Risk Assessment Toolkit for Pregnant Trainees in Psychiatry

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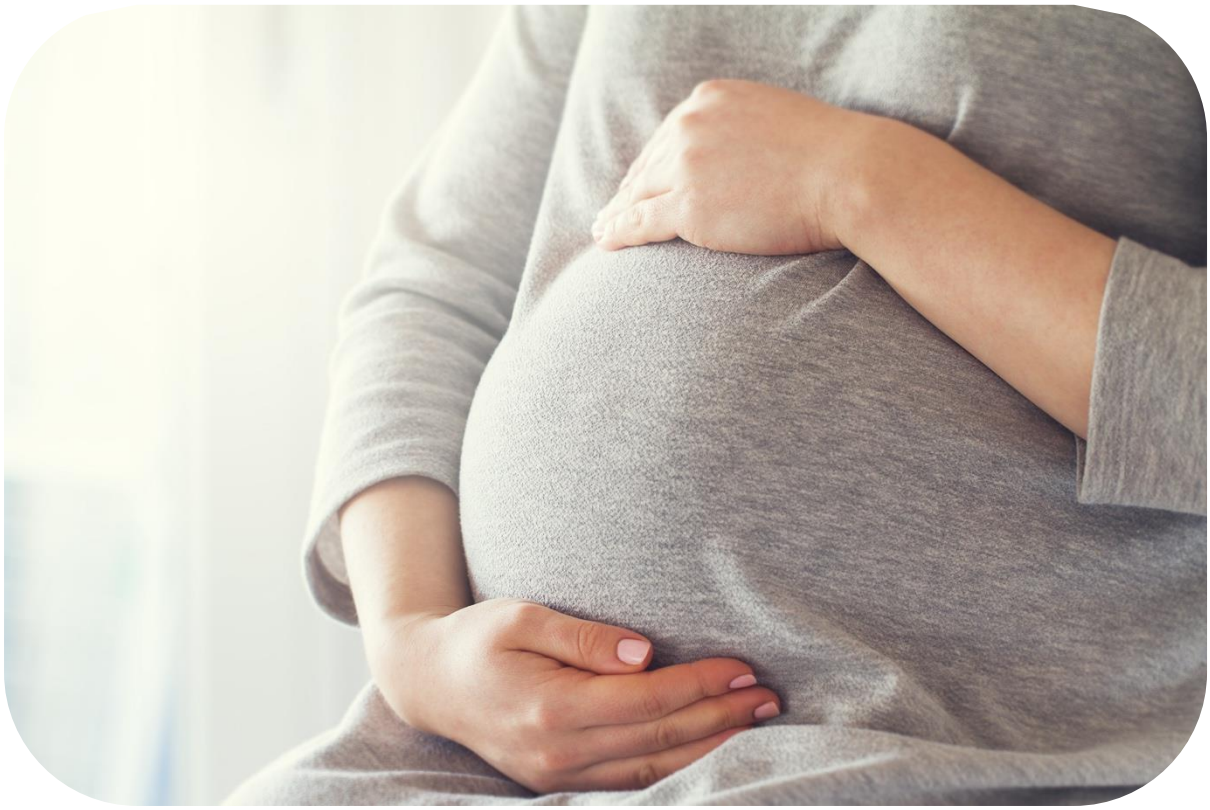

Introduction

Pregnancy is a special time in anyone's life, but it can also be a time of increased anxiety and is physically demanding. Although there is a lack of high-quality research examining the relationship between specific occupational hazards faced by pregnant trainees and adverse outcomes for both mother and baby, it is generally accepted long-hours and shift work can increase these risks[1].

As stated in the Lead Employer's Maternity Handbook[2], risk assessments should occur during a trainee's first and second trimester (12 weeks and 27 weeks). Risks faced by pregnant trainees are broken down into physical hazards, specific hazards, working conditions and mental job demands (see box 1). However, suggestions on how to minimise the impact of these are not specific as they need to be individualised and may be quite different depending on the job role. Psychiatric placements may present themselves with different risks to physical healthcare settings and doctors in training told us they weren't always sure how some of these risks could be reflected in their risk assessments and what adaptations to their work could be considered to mitigate them. The aim of this guide is to support risk management conversations in psychiatry placements and share possible ideas for the sort of adjustments that might mitigate risks. These suggestions are designed to be used in conjunction with the lead employer policy and to assist you in completing the pregnancy risk assessment (called Initial Risk Assessment). The form you need to complete can be found here Lead Employer - MWL | Forms . We hope you find this guide helpful.

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[1] Pregnancy, obstetrical and neonatal outcomes in women exposed to physician-related occupational hazards: a scoping review | BMJ Open

[2] Lead-Employer-Mat-Pat-Adoption.pdf (sthk.nhs.uk)

Common Workplace Hazards

Physical Hazards
Driving
Standing for long periods
Walking
Working at height/climbing steep steps
The need to access areas with limited space
Shift work
Specific Hazards
Use of chemicals, biological agents and exposure to radiation
Exposure to vibration
Need for PPE
Working Conditions
Lone working
Home working
Access to toilet and rest facilities
Restrictions on ability to take rest breaks
Pace of work
Risk of violence
Treating distressed/disturbed people
Contact with children or sick people
Unpredictable working hours
Dealing with emergencies
Obstacles
Indoor air pollution
Environmental temperature
Workstation/workspace problems
Mental Job Demands
Challenging deadlines
Rapidly changing priorities and demands
High degree of concentration

Box 1: Adapted from Lead Employer's Maternity Handbook

Risk Assessment Conversation Flow Chart

1.Do you feel safe to drive?
Yes. *Proceed to question 2.* *Reassess in 4 weeks.*
No. *Consider:* 1. Consider adjusting workload to reduce number of hours spent driving (for instance adjust community clinic/home visit) 2. Consider flexible start/finish times to reduce time spent driving by avoiding rush hour. 3. Consider if it is possible to work from home on certain days. 4. Consider whether alternative means of transport are appropriate or more comfortable. 5. Consider the difficulties of on calls e.g. driving longer differences to cover a wider locality out of hours and whether on calls can be adjusted.

2. Are pregnancy-related symptoms affecting your ability to work? (for example, fatigue, nausea, physical discomfort)
No. *Reassess in 4 weeks.* *Proceed to question 3.*
Yes. *Consider:* 1. Identify contributory factors– other caring responsibilities, physical health problems, concerns about mental health. 2. Consider if occupational health referral required. 3. Review workload: is there an appropriate balance of patients, is there adequate time for rest. 4. Review on call commitments – consider splitting long shifts, consider appropriateness of night shifts. Consider appropriateness of suspending on call commitments completely. 5. Ensure there are adequate facilities and time for rest breaks.

3. Do you work in inpatient areas?

No.

Review if risk changes.

Proceed to question 4.

Yes.

Consider:

1. Are alarms accessible and being worn appropriately
2. Is avoidance of lone working a possible, including accompaniment with appropriately trained staff during ward reviews.
3. Consider need to find cover for seclusion reviews.
4. Consider cover for more acute wards, in particular PICU.
5. Consider whether ward round reviews require adjustments to ensure safety.
6. Consider whether changes in mobility would increase risk in certain areas.
7. Consider the risk in A+E, the section 136 suite and police stations and whether adjustments need to be made to on calls
8. Consider coming off the on call rota to reduce the risk of seeing more agitated patients, seclusions reviews and MHA assessments.
9. If particular risks are identified with placement discuss with ES/TPD regarding placement review

4. Do you work in outpatient areas?

No.

Review if risk changes

Proceed to question 5.

Yes.

Consider:

1. Consider appropriateness of lone working on home visits and arrange joint reviews where appropriate.
2. Review clinic lists and risk assessments of patients +/- discuss with CMHT as to whether review is appropriate.
3. Avoidance of community MHA assessments particularly in later stages of pregnancy
4. Consider whether home visits may be completed in an outpatient clinic supported by other staff.
5. Bear in mind that discomfort and fatigue from necessity to drive, or ability to mobilise around patient's environment may effect ability to manage home visits and community reviews.

5. Do you work in a forensic setting?
No. *Review if risk changes*
Yes. *Consider:* 1. Consider whether there is opportunity to work in an environment with less acute risks such as a low secure unit or working with a pre-discharge caseload. 2. It is likely that your safety on the on call rota will need reviewing in this setting 3. Consider safety of prison clinics and considering modifying job plan to avoid these or review if a video link can be arranged. 4. If placed in Ashworth it is advised that all staff are moved to another role outside of the high secure unit so please advise your clinical supervisor as soon as you feel comfortable to do so after pregnancy is confirmed.

Case Studies

Case 1

Dr. X is a psychiatry trainee, who works in the community mental health team and is currently 28 weeks pregnant. They have been experiencing more fatigue than usual and have noticed a decline in sleep quality. Previously, they could see 5 patients in a clinic, but now struggle to complete tasks by the end of the clinic and are falling behind with clinical admin. This has caused Dr X to feel stressed and low. In addition, today they have been asked to review a patient at home who has a diagnosis of first episode psychosis and is refusing medication. Dr X is worried this might be a difficult consultation based on the risk of aggression as recorded in the notes.

Dr. X raised these concerns during supervision with the clinical supervisor. They decided to adjust the clinic numbers to three to give more time to complete the tasks generated from these appointments. They also agreed that Dr X. will take a break from home visits and Mental Health Act assessments and instead complete more tribunal reports.

With these changes, Dr. X felt able to continue to provide good-quality care to patients whilst maintaining good mental and physical health during pregnancy.

Case 2

Dr. Y is a core trainee doctor who is 16 weeks pregnant and working in a Home-Based Treatment Team. Dr Y is experiencing morning sickness and fatigue and has needed to take some time off sick. Dr. Y has been driving to work every day, but often has to stop due to sickness.

Dr Y meets with the clinical supervisor and together they decide to make some changes to the work. It is suggested that Dr Y work from home 1 day a week and reduce the number of home visits, instead doing more reviews in clinic to reduce travel time in the car.

They also decide that it would be best for Dr. Y to come off the on-call rota due to fatigue which has been compounded by working night shifts.

Case 3

Dr. Z is a higher trainee who is 25 weeks pregnant and working in an acute inpatient setting. She has been experiencing anxiety about reviewing patients who are in seclusion, fearing for her safety and the safety of her unborn child. As her pregnancy has started to show some of the patients have begun to make comments about it and sometimes they have been verbally abusive, making derogatory comments about how she will be as a mother.

Dr. Z discusses her concerns with her supervisor, who is supportive and empathetic.

The clinical supervisor discusses with the site tutor and the TPD about whether it would be possible for this trainee to be placed outside of PICU for the remainder of the pregnancy. One of the other core trainees on site kindly agrees to switch to the PICU and Dr Z is able to work on the female acute ward which feels more manageable. Towards the end of the pregnancy (from 34 weeks) she focusses on audit, tribunal report writing and discharge summaries and minimises time on the acute wards. When there are patients who are deemed to be at higher risk of aggressive behaviour she sits out of those reviews.

Case 4

Dr A is 22 weeks pregnant and on the out of hour on call higher trainee general adult rota. She gets called to a community mental health act assessment where there is a warrant and the police are in attendance. The patient is very distressed and angry and the police end up having to step in front of the clinical staff at one point in the assessment. Though she doesn't tend to feel worried in these situations normally she did notice that she came out feeling physically anxious. She becomes concerned about doing further community assessments due to their unpredictability and that usually the police won't be there.

She discusses with her clinical supervisor and they agree that she will come off the on call rota for the remainder of her pregnancy. For now her day job in the community mental health team has not been amended but they have agreed that she won't be doing any community mental health act assessments in the day job either.

Additional Resources

Lead Employer Maternity Handbook:

https://leademployer.merseywestlancs.nhs.uk/media/Lead-Employer-Mat-Pat-Adoption.pdf

BMA: Your Rights During and After Pregnancy:

https://www.bma.org.uk/pay-and-contracts/maternity-paternity-and-adoption/your-rights/your-rights-during-and-after-pregnancy

Health and Safety Executive: Protecting Pregnant Workers and New Mothers:

https://www.hse.gov.uk/mothers/

Driving While Pregnant Safety Advice (NCT):

Driving while pregnant: seat belts and staying safe | Pregnancy articles & support | NCT