Guideline for Assessment of Medical Stability in Adult ED Patients Needing Psychiatric Evaluation and/or Transfer to PES

GOALS/OBJECTIVES

- To provide the best possible patient centered care to those needing psychiatric care.
- To describe and streamline the process for assessing medical stability in UNMH Adult ED patients requiring psychiatric evaluation and/or transfer to PES for continued care.
- To describe absolute and relative exclusionary criteria for sending patients to PES.

BASIC ASSUMPTIONS

- We want to provide the best care for all patients in the environment best suited to their needs.
- Ideal communication includes appropriate documentation and person to person conversations when questions and conflicts arise.
- Patients with acute psychiatric needs often have medically relevant contributing conditions.
- Medical Stability should be thought of as safe to discharge home if there were no psychiatric illness.

PROCESS FOR ASSESSING MEDICAL STABILITY IN THE ED

1. **History and physical exams should be performed on all patients presenting with mental health concerns evaluating for comorbid and contributing issues.**

2. **Diagnostic testing should be guided by patient needs and may not be required for assessing medical stability. No specific order set or list of diagnostic testing is required for all patients.**
    - Diagnostics that contribute to specific complaints or comorbid conditions can be helpful.
    - Pregnancy testing in women ages 18-50 is indicated.
    - Urine drug screens can provide a clearer picture of contributing issues and attempts to collect should be made but will not delay transfer.

3. **Acute medical conditions requiring immediate attention and intervention should be addressed prior to psychiatric evaluation or transfer as PES has limited ability to provide medical care beyond psychiatric evaluation and treatment.**
    - This stabilization does not mean patients are free from all other medical conditions, but that the patient is stable enough for safe psychiatric evaluation and/or transfer.

SPECIFIC APPROACHES FOR ASSESSING MEDICAL STABILITY FOR COMMONLY PRESENTING COMPLAINTS/SCENARIOS/HIGH RISK PATIENT POPULATIONS

a) **Suspicion for new-onset psychiatric condition or psychosis including new Altered Mental Status / Suspected Toxidrome including ingestions.**
    - Chem 7, CBC, ETOH-level, Urine and UDM are indicated, consider ASA/APAP-levels
    - ECG is indicated for ingestions and those needing multiple doses of antipsychotics
    - Advanced intracranial imaging should be strongly considered

b) **Unexplained Abnormal Vital Signs should trigger a larger work up for contributing organic causes.**
    - Temp > 38°C or < 35°C
      HR > 110 or < 50
      SBP < 90 or > 180 (2 separate reading at least 15 minutes apart)
      RR < 8 or > 22
      O2 Sat < 90% on RA

c) **Severely agitated patients and those requiring physical restraints.**
- Evaluate for potential underlying causes of agitation (toxidromes, intoxications, infection, metabolic derangements, withdrawal syndromes, neurologic causes).
- Use of chemical or physical restraints increases risk for metabolic derangements, delirium, and severe illnesses and/or sequalae from restraint.
- Consider **CK values** (and trend if indicated) with early fluids if safe.
- Patients receiving multiple doses of antipsychotic medications should get ***ECG*** for monitoring of QTc prolongation.

d) **Alcohol Intoxication**
- Consider Chem 7 and ETOH levels, treat withdrawal symptoms.
- Patients with ETOH ***levels > 200 mg/dL*** require ***a minimum 4 hours of Observation*** and need to be clinically stable (and interviewable) prior to psychiatric evaluation or PES transfer.

e) **Methamphetamine Intoxication**
- Consider ETOH-level, UDM, and Chem 7.
- Evaluation for comorbid conditions is warranted.

f) **Elderly Patients (>55 years)**
- Evaluate for Delirium.
- CBC, Chem7, Urine (if symptomatic or unable to discern), and ECG are indicated.
- Consider additional diagnostics as needed.

g) **Electrolyte abnormalities**
- Commonly occur in the course of evaluating psychiatric patients in the ED
- *Hypokalemia*- very common abnormality but rarely significant; for values < 3.0 mEq/L, an ECG to ensure no dysrhythmia is indicated and replacement initiated (oral is often sufficient); repeat K measurement is rarely indicated.

Patient Conditions and/or Diagnoses which are excluded for transfer to PES for evaluation and in-patient treatment

- Conditions requiring acute hemodialysis
- Active contagious diseases requiring airborne precautions such as pulmonary tuberculosis and disseminated herpes zoster
- Severe neutropenia/immunocompromise
- Conditions requiring intravenous therapy
- Blood glucose >450 or <60 or diabetes not responsive to standard medical treatment
- Conditions requiring daily specialty therapy services, including physical therapy, occupational therapy, speech therapy, and/or respiratory therapy

- Conditions requiring medical restraints to prevent ***interference with medical care*** (not for behavior/psychiatric reasons)
- Wounds requiring debridement and/or sedation; occupying more than 20% total body surface area; requiring wound devices; or those with bone, ligament and/or tendon involvement
- Hypoxia with need for oxygen supplementation over 4L nasal cannula
- Patients on comfort measures only (CMO)

Patient Conditions and/or Diagnoses which may require discussion with PES team before transfer to PES for evaluation and in-patient treatment

- Bed bound or patients requiring significant assistant with ADLs
- Unable to participate in psychiatric care due to medical problems
- Patients on hospice

BACKGROUND/GENERAL INFORMATION

- The term 'assessing medical stability' is used throughout this guideline in replacement of the commonly used term 'medical clearance' because we feel it better describes the process, avoids misleading non-standardized ideas/concepts such as 'medically clear,' and attempts to improve the flow of information between ED and Psychiatric medical teams caring for these patients.
- We recognize the importance for assessing medical stability prior to transfer to PES for psychiatric evaluation for a number of reasons- 1) a large proportion of our mental health patients have concomitant non-psychiatric illnesses which may be contributing to or exacerbating their mental health illnesses; 2) medical complaints or illnesses in psychiatric patients are often under-treated and poorly managed and may need to be addressed in the ED setting; and 3) PES is located in a separate geographic location at UNMH with limited capacity for close monitoring, access to additional diagnostic testing, and availability of medical specialists for consulting on non-psychiatric conditions and emergencies.
- By recognizing the lack of a standard definition for 'assessing medical stability,' we realize that no specific pathway, standard array of diagnostic testing, specific time for observation exist for ensuring patients are medically stable prior to psychiatric evaluation or transfer. However, we feel this underlies the importance for establishing a guideline for this process and the need to tailor evaluation and care towards each individual patient. This also increases the importance of direct communication between the ED and Psychiatric teams caring for patients so that if any questions or concerns for management arise (or interpreting diagnostic results and/or patient presentations), these are answered in real-time and by the providers caring for these patients.
- In this guideline, we attempt to address specific and commonly presenting scenarios (intoxicated patients, physically restrained patients, abnormal diagnostic results, high risk patient populations) to better standardize the approach for assessing medical clearance.
- Our over-arching goal for these guidelines is for providers (both in the ED and PES) to feel confident that when ED patients are determined medically stable for psychiatric evaluation and transfer, these patients would be ***eligible and safe for discharge if there were no need for further psychiatric evaluation and care***.