

Emergency Toxicology Services: Starting from Scratch

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This presentation will discuss the issues pertaining to the organization of care for the poisoned population in a Canadian urban setting. The first part will illustrate the problems with the current delivery of care in many North American communities, the factors involved and different models of care existing in the world for coordinated specialized teams in clinical toxicology. The second part will outline the project evolving at the McGill University Health Centre and the system challenges faced by clinicians aiming to set up a multidisciplinary team providing expert care for this population.

Deliberate self poisonings account approximately 10% of hospital admissions across the industrialized world. 40% of suicides deaths are by poisonings. Quality of care to this population is problematic because of multiple factors. Most admissions to the hospital occur via the emergency department where multiple doctors and nurses are scheduled shift work. Continuity of care is challenged with doctors or nurses changing every shift. It is also most difficult for patient to verbalize their problems with many different staff in a day. Toxicological expertise is almost exclusively done over the phone, recommendations are not always followed by the treating physicians and transmission of information is suboptimal between health care workers. DPS patients are at the heart of a triangle comprised of the social well being breakdown, psychological status breakdown and medical consequences of their gesture. The concept of a toxicology unit is to provide multidisciplinary, coordinated, efficient, expert level care to poisoned patients of a given area with a planned-for-purpose designated location. The goals are to 1- increase quality of care by judicious use of interventions, evidence based up to date knowledge expert care and coordination between team members 2- optimize use of health care resources by decreasing length of stay, maximizing bed utilization, increasing patient satisfaction and increasing likelihood for outpatient continuity of care to decrease recurrences. Different models have been tried in two countries visiting by the author UK and Australia. Medical models can be divided in three groups: Nurse led, general medicine led and emergency led. Locations other than intensive care units can further be divided in other groups: general medical ward, emergency observation area, or purpose built short stay admission ward with or without access to monitored beds. Various health care professionals are found in toxicology teams: toxicologist, psychiatrist, psychiatry liaison nurse, dedicated social work, drug and substance abuse counselor. Other resources that are important to have contact with are community workers, child protection workers, poison information centre, Intensive care, Transplant team, Dialysis team and laboratory analysis. Clinical research is important to develop with a specialized database of admitted cases. The McGill University Health Centre is currently working to implement a multidisciplinary team comprised of a psychiatry toxicology liaison nurse, social worker and toxicologist to care for poisoned patient of the island of Montreal. These patients would be admitted to a 14 bed short stay admission ward shared with the Royal Victoria Emergency Department in a DSP prevention purposed-built ward with locked doors and secure rooms, doors and windows. The author will discuss the approach taken and the structural and cultural modifications that will have

to occur within the organization to implement such a different approach in the management of these patients.
