RNAO Registered Nurses' Association of Ontario
L'Association des infirmières et infirmiers autorisés de l'Ontario
Speaking out for nursing. Speaking out for health.

Mental Health Nursing Interest Group newsletter

in this issue:

2013 MHNIG Membership Survey: The results are in!

In 2012, the Mental Health Nursing Interest Group Executive met over a weekend to a conduct strategic planning exercise for 2013-2015. Strengths, trends, opportunities for networking and partnership, engagement strategies as well as potential initiatives were discussed.

The following four goals were identified for 2012-2015:

1. Increase participation and engagement of membership and students in MHNIG existing and future opportunities
2. Promote mental health education
3. Strengthen articulation of mental health nursing identity
4. Build and strengthen relationships

In 2013, an online survey was distributed to members to elicit feedback regarding these goals, to help inform the top priorities of MHNIG as well as future initiatives led by its members. The survey consisted of 12 open-ended and multiple-choice questions. A total of 64 members responded to the survey over a 5-week period.

Out of the 64 respondents, 71% had more than 20 years of experience as ~~an~~ a Registered Nurse, with an average of 19.2 with practice experience in a mental health/psychiatric

setting. Respondents identified the following topics and initiatives taking place in their region:

Furthermore, out of the 4 goals identified above, survey respondents identified their top priority as promoting mental health education. More specifically, promoting mental

health education pre-licensure to students (i.e. through clinical placements), post-licensure to practicing nurses (i.e. CNA Certification) and to the public (i.e. anti-stigma campaigns and using social media). A number of suggested initiatives and activities were put forth which guide the activities led by members this year.

Congratulations to the individuals listed below for taking the time to complete the survey, your 2014-2015 MHNIG membership will be reimbursed for your participation:

* Anna Giallonardo
* Karen Anderson Keith
* Dania Versailles

Thank you to everyone who participated in this survey, we truly appreciate and value your opinions!

For more details about the results of the survey, please visit our website: http://mhnig.rnao.ca

Looking forward to wonderful year!

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Restraint Reduction Task Force

By: Stacey Roles RN, MScN and Dr. Albert P. Gouge C. Psych.

In November of 2011 a Restraint Reduction Task Force was launched with the inpatient psychiatric units of a schedule 1 facility in Northern Ontario (Health Sciences North). The goal of the task force was to reduce the use of restraint/seclusion interventions through the implementation of the SIX CORE STRATEGIES© developed by Huckshorn (2005). These strategies have been demonstrated to be effective and have been implemented in many leading institutions.

The Task force consisted of 2 clinical specialists as co-chairs, 1 Associate VP, 1 Mental Health & Addictions Program director, 2 Acute Inpatient Psychiatry managers, 1 risk manager, 3 clinical leaders, 2 frontline nursing staff and psychiatrists on an ad hoc basis. The members were assigned a subcommittee to lead based upon each of the 6 strategies. These subcommittees were comprised of front-line clinical staff from nursing, social work, psychology, occupational health and decision-support.

Examples of implementation of the key strategies from the subcommittees included:

1. Leadership: The administrative leadership team implemented a clear philosophy statement setting out the goal of restraint reduction through primary, secondary and tertiary prevention, provided re-instruction to staff regarding roles and responsibilities during code-white responses (emphasizing restraint as a last resort), and championed the approval of pre-printed Restraint Order Forms to increase accountability and to eliminate prn restraint orders.
2. Data: Online incident reporting of all restraint/seclusion interventions was initiated to capture data related to the nature and prevalence of such interventions and to drive unit based decisions. Procedures were developed to ensure daily review of restraint

upcoming events:

7th Annual Psychopharmacology Institute and ISPN 16th Annual Conference
Advanced Practice Psychiatric/Mental Health Nurses: Advancing Mental Health Across the Lifespan
March 25-29, 2014.
http://www.ispn-psych.org

14th Annual Meeting of the International Association of Forensic Mental Health Services
June 19-22, 2014.
http://www.iafmhs2014.ca

Canadian Psychiatric Association
Annual Conference
September 11-13, 2014.
http://www.cpa-apc.org/

incidents.

3. Workforce Development: A number of core educational requirements were suggested based on staff input (eg. Effective debriefing, trauma-informed care) and these were implemented in routinely scheduled staff education events. It was decided that additional training and a minimum of 6 months of experience was required prior to scheduling staff to work in the Psychiatric Intensive Care (PIC) unit.
4. Use of Seclusion and Restraint Prevention Tools: Comfort plans were developed to optimize primary prevention efforts, and completed with every patient admitted to the unit. This tool was implemented to ensure individualized assessments and discussions regarding clients' triggers, presenting symptoms when escalating, and effective interventions to aid in de-escalation were implemented. RNAO best practice guideline 'tools and tips' binders were made available to provide staff with additional resources for specific presenting symptoms and behaviours.
5. Consumer Roles: Consumer focus groups were initiated to survey patients post discharge to learn from their shared experience. As a result, changes were made to the PIC unit environment and to the staff mix on the unit.
6. Debriefing Techniques: Best practices were implemented regarding debriefing of staff, client and family. Client/family, staff, and incident debriefings were implemented to enable the rebuilding of the therapeutic relationship, to learn from previous experiences, and to decrease negative residual impact on patients and staff.

On two occasions throughout the 18 month period all staff were able to attend a one day training session each of which included information related to the above six subcommittees.

Initial outcomes of the task force were examined by comparing a six month period in 2010 prior to the initiation of the task force (July to December) to the same period in 2012. By comparing these two periods it was found that the incidence of mechanical restraints had been reduced by 77%, chemical restraints were reduced by 78%, and environmental restraints were reduced by 43%. The incidence of staff injuries during these two periods were also compared revealing a reduction in staff injuries involving patient violence by 69% and a reduction of staff injuries incurred while applying or removing mechanical restraints by 100%.

It has been decided that rather than disbanding the Task Force that the group will continue to meet quarterly for another twelve months in the interest of sustaining the gains achieved and in hopes of imbedding the changes into the standard of care. As well, several initiatives, such as Pre-printed Restraint Order Forms, have not yet been fully realized and will require continued perseverance.

This project has clearly demonstrated that purposeful implementation of evidence based restraint reduction activities can result in meaningful change. As well, reductions in the use of seclusion and restraint interventions appear to correlate with decreased numbers of physical injuries to staff related to the implementation of restraint interventions. This reduction may be the result of reduced physical contact between staff and patients and increased utilization of assessment and de-escalation/therapeutic techniques. Implementation of these initiatives resulted in many lessons learned that may benefit others planning to embark on a similar path.

- Involving all key stakeholders at the planning stage of such an endeavour is essential to avoid confusion later.
- Assume the interventions will lead to research projects and plan your data collection accordingly as it is easier to gather data at baseline and prospectively than to collect it retrospectively.

- If planned carefully and implemented successfully expect that you will be asked to disseminate your results and to spread the practice changes to other areas of your institution which will vary in acuity.
- Finally, always expect push back when engaging in a culture change as you are asking people to critically examine their values, beliefs, and manner of practice.

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Reflections from the 2013 CFMHN Conference:

Mental Health Nursing…A Journey of Collaboration, Culture & Change
CFMHN Conference Kelowna, B.C. 2013
By: Angela McNabb, RN

This year's CFMHN conference was held in beautiful Kelowna, B. C. and I would like to thank the MHNIG for supporting my attendance at this wonderful event and to share some of the conference highlights with you. The theme of the conference for 2013 was "Mental Health Nursing…A Journey of Collaboration, Culture & Change" and the event truly lived up to it's title!

Louise Bradley, President and CEO of the Mental Health Commission of Canada opened with her keynote presentation highlighting some of the most prominent issues related to mental health in Canadian society. She addressed the ongoing issue of stigma related to mental illness; in particular the fact that some of the most deeply felt stigmas toward clients -are held by front line health care workers. Louise also spoke about the importance of "psychological safety" in the work place. In her presentation she stated, "a fundamental way to better health care is through healthier health care work environments". She left us with a call to action to advocate for the implementation of the commission's National Standard of Canada for Psychological Health and Safety in the Workplace.
http://www.mentalhealthcommission.ca/English/node/5346#sthash.nCFh0Qxq.dpuf.

Louise was followed by Barbara Mildon, President Canadian Nursing Association, who called on all in attendance to think about when they felt most proud to be a mental health nurse. This was a point of reflection for all but also an opportunity for sharing and several attendees came forward to share stories from their career.

Day two opened with a panel presentation: First Nations Mental Health Across Canada. The panelists shared deeply moving stories either from their personal or professional experience (or sometimes both) and offered us a window into some of the work that is being done with First Nations peoples across the country. Importantly, they also addressed many of the gaps in service and challenges that remain.

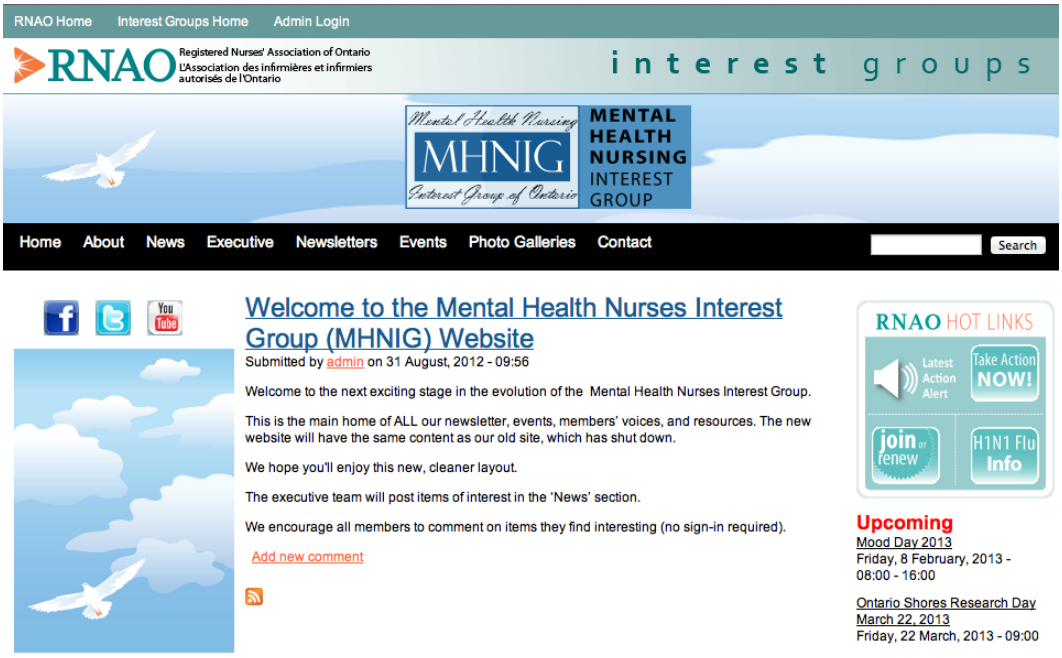
Of course there were also many informative concurrent sessions and, as always, it was difficult to choose which ones to attend. The topics were diverse but all highlighted the innovative and important work that is happening in this the field of Psychiatric/Mental Health Nursing.

Finally, one of the best things about attending any conference is the opportunity to connect or reconnect with colleagues. It was great to see so many familiar faces from Ontario and also to have the opportunity to meet new colleagues from across the

country. Thank you once again for your support!

New and Improved – MHNIG Website

Check out our new and improved website! - http://mhnig.rnao.ca



Let us know what you think of these new changes or if you have an upcoming event you would like promoted: inquiries@mhnig.org

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