



Psychiatry UNIVERSITY OF TORONTO

Department of Psychiatry Resident Training Safety Guidelines

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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 directors, 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 Trauma-informed De-escalation Education for Safety (TIDES) is MANDATORY at least twice for all residents within the psychiatry program (i.e. once during PGY1 and once during the senior years (PGY3 or PGY4).

Each training site must ensure that residents are provided with adequate personal protective equipment (PPE) to prevent transmission of infection to themselves, patients and the community. Residents are responsible for reviewing and adhering to the site policies and recommendations by IPAC (Infection Prevention and Control) where they are training. Residents must also report any breaches of their occupational safety with supervisors, postgraduate site directors, and occupational safety/infection control experts on site.

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:

1. Early recognition of potential or aggressive behaviour and predisposing factors for violence against staff and others
2. Appropriate management of violent patients
3. The physical layout of facilities for interviewing and treating patients should be safe and secure
4. 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)
5. 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.
6. 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.
7. 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

8. 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 behavior.

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.

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; ii) the resident is in his/her PGY 1-2 year; iii) if it is the first visit for the resident with the patient.

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://pg.postmd.utoronto.ca/wp-content/uploads/2016/06/PGMEResidentHealthSafetyGuidelinesMarch2009.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

Drs. S. Darani, M. Fefergrad Revised and approved May 2018

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