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## **President's Message**

In 2007, 45% of Australians aged 16-85 years (or 7.3 million people) had, at some point in their lifetime, experienced at least one of the selected mental disorders (anxiety, mood or substance use disorders) (ABS, 2009). A similar number of nurses and midwives can expect to suffer from such issues.

Further, patients who are mentally unwell present to all areas of health care organisations.

This newsletter addresses some of the complexities seen by the Council in the area of mental health and highlights some issues of concern.

In this month's newsletter the Council is looking at both the nursing of mental health patients, and the self care of nurses and midwives managing their own mental health issues.

Council Member, [Professor Iain Graham](#), in his editorial, examines the history of mental health nursing and asks whether a more cohesive approach is needed to help nurses working in this challenging area of practice.

Observation and documentation are critical to ensuring patient safety, especially when the patient has mental health issues. The first article, 'Standards of care: Keeping mental health consumers safe', highlights these issues which are further explored in the second case study, Patient Death. Whilst this case study demonstrates a sad and potentially avoidable outcome for the patient, it serves to highlight the importance of observations and honest, accurate documentation.

Kim Ryan, Chief Executive, Australian College of Mental Health Nurses, discusses the importance of [training in mental health](#) for all nurses while Frances Hughes, Chief Nursing and Midwifery Officer (QLD), looks at the importance of post-qualification learning and development for nurses working in mental health.

This month, the Council has also looked at two other case studies. In the first, we look at the NSW Civil and Administrative Tribunal's decision in a disciplinary misconduct matter in which the Tribunal dismissed impairment as a mitigating factor to misconduct. In the last case study, we consider how the Council's health pathway can assist nurses managing their own mental health issues. In this month's short [reflective practice exercise](#) there is an opportunity to consider what constitutes good record keeping.

Adj Prof John G Kelly AM  
Council President

## Editorial: Mental Health Nursing - Where to Now?



The key message to reflect upon, is this: the status, educational preparation and expected scope and standard of practice amongst those who work as nurses with the mentally ill is still a debate. The history of psychiatric/mental health nursing covers many decades with an argument to be made that the attendants who worked at the St Mary of Bethlem in London in 1377 are

but a footnote in the history of mental health care.

It represents a timeline stopping point between historical times, stretching through Ancient Greece and Rome, to our society of today. A theme that runs through this timeline is the identification of mental illness and the methods employed by various societies to care for mentally ill individuals. Arguments have raged over to whom this accountability for care provision should fall, family, community or state? Privately or publicly funded? In the domain of religious organisations or of scientific medicine?

Where does one find nursing within this debate? The role of the attendant/nurse has received little attention from historians in comparison to other nursing groups. If one acknowledges this, one has to also acknowledge that the identity of the mental health nurse really began to take shape in the mid nineteenth century. The publication in 1885 of the first edition of the 'Handbook for the instruction of attendants of the insane;' coincided with the evolution of scientific medicine, with psychiatry being part of this professional group and the transition of asylums into a more general hospital ethos. Educating and having standards and competence amongst the attendants was vital if the asylum doctors were to improve their status, along with those of their patients and of their work places.

Space does not allow us to explore this history in greater detail.

The key message to reflect upon though, from this brief flirtation with history, is this: the status, educational preparation and expected scope and standard of practice amongst those who work as nurses with the mentally ill is still a debate that continues today.

For whose benefit should society have such a workforce? Mental health nursing lost out in the scramble to achieve professional status for nursing. Some refer to mental health nursing as a Cinderella part of the nursing profession. Attracting and retaining nurses to work in the area remains a challenge for employers and even schemes to enable these nurses to practise somewhat autonomously are cumbersome in application.

We are aware of the impact of mental health problems across our society, all age groups and demographics are affected, yet we remain hesitant to foster the potential of mental health nurses. It is perhaps time for regulators, educationalists and service providers to come together to sort out this problem. The history of this occupational group is quite distinctive; some of the major changes to care provision of patients with mental health problems would not have been made or achieved without them. It is time, for the sake of our patients and clients, to come off the fence and state emphatically what education one needs to be a mental health nurse, what scope of practice is to be expected and what standards of care the practitioners will be held accountable for.

Such decisions are in our hands.

Professor Iain Graham  
Editor and Council Member

## Standards of care: Keeping mental health consumers safe

What are some of the challenges in providing timely and high quality mental health care to consumers in inpatient settings who are at risk of harming themselves and others? How do nurses meet these challenges?



Mental health service delivery presents a specific set of challenges in balancing the need to deliver quality healthcare in the least restrictive manner with caring for consumers so that staff and consumers are protected (Livingston et al; 2010, Mental Health Act 2007 (NSW)). This article explores some of the challenges in providing timely and high quality mental health care to consumers in inpatient settings who are at risk of harming themselves and others (high risk) and refers to the policies and guidelines designed to minimise risks and promote a culture of safety (The [Nursing and Midwifery Board of Australia's Code of Ethics for Nurses in Australia \(2008\)](#) and [The Nursing and Midwifery Board of Australia's Code of Professional Conduct for Nurses in Australia \(2008\)](#); and [Australian College of Mental Health Nurses: Standards of Practice for Australian Mental Health Nurses \(2010\)](#)).

### ***High risk consumers and the use of interventions***

The [National Practice Standards for the mental health workforce \(2013\)](#) highlight the need to provide people-centred care with respect and dignity while recognising that some consumers experience mental health services on an involuntary basis. For high risk consumers, emergency interventions are sometimes used as a last resort, in the least restrictive environment and for the minimum duration required to protect the health and safety of the consumer or others. Interventions include one-on-one nursing ('specialling'), the use of seclusion and restraint to ensure the consumer is moved safely into a seclusion room.

### ***Risks***

During interventions, additional care and supervision is required to minimise physical and psychological harm to consumers. Recently, the Nursing and Midwifery Council of New South Wales has received several complaints where the standard of care received by mental health consumers has dipped significantly at key times such as during night shifts, weekends, and shift change-over. This has resulted in the failure to recognise and respond to the clinical deterioration of consumers, and the failure to provide therapeutic care and safety to consumers.

### ***Minimising Risks***

For consumers in seclusion, observations and consumer engagement is critical in assessing the mental state of consumers and preventing a feeling of isolation. Verbal communications combined with a comprehensive review and risk assessment on each shift can also inform when to cease interventions at the earliest opportunity or, alternatively, identify any clinical deterioration of the consumer and the need to escalate any changes to a medical officer (NSW Health Policy PD2007\_054 '[Patients in seclusion Aggression, Seclusion & Restraint in Mental Health Facilities in NSW](#)'; NSW Health Policy in PD2011\_077 [Recognition and Management of a Patient who is Clinically Deteriorating](#); Clinical Excellence Commission: [Between the Flags](#) system).

### *Minimising risks summary for mental health care consumers under intervention*

- observation and monitoring (as appropriate for the consumer's condition)
  - thorough risk assessment
- active and therapeutic engagement with consumers
  - accurate and timely documentation

In the article "[Violations and Migrations in Nursing Practice](#)" in the Nursing and Midwifery Council's October 2014 newsletter, Reid discussed that the greatest risk for consumers is the normalisation of shortcuts, which digress from standard practices "without due regard to the consequences". In particular, our case study 2 highlights the serious consequences of falsely documenting that observations and assessments have been completed for consumers under seclusion. Health care records are an essential component in ensuring quality care is provided during shift handovers, transferring consumers between clinical settings and escalating the care for a deteriorating patient (NSW Health Policy PD2012\_069 [Health Care Records - Documentation and Management](#)).

While practice standards need to be maintained in all nursing settings, such standards are particularly relevant to providing the necessary balance in minimising risks to high risk consumers and staff safety while delivering quality healthcare. Practices of seclusion and restraint are used to minimise harm to staff and consumers. There are also risks of physical deterioration and death associated with these practices, and experiences of trauma and loss of rights and dignity are also present (Rakhmutaullina et al 2013). An international mandate to eliminate or reduce seclusion and restraint is in place (Knox & Holloman 2012), and this is supported by all Australian Health Directorates. Practices and projects that aim to reduce seclusion and restraint must be upheld (Maguire et al 2012). Continuous risk assessment, close observation and rigorous and accurate documentation are essential components of therapeutic care to consumers who require protective intensive care.

There also needs to be a review of the factors which may prevent such high frequency observations being completed such as staffing levels, skill mix and experience, maintaining staff safety, the desire not to disturb patients so that they can sleep during the night, and most importantly the culture within a unit and the acceptance of taking shortcuts, and recording observations inaccurately. These factors must be acknowledged and addressed to improve patient safety.

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## Becoming a mental health nurse in 2015



The context of service provision for Australians with mental health problems has changed significantly over the past 30 years. Accordingly, the scope of practice of Australian mental health nurses has had to adapt, the programs that provide educational preparation for mental health nursing practice have had to evolve, and the type and focus of mental health nursing research has had to respond to these sector changes.

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Developing and sustaining a specialist mental health nursing profession is an important strategy to improve health care access for people with mental health problems. At present, the Australian College of Mental Health Nurses Credential for Practice Program (CPP) is the only nationally consistent recognition for specialist mental health nurses. The CPP is a professional self-regulation program whereby members of the profession have set standards for practice and established a minimum requirement for entry, continuing professional development, endorsement and recognition. From an educational perspective, the CPP identifies that to be a 'mental health nurse' practitioners should hold postgraduate qualifications in mental health nursing.

Of course, the development of mental health nursing practice actually begins at undergraduate level during comprehensive nursing education – after all, empathy, kindness, being genuine and understanding the distress of someone who is experiencing a health crisis is part of every nurses' role, not just those who identify as mental health nurses. During undergraduate education, all nurses should be developing some knowledge and capacity around the impact on physical health by mental health issues and vice versa, and developing some skills in addressing the holistic health care needs of all patients/clients/consumers, including those who experience mental distress and illness.

Nurses who want to specialize in mental health nursing then need to undertake postgraduate mental health nursing qualifications. However, a scan of Postgraduate Mental Health Nursing Programs in Australia 2011 (ACMHN) identified a high level inconsistency between courses, particularly in how the education component interacts with clinical competency. As a consequence, nurses who have identified that they want to become a specialist mental health nurse can face difficulties in choosing a course that provides appropriate mental health nursing skills. To address these problems, the ACMHN has developed a [National Framework for Postgraduate Mental Health Nursing Education](#) (which builds on the Mental Health Nursing Education Taskforce pre-registration framework for mental health in undergraduate nursing) and is establishing an accreditation process for postgraduate mental health nursing education programs, to ensure that there is a clear articulation from undergraduate to postgraduate level study,

as well as a clear educational career path established for mental health nurses of the future.

At all levels and across all settings, there is an expectation that mental health nursing practice is based on evidence. Ideally, we would have a nationally defined set of research priorities and this is something that the ACMHN is working towards, with the aim of systematically building on the capacity of mental health nurses to practice in an ever-more evidence-informed way. Some of the research questions/priorities that have been identified by the mental health nursing profession in one jurisdiction (WA) are clinical (e.g. bed availability and the appropriateness of a range of clinical services in relation to consumer outcomes), others are professional (e.g. job satisfaction, mental health skills of comprehensively educated nurses, factors affecting recruitment into mental health nursing) (Wynaden et al 2014). It has not yet been established whether these priorities would be reflected across the profession more broadly. What is clear though, is that defining a research strategy for the mental health nursing profession that meets national and international mental health priorities is essential (Wynaden et al, 2014), and requires collaboration across universities and health services, with consumers, their families and with the profession's statutory bodies.

**Reference:**

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Kim Ryan  
Chief Executive Officer  
Australian College of Mental Health Nurses



## **Registered Nurses preparation to work in Mental Health**

I have been a registered psychiatric nurse since 1980s and by virtue of that education a mental health nurse. Since then I have undertaken more postgraduate education, practice and met credentialing requirements to now be a credentialed mental health nurse.

There has long been debate on what is a mental health nurse, but the debate should not exist. Why? Because we have clear definitions of mental health nursing both nationally and internationally by our profession. Mental health nursing is a specialist area of registered nursing (division one) practice, it has been for decades. Our history had psychiatric nursing as a separate registration and when these disappeared the definition did not change with regards to it being a specialist education; but it did change to state how it happens. Post registration through university postgraduate programmes at a minimum. So what does this mean for how RNs are prepared?

The comprehensive nature of our undergraduate programmes was never intended to produce a mental health nurse to meet the definition as a specialist. There is no health without mental health, so the registered nurse (division one) preparation is to ensure that the understanding of interplay of biological, psychological, social, environmental and spiritual context is understood. All registered nurses, wherever they are, should ensure they understand mental health within this wider context with all patients and do no harm to those families, consumers and patients who are experiencing mental health problems. Why is this important? Families and consumers/ patients with mental illness continue to experience a different relationship in all societies. We need all registered nurses to be able to work with all consumers and patients in a manner that ensures safety and quality of that interaction.

Are RNs then prepared to be mental health nurse? No, they are not able to claim the qualification of being a mental health nurse! This requires the registered nurse (division one) to undertake further education within this speciality. It is this further education, along with recognition of you by your peers that confers the standards of mental health nursing through processes like credentialing. This further education provides consumers and families to have a certain degree of confidence and reassurance as to a nurse's capability whilst working in this field. When mental health consumers enter into a therapeutic relationship with a nurse in order to work through their mental health problems we want it to be positive, safe and focused upon the best evidenced base approaches in order to build upon recovery.

For all nurses registration is a right of passage into the profession, it is what you do post registration level that is really important to our consumers and services. We commit by virtue of being in this profession, to professional standards and codes along with lifelong continued learning. In mental health this is extremely important, the nurse is the diagnostic tool, the vehicle for therapy, the assessor, the professional support to the most vulnerable. We must keep our competency at its highest level. When things go wrong with our relationships with consumers and patients, it is often to do with us – and our failure to provide care from receiving relevant education. Our families, consumers and patients who live with mental illness deserve the best nursing we can offer, so we need to provide the best.

Frances Hughes  
Chief Nursing and Midwifery Officer  
Queensland



## Tomorrow: Did You Know?

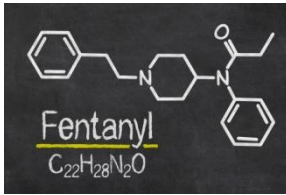


Recreational drug and alcohol use can affect your ability to practise safely, tomorrow, and maybe after that:

- regular use of any drug (every other day) may mean that you are never not affected by that drug
- different drugs will stay in your system for different periods of time
- alcohol continues to impair your performance longer than most drugs
- combining different drugs, and drugs and alcohol will increase the extent of the impairment suffered.

Are you practising your profession safely?

## Tribunal Matter- Impairment is not a mitigating factor



The NSW Civil and Administrative Tribunal (NCAT) dismissed 'impairment' as a reason to adopt a more benign approach to professional misconduct. Mr Ashford alleged to have developed Post Traumatic Stress Disorder (PTSD) during military service before becoming a registered nurse and to have suffered further trauma in caring for a patient with a severe burns injury.

In 2009, there was an incident in which Mr Ashford requested and obtained Fentanyl from the key holder of the controlled drugs cabinet for "dressing changes". Later in the shift, Mr Ashford was seen by colleagues returning from the staff toilet pale, diaphoretic and drowsy and needed to be taken to the Emergency Department. The incident was investigated by Mr Ashford's employer and he was questioned over inaccuracies in the recording and inconsistencies in the administration of Fentanyl for analgesia for a patient with a severe burns injury. Mr Ashford was suspended by his employer and, on returning to work, was put onto day shifts to enable closer supervision of his work.

The Health Care Complaints Commission (HCCC) investigated two further incidents occurring in 2013 in which Mr Ashford misappropriated schedule 8 drugs for his own use and subsequently gave false versions of events to account for their disposal. In the first incident, NCAT reflected on the professional misconduct and unethical behaviour of Mr Ashford in misappropriating Oxycontin, denying such misappropriation, providing the Pharmaceutical Services Unit of the NSW Ministry of Health with a medical certificate obtained through false or misleading information alleging he was allergic to Oxycontin. In the second incident, Mr Ashford not only misappropriated Fentanyl during a night shift but also failed to follow NSW Health Western Sydney Local Health District policy by not administering medication to the patient with a second registered nurse.

### *Decision*

NCAT disqualified Mr Ashford from being registered as a nurse for two years on the basis that Mr Ashford was guilty of:

- unsatisfactory professional conduct
- professional misconduct
- having an impairment; and
- otherwise not being a suitable person to hold registration as a nurse.

NCAT held that without an independent assessment, NCAT was not satisfied that Mr Ashford had PTSD, particularly as Mr Ashford later denied having the condition. However, NCAT found that Mr Ashford was impaired due to substance abuse or dependence, which detrimentally affected or was likely to detrimentally affect his capacity to practise nursing. NCAT also noted that if Mr Ashford were to return to nursing, he would need to undergo a comprehensive review of his mental state and drug use, see a pain specialist and have conditions placed on his registration, including urine drug testing.

The decision can be read in full here:

<http://www.austlii.edu.au/au/cases/nsw/NSWCATOD/2015/15.html>

## Case Study: Patient Death



The Council received a notification relating to the failure of three members of nursing staff to properly observe an inpatient with active suicidal ideation. The Council considered the full investigation report provided by the employer and consulted with the Health Care Complaints Commission (HCCC) in the management of the matter.

The patient had a mental health disorder and required close observation. The observations were not performed as required and the patient was found deceased in his bedroom and was unable to be resuscitated. A review of the chart revealed that observations on the patient were due to be undertaken every 15 minutes and were recorded as having been undertaken. CCTV indicated that many of the reported observations had not been undertaken or had not been undertaken at the times specified.

Two of the nurses involved in this incident, expressed regret for their actions, undertook further education and worked with their employer to improve their practice. A third nurse disputed the CCTV footage which showed that the patient had not been observed. An investigation of this claim showed the footage to be accurate.

The employer's investigation indicated that the third nurse did not appear to understand the gravity of the situation. At a formal meeting she finally conceded that she had not left the nurses' station but had signed the chart, and indicated that this had been common practice - especially on night shifts. The report concluded that the nurse felt no remorse, demonstrated no insight and did not accept responsibility for the patient's care. This nurse's employment was terminated.

The third nurse was advised that the Council would be considering immediate, interim action under Section 150 of the National Law (NSW) for the health and safety of the public. The nurse made submissions to the Section 150 Committee. The nurse raised contradictions with the employer's investigation report and felt that the seriousness of the patient's suicidal ideation had not been made clear to her at shift handover. The nurse reported that she had seen a psychiatrist in relation to how recent events had impacted her. She felt that she had expressed her understanding of the gravity of the situation and her remorse in a safe environment. The Committee determined that conditions on the third nurse's registration were required to protect the public safety. These conditions included supervision of practice.

The Council agreed to refer the registrant for a health assessment and to refer the matter to the HCCC for investigation. The other two nurses were also referred to the HCCC for investigation.

The Council has received a number of similar cases over the last two years which demonstrate the importance of taking regular close observations particularly during night shifts and at shift changeover. When an observation is missed, it should be recorded as missed (and the reason for this) – the observations should not be 'backfilled'. That is, if a nurse completes an observation at 2 am but the observation has not been recorded since midnight, the observations between midnight and 2 AM should be signed as missed rather than signed as completed. When the observation is delayed the correct time that the observation is taken must be completed. Observations must be signed off by the person who has completed the observation. Auditing observations is important and when observations are regularly missed the factors which are impacting on this should be explored and remediated.

## Case Study: the impact of the Council's Health Pathway



Being the subject of a complaint that is being managed by the Council can be a confronting and stressful experience for a nurse and/or midwife. However, when the public's safety is put at risk by a practitioner's impairment, the Council's health pathway can provide real support to the nurse and/or midwife in assisting their recovery and protecting the public.

### *About the Complaint*

The Registered Nurse (RN) suffered back injuries and was prescribed opioids for pain relief. Over time, the RN built up a tolerance for the medication and required increasing quantities leading to a diagnosis of addiction to opiates. The RN's addiction and its impact in the workplace came to the Nursing and Midwifery Council's (Council) attention when the RN's employer, a nursing home, notified the Council. The RN had reportedly been seen in the work bathroom with a tourniquet in their hand and appeared to be extremely fatigued. Needle caps and alcohol wipes were also found in the bathroom. The employer further reported that the same week, the nursing home ran out of medication, resulting in one of the patients needing to be transferred to the local hospital Emergency department.

### *Health Pathway*

The Council took immediate, interim action and imposed conditions on the RN's registration and required the RN to attend a health assessment with a Council appointed practitioner. The health assessment reported that the RN had an impairment under the Health Practitioner Regulation National Law (NSW) (Law) and recommended that the RN enter the Council's health pathway. The nature of the impairment included a mood disorder and opioid dependency and abuse likely to detrimentally affect the RN's capacity to practise nursing.

The health pathway aims to protect the public and assist health practitioners in a constructive and non-disciplinary manner. Accordingly, an Impaired Registrant's Panel reviewed the existing conditions imposed on the RN's registration and recommended to the Council conditions as follows:

- The RN must establish and maintain a therapeutic relationship with a counsellor, Drug and Alcohol Specialist and General Practitioner
- The RN must attend random urine drug testing with a minimum monthly frequency.
- The RN must not work as a sole registered nurse or act in a supervisory role or for an agency
- The RN must not possess, check, administer, handle, or dispense any drug of addiction (schedule 8 drugs) or any prescribed restricted substance (schedule 4D drug or schedule 4D derivative).

The Council imposed these conditions on the RN's registration.

### *Progress*

After 30 months in the health pathway and over 12 months of negative urine drug testing results, a subsequent Impaired Registrant's Panel recommended to the Council that the RN was no longer impaired under the Law. The RN commented that the conditions had been supportive and complying with the conditions encouraged the RN to develop better strategies to deal with addiction and manage pain. The IRP acknowledged the RN's progress and, in particular noted that the RN:

- had developed plans to manage pain;
- showed insight into the nature of addiction and risk factors;

- was actively engaged with treatment; and
- had developed support mechanisms to cope with stressors, including relapse-prevention counselling.

The RN was discharged from the Council's health pathway and conditions lifted.