Student Nurses

Te-Upoko-me-te-Whatu-o-Te-Ika
Mental Health, Addictions and Intellectual Disability Service 3DHB
Wairarapa, Hutt Valley and Capital & Coast DHBs

Mental Health Services

Acute Mental Health

Te Whare Ahuru

Student Name:

Acute Inpatient Mental Health Services

Welcome to Hutt Valley District Health Board Mental Health Services, which are part of the Te-Upoko-me-te-Whatu-o-Te-Ika, Mental Health, Addictions and Intellectual Disability Service 3DHB, Wairarapa, Hutt Valley and Capital & Coast DHBs (3DHB MHAID). Our intention is for you placement with us to be safe, enjoyable and have your learning needs met.

Welcome to Te Whare Ahuru, when translated means "The house of warmth/comfort and calm. We hope that you enjoy your placement with us. We as a team are committed to supporting you to achieve your learning objectives. In order to do this, it is important that you make your buddy (preceptor) aware of both your learning objectives and any assessments you are required to complete while on placement here. Please do not leave this till the last week.

The purpose of this unit is to provide a service to those clients experiencing an episode of acute mental illness that requires assessment and treatment in a safe hospital environment. The clinical focus of the inpatient service is to ensure the safety, stabilisation and clinical management of clients, including their return to the least restrictive environment as soon as practicable.

Service Overview.

The mental health service within Hutt Valley provides assessment and treatment services for people with moderate to severe mental illness and/or addictions. Consumers may present with issues related to chronic mental illness and/or addictions or may present as acutely unwell.

We aim to ensure that trained, skilled mental health and addictions staff provide quality services in a timely manner. We aim to work co-operatively with other providers of health services within the region.

Mental Health Services.

HVDHB supports a range of Mental Health Services including:

- Te Whare Ahuru inpatient unit, which includes Psychiatric Intensive Care (also know as Te Rangi Marie); and Transition Liaison.
- Consultation Liaison based in F Block Hutt Hospital.
- Crisis Resolution Service based in F Block Hutt Hospital.
- Community Mental Health and Addiction Team with bases at Public Trust House, Queens Drive in Lower Hutt and Sinclair Street, Upper Hutt.

- Infant, Child, Adolescent and Family Team based near Community Health at Hutt Hospital
- Central Regional eating Disorders (CREDS) sited in Johnsonville.
- Maori Liaison Team.
- Consumer and Family Advisors
- Older adults under the care of (OP&RS) who have a mental health team.

Regional Mental Health services accessed from C&CDHB include:

- Methadone clinic.
- Regional Detox unit. Regional Rangitahi Adolescent Inpatient Service.
- Forensic services and Court Liaison.
- Personality Psychotherapy Services.
- Maternal Mental Health.
- Early Intervention Service.
- Regional Mental Health Rehabilitation Service
- Te Haika call centre.

Philosophy.

Our philosophy is to provide high quality clinical services for mental health and/or addictions consumers within the Hutt Valley. The assessment and treatment services provided are consumer–centred, recovery–focused, accessible, accountable and integrated to include Family and Whanau, significant others, other service providers and the community.
As an inpatient service, this assessment and treatment is provided in a safe and comfortable environment with in resources provided.

Welcome!!
We are looking forward to working with you

Contacts

This should contain information on all the key contacts for the ward/unit

Te Whare Ahuru (TWA) Reception	04 5709536	Phone number for ward/Unit
Clinical Nurse Clinical Nurse Specialist		Mobile 0272425157 Pager
Clinical Nurse Manager		DD Pager
Associate Clinical Nurse Manager	04 5666 999 Ext 8346	DD Pager

TWA Roles.

Clinical Nurse Manager (CNM):
The Manager reports directly to the Service Directorate, Mental Health and Addiction Services and has an overall responsibility for the administration, service delivery and the quality of the services delivered.

Associate Clinical Nurse Manager (ACNM):
The ACNM reports to the CNM and is responsible for the day to day running of the ward. They oversee the intake of admission through to discharge, and are responsible for the liaison between all staff and services, utilisation of resources, and facilitation of multidisciplinary meetings.

Consultant Psychiatrist:
A Psychiatrist is a qualified medical doctor who has obtained additional qualifications to become a specialist inn the diagnosis, treatment and prevention of mental illness. In addition to their clinical work, psychiatrists train doctors who are working towards a post-graduate qualification in psychiatry (Psychiatric Registrars). They also teach and train House Surgeons, trainee interns (6th year medical students) and medical students.

Psychiatric Registrar:
Is a doctor who is training in psychiatry and growing in experience and knowledge. They work under the supervision of a Consultant Psychiatrist.

House Surgeons
These are doctors who look after the medical needs of client's on the ward.

Administration Staff:
Administration staff are essential for the establishment and maintenance of client information and data. They provide secretarial support, process client-related information and facilitate the smooth transfer of this information throughout the services. Administration staff include the receptionists who attend the telephone enquires and client appointments.

Registered Nurses & Enrolled Nurses:
The nurse's role includes administration of medication, client education and supporting clients to understand their diagnosis and assisting clients to develop strategies to minimise the impact of illness in their quality of life. RNs & ENS also provide care coordination and monitoring of client symptoms and risks. They are trained in de-escalation and C&R if an event occurs. Documentation, therapeutic use of self and the handing over of information are also important factors in being an RN or nurse on an inpatient ward.

Clinical Nurse Specialist (CNS):
This position offers clinical and professional support for nurses. The CNS functions as a role model for nursing practice and acts as a resource for nurses and for others about nursing. The focus of the role includes improved consumer outcomes and enhanced professional practice for nurses. The Intensive CNS supports and works to support RNs in their clinical development and practice. The current CNS role covers the community and inpatient areas.

Occupational Therapist (OT):
Occupational therapy is assessment and treatment through the specific use of selective activity. Functional assessments and group work are key in assessing day-to-day skills of our client group.

Social Worker (SW):
The role of the Social Worker includes: personal counselling and family therapy, working with consumers to resolve particular stresses, supporting consumers to obtain services, accommodation or practical support they may need and providing liaison with community agencies e.g. WINZ. Social Workers work within a strengths-based framework.

Transition Liaison (TL):
The TL role provides a link between the ward and home, oversees clients on leave from the ward, monitors mental state and medication compliance. TL also reports to the Responsible Clinician (RC) any concerns in regards to the client. This is a key role within MDT meetings of client's progress in the community.

Expectations of the Student Nurse while in Acute Inpatient Mental Health Unit

The shifts in the Acute Inpatient Mental Health Unit are:

Morning	:	07:00 to 15:30
Afternoon	:	14:45 to 23:15

Placement Work Areas:

First day Report at 8.15am then Ward: 1 week AM duty, 1 week PM duty. The weeks will be rotated between the students on placement and are often sorted out on the first day on the Ward.

We have available to nursing students training on a Wednesday PM 1400 to 1530 hours called Mental Health & Addiction Service 'Under-Grand Round". It is important to try to attend these trainings in order to support your learning. Please ask your tutor or CTA to come outside the hours of training.

Your Placement.

- If you are required to be away, or need to take sick or bereavement leave, this need to be communicated to your preceptor / ward staff **and** tutor or CTA.

- Should you encounter any difficulties, which you feel unable to successfully resolve with your preceptor, you can discuss these with either the Associate Clinical Nurse Manager or Clinical Nurse Specialist. Your lecturer and the team at HVDHB are here to support you and facilitate your learning.

- While on placement with us **you will need to wear your ID badge at all times**. Please dress in tidy casual mufti i.e. no short, short skirts/ dresses, no revealing tops, no jandals, trousers to be worn with belt if they do not adequately stay up. All personnel, including students, are required to abide by the DHB Code of Conduct. A copy of the Code can be found on the notice board by the staff room and in the resource folder.

- Mental Health Nursing is a specific scope of practice. All nurses working within Mental Health are required to meet the NZ Nursing Council competencies for a Registered Nurse. In addition, Te Ao Maramatanga (the NZ College of Mental Health Nurses) details competency based practice standards for RNs working in Mental Health. Familiarising yourself with these standards may enhance your learning experience throughout this placement.

Safety Measures in Acute Inpatient Mental Health Unit

Safety:

If you write in client files this entry must be signed by yourself with designation (student nurse) and co-signed by a registered nurse. Do not place yourself in an unsafe situation. If in the unlikely event of something occurs please ensure your safety by going directly to the Nursing station. Ensure other members of staff know where you are at all times. If you feel unsafe or uncomfortable please speak with your preceptor or unit coordinator.

Keys:

You will be given keys during your placement. The expectation is that you will return the keys to the Ward Clerk or Reception Administrator on your last day. **If keys are misplaces this must be communicated immediately to a senior nurse – please keep your keys safe at all times.** Keys not returned causes a major expense to the ward and you would be asked to pay for cost of changing the locks.

Locking doors:

It is important that you re-lock doors you find locked, they are locked for a valid reason. The nurse's station and staff areas must be kept locked at all times .

Alarms:

There are five different types of alarms at Te Whare Ahuru (please ask your preceptor to describe these for you).

Nurses call bell: Once activated these can be cancelled either from the place of origin or from the nurse's station alarm panel. These alarms are in all bedrooms, bathrooms and placed around the ward.

Emergency alarms: (Audible) In addition to the nurse call bells being non urgent if pressed quickly three or more times a emergency alarm will be activated. These alarms may be used in a situation where an incident involving the safety of staff/client's and visitors is occurring which requires urgent intervention from all staff on the unit. This alarm can only be cancelled in the nursing station

Duress alarms: (Silent) These are located in both the open side and PICU/TRM nursing stations on the wall by the door. These are the big red alarm buttons and should only be activated if staff require assistance from the main hospital. PRESS TO ACTIVATE these alarms which are silent in the unit, but sound at the hospital operators station who then notify the orderlies to assist in managing an emergency situation. This alarm flashes blue in the main office.

Personal Alarms: (Audible) These are kept in the front reception. All students are required to have one on them at all times while on the ward. The can be clipped onto the keys you are given. To activate these alarms you simply press the button.

Fire alarms: These are key operated. Red lights are activated on the ceiling, and a siren sounds. Please take direction from the senior nurse on duty who will be wearing the yellow fire hat and also follow the audible instructions.
777: In the case of cardiac arrest you may be asked to dial **777** to the hospital operator. The operator will then notify the emergency response team of the situation.

Emergency Trolley (Crash Trolley):
This is stored in the cupboard opposite the nurse's station on the open side. Please ask your preceptor to explain the items and their uses to you.

You will need to become familiar with the, emergency equipment i.e. the crash trolley, emergency alarms, fire extinguishers, hoses and evacuation procedures in the building you are based. Your preceptor will be happy to assist you with this.

Confidentiality.

Whilst on placement in this service, students are bound by the requirements of the Privacy Act and the Health Information Code in maintaining client confidentiality, which means information given by clients, must not be shared with anyone outside of the service at any time. Whilst discussing consumer – sensitive information, please be mindful of those who may potentially overhear your discussion.

From time to time you may notice information regarding a friend, family member or someone else you know outside of this placement. **It is a breach of the Privacy Act for you to access this information.** If you do become aware of this information, it is best that you advise your preceptor who can then ensure that you do not access this client's information. You are asked not to read or have any contact with this person while on placement.

Legislation.

There are a number of Acts and Regulations relevant to health care and mental health. These include (but are not limited to):

- Mental Health Assessment and Treatment Act 1992 (and amendments 1999).
- Privacy Act.
- Health and Disability Commissioners Act.
- Health Practitioners Competency Assurance Act.
- Human Rights Act.
- Medicines Act.
- Crimes Act.
- Health Information Code.

Full copies of all NZ Acts of Parliament, amendments, Bills and Regulations can be found at http://www.leglislation.co.nz/

Objectives

Whilst with us it is expected that on completion of your placement you will have:

- A basic understanding of main psychiatric diagnosis available.
- To have a basic knowledge of common psychiatric medications, their uses, action and side effects.
- To be able to discuss the concept of environmental safety, including boundaries.
- To be able to discuss the concept of risk management.
- To have a beginning knowledge and understanding of relevant legislation (mental health act, privacy act and the health and disability act).
- To understand and be able to complete a mental status examination form.
- To comfortably be able to use mental health terminology such as signs and symptoms of mental health.
- Absent without leave (AWOL) client leaving the unit. What actions need to be taken?
- To be able to explain consumer advocacy.
- To be able to complete Blood Sugar Levels (BSL); Temperature, Pulse, Respirations (TPR).
- Have an understanding of food and fluid balance charts (FBC)
- To have a basic understanding of what is required for admissions, discharges & referrals
- To have and understanding of MDT roles and relationship with community teams.

We will endeavour to create some continuity with your preceptor; however most nursing staff here work rostered and rotating duties and this will mean that you will be allocated to work with other nurses during that time. The continuity of your learning experience can be improved through clearly communicating with those who you work with to achieve your goals. All students will have a registered nurse responsible for supervising their practice. We ask students to take the initiative if they are not allocated a preceptor on a daily basis, to please ask the ACNM / coordinator for assistance.

During your placement with us please take time to read the student folder available within your area. We would appreciate you completing our evaluation form at the end of your placement and returning it to your preceptor or the units Clinical Nurse Specialist. We value your feedback and will use your feedback to make improvements in the placement of future students.

Should you encounter any difficulties, which you feel unable to successfully resolve with your preceptor, please discuss these with the Clinical Nurse Manager or Clinical Nurse Specialist. Your lecturer and the team within our Mental Health Service are here to support you and to facilitate your learning.

A Learning Framework during your placement

TWA is committed to providing all students with a supported theoretical and practical learning environment while on an Acute Adult placement and below is a table for you to develop and complete learning opportunities and experiences as a student.

The place is a two way process and it is important that the student recognizes they have a responsibility to engage the client and the Multi Disciplinary Team (MDT) Members. To ensure a valuable and rewarding learning opportunity.

During you placement you will be allocated a preceptor, however it will be explained that due to roster and rotating shift you may not get to work with your preceptor every shift. If unforeseen circumstances, such as sick leave occurs your preceptor may change. However please discuss your concerns and expectations with the ACNM or Coordinator on shift.

Please arrive at 8.15am on your first day. Shifts will be sorted on that day.

It is the Student responsibility to ensure they are up to date with any academic work and this should not interfere with the clinical placement.

	Day one onwards	During week One
The student will:	- Meet with the ACNM - Be orientated to the physical ward and alarms and safety features. - Have meal break and shifts explained - Be introduced to staff on duty - Find out the name of their preceptor - Expectation of student explained	- Meet staff - Meet clients - Understand the ward routines - Have introduced their tutor to preceptor and ACNM / coordinator - Have 1:1 with preceptor to evaluate the week. - Attend clinical MDT The following will be explained: - Use of restraint - Use of seclusion - Legal paper work relating to restraint and seclusion.
	Other activities	**DURING WEEK TWO**
The student will	Attend under grand round presentations	- Have a client allocated - Access the client files. Under no circumstances are client files to leave the office.

		- **Assist in medication administration, including any physical health obs.** - **Be allocated a named RN on the daily roster.** - **Participate and support client activities** - **With RN write client progress notes according to documentation standards** - **Be involved in Mental state examinations.** - **Have 1:1 with preceptor to evaluate their week and experiences.**
	Other activities	**DURING WEEK THREE**
The student will	**Be able to explain the Mental Health Act** **Be able to identify and explain the use of mental health medications and needed physical health observations**	- **Build on weeks one and two** - **Have 1:1 with preceptor to evaluate their week and experiences.**
	Other activities	**DURING WEEK FOUR**
The student will	**Within the last week the student will be completing their case presentation.** **Also be discussing their placement with ACNM or CNS or Preceptor**	- **Have 1:1 with preceptor to evaluate their week and experiences.** - **Complete their overall evaluation of clinical placement form (last page of this book) and leave for CNS in the tray in the front office**

Common Presentations to TWA Unit

Mental Health Awareness Facts About Mental Illness.

- 1 in 5 New Zealanders will experience a mental illness in any given year.
- The vast majority of people with a mental illness recover, raise families, hold down jobs and contribute to their communities. Most of us will know someone who has experienced, or may ourselves have experienced mental illness.
- The exact causes of mental illness are unclear – although it is thought to be caused by a number of factors including biochemistry, genetic inheritance and stress. Many things can contribute to the onset of mental illness such as trauma, conflict, drug and alcohol abuse, or the loss of a loved one.
- The vast majority of people with mental illness are no more likely than anyone else to commit a violent crime.
- Research has found that people with a mental illness are more likely to be victimized by violence than they are to commit act of violence.
- A combination of the following three factors make for an increased risk of violence
    - Currently experiencing symptoms of severe illness.
    - Not using effective medication.
    - Abusing alcohol and drugs.
- Nevertheless, only some people with these three factors will commit acts of violence and most will not.

Depression:

- The most common mental illness.
- Affects more than 1 in 7 New Zealanders.
- Profound sadness and/or loss of pleasure and enjoyment in most activities.
- Some of the symptoms experienced are:
    - Loss of energy and concentration.
    - Feelings of worthlessness.
    - Hopelessness and guilt.
    - Inability to cope with decision making.
    - Weight loss.
    - Sleep disturbances.
    - Thoughts of death (Suicidality).
- Can last for a few weeks or continue for months or years.
- A person may require hospitalisation.
- Depression can severely affect a person's life and relationships.
- In its most serious form a person may loose touch with reality and even experience hallucinations or delusions.

Schizophrenia:

- A serious mental illness that affects approx 30,000 New Zealanders.
- Acute phase interferes with a persons mental functioning so their thoughts and perceptions become distorted.

- **Schizophrenia does not mean a "split Personality"**

- People with schizophrenia may experience:
  - Delusions (fixed false beliefs that cannot be moved).
  - Hallucinations (perceptual experiences in the absence of actual external stimulus).
  - Frenetic activity (excited/ agitated activity).
  - Mood fluctuations.
  - Fear.

- Between active phases a person may experience disorganised speech and behaviour and loss of energy and interest.

Bipolar Disorder:

- Bipolar disorder, like depression causes fluctuations in mood.
- Was commonly called manic depression.
- Some people experience both high and low mood, others only the 'highs'. Episodes range from mild to severe.
- For some people moods swing to extremes regularly, for others highs and lows may be very occasional, with years of wellness in-between.

Typical features of mania:

- Feelings of euphoria.
- Over activeness.
- Reduced need for sleep.
- Rapid speech and thought.
- Irritability.
- Lack of inhibitions.
- Acting out of character (such as spending large amounts of money).
- Symptoms and behaviours can be damaging to people's lives and relationships.
- In addition to the illness, people often have to contend with the consequences of being ill such as large debt, broken relationships and damaged relationships.

Anxiety:

There are a number of Anxiety disorders, but all have in common a sense of fear and worry and uncomfortable physical sensations. People can experience an intense paralysing sense of fear, or a more sustained pattern of worrying, when there is no real threat or danger.

Symptoms may include:

- Sense of worry or impending doom.
- Irritability.
- Palpitations.
- Breathlessness.
- Dizziness.
- Sweating.

- Overwhelming sense of panic.
- Sleep disturbances.
- Changed perceptions.
- Because of the strong physical component, many people often seek help for what they believe is a physical illness.

Many types of anxiety disorder include:

- General anxiety.
- Simple and social phobias.
- Post traumatic stress disorder (PTSD).
- Agrophobia.
- Panic disorder.
- Obsessive Compulsive Disorder (OCD).

Treatment Options:

- It id important to remember that the vast majority of people recover from or manage their illness.
- Effective treatment relies on a balance of **Theory, Therapy and Medications.** It has been said that there is no right theory, no right therapy, there are only right people. Some people take medication; others see a counsellor or talk to a support person. Some combine both in their recovery.

The Assessment And Management Of People At Risk of Suicide.

(Best Practice Evidence Based Guideline Summary May 2003, available on the NZ Guidelines Group Website www.nzgg.org.nz).

Key Messages:

- Anyone who talks about suicide should be taken seriously.
- People who present following a suicide attempt are usually in a state of extreme distress.
- Asking about suicide does not create risk in people who do not have suicidal thoughts.
- Case notes should be augmented with structured assessments.
- Clinicians should involve Whanau/family and support people of the suicidal person wherever possible.
- Culturally appropriate services should be offered to the suicidal person wherever possible.

People expressing suicidal ideation who are informal and try to leave before an assessment is completed may be detained, under the provisions of the Mental Health (Compulsory Assessment and Treatment) Act 1992. (Section 111).

A safe environment should be provided for people who are intoxicated or cognitively impaired by drugs until they are sober. Then they should be further assessed.

There is no single explanation for suicide attempts or any simple solutions to treatment.

People who present with suicidal ideation or following an attempt are at increased risk of further attempts. They should not be allowed to leave before they have received a full medical examination and a psychiatric and a psychosocial assessment.

Assessment:

Despite best efforts, some people will successfully suicide. The reasons for a person attempting suicide are usually complex. Understanding the key risk factors making a person vulnerable to attempting suicide raises a clinician's index of suspicion for suicide risk.

- The majority of people who die by suicide suffered an associated psychiatric disorder at the time of their death. People who meet the criteria for more that one disorder at a time are at even greater risk.

- Substance abuse and intoxication are strong risk factors. Up to half of those who die by suicide have consumed alcohol before taking their lives.

- Recent loss, loved ones dying or committing suicide, isolation, depression or bipolar disorder, previous attempts, serious physical illness and a past history of abuse are key risk factors. In youth, identifiable stressful events (relationship break-ups, bullying) precedes most suicide attempts.

- The highest rates for suicide are among males 20-34 years. Maori youth have higher rates than non-Maori; however 75% of all suicides occur in people over the age of 24.

When a person presents with a suspected suicide attempt or are expressing suicidal ideation, staff need to determine:

- Whether the persons injury was caused by self-harm.
- How serious the deliberate self-harm was (including the seriousness of the intent).
- The key precipitants to self-harm/ideation.
- The current level of **risk.**
- The best way to keep the person safe and supported until further assessed.

DISCHARGE.

Any person expressing suicidal ideation should be assessed before they are allowed to go home.

A person can be discharged if during the assessment the following are taken into consideration:

- Suicidal intent is not present and the acute crisis has in some way diminished.
- The person is medically stable.
- The person is not intoxicated (intoxicated people are at an increased risk of acting impulsively).
- Attempts have been made to ensure objects that could be used to self-harm have been removed from the person.
- Whanau/family have been consulted and informed as appropriate.
- Arrangements have been made for the person to return to a safe environment and advice given about removing ropes, guns, medications and chemicals from the home.
- Social supports/case workers and counsellors have been consulted, and informed.
- The person has been given information about medications, emergency contact persons or services and some strategies to deal with continuing problems.
- Some treatment for any underlying psychiatric illness has been arranged, including a referral to mental health services if necessary.

Factors associated with risk of self-harm:

- Is the person depressed (low in mood), and or experiencing Self-Harm or Suicidal Ideation.
  - ❖ Has the person a clear plan or method?
  - ❖ Does the person have feelings of hopelessness?
- Past attempts.
- Any disinhibitors? Drugs, Alcohol, thought or mood disorders,
- Access to harmful substances or weapons.
- Are there any social supports in place for the person, and is the person making comments about being better off dead or that things will be better soon? Is the person making arrangements to give away personal property or making arrangements for after death?
- Do voices command the individual to harm him/herself? (What exactly are the voices saying?)
- Is the person able to resist the commands at present?
- Is there evidence of impulsive behaviour?

- Does the person have a traumatic past?

RISK FACTORS FOR SUICIDE.

This mnemonic **'Sad Person's escape'** can assist the clinician to cover the key factors in assessing for suicide risk. It provides a composite of predisposing risk factors. It should be used in conjunction with a detailed assessment of the precipitants of the person's suicidal crisis, exploration of factors maintaining their distress and their current mental state.

Sex: While more males die by suicide, more females attempt suicide.

Age: Highest risk groups are those aged 15-24 years and those over 60 years.

Depression: Present in as many as 70% completed suicides; this risk is greater with symptoms of anhedonia and more severe depressions.

Previous attempt: Of those who have previously made a suicide attempt, 10-20% will eventually die by suicide.

Ethanol and drug abuse: Substance abuse and intoxication are also strong risk factors in suicidal behaviour. Of people who die by suicide, 25-50% consume alcohol before taking their lives and suicide risk is substantially enhanced among people with co-morbid substance abuse, and depression and hopelessness.

Rational thinking is impaired: Of people with schizophrenia, 10-15% die by suicide. The risk of dying by suicide is especially elevated in people with psychotic depression.

Support networks: Isolation, loneliness or a disrupted Whanau/Family of origin have been associated with increased risk of suicide. A Whanau/Family history of suicide has also been shown to increase a person's risk of suicide.

Organised plan: The presence of an organised plan with available means increases the risk that a person will attempt suicide.

No spouse: people who live alone, are divorced or separated, or recently bereaved are at greater risk of suicide.

Sickness: Of people who dies by suicide 25-70% had a debilitating medical illness present at the time of their death. However, the important mediating factor for their suicide appeared to be a concurrent psychiatric illness, usually depression.

Experiences of adversity: these also place a person at risk of suicide. Such experiences include:

- Experiences of humiliation.
- Social and educational disadvantage.
- Whanau/family history of psychiatric illness.
- Poor relationships with parents.
- Being in trouble with the law.

Sexual abuse: people who have experienced all forms of abuse and neglect are at greater risk of attempting suicide.

Co-morbidity: co-morbidity: The majority of both adolescents and adults who die by suicide (over 90%) suffered from an associated psychiatric disorder at the time of their death.

People who meet the criteria for more than one disorder at a time are at an even greater risk.
Anxiety disorders (particularly panic disorders): People with anxiety disorders co-occurring with depression have an increased risk of suicide.
Personality disorders: diagnoses of Antisocial and Borderline Personality Disorders with and without co-occurring Axis 1 disorders are associated with an increased risk of suicide. Diagnosis of Conduct.
Disorder of oppositional defiant Disorder among youth are also risk factors.

Event In youth, an identifiable event preceded 70-97% of suicides.

Common Medications Used In Mental Health Service

Student Learning Exercise: Write underneath each drug name at least one common trade name. Also expected actions and side effects and what monitoring needs to occur.

1st Generation antipsychotic	2nd Generation antipsychotic	Intramuscular Antipsychotic Long Acting or Depot	Benzodiazepine & Hypnosedatives	Antidepressant (SSRI)	Antidepressant (tricyclic)	Antidepressant (other)	Mood Stabilizer Or MS Properties	Side-effect management
Chlorpromazine	Olanzapine	Zuclopenthixol Decanoate	Clonazepam	Citalopram	Amitriptyline	Venlafaxine	Lithium Carbonate*	Bentropine
Haloperidol	Risperidone	Fluphenazine Decanoate	Diazepam	Fluoxetine	Doxepin	Phenlyzine	Sodium Valproate	Procyclidine
Trifluperazine	Quetiapine	Pipothiazine	Oxazepam	Paroxetine	Nortriptyline	Tranylcypromine	Carbamazepine	Orphenadrine
	Ziprasidone	Risperidone Consta	Lorazepam		Imipramine	Amoxapine	Lamotrigine	
	Aripiprazole	Haloperidol Decanoate	Alprazolam		Trimipramine	Nefazodone	Olanzapine	
	Clozapine*	Flupenthixol Decanoate	Buspirone		Clomipramine	Bupropion	Risperidone	
		Olanzapine Pamoate monohydrate*	Zopiclone			Mirtazapine	Quetiapine	
		Paliperidone Palmitate	Temazepam					

Information about drugs used in New Zealand can be accessed from http://www.medsafe.govt.nz/

This site includes consumer information, information for clinicians and articles designed to keep health professionals up-to-date with the latest research around medications. *It is important to access local Policies on these medications.

Extra medications used in TWA. **Student Learning Exercise:** Write underneath each drug what they are used for.

Specific IMI Short Acting Anti-Psychotics	Benzodiazepines which are IMI.	Drugs kept in the Resus Trolley.
Zuclopenthixol Acetate (Clopixol Acuphase)	Clonazepam	Adrenaline 1:1000 1ml
Rapid Acting Olanzapine	Lorazepam	Atropine 600mcg IM
Haloperidol	Diazepam	Amiodarine HCL 150mg/3ml
		Sodium Chloride 0.9% 5ml

Drugs in the Epileptic Emergency Box are:

- Diazepam 10mg which is used when and for what

_____

_____

Pre-reading/Resources

Mental Health Act Summary

A Registered Nurse's Power to Detain For The Purpose Of Assessment.

(Section 111) Mental Health (Compulsory Assessment and Treatment) Act 1992.

Section 111(2)(a) of the Act allows a registered nurse to detain, for the purpose of an assessment examination, a person who has been admitted to hospital (or who has been brought into hospital) who is believed to be mentally disordered. This detention cannot be for more than six hours from the time the nurse first calls for a medical practitioner to examine the person [Section 111 (3)]. It should be noted that the power to detain is not limited to the premises of a psychiatric unit and should be exercised with discretion, according to good clinical practice.

At Hutt Hospital, in reference to a S111, a Sec 8 should be completed by the nurse making the application. A Psychiatric Registrar will be called to complete the Sec 8B. At Hutt Hospital the Catt team need to be notified of the Sec 111 being put in place so they can provide a Sec 9 to the client to ensure they are provided with a copy of their rights.

Section 111 of the Act does not necessarily apply in every situation in which assessment under the Act is initiated in respect of a person already in the hospital – it is intended for the use only in an emergency. Informal patients can be placed under the inpatient assessment process in the same way as any other person.

Mental Health Act Easy Reference Notes.

Section 8 Application for assessment.
By anyone who is over 18 has seen the proposed client within the last three days.
Must be accompanied by a Medical Practitioners Certificate.

Section 8B Medical Practitioners Certificate.
Must be examined by a Dr and reasonable grounds for believing that the person is suffering from a mental disorder.

Section 9 Notice to attend an assessment.
Date, time, place and with whom.
Given by a duly authorised officer.
Dr must not be the same Dr who issued 8B.

Section 10 Certificate of preliminary assessment by a Psychiatrist.

If the client is found to be mentally disordered a copy of the certificate must go to the:

- The client.
- Any welfare guardian of the client.
- The applicant for the assessment.
- The client's principle caregiver.
- The client's GP.

Section 11 Notice to undergo a 5-day assessment period.
Can be either inpatient or outpatient.

Section 12 Certificate of further 5-day assessment by a Psychiatrist.
Same provisions as apply to section 10.
A letter of reason for continuance to go to the Director of Mental Health by a Psychiatrist (DAHMS).

Section 13 Further assessment and treatment for 14 days.
Second period of assessment and treatment.
Same provisions as apply to section 11.

Section 14 Certificate of final assessment.
Can be adjourned 2 times to a maximum total of 6 weeks in 12 months.
If the client is to remain under the act an application for compulsory treatment order is to be made.

Section 16 Review of a consumer's condition by a Judge (2nd opinion required).

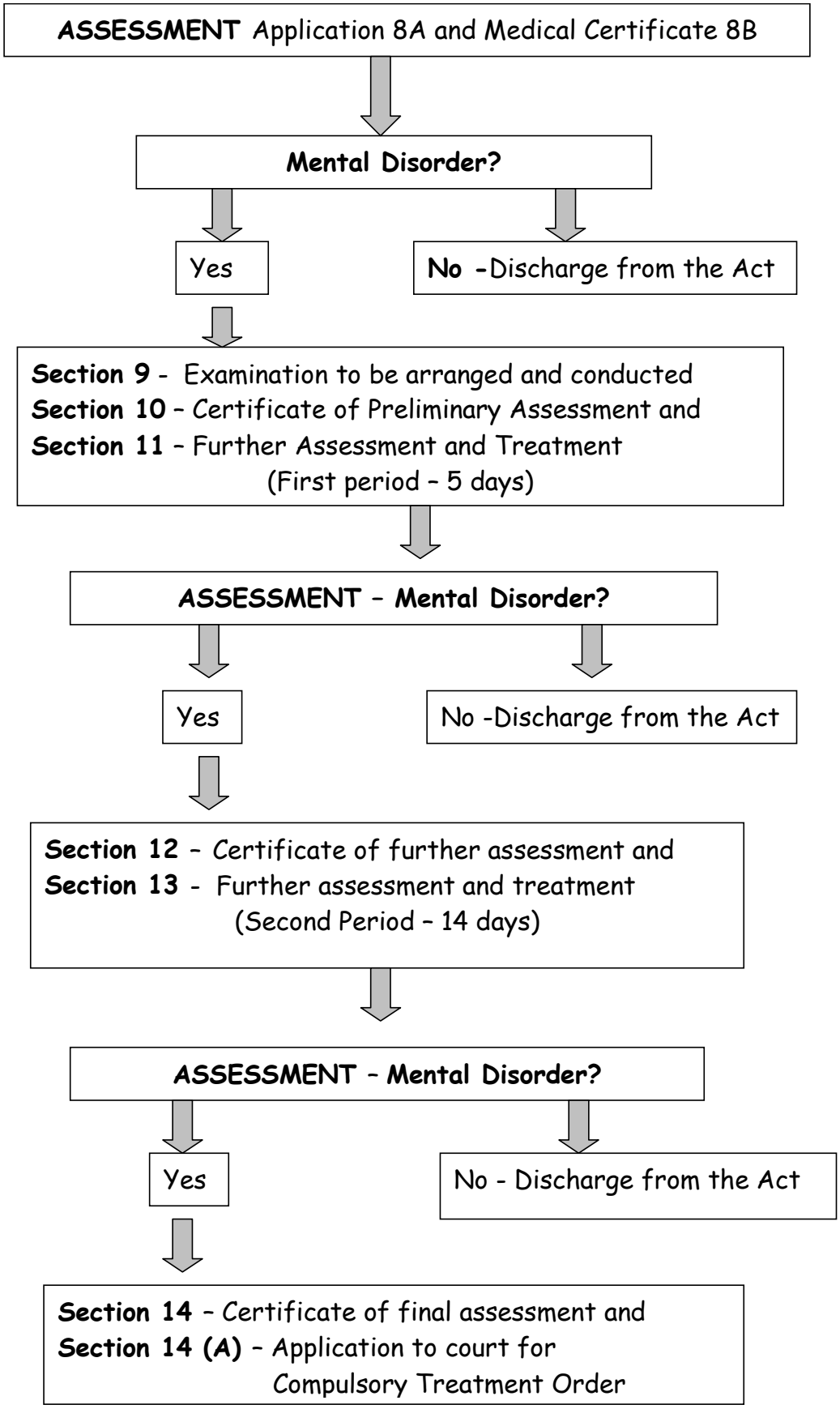
Section 29 **OUT-PATIENT** community order (6 months).
No power to detain the client for the purpose of treatment.
Made by a Judge.

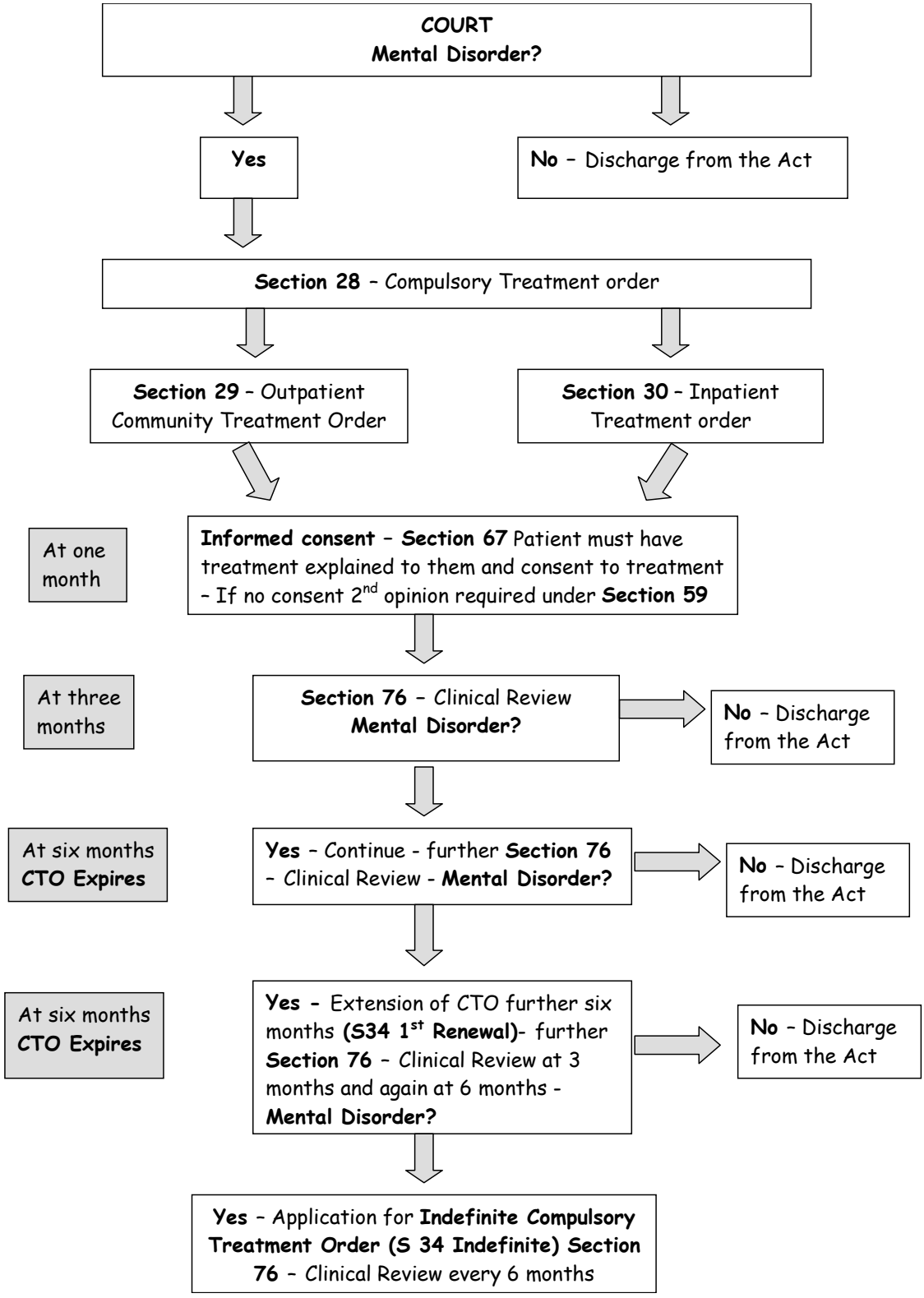
Section 29 (3) (A) Responsible Clinician can direct a consumer to be treated as an inpatient for up to 14 days.
Cannot be anymore than twice in a six month period.

Section 29 (3) (B) Responsible Clinician directs consumer subject to a community treatment order (CTO) to be assessed. CTO ceases and reassessed under section 13 & 14 of the act.
*It is possible for a consumer subject to a CTO to have an informal admission for a short period.

Section 30 **IN-PATIENT** order (6 months). Made by a judge.

Section 76 Clinical reviews if still mentally disordered extension of 6 months.
Clinical review at 3 months and again at 6 months.


ASSESSMENT Application 8A and Medical Certificate 8B
Mental Disorder?
Yes
No -Discharge from the Act
Section 9 - Examination to be arranged and conducted
Section 10 – Certificate of Preliminary Assessment and
Section 11 – Further Assessment and Treatment
(First period – 5 days)
ASSESSMENT – Mental Disorder?
Yes
No -Discharge from the Act
Section 12 – Certificate of further assessment and
Section 13 - Further assessment and treatment
(Second Period – 14 days)
ASSESSMENT – Mental Disorder?
Yes
No - Discharge from the Act
Section 14 – Certificate of final assessment and
Section 14 (A) – Application to court for
Compulsory Treatment Order


COURT
Mental Disorder?
Yes
No – Discharge from the Act
Section 28 – Compulsory Treatment order
Section 29 – Outpatient Community Treatment Order
Section 30 – Inpatient Treatment order
At one month
Informed consent – Section 67 Patient must have treatment explained to them and consent to treatment – If no consent 2nd opinion required under Section 59
At three months
Section 76 – Clinical Review Mental Disorder?
No – Discharge from the Act
At six months CTO Expires
Yes – Continue - further Section 76 – Clinical Review - Mental Disorder?
No – Discharge from the Act
At six months CTO Expires
Yes - Extension of CTO further six months (S34 1st Renewal)- further Section 76 – Clinical Review at 3 months and again at 6 months - Mental Disorder?
No – Discharge from the Act
Yes – Application for Indefinite Compulsory Treatment Order (S 34 Indefinite) Section 76 – Clinical Review every 6 months

Copy of client rights when being assessed and treated under MH Act

YOUR RIGHTS
Under the Mental Health Act 1992

If you are being treated under a compulsory order for a mental illness, you have the right to be treated with respect.

- You have the right to be fully informed in writing about your status and all aspects of your assessment, treatment and review.
- You have the right to receive medical and health care that is suitable for your condition. You must be told of the benefits and side effects of your treatment.
- You have the right to ask for the opinion of an independent psychiatrist.
- You have the right to ask a lawyer to advise you on your rights and status as a patient, on any other matter.
- You have the right to have your condition reviewed by a Judge, or a Review Tribunal.
- You can seek a judicial enquiry.
- You have the right to have your culture and your beliefs respected. You can have someone who speaks your language with you or someone from your family or whanau, a friend or advocate, at your assessment or review.
- You have the right to have visitors and use the telephone, at reasonable times. You can send and receive letters, unopened. These rights can be limited by your responsible clinician, only for a specific reason.
- You have the right to the company of others. Seclusion can only be used, where necessary for your care and treatment or the protection of others.
- You have the right to refuse any videos and tapes of your treatment being made or used.
- You have the right to assistance if you are not happy with the way you are treated. Ask the staff to help you make contact with the District Inspector, Official Visitor your lawyer, or a patient advocate.

Websites with Nursing and Mental Health Information. ONE Copy of this information is in the Student nurse box.

1. New Zealand Nursing Council Nurse Competencies – the framework basic competency for all Registered Nurses, Enrolled Nurses and Nurse Practitioners and Code of conduct and Professional Boundaries – Link: http://www.nursingcouncil.org.nz
2. Standards of Practice for Mental Health Nurses from the Te Ao Maramatanga – the New Zealand College of Mental Health Nurses which are based around Knowledge, Skills and attitude - Link http://www.nzcmhn.org.nz
3. Mental Health Organizations who provide help and support - Link: http://www.health.govt.nz/our-work/mental-health-and-addictions/mental-health/mental-health-organisations-and-initiatives
4. Health Mental Health Commission recovery Link: http://www.mhc.govt.nz/publications/recovery-competencies-mental-health-workers and Blue print Link: http://www.hdc.org.nz/about-us/mental-health-and-addictions http://www.hdc.org.nz/about-us/mental-health-and-addictions
5. Privacy– Link: http://privacy.org.nz

Feedback to Preceptor

Name of preceptor:	**Name of preceptee:**			
MY PRECEPTOR: Please tick the description which best describes your experience in each category	**Excellent**	**Strength**	**Satisfactory**	**Needs Improvement**
• was expecting me and made me feel welcome	☐	☐	☐	☐
• identified what previous knowledge and skill I had and set goals with me which reflected this	☐	☐	☐	☐
• had a wide range of clinical knowledge and skills to meet the patient/client needs	☐	☐	☐	☐
• assisted me with prioritising & time management skills	☐	☐	☐	☐
• communicated well with patients, family & colleagues	☐	☐	☐	☐
• was confident in dealing with clinical situations which assisted my learning	☐	☐	☐	☐
• used effective clinical teaching skills	☐	☐	☐	☐
• identified other people who could assist my learning	☐	☐	☐	☐
• role modelled caring nursing practice and patient centred care	☐	☐	☐	☐
• offered regular specific constructive feedback	☐	☐	☐	☐
• facilitates mutual trust & respect among colleagues	☐	☐	☐	☐
• extended my learning through creating practice opportunities	☐	☐	☐	☐
• challenged my knowledge base	☐	☐	☐	☐
• created a safe learning environment	☐	☐	☐	☐

Any other comments:	Signed by preceptee: Date:

Feedback to Preceptor continues over

TO BE COMPLETED BY THE PRECEPTOR: What will you do differently as a result of this feedback and how?	Signed by preceptor: Date:

Note this completed form can form part of the preceptor PDRP portfolio.