

**BHC Alhambra Hospital
POLICY AND PROCEDURE**

Date Issued: September 5, 1995	Emergency Services Assessment of Patients
Date(s) Revised: 3/2002, 7/2008, 9/2012, 10/2018, 2/2020, 3/2021, 1/2022, 1/2023, 1/2024, 1/2025	
Issued by: Assessment & Referral	Section 122.2

PURPOSE:

To describe the mechanism to access information emergency care, or stabilization, or evaluation of treatment needs.

POLICY:

I. It is the policy of BHC Alhambra Hospital to provide ready access to mental health inquiries and to assure that all individuals shall have equal access to emergency treatment, stabilization, and emergency care within the capacity and the capabilities of the facility, regardless of race, ethnicity, gender, disability, age, and/or sexual orientation. This service shall be provided to all individuals seeking an evaluation screening or assessment, 24 hours a day, 7 days a week.

II. When a person presents for evaluation, or when a potential patient is seen at an off-site location by the psychiatric assessment team, an appropriate assessment will be completed. The assessment as described in the Initial Point of Contact and/or psychosocial assessment may include: Personal Demographics, high social risk case findings; Medical History/Screening information, Psychiatric History/Mental Status Exam, Initial Diagnostic Impression.

PROCEDURE:

I. Assessments are completed 24 hours a day, 7 days a week. They are primarily performed on site but may also take place on an as needed basis at other facilities such as emergency rooms by the MAT Team.

Initial Point of Contact Assessments are performed by qualified mental health professionals and Psychosocial Assessments are performed by qualified mental health professionals such as social workers, although when staff other than a social worker perform these duties, the director of Social Work or a MSW qualified supervisory staff member may be involved to oversee the quality and appropriateness of services provided. Audits are completed by the director of Social Work to examine the social needs as addressed by those interviewing patients. Assessors may be employed by the facility or

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under the supervision of a licensed supervisor at the facility. Those under supervision by a licensed supervisor may include but are not limited to; practicum, students, interns, trainees, residents, fellows and may be working toward licensing hours toward degrees that may include but not limited to: psychology, marriage/family therapy, social work.

Individuals are trained and mentored to inquire, screen, and assess those presenting and/or inquiring about treatment. In the event the individual presenting for assessment presents as increasingly emotionally unstable and/or agitated, the individual is to be taken to a consult room on a unit or behind the locked door of the dining room for assessment. Upon presentation for assessment, all belongings are immediately removed from the individual and the pockets are turned out.

The essential elements of the intake assessment an individual is trained on include the presenting symptoms; reason and circumstances for seeking treatment; maladaptive and problem behaviors; psychological and social functioning affecting psychiatric and medical status; current behavioral/emotional functioning; background history of symptoms, treatment episodes, emotional, and behavioral; current and history of all levels of care of treatment; use of community resources; current and past medication trials; current and past chemical dependency use; medical conditions, interventions, laboratory data available; infectious and contagious disease history; allergies to medications and/or food; relevant family information and family participation; allergies to food and medication; family history of mental health or chemical dependency use; living situation; school/employment status; social support; protective factors; mental status exam and mental status exam summary, and preliminary diagnostics; and reason for admission. Additional factors that are examined include but are not limited to:

1. Patient makes a direct threat (or a clear and reasonable inference) of serious **harm to self**, or has made a suicide attempt within the past 24 hours that is serious by degree of intent and impulsivity. The Columbia Suicide Severity Rating Scale is utilized to determine Estimation of Risk.
2. Patient demonstrates violent, unpredictable or uncontrolled behavior which represents potential serious harm to body or property of others or there is evidence for a clear and reasonable interface of serious **harm to others**, and there is a clear risk of escalation or repetition of this behavior in the near future.

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3. Patient demonstrates **inability to care for own age-appropriate needs** adequately, such as nutrition, shelter, or other essentials of daily living due to a psychiatric disorder, and the family/community support system cannot be relied on to provide essential care.
4. Patient has **failed treatment in a lower level of care**, or requires a diagnostic assessment and/or treatment that is not safely managed on an outpatient basis, such as medication management.
5. Disordered/bizarre behavior or psychomotor agitation or retardation interferes with the activities of daily living to such a degree that the patient **cannot function in a lower level of care**.
6. Patient's condition **requires detoxification/stabilization** in a medically monitored setting from alcohol and/or use of other substances which has compounded their psychiatric condition and treatment and/or has impaired their functioning in employment, school, finance, relationships, created legal difficulties, etc.
7. The patient engages in eating disorder behavior that is unable to be contained outside of an inpatient hospital environment. Such behaviors may include but are not limited to restricting, bingeing, purging, over-exercising, laxative abuse, diuretic abuse, and diet pill abuse.
8. The patient could benefit from a medication adjustment and requires 24 hour monitoring while medication adjustment occurs.
9. Mental Status Exam Summary: mood, affect, thought content, judgment, insight, attention, concentration, memory, and impulse control.

After the clinical data is gathered, the physician makes the final determination about the level of care and disposition. This level of care and admission or referral status is documented on the 1371 Inquiry Call/Admission Form. All those presenting for assessment are documented in the EMTALA Log.

For those individuals who are admitted, a nurse will complete a Nursing Point of Contact assessment within 8 hours of admission; a psychiatrist will complete a Psychiatric Evaluation within 24 hours of admission; and an Internist will complete a History and Physical within 24 hours of admission.

Assessment Referral Counselors, Shift Leads, Shift Supervisors, and Mobile Assessment

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Triage Team consultants are trained to gather these essential elements for completion of Point of Contact Assessments. In addition to being trained on these essential elements, they are trained on the Columbia Suicide Severity Rating Scale through the Columbia Lighthouse Project at <http://cssrs.columbia.edu/> and/or by a supervisor trained through the Columbia Lighthouse Project, earning a certification of pass and completion of the training on the CSSR-S which is retained in the file within Human Resources.

The CSSR-S is used as a standardized evidenced-based tool to examine: if an individual wished they were dead or wished they could go to sleep and not wake up; actually had any thoughts of killing self; thoughts of how this might be done; thoughts and intention to act on the thoughts; working out the details of how to kill yourself; intention to carry out this plan; every done anything, started to do anything, or prepared to do anything to end life; was this act within the last three months. With this information, staff will then determine estimation of risk and resulting actions related to admission. The Assessment/Referral Director will include in the Quality Assurance Performance Improvement indicators monitoring of each walk-in and scheduled assessments to assure a CSSR-S was completed and completed appropriately. This will be reported to Quality Council per the reporting schedule.

Persons may arrange for or receive assessments through a variety of mechanisms including the following:

A. Telephone Inquiry

Incoming calls are screened and appointments are set for specific assessment times.

When a telephone call is received requesting information about services or assessments, the call is transferred to the assessment/referral department for processing of the inquiry call. The information is documented on an Initial Referral and Information form 1371. If appropriate, an appointment is made for the person to come in the facility for an assessment. Direct admissions may be arranged for those who meet medical necessity criteria for hospitalization from a medical facility, PMRT, or law enforcement and will go directly to the admitting unit for admitting assessments and processing.

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- B. Walk-Ins: Persons who walk into the facility without an appointment and request to speak with an assessor, will have an Initial Medical Screening Exam by a Qualified Medical Personnel to determine if an emergency medical condition exists. The receptionist will notify Assessment/Referral staff about the walk in without an appointment, who will then respond with the Qualified Medical Personnel. If the person does not appear to be in a medical crisis, the Point of Contact assessment will be performed by an Assessment/Referral Clinician. If an emergency medical condition exists and the individual needs to be medically cleared prior to psychiatric stabilization, the individual will be sent for medical clearance; 9-1-1 may be utilized.

C. Involuntary Commitment

1. Emergency detentions are usually brought in by the Police Department or ambulance and have been approved for involuntary commitment.
2. Involuntary patients may also be evaluated by consultants from the Mobile Assessment and Triage Team who have examined the patient and determined he/she is a danger to self (as determined by the Columbia Suicidality Severity Rating Scale), others, and/or gravely disabled, per LPS designation guidelines.

- III. All persons receive an inquiry, evaluation, and/or assessment based on their needs which are completed regardless of referral source or payor. Some of the information may come from sources other than the person being assessed: i.e., parent, guardian, or significant other; physician or therapist; other referral source.