Alberta Health Services

PROCEDURE

TITLE

PATIENT REFERRAL, ADMISSION, ASSESSMENT, TREATMENT AND DISCHARGE PLANNING

SCOPE
Provincial: Residential Addiction Treatment and Detoxification Programs

DOCUMENT #
AMH-08-01

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Vice President, System Innovations and Programs

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Executive Director, Provincial Addiction and Mental Health

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Residential Addiction Treatment and Detoxification Programs Policy (#AMH-08)

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NOTE: The first appearance of terms in bold in the body of this document (except titles) are defined terms – please refer to the Definitions section.

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OBJECTIVES

- To outline the role and responsibilities of Addiction and Mental Health (AMH) staff in the patient referral, admission, assessment, treatment, **passes** (referred to in youth programs as negotiated absences) and discharge planning processes in Alberta Health Services (AHS) Residential Addiction Treatment and Detoxification programs.

APPLICABILITY

Compliance with this document is required by all Alberta Health Services employees, members of the medical and midwifery staffs, Students, Volunteers, and other persons acting on behalf of Alberta Health Services (including contracted service providers as necessary).

ELEMENTS

1. Referral

1.1 Staff shall provide information on referrals and access to treatment to any person(s) making inquiries about the residential addiction treatment and detoxification program(s).

1.2 For **patients** who are pregnant, **health care providers** shall:

a) provide priority access to treatment/detoxification;

b) facilitate appropriate referral to another treatment/detoxification program;

c) facilitate appropriate referral for immediate assessment/management by an opioid agonist therapy provider; or

d) direct the patient to the Emergency Department.

1.3 Health care providers shall follow the AHS *Wait Time Measurement, Management, and Reporting of Scheduled Health Services Procedure Manual* when communicating receipt of referral to the referral source and when contacting patients for next steps.

1.4 Health care providers shall review referral packages for completeness, which may include facility-based application forms and supporting documents, as required.

2. Pre-admission Process for Residential Addiction Treatment Programs

2.1 Upon receiving a complete referral package, the appropriate health care provider shall:

a) review the patient's application, case notes, and any other supporting documents and create an admission recommendation;

b) make reasonable efforts to contact the patient within 14 calendar days;

(i) If the program is determined to be '<u>not suitable</u>' for the patient, the health care provider shall provide rationale and recommendations for alternate options to the patient and referral source, as appropriate.

(ii) If the program is determined to be '<u>suitable</u>' for the patient, the health care provider shall:

- contact the patient and referral source to inform them of the status of their application and provide admission information including program expectations;
- document the conversation(s) in the health record; and
- for programs with limited or no access to on-site health care professionals, ask the patient to go to their Family Physician to reconcile their medications and to their pharmacy to prepackage (e.g., dosette or other suitable container) any medications that will be needed for the duration of the program. Clear written directions for taking the medications should be included.

c) inform the residential addiction treatment team of the recommendation in order to track patient admission and manage the facility's wait list, if any.

2.2 Within 14 calendar days prior to the patient's scheduled admission date, the health care provider shall:

a) confirm with the patient the specific details pertaining to their upcoming admission; and

b) review with the patient any programs where there are expectations or requirements of abstinence from patient-identified substance use/misuse prior to admission, and assist the patient, if necessary, to arrange admission to their nearest detoxification centre.

(i) The health care provider shall explain the risks of detoxification based on the patient's application information or when risk is identified.

(ii) For opioid use, the health care provider should explain that detoxing alone is not evidence-based addiction treatment and there is an increased risk of poisoning including overdose or death after a period of abstinence due to diminished tolerance.

3. Screening Process for Detoxification Programs

3.1 Health care providers shall screen all patients via telephone conversations or face-to-face meetings, according to the facility's intake processes. Screening shall include but not be limited to:

a) present and past substance use, including specific screening related to opioid, alcohol, and benzodiazepine use;

b) pre-existing medical conditions; and

c) pregnancy status.

3.2 Screening for opioid use shall include inquiry into:

a) whether the patient is currently receiving opioid agonist therapy;

b) whether the patient has knowingly used opioids in the last 30 days, and if so, the frequency of use;

(i) If the patient has used opioids more than five (5) times in the past 30 days, further assessment is required.

c) the patient's mode of use (ingestion, inhalation, intravenous, etc.); and

d) the presence of withdrawal symptoms when the patient stops using opioids.

3.3 Further assessment related to opioid use disorder shall include consideration for initiation of opioid agonist therapy in consultation with an **authorized prescriber**.

3.4 Screening for alcohol and benzodiazepine use shall include inquiry into whether the patient has any history of delirium tremens and/or seizures during withdrawal from these substances.

3.5 Prior to concluding the screening, the health care provider shall provide the patient with information regarding admission.

3.6 If the health care provider determines that their detoxification program is not suitable for the patient at the time of presentation, they shall inform the patient and referral sources (if any). The health care provider shall provide an appropriate referral and/or information so that the patient can access the most appropriate service.

3.7 If the program is at capacity, the health care provider shall recommend the most appropriate alternative treatment setting (e.g., AMH community resources, emergency services) on a case-by-case basis.

4. Patient Admission and Initial Assessment

4.1 Upon the patient's arrival, the health care provider shall:

a) verify their identity per the AHS *Patient Identification* Policy and AHS *Patient Identification – Registration* Standard;

b) provide the patient with an admission package including a copy of the service contract in accordance with the *Mental Health Services Protection Act* (Alberta);

c) inform the patient of program expectations, the need to conduct searches of patients and their belongings, and a list of prohibited and restricted items;

d) obtain applicable patient consent as per the AHS *Consent to Treatment/Procedure(s)* Policy Suite for admission and complete the consent form and other required forms;

e) ask the patient for the complete and current medication list and/or all of the medications they are currently taking; and

f) conduct a search of the patient and their belongings.

4.2 Health care professionals, shall:

a) upon admission, determine if the patient should be considered for self-administration of medication;

b) obtain and appropriately record and store the patient's own medications in accordance with site process; and

c) ensure that the patient's **best possible medication history (BPMH)** and medication reconciliation have been completed as per the AHS *Medication Reconciliation* Policy.

4.3 Within 24 hours of admission, the health care provider shall:

a) complete or update the patient's assessment, including but not limited to:

(i) a medical history including history of substance use;

(ii) an assessment of the patient's current physical state and mental status; and

(iii) observations and screening for risk of suicide;

b) work collaboratively with the patient to identify their needs and develop an initial treatment plan; and

c) document the assessment and treatment plan in the health record.

5. Treatment Planning

5.1 Health care providers shall collaborate with the patient to review and revise the patient's treatment plan, discuss follow-up plans and treatment recommendations, and document in the health record.

a) The treatment plan shall be reviewed on a weekly basis for patients in residential addiction treatment and daily for patients in detoxification.

5.2 The patient's treatment plan shall include (with **family** involvement, as appropriate) but is not limited to:

a) a personal aftercare plan for post-treatment recovery;

b) education on risks associated with possible return to substance use (e.g., diminished tolerance leading to unintentional overdose) and prevention strategies; and

c) education and provision of a naloxone kit per the AHS *Distribution of Community Based Naloxone Kits* Policy.

5.3 For patients in detoxification, health care providers shall refer to the AHS *Management of Alcohol Withdrawal for Non-Hospital Detoxification Centres* Protocol (AMH) and standardized tools (e.g., Clinical Opioid Withdrawal Scales) for withdrawal from other substances as clinically appropriate.

5.4 For patients with opioid use disorder, health care providers shall offer a referral to an authorized prescriber for consideration of opioid agonist therapy.

a) Any person reporting current opioid use or requesting a naloxone kit shall be offered/given a naloxone kit per the AHS *Distribution of Community Based Naloxone Kits* Policy.

6. Passes / Negotiated Absences

6.1 Health care providers shall discuss with the patient and the appropriate clinical Supervisor/Manager as required, the patient's need for a pass / negotiated absence and its alignment with their treatment plan.

a) If the request for the pass / negotiated absence is denied, the health care provider shall meet with the patient to discuss the decision.

b) If the pass / negotiated absence is granted, the health care provider shall:

(i) review with the patient who to contact if the patient does not return;

(ii) provide the program contact information to the patient;

(iii) request the patient contact the program if delayed in returning; and

(iv) document that the patient is leaving the treatment facility.

6.2 A health care professional shall work with the patient to determine the need for medications while the patient is away on pass. The health care professional shall prepare any pass medications, labelled with the patient's name and directions for use, and shall offer to address any patient questions prior to the pass.

6.3 If a patient goes on pass / negotiated absence, the health care provider shall consider providing overdose awareness education and a naloxone kit, as there is an increased risk of death after a period of abstinence due to diminished tolerance, which may lead to unintentional overdose.

6.4 If a patient has not returned from pass / negotiated absence at the agreed time and has not contacted the treatment facility, the health care provider shall:

a) review their case file for the most current information, including areas that indicate increased risk;

b) make efforts to contact the patient as soon as reasonable;

c) make reasonable efforts to contact the person identified as per Section 6.1 b)(i) if unable to reach the patient; and

d) notify management to determine next steps if patient whereabouts or status are still unknown.

6.5 In the event a patient returns from pass and reports or appears to have engaged in substance use, health care providers shall:

a) meet with the patient to determine if and what type of substance use they engaged in and what led to the return to use; and

b) discuss with the patient their continued participation in the program and re-evaluate their treatment plan.

6.6 Considerations for **minors**:

a) Minors are rarely permitted non-accompanied passes / negotiated absences from a treatment facility. If a minor needs to leave the facility, it is usually for an appointment or treatment supported visit and they are most often accompanied by an adult. Requests for passes for minors who are unaccompanied shall be determined on a case-by-case basis.

b) Staff shall communicate and obtain consent as per the AHS *Consent to Treatment/Procedure(s): Minors / Mature Minors* Procedure.

(i) Facility staff shall request picture identification from the adult who will accompany the minor patient.

c) Health care providers shall provide any medication required during the absence to the **mature minor** or to the minor's accompanying adult or family.

d) If a minor patient, who has not been deemed a mature minor, has not returned from the pass / negotiated absence at the agreed time and has not contacted the facility, health care providers shall:

(i) contact the family or accompanying adult; and

(ii) determine next steps in consultation with the family.

(iii) Health care providers shall explain this process to the family at the time of admission.

7. Discharge Planning

7.1 Prior to a patient's scheduled discharge, health care providers shall:

a) meet with the patient to review follow-up plans and treatment recommendations at least three (3) business days prior to a residential patient's scheduled discharge and as appropriate for a detoxification patient's discharge; and

b) meet with the patient to review their personal aftercare plan which may include:

(i) return to use prevention education;

(ii) naloxone education and provision of a naloxone kit; and

(iii) a follow-up appointment with a prescriber for consideration of opioid agonist therapy.

7.2 In collaboration with the patient, the health care provider shall contact the referral source to report on patient status, discuss follow-up plans and share treatment recommendations.

8. Early Discharge

8.1 Early discharge may be initiated by health care providers when:

a) the patient does not or is unable to meet program expectations, including exhibiting violent or aggressive behaviour; or

b) the patient is experiencing or recovering from an illness that impacts their ability to participate in the program or that poses a risk of contagion.

8.2 Early discharge may be initiated by the patient at any time for any reason.

8.3 When an early discharge is initiated by either the health care provider or the patient, the health care provider shall:

a) make a reasonable attempt to meet with the patient to review patient risk, including risk of return to use and suicide, and revise the treatment / personal aftercare plan as required;

b) ensure medications are readied to be returned (if applicable) as per site process, as well as other patient belongings held in safekeeping;

c) offer/provide a naloxone kit to anyone with a history of opioid use disorder or would like one (refer to the AHS *Distribution of Community Based Naloxone Kits* Policy);

d) inform the patient's referral source (and family, if patient is a minor), discuss follow-up plans, share treatment recommendations, and book an appointment with the patient's referral source, as the patient agrees;

e) as appropriate, inform the Manager (or designate) of the discharge as soon as reasonably possible; and

f) for minors, inform and coordinate the discharge with the family as per the AHS *Consent to Treatment/Procedure(s): Minors / Mature Minors* Procedure.

8.4 When the health care provider is concerned about potential patient aggression, they may arrange for the patient to be escorted from the facility or may activate a Code White response (see the AHS *Emergency Response Codes* Policy and the Code White Procedure specific to that facility or area).

DEFINITIONS

Authorized prescriber means a health care professional who is permitted by federal and provincial legislation, their regulatory college, Alberta Health Services, and practice setting (where applicable) to prescribe medications.

Best possible medication history means a complete and up-to-date list of the patient's current medications at the time of admission verified using at least two sources of information. The BPMH includes:

a) name of the medication (all prescribed, over-the-counter, herbal, vitamin, homeopathic, health remedies and substances for recreational use);
b) dosage;
c) route of administration;
d) frequency of administration; and
e) time of last dose (as appropriate).

Family(-ies) means one or more individuals identified by the patient as an important support, and who the patient wishes to be included in any encounters with the health care system, including, but not limited to, family members, legal guardians, friends and informal caregivers.

Health care professional means an individual who is a member of a regulated health discipline, as defined by the *Health Disciplines Act* (Alberta) or the *Health Professions Act* (Alberta), and who practices within scope or role.

Health care provider means any person who provides goods or services to a patient, inclusive of health care professionals, staff, students, volunteers and other persons acting on behalf of or in conjunction with Alberta Health Services.

Health record means the collection of all records documenting individually identifying health information in relation to a single person.

Mature minor means a person aged less than 18 years, who has been assessed and determined as having the intelligence and maturity to appreciate the nature, risks, benefits, consequences, and alternatives of the proposed treatment/procedure(s), including the ethical, emotional and physical aspects.

Minor means a person aged less than 18 years.

Pass means that the patient is allowed to leave the premises or facility grounds for a specified period of time, either accompanied or not.

Patient means all persons, inclusive of residents and clients, who receive or have requested health care or services from Alberta Health Services and its health care providers. Patient also means, where applicable:

a) a co-decision-maker with the person; or
b) an alternate decision-maker on behalf of the person.

REFERENCES

- Alberta Health Services Governance Documents:
  - *Consent to Treatment/Procedure(s)* Policy (#PRR-01)
  - *Consent to Treatment/Procedure(s): Minors / Mature Minors* Procedure (#PRR-01-03)
  - *Distribution of Community Based Naloxone Kits* Policy (#HCS-246)
  - *Emergency Response Codes* Policy (#1132)
  - *Management of Alcohol Withdrawal for Non-Hospital Detoxification Centres* Protocol (#HCS-12-01)
  - *Medication Reconciliation* Policy (#PS-05)
  - *Patient Identification* Policy (# PS-06)
  - *Patient Identification – Registration* Standard (# PS-06-01)
  - *Residential Addiction Treatment and Detoxification Programs* Policy (#AMH-08)
  - *Wait Time Measurement, Management, and Reporting of Scheduled Health Services Procedure Manual* (#1151)
- Non-Alberta Health Services Documents:
  - *Mental Health Services Protection Act* (Alberta)

VERSION HISTORY

Date	Action Taken
Click here to enter a date	Optional: Choose an item
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