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12TH VICTORIAN COLLABORATIVE PSYCHIATRIC NURSING CONFERENCE – KEEPS GETTING BETTER

On the 11th & 12th of August 2011, 278 delegates attended the 12th Victorian Collaborative Psychiatric Nursing Conference at the Moonee Valley Racecourse in Moonee Ponds, Victoria.

Delegates came from various private and public Victorian Mental Health Services, South Australian and Queensland public Area Mental Health Services and Victorian, South Australian & Queensland academic institutions.

L-R: Images from the 12th Victorian Collaborative Conference; the program, and Assoc Prof Lorna Moxham with Kerri Reid Searl, both from Central Queensland University.

Delegates chose between three consecutive sessions over the two days, with a choice of 39 presentations, 3 workshops and 4 keynote presentations.

This years keynote presenters were: Mr John Mendoza, Director of ConNetica Consulting, Assoc Professor Kerri Reid Searl, Central Queensland University, Mr Brett Hayward, Office of the Senior Practitioner, Department of Human Services, Victoria and Mr Paul Leyden from Eastern Health.

The keynote speaker's presentations were all of the highest quality with feedback from the conference delegates showing that the keynote presentations were very relevant, as well as having an impact upon delegates by both stimulating thought and discussion or having personal impact upon clinicians practice.

John Mendoza discussed where mental health is placed in the current health arena and whether it had achieved equality with other health streams.

Kerri Reid Searle delivered a powerful and stimulating presentation on the use of the simulation masks for teaching nursing students in order to provide a "real experience" of dealing with patients.

Brent Hayward described a deeply personal experience of attending the Coroners Court that could happen within any mental health nurses career, and provided possible steps and actions that could assist clinicians if they ever found themselves in a similar position.

Paul Leyden detailed the impact and effect upon mental health services and clinicians in the recent change to the 0-25 clinical service.

This years conference presentations again provided a balance between consumer focused and clinical and research focused presentations.

The Early Bird Registration refund prize was also drawn at the conference closing ceremony and the winner was Ms Jennifer Wilkinson from Goulburn Valley Health. She will have her conference registration fee refunded.

To participate in this draw for next year's conference, you will need to register by 25th May 2012.

Unfortunately, as has been the case for the past three years, we had many people trying to register after the registration closing date. Again this year we were unable to accept these registrations due to venue size and catering close-off requirements.

We wish to remind future conference delegates that if they wish to attend the conference next year, they need to note that the registration closing date will be 13th July 2012 and they will need to diarise that date now to avoid disappointment.

Feedback from the delegates that attended this year's conference indicated that clinicians are happy with the format of conference and that it provides them with the opportunity to find out what is happening in other services and also provide the opportunity to network with other mental health professionals.

The collaborative parties, Centre for Psychiatric Nursing, Australian College of Mental Health Nurses (Vic Branch), Australian Nursing Federation (Vic Branch) and the Health & Community Services Union would like to thank all delegates, presenters, major sponsors and trade display sponsors for their assistance in making this another successful conference and look forward to the 13th Victorian Collaborative Psychiatric Nursing Conference to be held on the 9th & 10th August 2012.

Please diarise the registration close out date now: ***13 July 2012***

Every year we have people try and register after the closing date, however because of venue restrictions we are simply unable to accept any new registrants after the close out

IN THIS ISSUE

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CLINICAL SUPERVISION IN MENTAL HEALTH NURSING – A CLINICIANS PERSPECTIVE

Clinical supervision (CS) in mental health nursing is well explored in the nursing literature. It is gaining acceptance as a supportive mechanism pivotal in the facilitation of reflective practice including professional accountability and therapeutic skill development of nurses. The development and integration of CS frameworks in mental health nursing practice in both the Australian and international health care contexts continue to evolve with an increasing number of nurses engaging with CS processes.

Indeed, the recent 2011 seminal text Routledge Handbook of Clinical Supervision, Fundamental international themes: edited by Cutcliffe, Hyrkas and Fowler's puts CS back on the agenda for clinicians, academics, policy makers and administrators in the twenty-first century landscape of evidenced based mental health and primary care. This brief describes the author's clinical supervision journey and preferred ways of engaging in CS. In addition, the author outlines assumptions she views as central to CS in mental health nursing practice.

The practice of CS is firmly established in the psychotherapy and counselling disciplines. The current frameworks and structures of CS in mental health nursing reflect the close structural link that exists between psychotherapy and mental health nursing as well as the advancement of CS in nursing practice in the last ten years. CS frameworks that are responsive to the contextual factors, complexities and real world clinical experiences of mental health nurses, consumers, families and carers are required in the twenty-first century. The three main supervisory functions of support, education, and administration are common elements of supervision in the helping professions.

My journey with CS began in the late nineties when I was studying the Advanced Diploma in Family Therapy Training at Systems Co Coordinators in Melbourne. My participation in CS was a prerequisite course requirement for clinical membership of the Victorian Association of Family Therapists (VAFT) now the Australian Family Therapy Association.

I subsequently completed the Master of Clinical Family Therapy at the Bouverie Centre, La Trobe University in 2007. My primary learning goals at this time were to upgrade my qualifications and integrate systems theory into clinical practice with families. In addition, I was seeking to increase my knowledge, competence and confidence for working systemically with complex families.

Four hours of live clinical supervision, a masters course requirement provided opportunities to integrate theory and practice that enabled me to develop skills and competencies to work systemically with families. Whilst initially anxious about the live clinical supervision component, I now believe that this practice based learning was for me the most valuable learning aspect of the course. It provided opportunities to work with live families using a reflective team approach with guidance and support from a skilled clinical supervisor.

The nature of nursing work has changed over recent years, greater accountability and autonomy is expected of nurses. I consider CS to be a lifelong professional development process that enables me continue to provide safe and effective care to clients, carers and families. My CS practice philosophy endorses the Australian College of Mental Health Nurses 2007, CS position statement, and agreement for mental health nurses. The creation of a safe supervision haven 'sacred space' where trust and confidence between the supervisor and supervisee can flourish is pivotal to the success of the supervisory relationship and process. This safe supervision haven enhances opportunities for exploration of aspects of clinical practice in a non threatening supportive structure. Indeed the safety of the supervision space is in the author's view essential as it facilitates exploration of clinical practice, self disclosure and identification of educational needs, growth and professional development of both parties.

The author suggests that a solution-focused CS framework offers an alternative to the problem focused supervision approach and enables supervisors and supervisees to explore possible solutions to the problems of clinical practice in a proactive way. Solution-focused supervision is an interactive strengths and competency based collaborative approach that views the supervisee as the expert on the clinical caseload and work context and the expert on solutions to clinical practice issues.

Consequently, a collaborative, empowering and respectful supervisory partnership develops which is the authors preferred way of engaging in supervision. The solution-focused session structure and questioning techniques provide a useful guide that acknowledge the supervisee's existing knowledge and therapeutic skill, impact positively on client outcome and contribute to the development of practice wisdom in the supervisee. Solution focused questioning techniques that the author uses in CS include, future orientated, scaling, exception and the miracle question.

Solution-Focused CS Questioning Techniques

An important consideration for the supervisor is to develop an awareness of the supervisee's frame of reference in the first session. To elicit this information the supervisor asks *"Assuming that our discussion today is helpful, can you tell me what you would like to get out of it? What background information do you think I need to know about you and your work context at this stage? What do you see as the most pressing issue you would like to address at this time?"* This questioning technique will help to elicit background information and a brief description of the clinical practice issues the supervisee wishes to address.

Future goal orientated questions

The supervisor collaborates with the supervisee in articulating realistic, specific and achievable future orientated supervisory goals. To elicit this information the supervisor asks the supervisee *"What is your goal in coming to CS? What will your clinical practice be like one month from now? What do you need to do to get there? What are you doing now that is working?"* These questions help the supervisee to identify and clarify goals of CS

Exception and scaling questions

This questioning process identifies exceptions to the problems a supervisee experiences in clinical practice, allow news of difference to emerge and amplifies existing supervisee strengths that facilitate change and therapeutic skill development. The supervisor asks the supervisee to identify times when the clinical problem does not occur or is less troublesome. *"Can you tell me about a time in the last week when the practice issues were less problematic for you? On a scale of one to ten (one = little or no problems in clinical practice, ten = lots of problematic practice issues) can you rate where the problems are on the scale?"* If the supervisee's response is a six out of ten the supervisor may continue with *"Your response was a four last time we met, can you tell me what helped you get from a four to a six on the scale? What do you notice that is different about your clinical practice? What are you doing that is helping you to manage the problems of clinical practice?"*

Miracle question

This question invites the supervisee to consider a clinical practice where the problem does not exist or is significantly less. The supervisor asks, *"What if after our meeting today, you retire to bed and fall asleep. As you are sleeping a miracle is happening to you, but you do not know about the miracle. The miracle that happens is that all the clinical practice dilemmas that brought you here have dissolved. When you awaken tomorrow morning, what will you notice in your clinical practice that will tell you that a miracle has happened? What will be different about your practice? What will you be doing that is different?"*

A solution-focused approach to CS in mental health nursing characterises a proactive shift away from the problem dominated supervision models and adopts a collaborative solution construction framework that instils optimism and creates change.

Developmental Trajectory of Supervisees'

The author wishes to acknowledge that the supervisee's supervision requirements and needs will change over time. The CS needs of a graduate nurse will differ from those of an experienced nurse clinician. It is important to note that although the graduate nurse as a beginning practitioner has a need to consolidate skills and knowledge acquired at undergraduate level, pre existing skills, abilities and competencies need recognition and acknowledgement in the supervisory process. However, the author recommends that nurses at all levels be encouraged to participate in regular CS processes irrespective of their qualifications, advanced standing or years of clinical experience.

Over the past twelve years my CS requirements have changed in accordance with my career developmental trajectory. I have engaged with a range of differing CS arrangements depending on my professional development needs. I have participated in individual, group, peer and external private CS during this time. Consequently, I recommend a developmental approach to CS in mental health nursing tailored to the professional needs of the supervisee be considered. The reality is that the supervision needs of the mental health nurse will change over time and mental health nursing is at times stressful and complex.

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Nurses will need to develop a broad repertoire of therapeutic skills and strategies to manage the future complexities and demands of nursing work.

I believe that ongoing participation in CS will support and sustain me throughout my nursing career and assist my professional growth and continued development as a reflective practitioner. I gratefully acknowledge the Southern Health, Mental Health Program's ongoing commitment and support of clinical supervision processes. I believe that CS is akin to chicken soup for the mental health nurses soul, it paves the way toward optimal client care and reflective clinical practice.

Finally, to those nursing colleagues still thinking about engaging in CS, just try it.

CS Fundamentals

- 'do no harm' principal that is inclusive of all parties (client, family, carer, health service, supervisor and supervisee).
- A CS space that is safe, predictable, consistent, protected time with regular meeting dates.
- Ground rules and goals for CS clearly articulated in agreements, paying particular attention to confidentiality, record keeping and review processes. (ACMHN 2007 guidelines).
- CS time and space to support the supervisee to reflect on and explore difficult areas of practice bearing in mind the realities of mental health nursing work.
- Supervisee is expert on his/her clinical practice experience and practice context.
- Supervisor maintains a stance of curiosity, 'not knowing' position
- Fairness and equity principals apply to availability of CS for nurses.
- CS is a lifelong commitment and process of becoming a reflective practitioner
- Clinical supervisors are appropriately trained and currently participate in their own CS.
- CS is not personal therapy.
- Commitment to the ongoing evaluation of CS processes at all levels of health care organizations.
- Supervisors adopt a flexible approach to the application of CS approaches in practice and integrate a crisscrossing of ideas from the available modern and postmodern CS frameworks.

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IMI PRACTICE UPDATE

The administration of intramuscular injections is a primary focus of the CPN's current medication safety research program and we are receiving a growing number of requests from health services for advice and consultation regarding best practice. This article provides a brief update on our research and suggests some important issues to be considered by clinicians and health services in the implementation of evidence-based IMI practice.

Recent evidence reviews and nursing text books recommend the ventrogluteal (VG) site as best practice for intramuscular injections administered to adults and most undergraduate nursing students are now taught to use this site, especially for larger volume injections 1. Many clinicians are unfamiliar with the VG site and mental health nurses, along with nurses working in other clinical areas, use the dorsogluteal (DG) site for large volume intramuscular injections. The DG site, commonly referred to as the "upper outer quadrant" of the buttock, is no longer supported by popular undergraduate nursing texts due to risks associated with striking underlying nerves and blood vessels 1. There is also compelling evidence that the majority of injections administered via the DG site may fail to penetrate muscle because the depth of subcutaneous adipose tissue for many patients is greater than the length of commonly used needles. This means that many injections prescribed for intramuscular delivery may be inadvertently administered subcutaneously, with potential adverse consequences such as poor absorption, tissue damage and irritation, pain, and granuloma formation 2-11. Since the pharmacokinetic properties of medications formulated for intramuscular administration are largely unknown if administered subcutaneously, the clinical consequences are difficult to predict.

A logical response to the evidence outlined above would be for health services and individual clinicians to take the necessary steps to discontinue use of the DG site and to ensure competence in the administration of intramuscular injections using all approved sites including the ventrogluteal (VG), vastus lateralis and deltoid sites. However, practice change may pose significant clinical risks. For example, because injections administered into the VG site are more likely to penetrate muscle tissue than those administered into the DG site, it is probable that more patients will receive intramuscular injections rather than inadvertently receiving subcutaneous injections. Due to the predictably poorer absorption of medications administered via the subcutaneous route compared to via the intramuscular route, it is possible that practice change could significantly effect the pharmacokinetic action of some medications and thus the blood concentrations of medications in some patients. This may pose a significant clinical risk.

Long acting injectable antipsychotic (LAIA), or depot antipsychotic, medications are commonly used in Victoria with some mental health services reporting 30 percent of currently registered consumers being prescribed treatment with a LAIA. Because of the frequent prescription of LAIAs, the administration of IMIs is a routine aspect of clinical practice for many mental health nurses. For the reasons outlined previously, the adoption of the VG site in accordance with current evidence and best practice recommendations may pose significant risk to patients treated with LAIAs, particularly those who have previously received regular injections into the DG site. An increase in the plasma concentration of antipsychotic medication could cause a range of dose-related adverse effects.

The Director of the CPN, A/Prof Stephen Elsom, is leading a multi-site clinical study designed to examine the effects of changing from the dorsogluteal to the ventrogluteal for the administration of LAIAs. The research team includes 3 psychiatrists, 6 nurses, a consumer, a psychopharmacologist, a pharmacist and a statistician. The primary outcome measure for the study is plasma levels of antipsychotic medication. Standardised clinical measures including side effect and symptom scales will also be used to monitor effects of the practice change and to manage potential risks associated with changes in antipsychotic blood levels. The complex process of multi-site ethical approval is well advanced and we anticipate having the first results of the study by early 2012.

The findings of this research are expected to inform a large scale approach to training in best practice in the administration of intramuscular injections. We anticipate offering this training on-site for nurses employed in Victorian Mental Health services and will be negotiating with services regarding the roll-out commencing in 2012. Health services or individual clinicians seeking to change IMI administration practice before the results of this study are available should ensure that appropriate clinical risk management strategies are in place. In the case of LAIAs, such strategies should include plasma monitoring and clinical measures to ensure that any adverse effects are detected early and managed appropriately.

Enquiries about training in IMI administration should be directed to: **cpn@nursing.unimelb.edu.au** or phone: **03 8344 9626**

CARILLON – now an eNewsletter

As a contribution to reduce our effect upon the environment, the Carillon will no longer be available in a hardcopy format from the beginning of 2011.

An e-copy Carillon will be available via email and can also be accessed via Centre for Psychiatric Nursing's website: **http://www.cpn.unimelb.edu.au/**

If you currently receive a hard copy of the Carillon and still want to receive an e-copy starting in 2011, please email us at **cpn@nursing.unimelb.edu.au** to provide us with your current email address.

STATISTICS IN NURSING RESEARCH

VARIABLES

A variable is any measurable characteristics, qualities, traits, or attributes of individual, object or situation which can have more than one value. A variable represents a concept or abstract idea that can be described or constructed in measurable terms and takes different values when measurements are made on different individuals, objects or situations at different times. As far as measurement is concerned some variables such as gender, weight, or blood pressure are straightforward while others such as health status, self-esteem, or pain level can be more abstract or vague to measure. Let us use examples to illustrate the concept variable. Suppose a researcher is interested in examining if gender is related to health status. Gender and health status of participants are two concepts that could take different values. Gender could take male or female as values and health status of participants could be measured as Poor, OK or Good health status, and hence both are variables. However, if a researcher is interested in studying the health status of females, gender is not a variable as it takes only one value, female - only health status is a variable.

Most research attempts to uncover relationships between two or more variables. Depending on the roles they played, variables in such research can be called dependent, independent or control variable. Dependent variable is also known as outcome, response, target, measured, output or etc. variable. Similarly, independent variable is also known as predictor, explanatory, covariate, intervention, exposure or etc. variable. In experimental research, a condition when a researcher has full control of manipulating one or more variables and measure changes in other variable(s), an independent variable is a variable that is manipulated by the researcher, and a dependent variable is the response that is measured for variation as a presumed result of the variation in the independent variable. An independent variable is the presumed cause, whereas the dependent variable is the presumed effect.

In non-experimental/observational research, where there is no experimental manipulation, the independent variable is the variable that 'logically' has some effect on a dependent variable. For example, in a research on cigarette-smoking and lung cancer, cigarette-smoking is the independent variable. Variables that designate status such as gender, ethnicity, etc. often treated as independent variables, although researchers are not able to control and manipulate them. Controlled variables are quantities that a researcher wants to remain constant when relation between variables of interest is examined.

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