Recovery Alberta
MENTAL HEALTH AND ADDICTION SERVICES

PRACTICE SUPPORT DOCUMENT

MEDICAL CAPABILITIES ON INPATIENT PSYCHIATRIC UNITS

Addiction & Mental Health – Calgary Zone

OBJECTIVES

- Establish consistent guidance and criteria when admitting individuals to an inpatient Mental Health and Addiction (MHA) unit in the Calgary Zone.
- Establish consistent guidance and criteria when treating physical medical conditions on inpatient MHA units in the Calgary Zone.
- To provide guidance when admitting patients for a primary mental health diagnosis and concurrent medical management. The individual being admitted will benefit from psychiatric treatment.
- Ensure the admission criteria specific to comorbid medical conditions and expectations are clearly understood allowing appropriate monitoring and responses as indicated.
- Establish the consistent approach of Section 6 in this document for individuals requiring containment due to disorder resulting in persistent impairment caused solely by an acquired or congenital irreversible brain injury, including ASD/PDD/IDD.
- Establish consistent criteria for medical support including transfers between mental health units and medical units.
- Ensure the variations in medical capabilities and site resources are considered when evaluating admissions.
- Clinical judgment may be exercised when a situation is determined to be **outside the parameters** provided in this Practice Support Document. If a deviation from this Practice Support Document is determined to be appropriate or necessary, documentation of the rationale shall be included on the patient's health record. **Refer to Section 6 of this Practice Support Document for further direction.**

PRINCIPLES

Recovery Alberta is committed to providing the highest standard of care in a safe, respectful, and inclusive environment where all individuals feel valued and supported. This practice support document is designed to guide the delivery of comprehensive medical care for individuals admitted with a primary psychiatric disorder to mental health and addiction inpatient units across the lifespan.

Recognizing the complex interplay between physical and mental health, this document supports clinical teams in addressing medical needs as an essential component of psychiatric care. While not every scenario is explicitly outlined, the principles and guidance provided aim to ensure that patients receive timely, appropriate, and effective medical attention throughout their inpatient stay. Any complex medical conditions or uncertainty regarding the capacity to deliver safe and effective comprehensive care, as

defined in this document, must be escalated in accordance with Section 6 to the appropriate leadership for individualized clinical decision-making.

Interpreting physical symptoms within a mental health setting presents unique challenges. By equipping staff with standardized criteria and supportive practices for admission, transfer, and discharge decisions, Recovery Alberta enhances both patient safety and staff wellbeing. Our goal is to deliver the right care, at the right time, to the right individuals—ensuring that physical health is never overlooked in the pursuit of mental wellness.

APPLICABILITY

Compliance with this document is required by all Recovery Alberta employees, members of the medical and midwifery staffs, Students, Volunteers, and other persons acting on behalf of Recovery Alberta (including contracted service providers as necessary) working within Calgary Zone Addiction and Mental Health inpatient units.

Patients admitted with a primary medical/surgical issue can access input from psychiatry through Psychiatric Consultation Liaison (CL).

ELEMENTS

The following make up the elements to guide decision making as it relates to admitting patients to MHA inpatient units for a primary mental health diagnosis and concurrent medical management (excluding the Eating Disorder unit). These elements will also provide guidance when assessing patients requiring transfers between mental health units and medical units.

1. MEDICALLY STABLE

1.1 LEVEL OF CONSCIOUSNESS

a) Individual is alert.

b) Drowsy or difficult to rouse if given sedation/antipsychotic medication.

c) Glasgow Coma Scale (GCS) 13 and above.

d) Unable to manage:

(i) Unexplained/uncertain reason for decreased level of consciousness (i.e.: Head injury, overdose, etc.).

(ii) Unexplained disorientation and fluctuating alertness and attention (i.e.: delirium).

1.2 VITAL SIGNS

a) Vital signs are stable.

b) No significant fluctuations from patient baseline. If outside of normal limits a conversation must occur between clinical team.

c) Individual is asymptomatic.

d) Chronic conditions are managed.

1.3 CONTINUOUS OXYGEN

a) MHA units at South Health Campus (SHC), Peter Lougheed Centre (PLC) SSU, PLC general psychiatry, Rockyview General Hospital (RGH) Unit 48 High Observation have wall oxygen. Potential admissions require consultation with the unit manager and Clinical Medical Director (CMD).

(i) If oxygen saturation (SpO2) remains stable (not fluctuating) on oxygen.

(ii) Suicidal Ideation/ Self Harm/ Homicidal Intent (with stable continuous Oxygen); requires safety planning on mental health units.

b) Unable to manage:

(i) Optiflow or Airvo devices.

(ii) High flow devices.

(iii) Oxygen needs that are fluctuating.

(iv) Desaturating quickly when oxygen flow is interrupted.

(v) High Risk patients. Refer to policy for high-risk criteria: Adult Respiratory Assessment & Oxygen Learning Module.

(vi) Unstable airway.

(vii) Increased oxygen demands without identified etiology.

(viii) Suicidal Ideation, Self Harm, Homicidal Intent (with unstable continuous oxygen - tubing); mental health can support medical unit with safety planning.

2. LINES

2.1 PERIPHERAL LINES (INTRAVENOUS) INCLUDED.

a) Intravenous (IV) Medication

(i) Monitoring standards in the parenteral monogram.

(ii) Single medication administration at a time (i.e.: antibiotic).

(iii) Intermittent infusions.

(iv) Short term continuous infusion.

(v) IV saline lock for antibiotic therapy.

(vi) May require support from medical nurse to start/replace IV site if necessary.

(vii) IV Ketamine therapy may be considered, in consultation with Nurse Educator and physician team (Adults only; PLC, FMC and RGH); refer to INTRAVENOUS KETAMINE FOR THE TREATMENT OF ADULT DEPRESSION (AMH-10-01).

(viii) Intermittent bolus for hydration.

b) Unable to Manage:

(i) Central Vascular Access Device access only.

(ii) IV Direct Medication administration.

(iii) IV chemotherapy/ Cytotoxic Medication.

(iv) Continuous infusions:

- heparin infusions,
- insulin infusions,
- naloxone infusions,
- narcotic infusions,
- blood components or products,
- vasoactive medications,
- electrolyte replacement,
- patient-controlled analgesia pumps (controlled analgesia),
- lidocaine infusions, or
- parenteral nutrition (peripheral or central).

2.2 IV FLUIDS

a) Intermittent boluses.

b) 0.9% NaCl, 0.45% NaCl, D5W, Ringers Lactate.

c) Not continuous beyond 24 hours.

d) Iron infusion may be considered.

e) Potassium infusion may be considered (refer to parenteral monogram), restricted to eating disorders.

f) Unable to manage:

(i) IV Electrolyte replacement with cardiac monitoring.

(ii) Inability to meet monitoring standards as laid out in the parenteral monogram.

(iii) 3% NaCL infusions.

2.3 CENTRAL LINES

a) De-accessed Port – require flushing every 30 days when not in use and no dressing.

(i) If patient admitted >30 days, MHA requires support from certified nurses to access port and flush.

(ii) A support plan must be made PRIOR TO ADMISSION.

b) Unable to manage:

(i) Any Medications via central line.

(ii) Peripherally Inserted Central Catheters (PICC), Direct Percutaneous or Tunneled Line and Accessed Ports – no exceptions.

2.4 URINARY CATHETER

a) If the patient has a suprapubic or indwelling Foley catheter in from the community and is a chronic condition that is managed well.

(i) Will need a plan to have a medical/surgical nurse come to the unit to exchange every 29 days and just in time education provided to staff about concerns and what to look for.

b) If the patient manages catheterization (i.e.: intermittent) independently in the community.

c) In-out catheters for urinary retention.

d) Unable to manage:

(i) New insertion of suprapubic or indwelling Foley Catheter where the patient is not yet independently managing same in the community.

(ii) New catheter for an acute presentation.

(iii) Intermittent or continuous bladder irrigation.

2.5 NASOGASTRIC TUBE (Child & Adolescent Mental Health only at SHC, ACH and FMC – due to frequency of encounter)

a) Can insert Silastic nasogastric on the unit.

b) Provide nutrition, flushes, and medications through Nasogastric Tube.

c) With support from Alberta Children's Hospital (ACH) U4, SHC U58, or FMC U32.

d) Unable to manage:

(i) suction/decompression required.

2.6 PERCUTANEOUS ENDOSCOPIC GASTROSTOMY (PEG) TUBE (Alberta Children's Hospital only)

a) Only considered with the multispecialty team for ability to manage at ACH.

b) Can have and maintain on unit if it is a long-term tube insitu from community.

c) Can provide nutrition, Flushes, and medications through tube.

d) Unable to manage:

(i) tube was recently inserted and needs dressing changes and patient is not independent with same.

3. ISOLATION

3.1 CONTACT, CONTACT/DROPLET OR DROPLET

a) Private rooms are very limited in Mental Health; private bathrooms are even more limited. Acceptance of these patients will need to be considered on an individual basis in consultation with Infection, Prevention and Control (IPC) and will be dependent on other patient demands.

3.2 AIRBORNE/NEGATIVE PRESSURE

a) Unable to manage:

(i) Airborne/Negative pressure (as patients are typically medically unwell).

- SHC has the potential for medically cleared patients requiring airborne isolation, with no additional medical interventions. Potential admissions to these spaces MUST be reviewed with leadership team (managers, psychiatrists, and directors).

  - SHC has one negative pressure room for patients 17 years old and under with available headwall. All medical interventions must fall within this Practice Support Document.

- SHC has one negative pressure room for adult patients, 18+ with NO headwall. All medical interventions must fall within this Practice Support Document.

- Only in consideration of team and in collaboration with Infection Prevention and Control (IPC).

4. COMPLEX MEDICAL/SURGICAL CONDITIONS

4.1 CARDIAC MONITORING

a) 24-hour Holter monitor.

(i) No staff training because tech applies and removes.

b) Unable to manage:

(i) Telemetry.

4.2 CHEST TUBES (NONE – EXCLUSION)

a) Unable to manage:

(i) No chest tubes can be managed on an inpatient MHA unit.

4.3 DIABETES

a) Preexisting medical condition where patient is medically stable with treatments).

b) Hyperglycemia is managed with Basal Bolus Insulin Therapy (BBIT), refer to PROVINCIAL CLINICAL KNOWLEDGE TOPIC BASAL BOLUS INSULIN THERAPY, ADULT – INPATIENT.

c) New Insulin dependent diagnosis where Endocrine is actively involved in monitoring and treating.

d) Insulin Pumps

(i) Can be considered case by case if the patient is independent with same in the community and with the GUIDELINES FOR THE SAFE MANAGEMENT OF INSULIN PUMP THERAPY IN HOSPITAL - DIABETES, OBESITY & NUTRITION STRATEGIC CLINICAL NETWORK.

(ii) This excludes patients with suicidal ideation, self harm, or homicidal intent.

e) Unable to manage:

(i) Those requiring an Insulin Infusion to manage blood glucose with infusion.

(ii) Those frequently hypoglycemic, requiring IV Direct Dextrose as a rescue.

(iii) Unstable diabetes; Diabetic ketoacidosis (DKA) and Hyperosmolar hyperglycemic state (HHS).

(iv) Patients with suicidal ideation, self harm, or homicidal intent with insulin pump requirements.

4.4 DIALYSIS

a) Mental health units do not offer dialysis treatment directly on unit.

b) Only with prearranged, confirmed appointments with Dialysis clinic and individuals' mental health is stable with ability to go on pass to attend appointment.

c) Staff education is available for post dialysis monitoring (24hrs) and urgent response if needed.

d) Nephrology team engaged with treatment team.

e) Unable to manage:

(i) Hemodialysis: new intervention and currently medically unstable. Dialysis requiring ongoing monitoring due to the acuity.

(ii) Peritoneal: New diagnosis requiring monitoring due to acuity.

4.5 EATING DISORDERS

a) This section does NOT apply to the Eating Disorder unit.

b) Concurrent psychiatric and eating disorder diagnosis.

c) Eating independently (may require monitoring; but not intensive meal supports).

d) Weight greater than 70% of standard (BMI) and no acute weight decline with food refusal.

e) Mild Hypokalemia- can be replaced with low dose Potassium.

f) Eating Disorder Vital Signs:

(i) Blood Pressure:

- Adult 90/60 mmHg or higher, asymptomatic
- Child and Adolescent 80/50 mmHg or higher, asymptomatic

(ii) Heart rate:

- Adult heart rate of 40 bpm or higher
- Child and adolescent heart rate 45 bpm or higher

g) Unable to manage:

(i) Eating disorder is primary Mental Health Disorder with no concurrent psychiatric diagnosis.

(ii) Heart rate:

- Adult heart rate lower than 40 bpm
- Child and adolescent heart rate lower than 45 bpm

(iii) Child and adolescent orthostatic hypotension with systolic blood pressure changes more than 20 mmHg.

(iv) Child and adolescent orthostatic heart rate changes more than 20 bpm.

(v) Cardiac monitoring with telemetry.

(vi) Re-feeding syndrome.

(vii) Nasogastric tube feeds or PEG tubes for adult individuals.

4.6 MOBILITY

a) Can transfer independently, or with maximum one-person assist.

b) Uses walking aides independently.

c) limited wheelchair accessibility in Mental Health.

d) Unable to manage:

(i) Lifts (including portable) requiring more than one person assist.

(ii) Total care patients.

4.7 ORTHOPEDIC/ FRACTURE MANAGEMENT

a) Clear post op instructions needed.

b) Pain management controlled with oral narcotics.

c) Identified responsible physician for Narcotic pain management.

d) Vital signs stable (i.e.: no fever).

e) Physio has completed their assessment Prior to coming to Mental health unit.

f) 1 person assist.

g) Must be full weight bearing.

h) Minor frostbite.

i) Casts/splints – with pre-scheduled follow-up appointment at cast clinic & with surgeon has been identified (date/time).

j) Unable to manage:

(i) Intravenously (IV), intramuscular (IM), or subcutaneous narcotic medication administration.

(ii) Frostbite if Iloprost protocol/reperfusion protocol required or wound care required.

(iii) Aspen Collar.

(iv) Hard Collars.

(v) External fixators.

(vi) Halos.

(vii) Spinal precautions.

4.8 OVERDOSE

a) Poison & Drug Information Service (PADIS) has been consulted, if appropriate, and recommendations followed.

b) Delayed effects have been reviewed and mitigated; not expecting changes.

c) Opioids or chemical ingestions have been stabilized.

d) Charcoal has been given (when required).

e) Medically stable (Level of consciousness is alert, blood work is within normal limits or trending downwards, and vital signs have stabilized).

f) Unable to manage:

(i) Infusions running (Naloxone, Acetylcysteine).

(ii) Clinical exam (involving Psychiatric Consult Liaison) consistent with toxidrome or delirium.

4.9 POSTOPERATIVE CARE/POST SEDATION

a) Cleared by surgical team, PACU and Psychiatric Consult Liaison

(i) Must have been seen by Consult Liaison team prior to transfer.

(ii) IV support not continuous beyond 24 hours.

(iii) Sutures/staples in place with appropriate dressings and clear plan/directions for removal.

(iv) Vitals signs are within normal limits.

(v) Post-operative follow-up appointments have been scheduled (where needed).

(vi) Pain management controlled with oral narcotics.

(vii) Identified responsible physician for Narcotic pain management.

(viii) Progress/transfer note with medical treatment recommendations including lab investigations, vitals, and medication reconciliation.

b) Unable to Manage:

(i) Drainage tubes or other tubes/lines.

(ii) Intravenously (IV), intramuscular (IM), or subcutaneous, or subcutaneous narcotic medication administration.

(iii) Patients directly from PACU without prior plan in place.

4.10 RESPIRATORY

a) Inhalers via aero chamber accepted.

b) Unable to manage:

(i) Nebulizers (NONE - Exclusion).

- Nebulizers usually given because 1st line treatment (inhaler + aero chamber) has failed – resulting in increased respiratory distress. Also need continuous oxygen source.

(ii) Suctioning (no suctioning capacity on units).

4.11 SEIZURES

a) Preexisting medical condition and not a new diagnosis (diagnosed with last two years).

b) Psychogenic/Non epileptic.

c) Managed with oral medications.

d) Unable to manage:

(i) New diagnosis of seizures (diagnosed with last two years).

(ii) Uncontrolled seizure disorders, seizures are not to be managed by medication.

4.12 SLEEP APNEA

a) Home CPAP: Independent with initiation, removal, and care. No suicidal ideation or self harm and machine MAY need to be stored somewhere safe during the day as cords would be a strangulation risk.

(i) Consult with Respiratory required if available onsite.

b) Registered Respiratory Therapist (RRT) Provided CPAP: Independent with initiation, removal, and care. No suicidal ideation or self harm and machine may need to be stored somewhere safe during the day as cords would be a strangulation risk.

c) Sleep assessment for moderate sleep apnea – proactive referral.

d) Unable to Manage

(i) BiPAP including home BiPAP.

4.13 TRACHEOSTOMY

a) Unable to Manage

(i) No acute or chronic tracheostomies.

4.14 WOUND CARE

a) Dressings:

(i) Simple dressings, including gauze, bandages, cotton wool, non-adherent dressings, and wound healing gels and creams.

(ii) Clear wound care orders entered, or consultation is available from Wound Care Team.

b) Unable to Manage:

(i) Complex wounds where healing has been complicated by medical factors (infection, pressure, blood supply).

(ii) Wound bed contains slough, eschar, exposed fat, fascia, muscle or tendons.

(iii) Complex wounds that require comprehensive treatments such as negative pressure wound therapy or vacuum Assisted closure (VAC), wound packing, packed dressings, compression therapy, pressure management devices/offloading strategies.

(iv) Dressings that require a sterile field.

4.15 GASTROINTESTINAL (GI) / GENITOURINARY (GU)

a) If the patient has a colostomy or ileostomy in from the community and is a chronic condition that is managed well.

b) Prior to admission orders, a plan to address care and just in time education provided to staff about concerns and what to look for as required.

c) If the patient manages ostomy independently in the community.

d) If the patient has a suprapubic or indwelling Foley catheter in from the community and is a chronic condition that is managed well.

(i) Will need a plan to have a medical/surgical nurse come to the unit to exchange every 29 days and just in time education provided to staff about concerns and what to look for.

e) If the patient manages catheterization (i.e.: intermittent) independently in the community.

f) In-out catheters for urinary retention.

g) Unable to manage:

(i) Ostomy that has been surgically created within the last 3 months.

(ii) Patient is not fully independent with managing all aspects of ostomy care and maintenance in the community.

(iii) Patient who was independent with care but no longer is due to worsening of medical or psychiatric condition.

(iv) Ostomy that has had any surgical interventions in the last 3 months.

(v) Intermittent or continuous irrigation/ flushing of ostomy.

(vi) Peristomal skin must be healthy with no skins of skin breakdown, infection, irritation, or ulceration present.

(vii) Ostomy with high output:

- Ileostomy with >2L output in 24 hours
- Colostomy with >1.5L output in 24 hours

(viii) Jejunostomy tubes and cecostomy tubes need a plan in place prior to admission

(ix) Rectal tubes.

(x) Rectal (Balloon or Macy), Cecostomy (requires irrigation Q3 days) or other GU/GI catheters not listed here.

(xi) New insertion of suprapubic or indwelling Foley Catheter where the patient is not yet independently managing same in the community.

(xii) New catheter for an acute presentation.

(xiii) Intermittent or continuous bladder irrigation.

(xiv) Urostomy and nephrostomy need a plan in place prior to admission

5. WITHDRAWAL

5.1 MILD TO MODERATE ALCOHOL WITHDRAWAL

NOTE: Patients that have previously required medical admissions related to alcohol withdrawal (e.g., Delirium Tremens) will **NOT** be considered for psychiatric admission from the Emergency Department. *Mental Health & Addiction is running a six-month trial of CIWA scores up to and including nineteen (19) from June 16 to December 31 2025.*

a) CIWA Score 0 – 19 and score trending downwards for a minimum of three consecutive scores **without** precipitating medication on two of the three downwards trending scores.

b) Vital signs stable, with less than 20 beats/minute heart rate elevation, and less than 20mmhg elevation in systolic BP.

c) Benzodiazepine requirements within scope of psychiatry prescribing (low-mid dosing).

d) Benzodiazepines need to be orally administered only (no IV medications).

e) Unable to manage:

(i) Severe alcohol withdrawal with CIWA Score ≥20 **or** trending upwards.

(ii) Vital signs UNSTABLE with tachycardia or hypertension.

(iii) Patients requiring ≥80 mg Diazepam per 24 hrs **or** 16 mg Lorazepam per 24 hrs. More specially patients requiring ≥40 mg Diazepam over 8 hrs **or** 8 mg Lorazepam over 8 hrs.

(iv) Patients requiring ≥3 (three) consecutive doses of Diazepam or Lorazepam.

5.2 MILD TO MODERATE OPIATE WITHDRAWAL

a) Mild or moderate withdrawal COWS Score 5 – 24 for individuals being treated with suboxone induction.

b) Vital signs stable, with less than 20 beats/minute heart rate elevation, and less than 20mmhg elevation in systolic BP.

c) Sustained resting heart rate less than 120 beats/minute over the previous 24-hours.

d) Progress/transfer note with medical treatment recommendations including lab investigations, vitals, and medication reconciliation. Note: Fentanyl is a synthetic opioid, not an opiate.

e) Unable to manage:

(i) Moderately severe or severe opiate withdrawal COWS Score ≥25 for individuals being treated with suboxone induction. *Note: Treatment should be reevaluated if ongoing high scores continue.*

(ii) Vital signs unstable with tachycardia or hypertension.

(iii) IM/IV narcotics.

(iv) Individuals' refractory to short-acting opioids or opioid agonist therapy to treat withdrawal.

6. PATIENT MOVEMENT OUTSIDE OF THIS PRACTICE SUPPORT DOCUMENT

6.1 DURING BED FLOW COORDINATOR HOURS

a) Connect with Bed Flow Coordinator.

b) Bed Flow Coordinators have standard processes to address admissions that may fall outside of this Medical Capabilities on Inpatient Psychiatric Units Practice Support Document.

c) Requests for admissions that do not align with this Medical Capabilities on Inpatient Psychiatric Units Practice Support Document must receive approval from the leadership team (including the Bed Flow Coordinator, Director, Manager, Physician, and Physician leadership) at both the sending and receiving units/sites.

6.2 OUTSIDE OF BED FLOW COORDINATOR HOURS

a) Engage Level 1 on-call manager.

b) Collaboratively address admissions that may fall outside of this Medical Capabilities on Inpatient Psychiatric Units Practice Support Document.

(i) This may include refusal of admissions of individuals with conditions outside of MHA unit medical capabilities.

(ii) The on-call manager will work with the units involved to ensure an individual is being admitted with special medical needs or supports will ensure these supports are in place before admission.

c) Requests for admissions that do not align with the Medical Capabilities on Inpatient Psychiatric Units Practice Support Document must receive approval from the leadership team (including the Bed Flow Coordinator, Dirshockor, Manager, Physician, and Physician leadership) at both the sending and receiving units/sites.

DEFINITIONS

None

REFERENCES

- Appendix A: Medical Stability Guidelines for ED Patients on a Mental Health Unit

- Alberta Health Services Governance Documents (adopted by Recovery Alberta):
  - *INTRAVENOUS KETAMINE FOR THE TREATMENT OF ADULT DEPRESSION* (#AMH-10-1)
  - *Guidelines for the Safe Management of Insulin Pump Therapy in Hospital - Diabetes, Obesity & Nutrition Strategic Clinical Network*
  - Provincial Clinical Knowledge Topic Basal Bolus Insulin Therapy, Adult – Inpatient V 1.0

- Non-Alberta Health Services Documents:

VERSION HISTORY

Date	Action Taken
October 18, 2023	Revised
March 14, 2024	Revised
March 22, 2024	Non-substantive change
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