

Safety Guidelines

General Psychiatry Residency Program

Background

Residents are both *learners* and *service providers*; as such, residency training must occur in safe learning and clinical (work) environments. The General Psychiatry Residency Program thus endeavours to promote a *culture of safety* across training experiences and clinical training sites. Residency programs at the University of Toronto must also comport with Postgraduate Medical Education (PGME) [guidelines](#) relating to safety along with Royal College of Physicians and Surgeons of Canada (RCPSC) [Standards of Accreditation](#) for Residency Programs in Psychiatry relating to safety (see Standard 5). In these guidelines, safety refers to both the *psychological* and *physical* safety of residents in the General Psychiatry Residency Program across all elements of the residency training program. As safety is a prerequisite for achieving well-being at work, these guidelines are also informed by other key subcommittees and components of the residency program (for example, the Subcommittee on Resident Wellbeing, Resident Leadership Council, feedback from rotation evaluations and clinical teaching assessments). Finally, as residency training is distributed across multiple different clinical training sites, faculty supervisors are expected to support the safety of trainees through ensuring that residents are aware of and comport with any hospital or organization-based safety requirements (for example, policies articulated by Infection Prevention and Control and Occupational Health and Safety).

Although most patients suffering from psychiatric/mental health conditions or addictions do not pose a threat of violence to residents or others in the community, there is a risk that some patients attended to by psychiatric/mental health clinicians may exhibit violent or unpredictable behaviours in acute care settings (e.g. emergency departments and inpatient units), outpatient clinics, or community settings. These guidelines are intended to ensure that any safety risks posed to general psychiatry residents in the aforementioned circumstances and settings is mitigated by robust preventative measures.

Statement on Psychological Safety

Psychological Safety is defined as a shared belief that an individual will not face negative consequences for speaking up about any concerns. Psychologically safe environments in Psychiatry invite diverse perspectives and create space for dialogue and critical reflection on challenges and difficult situations in training, for example, discussion about difficult restraints of patients, implementation of Mental Health Act (MHA)/involuntary admission for patients, counter-transference reactions, and the moral distress that can occur for residents, even when providing good quality and evidence-based care. Though each rotation includes different clinical experiences, the principles which lay a foundation for psychological safety can be applied across rotations.

Further, psychological safety requires that trainees feel comfortable to discuss, disclose, and/or report all kinds of mistreatment in a safe and confidential manner without any risks of repercussions. Residents are encouraged to come forward with any concerns that they experience in the workplace via a variety of routes within the residency program and PGME. Faculty teachers have a responsibility to their learners to effectively address mistreatment, including recognition that bias incidents may occur, and that such incidents require a response.

In addition to the resources that exist (including policies guiding resident wellness), the Safety Subcommittee, alongside the Resident Wellbeing Subcommittee, and PRPC, will work collaboratively to ensure that teachers, residents and others in our education community in the Psychiatry Residency Community have the supports required to contribute to psychologically safe learning environments, recognizing shared accountability (but not equal responsibility) to this.

Important Resources

Office of Learner Affairs <https://meded.temertymedicine.utoronto.ca/office-learner-affairs>

Learner Mistreatment <https://meded.temertymedicine.utoronto.ca/learner-mistreatment>

[Professional Responsibilities in Medical Education](#) – CPSO

Guidelines

1. Required training and orientation

All residents will be required to complete TIDES (Trauma-informed De-escalation Education for Safety and Self-Protection) training offered through the Centre for Addiction and Mental Health (CAMH) in their first and fourth years of training (PGY1 and PGY4). Residents will also receive specific orientation to site/rotation-based safety resources, guidelines, and policies at the beginning of each rotation, including on-call orientation. All faculty supervisors must review the [Rotation Plan and Safety Review Form](#) at the beginning of each rotation.

2. Prompt reporting of violence or aggression & support for residents

Violence and aggression toward residents, other healthcare staff, and co-patients is not acceptable and should be addressed appropriately. Any violence or mistreatment of residents should be reported to supervisors, Chief Residents, Postgraduate Site Directors, and as appropriate, to the Resident Safety Subcommittee and the Program Director. Hospital-based leadership should also be informed as per hospital-based guidelines, policies and procedures to report such incidents.

Residents experiencing threats or actual violence will be personally supported at all levels including but not limited to by faculty supervisors, Postgraduate Site Directors, Psychiatrists-in-Chief, and the Program Training Director. The [Adverse Events Policy](#) provides step-by-step guidance for how adverse events impacting residents should be reported, and the necessary support offered to residents in these situations. Residents will also be connected to supports available via the Office of Learner Affairs at the Temerty Faculty of Medicine.

Various supports may be offered to residents following an incidence of violence or aggression including:

- 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

Information about supports for residents can be found on the [Resident Wellness](#) section of the residency program website and also via the [Office of Learner Affairs](#).

3. Investigation of violence towards residents

In the event of any incident of violence toward trainees, this will be fully investigated and reviewed by the Safety Sub-Committee for the purpose of informing current safety policies, protocols, processes, and systems. New safety policies or procedures will be created and disseminated as needed to the residents and faculty in a fulsome and timely manner.

4. Appropriate training for mental health personnel and security staff at hospitals

Hospital-based leadership must also ensure that mental health personnel and security staff receive training in proper methods of managing violent and aggressive 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 and aggressive 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 high-risk areas.
- 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.
- A process for ensuring that residents and all members of the health care team are not required to see potentially violent patients unless appropriate steps have been taken to maximize their safety and reasonable safety standards have been implemented. For example, the TAHSN algorithm for Responding to Mistreatment Flowchart can be used to determine the safest process. [3-2 Responding to Mistreatment Flow Chart Only Sept 6 \(002\).pdf](#)
- A process for reviewing available information about new patients’ potential for violence before beginning any assessment, in order to prepare for additional staff presence at

the time of interview/assessment if necessary

- Residents' awareness 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. See TAHSN-Education approved algorithm and principles.

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) must 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 near 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 treatment may exhibit violent behavior, typically in the context of neurocognitive disorders such as dementia or delirium or with acute intoxication or withdrawal from a variety of substances. When caring for patients in these settings, residents should both be aware of and adhere to hospital guidelines or policies for physical and chemical restraint and should be encouraged to take all steps necessary to maintain their safety alongside the safety of patients and other members of the healthcare team.

Residents should be informed of and comport with all relevant hospital-based policies and guidelines related to infection prevention and control (IPAC) and Occupational Health and Safety guidelines. Faculty supervisors are responsible for ensuring that residents are apprised of the applicable hospital based IPAC and occupational health and safety guidelines or policies for residents to safely conduct clinical care in the hospital environment.

Residents should feel free to discuss any perceived breach of their safety in the workplace with faculty supervisors and hospital leadership in IPAC and OHS. 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.

Like in all clinical settings, if a resident has any potential safety concerns regarding a patient, there should be an available staff (supervisor, allied health staff, security, etc) who can accompany the resident during the encounter. There should be available an option to move potentially violent patients to alternate inpatient or emergency department interviewing rooms for increased safety. The supervisor (or a delegate covering staff psychiatrist) should be on site and available to provide immediate support, including accompaniment to the encounter.

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 Serious Mental Illness (SMI). In the community, patients with a potential for violence should only be seen with appropriate precautions. As such, residents participating in rotations that may involve community visits should receive specific orientation relating to maintaining safety in the community/home visit setting at the start of the rotation and as needed throughout the rotation.

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 healthcare team member who is familiar with the patient under the following circumstances:

- the resident (at any level of training) or a health care team member has any safety concerns;
- if it is the first visit for the resident with the patient;
- or as per guidance from the faculty supervisor, based on the resident's clinical experience and training.

When there are safety concerns, residents may consider seeing the patient in a safe public setting in lieu of a home visit.

Residents should have access to mobile 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.

Integrated Mental Health Care (IMHC)

Collaborative/integrated mental health care settings are heterogeneous in nature. For IMHC settings that take place in the community and outside typical medical or psychiatric clinic or hospital settings, the **Community Visits** of these guidelines should be applied to safe training and practice in those settings

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

<p>Prepared by: Chair, Safety Subcommittee with Program Director and Associate Program Director in consultation with rotation leads/coordinators and Vice Chair, Education</p> <p>Approved by PRPC: October 3, 2022</p> <p>Next review: 2025</p>
