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NURSE PROFILE INTERVIEW WITH JULIE LEMIEUX

– NWMH MENTAL HEALTH NURSE OF THE YEAR

1 What informed your decision to be a Division 2 nurse?

There were limited options in the 70's as to what career pathway was taken. I chose nursing as a occupation at that time. It was my perception of what nursing stood for that inspired me to enter into nursing. Reasons for this were empathy to the care of others, and a better understanding of the issues and challenges that mentally unwell persons face. A wonderful statement by the CPN unit quotes "Essence of the Psychiatric Nurse" defining as a reflection of why not just myself but mental health clinicians do what they do and do best in our daily practice. It is a notation that I take great pride in passing onto students during orientation. It reflects not just the discipline of the Registered Psychiatric Nurse but of all mental health clinicians.

I am a Registered Division 2 nurse and commenced my training in Intellectual Disability (Mental Retardation) as a Mental Retardation Student under the umbrella of Mental Health at that period of time. I trained at one of the older institutions in a country regional area - Caloola in Sunbury. As part of the deinstitionalization program I was involved with the transition support process of residents relocating to community. This 16 year period of working within intellectual disability services provided me with the underpinnings of nursing and the beginnings of the holistic approach.

2. Tell me about your work life …

After 33 years of nursing I have been able to reflect on my experience in Mental Health. Reflection is a useful tool in everyday practice. I find that one's experiences, skills, knowledge base, education and professional development consolidates over the decades. To date I have been working within NorthWestern Mental Health for 17 years; predominately within Aged Mental Health with a 2 year period in Adult and to present in Clinical Education.

Julie Lemieux:
The Northwestern Mental Health Nurse of the Year

Each area of the program has progressed my professional growth, reflecting and mentoring it back to my peers. The periods of time spent in each area of Mental Health and under the supervision of RN 1/3 generated opportunities as a clinician to experience and fulfill the role which progressed to being multidisciplinary member, team leader in some roles, role model, mentor and buddy to nurses. From all areas where skills and experience has been gained has led me to generate new ideas to piloting small projects that enhanced practice and created a learning environment for most of us. This could not have been achievable unless the support of the manager was there.

3 What's it like being a Division 2 nurse in an Education Team?

I was recruited in a newly created position with the Seniors Nurse Unit – APMHP as Division 2 Nurse Educator in our residential program. It is at this time the first time a RN Div 2 has occupied a clinical educator position. It is a supportive role, mentoring, role modeling, and providing educational support to both RN Div 2 and trainee div 2 nurses within our program.

The program is affiliated with the local TAFEs in providing clinical placements to Div 2 trainees. In 2008 the program piloted its first Div 2 post grad course in mental health. This was successful with external recruitment to the course attaining 70% retention within the program. As Clinical educator for the Div 2 my involvement was that of mentoring and support.

Continued over page >

MAJOR DISASTER RESPONSE - HOW READY ARE WE?

How ready are mental health nurses to respond to trauma arising from a major disaster?

On the 23rd July 2009, the Centre for Psychiatric Nursing is hosting a symposium that will explore issues associated with the immediate and long term effects of major disasters, and whether mental health nurses have the necessary skills to assist the community to deal with these effects.

Guest speakers with an interest and expertise in trauma and mental health nursing will present their views followed by questions from the audience, facilitated discussion and debate.

This symposium is of relevance to mental health nurses and mental health communities.

Thursday 23July 2009
4:30 pm – 6:00 pm
Room 421, Level 4 / 234 Queensberry St, Carlton
(Corner of Queensberry and Leicester Streets)

Guest speakers at the Symposium are:

- Professor Mark Creamer
  Director, Australian Centre for Post-traumatic Mental Health
- Ms Debbie Bloom
  Clinical Nurse Educator, NorthWestern Mental Health
- Ms Tracy Beaton
  Senior Nurse Advisor, Mental Health & Drugs Division
- Ms Margaret Farrell
  Team Leader, Northern CATT (NWMH)
- Dr Natisha Sands
  Senior Lecturer, University of Melbourne

Attendance at the symposium is free, and drinks and finger food will be served at the conclusion of the symposium.

For further information, or to register your interest to attend, please contact the Centre for Psychiatric Nursing at cpn@nursing.unimelb.edu.au or 03 8344 9626.

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NURSE PROFILE INTERVIEW WITH JULIE LEMIEUX

Continued from page 1

The core group of nurses in the program are Div 2 nurses. They are at the coal face and are presented with the day to day issues in care of a client group with complex care needs. They face the challenges of the behavioral, physiological, medical, psychological and environmental issues that impact daily on their care. In supporting through in mentoring, modeling and education I can reflect both from past experiences and promote best practice initiatives. It is a role that as a peer one can empathise with those challenges and collaboratively approach solutions.

I have found that every day is a learning experience in my role. I myself learn from my seniors and other disciplines, truly learned and experienced clinicians. I admit I do not have all the answers to what questions people ask me but I can, at end of the day, resource information and reflect back as best practice. To me this is learning and part of the modeling of best practice.

4 Tell me about your contribution to quality improvement in your work setting?

A tremendous amount of work goes into quality. In Aged Mental Health we also sit under the Aged Care Act (1997) and are required to meet accreditation standards set down by the relevent agency. Our quality initiatives are instrumental in identifying gaps and working towards problem focused solutions. Generated ideas become working projects based on best practice initiatives. In the last 3 months we have had 3 of our facilities pass accreditation. The work was immense and intensive. The quality initiatives for practice improvement from the Division 2 perspective were enormous with my main focus supporting staff in up skilling, staff development and education. This area covered the clinical care of Standard 2 in the identified outcomes of Aged Care Accreditation Agency. Under the supervision of RN 1/3 and directly working with the Div 2, these nurses are now taking up portfolios in local areas in each of the specialized areas of the standards. We hope that in time through further educational development and support that they will become champions in their area of expertise. This contributes greatly to continuous quality improvements with ongoing input from staff generating ideas in further improving best practice from project work that is generated with the program.

5 Northwestern Mental Health Nurse of the Year! What was it like for you to win this award?

Winning the award was quite surreal, totally unexpected...It was very flattering that my peers acknowledged me for such a distinguished accolade.

It was great to have that recognition for a Division 2 in North West Mental Health.

They/we are the core of our nursing population who work at the coal face day to day. We have so many Div 2 nurses within in program who do step up and take the initiative and contribute their skills and knowledge to the team. This award is in recognition for those nurses. There are more Div 2 Nurses taking on leadership roles now then in previous years, many seeking out and pursuing further professional and staff development. It would be great to see more acknowledgements for the skills that they bring to the team.

Division 2 nursing has progressed from not just an occupation but to a profession. In receiving this accolade the message of paving a career pathway can be inspired on to other Division 2 nurses or those wishing to enter Division 2 nurse training.

6 What are your professional goals / ambitions / objectives?

Like with most professions we are bound by the scope of practice though this does not deter us from continuing professional development and seeking out the information highway. My current role is diverse in many areas. Education can be directed in to many areas of care not just on the clinical aspects. My main focus is on clinical care Standard 2 of Aged Care Accreditation Standards, Education and support, modeling and mentoring of our Div 2 and Trainee Div 2 nurses. This will continue to evolve from further professional development. Evolvement and diversity continues to make the position grow. With the NBV scope of practice now broadening for Div 2 nurse so does the need for further education to the Division 2 workforce. My role is expanding as new projects are generated within the program. The need for evidence based practice establishes the template for further staff development.

NURSES HELPING NURSES

It's well acknowledged that around 10% of nurses will experience an alcohol and other drug (AOD) use problem at some time of their lives, but it is difficult to find any hard data related to nurses facing their own mental health issues (MH). The growing number of articles on burnout, self-care, vicarious trauma and compassion fatigue possibly reflects the significance of the problem within the profession.

The Victorian Nurses Health Program (VNHP) was set up in August 2006 to provide advice, support and case management to nurses facing the challenges of AOD issues. The scope of the programme was expanded in June 2007 to meet the needs of those with MH concerns.

The program is funded by the Nurses Board of Victoria (NBV) however it operates separately with its own Board of Management to protect the anonymity of the participants.

The program works with individual nurses and also offers advice and guidance to managers and employers who suspect that one of their nurse employees is facing these issues and need advice regarding how best to support them.

The program provides assessment, referral to a variety of services including counselling and financial support, case management for those with AOD issues, peer support groups and general advice regarding NBV and work-related issues. Industry advocacy however, is not within the program's brief.

Bella Anderson
(Case Manager)

Between August 2006 and June 2008, the program opened 155 episodes of care (111 for AOD and 44 for MH). A breakdown of the AOD referrals showed 64% were referred to the program for primary alcohol issues, 24% regarding over the counter and prescribed drugs such as codeine, and 12% for problems with illicit drugs. A breakdown of the MH referrals showed 35% were referred for stress, 26% with depression 11% with anxiety and 28% other / unknown.

But why set up a service for nurses, why not send them to generic community treatment programs?

Nurses do not readily seek help for AOD and MH issues because they fear:

- Exposure to their peers or their patients;
- Putting their jobs at risk or being reported to the NBV;
- Creating financial problems by having to take time off for treatment;
- There may be no effective treatment because of their regular contact with 'revolving door' AOD and MH clients in crisis, nurses rarely see people who have succeeded in making long term positive changes in their lives; and
- Becoming a patient and the associated powerlessness.

The VNHP encourages nurses to access help by:

- Providing a free service to those registered or able to be registered with the NBV;
- Not requiring phone enquirers to give identifying information;
- Inviting nurses to attend the office for initial information sharing and early referral before requiring they provide any identifying information;
- Being run by nurses, staffed by nurses and designed by nurses who have significant nursing experience to be able to identify and separate work-related and personal issues and provide suggestions for how to deal with both;
- Assessing and managing people with emerging issues, participants do not need to be suffering from serious problems before we will begin to work with them;
- Providing financial support to non-metropolitan nurses to access the program; and
- Ensuring confidentiality.

The VNHP invites interested nurses or managers to contact the program for further information or to make an appointment to meet our staff. The program's staff are also available to present information about the VNHP at staff meetings, inservice conferences and other appropriate forums.

The VNHP acknowledges the contribution of the Nurses Board of Victoria, the Australian Nurses Federation and the individual nurses who assisted in setting up the program and to the profession as a whole for consistently supporting it.

REDUCING SECLUSION AT THOMAS EMBLING HOSPITAL

‘Reducing use of, and where possible eliminating, restraint and seclusion’ was identified as a national safety priority in 2005. In 2007, the Thomas Embling Hospital (TEH) was funded to be one of eleven national Beacon demonstration sites that would implement and evaluate strategies for reducing seclusion. In 2008 funding was allocated to extend the project to June 2009. At TEH, a forensic mental health hospital, there are 118 beds in seven units for male and female patients transferred from the justice system.

For the Beacon Project, we adopted the US framework for reducing seclusion:

- Leadership guiding and supporting organisational change
- Continuous workforce development
- Genuine consumer involvement
- Enhancing therapeutic practice
- Use of data to support practice
- Rigorous review and audit

Leadership guiding & supporting organisational change

The Management Group comprising the Beacon Coordinator (Trish Martin), the Project Officer (previously Donna Melia and now Roslyn Young), and a Consumer Consultant (Keir Saltmarsh) has met fortnightly throughout the project. Reducing Seclusion is an item on the Corporate Plan and a standing item at the Inpatient Executive and at other meetings including the Consumer Advisory Group.

Continuous workforce development

Staff are introduced to the Beacon Project during the Induction Program. Clinicians are then led through the philosophy, aims, and local strategies and experience related to reducing seclusion during the management of aggression workshop. The Management Team regularly attend staff and patient meetings to discuss the progress of the Project and the Beacon strategies.

Genuine consumer involvement

A Consumer Consultant is employed one day each week for Beacon work. The other Consumer Consultants support the Project. The principles and strategies to reduce seclusion are discussed at the Consumer Advisory Group meetings and at Consumer Consultant led unit community meetings.

Enhancing therapeutic practice

New or strengthened practices include the Safety Plan (identifies stressors and helpful strategies), Post Seclusion Debriefing (for patients that have been secluded) and Seclusion Review (an examination by clinical staff of each seclusion event). A Seclusion Plan has been designed that facilitates more collaboration/transparency between the treating team and the patient in seclusion.

The main Sensory Techniques that are in use are the calming sprays and the use of space cleansing sprays in the seclusion rooms. The recent placement of an electric massage chair on each of the acute units has been a welcomed strategy. Five units at TEH have established Safe Rooms/Calming Rooms.

The admission process reflects a more welcoming approach. Patients that were transferred from prison used to be taken by nursing staff directly to the seclusion suite and examined in order to complete the corrections department *‘Marks and Scars’* form. This examination now takes place during the physical examination by the doctor.

Although the Structured Day has been implemented at TEH independently of Beacon, it is a strategy that is promoted widely as contributing to the reduction of aggression and seclusion.

The use of the locally designed Dynamic Appraisal of Situational Aggression: Inpatient Version (DASA:IV) has been reinforced as the assessment tool to identify early indicators of aggression and facilitate early intervention and prevention of incidents.

Use of data to support practice

An evaluation is being conducted to measure the impact of Beacon on the staff and patient cultures. A considerable amount of data is collected and sent to Canberra. At a local level, monthly data is disseminated to the clinical areas. The following graphs are summaries of the data for the two years before the project and during the project:

TEH Beacon

Rigorous review and audit

Every seclusion event is reviewed with the unit clinical team. Small focussed audits occur regularly, for example, case file audits to examine to what extent Post Seclusion Debriefing for patients is taking place.

What the Beacon Project has given us is an opportunity (supported by funding) to review our organisational processes and clinical strategies that are related to inpatient aggression

Sustaining the reduction of seclusion work beyond the Beacon Project

At TEH, the index offence of patients is commonly one of violence and the most common current risk is interpersonal violence. While the Project has had little impact on the number of patients that are secluded, we have managed to reduce the number of events (ie repeat seclusions) and the duration of seclusion. Can we eliminate seclusion at TEH? Not in any foreseeable future. The literature refers to ‘alternatives to seclusion’ but what are then described are early intervention strategies for someone that is becoming aroused/agitated. If that person then becomes an immediate or immanent risk to others we do not know of any safer or less coercive intervention than seclusion.

What the Beacon Project has given us is an opportunity (supported by funding) to review our organisational processes and clinical strategies that are related to inpatient aggression. There is no doubt that we have made considerable progress. The main strategy for sustaining the work is to integrate the Beacon framework and initiatives with the existing management of aggression program. This program is well established but we acknowledge that we have put too much focus on intervention at the point of escalating aggression but to sustain the reducing seclusion momentum the emphasis must be on prevention and early intervention.

Dr Trish Martin

10th VICTORIAN COLLABORATIVE PSYCHIATRIC NURSING CONFERENCE

REGISTRATIONS

13 & 14 August 2009

As joint hosts the **Centre for Psychiatric Nursing, The Australian College of Mental Health Nurses (Vic Branch), The Health and Community Services Union** and the **Australian Nursing Federation** invite you to attend this exciting conference.

The aim of this conference is to focus on the practice of psychiatric nursing and how this practice contributes to better health outcomes for the consumers of services.

Registrations are now open

The registration form is available on the CPN website:
www.cpn.unimelb.edu.au

If you require further information please contact **Greg Mutter** at the CPN:

T: (03) 8344 9626
E: cpn@nursing.unimelb.edu.au
F: (03) 9347 4375

Early Bird registrations have already closed
All other registrations close: 17 July 2009

Themes

- Innovation in practice
- Sustainability of psychiatric nursing
- Consumer perspectives
- Carer perspectives
- Clinically-based research and evaluation
- Psychiatric nursing across the life-span
- Rural issues
- Cultural and indigenous issues
- Dual diagnosis
- Dual disability
- Recovery

PSYCH NURSES BIG NIGHT OUT

THURSDAY 13 AUGUST 2009

The San Remo Ballroom
Nicholson Street, Carlton North

7pm Start with Drinks & Canapés
followed by a 3 course meal
then dancing & fun until 11:30pm

Dress to Impress

For ticket prices and bookings visit the Conference website:
www.cpn.unimelb.edu.au

REGISTRATIONS WILL CLOSE WHEN THE VENUE CAPACITY IS REACHED OR ON FRIDAY 31ST JULY 2009.
NO DOOR SALES WILL BE AVAILABLE

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