Appendix F

Emergency psychiatry experience

The curriculum guidance states:

Emergency Psychiatry

Trainees must gain experience in the assessment and clinical management of psychiatric emergencies and trainees must document both time spent on-call and experience gained (cases seen and managed) and this should be "signed off" by their Clinical Supervisor/Trainer.

A number and range of emergencies will constitute relevant experience. During Core Psychiatry training, trainees must have experience equivalent to participation in a first on call rota with a minimum of 55 nights on call during the period of core specialty training (i.e. ***at least 50 cases with a range of diagnosed conditions*** *and* ***with first line management plans conceived and implemented****.) (Trainees working part time or on partial shift systems must have equivalent experience.) Where a training scheme has staffing arrangements, such as a liaison psychiatric nursing service, which largely excludes Core Psychiatry trainees from the initial assessment of deliberate self-harm patients or DGH liaison psychiatry consultations, the scheme must make alternative arrangements such that trainees are regularly rostered to obtain this clinical experience under supervision. Such supervised clinical experience should take place at least monthly.*

It is important that exposure to emergency cases occurs in all core trainee posts irrespective of setting and subspecialty. The 50 cases specified are considered an **absolute minimum**.

The following guidance summarises local interpretation of the curriculum with reference to the following domains:

Acute clinical presentations

Acute clinical syndrome e.g.

- Delirium
- Substance related e.g. delirium tremens
- Psychosis (first episode, acute relapse or acute on chronic)
- Major affective disorder (first episode, acute relapse or acute on chronic)

Psychotropic related e.g.

- Acute dystonia
- Lithium toxicity
- Neuroleptic malignant syndrome
- Clozapine-associated neutropaenia
- Prolonged QTc interval on ECG

Acute risk e.g.

- Self harm and Suicidal behaviours
- Violence
- Severe neglect e.g. malnutrition
- Firesetting

Service setting

Inpatient e.g.

- Emergency admissions without prior assessment by a psychiatrist
- Initial assessment following seclusion

- Section 5(2) assessments
- First psychiatric response to acute clinical presentations (see above)
- Assessment of capacity to consent to urgent treatment

Community e.g.

- First psychiatric assessment following urgent referral (i.e. within 24 hours)
    - Domiciliary
    - Outpatient
    - Accident and emergency (including capacity assessments)
    - General medical liaison (including capacity assessments)
    - Custodial

Rota arrangements e.g.

- Out of hours on call
- Working hours crisis/emergency cover

First line management plan

To include:

- Diagnostic formulation
- Risk assessment
- Immediate treatment and risk management plan
- Evidence of discussion or collaboration with other members of multidisciplinary team

All first line management plans should be discussed with a senior or experienced psychiatrist at higher trainee, specialty doctor or consultant grade level. Specific arrangements for supervision will vary according to trainee experience and competence, and local service protocols, and must be agreed with the clinical supervisor during initial job planning meetings.

Evidence

It is recommended that all emergency cases are logged on to the electronic portfolio (with management plans documented) and a proportion is assessed by WPBAs.