Admission Criteria for Center for Psychiatry Medicine (CPM)

Patients benefit from Psychiatric admission when they can physically participate in group activities on and off the unit. Patients too medically ill to leave a medical unit will be co-managed by intensive case management (daily psych consult) on the medical unit.

Before patients are transferred to CPM from the hospital or ED, Highlands ED, Freestanding ED or acute care setting *a physician-to-physician handoff call must take place*. Attending physicians in the ED Department have Direct Admitting Privileges to the Geriatric and Adult CPM Units. For Hospital transfers, CPM attending and nursing may elect to go assess select patients within 1 hour of call. Nursing is not to take transfer report until team has approved the transfer.

Transfers from acute care services across the UAB system are considered "medical cleared for CPM" when their condition has met an ambulatory level of needs, i.e. the patient would be discharged if not going to the psychiatry service. Accepting CPM services are encouraged to consult the hospitalist *consult team at time of admission* for ongoing management of any chronic conditions, and to reduce need for emergent calls when staffing is less available. Problems with hospitalist APP consult teams should have low threshold to escalate to service attending.

Patients admitted from the ER require:

- ***Resulted labs for age >65 or medical indication that influences disposition (i.e. patient unable to give history, intoxication, active medical complaint/condition, abnormal vitals, new psychiatric condition, altered sensorium/cognitive status)***
- Complete physical and neurologic exam
- Resulted EKG
- UCG, ETOH level and UDS when indicated
- Ordered: UA, CBC, BMP, Mg (especially patients with alcohol use disorder and/ or cardiac history); *must be resulted when medical indication* or when patient can't give history
- Head CT/MRI for acute mental status change, newly abnormal neurological exam, >55 & history of head injury within 2 months

Geriatric Population: For patients >65 years old:

- Resulted EKG, UA, CBC, BMP, Mg, Pulse ox
- Chest x-ray as indicated by vitals and labs and in confused, psychotic patients or if history of cardiac or respiratory disease
- Insurance for psychiatric admission should be verified prior to sending patient to unit (guidelines at end of document)

Conditional laboratory *requirements*:

- INR if on Coumadin
- LFTs/NH4 if suspicion of liver abnormalities
- Drug levels if taking: Valproic Acid, Lithium, Digoxin, Theophylline, Carbamazepine, Phenytoin
- If Overdose or suspicion of OD: Acetaminophen level, salicylate level, CK
- CK if acute physical injury, found down, or history of prolonged walking/activity

Exclusions for admission to CPM (for safety purposes):

Acute altered mental status changes, *especially* if no psych history
- Delirium, confusion
- Recent head injury
- Rule out CVA

- High risk for Delirium Tremens or complicated sedative withdrawal (suggested guidelines below)
  - CIWA scores objectively and consistently suggestive of severe withdrawal
  - VS: SBP>180 and/or DBP>110 or heart rate >110 w/o treatment)
  - Alcohol levels above 300 with minimal impairment, withdrawal symptoms with alcohol level over 150, prior DTs /complicated withdrawal/ withdrawal seizures, confusion, dehydration, electrolyte imbalance,(low Na, K, Mg, hallucinations

    Note: Remote history of DTs only and recent clinical pattern of straight-forward detox on oral medication is not an exclusion factor. Exceptions may be made for business hour transfers following a direct discussion with Dr. Lane

- Unavailable medical needs/unsafe equipment needs:
  - Telemetry, negative pressure rooms
  - New onset requirement for continuous oxygen
  - Heavy medical equipment,
  - IV tubing**
  - BPAP**
- Intensive Nursing Care items (distract from psychiatric/safety care provision)
  - Tracheostomy Care (*unless patient can reliably perform independently)
  - Continuous IV drip (blood products, heparin)
  - NGT, DHT, PEG, Central lines, PICC lines (unless for chronic access) (Hep Lock okay)
  - Quadriplegia (*unless patient can perform most of ADLs independently)

- Unstable medical conditions:
  - Highly contagious conditions
  - Infection: WBC >15 and left shift, fever >100.5(WBC>10, fever >99.5 for geriatric), or combination of: RR>22 ,SBP<100, acute MS change
  - EKG: ischemic changes or QTC > 500
  - Sickle cell crisis
  - Acute renal failure requiring dialysis, unstable CHF
  - Oncologic conditions requiring chemotherapy
  - Large non-healing wounds

    Note: or chronic conditions exceptions may be made following physician-to-physician agreement)

- Significant Lab abnormalities (****note: if corrected in ED underlying medical condition needs to be addressed <u>with ongoing treatment recs made prior to admission</u>***)
  - CK 5000+ or **not** trending down or with elevated creatinine.
  - Sodium: <130 or >150
  - Blood sugar > 300.

- Potassium <3 or >5 (if Mg and K+ repeatable consider admit to CPM with appropriate ongoing management recommendations)
- Creatinine ***acutely*** elevated (Within 48 hours .3 above baseline or <u>>1.5 times baseline</u>

  Note: Patients with higher creatinine that are producing adequate urine and discharge ready can have creatinine followed by consults on psychiatry service

- Hgb < 8 or acute changes in Hgb
- ETOH>300 and history of DTs or withdrawal seizures

- Abnormal Vital Signs: ***(Note: if corrected in ED underlying medical condition needs to be worked up and addressed, with recs made prior to admission***)
  - SBP < 80 Diastolic < 40
  - Malignant hypertension: SBP >180 or DBP>120. Admission can be reconsidered if BP is reduced, underlying medical causation addressed, labs and UA are negative, and patient is not symptomatic (i.e. SOB, chest pain, confusion, headache, dizziness, numbness, blurred vision).
  - Respiratory rate >24
  - Heart Rate < 45 or > 110.

  Note: If vitals are stabilized and condition is stabilized an oral agent should be recommended prior to admission to psychiatry. Underlying conditions contributing to abnormal values above should be assessed and stabilized with appropriate ongoing management recommendations prior to transfer

- Stable Chronic Behavior disruption in absence of Acute Psychiatric Condition
  - Intellectually disability (formerly Mental retardation)
  - Stable Neurocognitive Disorder (i.e. Dementia, static encephalopathy)

- Prisoners who require observation by a guard as armed guards are not allowed on the units
- Anyone that is to remain handcuffed or shackled.

<u>Available in CPM</u>
- Nebulizers.
- CPAP.
- Intermittent oxygen, < 3 Liters. O2 sats >90% on room air
- Regular Dialysis
- Support for wound care or IV access care when patient can manage independently

****<u>Exceptions may be made with approval by accepting attending and nurse manager for the following:</u>**

- Medically stable, completing a course of IV antibiotics
- Medically stable with chronic, *self-managed*: PEG tube, PICC line NGT, DHT Wound Vac, inability to eat solid food
- Independent functioning with Quadriplegia
- IV bolus treatment

Admission to CPM Adolescent Unit (5South)By Approval of Child Psychiatry only:

Given the design of this unit, there are only two single rooms: room C551 and room C564. One is at the end of a wing where male patients are clustered and the other is at the end of the wing where female patients are clustered. Patients whose acuity is such that they cannot share a room with another patient should be admitted to one of these two rooms. These are also the only handicap-accessible rooms. Barring an exceptional circumstance such as ED boarding, the two single rooms need to be considered as one for a male room who cannot share (in the male area), and one for a female room who cannot share (in the female area). Placing a male who needs a single room in the female wing of the unit or a female needing a single room in the male wing of the unit can only occur with the approval of the child and adolescent psychiatry attending during the day and with the on call child and adolescent psychiatry attending during the evening or weekend.

- When a patient who needs to be in a single room is referred for admission and there is a patient in one of the single rooms who could be transferred to a shared room, that room change should occur so that the youth needing to be in a single room can be admitted.

- When patients present for admission who can share a room, and there is a bed available in a shared room, they can be admitted to a shared room. However, if one of the rooms that cannot be shared is available a new patient who could share can go in that room. However, if a single room that cannot be shared is subsequently needed for a patient who cannot share (either one that is to be admitted or one already on the unit whose acuity heightens), then the patient who can share who is in the room that cannot be shared should be moved to a shared room to accommodate the new patient who cannot be shared. Similarly, patients in need of admission who could share a room but a shared room is not available should be admitted to one of the two single rooms.

Given the restrictions of the physical layout of the unit, the decision about whether a youth in the UAB ER can be safely managed on the CPM Adolescent Unit and hence can be accepted for admission should be made solely by the evaluating psychiatry resident or attending in conjunction with the child psychiatry fellow or attending. Referrals of adolescents from outside hospitals are reviewed by the Child Consult Service during the day and the Child psychiatry attending during evenings, weekends and holidays.

Examples of patients who are not appropriate for shared rooms and should be directed to single rooms include:

- Agitated psychosis or mania
- Uncontrolled intrusive behavior
- Established history of inappropriate sexual behavior
- History of sexual assault or predatory behaviors towards others