Organizational Map: Inpatient Geriatric-Psychiatric Unit

Step by step process for patient referral and enrollment into agency-specific opportunities

1a. Patient referrals are faxed to agency directly from emergency department/ hospital setting

1b. Patient referrals are faxed to agency directly from nursing home facilities

2. Referrals are received by the agency intake team and reviewed

3a. ACCEPTED, The patient is accepted following approval of medical clearance

3b. DENIED, The patient is denied based on medical concerns

3bl. Patient is referred to alternate healthcare facility for treatment

Yes → **4.** Once patient is accepted, the referral documentation is sent to the charge nurse

5. The charge nurse contacts the previous facility to confirm medical reports and further discuss rationale for patient admittance to agency

6. The charge nurse reviews prior medical records for the patient, acquires patient consent documentations and performs her own medical assessment

7. The Medical care technicians check vital signs, exact a physical body search, and perform a skin assessment on patient

8. Patient is enrolled at agency; given room number, patient identification number and personal possessions are removed

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9a. Room number is determined based on patients mental state, e.g., high risk patients are received to the suicide beds by nursing station

9b. Patient identification information includes risks as determined previously by technicians and nurse, e.g. fall risk and danger to others

10. Patient begins treatment plan individualized to the patients specific needs

11. Treatment plan is revised based on behavioral and psychiatric health

12. Treatment plan is discussed with the patient. Once treatment plan is finalized, patient signatures is requested

12a. Patient does not sign plan, patient denied signature reported — *No*

12b. Patient signs consent — *Yes*

13. A medical, psychiatric history and physical exam is performed by the nurse practitioner and psychiatric specialist. The psychiatric evaluation is completed by the licensed psychiatrist

14. The AUDIT and COLLATERAL contacts is completed by Social Services

15. The Psychosocial Assessment is completed by Social Services

16. Patient undergoes further assessment by dietician and physical therapist for diet and physical activity limitations

17. Bi-weekly clinical meetings occur with representation from the treatment team to reevaluate plan

18. The treatment plan is approved by psychiatric director and signed by the doctor, the patient, and Social Services when they are all in agreement with a plan. Treatment plans are updated every 7 days after the first 5 days

19. Patient is reevaluated for psychiatric stability. Is patient Stable?

19a. Patient is kept at agency if non-compliant with treatment plan and considered still at high risk to self or other as determined by the medical team — *No*

20. If patient is compliant with treatment plan and discharged by medical team, Social Services must complete a Risk Assessment on the patient. Review Crisis Safety Plan with patient; perform satisfaction survey with patient; Provide Medicare Rights form, and review discharge instructions — *Yes*

20a. If patient is discharged and previous facility is no longer available, the agency looks into alternate housing plans

20b. Patients receives transport to home upon discharge; a nursing facility, group home, or other location