AH0600 - EMERGENCY DEPARTMENT REQUIREMENT FOR ASSESSMENT OF OUTPATIENTS WHO RECEIVE INJECTABLE NARCOTICS

1.0 PURPOSE

To promote quality care and patient safety by ensuring Outpatients are appropriately assessed by an EDP or MRP when receiving or prior to receiving an injectable Narcotic in Emergency Departments (ED) of Interior Health (IH).

2.0 DEFINITIONS

EDP	Emergency Department Physician
MRP	Most Responsible Physician
Narcotic	Any substance set out in the schedule or anything that contains any substance set out in the schedule in the (Narcotic Control Regulations, CRC. C., 1041), see Appendix B.
Outpatient	A patient who presents to the ED for care and is not hospitalized or admitted to hospital.

3.0 POLICY

3.1 Assessment and Order Required

- This policy applies to Narcotic injection(s) administered to Outpatients being treated for acute and/or chronic conditions at IH EDs.

- Narcotic injection(s) will only be administered to Outpatients when the Outpatient has been assessed by an EDP/MRP (with active privileges in the administering facility) and the EDP/MRP has written an order dated within 24 hours of the Narcotic injection being administered.

  NOTE: Phone orders are acceptable on the undertaking the EDP/MRP will assess the Outpatient within 24 hours of the phone order.

- Orders for a series of Narcotic injections in excess of 24 hours require Outpatients be reassessed by an EDP/MRP (with active privileges in the administering facility) within 24 hours of the initial order and within every 24 hours thereafter while the Narcotic injection order is in effect.

- Patients will be triaged and assessed (including vital signs) by nursing staff at each visit by the patient for a Narcotic injection.

- Observation time following a Narcotic injection will be dependant upon the specific Narcotic administered and the individual Outpatient response. Depending on nursing judgement, this assessment may include selected vital signs and level of consciousness.

- This policy provides a minimum standard. More restrictive site specific guidelines may be developed.

3.2 Outpatient Transportation upon Release Required

- Outpatients must not receive a Narcotic injection unless they are accompanied by an individual who will be providing transportation for them upon release from hospital. Alternatively, the Emergency Department staff have reviewed with and are satisfied the Outpatient has made arrangements for safe transport home and will not be operating a motor vehicle.

- The details of the Outpatient's transportation arrangements MUST be documented.

3.3 Outpatient Discharge

Documentation of Outpatient reassessment for discharge is required.

3.4 Consequence of Non- Compliance

Failure to comply with the provisions of this policy may result in the rescinding of Narcotic injection orders under this policy. Outpatients could be required to be seen by a EDP/MRP in the ED at the time of each injection.

4.0 PROCEDURE

See Appendix A
See Appendix C for Frequently Asked Questions

5.0 REFERENCES

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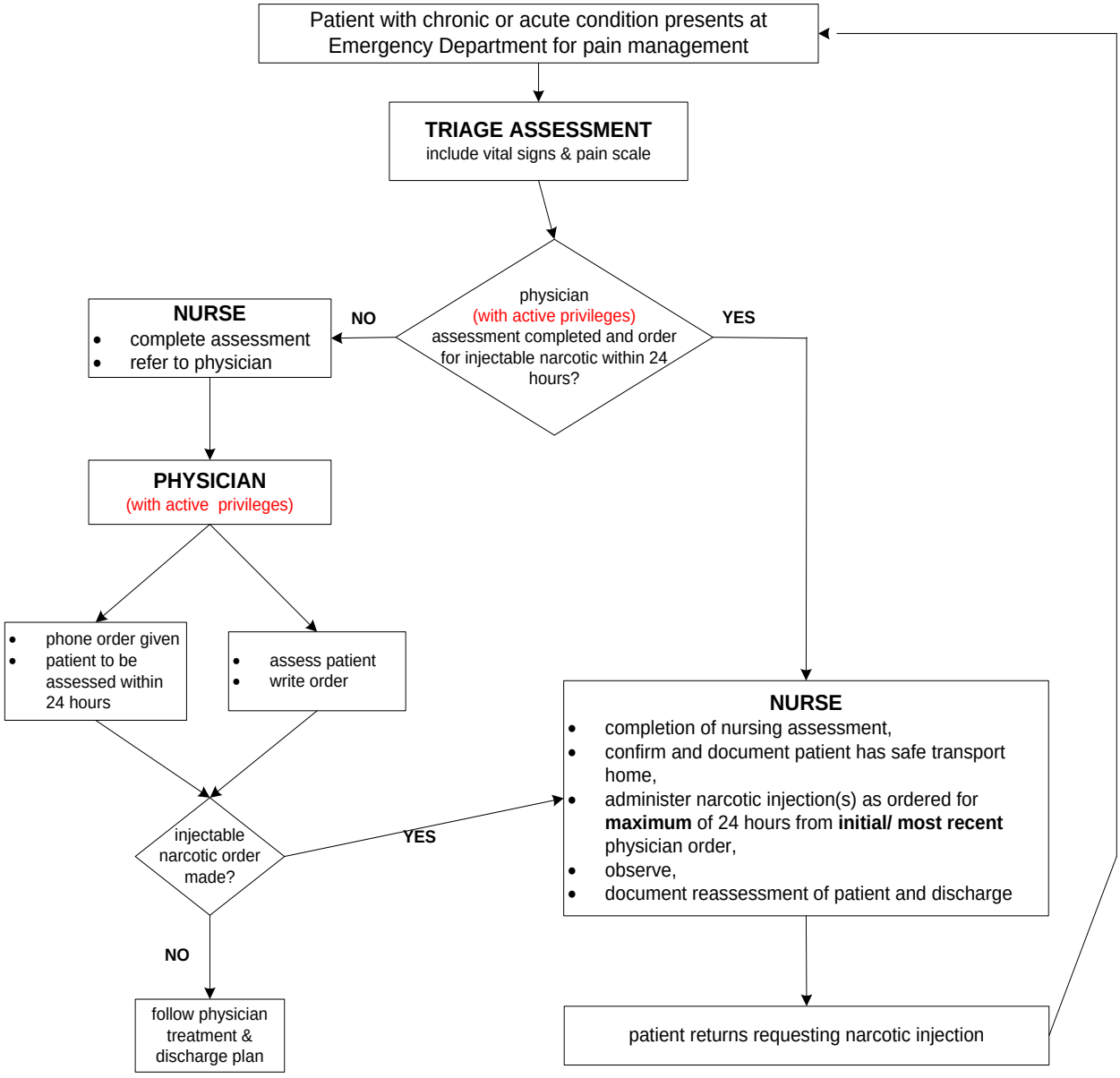
APPENDIX A

NARCOTIC INJECTION ORDERS



APPENDIX B

Narcotic Control Regulations
C.R.C., c. 1041

SCHEDULE
(Section 2)

1. Opium Poppy (Papaver somniferum), its preparations, derivatives, alkaloids and salts, including:
   (1) Opium
   (2) Codeine (methylmorphine)
   (3) Morphine (7,8-didehydro-4,5-epoxy-17-methylmorphinan-3,6-diol)
   (4) Thebaine (paramorphine)

   and the salts, derivatives and salts of derivatives of the substances set out in subitems (1) to (4), including:
   (5) Acetorphine (acetyletorphine)
   (6) Acetyldihydrocodeine (4,5-epoxy-3-methoxy-17-methylmorphinan-6-ol acetate)
   (7) Benzylmorphine (7,8-didehydro-4,5-epoxy-17-methyl-3-(phenylmethoxy) morphinan-6-ol)
   (8) Codoxime (dihydrocodeinone O-(carboxymethyl)oxime)
   (9) Desomorphine (dihydrodeoxymorphine)
   (10) Diacetylmorphine (heroin)
   (11) Dihydrocodeine (4,5-epoxy-3-methoxy-17-methylmorphinan-6-ol)
   (12) Dihydromorphine (4,5-epoxy-17-methylmorphinan-3,6-diol)
   (13) Ethylmorphine (7,8-didehydro-4,5-epoxy-3-ethoxy-17-methylmorphinan-6-ol)
   (14) Etorphine (tetrahydro-7α-(1-hydroxy-1-methylbutyl)-6,14-endo-ethenooripavine)
   (15) Hydrocodone (dihydrocodeinone)
   (16) Hydromorphinol (dihydro-14-hydroxymorphine)
   (17) Hydromorphone (dihydromorphinone)
   (18) Methyldesorphine (Δ6-deoxy-6-methylmorphine)
   (19) Methyldihydromorphine (dihydro-6-methylmorphine)
   (20) Metopon (dihydromethylmorphinone)
   (21) Morphine-N-oxide (morphine oxide)
   (22) Myrophine (benzylmorphine myristate)
   (23) Nalorphine (N-allylnormorphine)
   (24) Nicocodine (6-nicotinylcodeine)
   (25) Nicomorphine (dinicotinylmorphine)
   (26) Norcodeine (N-desmethylcodeine)
   (27) Normorphine (N-desmethylmorphine)
   (28) Oxycodone (dihydrohydroxycodeinone)
   (29) Oxymorphone (dihydrohydroxymorphinone)
   (30) Pholcodine (3-[2-(4-morpholinyl)ethyl]morphine)
   (31) Thebacon (acetyldihydrocodeinone)

   but not including
   (32) Apomorphine (5,6,6a,7-tetrahydro-6-methyl-4H-dibenzo[de,g]-quinoline-10,11-diol)
   (33) Cyprenorphine (N-(cyclopropylmethyl)-6,7,8,14-tetrahydro-7α-(1-hydroxy-1-methylethyl)-6,14-endo-ethenonororipavine)
   (34) Nalmefene (17-(cyclopropylmethyl)-4,5α-epoxy-6-methylenemorphinan-3,14-diol)

(34.1) Naloxone (4,5α-epoxy-3,14-dihydroxy-17-(2-propenyl)morphinan-6-one)
(34.2) Naltrexone (17-(cyclopropylmethyl)-4,5α-epoxy-3,14-dihydroxymorphinan-6-one)
(35) Narcotine (6,7-dimethoxy-3-(5,6,7,8-tetrahydro-4-methoxy-6-methyl-1,3-dioxolos[4,5-g]isoquinolin-5-yl)-1(3H)-isobenzofuranone)
(36) Papaverine (1-[(3,4-dimethoxyphenyl)methyl]-6,7- dimethoxyisoquinoline)
(37) Poppy seed

2. Coca (Erythroxylon), its preparations, derivatives, alkaloids and salts, including:
   (1) Coca leaves
   (2) Cocaine (benzoylmethylecgonine)
   (3) Ecgonine (3-hydroxy-2-tropane carboxylic acid)
3. Phenylpiperidines, their intermediates, salts, derivatives and analogues and salts of intermediates, derivatives and analogues, including:
   (1) Allylprodine (3-allyl-1-methyl-4-phenyl-4-piperidinol propionate)
   (2) Alphameprodine (α-3-ethyl-1-methyl-4-phenyl-4-piperidinol propionate)
   (3) Alphaprodine (α-1,3-dimethyl-4-phenyl-4-piperidinol propionate)
   (4) Anileridine (ethyl 1-[2-(p-aminophenyl) ethyl]-4-phenylpiperidine-4-carboxylate)
   (5) Betameprodine (ß-3-ethyl-1-methyl-4-phenyl-4-piperidinol propionate)
   (6) Betaprodine (ß-1,3-dimethyl-4-phenyl-4-piperidinol propionate)
   (7) Benzethidine (ethyl 1-(2-benzyloxyethyl)-4-phenylpiperidine-4-carboxylate)
   (8) Diphenoxylate (ethyl 1-(3-cyano-3,3-diphenylpropyl)-4-phenylpiperidine-4-carboxylate)
   (9) Difenoxin (1-(3-cyano-3,3-diphenylpropyl)-4-phenylpiperidine-4-carboxylate)
   (10) Etoxeridine (ethyl 1-[2-(2-hydroxyethoxy) ethyl]- 4-phenylpiperidine-4-carboxylate)
   (11) Furethidine (ethyl 1-(2-tetrahydrofurfuryloxyethyl)- 4-phenylpiperidine-4-carboxylate)
   (12) Hydroxypethidine (ethyl 4-(m-hydroxyphenyl)-1-methylpiperidine-4-carboxylate)
   (13) Ketobemidone (1-[4-(m-hydroxyphenyl)-1-methyl-4-piperidyl]-1-propanone)
   (14) Methylphenylisonipecotonitrile (4-cyano-1-methyl-4-phenylpiperidine)
   (15) Morpheridine (ethyl 1-(2-morpholinoethyl)-4- phenylpiperidine-4-carboxylate)
   (16) Norpethidine (ethyl 4-phenylpiperidine-4-carboxylate)
   (17) Pethidine (ethyl 1-methyl-4-phenylpiperidine-4-carboxylate)
   (18) Phenoperidine (ethyl 1-(3-hydroxy-3-phenylpropyl)-4-phenylpiperidine-4-carboxylate)
   (19) Piminodine (ethyl 1-[3-(phenylamino)propyl]-4-phenylpiperidine-4-carboxylate)
   (20) Properidine (isopropyl 1-methyl-4-phenylpiperidine-4- carboxylate)
   (21) Trimeperidine (1,2,5-trimethyl-4-phenyl-4-piperidinol propionate)
   (22) Pethidine Intermediate C (1-methyl-4-phenylpiperidine-4-carboxylate)
   but not including
   (23) Carbamethidine (ethyl 1-(2-carbamylethyl)-4-phenylpiperidine-4-carboxylate)
   (24) Oxpheneridine (ethyl 1-(2-hydroxy-2-phenylethyl)-4-phenylpiperidine-4-carboxylate)
4. Phenazepines, their salts, derivatives and salts of derivatives including:
   (1) Proheptazine (hexahydro-1,3-dimethyl-4-phenyl-1Hazepin-4-ol propionate)
   but not including
   (2) Ethoheptazine (ethyl hexahydro-1-methyl-4-phenylazepine-4-carboxylate)
   (3) Metethoheptazine (ethyl hexahydro-1,3-dimethyl-4-phenylazepine-4-carboxylate)
   (4) Metheptazine (ethyl hexahydro-1,2-dimethyl-4-phenylazepine-4-carboxylate)
5. Amidones, their intermediates, salts, derivatives and salts of intermediates and derivatives, including:
   (1) Dimethylaminodiphenylbutanonitrile (4-cyano-2-dimethylamino-4,4-diphenylbutane)
   (2) Dipipanone (4,4-diphenyl-6-piperidino-3-heptanone)

(3) Isomethadone (6-dimethylamino-5-methyl-4,4-diphenyl-3-hexanone)
(4) Methadone (6-dimethylamino-4,4-diphenyl-3-heptanone)
(5) Normethadone (6-dimethylamino-4,4-diphenyl-3-hexanone)
(6) Norpipanone (4,4-diphenyl-6-piperidino-3-hexanone)
(7) Phenadoxone (6-morpholino-4,4-diphenyl-3-heptanone)

6. Methadols, their salts, derivatives and salts of derivatives, including:
   (1) Acetylmethadol (6-dimethylamino-4,4-diphenyl-3-heptanol acetate)
   (2) Alphacetylmethadol (α-6-dimethylamino-4,4-diphenyl-3-heptanol acetate)
   (3) Alphamethadol (α-6-dimethylamino-4,4-diphenyl-3-heptanol)
   (4) Betacetylmethadol (ß-6-dimethylamino-4,4-diphenyl-3-heptanol acetate)
   (5) Betamethadol (ß-6-dimethylamino-4,4-diphenyl-3-heptanol)
   (6) Dimepheptanol (6-dimethylamino-4,4-diphenyl-3-heptanol)
   (7) Noracymethadol (α-6-methylamino-4,4-diphenyl-3-heptanol acetate)
7. Phenalkoxams, their salts, derivatives and salts of derivatives, including
   (1) Dimenoxadol (dimethylaminoethyl 1-ethoxy-1,1-diphenylacetate)
   (2) Dioxaphetyl butyrate (ethyl 2,2-diphenyl-4-morpholinobutyrate)
   (3) Dextropropoxyphene ([S-(R*,S*)]-α-[2-(dimethylamino)-1-methylethyl]-α-phenylbenzeneethanol, propanoate ester)
8. Thiambutenes, their salts, derivatives and salts of derivatives, including:
   (1) Diethylthiambutene (N,N-diethyl-1-methyl-3,3-di-2-thienylallylamine)
   (2) Dimethylthiambutene (N,N,1-trimethyl-3,3-di-2-thienylallylamine)
   (3) Ethylmethylthiambutene (N-ethyl-N,1-dimethyl-3,3-di-2-thienylallylamine)
9. Moramides, their intermediates, salts, derivatives and salts of intermediates and derivatives, including:
   (1) Dextromoramide (d-1-(3-methyl-4-morpholino-2,2-diphenylbutyryl)pyrrolidine)
   (2) Diphenylmorpholinoisovaleric acid (2-methyl-3-morpholino-1,1-diphenylpropionic acid)
   (3) Levomoramide (*l*-1-(3-methyl-4-morpholino-2,2-diphenylbutyryl)pyrrolidine)
   (4) Racemoramide (d,l-1-(3-methyl-4-morpholino-2,2- diphenylbutyryl)pyrrolidine)
10. Morphinans, their salts, derivatives and salts of derivatives, including:
   (1) Buprenorphine (17-(cyclopropylmethyl)-α-(1,1-dimethylethyl)-4,5-epoxy-18,19-dihydro-3-hydroxy-6-methoxy-α-methyl-6,14-ethenomorphinan-7-methanol)
   (2) Drotebanol (6ß,14-dihydroxy-3,4-dimethoxy-17-methylmorphinan)
   (3) Levomethorphan (1-3-methoxy-17-methylmorphinan)
   (4) Levorphanol (1-3-hydroxy-17-methylmorphinan)
   (5) Levophenacylmorphan (1-3-hydroxy-17-phenacylmorphinan)
   (6) Norlevorphanol (1-3-hydroxymorphinan)
   (7) Phenomorphan (3-hydroxy-17-(2-phenylethyl)morphinan)
   (8) Racemethorphan (d,1-3-methoxy-17-methylmorphinan)
   (9) Racemorphan (*d*, *l*-3-hydroxy-N-methylmorphinan)

   but not including

   (10) Dextromethorphan (d-1,2,3,9,10,10a-hexahydro-6- methoxy-11-methyl-4H-10,4a-iminoethanophenanthren)
   (11) Dextrorphan (d-1,2,3,9,10,10a-hexahydro-11-methyl-4H-10,4a-iminoethanophenanthren-6-ol)
   (12) Levallorphan (l-11-allyl-1,2,3,9,10,10a-hexahydro-4H-10,4a-iminoethanophenanthren-6-ol)
   (13) Levargorphan (*l*-11-propargyl-1,2,3,9,10,10a-hexahydro-4H-10,4a-iminoethanophenanthren-6-ol)
   (14) Butorphanol (17-(cyclobutylmethyl)morphinan-3,14-diol)
   (15) Nalbuphine (17-(cyclobutylmethyl)-4,5α-epoxymorphinan-3,6α,14-triol)
11. Benzazocines, their salts, derivatives and salts of derivatives, including:

(1) Phenazocine (1,2,3,4,5,6-hexahydro-6,11-dimethyl- 3-phenethyl-2,6-methano-3-benzazocin-8-ol)
(2) Metazocine (1,2,3,4,5,6-hexahydro-3,6,11-trimethyl-2,6-methano-3-benzazocin-8-ol)
(3) Pentazocine (1,2,3,4,5,6-hexahydro-6,11-dimethyl-3-(3-methyl-2-butenyl)-2,6-methano-3-benzazocin-8-ol)

but not including

(4) Cyclazocine (1,2,3,4,5,6-hexahydro-6,11-dimethyl-3-(cyclopropylmethyl)-2,6-methano-3-benzazocin-8-ol)

12. Ampromides, their salts, derivatives and salts of derivatives, including:
    (1) Diampromide (N-[2-(methylphenethylamino)propyl]propionanilide)
    (2) Phenampromide (N-(1-methyl-2-piperidino)ethyl)propionanilide)
    (3) Propiram (N-(1-methyl-2-piperidinoethyl)-N-2- pyridylpropionamide)
13. Benzimidazoles, their salts, derivatives and salts of derivatives, including:
    (1) Clonitazene (2-(p-chlorobenzyl)-1-diethylaminoethyl-5-nitrobenzimidazole)
    (2) Etonitazene (2-(p-ethoxybenzyl)-1-diethylaminoethyl-5- nitrobenzimidazole)
14. Phencyclidine (1-(1-phenylcyclohexyl)piperidine), its salts, derivatives and analogues and salts of derivatives and analogues, including:
    (1) Ketamine (2-(2-chlorophenyl)-2- (methylamino)cyclohexanone)
15. Fentanyls, their salts, derivatives, and analogues and salts of derivatives and analogues, including:
    (1) Acetyl-α-methylfentanyl (N-[1-(α-methylphenethyl)-4-piperidyl]acetanilide)
    (2) Alfentanil (N-[1-[2-(4-ethyl-4,5-dihydro-5-oxo-1H-tetrazol-1-yl)ethyl]-4-(methoxymethyl)-4-piperidyl]propionanilide)
    (3) Carfentanil (methyl 4-[(1-oxopropyl)phenylamino]-1- (2-phenethyl)-4-piperidinecarboxylate)
    (4) p-Fluorofentanyl (4′ fluoro-N-(1-phenethyl-4-piperidyl) propionanilide)
    (5) Fentanyl (N-(1-phenethyl-4-piperidyl)propionanilide)
    (6) ß-Hydroxyfentanyl (N-[1-(ß-hydroxyphenethyl)-4- piperidyl] propionanilide)
    (7) ß-Hydroxy-3-methylfentanyl (N-[1(ß-hydroxyphenethyl)-3-methyl-4-piperidyl] propionanilide)
    (8) α-Methylfentanyl (N-[1-(α-methylphenethyl)-4- piperidyl] propionanilide)
    (9) α-Methylthiofentanyl (N-[1-[1-methyl-2-(2-thienyl)ethyl]-4-piperidyl] propionanilide)
    (10) 3-Methylfentanyl (N-(3-methyl-1-phenethyl-4-piperidyl) propionanilide)
    (11) 3-Methylthiofentanyl (N-[3-methyl-1-[2-(2-thienyl)ethyl]-4-piperidyl] propionanilide)
    (11.1) Remifentanil (dimethyl 4-carboxy-4-(N-phenylpropionamido)-1-piperidinepropionate)
    (12) Sufentanil (N-[4-(methoxymethyl)-1-[2-(2-thienyl)ethyl]-4- piperidyl] propionanilide)
    (13) Thiofentanyl (N-[1-[2-(2-thienyl)ethyl]-4-piperidyl] propionanilide)
16. Tilidine (ethyl 2-(dimethylamino)-1-phenyl-3-cyclohexene-1-carboxylate), its salts, derivatives and salts of derivatives
17. Cannabis, its preparations, derivatives and similar synthetic preparations, including:
    (1) Cannabis resin
    (2) Cannabis (marihuana)
    (3) Cannabidiol (2-[3-methyl-6-(1-methylethenyl- 2-cyclohexen-1-yl]-5-pentyl-1,3-benzenediol)
    (4) Cannabinol (3-n-amyl-6,6,9-trimethyl-6-dibenzo-pyran-1-ol)
    (5) Nabilone((±)-trans-3-(1,1-dimethylheptyl)-6,6a,7,8,- 10,10a-hexahydro-1-hydroxy-6,6-dimethyl-9H-dibenzo[b,d]pyran-9-one)
    (6) Pyrahexyl (3-n-hexyl-6,6,9-trimethyl-7,8,9,10- tetrahydro-6-dibenzopyran-1-ol)
    (7) Tetrahydrocannabinol(tetrahydro-6,6,9-trimethyl-3- pentyl-6H-dibenzo[b,d]pyran-1-ol)
    (7.1) 3-(1,2-dimethylheptyl)-7,8,9,10-tetrahydro-6,6,9-trimethyl-6H-dibenzo[b,d]pyran-1-ol (DMHP)

    but not including

    (8) Non-viable Cannabis seed, with the exception of its derivatives
    (9) Mature Cannabis stalks that do not include leaves, flowers, seeds or branches; and fiber derived from such stalks

APPENDIX C

Frequently Asked Questions

1. **Why is it not a requirement that patients are seen by a physician prior to receiving a narcotic upon every visit to the ED?**
   In our focus groups with the physicians and staff in the rural communities, the participants stated that it would be very onerous and an unreasonable expectation for the physicians to see every patient who presents to the ED, if in fact they have already been assessed by a physician within a 24 hour time frame. During the night, the on-call physician will be called if a patient presents to the ED, and can order a narcotic over the phone if they determine it to be appropriate, but there will be an expectation that the patient will be seen within a 24 hour time frame.

2. **How will nurses ensure that patients are assessed within 24 hours of an ED narcotic phone order?**
   This will be the responsibility of the physician to assess the patient within 24 hours of providing the phone order, however, if the nurse has reason to believe this is not occurring they can confirm with the physician and/or report this to the manager and or Chief of Staff.

3. **In the case of recurrent orders for narcotics, how will nurses be able to determine that the patient has been assessed by a physician every 24 hours?**
   When a patient presents within a new 24 hour period they should have a new order for the injection to continue. The order should be dated, but the nurse can also ask the patient when they were last seen by the physician. If there is concern that 24 hrs has elapsed since the patient has been assessed, the nurse should phone the ordering physician or designate to arrange for reassessment of the patient.

4. **Does the physician have to provide the assessment or reassessment within 24 hours in the ED?**
   No, the policy does not specify where the assessment or reassessment is to take place - i.e. it can occur in the physician's office.

5. **If the nurse determines that the patient may not have been assessed within the 24 hour period but has the order in his or her possession, what actions should the nurse take?**
   The narcotic injection should not be given. The ordering physician or designate should be called and the patient advised to see the physician. If there is uncertainty as to the time of the last assessment, the patient should be given the benefit of the doubt and the injection administered.

6. **Should patients be triaged and have a nursing assessment prior to the administration of a narcotic injection, even if they are returning for recurrent injections?**
   All patients need to be triaged via the Emergency Triage Record (ETR) #826214 and have a nursing assessment including vital signs documented on the ETR prior to administration of a narcotic injection on every visit.

7. **During the nursing assessment for patients presenting for a narcotic injection, what types of questions should be asked to help determine that the patient's symptoms are still consistent with the original reason for the narcotic being ordered?**
As a general guideline, patients should be asked if the quality and intensity of their pain is similar to what they have been experiencing during this recent episode or exacerbation. If the patient states that things are different, the patient's physician or on-call physician should be notified of the change before the narcotic is administered.

8. **How long should a patient be observed in the ED following a narcotic injection?**
There is no hard and fast rule related to this, but for a patient who has not been receiving regular narcotics it has been suggested that a 30 minute observation in the ED be done post injection. For patients that take regular narcotics, a 15 minute observation is considered reasonable. Every case should be assessed on its own merit and nursing judgement should prevail.

9. **Should patients be reassessed after the observation period prior to discharge?**
Yes, depending on the nurse's judgement this assessment may include selected vital signs and level of consciousness followed by documentation of patient status.

10. **Why are nurses being asked to review with patient that they are accompanied by an individual who will be providing transportation or that arrangements have been made for safe transport home prior to the administration of a narcotic?**
. There is a moral and ethical responsibility to our communities that a reasonable effort has been made to determine that a patient will not be driving in a potentially impaired condition.

11. **What should staff do if, despite their best efforts, a patient is seen to be driving themselves away?**
Staff are not expected to follow patients to the parking lot or physically restrain them from driving but notification of the police should be considered on a case by case basis. The incident should be clearly documented and reported to the patient's physician and ED manager.

12. **Am I legally accountable if the patient does drive and causes an accident or untoward event?**
This is a very difficult question to answer and every case would be judged on its own unique circumstances. Generally speaking, staff are not held liable if reasonable efforts were made to prevent the patient from driving.

13. **The policy talks about consequences for non compliance. What does this mean?**
Non-compliance with the policy by patients or physicians, particularly if it happens more than once, could result in the ED not accepting any future orders for narcotic injections for that patient or by that physician.

14. **Are we not enabling addiction by allowing narcotic injections to occur without seeing a physician during each visit?**
Most patients presenting with acute or chronic pain are not addicted. A highly restrictive policy would be considered discrimination against patients who have a legitimate need for injectable narcotics. Additionally, we have clearly heard that a policy requiring that a patient be seen on every visit for an injectable narcotic visit would place an increased and unnecessary burden on physicians working in rural communities.

15. **Aren't there specialists or clinics available to help manage patients with chronic pain syndromes?**
We did include specialists in chronic pain to advise on this policy, unfortunately, there are very few specialists working in the field across the province and wait lists are long. We are recommending this issue of improving accessibility of pain management services be explored further.

16. **Has the removal of oral Demerol from the IH formulary made any difference?**
Yes, we have heard from many of our sites that removing oral Demerol has reduced drug seeking behaviour of some patients and many people are recommending the removal of injectable Demerol as well.

17. **Can physician orders be written greater than 24 hours in advance of the patient presenting to the ED for a narcotic injection?**
No, patients must be assessed and orders written within 24 hours of narcotic administration.

18. **Is the policy meant to apply to our migraine patients who are stable and are seen on a regular basis and whose regime has not changed?**
Yes, the physician can continue to order injectable narcotics that may be required by the patient but the difference is that the patient needs to be seen within 24 hours of receiving an injectable narcotic. Physicians are not able to write orders greater than 24 hours in advance.