

PSYCHIATRIC CONSULTATION SERVICE: SPECIAL GUIDELINES FOR PATIENTS WITH DEFINITE OR POSSIBLE HIGHLY CONTAGIOUS INFECTIOUS DISEASE

PURPOSE: To provide guidelines for the behavioral health care of patients with definite or possible highly contagious infectious disease, such as SARS-COV-2, on the medical and surgical units of Yale New Haven Hospital.

BACKGROUND: SARS-COV-2 is an example of an infection that is dangerous and highly transmissible. In patients with definite or possible infection, direct personal clinical contact creates a possibility for disease spread and thus can pose risk to the patient, to other patients, and to hospital staff. This policy describes procedures for ensuring good behavioral care while minimizing such risks. Specific situations discussed here include provision of psychiatric consultation and afterhours coverage by MOD (Medical Officer on Duty), general issues in treatment and isolation, patients with self-harm risk, patients with psychosis, patients with delirium, patients with addiction issues including nicotine use, patients with anxiety, claustrophobia, or other impairment in coping in isolation conditions.

GUIDELINES:

- 1. PSYCHIATRIC CONSULTATION.** Direct patient contact with behavioral health providers requires consideration of risk and benefit balance. In some cases, psychiatric consultation may be possible without direct patient examination. This may involve discussion with medical providers, review of the medical record, and interaction with collateral information sources. Documentation should be entered in Epic using the standard consultation template or using other note format, as appropriate. In cases where direct patient examination is required, the number of clinicians with direct contact should be limited to the minimum required. In particular, additional trainees should not be involved where not clinically necessary. Where possible, telephone, ipad, InTouch, or other remote means of communication should be employed. Documentation should note why remote means were employed to protect the patient, e.g., "Phone consult was performed to minimize risk to patient" or why the patient was not directly examined, e.g., "To minimize the risk of infectious exposure to the patient, I did not physically examine or speak with the patient in-person. All recommendations are based on chart review and discussion with the primary team."
- 2. Medical Officer on Duty (MOD) CONSULTATION.** After hours, the Psychiatric Consultation Service is covered by the MOD who may be a resident in training. As with consultation during the regular day, the necessity for direct patient examination should be considered carefully. The initial step is discussion with the medical team regarding the nature of the clinical situation and consultation question. In all cases, the MOD Physician MUST discuss with the covering Attending Staff whether to proceed with direct patient examination.
- 3. GENERAL CONSIDERATIONS.** Assessment and treatment of infection such as SARS-COV-2, with needs for isolation rooming and personal protective equipment, can be anticipated to be challenging for all patients, even outside of the special circumstances below. Clear information, reassurance, and support must be provided to the patient. Careful attention to patient comfort, including treatment of pain, insomnia, or other issue, is essential. Access to telephone, tablet, or laptop allowing contact with social supports should be verified. Such modalities also will permit entertainment, video games, and other activities. Books or magazines or other items may be provided if clinically appropriate. The Clinical Nurse Specialists / Behavioral Nurse Specialists (CNS / BNS) should be involved by the psychiatric consultation team for aid with emotional support and behavioral plans.

4. **PATIENTS AT RISK OF SELF-HARM.** Patients with risk of harm to themselves may require monitoring for safety, such as by constant companion. For patients with contagious disease, need for monitoring must be assessed promptly and critically by the medical team. The Psychiatric Consultation Service will be available for discussion and aid at all times. Since placement of a constant companion represents risk of infection of the patient, companion, and other patients or staff who may be exposed to the companion, such monitoring should not be instituted for patients with minimal evidence of actual risk. The nature of the self-harm risk should be analyzed carefully, as interventions for acute suicidal intent would differ from those for elopement, non-compliance, or fall risk. Ordering a constant companion for an admitted patient should be a very carefully considered decision. Hospital policy does NOT require assessment by a psychiatrist for the discontinuation of a constant companion. Additional aspects of care for the patient with self-harm risk, as described more fully in other hospital policy documents, include removal of personal belongings, removal of unnecessary cords, tubing, medical equipment, and plastic trash bags, yellow gowning, and the use of safe eating utensils.

5. **REMOTE MONITORING.** In the absence of infectious risk, patients at suicidal risk are ordered a constant companion at arm's length distance from the patient. In the presence of infectious risk, remote monitoring is imperative. Only a minority of hospital rooms permit visual monitoring from outside the room through a glass panel (eg, NP 9 and 10). At this time, we understand that definite or possible SARS-Cov-2 will be cared for on EP 9-5 and 9-7, SL-3 and SL-4, and NP 15. Five video-monitored rooms are available on EP 9-5 and 3 such rooms on 9-7. There are no video-equipped rooms on SL-3 and SL-4. Patients with self-harm risk and definite or possible SARS-COV-2 should have a high priority for a video-equipped room. Patients at acute risk of suicide MUST be under constant observation, whether remote or direct.

6. **PSYCHOSIS.** Patients with psychosis and consequent reduced insight will present particular challenges. Efforts should be made to improve understanding and reinforce compliance. Psychotropic regimens should be reviewed carefully and optimized. In cases of acute non-compliance which might place the patient, other patients, or hospital staff at risk, administration of appropriate treatment may be required, as permitted by Connecticut law. This may include antipsychotic medications, antianxiety medications, or a combination thereof (eg, haloperidol plus lorazepam). Other agents may be indicated depending on clinical context. For example, antipsychotic or antihistaminic medications may be safer than benzodiazepines or opioid agents in patients at risk of respiratory depression in pulmonary disease. Longer acting agents would reduce need for frequent dosing. Involuntary medication hearings are not required when there is acute risk to self or others. Behavior which endangers others in the hospital, such as non-compliance with hospital isolation, could represent such a risk to others.

7. **SUBSTANCE USE DISORDERS.** All patients should be assessed carefully for the presence of substance use, as withdrawal and cravings may increase risk of elopement and non-compliance. All patients must be screened for the use of cigarettes, vaping, or other nicotine products and should be offered the nicotine patch or other replacement options as appropriate. Alcohol withdrawal should be fully treated, using scheduled and/or symptom-triggered medications, using Epic ordersets, modified if needed for clinical circumstances. Scheduled and longer-acting medications may be more appropriate than symptom-triggered protocols requiring frequent contact for reassessment such as lorazepam by CIWA criteria. Loading protocols and anticonvulsant protocols may help decrease the need for repeated dosing and the associated patient contact. Treatment of opioid withdrawal should also be treated with methadone or non-methadone protocols, available as Epic ordersets. Benzodiazepine withdrawal is not effectively treated using symptom-triggered protocols in some patients, and appropriately intense

scheduled long-acting medication regimens are indicated (note that many patients who abuse street benzodiazepines are using 10 to 15 mg of clonazepam or alprazolam per day).

8. DELIRIUM/AGITATION. Appropriate treatment of delirium, confusion, and agitation is essential, both to permit safe care for the patient and for patient comfort. Possible etiologies of altered mental function should be carefully considered and treated. Medications which may exacerbate confusion should be discontinued as possible. Environmental factors should be optimized (consider using available smart phrases), and CNS/BNS staff consulted as needed. Medications for delirium/agitation should be considered: where agitation and non-compliance may result in acute risk to the patient and those around the patient, the balance of risk and benefit mandates early and adequate treatment. Low dose neuroleptic agents may improve restlessness and anxiety (eg, haloperidol/risperidone 1 mg q 8 hours, quetiapine 25 mg q 6 hours, olanzapine 2.5 mg qHS), but all regimens will need to be titrated promptly to clinical effect. It is emphasized that scheduled and adequate dosing of long-acting agents will reduce the need for more frequent patient contact for drug administration.

9. IMPAIRED COPING. Claustrophobia, anxiety, personality disorders, or other factors could impair coping with the stress of isolation and needed treatments. It may be possible to offer support by telephone or other remote means. As noted, the CNS / BNS staff should be involved early in coordinating a response plan when the patient is in an area of the hospital covered by such staff. Treatment with low dose benzodiazepines or sedating neuroleptic agents, scheduled or prn, should be considered. Patients with dementia or impaired cognition may require more intensive care, both behavioral and pharmacological.

10. LEGAL HEARINGS. Probate court hearings regarding commitment and conservatorship are being conducted by telephone conference calls. Involuntary medication hearings are to be conducted by audiovisual conferencing. Note that the treatment team must be present for the hearing. For patients with definite or possible infection, counsel for the patient will require assistance in communicating safely by remote means with his/her client.

11. DISCHARGE PLANNING FOR SARS-COV-2-positive PATIENTS TRANSFERRED FROM Yale Psychiatric Hospital (YPH). Social work staff from YPH will be available to collaborate on discharge plans for patients admitted to medical units, as these patients may not be able to return to psychiatric units.

ABBREVIATIONS

MOD, Medical Officer on Duty (resident covering afterhours); CNS / BNS, Clinical Nurse Specialist; YPH, Yale Psychiatric Hospital

ADDITIONAL REFERENCES

Yale New Haven Health Policy & Procedures: Restraint and seclusion, effective 3/14/18

Yale New Haven Health Policy & Procedures: Suicide Risk Screening, Assessment, and Precautions, effective 11/7/19

Yale New Haven Health Department of Pharmacy: Treatment of Acute Delirium in Adults in the Non-Intensive Care Units, revised 1/17

Yale New Haven Health SBAR: Consultative Services for all ED and Inpatients, effective 3/20/20