

**DEPARTMENT OF PSYCHIATRY CRITICAL INCIDENT RESPONSE FOR FACULTY
QUEEN'S UNIVERSITY, 2015**

1. Definition:

A critical incident is any work related incident that is perceived as critical.

Examples include patient or staff suicide, patient or staff death especially traumatic death, assault by patient or staff, homicide by patient or staff, stalking or threats by patient or staff, law suit, college complaint, etc.

- must be recognized that residents and other learners may be involved in incident as well.

2. Faculty Involved

- a. MRP/attending psychiatrist
- b. Resident/other learners involved
- c. Head of Department
- d. Residency Training Program Director – if residents involved
- e. Divisional Chair of MRP's division
- f. Program Medical Director for appropriate hospital site

3. Key characteristics

- a. Timely initial response (ideally within 24-48 hours)
- b. Regular and ongoing response
- c. Support, advice, facilitation, education
- d. Communication
- e. Orientation and access to policy and information on website

4. Process

(i) Anticipation (baseline, pre-incident)

- Critical incident response protocol for the department will be available on the departmental website along with related materials
- New psychiatrists to the Queen's University Department of Psychiatry will be directed to review the critical incident response protocol during orientation
- Every 2 years, the topic of response to a critical incident will be presented and discussed at a Grand Rounds and/or Faculty Development session

(ii) Acute Impact (immediately following a critical incident)

- Whenever a critical incident occurs, the MRP and the Head of Department should be informed as soon as possible.
- If learners are involved, they should be informed by the MRP/supervisor and the residency training program director is informed.
- The residency training program director is primarily responsible for initiating and implementing the critical incident response for physician learners
- The Head of Department is responsible for communicating critical incident to the MRP's Divisional Chair and the Program Medical Director for the hospital or community site involved

Response

1. MRP meets with Head of Department (if possible within 24-48 hours). This meeting is mandatory and should include:
 - Support for the MRP and empathy
 - Encouragement to connect with colleagues of physician's choice for support
 - Suggestion to contact CMPA as appropriate
 - If patient suicide, consideration of contact with family physician and family members if appropriate
 - If threat, aggression, stalking, consideration of reporting to police
 - Communication that likely to be a critical incident care review at whichever hospital site is involved; care reviews are a non-blaming review of incident and process involved
 - Consideration of attendance at patient funeral if appropriate
 - Offer of professional counseling support if needed
 - Explanation of full critical incident process for the department including subsequent meetings and department members who will be notified and available
 - If assault, consideration of medical evaluation and care
 - Encouragement of the MRP psychiatrist to discuss the event with any learners involved and provide support
 - Suggestion to access the online resources on the departmental website.

2. Head of Department makes Divisional Chair and PMD aware and preferably a meeting occurs with MRP as well, perhaps together with Head of Department if possible.
3. Divisional Chair and/or PMD checks in weekly for the first 2 months with the MRP to review any issues that may have arisen and provide support, direction and advice as needed.

(iii) Clarification and Initial Working Through (2 to 6 months post incident)

- Divisional Chair and/or PMD will continue to organize meetings with the MRP as required. Divisional Chair/PMD will organize or MRP can take initiative to meet at any time.
- Consideration of detailed psychological autopsy if helpful
- Alternatively, or in addition, MRP may decide to access outside resources and supports

(iv) Reorganization (6 to 18 months following incident)

- Longer term response will vary depending on individual needs
- If patient suicide, consider meeting with family at 1 year anniversary
- Divisional Chair and/or PMD will meet with the MRP between 12-18 months post incident
 - Address adjustment
 - Feelings of guilt/blame
 - Feelings of failure/self-doubt
 - Any effects on attitudes/work practice
 - Any ongoing medicolegal or College issues
 - If concerns, recommend access of outside resources including psychotherapy and ensure additional meetings