When to Transfer to the Emergency Department

Community residential withdrawal management services (WMS) are generally non-medical facilities with limited access to medical care. Transfer to the emergency department (ED) will be required if the client meets one of the following criteria and there is no on-site medical support. Please note that this is not an exhaustive list; in the absence of on-site medical support, staff should err on the side of caution when considering transfer to the ED for any medical concern. The transfer process should include consideration of WMS and local resources and the best interest and safety of the clients and staff.

INDICATIONS FOR TRANSFERRING CLIENTS FROM WMS TO THE ED

A. GENERAL

- Withdrawal from multiple substances (when appropriate medical expertise is not available for close monitoring on site)
- Inadequately controlled medical illnesses (cardiovascular diseases, liver diseases, respiratory diseases, or renal impairment), or patients presenting without their treatments for these conditions when prescribers are not available
- Wernicke's encephalopathy, presented with ophthalmoplegia (weakening eye muscles), ataxia (lack of muscle control), and confusion.
- Severe abdominal pain
- Chest pain
- Actively suicidal or homicidal with intent/plan and means
- Any of the following clinical features:
    - SpO2 < 92% on room air
    - RR < 10 OR > 20 breaths/min
    - T < 35°C OR > 38.5°C (if provider not on site)
- Irregular pulse or HR < 50 bpm OR > 120 bpm
- Systolic BP ≥ 180 or diastolic BP ≥ 120 in acute withdrawal

B. ALCOHOL INTOXICATION

- Symptoms are not consistent with estimated level of intoxication (e.g., the patient is drowsy, confused, ataxic even though their last reported drink was 24 hours ago and there is no odour of alcohol)

C. ALCOHOL WITHDRAWAL

- Tremor and other signs not improving or getting worse despite 80 mg of diazepam or 8 mg of lorazepam
- Risk for dehydration or electrolyte imbalance, e.g., repeated vomiting, profuse sweating
- In withdrawal but at high risk for benzodiazepine toxicity, e.g., COPD, liver dysfunction or failure, elderly, on methadone or high doses of opioids
- Seizure
- Possible early withdrawal delirium: Delusions, hallucinations, disorientation
- Pregnant
- Vitals of concern: Irregular pulse or HR > 120, systolic BP ≥ 180, or diastolic BP ≥ 120

D. OPIOID INTOXICATION/OVERDOSE

- Any signs of impending overdose:
  - Nodding off
  - Drowsiness
  - Pinpoint pupils
  - Sweating
  - Slow shallow breathing and/or loud snoring when asleep
  - Vitals of concern: SPO2 < 92%, RR < 10 breaths/min

E. OPIOID WITHDRAWAL

- Persistent severe withdrawal symptoms despite medical management, e.g., methadone, buprenorphine, clonidine, etc.
- Has a medical condition that warrants close monitoring and more intensive medical care, e.g., severe COPD, on high doses of sedating medications

F. CRYSTAL METH INTOXICATION

- Agitation, aggression, or psychosis not relieved with reassurance, benzodiazepines, antipsychotics
- Frightening delusions or hallucinations
- Vitals of concern: Irregular pulse or HR > 120, systolic BP ≥ 180, or diastolic BP ≥ 120

G. BENZODIAZEPINE WITHDRAWAL

- Benzodiazepine dependence suspected and provider not on site (daily benzodiazepine or daily fentanyl use reported)
- Benzodiazepine withdrawal with high risk for benzodiazepine toxicity, e.g., liver dysfunction or failure, on methadone or high doses of opioid, frail elderly, severe COPD
  - Has any of the following symptoms:
    - Disorientation, confusion, hallucinations
    - Seizure
    - Severe agitation
- Has not responded to one or two doses of provided benzodiazepine
- Vitals of concern: HR > 120, systolic BP ≥ 180, or diastolic BP ≥ 120