Psychiatric Admission Summary Instructions and Protocol

Policy

It is the policy of Spring Grove Hospital Center that each patient will receive an initial psychiatric evaluation by a licensed physician or Nurse Practitioner (NP) to ensure appropriateness for admission, and then, within 24 hrs, will receive a comprehensive psychiatric assessment to determine care needs. Patients admitted on Involuntary Certificates must be admitted by a psychiatrist, and not a nurse practitioner. Through a complete and comprehensive evaluation, accurate diagnoses will be established and significant problems requiring psychiatric hospitalization will be identified. The initial assessment will determine the need for additional data, the patient's treatment needs, and the care to be provided.

Purpose

1. To ensure that a comprehensive psychiatric assessment is completed in a timely manner in order to establish a psychiatric diagnosis and to identify significant problems requiring hospitalization.
2. To assign responsibility for the completion of the Psychiatric Admission Summary.
3. To establish guidelines for properly completing the Psychiatric Admission Summary.

Scope of Policy

This policy will apply to all patients upon admission.

Procedure

I. Who Completes?

A. **Monday–Friday**: For patients admitted after 12 noon on Sundays (or on holidays that immediately precede a regular workday), and before 3:00 p.m. on Fridays (unless the Friday is a holiday), the psychiatric admission summary is completed by the physician assigned to be the patient's primary treating psychiatrist. In the event that the primary treating psychiatrist is a psychiatric resident (with resident clinical privileges, only) the psychiatric admissions summary may be completed by the resident but must be reviewed and countersigned by an attending staff psychiatrist (See Section V. Subsection P below). If the assigned treating psychiatrist is unavailable at the time the patient arrives to the hospital due to an important matter, such as a hearing, the Second Call psychiatrist will be utilized to complete the "short form" admission paperwork. The typed or dictated "long form" note would still be completed by the treating psychiatrist.

B. **Weekends/Holidays**: For patients admitted after 3:00 p.m. on Fridays and before 12 noon on Sundays, the psychiatric admission summary is completed by the on-call psychiatrist (also known as the second on call or second call psychiatrist) or NP for the week ending on that Sunday. If a workday precedes a holiday, the second call psychiatrist or NP is responsible for admissions after 3:00 pm on the day preceding the holiday. If a holiday precedes a workday, the second call psychiatrist or NP is responsible for admissions that occur before 12 noon of the holiday. (This could eliminate the paragraph below.)

For Sundays that immediately precede a Monday Holiday: Since a new second call psychiatrist takes over on Mondays, the second call psychiatrist who is on duty on Sunday is responsible for completing the psychiatric assessment on any patient admitted *before* 12 noon on Sunday. For any patient admitted *after* 12 noon on Sunday, through 12 noon on the Monday, the second call psychiatrist who takes over on Monday is responsible for completing the psychiatric assessment. Monday admissions after 12 noon would be handled by the unit psychiatrist on Tuesday.
Note: The second call psychiatrist should routinely mention in their progress notes if they have dictated or typed the psychiatric assessment. This will help the attending psychiatrist know whether or not the assessment has, in fact, been completed.

III. When Completed?

The psychiatric admission summary is to be dictated for transcription by no later than **36 hours** after the patient's admission to the hospital. Alternatively, it can be typed and submitted to Health Information Management (HIM) by email for formatting. A brief note should also be entered in the chart to document completion of the assessment and to provide at least a diagnosis and initial treatment plan. It is recognized that certain clinical data called for in the admission summary format may not be available by the completion deadline, but the psychiatric admission summary is to be completed as fully as possible within the time frames noted above.

III. Medical Record Entry

The psychiatric admission summary is to be transcribed through the Health Information Management within 48-hours of submission and emailed back for final edits and signature. The completed psychiatric admission summary is to be filed in the patient's unit chart under the section labeled "admission report/history and mental status" (yellow tab). It is the responsibility of the completing psychiatrist to assure that the summary is dictated or typed and forwarded to HIM and that it is signed and placed in the medical record within **60 hours** of the patient's admission.

IV. General Guidelines

All sections of the Psychiatric Admission Summary must be completed/addressed. Avoid the use of phrases that would imply that you neglected to consider or to inquire about an entire section or subsection (e.g., avoid simply saying "no information" or "unknown").

V. Format

In the event that a patient stays less than 24 hours, the responsible physician may use the Discharge Summary Format to prepare a combined "Admission/Discharge Summary." (Any stay that is in excess of 24-hours requires both an Admission Psychiatric Assessment and a Discharge Summary.)

A. **Chief Complaint:**

Whenever possible, record in the patient's own words his/her understanding of the primary reason he/she is being admitted to the hospital.

B. **Informants and the Reliability of Each:**

List the name and/or identity of those who have provided clinical and other data used in the completion of the psychiatric admission summary. An estimation of the general reliability of each contributor should be included.

C. **History of Present Illness:**

Begin by giving the patient's age, sex, race, marital status, and admission status. (Note: For transsexual patients, give the patient's **genotypic** gender under "sex" unless the patient has had a completed sex change operation.) Describe, in narrative form, the sequence of events that led to the admission. Include a description of the patient's recent and past psychopathology that would substantiate the admission diagnosis and justify a psychiatric admission. Also describe what is known about the patient's recent treatment and treatment adherence.

D. **Past Psychiatric History:**

This section should include prior treatment as inpatient or outpatient for the current illness, as well as presence and treatment of other psychiatric conditions.

E. **Trauma History:**

Describe any history of physical or emotional trauma. If there is a history or sexual abuse, note whether it has been reported to authorities. Significant recent losses might also be noted here.

F. **Substance Use History:**

Describe the extent of the patient's consumption of alcohol, prescription drugs and illicit substances. Note any evidence of impairment related to substance use. Describe past treatment for substance abuse. Include results of pre-admission urine tox screens or blood alcohol levels if available.

G. **Somatic History:**

Provide a summary of the patient's somatic medical history and current physical status, including current medications for active conditions. Note any history of surgeries or significant injuries. Specifically note any history of head injuries, seizures, or other neurologic conditions, and the functional consequences of each. Note and describe any medication or food allergies. Document allergies/no known allergies.

H. **Social/Developmental/Family History:**

Describe any history of psychiatric or substance use disorders in the patient's family. Describe any history of pre or perinatal complications or developmental delays. Note the patient's family constellation during his/her childhood. Describe the patient's educational history, including highest level attained and the reason for premature educational cessation. Describe the patient's occupational history and current status. Note if the patient is on disability status. Note the patient's most recent living situation and its stability. Describe the patient's current social supports and significant relationships. Describe any history of legal involvement not listed in the Current Illness section.

I. **Patient Resources and Other Strengths:**

List those personal interests, strengths, and resources (at least two) that potentially improve the patient's prognosis, or which could be utilized in the patient's treatment and rehabilitation.

Typically, patient resources and other strengths include such things as the patient's interests/hobbies, community support networks (friends, family members, health care providers, co-workers), interpersonal skills, insight, intellectual abilities, as well as vocational skills. In addition, a past favorable response to psychiatric treatment would be considered a strength. List a minimum of two.

J. **Mental Status Examination:**

1. **General Appearance**: A narrative description of the patient's appearance, especially as it reflects the patient's personal organization, including hygiene, grooming, clothing, and unusual behaviors.
2. **Interview Behavior**: Describe the patient's behavior during the examination, including his/her degree of cooperation and engagement in the process.
3. **Motor Activity**: Describe the overall level and speed of motor activity. Describe any idiosyncratic movements, postures, or facial expressions, including stereotypies and mannerisms. Describe any tremors or movements consistent with Tardive Dyskinesia.
4. **Language Comprehension**: Note any difficulties with the patient's ability to understand the interviewer's questions or the interviewer's ability to understand the patient's responses that are due to language barriers.
5. **Speech**: Describe the patient's speech rate, volume, quantity, and articulation, especially as it deviates from social norms.
6. **Thought Process:** Describe the patient's speech performance, in terms of its relevance, goal directedness, clarity, and logical inferences. Include the presence of any neologisms, odd word or phrase usage, or incomprehensible figures of speech.
7. **Mood/Affect**: Describe the patient's self-reported mood and his/her emotional display. Include the intensity and range of affect and the most prominent affect displayed. If notable, include a description of the patient's emotional response to frustration. Note any occurrences of inappropriate or inexplicable affective displays including laughter.
8. **Thought Content**: Note and describe with some detail the presence of any delusions, obsessions, or prominent worries. Note the degree of preoccupation with these ideas, and their impact on the patient's behavior, functioning, or judgment.
9. **Sensory Distortions:** Describe the presence of any hallucinations, illusions, or other distortions in any sensory modality. Describe their content and their impact on the patient's emotional state, behavior, functioning, and judgment.
10. **Homicide/Suicide Risk**: Describe those emotions, behaviors, or specific animosities, whether current or past, that would make the patient a risk of physical harm to others. Describe any current suicidal ideation or self-endangering behavior. Note the patient's past history of self-harming behavior, as well as other known factors associated with suicide, that would increase the patient's current risk of self-inflicted harm. If risks are present, note the presence of factors that would reduce this patient's current risk.
11. **Cognition:** The following cognitive domains should be assessed. Also note the method or basis for the assessment
    a. Level of Consciousness
    b. Orientation
    c. Working Memory or Sustained Concentration
    d. Short term Memory
    e. Long term Memory
    f. Abstraction
    g. Insight
    h. Judgment
    i. Global Estimate of Intelligence

K. **Risk Assessment:**

A summary of factors from the patient's current and past history and current mental status that put the patient at risk of harm or community dysfunction, and that would justify the current

admission. Include SBQR-2 score and assessment of risk of harm to self and others.

L. **Summary of Findings and Reasons for Hospitalization**

M. **Diagnosis (Initial)**:

All psychiatric diagnoses must be fully consistent with the diagnostic criteria included in the DSM 5 (or its successor). At least one psychiatric diagnosis must be a non-rule out diagnosis.

N. **Initial Criteria for Discharge**:

The initial criteria for discharge should be stated in behavioral terms and should be patient centered.

O. **Initial Treatment Plan**:

List the initial orders for medications, precautions, and referrals, to address the patient's immediate needs. Note initial plans for therapy and education. Note any need for further information in order to inform the patient's care.

P. **Certification and Signature Line**:

The psychiatrist or NP who has conducted the psychiatric admission assessment should sign the completed document. *In the event that the psychiatric admission summary is completed by a resident (unless the resident has at least Category I privileges in psychiatry) then the psychiatric admission summary must be reviewed with and countersigned by a staff psychiatrist.* By signing, the psychiatrist or NP certifies that the patient requires inpatient psychiatric treatment (based upon the Spring Grove Hospital Center Utilization Review Admission Criteria). The complete full name of the psychiatrist or NP is printed under the signature. In addition, note the date that the psychiatric admission summary is signed.

Note: See also "Psychiatric Admission Summary Dictation Guide" (below).

Psychiatric Admission Summary Dictation Guide

1. IDENTIFYING INFORMATION:
2. CHIEF COMPLAINT:
3. INFORMANTS AND RELIABILITY OF EACH:
4. HISTORY OF PRESENT ILLNESS:
5. PAST PSYCHIATRIC HISTORY:
6. TRAUMA HISTORY:
7. SUBSTANCE ABUSE HISTORY
8. SOMATIC HISTORY: (*include allergies*)
9. SOCIAL/DEVELOPMENTAL/FAMILY HISTORY:
10. PATIENT RESOURCES AND OTHER STRENGTHS:
11. MENTAL STATUS EXAMINATION:

    General Appearance

    Interview Behavior

    Motor Activity

    Language Comprehension

    Speech

    Thought Process

    Mood/Affect

    Thought Content

    Sensory Distortions

    Suicide/Homicide Risk

    Insight (*based on what evidence*)

    Judgment (*based on what evidence*)

    Cognition

        Level of Consciousness Orientation

        Working (specify)

        Short Term Memory

        Long Term Memory

        Abstraction

        Global Assessment of Intelligence

12. RISK ASSESSMENT: *Include SBQR2 scores, risk of harm to self/others*

    SUMMARY OF FINDINGS AND REASON FOR HOSPITALIZATION
    PROVISIONAL DIAGNOSES:
    PRIMARY PSYCHIATRIC DISORDERS

    PERSONAL DISORDERS

    SUBSTANCE-RELATED DISORDERS

    OTHER MEDICAL CONDITIONS

    INITIAL CRITERIA FOR DISCHARGE

    INITIAL TREATMENT PLAN:

    CERTIFICATION AND SIGNATURE:

    _____
    Attending Psychiatrist

Approved by

12/28/23__
Monica Chawla, M.D., FAPA, Date
Chief Medical Officer

12/28/23__
Marie Rose Alam, M.D., FAPA, Date
Chief Executive Officer

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