*

<table>
<thead>
<tr>
<th>Immediately</th>
<th>Within 1 hour</th>
<th>Q 4 hours</th>
<th>Q 8 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>o Call Code Green for restraints (up to you and nurses for seclusion)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Call attending ASAP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Enter CPRS Order (Psychiatric/Behavioral Restraint/Seclusion Order)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Face-to-face evaluation of patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Behavioral Health Care Restraint/Seclusion Note Template (Physician Note) [enc: SEA MHS 7W or SEA MHS PE PSYCHIATRY IND if in PES]</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Talk to nurse re: further indication for restraint</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Written CPRS order (Psychiatric/Behavioral Restraint/Seclusion Order)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Enter CPRS order (Psychiatric/Behavioral Restraint/Seclusion Order)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Face-face evaluation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Behavioral Health Care Restraint/Seclusion Note Template (Physician Note)</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Consults While On Call

#### During initial call / Before you see the patient
- Name & last 4 of SSN
- Location
- Team & Attending
- What is the question?
- Ask team to place consult order in CPRS
- Who should I contact (and how) after I have seen the referral?

#### Decide if/when to see patient
- During the day
  - See all consults you are able to see (urgent first)
  - Patients w/ SI and a sitter must be seen daily
  - 5pm-7pm
    - Urgent consults must be seen
    - See non-urgent if you are not busy
  - 7pm-8am
    - urgent consultations must be seen
  - URGENT = SI, post-SA, Behavioral emergency, Active w/d, attempt to leave AMA

#### After you see patient
- Call Attending
- New Consult - Psychiatry Consultation-Liaison Initial Consult Report
- Follow up – Psychiatry Consultation-Liaison Follow-Up Consult Report
- Leave a message on the consult pager (797-0628)
- Update consult sign-out

### AMA Discharges

#### During patient assessment
- If possible, convince pt to stay until am
- If refuses, assess for SI/HI/GD
- Check sign-out to see if team left any recs for management

#### Pt still wants to leave
- Call attending
- Determine if there is grounds for MHP referral
- Discuss plans w/ nurses – consider code green if needed

#### Pt leaving
- Discharge Order (irregular)
- Meds (at your discretion, generally best to limit)
- AMA discharge form on iMedConsent
- PSYCHIATRY COVERING PHYSICIAN NOTE if known to primary team as they will do the d/c summary, and add primary resident as additional signer. If admitted over the weekend and the primary team has not seen them, the on-call resident must do
Entering Encounter [enc:] information

For inpatient/PES notes, you need to assign the encounter but need not complete all the required elements (e.g., diagnosis, visit type, etc.). If you are in an outpatient setting, you do need to complete all those elements.

Who is the “primary provider?” That would be your attending, not you.

1) Open patient chart
   ➔ Click inside box just to the right of the yellow box containing pt name
   ➔ New visit tab
   ➔ Select encounter type by double clicking
     - PES notes: SEA MHS PE Psychiatry Ind
     - Admit notes in PES/on call: SEA MHS PE Psychiatry Ind
     - Telephone notes on call: SEA MHS PE tele
     - Admit notes while on 7W: SEA MHS 7WEST
     - Daily progress notes on 7W: SEA MHS 7WEST
2) Box will disappear & you can write note

<table>
<thead>
<tr>
<th>Pt staying</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>o Psychiatry Covering Physician Note</td>
<td></td>
</tr>
<tr>
<td>o Update Hand-Off</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Phone Calls</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Initially</td>
<td></td>
</tr>
<tr>
<td>o Call 764-2333 &amp; ask to be put thru to the patient’s number</td>
<td></td>
</tr>
<tr>
<td>o Get last 4, name, location</td>
<td></td>
</tr>
<tr>
<td>Document</td>
<td></td>
</tr>
<tr>
<td>o Telephone Contact Note [enc: SEA MHS PE telephone]</td>
<td></td>
</tr>
</tbody>
</table>
Appendix IV – How to Use VA Hand-Off

- VA Hand-Off Tool can be found in CPRS
  - Click on Tools → Hand-Off Tool
  - Enter the same username and password you use to access CPRS
  - Set your Hand-Off preference: File > Change Preference > Seattle VA Medical Center (not Mental Health)
- To Find Patient click on Ward → 7W → Submit
  - If the patient has not been admitted to 7W yet, click on Patient → Enter patient’s name → Click on patient’s name → Click box for “Temporary List (one-time)”
- Fill in blanks according to the I-PASS format below

Hand-Off Tips:
- “Periods” are used to hold a space to make it easier to read through. The Hand-Off Tool does not recognize empty spaces
- Boxes that are unused after three days are automatically deleted by the system. Adding a period or comma daily will prevent data loss. Add something to every box, every day while managing the Handoff Tool.

<table>
<thead>
<tr>
<th>Illness Severity</th>
<th>Patient Problems</th>
<th>To Do/ If Then/ Synthesis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Watcher or Stable or Discharge</td>
<td>Legal Status:</td>
<td>Action List:</td>
</tr>
<tr>
<td></td>
<td>Patient Summary:</td>
<td>Situational Awareness:</td>
</tr>
<tr>
<td></td>
<td>- Age and gender</td>
<td>- Pain</td>
</tr>
<tr>
<td></td>
<td>- Primary diagnosis</td>
<td>- Insomnia</td>
</tr>
<tr>
<td></td>
<td>- Major co-morbidities</td>
<td>- Anxiety/Agitation</td>
</tr>
<tr>
<td></td>
<td>- Reason for admission</td>
<td>- AMA (if voluntary)</td>
</tr>
<tr>
<td></td>
<td>- Key 24hr events</td>
<td>- Others</td>
</tr>
<tr>
<td></td>
<td>Hx of Violence:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PMH:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(If appropriate)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>DNR/DNI:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Consults:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contacts:</td>
<td></td>
</tr>
</tbody>
</table>

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Appendix V – Outside Hospital List

Local Hospitals with Inpatient Psych Beds
• Listed in order of who to try first

**Madigan**: 253-968-1110
- Emergent Transfer, call ED: 253-968-1390
- Non-Emergent Transfer, call Madigan Referral Coordination Center: 253-968-6807
- Fax Consult to: 253-968-1328 or 253-968-5005

**Overlake**: 425-688-5175 (main number)
- Days 7AM-9PM: 425-688-5000, ask for admitting hospitalist
- Nights 9PM-7AM: 425-688-5000, ask for shift administrator

**St. Joseph (Tacoma)**: 253-426-6691 fax 253-426-6492

**St. Joseph Hospital (Bellingham)**: 360-734-5400 (main); unit fax 360-788-6995

**Skagit Valley Hospital**: 360-424-4111 (main); unit 360-428-2422; unit fax 360-814-8215

**Swedish (Edmonds)**: 425-640-4000 (main)

**Swedish (Cherry Hill)**: 206-320-2000 or 866-470-4233 (24/7)

**St. Peters (Olympia)**: 360-493-7313

**Valley**: Admitting hospitalist 425-228-3440 x1319

**Franciscan Network (all the Saints)**: 253-369-3772 for patient placement

With some caveats

**Fairfax**: 425-821-2000
- Doesn’t do well with young PTSD vets, we’ve been asked to avoid transfers there if at all possible

**NAVOS**: 206-933-7299
- Not many voluntary beds

**Geropsych**

**Auburn General**: 253-804-2813
- Have the best luck with Auburn

**Northwest**: 206-368-1747

**Highline Community Hospital**: 206-244-9970, NOD pager: 206-469-3711, cell 206-469-3711
- Geropsych screening: 206-244-0180 (9am-5pm), fax: 206-244-4795
  - After hours charge RN: 206-244-4704

Hospitals to try last (most expensive)

**University of Washington**: 206-598-6195, 7N 206-598-4720
- Fax: 206-598-6111

**Harborview**: 206-744-3076, resident pager 206-663-9595
Appendix VI - Phone Listings/Printers/Room Locations
When paged to a 5-digit extension from outside, call 762-1010, press * & enter the 5-digit text!
Long Distance: 9-1-the number, fast beeping tone, enter PIN CODE: 165863 . #’s below 206- unless stated

Seattle VA (in house ext 6-XXXX)
Doctors Lines: 764-2333 ; main line 762-1010-*-x
7West: 764-2101, 277-3208 fax 277-1807
AOD: 764-2810, p797-0798
ED main: 277-3487
ED PSA: 277-2600

VA prefix cheat sheet
764-(2000-2999)
277-(1000-1999;3000-5199; 5500-5599;6000-6999)
768-(5200-5499)
716-(5600-5999)

VA Police: 277-3113, 6-2899 (911)

Pharmacy
Ψ IP Pharm: (day) 277-1712
OP Pharm: (day) 764-7550
General IP Pharmacy: (hs) 277-2383; or -2382; or -1332

Medicine: Weekend/night hot pager: p416-1452
Cardiology: p416-1428
Other services: operator, or else CPRS->Tools->On-call roster

Social Work
PES fax 764-2225
24hr hospital wide SW: pg 797-0505
7W SW- Susan Kennelly: 277-3968, Ned Gignoux: 764-2073,
Jess Lynch 277-4661

Clinics
MHC: 764-2007 (atgg: Al Radant)
ATC: 764-2457 (atgg: Tim Bondurant)

American Lake VA (in house ext 7-XXXX)
Main Line: 253-582-8440
NOD: pg 253-207-2037
ER provider: 7-1235
Social Work Evening until 11pm: 7-1680

Amenities
Call Room: Bldg 1, Room 190 (MHC); Clean linens in call room-
return dirty linens to unit or to EMS (in basement)
Resident workroom 7B-102
Food Room: BA-101 2,7,9,1,8
Small canteen open 9am-4pm on Sat; closed Sunday
Food served 6:30-7:30p for residents in 100/4b102
Check the resident work room freezer/refrigerator
Ordering Food: www.Grubhub.com; site will show you all of the
restaurants that will deliver to the VA
VA address:1660 South Columbian Way Seattle, WA 98108

Scrub are in the basement laundry

Employee Health: bldg. 100, 1st floor, next to East Clinic
Police Office/Key Pickup: bldg. 100, entrance through double
doors across from canteen entrance

7W Door PIN: Usually 1234#
Consult Pager: 797-0628
*the key should open the 7W front door if needed

Resident Room Phone Numbers
(But people do sit in random spots)
Team 1 Resident: 277-3418
Team 1 Med Student: 277-6237
Team 2 Resident: 277-3851
Team 2 Med Student: 277-6195
Team 3 Resident: 764-2968
Team 3 Med Student: 277-5567
Consult Resident: 277-6236
Consult Med Student: 277-3841

Attendings
Buchholz: p416-4161 c253-273-6122
Borisovskaya: p797-0477
Li: c898-6440 p416-1875 h568-3043
Markman: p206-416-4957 h734-239-3249
Pascualy: o6-1843 p797-0627 h232-0188 c390-7431
Reoux: o6-1747 p416-4192 h463-6375 (c) 962-0846
Rusk: c310-406-6339
Wingerson: o6-3277 p97-0395 h236-6485

Outside Numbers
HMC PES: 744-3076
DESC: 464-1570
King County Detox: 325-5000
MHP: (day) 206-263-9202, (hs) 461-3210
Crisis Line: 206-461-3222

Printers / Photocopies / Fax Machines
ER Printer (by ER photocopier): MAS 222
ER fax: 206-764-2225
PES Printer: S102_ED_Ricoh2 | ED Ricoh2
7W fax: 206-277-1807
7W photocopier: ID = 7777, PW = 7777

CPRS/Computer Access
CPRS Help: 6-CPRS
Access: Doreen.Keyes@va.gov, 206-277-6887
HR: Lisa.Canady@va.gov, 206-768-5218
National Service Helpdesk: 855-673-4357

VA after hours tech support specialist: call AOD
206-764-2810
Sick Days/Call changes: notify Lisa
(Lisa.Canady@va.gov), Athena, and chief resident

Forgot PIV card: National Service Desk can grant
48h access: 855-NSD-HELP (855-673-4357).
### Appendix VII – VA Guidelines of Laboratory Work for Psychotropic Medication Monitoring

<table>
<thead>
<tr>
<th>Medication</th>
<th>At initiation</th>
<th>Titration period</th>
<th>Every year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Atypical antipsychotics</strong></td>
<td>Weight, lipid panel, glucose or HA1c, AIMS, BP, pulse</td>
<td>Weight every 1-2 months. Lipids, glucose, BP, pulse at 3 months.</td>
<td>Weight (every 6 months), glucose, BP, pulse, AIMS yearly. Lipids every 5 years minimum</td>
</tr>
<tr>
<td><strong>Typical Antipsychotics</strong></td>
<td>AIMS, glucose, EKG with thioridazine, mesoridizine, pimozide</td>
<td></td>
<td>AIMS, Weight</td>
</tr>
<tr>
<td><strong>Bupropion</strong></td>
<td>BP</td>
<td>BP at 2-3 months</td>
<td>BP</td>
</tr>
<tr>
<td><strong>Carbamazepine</strong></td>
<td>CBC with diff, LFTs, chem 7</td>
<td>CBZ Levels after dose change, CBC with diff, LFTs, CBZ levels</td>
<td></td>
</tr>
<tr>
<td><strong>Disulfuram</strong></td>
<td>LFTs, bilirubin,</td>
<td>Repeat LFTs at 10-14 days.</td>
<td>LFTs</td>
</tr>
<tr>
<td><strong>Lithium</strong></td>
<td>Weight, chem 7, calcium, TSH</td>
<td>Weight, chem 7 at 2-4 months, Lithium level after dose changes</td>
<td>Weight, chem 7, calcium, TSH, Lithium level</td>
</tr>
<tr>
<td><strong>Naltrexone</strong></td>
<td>LFTs, bilirubin</td>
<td>Repeat LFTs at 6 months</td>
<td>LFTs</td>
</tr>
<tr>
<td><strong>SSRIs</strong></td>
<td>Weight. Sodium if over 65. Citalopram: EKG, magnesium if dose &gt; 40 mg OR (over 60 and dose &gt; 20mg)</td>
<td></td>
<td>Repeat EKG if significant change in cardiac status</td>
</tr>
<tr>
<td><strong>Tricyclics</strong></td>
<td>BP, pulse, EKG if &gt; 40.</td>
<td>BP at 3 months</td>
<td>EKG if significant change in cardiac status</td>
</tr>
<tr>
<td><strong>Valproate</strong></td>
<td>Weight, CBC with diff, LFTs, INR</td>
<td>VPA level after dose changes, CBC with diff, LFTs, INR at 3 months.</td>
<td>VPA level, CBC with diff, LFTs, INR.</td>
</tr>
<tr>
<td><strong>Venlafaxine</strong></td>
<td>Weight, BP, sodium if over 65</td>
<td>BP at 2-3 months</td>
<td>BP</td>
</tr>
</tbody>
</table>

**Pregnancy test** before starting any medication if pregnancy risk.

**Summary of EKG considerations:**

There are no absolute guidelines about when baseline or repeat EKGs are required for patients on psychiatric medications. Obtaining an EKG should be based on the following considerations. 1) Age 2) Presence of structural cardiac disease 3) Use of other medications that might additively prolong the QTc interval. 4) Bradycardia (pulse<=50) 5) History of syncope potentially due to arrhythmia. 6) Family history of unexplained sudden death.

Note that that QTc interval is hard to quantify and the computer output is only an estimate. Cardiology felt that a QTc < 480 ms is usually benign. Cardiology does not think we order too many EKGs and encourages us to err on the side of caution and order one if we have concerns.

This link has detailed information about medications and QTc: [http://www.azcert.org/medical-pros/education/practical-approach.cfm](http://www.azcert.org/medical-pros/education/practical-approach.cfm) (at torsades.org).
Appendix VIII – Preparing Medications for Discharge

Preparing Medications for Discharge
Discharge medications should be prepared at least 24 hours in advance of discharge. Call psych pharmacy when you know of a d/c: 6/1712. Shorter notice? Do the below, but definitely call pharmacy asap.

General Rules
- Make the outpatient medication profile look as like what the patient should be taking.
- **Change** or **refill** medications whenever possible rather than discontinue an old script and write a new one. (You can always note changes in the comments section, eg, “Dose adjusted on 10/3/12.”) Beware patients with lots of meds at home – you don’t want to refill/change these!
- Patients going to the DOM will receive meds there by about 2pm; if your patient requires a dose sooner, order a one-time dose and ask social work and pharmacy to provide it as a carry to the patient. Also be sure the physician discharge note (or d/c sum) has an updated med list for the dom!
- Patients sometimes bring lots of meds with them; these are documented in the paper chart. Talk to pharmacy if you do not want patient to have these medications for safety purposes; otherwise they will receive on discharge (with instructions to not take).
- When in doubt, just call (or walk into) pharmacy and they’ll help!

Reconciliation
Compare the inpatient and outpatient medication profiles on CPRS. Print an outpatient medication list under Orders -> Custom View -> Active -> Pharmacy -> Outpatient medications, then meds to print.

<table>
<thead>
<tr>
<th>Situation</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stopped an outpatient medication</td>
<td>Discontinue medication in the outpatient window. Instruct patient to throw away supply at home.</td>
</tr>
<tr>
<td>Changed dose, quantity, refills of an outpatient medication</td>
<td>Change medication in the outpatient window, note date of dose change in comment box. Instruct patient to throw away supply at home.</td>
</tr>
<tr>
<td>Has too much of a medication at home (eg, patient has 90d but should only have 14d supply)</td>
<td>Change medication to X days, no refills, and note in comment box “Do not fill” and note the situation. Thus pharmacy will not fill on d/c but the medication will still appear in patient’s profile.</td>
</tr>
<tr>
<td>Needs a refill of a prior outpatient medication</td>
<td>Refill medication in the outpatient window</td>
</tr>
<tr>
<td>Outpatient medication about to expire but dose is unchanged</td>
<td>Renew the medication</td>
</tr>
<tr>
<td>Started a new medication while inpatient</td>
<td><strong>New Medication</strong> in the outpatient profile; or, Action-&gt; Transfer to Outpatient</td>
</tr>
<tr>
<td>Patient has adequate supply of outpatient medication, appropriate number of refills, without a change in dose</td>
<td>NTD</td>
</tr>
<tr>
<td>Giving stimulants, opioids</td>
<td>Pharmacy will print a paper copy of the prescription, which you need to sign</td>
</tr>
<tr>
<td>Patient brought in medications from home</td>
<td>Typically patients receive all their property back on discharge. Alert pharmacy if you do not want meds returned for safety reasons.</td>
</tr>
<tr>
<td>Already entered discharge medications, and now need to change!</td>
<td>Call pharmacy: 4-1712</td>
</tr>
</tbody>
</table>

Interpreting Prescription Status

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active</td>
<td>Patient has supply and current prescription</td>
</tr>
<tr>
<td>Hold</td>
<td>Patient must talk to a pharmacist to have prescription released</td>
</tr>
<tr>
<td>Active/Suspended</td>
<td>Patient has supply, new orders for medication are pending.</td>
</tr>
<tr>
<td>Suspended</td>
<td>No mas!</td>
</tr>
</tbody>
</table>

Contact Pharmacy

Inpatient Psych (0800-1600)
277-1712
Nights/weekends (gen pharm)
277-2382: 2383: 1332
Appendix IX– ED Alcohol Withdrawal Algorithm

Attachment to Alcohol Withdrawal Treatment Algorithm for ED

Metabolic/Electrolyte Abnormalities for Medical Admission of Intoxicated Patients or Patients in Alcohol Withdrawal
(Note: these apply after 2 hours of attempts to correct the abnormality in the ED or of when concerns about severity)

1. **Potassium**
   - <3.0
     - >6.0 in renal failure with h/o chronic hyperkalemia
     - >5.6 without chronic renal failure or with EKG changes

2. **Sodium**
   - Acute change in sodium of > 5 points
   - Hypernatremia after correction for glucose:
     - <130 with associated symptoms (headache, dizziness/vertigo, lethargy, seizures, confusion)
     - >150 with associated symptoms (headache, dizziness/vertigo, lethargy, seizures, confusion)
   - <125 without symptoms
   - >155 without symptoms

3. **Magnesium**
   - < 1.0 without symptoms
   - < 1.3 with symptoms (tetany, seizure, arrhythmias)

4. **Phosphate**
   - < 1.0 without symptoms
   - < 1.7 with symptoms (confusion, delirium, respiratory compromise, seizure)

5. **Glucose**
   - >300 with + Anion Gap or positive serum ketones
   - >500 without Anion Gap, ketones or signs of dehydration

**Systemic Inflammatory Response Syndrome (SIRS)**
SIRS is nonspecific and can be caused by ischemia, inflammation, trauma, infection or several insults combined. SIRS is defined as 2 or more of the following variables:

1. Fever > 38° C (100.4° F) or temperature < 36° C (96.8 ° F)
2. Heart rate of greater than 90 beats per minute
3. Respiratory rate > 20 breaths per minute or PaO2 < 32 mm Hg
4. Abnormal WBC > 12,000 mm³ or < 4,000 mm³ of > 10% Bands

**GI Bleed**
1. Active GI bleed (Orthostasis, melena, BRBPR, hematocrit<24%, and/or hematemesis)

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Appendix X – Emergency Medical Guardianship

In emergency situations Washington State Law and the Department of Veteran’s Affairs allow physicians to evaluate (obtain physical examination, labs, and other diagnostic tests) and treat patients without patient consent. Per Department of Veteran’s Affairs consent law CFR 17.32 (b):

“Practitioners may provide necessary medical care in emergency situations without the patient’s or surrogate’s express consent when immediate medical care is necessary to preserve life or prevent serious impairment of the health of the patient or others and the patient is unable to consent and the practitioner determines that the patient has no surrogate or that waiting for the patient’s surrogate would increase the hazard to the life or health of the patient or others. In such circumstances consent is implied.”

Under these circumstances, the law provides for two-physician consent to proceed with evaluation that will determine the extent and degree of medical illness and relative threat to the patient’s or other’s life or health. Furthermore, when two physicians agree that treatment is required to prevent life or health threatening consequences to the patient or others, then such treatment may proceed in cases where the patient (or patient’s surrogate) cannot provide consent.

In order to provide consent, patients must demonstrate understanding of the nature of their condition, its severity, options for further evaluation and treatment, and the risks and benefits of said proposed options AND must be able to communicate a clear choice in this regard.

While no specific diagnosis precludes a patient’s ability to provide consent, the following are common conditions under which a patient’s capacity for providing informed consent may be called into question:

1. Patients who are comatose, obtunded, mute, or otherwise completely incapacitated and unable to interact meaningfully with their immediate environment.

2. Patients manifesting signs or symptoms of delirium, toxic/metabolic encephalopathy, severe substance intoxication or poisoning, or other acute mental status change.

3. Patients with moderate to severe dementia.

4. Patients with serious mental disorders manifested by thought disorganization, frank psychosis, or loss of reality testing.

Each patient must be evaluated on a case-by-case basis. For example, presence of dementia or frank psychosis does not imply that the patient cannot understand his or her circumstances and communicate a choice in that regard. Furthermore, decisions considered to be in poor judgment do not imply incapacity for consent. If the practitioner is in doubt regarding a patient’s decisional capacity or ability to consent, the practitioner should seek psychiatric consultation. If the clinical situation is of such imminent risk to the patient’s or other’s life or health that psychiatric consultation is not feasible, then the clinician should treat as in CFR 17.32 (b) above.

If the decision to evaluate or treat a patient without consent is deemed appropriate to the given clinical scenario, it should be documented as such in the medical record and both the treating physician and physician providing the second opinion should sign the note. The note should then identify the Chief Medical Officer (CMO) as an additional signer so that the CMO may review the case within 24 hours in compliance with Veteran’s Affairs policy regarding emergency medical guardianship.

Appendix XI – Orders for ECT

- Place an ECT consult
  - Go to the Orders tab > CONSULTS > ALL SEATTLE CONSULTS > ECT consult

- Place an anesthesia consult
  - Go to the Orders tab > CONSULTS > ALL SEATTLE CONSULTS > Anesthesia (inpatient)

- Place an IV team consult
  - Go to the Orders tab > CONSULTS > ALL SEATTLE CONSULTS > IV team (Inpatient)
  - Request that they place a midline IV for ECT

- Once the patient is accepted for ECT, fill out ECT consent with them (Often already done by Dr. Anna)
  - Go to Tools > iMed consent
  - Go to All documents > Mental Health > Consents basic > Electro-convulsive therapy index course

- Then place ECT standing orders
  - Go to the Orders tab and click “ADMIT/TREATMENT ORDERS.” Then select “Pre-ECT Orders”