UNDERGRADUATE STUDENT PLACEMENT

Bendigo Health Mental Health Services: Orientation Manual

BENDIGO HEALTH MENTAL HEATH SERVICE

Mental Health Professional Development Unit

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Orientation Day program

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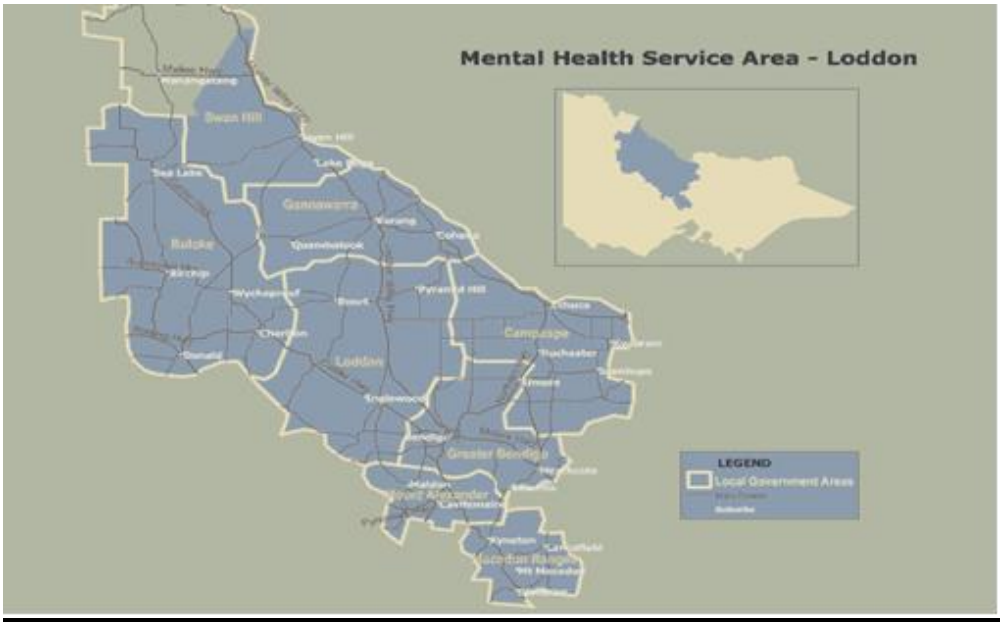
• Activity – self Care	1315 - 1400
• New Hospital Tour for in patient students • Check out student access while at sites	1400-1500
All other students should depart for a brief meet and greet to their own clinical area (including rural areas).	

Introduction to Bendigo Health Mental Health Services

The region of Victoria serviced by Bendigo Health Mental Health Services is defined by the Department of Health & Human Services (DHHS) as the Loddon-Campaspe/Southern Mallee Region, which is represented the maps shown below. The region covers just over 37,036 sq. kilometers, extends over 200 kilometers from top to bottom and has a population of over 310,000.



While most clinical services are located in Bendigo, including all inpatient facilities, regional clinical teams are located Swan Hill, Echuca, Castlemaine, Maryborough and Kyneton. Bendigo Health Mental Health Services is funded by (DHHS) to provide all public clinical services to residents of this region.

In contemporary practice, Mental Health Services provide treatment in a step care approach based on individual need in the least restrictive environment. This is supported by consumer advocacy, research and government policy. Wherever possible, people are treated and supported in the community. Sometimes however, inpatient care is required according to the patient's clinical, therapeutic and legal needs. Bendigo Health Mental Health Services comprises of the following:

Community Settings:
Adult Community (BACMT),
Older Person Mental Health Community (OPCMT)
Youth Services, Community and Youth Prevention and recovery (YPARC) (residential)
Adult Prevention and recovery (APARC) (residential) and Short Term treatment Team (STTT)
Child and Adolescent Community (CAMHS)

Inpatient Settings:
Adult Acute Unit (AAU), Extended Care Unit (ECU) Ecatt, Triage (ET), and Older Person Acute Unit (OPU)

We also provide Continuing Care Units in the community and the Dual Diagnosis Unit (residential) and a specialized Parent Infant Unit (PIU)

Our philosophy of care

Bendigo Health Mental Health Services deliver evidence based treatment and patient centred care, underpinned by recovery oriented principles and values. We deliver treatment and care that is sensitive to gender and culture, informed by an understanding of responses to trauma, and responsive to the contexts of patients' lives and communities. We aim to provide care and treatment in the most appropriate and least restrictive setting. We actively engage with patients, carers, families, nominated persons, General Practitioners and the broader community. We focus on the development of relationships that are collaborative and foster patient choice and self-determination, and will promote resilience. We support patients to pursue their own wellbeing by respecting their wishes as much as possible. (Refer to appendix for Recovery statement)

Best Fit Option

Sometimes there are instances whereby a patient's needs and circumstances or bed availability may not fit the age criteria set by Mental Health Services. In these cases negotiation between areas will take place and the service component most skilled and able to meet the patient's needs will provide the leadership and clinical service to the patient.

Student and Service Roles

Induction steps
On arrival to orientation day held with Mental Health Service the following induction steps should have taken place already

- Have organized and completed police check with Clinical Deanery and your education provider
- Completed declaration form and access form prior to placement commencing

- Issued with Bendigo Health Login details. These details should have been sent to either your student email and/or personal email attached with your education Provider prior to placement commencing

- Log in details will enable you to access online orientation package which you are required to be complete prior to arriving on placement

- Have completed online orientation to the organization inclusive of immunization, emergency codes, manual handling, infection control, incident reporting

- On arrival to placement log on details will also enable access to buildings by using your swipe card (this is given to you on day of orientation) and access to the ICT network systems your placement requires you to have such as Bendigo Health Network, online medical records, other database that may be necessary (triage/CMI)

If you have access issues please refer these to the following contacts:

Buildings & Infrastructure: Judy Lock - jlock@bendigohealth.org.au

ICT: ICT Service Desk – log into ICT help desk online (alternative contact name is Tania Ryan)

Clinical Placements/deanery: Jess and Sarah – clinicalplacments@bendigohealth.org.au

CP-DMR Project: Trish Arnold - cpdmrproject@bendigohealth.org.au (contact Name is Enya Murray)

Please note: Your access will be suspended if various attempts are made to access an area or ICT programs that are not within your scope or a part of your placement area.

Educator/s/Preceptors and buddy's

Bendigo Health Mental Health Service (MHS) strives to provide our students with a placement that promotes positive and safe learning opportunities. In order to encourage this type of environment the service works with a preceptorship model and often takes on a team approach to this. This provides our students with a broader range of learning opportunities and a diverse set of skills and knowledge from a variety of staff.

To ensure our clinical preceptors/buddy are well supported with students, the service's Clinical Placements Bendigo Health co-ordinate all undergraduate student placements and work collaboratively with Mental Health Professional Development Unit (MHPDU) to oversee this program.

In addition to the normal induction steps that Clinical Placements carry out prior to students commencing placement MHPDU provide; an intensive orientation day for students, indirect clinical supervision, resources and support to preceptors/buddy and students prior and during placement.

Direct Clinical Supervision
'When the supervisor is actually present and personally observes, works with, guides and direct the person who is being supervised' (ANMC, 2007, p. 2)
Indirect Clinical Supervision
'When the supervisor works in the same facility or organisation as the supervised person, but does not constantly observe their activities. The supervisor must be available for reasonable access. What is reasonable will depend on the context, the needs of the consumer and the needs of the person who is being supervised' (ANMC, 2007, p. 2)

Role of the Preceptor/Buddy

- Provide direct clinical supervision
- Complete student assessment
- Enable and encourage student with learning opportunities and to meet objectives
- To expand student clinical knowledge and skills that can encourage student to grow confidence, reflective practice and be proficient in duties

Role of the Undergraduate Student

- To be open to learning and receptive to suggestions and feedback.
- To be proactive in own learning and show enthusiasm to learn and be a part of a team
- To ask lots of questions
- To be prepared and ready for placement – set objectives and a plan with your preceptor/buddy at beginning of placement

  To be responsible for your assessments and work towards to competing your assessment with your preceptor/buddy

Mental Health Professional Development Unit:

Mental Health Nurse Educators	Phone	Email
MHPDU	03 54547612	jrodier@bendigohealth.org.au scrothers@bendigohealth.org.au
Ivane Greblo	0458339584	igreblo@bendigohealth.org.au
Timothy Lauder	0427273375	tlauder@bendigohealth.org.au
Christine Cummins	O418177939	ccummins@bendigohealth.org.au
Michael Thomson	0438551848	mthomson@bendigohealth.org.au

Resources

https://www2.health.vic.gov.au/about/key-staff/chief-psychiatrist

http://www.health.gov.au/

http://intranet/

https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/mental-health-act-2014

https://www.mhpod.gov.au/

Trouble Shooting

Students are encouraged to alert MHPDU and/or complete the declaration form prior to placement commencing with any issues or concerns that potentially can impact on their placement

Students are encouraged to approach their preceptor in the first instance with any concerns that arise during placement. If the situation requires to be escalated, then the student and the preceptor are to inform the Unit manager and MHPDU

If the matter is urgent or an emergency the preceptor is required to alert the area manager immediately and MHPDU educator/s. MHPDU will notify others as necessary such as Education Provider coordinators and Clinical Deanery

Placement Expectations

Sick Days.

Students must inform the clinical area they are allocated to if required to take a sick day. If the clinical area cannot be contacted then MHPDU can be contacted and made aware. A medical certificate is required from the student and to be presented to their own Education Provider Coordinator.

In any event that a student is sick the educators are to be informed of what days the student was absent so that this information can be relayed to Clinical Deanery.

Work Hours/Rosters

All students are required to attend the first day of placement to orientation with MHPDU educators. Orientation is usually held in West Wing Building, Ann Caudle Campus. Entry is via Hope Street and room details are forwarded to education providers prior to commitment with a start time of 8.30am. Students will then be directed to clinical areas in the afternoon for further orientation that is specific to clinical area assigned.

MHS prefers to encourage self-rostering on commencement of placement however, this varies according to clinical site allocated to the student.

Inpatient Units: Students will organize shifts during orientation to clinical area on first day -This is to ensure that the team, student and unit needs are taken into consideration.

Community Areas: Students are required to work 8.30am – 5.00pm Monday to Friday

Students do not work weekend or night shift.

Students are encouraged to arrive early for commencement of shifts to allow for traffic and parking. Students are asked to please contact the clinical area in the event that you are late

Professional Conduct and Boundaries

Definition of Professional Conduct

'Professional conduct refers to the manner in which a person behaves while acting in a professional capacity' (Code of Professional Conduct for Nurses in Australia).

Definition of Professional Boundaries

'Boundaries are the borders or limitations that a professional establishes (or can assist other professionals or persons in their care to establish) in order to protect them and their clients from developing unprofessional, unethical, confusing or conflicting relationships' (Nursing & Midwifery Council, NSW).

Students are required to familiarize themselves with the following documents:

Professional Boundaries for Nurses Australia

https://www.nursingmidwiferyboard.gov.au/codes-guidelines-statements/professional-standards.aspx

Code of Professional Conduct for Nurses

https://www.google.com/search?q=code+of+conduct+for+nurses+victoria&sourceid=ie7&rls=com.microsoft:en-AU:IE-Address&ie=&oe=&gws_rd=ssl

Bendigo Health Policy – Code of Conduct, Gift, benefits and hospitality framework

http://prompt1/Search/download.aspx?filename=1048009\1048229\35033668.pdf

Communication Tools

Mobile Phones: Students are advised to not carry mobile phones on their belonging whilst working within clinical inpatient facilitates. Students are given locker areas to store bags and mobiles away and can check these on assigned breaks.

Students assigned to community /residential setting are required to turn mobile phone on silent and leave stored in personal bag.

❋ **It is not appropriate for students to use personal mobile phones whilst engaging in care and treatment with patients, family and/or carer**

Students are advised to review our social media and confidentiality policy:

Bendigo Health Confidentiality Policy

http://prompt1/Search/download.aspx?filename=39835267\39836390\28172913.pdf

Social Media Policy

http://prompt1/Search/download.aspx?filename=20665716\20831220\29007874.pdf

Objectives

Students would have received information prior to placement from Education provider around objectives to be met whilst on placement.

Regarding mental health placement these objectives are often related to:

- Mental State Examination
- Risk Assessment
- Case study in relation to a major Mental Illness and treatment/care
- Medication
- In some circumstances ECT

Whilst there are the more common objectives as above, our clinical areas also provide a variety of other learning opportunities that could bring about further objectives such as:

- Assessment process/Triage
- Consultation with community services
- Home visits
- Rural Trips
- GP visits
- Clopine Clinic
- Housing worker
- Peer Support workers
- Mental Health Tribunal Review
- Forensic Specialist Consultant
- Older Person Specific – such as visits to nursing homes to conduct review and/or assessments
- Medication, including Depots (IMI)
- Education Sessions (inpatient and Grand Rounds which are held every second Wednesday at JBC meeting room).

❋ It is very important that you meet with your preceptor/buddy and work through what is specific to your area you are located for placements and work on a plan with them if you preceptor/buddy gets busy with own paper work. There are a variety of learning opportunities to be had.
Students must realize that mental health placement is quite unique and quite different from any other placement you have been through. This placement requires students and preceptors/buddy's to 'look outside the square so to speak' and be flexible in their approaches.

Uniform

Inpatient Settings: Uniforms are to worn in all inpatient settings. Shoes are required to be fully covered and jewelry to a minimum (studs or sleepers preferred).

Community /residential Settings: Smart casual attire is preferred. Fully covered shoes is essential also. No blue denim jeans are to be worn or singlet tops. Attire must be professional and appropriate, minimal jewelry.

Student ID/name tags should be visible and your swipe card issued. Whilst it is illegal to withhold your fully name it is personal choice if you display your full name on card or name tag. Please understand that if you are asked for this information you are required to give supply this. If you have concerns it is encouraged that you always report back to your preceptor for further advice.

Debrief

Students are required to attend an end of placement debrief with MHPDU educators. This debrief is held on the last day of placement at the Ann Caudle Campus (room details will be advised at orientation, entry is via Hope Street). Debrief will commence at 1400hrs and finish at approximately 1500hrs. Student can negotiate with the educators about travel allowances regarding attending debrief (this only applies to rural areas).

Debrief provides an opportunity to share your experiences whilst placement in a group setting. On an individual level each student also has a chance to complete a placement evaluation to provide feedback.

Students also have if necessary more formal process for feedback. And will be encouraged to also feedback to own education provider if deemed necessary and is appropriate.

Scope of Practice/Assessment

It is important for students to discuss the scope of practice in regards to the year level currently in, also in regards to designation (RN/EN) and mental health modules completed or not completed within curriculum. It is the student's responsibility to advise the preceptor/buddy if it is within scope for example: that medications can be undertaken (under supervision) or student can take blood etc.

It is important for the student and preceptor/buddy to discuss learning pace when setting objectives and discussing scope of practice. As individuals we all have different learning styles and levels of processing information given to us. Student assessment is based on current professional stage (that being year level in undergraduate course, RN or EN discipline).

❋ **Note: As a student, your education provider expects you to take full responsibility for your assessment and this includes advising your preceptor/buddy about the assessment structure and requirements.**

Please be aware that you preceptors/buddy may not be familiar with all assessments that are presented – as an industry provider there are a variety of assessments passed through and utilized. These tools are a great way of identifying strengths, areas for improvement and to provide feedback to each other.

Documentation

Mental Health Services (MHS) utilises the organization wide approach called Focus Documentation which will be covered in more detail within the orientation day, please refer to below ISBAR as revision and throughout your placement as required.

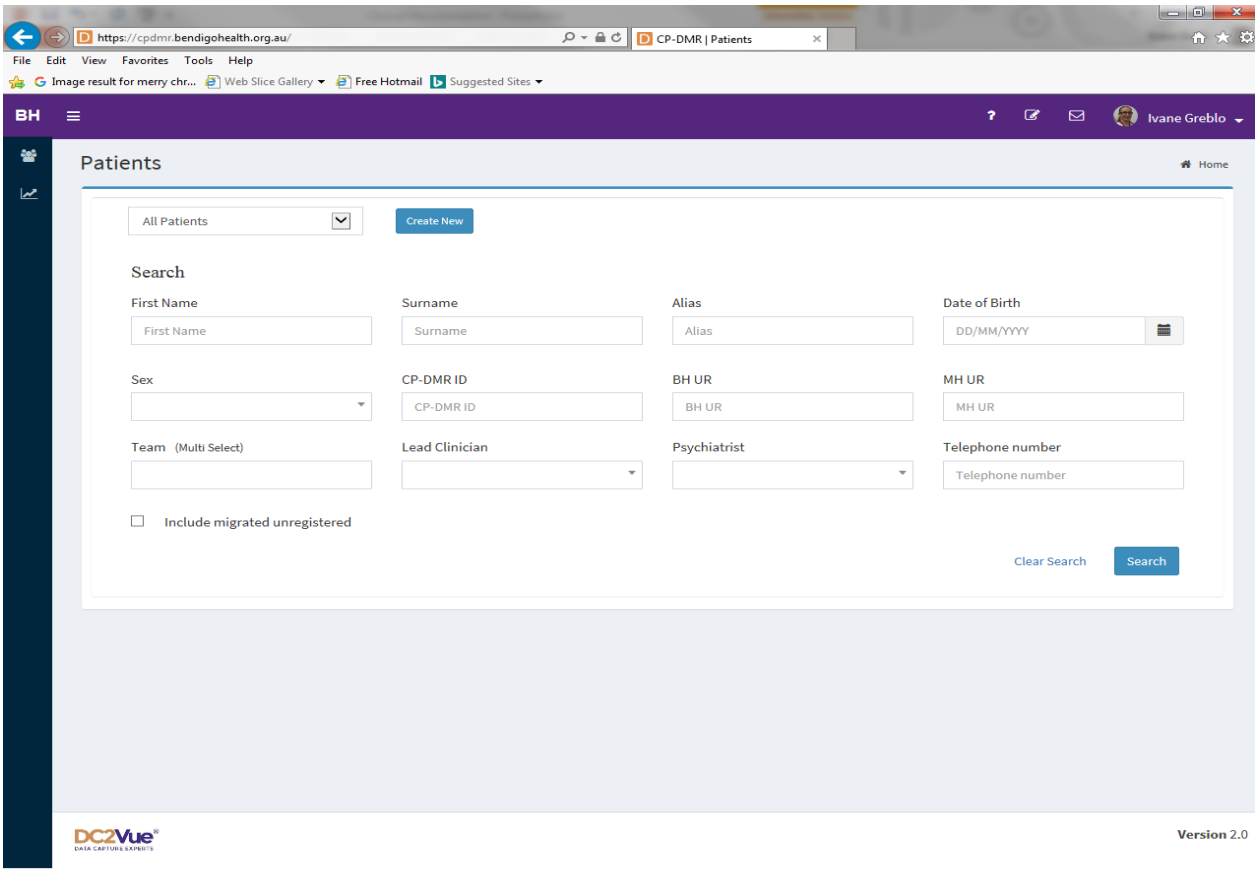
ISBAR: A Clinical tool for communication/handover

Identify **-**Yourself, name, position location & patient
Situation**-** Why are you calling? If urgent say so
Background **-Tell the story**
Assessment **-**What you think is going on
Request **-** What is it you want them to do?

MHS use online documentation programs.

The programs you will become primarily familiar with are called CP-DMR., Patient Flow. Some areas will require use of other programs such as Triage CMI.

CP-DMR holds our online digital documentation suite and there are clear guidelines/policy available on documentation requirements.



Students will be taken through these in orientation and should familiarize themselves with the following documents to prepare for working with preceptor/buddy around documentation:

- http://prompt1/Search/download.aspx?filename=39835267\39836390\31942836.pdf
- http://prompt1/Search/download.aspx?filename=39835267\39836406\35669202.pdf

Online documents to become familiar with for placement in our service:

1. CASP 2
2. CASP 5

Mental State Examination

Mental Status Examination: ***The MSE records <u>ONLY observed</u> behaviour, cognitive abilities and inner experiences expressed during the interview. MSE is a core component of the assessment process necessary to arrive at a provisional diagnosis and thus formulate a management plan.***

<u>Appearance and Behaviour:</u>

- Describe physical appearance: build a vivid description for the reader
    - Describe grooming/hygiene/clothing/hair/nails/build
    - Do they look stated age, are they appropriately dressed for weather/situation,
- Describe motor behaviour (psychomotor retardation, restless, repetitive, hyperactive, tremors):
- Describe individual's reaction to present situation (cooperative, friendly, guarded, withdrawn, uncommunicative):

<u>Mood:</u> – Internal or subjective (what patient describes) feeling or emotion which often influences behaviour/perception of the world.

Report what the individual says they feel, use inverted "commas" e.g.

depressed,	paranoid
angry,	down,
happy	sad,
suspicious,	fearful,
great,	irritable
rotten	miserable
fantastic	high

<u>Affect</u> – External or objective (what interviewer sees) emotional response

- Describe the individual's affect, how the interviewer sees the person's mood displayed.
- There are a number of components of affect, including:
    - Quality: "miserable", "suspicious", "euphoric", "hostile", etc,
    - Range:
        - Restricted affect: Decrease in intensity and range of emotional expression
        - Blunted affect: Severe decrease in intensity and range of emotional expression
        - Flat affect: Total or near absence of emotional expression, face immobile, voice monotonous)
    - Reactivity: is the affect pervasive, reactive or labile,
    - Congruence: mood-congruent or mood-incongruent
    - (Normal affect : Variation in facial expression, voice, use of hands, body movements

Speech:

- **Physical aspects of speech can be described in terms of**
    - Rate (slow, halting, hesitant, normal, fast, and pressured), volume (loud, quiet, whispered, barely audible, etc) and quality (slurred, dysarthric, nasal, accented, etc).
    - Consider particular characteristics – mutism, poverty of speech, pressured speech, intelligent, articulate, thoughtful, and rambling.

Disorders of Thinking:

1. ***Disorders of Stream of Thought***
    - Tempo (, fast, slow or normal,)
2. ***Disorders of the Form of Thought****:*
    - Derailment (loosening of association), circumstantiality, flight of ideas, incoherence (word salad), neologisms, tangentiality, word approximation, thought blocking, perseveration.
3. ***Disorders of Content of Thinking*****:**
    - Delusions eg.

      Paranoid Bizarre Grandiose Persecutory Somatic
      Jealousy Erotomanic Mood congruent Referential
    - Overvalued ideas
    - Pre-occupations,
    - Anti-social urges,
    - Hypochondriacal symptoms
    - Suicidal and homicide ideation
4. ***Disorders of the Possession of Thought***
    - Obsessions (own thought that appears against ones own will)
    - Thought Alienation (thought insertion, thought withdrawal, thought broadcasting)

Perception: (process of experiencing the environment via all the senses)

- **Hallucinations**
    - Tactile eg crawling sensations under or on the skin
    - Auditory eg Voices or noises most common type of hallucination
    - Olfactory eg smells that don't exist more common in organic disorders
    - Visual eg seeing objects, people or images that others can't (seen more in organic disorders)
    - Gustatory eg relation to taste (more seen in organic disorders)
    - Somatic eg false perception that things are occurring in or to the body

- **Derealisation** the external world appears different or unfamiliar. The individual feels distanced from the world and things may seem colourless and dead. Associated with extreme anxiety/panic disorder

- **Depersonalisation** The perception or experience of the self seems different or unfamiliar. The individual may feel unreal or that his body is somehow distorted, or may have the sense of perceiving himself from a distance. In severe form individual may feel as though they are dead. Associated generally with extreme anxiety, stress or fatigue.
- **Dissociation** Unconscious defence mechanism involving the segregation of any group of mental or behavioural processes from the rest of the person's psychic activity: may entail the separation of an idea from its accompanying emotional tone, as seen in dissociative and conversion disorders.
- **Illusions** A misperception or misinterpretation of a real external stimulus, such as hearing the rustling of leaves as the sound of voices.

<u>Cognition:</u> (refers to information processing – thinking and memory). If cognition impaired complete a MMSE.

Orientation: Test for orientation to

- Time
- Place
- Person

Write down exactly what they say use inverted commas (does the interviewer know this themselves?)

Attention: (test with 7 digit span) Forward (5 – 7) Backward (4 – 6)

Concentration: Serial 7's (subtract 7's from 100) Spell WORLD backwards

NB: The best way to assess **attention and concentration** is simply to talk to your patient and observe how they think. Are they able to concentrate on your questions? Can they maintain a train of thought as they answer you? If the answer to these questions is "yes" your patient's attention is intact.

Immediate Memory: Registration – the capacity for immediate recall, ask to repeat 4 items – dog/hat/green/
Peach. Score out of 4

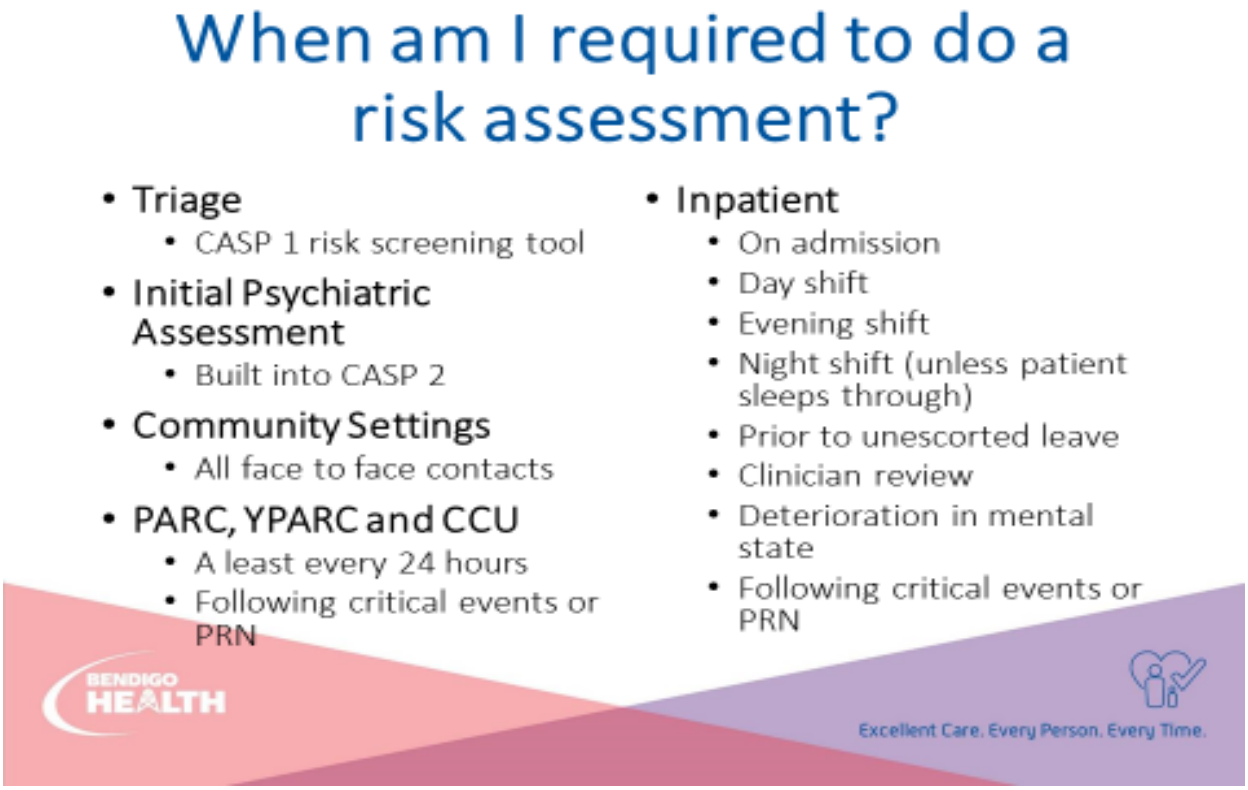
Short Term Memory: Ask to repeat dog/hat/green/peach after 3 mins, may prompt eg animal (dog), colour (green).
Score out of 4

Long Term Memory:
Episodic Memory Test eg Date of Wedding **YES** ☐ **NO** ☐
Semantic Memory Test eg Date of WWII: **YES** ☐ **NO** ☐

Insight: refers to the individual's awareness of his or her situation and illness. There are varying degrees of insight eg. An individual may be aware of his or her problem but may believe that someone else is to blame for the problem; alternatively the individual may deny that a problem exists at all. The assessment of insight has clinical significance since lack of insight generally means that it will be difficult to encourage the individual to accept treatment.

Judgement: involves weighing and comparing the relative values of different aspects of an issue. Determining whether a particular judgement is sound is situation dependent

Risk Assessment



Where do I find risk assessment tools

CP-DMR

- CASP 2
- CASP 5
- SD7 In depth suicide risk assessment

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Excellent Care. Every Person. Every Time.

Risk Assessment in CP-DMR

Excellent Care. Every Person. Every Time.

Engage, Ask, Support (EAS)

ENGAGE…

Active Listening
Non Judgmental
Understand
Empathize

EAS

ASK…

Current suicidal thinking
Plan?
Lethality/Intent
Specificity
History
Safety of others

EAS

SUPPORT…

Make a safety Plan

Identify Supports and choices

Seek extra assistance

Stay with the person

Remove any dangerous objects or means

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Assessing lethality of a suicide plan: L.A.S.T

- *L*ethality of chosen method
- *A*vailability of proposed method
- *S*pecificity of the plan and history
- *T*ime, proximity of help

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L.A.S.T –continuum scale

Method and Lethality

Low Risk of Death	Moderate Risk of Death	High Risk of Death
0	5	10

Risk Factors and Lethality

Low Risk of Death	Moderate Risk of Death	High Risk of Death
0	5	10

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Your responsibilities as a student if exposed to moderate to high risk

Community/PARC/YPARC/CCU

- Alert Team Senior/MO/Psychiatrist
- In conjunction with your preceptor you will work through documentation and complete SD7 (In-depth suicide risk assessment) only for mod to high suicidality (utilise strategies in SD7)
- You and you preceptor will write a management plan to address each mod to high risk and this is share the plan the with your team and other parties involved in ongoing care

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Your responsibilities as s student if exposed to moderate to high risk

Inpatient Units

- Alert shift manager if change to overall risk category and take appropriate action with guidance of shift manager
- Under supervision complete all necessary document including rationale beside all moderate to high ratings
- With preceptor write a management plan to address each mod to high risks, this may include change to visual observation

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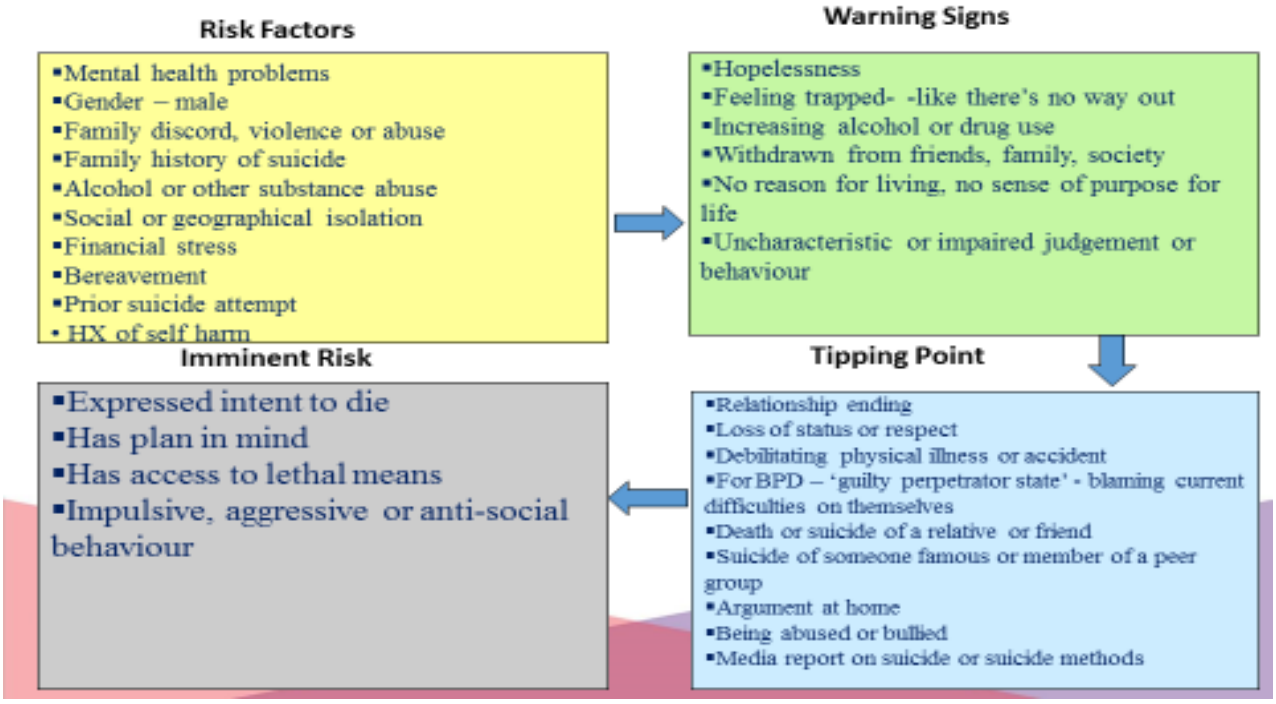
Making a Suicide Risk Ax



Map

http://intranet/Assets/Files/patient_services_map_may_2017.pdf

http://intranet/Assets/Files/BendigoHospital_12.pdf