To Go Over On Training Call:

- Shift times
- When to come in
    - 30 minute expectation
    - inclement weather expectation
- Medical Students on Call: When a medical student is on call, they will page you at the start of your shift. They work 5pm-11pm on weekdays and 8am-7pm on weekends.
- Locations of NPOD office, resident work room, inpatient wards
- How to get NPOD keys
- Where to sleep, park and eat
- How To's of Sign-Out
    - When and who to call
    - Checking in with charge nurses
    - How to update Hand-Off
- Safety Screens, Restraint Rules, Code Greens
- How to Admit a Patient
    - Orders
    - Documentation requirements
- Discharging a pt from ED
    - Documentation requirements
- Patient transfers from outside hospitals
    - What information to gather
    - How to decide to accept/not accept
- Consults on call
- Tips on working as a consultant in the ER (see below)

Because many of your on-call patient responsibilities will occur in the ED, a Note on The ED

As of Jan 2010, a new policy was put into place stating psychiatry residents provide consultation services to the ED and do not assume primary responsibility for any patients in the ED. Previously, patients were triaged directly to psychiatry and not seen by the ED attending (MOD) first. According to this policy, patients should be triaged to the MOD and only seen by psychiatry after this has happened and after the MOD has made clear the need/question for psychiatric consultation. The MOD is responsible for medical clearance before our evaluation and discharge of the patient after (if the patient is not being admitted to psychiatry).

If there are any concerns about the patient's mental status or general health (i.e. pt appears delirious or obtunded), discuss your concerns with the MOD. If there is no clear psychiatric issue and/or the pt is too obtunded or uncooperative to interview, document your findings, discuss with the MOD, and allow the MOD to decide how to proceed. We may try to advocate for the pt, (i.e. urge the ER to allow more time for evaluation), but ultimately the decision remains in the hands of the MOD as it would for inpatient consults.

This policy represents a major change in roles and procedures for ER staff. Some may not be aware of the details of this policy and, during this time of transition, may continue to call the NPOD first when a patient presents with psychiatric complaints. In this instance, you might say something like *"I'm happy to see this patient, but the MOD needs to see them first because this will affect my treatment recommendations."*

If the MOD is very busy and it may be hours before the patient is seen, or if the patient is volatile and there is some immediate concern, offer to see the patient prior to the MOD. Keep in mind what is best for the patient and your own time management.

If there is push-back or resistance to this policy, **do not get into a power struggle with the ER and never refuse to see a patient.** Just see the patient and then email the Chief Resident detailing the situation. Discuss the case with your on-call attending to see if they can be of assistance in interacting with the ER staff.

After your evaluation, staff the case with your attending and follow up personally with the MOD to share the assessment, treatment plan, and disposition. Keep the MOD and Nurses up to date on your plan/dispo for the pt so there is no confusion about the treatment plan.