Department of Psychiatry – Windsor Site

General Adult Outpatient Psychiatry Rotation

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)

Schedule: 0800h to 1600h.

Method of Assessment:

- **ITER**: General Adult Psychiatry - based on the rotation objectives/competencies listed below

Rotation Objectives/Competencies

*ME 1.3 Apply clinical and biomedical sciences as well as medical jurisprudence, to manage core patient presentations seen on outpatient psychiatry and in follow-up

*ME 1.3 Apply safety procedures and practices for psychiatric facilities and personnel

*ME 1.3 Apply interventions to minimize risk

*ME 1.3 Apply provincial and/or federal legislation pertaining to mental health care and delivery

*ME 1.4 Perform appropriately timed clinical assessments with recommendations that are presented in an organized manner

*ME 1.5 Carry out and prioritize professional duties in the face of multiple competing demands (On the basis of patient-centred priorities, seek assistance to prioritize multiple competing tasks that need to be addressed).

*ME 1.6 Recognize and respond to the complexity, uncertainty and ambiguity inherent in the practice of psychiatry while developing plans for patient care.

*COM 1.1 Communicate with patients and their families using a patient-centred approach that facilitates patient trust and autonomy and is characterized by empathy, respect and compassion.

*COM 2.1/2.3 Conduct a patient-centred interview, and seek collateral information, gathering all relevant biomedical information.

*COM 5.1 and 5.2 Document clinical encounters in an accurate, complete, timely and accessible manner, communicating effectively using a written health record, electronic medical record or other digital technology.

*COL 1.1 Receive and appropriately respond to input from other health care professionals.

*L 2.2 Apply evidence and guidelines with respect to resource utilization in common clinical scenarios

*HA 1.1 Demonstrate an approach to working with patients to advocate for health services or resources

*HA 1.3 Work with the patient and family to identify opportunities for disease prevention, health promotion and health protection

*P 1.1 Exhibit appropriate professional behaviours and relationships in all aspects of practice.

*P 4.1 Manage the impact of physical and environmental factors on performance, including regulation of attention, emotions, thoughts and behaviours while maintaining capacity to perform professional tasks.

PGY2 Outpatient Supervision Guidelines

6 Block PGY2 Outpatient Rotation

1. As many follow-ups as possible should be seen by the resident and supervisor together for the first week, depending on the comfort level of the resident. This should involve occasions where the supervisor leads the interview and resident observes. When the resident does the interview, an F2 observation should be done.

2. The 6-month supervisors must offer the resident an experience constituted by managing an ongoing case load where the resident is the primary clinician and following longitudinally. While some cases may

be “inherited” at the beginning of the rotation, many of the patients should be initially assessed by the resident and then followed by them for each subsequent visit.

3. All new consults seen (un-observed) by residents should be discussed with the supervisor as soon as possible. The patient should then be seen by the resident and supervisor together to clarify any unresolved details and review management plan with the patient (when the resident takes the lead doing this, a F3 observation should be done). Early in the rotation, the supervisor would take lead, with increased responsibility to the resident over time.

4. PGY2 outpatient supervisors are expected to commit to a minimum of 2 hours/week (preferably more) of face-to-face direct observation or supervision.

5. Supervisors must routinely review documentation by residents and provide feedback.

6. The cap (i.e., maximum) for resident work is 2 new consults, one new consult and 2 follow-ups, or 4 follow-ups per half day. This is a cap and not a minimum expectation.

7. The 6-Block supervisors will be expected to ensure the resident has an opportunity for the outpatient STACER

PGY1 Outpatient Supervision Guidelines

1 Block PGY1 Outpatient Rotation

The requirements for the 1 Block supervisors remain the same as for the 6 Block supervisors, with the exception of an ongoing case load and longitudinal follow-ups. One-time follow-up appointments with unfamiliar patients may make up a higher proportion of the clinical population.