



Queen's Psychiatry On-Call Handbook 2018 1st Edition

Practical Tips for Junior Residents and
Off Service Residents, a Reference for
Senior Residents and Faculty

Written and Compiled by Dr. Peter Wang
Queens Psychiatry Senior Resident
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OVERVIEW

Welcome to Psychiatry on call at Kingston General Hospital! This handbook was originally written in mind for junior residents who handle the pager while on call. For some of you (off service residents), this handbook will only serve as a temporary guide until you have completed your psychiatry rotation. For the rest (the psychiatry junior residents), it is my hope that this handbook will pass along some of the knowledge and wisdom that we (senior residents) have accumulated throughout the years. I hope that it will not only make you better juniors, but better seniors as well one day. This handbook may also be of use to Faculty members who are supervising residents while on call.

This handbook is not meant to be a clinical guide to psychiatric diagnosis. It does not contain any major suggestions for psychiatric management, either. The purpose of the handbook is to summarize the framework and logistics of being on call – while providing suggestions on common or not so common scenarios that can occur. If you find yourself in any uncertain situation while on call – you may look to this handbook for some guidance and support. As Osler once said:

“To study the phenomenon of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all.”

May this handbook keep you afloat on your boat while you are at sea every day/night you are on call so that you may focus your energies learning from the patients.

-Peter

(Please send all feedback to pwang@qmed.ca. If you encounter a situation on call that is not in this guide, I will look at including it for future editions.)

ANSWERING PAGES

The purpose of this section is to assist you with managing and triaging consults and situations that you will receive/encounter while on call. This section will troubleshoot some of the most common and important situations to be aware of during call and how to handle them.

BURR 4 Mental Health Inpatient Ward Common Issues

1) Code White:

A code white is an aggressive patient and they can take place elsewhere in the hospital, but you will probably only get called about them if they happen on Burr 4 or in the ER. The code can be called when a patient has displayed aggression or if there is concern over escalation of verbal aggression, and either patient or staff safety is at issue. Physician involvement is typically minimal as security will arrive on scene, and nurses will administer PRNs if necessary and if ordered. **If you are in hospital, it is a good idea, though not mandatory, to drop by code whites that occur on the inpatient psychiatric ward. There is no requirement for you to physically be at code whites in the hospital.**

Nurses may call you for some method of **restraints**, whether it be PRN medications (chemical restraint), locked seclusion orders, or orders for physical restraints or Pinel restraints (**Please see Appendix for the KGH Pinel Policy – page 65-67**). It is important to always use the least restraint, which is defined as: “The least restrictive measure, used for the shortest duration of time, which allows for the maximum freedom of movement within the restraint process.” Be mindful that staff must **exhaust all alternatives to restraints and behavioral management techniques before** deciding to restrain a patient. This includes verbal de-escalation, and following a patient’s behavioral management plan if there is one.

Safety of all staff and patients is a priority and it is important to be aware that both staff and patients can be injured in code white situations. In very rare cases, there may be a need to call the police if patient is too dangerous for security (brandishing weapon in room, etc). If you are present at a code white, always remind the nurse to prepare both an IM dosage of the medication and the PO pill form of the medication that you’d like to give. It’s best to always offer the patient a choice between receiving an injection and the pill. A surprising amount of patients will opt for the pill when given the choice. **Please see the Queens Psychiatry on Call resources for more formal teaching resources on aggression (<http://psychiatry.queensu.ca/home/on-call>)**

- **Suggested PRN options** include (but are not limited to):
 - **Children:**
 - Try seclusion and ignoring the behaviours first.
 - If medication is necessary (depends on age and size):
 - Risperidone 0.25-1.0mg PO
 - Olanzapine 2.5-5mg ODT/SL/IM
 - Clonidine 0.05mg-0.1mg
 - Consider Cogentin for acute dystonic reactions
 - Avoid benzodiazepines in children
 - **Adults:**
 - Loxapine 12.5-50mg with Ativan 1-2mg po/IM q1h PRN
 - Haldol 5mg with Ativan 2mg po/IM q1h PRN
 - Olanzapine 5-10mg po/IM q1h PRN – Never give Olanzapine and Benzodiazepines in the same syringe and they should not be given together IM.

2) Locked Seclusion Order: Some patients in the IOA (Intensive Observation Area) or in the ER, will exhibit behaviors that are unsafe to other patients or themselves. In these situations, nursing staff will request a locked seclusion order. **It is usually prudent (though not necessary) to grant the order over the phone, and the patient must be assessed in person within 2 hours (this is mandatory) to ensure the safety of the patient and staff, and that a locked seclusion order is necessary.** All locked seclusion orders need to be reassessed every morning during rounds.

3) Requests for extra medications: Patients will sometimes request extra medications for anxiety/sleep/pain from the nursing staff, who will then page you. Ask the nurses for information on the patients and always be mindful of the risks and benefits of prescribing benzodiazepines (very common). It is generally advisable to be very conservative with benzodiazepines. They are addictive, can cause falls, paradoxical disinhibition and are relatively contraindicated in patients with certain psychiatric conditions such as developmental delay/dementia/substance use disorders, and to be used with caution in elderly patients and children. Be mindful of patients who may be in substance withdrawal and never forget that psychiatric patients have medical issues too, which can cause anxiety/discomfort/and pain.

- Common medications for **sleep:**
 - For children: Melatonin 3 or 5 mg OR Zopiclone 3.75 - 7.5mg depending on age/size

- For adults: Zopiclone 7.5mg (3.75mg -5mg in elderly patients) OR Quetiapine 12.5mg, 25mg or 50mg (Quetiapine can also be given for **anxiety**). In adults these can be repeated as needed.
- For alcohol withdrawal – ensure that the patient is on a CIWA protocol. Lorazepam is the benzodiazepine of choice if the patient has compromised hepatic function. Otherwise, diazepam can be given as well. Be mindful of seizures and delirium tremens – potentially life threatening side effects of alcohol withdrawal.

4) Medical issues:

These can range anywhere from mild complaints of pain, to a RACE call. **The RACE (Rapid Assessment of Critical Event) team is a nurse/respiratory therapist/physician team that provides rapid resuscitation expertise to anywhere in the KGH hospital.** They are an invaluable resource to call if you have a patient on the inpatient psychiatric unit who you suspect is acutely medically unwell. It's important to be aware of the resources available on Burr 4 to care for patients with medical needs. There is no oxygen in the walls, and only supplemental canisters of oxygen available. There are no IVs. It is possible to obtain blood work and basic investigations. There is a physical exam room on the B side of the ward if you need to exam a patient. Patients can also be examined in their room if acutely unwell or unable to make it to the physical exam room.

Residents **must** be present for all **RACE calls**. Should a patient become **medically unstable** during the night, you may have to **call internal medicine** for a consult and possible transfer. A helpful tip for obtaining a CT scan for your patient who has had worrisome head trauma is to walk down to the radiology suite in Kidd 1 (on the ground floor of KGH, in between the Emergency Room and the Fraser Armstrong Center, **(see KGH map in the Appendix – page 41)**), and ask for the in-house radiology resident with a completed CT requisition in hand.

5) Planned admissions:

Patients may be transferred to Burr 4 from other psychiatric institutions after hours. In these situations, an attending physician on the inpatient ward will have accepted a patient for transfer from another institution. You will be required to fill out admission orders for this patient, see them briefly and document that you have done so. Always check with the unit clerk to ensure that you have filled out all the proper paperwork. It is not necessary to fill out an entire 4 page KGH ER psychiatry admission assessment form but **an admission note is required**. Always ensure that you have knowledge and

documentation of the patient's voluntary/involuntary status, accurate medication records, allergies, reason for psychiatric admission and any active medical problems.

6) Code Yellow/Missing Patient:

A code yellow is a missing patient. The nursing staff will usually call you if a patient has gone missing before calling a code yellow. The approach to this call depends on the voluntary/involuntary status of the patient. Please note that you may place someone on a form 1, **only** if you have assessed them clinically. The approach differs in the ER slightly in that you would want to inform the ER physician of patients that they have consulted you on, but have gone missing before you could assess them. This is collegial as the ER physician will have to decide whether or not place the patient on a form 1.

1) Voluntary patient: If a voluntary patient is nowhere to be found, it's usually helpful to get switchboard to call the patient's name on the overhead paging system in the hospital, instructing them to return to the Burr 4 inpatient unit. If the patient does not come back within a reasonable time (15-30 minutes), then a code yellow should be called.

Trouble shoot with the nursing staff to see where the patient might be and try calling the patient's home number, family/friend's home number etc. As a last resort, it may be necessary to ask the police to do a **wellness check** on a patient's home address. This request doesn't give the police the legal authority to bring the patient back to the hospital by force as they are a voluntary patient, but can be helpful to at least make sure that the patient is okay.

A missing voluntary patient's bed is held until the morning, upon which the regular inpatient attending psychiatrist that is assigned to the patient decides whether or not to release the bed for another patient.

2) Involuntary patient who has fled from the hospital: Similarly to before, calling the patient's name on the overhead paging system and calling a code yellow are all necessary. In these situations, though it will be imperative to issue a form 9 immediately. The form 9 gives the police the authority to search and apprehend the involuntary patient.

There is no standard policy for how long to hold a bed when an involuntary patient goes missing. Usually, the bed is held as long as necessary on a case by case basis.

3) Inpatients on the Child and Adolescent Psychiatry Ward are treated the same way as involuntary and voluntary patients on the adult side, if they go missing.

Always inform the guardians of the child, whether they be CAS, a foster parent or birth parents.

Basic Principles for Receiving a Consult:

There is a certain art to receiving a consult in a way that is collegial, emphasizes useful exchanges of information and places the patient as the central focus of the conversation. One of the biggest challenges for learners is to know how much information to ask for when receiving a consult. My experience has been that it is best to simply start by having a conversation with your colleagues on what concerns they have about the patient, why they have these concerns and what they hope psychiatry can help with. I've deliberately only chosen the most basic information to consider when you receive a consult. There is always more information that can be gathered in psychiatry; it's an art to make do with what little you get. **Please note that while non-physicians can speak with you about seeing a patient (IE Social Work), the most responsible physician (usually ER physician) must approve of the request for consultation. This is because ER physicians work closely with the mental health social workers.**

1) Demographics:

Always, always, always ask where the patient lives! Mental health services are allocated based on where a patient lives and thus our management will be very different based on geographical factors. For example, we would not be able to set up a patient with community based mental health resources if he lived in Ottawa and was in Kingston visiting family. Though a chart number for a patient is not always necessary, you must also know enough about a patient to be able to locate the patient in the hospital and access their hospital records.

2) Question for Psychiatry/Reason for Consultation:

Risk assessment/request for admission are most common reason for psychiatric consultation. Other times, the request is to **setup with community services, faster access to psychiatry, diagnostic clarification, and disposition and medication adjustment.**

For patients without safety concerns, **disposition** (shelters etc) or **setup with community resources (see Frequently Used Community Mental Health Resources – page 30-32)** can be handled by a mental health SW or crisis worker, but they only work regular hours, often only up to 8pm.

Medication adjustment is a tricky subject. In general, it is in the patient's best interests **NOT** to adjust medications in the ER setting, presumably during a crisis. It is always preferable to have a consistent psychiatrist or GP prescribe/adjust psychiatric medications and be able to provide follow up. The

ER is otherwise **NOT** designed for patients who are discontent with their psychiatric medications and are looking for a second opinion/approval to change their medications. It is also not a good idea to give more than a week's worth of medications in the ER.

For **diagnostic clarification**, it is important for the referring service to understand the limited nature of providing a diagnosis purely in the emergency room setting. Diagnosis such as conversation disorder and somatic symptom disorder are not only difficult to diagnose, but often have deeper meaning and ramifications behind the diagnosis that could not be possibly addressed adequately in the context of the emergency room. For **faster access to psychiatry**, the on call psychiatry team is limited in its ability to influence outpatient psychiatry wait lists. It is not an appropriate use of resources for patients to visit the emergency room purely for the reason that they cannot wait any longer to see an outpatient psychiatrist. If there are concerns with risk (self harm, harm to others etc), these can be addressed separately. For these situations, it often comes down to understanding the resources that the patient potentially has access to, or has tried.

Please note that while it is important to be assertive and state the roles and limitations to a psychiatry consultation, it is never appropriate to **refuse** a request for psychiatric consultation. You may disagree with a referring physician's clinical rationale, but you must keep in mind that as long as they have a reasonable question that psychiatry can answer – you **must** see the patient, even if you feel that you are able to answer the question over the phone.

3) Voluntary/Involuntary status:

a) Form 1: Any physician can complete this form if there are any acute safety concerns. A form 1 can be filled out up to 7 days after a physician has seen a patient and it is enforceable by the police for up to 7 days after this. Once the patient kept as an involuntary patient in a hospital, the form 1 is valid for up to 72 hours and can be discontinued at any time. It is possible for other non-psychiatric physicians to discontinue a form 1, though best practice falls to a psychiatrist to do so. When a patient on a form 1 begins their 72 hour involuntary period (which begins upon arrival to the schedule 1 facility, such as Kingston General Hospital), a form 42 needs to be filled out. Although not required by law to be physically given to the patient (in cases in which safety of staff may be at risk), by law the patient must be told that they are being held involuntarily under the Mental Health Act. Ideally, this is done by giving the patient the form 42, but you can also inform them verbally and document that you did so. Be mindful that occasionally you will meet a patient who is illiterate. Please leave a photocopy of the form 42 in the chart.

There is an area on the form 1 as well to document when the 72 hour period starts and when the patient received the form 42.

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 completed correctly 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. The Box B criteria can be confusing to navigate, when in doubt, just fill in the Box A criteria and leave the Box B criteria blank. Strictly speaking, filling out the Box B criteria in situations where it does not apply legally and filling out the Box A criteria properly on the same form does not invalidate the form 1. **(Please see the appendix for a sample form 1 and form 42 – page 60-64)**

- b) Form 2:** This is issued by a justice of the peace and is requested by a member of the public (ie. a family member). A form 2 lapses the moment a patient is brought into the hospital or clinic and the patient will be need to be placed on a form 1/3 if they are to remain in hospital as an involuntary patient.
- c) Form 3/4:** These are issued when the patient is already an inpatient at a psychiatric hospital. The form 3 holds patients for up to 2 weeks and the form 4 can hold people for longer and the duration depends on how many times the form 4 has been renewed (can be renewed indefinitely).
- d) Form 9:** instructs the police to search for, apprehend and bring patients who were involuntary patients (such as form 3/4) back to the hospital.
- e) Form 47:** This is issued when a patient on a community treatment order fails to comply with the terms of their treatment (usually some form of depot injection), and the police are instructed to search for, apprehend and bring the patient into hospital as an involuntary patient. A form 47 is only valid until the patient receives their treatment.
- f) Form 33:** This is issued when a patient is deemed incapable of making treatment decisions in relation to their mental health. It is separate from a patient's voluntary/involuntary status with respect to hospital admission.

4) “Medical Clearance” vs “Medical Stability”

Medical Clearance 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 patient¹.** 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 referring Physicians. Some suggestions to providing professional psychiatric consultations that are collaborative in nature include:

- a) If the psychiatric assessment indicates an organic cause of the presentation such as delirium, brain tumour, etc, then discuss the opinion with the referring physician with complete recommendations for further work up.
- b) 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 appropriate service that patient should be admitted to. Further investigations may be ordered, but care should be communicated and coordinated.
- c) 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 ER 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.
- d) If the 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.

Special considerations for consults from the KGH ER:

The majority of requests for consultations will be from the KGH ER. These will consist of consultations for a psychiatric opinion from ER physicians, or other services caring for the patient. Patients who are already admitted to the hospital at the time of the psychiatric consult are considered "Consultation Liaison (CL)" patients and need to be approached differently.

1) Patient's capacity to engage in an interview on a psychiatric level. This includes considerations such as:

Is the patient sedated (recent PRN medications for agitation/aggression)?

Is the patient intoxicated (alcohol, crystal meth etc)

Is the patient medically unwell/delirious?

Is the patient even willing to speak with psychiatry?

When in doubt about a person's ability to speak with psychiatry, ask the referring physician and it is suggested to see the patient if the referring physician feels appropriate to do so. There are no labs (electrolyte level, blood

alcohol level) that can predict how a patient can carry out an interview and therefore we must go by our colleague's judgement.

2) Aggression:

If this is the case, it may be useful to confirm that there will be security guards present during your assessment. Ask if there were things that helped with the aggression (IM chemical restraints, verbal de-escalation, assistance from police, etc) **Please see the section on Safety for more information – page 24-26)**

3) Alcohol levels/Drug Screen:

If there is a suspicion of drug or alcohol use, it can be helpful to ask for an alcohol level and urine drug screen to be ordered with the understanding that this would not delay the consult. **The emergency literature indicates that ordering a urine drug screen is unlikely to change the management of the patient in the emergency room².** From a psychiatric perspective, however, it may be useful in some situations to have these tests available to us. And though it may not change our management either – it can be helpful if the patient were to become admitted to hospital or return to the emergency room with similar issues.

4) Child and Adolescent Urgent Care Clinic:

If the consultation is for a risk assessment for a child aged 12-17, check with the ER physician if an urgent outpatient assessment is more appropriate. This is generally better for patient care and an option when the patient is not on a form 1, the parents are comfortable taking the child home, there is not a clinical suspicion of an imminent risk of suicide, and an admission is not felt to be necessary. Appointments are usually possible within 1-3 business days, and patients are seen by a Child Psychiatrist as opposed to psychiatry residents in the ER setting. This service is available for children age 12 and over, and they can admit patients directly to KGH if necessary after the assessment. For children under 12, COPC (the outpatient children's emergency clinic) at HDH, which is open Monday to Friday from 9 am to 4 pm, has a few spots available for urgent access to Child Psychiatry.

5) Geriatric Patients with Dementia:

Due to the complexity of care involved in these cases, it's important to obtain as much collateral information as you can from the family, substitute decision makers, patient's usual psychiatrist/doctor and long term care/retirement home (if the patient is living there) as part of your usual assessment. It can oftentimes be difficult for the on-call team to be able to gather all the necessary information. It is imperative to be mindful of medical conditions that could be causing psychiatric symptoms and always act in the best interests of the patient. There is no rule against admitting patients with dementia to the

psychiatric ward, but caution is certainly warranted due to the aforementioned issues.

**Special considerations for consults from the medical wards for
Consultation Liaison Psychiatry:**

1) Length of stay in hospital, location of stay and brief reason for hospital stay and disposition of patient:

This gives you a good idea of what the course of hospital stay is looking like for a patient. Did they just get admitted and still require a lot of medical treatment? Has it been a complex stay and there are still issues to be resolved? Is the primary medical issue resolved and the patient is only awaiting for a psychiatric assessment before discharging him from a medical point of view?

2) Does it appear that the treating team is experiencing difficulty with the patient (anger, frustration, feeling helpless, feeling anxious, and feeling a strong sense of wanting to help the patient)?:

This is helpful to get an idea of the dynamic between the patient and treatment team, which can give us opportunities for psychoeducation and support for our colleagues in our specialties who may be having a tough time with a difficult patient, which will ultimately lead to better patient care and more of an understanding of complex mental health issues in our colleagues.

3) Questions/Concerns regarding mental capacity of patients to make certain decisions:

A common misconception is that Psychiatry specializes in determining patient capacity. This is not the case, though we can assist with this in those with suspected mental illness, to determine whether their mental illness is affecting their ability to understand and appreciate the treatment options. Every physician has the responsibility to determine capacity within their scope of practice. For example, it would not be wise for a psychiatrist to determine capacity regarding a major surgical procedure, where he/she is not familiar with the risks/benefits of the procedure. A surgeon would be much better suited at determining capacity for a surgery he is familiar with. Financial capacity decisions are typically done with the help of Occupational Therapy. And, the capacity for LTC decisions is exclusively in the domain of CCAC. It is important to establish that consults to psychiatry with the purposes of establishing capacity not relating to the capacity to make decisions regarding treatment of mental health conditions, is a collaborative process between the treatment team and the psychiatric consultant.

4) Role of the on-call team: As a rule of thumb, it is good practice for the on call team to be as involved as they can when receiving consultations from the

medical and surgical wards. Psychiatric medications take time to start/adjust and it can be beneficial for the patient to start this process as early as possible. Additionally, a large part of consultation liaison psychiatry is looking ahead and addressing issues that might happen down the line. For example, if there is a man suffering from alcohol withdrawal, seeing him while on call could increase his chances of engagement with mental health and addictions services, in addition to optimizing his withdrawal treatment whereas he could potentially leave AMA if the consult was to be handled when the regular consultation liaison team returns during regular hours. That being said, ER consults are always prioritized and should generally be seen first.

5) Transferring patients to Psychiatry: The protocol for transferring patients goes through changes from time to time. In general, you have to fill out a set of psychiatry admission orders as well as a HARF. Always check with the charge nurse on the floor for the most recent up to date protocol. Be wary that no IVs are allowed on the psychiatric ward and we do not have oxygen outlets in the walls.

Special considerations for consults from the pediatric wards:

1) Who are the guardians of the child and if there is CAS involvement?

2) There is no age of consent for medical treatments, therefore if a child or adolescent can understand and appreciate the reason for admission or treatment then they can consent and parents can be informed (if the patient consents to this). Patients requiring involuntary admissions (ie. not willing to stay voluntarily and admission being necessary for safety reasons) should be placed on a form.

3) The urgent child and psychiatry consult clinic (please see page 13/page 31).

Special considerations for HDH ER Consults:

All HDH ER consults must come to KGH for assessment. **There is no need to check with your attending psychiatrist.** Always clarify the mode of patient transfer with the ER physician, and if they are on a form, and always inform the KGH ER charge nurse before accepting a consult from HDH ER. Patients coming from HDH must be assessed in the KGH ER, not on the floor of Burr 4.

Special considerations for Outside ER/GP Office/Psychiatric wards:

Always discuss the case with your staff psychiatrist and ER charge nurse when receiving a consult that is not from KGH or HDH.

1) Direct to Psychiatry?:

Direct to Psychiatry means that a patient will be sent from the community to the ER and be seen by the psychiatry team *directly* bypassing the standard ER physician assessment. **The staff psychiatrist and ER charge nurse must approve ALL direct to psychiatry requests.** These are some common situations that come up:

- a) Community Psychiatrist or Family doctor who is sending a patient to ER for psychiatric assessment and is medically stable AND from our geographical catchment area. We can usually accept these patients.
- b) 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/emergency room charge nurse and usually we are not able to accept.
- c) If a physician calls from one of the other local non-Schedule 1 facilities such as Perth or Trenton to send an adult patient for psychiatric assessment, they would usually be redirected back to their local Schedule 1 facility.
- d) 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)
- e) 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.

2) Urgent Child and Adolescent Consult Clinic:

Some GPs will request that you make an appointment at the urgent child and adolescent assessment clinic on their behalf. If this happens, kindly redirect them to call the child and adolescent psychiatry offices directly. **GPs are NOT to use the urgent child and adolescent assessment clinic spots reserved for the ER.** They have their own community spots they must access through the child and adolescent psychiatry offices. If a patient has been seen and assessed in an ER that is within the child and adolescent catchment area and the patients are from that area as well, (Kingston, Trenton, Belleville, Brockville, Perth, Smith Falls and surrounding communities) then you may book them into the urgent clinic and instruct the ER physician at the outside facility to fax in their assessment of the child to the phone number listed in the urgent clinic binder.

3) Transfers from Weeneebayko:

KGH has special agreement with Weeneebayko Hospital, which is located in Attawapiskat. There is a sizeable First Nations population living with significant mental health, addictions and psychosocial difficulties. KGH will accept patients from this hospital for mental health assessments. Whenever possible, it is advisable to make decisions for transfer during the day time when the regular staff are working. As noted previously all transfers require staff approval. For children and adolescents, child psychiatrists can do assessments over OTN during daytime hours to provide an alternative to admission. If you receive a call to transfer a child or adolescent from a northern community, please have them book an OTN appointment (they know how to do so) prior to transferring the patient. They can be transferred by the assessment physician on the previous day if necessary.

4) Catchment Area:

As stated previously, mental health services are based on where a patient lives. Therefore, if a patient is not in a “catchment area”. We cannot provide them routine care, and might only accept a patient under exceptional circumstances (referring facility is lacking beds and patient requires acute treatment).

The catchment area for Child and Adolescent Mental Health is as follows: Geographically, the areas that make up the South East Local Health Integration Network (LHIN) including Kingston, Trenton, Belleville, Brockville, Perth, Smiths Falls, and surrounding communities. The catchment area for Adult Mental Health is the Kingston region, Frontenac, Lennox and Addington Counties.

THE ON CALL TEAM

The on call team consists of a junior resident (PGY1/2/off service resident), senior resident (PGY3+) and staff psychiatrist. There is also usually a medical student. It is possible to find out who the team is on call by calling switchboard, or logging into PCS and clicking “KGH Weblinks” and selecting “on call schedule”. When in doubt, the switchboard has the authority on who is on call as they are responsible for paging residents/staff psychiatrists.

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. **It is not appropriate for seniors to supervise junior residents over the phone.** The residents are expected to assess patients and discuss all assessments with the staff psychiatrist. If the call is busy – it can be appropriate for the junior resident and the senior resident to split up and see patients

separately. This should only be done if both the junior and senior resident are confident that this will not compromise patient care. **A junior resident is never expected to see a patient alone when they are not comfortable and believe that doing so may compromise patient care.**

The staff psychiatrist is present during the Weekday Day call and Weekend/Holiday morning rounds. At other times (e.g. Night call), the staff is out-of-hospital and can be reached by phone or pager. **Official Queens Psychiatry policy at this time dictates that if there are five or more patients waiting to be seen in the emergency department, the on-call staff psychiatrist must come in person to assist directly with patient care.**

Medical students should be directly supervised by at least one resident at all times. Medical students are typically on call until 10:00pm. There are several reasons why we advocate for medical students being supervised, including their safety, teaching, feedback, etc. **It is the junior resident's role to liaise with the medical student before call begins and call them when a consult is to be seen.**

Call Shift Times

There are three basic call shifts with different start/end times and handover times. Generally, consults received within 30 minutes of the end of your shift can be handed over to the next team. Sometimes the call is busy. **It is okay to hand over all consults you have not seen, regardless of when you were received them as long as you have been seeing consults consistently to the best of your ability during your call shift.** (IE if a team receives 3 consults 3 hours before the end of the shift and is able to see 2 consults until the shift ends, it is okay to handover the remaining consult).

1. Weekday Day call

- a. Monday – Friday 8:00am-5:00pm
- b. Handover: 8:00am
- c. Meet 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.***
- e. Consults received within 30 minutes of morning handover (ie. Between 7:30 and 8am) can be handed over to the day ER Psychiatry team at the discretion of the on-call night team with

permission of the Emergency Medicine staff. All consults received prior to 7:30am are the responsibility of the on-call night team.

- f. Consults received within 30 minutes prior to evening handover (ie. Between 4:30pm and 5pm) can be handed over to the on-call night team at the discretion of the day call residents with permission of the Emergency Medicine staff. All consults received before 4:30pm are the responsibility of the on-call day team.

2. Weekday Night call

- a. Hours: 5:00pm – 8:00am
- b. Handover: 4:30-5:00pm
- 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 aforementioned responsibilities of the Day call team. In addition, they are also providing coverage for all Burr 4 inpatient units and emergency psychiatry consultation-liaison service to KGH medical and surgical wards.***
- e. Consults received within 30 minutes of morning handover (ie. Between 7:30 and 8am) can be handed over to the day ER Psychiatry team at the discretion of the on-call night team with permission of the Emergency Medicine staff. All consults received prior to 7:30am are the responsibility of the on-call night team.
- f. Consults received within 30 minutes prior to evening handover (ie. Between 4:30pm and 5pm) can be handed over to the on-call night team at the discretion of the day call residents with permission of the Emergency Medicine staff. All consults received before 4:30pm are the responsibility of the on-call day team.

3. Weekend or Holiday call

- a. Hours: 8:30am-8:30am
- b. Handover: 8:30am
- c. The junior 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.
- d. The attending psychiatrist, senior resident, and clinical clerk arrive at 9am to begin work.
- e. 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.

f. *In addition to these morning rounds, weekend/holiday calls include ALL of the aforementioned responsibilities of Night call and Day call.*

g. Consults received within 30 minutes of morning handover (ie. Between 8:00 and 8:30am) can be handed over to the day ER Psychiatry team at the discretion of the on-call night team with permission of the Emergency Medicine staff. All consults received prior to 8:00am are the responsibility of the on-call night team.

Who to Handover?

Handover is often confusing, as the on-call psychiatry team covers for many separate, discrete psychiatric services in the hospital. **It is the junior resident's role to coordinate all handover, but seniors are expected to guide them in this process as needed.** Please see the following flow chart for the different sources of handover and how to approach this process.

Burr 4 inpatient ward

You will not receive handover, unless the inpatient team feels necessary to do so. (IE, violent patient, medically unstable patient etc)

Consultation Liaison Team

You will not receive handover, unless there are consults that the team is passing along to you

Emergency Room Psychiatry Day Team

You **must** speak with the day team prior to starting your shift. If you have not spoken with the day team, you must call your senior immediately.

On Call Psychiatry Team

Weekend Team

It is courteous to give handover for patients whom you admitted or saw on call. Consults from the pediatric medical inpatient ward are handed over to the child psychiatry team.

Burr 4 inpatient ward

It is mandatory to give handover for issues dealt with by the call team for any patient who the CL team will continue to care for.

Consultation Liaison Team

You **must** call the team, even if there is nothing to handover. If a patient is admitted and staying in the ER due to lack of beds, handover to the ER team. Otherwise, handover all patients in ER consulted to psychiatry.

Emergency Room Psychiatry Day Team

If you are on call on Friday or Saturday, you must handover all Burr 4 inpatient ward, Consultation Liaison Team and Emergency Room Psychiatry Day Team information to the Weekend on call Team.

Weekend Team

Handover Tips

A good handover comprises of the following:

- a) Patient name, CR #, age, Form (if they are on one)
- b) Reason for presentation, past psych history (if any)
- c) Brief summary of presentation
- d) Important information for this particular patient, such as significant medical history to be aware of, violent behaviour etc.
- e) PLAN for the patient (eg. Waiting for bed upstairs, collect collateral from another agency in the morning, med reconciliation from outpatient pharmacy etc.) and anything that needs to be done for the patient that day

Which patients to handover:

- a) New consults that need to be assessed (ER Psychiatry Day Team)
- b) Patients admitted to psychiatry who are in ER due to bed shortages (ER Psychiatry Day Team)
- c) Patients assessed by psychiatry and have been held over in the ER (ER Psychiatry Day Team)
- d) New admissions (Inpatient Teams)
- e) Patients admitted to a medical ward who need to be assessed or followed up (Consultation Liaison team)

Consultation Liaison Handover: The CL team uses a handover tool located in PCS. To locate this tool: log onto PCS and look for the KGH weblink button at the top of the PCS desktop screen. Click on the downwards triangle on the KGH weblink button and select "Resident Handover". Please refer to this handover if you get paged or called about a patient that CL is following.

The Roles of the Psychiatric Teams at KGH

1) Burr 4 Inpatient Ward: There are several teams working on the inpatient ward:

Dr. Oliver (Adult), Dr. Habib (Adult), Dr. Marin (Adult), Dr. Prasad (Adult). **The adult psychiatry inpatient teams do not see consultations for patients admitted to the medical or surgical floors.**

Dr. Roberge (Child and Adolescent): **The Child and Adolescent inpatient team will see all consults from the pediatric medical ward but patients admitted to the child and adolescent ward but are in the ER due to bed shortages are seen by the ER psychiatry day team.**

2) Consultation Liaison (CL) Psychiatry: It is the role of the CL Psychiatry team to see all adult patients admitted to KGH to a medical or surgical floor (this includes OB/GYN). **The CL Psychiatry team will see patients who have been admitted to the hospital under medicine or surgery, but are still in the ER due to bed shortages.**

3) Emergency Room Psychiatry Day Team: **The Emergency Room Psychiatry Day Team sees new consults who have not been admitted to the hospital, though they will round on all patients admitted to psychiatry in the ER but are waiting for a bed due to bed shortages.** Most referrals are from Emergency Room Physicians, though any specialty can refer a patient to this team as long as the patient has not been admitted to hospital.

ASSESSMENT OF THE PATIENT IN THE ER SETTING

Seeing consults is the core of the on call experience. 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 EDIS (the emergency room electronic medical records) for patient information. Ask yourself "What are the circumstances that led to the patient's ER visit?" 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**. 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 and use the psychiatric 4 page form provided in the ER to record your history:

1. Patient's identification data and reason for assessment
2. Current concerns and the circumstances that led to the ER visit.
3. History of presenting illness: focus on the current episode and stressors.
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.
6. Medical history and *substance use*.
7. Family history/Criminal 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.
9. 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.**

Safety

The safety of every KGH employee, student and patient is always the top priority when on call. The literature on the correlation between acts of violence and psychiatric illness is not entirely clear due to the massive methodological difficulties in conducting such research and the wealth of confounders involved in why individuals, mentally ill or not, commit violence. The bottom line is that comorbid mental illness and drug abuse are very significant factors in predicting violence³. When on call, we will often encounter patients at high risk of becoming violent (drug use, desperate patients being held against their will with poor judgement etc). So, this section gives you some practical tips on being safe while on call.

Please see the Queens Psychiatry on Call resources for more formal teaching resources on aggression (<http://psychiatry.queensu.ca/home/on-call>)

A) PREPARATION

1) Panic Buttons

All Psychiatry residents can contact Sharon Thompson (Phone: 613) 544-3400, ext. 2507, sharon.thompson@kingstonhsc.ca for a panic button. Her office is located on Johnson 5 Hotel Dieu Hospital. You will need to pay a \$20 deposit. The panic buttons have been tested to work in the emergency room. When pressed, they will call KGH security to your location. Off service residents have access to panic buttons.

2) 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.

- a) 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.
- b) 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.
- c) 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.
- d) It is important for you to communicate effectively with security so that they know what is expected of them. For example, communicate very clearly where you would like security to be when you see the patient (outside of the room, inside the room, inside the room between you and the patient etc) as well as how many security guards you require.
- e) It is important to be aware that the presence of security guards may escalate the behavior of many patients. Sometimes it is helpful to ask security to be present in ER but out of sight of a patient.

B) THE CLINICAL ENCOUNTER

1) Personal Attire/Posture: Tie up pony-tails and loose articles of clothing that can be grabbed. Ensure that your ID badge holder cannot be used by a patient to choke you. Interview patients with your body pointing around 45 degrees away from them, this has the effect of making you appear less threatening and has the added benefit of making it easier for you to escape a dangerous situation since your body is facing away from the patient.

2) Respect and Empathy: It is important to realize how big of an impact our own attitudes towards patients can influence the likelihood of a violent encounter. Always try to be empathic and respectful, even if the patients do not reciprocate.

3) Preparing the interview: Do not carry anything into the room that can be used as a weapon. For example, avoid giving patients forms that have staples attached, they can and have been used as weapons. Ask agitated patients to sit down before interviewing them and if they refuse to comply, be very cautious proceeding forward. Be very careful about interviewing high risk patients alone.

4) Termination of interview during high risk states: Stay close to the door and be ready to leave when the patient causes you to feel unsafe (clenching fists, standing up from a seated position, making intense eye contact). Always trust your instincts!

5) Security presence: Though the presence of security can escalate patients, for situations where patients have already shown a great deal of

agitation/aggression (attempting to elope while on a form, verbally/physically aggressive moments before an assessment), it may be useful to bring security staff into the room to help complete the assessment safely. Keep in mind that the quality of the assessment with a security present will be obviously affected and this should only be used as a last resort.

Tips for Reviewing Cases

To maximize your learning, always try to take the initiative to propose a management plan to your senior resident. While it can be easy to get caught up in diagnosis or formulation, most times the relevant management plan has more to do with trans-diagnostic factors such as safety, practicality, understanding of patient's situation etc. The senior resident can give you feedback on your proposed management plan before you discuss it with the staff Psychiatrist. When you do discuss the case with the staff psychiatrist, be prepared to do a brief presentation about the case. Here's one possible format to organize your case presentation and your management plan:

Case Presentation:

1. Who is the patient (age, gender, name, employment, source of income, living situation, supports) and what was the reason for psychiatric consultation?
2. How did the patient arrive to the emergency room? Are they on a form?
3. What sources of collateral information did you collect?
4. What is the best possible story you can put together that explains why the patient is here?
5. What sort of psychiatric symptoms is the patient experiencing?
6. Past Psychiatric History (comment on previous hospitalizations if any), Past Medical History, Past Legal history, Family History.
7. Current Medications and Drug Use.
8. Mental Status Exam
9. What is your best possible diagnosis, or understanding of the situation?
10. What is your best estimate of the risk to self or others?

Management Plan:

- a) Disposition: Admission or Discharge? IOA or B-side?
- b) Certification status: Form 1 or no Form 1?
- c) Is there any further medical work up we need to complete?
- d) Is there any further collateral information we need to obtain?
- e) Would this patient benefit from psychiatric medication or medication adjustment? Who should do this and where?
- f) Would the patient benefit from any therapy? Groups, supportive, CBT, DBT, IPT, psychodynamic, motivational, addictions counselling, family therapy?

- g) How likely is the patient to follow up on any recommendations we provide?
- h) How quickly should our recommendations be implemented?
- i) Do I have any legal obligation to report/warn? I.E. homicidal ideation towards a specific target, concerns with impaired driving etc.
- j) Don't forget simple practical management options such as giving a patient a card for the crisis line, or getting the crisis team to call the patient to check on how they are doing after discharge from the ER.

Admission Process/Orders

1) Process:

When patients are admitted, they might have a lot of questions and it's not difficult to imagine the level of anxiety for some patients to be held involuntarily. It is in your patient's best interests for you to take the time to explain the admission process as best as you can.

Generally speaking, patients will receive whatever bloodwork/investigations you order in the ER and they may be subject to a search for contraband (drugs, weapons etc) prior to a porter bringing them upstairs to Burr 4. All the inpatient rooms on Burr 4 are designed for one patient, but most have to share a bathroom with the same gender, so there is a very reasonable degree of privacy. Patients who are on a form 1, **cannot**, leave the inpatient ward for a smoking break. This is an often a point of major contention with patients who smoke. Unfortunately, this is a hospital policy and should be communicated to patients as such.

Sometimes due to bed shortages, patients will have to stay overnight, or during the day in the emergency room. In these cases it may be prudent to proactively ask the nursing staff for a stretcher for the patient to sleep in overnight. Additionally, patients might ask for food or drink if they are hungry or thirsty, or ask for things like the use of the phone. **I would recommend that you never promise anything to a patient that you know you can't deliver yourself.** Very rarely, patients may be manipulative and escalate in aggression if you promised them something that nursing isn't able to provide. Additionally, the nursing staff looks after patients when you leave and there are times where based on the patient's behavior it may not be appropriate to give them certain things for safety reasons. For example, giving a blanket to a patient who is threatening to strangle themselves, with a blanket.

Family members and very close friends may visit patients on Burr 4. Visiting policy is stricter for the child inpatient ward – they typically will not allow classmates to visit. Patients have the right to refuse any visitor. Useful things that patients might want to bring to the unit (or ask loved ones to bring) might

include: 4-5 day wardrobe of casual, comfortable, appropriate clothing (there is access to laundry facilities), personal toiletries, reading material, a small amount of money for vending machines, a list of current medications including over the counter drugs and cell phones are allowed but will be kept at the nursing station and provided when on a pass only. All unnecessary valuables should be sent home, otherwise they will be stored at the KGH Security Office. They will be returned upon discharge with the exception of prohibited weapons or illegal substances as per hospital policy.

If possible, you may complete a physical examination and document that you have done so. **It is the standard of care as well as a requirement in the Ontario Hospitals Act (Provincial Law) that any patient who is admitted to KGH has a physical exam completed in 72 hours.** Doing so makes the work of your colleagues working on inpatient psychiatry much easier. **Please do not exam patients if doing so would pose a safety risk to you.**

You may wish to pick up the phone and call the mental health inpatient nurses if you had any specific concerns/information about a patient that you wanted to relay to them. It is, however not necessary to do this for all admitted patients routinely as it is the role of the ER nurse to give handover to the mental health inpatient nurses.

2) Orders:

Whenever you are unsure about admission orders: ask your senior resident to look it over! Please see the appendix for sample admission orders – page 45 to page 54.

Admission orders are now computerized and completed through the electronic medical records systems. To determine the attending physician, check to see which attending physicians have extra beds available and write the name of the attending physician who has the least amount of patients relative to available beds. There should be a sign in the ER that displays how many beds each attending is to have. Additionally, you can call switchboard and ask for the current bed allocation for each attending physician. Certain preprinted orders, such as the alcohol withdrawal (CIWA) protocol and the nicotine replacement protocol should be completed through electronic medical records.

When you are finished writing the orders in the electronic medical record, you must submit the orders, enter in your electronic signature (special password) and print out copies of the order for the nursing staff and unit clerk as well. There is no need to fill out a HARF unless the unit clerk specifically asks you to.

The IOA (Intensive Observation Area) should be reserved for violent patients, severely agitated patients and patients at imminent risk of self-harm. The

decision to place a patient in IOA is a clinical decision and it's best to have a conversation with a staff psychiatrist or senior resident if you are unsure.

Is it important to write down your understanding of all the home medications that the patient takes, even if you are not going to continue them in the hospital. There is an option in the order sets to discontinue, change or hold admission medications. This is important because it helps the inpatient team figure out what medications a patient was actually takes versus what medications are prescribed.

DISCHARGING THE PATIENT FROM THE HOSPITAL

When it comes to sending a patient home, it's helpful to be aware of frequently used community resources. Many patients have family doctors and EAPs (Employment Assistance Program) that can be a source of counselling and/or mental health support. Currently, we do not have the resources available for patients in the ER to be quickly seen by a psychiatrist alone. We do however, have the capacity to refer patients to mental health services that have psychiatrists as part of the team who can see patients very quickly and provide treatment that addressed most of what brings patients into the ER.

FREQUENTLY USED COMMUNITY MENTAL HEALTH RESOURCES

ITTP (Intensive Transitional Treatment Program)

This is an intensive 4-6 week mental health program at Kingston General Hospital. Patients can be referred if they are in the KFLA area, over age 18 and are stable enough to engage in outpatient services (come to the hospital 2 times a week). This service is covered by OHIP and offers access to a psychiatrist (time limited, with variable wait times, sometimes a few weeks), but the main focus is an award winning interprofessional mental health team consisting of nursing, social work, behavioral science technician, occupational therapy and psychology. The hallmark of the program are the evidence-based group therapies offered, which includes the core group, relaxation group, skills group and the managing powerful emotions group. The managing powerful emotions group can be used as a precursor to DBT groups for patients who have a borderline personality disorder.

Referral Forms are can usually be found in section E of the ER. You can also find the form online at:

http://www.hoteldieu.com/sites/hoteldieu.com/files/seoamhs-regional_access_form-september-2015.pdf

TCM (Transitional Case Management)/Crisis Team/Addictions Counselling (AMHS-KFLA)

TCM is a community based service offered by **AMHS-KFLA** (Addictions and Mental Health Services – Kingston Frontenac Lennox and Addington). It is a time limited service for patients who have been seen in hospital and need to be transitioned back to the care of their family doctor or usual mental health provider. The advantage of this resource is that they have access to a crisis psychiatrist (time limited, with wait times of weeks to months), as well as mental health team that is able to work with individuals in the community (IE coming to people's homes directly).

Please note that TCM is different from the Crisis Team also offered by AMHS-KFLA. The Crisis Team is designed to help people in acute crisis, and only patients that have more long term mental health needs that are not being addressed should be referred to TCM. Both teams have a separate psychiatrist that works alongside the mental health workers.

As an aside, free addiction counselling services are offered through **AMHS-KFLA**, the same organization, and it is a self-referral process. We have cards in the ER that can link people to the crisis line, which is run by **AMHS-KFLA** and they can call this number to be linked to a variety of services, including addictions counselling.

Referral Forms are can usually be found in section E of the ER. You can also find the form online at:

http://www.hoteldieu.com/sites/hoteldieu.com/files/seoamhs-regional_access_form-september-2015.pdf

ERDCM

A program initially designed for patients with mental illnesses who are using the ER often. It is now a program similar to TCM where patients can get access to case management and a psychiatrist for a time limited period. Practically speaking, **AMHS-KFLA** offers this program. Thus, any referral to TCM can be triaged to this program at AMHS's discretion. ERDCM typically aims to provide faster follow up than TCM – they are mandated to make contact with new referrals within 48 hours. Please consult the crisis worker or fill out the same referral that you would to TCM to help patients access this service.

CHILD AND ADOLESCENT URGENT CONSULT CLINIC

This is an urgent clinic run by Dr. Roberts, a child psychiatrist. The mandate of the clinic is to see children aged 12 – 17 who have a high risk to self-harm or harm to others. The clinic provides a one-time consultation and some limited

follow up for some patients. The clinic only sees children who do not have a psychiatrist. Most of the time, children can be seen within 1-3 business days.

To refer patients, check in Section A or Section E of the ER for the binder that is labelled Urgent Consult Clinic. Then, follow the instructions in that binder.

MALTBY CENTER (Previously - PATHWAYS FOR CHILDREN AND YOUTH)

This is the premiere community resource for parents and children with mental health needs. It is always worthwhile to set families up with this resource. Very recent literature⁴ has found that in Ontario, more than 50% of youth presenting to the emergency department for mental health related concerns have not accessed outpatient mental health supports. Additionally, the waitlist is so long to see a child psychiatrist in Kingston (up to one year for some) and the Maltby Center can work with the child while they wait. The website can be found here: <http://maltbycentre.ca/>

K3C Counselling

Community based resource that offers therapy at a price that is based on the person's income level. The website can be found here: <http://www.k3c.org/>

BEHAVIORAL SUPPORT SERVICE "MOBILE RESPONSE TEAM":

The Mobile Response Team is generally seen as a first line approach to managing individuals in long term care homes exhibiting responsive behaviors, before medications are considered. The team consists of a specialized PSWs, RPNs and RNs who support individuals residing in long term care with behavioral concerns. They can be an invaluable resource in assisting long term care homes identify triggers and develop strategies to support individuals exhibiting responsive behaviors. Patients do not need to have dementia, they only need to be residents of a long term care home.

They provide 7 days a week nursing and PSW support as required to residents and staff in long-term care homes throughout southeastern Ontario.

Catchment area includes: Leeds, Grenville & Lanark, Frontenac, Kingston, Lennox & Addington and Hastings and Prince Edward County.

Referrals to this service are made by long term care homes or with agreement from long term care homes. Generally speaking, it's best to check first with the long term care home to see if the mobile response team was involved, as all patient records are kept at the long term care home.

The Mobile Response Team is not designed to be a crisis based resource allocation service, however, and one should avoid sending patients from the ER back to the long term care home on the basis that the Mobile Response

Team can send more support staff. The Mobile Response team cannot provide extra staffing etc to the long term care homes. They are mainly a consultation service that attempts to troubleshoot problems and offer suggestions to the long term care homes.

Discharge Summaries:

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 (e-discharge on PCS). Please contact Medical Records in order that the discharge summary correctly reflects the name of the attending physician you are on-call with (this is not always automatically done, and if there is an error, the discharge summary will enter the queue of the wrong Psychiatrist).

Helpful things to include in the discharge summary:

Date of admission and discharge, discharge diagnosis, medication changes, past psychiatric history, past medical history, substance use, past forensic history, social/developmental history, family history, brief course in hospital, reason for admission, mental health status at discharge, mental health forms during hospitalization and follow up on discharge.

If there are community teams involved in the care of the patient, such as any outreach teams, ACT teams etc. it is both collegial and extraordinarily beneficial for patient care to fax over a copy of the discharge summary. Sometimes even picking up the phone and calling the most responsible psychiatrist or mental health care provider after the discharge is a great way to ensure that your treatment plans and recommendations are carried through, and could mitigate your patient coming to the ER unnecessarily.

Please see the appendix for a sample discharge summary – page 55-58

INTRODUCTION TO COMPETENCY-BASED MEDICAL EDUCATION (CBME)

Canada has long been a leader in medical education, and the Royal College will be directing the implementation of Competency-Based Medical Education (CBME) across all residency programs in Canada in the near future.

While some programs are already operating within the CBME model (Family Medicine Triple C Curriculum, Toronto Orthopedics, Ottawa Anesthesia), Queen's University has taken a leadership role within Post Graduate Medical Education. Starting July 1st, 2017 all of Queen's first-year residents, from all residency training programs will be using the CBME model and will continue to use this model throughout their residency years.

So what is it? CBME is not completely new, it's not radical, but it is different from the old model and does have evidence for its use. Your residency (5 years) is divided up into stages. These still roughly correspond to the current postgraduate years but are called (1) Transition to Discipline, (2) Foundations of Discipline, (3) Core of Discipline, and (4) Transition to Practice.

For each stage, we have Entrustable Professional Activities (**EPAs**). These are bundles of skills that a resident needs to be able to do during each stage. During the first stage, as you transition to the discipline of psychiatry, you will be doing both psychiatry rotations and off-service rotations. A common EPA for both types of rotations is to gather a history, do a physical examination and then choose initial investigations for common presentations. You will need to familiarize yourself with the EPAs of the first stage (PGY1) as you will be expected to trigger the assessments of these small, bite-sized tasks. **You can complete these EPAs while on call.**

For example, after an attending observes you taking a history, he/she will likely (as has always been the case) give you some helpful feedback on how it went. In CBME, you would likely then trigger a brief form on your device or computer so your attending could document his/her feedback. You'll be able to check online to see roughly how many assessments you've accumulated for each EPA and know where you then need to focus more time or effort.

Assessment in CBME is, again, different but not radical. There will be more assessments than previous residents had, *but this is in your favour*. Lots of brief assessment points helps you improve and keeps it so that less rides on an end-of-rotation assessment form that an attending fills out after he/she has forgotten who you are. Don't worry: there are only 5 EPAs for your whole first year. And you'll have plenty of support as you navigate CBME.

MISCELLANEOUS TIPS/TRICKS

1) If you are having any difficulties while working on call, you should report them to the chief residents and/or the program director. It would also be reasonable to try to resolve these issues with the on call team first, if possible. This would include, but not be limited to: any instances of unprofessional behavior, problems with medical records, problems with the on-call rooms etc.

Dr. Mazhar, Program Director for Queens Post-Graduate Psychiatry:
MirNadeem.Mazhar@kingstonhsc.ca

Psychiatry Chief Residents: psychief@queensu.ca

2) When ER physicians consult a service, for some there is an expectation that the consulting service takes over full care of the patient and decides disposition. Most of the time this will not be an issue. It tends to be an issue when there are senior patients with dementia and complex health needs who are not always able to return home, but sometimes are not deemed appropriate for psychiatric admission. The lesson here is to always communicate expectations clearly with other physicians before and after a consult. If the psychiatry team sees a patient and neither makes a recommendation to discharge the patient from the hospital or send the patient home, then it will be crucial to have a discussion with the team to figure out who will care for the patient in the meantime. **There is a Nurse Practitioner, Danny Quann, who works in the ER who helps care for the seniors with dementia who sometimes inevitably have to stay in hospital.**

3) Sometimes despite our best efforts, patients complete suicide. Should this ever happen to any of you, I would suggest taking some time to care for yourself and reflect on if this is something that you should speak to someone with. At the very least I would suggest speaking with the psychiatric team that you were on call with when you saw the patient. **Please see the Burn out/Resident Wellness section for more information on additional resources you can access – page 36-38.**

4) The importance of documentation cannot be overstated. In simple medical-legal terms, if an action was not documented, then it did not happen. Use documentation to your advantage. For example, when documenting risk assessment, always comment on the presence of **suicidal ideations**, whether they are **chronic suicidal ideations at base line or acute suicidal ideations**, and the **intent and plan** for the suicide ideations, if any. Always comment on **future orientation and protective factors** as well. It can be helpful to provide concrete examples of how patients are future oriented. For example, occasionally

patients will ask you for a note to give their employer or teacher to excuse their absence from work or schooling. It can be easy to forget to document this, as this often happens after you have documented your initial assessment and after you have discussed your management plan with the staff psychiatrist and informed the patient of the plan to discharge them from ER. **Remember, if it wasn't documented then it didn't happen.**

5) When writing prescriptions in the ER setting, be sure to include a contact number as well as the staff psychiatrist you are working with that night so that the pharmacy can contact someone if they have questions or concerns about the prescription. If you do not do this, the pharmacy has been known to contact the departmental head of psychiatry's office directly (currently Dr. Soares's office), so it's best to make yourself available.

6) Being on call can be an incredibly valuable experience in terms of learning psychiatry-specific skills, such how to admit a patient, how to manage aggressive patients, and how to deal with emergency situations and crises. However, being on-call can also be challenging: the workload can be high, you are expected to work for the full 24 hours, and sometimes, you are expected to deal with very complex situations that you have little preparation for. That being said, your attitude on call can help you get through difficult times. For example, knowing that you have support in the form of your senior resident and staff, can often make the difference between a terrible call shift and a great one. The golden rule definitely applies to being on-call: treat others how you want to be treated. With that said, if there are times when you experience unprofessional behaviour, or safety issues, you need to know that you are not expected to deal with those on your own: when possible, discuss these issues in a safe place with your senior resident, and together, you can come up with a plan on how to address the situation going forward.

BURN OUT/RESIDENT WELLNESS

Residency is an incredibly taxing time, especially during times of transition (in between rotations, in between PGY years, events in our personal lives). For whatever reason, we can find ourselves over-burdened emotionally and become burnt out. **In a recent survey of Canadian Residents⁵, out of the 48% of residents who responded, almost half of them replied that they were burnt out.** Burnout is common and if you think it's happening to you, seek help! There are several resources available for those who are interested in seeking help for wellness. Most of these services are confidential and have excellent resources available to them.

1) OMA Physician Health Program

<http://php.oma.org/>

(taken from website)

Confidential Toll-free-line: 1.800.851.6606

Open Monday to Friday 8:45 am to 5 pm.

2) Queens School of Medicine and Queen's Student Wellness Services

<https://meds.queensu.ca/education/postgraduate/wellness/counselling>

(taken from the website)

Residents have access to a counselling service provided by the School of Medicine and Queen's Student Wellness Services (SWS). Services are provided through SWS's office in the LaSalle building at 146 Stuart Street. As such, services are provided at arm's length from the School of Medicine for the purposes of maintaining anonymity and confidentiality. Appointments may be requested by contacting Counselling Services at 613.533.6000 ext. 78264 or by email at counselling.services@queensu.ca.

Therapy / counselling is available free of charge. Lunch appointments and some after-hours appointments are also available. Additionally, sessions are also available virtually or via phone for those who are unable to attend sessions in person. One initial face-to-face session is often preferable prior to scheduling these alternatives. For those who may prefer a self-help approach, the following self-help workbooks are free and accessible online: <http://www.queensu.ca/hcds/workbook.php>.

3) Resident affairs via the Learner Wellness office

<http://meds.queensu.ca/education/postgraduate/wellness/director>

For the residents who want career advice, advice regarding evaluations, transfers, or want to discuss stressful or health situations with someone at

arm's length from their program, but still within postgrad and aware of policies etc, this is a great resource to access.

An appointment can be made with Dr. Andrews (Psychiatrist) by emailing: Learnerwellness@queensu.ca

Dr. Andrews on her role in the Learner Wellness Office:

"I deliberately stay arm's length away from the psychiatry RPC [Resident Program Committee, the council that plays a role in academic advancement] and don't supervise residents who I have a conflict of interest with (for a variety of reasons including learner wellness contact) so any conversations remain confidential from the program. But in the rare situation that the resident would prefer to avoid a psychiatry departmental member entirely, they can email learner wellness and request this. The assistant will link them with another wellness advisor and I would never know they had contacted.

4) Family doctor

The Queens Family Health Team, Kingston Family Health Team and Maple Family Health Team typically have good access to mental health resources within the family health team that are free and should be reasonably quick to access. It may be possible to access counselling through Social Workers. Keep in mind that some of your senior colleagues may be working with the Psychiatrists that collaborate with these family health teams.

5) Program director

Dr. Mazhar, Program Director for Queens Post-Graduate Psychiatry: mazharm@kgh.kari.net

6) Private therapist in Kingston

<https://therapists.psychologytoday.com/rms/state/ON/Kingston.html>

Some of these therapists may have some current or past affiliation with the department of Psychiatry at Queens or the three major hospitals in Kingston (Kingston General Hospital, Hotel Dieu Hospital, Providence Care Mental Health Services) and some of them are not. Please note that PARO extended benefits cover up to 500\$ for psychology and MSW counselling services every 12 months (http://www.myparo.ca/During_Residency#Your_Benefits)

7) Professional Association of Residents of Ontario (PARO)

As a resident doctor training to be a specialist in Ontario, PARO is your professional organization. One of PARO's priorities is to promote strategies to

achieve optimal success in training. Keep your eyes open for PARO organized social events, as they are a good opportunity networking and sharing of experiences. Additionally, PARO has a 24/7 anonymous and confidential helpline referral service. It can be accessed by residents and/or their families and is staffed by Toronto Distress Centre volunteers who are trained by PARO. This service can be reached at 1-866-HELP-DOC . If you have any questions about Benefit Information, the Queen's contact is [613-549-6666 ext 2365](tel:613-549-6666). For any other questions or concerns related to your residency training, feel free to contact your Queen's PARO General Council representatives, PARO head office directly at [1-877-979-1183](tel:1-877-979-1183), email paro@paroteam.ca, or visit www.myparo.ca.

8) KGH: The employee assistance program

<http://www.homewoodhealth.com/corporate>

KGH residents have full access to a wide range of confidential services through Homewood Human Solutions. Visit their website or visit KGH Occupational Health, Safety, and Wellness to find out more, or call Homewood Human Solutions at 1-800-663-1142

Residents will be linked to counsellors and other resources. The program is free for residents who are employees of KGH and do not use up any of the PARO allotment.

APPENDIX/REFERENCES

References:

1. Reeves, R. R., Perry, C. L., & Burke, R. S. (2010). What Does “Medical Clearance” for Psychiatry Really Mean? *Journal of Psychosocial Nursing and Mental Health Services*, 48(8), 2-4. doi:10.3928/02793695-20100701-06
2. Schiller, M. J., Shumway, M., & Batki, S. L. (2000). Utility of Routine Drug Screening in a Psychiatric Emergency Setting. *Psychiatric Services*, 51(4), 474-478. doi:10.1176/appi.ps.51.4.474
3. Stuart, H. (2003). Violence and mental illness: an overview. *World Psychiatry*, 2(2), 121-124.
4. Gill, P. J., Saunders, N., Gandhi, S., Gonzalez, A., Kurdyak, P., Vigod, S., & Guttman, A. (2017). Emergency Department as a First Contact for Mental Health Problems in Children and Youth. *Journal of the American Academy of Child & Adolescent Psychiatry*, 56(6). doi:10.1016/j.jaac.2017.03.012
5. Kealy, D., Halli, P., Ogrodniczuk, J. S., & Hadjipavlou, G. (2016). Burnout among Canadian Psychiatry Residents: A National Survey. *The Canadian Journal of Psychiatry*, 61(11), 732-736. doi:10.1177/0706743716645286

SAMPLE 4 PAGE EMERGENCY ROOM PSYCHIATRY ASSESSMENT



Hotel Dieu
HOSPITAL



KINGSTON
GENERAL
HOSPITAL

ADULT PSYCHIATRY EMERGENCY ASSESSMENT

Date: 2000 / January / 01 Time 15:00
Year Month Day

-
- 1. Identification:** (reason for referral, who patient lives with, etc): **Age:** 25 **Gender:** M/ F
 - 2. Allergies:** penicillin (leads to hives and urticarial rash)
 - 3. Mode of Arrival and Accompaniment:** brought in by parents for mental health assessment
 - 4. Sources/Collateral:** mother, father, KGH emergency physician, PCS records
 - 5. Chief Complaint** (Why here, Why now): hallucinations and delusions
-

6. History of Presenting Illness: (onset, duration, predisposers, precipitators, perpetuators, severity)
This 25-year-old male was brought in to KGH ER by his mother and father following a 2 month period of increasing auditory hallucinations, including hearing a number of voices conversing in a third-person context about the actions and behaviours of the patient, such as commenting on what the patient is doing, and at times, instructing him to harm himself and others. The parents reported that the patient also believes that multiple chips and security devices have been implanted in his brain, his body, his apartment, and that clones have taken over the bodies and minds of people he knows, which has led to an intense sense of suspiciousness and paranoia. This is not the first time this has happened: 2 years ago, a similar symptom cluster occurred, which required admission to hospital.

Of late, the parents have noticed that the patient has been using increased crystal meth on a daily basis, and is not compliant with his medication, Risperidone (2 mg po BID), which he was prescribed following the admission two years ago. The parents also reported that the patient was recently fired from his job as an attendant at a gas station as he was showing up to work late on a regular basis, and was caught stealing money from the cash register on two or three occasions.

The patient's family currently feel that he is not at his "baseline" and do not think he can manage on his own at this time: he has not been eating meals on a regular basis, has lost about 20 pounds over the last two months, has not been showering or attending to his personal hygiene, and is often roaming the streets without shoes for days at a time, asking strangers for money or food. The parents are quite concerned about his overall wellbeing and would like to help him return to his baseline, which they describe is "quite well...you wouldn't know he has a mental problem."

- 7. Current Follow-up:** (involvement with CAS/CCAS/JFCS/KFH/ACT).
Family Doctor: patient does not have a GP Psychiatrist: patient enrolled in FACTT under Dr. X
Mental Health Worker: patient has worker, JT Community resource: FACTT (ACT Team)
- 8. Medications:** (include dose, herbals, homeopathies, OTC, recent changes, vitamins, etc.)
The patient takes Risperidone 2 mg po BID, however, compliance appears to be poor.
As per the patient's family and case worker, JT, he does not take any other medications.
No recent medication changes.
- 9. Last Admission:**
Date: Jan 1, 1998 Facility: KGH Inpatient Unit Diagnosis: schizophrenia
Treatment: Risperidone 2 mg PO BID Discharge: January 31, 2008 to FACTT

ADULT PSYCHIATRY EMERGENCY ASSESSMENT

10. Past Psychiatric History: diagnosis, medications, hospitalizations, counselors

The patient had one previous episode of psychosis two years ago, which led to a one month psychiatric admission here in 1998, and he was started on Risperidone.

The patient was followed by the Frontenac Assertive Community Treatment Team (FACTT) since the last admission, however, his case worker reported that he had not attended appointments during the last two months, and had failed to refill his prescription last month, leading her to believe he has not been taking his medications.

11. Past Medical History: (only positive and pertinent negative) hospitalizations, diagnosis, medications, pregnancy, ROS, head injury, seizures

The patient is overall, quite healthy. He has not had other hospitalizations or other diagnoses made. He does not take any other medications, and on review of systems, there is no mention of overt cardiac, respiratory, abdominal, dermatologic, or neurologic symptoms. He denies a history of head injuries and seizures. He reports that he does not have any known medical problems (like hypothyroidism or hypertension).

12. Substance History: EtOH-Freq: denies last use: n/a IV Drugs-freq: denies last use: n/a
Marijuana-freq: denies last use: n/a Smoking: 1 pack per day x 12 years
Does report daily crystal methamphetamine use (snorted) for past 2 months.

13. Criminal History: (charges, incarcerations, behaviours – not charged, current status, etc)

The patient was charged for uttering threats in public in December 1997, just before the admission in January 1998. He was later cleared of these charges. He has not been incarcerated, and there have been no other recent charges.

14. Social History/Personal History: (social/academic functioning, impulsivity, abuse, aggression, premonitory personality.) Highest grade/degree attained: high school

The patient briefly worked as a gas station attendant as noted previously. He did complete high school without significant difficulty but didn't pursue post-secondary education. He has a history of aggression, and as stated previously, was charged for uttering threats in public, however, there was not incidence of physical aggression. He does not currently have a partner, but has been in several short-term relationships. He does live alone in an apartment in Kingston, and supports himself with EI, as he was previously employed by the gas station. He has not been on ODSP or OW in the past. He does not have any siblings, or many friends, however, he is in close contact with his family, who have been supporting him more financially and with meals over the past two months.

15. Family History: (include psychiatric illness (medications too), suicides, effective treatments, EtOH and drug abuse)

The patients' paternal uncle and maternal grandfather were both diagnosed with schizophrenia, and treated with chlorpromazine, and later, flupenthixol injections; they were institutionalized for many years at a time. There are no known completed suicides. There is no history of substance abuse.

16. Physical Examination: Vitals: HR 90 BP 112/76 RR 15 Temp 36.4 po/pr/tympanic

Although deemed medically stable by the ER physician, a cursory physical exam was performed, which was grossly normal, including cardiac, abdominal, and neurological assessments. The patient was alert and oriented.

ADULT PSYCHIATRY EMERGENCY ASSESSMENT

17. **MENTAL STATUS:** (in addition estimate IQ function, frustration tolerance/impulsivity)

Appearance: (appears stated age?, dress for season?, groomed?, clean?): the patient appears his stated age, and is malodorous, with very untidy hair, and wearing baggy-poorly fitting clothes. The patient was dressed in a loose t-shirt, and was not wearing a jacket, despite the temperature being -4 outside. He had a heavy beard as well; there were some tattoos observed on his left arm.

Behaviour: (cooperation with interview, psychomotor behaviour, eye contact): The patient was initially cooperative with interview, but he became increasingly agitated, and began to look fearful, staring intensely at the interviewer.

Speech: (rate/rhythm/volume/grammar/? pressured/? latency): the patient was speaking with grossly normal rate, rhythm, and volume, however, there was diminished content of speech, and his speech was not spontaneous. There was no pressured or latent speech detected.

Mood: (state of feeling and mind of the patient subjectively and objectively): patient reported he was "fine".

Affect: (emotional expressions/appropriateness to content and congruency to mood with objective qualitatators): the patient at times was laughing inappropriately, but for the majority of the interview, his affect was flat.

Perception: (hallucinations, illusions): endorsed auditory hallucinations; responding to internal stimuli.

Thought form: (connection or lack thereof between subsequent thoughts – LOA, FOI, tang, circ, etc): tangential thought form, speaking about voices, then about baseball, and then about wanting to go on vacation in Aruba.

Thought content: (delusions – thought insertion, ideation patterns, thought pathology experienced subjectively, paranoia, themes expressed, obsessions): thinking consistent with paranoid delusions, believing that multiple surveillance devices were implanted in his body and apartment, which was not felt to be physically possible.

RISK ASSESSMENT: (please ensure you elaborate)

Suicide: Y N

Thoughts about death; dying; killing self – how long: the patient reports having had suicidal thoughts, such as thinking it would be better if he were not to "exist", however, recently, he has realized that he has not been able to meet his potential in life, and has thought about taking his life.

Plan for doing this: the patient reports he has several ideas, such as jumping out of the car when his parents are driving on the highway.

Means available pills; guns; knives; poison: he does not have any access to firearms or weapons.

Have you rehearsed in your mind or actually practiced: he has thought about this, but hasn't practiced.

Previous attempts – impulsive planned – method and severity: no prior attempts.

Homicide: Y N

Thoughts about hurting others; killing others – how long and who: denies HI.

Plan for doing this: n/a.

Means available guns; knives; poison: n/a.

Have you rehearsed in your mind or actually practiced: n/a.

Previous attempts &/or violent behaviour – method and severity: no prior HI or HA or physical violence, however, has a charge for uttering threats, so this may have involved expressing HI in the past.

ADULT PSYCHIATRY EMERGENCY ASSESSMENT

Cognition: (orientation, memory, attention, concentration, abstraction): the patient was alert and oriented to person, place and time, however, a formal assessment of cognition was not possible as the patient was attending to internal stimuli and became increasingly distressed and distracted by his internal experiences.

Insight (lacks illness insight; lacks treatment outcome insight; lacks insight to outcome without treatment): the patient endorses his diagnosis of schizophrenia, however, he does not believe he requires medication, stating that the Risperidone is "poison", and believes that he can control his thoughts on his own. Overall, his insight is poor.

Judgment: (actions reflect poor judgment; actions place person at risk of harm; actions place others at risk of harm): the patient was actively attending to internal stimuli, and became increasingly paranoid regarding the possibility that the interview was conspiring against him; the patient was not able to answer all questions, and as such, his judgment is impaired.

Formulation: this is a 25 year old male with a history of schizophrenia, who was brought in by his parents after a two month history of increasing positive psychotic symptoms (auditory hallucinations, paranoid delusions), negative symptoms (more withdrawn, suicidal ideation, avolition), and a decline functioning (poorer ability to tend to basic hygiene, loss of job). These appear to be triggered by a combination of noncompliance with Risperidone and FACTT follow-up, increased crystal methamphetamine abuse, and psychosocial stressors in the form of job loss.

Diagnostic Impression: (including differential diagnosis, star preferred diagnosis)

Axis I: schizophrenia, multiple episodes, active psychotic symptoms

Axis II: defer

Axis III: defer

Axis IV: recent noncompliance with antipsychotic medication and increased stimulant use

Axis V: current GAF: 45 Best GAF in last year: 80

Treatment Plan: (labs, meds, more collateral, referral):

1. Admit to inpatient unit on a Form 1 (checked for Box A criteria: SI, physical impairment).
2. BW, EKG, Urine Drug Screen (to check for other drugs of abuse)
3. Restart Risperidone with plan to offer and educate patient on Long Acting Injectable (Consta)
4. Gather more collateral from treating psychiatrist in community.

BELOW MUST BE COMPLETED

Treatment:

Lab. Results: pending admission orders

Consultations: will refer to OT and SW for assessment of skills, finances, and housing

Medications: Given in ER: Risperidone 2 mg po was given to the patient.

Prescription: none given as plan is to admit to Psychiatry.

Emergency strategies: exam door locked [] IM meds. to restrain [] Security present []
Police escort [] Police presence [] Physical restraints used []

Disposition: Admitted: Y [✓]/N [] Ward: Burr 4 Attending Physician: Dr. Admission
Certified (Form 1): Y [✓]/N [] Patient notified (Form 42): [✓]
Discharged: Y []/N [✓] To where: n/a Accompanied by: n/a

Resident: Sample Resident R1

Print name: Sample Resident R1

Date: 01/January/2000 Time: 17:00

Discussed with Psychiatrist:

Seen with on-call psychiatrist, Dr. Admission

Date: 01/January/2000 Time: 17:00

SAMPLE ADMISSION ORDER SET FOR ADULT INPATIENT WARD (18 or over)



Patient Care Order Set

Review Due Date: 2019 April

7

Mental Health Admission Order Set (Adult)		TRANSCRIPTION
<p>Adverse Reactions or Intolerances</p> <p>Wheat: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Eggs: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Latex: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p>Orders Transcribed</p> <p>Date: _____</p> <p>Time: _____</p>	
<p>Admission</p> <p><input checked="" type="checkbox"/> B Unit (Adult) <input type="checkbox"/> Inpatient (Emergency, Community Services, or Psych Unit) <input type="checkbox"/> Outpatient</p> <p>Admit to Dr.: <u>Habib</u></p> <p>Diagnosis: <u>psychosis</u></p>		
<p>Risk Assessment</p> <p>Imminent risk to self: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Imminent risk to others: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Falls risk: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>		
<p>Mental Health Act</p> <p><input checked="" type="checkbox"/> Voluntary</p> <p>OR</p> <p><input type="checkbox"/> Involuntary (Part 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100)</p>		
<p>Observation</p> <p><input checked="" type="checkbox"/> Observe <u>Every 1 hour</u></p> <p><input type="checkbox"/> N/A</p>		<p>Transcription Checked By (must be a nurse)</p> <p>Date: _____</p> <p>Time: _____</p>
<p>Consults (Attach yellow consult form)</p> <p><input type="checkbox"/> Psychiatry <input type="checkbox"/> Family Medicine <input type="checkbox"/> Geriatrics <input type="checkbox"/> Neurology <input type="checkbox"/> Nephrology</p> <p><input type="checkbox"/> Endocrinology <input type="checkbox"/> Oncology <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Radiology <input type="checkbox"/> Social Work</p>		
<p>Diet</p> <p><input checked="" type="checkbox"/> Diet <u>Regular</u></p> <p><i>(KGH List of Acceptable Diet Orders and Modifications (see associated document))</i></p>		
<p>Submitted by _____ ID _____</p> <p>Prescriber _____ ID _____</p>	<p>_____ IM</p> <p>21 Electronically signed by EP IM SIGNATURE</p>	<p>Pharmacy Use Only</p> <p>Reviewed By: _____</p> <p>Entered By: _____</p> <p>Checked By: _____</p>

Patient Care Order Set

Review Due Date: 2019 April

Mental Health Admission Order Set (Adult)

TRANSCRIPTION

ADMISSION ORDERS FOR HOME MEDICATIONS

Orders Transcribed

Prescribers: List **ALL** outpatient prescriptions, over the counter medications and herbal remedies the patient is taking at home (i.e. 'home medications') at the time of admission and specify the status at admission (i.e. continue, discontinue or change).

Date: _____

Order (1) changes in dose, route or frequency to 'home medications' and (2) all new medications started on admission to hospital, on the **"New Admission Medication Orders"**

Time: _____

Transcribers: Only transcribe medications that are identified as 'continue'.

Medication Name (Use generic names if possible)	Dose (e.g. mg, mcg, units)	Route (e.g. PO, SL, IM, topical, inhaled)	Frequency (e.g. daily, bid, tid) (Include indication for prn medications)	CONTINUE	Discontinue	Change (write new order on page 5)	Patient Supply	Self-Administer	Keep at Bedside
<input checked="" type="checkbox"/> Patient has no home medications				<input type="checkbox"/> See Best Possible Medication History completed by: _____					
1				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Transcription Checked By (must be a nurse)

Date: _____

Time: _____

Prescribers: Please complete an Additional Admission Orders for Home Medications Form if needed

Refer to the Additional Admission Orders for Home Medications Form for more medication

Resource(s) used:

- Patient / Family interview
- Review of home medication vials, packages and devices
- Community pharmacy records
- Review of patient's own medication list
- External Referral/Link/Praxis
- Other

Submitted by _____
ID _____

4

Prescriber _____
ID _____

1 Electronically signed by EP
1 SIGNATURE

Pharmacy Use Only:

Reviewed By: _____

Entered By: _____

Checked By: _____

Patient Care Order Set

Review Due Date: 2019 April

Mental Health Admission Order Set (Adult)		TRANSCRIPTION
<p>Alcohol Withdrawal Therapy</p> <p><input type="checkbox"/> (Physician to complete Alcohol Withdrawal Syndrome Order Set)</p>		<p>Orders Transcribed</p> <p>Date: _____</p> <p>Time: _____</p>
<p>Insomnia Management</p> <p><input checked="" type="checkbox"/> Zopiclone 7.5 mg PO nightly prn for insomnia</p> <p>OR</p> <p><input type="checkbox"/> Zopiclone 3.75 mg PO nightly prn for insomnia (maximum of 4/day)</p>		
<p>Nicotine Replacement</p> <p><input type="checkbox"/> (Physician to complete Smoking Cessation Pharmacotherapy Order Set)</p>		<p>PRINT NAME</p> <p>_____ _____ _____</p>
<p>Pain/Bowel Management</p> <p>Pain Management</p> <p><input checked="" type="checkbox"/> Acetaminophen 650 mg PO q4 h prn for pain (maximum 4 g/day acetaminophen from all sources)</p> <p>Bowel Management</p> <p><input type="checkbox"/> Sennosides 17.2 mg PO nightly prn for constipation</p> <p><input type="checkbox"/> Other _____</p>		<p>PRINT NAME</p> <p>_____ _____ _____</p>
<p>Severe Agitation Management</p> <p><input checked="" type="checkbox"/> Loxapine 25-50 mg PO/IM (PO/IM) q 1 h prn for severe agitation (with LORazepam) Maximum 200 mg per 24 hours</p> <p>AND</p> <p>LORazepam 1-2 mg PO/IM (PO/IM) q 1 h prn for severe agitation (with loxapine) Maximum 8 mg per 24 hours</p> <p>OR</p> <p><input type="checkbox"/> OLANzapine</p> <p><input type="checkbox"/> oral disintegrating tablet (ODT) _____ mg PO q _____ h prn for severe agitation</p> <p><input type="checkbox"/> _____ mg IM q _____ h (maximum of 10 prn for severe agitation (do not give within 1 hour of parenteral LORazepam))</p> <p><input type="checkbox"/> Maximum olanzapine per 24 hours is _____ mg (total maximum 20 mg/day)</p> <p>OR</p> <p><input type="checkbox"/> Other _____</p>		<p>Transcription Checked By (must be a nurse)</p> <p>Date: _____</p> <p>Time: _____</p> <p>PRINT NAME</p> <p>_____ _____ _____</p>
<p>Submitted by _____</p> <p>ID _____</p> <p>MM</p>		<p>Pharmacy Use Only</p> <p>Reviewed By: _____</p> <p>Entered By: _____</p> <p>Checked By: _____</p>
<p>Prescriber _____</p> <p>ID _____ PRINTED NAME _____</p> <p>YYYY-MM-DD HH MM</p>		<p>J:21 Electronically signed by EP</p> <p>SIGNATURE</p>
<p>GH # <u>0119</u> Orig <u>11/Aug</u> Rev <u>16/Apr(V1)</u></p>		<p>Page 4 of 5</p>

SAMPLE ADMISSION ORDERS FOR CHILD INPATIENT WARD (17 or younger)



Patient Care Order Set

Review Due Date: 2019 April

Mental Health Admission Order Set (Pediatric)	TRANSCRIPTION
<p>Adverse Reactions or Intolerances</p> <p>Food: <input type="checkbox"/> No</p> <p>Drugs: <input type="checkbox"/> No</p> <p>Latex: <input type="checkbox"/> No</p> <hr/> <p>Admission</p> <p><input checked="" type="checkbox"/> C Unit (Pediatric) <input type="checkbox"/> Other (specify): _____</p> <p>Admit to Dr: <u>Roberge</u></p> <p>Diagnosis: <u>Psychosis NOS</u></p> <hr/> <p>Risk Assessment</p> <p>Imminent risk to self: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>Imminent risk to others: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <hr/> <p>Mental Health Act</p> <p><input type="checkbox"/> Voluntary</p> <p style="text-align: center;">OR</p> <p><input checked="" type="checkbox"/> Involuntary (charge nurse to be informed)</p> <p> <input checked="" type="checkbox"/> Form 1 <input type="checkbox"/> Form 2 <input type="checkbox"/> Form 3 <input checked="" type="checkbox"/> Form 42 <input type="checkbox"/> Form 43</p> <hr/> <p>Observation</p> <p><input checked="" type="checkbox"/> Observe <u>Every 1 hour</u></p> <p><input type="checkbox"/> Other: _____</p> <hr/> <p>Consults (Attach yellow consult form)</p> <p><input type="checkbox"/> Psychiatry <input type="checkbox"/> Child Psychology <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Social Work</p> <p><input type="checkbox"/> Occupational <input type="checkbox"/> Pediatric Radiology <input type="checkbox"/> Pathology <input type="checkbox"/> Pharmacy</p> <hr/> <p>Diet</p> <p><input checked="" type="checkbox"/> Diet <u>regular as tolerated</u></p> <p><i>(KGIH List of Acceptable Diet Orders and Modifications (see associated document))</i></p> <hr/> <p>Activity</p> <p><input type="checkbox"/> Activity: _____</p> <p><input type="checkbox"/> Other: _____</p> <hr/> <p>Submitted by _____ ID _____ MM _____</p> <p>Prescriber _____ ID _____ PRINTED NAME _____ YYYY-MM-DD HH MM :33 Electronically signed by EP _____ SIGNATURE _____</p>	<p>Orders Transcribed</p> <p>Date: _____</p> <p>Time: _____</p> <hr/> <p>Transcription Checked By (must be a nurse)</p> <p>Date: _____</p> <p>Time: _____</p> <hr/> <p>Pharmacy Use Only</p> <p>Reviewed By: _____</p> <p>Entered By: _____</p> <p>Checked By: _____</p>

Patient Care Order Set

Review Due Date: 2019 April

Mental Health Admission Order Set (Pediatric)							TRANSCRIPTION				
ADMISSION ORDERS FOR HOME MEDICATIONS Prescribers: List ALL outpatient prescriptions, over the counter medications and herbal remedies the patient is taking at home (i.e. 'home medications') at the time of admission and specify the status at admission (i.e. continue, discontinue or change). Order (1) changes in dose, route or frequency to 'home medications' and (2) all new medications started on admission to hospital, on the "New Admission Medication Orders" Transcribers: Only transcribe medications that are identified as 'continue'.							Orders Transcribed Date: _____ Time: _____				
	Medication Name <small>(Use generic names if possible)</small>	Dose <small>(e.g. mg, mcg, units)</small>	Route <small>(e.g. PO, SL, IM, topical, inhaled)</small>	Frequency <small>(e.g. daily, bid, tid)</small> (Include indication for prn medications)	CONTINUE	Discontinue	Change <small>(write new order on page 5)</small>	Patient Supply	Self-Administer	Keep at Bedside	PRINT NAME SIGNATURE
<input type="checkbox"/> Patient has no home medications					<input type="checkbox"/> See Next Page for Medication History completed by _____						
1	Sertraline	50mg	PO	QHS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date: _____ Time: _____
2	Risperidone	0.5mg	PO	QAM	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Transcription Checked By (must be a nurse) Date: _____ Time: _____
3	Risperidone	1.5mg	PO	QHS	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PRINT NAME SIGNATURE
4					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date: _____ Time: _____
5					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PRINT NAME SIGNATURE
6					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date: _____ Time: _____
7					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PRINT NAME SIGNATURE
8					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date: _____ Time: _____
9					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PRINT NAME SIGNATURE
10					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date: _____ Time: _____
11					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PRINT NAME SIGNATURE
12					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date: _____ Time: _____
13					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PRINT NAME SIGNATURE
14					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date: _____ Time: _____
Prescribers: Please complete an Additional Admission Orders for Home Medications Form if needed											
<input type="checkbox"/> Refer to the Additional Admission Orders for Home Medications Form for more medications.											
Resource(s) used:											
<input type="checkbox"/> Patient / Family Interview						<input type="checkbox"/> Review of patient's own medication list					
<input type="checkbox"/> Review of home medication vials, packages and devices						<input type="checkbox"/> Patient Drug By (M) (and (P) (and (R) (and (S) (and (T) (and (U) (and (V) (and (W) (and (X) (and (Y) (and (Z)					
<input type="checkbox"/> Community pharmacy records						<input type="checkbox"/> Other					
Submitted by _____ ID _____ AM _____											
Prescriber _____ ID _____ PRINTED NAME _____ YYYY-MM-DD HH:MM _____ .33 Electronically signed by EP _____ SIGNATURE _____											
Pharmacy Use Only:										Reviewed By: _____	
										Entered By: _____	
										Checked By: _____	

Patient Care Order Set

Review Due Date: 2019 April

Mental Health Admission Order Set (Pediatric)		TRANSCRIPTION
Insomnia Management <input checked="" type="checkbox"/> hydroOXYzine 10 mg PO nightly prn for insomnia for 3 days THEN reassess <input type="checkbox"/> Other _____	Orders Transcribed Date: _____ Time: _____	
Nicotine Replacement <input type="checkbox"/> (Physician to complete Smoking Cessation Pharmacotherapy Order Set)	_____ _____ _____	
Pain/Nausea/Bowel Management Pain Management <input checked="" type="checkbox"/> Acetaminophen <u>325</u> mg (10 - 15 mg/kg/dose) PO q4 h prn for pain for three days THEN reassess (maximum 75 mg/kg/day or 4 g/day acetaminophen, whichever is less, from all sources) <input type="checkbox"/> Ibuprofen _____ mg (5 - 10 mg/kg/dose or 400 mg/dose, whichever is less) PO q6 h prn for pain for three days THEN reassess	_____ _____ _____	
Severe Agitation Management <input checked="" type="checkbox"/> OLANzapine <input checked="" type="checkbox"/> oral disintegrating tablet (ODT) <u>2.5-5</u> mg PO q <u>2</u> h prn for severe agitation <input checked="" type="checkbox"/> <u>2.5-5</u> mg IM q <u>2</u> h (minimum q2 h) prn for severe agitation (do not give within 1 hour of parenteral LORazepam) <input checked="" type="checkbox"/> Maximum OLANzapine per 24 hours is <u>20</u> mg (usual maximum 20 mg/day) OR <input type="checkbox"/> Other _____	Transcription Checked By (must be a nurse) Date: _____ Time: _____ _____ _____	
Submitted by _____ ID _____	Pharmacy Use Only: Reviewed By: _____ Entered By: _____ Checked By: _____	
Prescriber _____ ID _____ PRINTED NAME _____ _____ YYY-MM-DD HH MM	<input checked="" type="checkbox"/> Electronically signed by EP SIGNATURE	

Patient Care Order Set

Review Due Date: 2019 April

Mental Health Admission Order Set (Pediatric)

NEW ADMISSION MEDICATION ORDERS

Prescribers: Include: (1) All new admission medications not taken at home, and
(2) Changes in dose, route or frequency to medications taken at home
(i.e. 'home medications').

Transcribers: Transcribe all selected and written medications.

	Medication Name (Use generic names if possible)	Dose (e.g. mg, mcg, units)	Route (e.g. PO, SL, IM, topical, inhaled)	Frequency (e.g. daily, bid, tid) (Include indication for prn medications)	Patient Supply*	Self-Administer	Keep at Bedside
1					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Prescribers: Please complete an Additional New Admission Medication Order Form if needed
 Refer to the Additional New Admission Medication Order Form for more medications.

Submitted by _____
ID _____

Prescriber ID _____ PRINTED NAME _____
YYYY-MM-DD HH MM

Electronically signed by EP
SIGNATURE

TRANSCRIPTION

Orders Transcribed

Date: _____

Time: _____

PRINT NAME

Signature of Transcriber

Transcription
Checked By
(must be a nurse)

Date: _____

Time: _____

PRINT NAME

Signature of Transcriber

Pharmacy Use Only

Reviewed By: _____

Entered By: _____

Checked By: _____

SAMPLE DISCHARGE SUMMARY:

ADMISSION DATE: January 1st 2000

DISCHARGE DATE: March 15th 2000

DISCHARGE DIAGNOSIS: Schizophrenia, relapse of psychosis.

PATIENT IDENTIFICATION: 25 year old single and unemployed male, followed by Frontenac Assertive Community Treatment Team. He lives alone in an apartment in Kingston.

REASON FOR ADMISSION: Brought in by parents to the ER due to a two month history of exacerbation of psychosis, with suicide ideation.

HPI: Patient was brought into the emergency room after parents found him alone in his apartment, and having conversations about ending his life to people that "were not there". The patient lives by himself in an apartment, but usually is close with his parents. In the last two months, however, he had been isolating himself more and his parents became increasing concerned and decided to check up on him today, which resulted in the ER visit.

Collateral was obtained from the parents and combined with the clinical interview, suggested that the patient was experiencing both positive (hallucinations and delusions) and negative (poor self-care, and decreased interest in social activities) symptoms of schizophrenia. He had reported paranoid delusions and reported hallucinations commanding him to commit suicide as well as harm others who are part of his paranoid delusions. The patient believed that there was a "cataclysm that opened" after the election of Donald Trump, which resulted in "spirits" being released into the drinking water by a group of "demons" that represent the will of the antichrist "Barack Obama". He had been preoccupied with protecting himself from the spirits and had made crude machines to expel the "spirits" from his blood. He reported that he can hear the "spirits" whispering in his ears and inserting thoughts and impulses into his head. He reported that the "spirits" tell him to take his own life, and tell him to harm others though they have not provided specific instruction on how to do so. He reported that he actively resists listening to the spirits.

The patient was extremely suspicious, exhibited thought blocking and was clearly responding to internal stimuli during the ER assessment. He declined to speak much to the ER psychiatry team and he demonstrated suspicious behaviors while in the ER as documented by nursing staff (looking for microphones in the room, accusing the mental health staff of working in

tandem with the “spirits” and refusing all food and drink because of concerns that they were poisoned).

The current presentation is very similar the patient’s last psychotic episode, 2 years ago for which he required admission to Kingston General Hospital. The patient was previously adherent to Risperidone treatment and followed by an ACT team, but has not been adherent to either in the last few months. Additionally, there had been some recent crystal meth use in the last few months. Urine drug screen was positive for crystal meth on admission. Other routine investigations were normal. He was admitted on a form 1.

PAST PSYCHIATRIC HISTORY:

Schizophrenia, first diagnosed at age 20. Has had several relapses, requiring several hospitalizations. The relapses are often related to use of crystal meth. His last hospitalization was 2 years at KGH for 3 weeks and he was treated with Risperidone. He had previous unsuccessful trials of Olanzapine and Quetiapine. He has never attempted suicide. Has never been on a long acting injectable antipsychotic. Has never had ECT. Has never had clozapine.

PAST MEDICAL HISTORY:

None. No history of seizures or head trauma.

MEDICATIONS ON ADMISSION:

None, but was supposed to be taking Risperidone 2mg BID PO as per the ACT team.

ALLERGIES: Penicillin (anaphylaxis)

SUBSTANCE USE HISTORY: Smoking since age 18, 2 packs per day. Occasional marijuana use, around 1g a week. Doesn’t drink alcohol. Has used crystal meth (snorted) intermittently for the last 5 years. No history of IVDU.

FORENSIC HISTORY:

Has never been incarcerated, but has been charged with uttering threats during a psychotic episode, for which the charges were dropped after he was hospitalized and treated with antipsychotics.

FAMILY HISTORY:

Paternal/Maternal Grandfather – Schizophrenia, both treated with chlorpromazine and later, flupenthixol injections. There are no completed suicides. There is no drug abuse.

SOCIAL/DEVELOPMENTAL HISTORY:

Parents reported an unremarkable childhood until age 17 when the patient was diagnosed with schizophrenia after a prodromal period of 6 months where he withdrew from school and uncharacteristically failed all of his classes. He managed to finish high school. He has had several short term relationships. He has a few friends. He does not have any siblings. The parents describe the patient's personality as being very kind and gentle. When he is not psychotic, he enjoys the company of animals and is a very religious person. He briefly worked as a gas station attendant, but was fired after he was caught stealing money from the cash register several months ago. He is currently on unemployment insurance.

COURSE IN HOSPITAL STAY:

The patient was initially very uncooperative with the inpatient team due to his paranoia and spent the two weeks in the intensive observation area. He was not violent and mostly kept to himself. Due to the severity of his psychosis (he continued to decline food, though he accepted unopened bottles of ensure and fluids from unopened water bottles) and lack of insight, he was placed on a form 3 and a form 33 was applied. He did not contest either form, as he did not recognize the legitimacy of either form. His parents acted as substitute decision makers in making the decision to start the patient on long acting risperidone consta injections due to his refusal to take pills during the admission. After about two weeks of admission, the patient's psychosis began to clear and he started to eat food and become more trusting of the inpatient team. He was moved over to the general side of the ward and eventually received accompanied passes with his family, which went well. His psychosis continued to improve and the risperidone consta was increased to 25mg IM q2 weeks, but the patient noticed side effects of galactorrhea and a prolactin level was done and found to be elevated. At this time, the patient was found to be capable of making treatment decisions, and not found to be a certifiable patient. Thus, he was made a voluntary patient. The patient made the decision himself to try aripipazole long acting depot injection. He was started on aripipazole 400mg IM q4 weeks and bridged to this dose with oral aripipazole. He tolerated the dosage well and continued to do well on accompanied passes with his family. The inpatient team explored the reasons behind his latest relapse and we identified that high expressed emotion likely played a significant role. The patient admitted that the drug use was also in response to emotional pain caused by his inability to obtain a better job and "feeling useless" as a result. Additionally, he acknowledged that his apartment was full of people who encouraged him and enabled him to use drugs. At the time of discharge, the patient was motivated to stop crystal meth use and the family was agreeable to try family therapy. The patient was also ready to start looking for work again. To that end the following plan was made during a family meeting where the

ACT team, the patient, inpatient psychiatry as well as the patient's parents attended:

DISCHARGE PLAN:

1) Medications:

Aripipazole long acting depot 400mg IM PO q4weeks.

2) ACT team to provide continuing follow up.

3) Family is agreeable to try family therapy to address the high expressed emotion, which contributed to this relapse.

4) Patient will undergo vocational training by the ACT team, and the ACT team also has addictions support. The patient is also aware that he can self-refer himself for addictions counselling at AMHS-KFLA at any time.

5) Patient has applied for Ontario works with the assistance of the inpatient mental health social worker.

6) Patient will stay with his parents until he can find better housing.

SAMPLE FORM 1



Ministry
of
Health

Form 1
Mental Health Act

Application by Physician for
Psychiatric Assessment

Name of physician Dr. Medical Student
(print name of physician)

Physician address Kingston General Hospital, 72 Stuart Street, Kingston, ON, K7L 2V7
(address of physician)

Telephone number (613) 548-2473 Fax number (613) 548-6091

On October 31, 2016 I personally examined John Richardson
(date) (print full name of person)

whose address is 1234 Main Street, Kingston, ON, K7L 2V7
(home address)

You may only sign this **Form 1** if you have personally examined the person within the past seven days. In deciding if a **Form 1** is appropriate, you must complete **either** Box A (serious harm test) **or** Box B (persons who are incapable of consenting to treatment and meet the specified criteria test) below.

Box A – Section 15(1) of the Mental Health Act Serious Harm Test

The Past / Present Test (check one or more)

I have reasonable cause to believe that the person:

- has threatened or is threatening to cause bodily harm to himself or herself
- has attempted or is attempting to cause bodily harm to himself or herself
- has behaved or is behaving violently towards another person
- has caused or is causing another person to fear bodily harm from him or her; or
- has shown or is showing a lack of competence to care for himself or herself

I base this belief on the following information (you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.)

My own observations:

Mr. Richardson has endorsed active suicidal ideation, a plan to kill himself by locking himself in his car in his sealed garage and turning on the car, to "fall asleep". He has stopped his antidepressants, and is very hopeless and depressed.

Facts communicated to me by others:

Mr. Richardson's daughter and wife have expressed concerns about Mr. Richardson's mental health, and have observed worsening depression, and have realized that Mr. Richardson has stopped taking his antidepressant medication.

The Future Test (check one or more)

I am of the opinion that the person is apparently suffering from mental disorder of a nature or quality that likely will result in:

- serious bodily harm to himself or herself,
- serious bodily harm to another person,
- serious physical impairment of himself or herself

Box A – Section 15(1) of the Mental Health Act
Serious Harm Test (continued)

I base this opinion on the following information (you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.)

My own observations:

Mr. Richardson has endorsed active suicidal ideation, a plan to kill himself by locking himself in his car in his sealed garage and turning on the car, to "fall asleep". He has stopped his antidepressants, and is very hopeless and depressed.

Facts communicated by others:

Mr. Richardson's daughter and wife have expressed concerns about Mr. Richardson's mental health, and have observed worsening depression, and have realized that Mr. Richardson has stopped taking his antidepressant medication.

Box B – Section 15(1.1) of the Mental Health Act
Patients who are Incapable of Consenting to Treatment and Meet the Specified Criteria

Note: The patient *must* meet the criteria set out in *each* of the following conditions.

I have reasonable cause to believe that the person:

1. Has previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in one or more of the following: (please indicate one or more)

- serious bodily harm to himself or herself,
- serious bodily harm to another person,
- substantial mental or physical deterioration of himself or herself, or
- serious physical impairment of himself or herself;

AND

2. Has shown clinical improvement as a result of the treatment.

AND

I am of the opinion that the person,

3. Is incapable, within the meaning of the *Health Care Consent Act, 1996*, of consenting to his or her treatment in a psychiatric facility and the consent of his or her substitute decision-maker has been obtained;

AND

4. Is apparently suffering from the same mental disorder as the one for which he or she previously received treatment or from a mental disorder that is similar to the previous one;

Box B – Section 15(1.1) of the Mental Health Act
Patients who are Incapable of Consenting to Treatment and Meet the Specified Criteria
(continued)

AND

5. Given the person's history of mental disorder and current mental or physical condition, is likely to: *(choose one or more of the following)*

- cause serious bodily harm to himself or herself, or
- cause serious bodily harm to another person, or
- suffer substantial mental or physical deterioration, or
- suffer serious physical impairment

I base this opinion on the following information *(you may, as appropriate in the circumstances, rely on any combination of your own observations and information communicated to you by others.)*

My own observations:

Facts communicated by others:

I have made careful inquiry into all the facts necessary for me to form my opinion as to the nature and quality of the person's mental disorder. I hereby make application for a psychiatric assessment of the person named.

Today's date 31-Oct-2016

Today's time 20:26

Examining physician's signature

AB

(signature of physician)

This form authorizes, for a period of 7 days including the date of signature, the apprehension of the person named and his or her detention in a psychiatric facility for a maximum of 72 hours.

For Use at the Psychiatric Facility

Once the period of detention at the psychiatric facility begins, the attending physician should note the date and time this occurs and must promptly give the person a Form 42.

31-Oct-2016 20:26

(Date and time detention commences)

AB

(signature of physician)

31-Oct-2016 20:26

(Date and time Form 42 delivered)

AB

(signature of physician)

SAMPLE FORM 42



Ministry
of
Health

Form 42
Mental Health Act

Notice to Person under Subsection 38.1 of
the Act of Application for Psychiatric
Assessment under Section 15 or an Order
under Section 32 of the Act

Part I (complete only if appropriate)

To: John Richardson
(name of person)

of 1234 Main Street, Kingston, ON, K7L 2V7
(home address)

This is to inform you that Dr. Medical Student
(name of physician)

examined you on 31-Oct-2016 and has made an application for you to
(date of examination) (day / month / year)

have a psychiatric assessment.

Part A and/or Part B must be completed

Part A

That physician has certified that he/she has reasonable cause to believe that you have:

Check
Box(es)

- threatened or attempted or are threatening or attempting to cause bodily harm to yourself;
 behaved or are behaving violently towards another person or have caused or are causing another person to fear bodily harm from you; or
 shown or are showing a lack of competence to care for yourself.

and that you are suffering from a mental disorder of a nature or quality that likely will result in:

Check
Box(es)

- serious bodily harm to yourself;
 serious bodily harm to another person; or
 serious physical impairment of you.

Part B

That physician has certified that he/she has reasonable cause to believe that you:

- a) have previously received treatment for mental disorder of an ongoing or recurring nature that, when not treated, is of a nature or quality that likely will result in
 serious bodily harm to yourself,
 serious bodily harm to another person,
 substantial mental or physical deterioration of you, or
 serious physical impairment of you;
- b) have shown clinical improvement as a result of the treatment;
- c) are suffering from the same mental disorder as the one for which you previously received treatment or from a mental disorder that is similar to the previous one;

(Disponible en version française)

See reverse

Part B (continued)

d) given your history of mental disorder and current mental or physical condition, you are likely to

- cause serious bodily harm to yourself,
- cause serious bodily harm to another person,
- suffer substantial mental or physical deterioration, or
- suffer serious physical impairment;

e) have been found incapable, within the meaning of the Health Care Consent Act, 1996 of consenting to your treatment in a psychiatric facility and the consent of your substitute decision-maker has been obtained; and

f) you are not suitable for admission or continuation as an informal or voluntary patient.

The application is sufficient authority to hold you in custody in this hospital for up to 72 hours.

You have the right to retain and instruct a lawyer without delay.

31-Oct-2016

(date)

AB

(signature of attending physician)

Part II (complete only if appropriate)

To: _____
(name of person)

of _____
(home address)

This is to inform you that _____
(name of Minister of Health and Long-Term Care)

Minister of Health and Long-Term Care for the Province of Ontario, has reasonable cause to believe that you are suffering from mental disorder of a nature or quality that likely will result in:

Check
Box(es)

- serious bodily harm to yourself; or
- serious bodily harm to another person.

unless you are placed in the custody of a psychiatric facility and has by Order dated

31-Oct-2016

(date of order) (day / month / year)

, authorized your custody in a psychiatric facility for up to 72 hours.

You have the right to retain and instruct a lawyer without delay.

31-Oct-2016

(date)

AB

(signature of attending physician)

KGH PINEL POLICY

Procedure PINEL® Restraint System and Seclusion

1. Initiation of Seclusion or PINEL® restraint system

- a. Orders for seclusion and PINEL® restraint system should not be ordered simultaneously
- b. A Regulated Health Care Provider (RHCP) will notify the attending or covering physician immediately regarding the clinical status of the patient. An order will be obtained at this time.
- c. Notify the physician upon initiation of a PINEL® Restraint System or Seclusion. The physician will assess the patient face-to-face, review their legal status and document their clinical findings and their understanding of what lead up to the event.
- d. An order for PINEL® Restraint System or Seclusion will be in effect for a period 24 hours only. Attempt a trial release of the restraint system or seclusion and if unsuccessful the patient may be restrained for the remainder of the 24 hours, using the initial order. If seclusion or PINEL® restraint is reinitiated after the two hour trial release, it is considered a new episode and it requires a new order and a face-to-face assessment by the physician.
- e. A patient in seclusion or PINEL® Restraint System will be re-assessed face to face by a physician every 12 hours.
- f. Discontinue seclusion and PINEL® restraint systems as soon as clinically possible. A physicians order is NOT necessary to discontinue seclusion or PINEL® Restraints and discontinuation can be implemented by a RHCP regardless of the time remaining on the order.
- g. If required, holding a patient prior to initiation of seclusion or application of the PINEL® restraint system will be consistent with the techniques taught in the KGH Non-Violent Crisis Intervention Training Program or the Restraint Management Program for Security Professionals.
- h. Communicate the reasons for PINEL® restraints or seclusion and the behavioral criteria for release to the patient and all staff members.
- i. Burr 4 staff should ensure an emergency stretcher with a PINEL® Restraint System attached is ready for use at all times. Located on Burr 4.

Monitoring

1. Seclusion

- a. For the first hour in seclusion, provide constant observation of the patient. Close observation can then be initiated for the remaining period of locked seclusion unless the clinical condition warrants constant observation as determined by the RN in consultation with the physician.
- b. Attempt a trial release or discontinuation of PINEL® or seclusion as soon as the set goals for discontinuation are met.
- c. Maintain cleanliness and hygiene of a seclusion room in order to facilitate patient dignity, safety, and infection prevention and control.

2. PINEL® Restraint System

Only apply the following PINEL® mechanical restraints:

- a. Limb Restraint: for the purpose of safely securing a patient's arm and legs
- b. Shoulder strap: for the purpose of safely securing a patient's shoulders and upper body
- c. Waist belt or pelvic strap: for the purpose of safely securing a patient's waist and pelvic area. (These devices are typically NOT applied in an emergency event.

These devices are typically used when a patient is in mobile/walking restraints.)

- d. Extended straps: for the purpose of safely securing a patient's limbs.
3. Provide constant observation of the patient during the period of restraint and the RHCP will conduct assessments and document in the patient care record.

Physician Consultation (72 hour consult)

A Physician consultation is required after every 72 hour period should a patient remain in seclusion or a PINEL® restraint system. The attending physician must request a consult; from an alternate physician. The consultation will be performed as soon as possible following the request.

The goal of the consult is to:

- 1) Assess whether the use of PINEL® restraint or seclusion is warranted
- 2) Assess whether KGH's Mental Health Policies are being followed:
 - a) Appropriate orders have been placed in a timely manner;
 - b) Detailed documentation including the rationale for use of PINEL® restraint or seclusion and how the patient has responded to its use;
 - c) Considerations given to alternatives;
 - d) Whether the patient has been informed of the behaviours they need to demonstrate in order to be released (goals for discontinuation);
 - e) Close or constant observation using the In-Patient Mental Health PINEL® Restraint

Record (see end of this document) or the Observation Tool (Appendix C) for seclusion; reorders at least every 12 hours along with a face-to-face assessment.

- f) Provide a second opinion regarding the use of psychotropic medications and alternative strategies to promote release from seclusion or PINEL® restraint.
- 3) The attending physician documents their review of the consultation.

Documentation required for Seclusion and PINEL® restraint system

- 1) Complete the PINEL® Restraint Record q15 minutes and as outlined in the flowsheet. (see Appendix I)
- 2) Document in the Interprofessional progress notes
 - a) The patient's response to the use of restraint, therapeutic support, counseling interventions.
 - b) Assessments of patient when unrestrained for trial release

c) All other clinical observations, interventions, and care while in seclusion or PINEL® restraints in accordance with the requirements of this policy.

a) Document the discontinuation of a restraint in the discontinuation section of the Mechanical Restraint Record and discontinue the Restraint Record at this time. (see Appendix I)

b) Physicians document the discontinuation of seclusion or PINEL® restraint system in the progress notes and needs to order a decrease in observation level.

Debriefing Process

1) Security leads an emergency restraint debriefing process according to Administration policy

02-141 Assessing, Flagging, and Managing the Risk of Patient Violence Cleaning protocol

1. Ensure all locking pins have been removed from soiled restraint; wipe off with pre-wet wipes (Sani-cloth Plus-red lid SAP# 66491)

2. After locks have been cleansed, secure them in the holding location in the storage bag that houses the entire PINEL® restraint system.

3. The soft material portion of the restraint system (limb, shoulder, waist, pelvic, side straps, etc.) that have been used and soiled, are washed in the washing machine.