# Queen's University Department of Psychiatry
# On Call Psychiatric Emergency Handbook

## 1. Introduction

Seeing patients on call is an important learning experience for the resident. It provides an excellent opportunity for expanding the resident's roles as a medical expert, professional, collaborator, and health advocate. As with all aspects of our learning, we will only get out of it what we put in. The following is meant as a *general guide* and *cannot encompass every clinical or administrative issue encountered*. Important questions should be directed to senior residents or to your staff-person.

### a) Call Shift Times and Coverage

Coverage: Day call provides coverage to HDH UCC and KGH ER for emergent psychiatric assessments as well as fielding urgent phone calls from the community. The day call team also sees urgent consultations in the Rapid Access Psychiatry Assessment Service or RAPAS, and covers the short stay beds on Burr 4.

Night and weekend call provides coverage as above plus urgent coverage to the adult and child psychiatry inpatient wards, and urgent consults to medical/surgical wards at KGH.

There are three basic call shifts:

1. Weekday day-call: with regular residents on an Emergency Psych Rotation and one of 5 designated staff-people. Day-call takes new consults and calls from 8:30-17:00 Monday to Friday.
2. Evening/night-call: with a variety of residents and staff-people. Evening/night-call takes new consults and calls from 17:00-08:30.
3. Weekend and holiday call: 24-hours in length and lasting from 08:30 Saturday/Sunday to 08:30 Sunday/Monday. The resident on-call on the weekend should be present at Burr 4 by 09:00 to see newly-admitted patients with the staff-person on-call that day. This should occur unless there are urgent consults to be seen in the ER, and your staff-person should be made aware if you are in the ER.

It is quite common that consults come in just before your shift will end or there will be so many consults prior to shift's end that all patients cannot be seen. In this case it is reasonable to approach/page the resident in the next call shift to see some of these patients, which they will often do as a courtesy. Any patient identified as needing immediate assessment MUST be seen immediately.

### b) Trading Call Shifts

It is better to avoid switching your call shift but, of course, we all have illness and other obligations that come up. It is up to the resident to find someone to trade, unless circumstances prevent them from doing so. Please send your shift change and call requests to the chief resident in a timely manner and every effort will be made to accommodate them. If you want to switch a call you need to inform the people whose emails and numbers are mentioned below, ASAP. If you are the junior resident on-call,

you can only switch with another junior resident (someone on first call). If you are prevented from doing call at the last minute, and can't arrange a replacement, contact the chief resident who will make arrangements.

KGH Emergency Section A ward clerk
HDH UCC ward clerk
KGH Switchboard swboard@KGH.KARI.NET
HDH Switchboard HDHSwitchboard@hdh.kari.net
Chief Residents queens_psych@yahoo.ca

## c) Handover

*Handover is essential for patient management and safety and must be done.* Communication through a one- or two-liner of each relevant individual issue during the previous shift is important for improving professionalism and communication. It is not just a courtesy but is essential.

Morning handover should occur physically to the emergency team who meet at KGH ER on weekdays or over the telephone (call the HDH switchboard and ask for the daytime/nighttime resident on call). It should be done between 8:20 to 8:40 AM. Please don't leave it too late. Evening handover should be done between 4:30 and 5:00 PM.

It is the junior resident's responsibility to do handover, but they should feel free to ask the senior's input on what to include if uncertain. *Please phone even if there were no issues.* What is important to include is:

1) *All patients currently in both HDH and KGH ERs that are admitted to psychiatry but are awaiting transfer to a bed on Burr 4.* These patients are the on-call team's responsibility to manage when issues arise while in the ER and are the day on-call team's responsibility to round on while in the ER.
2) *Number of beds available on Burr 4 ward.*
3) *Patients that have been accepted directly to psych for assessment from other locations and are expected to arrive.*
4) Patients discharged home from the ER that may likely be back the next day.

If there is a difficult situation regarding consultation to other services, bed management, etc., it is helpful for staff psychiatrists to hand over to each other as well.

## 2. Roles of the Medical Student, Junior Resident, Senior Resident, and Staff Psychiatrist

Our psychiatry program has moved to an expanded psychiatry call team including: staff psychiatrist, senior psychiatry resident, junior resident and medical student. All of these physicians fulfill specific roles and expectations. There are several reasons for expanding the team but primarily to enhance patient care, improve safety for patients and residents, to provide more supervision and education, and to provide more support when call is busy. The expectations of the 2 residents on call differ to provide level appropriate educational experience to all residents. Junior residents are considered to be PGY 1 and 2 psychiatry residents, family medicine residents and emergency medicine residents. Senior residents are considered to be PGY3-5 psychiatry residents.

1. Medical students: the medical student doing a rotation in psychiatry is on call on weeknights and weekends until 11pm, and is expected to attend any emergency or ward presentations with the resident. A medical student should never be asked to assess a patient alone, and particularly should never be asked to go to the other site alone to assess a patient. The primary teachers for the medical students on call are the residents so they appreciate discussion and supervision. This is a good opportunity for recruitment.
2. Junior residents: the junior residents are first call by switchboard for any emergency assessments, ward calls, emergency consultations to the medical wards and any outside calls. The junior resident should present and discuss the case with the senior resident before discussing with the staff psychiatrist.
3. Senior residents: the role of the senior resident is to be actively involved in assessment, supervision and teaching of the junior resident and medical student. The senior resident is also actively involved in triaging patients and bed management decisions. The senior resident is expected to be present for each case, not just when there are several patients referred and waiting to be seen. It is not acceptable for the senior resident to provide telephone supervision only unless it is very busy and both residents are seeing patients at different sites.
4. Staff psychiatrist: the staff psychiatrist must be easily accessible by phone and in town while on call. The staff supervises the residents by phone but is welcome to supervise in person in the ER and must come to the ER physically if asked by a resident. This would be if many patients are waiting to be seen (ie. more than 4) or if it is a very difficult patient presentation. The staff psychiatrist is primarily responsible for finding beds and liaising with the bed manager, other hospitals and ER and administration in this regard. The staff psychiatrist sometimes fields phone calls directly from community or hospital physicians looking for advice on how to deal with a patient with a psychiatric presentation. The staff is expected to work collaboratively with our junior colleagues and provide some teaching for each case discussed. Please explain your decision making and why it may differ from the residents'.

When ER is not that busy, senior residents may decide to observe junior residents interviewing patients and provide feedback, or demonstrate interviewing skills by doing the interview themselves or seeing the patient briefly after the junior has assessed the patient. Junior residents and senior residents can both learn from these various scenarios. The residents are expected to work as a team with discussion of each case that presents.

One of the residents is expected to check in with the inpatient wards at night between 9-11pm. Contact with the wards should be more regular if there are patients in seclusion, on constant observation or in withdrawal states.

## 3. Assessment of the Patient in the ER

### a) Assessing a patient

There are times when psychiatry is consulted on more patients than can be seen in a reasonable amount of time. The psychiatry resident should be able to triage patients in the ER based on the acuity of their problems and the potential risks posed. If there are too many patients that can be seen in a timely and safe manner you may phone your staff-person for their opinion or to ask for help in assessment. We have now moved to a two-resident system for call, which should make this less of a problem.

Before you see the patient take a few minutes to review the referral and talk to the referral source if possible. The police, friends, and family are particularly important to talk with early in the process, as they can often leave unexpectedly. Determine whether there is accompanying documentation, for example a form 1, note from a referring physician, suicide note, etc. Search through MYSIS for patient information. Ask yourself "What are the circumstances that led to the patient's presentation to the ER?" Review what was already done (assessment by the ER staff, vitals, blood work, *what meds have already been given*). Determine if the patient was seen by social work. If so, read their reports and talk to the social worker. Try to determine if there is someone else that you could talk to for collateral information after you see the patient

When you go in to see the patient you must remember safety first and, if in doubt, check with your staff-person and have security present. Just as one would quickly assess a medical patient by looking at them and their vitals, then saying 'critical, sick, or stable', we often do a quick-look test, essentially a brief mental status exam, prior to entering the room. Examine the patient for appearance, agitation, psychomotor activity, disorganized speech, dysthymia, level of intoxication. Then knock and enter the room, introducing yourself as a resident physician who has already reviewed their chart. Perform a brief ER-oriented psychiatric assessment. This should last no longer than 20-30 minutes. Use the psychiatric database form provided in the ER to record the data you may collect:

1. Patient's identification data and reason for assessment
2. Current concerns and the circumstances that led to the presentation to the ER.
3. History of presenting illness: focus on the current episode and stressors. *Don't forget questions about suicide and harming others!*
4. Review of symptoms ie. screen for other psychiatric disorders
5. Psychiatric history: previous admissions and circumstances (voluntary or certified), diagnoses, and previous and current treatments and medications. Do not forget to determine if there is a history of *criminal problems*.
6. Medical history and *substance use*.
7. Family history
8. Social history: focus on the relevant information: living conditions, supports, current employment. You may not need to take a detailed developmental history unless, of course, this is a child or adolescent. However, personal history gives a

longitudinal history important in identifying personality disorders, and is useful for identifying trauma, ADHD and learning disabilities.

Your assessment should answer the following questions:

1. Are there safety concerns at the time of the presentation to the ER?
2. Is the patient certifiable (should Form 1 be placed/continued) and on what basis?
3. Does the patient need admission and why?
4. If I discharge the patient, what would I need to ensure adequate management?
5. Ask the patient for permission to talk to a family member about the treatment plan, if appropriate. ***Collateral information is often more important in the emergency psychiatry case than in any other specialty.***

**b) <u>"Medical Clearance"</u>**

This is a very controversial term and should be avoided. The emergency physicians do a focused assessment on a patient which includes whatever physical and medical assessment they consider appropriate in their judgement. They are not a physical exam and routine lab investigation screening service. The emergency medicine literature indicates that there is no medical benefit to doing routine screening on every patient. Moreover, a patient is never medically cleared as anything can happen at any time after a patient is medically assessed. The goal is assessment and stabilization not clearance.

It is important to remember that we are medical doctors and psychiatric consultants to the emergency doctors. Some suggestions to providing professional psychiatric consultations that are collaborative in nature include:

1. If the psychiatric assessment indicates an organic cause of the presentation such as delirium, brain tumour, etc, then discuss the opinion with the emergency physician with complete recommendations for further work up.
2. If there is a psychiatric diagnosis and need for admission but the patient is medically unstable (eg. Overdose, acute medical problem, suspected delirium, etc) then consult actively with the emerg doc. Psych or ER may order further investigations and referrals, but care should be communicated and coordinated.
3. If patient requires admission psychiatrically but has a medical issue evident on investigations already done or needs a medical condition ruled out before going to the ward, then order the investigations needed. The emerg physicians are always available and happy to consult about any concerning findings including making suggestions about level of concern, any further follow-up, reviewing EKGs or X-rays, etc.
4. If patient requires routine investigations, then order them. Usually labs will be drawn in ER and EKGs done in ER, but the patient will not have to stay in ER until results are back.

Remember that we are the experts in psychiatry and our emergency medicine colleagues benefit from discussion of interesting presentations and cases.

### c) Rules for Collecting Collateral Information in Emergency Situations

Collateral information is very important and often essential when assessing a patient and deciding on a treatment plan. We often ask the patient whether they would agree to allow us to talk to other people to gain collateral information and provide better treatment. However, in an emergency situation we do not necessarily need their consent to contact other sources. When talking to outside sources without consent in the emergency situation we identify ourselves as a physician from KGH/HDH and explain that *we can ask for information about an emergently ill- patient*, but *we cannot give out information about them*.

### d) Reviewing the Case With Staff

After the assessment, formulate the case and decide on a presumptive diagnosis and a management plan *before* you talk to your staff-person. Be prepared to do a brief presentation about the case that will allow you to demonstrate your ability to synthesize the information in a logical, cohesive way and demonstrate that you are able to function as a medical expert, consultant and health-advocate. A useful layout for the case presentation may include:

1. Always start with ID and reason for presentation
2. The patient was brought by …… and is / is not on a form
3. I spoke with the patient, ER staff, family member, social worker, police etc.
4. The patient presents with symptoms indicating …...
5. Past psychiatric history is relevant for…..
6. Medical history is relevant for….
7. Family history is significant for…
8. The patient lives with …. .and …. .are the main supports
9. On mental status …. (Also indicate if the patient was a reliable historian)
10. My diagnosis at this time is **...**
11. I suggest the following treatment:

### e) Disposition

Please see the "ER Protocol for children under 18" sheet in the HDH 'psychiatry' side-office for different scenarios in dealing with C&A patient disposition (see below). If you and your staff make the decision to admit an *adult patient*, there are a number of things that must be done:

1) Phone to Burr 4 to determine which staff psychiatrist the patient will be admitted under. Give handover on the patient to nursing.
2) Physical exam, if not already done.
3) Fill out a HARF form (absolutely required for admission)
4) Fill out admission orders (some suggestions for ADDAVID admission orders are in the appendix I). Make sure to include blood work, urine toxicology screen, *regular meds they are already on and prn agitation meds*, as needed. If you have any questions about specific admission orders, discuss it with your staff person.
5) If the patient is to wait for a bed in the ER for (possibly) a lengthy period talk to the ER nursing staff and reassure the staff that you had assessed the risk for suicide/elopement and provided the necessary treatment. Offer to come to reassess the patient if necessary.

If you plan to discharge the patient consider faxing your report to the GP (you may need to ask the GP for an early appointment) and decide if there is a need for personal phone communication the next day. Consider contacting the patient's current psychiatrist with an update regarding the ER presentation or admission, a matter of professionalism and courtesy. Social work can help you with the discharge planning.

Remember, that a further option for disposition is jail. Some of our patients have committed a crime and assessment may indicate they do not need psychiatric hospitalization. This is really only an option if the patient is brought to ER by police and you are informed that charges will be laid if the patient is not admitted or on discharge from hospital. Due to confidentiality, police cannot be contacted unless homicide risk assessment indicates a breach of confidentiality is required.

## f) Management of Bed space (for full bed flow protocol, see Appendix)

In theory, management of bed space on Burr 4 should not be a resident concern, but is the concern of your staff-person. However, in practice, we are involved in helping the staff-person and nursing team make decisions, and this is an important part of the manager role in psychiatry. Handover will always include the number of beds available on Burr 4, or the absolute number filled (35 is maximum). This is often in flux during weekdays and it may be necessary to check with Burr 4 nursing as to the bed situation throughout the day. We communicate this to our staff-person, who may have to phone to other facilities to transfer patients, and to ER nursing staff, who may have to make accommodations if the patient is to stay in the ER overnight.

When the beds on Burr 4 are full some decisions need to be made, *always by your staff-person*. Pass beds are beds reserved for patients out on an overnight pass and may be used in an emergency. The staff-person may ask you to phone the bed manager for their permission to use them. You would need to get the bed manager's phone number from the Burr 4 nursing desk and phone them to ask to use the pass beds.

If the beds on Burr 4 are full and there are patients in the ER that need admission, the staff-person will need to contact other psychiatric facilities in the region. *It is the staff person's responsibility, not the resident's, to phone Belleville and Brockville to search for the possibility of transfer. Always look to see where the patient is from*, as it makes

transfer to another site much easier if they are from that area. If you expect to transfer someone, it is wise to ensure the patient is medically stable from the ER doctor's point-of-view and not unduly influenced by substances. We can workup a patient to facilitate smooth and appropriate transfer with basic bloodwork to help rule out a medical illness, serum EtOH, urine drug screen, and any other relevant investigations.

The protocol for admission of adult patients is to admit to Burr 4 adult psychiatry ward until the beds are full. The next step is to contact the bed manager to see if there are any flexible beds available on Burr 4, for example pass beds that if filled will take the ward over count. If the beds are completely full, call **Brockville (Elmgrove hospital) at 613-345-1461** and/or **Belleville (Quinte hospital) at 613-969-7400** to see if a patient transfer is possible. If so, let the charge nurse in ER know so that transfer can be arranged. If not, let the charge nurse know so they can make arrangements for the patient to be kept in ER. If there is 1 patient in HDH UCC requiring over night stay, they generally are transferred to KGH, if more than 1, HDH UCC stays open over night. Usually if there is no bed for the night on Burr 4 and patient is in KGH ER, they can stay until morning. For patients admitted and situated in HDH UCC, we would want to be calling for a bed until we have exhausted the possibilities of Brockville and Belleville. Since HDH is only open until 10pm, this rarely would go later than midnight.

If a patient is being assessed in ER, needs admission and is from out of town, please try to arrange transfer to the patient's local hospital first to try and avoid an admission in Kingston.

## 4. Assessing a Child or Adolescent in ER

### Admission protocol for Suicidal children and Adolescents in ER

If you are on call and a child or adolescent presents to the Emergency room you have two options these differ depending on time of day and whether it is during working hours Monday to Friday or night and weekend.

**During working day Mon- Fri**

1. Ask the resident to contact Dr. Roberts or her cover, in my absence and we maybe able to provide supervision/ see the patient ourselves and decided whether to admit or to f/u in our ambulatory clinic ( Contact us through switch board or Divisional secretaries HDH ext 2554 2508 or 3017)

2. If you want to supervise resident your self and decide you want to admit patient Please inform C5 ext 2500 or contact Dr. Roberts/ her cover. In case beds are full we may be able to come up with a viable plan which does not require the patient to be held in the ER such as urgent follow-up

**After Hours and W/E**

**1.** You may advise the Resident to contact me, if I am in town, I do not mind

**2.** If you want to supervise resident yourself, and wish to admit you are welcome to admit to C5. Please contact C5 EXT 2500 to arrange.

**Note:**
**a) Patients under age of 16 years DO NOT need to be certified on Form 1 if parent or Guardian is agreeable to their Admission**

**b) Normally we do not order Q15-30 min observations on C5 as the Patients are always supervised**

**c) Benzodiazepines, as potentiaters, are not necessary for children and adolescents as they seem to cause disinhibition and acting out kids get more combative on them. We tend to Use Olanzapine Zydis if needed**

### Suicide Risk assessment of Children and Adolescents

Assessment and intervention of "Suicidality" is somewhat different in C and A population to that in Adults. This is based on our best practice guidelines for C and A which are different for suicidal threats/ ideation as opposed to attempts. For attempts we consider intent and lethality, again based on evidence based risk factors for completion which mark males >14 years of age, showing, high intent high lethality behaviors with

substance use/abuse and family histories of suicides and psychiatric disorders as significant risk for completion.

Females presenting with low intent low lethality behaviors such as cutting are more suitable for urgent consult clinic. But again if you deem them at risk for completion feel free to admit

(Stats Canada 2007 Prevalence of suicide 11/100000 for 14-19 year  there is no record of any completed suicides in<14 years of age)

When admitting a child or adolescent to the ward, the resident should complete the following steps:

1. Phone Burr 4Child and Adolescent ward and give handover on the patient to nursing.
2. Fill out a HARF form (absolutely required for admission)
3. Fill out admission orders.  Make sure to do a physical exam and write all the orders including blood work, urine toxicology screen, regular meds and prn meds.
4. Offer the ER staff to come to reassess the patient if necessary.  Most importantly, make sure that the ER staff know that you are available for further consultation regarding treatment.

## 5. Urgent Clinics

### a) Social Work and Social Work Urgent Clinics

Social work is an important part of the HDH urgent care center. They are usually first line consultants to the ER physicians for patients with psychiatric and psychosocial difficulties. They may then advise the ER physicians to consult psychiatry. If so, social work can often share many important pieces of information that greatly aids in the efficiency of the subsequent interview. They are our close partners in the ER. Social work also offers clinic appointments, located in the HDH ER/J5 that can be booked by psychiatry. These are very useful for patients with psychosocial difficulties that would benefit from *short-term* social work follow-up and do not require urgent psych consults or admission. Of course, social work may not consult psychiatry and simply book the patient into their own clinics themselves. To book urgent social work appointments the process is:

1) Write the patients name, CR#, reason for referral, contact phone number and name of person making the referral on the appropriate appointment slot in the Urgent Social Work Clinic binder (HDH 'psychiatry' office).
2) Leave a detailed voicemail message about the appointment at extension **2356**.
3) Fax a copy of the HDH UCC face sheet and the mental health assessment booklet to Eleanor Casey, MSW at **613-544-9666**.

### b) Rapid Access Psychiatric Assessment Service (RAPAS) formerly adult urgent psychiatry clinic

These are clinics held Mon-Thurs mornings on Burr 4. Their purpose is to provide rapid access to care when urgently needed and when an admission is not warranted. Patients may be referred to RAPAS by emergency physicians, UCC/ER social workers, on-call psychiatry residents and staff, and adult psychiatry intake workers, and is occasionally accessed by physicians from KGH. However, if a family physician calls and requests an urgent assessment and it is decided to be the most appropriate place to be seen, an urgent clinic appointment can be arranged by the on call psychiatrist. There are specific criteria for booking urgent adult psychiatry appointments:

1) Patient must be at least *18 yrs old*. For C&A urgent appointments see below.
2) The patient *is in the emergency department* or assessed through central intake (except for the case of the consulting family physician above).
3) Does *not* need admission
4) Needs an Urgent Outpatient Psychiatry Assessment within two weeks (is *urgent*)
5) Patient does *not* have a psychiatrist following them (includes geri-outreach, ACT)
6) Preferably does not have a *chronic* mood or psychotic disorder.
7) Has *not been recently discharged* from the inpatient unit (within the last month)

To book patients into this clinic the process is as follows:

1) Write the patients name, CR#, reason for referral, contact phone number and name of person making the referral on the appropriate appointment slot in the RAPAS binder (KGH ER Section A)
2) Any patient may be booked into any slot, but try to match patients with staff where appropriate. For example: concurrent disorders (substance + other psych disorder), try to refer to Dr. Finch or Dr. Mazhar; reproductive psychiatry concerns, refer to Dr. Prost; if comorbid medical illness, refer to Dr. Oliver)
3) Leave a message with Cheryl KGH **ext.7839**, giving patients name, CR#, appt. time.
4) Fax a copy of your assessment to **613-548-6030** attn. RAPAS
5) Give patient a yellow appointment slip giving directions to Burr 4. Appt. times are not flexible and missed appts. will not be rebooked.

**c) <u>Child and Adolescent Urgent Clinics</u>**

To book patients into this clinic the process is as follows:

1. Ensure the patient lives within our catchment area (see map on inset of binder)
2. Make sure patient needs to be seen urgently and cannot wait 3-4 weeks for an outpatient appointment in the C&A psychiatry clinic.
3. Parents/foster home/group home or Children's Aid workers involved find it acceptable to take child home (see next section for cases in which they are not).
4. Write the patients name, CR#, reason for referral, and contact phone number on the appropriate appointment slot in the C&A Urgent Clinic binder (HDH 'psychiatry' office).
5. Give the patient and caregiver the time and date of the appointment. *A parent/legal guardian must accompany the child/adolescent to the Urgent Clinic Appointment. Children in the care of the CAS must have a CAS worker accompany the patient to this appointment.* Tell them the location of the clinic is HDH Brock 5 suite 564.
6. Leave a message at x**2508**, giving patients name, CR#, and appt. time.
7. Fax a copy of your assessment to **613-544-7623** attention C&A Urgent Clinic
8. Patients booked for an urgent consult must be seen within 48 hours after presenting to emergency. If no appointments are available within 48 hours fax the information to the above number and tell the patient that Dr. Roberts will review it and contact them with an appointment time.

Cases will arise in which the child is seen in the ER and deemed to be safe for an urgent consult but this is not acceptable to the caretakers. If the patient is from a group home we recommend an awake 1:1 watch until the next morning. If the child is accompanied by the parents and they refuse to take them home, inform them that the child cannot be left at the hospital and that CAS will be phoned.

## 6. Fielding Phone Calls from Outside physicians

### a) Phone calls from outside physicians

You will frequently receive a call from an outside physician regarding a number of issues ranging from advice to wanting to transfer a patient on a Form 1 to our facility. Always identify yourself as a resident and your PGY level. It is advised that you take the information on the patient and their case as well as the contact info for the physician that is contacting you. You often must then refer the case to your staff-person and together you will discuss suggestions or arrange a plan. This arrangement is to provide teaching around cases while deferring responsibility to the more-experienced staff-person. After this, the staff-person will return the call if needed.

Psychiatry supervisors must be readily available by phone for discussion of any resident concerns, and must be available to come in to see the patient if requested by a resident and available to speak with physicians by phone if requested. Residents must always contact their staff supervisor for discussion of the following scenarios:

a. Any time a patient is admitted or discharged
b. Any time a mental health act form is put in place or discontinued and even if this is considered
c. Any time a patient is seen in consultation in ER or on the medical wards at KGH
d. Any time a family doctor, allied health professional or other physician calls to ask for advice, asks a question or is looking for an urgent assessment
e. Any time any type of medicolegal issue arises such as homicidal ideation, patients transferred from the penitentiary, CAS concerns, etc.
f. Any time the resident is uncertain or would benefit from further discussion or input.
g. Any assessment on the psychiatry wards where a patient is transferred to ER or it is a more complicated medical scenario
h. Any time there is a request for sending a patient to the ER "direct to Psychiatry"

If the resident gives the advice, they should document the case, what advice was given, and that it was discussed with the staff-person. There are a number of situations in which we may provide some additional guidance, though this is usually provided by the staff-person.

### b) Requests for taking a patient "Direct to Psychiatry"

1. *Always ask where the patient lives.* You won't be told if you don't ask. If the physician wishes to transfer a patient on a Form 1 for assessment it may be more appropriate to transfer them to Brockville or Belleville if they live in that area.
2. Always discuss with your staff person before accepting a patient direct to psychiatry. We only accept patients direct to psychiatry if the request is made by

a physician outside of the hospital who has assessed the patient that day, believes the patient is medically stable and there is a bed available on the ward

3. After you speak to an outside physician about a patient, **always** let the emergency physician and charge nurse know if you have accepted the patient direct to psychiatry or not. If you do not inform the ER team, they will assume the patient is accepted direct to psychiatry if an outside physician has discussed the patient with psychiatry.
4. *Ask if they are medically stable and what additional care needs to be set up.* If you are not convinced that they are medically stable, medical issues require follow-up, or that another service may be more appropriate, always discuss this with the your staff-person and the ER physician at KGH or HDH. These patients are usually not accepted direct to psychiatry. Rarely a patient will be transferred for an assessment with the likelihood of discharge if there are no beds available for admission. However, this would require a discussion between the staff psychiatrist and the emergency physician.
5. *The transferring physician always has responsibility that the patient arrives for assessment.* We usually suggest ambulance or police. If the transferring doctor decides to send them by other means they must remember it is their responsibility if an accident, suicide, homicide, or elopement occurs along the way. There may be some education surrounding the mental health act required. We do not give specific appointment times for emergency assessment (though may for the Urgent clinic) and we do not accept responsibility for ensuring the family doctor they make it here. Of course, they can phone to make sure the patient has arrived at our ER.
6. *Do not accept a C&A patient for transfer without you or your staff-person first talking with Dr. Roberts (or Dr. Khan in her absence).*
7. We will often get calls from physicians at KGH from specialties other than Emergency. *Ask if the consult is regarding an inpatient or a patient already admitted to another service (even if physically in the ER).* In general, these physicians wish to consult psychiatry regarding an inpatient with a known or as-yet undiagnosed psychiatric illness. These cases are usually *referred to consult-liaison psychiatry x7839, whose hours of seeing consults are 8 AM – 5 PM, Monday to Friday.* However, if there is an urgent case that cannot be addressed in the morning, the resident should discuss with their staff-person about appropriate advice and whether that patient needs to be seen. Often the cases can wait until the CL-psychiatry team returns. If the medical or surgical team identifies that the patient needs to be seen urgently then the patient is seen without delay. It is part of the responsibility of the on call team on nights and weekends to see urgent consults.

# Appendices

## I. Sample admission orders

In general, follow the ADDAVID approach (Admit to, Dx of, Diet, Activity, Vitals, Investigations, Drugs). Here is a sample of some considerations that may be included for admitting an adult, all of which will likely not be necessary. These are suggestions to be discussed with your staff-person:

**A** Admit to J3 adult psychiatry / C5 child psychiatry under Dr. X

**D** Dx Schizophrenia, Bipolar mania, etc.

**D** Diet Regular, Diabetic 7500 kJ, Cardiac, Renal, Soft texture, etc.

**A** AAT, restrict to ward, etc.
Form 1 + Form 42 given or voluntary

**V** Vitals routine (means once on admission), specify more often if required
Constant observation, q15 minute observation

**I** B/W (CBC, diff, lytes, Ca, Mg, Phos, Crt, albumin, ALT, ALP, GGT, serum EtOH
TSH, B12, folate, glucose, HbA1C, prolactin, fasting lipids)
Drug levels (epival, carbamazepine, lithium, drug overdosed on)
Urine (dip, beta-HCG, drug screen)
ECG
CT head

**D** In general, leave them on most general meds that they came in on, unless increasing, starting, or lowering a psych drug or eliminating meds that may be contributing to the psychiatric condition or delirium.

**Prn** Smoker? Don't forget a patch or gum.
Nicotine patch 7/14/21 mg apply to skin q24h OR Nicotine gum 2 mg PO q1h prn
Immovane 3.75-7.5 mg PO qhs prn OR Seroquel 12.5-25 mg PO qhs prn sleep
Tylenol 325-650 mg PO q4-6h prn pain
Gravol 25-50 mg PO q6h prn nausea
**Agitation**
Olanzapine zydis 2.5-5 mg PO q4h prn for agitation (Max dose of X/24 hrs)
Benzodiazepene ex. Clonazepam 0.5 mg PO q6h prn for agitatation
**Chemical Restraint**
Loxapine 25-50 mg PO/IM q4h to be given with Ativan 1-2 mg PO/IM q4h prn for chemical restraint (Max dose of X/24 hrs)
Olanzapine 10 mg PO/IM q6h prn for chemical restraint

**CIWA** CIWA protocol
Diazepam 10-20 mg PO/IM q1h (or Ativan 2 mg PO/IM q1h if elderly/cirrhotic)
If CIWA > 8 (max valium 60 mg/24 hr, phone MD if > 60 mg required)
Thiamine 100 mg PO/IM OD x 3 days

## II. Specific pt scenarios (Suicidal, Elopement, Agitated, Intoxicated)

### *A. Suicidal*

If a patient is acutely suicidal, please ensure they are in a secure, watched environment while in your care. If planning to place the patient on a Form 1, alert security sooner rather than later according to your judgement of elopement/suicide risk.

### *B. Elopement*

Security, particularly at KGH, can be overwhelmed with mental health patients. If a patient leaves the ER, they are on a Form 1, and they have been assessed by psychiatry there are at least two options. If you placed the patient on Form 1 you are responsible for either alerting the police and filling out a Form 9 to have them brought back to the emergency department or to cancel the form. Both options need to be discussed with your staff-person, and the ER physician will need to be informed. You will need to give the police their description and address.

If the patient leaves the ER, are not on a form, and have been assessed by psychiatry there are at least two options. You can either place the patient on a Form 1 if they fulfill criteria and alert the police or you can allow them to leave. In either situation, the case should be discussed with your staff-person and the ER physician.

If a patient leaves the ER prior to being assessed by psychiatry the ER physician has the option of placing the patient on a Form 1 and notifying the police. Of course, we should try to minimize this risk by timely assessment and can advise the ER physician on the MHA.

### *C. Agitation*

Always have a high suspicion for agitation and actions that will cause agitation. Patients can escalate quickly, and one should watch for signs this is occurring. Some suggestions:

1. Have security nearby when interviewing agitated/potentially agitated patients. Be aware that the patient may have weapons on their person.
2. Tie up pony-tails and loose articles of clothing that can be grabbed. Do not carry into the room anything that could be used as a weapon. Try to remove chairs or any other potential weapons.
3. Panic buttons are available from the HDH and KGH emergency desks.
4. If a patient is agitated offer some medication to calm them, have nursing prepare an IM ready to be used if necessary.
5. Sit/stand close to the door, but not directly between the door and the patient. Do not turn your back. If a patient is escalating, try turning your body perpendicular to the patient and keep your hands free.
6. If concerned about your safety, and go by your gut feelings, express this to the patient, pause the interview, and discuss this with your staff-person. You may call for a code white if particularly concerned or attacked.

### ***D. Intoxication***

Intoxicated patients can be difficult to deal with. It is also next to impossible to do a psychiatric assessment on such a patient. It may be reasonable to ask the referring ER physician to do a blood alcohol level and to refer the patient when they have sobered up. Many drunk and suicidal patients will dramatically change when sober.

## III. Dealing with Security

Security guards are often utilized in the emergency department and on the inpatient wards to watch patients with difficult behaviours and help subdue agitated patients. They are an important part of the hospital team, and it is important to be comfortable dealing with them.

1. It is important to recognize that they have no mental health training. When they watch a patient they are expected not to communicate with the patient.
2. They do have training in restraining patients during a code white and you do not. It is not the role of the psychiatrists to physically restrain a patient.
3. You are the leader of the team response to the agitated patient so communication is very important with all team members for a coordinated response.
4. It is important for you to communicate effectively with security so that they know what is expected of them.
5. It is important to be aware that the presence of security guards escalates many patients. Sometimes it is helpful to ask security to be present in ER but out of sight of a patient.

## IV. Useful Phone Numbers

| | |
|---|---|
| KGH ER | 549-6666 x2335 |
| KGH ER fax | 548-2420 |
| Consult Liaison Psychiatry | 549-6666 x7839 |
| KGH core lab | 549-6666 x7806 |
| HDH ER | 544-3310 x2100 |
| HDH ER fax | 544-7639 |
| HDH Johnson 3 | 544-3310 x2323 or x2324 |
| Pharmacy | 544-3310 x2159 |
| C&A Urgent Clinic | 544-3310 x2508 |
| C&A Urgent Clinic Fax | 544-7623 |
| C&A Non-Urgent Clinic | 544-2554 |
| Urgent Adult Psych Clinic | 544-3310 x2550 |
| Urgent Adult Psych Clinic Fax | 544-9666 |
| FCMHS ACTT | 544-1356 x2225 |
| Providence Care ACTT | 547-8992 |
| FCMHS Crisis | 544-4229 |
| L&A Crisis | 613-354-7388 |
| Options for Change | 544-1356 x4200 |
| Detox Center | 549-6461 |
| Street Health | 549-1440 |
| CCAC | 544-7090 |
| Saint Mary's of the Lake | 548-7222 |
| Providence Care MHS | 546-1101 |
| Providence Care MHS fax | 548-5588 |

## V. How to Voice Concerns

If you have any concerns about your Emergency room experience, talk to the Chief resident, Program Director, or the Residency Training Committee. Residents are encouraged to give feedback to their staff-person and the program director if there is any delay in reaching their staff-person when on call.

## VI . Useful References