DEPARTMENT OF PSYCHIATRY

WESTERN UNIVERSITY

PSYCHIATRY RESIDENT ON-CALL POLICIES

Objectives:

To provide a graded responsibility training experience for residents who, by the completion of training will have:

I. Demonstrated the ability to assess, diagnose and treat the full range of mental disorders in males and females across the life span in the emergency psychiatry context.
II. Effectively planned the use of Emergency Room professional time, applying practice management principles.
III. Coordinated the efforts of the ER treatment team by effectively using the varied skills of other health care professionals.
IV. Demonstrated knowledge of important community resources for patients and showed ability and willingness to direct patients to those resources.
V. Demonstrated the ability to facilitate ER psychiatry learning for other trainees and other health professionals.
VI. Consistently responded to urgent consultation requests from all department services that cannot wait until regular operating hours of Consultation Liaison.
VII. Consistently responded appropriately to pages / calls from the Inpatient Psychiatry units regarding acute patient concerns.

Evaluations:

An on-call evaluation should be completed by the consultant for every shift. Similarly, residents should be completing an evaluation/feedback form for both consultants and medical students. In keeping with Competency By Design model, residents are assessed based on level of entrustability of skills in information gathering, knowledge, management and communication skills.

Timing:

On call obligations start Monday to Friday at 16.30h and continue until approximately 09:00 the following day. On-call obligation on Saturdays, Sundays and stat Holidays start at 09:00 and end at 09:00 the following day. According to the current PARO-CAHO contract, the on-call obligation is considered an in-house or “confined” call.

In all circumstances while on call, residents are expected to attend to the patient promptly, but no longer than 30 minutes after being paged. A phone call is expected to confirm receipt of all the pages. Resident call shifts are currently in-house only.

ROLES ON-CALL

Adult Consultant*(s)* (16:30-08:30)

- Will be present for handover
  - Remains on-site if outstanding work related to admitted patients in E.D. (e.g. patients requiring rounding, unfinished consults from daytime)
- Will review all new consults by phone
  - Also will review any significant changes in care for inpatients (e.g. discharges)
- May return to hospital in situations with extreme workload
  - This will be at the request of the SPR, based on the criteria in the Consultant Support On-Call Best Practice Guideline posted in CEPS

C&A Consultant

- Will review new consults by phone
- Will accept C&A consults from other hospitals or the community
- Will handle ward issues from C&A Inpatient Unit (although may request support of in-house residents)

C&A Fellow (PGY 5 – 6)

- If fellow present, will handle C&A psychiatry issues

SPR / Senior Psychiatric Resident (PGY 3 – 5)

- Holds the psychiatry resident pager (19905) for majority of shift
  - Accepts consults from:
    - Adult E.D. (sometimes with input from CEPS Screening Nurse)
    - Paeds E.D. (unless fellow present)
    - Consultation-Liaison (expiring form 1 OR medically cleared and ready for D/C pending psych consult)
    - Other Hospitals / Community (for adults only)
  - Handles ward issues for adult psychiatric inpatients (B7 / GBU / E.D.)
- Manage the on-site team
  - Lead handover (on weekends, this involves assigning patients for rounding)
  - Triage consults and distribute workload to self/ junior residents / clerks
    - When dividing consults, consider
      - workflow (e.g. Can I do this consult on my own in 20 minutes?)
      - urgency (e.g. Patient wanting to leave and not on a form)
      - experience of trainee
      - complexity of case
      - fairness
    - In some situations, it might be reasonable to “split” the night so that one resident does multiple consults consecutively rather than alternating between two; it is also reasonable to ask juniors to handle the pager for part of the night if the team is “caught up”, so long as SPR is always available
    - Make sure the team cares for themselves (e.g. food) and provide support when requested
- Adopt a versatile role in reviewing consults
  - Most common setup: assign consult to clerk/junior team; clerk reviews history with junior and SPR provides guidance/supervision if needed; junior reviews with staff
  - Alternatives:
    - SPR assigns consult to junior resident acting independently, who will review with staff (no clerk involved)

- SPR assigns consult to clerk, who will review with SPR, who reviews with staff (no junior involved)
- SPR does consult independently then reviews with staff (e.g. to improve workflow or to manage a complicated issue)

- When possible, provide structured educational opportunities for the full team (e.g. discuss a specific topic over dinner)

One-Two Junior Residents (Off-Service or PGY1 - PGY3)

- Perform the following tasks (generally assigned by SPR)
  - MOST COMMON: Reviewing new consult with medical student, then reviewing with staff
  - Rounding on admitted patients in E.D. or managing an inpatient issues in person (B7/GBU/ED)
  - Seeing new consult independently
- May ask for guidance from SPR during the consult process (e.g. if complex case)
- May be asked to handle pager in some situations (e.g. if SPR is seeing a patient)
  - Whenever possible, juniors are encouraged ask SPR about handling ward issues or receiving consults
- Provide case-specific teaching to medical students when reviewing new consults

Two Medical Students

- Perform tasks as per SPR or Junior
  - Tasks include: rounding on admitted patients, gathering history for new consults, reviewing case history with junior or senior resident, physical exams

PARO Contract:

All call schedules need to be supplied to residents and to the PARO office at least two weeks prior to the effective date of the call schedule (meaning prior to the start of the block).

The in hospital maximum is 1 in 4. For a “28-31 day (“one month”) rotation these maximums are:

NUMBER OF DAYS	NUMBER OF CALLS
19-22	5
23-26	6
27-29	7

In hospital call maximums for rotations >1 month can be averaged over the length of the rotation (maximum averaging length is 3 months) with a maximum of 9 calls in any given month. The total number of calls on a rotation longer than one month can be calculated by taking the total of number of days ON service, divided by 4 and rounded to the nearest whole number (.5 rounds up)

You must have 2 COMPLETE weekends off per 28 days; including Friday night/Saturday morning as well as Saturday and Sunday.

TYPE OF STIPEND	AMOUNT	EFFECTIVE JULY 1/19 WEEKEND AMOUNTS
In-hospital	$127.60	$140.36

Call Points:
In order to ensure equity between residents, Western Psychiatry uses a call point system whereby each call shift is worth a set number of points. The goal is to have an equal number of points per cohort for each academic year.

16 hour shift	1 point
24 hour shift	1.5 points
"Rounding" bonus (on weekends and holidays)	0.5 points
Loss of post-call day (on Friday/Saturday/pre-holiday)	0.5 points
Senior Psychiatric Resident Bonus	0.5 points

Frequency:
1:7 for PGY1 / PGY2 / Off-service residents
1:10 for PGY 3
1:12 for PGY 4
1:14 for PGY 5

This translates to approximately:
2 weekdays plus 2 weekends for PGY1/PGY2/Off-service residents
2 weekdays plus 1 weekend for PGY 3
1-2 weekdays plus 1 weekend for PGY 4
1 weekday plus 1 weekend for PGY 5 (excluding subspecialty residents)

Within a cohort, there may be variation in points per resident per block (particularly if extended vacation). The goal is that by the end of the year each cohort has roughly the same number of points to ensure equity in shift numbers and types.

Points do not roll-over to the next year unless exceptional circumstances.

Call Scheduling:
A resident can never be scheduled during their vacation, including the night before vacation starts. See Time Away Policy.

Our internal google calendar allows residents to request days off-call (for example, the night before a presentation or a special weekend away). Residents must be mindful of the target number of call shifts when making requests, such that they are not, for example, requesting 3 weekends off when they are a junior resident.

Permission for permanent requests off-call, for example for personal weekly psychotherapy, can be granted by the Program Director.

Requests to be on-call can also be made through the google calendar. Residents are expected to be considerate to their colleagues when placing such requests.

Of note, google calendar requests can not always be accommodated, that is, they are requests only. This is in contrast to one45 vacation requests which will be accommodated if the resident has been given permission to be on vacation.

Trading of a call shift is allowed if a conflict arises, including illness. Please see Backup Call section below. Residents must inform both the PGE and the Chief Resident of any trade. Call points are updated based on the shift worked, not the initial shift assigned. Therefore, if a resident trades a weekend for a weekday, they would be expected to "make-up" for the weekend shift at a later date.

Every effort will be made to ensure that residents work with a wide array of their colleagues. Trading shifts frequently to be with certain individuals is discouraged and may be reviewed.

Extended Periods Off Call:

Electives:

Residents may be off the call schedule for up to 3 months for external electives. Western Psychiatry Elective Policy allows residents to do up to 6 months of external electives, with the approval of the Program Director. See Elective Policy for more details. Therefore, if a resident chooses to take 6 months off call for electives, they must make-up 3 months of call when they return.

Pregnancy Leave:

PARO-CAHO Agreement states that "in no event will a resident be scheduled or required to participate in on call duty after twenty-seven (27) weeks gestation unless otherwise agreed to by the resident". As well, residents have the right to have their workload modified somewhat because of the physical limitations caused by pregnancy to enable continued training with minimal interruption. For Western Psychiatry, residents may elect to stop doing call at any point during their pregnancy, particularly if there are any concerns for safety.

For the purposes of call, the resident on leave will be scheduled at the same frequency of shifts that they would have had during their pregnancy when they return. For example, if a resident stops doing call at 24 weeks gestational age and then starts a maternity leave at 38 weeks coinciding with the start of a new academic year, then they would still have to do 14 weeks of call at the previous academic year's frequency before progressing.

Illness Leave:

As an illness leave cannot be predicted in most circumstances, back-up call policy would most frequently apply. In general, time missed needs to be made up (see Time Off Policy), at which point the call missed would also be made up. If it is a brief illness that does not prolong residency, the expectation is that residents would make up the call missed over the course of the academic year.

Backup Call Coverage:

Backup call is a systematic means of providing coverage in the event that a resident is unable to fulfill their scheduled duty ("backup call scenario"). The "backup resident" will not be utilized to provide additional coverage (beyond scheduled clinicians) in the event of extreme clinical demands.

Who Provides Coverage?

- The Chief Resident and the Assistant Chief Resident are responsible for the majority of backup call
    - The Chief and Assistant Chief alternate months for “first call” for backup. They can be scheduled relatively fewer calls during that block if they wish.
    - The second backup shift required in a block goes to the alternate Chief/Assistant Chief - “second call”
        - The second person takes the backup call if the “first call” resident is pre-call, on-call or post-call
    - The third backup shift required in a block goes to a Senior Resident
        - Senior Residents divide the year amongst themselves to be “third call” (e.g. 4 months per resident). In the event that a Senior Resident takes a backup call shift, then the next Senior Resident begins their rotation to be “third call”.
        - If the Chief of Assistant Chief are on vacation then the Senior Resident becomes “second call”

<u>When Is Coverage Required?</u>

- A **backup call scenario** occurs when a resident cannot perform on-call duties due to unforeseen circumstances, including medical emergencies (e.g. severe illness) and family emergencies (e.g. death or funeral).
    - Other potential non-emergency “backup call scenarios” include situations in which a resident is removed from the call schedule after it has been sent out (e.g. when resident placed on medical leave / hospitalized, compassionate leave, or when resident taken off the call schedule by the RPC due to remediation)
    - If a resident wants to change a shift but it is not a “backup call” scenario, it is the responsibility of that resident to find their own coverage.
- At any point when a resident is unable to perform call and it is a backup scenario, they should contact the chief resident and PGE office as soon as possible of the illness/emergency.
    - Residents are encouraged to attempt to arrange a shift swap if possible, but this may not be feasible in many backup call scenarios.
    - If a swap is not possible, then the Chief resident or alternate (as described above) takes the call shift
        - The expectation is that the resident who missed a call shift makes it up at a later date (that is, in effect, they are trading with the “backup resident” who will do 1 less shift in the future)
        - If there is an extended leave, nearing a month or greater, then a resident would make up that call during the “extra” block of residency (beyond typical residency) and would not be required to make it up within the academic year
        - If there is no extension to training, the resident is expected to make up the call shift(s) during the academic year or shortly thereafter if the emergency takes place in June

<u>How Is Coverage Provided?</u>

- In the event of a backup call scenario that occurs **prior** to the shift beginning, the backup resident should provide a full night of call and would assume the role of either the senior or junior resident.

- In the event of a backup call scenario that occurs **during** a call shift (e.g. if the SPR becomes unwell at 20:00), the backup resident should go in to provide coverage if necessary
    - In arranging backup coverage for a resident partway through the night, considerations include:
        1. When the notification for backup coverage occurs (i.e. early vs. late shift)
            a. If notification occurs later in the shift, what is the current workload?
        2. Who are the other members of the call team during the shift?
            a. Is it a night with no medical students?
            b. Are there two high-seniority residents still present?
            c. Is a child subspecialty resident on call that day?
    - At a minimum, the backup resident should be *available* to provide coverage for the majority of the shift
- If covering for a junior resident, the backup resident is not obligated to assume the role of SPR. In this case, the SPR should divide up service duties such that the resident providing emergency coverage is the first to be dismissed (e.g. in a “splitting” scenario). In other words, it is not an expectation that the backup resident performs clinical duties throughout the night while the other junior resident or senior resident are allowed to sleep.

        - This allows for the backup resident to provide backup without interfering with clinical duties the next day, as a post-call may not be possible.