VALLEYCARE
OLIVE VIEW-UCLA MEDICAL CENTER/HEALTH CENTERS
POLICY & PROCEDURE

NUMBER: 777
VERSION: 3

SUBJECT/TITLE: **MANAGEMENT OF PSYCHIATRIC PATIENTS ON NON-PSYCHIATRIC INPATIENT UNITS**

POLICY: Psychiatric and non-psychiatric inpatient services will collaborate, using the guidelines established below, on the care of all psychiatric patients that are admitted to general (non-psychiatric) inpatient units for evaluation and treatment.

PURPOSE: Patients with psychiatric issues who require hospitalization on general (non-psychiatric) inpatient wards present some of the most difficult challenges in our hospital. While requiring inpatient work-up and treatment of their proven or suspected medical illness(es), they also require adequate attention to their psychiatric issues and, in the case of patients on legal holds, the same level of protection from harm afforded to psychiatric inpatients. The medical and mental health inpatient units function independently from each other, often by necessity, thus it is important guidelines are established to ensure the collaboration between Psychiatry and the non-psychiatric inpatient services in caring for these high-risk patients.

DEPARTMENTS: All

DEFINITIONS:

PROCEDURE:

I. PATIENT ASSESSMENT AND DOCUMENTATION OF CARE

A. Admitting Service (Non-Psychiatric)

1. Pursuant to the bylaws of the Professional Staff Association, all patients who express suicidal (or homicidal) ideation must have consultation with Psychiatry documented in the chart.

2. Patients with active behavioral issues, especially those on legal psychiatric holds, should have those issues addressed in the primary team's daily progress notes. This includes, but is not limited to:
   a. Documentation in the daily note of the findings and recommendations of the Psychiatric consultants.
   b. Any recommendations not to be followed should be acknowledged and an explanation for the difference in plan documented.

c. Findings and recommendations of other ancillary services (such as Social Work, Occupational Therapy, etc.) regarding behavioral issues also should be acknowledged in the progress notes.

3. Changes in patient's behavior that may potentially require intervention to prevent an unsafe situation should prompt the following:
   a. Notification of the primary physician.
   b. Notation of the change in behavior in the medical record.
   c. Consultation of the Psychiatry service, if not already done.
   d. Notification of the consulting Psychiatrist. During daytime hours contact the Consultation and Liaison service. On nights/weekends, contact the on-call resident in the Psychiatric Emergency Department. The use of the Code Gold team is encouraged in situations where immediate action is needed.
   e. Stabilizing treatment or environment change as ordered by the primary team and/or consulting Psychiatrist.

4. Patients with ongoing psychiatric issues or legal holds who have been stabilized medically and no longer require acute hospital care should be discussed with the Psychiatry service for help with disposition.
   a. Patients no longer requiring acute medical/surgical hospitalization should be evaluated for the need for ongoing inpatient Psychiatric care, and transferred to the locked ward as soon as appropriate.
   b. Disputes regarding the suitability of the patient for transfer to Psychiatry or the completeness of the inpatient work-up and medical treatment should be resolved by direct discussion between the attending MDs on service.
      i. Patients should not be noted to be "medically stable for transfer" nor should transfer orders be written to the locked ward prior to the patient's being accepted by the Psychiatry service.
      ii. Disputes that cannot be resolved at the attending level should be adjudicated by the respective service chiefs, the Medical Officer of the Day, or the Chief Medical Officer, in that order.

B. Psychiatry service
   1. Consultations for management of patients with psychiatric issues should be acknowledged and completed in a timely manner.
      a. Off-hours/weekend consultations should be initiated by the Psychiatrist on-call (in Psychiatric Emergency Room) and passed along to the Consultation and Liaison Service.
      b. Consultation may only be deferred at the discretion of the Consultation and Liaison Attending. Consultation should not be deferred for patients with active suicidal or homicidal ideation.

   2. Patients with active psychiatric issues on legal holds should be followed daily by the Psychiatry service. The on-call Psychiatrist should be able to evaluate and assist in the care of these patients as changes in status occur.
      a. Patients with changes in psychiatric status should be evaluated by the Psychiatry service, at the request of the primary team.
      b. Patients requiring active intervention for their change in psychiatric status, including those requiring the use of the Code Gold team, should be re-evaluated for safety and possible placement in the locked psychiatric ward.

   3. Initial consultation, daily follow-up notes, and interim evaluations for changes in psychiatric status should be noted in the medical record.
      a. Recommendations for care should be written; if urgent interventions are needed, the primary team or covering physician should be notified directly.
      b. Recommendations for care that are not followed or are in conflict with the primary team's treatment plan should be discussed with the attending physician(s) caring for the patient.

   4. Patients no longer requiring acute medical/surgical hospitalization should be evaluated for continuing inpatient psychiatric care.
      a. The primary team should be notified of patients suitable for transfer to the inpatient psychiatric ward.
      b. Patients not requiring inpatient psychiatric care should have any legal holds removed and have outpatient mental health care arranged, as appropriate.
         i. Patients who are eligible for discharge from acute

medical/surgical care and do not require inpatient psychiatric care should not, by definition, be on a legal/behavioral hold.

ii. Patients not requiring inpatient psychiatric care but needing subacute, skilled nursing, or custodial care should not be on a psychiatric/legal hold.

c. Disputes regarding appropriate placement of these patients that cannot be resolved by the attending physicians involved should be adjudicated by the service chiefs, the Medical Officer of the Day, or the Chief Medical Officer, in that order.

II. CRITERIA FOR PLACEMENT OF ACUTE MEDICAL/SURGICAL INPATIENTS ON LOCKED PSYCHIATRIC WARDS

A. Exclusions: Certain conditions preclude placement on the inpatient psychiatry ward regardless of the patient's psychiatric issues and these are:

1. Need for telemetry, cardiopulmonary monitoring, or SDU/ICU level of care.

2. Indwelling lines, catheters, or removable devices including any intravenous catheters, oxygen cannulas, and urinary catheters.

3. Patients requiring medication adjustments, blood draws, or other nursing interventions for non-psychiatric issues more than once per shift.

B. Patients requiring acute psychiatric management, without the exclusions listed above, should be discussed by the attending physicians of the primary inpatient service and the Psychiatry service for possible transfer. Disputes that cannot be resolved at that level should be adjudicated by the service chiefs, Medical Officer of the Day, or Chief Medical Officer, in that order.

1. For patients transferred before "medically clear," the notes should clearly document the remaining work-up/treatment required and the reason for early transfer.

2. The Medicine consult service, and any other appropriate consulting services, should be notified in order to provide continuing care on the inpatient psychiatric unit.

3. Patients may be transferred back to the open Medical inpatient ward at any time if exclusions listed above develop.

References:	
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