

## **EMERGENCY PSYCHIATRY PROCESSES AND PROCEDURES**

### **1. On Call Team and Coverage**

- a. The on call team consists of a junior resident, senior resident and staff psychiatrist. There is also usually a clinical clerk.
- b. The junior resident is first call, but senior residents are expected to supervise junior residents in person, manage and prioritize the service, triage response, etc. The residents are expected to assess patients and discuss all assessments over the phone with the staff psychiatrist. If needed, the psychiatrist can be asked to come and see the patient in person.
- c. Weekday Day call
  - a. Monday –Friday 8:30am-5pm
  - b. Handover: 8-8:30am
  - c. Meets in section E of the KGH emergency department at 8:30.
  - d. Their main responsibility is consults from KGH ED and from HDH urgent care, and accepting calls from clinicians in the community. In addition, they are also primarily responsible for any patients admitted to Psychiatry who are still in the emergency department, and any short stay admissions on the ward.
- d. Weekday Night call
  - a. Hours: 5pm – 8:30am
  - b. Handover: 4:30-5pm
  - c. After receiving handover, the junior resident will contact the senior resident and the clinical clerk to instruct them to come to hospital whenever there is work to be done.
  - d. Their responsibilities include all of the responsibilities of the Day call team. In addition, they are also providing coverage for all Burr 4 inpatient units and psychiatry consultation/liaison service to KGH medical and surgical wards.
- e. Weekend or Holiday call,
  - a. Hours: 9am-9am
  - b. Handover: 8-8:30am
  - c. The junior and senior resident should arrive early no later than 8:30am to the Burr 4 Unit B nursing station, to receive handover from both the previous resident as well as the Burr 4 charge nurse. The attending psychiatrist and clinical clerk arrive at 9am to begin work.
  - d. In the morning, the psychiatrist personally assesses any new admissions to Psychiatry, admitted patients in the ER, and needs to be involved when Forms of involuntary certification have to be re-assessed. The psychiatrist will therefore be present for rounds, usually all morning, and thereafter can be reached through switchboard, as usual.

- e. Apart from morning rounds, weekend or holiday calls follow the same rules as a Night call.
- f. As always, acute safety issues on call take precedence for the team. On psychiatry call, these most often are medical issues with Burr 4 patients, and occasionally safety concerns about voluntary patients asking to leave hospital. Depending on the situation, the team may decide to focus on the acute issue at hand, or the residents may split up the work.
- g. Note that the call schedule in your files may be out of date. The switchboards have the most up to date information, therefore verify with switchboard who your team members are. This is also important when receiving and giving handover to the appropriate residents.

## **2. Referrals**

- a. Referrals are made directly from physician to physician. The emergency physician is responsible for referring the patient to psychiatry. In KGH ED, we work closely with the mental health social workers who assess the patient first and discuss with the emergency physician. Sometimes the MH SW will relay the referral because they have more information, but the emergency physician must be the one requesting referral.
- b. If a patient is referred by the emergency physician at HDH, the patient is usually transferred to KGH for assessment. This is done for two reasons, first because many of the mental health resources are based at KGH, and the HDH urgent care closes for the night. In some circumstances, the team may decide to see the patient at the HDH. This may occur, for instance, if the patient can be seen by the team imminently and the transfer to KGH is delayed.
- c. Referrals from outside the hospital – ALWAYS discuss with the staff psychiatrist, and emergency department charge nurse, before you accept a patient to KGH ED for assessment. When speaking to an outside clinician, always remember to get their name, telephone number, and details of their clinic setting (e.g. an emergency department vs. a family doctor's office).
  - (i) If a community psychiatrist or family doctor calls to let us know that a patient is being sent in to ER for psychiatric assessment AND is medically stable AND is from our area, we can accept the patient as direct to psychiatry. This decision is made by the staff psychiatrist. Please let the charge nurse know if you have spoken with a community physician about a patient and whether it is accepted as a direct to psych or not. Note that if they are direct to psychiatry, then they are not seen first by our ER physician.
  - (ii) If a physician calls from another hospital about a patient from the Kingston area who is admitted to psychiatry, please ask the physician

to speak directly with the inpatient director. This is organized as a direct ward to ward transfer.

- (iii) If a physician calls from Napanee Hospital about sending a patient from their ED for psychiatric assessment, usually we would accept the patient unless we don't have a bed, or KGH is in gridlock, in which case, it will need to be discussed with the emergency physician and usually we are not able to accept.
- (iv) If a physician calls from one of the other local non-Schedule 1 facilities such as Perth or Trenton to send a patient for psychiatric assessment, they would usually be redirected back to their local Schedule 1 facility.
- (v) If a psychiatrist calls from Belleville or Brockville hospital about a patient who is assessed and needs admission, but they have no bed, we try to accommodate if we have any beds. (This rarely happens)
- (vi) If a physician from an ED anywhere in the SELHIN calls about a child under age 18 who needs assessment for psychiatry, usually we will try to have them stay in their local ED and sent during the day for assessment by the C&A team, especially if there are no beds on the C&A ward.

### **3. Assessment**

- a. Assessment of the patient should include a history from the patient, a mental status examination of the patient, a physical examination of the patient, collateral history from physicians, family, friends, police, counsellors, etc., medication history confirmed by the pharmacy and investigations.
- b. Please discuss each patient assessment with the staff psychiatrist whether the patient is admitted or discharged. Discuss each patient as you finish the assessment. Do not batch.
- c. Emergency physicians will do as much of a medical work-up as they feel is necessary with each presentation, and will refer when they think the patient is medically stable. If you think the patient requires more medical work up or is not stable, you may need to order further investigations, order a consult or complete the consult and shift the care of the patient back to the emergency physician with recommendations.
- d. A physical examination should be completed within 24 hours unless it is dangerous to do so, ie. with an aggressive, unsettled patient. This should be completed in the ED, but if not done, will be completed on the ward.
- e. Patients should have had their belongings removed and sometimes a search done in the ED. However, this process is not always routinely established. Please ask the nursing staff or security to remove belongings if present in

patient room, and be aware that it is always possible that a patient may have some sort of weapon (eg. small blade) or something that could be harmful on his/her person.

- f. Please ensure the physical safety of yourself and others, especially your clinical clerk. Ask your senior resident for advice at any time regarding strategies to optimize one's physical safety while on call.

#### **4. Medications**

- a. Please try to get the most accurate information of patient's medication list at the time of admission including dosages, timing, etc. You may need to call the pharmacy or speak with their care team. If this cannot be done at the time of admission, then please take steps to ensure that the reconciliation can be done at the earliest convenience. This may entail contacting the pharmacy in the morning, or at least informing the treating team that this needs to be done.
- b. Generally in the ED, we use prn medications, and don't make significant changes to the medications (although it is a good exercise to think about med changes you would make if you were treating the patient on the ward)
- c. If you are treating agitation or anxiety or distress, please avoid polypharmacy as much as possible and use extra doses of patient's current meds if possible. For example, if a patient is on 200mg seroquel and is agitated, don't give olanzapine, give an extra dose of seroquel, say 100mg.
- d. Be aware of the possibility of substance intoxication and withdrawal. If a patient is likely to go into alcohol withdrawal, ensure that benzodiazepines are ordered to cover or use the CIWA protocol. You may also want to order thiamine. There is a pre-printed order for this purpose.
- e. Many patients are smokers, please ensure you order nicotine replacement if they are involuntary
- f. If you have a patient who you think is catatonic or dissociative and you cannot get a history, give 1-2mg ativan and wait 45 minutes. Sometimes this changes the whole picture.
- g. Medications for agitation and aggression
  - (i) If agitation is purely related to intoxication or withdrawal, benzodiazepines are the primary choice, usually ativan as it can be given im
  - (ii) Usually we use olanzapine 10-20mg po/im for agitation/aggression, max 30-40mg in 24 hours. Alternatively use loxapine/ativan

combination or haldol/ativan combination (since loxapine im is not as available anymore)

- (iii) NEVER give olanzapine and ativan or any benzo together in the same syringe, and they shouldn't be used together im or even orally.
- (iv) If you think the patient is likely to require more meds than the max of olanzapine or agitation/aggression is at least in part due to intoxication/withdrawal, go directly to typical antipsychotic/ativan option.
- (v) For extreme agitation/aggression, order prn doses hourly until patient settled. Advise and support emergency staff to wait at least 30min for im or 60min for po between doses to avoid over sedation.

## **5. Forms and Documentation**

- a. Please complete and sign the psychiatric assessment form when patient is assessed. The whole form should be completed including physical exam, diagnosis, treatment plan and which psychiatrist the patient was discussed with. Also include the date and time of the assessment. This is a medical document and should be as thorough as possible.
- b. If the patient is admitted to the hospital, please ensure that you complete the pre-printed order set with medication reconciliation, and any other PPOs that are relevant to the patient such as CIWA, nicotine replacement, diabetes management, etc.
- c. If the patient is to be put on a Form 1, please complete it accurately and give the Form 42 to the patient. All of Box A or all of Box B must be completed on the Form 1, and the Form signed and dated and the 2 lines at the bottom must be signed and dated (when Form 42 given and when confinement begins). If the Form 1 was completed by the emergency physician or a physician outside of the hospital, make sure the Form 1 is the original and that it is complete and Form 42 given. If there are major deficiencies with the Form, for instance the original Form 1 cannot be found, or there is a significant omission but the signing MD is not available to correct it, then consider writing a new Form 1 and 42, if the team feels that a Form is still warranted.
- d. There are three additional steps to admit a patient. A HARF form must be completed. The HARF form, ER physician note, and a pink sheet must all be submitted to the unit clerk in section A of the ED. Finally, the team must contact the charge nurse on Burr 4 to give a report.

## **6. Discharge Planning**

- a. If the patient has a care team, worker, community psychiatrist, etc., please make contact with the team at time of discharge to ensure follow-up and continuity of care.
- b. If the patient is elderly, has a mental illness of the elderly and requires follow-up, please coordinate with the family physician to refer to the geriatric psychiatry outreach team.
- c. If the patient does not need admission, but does need urgent psychiatric assessment and follow-up, the patient can be referred to our urgent psychiatry clinic (RAPAS) through the MHSW in ED or the FCMHAS crisis team, crisis worker in ED. The crisis team can assist in very acute follow-up and often can make a connection in ED and transporting the patient home. Note, however, that the crisis team is not to be used solely as a taxi service.
- d. Please give patients the crisis line number when they leave ED.
- e. If the patient should have psychiatric follow-up but it is not that urgent, referral can be made to adult outpatients at HDH or to the psychiatrist at the patient's family health team.
- f. If the patient could use some crisis counselling or therapy, that can be arranged through RAPAS, or Kingston Community Counselling Centres, or employee assistance program.
- g. The crisis workers and MH SWs in ED are a great resource for information on local MH resources.
- h. RAPAS should not be accessed if the patient is under age 18, already has a psychiatrist, is less than 1 month post-discharge, or has seen many care providers in the system over time. Patients are seen by the MH SWs first, please let them know. When making a referral to RAPAS, please follow the detailed instructions included in the RAPAS binder. There are also detailed instructions for referring to the child and adolescent urgent clinic.
- i. When a patient is formally admitted and then discharged by the on call team – whether Day, Night, or Weekend call – it is the responsibility of that on call team to produce a discharge summary.