Windsor Psychiatry Residency

(Site-Specific Document)

CONTACT INFORMATION

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INTRODUCTION

- Welcome to Western University psychiatry in Windsor!
- Our program is a small tight-knit group which allows for close one-on-one interactions with each other, as well as with staff psychiatrists.
- This not only allows for enhanced learning experience, but also allows for increased unique program opportunities with each other described below.
- Our committees and groups strive to ensure the best experience possible while learning at the Windsor distributed-education site of Western psychiatry!

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POST-GRADUATE EDUCATION PSYCHIATRY ADMINISTRATIVE SUPPORT

Windsor Schulich Coordinator
Alex Carson
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London Health Sciences Centre- Victoria Hospital
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Phone: 519.685.8500, ext. 75701
Email: PGEPsychiatry@lhsc.on.ca

- The Schulich coordinators will provide you with weekly, monthly and yearly updates for your residency in Windsor from PGY 1-5. Their roles include building your residency schedules, ensuring evaluations are submitted, tracking vacation, setting up Thursday video conference lectures and assisting with any rotation questions or inquiries you may have.
- As a Windsor resident, you will primarily communicate with Alex Carson, but in the following instances, ensure you cc: the PGE Psychiatry coordinators (PGEPsychiatry@lhsc.on.ca) so they are aware of any changes:
    - **Vacation** – approvals
    - **Time away** – sick or education leave
    - **Funding** – Includes travel reimbursements when going to London and resident allowance
- Any scheduling, rotation concerns, undergrad teaching or Windsor specific residency information can be sent to Alex.

WINDSOR PSYCHIATRY COMMITTEE ROLES

Residency Program Committee Members (and Chief Resident)
2024-2025 Leads: Dr. Tanuj Sharma (PGY-4), Dr. Levang, Dr. Botsford
Act as the liaison point between staff and residents. Attend the Residency Program Committee meetings to liaise between London and Windsor. Function to coordinate resident activities and Windsor specific Programming. Organize the Windsor orientation weeks and site visits for incoming PGY-1s. Prepare the psychiatry on-call schedules for residents and medical students.

Windsor Wellness Representative (*2 representatives)*
2024-2025 Lead: Tanuj Sharma (PGY-4) and Dr. Priya Sharma

- Organize the annual Windsor Psychiatry Residents Wellness retreat
- Organize food and refreshments for Windsor groups and meetings
- Liaise with residents to schedule and organize regular gatherings to promote resident cohesiveness and wellness
- To collaborate with London Wellness Committee Lead, Dr Laura Powe (London)

CaRMS Windsor Representative(s)
2024-2025 Leads: Dr. Botsford and Dr. Levang

- Liaise with the London PGME office to aid in the initial file review process for CaRMS applications to the Psychiatry PGME program
- Attend meetings on a regular basis via Zoom with London PGME office to discuss the CaRMS application process
- Attend the CaRMS interview days, rank meeting, and post-match meeting

Undergraduate Medical Education (UGE) Committee
2024-2025 Leads: Dr. Bridgen

- Liaise between PGE Psychiatry and the UGE Academic Director
- Coordinates resident teaching for medical students
- Coordinates the Clerkship Psychiatry Professorial Rounds with the Research Committee
- Communicates with the UGE Psychiatry Interest Group lead to help with programming (e.g. Meet-and-greet, mentorship groups, shadowing experiences)

Competency Based Medical Education (CBME) Representative
2024-2025 Leads: Dr. Levang & Dr. Botsford

- Liaise with the London PGME office to develop programming consistent with CBME development.

Research Committee
2024-2025 Lead: Dr. Priya Sharma

- Acts as point of contact for residents with regards to research programming.
- Facilitates regular meetings and check-ins with the staff research coordinator.
- Coordinates the Clerkship Psychiatry Professorial Rounds with the UGE Committee

Safety Committee
2024-2025 Leads: Dr. Botsford, Nick Laird (PGY-2)

- Responsible for ensuring trainee safety (residents and medical students) both at Windsor Regional Hospital and Hotel-Dieu Grace Healthcare sites.
- Implementation of safety measures including code white training, panic alarms, use of screamers, and policies/procedures with regards to trainee safety

Academic Advisors
2024-2025 Leads: Dr. Levang, Dr. Botsford

- Help provide ongoing longitudinal support to residents to ensure competencies and goals are met over the course of residency

WINDSOR SITE-SPECIFIC PROGRAMMING

Windsor Academy of Psychiatry (WAP)
Lead: Dr. Villella & Dr. Velehorschi

- **Is this mandatory? No, but recommended**
- The Windsor Academy of Psychiatry (WAP) is a non-profit organization of psychiatrists practicing in the Windsor and Essex County
- Membership fee is waived for residents in the Windsor Psychiatry Program
- Membership grants admission into the annual psychiatric symposium
- Opportunities are available for residents to attend general meetings for discussion around clinical issues, program development, and service delivery in the community
- Contact Information: windsoracademyofpsychiatry@gmail.com

Professorial Rounds Presentations
Lead: Dr. Bridgen

- **When? Monday evenings every six weeks**
- **Is this mandatory? Yes**
- Medical students rotating through psychiatry clerkship are tasked to complete a research project at the end of their block
- This is an opportunity for the students to ask and answer a focused and relevant question in the care of a psychiatric patient (e.g. Diagnostic tools or treatment options)
- Residents are involved as a teaching opportunity as well to assist in selecting a focused research topic

WINDSOR RESIDENT PSYCHOTHERAPY CLINIC

Windsor Psychotherapy Lead: Dr. Kristina Levang

This section outlines the Windsor psychotherapy training based on the University of Western Ontario and Royal College of Physicians and Surgeons of Canada training requirements.

Please review the following section as a companion to the UWO Department of Psychiatry Resident Psychotherapy Guide. There, you will find information for:

- Types of psychotherapies required in training
- Learning objectives and competencies
- Evaluations
- Logging hours for psychotherapy
- Suggested resources for study

Psychotherapy Residency Training Requirements – refer to Psychotherapy Handbook

Windsor Protected Time for Psychotherapy

- Psychotherapy training starts in PGY-2 year
- Windsor psychotherapy training is accommodated through the Windsor Resident Psychotherapy Clinic at HDGH.
- Tuesday afternoons are recognized as protected time to allow residents to participate in psychotherapy training. The clinic is structured such that:
    - 1:00 PM to 3:00 PM – patient encounters
    - 3:00 PM to 4:00 PM – group supervision with Dr. Levang
- It is expected that the resident will schedule patients accordingly for psychotherapy with review of his/her own call schedule and vacation time
- Location: HDGH, 1453 Prince Rd, 3rd floor CPH

WINDSOR INTERVIEW SKILLS SEMINARS

Introduction

- The psychiatric interview consists of two components:
  - (1) content, which is the actual information derived from the patient and,
  - (2) process, which is how the information is obtained from the patient
- By nature of the specialty, patients disclose sensitive information. Therefore, psychiatrists must be adept at navigating the interview to ensure the patient is comfortable in sharing the information
- The objective of the interview skills course is to:
  - Learn about the components of the psychiatric interview
  - Practice interview techniques in an observed environment

Course Text

- Psychiatric Interviewing, The Art of Understanding, 3rd ed. (2017), by Dr. Shawn Shea

Session Structure

- The interview skills seminars are delivered as a regular component of academic day
  - 10:00 AM – 10:30 AM – Didactic learning and preparation for interview
  - 10:30 AM – 11:30 AM – Observed interview
  - 11:30 AM – 12:30 PM – Interview debrief
- Patients are often recruited to help trainees practice interview skills. This allows for discussion of psychopathology and learning of phenomenology
  - Therefore, it is a professional expectation that trainees are present for the interview skills seminars
- **This may occur in-person with Windsor faculty, or by Zoom with London**

PGY-1 Interview Skills Schedule (EXAMPLE SCHEDULE – SUBJECT TO CHANGE)

Date	Time	Topic	Facilitator
August	10:00 am – 12:30 pm	PGY 1-	Via WebEx with London
September	10:00 am – 12:30 pm	PGY 1-	Via WebEx with London
October	10:00 am – 12:30 pm	PGY 1-	Via WebEx with London
November	10:00 am – 12:30 pm	PGY 1-	Via WebEx with London
December	10:00 am – 12:30 pm	PGY 1-	Via WebEx with London
January	10:00 am – 12:30 pm	PGY 1-	Via WebEx with London
February	10:00 am – 12:30 pm	PGY 1-	Via WebEx with London
March	10:00 am – 12:30 pm	PGY 1-	Via WebEx with London
April	10:00 am – 12:30 pm	PGY 1-	Via WebEx with London
May	10:00 am – 12:30 pm	PGY 1-	Via WebEx with London
June	10:00 am – 12:30 pm	PGY 1-	Via WebEx with London

PGY-1 Interview Skills Learning Objectives

By the end of each session, trainees will be able to…

Session #1: Foundations of the Psychiatric Interview
Readings: Chapter 1 (The Delicate Dance), Chapter 2 (Beyond Empathy)

- List the required components of the psychiatric consultative interview
- List the stages of the clinical interview
- Define therapeutic alliance and empathy
- List the factors that affect the therapeutic alliance

Session #2: The Mental Status Exam
Readings: Chapter 16 (The Mental Status), Chapter 6 (Understanding the Person)

- List the components of the mental status exam
- Understand the dynamic nature of the mental status exam
- Develop an understanding of the patient in terms of strengths, skills and hobbies
- Understand the nature of culture on mental status and patient presentation
- Summarize and present the patient presentation as a case

Session #3: Suicide Risk Assessment
Readings: Chapter 17 (Exploring Suicidal Ideation), Chapter 5 (Validity techniques)

- Differentiate between static and dynamic suicidal risk behaviours
- List examples of protective risk factors
- Differentiating chronic suicidal risk vs. imminent suicidal risk
- Use a chronological, organized, and open approach to assess suicidal risk in a psychiatric consultative interview
- Utilize techniques of validation and normalization in exploring sensitive materials

Session #4: Violence Risk Assessment
Readings: Chapter 18 (Exploring Violent and Homicidal Ideation), Chapter 8 (Non-verbal Behaviour, parts 1-2 only)

- List examples of risk factors for violence
- List examples of non-verbal de-escalation techniques
- Use a chronological, organized, and open approach to assess homicidal risk in a psychiatric consultative interview

Session #5: The Social and Personal History
Readings: Chapter 7 (Assessment Perspectives and the Human Matrix)

- List the components of the personal history
- List the dimensions of the patient's psychosocial system
- Understand the value of the psychosocial context in the patient clinical diagnosis and how it makes the presentation unique
- Utilize previously learned interview techniques to elegantly and gracefully interview patients for a thorough social and personal history
- Summarize and present the patient presentation as a case

Session #6: Introduction to Formulation
Readings: Chapter 3 (Dynamic Structure of the Interview), Chapter 4 (Facilics)

- Recap on what has been covered in the course to date
- List the 4 P's of formulation in the biopsychosocial framework
- Identify content and process regions of the diagnostic interview
- Utilize and apply facilics to navigate between content and process regions sensitively
- Summarize and present the patient presentation as a case
- Utilize the biopsychosocial framework for formulation

Session #7: MOCK STACER
Readings: None

- Understand the format of the STACER
- Utilize the techniques learned to date to sensitively interview a patient
- Summarize and present the patient presentation as a case
- Utilize the biopsychosocial framework for formulation

Session #8: Depressive Disorders
Readings: Chapters 9 + 10 (Mood Disorders)

- List the differential diagnosis of mood disorders
- Utilize the techniques learned to date to sensitively interview a patient
- Summarize and present the patient presentation as a case
- Utilize the biopsychosocial framework for formulation

Session #9: Bipolar Disorders
Readings: Chapters 9 + 10 (Mood Disorders)

- Recognize the value of the reproductive history in bipolar disorder
- List the differential diagnosis of mood disorders
- Utilize the techniques learned to date to sensitively interview a patient
- Summarize and present the patient presentation as a case
- Utilize the biopsychosocial framework for formulation

Session #10: Psychotic Disorders
Readings: Chapters 11 + 12 (Psychotic Disorders)

- List the differential diagnosis of psychotic disorders
- Utilize the techniques learned to date to sensitively interview a patient
- Summarize and present the patient presentation as a case
- Utilize the biopsychosocial framework for formulation

Session #11: Personality Disorders
Readings: Chapters 13 + 14 (Personality Disorders)

- List the differential diagnosis of personality disorders
- Utilize the techniques learned to date to sensitively interview a patient
- Summarize and present the patient presentation as a case
- Utilize the biopsychosocial framework for formulation

PGY-2-5 Interview Skills Schedule (EXAMPLE SCHEDULE – SUBJECT TO CHANGE)

Date	Time	Topic	Facilitator
August	10:00 am – 12:30 pm	PGY 2—5- MOCK STACER	Dr.
September	10:00 am – 12:30 pm	PGY 2—5- MOCK STACER	Dr.
October	10:00 am – 12:30 pm	PGY 2—5- MOCK STACER	Dr.
November	10:00 am – 12:30 pm	PGY 2—5- MOCK STACER	Dr.
December	10:00 am – 12:30 pm	PGY 2—5- MOCK STACER	Dr.
January	10:00 am – 12:30 pm	PGY 2—5- MOCK STACER	Dr.
February	10:00 am – 12:30 pm	PGY 2—5- MOCK STACER	Dr.
March	10:00 am – 12:30 pm	PGY 2—5- MOCK STACER	Dr.
April	10:00 am – 12:30 pm	PGY 2—5- MOCK STACER	Dr.
May	10:00 am – 12:30 pm	PGY 2—5- MOCK STACER	Dr.
June	10:00 am – 12:30 pm	PGY 2—5- MOCK STACER	Dr.

PGY-2-5 Interview Skills Learning Objectives

Session #1: Anxiety Disorders

- List the differential diagnosis of anxiety disorders
- List the cognitive distortions common in anxiety disorder
- Utilize the techniques learned to date to sensitively interview a patient
- Summarize and present the patient presentation as a case
- Utilize the biopsychosocial framework for formulation

Session #2: Obsessive-Compulsive/Post-Traumatic Stress Disorders

- Understand the phenomenology of obsessions and compulsions
- List the diagnostic clusters in PTSD
- Utilize the techniques learned to date to sensitively interview a patient
- Summarize and present the patient presentation as a case
- Utilize the biopsychosocial framework for formulation

Session #3: Substance Use Disorder / Gambling Disorder

- List the diagnostic clusters in substance use disorders
- Utilize the techniques learned to date to sensitively interview a patient
- Summarize and present the patient presentation as a case
- Utilize the biopsychosocial framework for formulation

Session #4: First Episode Psychosis

- List a differential diagnosis for psychosis
- Utilize the techniques learned to date to sensitively interview a patient
- Summarize and present the patient presentation as a case
- Utilize the biopsychosocial framework for formulation

Session #5: Severe-Persistent Mental Illness

- Understand the recovery framework in interviewing SPMI patients
- Utilize the techniques learned to date to sensitively interview a patient
- Summarize and present the patient presentation as a case
- Utilize the biopsychosocial framework for formulation

Session #6: Attention-Deficit Hyperactivity Disorder

- List the diagnostic clusters in ADHD
- Utilize the techniques learned to date to sensitively interview a patient
- Summarize and present the patient presentation as a case
- Utilize the biopsychosocial framework for formulation

Session #7: The Child and Adolescent Interview

- Understand the value of collateral history in the child and adolescent interview
- Understand the family structure and family centered care

- Utilize the techniques learned to date to sensitively interview a patient
- Summarize and present the patient presentation as a case
- Utilize the biopsychosocial framework for formulation

Session #8: Dual-Diagnosis Patients

- List the diagnostic criteria for autism spectrum disorders
- Understand the value of collateral history in the dual diagnosis patients
- Utilize the techniques learned to date to sensitively interview a patient
- Summarize and present the patient presentation as a case
- Utilize the biopsychosocial framework for formulation

Session #9: The Geriatric Interview

- Understand the value of collateral history in the geriatric interview
- Understand the family structure and family centered care
- Utilize the techniques learned to date to sensitively interview a patient
- Summarize and present the patient presentation as a case
- Utilize the biopsychosocial framework for formulation

Session #10: Dementia Patients

- List the differential diagnosis of major neurocognitive disorders
- Administer cognitive testing (both MMSE and MoCA) and interpret the results
- Utilize the techniques learned to date to sensitively interview a patient
- Summarize and present the patient presentation as a case
- Utilize the biopsychosocial framework for formulation

Session #11: Medically Ill Psychiatric Patients

- Understand the practical limitations of interviewing on a medical ward
- Utilize the techniques learned to date to sensitively interview a patient
- Summarize and present the patient presentation as a case
- Utilize the biopsychosocial framework for formulation

Session #12: Forensic Assessment

- List the diagnostic criteria for antisocial personality disorders
- Utilize the techniques learned to date to sensitively interview a patient
- Summarize and present the patient presentation as a case
- Utilize the biopsychosocial framework for formulation

WINDSOR ON-CALL STRUCTURE

Introduction

- The Windsor on call experience is fully supported by psychiatry residents and staff psychiatrists.
- Residents on Psychiatry rotations in PGY-1 to PGY-5 will be on call on as a part of their training, specifically to satisfy the Royal College requirement of emergency psychiatry.
- First and foremost, it is important to understand that the role of the on-call experience is both for learning and service requirements.
- If there are any issues that arise on call with regards to safety, unprofessional conduct, inappropriate referrals, etc., please notify the staff psychiatrist immediately so that he/she can support the resident. The program director should be notified afterwards to review the incident.

Safety Requirements in Psychiatry

- Trainees (residents and clinical clerks) in the emergency room (ER) must carry a personal alarm (PAL)
    - It is the responsibility of the trainee to routinely test the functionality of the PAL system.
    - PAL systems can be obtained from security (WRH-Ouellette Campus parking garage) prior to starting a call shift.
- Trainees must be familiar with how to obtain assistance with security staff and their role in learner and patient safety.
- Trainees in the emergency room must be aware of the precaution notices commonly used in the emergency room and MHAU.
    - E.g. Open seclusion door only if two-staff present
- Trainees must be familiar with common verbal de-escalation techniques, and use of both chemical and physical restraints

There are many stressors on call, but you are there to learn.
Therefore, know your limitations, practice within them, and never be shy to ask questions and to ask for help.

RESIDENT ON CALL REQUIREMENTS AND EXPECTATIONS

Hours of Call

- Call for the resident begins at 3 pm (1500 hours) Mon/Tues/Wednesday and 5pm (1700 hours) on Thursday to accommodate academic lectures. Termed “HOME CALL” per scheduling/PARO guidelines.
- The resident will be excused from usual clinical duties to attend call. The resident should be excused with enough travel time to be in the Mental Health Assessment Unit (MHAU) by 3:00pm
- Evening call ends firmly at 11:00pm. No exceptions. Residents must be out of the MHAU by 11:00pm. However, there may be paperwork and other items to wrap up duties such that all work is firmly completed by midnight. The resident will then attend scheduled rotational duties the following day (No post call day)
- Residents answer pages until 11 pm (2300 hours). Ward issues will be managed by Staff Psychiatrist between 2300-0700.

Alignment with PARO Contract

(c) For clarity, the right to be relieved of duties by 1200 hours under either 16.4 b (i) or (ii) applies to a resident on out-of-hospital call in either of the following two circumstances:

i. a resident who commences work in the hospital after midnight but before 6 a.m.; and,
ii. a resident who works for at least four (4) consecutive hours at least one hour of which extends beyond midnight.

- A resident who is scheduled on home call but who works more than four hours in hospital during the call period, of which more than one hour is past midnight and before 6 a.m., is entitled to be paid the in-hospital call stipend. PARO agrees that the hospitals have the right to implement reasonable rules to verify that residents are entitled to be paid the in-hospital call stipend rate for that call.

On Call Evaluations

- Evaluation of the resident on call MUST be done at the end of EVERY shift.
- It is the responsibility of the resident to initiate this process in ONE 45.
    - Ensure if required, a paper copy of the On Call evaluation is given to faculty to complete if they are not listed in ONE45 and trigger the assessment in ONE45 as well. Send Alex Carson the completed paper based on call assessment to be inputted into ONE45.
- It is the responsibility of the staff to complete the resident evaluation ideally before the end of the shift (at latest, 2-weeks after that shift)
- The resident shall evaluate the on-call psychiatrist through ONE45 or Elentra.

Graded Level of Responsibility

- The Windsor psychiatry on call experience provides a graded level of responsibility and expectations.
    - PGY-1: Exposure into the ER; with Psychiatry Staff, no Emergency Room Physician (ERP) direct referrals to MHAU; will complete 1 block of Emergency Psychiatry outside of on-call schedule.
    - PGY-2: Development of core emergency Psychiatry skills; working with Psychiatry Staff for direct supervision until October 1st. After October 1st, PGY2's will receive Emergency Physician direct referrals to MHAU (please see PGY2 transition below). Can receive Psychiatry ward calls.
    - PGY-3 and above: Exposure into the MHAU independently; no Psychiatry staff requirement. Will receive direct referrals from ERP for the MHAU and handle hospital ward issues between 1500-2300 (3pm-11pm). Not responsible for bed management, or assessment wait times. Should more than 5 patients be awaiting assessment in the MHAU, staff should accompany senior residents to help with MHAU flow.

Call Frequency (*Note this is an evolving model and subject to change*)

- PGY-2 residents complete approximately 4 call shifts every 5 weeks
- PGY-3 residents complete approximately 3 call shifts every 5 weeks (excluding time on child psychiatry)
- PGY-4 residents complete approximately 1-2 call shifts every 5 weeks (reduced frequency for Royal College)
- PGY-5 residents complete approximately 3 calls shifts every 5 weeks. Some shifts will be independent and some shifts will be with junior residents to provide teaching experience in preparing for Transition to Practice

RESPONSIBILITIES OF THE RESIDENT ON CALL (PGY 2 OCTOBER – JUNE; PGY3-5)

- Windsor Regional Hospital (WRH) – Ouellette Emergency Room (ER/MHAU) Consultation
    - The resident will perform appropriate assessments to determine suitable management and dispositions for patients in the ER/MHAU
    - The resident will appropriately document assessment and management planning.
    - The resident will work with the PAN nurse, social worker, and staff to determine if an admission is appropriate and to provide admission orders, as necessary. Or if safe to do so, facilitate discharge from MHAU.
- Management of Acute ER and Ward Issues
    - The resident will manage acute emergencies in the MHAU and Psychiatry floor issues between 1500-2300 including:
        - Acute agitation
        - Sedation
        - Psychiatric emergencies e.g. Acute dystonic reactions, serotonin syndrome
        - Form status
        - Medical issues
    - The resident will appropriately document assessment and management
- Liaison with Community Hospital Sites
    - The resident will perform Ontario Telemedicine Network (OTN) assessments for patients from WRH – Metropolitan Campus
    - The resident will communicate with physicians from community hospital sites (e.g. Erie Shores Healthcare or Chatham-Kent Health Alliance) to determine if there is a need for patient transfer and admission to acute care psychiatry. The resident will provide admission orders, as necessary.
- Supervision of Junior Learners (M3-M4 student)
    - The resident (PGY1-5) will provide the appropriate level of teaching and supervision according to their level of training.
    - This includes ensuring safety of learners.

SPECIAL RESIDENT ON CALL CONSIDERATIONS

PGY-1 Orientation Block and Psychiatry Rotations

- PGY-1 residents on orientation month will be put on shadow call once during this block to obtain initial call experience.
- PGY-1 residents will be put on service call 2-3 times per psychiatry block.
- PGY-1 residents will receive direct supervision with either staff psychiatrist or will accompany PGY4/5.

PGY-2 Transition Period (July, August, September)

- PGY-2 residents will be accompanied by staff psychiatrist to observe direct emergency physician referrals. PGY-2 residents are to take this time to learn what appropriate referrals are to the MHAU (Mental Health Assessment Unit). If you are questioning a referral, PLEASE contact staff on call to discuss case before accepting referral.
- Psychiatry staff will be readily available (on site) to review patients in person when needed.

PGY-3 Transition Period

- PGY-3 residents who have been away from adult on call structure during 6-month child and adolescent block will have the opportunity to accompany a senior resident PGY 4 or PGY 5 for 1-2 shifts to reorient themselves to the adult MHAU call shift.

RESIDENT ON CALL SCHEDULE

Chief Resident Responsibilities

- A Google Calendar will be used to facilitate on call scheduling.
- The chief resident will suggest the call schedule **1 month** before the start of the next block.
- The final call schedule is submitted to the Assistant Program Director and Scheduling Clerks at WRH, 1 month to the start of the next block so it can be posted on the Intranet.
- Vacation time and no-call requests must be made before this time.
- Chief resident will be responsible for updating the call schedule on the white board in the physician on call room.

5-Week Call Schedule

- Call scheduling is done by the chief resident based on a 4–5-week schedule.
- It is the chief resident's responsibility to ensure shifts are assigned such that:
    - There is balanced call for residents across different days of the week, (i.e. only one Thursday shift per month; fair distribution of Friday and weekend shifts).
    - Call frequency for residents of different years is met.
    - There are pairings of junior and senior residents, when appropriate, to allow for learning of the graded responsibilities from junior to senior years
    - On-call/no call requests are considered with high priority, but not guaranteed.

Vacation/Call/No Call Requests

- Residents will indicate on Google Calendar vacation, on-call, and no-call requests.
    - The rotation supervisor must approve vacation prior to this request.
    - You are excused from call (and points do not need to be made up). Note this excludes PGY4s, since call frequency is already reduced.

Changes to the Finalized Call Schedule

- The chief resident will make a draft schedule, considering requests, to be reviewed by residents prior to publishing of the finalized call schedule. This is the time for residents to make shift swaps in consultation with the chief resident.
- ***Every effort should be made to follow the finalized call schedule. In the event of illness or an emergency that necessitates a call swap or shift cancellation (last resort for unforeseen circumstances), the chief resident, attending psychiatrist, scheduling/ER clerk and Alex Carson should be notified as soon as possible.***

Points System

- Call shifts scheduled on weekdays are worth 1 point.
    - Monday, Tuesday, Wednesday, Thursday to be submitted as PARO "Home Call"
- When on call on a statutory holiday, a Lieu Day is credited in accordance with PARO guidelines.
- Any call on a long weekend/holiday is equivalent to 2 call days (2 points).

SUBMIT ON CALL CLAIM FORM TO callschedules@lhsc.on.ca

- An email will be sent out asking for your on-call claim form. To ensure you are paid appropriately, please send it before the deadline given.
- See last page in the Windsor site document for on-call claim form

STAFF PSYCHIATRIST ON CALL REQUIREMENTS AND EXPECTATIONS

The staff on call psychiatrist is:

- Always available by phone.
- Expected to assist the resident on site if the volume of patient care is too high
    - One resident and the number of referred patients is 5 or more.
    - Nearing end of evening and number of patients waiting to be seen exceeds resident's time
        - **It is the staff psychiatrist's responsibility to ensure patient flow is maintained and that patients are not held in MHAU unnecessarily overnight
    - As courtesy, the resident should notify the psychiatrist on-call as early as possible once the numbers in the MHAU have been established.
    - The staff psychiatrist/PAN is responsible for referred patients to MHAU that are remaining past 11pm.
    - For PGY 1 residents' staff should be available in person to support the resident, PGY1-2 can start assessments without staff and review once staff arrives in MHAU.
    - PGY2 residents' staff should be available in person from July-Oct to allow residents to observe direct emergency physician referrals and to review patients in person.
- Expected to cover the MHAU on Thursdays from 1500 – 1700, and complete assessments for patients who are waiting to be seen during this window of time to ensure maintenance of patient flow while the residents are at their protected academic day
- Responsible for providing timely and objective feedback to the trainee as expected in a competency-based medical education (CBME) framework.
    - Staff are expected to complete trainee evaluations ideally before the end of the shift (at latest, 2-weeks after that shift)
    - Adherence to evaluation completion will be reviewed regularly. If a staff has at least 10 overdue evaluations:
        - If this is the first instance of such event occurring, an email prompt will be delivered to the staff as a reminder to complete evaluations.
        - If this is the second instance of such event occurring, then residents shall not be assigned to that staff until such evaluations are completed.
- Responsible for supporting the resident with safety and professional conduct.
    - If there are any issues that arise on call with regards to safety, unprofessional conduct, inappropriate referrals, etc., please notify the staff psychiatrist immediately so that he/she can support the resident.
    - The program director should be notified afterwards to review the incident, and formal documentation of the event to be completed by the resident.
- Responsible for approving direct admissions to the ward.
    - The resident psychiatrist CANNOT approve direct admissions to the unit without assessment.
- The staff psychiatrist is responsible for overnight issues after 11:00pm

- The resident will have been expected to wrap up as much of the outstanding issues prior to the end of his/her shift.
- The resident is to use their discretion when reviewing referrals towards the end of the shift. E.g. Residents receiving referrals beyond 2230hrs (1030pm). If the resident does not feel they can complete the consultation and documentation prior to 2300hrs (11pm), it will not be the resident's responsibility to stay beyond the 2300 cut off to do so. Residents are expected to return to scheduled rotational duties the following day to assist in continuance of patient care and reduce rotation interruption.

CLINICAL CLERKS ON CALL

Hours of Call

- Clerks should arrive around 5:00pm to the MHAU office. (hours may differ with academic lectures)
- Clerks MUST be released from call by 10:00pm. No exceptions. Clerks must have completed all on-call duties (including dictations, orders, etc…) by 11:00pm.
    - Clerks should not pick up any new cases after 8:30pm to anticipate being able to wrap up and leave the ER by 10:00pm
- Clerks return to normal clinical duties the next morning.

On Call Evaluations

- Evaluation of the clerk on call MUST be done at the end of EVERY shift.
- It is the responsibility of the clerk to initiate this process.
- It is the responsibility of the supervisor to complete the clerk evaluation ideally before the end of the shift (at latest, 2-weeks after that shift) Psychiatry staff or Resident can complete this documentation.
- The clerk shall evaluate the on call supervisor through one45/Elantra

Responsibilities of Supervisors (Resident or Staff) For Clerks On Call

- The supervisor shall act as a teacher for the trainee in the emergency room which may include up to all the following:
    - Observing and providing feedback for interview skills
    - Refining the trainee's mental status exam
    - Providing feedback for presentation and synthesis skills
    - Teaching around the case
- The supervisor shall ensure that a patient is safe to be seen by the trainee.
    - Best practice is for the supervisor to introduce the patient to the trainee and obtain permission for the trainee to assess.
- The supervisor shall triage to determine which case will be valuable for learning.
- The supervisor MUST see the patient reviewing the case presentation before determining final management.

Responsibilities of The Clerk on Call

- Conducting the initial interview of the patient in the MHAU
- Reviewing hospital charts, labs, investigations, etc.….
- Presenting the case to the supervisor (resident or staff)

Clerk on Call Schedule

- Each clerk will be on call approximately 3-4 days during the 4-week block.
    - This includes one Saturday and one Sunday on call

WINDSOR CHIEF RESIDENT

Introduction

- The chief resident is a leadership role for a resident to represent the program, contribute to program development, and provide structure/supports to the residents

Application Requirements

- The resident must be in their PGY-3 year (or higher)
- Must have no prior major academic concerns (e.g. Probation)
- The chief resident will be voted on by the Residency Program Committee on basis of:
    - Submission of a Letter of Intent
    - Submission of the Curriculum Vitae

Chief Resident Responsibilities

- Make and manage the call schedule
    - Be aware of the PARO guidelines for making the call schedule
    - Approve vacations on ONE45 and monitor call request / no-call request calendar
    - Submit schedule 4 weeks prior to each block to PARO, PGE, residents (or earlier, in case of winter holidays)
    - Coordinate call substitutions / swaps when needed
- Represent the department
    - Liaison between hospital admin / residents / PGE / UGE / PARO / etc.
    - Represent department at events such as UGE Psychiatry days, etc.
    - Speak at CaRMS interview days, Medical Student Orientation week
- Leadership / administrative role in hospital and department
    - Sit on SWCAC and other resident committees in Windsor
    - Orientation for PGY-1 (meet-up in June, orientation in July, emails as needed)
- Represent the residents of the program in committees
    - Monthly meetings: UGE psychiatry committee, RPC
    - CaRMs committee member (incl. file reviews, program interviews)
    - Meetings with PGE, Academic Director of Psychiatry as needed
    - HDGH meetings; Mental health and addictions Program meeting, Medical Quality Assurance Committee
- Designating responsibilities and roles to other residents as appropriate
- Addressing issues of concerns, education and professionalism in the program
- Working with the program director and support staff directly to manage and improve concerns

PGY-1 MANDATORY ROTATIONS

Introduction

- The PGY-1 rotations in Windsor are set such that they provide a broad range of clinical experiences in order to consolidate learning as a medical student
- PGY-1 is organized in 4-week blocks, with a total of 13 blocks

Rotation Structure

- Psychiatry Orientation Block x 1 block
  - **Coordinator**: Dr. Kristina Levang
  - **Contact**: krislevang@hotmail.com
- Family Medicine x 1 block
  - Rotation will be preceptor dependent
- Emergency Medicine x 1 block
  - **Coordinator**: Dr. Mucciaccio
  - **Contact**: mucciac@gmail.com
- Internal Medicine Clinical Teaching Unit (CTU) x 1 block
  - **Coordinator**: Nikesh Adunuri
  - **Contact**: nadunuri@uwo.ca
- Adult Neurology x 1 block
  - **Coordinator**: Dr. Maria Bres Bullrich
  - **Contact**: Maria.BresBullrich@wrh.on.ca
- Paediatric Neurology x 1 block
  - **Coordinator**: Dr. Hema Gangam
  - **Contact**: hgangam@uwo.ca
- Addictions x 1 block
  - **Coordinator**: Dr. Kristina Levang
  - **Contact**: krislevang@hotmail.com
- Psychiatry Blocks x 3 blocks
  - General Adult Psychiatry – Inpatient
  - General Adult Psychiatry – Outpatient
  - Psychiatry ER -MHAU
- Selective (non-psychiatry) x 2 blocks
- Elective (psychiatry or non-psychiatry) x 1 block

PGY-1 PSYCHIATRY AND NON-PSYCHIATRY ELECTIVES CATALOGUE

You may repeat any of your core rotations as an additional non-psychiatry elective if you like. Additional choices for non-psychiatry electives are:

- **Palliative Care**
- **Geriatric Medicine**
- **Internal Medicine Outpatient Clinics**
- **Paediatric CTU (Clinical Teaching Unit)**
- **Hospitalist Services**

Assertive Community Treatment (ACT) Team Psychiatry

Preceptors: Dr. Pat Montaleone

- Description: The Assertive Community Treatment (ACT) team is an intensive community support program for those with severe persistent mental illness. The ACT teams reach out to clients directly at their home within their community. The ACT team brings an inter-professional team of healthcare providers together including psychiatrists, social workers, nurses, occupational therapists, and rehabilitation therapists to provide an integrated and specialized service. The goal is to promote a recovery model of care allowing independence, stability, better control of mental health symptoms, and reducing the likelihood of hospitalization with a better quality of life.
- Resident Role
    - Conduct psychiatric assessments for those with severe persistent chronic illness
    - Collaborate with the interdisciplinary team involved in the ACT team
    - Participate in assessments for patients in their home
    - Opportunity to administer intramuscular injections in psychiatric patients
- Highlighted Learning Objectives: By the end of this rotation, you will be able to…
    - Medical Expert: Navigate a psychiatric interview in a patient with severe persistent mental illness (SPMI)
    - Medical Expert: Recognize psychopathology of patients with severe depression, mania, psychosis
    - Medical Expert: Understand rational antipsychotic polypharmacy in patients with treatment-resistant schizophrenia or treatment-resistant bipolar disorder
    - Medical Expert: Understand the recovery model and approach to treatment in those with SPMI
    - Health Advocate: Recognize patients who may benefit from more intensive case management vs. other levels of case management
    - Health Advocate: Understand community resources to manage those with SPMI
    - Collaborator: Provide valuable input as part of an interdisciplinary team

Tertiary Care Psychiatry

Preceptor: Dr. Richard Owen

- Description: Tertiary care psychiatry involves treatment for those who have severe persistent mental illness (SPMI). These patients often have depression, bipolar disorder, or schizophrenia which are treatment-refractory and require an increased demand for resources in order to manage them effectively in the community under a recovery model. These community programs include the Windsor Program for Extended Psychosis (WPEP) and Assertive Community Treatment Programs (ACT). Those who are acutely admitted are also admitted to the Toldo Neurobehavioural Institute tertiary care facility for more long-term stabilization before returning their care back into the community. There are also opportunities to participate in specialized programs such as the CPGDD (Centre for Problem Gambling and Digital Dependency.
- Resident Role
    - Conduct psychiatric assessments for those with severe persistent chronic illness
    - Collaborate with the interdisciplinary team involved in various programs including ACT, RTF, WPEP, and tertiary care inpatients
- Highlighted Learning Objectives: By the end of this rotation, you will be able to…
    - Medical Expert: Navigate a psychiatric interview in a patient with severe persistent mental illness (SPMI)
    - Medical Expert: Recognize psychopathology of patients with severe depression, mania, psychosis
    - Medical Expert: Understand rational antipsychotic polypharmacy in patients with treatment-resistant schizophrenia or treatment-resistant bipolar disorder
    - Medical Expert: Understand the recovery model and approach to treatment in those with SPMI
    - Health Advocate: Recognize patients who may benefit from more intensive case management vs. other levels of case management
    - Health Advocate: Understand community resources to manage those with SPMI
    - Collaborator: Provide valuable input as part of an interdisciplinary team

Concurrent Disorders/Addiction Psychiatry

Preceptor: Dr. Kristina Levang

- Description: Residents will have the opportunity to participate in programs across the spectrum with respect to addictions programming. The Concurrent Disorders Treatment Program (CDTP) at HDGH offers an evidence based integrated treatment approach, where both the mental health and addictions components are treated at the same time by trained clinical social workers and psychiatrists. Also, consultation and outreach is provided to Brentwood residential treatment program
- Resident Role
    - Conduct psychiatric assessments for those with substance use disorders
    - Obtain knowledge of the role of medications in treating substance use disorders
    - Utilize basic principles of motivational interviewing and cognitive behavioural therapies
    - Collaborate with the interdisciplinary team involved in substance use disorder treatment
    - Participate and understand the role of individual and group treatment for substance use disorders
- Objectives: By the end of this rotation, you will be able to…
    - Medical Expert: Navigate a psychiatric interview a patient with substance use
    - Medical Expert: Diagnose patients with substance use disorders
    - Medical Expert: Utilize the principles of motivational interviewing to assess and guide treatment in those with substance use disorders
    - Medical Expert: List the intoxication and withdrawal effects of common substances including stimulants, depressants, and hallucinogens
    - Medical Expert: Understand the role and evidence for medication-assisted treatments in substance use (e.g. Naltrexone, methadone, buprenorphine, etc…)
    - Communicator: Communicate and collaborate with substance use disorder patients in a non-judgmental manner
    - Health Advocate: Recognize the community resources for substance use
    - Health Advocate: Connect patients to appropriate levels of programming (e.g. 12-step outpatient programs vs. residential treatment)
    - Collaborator: Provide input as part of an interdisciplinary team

Dual Diagnosis Psychiatry

Preceptor: Dr. Ryan Parker

- Description: The dual diagnosis program at HDGH provides management to those with a pre-existing Developmental Disability (i.e. IQ < 70) and also have a psychiatric disorder. The dual diagnosis program is supported by registered nurses, community organizations (e.g. Community Living Staff), and psychiatrists. The dual diagnosis support staff perform outreach support to patients living in the community and there will be opportunity for the trainee to observe in these community assessments.
- Resident Role
    - Conduct psychiatric assessments for those with dual diagnosis
    - Understand the role of the interdisciplinary team in the management of those with dual diagnosis
    - Collaborate with the interdisciplinary team involved in management of those with dual diagnosis
    - Participate in assessments for patients in their home
- Highlighted Learning Objectives: By the end of this rotation, you will be able to…
    - Medical Expert: Navigate a psychiatric interview in a dual diagnosis patient
    - Medical Expert: Diagnose patients with psychiatric disorders with a developmental delay
    - Medical Expert: Collaborate with informants in forming a diagnosis for those with dual diagnosis
    - Communicator: Communicate and collaborate with patients with dual diagnosis in a non-judgmental manner
    - Communicator: Communicate and collaborate with caregivers of those with dual diagnosis
    - Health Advocate: Recognize the community resources for dual diagnosis disorders and connect patients to appropriate programming
    - Collaborator: Provide valuable input as part of an interdisciplinary dual diagnosis treatment team

Geriatric Psychiatry

Preceptor: Dr. Priya Sharma

- Description: Tertiary care psychiatry involves treatment for those who have severe persistent mental illness (SPMI). These patients often have depression, bipolar disorder, or schizophrenia which are treatment-refractory and require an increased demand for resources in order to manage them effectively in the community under a recovery model. These community programs include the Windsor Program for Extended Psychosis (WPEP) and Assertive Community Treatment Programs (ACT). Those who are acutely admitted are also admitted to the Toldo Neurobehavioural Institute tertiary care facility for more long-term stabilization before returning their care back into the community. There are also opportunities to participate in specialized programs such as the CPGDD (Centre for Problem Gambling and Digital Dependency.
- Resident Role
    - Conduct psychiatric assessments for those with severe persistent chronic illness
    - Collaborate with the interdisciplinary team involved in various programs including ACT, RTF, WPEP, and tertiary care inpatients
- Highlighted Learning Objectives: By the end of this rotation, you will be able to…
    - Medical Expert: Navigate a psychiatric interview in a patient with severe persistent mental illness (SPMI)
    - Medical Expert: Recognize psychopathology of patients with severe depression, mania, psychosis
    - Medical Expert: Understand rational antipsychotic polypharmacy in patients with treatment-resistant schizophrenia or treatment-resistant bipolar disorder
    - Medical Expert: Understand the recovery model and approach to treatment in those with SPMI
    - Health Advocate: Recognize patients who may benefit from more intensive case management vs. other levels of case management
    - Health Advocate: Understand community resources to manage those with SPMI
    - Collaborator: Provide valuable input as part of an interdisciplinary team

Child and Adolescent Psychiatry

Preceptors: Dr. Yousha Mirza, Dr. Saima Ahmad, Dr. Adeola Akinlaja

- Description: Windsor provides a comprehensive range of psychiatric services through the Windsor Regional Children's Center (WRCC) and Maryvale Adolescent and Family Services for patients up to age 16. Acute inpatient psychiatric care is provided through the Rotary Home which is a 6-bed inpatient unit. Rotary home is supported by nursing staff, social workers, psychologists, school-liaison staff and child and youth workers. Outpatient experiences are available through both Maryvale and WRCC.
- Medical Student Role
    - Conduct psychiatric assessments for child and adolescent patients (age ≤ 16)
    - Collaborate with the interdisciplinary team involved in management of child and adolescent patients
    - Communicate with family members and collaborate for purpose of diagnostic clarification and management of the geriatric patient
- Example Schedule:
    - Monday: Maryvale Outpatients/Rotary Home Inpatients
    - Tuesday: Maryvale Outpatients/Rotary Home Inpatients/WRCC
    - Wednesday: Maryvale Outpatients/Rotary Home Inpatients
    - Thursday: Maryvale Outpatients/Rotary Home Inpatients
    - Friday: Maryvale Outpatients/Rotary Home Inpatients/WRCC
- Highlighted Learning Objectives: By the end of this rotation, you will be able to…
    - Medical Expert: Navigate a psychiatric interview in a child and adolescent patient
    - Medical Expert: Diagnose child/adolescent patients with psychiatric disorders
    - Medical Expert: Collaborate with informants in forming a diagnosis for child/adolescent patients
    - Medical Expert: Collaborate with the interdisciplinary team in managing the child/adolescent patient in the community and on the medical floor
    - Communicator: Communicate and collaborate with caregivers for child/adolescent patients
    - Health Advocate: Recognize the community resources for child/adolescent patients and connect patients to appropriate programming
    - Collaborator: Provide valuable input as part of an interdisciplinary child/adolescent treatment team

General Adult Inpatient Psychiatry Rotation

Preceptor: various

- Description: Acute inpatient psychiatry at Windsor Regional Hospital (Ouellette Campus) houses 65 acute-care beds over two units as well as an 8 bed psychiatry intensive care unit. The resident will be assigned to an inpatient psychiatry staff to work in an interdisciplinary setting including nursing staff, social workers, occupational therapists, as well as other community support staff (including but not limited to Canadian Mental Health Association (CMHA) staff and community treatment order (CTO) coordinators)
- Resident Role
    - Provide direct clinical care for patients admitted to the acute psychiatry units
    - Case load:
        - Residents and supervisors agree on a caseload and adjust up or down based on case complexity and resident competency
        - The maximum case load assigned to a junior resident should be 8 patients
        - Please note that this is a maximum, and not a number that needs to be achieved. For example, a supervisor may feel that six would be a more appropriate case load to have if the patients are particularly complex or might have a resident manage only 5 inpatients if 2 of the patients are new admissions requiring full assessment
    - Participate in daily interdisciplinary rounds for admitted inpatients
    - Communicate with family members in meetings for admitted inpatients
    - Provide supervision to medical students as appropriate for training level
- Highlighted Learning Objectives: By the end of this rotation, you will be able to…
    - Medical Expert: Have working knowledge to manage low-to-medium complexity psychiatric patients admitted to an acute inpatient unit
    - Medical Expert: Function effectively in an interdisciplinary team to care for acutely ill adult psychiatric patients
    - Communicator: Communicate effectively with the interdisciplinary team in terms of requesting consultations and providing a management plan
    - Communicator: Communicate effectively with patients and their family members with regards to diagnosis, progress, and management plan
    - Health Advocate: Connect patients with appropriate resources for improved management in the community
    - Collaborator: Understand the roles of other members in the interdisciplinary team and provide/receive appropriate input with regards to patient care

General Adult Outpatient Psychiatry Rotation

Preceptors: Dr. Pat Montaleone, Dr. Kristina Levang

- Description**:** This rotation involves general adult outpatient care. Referrals are from primary care providers. Most consultations are a 1-time visit, with comprehensive recommendations being provided to the primary care provider for guidance of ongoing management. Complex or more acute patients may be provided follow-up short-term, and then once stable are discharged back to the primary care provider. Residents will develop basic skills, including interviewing, case presentation, diagnostic, and learning to develop comprehensive management plans including enhancing knowledge of basic psychopharmacology. In addition to the HDGH General Adult Outpatient Psychiatry Clinic, residents will also have to the opportunity to work in the HDGH Concurrent Disorders Treatment Program and Brentwood Recovery Home, which both provide outpatient consults and follow-ups.
- **Supervisors:** Dr. Pasquale Montaleone, Dr. Kristina Levang
- **Length**: 1 block in PGY1; 6 blocks in PGY2

Location: Hotel-Dieu Grace Healthcare (1453 Prince Rd), HDGH Mental Health and Addictions Downtown Campus (500 Ouellette Ave), Brentwood Recovery Home (2335 Dougall Ave)

Consultation-Liaison Psychiatry

Preceptors: Various (all WRH preceptors) and Dr. R Owen (HDGH)

- Description: The consultation-liaison (CL) psychiatry service provides psychiatric consultation for patients who are suffering from mental illness admitted to a medical / surgical inpatient unit. Therefore, the CL psychiatry service works at the interface between medicine and psychiatry. Trainees may be exposed to patients on the medicine clinical teaching unit (CTU), neurology services (e.g. Post-stroke patients), nephrology service, OBGYN, palliative care, among others. Trainees will learn how to provide appropriate recommendations for psychiatric treatment while admitted to a medical / surgical service as well as determine which patients may require a longer hospitalization once medically cleared.
- Resident Role
    - Provide psychiatric consultations (assessments and recommendations) for patients admitted to a medical / surgical floor at either **WRH-Ouellette or WRH-Metropolitan campuses**
    - Manage the CL resident pager while they are on service
- Highlighted Learning Objectives: By the end of this rotation, you will be able to…
    - Medical Expert: Diagnose common psychiatric illnesses in the inpatient medical / surgical setting (e.g. Adjustment disorder, mood disorders, delirium, etc…)
    - Medical Expert: Recommend appropriate treatment settings for patients who have mental illness admitted to the inpatient medical/surgical setting
    - Medical Expert: Recognize common comorbidities between medical and mental illness and how these affect treatment planning (e.g. chronic kidney/liver disease, bleeding disorders, pregnancy, delirium, dementia, etc…)
    - Communicator: Recognize the difficulties in providing confidentiality and privacy of a psychiatric assessment on the inpatient medical/surgical unit.
    - Communicator: Communicate effectively with the interdisciplinary team (esp. in the inpatient unit setting) with recommendations and treatment planning
    - Communicator: Communicate effectively with patients and their family members with regards to diagnosis, progress, and management plan
    - Health Advocate: Recognize patients who may benefit from other community services upon discharge (e.g. Outpatient consultation, psychotherapies, etc…)
    - Collaborator: Provide valuable input with the inpatient medical/surgical teams.

Psychiatry Research Elective

Preceptor: Dr. Priya Sharma

- Description: Research and other scholarly activities are important components in academic psychiatry. The psychiatry research elective is a 4-week rotation allowing for a more intensive opportunity to initiate a research project and to gain some initial productivity with regards to a scholarly project. This experience is not meant to replace the formal scholarly project as part of residency training, but rather to complement and allow for additional productivity.
- Resident Role
    - Conduct a short-term, focused, and time-limited scholarly project in an area relevant to psychiatry
    - Produce an outcome from the scholarly project in the format of an abstract, poster or oral presentation
- Highlighted Learning Objectives: By the end of this rotation, you will be able to…
    - Medical Expert/Scholar: Understand how to conduct an organized systematic literature review using a PICO format
    - Medical Expert/Scholar: Use appropriate research methods to answer a focused question in an area of psychiatry
    - Communicator: Communicate findings of the scholarly project to other professionals through written and oral formats
    - Health Advocate: Understand the relevance of research in advancing patient care
    - Collaborator: Work collaboratively with other professionals

Chatham Community Psychiatry

Preceptors: Chatham Preceptors

- Options are available possibly for inpatient psychiatry, outpatient psychiatry, consultation-liaison psychiatry
- Opportunities are flexible and open to discussion

GENERAL LEARNING OBJECTIVES OF PGY-1 ELECTIVES

Medical Expert

1. Establishes and maintains rapport and effective working relationships with patients.
2. Conducts and organizes a coherent, appropriate interview.
3. Arrives at a reasonable diagnostic conclusion based on the information collected; constructs a differential diagnosis

Communicator

1. Listens effectively.
2. Able to convey to patients and families an accurate and coherent understanding of the diagnosis, treatment plan, and prognosis.
3. Discusses appropriate information with the health care team.
4. Effectively conveys pertinent information and opinions to colleagues.
5. Maintains accurate and complete medical records in an accurate and timely manner

Health Advocate

1. Identifies and understands the determinants of health as it affects patients and communities.
2. Responds effectively in advocacy situations.

Collaborator

1. Consults and works collaboratively and effectively with other health care professionals.
2. Ability to teach colleagues, and willingness to learn from them.
3. Recognizes roles and responsibilities of other members of the health care team
4. Contributes to interdisciplinary team activities.
5. Ability to facilitate the learning of patients, students, and other health care professionals.

Leader

1. Exercises sound judgment in using resources in a cost-effective manner and evaluates such use.
2. Directs patients to appropriate community resources.
3. Sets realistic priorities and uses time effectively to optimize professional performance.
4. Coordinates efforts within the health care team.

Scholar

1. Develops and implements an effective personal learning strategy.
2. Critically appraises medical literature and integrates information from a variety of sources.

Professional

1. Demonstrates integrity, honesty, compassion, and respect for diversity.
2. Fulfills medical, legal, and professional obligations.

3. Responsibility, dependability, self-direction, and punctuality.
4. Acceptance and constructive use of supervision and feedback.
5. Awareness of the application of ethical principles.
6. Awareness of personal limitations and takes appropriate action to address these limitations

PGY-1 ORIENTATION BLOCK

Introduction

- Western University is proud to have the first block as an orientation month to help you learn about community mental health services and bond with your co-residents
- In the first two weeks of orientation, you will visit community mental health agencies and attend tours throughout the city
- In your final two weeks of orientation, you will be paired with one of our psychiatry preceptors to learn about the psychiatry physician services
    - Dr. Kristina Levang
    - Dr. Sabrina Botsford
    - Dr. Pat Montaleone
- During the orientation block, you will be scheduled to be on “shadow call” with a senior resident to become familiarized with the emergency psychiatric services

Objectives of Orientation Block

- Familiarize with the various community resources available in Windsor
- Complete orientation tasks to be able to start rotations in the following block
    - Obtaining ID badges at Windsor Regional Hospital and Hotel-Dieu Grace Healthcare sites
    - Obtaining parking passes at both sites
    - Completing Electronic Medical Records training
- Have opportunity to meet other co-residents and academic psychiatry staff
- Familiarize with the residency training program schedule and requirements

Resident Social

- The social committee will organize an event during one evening of the orientation block to facilitate a meet-and-greet amongst the resident cohort.

PERSONAL ALARM LOCATING SYSTEM (PALS)

Mandatory Requirement

- You are required to wear a PALs Alarm while on your psychiatry rotation at both Windsor Regional Hospital (WRH) and Hotel Dieu HealthCare (HDGH).

PALS at HDGH

- Alarms can be signed out at the beginning of your PGY 1 year.
- Each trainee should meet with Chantelle McIntyre (Chantelle.McIntyre@hdgh.org) in the Medical Affairs office on the 2nd floor of the main HDGH building.
- Please ensure you email Chantelle prior to picking up your PALs alarm and ensure you've filled out the portal form- HDGH.

PALS at WRH – Ouellette Campus

- You must meet Melissa Larsen (Melissa.Larsen@wrh.on.ca) at the security office in WRH-Ouellette Campus Parking Garage. Ensure you email Melissa prior to picking up your PALs alarm and ensure you've filled out the portal form-WRH.

PROFESSIONALISM AND EXPECTATIONS

Communication

- Contact your preceptors at least 48 hours before meeting them for the first time to confirm details of your rotation or shift.
- Text message is also a useful medium. Contact your preceptor to via text message to give them your number and allow them to update you more quickly
- Check your email often (at least daily) since SCHEDULES MAY CHANGE AT THE LAST MINUTE DUE TO UNFORESEEN CIRCUMSTANCES

Attendance

- Trainees are required to attend all scheduled teaching sessions, clinical work and call duty commitments, including the last day of rotation, unless they have received prior permission to be excused

Vacation

- It is imperative that you request your vacation time 4 weeks in advance to obtain approval. In some instances, less than 4 weeks may be approved however off service rotations that are not Psychiatry require the 4 week minimum.
- Ensure you request your time away through ONE45 including the dates you'd like to be off service and forward your approval from your primary preceptor by email to Alex Carson & PGE Psychiatry.
- NOTE: For your ER Rotation, ensure you submit your request no later than 4 weeks in advance, as once the ER medicine schedule is made there are minimal changes allowed.
- For Med CTU, ensure you submit your vacation requests well in advance (earlier than 4 weeks in advance) through the DOMEducation website system as vacation time allowed on MED CTU is variable based on coverage for the unit https://domws.lhsc.on.ca/DOMNET/DOMLogin.aspx.

LEARNING RESOURCES

Textbooks

- *Diagnostic and Statistical Manual of Mental Disorders.* 5th ed. American Psychiatric Association, 2013.
- *Kaplan and Sadock's Synopsis of Psychiatry: Behavioural Sciences/Clinical Psychiatry*, Harold I. Kaplan and Benjamin J. Sadock, 11th ed., Lippincott Williams & Wilkins, 2014.
- *Introductory Textbook for Psychiatry*, Donald Black and Nancy C. Andreason, 6th ed., American Psychiatric Publishing, 2014.
- *Psychiatric Interviewing: The Art of Understanding*, Shawn Christopher Shea, 3rd ed.
- Stahl, S. M., (2017). *Stahl's essential psychopharmacology: The prescriber's guide (6th ed.)*. Cambridge, UK ; New York: Cambridge University Press.

Review Books

- First Aid for the Psychiatry Clerkship (4th ed.)
- Case Files Psychiatry (5th ed.)
- Psychiatry Pre-Test Self-Assessment and Review (14th ed.)
- Lange Q&A Psychiatry (11th ed.)

Online Resources

Note: The following resources should only be used to supplement learning.

Videos

- Online Med Ed: https://onlinemeded.org/psychiatry (10-20 min video lectures on key psychiatric topics)
- University of Nottingham Psychiatric Interviews: https://www.youtube.com/watch?v=4-bH55MCa1U&index=102&list=PLpRE0Zu_k-BxWZoSNhjTxYLE3t14XUljV (sample standardized patient interviews on anxiety, depression, mania, psychosis, self-harm, somatization)

Podcasts

- PsychEd Podcast: https://www.psychedpodcast.org/ (each 30-60 min long episode focuses on a common psychiatric condition, with an overview of diagnosis and management provided by a staff psychiatrist with pertinent clinical pearls)
- Psych Essentials: http://psychessentials.org/ (10-20 min episodes on basic concepts with mnemonics and self-test questions)

Other

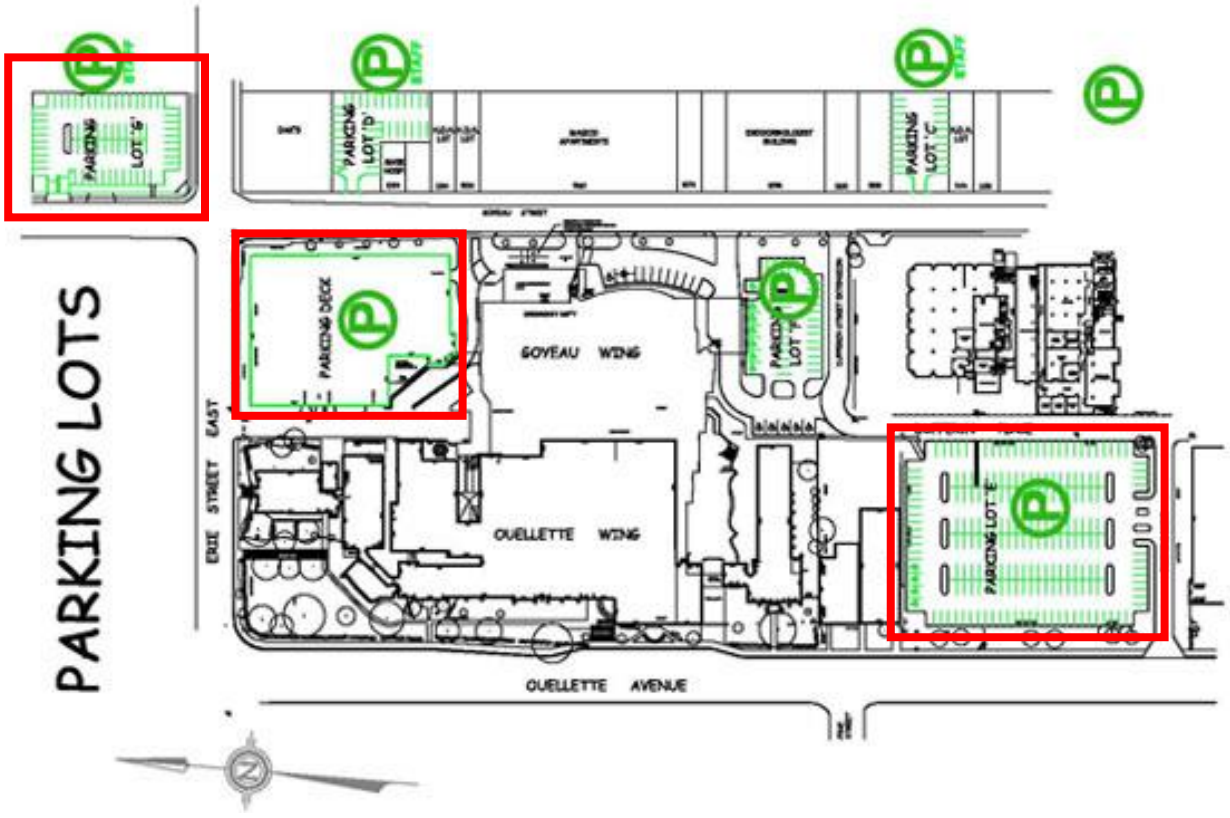
- UCSD Practical Guide to Medicine – Mental Status Exam https://meded.ucsd.edu/clinicalmed

PARKING

Windsor Regional Hospital – Ouellette Campus

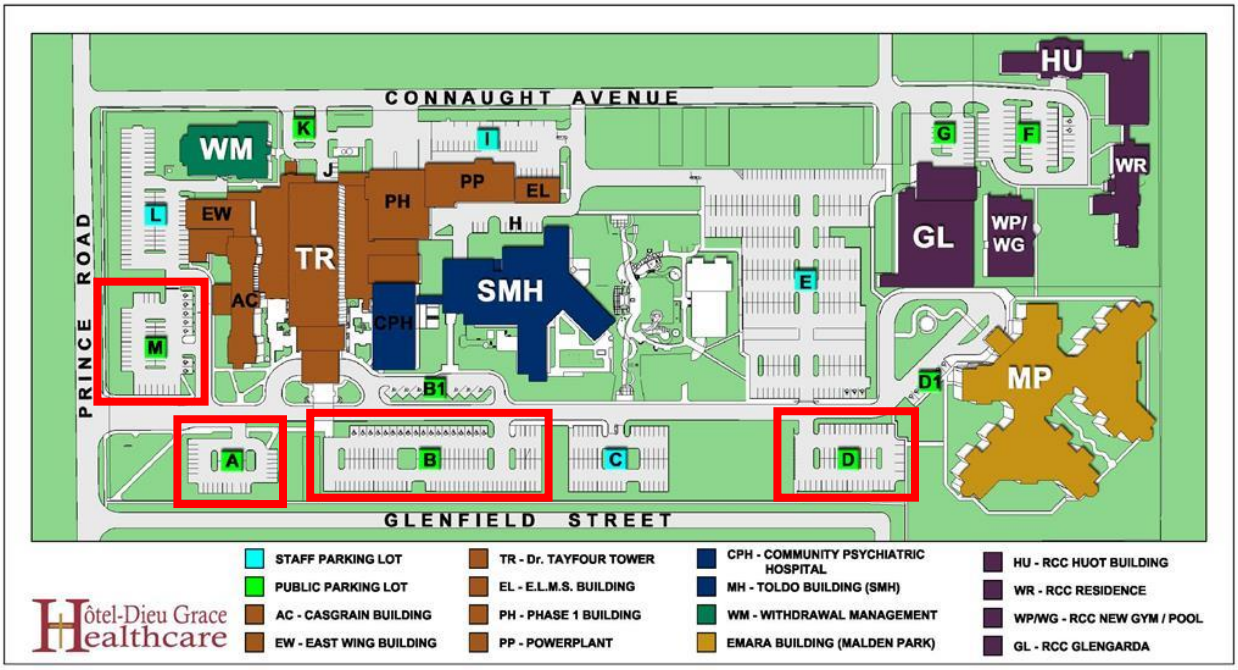
- Learners must purchase parking. There are two options:

1. Purchase tokens from Cashier's office found on level 1 of the Hospital, at the Ouellette Street entrance.
    - They are $1.00 each. To use them, park in the parking structure or lot E
    - For the parking structure, when you are ready to leave, exchange a token for a ticket at the security office on the 1st floor of the parking garage. Use the ticket to open the parking garage gate.
2. Pay for access to Lot G to be added to your prox card.
    - $200.00 for 1 year
    - $18.00 for 30 days



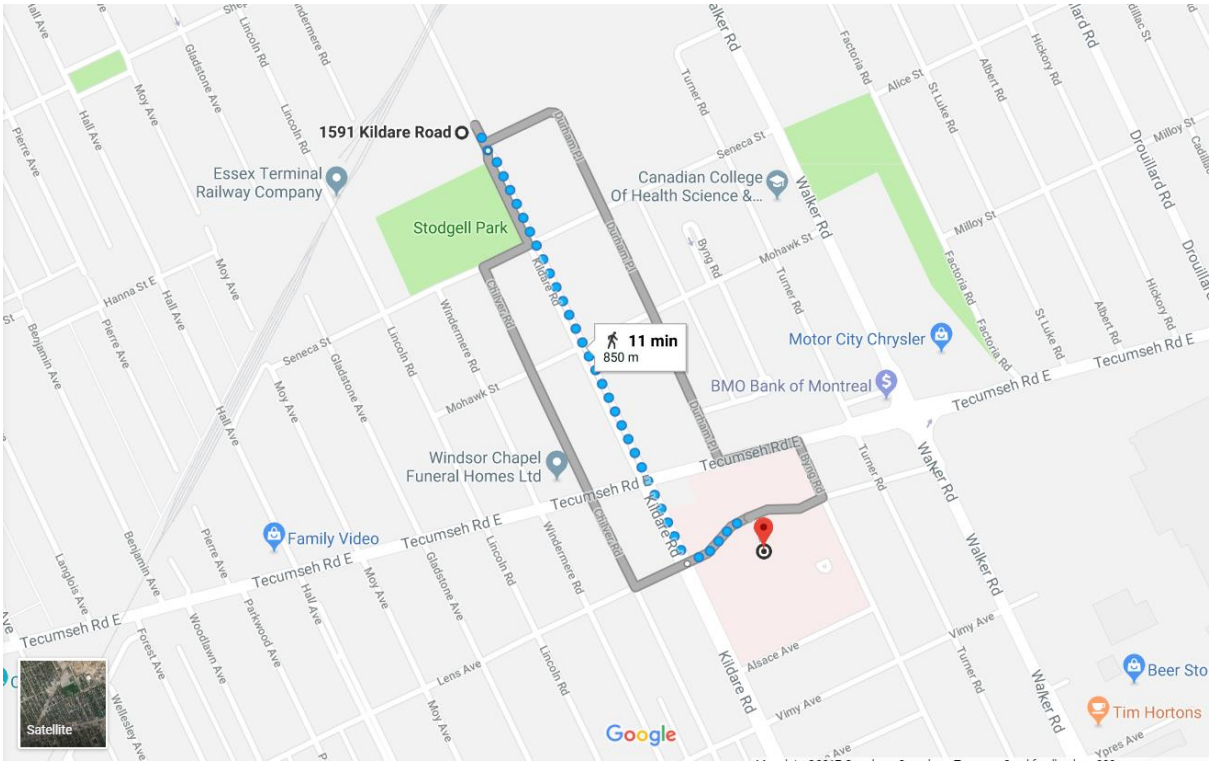
Hotel Dieu Grace Healthcare (AKA Tayfour Campus)

- If you paid for the annual parking access to Lot G for WRH-Ouellette, you will get a parking pass to display for the year
    - This grants you access to Lots A, B, D, and M
- Alternatively, trainees can purchase parking tokens for $1 at the cashier's office
    - You may use the tokens for the "pay and display" system in the above visitor lots



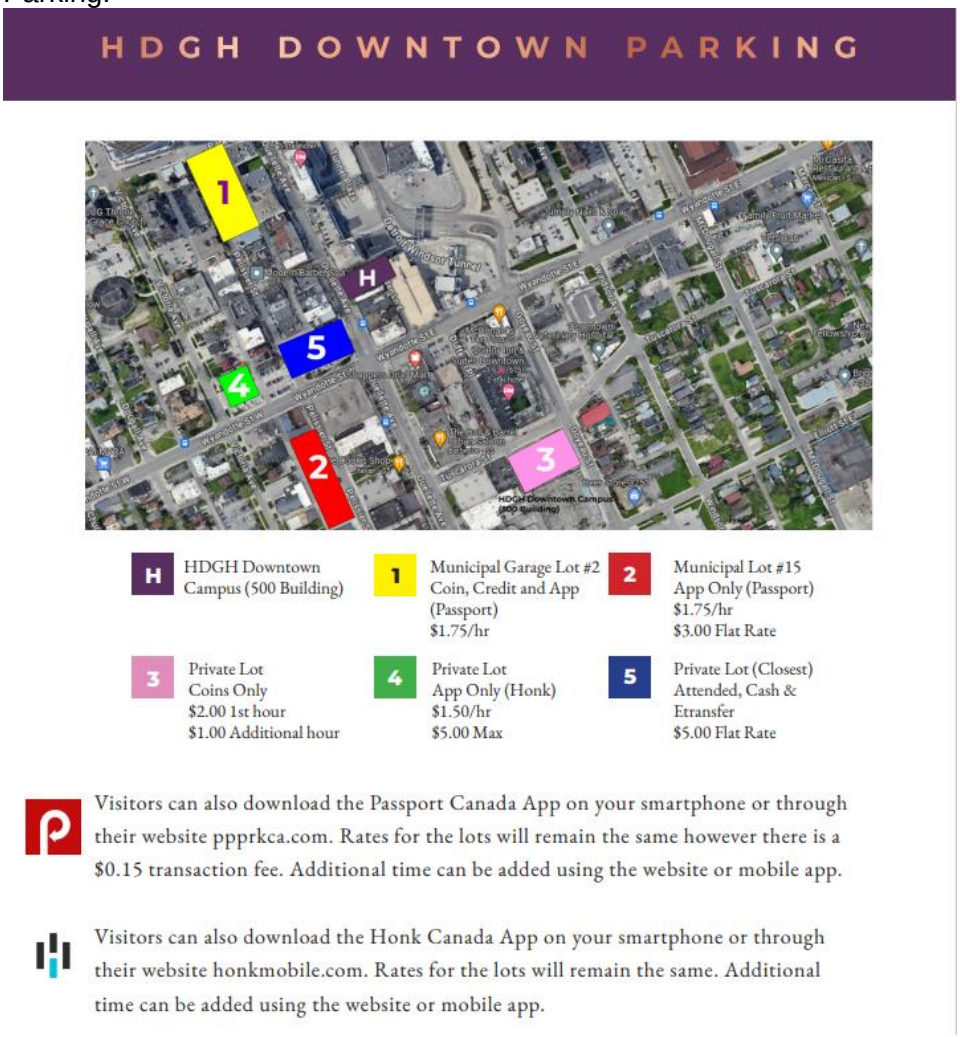
Windsor Regional Hospital - Metropolitan Campus

- Trainees must park at the offsite lot at 1591 Kildare Rd, Windsor, ON N8W 2W2
- Off-site shuttle parking to the hospital from Kildare is provided by purchasing bi-weekly, monthly, or yearly access with WRH-Ouellette or HDGH parking
- The shuttle operates from 6am to Midnight Monday to Friday
- Courtesy parking is available in the surface parking lot if your shift extends past midnight or on weekends



HDGH Mental Health and Addictions Downtown Campus

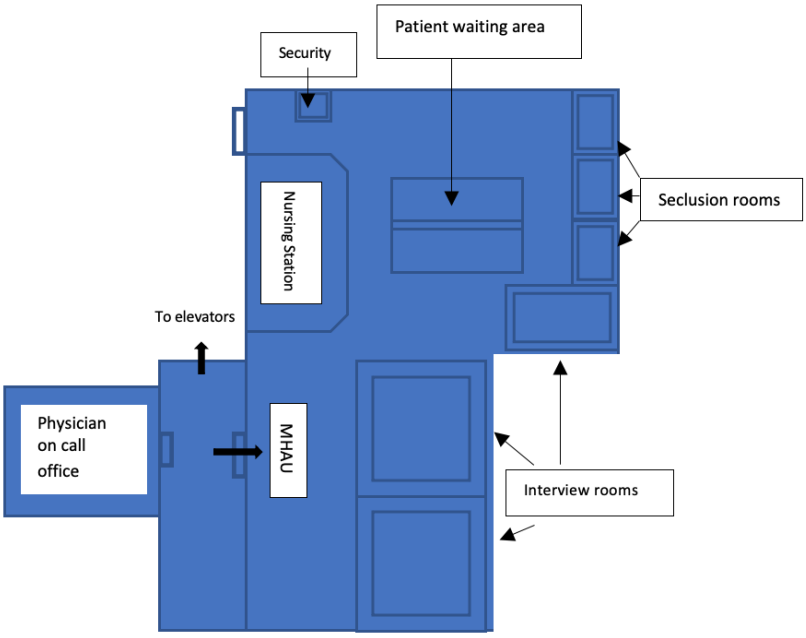
- Located at 500 Ouellette Ave
- Security: Security will let you into the building and provide you with prox access.
- *Access*: Your hospital prox card should give you access within this building. If not, contact security onsite and they can assist you with setting up the access.
  Clinics: General Outpatient Psychiatry Clinic with Dr. Levang and Dr. Grbevski. Transitional Youth Clinic with Dr. Botsford.,
- Parking:

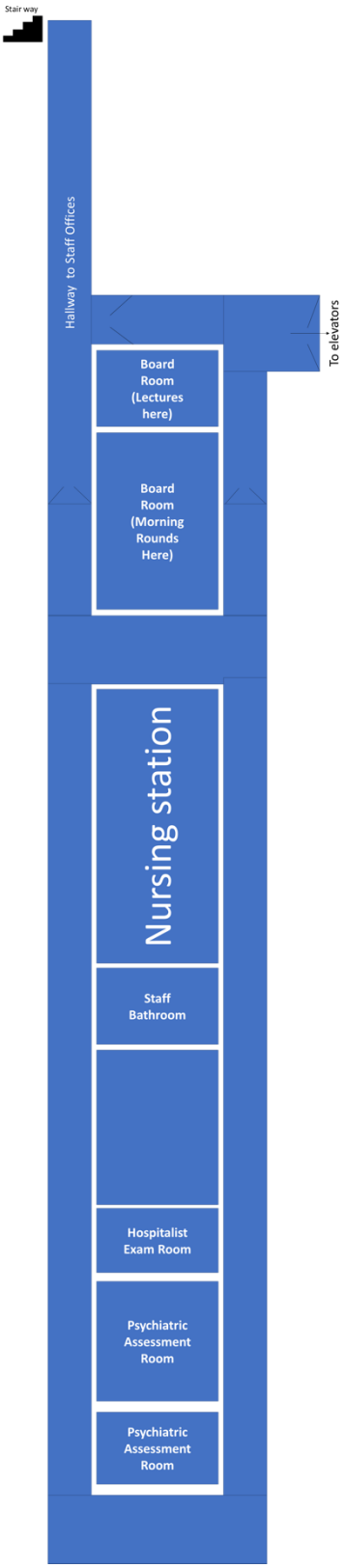


NAVIGATING OUELLETTE CAMPUS

Ouellette ER – Mental Health Assessment Unit (MHAU)

- Shown in the diagram is:
  - From main elevators (Ouellette Avenue), turn right for 3-North.
  - MHAU can be accessed through the door on the LEFT and on call office on the RIGHT. You will require your prox. Card to access MHAU.
  - There are a total of 3 assessment rooms and 3 seclusion rooms as labelled in diagram.
  - Keys to the physician on call office are located in the nursing station.

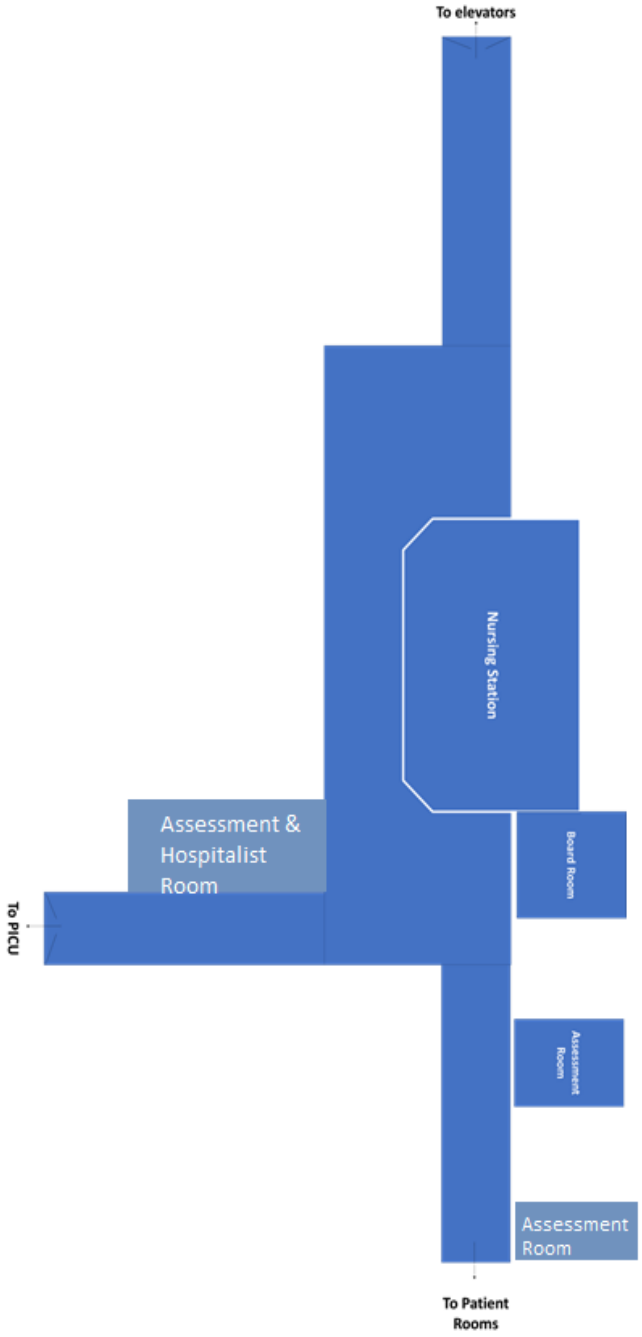




OC Psychiatry Unit - 3rd Floor

- From main elevators (Ouellette Avenue), turn left for 3-South and right for 3-North
- Ensure that **NO DOORS ARE LEFT OPEN. This is a key rule on the Psychiatric Unit.**
- **Ensure that you DO NOT USE ANY of the stairwells or elevators** on the inpatient unit.
- To access the locked assessment rooms or staff bathroom, ask a nurse, station clerk, or security guard to open it for you. The clerk may let you borrow their key.

Ouellette Campus – 3 North and PICU



EMR/DICTATION INSTRUCTIONS
WRH-Ouellette Campus, Met Campus, HDGH, ESHC (Leamington), CKHA (Chatham) all operating on Cerner Power chart EMR. All documentation will take place on this electronic domain. Residents will receive basic EMR Training throughout orientation block.

EMR/DICTATION GUIDELINES

Dictation Structure for Full Consultation

- State __Date of Clinic Visit__, __Time__
- "This is (Your name, Medical Student/Resident) dictating behalf of Dr. _____"
- "Dear _____," ("New paragraph")

  "_____ is a _____ year old (woman/man) who was referred to the General Psychiatry Clinic today for _____"
- "History of Presenting Illness":
  - Mood (Depression/Mania)
  - Anxiety (GAD / Panic / Sp. Anxiety / Soc. Anxiety / Agoraphobia / OCD)
  - Psychosis
  - PTSD / Eating Disorders / Abuse
  - SI/HI
- "Past Psychiatric History": Diagnoses / Admissions / Meds
- "Past Medical History": List 1) → … incl. history of seizures or head injuries
- "Medications" List 1) → …
- "Allergies" List 1) → …
- "Family Psychiatric History"
- "Substances"
- "Social History" → Family members / occupation / income source
- "Mental Status Examination"
- "Diagnosis" List 1) …
- "Recommendations" List 1) …
- "Thank you for involving us in the care of your patient. We hope the above assessment and recommendations are helpful."
- **Do not forget to send a copy of your consultation to the referring physician/ GP. This can be done on Cerner before signing your completed consultation note.**

Example of Model EMR/Dictation Report

Dictation by _____, PGY-1 dictating on behalf of _____.
Dictation by John Chan, PGY-1, dictating on behalf of Dr. Akinlosotu.

ID/RFR (reason for referral): One-liner providing essential information on the patient's reason for seeing you today.
25y male patient with history of bipolar 1 presenting to ER today by EMS following bizarre behaviours at home

HPI: The history of presenting illness should be presented in an organized fashion to deliver a concise yet detailed account of the patient's recent history leading up to his/her arrival at your service. Beyond that, it is important to inquire and document the presence or absence of symptoms relating to all major facets of psychiatric conditions. In psychiatry, it is crucial to obtain collateral history whenever possible. An example is provided below with relevant commentary.

Patient by the name of John Doe was diagnosed with bipolar I following his first and only admission to the psychiatric units ~1 year ago after patient expressed passive suicidal ideations to his parents. Following his admission, patient has been followed in the community by Dr. Psych. Pt last saw Dr. Psych ~3 months ago and is scheduled for another follow-up next month. If the patient has prior psychiatric admissions, it is important to give a brief history with focus on past diagnosis and MRP. One should also include any outstanding events from prior admissions (ie. adverse behaviours, drug reactions, management changes etc).

According to the patient's parents, patient has been demonstrating bizarre behaviours dating back to ~4 days ago when they first noted that the patient was wandering around the house nude. Over the next few days, parents noticed that the patient was behaviour more erratically characterized by insomnia, belligerent shouting at neighbours, and claims that he was going to become the president. Today, patient expressed to his parents that he was hearing voices from God and that he was "seeing demons that he must fight off". Patient's parents called the authorities after patient punched a hole in the wall in his efforts to "fight off the demons". Subsequently, patient was brought to the ER where he became very agitated and was given a dose of Haldol. Currently, the patient is calm and cooperative in providing a history. This provides a brief outline of events that led to the patient coming to see you. If you are seeing patients in ER, it is important to include any acute managements that was administered by the ERP.

Patient stated that he has started hearing voices over the past few days and has been seeing "demons" this morning. According to the patient, he hears multiple voices of both male and female that he believes come from God. He mentions that these voices are heard most prominently in later afternoon but can occur intermittently throughout the day. Patient states that the voices are not persecutory but instead, encouraging that they tell the patient that he "is the chosen one". This morning, these voices became commanding as they were telling the patient that he "must fight the demons to save the world". Patient states that he only started to "see demons" this morning and describe these "demons" as slim shadowy figures with no faces and inaudible. He does not fear these "demons" but feels that it is his duty to fight them off as he is the "chosen one". Patient states that he is currently not hearing any voices or seeing any figures

but anticipates that they will be back. It is clear that the patient in the example is experiencing psychosis with auditory and visual hallucinations as predominant symptoms. It is important to highlight the details of these hallucinations. For example, for auditory hallucinations, note what type of sound is being heard, whether it is external or internal. If it is a voice, how many voices, what their gender is, and what the content of speech is (e.g., persecutory, suicidal, homicidal…etc.).

When questions regarding delusions of persecution, patient does not believe that there's any individuals out to harm him apart from his perceived "demons". Patient does exhibit delusions of reference as he believes God is trying to communicate to him in every way possible including through TV and magazines. He dismisses any delusions of ertomania, guilt, or jealousy. He does not demonstrate any believe in thought insertion or thought withdrawn. Other symptoms of psychosis include delusional thinking. Here, highlight some qualities of the patient's delusions (religious, grandiose, reference).

Patient acknowledges that he has a history of bipolar and has heard voices in the past. He denies the possibility that this may be his bipolar I acting up and insist repeatedly that he is the "chosen one". When inquired about associated symptoms, patient mentions that he has not slept since last week but does not feel tired at all. He states that he his mind has been racing and he wants to accomplish many things after he "defeats the demons". These include becoming the president, starting his own company, and pursuing a career in acting. It is likely the patient is experiencing a manic episode. List all the features of their manic episode(s).

Patient mentions that he has had bouts of depressive phases in the past lasting from weeks to months. The last time he felt depressed however, was prior to his former psychiatric admissions here. Patient recalls that his depression was predominated by hypersomnolence, poor appetite, and low mood on most days. Depressive phases of bipolar.

Patient denis experiencing nightmares or flashbacks during the day. He was unable to identify any phobias and does not describe any history of panic disorder. He only occasionally experiences situational anxiety characterized by palpitations and diaphoresis. Include the results of the rest of your functional screen (i.e., PTSD, phobias, and anxiety disorder symptoms) here, or in a separate section labelled as such.

When asked about medications, patient states that he is currently on Lamictal and Cipralex. However, over the last 2 month, patient has taking only half of his prescribed dose of Lamictal without consulting with his family nor his community psychiatrist. Patient states the reason behind his actions is that he was feeling great and felt he didn't need as much of the medication anymore. As part of your report of the HPI, you can include the patient's current psychiatric medications, their effects, and crucially, the patient's compliance. In this case, patient was likely shifted to manic phase by his antidepressant after dropping his mood stabilizer levels by himself.

Patient denies any thoughts of suicide or self-harm. He states he has not had those thoughts since his last depressive episode which was prior to his last admission. He denies any thoughts of harming others. Always ask about thoughts of self-harm and harm to others.

Past Psychiatric History: List the previous psychiatric diagnosis

1) *Bipolar I disorder*
2) *Substance misuse disorder*

Past Medical History: List other concurrent medical conditions

1) *Primary HTN*
2) *GERD*

Family Psychiatric History: List any family psychiatric history. If managed with medications, it is important to also state the medications, and if possible, comment on their success.

1) *Mother; depression managed well with low dose Cipralex*
2) *Maternal grandmother; bipolar I well managed with Lamictal monotherapy*

Family Medical History: List any family history of medical conditions

1) *Father; MI, DM, HTN*
2) *Mother; HTN*

Substance Use History: List any past and current substance use by the patient. Also mention toxicology reports if available.

Patient denies the use of any illicit drugs such as cocaine, meth, LSD or heroin. Patient denies the use of any marijuana. He smokes cigarettes occasionally at parties but never on a regular basis. He does not drink any alcohol. Patient initial urine tox report on ER admission was negative for all substances. No alcohol was detected in his system.

Perinatal and Developmental History: List any complications that patient was subjected to while in the womb.

Patient's mother reported no complications throughout the pregnancy and delivery of the patient. There was no history of any developmental delays for the patients. No history of any learning disabilities, ADHD, ODD, or conduct disorder for the patient.

Legal History: List any legal issues both past or present for the patient (particularly reflecting criminal or negligent behaviour).

No criminal record or relevant legal history.

Social History: In psychiatry, the social history is aimed at focusing on patients past and current life situations that may be contributing to their current symptoms. Major stressors such as childhood abuse (emotional or physical), sexual assault, history of being bullied in school, and other traumatic experiences are important to document. In addition, it is also important to get basic details of the patient's life such as living situations, work, education level, relationship status, and sexual orientation. Other relevant information about the patient's social situation may be documented at the interviewer's discretion.

Patient is a native Windsorite that was born here and lived as a child with parents and younger sister. Patient describes that he had a "normal" childhood and denies and history of abuse, molestation, or being bullied in school. After high school, patient went on to pursue a post-secondary education at the University of Windsor majoring in Biology. He is currently starting his masters this year and was looking forward continuing his work after his previous admission where some of the work was put on hold. Patient mentions he also works part time at the local YMCA and has been working there for the past 2 years.

Patient states that he has very good relationship with both of his parents. When patient was in high school, his younger sister past tragically from a car accident and he described that it was a difficult time for everyone in the family. He states that the family has since moved on and he does not consider the tragedy as a significant stressor to his current life.

Currently, patient lives at home with his parents. He states that he has started a romantic relationship with a female partner recently and is excited to see where it goes. Patient denies any significant stress from his home, work, or school.

MSE (Mental Status Exam): This is equivalent of the physical exam in other facets of medicine. In psychiatry, the mental status exam provides the reader with a concise and objective assessment of the patient mental conditions. The ASEPTIC acronym is commonly used.

Appearance: Patient's presentation to you in terms of grooming, hygiene, gross habitus, facial expressions, tattoos or piercings etc.
Patient is a young Caucasian male that appears his stated age. He was appropriately groomed in hospital wear. Hygiene appear appropriate. He demonstrated good eye contact and was facially expressive during conversation. No signs of distress.

Speech: Assess rate, rhythm, volume, tone, and other qualities of speech.
Patient's speech had appropriate rate, rhythm, and tone. Not excessive nor limited. Volume was quiet at times and occasionally had to be re-questioned to stimulate audibility. No sign of any tangential speech.

Emotion: Patient's mood (subjective emotional state) and affect (objective emotional state).
Patient described his mood today to be ~6/10 and stable for the past month. His affect was euthymic, in full range, and appeared to be fixed on consultation. He demonstrated appropriate mood congruency during our conversation today.

Perception: Any presence of psychotic symptoms such auditory and visual hallucinations. Also assess for any delusional thinking.
Patient denied any auditory or visual hallucinations today on consultation and only mentioned those experiences prior to his admission. He still exhibits some delusional thinking consistent with the HPI but now, after his acute managements, entertains the possibility that it may due to his bipolar disorder.

Thought Process: Coherency in patient's thought and whether or not patient's thoughts are logical. Further, assess for patient's stream of thought to see if his/her thoughts are goal-directed, circumstantial, or tangential. Also assess for any presents of flights of ideas or loosening of associations.
Patient's thought process was grossly coherent and logical.

Thought Content: Assess for presence of suicidal ideations/homicidal ideations, preoccupied thoughts, obsessions, magical thinking, overvalued ideas, and/or delusions.
Patient denied any thoughts to harm self and others and did not demonstrate any fixed ideations. There was no evidence of delusions or perceptual abnormalities.

Cognition: Level of consciousness, orientation to time and space, memory etc. MOCA and MMSE are cognitive assessments but this is typically ordered through the physicians.
Patient was alert and oriented x 3.

Insight: Patient's ability to comprehend his psychiatric and/or medical conditions.
Judgment: Patient's ability to understand relationships and draw conclusions based on someone's actions.
Patient's insight and judgment today were fair.

Summary: Allows you to recap the history, mental status exam, and investigations in 1-2 sentences.
This is a 25y male patient with history of Bipolar I presenting with bizarre behaviours likely amidst a manic phase with psychotic features. Following acute management in the ER, patient is currently calm and cooperative and does not exhibit any suicidal or homicidal thoughts.

Impression: This is where a diagnosis is made for the presentations. It can be a differential if precise diagnosis is unclear.
Bipolar I Disorder: current episode manic with psychotic features.
Short summary of the patient's case followed by management plan.

Plan: This is where you discuss a treatment plan using the biological, psychological, and social framework
We educated the patient regarding the importance of staying his previous doses of Lamictal and patient agrees to revert back to his previous doses. We will admit the patient under psychiatry today as we restart him back to his earlier medications doses. We will reassess the patient in the coming days for any recurrent manic presentations. Patient is currently not on a Form 1 but is willing to be admitted to be monitored for safety purposes.

EMR/Dictation Structure for Progress Note example:

ID: Short description of patient. Helps to remind other staff about the patient and why they are in hospital. Include age, sex, relevant diagnoses, voluntary status, and any other pertinent details.
25y male patient with history of bipolar I admitted for manic episode. Currently on no Forms.

Subjective: The subjective component of the SOAP note documents the details of the topics of discussions with the patient. The goal here is to document the presence and absence of relevant symptoms in the patient. It is not always necessary to reassess and document all psychiatric symptoms, as in the initial consult, but it is important to re-assess subjective mood, suicidality/homicidality, and any psychotic presentations.
Patient was pleasant and cooperative today on consultation. He described his mood to be 8/10; an improvement since his initial admission. He mentioned that he was able to finally get a good night's yesterday after a few days of very little rest. His described his appetite to be good and he denied any thoughts of harming himself or others. Patient denied any auditory or visual hallucinations; noting the last time he experienced these was prior to his admission. He did not demonstrate any delusional thinking and appeared to be in overall a good spirit. Patient was able to appreciate in conversation that much of his experiences from earlier days were not real likely stemmed from his primary psychiatric condition.

A prominent subject of talk today with the patient was on the importance of medication compliance. Patient expressed that he was under the notion that he could be "weaned off" his medications if his symptoms were well under control. We educated to the patients the necessity of these medications as long-term management for his bipolar disorder and the patient stated that he is willing to follow through with his medication. Patient still states that he wishes he was taking the minimum dose of medications possible but agrees to not make any alterations before consultation with his community psychiatrist.

Objective (MSE): The objective component of the SOAP note is the mental status examination.
Patient was appropriately groom in hospital wear today. His speech was appropriate and he described his mood today to be 8/10; an improvement from his admission. His affect was euthymic and in full range. He demonstrated good eye contact, was facially expressive, and did not show any distress throughout the interview. Patient did not demonstrate any signs of psychosis today. His thought process and insight were fair. Alert and oriented +4. There were no abnormal movements appreciated on exam.

Assessment: Short summary for the patient and his progress. Document the diagnosis first followed by the patient's progression.
Patient appears to be doing very well following the increase of Lamictal to his prescribed dose.

Plan: Document any changes to management, additional treatments and disposition planning.
No changes to current management plan. We anticipate a short stay for this patient given his progression thus far. We will reassess the patient tomorrow and should he continue with his current stability, we will discharge the patient home with follow up to his community psychiatrist.

PARO ON CALL CLAIM /RESIDENTS/ELECTIVES

PLEASE COMPLETE AND EMAIL TO: callschedules@lhsc.on.ca

PLEASE REPORT CALL AS SOON AS IT IS COMPLETED AND WITHIN 30 DAYS OF COMPLETION					
NAME:	**SERVICE (S) AND LOCATION (City and Hospital):** **Psychiatry – Windsor ON- Windsor Regional Hospital**				
PLEASE LIST DATES ON CALL:	**IN-HOSPITAL CALL**	**Time of Call Shift**	**HOME CALL (X)**	**CONVERTED CALL (X) See criteria below**	**QUALIFYING (Home) ER SHIFTS (X)**