Emergency Psychiatry

A Handbook for Residents

Psychiatric Emergency Services
Sunnybrook Health Sciences Centre

Michelle Sukhu & Harkiran Kalkat
Revised June 2018

Psychiatry call at Sunnybrook Health Sciences Centre promises to be exciting, fun, and a tremendous learning experience. Call requests must be submitted by email to the Chief Residents. You should receive an email reminding you to submit your requests by a certain date, but if in doubt please contact the psychiatry chief residents directly.

The final call schedule should be available by the 15th of the month prior (i.e., by August 15 for the September call schedule). The call schedule can be found online through the Sunnybrook intranet site by typing "psych". Residents will be scheduled for both on-call and backup call shifts. A points system is used to fairly assign the workload.

Call Points

Weekdays = 2; Fridays = 2.5; Weekends/Statutory Holidays = 4 (& don't forget the lieu day you get for working any part of a stat – as a back up or in hospital, except for Christmas Day, Boxing Day and New Years Day).

Back-Up Call

The backup resident must be available throughout the shift by pager (i.e. the pager must be ON) and must be able to get to the ED within 1-hour. If the backup resident is called in the resident calling in the backup will take the backup resident's next shift (or another of the backup resident's shifts at a mutually agreed time). Ideally the residents involved will make the arrangements independently. Also note that if the on-call resident is overloaded with consults, the on-call staff should be called to help, not the back-up resident.

Call Schedule Changes

THE SCENARIO	THE SOLUTION	THE PROCEDURE
1 The on-call resident has a health or personal emergency that prevents them from attending their call. They are scheduled for call **tonight**.	In this case, the shift will need to be covered by the back-up resident (unless an alternate replacement is found). There is a list back-up schedule for this purpose and it is available on the Sunnynet site.	The on-call resident is expected to contact the backup resident as soon as possible. In addition, should update via email the (1) chief residents (2) hospital base site coordinator
2 The on-call resident needs to change their call ***less than two business days away.***	The on-call resident must find a replacement. After the final call schedule is published, any changes are the responsibility of the residents involved in the switch. All residents involved must consent to any switch.	Once the on-call resident has found someone to switch with they **MUST** notify all of the following: • Sunnybrook locating x4244 • ED x4207 • PES team nurse x5360 • Chief residents • Psychiatry ward on F2 x4323 • Lynn Steele lynn.steele@sunnybrook.ca
3 The on-call resident needs to change their call ***two or more business days away.***	The on-call resident must find a replacement. After the final call schedule is published, any changes are the responsibility of the residents involved in the switch. All residents involved must consent to any switch.	The residents making the switches **MUST** inform Lynn Steele via email of your changes so that she can post the changes online. The chief resident must be informed.

On Call Teaching Duties

Policy on Junior/Senior Resident Call Responsibilities. In the spirit of graduated responsibility for residents in their upper years, the residency program has begun an initiative to differentiate the role of junior and senior residents when they are on call together. The goal is to train senior residents to be consultants and independent practitioners, and give them the responsibility of supervising a resident and making treatment decisions, while having back-up from the on-call staff. The benefit to the junior residents is the opportunity to learn from the senior resident and practice presentation and management skills with someone who is closer to their level of training.

At Sunnybrook, we most frequently have only one resident on call, thus the distinction between junior and senior resident is moot. However, when there are two residents on, the role of each resident has been unclear up to this point. The following policy is an attempt to clarify these roles for residents and staff on call.

In the event that two residents are on call on the same day, we will attempt (where possible) to pair residents at different levels of training, preferably a junior (PGY1 and 2) with a more senior resident (PGY3-5). Ideally, the senior resident will be provided with the consults from the ED staff or ward, and will then notify the junior of the consult. The senior will assess whether it is appropriate for the junior resident to see the patient independently. If it is not, the two residents will see the patient together.

The role of the junior resident will be to see the patient, perform the history and MSE as is appropriate, come up with a treatment plan, and then report the case to the senior resident. The senior resident will then have the opportunity to ask questions and clarify the history, and return with the junior resident to see the patient if they feel it is appropriate (as a staff psychiatrist would do when reviewing a new consult in person). Once the case has been reviewed, the residents together will finalize the treatment plan, and either the junior or senior resident can then report the case to the staff on-call. Documentation will primarily be completed by the junior resident, but the senior resident is expected to provide a note highlighting any history they obtained and consolidating the recommendations. In the event that the two residents are at the same or similar levels of training and it is unclear who might take on the role of senior or junior, the residents are encouraged to negotiate amongst themselves who might take on the role of senior for all or part of the call shift.

In the event that there are multiple consults waiting to be seen, the residents should do their best to maintain the above described structure, while at the same time balancing the patient care needs. Patient care should never be compromised simply to maintain the above described roles, and it is still our goal to keep wait times to reasonable limits. It will be up to the senior resident to decide how best to divide the responsibilities, although they are free to consult with the on-call staff.

Clinical Clerks

Clinical clerks will be scheduled for call. The resident is responsible for directly supervising (observing in-person) the clinical clerk interviewing patients, and providing them with feedback about their performance. Please page the clerk on call when there is a case to be seen. Clerks are on call until 23:00h and are not expected to stay beyond that time. If the case is referred late, encourage the clerk to participate in the assessment as much as is possible before 23:00h. Please do not send the clerks home early.

If the clerk is early in the rotation or it is early in the year, it is reasonable that the clerk may only perform a portion of the interview (e.g., depressive symptoms) and then will observe the resident completing the rest of the assessment. By the second half of the clerkship rotation, the clerk should be able to perform the entire assessment interview under the resident's supervision. The clerk should also be writing up the assessment note that must be signed by the resident. The resident is expected to write a case summary note to accompany the clerk's note. The clerk will also be expected to present their cases at morning teaching rounds and residents should assist in preparing the clerk to present. Morning sign-over rounds serve to safely transfer care to the day time and provide teaching about the on-call experience. Clerks are expected to attend morning report.

PGY-1 Residents & Off-Service Residents

These residents can see referred cases independently & present to staff. The senior resident should provide close supervision.

The senior psychiatry resident's responsibilities include "eye-balling"/meeting briefly with the patient and the PGY-1/off service resident to ensure that there are no acute safety issues and that the resident is prepared to do the consult, reviewing management plans and any orders written, writing a summary note and providing guidance and teaching to the off service resident. In some cases, the senior psychiatry resident should provide more support. There is also a significant role for teaching around the case and related issues.

On Call When and Who

During the weekdays, residents are on from 17:00h to 08:30h the next day. The call shift begins at 17:00h in room AG110 (PES office) with teaching rounds by the on-call staff and is attended by the on-call resident(s), on-call clerk and Psychiatry Emergency Services (PES) RN (* 5360 or 6863).

Call ends at 08:30h at which time morning teaching and sign-over rounds begin in the Psychiatric Emergency Services (PES) office (AG110). About 45 minutes will be spent reviewing cases seen overnight, teaching around those cases, or other topics. All on-call resident(s) and clerks MUST attend morning rounds; whether or not any cases were seen (the only exception is PGY-1s in psychiatry off-site on their addictions rotation). The junior trainee or clerk is expected to present the case.

On weekends and holidays, the on-call residents and clerk(s) must attend Psychiatric Intensive Care Unit (PICU) rounds at 09:00h in PICU on F2.

The on-call resident, clinical clerk and the on-call staff person round on the PICU patients. The staff is the primary responsible physician for admit-no-bed (ANB) patients, new admissions to F2, and consultations from the Medical/Surgical wards of the hospital. It is strongly suggested that on-call residents and clinical clerks round with the on-call staff on the admit-no-bed patients held in the ED. They can assist with seeing new admissions to F2 patients or ward consults if they wish. The on-call residents are primarily responsible for ED referrals – therefore, if there is a consult in ED (in the morning or any other time) this takes priority over other tasks.

There are no morning teaching rounds on the weekend, so a resident on-call on Friday or Saturday does not have to come in the next morning for rounds. They must call the incoming resident at 09:00 to give report from the night and also sign over any cases in the ED including any patients designated *"admit-no-bed"*. Admit-no-bed patients are those patients assessed and given admission orders but for which an appropriate ward or PICU bed is not available. These are considered psychiatry inpatients and must be rounded on by the team each morning. Please note that if patients are involuntary (Form 1 or 3) they require constant observation and they will have a 24-hr sitter or security with them. Please be aware that patients in the ED that are not on a form have very little if any supervision overnight. Assess their safety requirements in such an environment accordingly.

PGY-1 Psychiatry Residents & Off-Service Residents

PGY-1s in psychiatry, family medicine residents, and neurology residents will be paired with senior psychiatry residents (PGY-2-5) for call. The PGY-1 psychiatry resident has 3 shifts; one weekday and one weekend call until 23:00h, and the third is on the weekend and is overnight. Family medicine and neurology residents stay overnight for 3 shifts (one of which will be on a weekend).

Role of the Psychiatric Emergency Services (PES) Nurse

The PES nurse is an integral part of the multiprofessional clinical team. They are a tremendous resource for residents, clerks, and staff. They have advanced training and knowledge in patient assessment, triage, crisis intervention techniques, and other forms of management including disposition and referral to community resources. The role of the PES nurse is to participate alongside the most responsible physician and residents with management of psychiatric issues. The expectation is that all team members maintain good communication and share the workload. Always notify the PES nurse if you are paged to see an ED patient or are called otherwise away from the ED.

Cases may arise where the PES nurses may work independently with an attending emergency staff physician (AESP) in the assessment and disposition planning of a patient. The nurse in collaboration with the recommendations of the

AESP may determine that the on call staff or resident is not required to see a patient. The resident on call is therefore not involved in such cases. The disposition remains the responsibility of the AESP (e.g., if the patient is discharged from the ED, the AESP is the discharging physician).

Also there may be situations then a PES nurse may suggest to the AESP that, based on their assessment, a referral to psychiatry is appropriate. If so, a call from the PES nurse is equivalent to the AESP personally making a referral to the resident on-call. The patient becomes an emergency room referral and that patient must be seen by the resident on-call, as detailed above.

The AESP may specifically request a patient be seen by the resident on call. If so, then the management of a patient referred to psychiatry cannot be delegated to a PES nurse.

A PES crisis nurse will be available on weekends from 11:00h - 23:00h; holidays from 10:00h - 18:00h; weekdays 08:00h - 23:00h. There may be occasions when the nurses scheduled for shorter shifts due to vacation time or leaves. Residents will be notified about this in advance.

In House Call and Call Rooms

Residents and medical students are expected to remain on-site for the duration of their call *(i.e., you cannot leave hospital grounds)*. The call rooms are H310 & H311. **The key is kept within a coded lock box on the call room door – the current code is 0717. Please ensure you return the key when you finish call.** The family practice residents can use the family practice call rooms which are located on the same floor (they will have to obtain the key from Sinthujah Santhirasiri room F324 ext 85044 during business hours) – or they can use one of the psychiatry call rooms. The H-wing duty rooms all have a single bed, bedside table and lamp, desk, chair, and desk lamp. The room has a telephone, computer and an air conditioning unit and also a wash sink. The room is cleaned every day and there is towel and linen service provided. There is a kitchenette in the same area as the resident's lounge on H3. In the Residents Lounge there is a computer workstation (Sunnycare and internet connected), as well as a television with cable, and couches. There are washroom and showering facilities in the area (towels are provided).

On Call Safety Protocol

Patients with mental illness may be at higher risk for violence toward themselves &/or health care providers. Statistically, nurses are at highest risk for injuries and assault followed closely by physicians. Always keep your own safety first and foremost in mind before beginning your assessment. If you are feeling unsafe leave the room and seek out assistance. If you believe there is a risk of violence you can ask one of the security officers to accompany you during the interview. Always ensure both you, and the patient, have access to exit the room. Never try to physically stop a patient from leaving the room. This is a role for security only. Please take the time to read over Sunnybrook Health Sciences Centre's least restraint policy for the use of physical restraint of patients (see attachment #4).

There is always one or more security officers assigned to the ED areas. In an emergency situation or for a patient leaving AWOL (away without leave) push your alarm button or **dial x 5555** and state who you are, where you are located as well as the name of the patient. For non-emergency situations when you would like security to attend contact them at **x 4589**.

Alarm Buttons

All residents working in the ED must pick up an alarm button to wear on their person PRIOR to the patient assessment (can be retrieved from Nancy, or PES has a spare alarm). F-wing and the ED have a wireless alarm system that is activated when the mobile alarm button is pressed. All the alarm buttons are coded so as to allow security to locate you in the ED. They are coded for the ED and F-wing only and do not work in other areas of the hospital. You will be assigned an alarm button at the start of your rotation. They are also available in the PES filing cabinet at the nursing station. They are very expensive and must be returned when leaving the ED. The resident will be charged the replacement fee for missing alarm buttons.

The Green Zone

Psychiatry assessments should, whenever possible, be conducted in **Room 28 or 27** in the Green Zone. These are specially designed for additional safety with weighted chairs, bolted table, non-barricadable door, clear of objects that could be thrown as a weapon, and video surveillance. There is a camera switch on the wall adjacent to the door. Remember to switch the button to the "on" position before entering the room. Video recordings saved short term and are not constantly monitored. They are intended primarily for incident review.

Rooms 27 and 28 are not exclusively dedicated to psychiatry and are also used for medical patients. Patients referred to our service may be located in other rooms in the ED. If you have any concerns about the safety of interviewing a patient in the room they are in then speak to the PES nurse or emergency room nurse and request the patient be transferred to room 28 or 27. This is advisable if for example the patient is agitated; has a history of unpredictability and/or violence on reviewing chart, or is intoxicated. If you experience any difficulty with such a request please discuss it with the on call psychiatry staff.

In the event of a violent incident or near miss

Providing a safe learning environment for residents and clerks is a high priority of the department and the hospital. You can contribute to supporting a safe environment for yourself and others by having an awareness of the policies and practices that currently exist. While it is very unlikely that you will ever experience a violent incident or near miss, violent situations potentially could take the form of physical violence, verbal violence, emotional violence, sexual violence, or cyber bullying. Possible perpetrators may include patients, co-workers, or visitors. These situations are taken very seriously by the department and the hospital. It is important to know that residents in training are considered employees of the hospital and are entitled to the same access to incident reporting and hospital safety policies.

Sunnybrook Health Sciences Centre has an online incident reporting tool. An adverse event is defined as unexpected and undesired incident or error that results in patient injury or harm and is directly associated with health care or services provided to the patient. Adverse events may also be called an incident, sentinel event, or critical event, depending on the severity of harm or potential harm. A near miss is an error or hazardous situation that was identified and resolved before any patient involvement, consequence or harm occurred. If you encounter an adverse event please use the reporting system that can be accessed at the Sunnynet website:

(http://safetyreport/riskweb3.dll/FrmLogin)

If you are confronted with a violent situation consider the following steps:

1. Ask the person to stop what they are doing and/ or leave the situation.

2. Request assistance from co-worker.

3. Call Ext. 5555 for assistance with a violent patient or visitor. Inform the communication department of the nature of the violent situation and the exact location.

4. Seek appropriate medical attention and follow up with the Employee Assistance Program if required.

5. It is important to notify your chief resident and the postgraduate site director about all incidents and near misses as soon as possible (refer to Critical Incident Reporting Protocol detailed in the next section).

6. If required, fill out a paper employee incident report form with your staff supervisor and bring it to the Occupational Health & Safety Department in room HG46 (see attached in appendix).

7. Document on the patient's care record to assure other staff are aware of a potentially violent situation.

8. An investigation by your supervisor, chief resident and postgraduate site coordinator may occur to determine if there is a high potential of future risk to another resident from the same patient, visitor or co-worker.

9. Following the investigation, it is important that steps be put in place to prevent future situations from occurring.

10. Remember prevention is important. Always include the name of your staff supervisor and Dr. Justin Weissglas (postgraduate site coordinator.)

Departmental Critical Incident Reporting Protocol

This is designed to be a guide for team members for disclosing critical incidents to the patient's primary health care providers for both inpatients and outpatients. It is meant to be a fluid document, which can be changed and adapted over time. When a critical incident happens as defined by an unexpected patient death or serious harm from any cause, the first person to be notified of a critical incident should be the most responsible physician (MRP) for that patient. If the incident occurs after hours or on the weekend the first person to be informed would be the staff psychiatrist on call. Next, the following people should then be contacted as soon as possible (see below).

Also see Postgraduate Education Committee resident clinical care safety standards February 2007 in Attachment #5.

Notification List

critical incident

1) **MRP/ Psychiatrist on-call**
2) **Staff Psychiatrist (primary care provider For the patient)**
3) **Chief Psychiatrist**
4) **Deputy Chief Psychiatrist**
5) **Inpatient Director**
6) **Postgraduate Site Director**
7) **Undergraduate Site Director**
8) **Chief Psychiatry Resident(s)**

If the resident's primary supervisor, is not the same person in bullet "2" i.e. the critical incident occurred on call regarding an inpatient, and the resident is on an outpatient rotation, then their outpatient supervisor should be informed.

If the critical incident involves an inpatient, the nurse in charge would notify the patient care manger (or shift manager if after hours).

The staff psychiatrist who is MRP at the time of the incident and the resident's primary supervisor have a discussion about who should disclose the critical incident to the resident directly involved in the patient's care.

The MRP at the time of the incident or the primary supervisor then phone the psychiatry resident(s) primarily involved in the patient's care and disclose the critical incident to them.

Any other residents (such as those who are off-service or elective), fellows, or medical students who were directly involved in the patient's care should then be contacted.

At next regular work day, the Primary Supervisor, Inpatient or Outpatient Director, Postgraduate Site Director, Undergraduate Site Director, and Chief Resident meet with all learners, nurses, and interdisciplinary team members directly involved with patient's care for initial debrief around the incident.

Process For Disclosing Critical Incidents To Groups

It is important to note that any communication to groups not directly involved in the patient's care, should not have any identifying patient information.

1. Residents, Fellows, Medical Students
2. Postgraduate Site Director, PGY1 Site Coordinator and/or Chief Resident to email residents and fellows to inform them that critical incident occurred, and that a debrief will be scheduled.
3. Undergraduate Site Director to email medical students to inform them that a critical incident occurred, and that a debrief will be scheduled.
4. Debrief should be done during next available resident protected time (i.e.: whenever the next seminar time slot is scheduled should then be made into a formal debrief, if it occurs on a weekend, this by default would mean the debrief occurs at resident lunch).

Presence at formal group debrief should be the following:

i. Postgraduate/Undergraduate site directors
ii. Inpatient or outpatient director
iii. Chief resident
iv. Primary supervisor
v. Patient care managers
vi. Primary Supervisor
vii. Any residents directly involved in the patient's care
viii. All residents or learners who wish to attend
ix. Any nurses or interdisciplinary team members who wish to attend
x. Staff Psychiatrists
xi. Nurses and Interdisciplinary Staff
xii. Other patients

On Call Emergency Department Referrals

The resident on-call handles all calls from the Emergency Department. The Attending Emergency Staff Physician (AESP) (or an emergency resident trainee) may call the resident directly or may contact the PES nurse who will then contact you. All patients referred to the on-call resident must be seen by the on-call resident. Hospital guidelines for emergency department consults were recently updated in an attempt to reduce wait times in the ED. These apply to all services including psychiatry as follows:

- respond within 10 min for a STAT page
- respond within 30 min for a NON-URGENT page
- consult will be INITIATED within 1 hour of page
- management Plan documented on patient's chart within 4 hours of page

When you or the clinical clerk arrives at the ED to begin the consult please ensure that you sign into EDIS (the ED patient tracking system) and write down the start time of your consult in the patient's orders. EDIS is located on all computers in the ED.

This will ensure that the consult receives a time stamp which is important for ED to track consults and wait times as mandated by the Ministry of Health and Long Term Care. Also indicate the time you begin the assessment on the patient's order sheet. The login and password for EDIS is:

LOGIN: MD
PASSWORD: MD

Also, when you see a patient please ensure you write down the patient name, MRN# and time of the consultation in the PES black patient log book which is located on the table in the PES office.

At Sunnybrook, when a patient is referred to the on call resident, care is also handed over to the on call resident (and, therefore, the staff on-call) at the time the referral call is made. In other words, when the referral is made, the on-call resident becomes responsible for the patient. The staff on-call becomes the "Most Responsible Physician," or MRP for the patient referred.

As care is transferred to the resident on-call, the resident MUST see the patient, conduct an assessment, write an appropriate assessment note, and review the proposed disposition with the staff psychiatrist on-call. Note that the transfer of care means the resident is responsible for attending to the management of all psychiatric and non-psychiatric medical issues. This is true whether the issues were known at the time or referral or discovered in the course of the assessment. This may involve, for example, a request for consultation by the medicine consult service. It is not formally possible to simply refer the case on to another service such that the other service would become the responsible service, unless this is explicitly negotiated and agreed upon with that service. All medical issues must be managed by the resident on-call (with referrals to other services, if needed) and not left for the daytime staff.

The system makes no formal allowance for referring the patient back to the AESP. Therefore, it is wise to discuss the medical assessment, in a collegial manner, with the AESP at the time of referral. It is useful to inquire (1) what the patient's vital signs are, (2) physical examination findings including any evidence of a toxidrome, and (3) that pertinent initial investigations have been completed. Try to avoid using the term "medical clearance" as it is nonspecific, and can be misleading. If that discussion yields a mutually agreed decision that the AESP will do further medical work-up prior to the formal referral being made, the on-call resident and the AESP must be in clear and explicit agreement about when the referral takes effect. This discussion cannot be delegated to, for example, a PES nurse.

At times concerning issues may arise during a shift (e.g., you get an inappropriate referral; you are experiencing push back against your disposition decision or request to move the patient to a different room; unprofessionalism; you feel investigations done prior to the referral were insufficient; there is conflict between multiple consult teams as to who will be the MRP / admitting team). You can begin to try to manage the issue, however, we **strongly encourage residents to quickly inform and request assistance from the on-call staff psychiatrist in dealing with these issues via staff-to-staff discussions.** For example, it is much more effective and efficient for the on-call staff psychiatrist to discuss with the AESP any specific concerns that arise, during the AESP's

shift. The staff is later asked to update Dr. LaCroix and Weissglas about concerns identified the next business day.

Documentation

Emergency psychiatric assessments are now standardized at most hospital sites. The hospital utilizes an electronic medical record for all patients called SunnyCare free text. All notes must be typed or dictated directly into the SunnyCare system. Your assessment will become part of the patient's permanent record. Currently most orders are on paper and handwritten so please ensure your writing is legible.

Please remember to document the name of the staff that you reviewed the case with.

When you see a patient please ensure you write down the patient name, MRN# and time of the consultation in the PES black patient log book which is located on the table in the PES office. You are responsible to present the case at morning report. Usually the most junior on-call who has been involved in the assessment is given the opportunity to present the case.

Dictation

Some residents will prefer to dictate their notes into SunnyCare. Sunnybrook currently provides accesss to a cloud-based Dragon speech recognition service. To use this, you need either a microphone or the free PowerMic Mobile app, which enables you to use your smartphone as a microphone. The software has been installed on the PES computers (shortcut on desktop). You can also install it on your office computer, with this link: http://dragonmedicalone.nuance.com/OneClick/index.htm?Id=e075dd9b-e8db-4e48-8cfc-0ff537155133 To install the app on your phone, search for PowerMic Mobile in your iPhone or Android app store. Once you have downloaded your app, to configure it, you'll need to go to these links *FROM YOUR PHONE*: iPhone Users: dmic://config_?NmsToken=NTMxOTk1RjktRDUxRS00NjVELUI1NjMtRjA4RkUxMDRCMTNF

Android Users: http://config_?NmsToken=NTMxOTk1RjktRDUxRS00NjVELUI1NjMtRjA4RkUxMDRCMTNF

When logging into the PowerMic Mobile app, provide your Windows User ID to automatically pair with the target application. On the PES computers, ensure you use *your own Windows User ID* in the Dragon app when you load it (just type it in).

Electronic Order Sets

The features of SunnyCare are expanding and services are transitioning to electronic order sets. In psychiatry, we currently use electronic order sets for Adult PRN medications for admissions to F2. A detailed video on how to use electronic order sets is available: https://youtu.be/TINFf_HH6Pk. The order sets are completed on Sunnycare and printed when signed. The paper version is placed in the chart for nurses to use. Do not add written orders onto the printed electronic order sets, as they are sent to pharmacy electronically at the time of electronic signing.

A Word about Professionalism

When you are on-call, it helps to remember you are a member of the Psychiatric Emergency Services team. You, alongside your staff and team, will ensure that patients are seen and things run smoothly overnight in the ED. If this is not occurring please raise the issue first with your on-call staff &/or during morning report. Ultimately any concerns can be addressed by the clinical director of PES, Dr. LaCroix x5360 or by the ambulatory care director.

PATIENT	PHYSICIAN	SUPPORT STAFF
CL surgical, medical, or burn or CrCU	**Robert Jaunkalns**	**Lynn @6833**
Obstetrical	**Robert Jaunkalns** (courtesy notice to Joanna Mansfield W+B outpatient)	**Lynn @ 6833** (Nancy @5677 or fax 6878)
CPSE Patient	**Carole Cohen**	**Thuvaa @ 4663** or fax 5889

It is very important to patient safety that succinct, timely, and accurate sign-over information from one physician to another occurs. On weekends you must page the oncoming resident to notify them of any ED cases.

In the event that you are paged to see a patient ≤1hr before your call ends (i.e. 07:30 weekdays

or 08:00 weekends) please go to the ED and try to ensure that things are in place for the resident who will be seeing the patient that day. This would include locating the patient's hospital chart, reviewing the ED face-sheet and reason for referral, and obtaining the pink-sheet. Any background information you can obtain will be tremendously helpful. You should lay eyes on the patient (as psychiatry is the MRP), and if appropriate, you can reassure them that someone from the team will be seeing them shortly.

Calls from F2 or Medical/Surgical Floors

All calls from F2 or from medical/surgical floors are supposed to go through psychiatry staff. The staff triages the call. If residents are paged from F2 or medical / surgical wards please do not manage / triage the issue, and redirect them to the on call psychiatry staff. At the staff's discretion, the resident on-call may be directed to manage whatever urgent issue is presented (especially since the staff is often off-site). That being said, the primary responsibility of the on-call resident is to ER. Thus, if the resident is already occupied with an ER referral, the staff is expected to manage urgent F2 or medical/surgical floors issues, at times requiring that they come on-site to do so.

Though staff should manage all requests for medical/surgical consults, residents should know that the process for CL referrals has changed. All CL referrals need to be seen as they come in.

The new paging system will now automatically route ward consults to the staff physician on call. Consults should be seen as they come in. We would also ask that the handover of these consultations be made to ***both physician and assistant***, and that the staff physician be the one responsible for conveying this information to both parties.

If the resident on-call manages an issue related to a patient being followed by the psychiatry CL service, the resident should update the on-call staff and update the online Sunnybrook sign-over system. It is the on call staff's responsibility to update the CL team the next business day.

ECG Protocol

During regular hours there is an ECG tech that is available to perform ECGs for inpatients on F2.

ECG Tech Hours of Coverage

Day	Hours	Who to Call
Monday – Friday	08:00 - 18:00	Page ECG technician @ pager 1040 (alphanumeric)
Weekends and STAT holidays	10:00 – 14:00	

Guidelines for After Hours ECGs

1. **Urgent** - If a patient's condition changes (e.g. complains of chest pain), call 5555 and ask for the Rapid Response team to come and assess the patient and to perform the ECG.

2. **Non-Urgent**: Steps to Obtain ECG:
If possible, defer the ECG to the next day when the ECG tech will be available. If not possible to defer ECG until the next day, the protocol for ECGs after hours is as follows:

a. Ensure ECG order is placed in EPR.

b. Resident, Staff Psychiatrist, or RN to do the ECG if they are able to.

c. If resident, staff, or RN is not able to perform the ECG then the process is for the RN assigned to the patient to call the charge nurse on one of the medicine units and let them know that an ECG needs to be done. F2 to arrange for ECG machine (located on E2) to be brought to unit for the medicine nurse to be able to perform the ECG. ECG once completed to be reviewed by resident and/or staff psychiatrist. Extensions for the medicine units are:

B4 – ext. 7870
D2 – ext. 4306
C4 – ext. 4947

On Call Disposition Options for ED patients

All disposition decisions should be reviewed with the on-call staff psychiatrist. At SHSC, all orders are written on order sheets. For processing in ED, these are placed in the 'Orders' bin at the relevant nursing station. Nurses should be informed verbally of any urgent / STAT orders.

Reassessment

Occasionally the patient has stable vitals but is not yet able to participate in a psychiatric interview e.g. intoxicated or chemically restrained patients. Often these patients are not suitable for discharge home due in an incomplete assessment. In these situations please see the patient briefly to ensure their safety and ongoing stable medical condition. If there has been a change in their medical condition you can discuss this with the AESP, as well as your staff, considering if a referral to Internal Medicine (or another service) is appropriate. Ensure to document the time that you saw the patient and the mental status exam findings. Write a clear plan for management in the patients orders and in your note, e.g. "patient will be reassessed in x hours" and update the nurses about the plan. In this case ensure there are reassessed and a disposition plan is made with the staff-on call prior to morning report.

Adult Crisis Clinic–Psychiatric Emergency Services Clinic (PES)

Patients may be referred to the Psychiatry Emergency Services Clinic by (1) an AESP (on her/his own initiative, or as suggested by a PES nurse), or by (2) the psychiatry resident or staff on-call, after an emergency room assessment.

Patients appropriate for referral to the PES clinic are those seen in the ED and/or referred to Psychiatry while in the ED, who **need brief, urgent follow up care**, (e.g. a patient is started on a new medication, or is in crisis) and who **do not have a current psychiatrist.** Inappropriate referrals to the crisis clinic are, for example, patients seeking a second opinion or whose psychiatrist is on vacation.

At this time the adult crisis clinic does not have a specific catchment area (so ignore this question on the referral form), though one should keep in mind we may be more limited in connecting patients to services if they live quite a distance from us / the GTA.

PLEASE DO NOT SCHEDULE THE APPOINTMENT OR INSTRUCT THE PATIENT TO RETURN THE NEXT DAY.

The resident on-call should complete the referral form located in the filing cabinet in the PES office. Please ensure the contact number is accurate and documented on this form. Leave the referral form + the pink copy of the ED triage sheet in the PES office. Please inform the PES RN who will schedule the appointment. If there is no PES RN on duty, please leave all the referral information on the PES table and inform the team during the morning report. Inform the patient that someone will call them on the next business day to schedule an appointment. (Sometimes PES Nurse will contact the patients on weekends also).

Patients are usually seen within several days. Please **do not** inform patients that they will be seen the next day please **do** tell them it is brief time limited care.

Youth Urgent Assessment Clinic (UAC)

This clinic is for youth between the ages of 14 and 18 (inclusive) who are experiencing a psychiatric crisis. Crises may include psychotic symptoms, suicidal or homicidal ideation, anxiety, and/or major mood symptoms. The UAC is not appropriate for patients who:

- are not in crisis,
- are already under the care of a psychiatrist, or
- whose **primary** mental health issues are substance abuse, eating disorders, developmental disabilities, or disruptive behaviour disorders.

The patient must reside in the 416-Toronto area to be eligible for this clinic. If the patient requires outpatient follow-up and is connected with a psychiatrist, they will **not** be seen by the crisis service and should be referred back to their community psychiatrist for continuing care. The patient must reside in the 416-Toronto area to be eligible for this service.

A social worker will contact the patient within **72 hours** of initial referral to the crisis service. Call **ext. 4098** to make a crisis referral and leave the completed referral form with a copy of the

Emergency Report in the Emergency Department PES filing cabinet to be picked up by the Social Worker.

Please be aware that youths referred to this service are not always seen within a week or two of referral (at times the wait can be longer). You should be mindful of this, especially if starting a new medication.

If crisis follow-up is not required, an outpatient consultation or assessment can be provided by the Division of Youth Psychiatry, through a referral from a community physician.

Socially Compromised Patients presenting in the Emergency Department

At times patients are referred to psychiatry and no acute / active treatable psychiatric condition requiring hospitalization is identified. These patients are not to be admitted to F2. The F2 ward is not an appropriate setting for their long term care needs. You may be referred such a patient who may have dementia and whose family feel they cannot care for them any longer, or patients with dementia who have gradually developed safety concerns specific to their home or nursing home environment. Admissions of such non-acute yet socially compromised patients result in an unnecessary admission with lengthy lengths of stay that could be for months to years. **All such patients *should not* have admission orders written.** Rather, write an order to 'Hold in the ED' and for 'SW and/or CCAC and/or GEM nurse' to see for the next business day should be written. The care of these patients during their stay in the emergency department will be psychiatry along with the SW and/or CCAC and / or GEM team. Ensure that appropriate medication orders are written for the patient.

At times the lines get blurry with regard to whether an acute, treatable issue is, or is not, present. We encourage residents to hold the patient in the ED if you are unsure (rather than admit) and discuss with your on-call staff. If conflict or tensions arise between you and ED, please readily involve your staff for potential staff-to-staff conversations to manage the situation.

Adult Admission Inpatient Psychiatry

Inform the Emergency Department nurse caring for the patient of the plans to admit. In the admission orders always specify the name of the unit and the type of nursing care your patient needs i.e. F2 constant observation or q 15 minute observation. Constant observation generally requires a PICU (Psychiatry Intensive Care Unit) bed. In your orders specify the legal status of the patient i.e. voluntary or involuntary indicating that the Form1 is completed and the Form 42 given to the patient. The patient is to be admitted under the name of the staff on-call with you. Give report to the ward nurse on the patient including patient's legal status and condition. Transfer times will be organized between ED nurse and ward nurse. A standardized order set is also available for PRN orders.

Psychiatry Admission Orders Sample
using ADDAVID

A Admit to Psychiatry F2 Ward, c/o Dr. "Staff-on-call"

D Dx: Bipolar I Disorder–acute mania

D DAT

A Form 1 involuntary status; Form 42 given to patient
Q 15 min nursing observation

V Vitals q shift

I Investigations: CBC and diff; electrolytes, BUN, Cr, Glucose, LFT's, TSH, ECG

D Medications:

1. Lithium 900 mg po qhs
2. Risperidone 2 mg po BID
3. Clonazepam 0.5 mg po qhs
4. Nicotine 14 mg patch apply to arm once daily

It is helpful to be aware of Sunnybrook's (and F2's) no-smoking policies, and discuss these with patients being admitted, in advance (see smoking section below for details), as well as to consider prescribing Nicotine Replacement Therapy (NRT) accordingly.

The psychiatry inpatient unit is not able to manage medically unstable or non-ambulatory patients due to the physical layout (one central ward washroom, absence of call bells and telephones in the rooms), lack of availability of monitors or telemetry, and lack of staff expertise. These patients may require a consultation from Internal Medicine or other specialty services while still in the ED. If you are uncertain, discuss this further with the PES RN, F2 charge nurse, and/or the on-call staff psychiatrist. Inpatient unit phone numbers: F2 4323 PICU 2225.

Youth Admission Inpatient Psychiatry

Clarification as to what age range a patient can be admitted to Youth beds on F2.

Patients between the ages 14 and 18 years (inclusive) can be admitted to F2 Youth inpatient ward.

Patients aged 13 years or younger ***cannot*** be admitted to F2 and would need to remain in the ED until alternative resources can be arranged. Alternative appropriate resources for these younger patients include North York General, Rouge Valley, TEGH, St. Joseph's or Humber River; HSC is also an option so long as the patient is (i) ill enough to require an admission and (ii) **not** being admitted on a Form (i.e., under the Mental Health Act).

Patients aged 19 or 20 years **uncommonly** may be admitted to F2 Youth beds; however, whether to admit to Youth versus Adult should be guided by their level of independence, as well as their potential for adversely impacting on the milieu in the Youth ward. The youth ward is high school curriculum-based. Some factors to consider: If the patient is still in high school and is still living with their family, they may be more suitable for the Youth ward. If the patient is in post-secondary education, they are more suitable for the Adult ward. If the patient has the potential for being aggressive or inappropriate with younger (14-18 yr old) patients, they should not be admitted to the Youth ward.

Admit-No-Bed Patient (ANB)

An ANB occurs when a patient has been admitted to psychiatry, but must remain in the ED as there are no beds on F2. When admitting a patient who will have ANB status, it is helpful to inform them of what to expect. In such cases, we continue to be the MRP, and a follow-up note must be added to the chart every day. Psychiatry staff on-call are responsible for ANB patients. They should know that they will be remaining in ED and be seen by psychiatry once daily. They may be (1) reassessed for discharge home; or (2) transferred to F2 if they still require admission and a bed become available; or (3) they are transferred to another hospital under Criti-Call procedures.

Note that if patients are involuntary (Form 1 or 3) they will receive constant observation via a 24-hr observer or security. Please be aware that voluntary patients in the ED have very little supervision, if they are ill enough to require admission that little supervision in ED is felt to be insufficient. Assess their safety requirements in such an environment accordingly. Generally speaking, ANB patients will be certified. This is because they are usually ill enough to have required an admission despite there being a lack of bed.

Discharges

Once a decision for discharge has been made, write the orders and inform the PES and ED nurses. A 'Dear Dr.' carbon-copy letter is available behind the printer in the PES office. This is an efficient way of updating the patient's physicians as well as providing the patient with a copy of the assessment findings and discharge instructions. If admitted patients stayed in an ED bed (admit-no-bed) and are being discharged during your shift, a discharge report needs to be completed. At SHSC we utilize the e-discharge system. Residents are asked to familiarize themselves with this program, through: https://sunnynet.ca/ (login using your windows ID and password), click physicians, then click e-discharge training module. Patients admitted on the weekend and discharged prior to being assigned to an inpatient psychiatrist on Monday will require a discharge summary to be completed by the resident and staff who discharge them.

Resources for Residents On-call

There is a blue binder in the PES filing cabinet top drawer with helpful resources including information such as phone numbers for other hospitals; GP Psychotherapy; The Gerstein Centre; Withdrawal Management Services; etc. The second drawer has Forms 1 & 42 (also available online at the Ministry and Health Long Term Care website); Authorization for Release of Information; Withdrawal Management Information and Referral forms for Adult Youth Crisis Clinics.

A final note: If you find yourself getting caught in turf battles or inappropriate demands with the ED or other services, **don't hesitate to inform your staff. It is best that these issues are handled staff-to-staff immediately.**

SUNNYBROOK HEALTH SCIENCES CENTRE IS A SMOKE FREE CAMPUS

Smoke-free Policy

1. Smoking is no longer allowed in any building or on Sunnybrook Campus.
2. Cigarettes or any other smoking materials are not allowed on the inpatient unit.
3. All patients being admitted to F2, either through the emergency department, the Psychiatric Emergency Services Team (PES) or a physician's office/clinic will be informed that several items are not permitted on the unit, including smoking materials, alcohol, drugs, weapons, cell phones, and the items will be removed once the patient arrives on F2. If family is with the patient, the crisis nurse/resident/physician may suggest to family members to take the cigarettes/items home with them.
4. **Upon arrival to F2, patients must hand in all smoking materials and these will be stored with their valuables in the safe located in the security department. Only patients with an overnight pass can retrieve their smoking materials before leaving on pass. Otherwise, smoking material will not be returned until discharge. It is often helpful to inform patients of this policy on admission so that they know what to expect.**
5. In keeping with standard practice, when patients return from passes, they must report to the nursing station to have their belongings checked for items that are not allowed on the floor including smoking materials.
6. All visitors must report to the nursing station. Items brought for the patients will be checked. Smoking materials and items deemed unsafe for use on the floor will be returned home.
7. Nicotine gum or patch will be ordered by the physician and offered to patients upon admission. The patch and/or nicotine gum will be titrated in relation to patients' smoking habits. If the patient is admitted through emergency, the physician who admits the patient may order a patch and/or gum for nicotine replacement therapy (NRT). Nicotine patches/gum will not be dispensed for weekend passes unless requested by a patient.
8. Supportive groups addressing withdrawal symptoms and coping strategies associated with smoking cessation will be offered on the inpatient unit (F2) as part of the therapeutic group program, when possible.
9. Patients found smoking on SHSC property may be subject to a municipal fine and security personnel will return the patient to the unit. The incident will be documented on the patient's chart. The physician will be notified by the team leader/nurse when such an incident occurs.
10. If patients are found smoking, privilege levels will be reassessed by the team. Such incidents will be documented on the patients' chart.

Management of Nicotine Withdrawal on F2 – Guidelines for Staff/Residents

It is recommended to treat smokers with nicotine replacement therapy (NRT) to avoid withdrawal symptoms.

Immediate nicotine withdrawal symptoms may include:

- Dysphoria, irritability, anxiety, frustration, anger
- Insomnia, difficulty concentrating, restlessness, bradycardia, increased appetite
- Cravings to smoke

NRT therapy available on the unit includes

Nicotine patch (Nicoderm®): 7 mg/24 hours, 14 mg/24 hours, and 21 mg/24 hours

Nicotine gum (Nicorette®): 2 mg and 4 mg strengths.

Based on the experiences of other organizations, it is recommended that NRT be offered to all smokers. Patients should be assessed according to usual smoking habits. A patient's need for a cigarette first thing in the morning is a key sign of nicotine dependence.

Recommendations for NRT on the unit are

Use of a regular daily patch along with gum prn together is recommended to curb cravings. Light smokers may only require the gum prn, or could use the lowest strength patch. Non-daily smokers, or smokers not experiencing

withdrawal, do not require NRT. For adolescents: NRT can be considered for adolescents that are close to adult age and are heavier smokers and at risk of withdrawal. There is more limited experience with NRT in adolescents, but the Ontario Medical Association (OMA) does endorse the use of NRT in young adults under 18 who require it. Treatment can start in Emergency if needed (not all strengths of nicotine products may be available in Emergency due to space issues). Titrate NRT up according to withdrawal symptoms / cravings, and titrate down according to symptoms of nicotine toxicity. Nicotine toxicity symptoms include: nausea, vomiting, abdominal pain, diaphoresis, diarrhea, tremors, dizziness, confusion or weakness. For patients who are capable of managing the gum on their own, it may be beneficial for nurses to give multiple doses at a time to the patient, to reduce nursing administration time and to give the patient more control over relieving their cravings.

Recommendations for NRT:

(Note: a large pack = 25 cigarettes; small pack = 20 cigarettes)

# of Cigarettes Smoked Per Day	Suggested NRT
> 15 cigarettes per day	Nicotine patch 21 mg/24 hours + nicotine gum 4 mg q1h prn For heavier smokers (>1 ppd) who continue to experience withdrawal symptoms on the 21 mg patch (can assess after 48 hours), can consider adding 7 mg patch.
7 – 14 cigarettes per day	Nicotine patch 14 mg/24 hours + nicotine 2 or 4 mg gum q1h prn
<7 cigarettes per day	Nicotine patch 7 mg/24 hours AND/OR nicotine gum 2 or 4 mg gum q1h prn alone
	Maximum amount of gum – suggest 6 gums/24 hours if used in combination; 12 gums/24 hours if used alone

NRT	How to Use	Possible Adverse Effects	Cautions / Contraindications
Patch	-Place patch daily on clean dry area of skin anywhere above the waist (chest, back, or upper arm). -Skin should be free of lotion or soap as this can cause the patch to fall off (can wipe area with alcohol if needed). Rinse hands in water after applying (soap can increase nicotine absorption into skin). -Rotate sites daily - do not use same site for at least one week. -Dispose of patch in area safe away from pets or children – can be harmful.	-Contact hypersensitivity to the patch: erythema, pruritis, edema, hives, or generalized rash orurticaria. Hydrocortisone cream 1% on affected area may help -Nightmares or insomnia: can remove patch before bedtime (keep in mind nicotine withdrawal may also cause insomnia) -Headache, nausea, lightheadedness	-Use with caution in patients with recent CVA, immediately post-MI, angina, or life threatening arrhythmias
Gum	-Use "bite and park" method – bite gum once or twice until peppery / tingling taste, and then "park" it between cheek and gum. Wait a minute, and then bite again. -Avoid swallowing saliva to prevent GI side effects -After 30 minutes all the medication will have been released. Avoid drinking acidic beverages such as coffee, tea, soft drinks, alcohol, or citrus drinks 15 minutes before and while chewing gum (they prevent the nicotine from being absorbed).	-Headache, lightheadedness, mouth or throat soreness -Hiccups, nausea, upset stomach (especially if chewed too fast or saliva swallowed)	-Not for denture wearers or with TMJ dysfunction. -Use with caution in patients with recent CVA, immediately post-MI, angina, or life threatening arrhythmias

Department of Psychiatry Resident Training Safety Guidelines

Resident education must occur in safe clinical settings. Trainee safety is essential to permit learning; this has been stressed in numerous presentations and position papers of the Royal College of Physicians and Surgeons of Canada, the Canadian Psychiatric Association and other professional bodies. Although the large majority of patients suffering from psychiatric illnesses or addictions do not pose a threat of violence to trainees or others in the community, there is a risk that some patients attended to by psychiatric clinicians may exhibit violent or unpredictable

behaviours in emergency departments, inpatient units, outpatient clinics or community settings. Furthermore, the authority utilized in certifying patients involuntarily and the doctor-patient tensions that can arise as a result, is a feature of psychiatric practice that must be attended to in psychiatric practice; to the degree to which these tensions can also increase safety risks, it is important that trainees take this into account in both risk assessment and requests for assistance.

The following is a policy for resident clinical care safety in Postgraduate Education in the Department of Psychiatry at the University of Toronto. This is adapted from the CPA position paper on Trainee Safety. It is regularly reviewed and revised:

Departmental Policy

- Trainee safety in the Department of Psychiatry of the University of Toronto is of the utmost importance. The department will work to foster and maintain a "culture of safety" in resident training in all training sites
- Violence toward residents, other staff and co-patients is not acceptable and should be reported to supervisors, postgraduate coordinators, the Resident Safety Sub-Committee and the Program Director
- In the event of any incident of violence toward trainees this will be fully investigated and reviewed for the purpose of devising new safety policies, protocols, processes and systems. New safety policies or procedures will be disseminated to the residents and faculty in a fulsome and timely manner.
- Residents experiencing threats or actual violence will be personally supported at all levels including resident supervisors, managers, resident coordinators, Hospital Chiefs other hospital personnel and the Program Training Director. This support may include temporary modification of training or training site as required, provision for safe passage out of the facility or home as necessary, referral for appropriate medical attention or counseling and also include assistance from training facilities to assist the resident in taking legal action against the perpetrator of the violence or threat.
- Trainees will receive regular training in the prevention and management of aggressive behaviour. Training in Preventative Management of Aggressive Behaviour is MANDATORY for all PGY-2 and PGY-4 residents within the psychiatry program.
- Each training site must also ensure that mental health personnel and security staff receive training in proper methods of handling violent patients. Such training should include:
    - Early recognition of potential or aggressive behaviour and predisposing factors for violence against staff and others
    - Appropriate management of violent patients
    - The physical layout of facilities for interviewing and treating patients should be safe and secure
    - A clear policy for restraining practices should be available in each facility and restraints or seclusion rooms should be available in areas where there is the potential for aggression to occur (i.e. inpatient units, Emergency units)
- Each facility should have an easily identifiable alarm code that indicates a potential or actual assault (e.g. "Code White") and an adequate number of trained staff should be available for immediate response.
- Residents and all members of the health care team should not be required to see potentially violent patients unless appropriate steps have been taken to maximize their safety and reasonable safety standards have been implemented
- All available information about new patients should be reviewed for potential for violence before beginning any assessment in order to prepare for additional staff presence at the time of interview/assessment if necessary

- Residents should be aware that they can and should request additional accompaniment/support from members of the health care team or security staff if there are perceived concerns regarding personal safety or the adequacy of available risk assessment information

Emergency Departments

- Designated psychiatric interviewing rooms in emergency departments should be of adequate size and located in close proximity to the nursing station to ensure the availability of immediate assistance if required
- Residents should be oriented to the importance of chart review and risk assessment when determining the best room and clinical support for a patient interview/assessment. These rooms should be clear of objects which could be used as weapons and have minimal furniture.
- Furniture should be appropriately weighted to reduce the likelihood of the furniture being utilized aggressively.
- Residents should be oriented to the safest seating arrangement of patient and clinician/resident for each room utilized for interviewing.
- Interviewing rooms should have an accessible, functional alarm system which if activated produces an immediate and sufficient staff response
- In the absence of an alarm system in place, residents should have access to security staff in close proximity and/or the opportunity to jointly assess a patient with a clinical colleague
- Rooms should be clear of objects, which could be used as weapons. Furniture should be securely fastened to the walls and/or floor. Doors should open outwards or ideally open both ways (i.e. in and out) and should not be lockable from the inside, nor capable of being barricaded
- Appropriately trained hospital personnel (i.e. security staff or fellow clinician) should be available for assistance if any patient has a history of violence or any clinical staff suspects the potential for aggressive behaviour
- Interview rooms should have setups for visual monitoring, either through a camera or a windowed door/wall
- On-call sleeping rooms for residents need to be secure from unauthorized intrusions
- Police officers who bring an assaultive/aggressive patient to any emergency department should be requested to remain available until sufficient hospital personnel have taken over and the safety assessment is complete. Police officers or hospital personnel should be expected to remain in close proximity while such patients are in the interviewing room or the emergency department

Inpatient Wards

- Residents should be oriented to the importance of chart review and risk assessment when determining the best room and clinical support for a patient interview/assessment
- In patient situations where risk of aggression has not yet been determined to be low, residents should generally request accompaniment by a member of the health care team or security staff member or alternatively, interview the patient in a location that is both safe in proximity and in visibility to other staff so that immediate assistance can easily be provided if aggression should suddenly occur.
- Each unit must provide one room of adequate size, located in close proximity to the nursing station to ensure the availability of immediate assistance if required. These rooms should be clear of objects which could be used as weapons and have minimal furniture.
- Furniture should be appropriately weighted to reduce the likelihood of the furniture being utilized aggressively.
- Residents should be oriented to the safest seating arrangement of patient and clinician/resident for each room utilized for interviewing.
- Alarm buzzers or personal alarms should be available for residents or other staff in interview rooms. When activated these alarms should produce an immediate response of personnel.

Medical Surgical Wards

- Patients receiving medical or surgical therapy may exhibit violent behavior, typically when delirious, intoxicated, demented, or at times when physical symptoms are inadequately treated. When dealing with such patients residents need to be aware of the hospital rules for physical and chemical restraint and should be encouraged to take all steps necessary to maintain the safety of themselves, the patient, and other staff.
- Residents are also encouraged to be mindful of adopting appropriate infection control procedures when visiting medically ill individuals to prevent transmission of disease to themselves, other patients and the community.
- Residents should feel free to discuss any perceived breech of their occupational safety with both direct supervisors and occupational safety/infection control experts on site. Early involvement of the staff psychiatrist to ensure that these goals are met is encouraged.

Outpatient Offices

- Resident offices should be of adequate size and design for the safe interviewing of patients
- Residents should be oriented to the safest seating arrangement of patient and clinician/resident for each room utilized for interviewing.
- Residents should be oriented to the importance of chart review and risk assessment when determining the best room and clinical support for a patient interview/assessment
- Alarm buzzers or personal alarms should be available for residents or other staff in their offices. When activated these alarms should produce an immediate and adequate response of personnel. Such alarms should also be available whenever residents see patients in offices off-site
- All available information about new patients should be reviewed for potential for violence before beginning any assessment in order to prepare for additional staff if necessary
- There should be available an option to move potentially violent patients to alternate inpatient or emergency department interviewing rooms for increased safety
- Residents are reminded not to see new or potentially violent patients in their offices late in the day when back-up staff may be less immediately available. Residents should not see patients alone after hours.

Community Visits

- Residents may be involved in community visits on rotations such as Geriatric Psychiatry and Chronic Care.
- In the community, patients with a potential for violence should only be seen with appropriate precautions.
- All available information about new patients should be reviewed for potential for violence before any visit. Any new information regarding a change in the potential for violence about known patients should also be reviewed prior to a visit.
- All residents should be accompanied by a health care team member who is familiar with the patient under the following circumstances: i) the resident (at any level of training) or a health care team member has any safety concerns or ii) the resident is in his/her PGY1-3 year.
- When there are safety concerns, residents may consider seeing the patient in a safe public setting in lieu of a home visit.

Residents doing rotations which may involve community visits, should receive specific orientation to maintaining safety in the community/home visit setting, per the goals and objectives safety review at the start of every rotation

- Residents should have access to cell phones (their own or those provided by the community team) for easy communication to their base site and/or to police to call for assistance whenever required.

Collaborative Care

Preamble: The Psychiatry Residency Program encourages collaborative care in various settings as part of both Core Royal College Training Requirements and Selectives for its Trainees. These settings are heterogeneous in nature. For Collaborative Care settings that take place in the community and outside typical medical or psychiatric clinic or hospital settings, the **COMMUNITY VISITS SECTION** of these guidelines should be applied to safe training and practice in those settings. In general, any settings being considered for resident training in collaborative care should meet basic PGME standards for safety. The full guidelines can be found here:
http://www.facmed.utoronto.ca/Assets/FacMed+Digital+Assets/Faculty+of+Medicine+1/FacMed+Digital+Assets/about/Edu-deans/Education+Policies/Resident+Health+and+Safety+Guidelines.pdf
Most pertinent to planning collaborative care rotations is the following section of the current policy which describes the goals and expectations **for personal health and safety: "Personal Health and Safety (excerpt)**

The University of Toronto Faculty of Medicine strives for a safe and secure Environment for medical residents in all training venues. All teaching sites, hospitals, and long-term care institutions are responsible for ensuring the safety and security of residents training in their facilities in compliance with their existing employee safety and security policies/procedures as well as the requirements outlined in the PAIRO-CAHO collective agreement. During block time in community-based practices, residents may be required to attend patients in doctor's offices or patient homes. Residents will not be required to see patients alone in the clinic, on house calls, or other settings that are not appropriately supervised. Locations without a formal health and safety policy or joint committee will be guided by the standards outlined in the Occupational Health and Safety Act.:

- Intake Risk Assessment/Triage information should be available for review before patient assessment
- Physical infrastructure/office/assessment space for clinical work should free of extraneous materials or equipment and set up to allow for an easy exit and access to support, as needed for safety
- There should be an established procedure for quickly accessing assistance as needed for safety e.g. a hard wired alarm, personal alarm or telephone access together with a workplace plan/training for alarm response
- Senior residents training in Collaborative Care are encouraged to use their Medical Expertise, Collaborator and Manager competencies developed in Risk Assessment to bring that lens to Collaborative Care settings and offer advocacy and consultation regarding safety optimization
- Appreciating that on-site clinicians and faculty in Collaborative Care settings may not be Psychiatry Faculty, Psychiatry program residents, site coordinators and Collaborative Care leads are reminded to provide a copy of these Residency Training Safety Guidelines to new Collaborative Care training sites and regularly at the beginning of each rotation

Drs. B. Buckingham, I. Dawe, P. Voore, Feb 2007
Drs. H. Flett, L. Wiesenfeld, A. Zaretsky Revised and approved April 2011
Revised October 2011, Approved November 10, 2011
Community Visits Section Revised June 2012 Collab Care Section Added Dec 2012
Scheduled Annual Review: October 2013