2019 Orientation Manual - Mental Health

ORIENTATION MANUAL FOR MEDICAL STAFF
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Medical Staff

The Consultant for each of the sector teams will have overall clinical responsibility for consumers in the community or in the inpatient units.

Senior Medical Officer: There are currently four SMOs, working across the service.

Registrars maybe allocated to any area depending on training needs. Currently the service is approved to offer training in adult general psychiatry, consultation-liaison psychiatry, child and adolescent psychiatry, rehabilitation psychiatry and rural psychiatry.

Principal House Officers may be allocated to the Adult Acute Mental Health Inpatient Units (either Mental Health Ward 1 or Mental Health Ward 2), Adult Community Teams (CAMHT or RAMHT), Redcliffe Caboolture Community Care Unit (RCCCU) or RACT depending on service requirements. PHOs with primary inpatient responsibilities will also have one or two clinics per week in the community and attend clinical meetings both in the community and the inpatient unit.

The Resident Medical Officer will work in the inpatient unit covering both Redcliffe and Caboolture sectors. The RMO will need to attend only the clinical meetings at the inpatient unit.

Interns and JHO’S from Redcliffe Hospital work under the supervision of Dr George Bruxner, across the Consultant Liaison Service based at Redcliffe [please refer to orientation guide for RMOs for Redcliffe CL/CCU position provided on orientation to term] The Redcliffe intern /JHO also attends CCU under the supervision of Dr Jatheesh Pala Valapill.

Accreditation

The Mental Health Unit is accredited with the Postgraduate Medical Education Council of Queensland (PMCQ) as an Intern elective rotation for a maximum of 1 Intern per term. The unit is also accredited by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) for Registrar training and is affiliated with the University of Queensland as part of the Northside Clinical School for medical student teaching.

Normal Working Hours

Normal working hours for Registrars / PHOs are from 0800 hrs to 1606 hrs with a half-hour for lunch. RACT doctors work between 0800 hrs and 1606 hrs. CI doctors work between 0830 and 1636.

Registrars/PHOs working after hours: This roster is now a continuous rolling 3 night roster.

After Hours duty is 1600-0006. Remote on call until 0800.

Saturday/Sunday day shift: 0800 hrs to 1606 hrs.

Consultants work from 0830-1700. Week day on-call is from 1600-0800 and weekend / public holiday 0800-0800.

Resident Medical Officers work hours are the same as those of the registrar in their work area.
Duties

Consultant Psychiatrist

- This position is responsible for delivering high quality specialist psychiatry services and for contributing to an integrated model of mental health care, consistent with current mental health standards.
- Provide clinical leadership and consultation services to a nominated team or teams.
- Provide direct clinical psychiatry services to patients of the Metro North Mental Health – Redcliffe Caboolture Service in both inpatient (acute and extended care) and community settings as per allocated team or work unit.
- Use a patient centred and team based model of care, supported by collaborative communication with the patient’s family, carers, team members and/or other relevant stakeholders.
- Ensure comprehensive, accurate and concise clinical records are maintained and relevant data collection requirements met.
- Maintain and update knowledge of relevant legislation (specifically, the Mental Health Act 2000) standards, and state and national plans.
- Provide consultation/liaison services to the general hospitals and other agencies as required.
- Provide supervision for medical officers and RANZCP trainees.
- To help promote an integrated model of mental health care consistent with current mental health standards. Including liaising with all teams within the district.
- Promote links with other service providers including General Practitioners, other Community Services and other hospital areas. Includes providing phone consultation and written documentation as required.
- Participate in the ‘second on call’ after hours roster.
- Participate in team meetings and relevant committees, sometimes as a representative of the service.
- Complete mandatory training requirements and participate in ongoing personal professional education, peer review, quality improvement and research activities.
- Utilize and ensure compliance with contemporary human resource management practice and principles including workplace health and safety, equal employment opportunity and anti-discrimination requirements. Contribute to planning and clinical governance to achieve KPIs.

Registrars/PHOs

- Under the supervision of the relevant Consultants, initiate, maintain and be responsible for the clinical care of patients of the Mental Health Service.
- Conduct interviews, examinations and the identification of clinical problems.
- Conduct day to day review of patients and participate in clinical team meetings.
- Arrange investigations, medical treatment and discharge as directed by the Consultant to which assigned.
- Use a patient centred and team based model of care, supported by collaborative communication with the patient’s family, carers and/or other relevant stakeholders.
- Ensure comprehensive, accurate and concise clinical records are maintained and relevant data collection requirements met. Including discharge summaries and MHRT reports
- Maintain and update knowledge of relevant legislation (specifically, the Mental Health Act 2000) standards, and state and national plans.
- Provide consultation/liaison services to the general hospitals and other agencies as required.
- Participate in team meetings and relevant committees, sometimes as a representative of the service.
- Participate in the ‘on call’ roster as required by the Clinical Director.
- Provide support for senior medical staff as required.
• Assist with case presentations at teaching meetings where necessary.

• Complete mandatory training requirements and participate in ongoing personal professional education, peer review, quality improvement and research activities.

• Utilize and ensure compliance with contemporary human resource management practice and principles including workplace health and safety, equal employment opportunity and anti-discrimination requirements.

**Resident Medical Officer**

• Under the supervision of the relevant registrar or Consultants, initiate, maintain and be responsible for the medical care of patients of the Mental Health Service.

• Conduct examinations and the identification of medical problems. Document physical examination findings on approved clinical form.

• Conduct day to day review of patients and participate in clinical team meetings.

• Arrange investigations, medical treatment and discharge as directed by the registrar to which assigned.

• Use a patient centred and team based model of care, supported by collaborative communication with the patient’s family, carers and/or other relevant stakeholders.

• Ensure comprehensive, accurate and concise clinical records are maintained and relevant data collection requirements met.

• Maintain and update knowledge of relevant legislation (specifically, the *Mental Health Act 2000*) standards, and state and national plans.

• Provide consultation/liaison services to the general hospitals and other agencies as required.

• Participate in team meetings and relevant committees, sometimes as a representative of the service.

• Provide support for senior medical staff as required.

• Assist with case presentations at teaching meetings where necessary.

• Complete mandatory training requirements and participate in ongoing personal professional education, peer review, quality improvement and research activities.

• Utilize and ensure compliance with contemporary human resource management practice and principles including workplace health and safety, equal employment opportunity and anti-discrimination requirements.

**Scope of Practice**

It is the responsibility of the Resident and their Unit Educational Supervisor (or delegate) to discuss the individual’s scope of practice relevant to their clinical area and their level of experience. This discussion should include identification of clinical skills which require direct observation prior to independent practice and any limitations in clinical duties.

**Learning objectives for Interns/RMOs**

The Australian Curriculum Framework for Junior Doctors outlines the learning objectives for RMOs/JHOs/SHOs or interns who come on a rotation basis to Mental Health Services (MHS). The common psychiatric problems and conditions these doctors should see during their rotation include: delirium, dementia, depression and anxiety, disturbed and aggressive patient, psychosis and substance abuse. The essential skills these doctors should learn during their rotation include: Mini-mental status examination, Psychiatric Mental Status Examination, Suicide Risk Assessment, Alcohol withdrawal Scale use and Mental Health Act application.
**RMO / Interns**

At the commencement of your rotation, please, identify learning objectives to be completed during your rotation. It is suggested for 5 week rotations, you select at least 3, and for 10 week rotations, perhaps 5 (depending on allocated leave during your rotation).

Please identify these objectives by end of week 1, so you will have sufficient time to complete them.

Learning objectives we have identified at the commencement of your intern rotations,

Suggested objectives;

1) To become knowledgeable about the major Mental Health Disorders managed in a public hospital settings including the investigations necessary for their evaluation

2) To be competent in performing and presenting a mental state examination

3) To be competent in assessing risk to self and others that might arise from common Mental Disorders

4) To gain a working knowledge of how the Mental Health Act can be properly used in the management of major Mental Health Disorders in general practice, departments of Emergency Medicine and other hospital settings

5) To gain a working knowledge of the benefits, adverse effects, safe prescribing and monitoring of medications commonly used in the management of Mental Health Disorders

6) Other intern identified goals

______________________________________________________________________________________________________________
__________________________________________________________________________
____________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________

Review of the outcome of the learning objectives at the completion of your intern rotation

1) Clinical knowledge of disorders:

Observed your supervisor assessing a patient

Able to conduct an informed discussion of particular clinical cases with your supervisor including investigations ordered

Provide a competent hand over to a fellow junior medical officer

Additional resource website:

- find SBAR Toolkit at [http://www.ihi.org/resources/Pages/Tools/SBARToolkit.aspx](http://www.ihi.org/resources/Pages/Tools/SBARToolkit.aspx)

For the following points, there are 3 websites with the following links.

[https://queenslandlawhandbook.org.au/](https://queenslandlawhandbook.org.au/)

2) Mental state examination

- Chapter on mental health state examination in Primer of Clinical Psychiatry available on CKN.

Additional resource QC48 (Mental state examination)

- Follow link to qcmhl, enter the online training system, start learning & enter code QC48.
- Sign in and find mental state examination

Present a mental state examination of a patient to your supervisor.
3) Risk assessment
- Resource - QC50 (Suicide risk assessment and management in ED setting foundational)
- Resource - QC51 (Suicide risk assessment and management in ED setting Advanced)
- Follow link to qcmhl, enter the online training system, start learning & enter code QC50 & 51.
- Sign in and find suicide and risk assessment and management in the emergency department

Present a risk assessment of an appropriate patient to your supervisor

4) Mental health act
- Following iLearn instructions for both modules
- Find section on treatment authorities.

Another source
- Enter the Qld law handbook, browse and find chapter on health and wellbeing and the mental health act.

5) Assessment of legal capacity to consent.
- Resource – QC40 (capacity assessment training on advanced health directives)
- Follow link to qcmhl, enter the online training system, start learning & enter code QC40.
- Sign in and find capacity assessment training on advanced health directives
- Resource – Qld Law handbook
- Enter the browser find health and wellbeing then enter Laws relating to individual decision making.

Present a case to your supervisor regarding capacity to consent with respect to medical treatment, or discuss scenarios from your past experience.

6) Drug treatments
- Find section on psychotropic medication
- Discuss the rationale and process of medication management with your supervisor regarding initiation of a psychotropic medication.
- Alternatively, attend a presentation and discussion of safe clozapine use with Dr Behan (or proxy)

Access to a power point presentation and other material will be provided by Dr Behan, if you choose this option.

7) Other objectives.

You are also free to choose a learning objective of your own choice & arrange presentation or discussion with your supervisor.

Specific learning objectives identified.
At completion of your rotation, please give the following feedback if you wish.
What factors assisted you in achieving your objectives?
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
What factors limited the achievements of your objectives?
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________
______________________________________________________________________________________________________________

_________________________  ___________________________  ___________________________
Intern Signature            Inpatient Supervisor           Dr Chris Behan

_____________  ________________  ________________
Date              Date              Date
CANMEDS

The service has adopted the CANMEDS model of overall goals of medical competencies. These were developed by the Canadian College of Physicians and Surgeons, and are:

1) Medical expert/Clinical decision maker
To be knowledgeable about:
- Normal biological, psychological and social development from infancy to old age
- Aspects of those biomedical, social and psychological sciences which underpin the practice of clinical psychiatry
- The epidemiology, aetiology, psychopathology, clinical features, and natural history of psychiatric disorders and psychological reactions in people with mental health problems and mental illness and carers, including concepts of impairment, disability and handicap
- General medical and surgical conditions, particularly those areas of general medicine which relate to psychiatric practice
- Impact of psychiatric disorders and their treatment on people with mental health problems and mental illness and carers.

To be able to:
- Perform a comprehensive psychiatric assessment in people with mental health problems and mental illness of all ages
- Care for mental health problems in people with mental health problems and mental illness from infancy to old age
- Competently assessing people with mental health problems and mental illness for the presence of medical illnesses.

2) Communicator
To be able to clearly, considerately and sensitively communicate with people with mental health problems and mental illness, carers, other health professionals and members of the general public in a variety of settings.

3) Collaborator
To be able to collaborate effectively with people with mental health problems and mental illness, carers, other health professionals and members of the general public in a variety of settings.

4) Manager
To be knowledgeable about the organisation and delivery of mental health care including the ethical, economic, geographical and political constraints within which it is delivered. To be able to "manage" effectively in a health setting and the community.

5) Health Advocate
To be knowledgeable about and be able to apply the principles and processes of (mental) health promotion and (psychiatric disorder) illness prevention.

6) Scholar
To be involved in constant critical review of scientific principles and clinical precedent. To be knowledgeable about the principles of scientific method in practice and the use of this knowledge to evaluate developments in psychiatric research. To be able to undertake a research or evaluation study and critically appraise published research relevant to psychiatry.

7) Professional
To uphold the integrity of the medical profession and recognise the privileges accorded them. To be knowledgeable about the principles of medical ethics, the development of professional attitudes and mechanisms for the development and maintenance of clinical competence, acknowledging the need for professional and public accountability.
Communication

Please retain your DECT phone during all working hours. You are responsible to maintain its function. If you are leaving the ward for a period, please inform the Clinical Nurse on duty or the Ward Administrative Officer.

Registrars/PHOs usually carry their own mobile, but could get DECT phones from switchboard if requested.

Mental health has its own individual switch board, which is located at the entrance to the Core facility. The phone number is 5600 and during working hours this is the switch board to use for contact with your registrars and consultants.

Rosters and AVAC’s

Your normal working hours, including your remote call shifts, have been pre-plotted and entered into the electronic system based on the terms of your appointment and on the on call roster provided. Therefore, it is important that any changes to your regular working hours (ie: unplanned leave – sick leave, family leave, shift swaps, etc) are reported to: The Clinical Director’s Support Officer (CDSO), Mental Health Services, phone: 5316 5661.

You are also required to leave a message on phone 5316 5658, if you are calling in for unplanned leave, as well.

Any On Call Shift Swaps must be reported to the Caboolture Hospital Switch (ext 8888) Mental Health switch (5600), the Acute Care Team (ext 5796) and The Clinical Directors Support Officer (ext 5661) after which you will be required to complete a Shift Swap Form or Roster Adjustment Form.

Any overtime or call back claims are to be forwarded to the clinical director for approval. This needs to be submitted on an AVAC.

Please make sure that you enter these details promptly as this is required before payment can be made.

The Resident Medical Officer who does afterhours duty for the Emergency Department, Medical or Surgical Units is to forward their claim to the respective Director for approval.
Senior Medical Officers

Dr Naeem Jhetam: A/Clinical Director, Takes overall clinical responsibility for the Service, as well as for one Caboolture in-patient team.

Mental Health Ward 1

Consultants – Dr Brunhilde Davis
Registrars - Dr Bart Wlodek
Dr Sarah Nguyen
Consultant - Dr Fatma Abdelmalek
Registrars - Dr Melanie Johnston
Dr James Barton

RMO - Rotational

Mental Health Ward 2

Consultant - Dr Michael Peck
Registrars - Dr Martin Neilson
Dr Sarah Newby

RMO - Rotational

Secure Mental Health Rehabilitation Unit

Consultant - Dr Naeem Jhetam
SMO - Dr Shajee Purayil
Registrar - Dr Ronald Glastonbury

RMO - Rotational

Redcliffe-Caboolture Acute Care Team

Consultant - Dr Simone Garrett-Walcott
SMO - Dr Gonzalo Carrasco
Registrars - Dr Ilina Agarwal
Dr Homayoun Khorram
Dr Charana Perera

Redcliffe Adult Mental Health Team

Consultants – Dr Leslie Jayasekera
Dr Dean Isherwood P/T
Dr Jatheesh pala Vallapill P/T
Dr Bjorn Burgher (1/2 day sessions)

Older Persons Mental Health

Consultant - Dr Trevor Hollingsworth
Dr Luke Purvey
SMO – Dr Iqbal Chowdhury

**Caboolture Adult Mental Health Team**

Consultants – Dr Melissa Ramsden

Dr Bjorn Burgher (1/2 day sessions)

SMO – Dr Chris Behan

Registrars – Dr Samir Bhagwat

**Redcliffe-Caboolture Community Care Unit**

Consultant – Dr Jatheesh Pala Valapill P/T

Registrar – (Redcliffe) Dr Sandra Williams

(Caboolture) Dr Tom Turvey

**Child & Youth**

Consultant – Dr Sunanda Gosh

Registrar – Dr Bridget Johnson

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**Allocation of Registrars / PHOs**

Registrars / PHOs will be allocated at the start of each term, balancing training needs and Service needs.

**Clinical Meetings**

It is a requirement that doctors attend all clinical meetings relevant to their area. No clinics should be booked for meeting times. It is also required that clinical discussions get documented on appropriate forms when inpatient reviews are presented.

On commencement of your rotation, please ascertain your current clinical duties and clinic times (if required) and your off-ward times/responsibilities so that other team members will be aware of your unavailability.

**Discharge Protocol**

Be familiar with the relevant Procedure for “Discharge from inpatient units”. All consumers should have a risk assessment tool completed at or around the time of discharge.

Ensure the relevant community team is advised of the discharge. If the consumer needs medical review immediately on discharge, please ensure that the ACT, C/RAMHT, CCU or PGU is aware of this. Also please inform the C/RAMHT, CCU or PGU of the dose of Depot medications and when next due. Discuss the discharge with the consumer and family and carer before the day of discharge.

Obtain and complete CIMHA ‘Consumer End of Episode and Care Review Summary’ preferably on the same day (or within 48 hours latest) of the discharge.

Medications can be prescribed for up to one month, and thereafter must be prescribed in the community. Consider risk factors when determining amounts of medication to be given to patient on discharge.

**Link to MNMSD Discharge from inpatient Unit Procedure RCKHS0718v1**

ECT

ECT processes are currently being reviewed and reformed, particularly to improve the level of training and supervision, in keeping with Queensland Health Guidelines for ECT (see Mental Health Unit website on QHEPS). ECT is conducted in Day Procedures Unit (DPU) at Caboolture Hospital. Dr Arnold Waugh supervises the provision of ECT in the service.

Following is a note from Dr A Waugh, Clinical Lead, ECT in relation to ECT Bookings –

“We have agreed to limit the ECT list to a maximum of 6 patients on any day due to the inability of Caboolture O.T. to handle more than this. Thus, when ECT is busy, we need to be able to prioritize patients and minimize cancellations. To help achieve this …

ECT Bookings

• Gena James (Ward 2) and Jenny Wilson (Ward 1) are the two nurses co-ordinating ECT. Either can be contacted by telephoning 8093.

• As soon as a decision is made to give a patient a course of ECT contact either Gena or Jenny, in person or by phone, to book the ECT sessions and discuss other preparations for ECT. Follow up this call with a brief email to both Gena and Jenny.

• For all patients having a current course of ECT (both inpatient and outpatient), ensure all ECT prescriptions are kept up to date and inform the ECT nurses of any changes. (If the prescriptions don’t match up with the clinical plan for ECT, there is a risk of ECT not proceed)

ECT Consent

• Voluntary consent for ECT is good for 12 treatments or 3 months, whichever comes first

• Patients having maintenance ECT should have a second opinion every 12 months of the maintenance course

Outpatient ECT

• All patients having outpatient ECT should have a case manager in regular contact with the patient, their family, psychiatrist and ECT co-ordinators. This will minimize the risk of non-attendance &/or cancellation of ECT.

• Treating team should work with ECT co-ordinators to plan the day on which outpatients are having maintenance ECT. It doesn’t have to all be done on Wednesdays.

Patient Allocation at the Mental Health Units

The key principles of new process will be as following.

(1) The clinical work is currently divided between two Redcliffe and two Caboolture in-patient teams, each led by a Consultant Psychiatrist to cater for patients from respective catchment area.

(2) Existing community patients of the Consultant will be admitted under the same consultant in the in-patient units. This will ensure integrated care for the patients. Similarly, a patient who had been admitted under the in-patient team during previous 12 months will also automatically go under the same consultant team. This will also assist in patient recovery.

(3) Existing patients of other community psychiatrists and those admitted via Acute Care Team or other hospitals will be deemed as ‘new’ patients. These patients will be allocated to the teams catering for their catchment area (i.e. Redcliffe or Caboolture). This also applies to patients who may have moved from elsewhere. Among the individual consultant psychiatrist, these ‘new’ patients will be allocated on an alternate basis. However, when respective team number exceed approximately 14 there will be a mutually redistribution of new patient to avoid disproportionate imbalance in clinical loads.

(4) Patients from ‘out of area’ or those, whose usual residential address is neither Redcliffe nor Caboolture, will be allocated to the Consultant Psychiatrist team with least number of total in-patients.
(5) Patients from same catchment area will go under other consultant psychiatrist catering for same geographical area.

**Information Management and Clinical Records**

All consumers will be registered on a dedicated Mental Health database called CIMHA. All occasions and or provisions of service (POS) must also be recorded on CIMHA. Each team has a dedicated CIMHA expert who will provide you with training. You will also be expected to carry out a number of Outcome Measures on your consumers. You will also be provided with training. At the moment, we have integrated clinical records for the Hospital and the Community. Routine documentation on CIMHA that you will be required to complete is: End of Episode, Care Review Summary, Risk Assessment and Clinical Notes.

**Q Fleet Vehicles**

You may be required to use a Q Fleet vehicle in carrying out your duties. It is required that you have a current drivers licence. Contact the CAMHT administration officer to book the vehicle for you. Please complete the mileage sheets in the vehicle. The vehicle cannot be used for personal use. A BP Fuel card is provided and is usually located in the console of the car. Please report any damage sustained to the vehicle while you are the driver.

**MHS Orientation and Mandatories**

The MNMH – Red Cab Service conducts Orientation Programs specific for Mental Health staff. They are run quarterly throughout the year. Details are available from the Medical Education Unit, Caboolture Hospital, ext 8243.

Mental Health Act 2016 Training is now conducted on-line. All mental health doctors must become Authorised Doctors/Psychiatrists to allow them to perform their duties with respect to the MHA 2016. A doctor can only become Authorised by completing the on-line training.

All doctors working in MHS are required to fulfill annual requirement of mandatory training (fire, infection control, basic life support, child safety, fatigue management module) as well as aggression behavioural management and other required training arranged. CDESO – Executives currently monitors the doctor's mandatories compliance and can be contacted if needed etc. 5661.

**After Hours / Public Holidays**

1. The Redcliffe-Caboolture Acute Care Team (RCACT) will be the first point of entry during normal extended hours and it is the role of the doctor to advise and support the Intake Officer. If admission is required, this can be arranged through the Registrar/PHO in the Emergency Department. Phone consultation may be sufficient, however, if you feel that you personally need to review the patient then assessment should occur in the Emergency Department.

   Similarly, after hours assessments and admissions will be conducted by the After-hour Clinical Nurses or Emergency Department doctor in telephone consultation with the on-call Mental Health Unit doctor. Once again doctors need to use discretion about whether they personally need to assess the patient.

2. Afterhours, registrars/PHOs are supported by Mental Health after hours nurse unit manager, who work across all the facilities as well as Acute Care Team. They can assist Registrar/PHO to conduct psychiatric assessments in Emergency Departments and to find suitable beds within the service or out of area.

3. Telehealth facilities are anticipated to be available soon. This involves videoconference instrument being in place at RCACT office as well as within both the Emergency Departments. The registrar should ensure that a consent form (to participate in Telehealth) has been completed for the patient, as well as presence of a mental health clinician with the patient. The Telehealth facility is intended to minimize the travel time for after hour registrars in between two Emergency Departments.

4. Whilst after-hours medical problems from the ward will be attended to by the ward medical officer on-call, psychiatric issues will be dealt with by the doctor on call. The issue may be able to be dealt with over the phone in consultation with the nursing staff. However, doctors need to be aware about the nurses’ level of clinical concern and if your presence is required in the ward the time delay should be discussed with the nurses. Use your clinical judgments based on risk assessment and respond accordingly.
Emergency medical problems requiring urgent attention and lacerations after-hours will be treated by the Medical Officer on ward call.

5. The On-call Doctor will be required to review the patients in both AAMHIUs, particularly those new admissions and the Psychiatric Intensive Care Unit (PICU) patients. Non-urgent issues should be delayed until normal working hours.

6. The doctors will provide support to the R.C.A.T. When you visit the ward on the week-end please contact R.C.A.T to check if they need your assistance for any problems.

7. Whilst on call after hours, the on-call doctor will be required to carry a mobile phone and pager.

8. The doctor is also expected to ‘handover’ pending clinical decisions on to the Acute Care Team or the ‘doctor-on-call’ next day or shift whichever is relevant. An appropriate handover involves telephone call, faxing relevant information and ensuring that the relevant information is being received.

9. It is expected that the doctor will complete the after-hours POS sheet and leave in the ACT tray for the AO to input after their shift.

Training Activities and Administration Meetings

1. One hour of individual supervision should be provided by:
   Consultants for Registrars in training (excepting first year registrar that are provided 2 hours). PHOs and RMOs are also provided with supervision. For RMO’s your clinical line of supervision is with your registrars and consultants.

   Registrars/PHOs will also be receiving ongoing education and support in a formally allocated time slot.

2. There is a medical education meeting for all mental health doctors every Tuesday afternoon from 3-4.30 pm. All teams will take turns presenting. The roster is organized by Dr Trevor Hollingsworth and the CDES. Doctors can select their own topic for presentation e.g. a journal article, case presentation. Doctor’s meetings are on fourth Thursday of every month.

   If you are unsure of what to present, discuss with your consultant. From time to time trial exams will be conducted in this time. Doctors will be advised of the appropriateness of attending to observe these sessions.

3. There is also a Thursday morning teaching session for junior doctors at 8:30 am in meeting room 1 at reception, which are conducted by one of the Senior Medical Officer. This session is arranged for basic trainees to learn basic psychiatry as well as for exam going trainees to assist their examination preparation.

4. During the Thursday morning sessions, remaining Senior Medical have a meeting every Thursday meeting between 8.30 am and 9.30 am. First Thursday of the week is the Supervisor’s meeting and third Thursday of the week is the Senior Doctor’s meeting. MOPS meeting occur on other Thursdays.

5. Day to day Clinical Supervision and presentations in review sessions and documentation in the consumer’s chart.

   These would be considered as legitimate teaching activities where the consultant would facilitate the trainee’s assessment and formulation, management planning and consultancy skills.

6. Registrars in training are supported to attend lectures offered by the Queensland Branch of Training Committee at Princess Alexandra Hospital either in person or using videoconference facilities.

Library Facilities: There are 2 main libraries located at each hospital, Caboolture and Redcliffe. They are accessible 24 hours a day, by using your identity/proximity card.

Medline access is also available at both Hospital Libraries. Inter-library loans and requests for journal articles are available through the Librarian at Redcliffe Hospital. The Library will have instruction on how to contact a librarian.

The Clinicians Knowledge Network (CKN) is available on QHEPS. This offers access, via the E-Journals site, to an extensive range of scientific journals, including all the major psychiatric journals.


Policies, Procedures and Guidelines
Medical staff must familiarize themselves with the Policies and Procedures specific to this mental health service MHS. These are listed on the Redcliffe-Caboolture website on QHEPS;


The website of the Mental Health Alcohol and Other Drugs Directorate (MHAODD) also contains a number of important Statewide Guidelines for safe mental health practice:


Leave Arrangements

Applications for leave should be forwarded to the clinical director via his ESO for consideration. As a general principle, not more than one doctor from each geographical stream should be on leave at one time.

Ensure there is an adequate handover given to the relieving doctor, or if no locum is organized, ensure the relevant consultant is aware of any particular issues which may need addressing during your absence. For short periods of leave, i.e. up to 3 weeks, cancel outpatients and ensure there are alternative arrangements for any outpatients who definitely need review in that time. Advise both the Team Leader and Administration Officer of teams to ensure clinics are put on hold. For any length of absence, review outpatient lists and consider which patients can have appointments delayed until your return.

Sick leave or any unplanned leave should be reported as soon as possible to the Clinical Director, via the Executive Support Officer (ESO) (5316 5661) and also leave a message on 5316 5658.

Conference / Study Leave require the approval of the Clinical Director, and as such, should be planned well in advance.

Please check the Mental Health Medical Leave planner before applying for leave;

Leave Applications can be found at:

Appendix 1

POLICY ON SUPERVISION OF CLINICAL EXPERIENCE FOR JUNIOR DOCTORS

1. INTRODUCTION

Supervision of clinical experience allows junior doctors to learn in safety as they progress towards independent practice.

2. SUPERVISORS

2.1 Supervisors must be doctors registered with the Medical Board of Queensland.

3. LEVELS OF SUPERVISION

There are three such levels, viz.:-

3.1. Level 1 The Supervisor is present in the clinical unit.

3.2. Level 2 The Supervisor is present in the hospital or facility.

3.3. Level 3 The Supervisor is on call from an on call residence, or from his or her usual residence.

4. MINIMUM SUPERVISION LEVELS

4.1 PGY 1/INTERNS

4.1.1 Supervision must be at Level 1 or 2 for all interns.

4.1.2 Supervision must be provided by a supervisor with appropriate experience of the particular discipline. The supervisor must have at least two years’ clinical experience (ie PGY 3 or more senior)

4.2 PGY 2/JHOs

4.2.1 Supervision may be at Level 1, 2, or 3

The same standards of supervision must apply both in-hours and out-of-hours.

Junior doctors must be encouraged to seek advice and/or assistance as early as possible whenever they are concerned about a clinical issue. This applies both in and out of hours. At all stages of training, a supervisor must attend whenever a junior doctor requests assistance.
Appendix 2

Handover of Patients – ISOBAR

Use of the ISOBAR Clinical Handover Template will assist in optimizing patient care.

Identify
  Yourself
  Who you are talking to
  Who you are talking about (at least name and date of birth)

Situation
  What is the current situation or the concerns?
  Are there any advanced directives?

Observations
  What are the recent and latest vital signs and clinical assessment data?
  What type of lines in/out does the patient have (e.g. IV, IDC)?

Background + History
  What is the (brief) relevant background? This sets the context for the patient
  History, Evaluation and Management

Agree to a plan
  Given the situation, what needs to happen?
  What are you wanting (e.g. advice, orders, transfer)?
  What is the level of urgency?
  What is the plan?

Readback
  Clarify and check for shared understanding – who is
  responsible for what and by when?
  Read-back, of critical information, especially in the situations where face-to-face
  handover is not possible
Appendix 3

RMO END OF TERM HANDOVER POLICY

Term handover is an excellent learning experience, which can enhance the junior doctors’ communication, professionalism and clinical management skills.

It is the responsibility of the incoming RMO to meet with the outgoing RMO, to discuss clinical handover of complex patients, as well as unit and ward specific information. This process assists RMOs in their orientation to their new units.

This process does NOT replace the responsibility of the Term Supervisor to provide unit orientation on the first day of the new term. It is equally the RMO’s responsibility to ensure that this unit orientation meeting occurs. At this meeting you and your supervisor will discuss your goals and learning objectives for your new term, and the new unit’s expectations of you.

Process:

➢ The week before the end of a term, RMOs are reminded via email of the requirement to complete an End of Term Handover with the RMOs who are replacing them

➢ An email will be sent to you that will include the name of the person being replaced and his/her contact details.

   o (If the pager number is not included, please use the phone directory on the intranet homepage to find this, or contact switch. If the details provided are incorrect e.g. because a recent roster amendment has occurred, it remains your responsibility to follow up the correct person and undergo term handover)

➢ Protected time is allocated for this process after the RMO Education session at lunchtime on the Friday before the new term begins. RMOs are able to exchange information as above, as well as useful tips.

   o If either the previous or next RMO is not available on the relevant Friday, then it is the responsibility of the both RMOs to arrange a meeting between themselves.

   o You are expected to attend your Intern/RMO protected training.

➢ Handover notes for the term can be documented and provided to the incoming resident for reference. Please use the space provided overleaf to record term handover details.

   You may wish to consider providing details on the following:

   o Ward Routine/Rounds, Clinics, Meetings, Training, Consultant/Registrar Expectations, Complex patients, Casemix, Discharge Summaries
Clinical Unit: PSYCHIATRY/MENTAL HEALTH  Term 1 2 3 4 5 (Please Circle)

RESIDENT’S NAME: CONTACT DETAILS:

____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

Reminders:

CURRENT UNIT

❑ Complete the Unit Evaluation Form for your current term, and return to Medical Education Unit

❑ Seek out your current Term Supervisor to facilitate the completion and discussion of your End of Term Assessment

❑ Ensure that you meet with the next RMO for term handover

NEXT UNIT

❑ Identify and read through the Unit Orientation Manual for your new term

❑ Visit your new unit/ward for an informal orientation, and ensure that you meet up with the current RMO

*Ensure that you meet with your new supervisor to discuss your goals and learning objectives for your new term*
**Appendix 4**

**Consumer self-harm flow chart**

**Consumer self-harms**

- **Nursing Staff**
  - Initiate First Aid (as appropriate)
  - Consider MET Call (as indicated)
  - Inform NUM/After Hour MH Co-ordinator

- **NUM/After Hour MH Co-ordinator along with nursing staff**
  - Review visual observations
  - Review physical observations
  - Repeat and document risk assessment
  - Search of consumer’s room for items that may be used to self-harm
  - Consider management strategies to prevent reoccurrence such as move the consumer to PICU, reconsider their MHA Status, PRN Medications, spending 1:1 time with patient
  - Inform treating/on-call doctor
  - Nursing documentation in medical record of self-harm incident and actions undertaken
  - Ensure information is handed over at nursing handover
  - Inform MH Executive as appropriate
  - **All self-harm incidents are to be entered into PRIME**

- **Treating/On-call doctor**
  - Consider review of the consumer
  - Repeat Risk assessment
  - Consider location of the consumer (PICU/Open), MHA (Vol/invol), medications (including PRN), level of nursing observations
  - Contact treating/on-call psychiatrist as appropriate

- **Treating team - In case of ongoing concerns/ multiple self-harm attempts**
  - Inform Clinical Director or MH Executive on call
  - Involve Patient Safety Liaison Officer to consider review of Consumer care
  - Discuss the consumer at Complex Care Review Meeting/MOPS
Appendix 5

Mental State Examination

The MSE is the part of the clinical assessment that describes the sum total of the examiner’s observations and impressions of the psychiatric patient at the time of the interview. Whereas the patient’s history remains stable, the patient’s mental status can change daily or hourly. Even when a patient is mute, incoherent, or refuses to answer questions, one can obtain a wealth of information through careful observation.

General Description

• Appearance
• Behaviour and psychomotor activity
• Attitude towards examiner

Speech
Rate, volume, stream, spontaneity (rapid, slow, pressured, hesitant, emotional, dramatic, monotonous, loud, whispered, slurred, staccato or mumbled, monosyllabic)

Mood and Affect

• Mood: Pervasive emotional state-reported (e.g. depressed, irritable, anxious, angry, expansive, euphoric, guilty, frightened, and perplexed).
• Affect: Range, reactivity, appropriateness (e.g. within normal range, reactive, restricted, blunted, labile or flat)
• Appropriateness or Congruency of Affect: Consider the patient’s emotional responses in the context of the subject matter being discussed (e.g. laughing when talking about death).

Thought

• Stream refers to the rate of production of thought - from poverty of thought through to flight of ideas
• Form refers to cohesiveness and logical linkages - disturbances include circumstantiality, tangentiality, derailment, incoherence
• Content includes suicidal or aggressive ideation, delusional material, paranoid ideas etc

Perceptual Disturbances

• Auditory and visual hallucinations, illusions: All 5 senses may involved such as auditory, visual, olfactory, tactile or gustatory.

Sensorium and Cognition

• Alertness and orientation to time, place and person. It is appropriate to perform a Folstein Mini Mental State Examination (MMSE) or a modified version of this.

Impulse Control

• Is the patient capable of controlling sexual, aggressive and other Impulses? Estimate from the information in the patient’s recent history and from behaviour observed during the interview.
• Collateral from friends/relatives is important when assessing impulse control. Impulse control (in respect to aggression, absconding, self-harm/suicide, sexual vulnerability) is characterised in the risk assessment and not the mental state examination. This is on the basis that these risks are
determined as a combination of both historical and current factors as well as information from collateral sources, not just current observed features of the patient’s behaviour (which is all that can be included in the MSE).

**Judgement and Insight**

- **Judgement:** Does the patient understand the likely outcome of their behaviour, and are they influenced by that understanding? This is usually best assessed from the patient’s recent history.
- **Insight** Describe the degree of awareness and understanding that the patient has that he/she is ill.
- **Reliability:** Your impressions of the patient’s reliability and capacity to report their situation accurately. Include your impression of the patient’s truthfulness or veracity.

### Assessing for Suicidal Risk

#### Predictors of Suicide Risk

- **S3:** Sex, Significant others/Supports, Stressful life events
- **U3:** Unsuccessful attempts, Unemployment, Unexplained improvement
- **I:** Identification with loved one or friend who has suicided/died
- **CI:** Chronic Illness of any kind
- **D2:** Depression, Decision to commit suicide
- **A3:** Age, Alcohol, Availability of means
- **L:** Lethality-severity of means used
- **S:** Spiritual/religious beliefs; Cultural factors; Gender Identity Issues

#### When to consider the need for admission

- Persistent wish to die
- Abnormal MSE
- To remove person from toxic environment
- To observe closely for risk
- To intervene if at increased risk
- Serious attempt
- Increased frequency and/or change in lethality of attempt
- Co-morbid psychiatric disorders

#### Immediate risk

- Attempted hanging
- Self-inflicted gun-shot wound
- CO poisoning
- Serious laceration
- Need for extraordinary medical/surgical Rx
- Admission to CCU
### When to consider discharge from ED

- No longer suicidal
- Agrees to contact if suicidal urges
- Treatment arranged for psychiatric disorders
- Underlying problems/precipitants resolved
- Not delirious / intoxicated /psychotic
- No firearms
- Family/supports agree with discharge plan
- Follow-up arranged with ACT/ CYMHS/ Private clinician
- You believe patient's statements that he is no longer suicidal
- Discuss with ED Registrar/ ED consultant/ ACT/ Psychiatry
- Registrar/ Consultant Psychiatrist (safety net)
- Safety and follow up plans clearly documented

### Assessment for Violence Risk

- Interview with police/security in room or nearby
- Previous incidents of violence
- Previous use of weapons
- Under 35 yrs of age
- Criminal history
- Previous dangerous acts or violent ideation-specify
- Role instability (e.g. Work relationships, accommodation)
- History of Drug and Alcohol use

### Increased current risk if:

- Expressing intent to harm others(specify)
- Access to available means
- Violent command hallucinations
- Preoccupation with violent ideation
- Inappropriate sexual behavior
- Drugs and Alcohol
- Reduced ability to control behavior-(specify)

**NOTE** presence of protective factors and supports
Acronym to remember to elicit the essentials in history of presenting illness

- S - symptoms (systematic review)
- T - timeline (and why now?)
- A - attribution (patient's own beliefs about why he/she is ill)
- I - impact (self/personal, relationship, work, school)
- R - treatment and response (including side-effects)
- S - stressors/strengths/supports

Formulation/Summary/Referral: Putting it all together i.e. the information you need gather before you present the patient you have seen

- Demographic essentials (NB: supports available)
- MHA status (Voluntary/Involuntary?)
- Presents with (symptoms indicative of and include…)
- Context of (stressors/precipitants)
- Background history of (salient features of past history)
- MSE reveals (salient features)
- Risk factors identified are (major and relevant)
- Referral questions:
  1. Why am I concerned?
  2. Why do I need call ACT or the Psychiatry Registrar?

Example of basic expectation of a psychiatric case presentation/referral

“My name is Dr Taylor and I’m a resident in Caboolture DEM (staff identifier and hospital identifier). We have a patient here who I believe needs admission to a mental health unit due to his risk to himself (clear explanation of reason for calling). I think he has had a relapse of a schizophrenic illness, probably due to non-compliance with his medication (provisional diagnosis). Mr Smith is a 28yo single unemployed male (patient identifier) who lives with his parents (social supports). He self presented (means of presentation) to the hospital this evening complaining of voices in his head for the last 3 days (history of presenting complaint) telling him to kill himself. From the notes, he has a diagnosis of schizophrenia since 2004 with an admission to Caboolture Mental Health Unit last year (past psychiatric history). He doesn’t have any medical history (medical history) and isn’t on any medication (medication history). He says he stopped his Zyprexa 3 months ago and stopped coming to see his case manager or doctor because he was well (history of presenting complaint). He denies any using any drugs or alcohol (drug and alcohol history). His physical examination is normal (physical examination). On mental state exam (mental state exam), he was dishevelled and distressed, and talked angrily to his voices at times, and at times hit himself in the head, telling the voice ‘Get out!’. He’s blunted in his affect and is tangential in his thoughts. He feels unable to control an internal voice of his father is telling him to stab himself in the stomach and is really upset by it and wants some help. He’s oriented to time, place and person and is
alert. I haven’t done any investigations, as it doesn’t seem warranted (investigations). I’ve given him 10mg of diazepam orally (treatment to date).”

If you have little or no knowledge of the MSE you are welcome to attend a half day workshop on this. If you wish you can also remain for the rest of the day and do the Clinical Interviewing skills workshop in the afternoon if this is required. These workshops run at the end of each month on a Friday.