I. **PURPOSE**: To provide guidelines for assessing patients' psychiatric needs while they are at Montana State Hospital (MSH).

II. **POLICY**: Patients' psychiatric needs will be evaluated in a systematic manner at regular intervals throughout their hospital stay. This information will facilitate prompt and accurate decision making about each patient’s care.

III. **DEFINITIONS**: None.

IV. **RESPONSIBILITIES**:

A. **Nursing staff** is responsible for notifying the licensed independent practitioner of any new admission to the treatment unit as soon as the patient physically arrives on the unit.

B. **Licensed Independent Practitioners** are responsible for assessing the patient, completing an admission psychiatric evaluation, and charting the progress of the patient per policy standards.

C. **Admissions staff** will send out a list of the patients due for recommitment no later than three weeks prior to the due date.

V. **PROCEDURE**:

A. The *Admission Psychiatric Evaluation* is performed by a licensed independent practitioner within 24 hours of the patient's admission to MSH. This report will include the following information:

1. Identifying data,
2. Chief complaint/reason(s) for admission,
3. History of present illness,
4. Past history (psychiatric, medical, substance abuse, social, family),
5. Mental Status examination,
6. Summary and Formulation,

7. ICD-10 / DSM 5 diagnoses,

8. Determination of patient strengths/assets,

9. Estimated length of stay,

10. Initial Plan for Treatment,


B. Psychiatric reassessments will occur when there are major changes in the patient's condition. Progress notes will be recorded by the attending Licensed Independent Practitioner. The frequency of the progress notes is determined by the condition of patient, but will be recorded at least weekly for the first two months and at least once a month thereafter.

The progress notes will contain recommendations for revisions in the treatment plan as indicated, as well as precise assessment of the patient’s progress in accordance with the original or revised treatment plan.

C. An Annual Psychiatric Summary will be completed for each patient on a yearly basis. This report will summarize the following information:

1. Pertinent past history,

2. Hospital course (including response to medications),

3. Medications,

4. Mental status examination,

5. ICD-10 / DSM 5 diagnoses,

6. Treatment plan.

D. An annual Dangerousness Assessment will be completed for criminally court-ordered patients in lieu of the Annual Psychiatric Summary.

VI. REFERENCES: CMS Hospital Licensure Standards – § 482.61(b).
VII. **COLLABORATED WITH:** Medical Staff, Director of Health Information, Director of Nursing.


IX. **DISTRIBUTION:** All hospital policy manuals.

X. **ANNUAL REVIEW AND AUTHORIZATION:** This policy is subject to annual review and authorization for use by either the Administrator or the Medical Director with written documentation of the review per ARM § 37-106-330.

XI. **FOLLOW-UP RESPONSIBILITY:** Medical Director.

XII. **ATTACHMENTS:** For internal use only.

A. Psychiatric Assessment Template
B. Annual Psychiatric Template

Signatures:

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