Centre for Addiction and Mental Health

Resident Guide to the Emergency Service (ED/EAU)

JULY 2017

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INTRODUCTION AND WELCOME

The Gerald Sheff and Shanitha Kachan Emergency Department is the only stand-alone psychiatric ED in Canada. Over 1000 psychiatric assessments are conducted here every month, comprising well over 40% of all emergency psychiatric assessments completed in the Toronto Central LHIN. In addition, the Emergency Assessment Unit (EAU) is a short-stay unit with 8 inpatient beds that is located adjacent to the ED and staffed by the ED clinical team. Over the last several years, we have hit record after record with respect to our volumes.

We are so grateful to the high quality of care that our residents help us provide to our clients. Call at CAMH guarantees busy shifts, acute patients and a variety of presentations. It also means that by the end of your rotation you will have encountered much of the DSM and you will feel comfortable managing various presentations including agitation, aggression and suicidality. Safety for our staff and learners is our biggest priority at CAMH. We take safety very seriously and have an excellent safety record.

Having been in the CAMH call pool myself, I know that it can feel anonymous at times. I am hoping that I can meet with each of you over the course of the next six months to get to know you better and to collect feedback to improve your experiences. I would encourage you to consider booking a meeting - it would be great to learn more about all of you (even the ones of you I know well) and to have an honest discussion about your call experiences.

I am always available via email or in person to chat about things that are going well, things that are going not so well, or a case that you have been thinking about. Please contact me with any safety issues, challenges with on-call staff or positive feedback.

Finally, please email me if you have an interest in a senior selective (one day per week) in the CAMH ED - between 3 and 12 months. We can arrange a selective that focuses on any number of goals: 1) Exam preparation (both PDM style and for MCQ - asking questions around cases that show up on exam, and running scenarios that show up on PDM) 2) Teaching to teach (working in a junior staff capacity - getting supervision on your supervision) 3) Managing agitation in an emergency setting 4) Preparing for practice (feedback around billing, time management, work life balance, leading / managing /collaborating with a team, self-care and identity).

Thanks so much,
Juveria

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OVERVIEW

The Emergency Service consists of the Emergency Department and the 8-inpatient bed Emergency Assessment Unit.

The ED/EAU has partnership arrangements with the Emergency Departments of Mount Sinai Hospital (MSH) and Women's College Hospital (WCH). In turn, the MSH ED provides medical backup for the CAMH ED.

The CAMH ED/EAU operates 24 hours a day, 7 day per week, and sees both new and returning patients. Patients self-refer, and are often accompanied by family or significant others. Various community services refer patients, including family doctors, community psychiatrists and mental health agencies, police, and other social service providers. Any patient can be assessed and treated in the CAMH ED/EAU. Patients 15 and under can be redirected to the Hospital for Sick Children, or St. Joseph's Hospital; if there are acute safety issues or the patient or family insists on an assessment, we can see patients 12 or older.

The CAMH ED/EAU is the busiest psychiatric emergency service in Toronto, averaging over 900 ED assessments per month, with an admission rate of approximately 25 percent. The CAMH ED/EAU is also a major teaching site for the University of Toronto Department of Psychiatry. More than 200 residents and other medical trainees complete rotations in the CAMH ED/EAU each academic year.

The Emergency Service serves people from every background. We pride ourselves on our ability to work with a diverse range of people and families, and continually try to improve this aspect of our care. Cultural competence is an important element of excellent service.

The Emergency Department and Emergency Assessment Unit, like the rest of CAMH, is a tobacco-free environment as of May 2014. There are no passes from the EAU and only from the ED if client is voluntary and/or low risk. Tobacco products are returned to ED and EAU patients only at discharge.

ON-CALL POLICY

The Chief Residents of CAMH and MSH prepare the on-call schedule. The deadline for call schedule requests is early in the preceding month, after which time it will become the responsibility of individual residents to arrange any necessary changes. If a change is made to the schedule after it has been finalized, the Chief Residents, Emergency Department, and Switchboard must be notified. The on-call schedules are distributed to each resident and staff and are posted throughout CAMH. All residents will be expected to be available over the Christmas or New Year's period. A five-day vacation block will be assigned when the December call schedule is written.

Each evening, night and weekend day there are five residents listed on-call. One resident remains in hospital from 5:00 p.m. to 11 p.m. during the week and from 9:00 a.m. until 11:00 p.m. on weekends. Three residents are on-call from 5:00 p.m. until the end of morning report at 9:30 a.m. on weekdays and until 10:00 a.m. the next day on weekends. Weekend call is not to be split between residents and residents must be on site during weekend days and evenings as

is the policy throughout the department. The fifth resident is on back-up, and is to be available to do call for one of the four residents if they are ill or otherwise indisposed. The back-up resident should be available to come to the Emergency Department in a reasonable time and should not leave the city while they are on back-up call. Residents and the on-call clinical clerks meet with the staff on-call at 5pm on weekdays and 9am on weekends for handover. On weekends, residents and the staff on-call re-assess all patients in the EAU on a daily basis.

Residents on-call must be available to see Emergency Department patients and respond to other medical and psychiatric inpatient emergencies. The residents who are on-call during each 24-hour period will carry a pager or cell phone. Staff act as consultants and should be contacted for every patient seen in the case of junior residents and for every significant clinical event for senior residents. In the case that there are **six or more** patients waiting for assessment in the Emergency Department the staff on-call should be called in by the nursing Team Leader to assist with the clinical work.

The resident's duties and responsibilities pertain to the management of all medical matters occurring in CAMH, during the call period. This includes:

1. Emergency patients
2. Telephone calls
    a) If requested by an emergency triage nurse
    b) Referrals from physicians, hospitals and agencies
3. Code White, Code Blue and Medical Staff Stat calls
4. Psychiatric and medical emergencies on inpatient units. Non-emergency issues on the ward are to be dealt with by the attending on-call to the ward.

Resident responsibilities while on-call can be found on the postgraduate website. While on-call, one resident at a time may leave the building when the clinical load is low, for brief periods of time (e.g. meals), but should notify nursing staff and their resident colleagues when they leave and upon their return.

There are three call rooms available in the Emergency Service. The resident lounge at the College Site is equipped with a computer, refrigerator, microwave and television for resident use.

Each resident is responsible for their night and weekend duty and in the event of illness must contact the Chief Resident and the back-up resident. If no coverage can be arranged and the duty resident is unable to complete their assigned call, the staff psychiatrist on-call will assume the duties of the on-call resident. Please see the Policy Regarding Missed/Modified Call.

By the PARO/CAHO contract all residents are eligible for the on-call stipend of $105 per call and must submit their completed call stipend form by the 4th of each month to the Education Office to be eligible for these funds. Residents are also eligible for $52.50 for back-up calls.

STAFFING AND ROLES

The CAMH ED/EAU is staffed by a multidisciplinary team:

1. **ED/EAU Nurses**
   ED nurses have all received specialized training in emergency psychiatry. They complete psychiatric assessments, provide crisis intervention, psycho-education and support for patients and families, and undertake liaison and referral. The role of each ED nursing staff has various functions that include conducting Triage, initial assessments (when time permits), as well as ongoing assessments, interventions, and co-ordination of functions. On each shift, there is a Nurse Team leader for the service. The RN staff co-ordinate the function of the emergency department. Along with other staff, they ensure that patients are seen in a timely and safe fashion.

2. **ED/EAU Social Workers**
   The SW staff conduct assessments and assist with social needs of clients including housing, Children's Aid involvement, community supports and referrals.

3. **ED/EAU Program Assistants**
   The program assistants help manage the milieu of the environment, transfer clients and help with other tasks assigned by the RNs such as searching clients.

4. **Staff Psychiatrist**
   Over the last year, we have increased our ED psychiatrist coverage from 21 hours a day (2 8:30 – 17:00 shifts and the 17:00 - 21:00 call shift) to 44.5 hours a day (an additional 8:30 – 13:00, 13:00 – 21:00 and 17:00 – 00:00 shift) to manage the increase in volumes that the department has seen.

   The ED day shift psychiatrists assess new patients in the ED, review patients in the EAU, and teach psychiatry residents, medical students and learners of other disciplines. They lead the morning report and are available to assist with process issues that arise.

   From 17:00 – 00:00 Monday to Friday there is one psychiatrist assigned to the ED/EAU to provide further support to residents as well as see clients to help manage volumes. The swing shift psychiatrist (13:00 – 21:00) is also available for supervision – residents are free to review with either psychiatrist.

   After 00:00, the ED on-call staff psychiatrist takes over. If there are **6 or more** patients waiting to be seen at 21:00 on weekdays, the on-call staff psychiatrist is expected to come to CAMH to help expedite assessments and support residents. The on-call psychiatrist should also be asked to report to CAMH if there are any urgent or critical situations. On weekends, the on-call staff psychiatrist is present at 09:00 to round on patients in the EAU and to provide supervision. Safety and other management issues should be discussed with the on-call staff psychiatrist.

   The overnight / weekend on-call staff psychiatrist is available to the ED by phone or pager and should respond within 15 minutes. Staff on-call should not leave the city while they are on-call, and should be prepared to come to the hospital within 20 minutes in the case of an emergency or if excessive workload requires.

   According to guidelines of the College of Physicians and Surgeons of Ontario, residents on-call should consult the staff psychiatrist on-call about all patient assessment and

management issues. The staff psychiatrist should be notified of any significant events that occur during call, even if the event is not a management problem.

5. **Nursing Supervisor**

   The nursing supervisor is the hospital administrator on evenings, nights and weekends. As such, s/he is responsible for facilitating admissions and transfers, coordinating staffing, and for any other administrative matters that arise. The nursing supervisor is accessible by pager through switchboard.

6. **Residents**

   Residents are an integral part of the ED team. In the PGY 1 year, psychiatry residents from MSH and Competency Pilot residents from Sunnybrook attend the ED/EAU for 4 weeks during the day shift to receive training in emergency psychiatry assessment, diagnostic, and management skills. They work closely with the staff psychiatrists and the rest of the multidisciplinary team to acquire the knowledge and skills that are essential for emergency work in psychiatry that they will use in their further training and time on call. In addition, 13 PGY 1 Family Medicine Residents from WCH do a month-long rotation in the ED/EAU. PGY 2 psychiatry residents do one day per week in the ED during their six-month outpatient general psychiatry rotation. Many senior psychiatry residents choose to do selectives in the ED/EAU due to the richness of the learning experience.

   At the start of an on-call shift, the team will meet in the conference room. RNs will review any patients waiting to be seen with the residents and staff psychiatrist on-call. Assessments will then begin.

   The residents work closely with the RNs and SWs. RNs will do the initial triage of patients and often complete parts of the assessment, depending upon the level of activity in the department. RNs will also advise the residents as to which patients need to be seen urgently and advise the residents about safety concerns or other issues.

   The residents see patients based on acuity and can work together on specific patient problems where they can support or teach one another. As much as possible, junior and senior residents are paired to work together while on call. The residents should focus their assessments on the specific emergency problems of patients and duplication of interviews and notes should be avoided. Residents will review all assessments and discuss significant clinical problems and events with the staff on-call.

7. **Hospitalist**

   The ED has a full-time hospitalist during the day, Monday to Friday, who will order necessary investigations and complete a thorough medical history and physical exam on all patients who are going to be admitted. Please notify the team of any patient medical concerns at morning report so we can inform the hospitalist.

8. **Pharmacist**

   We have a full-time pharmacist working in the ED on Monday-Friday from 08:00 – 16:00 to help support the BPMH process. Our pharmacist is Hermia Cheung (Hermia.cheung@camh.ca). We are working toward increasing our pharmacist

coverage for evenings and weekends. THERE IS A PHARMACIST ON CALL AFTER HOURS AND ON WEEKENDS FOR ANY ISSUES.

9. **Patient/Client Flow Manager**

Clara Tam is the assistant manager of the CAMH ED and responsible for bed flow. She coordinates daily patient flow into inpatients beds at CAMH. She works closely with intake from other hospitals and managerial staff in all programs at CAMH, including the Emergency Department, to ensure coordinated access into appropriate beds, transfers, and facilitation of discharge from beds. Clara can be reached at clara.tam@camh.ca from Monday-Friday, 08:30-16:30hrs. During the evening or weekend, the nursing supervisor (ext. 33435) is responsible for the patient/client flow.

As a resident, you are not responsible for managing bed flow challenges. If the team has concerns, you can relay these to the staff psychiatrist on call.

10. **Security**

Security is located adjacent to the ED waiting room. Security personnel monitor all of the ED cameras and are updated on the ED clinical status at the beginning of each shift. We work closely with security and they can be called at any time to help with clinical situations that arise in the ED. Please work with the ED staff to decide when you think security should be involved to help manage any acute situation.

11. **ED Leadership**

A five person clinical and administrative team manages the Emergency Service, consisting of Brittany Poynter, MD (Clinical Head), Marc Greene (ED Manager), Clara Tam (Assistant Manager and Bedflow), Christine Buicago (Nurse Educator) and Juveria Zaheer (Education Administrator). All are available to discuss any issues of concern.

THE ED ASSESSMENT PROCESS

Triage

There is a Triage and Admitting desk in the lobby area of the College site. Admitting clerks staff this desk 24 hours a day, seven days a week. When patients arrive for an emergency assessment the triage nurse in the ED is notified. The nurse will triage the patient and complete the ED Triage, Vital Signs and Febrile Screen and initiate any infection control precautions. In order to ensure the safety of this procedure, security staff are immediately accessible across the lobby, and are available whenever an ED triage is done. Following the triage, the triage nurse will notify the resident of any immediate concerns, which must be attended to. The triage nurse will identify the patient's level of urgency, in accordance to the Canadian Triage and Acuity Scale (CTAS), assign them to the acute or less acute waiting area, and determine the next steps in the assessment and treatment process. If a patient is unable to be registered or triaged in the admitting area (e.g. brought by police and agitated), they will immediately be brought to the ED to begin the assessment with the resident and the RN and SW Staff.

Review of the Health Record and Patient Care Alerts

The patient's Medical Record Number (MRN) is the key to knowing whether they have been seen at CAMH before. At the time of writing, MRNs were at 810XXX. Anything less than this

means that the patient has an old chart at CAMH. All old records are accessed on I-CARE, our Electronic Medical Record. Old records should be reviewed prior to assessing any patient.

Any past history of violence should be reviewed. A past history of violence is the best predictor for any risk of future violence. It is important to review the circumstances of past violence and the management plans that were successful in the past. **A BLACK CIRCLE ICON IS VISIBLE ON THE ED WHITEBOARD FOR PATIENTS WITH A KNOWN HISTORY OF VIOLENCE.**

Patients with frequent ED presentations, a propensity for violence and aggression, or recurrent self-harm behaviours, often have a multidisciplinary "Care Plan" or "safety alert" that is located on the patient chart or in the care plan binder – ask the nursing staff for help to find it. These care plans advise staff on management strategies that have worked in the past, patient triggers, and patient preference, and function to maintain consistency of care for these challenging patients.

<u>The Emergency Assessment</u>

After a patient has been triaged, the triage RN will assign a primary RN to the patient who will perform an initial assessment – this RN will then "give report" to the assigned resident, who will complete the assessment. The triage RN will record the patient's triage code on the electronic white board (ranging from non-urgent (Level 5) to resuscitation (Level 1). This determines how quickly the patient should be seen. If there is more that one patient in the ED, the team leader will indicate to the residents and team which patients should be seen first. In managing workload, the team should take into account the number of patients, the acuity of the patients, any potential for immediate medical or psychiatric risk, the number of residents and medical students in the department, and which patients could be seen by medical students.

An emergency assessment should be focused on the presenting complaint. After all, the primary questions to be answered are: Does this patient need admission? If not, how can the needs of the patient and family best be met outside hospital? TA complete history is usually not required, but certain elements are essential, especially those dealing with safety, organic illness, and social supports. The presenting problem needs to be carefully delineated, relevant symptoms explored and understood in the context of the patient's long-term history and the individual's life. In the case of a pre-existing illness, it is important to understand any recent changes or deterioration that may have occurred. The past psychiatric history must be reviewed to understand the severity of illness and efficacy of past treatment. A mental status exam must be done for every patient, with a focus on suicidal and violent ideation or intent. Cognitive testing should be done when appropriate to help rule out organic illness.

Family members and others who accompany patients should be interviewed and efforts made to contact by telephone those who can provide relevant information. Collateral information can be crucial in developing a plan, and for making decisions about hospitalization.

It is important to remember that this is a multidisciplinary team assessment and the information obtained from each team member needs to be synthesized. It is not necessary to repeat other team member's assessments or interviews, or information that is already clearly documented in the medical record. It is important to review the past notes and records and to be aware of important details. Repeated interviews are stressful for the patient.

Clients often present to the emergency department with non-acute psychosocial problems that do not involve a risk to themselves or others. Many of these clients have an established psychiatric diagnosis, and others do not require immediate diagnostic assessment. These clients can often be successfully assessed and assisted without an immediate, full diagnostic assessment by a psychiatrist. In this situation, non-physician ED staff can complete the majority of the assessment if the level of activity in the department is such that this is possible. Such clients include (but are not limited to) those who make frequent visits to the department who typically do not pose a risk to themselves or others; individuals seeking information for outpatient mental health / addiction services; clients seeking a psychiatric assessment to fulfill legal obligations (such as completing a bail or probation requirement); and established CAMH clients (often with chronic psychiatric illnesses) presenting for psychosocial support. Of course, a more thorough assessment by a physician is required for those clients who, in the opinion of the assessing non-physician clinician, pose a risk to themselves or others or who are grossly unable to care for themselves. Also, clients presenting with acute psychiatric symptoms of moderate or greater severity and those with acute medical problems must have a more thorough assessment by a physician.

The RN or SW completing the assessment should review the case with the resident, and the resident can then choose to perform a brief evaluation of the client, with an emphasis on mental status and any questions the client might have for the resident physician. The resident can then *succinctly* document his/her evaluation on the ED MULTIDISCIPLINARY ASSESSMENT, the majority of which will have been completed by the assessing ED staff member, if time allows. In the case of well-known clients or those not requiring extensive assessment, those sections not deemed relevant to the presenting situation do not necessarily have to be completed however there should be documentation to that effect (i.e.: not assessed). If this information is available in the chart (for those currently or previously receiving CAMH services), the location of this information in the chart should be noted on the assessment form (for example, “For full details of the social history, please see the progress note by Susan Jones, MSW, from March 2, 2017.”).

The assessment and disposition for every patient should be discussed with the ED staff to make sure that all issues have been taken into consideration. The ED staff play an essential role in ensuring that an appropriate disposition/plan is reached for every patient.

For every discharge, a Client Summary form should be completed as part of the Firstnet “Depart Process” and given to the patient. A Clinical Summary can also be printed and faxed to the primary outpatient care provider.

Cultural Assessment and Diversity

An important part of the emergency assessment involves assessing client’s culture and diversity, by asking for language preference, cultural and ethnic background, immigration and refugee experience, religious and spiritual practice, use of alternative care, and other diversity issues including sexual orientation, gender identity, etc. Interpreters can be booked through the Cultural Interpretation Service by contacting Stella Rahman at ext 36462. After-hours interpretation services can be arranged through the Nursing Office.

There is also a “language line”, which should be used only in emergencies. This is a very expensive service that allows access to interpreters over the phone. A speakerphone is

necessary to use this service. To access this service: 1) dial 416-504-4578; 2) identify the language desired; 3) when asked, give CAMH's client ID number 252988; 4) provide the personal code when asked – 5358501; and 5) the interpreter will be connected in a few minutes.

ASSESSMENT OF MEDICAL STABILITY (MEDICAL CLEARANCE)

As mentioned earlier, we are partnered with Mount Sinai Hospital, and the MSH ED provides medical back up for the CAMH ED/EAU. When assessing a medical/physical complaint, it is important to remember that the ED has limited medical equipment (stethoscope, blood pressure cuff, thermometer; glucometer; defibrillator, crash cart).

In an acute emergency, 911 should be accessed. For less acute but urgent situations, a patient can be transferred to MSH ED:

1. 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.
2. Phone MSH ED and speak with the physician about your reason for requesting Medical clearance. At times, the medical situation can be clarified through discussion with the MSH physician (i.e. a medical question can be clarified without the need to transfer the patient directly to MSH ED).
3. A PA accompanies all patients for medical clearance.
4. 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.
5. Original Form 1 and Medical Clearance form is sent to MSH with copies kept in the College ED patient chart.
6. Remember to complete relevant transfer forms for all transfers and obtain the transfer number (PTAC).

It is recommended to send patients with reported or suspected overdose for medical clearance. Residents are encouraged to call MSH and seek advice from the ED physicians on whether a medical assessment is warranted and to determine if the situation can be adequately managed without the need for transfer. Please be aware that because of our formal partnership with MSH ED patients requiring medical clearance should be accepted regardless of Critical Care bypass in the MSH ED. When the patient is cleared at MSH and ready to return to CAMH it is important that a resident discuss the case with MSH physician to ensure all relevant tests were completed and that CAMH has the capacity to manage the client given this updated medical information. If there are concerns about CAMH being able to manage client, the resident should work with MSH to keep client at MSH. This can be facilitated with nursing supervisors or the on-call staff psychiatrist.

Please see Appendix 1 for the CAMH/MSH memorandum of agreement for more details about MSH-CAMH transfers.

ADMISSION OPTIONS AND INSTRUCTIONS

Patients can be held in the EAU for up to 24 hours for further observation and assessment. We try to avoid patients sleeping over in the ED (except for withdrawal patients) and instead would prefer to transfer to an inpatient bed if admission is required. Patients in the ED/EAU can be

admitted to any of the inpatient units of the Centre for Addiction and Mental Health provided that they meet the mandate of the particular unit. Appropriate patients can also be admitted to 9 South at Mount Sinai Hospital when a bed is available. If a patient requires admission, you have several options. The best approach is to touch base with the assigned RN and Nursing Team Leader and discuss what the patient would benefit from. They are in charge of actually finding a bed for the patient.

Overnight, the majority of the patients admitted from the ED go to the EAU. They are then transferred the next day. Below are some of the inpatient units, which receive the majority of the admissions from the ED/EAU:

1. EAU- Emergency Assessment Unit – admit here if no beds on appropriate unit, if the disposition is unclear, or if patient needs a short stay for stabilization
2. MWS- Medical Withdrawal Services aka "White Squirrel Way" –We hold patients in the ED on a CIWA protocol for up to 8 hours to manage uncomplicated alcohol withdrawal. If, after 8 hours, the patient is still in active withdrawal, transfer directly to MWS.
3. ACU- Acute Care Unit- 5th floor College St. Campus – acutely agitated clients
4. GPU- General Psychiatry Unit – 5th floor College St. Campus – the majority of our inpatients go here
5. WIU- Women's Inpatient Unit – 9th floor College St. Campus – women who would benefit from hospitalization for mood and anxiety, borderline personality disorder, often in the context of trauma histories
6. EPU- Early Psychosis Unit – 10th floor at College St. Campus – <3 years since first psychotic episode
7. MAUI- Mood and Anxiety Inpatient Unit @ Queen St. Campus
8. SZHR, SZUA, SZUC, SZUD – Schizophrenia Inpatient Units @ Queen St. Campus
9. GAUA, GAUB – Geriatric Units @ Queen St. Campus (>65 yo)
10. MSH 9 South – General Psychiatry Inpatient Unit at Mount Sinai Hospital

A bed board in the ED lists all available inpatient beds in the hospital. After hours, the Nursing Supervisor is contacted to facilitate admissions. There are now three new protocols in place in the ED.

1. Psychiatric patients presenting to the MSH ED will be assessed there by the on-call psychiatrist when there is a bed available on 9 south, or will become available in the next 4 hours, without coming through the CAMH ED, until 11pm. Between 11pm and 8am, patients will be sent to CAMH ED, regardless of bed availability at MSH

2. Dementia patients presenting to the MSH ED may be sent over to the CAMH ED for a geri-psych consultation. If there are no psychiatric issues requiring hospitalization, then we repatriate the patient back to MSH once our consultation and recommendations are complete

3. Patients seeking and in need of medical detox are held in the ED on a CIWA protocol for up to 8 hours. After that, they are discharged or transferred to MWS. See [Appendix F] for full details.

<u>Emergency Assessment Unit (EAU)</u>

The 8-bed EAU is located behind the Emergency Department. This is an integral part of the Emergency Crisis Service where patients are held for extended assessment (less than 24 hours) or when waiting for an inpatient bed at CAMH or at another facility. All patients who need to be held overnight should be kept in this area. For safety reasons and acuity, all patients in the EAU are on close observation (every 15 minutes). Every patient in the EAU is assessed daily by an MD - either a resident or staff psychiatrist.

Residents must keep the on-call staff psychiatrist informed of bed availability in the EAU. The psychiatrist can opt to contact the nursing supervisor if she / he has concerns about the volumes in the ED/EAU.

Progress notes in the EAU are documented as SOAP style notes in the documentation tab as: "Simplified Inpatient Progress Note", "Transfer Note" or "EAU Discharge Note".

Assessment of Capacity

All patients should be assessed for their capacity to make treatment decisions in the ED. Whenever patients are found to be incapable, this must be properly documented and the necessary forms completed. Every attempt should be made during the ED visit to determine who could give substitute consent. If such an individual is present during the ED visit, he/she should be approached by the ED staff to obtain substitute consent. Typically, the notification of incapacity to consent to treatment (Form 33) follows voluntary or involuntary admission, and is not given to the patient during the psychiatric assessment period (Form 1). If a patient is in the ED/EAU on a form 1 and is judged to be incapable to consent to treatment and in need of involuntary hospitalization, it is often best to issue forms 3 and 33 promptly. This can alleviate significant delays in initiating treatment.

Issuing a Form 3

1) Complete F3 (remember – it's 14 days INCLUDING the day of completion) and F30
2) Make two copies of the F30, leave in chart – original to patient
3) Fax completed 3, 30 to Health Records
4) Complete rights advisor form and fax to PPAO (pre-programmed in fax machine)

Issuing a Form 30

1) Complete F30
2) Make two copies of F30, leave in chart – original to patient
3) Fax completed F30 to Health Records
4) Complete rights advisor form and fax to PPAO (pre-programmed in fax machine)

Ontario Review Board Dispositions

1) DETENTION ORDER – The patient needs to be admitted on a F49 (is in the chart, also there is always communication from the team). Sometimes a patient will bring themselves in – best to keep them in ED until we can communicate with team
2) CONDITIONAL DISCHARGE – Requires assessment for F1. If the patient is seeking a voluntary admission, it makes the most sense to admit and contact the team the next day
3) ABSOLUTE DISCHARGE – Proceed as you normally would

How to Admit

Following this guide like a checklist reduces the chance of missing things when admitting someone. Specifics are described below the list.

1. You and the assigned nurse should tell the Team Leader your decision to admit the patient, and decide on the most appropriate unit as a team
2. Complete the Firstnet Multi-Disciplinary Assessment
3. Complete the "General Admission Orders via the ED" order set
4. Complete the "Documented Medications by History" which is a list of the patient's home meds
5. Order any new standing and PRN medications
6. Complete the Admission Medication Reconciliation
7. Order any labs (Urine Tox Screen or Therapeutic Drug Monitoring)
8. Order anything else (NRT, CIWA Protocol, Opioid Withdrawal Protocol)
9. Do a quick physical exam and complete the "Brief Physical Exam" form available on Firstnet (unless patient was transferred from Mount Sinai or are too agitated for a physical)
10. Medicolegal status (pre-populated forms are available on INSITE):
    A)If you are putting patient on a Form 1→ Fill out 1 and 42→copy 42→fax 1 and 42 to patient records, give original 42 to patient.
    B)If the patient is on Form 1 and they have not gotten 42, give them 42, fill out the time of holding on Form 1, fax Form 1 and 42 copy to patient records.
    C)If patient is ORB you don't need to fill anything out if they are on a Form 49.
    D)Form 2, Form 47, EDP→ you need to do an assessment for a Form 1.
11. Any unanswered medication questions should be directed to our pharmacist, Hermia Cheung, at Morning Report.
12. Call the patient's psychiatrist/ family/ family physician to inform them of the admission and obtain collateral information if indicated.

Medication Reconciliation

This is mandatory for every patient admission and discharge, in any accredited hospital in Ontario. The primary goal of medication reconciliation is to prevent errors by eliminating medication discrepancies at interfaces of care. It is the most complete and accurate list possible of all medications a patient is currently taking; then deciding and documenting which medication is to be continued, changed, or stopped; and ensuring medication orders reflect these decisions. At discharge, the medication reconciliation list will automatically pull into the Client Summary and should be given to the patient.

Ordering PRNs

Please specify the dose of all "PRN" medications ordered. Dose ranges ("1 to 2 mg Ativan prn for agitation") are not allowed. Intramuscular medications that are to be administered as chemical restraints need to be ordered as STAT orders only, not as PRN.

At CAMH we have a guide to help you order PRNs (oral medications given without coercion to alleviate symptoms) and chemical restraints (medications given acutely with coercion in order to prevent harm to the patient or harm to others).

Integrated Care Pathway for the Management of Agitation and Aggression
This is one stop, easy to use pathway to order chemical and physical restraints. If a patient is agitated, this order set to be used to order PRN, STAT and physical restraints.

What to consider when ordering medication:

1. Allergies
2. Past History of Agitation – Does a patient have a history of agitation? If so, what doses of medication have they required? Do they have a Care Plan?
3. Team Experience – Always consult with the team before ordering medication. They have a lot of experience and are often familiar with patients who have been in the ED previously. It's important for the staff be on the same page in these situations
4. Patient Size – is the patient very large? They may require a higher dose of medication
5. Patient Age – in frail, elderly patients, consider using lower doses of PRN medication (i.e. 2.5 mg of IM Haldol or 12.5 mg of PO Loxapine)
6. Comorbid Conditions – In patients with complex medical history (i.e. COPD, heart failure) use lower doses. Similarly, consider lower doses (i.e. geriatric doses) in patients with dual diagnosis or organic brain syndromes
7. Antipsychotic History - Always consider using doses on the lower end (ie 25 mg of Loxapine vs 50 mg) if they have never received these before. Order PRN Cogentin as well. On the other hand, if someone is not antipsychotic naive, consider using higher doses. Also consider using a PRN of their prescribed medication such as Risperidone M-tab or Olanzapine Zydis.
8. Comorbid Substance Use – If someone has a history of alcohol withdrawal initiate a CIWA protocol.
9. Patient Preference – Often patients can tell you what works best for them. For example, some prefer Olanzapine to Loxapine if they take Olanzapine regularly. If the patient can safely be given a choice, ask.

Ordering Labwork

In general you should only be ordering urine tox screens and/or serum drug levels when indicated. Urgent/Stat labs required to manage medically complex patients will be ordered by the ED when necessary. After hours, patients will need to be taken to Mount Sinai Hospital to access immediate lab testing as per current practice. All other non-urgent lab tests will be ordered by **inpatient teams** (including the EAU) and/or the hospitalist. Labs will only be ordered for patients who we predict will be in hospital at the time results come back to ensure proper follow up and lab test utilization.

Exceptions: lithium or epival levels on clients who are being admitted to inpatient units can be a tricky situation - not ordering a level could potentially delay care. The same case can be made for ordering a CBC in a patient receiving clozapine. In this case, ordering a **lithium or epival level**

or a CBC on a patient receiving clozapine on admission is reasonable and helpful and has clear implications for patient care. If you feel that not having a lithium level first thing in the AM could impact care, please order one and make your rationale clear in the chart.

The most responsible physician (MRP) attending to the patient in hospital is responsible for following through with lab results, particularly abnormal ones.

DISCHARGE OPTIONS AND INSTRUCTIONS

Following this guide like a checklist reduces the chance of missing things when discharging someone.

1. Work with assigned RN on a disposition decision and then together inform Team leader your decision to discharge the patient, and decide on the most outpatient resources together
2. Complete the Firstnet Multi-Disciplinary Assessment
3. Complete the "Documented Medications by History" which is a list of the patient's home meds
4. Create a Prescription if applicable and print for staff or resident to sign
5. Complete the "Depart Process" including any follow up instructions and patient education which can be pulled into the report and print the "Client Summary" for the patient
6. Inform any outpatient care providers and/or community supports, such as family, of the discharge, if applicable, and consent is provided to do so. Print and fax the "Clinical Summary" to the primary care provider, if applicable
7. Ensure patient has all their belongings, ask a PA or RN to let the patient out of the department

Outpatient Discharge Planning

1. Connect with their pre-existing services, GP.

2. CAMH Addictions→
    a. ADDICTION MEDICINE SERVICE – order is available through FIRSTNET, also provide patient with handout available in referral drawer

3. CAMH Mental Health→
    a. NON-URGENT REFERRALS – provide patient with ACCESS CAMH referral form to be completed by family physician.
    b. URGENT REFERRALS – "URGENT CARE" order: Select appropriate service. Remember to provide 14 days of medication when referring to these services if you are prescribing:

        i. 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.

ii. 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.

iii. MOOD AND ANXIETY URGENT CARE CLINIC – 10 referrals per week are provided to the ED. 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.

iv. RAPID GERIATRIC ASSESSMENT: Late Life Mood Disorders service - Geriatric Mental Health Services (GMHS

c. PARTIAL HOSPITAL PROGRAM – they will contact the patient directly to set up an intake. Usually within 24 hours of the ED visit. Order available in ICARE

d. SLAIGHT EARLY INTERVENTION REFERRALS: 30 or under, no catchment area, treatment of psychotic symptoms for 3 years or less. Referral available on ICARE and handout in referral drawer

e. Insite or www.camh.ca will provide you with program-specific descriptions of services available. Printing these out for patients to take home and read is always a good idea.

4. Community Resources→
   a. Community Resources Drawer – Our social workers work tirelessly to keep our community resource file folders up to date. These are all located in the large drawer at the front of the ED. There is a wealth of resources in there, covering every diagnosis and psychosocial situation. There are also information booklets on some of the common diagnoses (although these will be online moving forward).
   b. The community resources file on the T drive is full of great lists of community resources that you can print out for patients.
   c. 211 Toronto(www.211toronto.ca). When all else fails you can always use this website to search for specific community resources.

Medications Dispensed from the Emergency Department

Only medications that are urgently needed should be dispensed from the Emergency Department, for patients to take with them. Quantities should be limited (1-3 days) and patients should be instructed to return to their treating doctor as soon as possible to obtain repeat prescriptions. Prescriptions, on the other hand, can be ordered for a maximum of 14 days. Caution should be exercised and prescriptions written judiciously since you will not be able to follow up with the patient. Prescriptions MUST BE done as an order through Firstnet, but need to be printed and signed.

Obtaining and Sharing Information

The Personal Health Information Protection Act (PHIPA) came into effect on November 1, 2004, and has important implications for emergency room practice. It's important to know that personal health information should be obtained directly from the client unless the client grants permission to speak to others, or if the patient is unable to provide accurate and / or timely information. Information can always be obtained from others without the patient's consent (including other medical institutions and caregivers) when one is performing an assessment under the mental health act (under a Form 1, for instance). Also, we are required to perform our duties up to the standard of our college, that is, the College of Physicians and Surgeons of Ontario. If refusal to grant consent to gather information prevents a physician from performing her clinical role up to an expected standard, the patient's refusal can be overridden. Whenever information is obtained against a client's wishes, the rationale for gathering such information should be very clearly documented and should be discussed with the attending physician.

While PHIPA allows for open sharing of information within a client's "circle of care", it is CAMH policy to obtain expressed consent for information sharing from other medical or psychiatric institutions except for the situations mentioned above.

PHIPA contains a "lockbox" provision. This allows clients to prevent specified healthcare givers or institutions from viewing designated portions of the medical record. The lockbox can also be used to prevent clinicians within the same institution from accessing a specific portion of the chart. PHIPA allows access to the entire chart if the client is being assessed under the Mental Health Act (ie/on a form 1), though the reasons supporting the need to review the entire chart against the client's wishes must be very clearly documented. Also, the lockbox provision must never impede clinicians from performing their duties to the standard of their professional governing bodies (in this case, the College of Physicians and Surgeons of Ontario). If the resident has reason to believe that important information is "locked away" and that this information is vital to the assessment of the client, he / she should clearly document the reasons for complete access to the chart. A "lockbox access" form is available on I-CARE and should be completed. Of course, all decisions to access a sequestered portion of the record should be discussed with an attending psychiatrist before this portion of the chart is examined.

If you have questions about privacy issues, you can speak to the CAMH Privacy Office [Appendix H].

MANDATORY REPORTING

The CPSO mandates that the following circumstances be reported. This means that patient confidentiality is trumped by a professional duty to warn:

1. Child Abuse or Neglect
2. Impaired Driving Ability
3. Long-Term Care and Retirement Homes
4. Sexual Abuse of a Patient
5. Facility Operators: Duty to Report Incapacity, Incompetence and Sexual Abuse
6. Terminating or Restricting Employment
7. Births, Still-births and Deaths
8. Communicable and Reportable Diseases
9. Controlled Drugs and Substances
10. Community Treatment Plans

11. Gunshot Wounds
12. Pilots or Air Traffic Controllers
13. Railway Safety
14. Maritime Safety
15. Occupational Health and Safety
16. Correctional Facilities
17. Preferential Access to Health Care

Impaired Driving Ability

The following is taken from the CPSO web site regarding mandatory reporting of individuals with health conditions making them unsafe to operate vehicles:

The *Highway Traffic Act* requires that physicians report every individual sixteen years of age or over to whom the physician has provided medical services (patients or otherwise) when physicians are of the opinion that the individual has a medical condition or functional impairment that may make it dangerous for him or her to operate a motor vehicle.[16]

Reports must include the name and address of the individual and the medical condition or functional impairment that affects the individual's ability to drive. In order for the Ministry of Transportation to apply the information to the correct driver, the date of birth should be indicated in the report. Reports should be sent to the Registrar of Motor Vehicles of the provincial Ministry of Transportation. If you decide that there is a duty to warn, the patient should be informed of your intent.

Child Abuse or Neglect

Residents are reminded that all circumstances of suspected child risk, abuse and neglect must be reported to appropriate child protection agencies at the time of assessment. If you are not sure whether reporting is necessary, you can call CAS and discuss the situation without using the patient's name. If CAS advises that you must report, identifying information must be given to them.

MANAGING AGGRESSIVE AND AGITATED CLIENTS

Staffing Level

Whenever a patient has a history of aggression or agitation, or if there are new concerns that aggression may occur, it is important to plan in advance for the number of staff who should be present for the safe assessment of a patient. The team should consider any past incidents of aggression, recent aggression, the present degree of agitation, reports from police, family or others, and any present substance abuse, intoxication or medical issues. The resident and ED staff should discuss how many staff are required, whether restraints might be needed and the assessment should not be started until adequate staff (ED staff, program assistants, security and residents) are present.

Staff at the Centre are trained in non-violent methods to contain and manage disturbed patients. On occasion some patients require a more coordinated response to manage safety. If this occurs, staff should call "5555" to call a Code White and/or request police assistance.

Choice of Interviewing Room

Once the patient has been triaged, the history reviewed and preparations made for the interview, it is important to consider the safest place to interview the patient. If any patient is extremely agitated, other patients should be cleared from the waiting area and the patient can be seen there, or the patient can be brought directly into the EAU. This is the largest space, can be locked, and is visible from the ED care station. Interview rooms 2 and 4 have double egress, and rooms 8 and 9 are the next safest interview rooms. All interview rooms have weighted chairs that are difficult to move or throw. All ED clinical areas are on camera and have hard-wired security panic buttons. Whenever a patient with a potential for aggression is interviewed in the ED, staff can ask security to view the interview on camera and intervene if the patient becomes more agitated. Residents can also request a clinical staff member to sit in on the interview with them if concerned about safety. Security can be present outside the interviewing room for situations that may escalate.

RESTRAINTS

The use of mechanical restraints is confined to situations in which the client poses an immediate significant risk of harm to himself or others and cannot be calmed and contained by other means.

As you are all aware the Revised Emergency Use of Chemical Restraint, Seclusion and Mechanical Restraint Policy was implemented on June 1, 2009. It is essential that you review this policy, which is available on insite or via the following link:

http://insite.camh.ca/policies/PC_2_E_2_Emergency_Use_of_Restraint-43948.pdf

Minimize Need for Restraint

- **All Patients should be assessed as soon as possible** for the potential for agitation, aggression, and harm to self or others. Appropriate treatment plans must be put in place, and must include strategies for de-escalation as alternatives to restraint.
- PRN medication orders must take into account the risk for agitation, aggression and harm to self or others. PRN medications must be of adequate dose. For standardized prn / stat dose guidelines see Appendix G.
- Oral prn medications may be prescribed for anxiety, agitation, aggression, and insomnia or other circumstances but they can only be administered to patients with consent (from the patient or SDM). PRN medications are not considered chemical restraint but rather a form of treatment that must be governed by the Health Care Consent Act.
- In order to maximize safety for patients and staff, escalating agitation in patients must be identified early in all clinical settings, and every effort must be made to assist patients to de-escalate in the least intrusive manner. Mechanical and Chemical restraint are to be used only as a last resort.

Chemical Restraint

- **Emergency Chemical Restraint orders can only be prescribed as STAT medications. Physicians must assess face-to-face all patients requiring chemical restraint and document their findings in the Treat Progress Note. While emergency chemical restraint can initially be ordered by telephone, residents will have to assess the patient face-to-face within 2 hours of giving the order and document their assessment.** Unlike prn medications which are given as treatment and require informed consent, stat medications for emergency chemical restraint do not require consent;

however good clinical care dictates that patients must be informed of the restraint and engaged in clinical interaction.

- IM medication administered without Patient/SDM consent or PO medication given under coercion are considered chemical restraints.
- **IM PRN and PO/IM PRN chemical restraint orders are no longer permitted.** Registered Nurses may not administer medications ordered in this manner. Nurses or pharmacy staff must reject such orders and notify the physician to revise the treatment plan. There may be rare circumstances when a PRN IM order is acceptable (e.g. patient with swallowing difficulties). Other non-restraint IM medications such as for analgesia for migraine headaches and benztropine for acute dystonia are permitted as previously.

Seclusion

The seclusion room is part of a multipurpose space which also includes the negative pressure room. We are required to have a NPR by Ministry requirements but rarely need to use this room for its intended purpose. While we will likely use this multipurpose space primarily as a seclusion room, if a client comes in with an airborne illness, the priority should always be given to the infectious client and client's requiring seclusion should be managed in another manner.

Seclusion Definition: means the confinement of a client/patient in a locked room or area designated for seclusion to restrict movement from one location to another (also referred to as environmental restraint).

When to Use Seclusion

When a patient has become unsafe in milieu and is a threat to self or others, a decision between seclusion, mechanical or chemical restraints will need to be made. As always, staff should first use PMAB principles and employ verbal de-escalation and other less restrictive methods prior to considering any type of restraint.

Situations where seclusion may be considered include (but not limited to):

- Client intrusive/aggressive with other clients and this is escalating other clients
- Client threatening others but not self harming

If trial of seclusion is used and client presents further safety risks (ie: jumping off bed, self harming) then the team may need to consider mechanical restraints if this will mitigate the risk to client.

If client can not be safely placed in seclusion room (ie: rushing the door, trying to hit staff when they are leaving room) or can not be safely escorted to room, mechanical restraints may be more appropriate.

- Much like mechanical restraints, seclusions can be initiated by an RN, with an MD order to follow.
- An order for seclusion will be in effect for a period no greater than **12 hours**. During this 12-hour period, another physician's order is not required when attempts to end seclusion (release trial) are unsuccessful and the client/patient is placed back in seclusion.

- Typically, after two continuous hours, a release trial will be considered successful and seclusion will be discontinued. If seclusion is subsequently initiated, it is considered a new episode and it requires a new order and face-to-face assessment.
- Seclusion will be re-ordered by a physician every 12 hours based on a face-to–face assessment of need. Seclusion will be discontinued as soon as clinically possible.
- A physician order is NOT necessary to discontinue seclusion or mechanical restraint. Example of seclusion order: "Seclusion for aggressive behaviour (throwing objects at others) for up to 12 hours starting at ____ (time)".

Mechanical Restraint

- A Registered Nurse may initially place a patient into mechanical restraint without a Doctor's Order and obtain the written order as soon as possible thereafter. The RN must contact the resident or on-call physician to notify them of the restraint. **The resident or on-call physician is required to conduct a face-to-face assessment of the patient within two hours of the patient being placed in restraints.** This assessment must be documented in a "Restraint Event" note. This assessment is required even if the patient is removed from restraints within the two hour period.
- A Doctor's Order for Mechanical restraint must specify the reason for restraint and the duration up to a maximum of 12 hours. An order cannot read "Mechanical Restraint PRN".
- **If a patient remains in mechanical restraint for longer than 12 hours, a face-to-face physician reassessment is required to renew the order.** This has not occurred in the ED for many years.
- When a patient is placed in mechanical restraint, The 12 Hour Emergency Use of Chemical Restraint, Seclusion and Mechanical Restraint Record must be initiated by the RN.
- The RN may remove a patient from restraint, when clinically indicated, without a Doctor's order.
- Any patient requiring restraint/seclusion for **greater than 72 hours will require mandatory consultation** by a psychiatrist from outside the program (contact Dr. Ravindran's office for the roster list of senior physicians for such consultations)
- A voluntary patient may be placed into mechanical restraints if there is immediate risk of harm. The patient must be assessed by a physician face-to face as soon as possible to determine if voluntary status continues and the restraints must be removed; or if the patient should be made involuntary and the restraint is still indicated.

Nurses will need to be able to contact attending or on-call psychiatric staff without delay to obtain any restraint order when needed (within at most 15 minutes). Failure by psychiatrist staff to respond to pages in a timely manner may lead to unsafe situations. Nurses will report any difficulty reaching attending or on-call staff to the relevant Unit Manager, Clinical Head, Medical and Executive Directors. All such incidents will be reviewed with the Physician-in-Chief.

The Psychiatric Patient Advocates Office (PPAO) is contacted whenever a client is restrained. It is the responsibility of the PPAO to follow up with the client which will happen during regular business hours.

Chemical and mechanical restraint can be a traumatic event for patients and the team. All these incidents must be debriefed. All relevant staff will be expected to attend. Staff will support and debrief all patients after these events. The Team leader is responsible for facilitating the debrief after each incident.

Searching Patients

The decision to search patients in the emergency department is based upon the assessment of the patient's risk to himself or others. Any patient with a known history of carrying weapons or patients whose history suggests that they are carrying weapons should be searched. Also, if a patient presents to the emergency department as the result of a Mental Health Act form (a Form 1, for instance), it is strongly recommended that the patient be searched immediately after triage. If a patient who presents on a voluntary basis is felt to be at risk of harm to self or others and refuses to be searched, consideration should be given to completing a form 1 and the search performed. The reasons for the certification and the decision to perform the search against the patient's will should be discussed with the attending physician and thoroughly documented. A clinical staff member must be present for all searches by security. In all other instances, a patient is searched only upon admission. Security will wand all admitted patients with a metal detector. All patients should have their personal belongings itemized and documented in the clinical record by PA. All medications, potentially dangerous and/or contraband items (including tabacco products, lighters and matches) will be removed by staff and placed in safe–keeping (either in the care station or with Security). Removal of all items is to be clearly documented in the clinical record, usually by the PA.

Discussion of Admission or Discharge

The discussion of admission with agitated or aggressive patients, especially when the admission will be involuntary, can provoke aggressive behavior. As well, certain patients who are seeking admission may become distressed when not admitted. At all times potential difficulties should be anticipated and preparations made before the patient is told about the admission/discharge. Consider being accompanied by another person (fellow resident, RN, PA) when informing agitated patients about certification, admission or discharge. The plan of action should be discussed with the ED Staff to ensure that there are sufficient staff if it becomes necessary to restrain and medicate the patient, or to escort the patient from the department. When discharging a client, please check in with ED staff to ensure the client has all belongings before being let out of the unit.

Managing Safety Concerns that Arise During the Assessment

If at any time during the assessment a patient becomes agitated and cannot be redirected, the interview should be stopped and the safety of the situation reassessed. Whenever necessary, extra staff or a "Code White" (dial 5555) can be called and physical/chemical restraint can be initiated. The resident should consult with the ED staff on any or all of these options. If patients are too agitated or threatening to be restrained by usual methods, police can be accessed by calling 5555 who will then call police for us.

DOCUMENTATION

Careful documentation of all interviews and components of the emergency assessment is essential. This should include, at a minimum, the HPI, Diagnosis, MSE, assessment and plan. Any emergency treatment, medications or forms of the Mental Health Act must be noted. The plan must be described and include the patient's response to the plan, especially if they disagree, or

express dissatisfaction with their ED visit. Residents should learn the skill of writing brief, concise, accurate, relevant and medico-legally sound notes.

All clinical information is recorded on the MULTIDISCIPLINARY ED ASSESSMENT powerform in Firstnet. The purpose of this form is to decrease unnecessary repetition in the clinical record and to improve team collaboration. This form allows for multiple assessors to record the joint assessment on the same document if so desired. For instance, the assigned nurse might complete the history of present illness portion of the form, the medical student the mental status section, and so on. However, physicians are solely responsible for completing the final three sections, Diagnois, MSE, Assessment and Plan. It is important that all assessors print their name and credentials when completing the assessment. Finally, please indicate the name of the staff psychiatrist with whom the case was discussed in the last section.

All physician contacts must be dated and timed, including the interaction start time and ending time (at the end of the final section of the multidisciplinary ED assessment). An episode of patient care includes any clinical activity related to the patient's assessment and treatment, including chart review, phone calls, collaboration with other ED staff, etc.

HELPFUL HINTS AND MISCELLANEOUS INFORMATION

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.

Helping Families, Friends, and other Caregivers

Families and accompanying friends should be included in the assessment whenever possible (and permitted by the client). Particular attention should be given to providing "feedback" and treatment recommendations to them. An elegant, insightful evaluation isn't worth much if the recommendations it generates are not thoroughly and artfully conveyed to the client and his or her support network. It is our "default" position that other professional caregivers (family doctors, community agencies, outpatient psychiatrists and so on) should be consulted by phone as part of the assessment and should receive a written copy of the assessment. Of course, privacy regulations must be respected, but these are quite liberal regarding patients being assessed in a psychiatric emergency department (please see "Obtaining and Sharing Information").

Police Redirect

The Public Hospitals Act states that any patient presenting to an Emergency Department cannot be turned away and must be assessed. The police do not have the capacity to inform officers to direct prospective patients away from any particular emergency department(s). Thus the term "police redirect" is a fiction.

Forthwith Patients (court-ordered mental health assessments)

In May 2005, clients in custody who were ordered by the court to undergo mental health assessment and / or treatment were required to receive such services “forthwith”. Given capacity challenges facing the Law and Mental Health program, such clients were sometimes sent to the CAMH ED. Since they were both CAMH patients and persons in custody, they merited special consideration. This practice has been suspended, and should a patient arrive at the CAMH ED with a court order for an assessment, the patient should not be assessed until the situation has been discussed with the nursing supervisor, attending physician, and a representative of the Law and Mental Health (LAMH) program.

Infection Control

A number of procedures have been instituted in the ED/EAU following provincial directives. Residents are an important part of the infection control team and must be aware of present infection control practices. Infection control procedures and the Communicable Diseases Form must be completed upon admission of a patient to the EAU or any other CAMH inpatient unit. Prospective clients should be screened regarding their risk of having tuberculosis, and depending on the season, clients are asked if they have received the influenza vaccine. A negative pressure room is available in the ED. It is to be used for those clients displaying any symptoms of an infectious respiratory illness (cough, fever, etc.). All residents must be up to date with vaccinations, mask-fit testing, and TB status. **All residents are required to carry on their person a valid mask-fit card.**

Passes from the Department

If a client is waiting to be assessed in the ED or has been assessed and is waiting for transfer, the client can leave the ED if the clinical staff believe the client is safe to do so. It is important that the risk of going AWOL is seriously considered for those clients who pose a risk of harm to themselves or others. If there is any concern that such a client might leave before the assessment is completed, they should be assessed immediately by a physician to determine if they meet criteria for involuntary admission. In such a case, the client should not be allowed to leave the department. We do not accompany patients outside at any time except when we are transferring them to another unit or for medical clearance. We do not grant passes to certified clients in ED. Once a client has been admitted to the EAU there are no passes in the EAU for any circumstance.

If a voluntary patient admitted to the EAU wishes to leave for any reason (including to smoke) and insists upon this, the patient must be reassessed by a physician regarding safety issues and potential risk to herself or others. If smoking is the matter at hand, nicotine replacement therapy should be vigorously offered. However, if the patient is judged not to be certifiable and insists on leaving the department, he / she should be discharged against medical advice with appropriate careful documentation of this. Residents must discuss such potential AMA discharges with the on-call staff psychiatrist prior to the patient's discharge from the department.

Telephone Calls

The College ED receives numerous phone calls from patients, families, and community agencies. The receptionist or switchboard after hours will pass on the caller’s name, telephone number and reason for call to the ED team. It is the shared responsibility of the RN staff and residents to respond to these phone calls. When responding to these calls, do not prescribe medication, order repeats, or give away any other medication advice. Patients with medication concerns

should be assessed by their treating physician or be advised to go to their nearest ED if the concern is urgent. All clinically relevant calls should be documented.

Morning Report

Morning report is held from 0830-0930h on weekdays and 0900-1000h on weekends. At this time the residents will review the patients seen overnight with the incoming team. Priority will be given to patients who were admitted to the EAU and to patients the resident(s) wish to discuss in further detail because of a particular challenge or question. **Emphasis is placed on patient formulation.** Patients held overnight should be reviewed in morning report and handed over to the day team. Residents may be asked to stay longer in the morning if their notes are incomplete or if they need to complete a Form 1 for the return of a patient. If residents need to leave the report early, please notify staff so they can give their report first.

Maintaining safety in the Emergency Department is of great importance to the entire team. Any issues of safety should be brought up in the morning report to review how the issues were handled, to teach around the issues and to look for other management options. This is also a forum to support residents in their work with difficult patients.

If the fourth call resident has not admitted a patient to the EAU, and has discussed all cases with the staff on call, then the resident is not required at morning report. We highly encourage the fourth call resident to come back the next morning (weekdays only) to hand over their cases; if this is not possible please provide adequate handover in SBAR format to a colleague.

Preventing ED Backup

One of the expectations in the ED is that a high quality of patient care be delivered to all patients. This includes assessing and treating patients as efficiently as possible. Agitated and potentially violent patients cannot tolerate waiting for long periods of time before they become even more agitated and threatening. For these reasons, it is important to ensure that the ED functions in an efficient manner and that no patient be forced to wait for an excessive period of time. Here are some tips to keep the patient flow moving and the waiting times reasonable:

- **The workload and acuity of patients should be discussed with the ED staff to come up with a reasonable plan of action and division of workload. Residents will need to be adaptable to the needs of the department.**
- **The emergency assessment should be focused on the presenting problem.** Although all assessments must be appropriately detailed to arrive at a good understanding of the presenting problem, risk factors, diagnosis and emergency treatment plan, a complete psychiatric history is not always required. Excessive or repetitive history taking cannot only cause unnecessary distress to the patient, but will also slow down the proper functioning of the Emergency Department. More complete psychiatric histories should only be done when there is a clinical need, as with a new or complicated patient, or when there is sufficient time to do so. **It is not necessary for the resident to repeat all the history that the ED staff has already documented.** The Emergency Service is an excellent site for teaching because of the great variety of patients and psychopathology, but excessively long history taking can create significant clinical difficulties and distress.
- **The attending psychiatrist on call should be informed of all significant occurrences in the Emergency Department.** The attending psychiatrist is available to help with any clinical or administrative problems, which include questions about safe practice and

patient management in the emergency room. The management of workload can also be discussed.

Tips for Success from our Nursing Team:

"Tish's Top Ten List of Pointers for Resident Success in the CAMH ER"

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.

9. Residents are part of the Code White.

10. Our priority is safety of the client, and staff. Do not do anything that feels unsafe...get back-up, we are here to help the call go as smoothly and safely as possible.

Reporting of Incidents

In addition to discussing any incidents with staff on-call and in morning report, residents should also report incidents of concern to the chief residents and to the Clinical Head and Manager of the Emergency Service. This feedback is essential to the team to ensure that practices are reviewed and improved where necessary.

Dress Code

It is expected that all CAMH employees will wear casual business attire to work. Residents should also keep safety considerations in mind when choosing their "ED wardrobe": items such as neckties and heels can be hazardous in difficult situations. According to the CAMH dress code the following are not considered appropriate: tank/tube tops, bare midriffs, bare backs, jeans with holes, T-shirts with suggestive writing, pictures or logos, short shorts. In addition, closed toed and heeled shoes should always be worn in clinical areas.

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
- Medical student expectations:
    - 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

ADDICTIONS PROTOCOLS

Please see appendix 2 for Medical Withdrawal Service Transfer Protocol, and appendix 3 for an informative powerpoint presentation about the ED's upcoming suboxone protocol

APPENDIX 1: MSH - CAMH Protocol for Emergency Department

MSH - CAMH Protocol for Emergency Department

Originator/Owner: Emergency Department	**Initial Issue Date**: Nov 2016
Reviewed By: MSH ED and Psychiatry Leadership CAMH ED Leadership	**Review Date**: July 2017

Purpose:

- To outline clinically relevant issues detailed in Memorandum of Understanding Partnership Agreement between CAMH ED and MSH ED
- To ensure proper transfer of care of clients between CAMH and MSH Emergency Departments

Background

CAMH ED and MSH ED have a formal partnership which outlines expectations of staff at each organization. Both CAMH and MSH recognize the value in constructing a model that is sustainable over the long term. We believe that this protocol reflects our objectives of good patient flow; patient centred care; a commitment to partnership and a sense of equity with regard to the provision of care.

MSH ED transfer to CAMH ED procedure:

Clients presenting to MSH ED who need psychiatric assessment/consultation will be assessed by the on-call psychiatrist at MSH between the hours of 07:00 – 23:00, if there is a bed, or will be a bed in the foreseeable future (i.e / the next four hours) on MSH9S. When there is no bed availability, the patient will be transferred to the CAMH ED for assessment/consultation.

Clients requiring psychiatric assessment/consultation in the MSH ED between the hours of 23:00 – 07:00 will be sent to CAMH ED for this purpose, whether a bed is available at MSH9S or not.

Regardless of bed availability, psychiatric patients presenting to the MSH ED with complex medical needs will be assessed in the MSH ED by the on call psychiatrist to effect a collaborative decision regarding the most suitable disposition. Geriatric as well as perinatal mental health patients will also be assessed directly in the MSH ED regardless of bed availability because their initial clinical care may be better served in a general hospital.

For all patients being transferred to the CAMH ED, the following will occur:

- the MSH ED MD will call the CAMH MD to give a verbal telephone report. The CAMH MD will document relevant information on a Firstnet Pre-arrival form and will ensure the client is medically stable for CAMH.
- The MSH ED RN will call the CAMH RN to give a verbal telephone report. The CAMH RN will document any additional relevant information on a Firstnet Pre-arrival form and will

arrange a time for transfer, although time of transfer should be immediate unless in special circumstances.

- The MSH team is responsible for transferring the client to the CAMH, checking in at admitting and waiting with the client to give a brief face-to-face hand over report to the CAMH triage nurse. MSH staff are responsible for the client until care has been transferred. The MSH team will bring the following documents:
  - Copies of triage form, ER patient record, nursing documentation and any relevant lab/diagnostic test results
  - Original Form 1 and copy of Form 42 (if applicable)
- MSH arrivals will be prioritized at CAMH triage to ensure transfer of care occurs in a timely manner thus allowing MSH staff to get back to their hospital quickly. The CAMH triage nurse will proceed with triage as per our regular process.

Medical Consultation: CAMH ED/EAU transfer to MSH ED procedure:

CAMH has limited capacity to treat clients with medically complex issues given the nature of our facility. Clients who present with a medical issue that is beyond the scope of practice at CAMH are sent to the MSH ED for any necessary investigations and/or treatments. For medical emergencies, CAMH staff will call 911 for immediate medical intervention.

CAMH MD will call the MSH ED MD for a phone consult on the client. The transfer will occur after report if medical assessment is indicated. The CAMH MD will complete the "Medical Clearance Transfer ED-MSH form" found in Firstnet under “Additional Forms”.

The CAMH RN will call to give a verbal telephone report to the MSH ED Team Leader including whether or not the patient is on a Form 1 and the need for security and/or restraints.

- As the client is leaving CAMH, the assigned CAMH RN will update I-Care accordingly
- CAMH staff (usually a PA) is responsible for transferring the client to MSH (refer to *Transfer protocols in ED*), checking in at MSH triage and waiting with the client to give a brief face-to-face hand over report to the MSH triage nurse. The CAMH staff are responsible for the client until care has been transferred, after the triage and registration process. If there is concern about keeping the client safe, notify MSH staff immediately. The transferring CAMH staff are not to leave until the MSH Team Leader and/or triage nurse has released them. CAMH team are responsible for bringing the following documents to MSH ED at the time of transfer:
  - Medical Clearance form
  - Original Form 1 and copy of Form 42 (if applicable)
  - Print out of PTAC authorization
- CAMH arrivals will be prioritized at MSH triage when possible to ensure transfer of care occurs in a timely manner thus allowing CAMH staff to get back to their hospital quickly.
- If the client is an involuntary patient, then CAMH staff will remain with the patient until relieved by MSH security.

Return of Clients from MSH ED to CAMH after medical assessment:

- The MSH MD will either provide a written report/chart copy to accompany the client, or call the CAMH MD to discuss the client once medical assessment is near completion. If a verbal report is provided it should be documented in I-Care. If questions arise after transfer, a phone call back to MSH ED is encouraged in order to address them as soon as possible.
- The MSH ED RN will call to provide a verbal telephone report to the CAMH RN with relevant information from medical clearance. The CAMH RN will document the report in I-Care.
- The CAMH ED will send staff (usually PA) to pick up a client from MSH (refer to *Transfer protocols in ED*)
- MSH team is responsible for sending the following documents back with client:
  - ER Patient Record, the Nursing Documentation, printed lab tests or diagnostic studies

Original copy of Form 1, photocopy of Form 42 if applicable.Upon arrival, the assigned CAMH RN will update the client's status in I-Care accordingly.

ED Management of Psychogeriatric Patients with Dementia/Major Neurocognitive Disorder

Geriatric Patients arriving at the CAMH ED with a primary diagnosis of dementia will be assessed in the CAMH ED. If medical assessment is warranted they will be transferred to MSH ED, as per the above protocol. Once medical assessment is completed, they will be repatriated to CAMH (with CAMH staff accompanying) for disposition including consideration for admission to one of the CAMH geriatric inpatient units

Geriatric Patients arriving at the MSH ED requiring psychiatric consultation will have their consult arranged as per the MSH and CAMH transfer protocol above (07:00 – 23:00 by MSH Geriatric Psychiatry (x8419) or on-call psychiatry (x5133), 23:00 – 07:00 at CAMH ED). If the result of the initial consult leads to a primary diagnosis of dementia AND/OR co-morbid mental illness (i.e. Schizophrenia, Bipolar disorder, Depression) without acute medical concerns, requiring psychiatric admission, THEN admission to MSH will be considered first and CAMH second, depending on bed availability.

If the result of the CAMH assessment of patients who originate in the MSH ED concludes a primary diagnosis of dementia and an absence of other co-morbid psychiatric illness requiring psychiatric admission or medical/surgical illness requiring acute hospital care BUT the patient requires increased CCAC services, the patient should be returned to MSH ED (with MSH staff accompanying) for CCAC review and advice regarding disposition.

We recognize that some patients who require admission may pose disposition challenges. Two further principles will guide decision making in these instances. These patients should be cared for at the site in which they first came to the ED; and we will aim to support pre-existing treatment relationships and continuity of patient care.

NB: Sunday to Thursday evening/night consideration will be given to holding the patient in MSH ED for geriatric psychiatry consult in the morning on site at MSH.

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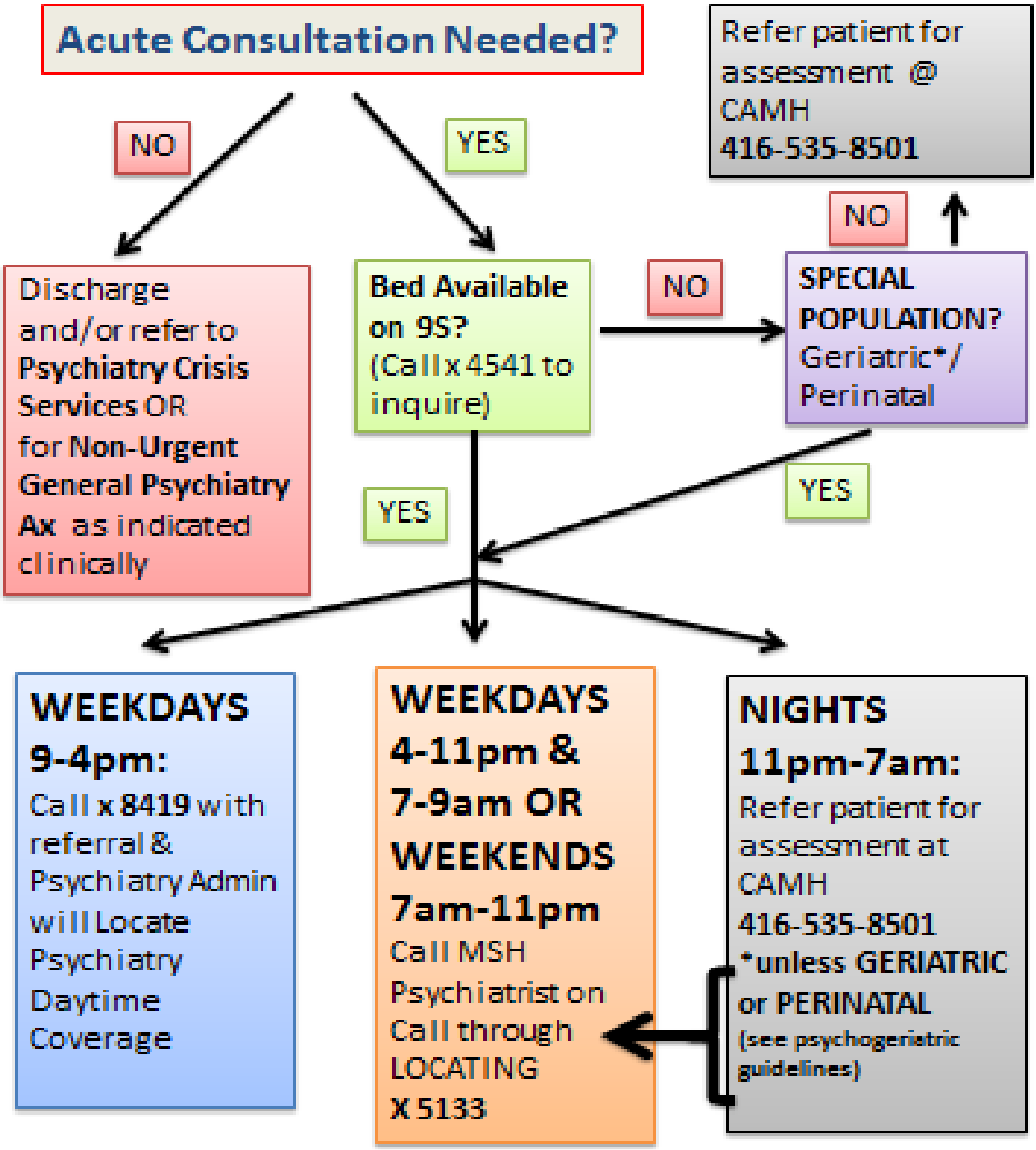
MSH ED Psychiatric Referral Guidelines

revised Nov 3rd, 2014



APPENDIX 2: MWS Transfer Protocol

Alcohol Withdrawal Management and Transfer Protocol for Emergency Department

Originator/Owner: Emergency Department	**Initial Issue Date**: August 28, 2014
Reviewed By: Emergency Department, Addiction Medicine Service (AMS) and Medical Withdrawal Service (MWS) Leadership	**Review Date**: April 11, 2017 **Next Review Date:** October 1, 2017

Protocol Purpose:

- To describe procedures for management of clients presenting to the ED with acute addiction issues
- To describe proper transfer of care between ED and MWS
- To describe procedures for referral to AMS

Definitions:

Non-Medical Detox	Detox that does not require medical treatment (i.e., does not require medications to manage withdrawal symptoms)
Medical Detox	Detox that requires medical treatment (i.e., requires benzodiazepines to manage withdrawal symptoms)
Complicated Withdrawal	Clients who have experienced delirium tremens (DTs), withdrawal-related psychosis, seizures, pregnancy, or medical complexity (e.g**., hepatitis, pancreatitis, liver disease)** ***Complicated withdrawal is an admission criteria for the Medical Withdrawal Service***

ED Management Procedures for Clients Using Alcohol:

Intoxicated Clients

- Clients presenting intoxicated will be held in the ED until they are sober. Once sober, they be reassessed and discharged home if there are no safety concerns and no withdrawal symptoms present. If acute withdrawal and/or safety concerns persist, admission should be considered. If safety concerns are paramount over withdrawal, admission to a mental health unit should be considered.

Clients in Withdrawal

- Clients presenting in active withdrawal will be held in the ED and a CIWA protocol initiated. After 3 consecutive negative CIWA scores, the following options are available:
    a. Discharge home with a referral to AMS
    b. Discharge to Day Detox at AMS
    c. Discharge to **non-medical detox** through Central Access for Toronto Withdrawal Management Services (1-866-366-9513). A one-page paper referral should be faxed to the receiving facility and the original sent with the patient. These patients should also be referred to AMS, in the absence of other supports.

- If, at 8 hours, the patient is still in active withdrawal, we will admit to the following locations 24 hours a day/7 days a week, depending on bed availability. (See 'ED Transfer to MWS Procedures' for case-by-case exceptions to waiting full 8 hours).
    a. Admit directly to MWS (see 'ED Transfer to MWS Procedures' for details)
    b. Admit to EAU for reassessment next morning
    c. Discharge to Day Detox at AMS

- If client has a known history of complicated withdrawal, or requiring longer admissions to stabilize, the client does not need to wait 8 hours in ED prior to admitting to MWS or EAU however they cannot be intoxicated for a MWS admission. The benzodiazepine load should be completed prior to transfer in order to minimize risk of seizure during the transfer process.Likewise, if a client with a history of complicated withdrawal has three consecutive negative CIWA scores while in the ED, but you are concerned that symptoms may recur, this person should also be considered for admission to MWS.

**NOTE: Do not put client in ED HOLD in I-CARE while we are holding client for withdrawal as this admits client.

For all Clients Using Alcohol

- We should not dispense or prescribe benzos at discharge to anyone (except in rare circumstances), but will instead manage their withdrawal on site.
- All clients presenting in any of the above categories should be provided with appropriate referral information, including Addiction Medicine Service (AMS)/Addiction Medicine Intake Group (AMIG), concurrent disorders, etc. upon discharge.
- Should a client decide to leave AMA, psychoeducation should be provided regarding the risks of withdrawal and appropriate management. Clients can also be advised to continue drinking, monitor their intake, slowly reduce it, while they wait for their intake group/assessment.

ED Transfer to MWS Procedures:

Clients Using Alcohol Only

- See 'complicated withdrawal' definition for MWS alcohol admission criteria. Exceptions for clients with uncomplicated alcohol withdrawal can be made on a case-by-case basis (e.g., severe ED bed pressures, client presenting for first time addictions treatment; concurrent illness)
- Transfers to MWS can take place 7 days a week, 24 hours a day, providing the following are complete:
    - Brief assessment of medical stability (at CAMH) or medical clearance (at MSH)
    - MWS and CAITS Residential Direct Admission Order Set (located in the ED Common Order Sets folder)
    - CIWA Order Set
    - Nicotine Replacement Therapy order set
    - Clinical documentation

Information to Share with Clients Prior to Transfer

- Client should be informed that MWS does not allow passes, privileges, or visitors (other than community case workers) for clinical reasons and that it is a non-smoking unit
- Clients who are also using opiates should be aware that MWS will not detox them from opiates, but will initiate opioid maintenance therapy (i.e., Suboxone or methadone)

Medically Unstable Clients and Clients Using Multiple Substances

- Clients who are medically unstable should be medically cleared at Mount Sinai Hospital. Once medical stability is established they can be admitted to MWS (when a bed is available) during working hours Monday – Friday. Due to limited medical and addiction medicine support after hours, complex clients should be transferred during working hours when MWS attending physicians are present to assess and monitor clients.

MWS Bed Flow Logistics

- Each afternoon (M-F) MWS bed coordinator (Cherry Dator) will inform MWS overnight charge nurse and CAMH Bed Flow manager prior to 1600 of any bed availability. Bed Flow will then be responsible for informing After Hours Managers of bed availability over night. On weekends and holidays, bedflow is managed by the After Hours Manager and any bed availability should be communicated directly to that person.

ED Referrals to Addiction Medicine Service Procedures:

Referrals to AMS should be made using the **ED Request to AMS order in I-CARE**. For same day referral management, ED staff should call **x 34547** which is the direct line to the RN working in Day Detox. He/She will direct us to the "fit-in" (on-call) MD in AMS that day, and a direct transfer from ED to day detox or rapid access clinic can be facilitated.

- Clients being referred to **AMS for Day Detox** should meet the following inclusion criteria: alcohol dependence, experience significant daytime withdrawal symptoms, able to return to clinic at a pre-determined time for follow-up, does not satisfy any of the inclusion criteria for MWS, medically stable, if smoker willing to use NRT for the day, may have history of seizure disorder/alcohol related seizures (clinical judgement)
- Clients reporting problematic use of **opioids** can be referred to AMS for a more comprehensive assessment and treatment. Clients who are opioid dependent may be initiated on suboxone in clinic – ideally clients should present in early stages of withdrawal. Please note that detox from opioids is usually not offered in AMS but outpatient tapers will be considered if appropriate.
- Clients reporting **benzodiazepine dependence** who require medical supervision to manage withdrawal/taper off medication can be referred to AMS for a more comprehensive assessment and treatment.
- Clients reporting problematic use of substances such **GHB, methamphetamine, crack cocaine and/or cannabis** should be referred for further medical assessment and treatment. Clients reporting GHB use around the clock should be referred to MWS. Clients should be aware that consent to speak to all prescribers will need to be obtained during our initial assessment.

APPENDIX 3: Suboxone information

CAMH ED Suboxone Induction Pathway

Christine Bucago, RN, APCL
Hermia Cheung, RPh
Brittany Poynter, FRCPC
28 April 2017

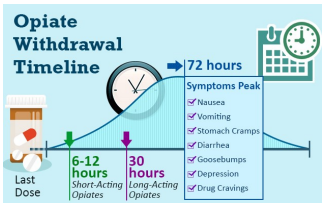
camh
Centre for Addiction and Mental Health
Centre de toxicomanie et de santé mentale

Objectives

- Review the signs and symptoms of opioid withdrawal
- Learn about the pharmacological properties of Suboxone
- Discuss inclusion and exclusion criteria for the pathway and rationale for its development
- Define the pathway through an interdisciplinary lens

Why now?

Opioid withdrawal



Time course: Symptoms start six hours after last use of short-acting opioid, peak at 2-3 days, and begin to resolve by 5-7 days (methadone withdrawal peaks on day 5, and bup/nx withdrawal peaks on day 7). Psychological symptoms, can last for weeks.

Physical symptoms: Flu-like: Myalgias, chills, sweating, nausea and vomiting, abdominal cramps, diarrhea, rhinorrhea, lacrimation, piloerection.

Psychological symptoms: Insomnia, anxiety and irritability, restlessness, dysphoria, craving.

Opioid withdrawal

- Opioid withdrawal itself is not fatal but comes with complications

Complications:

a. Suicide
b. Overdose if opioids taken after a period of abstinence (loss of tolerance).
c. Gastritis or peptic ulcer
d. Acute exacerbation of cardiorespiratory illnesses, e.g., asthma, angina.
e. Exacerbation of psychiatric conditions: anxious patients may experience panic attacks, schizophrenic patients may experience psychosis, etc.

Suboxone® Pharmacology

Tablet consists of 2 ingredients in a 4:1 ratio

- Buprenorphine
- Naloxone

Buprenorphine:

- Long acting opioid that binds more tightly to opioid receptor than other opioids (will kick other opioids off the receptor)
- Slowly dissociates from receptor
- Acts as a partial μ-receptor agonist (low intrinsic receptor activity)
- Reduces cravings for opioids but can also precipitate withdrawal
- Has negligible effects orally; must be administer sublingually

Naloxone:

- Short acting opioid antagonist
- Has negligible effects orally and sublingually
- If injected, will block the opioid receptor
- Intended to prevent injection of Suboxone

Suboxone Pharmacology

Suboxone is a tablet that is to be taken sublingually

- Can be prescribed by any MD (unlike methadone)
- Daily dispensing of medication until more stability achieved
- Weekly urine drug screening required

Benefits:

- Has a "ceiling effect": its opioid agonist effects plateau at higher doses
- Much lower risk of overdose than methadone and other potent opioids
- Slow onset of action – Lower risk of sedation or euphoria at effective dose
- Patients on a maintenance dose may have a blunted analgesic and euphoric response if they take other opioids concurrently.

Administration of Suboxone

- Low oral bioavailability – Must be administered sublingually
- To avoid precipitated withdrawal, the ED physician must ensure that:

  (a) the patient has not used any opioids for at least 12 hours (typically longer if using sustained/controlled release opioids); and

  (b) the patient is in moderate to severe withdrawal via a COWS score

Suboxone Side Effects

- Sedation
- Constipation
- Nausea
- Less likely to prolong the QT interval than methadone
- Less likely to cause erectile dysfunction
- Buprenorphine-maintained patients perform better than methadone-maintained patients on cognitive and psychomotor tests
- The cognitive and sedating effects of concurrent benzodiazepine use are less pronounced than with methadone

Suboxone Quick Facts

- In the appropriate dose it relieves withdrawal symptoms and cravings for a full 24 hours, without causing sedation or euphoria.
  - Note: Some patients take it BID in community
- It is dispensed daily under observation, to minimize the risk of overdose and diversion.
- Take-home doses are gradually introduced when patients become stable and reduce or stop their illicit drug use.

JAMA article

Original Investigation

Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence
A Randomized Clinical Trial

Gail D'Onofrio, MD, MS; Patrick G. O'Connor, MD, MPH; Michael V. Pantalon, PhD; Marek C. Chawarski, PhD; Susan H. Busch, PhD; Patricia H. Owens, MS; Steven L. Bernstein, MD; David A. Fiellin, MD

JAMA. 2015;313(16):1636-1644.

JAMA article

OBJECTIVE To test the efficacy of 3 interventions for opioid dependence: (1) screening and referral to treatment (referral); (2) screening, brief intervention, and facilitated referral to community-based treatment services (brief intervention); and (3) screening, brief intervention, ED-initiated treatment with buprenorphine/naloxone, and referral to primary care for 10-week follow-up (buprenorphine).

DESIGN, SETTING, AND PARTICIPANTS A randomized clinical trial involving 329 opioid-dependent patients who were treated at an urban teaching hospital ED from April 7, 2009, through June 25, 2013.

INTERVENTIONS After screening, 104 patients were randomized to the referral group, 111 to the brief intervention group, and 114 to the buprenorphine treatment group.

MAIN OUTCOMES AND MEASURES Enrollment in and receiving addiction treatment 30 days after randomization was the primary outcome. Self-reported days of illicit opioid use, urine testing for illicit opioids, human immunodeficiency virus (HIV) risk, and use of addiction treatment services were the secondary outcomes.

JAMA. 2015;313(16):1636-1644.

JAMA article

RESULTS Seventy-eight percent of patients in the buprenorphine group (89 of 114 [95% CI, 70%-85%]) vs 37% in the referral group (38 of 102 [95% CI, 28%-47%]) and 45% in the brief intervention group (50 of 111 [95% CI, 36%-54%]) were engaged in addiction treatment on the 30th day after randomization ($P < .001$). The buprenorphine group reduced the number of days of illicit opioid use per week from 5.4 days (95% CI, 5.1-5.7) to 0.9 days (95% CI, 0.5-1.3) vs a reduction from 5.4 days (95% CI, 5.1-5.7) to 2.3 days (95% CI, 1.7-3.0) in the referral group and from 5.6 days (95% CI, 5.3-5.9) to 2.4 days (95% CI, 1.8-3.0) in the brief intervention group ($P < .001$ for both time and intervention effects; $P = .02$ for the interaction effect). The rates of urine samples that tested negative for opioids did not differ statistically across groups, with 53.8% (95% CI, 42%-65%) in the referral group, 42.9% (95% CI, 31%-55%) in the brief intervention group, and 57.6% (95% CI, 47%-68%) in the buprenorphine group ($P = .17$). There

JAMA. 2015;313(16):1636-1644.

camh

Dr Kahan project to pilot Rapid Access Clinic for Addiction Medicine treatment (RAAM)

camh

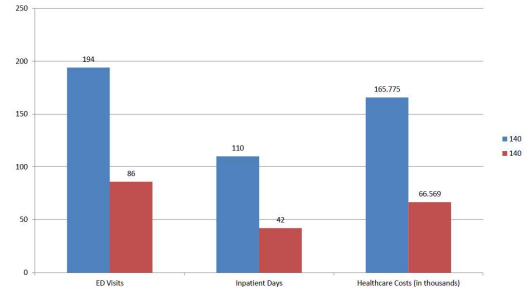
Reduction in Healthcare Utilization across 4 sites in the first 90 days of RAAM

	Region 1 n=22		Region 2 n=14		Region 3 n=11		Region 4 n=93		Total reduction (n=140)
	90 days Pre-RAAM	90 days Post-RAAM	90 days Pre-RAAM	90 days Post-RAAM	90 days Pre-RAAM	90 days Post-RAAM	90 days pre-RAAM	90 days Post-RAAM	90 days Post-RAAM
ED Visits	16	9	24	9	20	7	134	61	⬇ 108 visits
Inpatient Days	45	27	49	8	3	0	13	7	⬇ 68 days
Cost	ED = $4,384 Inp = $46,080 $50,464	ED = $2,466 Inp = $27,648 $30,114	ED = $6,576 Inp = $50,176 $56,752	ED = $2,466 Inp = $8,192 $10,658	ED = $5,480 Inp = $3,072 $8,552	ED = $ 1,918 Inp = $ 0 $1,918	ED = $ 36,716 Inp = $ 13,312 $50,028	ED = $ 16,714 Inp = $ 7,168 $23,882	$99,224 Saved
		$20,350 saved		$46,094 saved		$6,634 saved		$26,146 saved	

ED Visit = $274
Hospital Day = $1024

RAAM Impact on Healthcare Utilization

First 140 Patients



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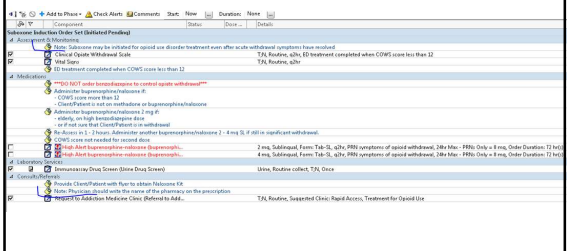
Suboxone Induction Order Set



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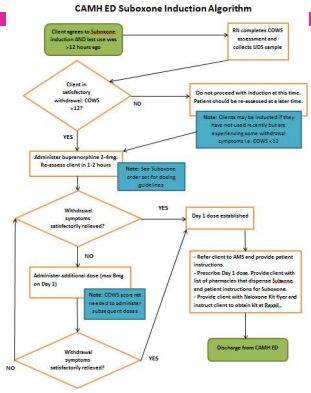
CAMH ED Suboxone Induction Algorithm



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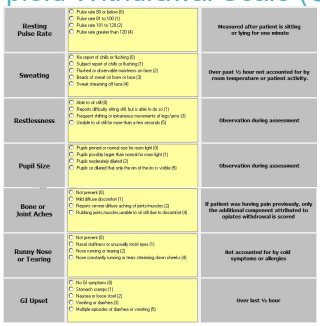
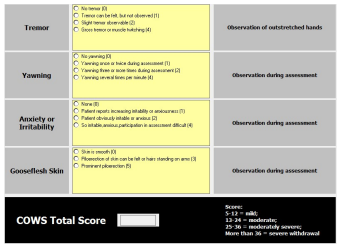
Clinical Opioid Withdrawal Scale (COWS)



Resting Pulse Rate	○ Pulse rate 80 or below (0) ○ Pulse rate 81 to 100 (1) ○ Pulse rate 101 to 120 (2) ○ Pulse rate greater than 120 (4)	Measured after patient is sitting or lying for one minute
Sweating	○ No report of chills or flushing (0) ○ Subject report of chills or flushing (1) ○ Flushed or observable moistness on face (2) ○ Beads of sweat on brow or face (3) ○ Sweat streaming off face (4)	Over past ½ hour not accounted for by room temperature or patient activity.
Restlessness	○ Able to sit still (0) ○ Reports difficulty sitting still, but is able to do so (1) ○ Frequent shifting or extraneous movements of legs/arms (3) ○ Unable to sit still for more than a few seconds (5)	Observation during assessment
Pupil Size	○ Pupils pinned or normal size for room light (0) ○ Pupils possibly larger than normal for room light (1) ○ Pupils moderately dilated (2) ○ Pupils so dilated that only the rim of the iris is visible (5)	Observation during assessment
Bone or Joint Aches	○ Not present (0) ○ Mild diffuse discomfort (1) ○ Reports severe diffuse aching of joints/muscles (2) ○ Rubbing joints/muscles unable to sit still due to discomfort (4)	If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored
Runny Nose or Tearing	○ Not present (0) ○ Nasal stuffiness or unusually moist eyes (1) ○ Nose running or tearing (2) ○ Nose continually running or tears streaming down cheeks (4)	Not accounted for by cold symptoms or allergies
GI Upset	○ No GI symptoms (0) ○ Stomach cramps (1) ○ Nausea or loose stool (2) ○ Vomiting or diarrhoea (3) ○ Multiple episodes of diarrhoea or vomiting (5)	Over last ½ hour

Clinical Opioid Withdrawal Scale (COWS)



Tremor	○ No tremor (0) ○ Tremor can be felt, but not observed (1) ○ Slight tremor observable (2) ○ Gross tremor or muscle twitching (4)	Observation of outstretched hands
Yawning	○ No yawning (0) ○ Yawning once or twice during assessment (1) ○ Yawning three or more times during assessment (2) ○ Yawning several times per minute (4)	Observation during assessment
Anxiety or Irritability	○ None (0) ○ Patient reports increasing irritability or anxiousness (1) ○ Patient obviously irritable or anxious (2) ○ So irritable, anxious participation in assessment difficult (4)	Observation during assessment
Gooseflesh Skin	○ Skin is smooth (0) ○ Piloerection of skin can be felt or hairs standing on arms (3) ○ Prominent piloerection (5)	Observation during assessment
COWS Total Score		Scores: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; More than 36 = severe withdrawal

Suboxone Prescription

Buprenorphine/naloxone 8/2 mg 1 tab SL OD

Start date – end date inclusive

Dispense daily observed

Include name of Pharmacy

Ontario Drug Benefits (ODB) pays $1.34 for a 2 mg tablet of bup/nx, and $2.37 for an 8 mg tablet.

Advice for patients at risk for overdose

- If you relapse after being recently abstinent, do not inject, and take a much smaller opioid dose than usual. You have lost tolerance and could die if you take your previous dose.
- Do not mix opioids with alcohol or benzodiazepines.
- Always have a friend with you if you inject or snort opioids.
- If one of your friends appears drowsy, has slurred speech, or is nodding off after taking opioids: □ Shake them and keep talking to them to keep them awake.
- **Do not let them fall asleep, even if someone watches them overnight.**
- Call 911.
- The best way to avoid an overdose is to get treatment for your addiction. **Please attend the next rapid access addiction medicine clinic.**

Naloxone Kits

- Patients with an opioid use disorder, or their friends/relatives, should be given take-home naloxone if they have the following risk factors:
- Started on methadone or buprenorphine/naloxone within the past two weeks.
- On high-dose opioids for chronic pain.
- Treated for an overdose in the emergency department, or reports a previous overdose.
- Injects, crushes, smokes, or snorts opioids (fentanyl, morphine, hydromorphone, oxycodone).
- Buys methadone or other opioids from the street.
- Recently discharged from an abstinence-based residential treatment program, withdrawal management service, hospital, or prison.
- Uses opioids in a binge pattern (i.e., does not use the same opioid dose every day).

Resources

CPSO Buprenorphine/Naloxone for Opioid Dependence Clinical Practice Guideline: https://www.cpso.on.ca/uploadedFiles/policies/guidelines/office/buprenorphine_naloxone_gdlns2011.pdf

META:PHI (Mentoring, Education, and Clinical Tools for Addiction: Primary Care-Hospital Integration): http://www.womenscollegehospital.ca/programs-and-services/METAPHI

References

D'Onofrio, G., O'Connor, P.G., Pantalon, M.V., Chawarski, M.C., Busch, S.H., Owers, P.H., Bernstein, S.L., Fiellin, D.A. (2015). Emergency Department-Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence A Randomized Clinical Trial. ***JAMA, 313****(16)*, 1636-1644.

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APPENDIX 4: Safety Planning Template

SAFETY PLAN

Step 1: Warning signs that I may not be safe

1.

2.

3.

Step 2: Remind myself of my reasons for living

1.

2.

3.

Step 3: Coping strategies that I use to distract myself or feel better

1.

2.

3.

Step 4: Social situations and people that can help distract me

1.

2.

3.

Step 5: People who I can ask for help

1.

2.

3.

Step 6: Professionals or agencies I can contact during a crisis

1.

2.

3.

4.

5.

Making my environment safe

1.

2.

3.