RESIDENT ORIENTATION CAMH ED/EAU

July 5, 2017

OUTLINE

- Welcome to the CAMH ED
- What to expect on call
- Triage, Assessment and Disposition
- Medical Clearance
- Safety
- Tips and Tricks
- I-CARE and Med Rec
- Code Blue Review
- Common Referrals from the ED

WHAT WOULD YOU LIKE TO COVER?

- Clinical scenarios
- Logistical issues
- Documentation!
- Orders and Med Rec
- Morning report
- Safety

(We will address your questions during the presentation or via email this week)

THE GERALD SHEFF AND SHANITHA KACHAN EMERGENCY DEPARTMENT AT CAMH

WELCOME TO THE CAMH ED

LEADERSHIP TEAM

- ED Clinic Head: Dr. Brittany Poynter (brittany.poynter@camh.ca)
- ED Manager: Marc Greene (marc.greene@camh.ca)
- Assistant Manager and Bedflow: Jennifer Weese (jennifer.weese@camh.ca)
- Advanced Practice Nurse: Christine Bucago (christine.bucago@camh.ca)
- Education Administrator: Dr. Juveria Zaheer (Juveria.zaheer@camh.ca)

WELCOME TO THE CAMH ED

- We value the work that you do, and we strive to provide a safe, engaging, and supportive learning environment

- To book a tour before your first shift: email christine.bucago@camh.ca

- If we haven't met, please consider setting up a meeting; please email with any questions / concerns / feedback on call: juveria.zaheer@camh.ca

ENHANCING YOUR EXPERIENCE

- Additional staff psychiatrist coverage (8:30-13:00 shift, 13:00 – 21:00 shift)
- NEW: ED staff psychiatrist shift (17:00 – Midnight)
- Streamlining of integrated care pathway for agitation, multidisciplinary assessment
- Quality control for staff psychiatrists on call, morning report
- New GPU / ACU opening in 2018 on fourth floor

ENHANCING YOUR EXPERIENCE

- One urgent care entry point for Mood & Anxiety, Crisis Clinic, Youth Crisis Clinic, and Geriatric Psychiatry
- Urgent access to Slaight Early Intervention Service through the ED
- Pharmacist coverage – On Site on Saturday and Sunday from 8:00 – 16:00; until 21:00 Monday to Wednesday
- Tours of ED available at 16:30 before your first shift
- Connecting Ontario: clinical information from 11 GTA hospitals, Ontario Laboratory Information System (OLIS), and 6 Community Care Access Centres (CCAC)

WHAT TO EXPECT ON CALL

- Begins at **17:00 on weeknights** and **9:00 on weekends and holidays**
- You are one of **4 residents** on call; often **3 medical students** are present as well.
- You will receive handover about the cases in the EAU
- The **RN Team Leader** will arrange for you to hear about the cases waiting to be seen
- Morning report begins at 8:30 am on weekdays; if you are 4th call and can come back for handover, that would be great.

WHAT TO EXPECT ON CALL

- You will see and review cases with both the **1-9 swing shift psychiatrist** and the **5-midnight psychiatrist**
- At approximately 11:30 PM, the 5-midnight psychiatrist will provide verbal handover to the staff psychiatrist on call overnight
- If there are **6 or more cases** waiting to be seen, touch base with the team leader – it is his or her responsibility to call in the staff psychiatrist
- Parking passes are available – your chiefs can fill you in
- You attend to the code whites on the inpatient units, but the inpatient call psychiatrist is responsible for all non-emergent issues
- We see all patients aged 16+; if a patient under 16 cannot be redirected we will see them too.

WORKING WITH MEDICAL STUDENTS

- Please ensure that medical students leave the ED by **23:00 sharp** – even if they are in the middle of a case / documentation. This is a **key accreditation issue**
- Medical students can definitely see appropriate cases on their own and review with you thereafter; you can then go in with them to finish the assessment

WORKING WITH MEDICAL STUDENTS

- Shift 1: Observe a full interview conducted by a resident; ideally if volumes allow, ask a resident to observe the first few minutes of the interview then complete it independently. Only see cases that are CTAS 4 or 5 in the less acute waiting room.
- Shift 2 & 3: Ideally see patients independently and review with the resident or staff; may ask staff or resident for assistance in the assessment if needed. Only see cases that are CTAS 4 or 5 in the less acute waiting room, unless feeling comfortable with more acuity.
- Shift 4, 5, 6: See patients independently and review with resident or staff

AGE RESTRICTIONS

- In the past, the CAMH ED would only see clients age 16 or older
- Due to several complex logistic and medicolegal issues, we cannot refuse care to those under the age of 15
- Our nursing team is experienced in attempting to redirect younger patients to St. Joseph's or Sick Kids
- If a patient is acutely agitated or suicidal, this may not be possible – if you are asked to see a patient under age 15 please page your staff immediately and have the team contact the nursing manager to come up with a plan

THE ED TEAM

- Team Leader
- Triage Nurse
- Clinical RNs
- Social Workers
- Program Assistants
- Ward Clerk
- Pharmacist
- Security
- Hospitalist (on weekdays)

TRIAGE PROCESS

- Dedicated triage nurse each shift
- Triage is a **short risk assessment** (5-10 mins) to find out presenting problem and level of urgency
- Active triaging (levels of acuity may change)
- Most urgent need to be seen first
- **May be pulled from paper work or interview to deal with escalating situation**
- The triage nurse will give report to the receiving nurse or social worker, who will see the case and then give report to you.

THE ED MULTIDISCIPLINARY ASSESSMENT

- ED staff will aim to have part of the ED assessment completed depending on volumes/acuity
- Ensure key areas completed (ie: HPI, risk assessment, MSE, diagnosis, impression and plan)
- Collaborate with ED staff on disposition
- Get collateral information when possible

THE PSYCHIATRIC ASSESSMENT

- Move danger towards safety
- Move acute patient towards outpatient
- Move disengagement towards engagement
- Emphasize autonomy
- Stay solution-focused
- Find common ground
- Validate
- Find out what motivates the patient
- Avoid contentious issues like diagnosis or non-adherence

DISPOSITION: ADMISSION

- Your manual contains a list of all admitting units at CAMH
- EAU admission if:
  - The patient is very acute (i.e. has required restraints or seclusion) and no ACU bed is available
  - The patient is in crisis, intoxicated or withdrawing and may only need an overnight stay
  - We need more information
  - No bed is available on the appropriate unit
- For medical withdrawal – can hold in ED for eight hours – if continuing to withdraw admit to MWS or EAU (this is a flexible rule). Comorbid Opioid withdrawal is an indication for MWS if the patient is willing to start suboxone or methadone.

DISPOSITION: DISCHARGE

- Connect with their pre-existing services, GP.
- CAMH Addictions→
  - ADDICTION MEDICINE SERVICE – order is available through FIRSTNET
- CAMH Mental Health→
  - NON-URGENT REFERRALS – provide patient with ACCESS CAMH referral form to be completed by family physician.
  - URGENT REFERRALS –
    - CAMH URGENT CARE SERVICE: Includes crisis clinic, youth crisis and mood and anxiety urgent care:
      - CRISIS CLINIC- only if they do not have psychiatrist/mental health worker, if they are safe to be discharged, have no primary addiction issue and are in crisis. Patients are seen within 48 – 72 hrs of their ED visit, and have 6 sessions total.
      - YOUTH CRISIS CLINIC – for youth aged 16 – 22. Model of care is similar to the adult crisis clinic but patients are seen for up to 8 sessions, with active psychiatry involvement.
      - MOOD AND ANXIETY URGENT CARE CLINIC –Patients may have outpatient follow up in place, but are in need of urgent management. Model of care is similar to that of the crisis clinic but patients are seen by a psychiatrist at the first appointment. Patients are seen within 48-72 hrs of their ED visit, and have 6 sessions total.
      - RAPID GERIATRIC ASSESSMENT: Late Life Mood Disorders service - Geriatric Mental Health Services (GMHS)
    - PARTIAL HOSPITAL PROGRAM – they will contact the patient directly to set up an intake. Usually within 24 hours of the ED visit.
    - SLAIGHT EARLY INTERVENTION REFERRAL: ED request through firstnet

RISK ASSESSMENT IN THE ED: OVERVIEW

- Suicide is a major public health concern and the assessment and prevention of death by suicide is a cornerstone of psychiatric practice.
- 6-12% of patients who present to general EDs report suicidal ideation and individuals who die by suicide often receive care in an emergency department within one year of death.[1,2,3,4]
- In Ontario, 7% of those who die by suicide are seen in an emergency department for mental health reasons in the month prior to death and 21% are seen within a year of death.[5]

RISK ASSESSMENT IN THE ED: BARRIERS

1) A lack of dedicated psychiatric support staff
2) Limited knowledge of mental health and suicide risk assessment
3) High volumes and medical emergencies taking priority
4) Limited access to mental health resources
5) Stigma and perceived patient discomfort
6) Discomfort with specific populations, including children, teenagers, older adults, ethnic minorities or marginalized populations.[1,6,7]

RISK ASSESSMENT IN THE ED: THE CAMH ED EXPERIENCE

1) Fully staffed by mental health professionals including psychiatrists

2) Focuses on psychiatric rather than medical emergencies

3) Has access to robust mental health resources including inpatient and outpatient services.

4) A formalized suicide risk assessment tool within the ED Multidisciplinary Assessment Form: although suicide is a rare event and difficult for even the most skilled mental health professional to predict, robust evidence exists that formalized tools improve the quality of risk assessment.[8,9,10]

RISK ASSESSMENT IN THE CAMH ED: ON-CALL APPROACH

- The evidence suggests that suicide risk assessment improves with training and experience.[12,13]
- Suicide assessment tools like the one used in the CAMH ED have been shown to improve the quality of risk assessment particularly for junior trainees in psychiatry and residents in other medical fields.[13]

RISK ASSESSMENT IN THE CAMH ED: ON-CALL APPROACH

- The suicide risk assessment tool is a great framework
- Focus on: DEMOGRAPHIC, CLINICAL, and SUICIDE RELATED risk factors as well as WARNING SIGNS for suicide
- Consider the PATTERN OF SERVICE UTILIZATION, how they PRESENTED TO HOSPITAL, COLLATERAL from FAMILY and PRIOR HOSPITALIZATION
- Beware "patient at baseline" and "no intent no plan"

RISK ASSESSMENT IN THE CAMH ED: CASE EXAMPLES

A 33 year old Arab-Canadian woman brings self to ED on the advice of friends. Complex trauma history. Previously worked as engineer, unable to work for the first time over the last two months due to depressive symptoms and worsening PTSD symptoms. In bed most days.

Chronic thoughts of suicide since childhood, no history of self harm. One month ago, in context of family conflict, felt very agitated, distressed, overwhelmed – tried to run into traffic, considered jumping in front of subway.

PHQ-9 score is 24. Felt agitated and overwhelmed last night, feels like burden, strong passive SI, no active SI, no intent, no plan, but is scared that it could happen again. Help seeking. One psychiatric ED visit, saw psychiatrist three times as a teen.

RISK ASSESSMENT IN THE CAMH ED: CASE EXAMPLES

Option 1:

"No suicidal ideation, intent or plan. Chronic risk at baseline"

Option 2:

This patient has several risk factors for suicide. She is single and has a history of MDD and PTSD and a past history of suicidal behaviour. She has severe functional impairment for the first time, worsening MDD and PTSD, sense of burdensomeness. She has chronic passive thoughts of suicide and in the context of distress, had an impulsive episode of suicidal behaviour one month ago. She thinks about death constantly and the things that kept her safe in the past (her family, her work), are compromised. She is having increasing emotional lability and feels overwhelmed and out of control at times.

However, she does have several protective factors. She is not in a demographically high risk group. She is not experiencing psychosis, does not use substances, and has no history of self-harm behaviour. She brought herself into hospital and is help seeking. Although her suicide risk is difficult to predict on a moment to moment level, at this time her risk is certainly lower than it was one month ago. She is able to discuss various options and would consider returning to hospital. She was not agitated, irritable or displaying anxiety during our assessment. She does not have access to firearms at home and has discussed keeping herself safe with her roommates. She was offered admission but declined.

RISK ASSESSMENT IN THE ED: VIOLENCE RISK ASSESSMENT

- Use the same frame you use for suicide risk assessment
- The DASA (Dynamic Appraisal of Situational Aggression) score is important, and is available for all EAU clients
- Past history of violence including sexual violence, domestic violence, destruction of property
- CONTEXT for violence: Intoxication? Psychosis?
- Consider reviewing risk factors for violence: Historical, Clinical and Risk Management – 20
  - Wong L, Morgan A, Wilkie T, Barbaree H. Can. J. Psychiatry 2012; 57(6): 375-380.

ADMISSION VS. DISCHARGE

- Did you get information from more than two sources?
- What are your goals for admission? Are they reasonable / attainable?
- Can this patient be managed as an outpatient?
- Has this patient benefited from admission in the past?
- Do you need more information to make a decision?
- What do the people who know the patient best think?

OTHER HELPFUL INFORMATION

- If someone with a psychotic disorder has decompensated, and you aren't sure if it's substance related, please order a urine tox screen
- Work through a med rec with a pharmacist so you can do it well on your own
- Find a resident who has been here before to take you through the first couple sets of documentation / orders
- ORB dispositions review ED manual
- Consider ordering lower doses of benzodiazepine in the absence of agitation --- we can accidentally foster dependence

OTHER HELPFUL INFORMATION

- If you could leave a phone message / email overnight with the patient's team, we really appreciate it!
- You can't transfer to YOUTH CONCURRENT – you have to discharge first and then admit. If you transfer to MED WITHDRAWAL they have their own admit order set.
- The CAMH ED printer is THE WORST. Try to set them up when you have some downtime, or at the beginning of your shift.

MEDICAL CLEARANCE AND REFERRALS FROM MSH

MOUNT SINAI PARTNERSHIP

- We act as MSH's psychiatric consultation service and they provide us with medical support
- They will manage ALL MSH ED psych pts if bed available (or will be in 4 hrs) on 9 South until 2100 on weekdays
- If you are admitting someone to 9S (MSH) – there is a paper order set to complete; if you transfer to MSH from EAU, it's a discharge order and discharge note.

RECEVING REPORT FROM MSH

- Please complete a pre-arrival note in FIRSTNET
- If you think the patient doesn't need a psych assessment, we can deal with it the next day. If you think the patient isn't medically stable, discuss your staff on call and remember you can always send the patient back.
- Important points:
  - Legal status (is there a copy of the F42 on the chart?)
  - Have they received medication for agitation?
  - What investigations have been done?
  - What are they hoping for / how do they feel about the transfer?

MANAGING MEDICAL ISSUES

- In an EMERGENT, time-sensitive situation (chest pain, suspected CVA, unstable vital signs) – call 911. We can request MSH, but no guarantee. Call ahead to the receiving hospital – if it's MSH, send over a med clearance form via fax or with paramedics if you have time
- In an URGENT situation, the patient can be transferred via voyageur or cab
- In an NON-URGENT situation, you can hand over any issues to Dr. Logan, our hospitalist, who attends morning rounds
- **The MSH ED docs are very happy for you to call them to consult if you need advice**

PROTOCOL FOR MSH TRANSFER

- Determine reason for medical clearance and any specific tests (if necessary), and complete the Medical Clearance Transfer Form available on Firstnet.
- A decision must be made at this point about whether to certify the patient.
- Phone MSH ED and speak with the physician about your reason for requesting Medical clearance.
- A PA accompanies all patients for medical clearance.
- Acutely agitated patients, or those with other risk factors, can be transferred by ambulance or Voyageur. Otherwise, the patient can be sent in a taxi.
- Original Form 1 and Medical Clearance form is sent to MSH with copies kept in the College ED patient chart.

PROTOCOL FOR MSH TRANSFER

- Please review the CAMH/MSH memorandum of understanding, located in the appendices of the ED manual

CODE BLUE

- Please watch the CAMH Code Blue video tutorial, available on insite
- Most common Code Blue presentations: decreased LOC, seizure / pseudoseizure, chest pain, self harm behaviour
- REMEMBER that if you call 911, please give the receiving hospital a call and send documentation if you can! It is always very much appreciated and improves patient care

SAFETY

YOUR SAFETY IS OUR #1 PRIORITY

- Lowest restraint and seclusion rates in Ontario
- Highly trained team and milieu built with safety in mind
- Program assistants and security team available
- Please do not ever see a case on your own if you don't feel safe; please do not stay in an assessment where the patient is displaying early signs of agitation
- PLEASE CALL OR EMAIL JUVERIA ZAHEER IF A SITUATION ARISES WHERE YOU DID NOT FEEL SAFE OR SUPPORTED.

ENVIRONMENTAL FEATURES

- Panic Alarms (Hard wired and personal alarms)
- Weighted/bolted furniture
- Monitored security cameras
- Interview Rooms
  - – swinging door (latch), double egress
- Mirrors in hallway
- Lexan Glass windows in nursing station
- 2 Restraint Beds ready at all times
- Seclusion Room

WORKING ON A TEAM

- Discuss with team whether you should interview accompanied by staff (agitated patient)
- Security stand-by PRN
- Choose the appropriate interview space (waiting room?)
- If you are concerned a patient may escalate, clear the waiting room, have staff support (i.e. notify security and team members), have a restraint bed ready, have seclusion room ready
- Check in with each other at the beginning of shift to understand each others' experience!

CALLING A CODE

- Dial 5555 or press hardwire panic alarm
- Alert team
- If possible, move patients not involved in code
- Clinical Assist (not calling overhead)

RESIDENT ROLE IN CODE WHITE

- Review the chart, order medication
- You are not expected to participate in the physical restraint event; that said, if you are comfortable doing so and can do so safely, it is appreciated by the team

WORKING WITH POLICE

- Goal is to have responsibility for patient transferred as *quickly* and *safely* as possible
- MD involvement not necessary (but often helpful)
  - If you want input from police, you need to let front line staff know and make yourself available
- Police should not be expected to provide patient supervision for longer than is necessary for handover
- Involve security early if necessary

LEAST RESTRAINT POLICY

- Effort to reduce frequency and duration of restraints
- Chemical restraints
  - Tendency to be reactive (given *after* patient placed in mechanical restraints)
  - Tension over doses (nurses want higher doses, some residents reluctant)
  - Need to balance risk
    - Risk of receiving high doses (sleep)
    - Risk of not receiving adequate doses (safety)
- Need to know patient history

  See our Integrated Care Pathway to guide your management

COMPLETING FORMS / ORB DISPOSTIONS

- Your ED manual contains valuable information on all the CAMH inpatient units, how to complete a F1, F3 and F33, and how to manage ORB clients.

HOW TO ~~SURVIVE~~ THRIVE IN THE CAMH ED

TIPS AND TRICKS

1. Work as a team – check in with each other, and the team leader run the board, be proactive, support each other
2. Save time where you can – have your medical student get collateral, document concisely, keep your assessments focused
3. The old chart (and connect ONTARIO) is your best friend – reviewing the last ED visit, the last discharge summary, the last outpatient note, and EAU nursing notes saves you +++ time
4. Triangulate data: information from multiple sources is key
5. Do quick things quickly – see a patient at triage with the triage RN and police; get someone going from less urgent
6. Your manual has a lot of information – including F47, F49, F2 procedures
7. You do not need to order bloodwork except for a urine tox if you think it's indicated. Everything else can be handed over to Dr. Logan in the AM.

HOW TO MAKE YOUR LIFE EASIER (FROM LETITIA, RN)

1. Familiarize yourself with the team leader and the key players...this includes RN's, Program Assistants, social workers.

2. Be willing to collaborate with staff, including attendings, RNs, PAs and social workers.

3. Introduce yourself at the beginning of the shift so that everyone is not only aware of your role, but also your limitations in the ER.

4. Letting RN staff know if you are leaving the unit for a period of time, being flexible.

5. When handover is given to a resident by an RN or social worker, please liaise with the person from whom the report was received to discuss disposition.

6. Take time for self-care, including eating, making time for lunch and dinner.

7. Inform nursing staff the call room number you will be taking and who the next resident "up" will be.

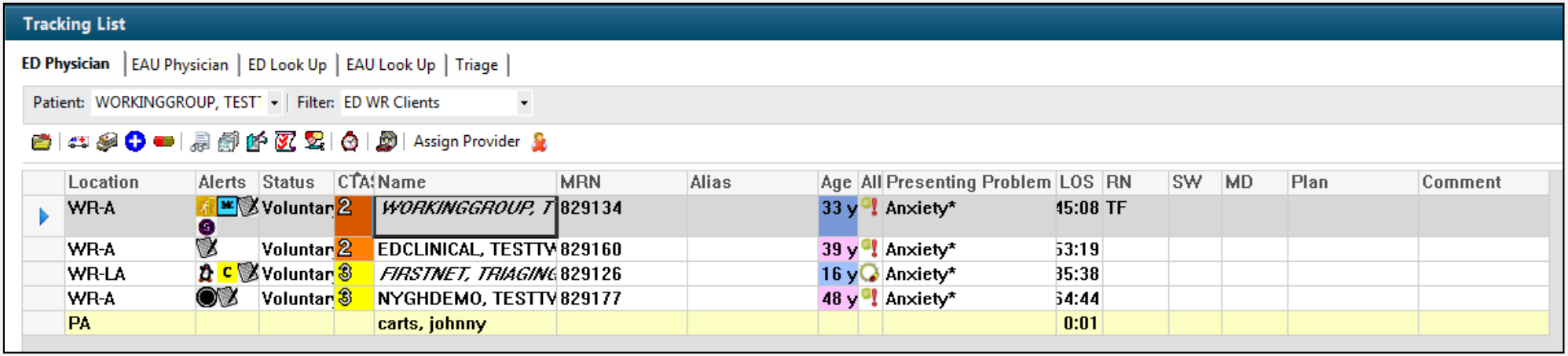
8. Leave cell or pager number and which one you prefer to be used.

OPPORTUNITIES FOR RECOGNITION

- ED Interdisciplinary Professionalism and Collegiality Award
- Masters of Interprofessional Education Award for Allied Health Team

I-CARE - FIRSTNET: DOCUMENTATION, ORDERS AND MED REC

FIRSTNET PHYSICIAN TRACKING LIST

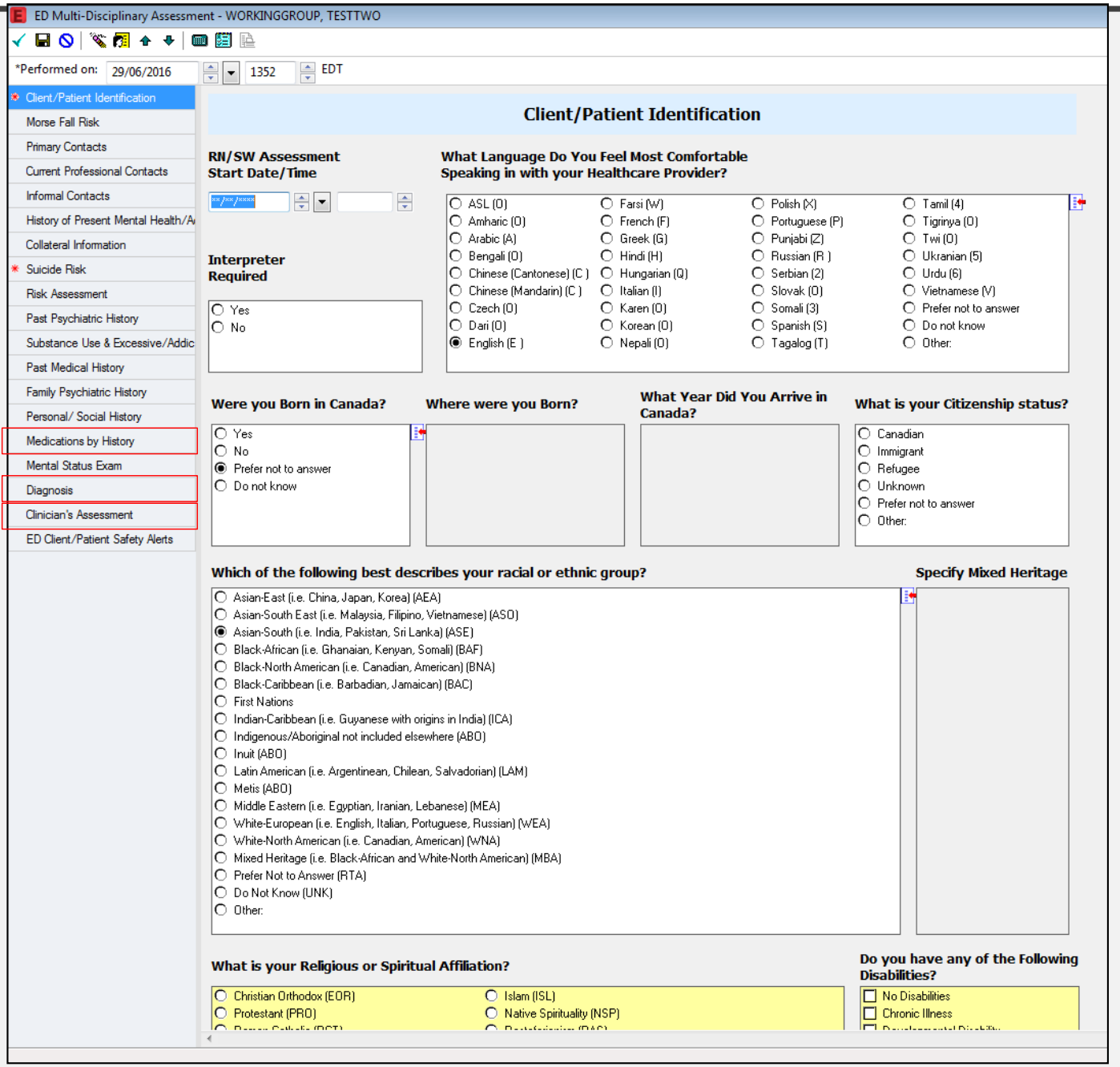


ED DOCUMENTATION

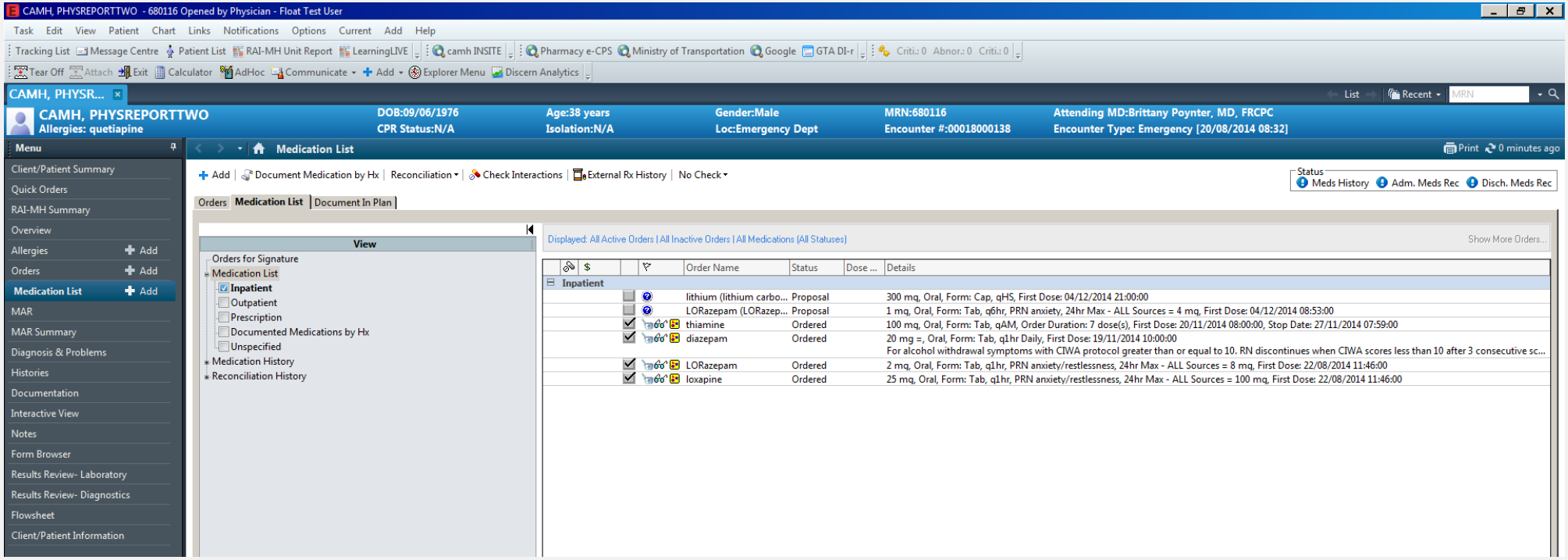
Includes:

- Multidisciplinary Assessment (powerform)
- Medical clearance form
- Depart Process (client summary and clinical summary)
- Pre-Arrivals
- Simplified Inpatient Progress Note (Dynamic Doc)
- EAU Discharge Note (Dynamic Doc)
- Transfer Note (Dynamic Doc)
- Legal forms (paper)

ED MULTI-DISCIPLINARY ASSESSMENT



DOCUMENT MEDS BY HX



ED MULTI-DISCIPLINARY ASSESSMENT

Disposition Date/Time **/**/****

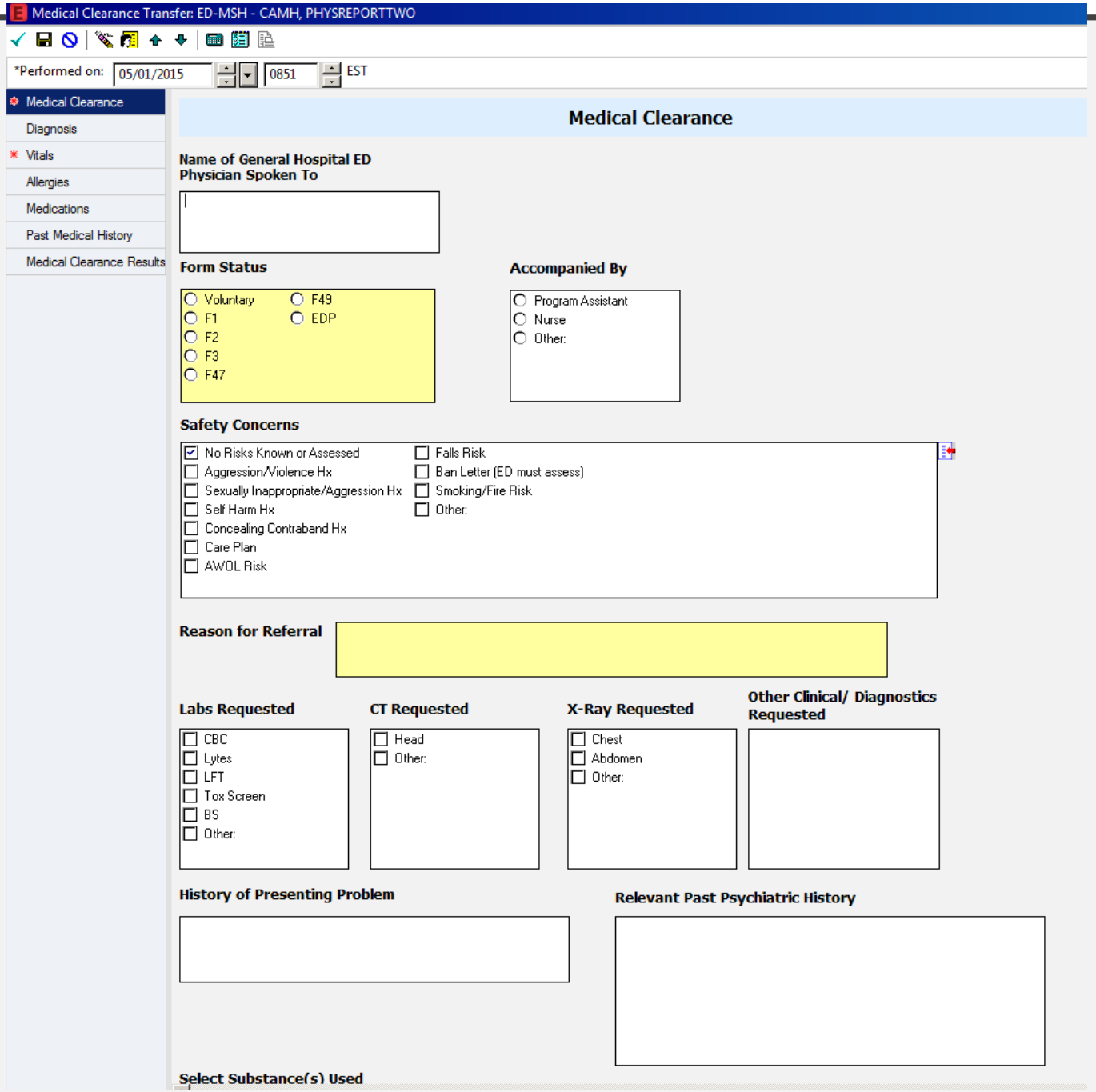
Physician Assessment Start Time **/**/****

Physician Assessment Stop Time **/**/****

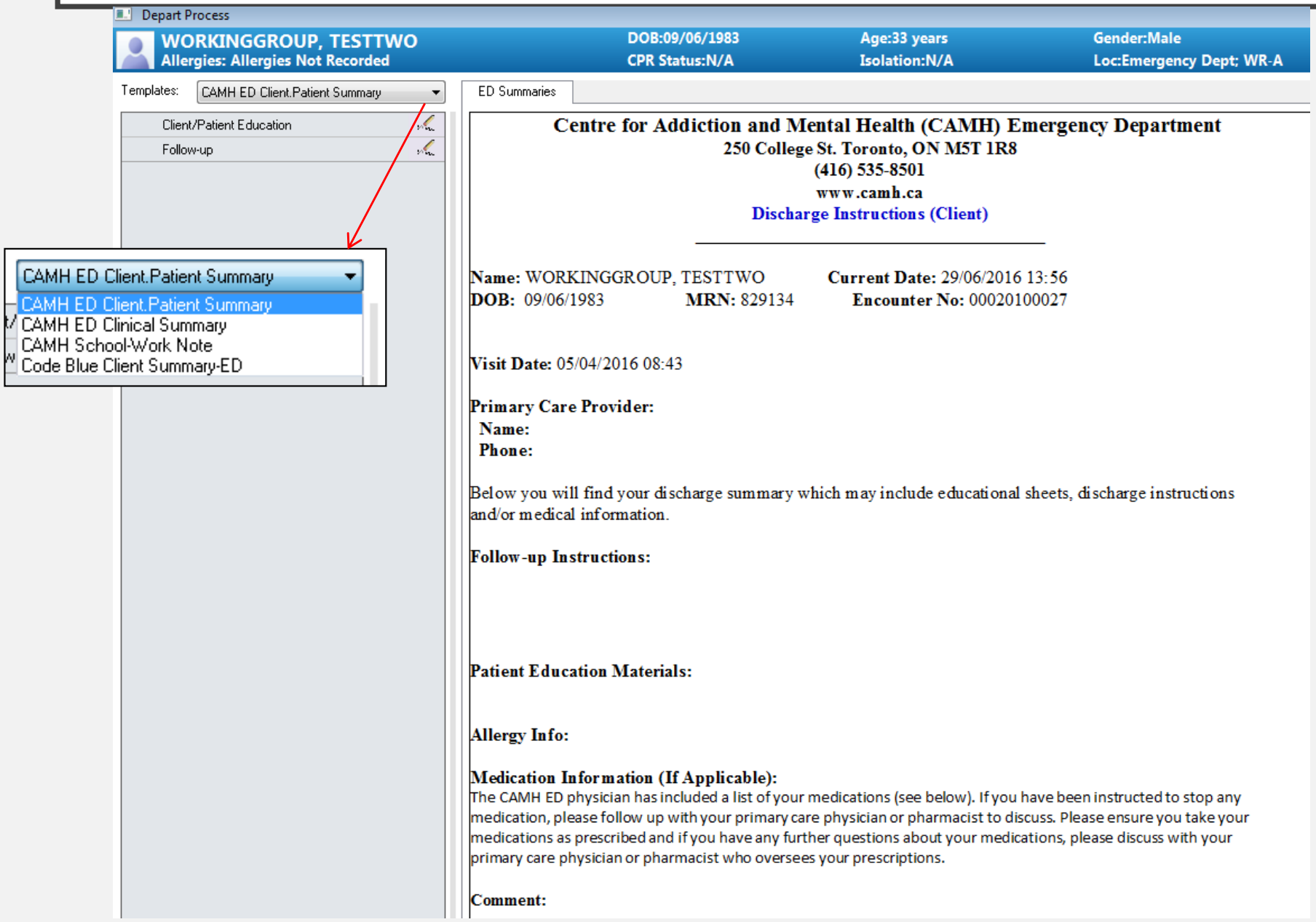
Case Reviewed With Dr.

Time Case Reviewed **/**/****

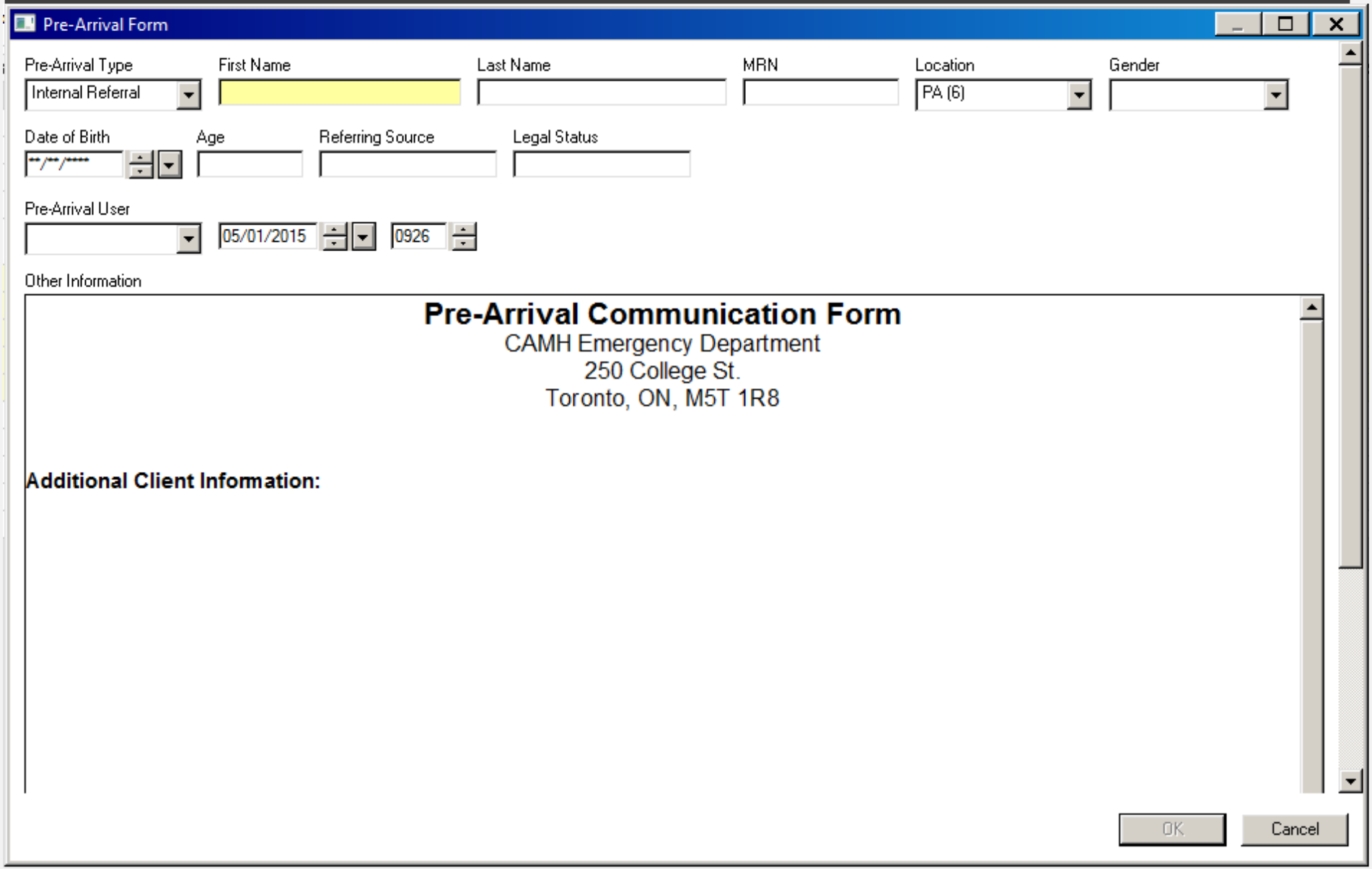
MEDICAL CLEARANCE FORM



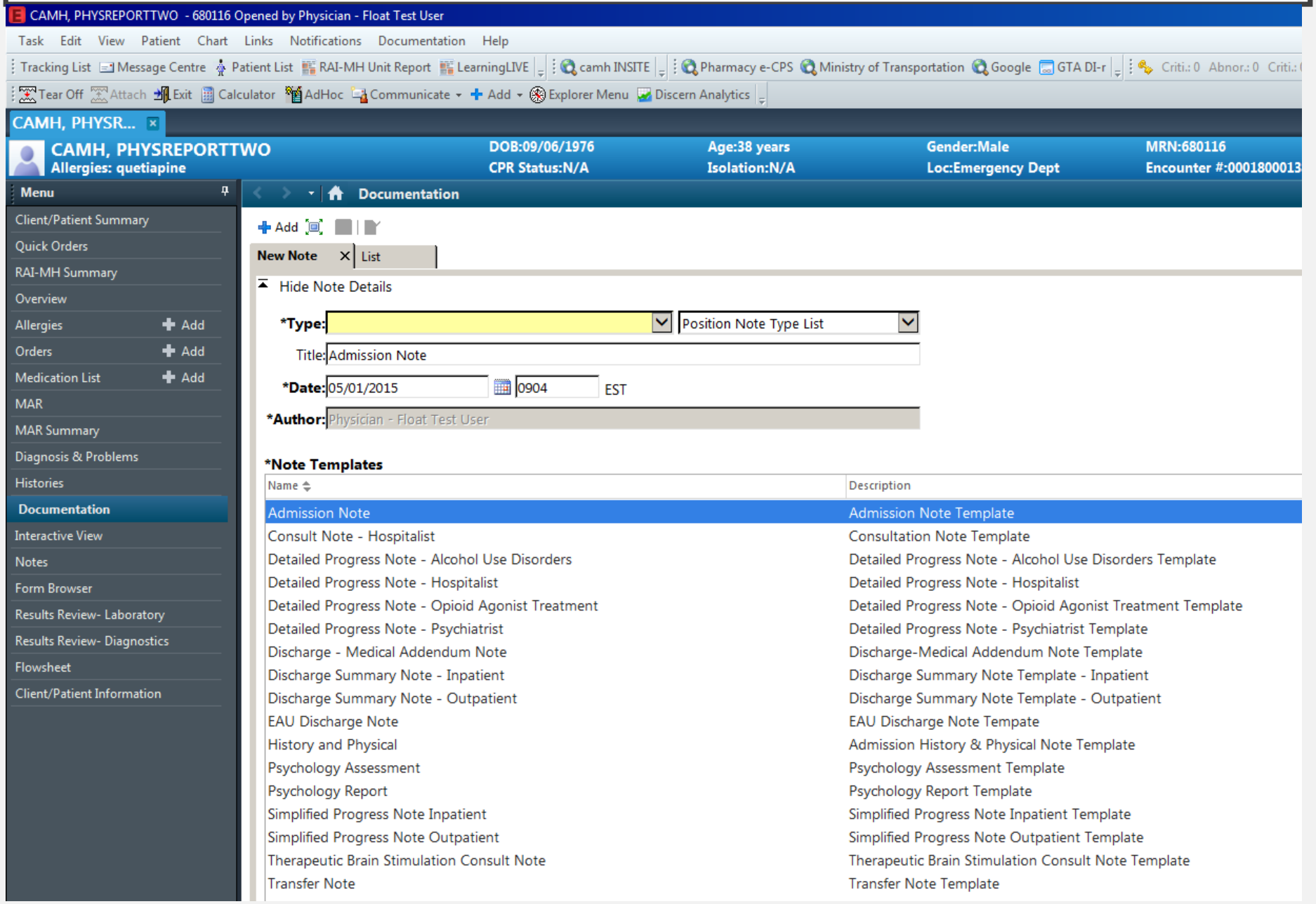
DEPART PROCESS



PRE-ARRIVAL


Pre-Arrival Form
Pre-Arrival Type
Internal Referral
First Name
Last Name
MRN
Location
PA (6)
Gender
Date of Birth
//****
Age
Referring Source
Legal Status
Pre-Arrival User
05/01/2015
0926
Other Information
Pre-Arrival Communication Form
CAMH Emergency Department
250 College St.
Toronto, ON, M5T 1R8
Additional Client Information:
OK
Cancel

DYNAMIC DOCUMENTATION

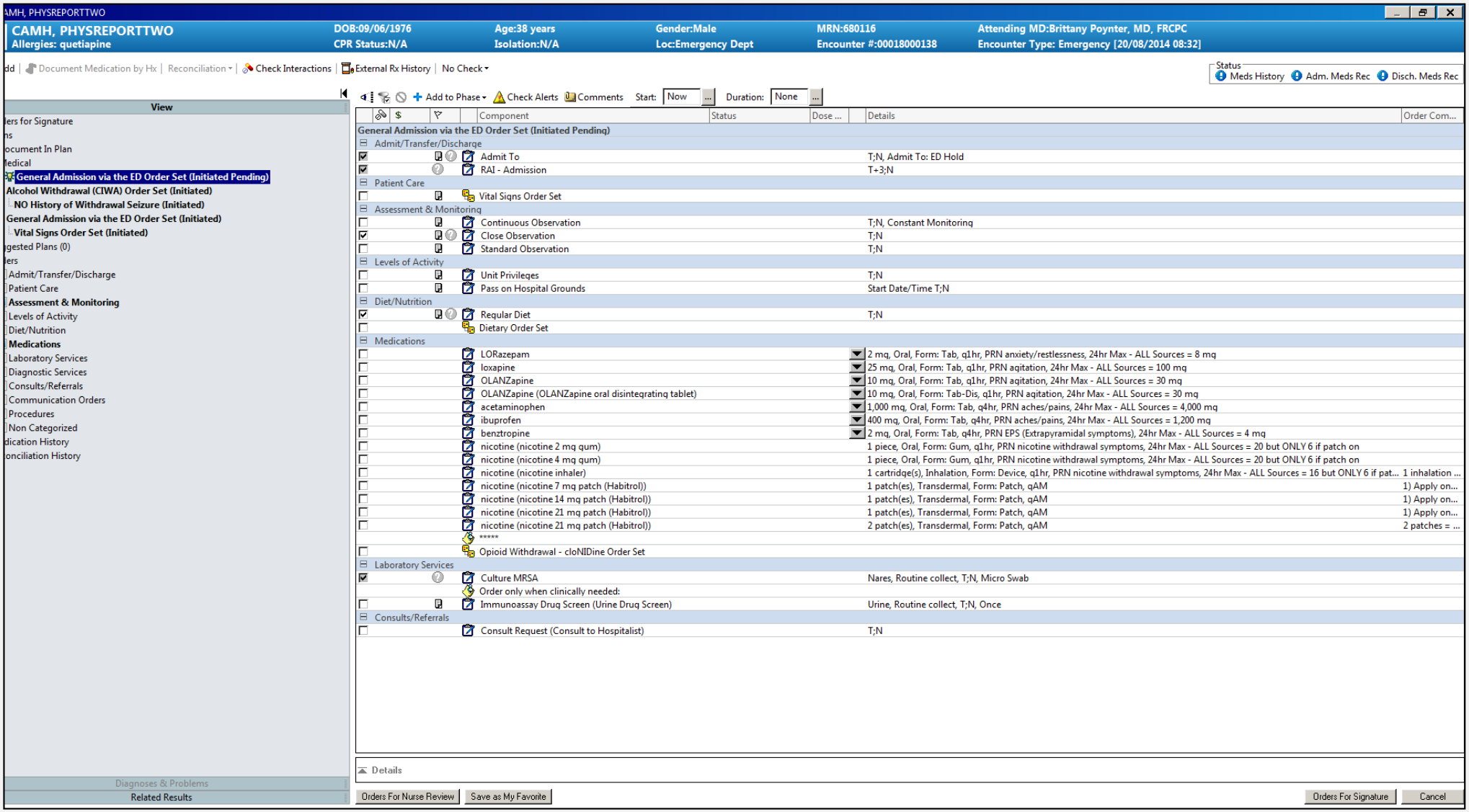


ED ORDERS/MEDS

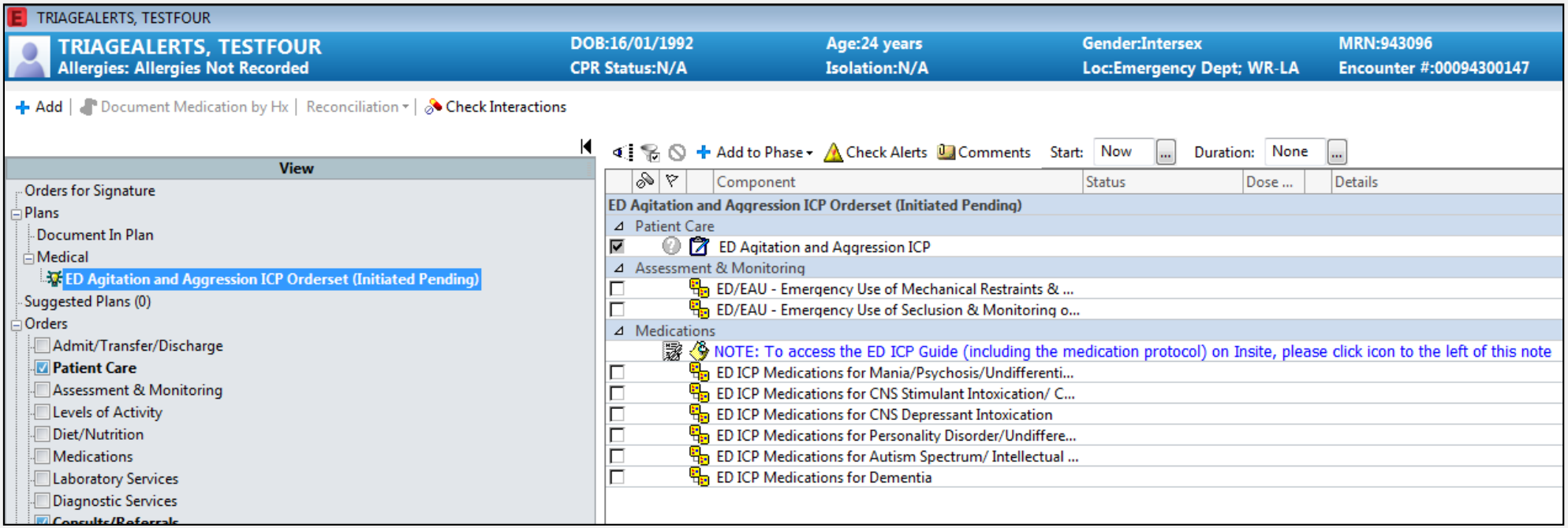
Includes:

- Documented meds by history +/- admission med rec
- General Admission via ED order set
- ED Agitation and Aggression ICP Order Set
- Meds and labs orders (UTS, serum med. Levels)
- Rx
- ED Referral Orders

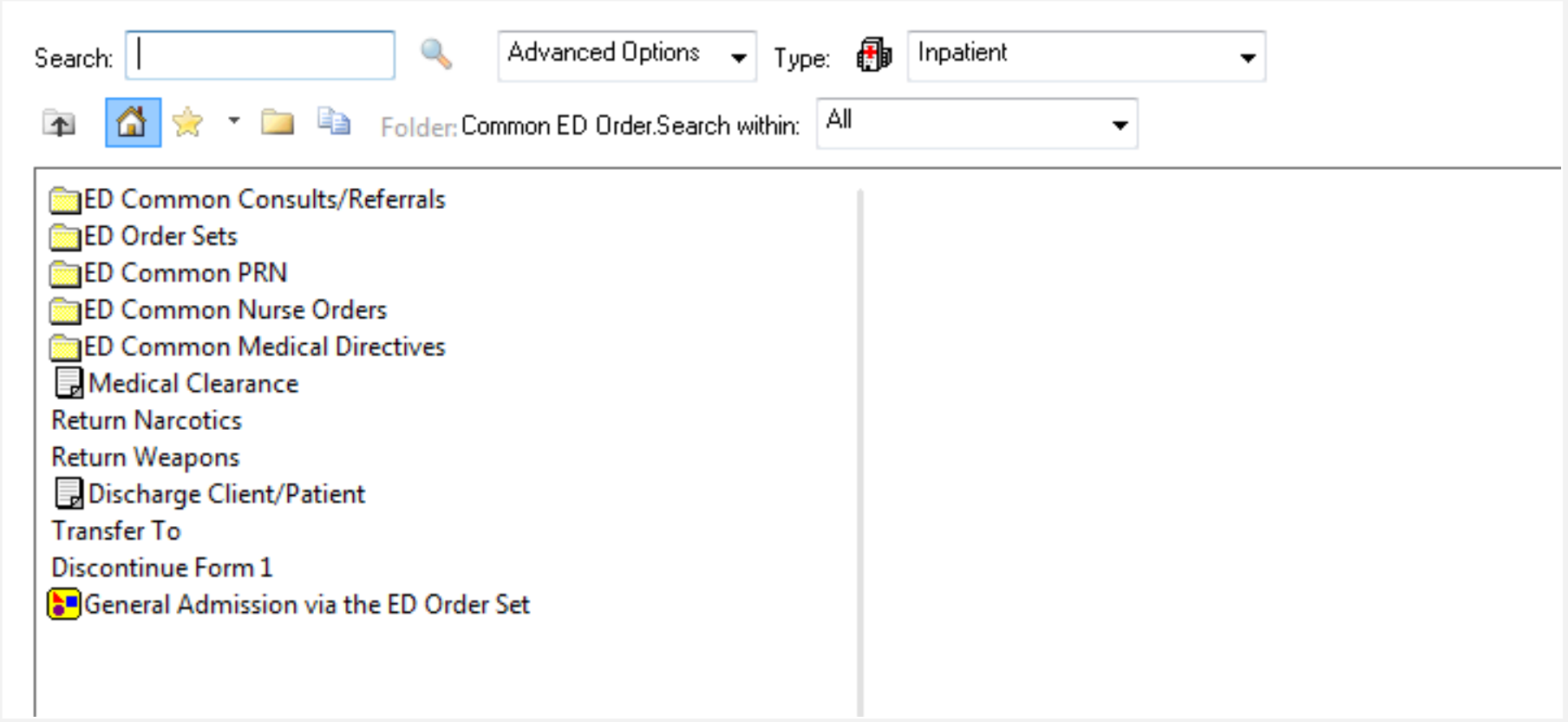
GENERAL ADMISSION VIA ED ORDERSET



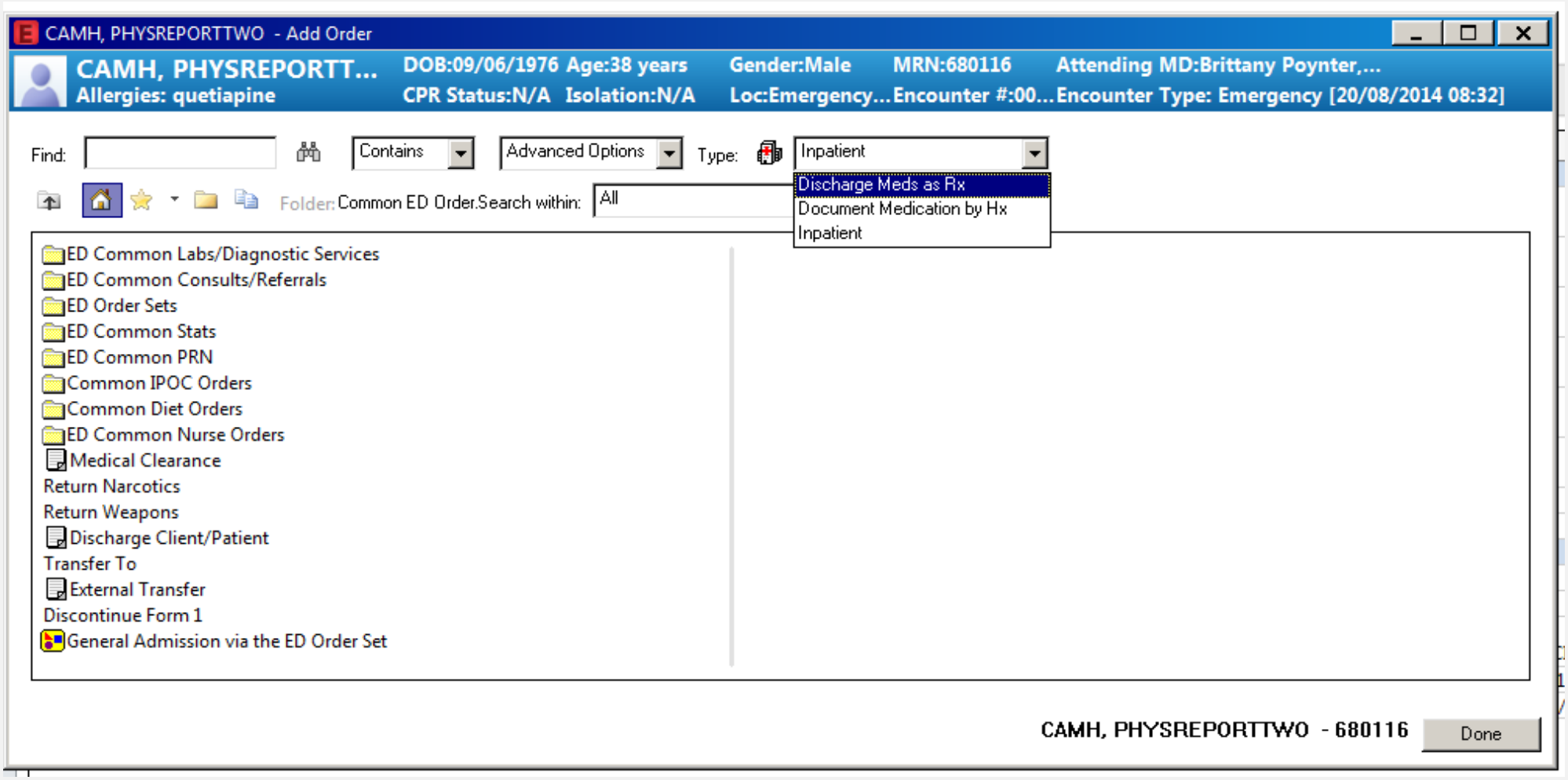
ED AGGRESSION & AGITATION ICP ORDER SET



ED COMMON ORDERS



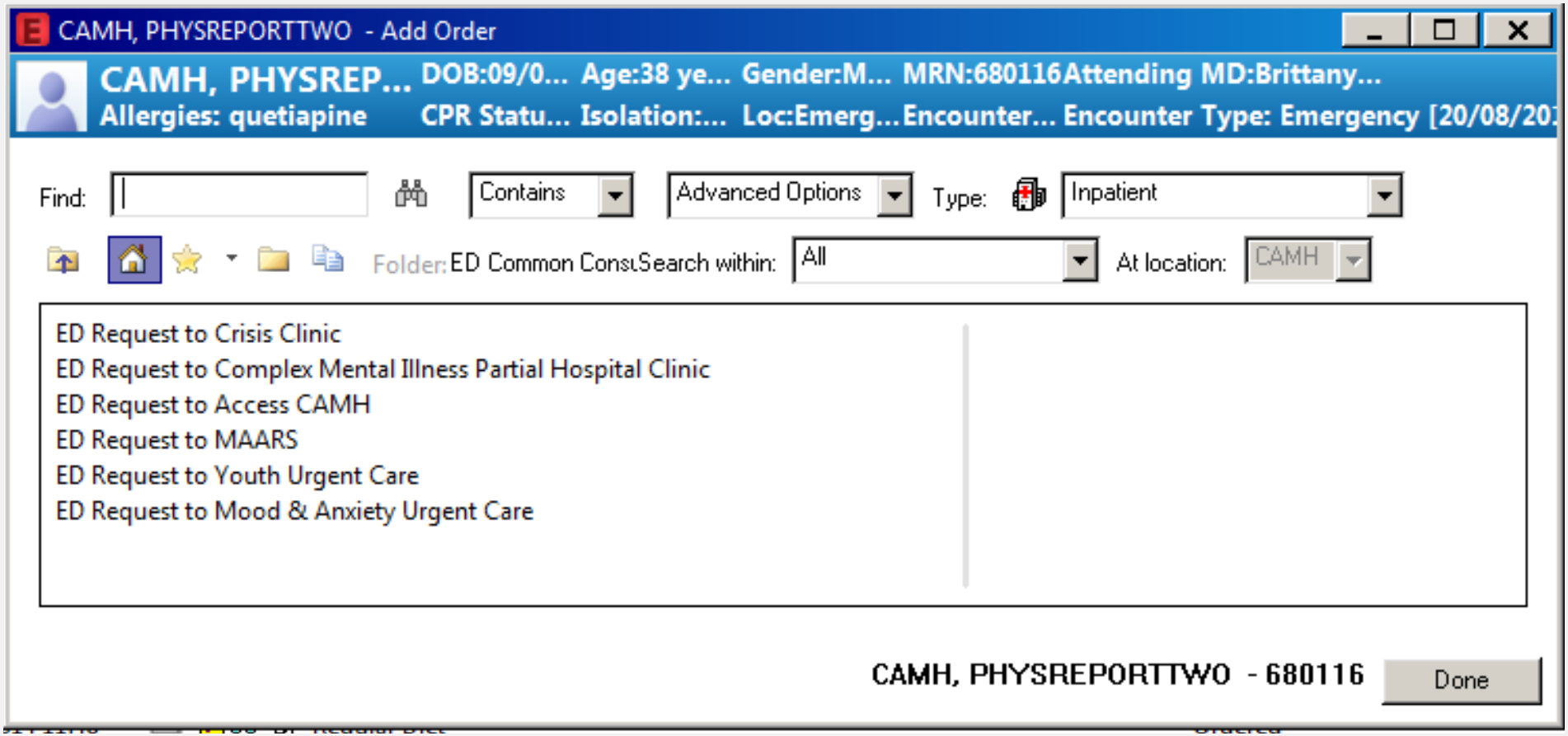
PRESCRIPTIONS



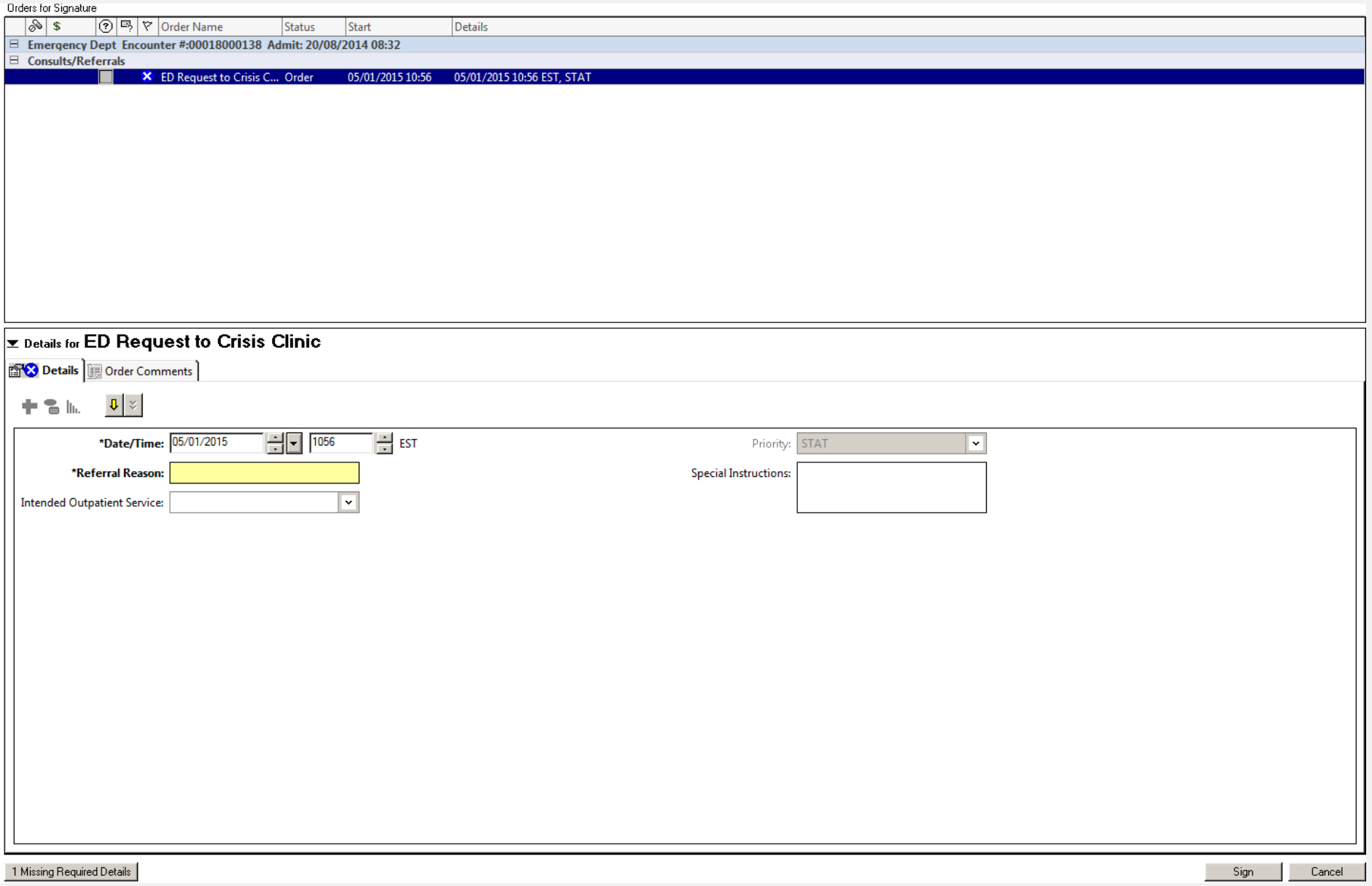
HOW TO REFER IN THE ED

- Use the "ED Common Referrals" folder – the referral should always be "ED REQUEST TO…"
- Urgent referrals are done through I-CARE (urgent care service, AMS, Slaight Family, PHP)
- Non-urgent referrals are done via the paper referral form (direct patient back to their GP or walk-in clinic to have it completed)

ED COMMON REFERRALS



ED COMMON REFERRALS



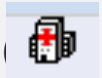
OVERVIEW OF COMMON I-CARE PITFALLS IN THE ED

- Documented Meds by History and Med Rec. checkmarks
- Assessment Start, Stop, and Disposition Times
- Diagnosis and Med Rec sections can only be completed by an MD
- EAU Note type (EAU Transfer note/EAU Discharge note/Simplified Inpatient Progress note)
- Print the Rx – Health Records won't accept paper Rx

GENERAL MED REC REMINDERS

- In the ER:
  - ALL patients should have a Document Medication by Hx completed
  - Patients who are admitted should also have an Admission Med Rec completed
- In the EAU:
  - ALL patients should have a DMbH and Admission Med Rec completed
- The DBbH is a current and complete list of home medications
  - Search "Non-Formulary" to free text medications if you can't find them
  - Include sources of information – at least 2
  - Look for the  or  icons – use the patient's own medications as one of your sources

GENERAL MED REC REMINDERS

- In Admission Reconciliation, decision must be made on every entry
- When ordering/continuing I.M. injections, or medications not taken every day, "Start Date" should correspond to when the next dose is due.
- Inpatient orders will appear on the right hand side ( icon) – check for duplicates
- Residents cannot order methadone - please ask staff to order and apply for a Health Canada Temporary Exemption (search for application on InSite).
- Use www.e-therapeutics.ca direct link through FirstNet – click on "Pharmacy e-CPS"

ORDER SETS FOR MEDICATIONS

- Under "Orders" in left hand menu
- Commonly used:

  - Alcohol Withdrawal (CIWA) order set
  - Opioid Withdrawal – Clonidine order set
  - Nicotine Replacement Therapy order set
  - Diabetes Management order set (for sliding scale insulin)

MED REC CASE EXAMPLES

EXAMPLE #1 **CLOZAPINE**

56 year old man, on CTO. Multiple psychiatric medications including clozapine. Left supportive housing two weeks previous, brought to ED on Form 47, admitted on Form 1 to EAU. Medications ordered including clozapine 25 mg.

MED REC CASE EXAMPLES

EXAMPLE #1 – **CLOZAPINE**

ISSUES:

- DMbH was not done (no green check mark), with duplicate medications listed, old meds that client was no longer taking, and omissions of newer meds.
- Progress notes from team were very clear that client had been non-adherent with clozapine and that the recommendation from the clozapine clinic was that bloodwork should first be done before restarting clozapine. Bloodwork was not ordered, yet clozapine was restarted that night (at 25mg) and client received one dose.

MED REC CASE EXAMPLES

EXAMPLE #1 – **CLOZAPINE**

TAKE HOME POINTS

- CAMH clients have ++ info on their charts that can help with the med rec process; important to check each med before reconciling
- Patients who have not had recent bloodwork should NOT be restarted on clozapine
- Clozapine does not show up on ODB!

MED REC CASE EXAMPLES

EXAMPLE #2 - **USING MULTIPLE DATA SOURCES**

- medication reconciliation completed based on previous/old medication list (from March 2016?). ODB DPV was available.
- The following errors occurred (changes to existing regiment & new medications missed):

  -methylphenidate 30mg po qam (not documented)

  -duloxetine ordered ad 60mg but dose increased to 120mg po daily

  -vitamin B12 1000mcg IM q week (not documented)

  -ferrous fumarate 300mg po qam (not documented)

  -gabapentin ordered at 900mg but dose was increased to 1200mg po qhs

MED REC CASE EXAMPLES

EXAMPLE #2 - **USING MULTIPLE DATA SOURCES**

- RESULT:
  - wrong dose administered yesterday of duloxetine and gabapentin
  - methyphenidate dose missed yesterday and today
  - ferrous fumarate dose missed yesterday
- THREE SOURCES OF DATA can help – patient report, ODB, pharmacy faxed list, old chart, family report, physician info, pill bottles / dossette etc.

MED REC CASE EXAMPLES

EXAMPLE #3 - **DEPOT TIMING ISSUES**

Both DMbH and the admission medication reconciliation were complete (green check marks for both). The client is on zuclopenthixol 200mg I.M. q2 weeks, which was correctly documented in DMbH. Clear documentation by ACT team progress note and in the MAR summary for that encounter that the last injection was given on May 5, 2016. Zuclopenthixol was ordered, with the date of next dose for today May 10 (nine days early and 5 days after the last dose). Order was caught and "rejected" before it was administered, has subsequently been amended to the correct date.

MED REC CASE EXAMPLES

EXAMPLE #3: **DEPOT TIMING ISSUES**

TAKE HOME POINTS:

- Determining the last dose of a depot can be challenging – cannot rely on ODB dispense date
- If you are unsure, you can order the DEPOT for 1 month + in advance and flag it for the pharmacist who can follow up the next day (or give the pharmacist on call a page in the AM to hand over if it is on a Sunday)

MED REC CASE EXAMPLE

EXAMPLE #4 – **METHADONE AND SUBOXONE**

A patient presents to the ED and tells you she has missed two days of suboxone – daily dispense but her pharmacy is closed on Sundays

Or

You admit someone who tells you they are taking a dose of methadone that does not match up with ODB; you also can't determine the last dose

MED REC CASE EXAMPLE

EXAMPLE #4 – **METHADONE AND SUBOXONE**

TAKE HOME POINTS

- These cases are really challenging
- Residents cannot prescribe methadone; but your staff can obtain a temporary license to do so easily
- When in doubt, contact the addictions physician on call and the pharmacist on call

COMMON REFERRALS FROM ED

13:00– 1400

COMMON REFERRALS

- CAMH Urgent Care Service and Access CAMH
- Addictions Services
- Slaight Early Intervention Service
- STARS (Schizophrenia Service)
- Partial Hospitalization Program
- PACE (Geriatric Service)
- FASTER DBT study
- Gerstein Centre
- Community resources

ADDICTIONS PROTOCOL

- The CAMH / MWS updated protocol is available in your notes
- Suboxone can be initiated in the CAMH ED as per the new suboxone pathway – this has not gone live yet, when it does, I will send you an update
- COWS scale is helpful to determine the amount of suboxone needed
- Suboxone information powerpoint is included in your orientation materials

THANK YOU