Essential skills and knowledge

Rapid Mental Health Nursing, First Edition. Grahame Smith and Rebecca Rylance.

Assessment

Background

Assessment is a fundamental part of mental health nursing practice; it establishes an understanding of the service user's situation through a process of asking questions. Assessment is not a one-off, it is an ongoing process which is built on partnership working, starting with a service user's admission to mental health services and continuing until they are discharged. Information gathered from the initial assessment process is the first step in planning and delivering care across services to ensure that the care delivered is effective and based upon the service user's needs.

Assessment can be broadly divided into two categories or methods:

- formal assessment, including checklists, questionnaires, rating scales, tools, and structured interviews;
- informal assessment, when information is collected through less formal and planned methods, such as day-to-day observations and interactions.

Both methods provide the mental health nurse with valuable information, and both methods should have equal weight; however, formal assessment tends to be viewed as more objective and value-free. Sometimes this can lead to information gathered through formal assessment methods having more weight than informally gathered information. The strength of using both methods is that information can be triangulated in way that captures the whole clinical picture rather than just part of the picture.

Assessment information should describe the service user's situation, both generally and specifically; it should also identify the degree to which any identified problem has impacted, and is impacting upon, the service user's ability to function. To elicit this information the nurse should use:

- open questions to scope the broad issues;
- more probing questions to identify the specific issues;
- closed questions to confirm their understanding of the specific issues is correct.

Professional skills

Mental health nurses should be able to:

- undertake nursing assessments that are comprehensive, systematic and holistic;
- utilise assessment information to plan, deliver and evaluate care;
- work in partnership with the service user, their carers and their families throughout the assessment to negotiate goals and develop a personalised plan of care.

Types of assessment

Mental health nursing assessments should be holistic and, as such, during the assessment process the nurse should gather a wide range of information about the following:

- physical health and functioning;
- psychological functioning;
- social functioning;
- spiritual needs.

A variety of assessment tools should be used to gather specific information about:

- risk;
- history;
- symptoms;
- social functioning;
- quality of life.

Assessment tools

Specific assessment tools used in mental health nursing include:

- Brief Psychiatric Rating Scale (http://www.public-health.uiowa.edu/icmha/outreach/documents/bprs_expanded.pdf);
- Beck Depression Inventory (http://mhinnovation.net/sites/default/files/downloads/innovation/research/bdi%20with%20interpretation.pdf);
- Positive and Negative Syndrome Scale (http://egret.psychol.cam.ac.uk/medicine/scales/panss.pdf);
- Beliefs About Voices Questionnaire (http://www.hearingvoices.org.uk/pdf/bavqr.pdf);
- Rosenberg Self-Esteem Scale (http://www.yorku.ca/rokada/psyctest/rosenbrg.pdf);
- Health of the Nation Outcome Scales (http://amhocn.org/static/files/assets/2ad72217/honos_glossary.pdf);
- Camberwell Assessment of Need (http://www.researchintorecovery.com/files/cansas-p.pdf);
- Social Functioning Scale (https://mh4ot.files.wordpress.com/2012/05/social-functioning-scale.pdf);
- Quality of Life Scale (http://www.mentalhealth.com/qol/imhqolscale.pdf);
- Patient Health Questionnaire (http://phqscreeners.com/pdfs/02_phq-9/english.pdf).

Assessment skills

The therapeutic relationship should drive the assessment process which should be person centred, collaborative and underpinned by the use of effective communication skills such as questioning, active

listening, clarifying and summarising. The skills required of mental health nurses are to:

- interview — ask questions about behaviours and symptoms;
- observe — record what they see;
- measure — rate the severity of behaviours and symptoms.

Mental health nurses should utilise all three strategies. It is also important to focus on what the service user can do rather than what they cannot do; this strengths-based approach underpins the recovery process.

Assessment and care delivery

Assessment information is used to inform the delivery of care. It assists the mental health nurse and the service user in partnership to identify what the issues are and what needs to be addressed. The next step after assessment is to consider what the partnership is trying to achieve, and what change the partnership would like to take place and by when. After this step the partnership can consider what interventions would be the most useful, and it is at this stage that the relevant clinical guidelines need to be taken into consideration. The final step is to review the process — were the goals achieved? If not why not? Is there another approach that could be considered? Overall the process should look like this:

1. assessment;
2. care planning and goal setting;
3. care delivery;
4. evaluation.

Care planning

Background

Care planning follows on from the previous section on assessment. Care planning is concerned with the practice of planning care with a service user in order to meet their individual health and well-being needs. Traditionally, a nurse would assess a service user's needs, identify their problems, plan care and evaluate the success of the plan. However, there has recently been a significant shift within mental health services to refocus the clinical language to that of goal identification instead of problem identification. When goals have been identified (utilising a strength-based approach) a collaborative plan of care is developed to help the service user achieve their goals. Regular evaluation, preferably with the service user and their family as well as the clinical team, will ensure that the care plan is effective and also responsive to any changes.

The Care Programme Approach (CPA; The Care Programme Approach Association 2008) is the key framework which informs the care-planning

process in mental health in the UK. The CPA aims to ensure that people have access to services to meet their diverse needs, choices and preferences. Only through collaboration with the service user, their carer, the CPA coordinator, and health and social care professionals can an appropriate plan of care be devised. A useful document that describes effective collaboration is *Ten Essential Shared Capabilities* (DoH 2004), which lists the key principles for inclusive practice for nurses across health and community settings:

- working in partnership;
- respecting diversity;
- practising ethically;
- challenging inequality;
- promoting recovery;
- identifying needs and strengths;
- providing service-user-centred care;
- making a difference;
- promoting safety and positive risk taking;
- personal development and learning.

Professional skills

Mental health nurses should:

- actively empower service users and carers to be involved in the care-planning process;
- understand the public health dimension of planning and delivering care;
- ensure a service users physical, social, economic, psychological and spiritual needs are addressed when planning and delivering care;
- ensure that care planning and delivery is person centred, collaborative, evidence-based and framed by the relevant ethical and legal frameworks.

Partnership

It is vital that nurses work in partnership with people experiencing mental health issues and empower them to make decisions about their care. By utilising a recovery-focused approach, nurses can support a service user to achieve well-being and recovery. Therefore, it is important for mental health nurses to assess each service user's needs holistically, facilitate goal setting, devise a care plan collaboratively and then evaluate it regularly. In the UK, the NMC's professional code of conduct (Nursing & Midwifery Council 2015) is central to the nursing process.

Nursing models

The body of knowledge for nursing is supported by a number of nursing models that are highly abstract and broad in nature; however

they provide a structured way to make sense of the care planning and care-delivery process. Nursing knowledge can be categorised in the following four ways (Carper 1978):

- empiric — explaining and predicting;
- aesthetic — particular and unique to the situation;
- personal — interpersonal;
- ethical — doing the right thing.

The following is a list of the most well-known nursing models:

- Henderson's nursing model;
- Johnson's behavioural system model;
- King's open systems model;
- Neuman's systems model;
- Nightingale's nursing theory;
- Orem's self-care model;
- Peplau's interpersonal relations model;
- Rogers science of unitary human beings;
- Roper's activities of living model;
- Roy's adaptation model.

Peplau's interpersonal relations model (Peplau 1952) is specific to mental health nursing and articulates the view that mental health nursing is an interpersonal and therapeutic process. Nursing models are applied to practice through a framework that provides a systematic process; in the case of Peplau's model, the Tidal Model of mental health recovery provides this framework. It is important to note that mental health nursing is also heavily influenced by biological theories, psychodynamic theories, learning theories, cognitive theories and social theories.

Discharge planning and the CPA

The CPA provides:

- a systematic assessment of needs and risk;
- a care-planning process that is based on needs and risk;
- a care coordinator;
- regular reviews.

The CPA influences the discharge planning process in two ways. Firstly, a mental health service user discharged from inpatient services, where supported by community mental health services, is likely to be placed on a CPA plan. Secondly, the service user being supported by community services is discharged from the CPA when it is deemed by those services that they are well enough.

Clinical decision-making

Background

Mental health nurses are organisationally and professionally accountable for their day-to-day clinical decisions. Some decisions are more complex than others, but irrespective of their complexity the nurse needs to be able to justify the decisions they make. Therefore clinical decisions should be based on evidence, and the nurse should be able to explain which evidence they used and why. The motivation behind the use of evidence should not be to defend a decision, rather the use of evidence should be a regular part of the clinical decision-making process, which actively involves other professionals and, more importantly, service users and carers.

When delivering care mental health nurses have to be effective decision makers. This need for effective clinical decision-making is driven by an expectation that care delivery is of a high standard, and nurses are publically accountable for the clinical decisions they make. To make a clinical decision the mental health nurse needs to:

- identify the issue/s;
- analyse the evidence;
- consider the options;
- plan a way forward;
- implement the decision;
- evaluate the outcome.

Making a decision in this way can appear logical and unemotional, and it is important to note that decision-making in clinical practice will, most of the time, have an emotional context. That is why the evaluation of the decision is so vital and should be linked into the nurse's reflective practices, such as clinical supervision. As there is a values-based context to mental health nursing there is also a need to be ethically sensitive and pay attention to the service user's viewpoint, especially when dealing with the sensitive issue of restricting a service user's freedoms.

Professional skills

Mental health nurses should:

- ensure that clinical decision-making is person centred and evidence based, and the outcomes of the decision-making process are evaluated;
- make decisions in partnership with others involved in the care process to ensure high-quality care;
- signpost to others when the complexity of clinical decisions requires specialist knowledge and expertise;
- recognise and address the ethical context of clinical decision-making in a way that focuses on agreed and acceptable solutions.

Risk

Decision-making has an element of risk; which the best option? In the mental health field practitioners can become defensive, especially when dealing with harms, and this might mean that a decision is more inclined towards being risk adverse, which might not be in best interest of the service user. To make a considered decision the nurse has to weigh up all potential outcomes and also factor in the needs and wants of the service user.

Analysing the evidence

Analysing and using the best evidence is a key part of the clinical decision-making process. The focus of this approach is to provide the best care available. Using the best evidence ensures that established care delivery is also supported by research-based evidence; the evidence used in this approach is usually scientific evidence. Utilising evidence-based knowledge in the clinical decision-making process requires the mental health nurse to be able to:

- identify the clinical issue;
- understand the issue as a clinical question;
- search the scientific literature;
- critique different types of evidence;
- deliver the chosen intervention;
- evaluate the delivery of the intervention.

In addition to choosing a specific intervention, the mental health nurse will also have to consider whether this intervention can be situated within the therapeutic relationship in a way that reflects the specific needs of the mental health service user.

Challenges

Decisions are not made in isolation and there are a number of influencing factors that the mental health nurse will have to take into consideration, including:

- Is there enough information available to make an effective decision?
- What are the timescales?
- What are we trying to achieve?
- Are the required skills and resources available to implement the chosen intervention?
- What are the risks of either taking action or not taking action?

Real-time decisions

Systematic approaches to decision-making can be useful, but it has to be accepted that a number of clinical decisions have to be made in real time. For example, a mental health service user may be actively seeking

to harm themselves; in this situation the mental health nurse will need to act quickly and keep the service user safe. Acting quickly is not an excuse for not doing the right thing, however, and the mental health nurse will need to ensure that they are properly prepared to be able to deal with this type of situation effectively. Being properly prepared stems from:

- having a good foundation of knowledge and skills;
- being able to utilise different forms of knowledge such as empiric, aesthetic, personal and ethical knowledge;
- having the commitment to engage in reflective practice that is structured and protected;
- working in true partnership with mental health service users;
- being a lifelong learner.

Clinical observations

Background

A key role of mental health nurses is to develop a comprehensive and personalised plan of care, and this plan of care should consider a service user's physical health needs. To ensure that a service user's physical needs are systematically assessed the mental health nurse will need to undertake a number of clinical observations.

Undertaking clinical observations is an important, but sometimes forgotten, part of the mental health nurse's role. This is particularly the case when you consider that mental health service users have higher rate of physical health needs than the general (DoH 2011a). For data from clinical observations to be meaningful in the long term they need to be integrated with information obtained from other sources, such as clinical examination and medical history data. In the short-term, however, clinical observations (also known as vital signs) can assist in the process of determining whether the nurse is dealing with a physical emergency. Clinical observations include:

- temperature;
- pulse rate;
- respiratory rate;
- blood pressure;
- peak flow rate;
- urinalysis;
- blood glucose level;
- central venous pressure;
- neurological observations.

Clinical observations are sometimes called vital signs and historically consist of temperature, pulse rate, respiratory rate and blood pressure. In addition to these vital signs mental health nurses also need to be familiar with observations of peak flow rate, urinalysis and blood glucose level.

Professional skills

Mental health nurses should be able to:

- collect and interpret routine data related to the care-planning process;
- measure and record a services user's weight, height, temperature, pulse rate, respiratory rate and blood pressure;
- respond appropriately when a service user's vital signs are outside the normal range or when there is a sudden deterioration in service user's vital signs;
- carry out and interpret routine diagnostic tests, such as a urinalysis.

Temperature

Normal body temperature is in the range 36.0–37.2°C. Body temperature should be monitored in case it is too high (a body temperature above 37.5°C is called pyrexia) or too low (a body temperature below 35.0°C is called hypothermia). Temperature readings can be taken by digital or non-digital thermometers at the mouth, forehead, ear canal or under the arm.

Pulse rate

Measuring the pulse rate gives an indication of how well the heart is functioning; counting the pulse or beats per minute is equivalent to measuring heart rate. A 'normal' pulse rate for a healthy adult is between 60 and 100 beats per minute. The pulse can be felt in any place where an artery can be compressed against a bone, such as the neck, wrist, knee, inside of the elbow and near the ankle joint. The pulse is usually taken at the wrist — the radial site — and not only is the rate noted but also the rhythm and amplitude (pulse strength).

Respiratory rate

The role of the respiratory system is to ensure that the body has enough oxygen to function correctly and toxic carbon dioxide is removed; the respiratory process consists of:

- ventilation — movement of air in and out of the lungs;
- external respiration — gas exchange;
- transport — movement of respiratory gases;
- internal respiration — delivery of oxygen and uptake of carbon dioxide.

Generally, a respiratory assessment consists of assessing the:

- airway — checking for obstructions;
- breathing — rate, rhythm and depth;
- skin colour — looking for cyanosis (a blue tone to the skin);
- use of accessory muscles — such as breathing through flared nostrils or pursed lips;
- general condition — level of consciousness.

Blood pressure

Blood pressure is a measure of the force of blood against the vessel walls such as the brachial artery in the upper arm, which is the usual site for measuring blood pressure. Blood pressure as a value is expressed as systolic pressure over diastolic pressure; systolic pressure is a measure of the peak pressure of the left ventricle in the heart and diastolic pressure is a measure of aortic pressure at its lowest. Normal blood pressure, which is measured in millimetres of mercury (mmHg), can range from 110 to 140 mmHg for systolic pressure, and from 70 to 80 mmHg for diastolic pressure. When an individual's sustained blood pressure is greater than 140/90 mmHg this is defined as hypertension; if they have a systolic reading less than 100 mmHg this is defined as hypotension.

Clinical risk in mental health

Background

The focus of this chapter is on managing risk within a specific context; where there is the potential that a mental health service user poses a risk to self and/or others, or is at risk from others, including neglect. Risk management in this context needs to be in partnership with the service user; it also needs to be systematic. The process of managing risk is dynamic in nature as levels of risk can change quite quickly. At times the management of risk can be perceived as controlling to the service user especially where risk is managed through the use of legally restricting a service user's freedoms.

Managing clinical risk within mental health care involves calculating the likelihood that harms, or the threat of harms, will occur. To manage this potential risk the mental health nurse will undertake an assessment of risk; any risks identified will be documented and communicated appropriately to the multidisciplinary team. The next stage is to manage risk systematically through the implementation of a risk-management plan.

Professional skills

Mental health nurses should:

- recognise and manage risk in a way that is person centred and recovery focused, and protects vulnerable individuals;
- empower choices and promote well-being while managing risk;
- work positively and proactively with individuals who are at risk using evidence-based models of care that prevent, reduce and minimise risk;
- manage risk both independently and as part of a team approach in a way that promotes effective communication, positive risk management and continuity of care across services.

Risk assessment

Managing risk within the field of mental health has been influenced by a number of governmental initiatives and policies in the UK, one of

these being the Care Programme Approach (CPA; CPAA 2008). Based upon this approach when assessing risk the mental health nurse should consider:

- What is the type of risk; for example, self-harm or neglect? To others or from others?
- How recently did the risk-related incidents occur? How severe is the risk and what is the level of intent?
- How frequently have the risk-related incidents occurred?
- When do the risk-related incidents happen? Are there trigger factors? Is the individual under the influence of drugs and/or alcohol when the risk-related incidents occur?
- What is the service user's understanding of the identified risks? What is their present mental state and do they have mental capacity?

Types of risk assessment

Risk-assessment approaches include:

- unstructured risk assessment — clinical risk information is accrued unsystematically;
- actuarial risk assessment — risk information is collected and processed using a risk-assessment tool and a risk score is calculated;
- structured risk assessment — evidence-based research influences the types of risk information collected, usually through the use of specific risk-assessment tools. This information is then discussed in combination with both the nurse's knowledge of the service user and the service user's own views.

A structured approach is generally thought to be best practice; however, this is dependent upon the skill of the nurse and the availability of suitable risk-assessment tools.

Managing risk

Managing risk should be based on a positive risk-management approach with a focus on collaboration and recovery especially when engaging in supportive observations of service users at risk. The level of supportive observation is implemented as indicated by the level of identified risk:

- level 1 (general) observation: the minimum level of observation for all inpatients;
- level 2 (intermittent) observation: the service-user's location on the ward is checked every 15–30 minutes;
- level 3 observation: the service user is kept within sight at all times;
- level 4 observation: the service user is kept within an arm's-length of the observing nurse.

Using a positive and supportive approach prevents over-defensive practice and promotes therapeutic engagement, a positive approach includes:

- actively listening to the service user's views;
- collaborative action planning and decision-making;
- thoughtful consideration of potential benefits and harms when deciding on actions;
- implementing decisions that involve an element of risk where the benefits outweigh the risk;
- ensuring that the risk-management plan is fully communicated.

When managing risk it is useful to note that risks can be static or dynamic. Static risks are risk-related incidents that happened in the past, or factors such as age or employment that indicate that an individual is statistically at risk. Dynamic risks are factors that influence risk constantly, such as an individual's mental state or their social circumstances. By taking into account the dynamic nature of risk and how it might change over time, the nurse can not only identify the present risk but also consider the impact of these dynamic factors on the service user's level of risk at any point in time. These dynamic risk factors can also be protective especially in the case where a service user has all of the following:

- the skills and psychological resources to cope;
- meaningful work;
- a social network that is supportive;
- access to the required services.

Communication

Background

A mental health nurse is expected to demonstrate compassion when delivering care as well as being an effective communicator. Unlike most healthcare relationships the therapeutic relationship in mental health care is both the medium for treatment and, in most cases, the main treatment. Being an effective communicator gives the mental health nurse a platform from which to deliver a range of psychological interventions tailored to meet the specific needs of the mental health service user. Good communication is also pivotal in the establishment and continuation of a therapeutic relationship that manages risk, is recovery focused and has positive outcomes.

It is important to recognise that the more effective a mental health nurse's communication skills the more effective the nurse will be in delivering care. Communication should be seen as a two-way process in which information is shared between the service user and the mental health nurse; other people (including carers,

relatives who are not carers, health professionals, health and social care professionals, social care staff, volunteers and befrienders) or agencies may also be part of this process. At times sharing information can be disrupted or blocked by a number of factors. In these situations the responsibility lies with the mental health nurse as the practitioner to firstly understand why this has happened and to secondly develop strategies to overcome any identified communication difficulties.

Professional skills

Mental health nurses should:

- have excellent communication, interpersonal and therapeutic skills;
- be skilled in working in partnership with service users and carers;
- engage in person-centred care that is compassionate and empowering;
- preserve dignity, be anti-discriminatory and practise within the law, considering such issues as confidentiality and consent.

Types of communication

Communication can be broken down into verbal communication and non-verbal communication. Verbal communication contains three key elements:

- the spoken word — vocals;
- the way the spoken word is expressed — paralanguage;
- the way spoken word is perceived by the other person — meta-communication.

The majority of our communication, however, is conveyed through non-verbal communication or body language, such as:

- facial expressions;
- eye contact;
- gestures;
- posture;
- head movements;
- personal space;
- touch;
- appearance.

During the communication process the mental health nurse needs to be aware of their own body language and its impact upon the service user. Nurses also have to be able to understand the potential messages that the other person's body language is conveying: is the service user angry; are they sad; do they look confused? The mental health nurse will, at times, need to adapt their body language; for

example, if a service user is angry the mental health nurse will adopt a non-threatening but assertive posture.

Listening and responding

An important part of the communication process is actively listening to what the service user is saying and then responding appropriately. As an active listener the mental health nurse must concentrate on what the service user is saying; they must also control any potential distractions, giving the service user time and space to talk. The mental health nurse demonstrates that they are listening by responding in way that is appropriate to what is being said. This can be achieved through the mental health nurse nodding their head, a non-verbal sign that they are listening, summarising what the service user has said, and then checking and clarifying with the service user that their understanding of what has been said is correct. A key part of understanding requires the mental health nurse to be skilled in asking open questions (e.g. tell me about feeling sad) and also to be able to ask probing questions (e.g. what time of day do you feel most sad?).

The 6Cs

People with mental health needs can be at their most vulnerable, so it is essential in this situation that the mental health nurse shows empathy through a genuine understanding of the service user's experiences. In other words, they needs to engage in and promote person-centred care which is first and foremost compassionate in nature. By being an effective and compassionate communicator the mental health nurse will have a good foundation of skills, values and behaviours from which they can develop and deliver a range of psychological interventions. These baseline communication skills, values and behaviours are known as the 6Cs (CBCNO and DoH CAN 2012):

- care — service users receiving care expect it to be appropriate for them, whatever the circumstances;
- compassion (sometimes described as intelligent kindness) — how service users perceive the delivery of the care they receive;
- competence — the expertise, clinical and technical knowledge to deliver effective care at the right time;
- communication — an effective and central part of a successful therapeutic relationship, inclusive of all partners in the care-delivery process;
- courage —doing the right thing at the right time for the service users, including speaking up when they have concerns;
- commitment — placing service users and carers at the centre of a therapeutic relationship, driven by the service users' needs.

Diagnosis and classification

Background

Psychiatrists predominately classify mental distress as mental illness when the distress is greater than the statistical norm. Mental illness is further categorised into statistically agreed groupings or classifications, including:

- addictive disorders;
- anxiety disorders;
- eating disorders;
- mood disorders;
- neurocognitive disorders;
- neurodevelopmental disorders;
- personality disorders;
- psychotic disorders;
- sexual disorders;
- sleep disorders.

These disorders are further defined through a diagnostic process which is supported by internationally agreed frameworks and classification systems. It is important to acknowledge that psychiatric diagnoses do not fit as easily into the practice of the mental health nurse as into the practice of the psychiatrist. For mental health nurses a fundamental problem with applying diagnostic classifications is that classifying or applying labels is not holistic enough to identify all the needs of a mental health service user. However, mental health nurses have to be able to understand and work with this system because diagnosis and classification is a fundamental form of communication throughout mental health care.

Professional skills

Mental health nurses should:

- recognise different forms of mental distress and respond effectively irrespective of age or setting;
- understand the impact that different forms of mental distress can have upon an individual's ability to function;
- apply and value the use of evidence about appropriate interventions for different forms of mental distress and mental disorders;
- have an in-depth understanding of how different mental disorders need to be considered during the care and treatment of individuals with mental health needs.

Classification

Classifying mental illnesses provides a scientific basis upon which the practice of psychiatry can be built. Classification also provides a framework that improves:

- the diagnostic process — both reliability and validity;
- communication — by providing a common language;

- treatment outcomes and clinical management — using common approaches.

There are two established frameworks for classifying mental disorders:

- International Classification of Diseases (ICD; WHO 2010);
- Diagnostic and Statistical Manual of Mental Disorders (DSM; APA 2013).

The ICD was established in 1993 and it is now in its 10th version, at the time of writing it is currently being revised with the 11th version planned for released in 2018. DSM was established in 1952, the 5th version was released in 2013 and is currently in the process of being implemented. Both frameworks are distinct but generally they complement each other. North America tends to use DSM and the rest of the world tends to use ICD. ICD is a requirement of the World Health Organization. DSM maps to ICD. Some psychiatrists in the UK prefer DSM and will diagnose using that classification system; at coding this is then converted to ICD.

Diagnosis

The diagnostic process comprises an assessment of the service user. This process has two distinct steps:

- the psychiatric history and mental state examination;
- the formulation of a treatment plan.

The first step provides the psychiatrist with baseline assessment information related to the service user, including the history of the presenting problem and mental experiences, together with a description of the service user's behaviour at the time the assessment took place. The second step, the formulation of a treatment plan, summarises what the issues are, and at this stage a diagnosis is usually applied by the psychiatrist using the ICD classification system or, on occasion, the DSM classification system. The treatment plan is then formulated based upon the best available evidence.

The role of the mental health nurse

Mental health nurses usually have the most direct contact with mental health service users. This unique position shapes the care that the mental health nurse delivers. The knowledge generated from being in this unique position should be used to complement the information gathered during the diagnostic process. Using a psychiatric diagnosis in isolation provides only limited information, as it does not inform the mental health nurse how to support the service user at a person-centred level. On this basis the nurse needs to pay attention to the service-user's narrative and deliver any subsequent interventions through a collaborative and therapeutic relationship. These interventions should be:

- underpinned by psychological methods and theory;
- clinically effective and, where possible, evidenced based;
- person centred;
- focused on considering values and meanings.

Documentation

Background

Keeping a record of the planning and delivery of care is an important and essential part of mental health nursing practice. Records should provide a clear and accurate description of the care-delivery process; in the UK they should also adhere to the Nursing & Midwifery Council's (NMC's) guidance on record-keeping. When recording care the mental health nurse will need to find a balance between their professional view of a given situation and the service user's view; the nurse will then need to find an agreed viewpoint. Employing a person-centred and collaborative approach will assist in this process.

Record-keeping is 'essential to the provision of safe and effective care' (NMC 2009). Records are also part of the communication process, and better communication generally means that a better quality of care delivered. For example, if a service user's condition is clearly and accurately recorded then other members of the care team should be able to detect whether there have been any changes to the service user's condition over time and then act accordingly. This is particularly important when there are constant changes to the personnel delivering care, such as in the case of shift-pattern working. As mental health nurses work in different settings, for example in inpatient and community settings, records are often kept in several different formats, including paper and electronic records. Whatever the format of the records, the principles of good record-keeping remain the same. Types of records include:

- handwritten clinical notes;
- emails and text messages;
- clinical letters;
- X-rays, laboratory reports and printouts;
- incident reports and statements;
- photographs and videos.

Professional skills

Mental health nurses should:

- ensure that they maintain records that are based on the best available evidence and that these records are accurate, clear and complete, whatever the format;
- participate fully in the care-planning process, including the completion of relevant documentation;

- document care that fully meets the service user's needs, including taking appropriate action where required;
- manage record-keeping in a way that adheres to the relevant professional and legal frameworks.

The function of documentation

Documentation is used in many contexts and for a number of purposes, such as:

- improving accountability;
- presenting and supporting the clinical decision-making process;
- supporting effective communication;
- providing documentary evidence of the care delivered;
- supporting the clinical risk-management process;
- supporting clinical audit and research, and the complaints process.

Documentation standards

In the UK a mental health nurse's clinical record-keeping should adhere to the NMC's guidance and standards. The following list is a summary of these standards; it is recommended that the guidance is read in full (NMC 2009):

- handwriting should be legible and all entries should be fully signed with the date and time;
- the entry should be accurate, factual and the meaning clear with no unnecessary jargon;
- professional judgment should be used to decide what should be recorded;
- information related to a service user's care should be fully recorded;
- records should not be altered and/or destroyed without the relevant authorisation;
- any authorised alteration must be fully signed with the original entry record still clearly readable or auditable;
- ensure that the record-keeping process adheres to the relevant professional and legal frameworks as well as national and local policies;
- service users and carers should, where appropriate, be involved in the record-keeping process;
- information that is not clinically relevant should not be kept;
- service users should be made aware that their clinical records may be seen by other people or agencies involved in their care.

Further to the NMC's documentation standards as outlined above, the NMC included the professional expectation that nurses should 'keep clear and accurate records relevant to their practice' (NMC 2015).

This expectation covers all records not just service-user records. To achieve this expectation the nurse should:

- complete all records at the time or as soon as possible after an event;
- identify any risks or problems that have arisen and record the steps taken to deal with them;
- complete all records accurately and without any falsification;
- attribute any entries to yourself; they need to be clearly written, dated and timed;
- take all necessary steps to ensure that all records are kept securely;
- collect, treat and store all data and research findings appropriately.

Improving record-keeping

It is essential that mental health nurses adhere to the professional guidance on record-keeping but they also need to reflect on how they can continually improve their practice. When engaging in this process of reflection it might be useful to consider:

- Does your entry provide accurate evidence of the standard of care delivered?
- Is your entry person centred?

Early intervention services

Background

Early intervention services are a specialist mental health service offering treatment and support for young people experiencing psychoses for the first time and during the first three years following diagnosis. Early intervention services are set up differently across the country but broadly they offer a service that consists of family therapy, individual cognitive behavioural therapy (CBT), art therapies and occupational activities to young people between the ages of 14 and 35 years.

The Early Intervention Service was set up as a result of an ever increasing evidence base that there is a poorer prognosis for psychosis and schizophrenia when onset is in childhood or adolescence (NICE 2009, 2014), and furthermore there is a strong argument that an early intervention promotes a better health outcome for young people. The strength of the Early Intervention Service is that it is designed to deliver support and evidence-based interventions in a 'normalising' environment as opposed to admitting a young person to a mental health inpatient ward.

There is a natural partnership between Child and Adolescent Mental Health Services, including early intervention services, and adult mental health providers; thus it is vital that any transition from one care provider to another is managed properly and in a supportive way.

Professional skills

Mental health nurses should:

- be able to work with service users of all ages working in a way that promotes positive and is inclusive;
- recognise and respond to the needs of all service users who come into their care, drawing on a range of recovery-focused psychosocial interventions;
- use effective relationship-building and communication skills to engage with and support service users distressed by hearing voices, experiencing distressing thoughts or experiencing other perceptual problems;
- assess and meet the full range of essential physical and mental health needs of service users of all ages who come into their care;
- help service users experiencing mental health problems to make informed choices about pharmacological and physical treatments.

Prevention

When a person presents within primary-care services as:

- distressed and with a decline in social functioning;
- with transient psychotic symptoms or symptoms that are suggestive of a possible psychosis;
- or with a first-degree relative with psychosis;

they should be referred immediately to specialist mental health services. Current clinical guidelines advise that when a person is considered to be at risk of developing a psychosis they should be offered:

- individual CBT with or without family intervention;
- other interventions in accordance with agreed clinical guidelines.

First episode

Current clinical guidelines advise that when a person is experiencing a first episode of psychosis early intervention services should offer:

- care irrespective of age or duration of the untreated psychosis;
- an assessment for post-traumatic stress disorder and other trauma reactions;
- a choice of antipsychotic medication.

Medication

Young people are often treated with antipsychotic medication and, as such, mental health nurses are required to monitor symptoms, side effects and adherence. Before starting an antipsychotic medication it is recommended that a series of physical health baseline assessments are

completed. Mental health nurses should be competent in the basic physical health checks below:

- weight and height;
- waist and hip circumference;
- pulse and blood pressure;
- fasting blood glucose, HbA1c, blood lipid profiles and prolactin levels;
- assessment of movement disorders;
- assessment of nutritional status, diet and level of physical activity.

It is important to monitor and record any behavioural changes during the titration of an antipsychotic medication. Side effects must be monitored, particularly the emergence of movement disorders.

Psychoeducation

It is essential that mental health nurses work in a multidisciplinary way that is quite distinct from other mental health services. Working with families and/or educators is key to a successful episode of care for a young person, and psychoeducation is therefore a significant part of the mental health nurses' role. Psychoeducation focuses on providing an individual diagnosed with a psychosis with the necessary information and skills to manage the symptoms of their condition. Good communication and negotiating skills are key to facilitating this process.

Capacity

All mental health nurses working with young people should be able to assess capacity including 'Gillick Competence' as well as a knowledge of other legislation such as the *Mental Capacity Act*, *Mental Health Act 1983 (amended 2007)*, and *The Children Act 1989 (amended 2004)*.

Psychological interventions

Knowledge of the evidence base and current National Institute for Health and Care Excellence (NICE) guidelines in the UK are crucial to ensuring that young people are receiving the best possible interventions and care. Depending on expertise, CBT may well be a key competency of the mental health nurse. In almost all cases, knowledge of family therapy, counselling and other specific psychosocial interventions will be a fundamental aspect of the mental health nurse role. Attention to culture, ethnicity and social inclusion are paramount when working with all people; remember that stigma and discrimination can often occur amongst young persons in mental health services. Central to the success of all the skills mentioned above is the compassion and interpersonal skills of the mental health nurse, which will ultimately facilitate a therapeutic relationship.

Electroconvulsive therapy

Background

Electroconvulsive therapy (ECT) is a treatment for number of mental health conditions, and involves passing electrical currents through the brain with the intention of causing a seizure. Inducing convulsions to treat mental health conditions has been used for centuries; in recent times insulin was used and then electric shocks. During the 1950s short-acting anaesthesia and muscle relaxants were used during ECT which reduced muscle pain and fractures.

ECT was previously used for quite a few mental health conditions, but is now is indicated in the case of:

- severe depression;
- a severe and prolonged episode of mania that has not responded to treatment;
- moderate depression that has not responded to multiple drug treatments.

Cognitive impairment can be a side effect of treatment. Dependent on the balance of risk, and bearing in mind that ECT can be a lifesaving treatment, ECT is contraindicated in:

- raised intracranial pressure;
- cardiovascular disease;
- dementias;
- epilepsy;
- cervical spine disease.

Professional skills

Mental health nurses should:

- ensure that they have an in-depth knowledge of common mental health treatments;
- offer holistic care and, working as part of the multidisciplinary team, offer a range of treatment options of which ECT may form a part;
- assist individuals with mental health problems to make informed choices about treatments;
- provide education, information and support related to the provision of pharmacological and physical treatments.

Procedure

Prior to an ECT procedure the service user will have a full physical examination, their consent will be obtained; this process may need to be managed in the UK through the provisions in the *Mental Health Act 1983 (amended 2007)*, and the service user will then be nil by mouth from midnight of the day before the procedure (NICE 2003). During the procedure the service user will be given a short-acting general anaesthetic

and then a muscle relaxant is administered and a tongue guard is place in the mouth. Two electrodes are placed on the service user's temples; usually on either side (bilateral) or occasionally one side (unilateral). A brief electrical pulse is delivered at a voltage that is above the service user's seizure threshold (whereupon a seizure is normally induced). Bilateral ECT is more effective than unilateral ECT; however unilateral ECT has fewer side effects.

Treatment course

Service users can be given 6 to 12 ECT treatments over 3 to 6 weeks. The course of treatment will normally be stopped if there is no improvement in the service user's symptoms after 6 to 8 treatments.

Side effects

Common side effects include:

- feeling tired and drowsy;
- headache;
- muscle ache;
- nausea;
- confusion;
- temporary memory impairment.

It is important to note that the service user may experience side effects from the anaesthetic, which include cardiovascular problems.

Consent

ECT is normally given if consent is obtained, irrespective of whether the service user is detained under the *Mental Health Act 1983 (amended 2007)*. If a service user refuses to consent, or is so unwell that they either cannot consent or do not have the capacity to consent, and the procedure is essential then ECT may still be given under certain conditions. Under the *Mental Health Act 1983 (amended 2007)* a second opinion is sought from an independent psychiatrist who will consult with the multidisciplinary team, the service users and their relative/s; the second opinion doctor will then make a decision on whether the service user should receive ECT.

Elimination

Background

Supporting mental health service users to meet to their own physical needs can be a sensitive issue, especially when dealing with bowel and bladder care. The majority of mental health service users will be able to meet their own 'elimination' needs independently, in which case the role of the mental health nurse will focus on providing support and advice when personal hygiene issues arise. When a service user is unable to meet their own elimination needs independently, however, the mental health nurse should offer effective care that respects and maintains dignity.

Assisting service users to manage their elimination needs requires not only a sensitive approach but it also requires the mental health nurse to work in partnership with the service user. For this assistance to be effective the mental health nurse has to obtain consent, and when a service user is unable to provide consent their rights need to be protected. The type of assistance provided might range from prompting and reminding an individual to go to the toilet, to providing equipment such as commodes or bedpans. If physical assistance is required, whether this is with or without equipment, a manual handling assessment needs to be undertaken. It also has to be recognised that, although most individuals have a bowel and bladder routine, this routine can be quite specific to the individual and their circumstances.

Professional skills

Mental health nurses should:

- provide safe, person-centred care for service users who are unable to meet their own physical needs;
- act with dignity and respect to ensure that service users who are unable to meet their own physical needs feel empowered;
- deliver care that meets service user's essential needs, such as bowel and bladder care;
- work collaboratively to ensure an adequate fluid intake and output.

Elimination assessment

Elimination is the excretion of urine and faecal matter from the body. When assessing service user's bowel and bladder routine it is important to note the level of support they require and whether they have any concerns. Other types of information you might collect are the:

- frequency, volume, consistency and colour;
- presence of blood, mucus, undigested food or offensive smell;
- report of pain and/or discomfort;
- sample for urinalysis.

Incontinence

Incontinence is an inability to control the function of the bladder or bowel, which can be due to a dysfunction and/or underlying health problem. In most cases incontinence can be managed effectively through a continence management and treatment regime. Types of incontinence include:

- stress incontinence — a leakage of urine that usually happens during physical activity;
- urge incontinence — an uncontrollable urge to pass urine and at times an individual may find it difficult to make it to the toilet in time;

- overflow incontinence — an individual uncontrollably passes small amounts of urine during the day and night;
- reflex incontinence — a complete leakage of urine without the individual having a feeling of needing to go to the toilet or having control;
- constipation — when the stools become difficult to pass;
- faecal incontinence — when there is a loss control of the bowels.

Assisting with elimination

When managing incontinence the nurse might need to consider if a service user's continence could be due to mobility difficulties or the fact that they do not understand their surroundings. Some ward environments manage these issues by having good signage and by undertaking ward rounds every two hours. During rounds the nurses routinely engage with the service users, focusing on personal care including bladder and bowel care. This does not mean that a service user's specific elimination needs are not dealt with outside of these times. While undertaking bowel and bladder care the nurse must remember to:

- wear disposable gloves;
- wash hands even if wearing gloves;
- wash the service user;
- keep the skin clean;
- use a barrier cream sparingly and preferably use a cream that has a pH near to that of normal skin (pH5.5);
- not use solutions that contain alcohol or disinfectant.

Within a home environment the mental health nurses should work with other agencies to ensure that a service user's independence is maintained. This might include adapting the environment so that a service user has easy and safe access to toileting facilities.

Infection control

Background

Mental health nurses deliver many different clinical interventions, the majority of which are psychosocial. Yet it is easy to forget that mental health nurses are at times required to provide physical health care, such as clinical observations and wound care amongst many other interventions. When delivering these interventions it is important that the mental health nurse follows principles that focus on preventing and controlling infections.

Infection-control measures aim to have a zero tolerance of infection; mental health nurses have a key role to play in achieving this aim. It is also important to remember that when delivering physical health care there is always a risk, including that of cross-infection; the mental

health nurse will need to manage these risks. One aspect of managing this risk is to implement effective infection-control procedures; the other aspect requires the mental health nurse to frame their practice through the risk-management process.

Professional skills

Mental health nurses should:

- adhere to local and national policies on the prevention and control of infection;
- apply agreed infection-control and prevention practices in all environments;
- provide effective nursing care in the case of infectious diseases, including the use of isolation techniques;
- act to reduce risk when handling sharps, contaminated linen and clothing, and when dealing with spillages of body fluid.

Physical health interventions

Mental health nurses deliver a number of physical health interventions that require the nurse to think about infection control and prevention. The following is an illustrative list of some of those interventions:

- taking a pulse;
- measuring blood pressure;
- taking a temperature;
- administering wound care;
- administering injections;
- collecting a sputum sample;
- measuring a peak flow rate;
- collecting urine for urinalysis;
- testing for blood glucose levels;
- administering first aid;
- administering basic life support.

Spreading of infections

Microorganisms can be spread in different ways, including by:

- aerosol;
- droplet;
- faecal–oral means;
- person-to-person contact, most often by contaminated hands;
- indirect contact, such as through food, water and inanimate objects;
- body fluids;
- insects and parasites.

Infection-control practices

There is a currently a national initiative to ensure that infection-control practices are consistent whatever the environment (RCN 2012). This is important for mental health nurses as they can practice within a wide variety of health and social care settings. The emphasis of the initiative is to maintain standards through training and to establish systems that ensure consistent and reliable practice, and there is a focus on clinical leaders acting as infection-control role models. To maintain consistency with this initiative mental health nurses need to:

- receive training on the standard principles of effective infection control and prevention;
- adhere to local and national reporting procedures for infections;
- manage and monitor the prevention and control of infection using a robust-risk-assessment process;
- provide and maintain a clean and a safe care environment;
- provide user-friendly and accurate information on infections and infection control to service users and carers;
- ensure that service users who have developed an infection receive care that aims to reduce the risk of passing the infection on to others;
- access laboratory support as appropriate.

Infection-control skills

Effective infection prevention and control ensures that the people who access health and social care services receive safe care. On this basis mental health nurses should be trained in:

- hand hygiene;
- personal protective equipment;
- safe use and disposal of sharps;
- aseptic technique.

Leadership

Background

It is easy to think that leadership is defined by being in a specific leadership role when, in reality, it is can be defined by assuming an informal leadership role when care delivery dictates. For example, a nurse might take a lead role within a multidisciplinary team meeting when advocating a specific treatment on behalf of a service user. At a professional level, leadership is a developmental journey whereby the nurse is able to contribute positively to the delivery of high-quality care.

Effective leadership within health and social care is a key component in the drive to improve care quality. To do this mental health nurses must be able to work in partnership with individuals

living with mental health problems, and also with other professionals and external agencies. During this process to improve care quality they must also be able to utilise leadership skills, behaviours and values which include:

- being able to communicate effectively;
- dealing constructively with setbacks;
- taking on board others' viewpoints;
- being clear about the way forward;
- engendering trust.

Depending on the situation, the mental health nurse might use different leadership styles. For example, in an emergency situation an autocratic or directive style might be more appropriate than first seeking everyone's view (democratic style) or just allowing everyone to do their own thing (a laissez-faire style).

Professional skills

Mental health nurses should:

- be able to manage themselves and others to ensure that the quality of care and the safety of the service user are maintained or enhanced;
- be self-aware and professionally accountable, using clinical governance processes to maintain and improve practice standards;
- work effectively across professional and agency boundaries to create and maximise opportunities to help improve care delivery;
- actively participate in further developing their management and leadership skills through structured reflection.

Models of leadership

There are a number of theories and models of leadership, including:

- traits-based leadership — leaders are born not made, and they are born with the personality traits to be leaders;
- leadership as a behavioural style — leadership behaviours should be applied dependent on the situation; for example, some situations might require the leader to demonstrate decisiveness other situations might not;
- situational-contingency approaches to leadership — a leader is required to adapt their leadership style to suit the situation or circumstances; at times they might be required to be an authoritarian team leader and at other times they might seek the advice of the team;
- transformational approaches — a leader focuses on enhancing the performance of the individuals they lead through a number of different approaches, such as motivating individuals, providing a vision or direction, and through being a role model.

Improving practice

Clinical leadership should focus on continually improving the quality care delivered to mental health service users, irrespective of whether a mental health nurse's leadership role is an informal or formal role. To establish a strong foundation for being an effective clinical leader it is useful if the mental health nurse develops their practice to a level where they can cope skilfully with a range of clinical situations. Building on this foundation through lifelong learning the mental health nurse as a leader should consider cultivating the following qualities:

- effective self-management;
- integrity;
- having a focus on quality;
- motivation;
- influencing others;
- being adaptable and astute;
- being an agent for change;
- being authentic;
- being a coach.

The roles of mental health nurse and clinical leader use similar skills, values and qualities. To ensure that these are cultivated and directed in the right direction the mental health nurse, both as a practitioner and as a leader, should actively engage in:

- lifelong learning;
- expert skill development;
- critical reflection.

Emotional intelligence

Emotional intelligence is an important leadership skill. By being emotionally intelligent the mental health nurse has the ability to be emotionally aware of their feelings and the feelings of others. In addition, they can work with this emotional information to guide themselves and others appropriately. Emotional intelligent leaders have five characteristics:

- they are self-aware;
- they can control their emotions appropriately;
- they are motived and highly productive;
- they are empathetic;
- they have strong social skills.

Lifelong learning

Background

Mental health nurses should be committed lifelong learners who utilise the reflective process to explore, appreciate and develop their practice experiences. Continuing professional development (CPD) is a key part

of the nurse's lifelong learning journey; however, lifelong learning is a wider concept that also takes into account personal learning which or may not relate to a nurse's professional practice. CPD, when actively underpinned by effective reflective practices, will help the nurse become an expert in their practice and has the benefit of improving the care that they deliver. It is important to recognise that because each nurse's experiences are unique then their lifelong learning journey will be unique and also dynamic. Being unique does not mean that formal education has no part to play in this journey, it just means that formal and informal learning should be utilised so that they complement each other.

In terms of mental health nursing the concept of lifelong learning is used to describe the expectation that mental health nurses will keep their skills and knowledge up-to-date throughout their working life. More formally, and at a professional level, lifelong learning is entwined with the process of CPD. On this basis, the Nursing & Midwifery Council in the UK has set a number post-registration education and practice (Prep) standards for CPD. These standards assist the mental health nurse to:

- provide a high standard of care;
- keep up-to-date with new practice developments;
- think and reflect;
- demonstrate that they are up-to-date and are developing their practice.

Professional skills

Mental health nurses should:

- keep their knowledge and skills up-to-date by learning from experience, through supervision, feedback, reflection and evaluation in a process of CPD;
- demonstrate a commitment to their own and others' lifelong learning and professional development;
- facilitate others, including nursing students, to develop their competence, using a range of professional and personal development skills;
- as both team member and team leader, actively seek and learn from feedback to enhance care delivery.

Post-registration education and practice standards

The Prep standards are legal requirements set by the NMC, and to which the nurse must adhere in order to maintain and renew their registration. Two standards are articulated in *The Prep handbook* (NMC 2011) as follows:

- the practice standard requires the nurse to have practised in some capacity by virtue of their nursing qualification for a minimum of 450 hours during the three years prior to the renewal of their registration. If the nurse does not meet this requirement they will need to undertake an approved return to practice course before they can renew their registration.
- the CPD standard includes a commitment to undertake at least 35 hours of learning activity relevant to their practice during the three years prior to their renewal of registration; to maintain a personal professional profile of their learning activity; and to comply with any request from the NMC to audit how they have met these requirements.

The Prep standards will be superseded by the revalidation standards when they come into effect in April 2016. Revalidation as a process is currently being piloted and the evaluation of these pilots will inform the implementation of these standards. For more information on the NMC's revalidation process, please see http://www.nmc.org.uk/standards/revalidation/

Expert practice

By maintaining and continually improving their practice the mental health nurse is engendering an opportunity to develop their expertise. The benefit of becoming an expert mental health nurse is that they are more effective than novice nurses when managing clinical situations that are ambiguous, complex and have no certain outcome (Smith 2012, 2014). This does not mean that the novice nurse or newly qualified mental health nurse will not be able to cope with a range of situations; at first they will simply not be as practised in dealing with situations as the expert mental health nurse. The knowledge and wide range of skills of the expert nurse are built through a number of stages in their development; these stages are described in the seminal work of Benner (1982) and include:

1. Learning to be a registered nurse (novice).
2. Starting to use practical experiences to contextualise knowledge.
3. Managing standard clinical situations but lacking in speed and flexibility.
4. Recognising and understanding non-standard situations.
5. Managing situations using both scientific and naturalistic knowledge (expert).

Reflection is key to being an expert; the process of reflection enables the nurse to develop their self-awareness to a level where they are able to clearly identify both their strengths and the areas that they need to develop further. It is important to recognise that knowledge

accrued through the reflective process is especially useful as it is based upon experience. Similar to scientific knowledge, experienced-based knowledge should not be used in isolation, but rather it should be used to complement scientific knowledge to link both forms of knowledge directly to the nurses ongoing practice experience.

Managing aggression and violence

Background

Managing violence and aggression refers to managing behaviours that can result in harm to another person. This behaviour can be verbal and/or non-verbal, injury may or may not be sustained, and the intention to injure may or may not be clear.

Mental health nurses manage violence and aggression as part of managing risk, and the overwhelming focus is on prevention rather just intervening when an incident occurs. Incidents of violence and aggression, including assaults, are more likely to happen within inpatient settings. The factors behind these incidents include:

- the individual service user is highly impulsive;
- poor staff attitudes and behaviours — especially poor communication skills;
- inaccessible staff;
- locked wards;
- lack of privacy for service users;
- overstimulation — busy environments;
- understimulation — lack of activity;
- inconsistency in setting limits for what is and is not acceptable.

Professional skills

Mental health nurses should:

- work with service users in a way that that values and respects the person irrespective of their behaviour;
- prioritise actions that enhance the service user's safety and psychological security by taking a positive risk-management approach that is seamless across all services;
- use effective communication skills when dealing with even the most challenging situations, including emergencies, unexpected occurrences, complaint, disputes, conveying unwelcome news, and de-escalating aggression;
- recognise the signs of aggression and react appropriately, keeping themselves and others safe;
- select and apply appropriate strategies and techniques for conflict resolution, de-escalation and physical intervention (restraint).

Reducing incidents

To reduce incidents of violence and aggression the mental health nurse will need to carry out a comprehensive risk assessment as required (e.g. on admission to services and on a regular basis while in services, and when there is a change in circumstances, such as becoming unwell or exhibiting risky behaviour). The risk assessment should identify following:

- history of aggression;
- trigger factors;
- history of abuse;
- previous risk-management plans.

When managing inpatient settings the staff teams should take a strengths approach to risk, recognising the need to work therapeutically in a positive and enabling manner.

The environment

Being a service user on an inpatient ward can be frustrating, especially when restrictions are applied to movement and/or behaviour. Although these restrictions are applied in the best interest of the service user they can still feel coerced and it is therefore important that the service user is supported to communicate their needs and feelings in a healthy way. Providing an environment that offers the appropriate psychological therapies and psychosocial interventions is important; however, just as important is the need to offer other structured activities such as:

- physical pursuits;
- leisure time and leisure activities;
- leave — both escorted and unescorted;
- occupational activities;
- quiet time and space.

The inpatient environment should also:

- be clean with bright and friendly decor;
- provide outside space that is easily accessible;
- provide private spaces, including storage for personal items;
- bedrooms that promote sleep and are easy to personalise.

In addition inpatient settings can, at times, be intimating and bullying, amongst other things, can take place. The staff team need to work together identify and managing these potential problems in a way that is supportive but also sets acceptable limits on behaviour, attitudes and values.

Training

To manage violence and aggression effectively mental health nurses working in all settings need to be supported to continually develop their emotional intelligence and leadership skills. Mental health nurses will also need to develop the following knowledge and skills:

- values-based practice;
- understand the risk factors that increase the incidences of violence and aggression;
- de-escalation:
  - recognising the signs of aggression;
  - using effective communication in all circumstances;
  - using distraction and relaxation techniques.
- break-away techniques;
- restraint — always used as a last resort;
- post-incident debriefing (a structured format);
- post-incident reviews (unstructured format);
- medication — the appropriate use of rapid tranquillisation medication when required.

Community

When working in the community for a community team it is important the mental health nurse follows the organisation policy on lone working in order to minimise their risk of experiencing aggression or violence.

Managing people

Background

Part of the role of the mental health nurse is to manage others; this may be in a formal or informal capacity. Before the nurse starts to manage others they first have to be able to manage themselves, and key to this is self-awareness. By being self-aware the nurse is not only aware of their own thoughts and feelings, but they should, in time, also be able to understand how these affect others. As the nurse becomes skilled in understanding themselves and others then the next stage is to use this knowledge to influence and facilitate positive change. During this process the nurse will also become assertive, whereby they are neither aggressive (i.e. impose their will on others) nor submissive (i.e. allow others to impose their will on them).

During recent times the formal role of managing nursing teams has become more complex. Not only are there many different nursing management roles but it is not always clear from a title what a nurse manager does or does not manage. Management roles within health and social care can also change almost overnight.

There are some common management functions, however, including the following:

- managing the performance of a team and the individuals within that team;
- delegation;
- resolving conflict;
- managing change;
- decision-making.

At an informal level, for example when a nurse is part of a team but is acting as a leader by advocating for a service user, the nurse needs to be an effective influencer. This is especially the case when they need to change the attitudes of others to gain an agreed position or way forward. Influencing skills include:

- active listening and questioning;
- persuasion;
- being assertive.

Professional skills

Mental health nurses should:

- manage themselves and others effectively;
- work collaboratively with mental health service users, carers, other professionals and agencies to enhance care delivery;
- engage actively in lifelong learning both as a practitioner and as a leader to enhance care;
- assertively challenge bad or sloppy practice in self and others,
    - act as an effective role model and as an effective clinical supervisor during the care-delivery process.

People-management skills

Managing people can be stressful but it can also be rewarding; the key to being effective in this role is preparation. This can take the form of a formal course and/or being mentored while developing effective people-management skills. The types of skills the mental nurse should develop include:

- being a role model;
- actively listening to people;
- communicating a clear vision of the way forward;
- being adaptive — using different skills for different situations;
- making assertive decisions;
- enabling people to make decisions;
- taking systematic approach to problem-solving;
- being emotionally intelligent.

Coaching and mentoring

During their day-to-day role mental health nurses will support and mentor students. Mentoring is a process whereby the nurse supports a student to achieve a number of set goals. To do this the nurse will facilitate the student's learning through a systematic process during which they will:

- role model a skill;
- give the student an opportunity to practice the skill safely;
- support the student to carry out the skill in live practice;
- provide structured feedback;
- engage the student in critical thinking.

Coaching is a similar process, although there is less focus on teaching and more focus on improving performance through an action-focused dialogue. The coaching relationship gives the coachee the opportunity to have protected space to focus on their development, which is similar in some aspects to the clinical supervision process/relationship. The mental health nurse as a coachee may utilise this approach to develop their own people-management skills or they may coach others. Coaching can also be used as way of ensuring that coachees are accountable for their development through the setting of agreed actions and outcomes; coaching can also be used to support individuals through change. A typical coaching session/process is outlined below:

1. establish trust between the coach and the coachee through an agreed contract;
2. agree a developmental plan and set achievable goals and timescales;
3. implement the development plan;
4. evaluate progress.

Managing change

Change can have an emotional impact that needs to be managed by a leader who is sensitive to this emotional context. One way to doing this is to seeing the role of managing people through change as more about managing relationships and building support than just driving through change. In this situation the mental health nurse needs to engage in a discussion with the individuals they manage in a way that promotes negotiation and agreement, but is also:

- collaborative;
- productive;
- positive.

Managing risk

Background

Mental health nurses are required to manage clinical risk, though there is a tendency to focus on a service user's risk to self and others rather than seeing risk as a wider issue. Clinical risk management in a wider context focuses on keeping service users safe; to do this you have to be able to identify potential hazards and risks. Within mental health care the nurse also has to take in consideration that managing clinical risk should be a process that is partnership focused.

Risk relates to the threat or likelihood that an adverse action or event will occur. Therefore, clinical risk management is concerned with the development of strategies that prevent such an action or event from occurring, or if prevention is not possible the focus is on minimising harm/s. Hazards and risks can include events that involve not only service users but also staff and carers. These events include deliberate self-harm and violence to others, slips and falls, and also administrative errors that may have a negative impact upon care.

Professional skills

Mental health nurses should:

- recognise risk;
- manage risk in a way that is person centred and recovery focused;
- be aware of the potential risks of the care they deliver;
- report concerns promptly and change care when required to maintain safety;
- manage risk both independently and as part of a team approach.

Risk

Risks are adverse incidents that are waiting to happen, whereas a hazard is something that has the potential to cause harm, such as a spillage on a floor that has not been dealt with. Clinical risk refers to risk within a care-delivery context. Use of the term risk with a narrow definition tends to focus on the potential for clinical errors rather than enabling the nurse to manage risk holistically. It is therefore important that risk is framed in terms of a managed and holistic process. Mental health nurses tend to use the language of risk in a holistic way that includes hazards; risk is also used to refer to the potential of something going wrong when delivering care. Risks can include:

- medication incidents;
- consent and capacity incidents;
- control and restraint incidents;

- breaches in confidentiality;
- accidents to staff, service users and visitors;
- environmental incidents such as flood and fire.

Risk management

Risk management is a systematic process of identifying and then managing risk through preventing, eliminating or minimising the identified risk. The steps of a risk-management process are to:

1. identify the risk and its relationship to care outcomes;
2. analyse the potential impact of the risk;
3. evaluate the risk, considering benefits and potential costs;
4. review: what has been learnt in the process of managing risk?

In terms of nursing practice the mental health nurse needs to have systems in place that focus on keeping themselves and the people they work with safe. The risk-management process also requires the mental health nurse to learn from their experiences of adverse incidents and change their behaviour to reduce the potential of the event occurring again. Learning from incidents both at an individual level and at an organisational level requires the mental health nurse to be effective in how they communicate and also document the issues that have arisen.

Risk and organisational culture

Risk management is not just about preventing risk; for an organisation to grow it must, at times, take risks but these risks need to be identified and managed. For example, on the basis of evidence that seems to show a benefit, an NHS Trust might want to introduce a new psychological intervention into the care of people living with dementia. Before introducing this intervention the Trust needs to identify the risks and the benefits; if they decide to go ahead they need to develop an action plan that manages those identified risks.

Clinical governance

Risk management is a component of clinical governance, which is a process or system whereby healthcare organisations are required to keep improving the quality of the services they provide. To do this organisations are required to safeguard high standards of care through promoting a working environment in which excellent care will grow. For clinical governance to work effectively there must be:

- clinical governance policies and procedures in place, which also include the management of risk;
- clear lines of responsibility and accountability;
- quality improvement systems in place;
- education and training plans;
- procedures to identify and manage concerns about the quality of care.

In addition to risk management, clinical governance as a process will usually include the following elements:

- education and training — ensuring staff have up-to-date skills and knowledge;
- clinical audit — measuring the performance of clinical practice against agreed standards;
- research and development — creating a culture of practice that is underpinned by robust evidence;
- candour — supporting staff to be open and willing to discuss poor practice and near misses;
- information management — collecting good quality information.

Medication

Background

When working with a mental health service user mental health nurses will deliver a number of nursing interventions; it is not unusual for the administration of psychiatric medication to be one of these interventions. On this basis it is important for the mental health nurse to not only understand what they are administrating but also to know how medication fits with the other interventions that they provide. The nurse also needs to be an educator, which means being able to provide information to individuals with mental health problems about the medication they have been prescribed.

Psychiatric medication is licensed medication that exerts a desired effect on the brain and nervous system. These medications can be prescribed for a range of mental disorders; they usually form part of a package of care that also includes psychological approaches.

Professional skills

Mental health nurses should:

- ensure that they have an in-depth knowledge of common mental health treatments including medication;
- offer holistic care and, working as part of the multidisciplinary team, offer a range of treatment options of which medicines may form a part;
- assist individuals with mental health problems to make informed choices about the pharmacological treatments they might receive;
- provide education, information and support related to the provision of pharmacological treatments.

Types of psychiatric medication

The main groups of psychiatric medication are:

- antidepressant drugs;
- antipsychotic drugs;

- anxiolytic and hypnotic drugs;
- mood stabilisers;
- anti-dementia drugs.

Antidepressant drugs

Antidepressant drugs are used to treat depression, usually moderate to severe depression. It is thought that they work by increasing the transmission of the monoamines (serotonin, noradrenaline and occasionally dopamine) in the brain. There are a number of categories of antidepressants and different categories cause different side effects. Common side effects include:

- nausea and dizziness;
- sexual dysfunction;
- drowsiness;
- insomnia;
- dry mouth;
- constipation;
- agitation and irritability.

Antipsychotic drugs

Antipsychotic drugs are used to treat the symptoms of psychosis, such as delusions, hallucinations and thought disorder. It is thought that they reduce the symptoms of psychosis by blocking the dopamine (D2/3) receptors in the brain. There are two categories of antipsychotic drugs: the typical antipsychotic drugs and the atypical antipsychotic drugs. Both categories of antipsychotic drugs have a number of side effects that include:

- movement disorders;
- sedation;
- weight gain.

The side effects of atypical antipsychotic drugs commonly include:

- weight gain;
- feeling sluggish;
- impaired glucose intolerance;
- hypersalivation, constipation, nausea (these side effects are generally only attributable to clozapine).

The side effects of typical antipsychotics commonly include:

- stiffness and shakiness (parkinsonism);
- feeling sluggish and slow;
- restlessness (akathisia);
- postural hypotension;
- sexual dysfunction;
- breast swelling or tenderness.

Anxiolytic and hypnotic drugs

Benzodiazepines are the most commonly used category of drugs in this group, and have both anxiolytic and hypnotic effects. They are effective for the short-term treatment of generalised anxiety, insomnia, alcohol withdrawal states and the control of violent behaviour. They work by increasing the inhibitory effects of γ-aminobutyric acid in the brain, and thereby induce sleep and muscle relaxation. Another anxiolytic drug buspirone is used in the short-term treatment of anxiety. Hypnotic drugs, such as zopiclone and zolpidem have a similar action to the anxiolytic drugs, but without the muscle relaxation. Common side effects of anxiolytic and hypnotic drugs include:

- dizziness;
- drowsiness;
- impaired coordination;
- memory impairment;
- dependence and withdrawal symptoms.

Mood stabilisers

Lithium is a mood stabiliser used in the treatment of recurrent bipolar affective disorder; its mechanism of action is unknown. Lithium can be toxic above a certain dose range; its optimal range is 0.4–1.0 mmol/L). Monitoring of the service user before commencement of the drug should include thyroid and renal function tests, repeated 6 months thereafter. In addition, lithium should be taken weekly initially and then every 12 weeks. Other mood stabilisers include sodium valproate and carbamazepine; although their precise modes of action are unknown, they tend to reduce excitability within the manic phase. Side effects of lithium include:

- nausea;
- fine tremor;
- weight gain;
- urinary problems;
- skin problems.

Signs of lithium toxicity include:

- vomiting;
- diarrhoea;
- coarse tremor;
- slurred speech;
- drowsiness;
- confusion.

Anti-dementia drugs

Donepezil, rivastigmine, galantamine and memantine are used in the early (mild to moderate) stages of dementia. Side effects include:

- diarrhoea;
- muscle cramps;

- fatigue;
- nausea and vomiting;
- weight loss;
- drowsiness.

Children

Psychiatric medication is frequently prescribed in the treatment of several psychiatric disorders in childhood, including nocturnal enuresis (bed wetting), attention deficit hyperactivity disorder, autism, sleep disorders, tic disorders, conduct disorders, anxiety disorders, depression and psychosis. It is important to recognise that children differ from adults in their ability to absorb, metabolise and eliminate drugs and should therefore be closely monitored while taking psychiatric medication.

Medicines management

Background

Medicines management is an important component of mental health nursing practice, especially when medication is utilised as the initial treatment. The term 'medicines management' encompasses not only the administration of medication, it also has a broader definition. As an example, medication can support the service user's journey to recovery but only if medicines management is viewed as a part of the therapeutic relationship. The value of this approach is that the service user is a collaborative partner in a process that aims to enable them to make autonomous decisions about their prescribed medication.

Administrating medication is an important part of medicines management. To ensure that mental health nurses safely and effectively administer medication they need to consider the issue of adherence. This issue is not unique to the mental health field; medication adherence is a major challenge for all healthcare professionals. If a person does not take their medication as prescribed it can impact adversely on their recovery as well as their health and well-being. Not adhering to a medication regime can be:

- unintentional — a person forgets to take their medication;
- intentional — a person decides not to take their medication.

To enhance adherence the mental health nurse should consider:

- providing education about medication and its role in treating and/or controlling the symptoms of the identified health condition;
- supporting the service user to shape their daily routine in a way that incorporates their medication regime; service users should also be encourage to talk about the drawbacks and the benefits of taking medication.

Professional skills

Mental health nurses should:

- ensure that medicines management is built on safe and effective practice, supported by a commitment to work in partnership with the service user;
- administer medicines, and keep and maintain records that relate to medicines management in accordance with the relevant professional standards;
- ensure that their medicines management practice adheres to the relevant ethical–legal frameworks and also to the relevant national and local policy guidelines.

Medication management standards

When managing medicines mental health nurses in the UK should adhere to the Nursing & Midwifery Council's standards (NMC 2008). The following is a summarised list of those standards; it is recommended that the guidance is read in full:

- methods — medication must only be supplied and administered via a patient-specific direction or patient medicines administration chart;
- checking — any direction to administer a medicine must be checked;
- prescription medicines — only in exceptional circumstances and with certain conditions a nurse may label from stock and supply a clinically appropriate medicine;
- storage — all medicines should be stored in accordance with their UK license;
- transportation — nurses may transport medication to service users in certain cases and under certain conditions;
- administration — the nurse must be certain of the identity of the service user and that they are not allergic to the medicine; the nurse must know therapeutic uses of the medicine to be administered, its normal dosage, side effects, precautions and contraindications; the nurse must check the expiry date of the medicine and that the prescription is clearly written and unambiguous; the method of administration, route and timing must also be considered;
- assessment — the nurse is responsible for the initial and continued assessment of service users who are self-administering medication;
- remote prescription or direction to administer — in exceptional circumstances and under certain conditions the use of information technology (such as fax, text message or email) may be used;
- titration — when medication has been prescribed within a range of dosages, it is acceptable for nurses to titrate dosages;

- preparing medication in advance — a nurse must not prepare substances for injection in advance;
- nursing students — students must never administer or supply medicinal products without direct supervision;
- management of adverse effects — if a nurse makes an error they must take action to prevent any potential harm to the service user and report the incident as soon as possible.

Psychoeducation

Psychoeducation is a holistic approach that focuses on supporting the service user to develop healthy coping strategies. This approach involves collaborating with the service user to become more knowledgeable about their condition and treatment, including medication. By empowering the service user to become more knowledgeable the service user will better engage with their treatment and, in the long term, there will be more positive health-related outcomes. For example, when a service user with a severe and enduring mental health condition undergoes psychoeducation they start to adhere to their treatment, attend cognitive behavioural therapy sessions and take their medication as prescribed this, in turn, leads to the stabilisation of their mental health condition.

Mental health law

Background

On a day-to-day basis mental health nurses have to make practice decisions that are consistent with a number of legal frameworks. The added dimension in mental health nursing is that these decisions might include either restricting a mental health service user's freedoms or, where these restrictions are in place, maintaining the use of these restrictions. This does not mean that a mental health user does not have rights, however, it is quite the opposite, and it is therefore important that the mental health nurse knows how to balance autonomy of the service user against managing risk.

There are a number of legal frameworks that mental health nurses need to both work with and understand. Not all of these frameworks are specific to mental health care (for example, the *Human Rights Act 1998*) nonetheless, the mental health nurse must still be able to work with and understand these frameworks. The mental health nurse will work within a framework, such as the *Mental Health Act 1983 (amended 2007)* for England and Wales, that allows mental health nurses to restrict freedoms in certain circumstances. They will also work with legal frameworks that support individuals with severe mental problems to make decision, including the *Mental Capacity Act* 2005 which applies to England and Wales.

Professional skills

Mental health nurses should:

- understand and apply current legislation within their practice in way that protects vulnerable individuals;
- act within the law when collaboratively working with individuals living with mental health problems;
- respect and uphold a mental health service user's rights, acting in accordance with the law and relevant ethical and regulatory frameworks, including local protocols;
- know when to share personal information with others when the interests of safety and protection override the need for confidentiality.

The *Human Rights Act*

The *Human Rights Act 1998* came into full force in the UK in 2000. This Act protects the rights of the individual through a number of articles. All of the articles are relevant to individuals with mental health problems, but when an individual's freedoms are restricted the following articles have particular relevance:

- the right to life (article 2);
- the prohibition of torture (article 3);
- the right to liberty and security (article 5);
- the right to respect for private and family life (article 8).

The *Mental Capacity Act*

Individuals are generally presumed to have the capacity to make their own decisions, such as:

- understand information relevant to a decision;
- retain, use and weigh that information in the process of making that decision;
- communicate the decision.

When individuals lack capacity there is a supportive and transparent process enshrined within the *Mental Capacity Act*. This process acknowledges that a lack of capacity may be temporary and transient, and that individuals lacking capacity should, where possible, be helped to make their decisions. This Act applies to England and Wales; Scotland has similar legislation (the *Adults with Incapacity Act 2000*); Northern Ireland does not have specific legislation but relevant legislation includes the *Enduring Powers of Attorney Order 1987*.

The *Mental Health Act*

The *Mental Health Act 1983 (amended 2007)* of England and Wales is the legal framework under which an individual can be compulsory admitted, detained and treated in hospital. The Act includes provision for a community treatment order, whereby following discharge from a Section 3 or Section 37 admission an individual may be recalled back to hospital on certain grounds. The Act has civil and forensic sections.

Civil sections of the Mental Health Act 1983 *(amended 2007)*

The following is a brief overview of the main civil sections of the *Mental Health Act* 1983 *(amended 2007)* a mental health nurse will use; however there are other sections that the mental health nurse needs to be familiar with:

- Section 2 is an admission for assessment. Two doctors must make the recommendation and the application is then made by an approved mental health professional (AMHP). A Section 2 admission is for a maximum of 28 days.
- Section 3 is an admission for treatment. Two doctors must make the recommendation, and the application is then made by an AMHP. The duration of a Section 3 admission is six months; it can be renewed for a further six months, and thereafter for further periods of 12 months.
- Section 4 is an urgent assessment in the community. One doctor makes the recommendation. The duration of a Section 4 admission is 72 hours; with a second medical recommendation, however, a Section 4 admission can be converted to a Section 2 admission.
- Section 5 defines the holding powers of nurses and doctors when a service user is an inpatient. Section 5 (2) defines the doctors' holding power with a duration of 72 hours. Section 5 (4) defines the nurses' holding power and has a duration of 6 hours.
- Section 136 is implemented when a mentally disordered person is found in public place. A police constable can remove a mentally disordered person from a public place to a place of safety for 72 hours to enable a registered medical practitioner and an AMHP to assess the individual and, if required, make arrangements for admission.

Forensic sections of the Mental Health Act 1983 *(amended 2007)*

The following is a brief overview of the main forensic sections of the *Mental Health Act 1983 (amended 2007)* that a mental health nurse will use; however there are other sections that the mental health nurse needs to be familiar with:

- Section 35 is a remand for a report. This applies when the courts remand an accused individual to a hospital setting for a report on their mental condition.

- Section 36 is a remand for treatment. This applies when the courts remand an accused individual to a hospital setting for treatment of a mental condition.
- Section 37 is a hospital order. Similar to a Section 3, this applies when the courts impose a hospital order, usually after a conviction. When restrictions apply then a Section 41 is applied and this is known as a Section 37/41 — a hospital order with restrictions.
- Section 38 is an interim hospital order. This applies when the courts impose a hospital order for a convicted person to receive treatment for a mental condition before sentencing.
- Section 47 is a prison transfer to a hospital. This applies when a person is transferred to hospital for treatment of a mental condition. When restrictions apply this is known as a Section 47/49 — a transfer with restrictions.

Scotland

Scotland has similar legislation to the *Mental Health Act 1983 (amended 2007)* for England and Wales, known as the *Mental Health (Care and Treatment) (Scotland) Act 2003*. The main assessment and treatment orders are:

- emergency detention — urgent assessment for a duration of 72 hours;
- short-term detention — for detention in hospital for a duration of 28 days;
- compulsory treatment order — for detention in a hospital or the community for a duration of 6 months initially and renewable for a further 6 months, after which it can be renewed every 12 months;
- nurses' holding power, which has a duration of 2 hours;
- removal to place of safety by the police when an individual appears to be in mental distress and in a public place and is need of care and treatment;
- interim compulsion — a longer period of assessment made by the court with a duration of 1 year and renewable every 12 weeks;
- assessment — an assessment order for 28 days made by the court;
- treatment — a treatment order made by the court for the duration of the remand period or until sentencing.

Northern Ireland

In Northern Ireland the *Mental Health Order 1986* is still in effect; however, it will be replaced by the Mental Capacity Bill. The Order is divided into the following parts:

- Part 1 — definitions;
- Part 2 — the legal framework for compulsory admission;
- Part 3 — framework for persons with a mental disorder concerned in criminal proceedings;

- Part 4 — law on consent to treatment;
- Parts 5 and 6 — protections for persons with a mental disorder;
- Part 7 — registration of private hospitals;
- Part 8 — the management of property and affairs of patients;
- Part 9 — miscellaneous functions and statutory duties.

Monitoring

The use of these legal frameworks is monitored by Care Quality Commission in England, the Healthcare Inspectorate in Wales, the Mental Welfare Commission in Scotland, and the Regulation and Quality Improvement Authority in Northern Ireland.

Nutrition and fluid management

Background

Nutritional health is the foundation for good physical and mental well-being. It is generally recognised that mental health service users often have poor nutrition and a lack of physical activity. This may be caused by the social circumstances of the service user (for example, living in more deprived areas or finding it difficult to gain employment), but it may also be caused by the side effects of psychiatric medication. Whatever the causes are, it is known that mental health service users have an increased risk of mortality and physical illness (DoH 2011a). On this basis mental health nurses play a key role in promoting good nutritional health within their client group.

Maintaining a balanced diet, which includes drinking enough water, is essential for good health and well-being. When someone is physically unwell, depending on the condition and the circumstances, this can negatively impact upon their ability to maintain a balanced diet, and if the person then becomes malnourished this can adversely affect their recovery. Being malnourished can impair a person's immune response, it can delay wound healing and it can also increase the risk of mortality and developing other physical problems and illnesses (NICE 2006). To maintain a balanced diet a person needs the right amounts of the following:

- carbohydrates;
- proteins;
- fats;
- vitamins;
- minerals.

A specific issue within the field of mental health is weight gain. Service users treated with antipsychotic medication are more likely to be clinically obese than the general population (Nash 2014). This, in turn, can increase an individual's chances of developing diabetes and

coronary heart disease. Taking this into consideration, when an individual commences antipsychotic treatment it is important that their weight is monitored regularly and action is taken where there are concerns about weight gain.

Professional skills

Mental health nurses should:

- assess and monitor diet and fluid status and, where required, formulate effective plans of care;
- support service users in choosing and maintaining a healthy nutritional diet and fluid intake;
- ensure that service users unable to take food and fluids by mouth receive adequate fluid and nutrition to meet their needs.

Assessing nutrition and fluid intake

Managing nutrition requires the mental health nurse to assess a service user's current nutritional status. This assessment should be part of a continuous process so that information can be compared over a period of time, which is particularly important when actual weight gain is identified over a specific time period. The type of information collected should include:

- body weight — then calculate the body mass index;
- waist-to-hip ratio;
- clinical examination/observations as appropriate — physical appearance, oedema, mobility, mood, wound healing;
- dietary intake over a 24 hour period;
- diet history such as food frequency, food habits, meal pattern, portion size and any eating difficulties.

Nutritional support

Within the inpatient setting nutritional support might range from providing a specific diet to assisting service users to eat and drink. The support provided will dependent on the service user's identified needs and their level of dependence. Interventions might include:

- diet modification, such as providing smaller and more regular meals, or increasing or reducing a specific food group;
- dietary supplements, such as specific vitamins and/or minerals;
- feeding a service user, where possible self-feeding should be encouraged and supported throughout;
- enteral tube feeding — providing a specific feed through a tube directly into the service user's gastrointestinal tract;
- intravenous fluids, which should be given when a service user is dehydrated.

When providing nutritional support it is important to recognise that a number of factors can impact upon a service user's ability to eat and drink independently. These can include:

- difficulty chewing and/or swallowing;
- weakness, stiffness or paralysis affecting the arms, hands and/or fingers;
- mobility problems that adversely affect a service user's ability to position themselves while eating.

Health promotion

When a service user is independent then nutritional support might take the form of promoting a good diet, which could include referring the service user to a dietician. It is important to note that changing a regular diet is a lifestyle change. With this in mind, the mental health nurse may be required to undertake motivational work to support the service user in their efforts to make a sustainable change to their eating habits. The health belief model (Nash 2014) is a model that has shaped the way nurses help people to change to a healthier lifestyle; at a practice level it has the following common features:

- recognising that there is a problem;
- understanding the risks of not changing;
- identifying the benefits of changing;
- recognising potential barriers to change.

Organising care

Background

Mental health nurses are professionally accountable for their own practice but they rarely work in isolation. Most mental health nurses will work as part of a multidisciplinary team, and they may also work as part of a nursing team. Within these different teams care-delivery decisions will be made and acted upon. During this process the mental health nurse needs to be both an effective team leader and an effective team member. They also need to ensure that the service user is at the centre of the decision-making process and ensure that the rights of the service user are fully respected.

Health and social care structures in the UK are constantly changing both at a national and at a local level. Organisational structures that are constantly changing can have an operational impact upon the way care is delivered. The role of the mental health nurse is to negotiate this constant change while delivering the best care available. An added challenge for the mental health nurse is the fluidity of organisational structures within the mental health field, especially when there is a greater focus on community working and multidisciplinary case management. The structure of an organisation is dependent on the aims of the organisation; for example, mental health NHS trusts aim to provide

health and social care for individuals with mental health problems. This provision is delivered through a number of services that include:

- acute inpatient;
- assertive outreach;
- community mental health;
- crisis intervention;
- drugs and alcohol;
- early intervention;
- forensic;
- liaison psychiatry;
- outreach;
- rehabilitation.

Professional skills

Mental health nurses should:

- work as an autonomous and confident member of the multidisciplinary team, while promoting the continuity of care;
- safely lead, coordinate and manage care that is responsive to the needs of individuals living with mental health problems;
- deliver personalised care that is based on mutual understanding and respect for the individual's situation;
- maintain a safe environment and safeguard individuals living with mental health problems from vulnerable and potentially harmful situations.

Organising care delivery

Different models are used to organise mental health nursing care, but whichever model is used it should always aim to provide a good quality of care. Within an inpatient environment the delivery of this care is influenced by the multidisciplinary decision-making process; this may be via multidisciplinary team meetings or ward rounds. At an operational level nurses deliver the majority of this care and care delivery will be organised through a number of different approaches, although these approaches are not mutually exclusive:

- the task approach — the focus is on delivering a task, such as administrating medication or undertaking observations;
- the service-user allocation approach — a nurse is assigned to care for a specific number of service users;
- the team nursing approach — a team of qualified and unqualified nurses will care for a specific group of service users;
- the primary nursing approach — throughout their stay in hospital a service user will be cared for by a named qualified nurse who will be responsible and accountable for the coordination of their care.

A case management approach to care delivery is typically used within the community mental health team settings. This is a multidisciplinary team approach whereby the team is involved in both the decision-making process and the delivery of care, although in terms of overall responsibility one member of the team is allocated to be the case manager. Typically the case manager's role is to:

- undertake a comprehensive assessment;
- devise a person-centred care plan that manages risk;
- monitor progress and evaluate the plan of care accordingly;
- signpost to other services or members of the team when required;
- be an advocate for the service user.

Person-centred care

Whichever approach is used, nursing care delivery should be person centred, focusing on the service user's needs, strengths and preferences. Care delivery should also take into account that a service user may lack capacity and, in this case, the mental health nurse should follow the relevant legal framework and/or guidance.

Best practice

Mental health nurses working in partnership with service users who have complex needs are required to deliver high-quality care. During this process they also have to be able to influence external agencies successfully to ensure that a holistic and integrated package of care is implemented effectively. At the same time they have to make sense of a health and social care environment where structures are constantly changing. Using a model of care delivery will provide a sense of consistency when dealing with all of this change, although it is important that the nurse is skilful enough to be adaptive to different ways of working. On this basis the nurse will have to complement their baseline skills by engaging in a journey of lifelong learning where they clearly identify and then address their learning needs.

Physical well-being

Background

The role of the mental health nurse is to promote good physical health and well-being. This is especially important when considering that individuals diagnosed with a severe mental health problem are more likely to experience physical health problems than the general population (Nash 2014). The first stage of promoting good physical health and well-being is to ensure that an individual's physical health needs are identified. This process should take the form of regular physical assessments, and any needs identified should be addressed through an integrated and holistic package of care. Mental health

nurses will also be required to deliver physical health care and/or signpost individuals to the appropriate services.

Physical health problems are common in individuals diagnosed with severe mental illness, such as depression, schizophrenia and bipolar affective disorder (Nash 2014). The most common types of physical health problems encountered by mental health nurses include:

- cardiovascular disease;
- respiratory problems;
- diabetes;
- digestive disorders;
- obesity;
- musculoskeletal diseases;
- cancer — lung, colorectal and breast cancer;
- viral infections.

It is also important to recognise that physical ill health can lead to a mental health problem. It is not uncommon for enduring physical health problems to be co-morbid with depression. These health problems include:

- cancer;
- heart disease;
- diabetes;
- musculoskeletal;
- respiratory problems.

Professional skills

Mental health nurses should:

- promote physical health and well-being through education, role modelling and effective communication;
- deliver physical care that meets the essential needs of people with mental health problems;
- recognise and respond to the physical needs of all individuals who come into their care;
- be able, where required, to signpost an individual with physical and mental health problems to the appropriate service.

Factors

There are numerous factors that might account for a higher incidence of physical ill health in individuals with mental health problems. These factors include:

- psychiatric medication — some medications increase the risk of obesity, diabetes and cardiac problems;

- lifestyle — individuals with mental health problems have a higher rate of smoking, and drug and alcohol misuse; they also tend to eat less well and exercise less;
- social — indirect factors such as poverty, poor housing and unemployment may also have an adverse impact.

There are also protective factors that keep mental health service users physically well such as:

- supportive and nurturing social networks;
- employment;
- self-awareness and having a sense of hope;
- having a healthy lifestyle.

Physical health assessment

Even when these factors are taken into account, individuals with mental health problems are less likely to have their physical health needs recognised than the general population. On this basis, a physical health assessment should include:

- the gathering of baseline physical health, including a medical history;
- a physical examination including baseline observations;
- baseline investigations including blood tests.

After the initial assessment the individual should be monitored annually, usually via their general practitioner (GP).

Managing physical health

The role of the mental health nurse in managing an individual's physical health is to be a health promoter, which includes:

- providing education about medication, including side effects;
- providing dietary advice or signposting to a dietician;
- promoting the benefits of physical exercise and monitoring weight;
- providing smoking cessation advice;
- liaising with the GP when required;
- signposting to family planning and sexual health services when required.

A key part of health promotion is to work collaboratively with the individual to change unhealthy behaviours by:

- recognising what behaviour needs to change;
- developing an agreed action plan;
- implementing the action plan;
- providing encouragement no matter how small the change;
- monitoring outcomes;
- developing agreed strategies to maintain change;
- persevering if the change does not happen.

Psychiatric examination

Background

The psychiatric examination is an assessment process carried out by a psychiatrist. The focus of the examination is to establish a diagnosis, formulate the problem (summarise the psychiatric examination), and then to provide a treatment plan. This process conceptualises the service user's mental distress through the lens of a medical diagnosis, so hearing voices and not coping from day-to-day can become a diagnosis of schizophrenia. This approach can be viewed as reductionist, whereby mental distress is reduced to a diagnosis and somehow the person suffering with the problem becomes forgotten. This does not have to be the case, however, as not all psychiatrists take a reductionist approach and, in addition, modern psychiatry is situated within a multidisciplinary team approach which, to function effectively, has to be holistic rather than reductionist.

The data gathered from the psychiatric examination, including the service user's history and information related to the presenting problem, feeds into the data collected by the multidisciplinary team. The mental health nurse will use this collective information in conjunction with the data they have collected through the care-planning process. The service user usually provides most of this information; however other parties may also be able to contribute, such as relatives and health and social care staff. This process has two distinct parts:

- the psychiatric history and mental state examination;
- the formulation.

Professional skills

Mental health nurses should:

- recognise different forms of mental distress and respond effectively, irrespective of age or setting, as part of a multidisciplinary team approach;
- have an in-depth understanding of the care and treatment of individuals with mental health needs;
- work within the context of a multidisciplinary team to enhance the care and treatment of individuals with mental health needs;
- apply and value the use of evidence within their practice and in their role as a member of a multidisciplinary team.

Psychiatric history

Physical examinations and investigations are carried out as part of the psychiatric examination more to exclude an underlying physical cause rather than to confirm a diagnosis. The psychiatry history is a catch-all

term for the collection of a large amount of historical data. The information collected is structured through the following headings:

- introductory information — including age, occupation, reason for referral and status according to the *Mental Health Act 1983 (amended 2007)*;
- presenting complaint and history — including the service user's view of what the problem is, and identifying the nature of the service user's symptoms;
- past psychiatric history — including previous episodes of mental distress, the date of these episodes, the duration and any treatments;
- past medical history — including current and past physical illnesses and any subsequent treatments;
- drug history/current treatments — including psychosocial treatments, prescribed medication and allergies;
- substance abuse — including alcohol, illicit drugs and tobacco;
- family history — including any family history of mental health problems and any recent issues within the family;
- social history — including accommodation, finances, hobbies and activities;
- personal history — including childhood, education, employment history and forensic history;
- informant history — supplementing the service user's information with information from a significant alternative source, such as a relative.

The mental state examination

Complementing the psychiatric history, the mental state examination is a snapshot of the service user's behaviour and mental experiences at the time of the examination. It is usually structured using the following headings:

- appearance and behaviour;
- speech;
- mood — this would include asking about suicidal ideas;
- thoughts;
- perception;
- cognition;
- insight.

The formulation

The formulation summarises the whole psychiatric examination process and is structured using the following headings:

- synopsis;
- differential diagnosis;
- aetiology;
- investigations;

- management;
- prognosis.

Psychological interventions

Background

Mental health nursing practice should be holistic and mental health nurses are professionally required to have the skills, knowledge and values to deliver holistic care that is safe and effective. Psychological interventions are a crucial part of this holistic approach, especially as they aim to improve an individual's biopsychosocial functioning.

There is an increasing need for mental health nurses to be able to deliver psychological interventions as part of their everyday nursing practice. Clinical guidance related to specific mental disorders might recommend a specific psychological therapy and/or a number of psychological interventions — collectively known as 'psychosocial' interventions. In the wider context of mental health nursing practice psychological interventions are mental health nursing interventions underpinned by psychological methods and theory with the intention of improving biopsychosocial functioning. The delivery of physical healthcare interventions should also be supported by psychological theories and methods. Whatever the context, it is important to recognise that these interventions should be delivered through a therapeutically structured relationship built on good communication skills and a commitment to partnership working.

Professional skills

Mental health nurses should:

- use a wide range of therapeutic strategies and interventions, and communicate about these interventions effectively to optimise health and well-being;
- be person centred and committed to building therapeutic relationships that are enabling and partnership focused;
- deliver care across settings that is underpinned by a range of evidence-based psychological, psychosocial and other complex therapeutic skills and interventions;
- deliver care that is systematic, balances the need for safety with positive risk taking and promotes recovery.

Psychological therapies

The psychological therapies commonly used in mental health care include:

- cognitive behavioural therapies;
- cognitive stimulation;
- dialectic behaviour therapy;

- interpersonal therapy;
- motivational enhancement therapy;
- psychodynamic therapy;
- systemic family therapy.

Communication skills

Any psychological intervention or therapy should be built on good and effective communication skills. Being an effective communicator also means being a safe practitioner: someone who is ethical, engenders trust and openness, and builds therapeutic relationships that are collaborative and positive especially when managing risk.

Psychological interventions

Although psychological interventions are usually eclectic and may correspond to more than one psychological therapy or theory they still need to be delivered systematically in such a way that their effectiveness can be evaluated. Depending on the skill of the mental health nurse the following types of psychological interventions might be delivered:

- build a collaborative and therapeutic relationship based on a person-centred approach;
- normalise an individual's experiences of mental distress;
- take a 'strengths approach';
- maintain safety and manage challenging behaviours effectively;
- explore the individual's capacity to change;
- modify thought processes — identify, challenge and replace negative thoughts;
- focus on the individual controlling and regulating their behaviour — promote and enhance healthy ways of coping;
- prevent social isolation and promote social functioning;
- focus on relapse prevention — establishing early warning signs and self-monitoring of symptoms;
- signpost the individual to self-help and relevant support groups;
- support recovery therapeutically.

Psychological interventions should be:

- based on robust evidence;
- collaborative;
- embedded within the multiprofessional team;
- recovery focused;
- skilful.

Being evidence based

Mental health nurses should deliver psychological interventions that are based on the best evidence available. It is also important to recognise that generalised evidence needs to be situated within the

unique nature of the therapeutic relationship. To do this the mental health nurse needs to complement the evidence-based knowledge with knowledge of the mental health service user they are working with. This comes from the use of good communication skills that focus on truly listening to the mental health service user's story.

Collaboration

Managing risk is an important part of the mental health nurse's role and being collaborative in this context can be a challenge, especially when the mental health nurse has the power to restrict the freedoms of a mental health service user. This type of power could have an adverse impact upon the therapeutic relationship and any subsequent psychological interventions that are delivered if it is not managed sensitively. To address both this power issue and also to continually improve their practice the mental health nurse must actively engage in critical reflection. The process of critical reflection starts with the mental health nurse using an 'open dialogue' approach that focuses on understanding and respecting the service user as a human being rather than as someone to be controlled. The next step is to learn from this approach through structured reflection such as participating in clinical supervision.

Psychological therapies

Background

On a day-to-day basis mental health nurses deliver psychological interventions; some of these interventions are clearly underpinned by a specific psychological approach or therapy. In fact, most psychological interventions delivered by mental health nurses will link to a corresponding psychological theory or model; however, due to the eclectic nature of mental health nursing it may be difficult to identify a specific supporting model or theory. To add further complexity the terms psychological interventions, psychosocial interventions, psychological therapies and psychotherapy are used interchangeably.

Psychological therapies are built on a platform of psychological interventions that are underpinned by a specific psychological model. For example, distraction as a psychological intervention would be used to deal with intrusive thoughts, which is a cognitive behavioural model, and the corresponding psychological therapy is cognitive behavioural therapy (CBT). Psychosocial interventions are psychological interventions which have a 'social' element such as an emphasis on social skills training and/or family interventions. Psychological therapies and psychotherapy can be viewed as synonymous and will sometimes be called 'talking therapies'. All mental health nurses should be able to deliver a number of different types of psychological interventions, though not all will be trained to deliver a specific psychological therapy.

Professional skills

Mental health nurses should:

- communicate effectively using a wide range of therapeutic strategies and interventions to optimise health, well-being and safety;
- use a range of evidence-based psychological, psychosocial and other complex therapeutic skills and interventions to provide person-centred care;
- deliver care across settings that is underpinned by a range of evidence-based psychological, psychosocial and other complex therapeutic skills and interventions;
- carry out systematic needs assessments, develop case formulations, negotiate goals and deliver both individual psychosocial interventions and group psychosocial interventions.

Behavioural therapy

Behavioural therapy focuses on behavioural change to influence the way we feel and act. For example, an individual might be fearful about specific situations to the point that they avoid this situation due to their overwhelming anxiety. Slowly learning to relax, even when they are exposed to this situation, can help them to both control their anxious feelings and stop using avoidant behaviours.

Cognitive therapy

Cognitive therapy is a short-term therapy concerned with modifying the way we think and then act. An individual might feel worthless, and use examples from their life to support this way of thinking. The mental health nurse challenges this way of thinking by supporting the individual to recognise what they can do rather than what they think they cannot.

Cognitive behavioural therapy

CBT is a short-term therapy that has components of both behavioural therapy and cognitive therapy. It focuses on changing both thinking and behaviour at the same time. It is recommended in the treatment of:

- depression;
- anxiety;
- obsessive compulsive disorder;
- post-traumatic stress disorder;
- eating disorders;
- psychosis.

CBT is available as a computerised package, and it can also be a component of other therapies, such as mindfulness-based cognitive therapy, dialectical behavioural therapy, and acceptance and commitment therapy.

Eye movement desensitisation and reprocessing

Eye movement desensitisation and reprocessing is a treatment that uses eye movements, sounds or taps to stimulate the way the brain processes information during an unpleasant memory such as those experienced during post-traumatic stress disorder. The underpinning theory is that the brain as an information processor becomes 'frozen' when an unpleasant memory is recalled, and by stimulating the brain when recalling the memory, the experience over time becomes less intense and has less of an impact upon the individual's ability to function.

Group therapy

Group therapy is an approach that utilises the psychological processes of the group to find facilitated solutions. This approach is based on the premise that the group has a dynamic that, if facilitated appropriately, is a safe way of motivating and supporting group members to become more aware about themselves and the way they function. By becoming more self-aware an individual is more likely to use healthier ways of coping.

Humanistic counselling

Humanistic counselling has a number of components; in essence, however, it is used to facilitate individuals to focus on their strengths to overcome their presenting mental distress. The approach is person centred meaning it values the person and their innate ability to find a solution.

Mindfulness-based therapies

Mindfulness-based therapies assist an individual to be in the moment, not to be overwhelmed by their mental distress, through techniques that are based on the principles of meditation. This approach can be combined with other therapies such as cognitive behavioural therapy.

Systemic therapy

Systemic therapy, which is also known as family therapy, focuses on managing and resolving an individual's mental distress through working with the interactions, patterns and dynamics of the individual's social group. The aim is to facilitate new, healthier interactions, patterns and dynamics to emerge.

Solution-focused therapy

Solution-focused therapy is also known as a brief therapy and it focuses, as the name suggests, on solutions rather than problems. The approach is goal focused; the individual identifies a goal and is then facilitated to

achieve this goal by using their internal resources, and/or developing new resources and/or using the resources of their social network.

Recovery

Background

Recovery as a therapeutic process is an integral part of mental health nursing practice. As a process, mental health nurses often see recovery in terms of eliminating or controlling symptoms of mental distress. This view is quite a narrow, as recovery should be a whole-person approach whereby the meaning of recovery is embedded within the hopes and aspirations of the individual. Recovery is also about social inclusion, whereby individuals are supported to live meaningful lives within society.

Utilising a recovery-based approach presents a significant challenge for mental health nurses especially when there are professional and policy drivers that require mental health nurses to utilise a recovery-based approach but at the same time there is no single agreed definition of recovery. With this in mind, recovery should be viewed relative to the individual and their circumstances, meaning that the recovery process for that individual is constantly redefined by their ever-changing needs. The challenge for the mental health nurse in these circumstances is that they need to be both receptive and responsive to the service user's ever-evolving needs and ensure that their practice is positively redefined by these experiences. Even though recovery as process is relative in nature it can have aims which include:

- promoting well-being;
- maximising opportunity;
- empowering individuals to take control;
- facilitating and supporting the individual in finding meaning and purpose.

Professional skills

Mental health nurses should:

- engage effectively with individuals with mental health problems in a way that is person centred and also promotes social inclusion and recovery;
- ensure their practice is recovery focused whatever the context or setting, and that it values, respects and explores the meaning of an individual's mental distress;
- promote the self-determination expertise of individuals with mental health problems while using their personal qualities and interpersonal skills to develop and maintain a recovery-focused therapeutic relationship;
- work with people living with mental distress and with other professionals and agencies to shape services in a way that aids recovery.

The recovery process

Recovery can be described in terms of a process which includes the following features:

- a whole-person approach is taken rather than just focusing on symptoms;
- recovery is viewed as a journey rather than a destination;
- optimism, commitment and hope are key values;
- support should be systematic but also innovative.

The components of recovery

There are a number of models of recovery, including the:

- Collaborative Recovery Model
- Strengths Model
- Tidal Model
- Well-being and Recovery Action Plan Approach

The Tidal Model is particularly pertinent to mental health nurses as it was created by mental health nurses in collaboration with mental health service users. The Tidal Model is made up of three key components or domains:

- self domain — narrative or story-telling component;
- world domain — the narrative component is shared with others;
- others domain — recovery is enacted through the care-delivery process.

Policy

Recovery is a key objective within the *No Health without Mental Health* policy document (DoH 2011a), which focuses on good quality care for people with:

- emerging mental health problems;
- acute mental distress;
- ongoing mental health problems.

Integrating the recovery approach within the care-delivery process should help:

- reduce distress;
- improved social functioning;
- maintain and develop good relationships;
- provide the opportunity for education, skills, employment and purpose;
- maintain good physical health;
- reduce the risk of relapse.

The recovery approach

During the recovery process the mental health nurse must be able to support the individual such that the individual's story is actively valued as a core part of the care-delivery process. The nurse must also recognise that interventions have to be outcome focused and adaptable to changing need. Building on this, the nurse must also be aware of the factors that influence the recovery process positively, including:

- positive and sustainable relationships;
- paid employment;
- meaningful activity;
- autonomy;
- resilience;
- personal growth;
- a healthy living environment;
- a supportive social network.

Reflection

Background

Mental health nurses are professionally required to engage in the process of reflection, the most common form of which is 'reflection on action', which involves reflecting on practice experiences in a way that promotes learning. For this process to be effective the nurse needs to be committed to better understanding their own values and how these relate to the values of the nursing profession; they also need to be committed to improving their practice constantly. A common method of systematically reflecting on practice is through clinical supervision, which is a formal activity whereby a clinical supervisor facilitates the nurse to reflect upon their practice and identify strategies that focus on improving their practice.

The professional expectation is that at the point of registration the mental health nurse is a critically reflective practitioner who learns from practice in a way that improves the quality of the care they deliver. Being critically reflective implies that the nurse is able to identify critical incidents that arise from their practice experiences. This essentially a process of questioning during which the nurse should consider:

- What is the issue, is it problematic and why?
- Why has it occurred?
- How does this issue impact upon the service user?
- What are the options or alternatives?
- Have you looked at the evidence?

The skills of critical reflection arise from engaging in reflection in two interconnected forms:

- reflection on action — reflecting after an experience and then taking action to improve practice;
- reflection in action — reflecting during the experience so that previous learning can be used to improve practice at that moment in time.

Professional skills

Mental health nurses should:

- participate actively in clinical supervision and reflection;
- engage in reflection and supervision to ensure they learn from their practice experiences in a way that enhances the quality of care they provide;
- participate in the reflective process as a mechanism to better understand their personal values, beliefs and emotions and how they can impact upon their practice;
- actively promote clinical supervision as clinical leader and as clinical role model.

Structured reflection

For reflection to be useful or action focused it has to have a structured process. A number of models are available and most have a common structure, such as:

- identifying and describing the experience/s;
- examining the experience in depth, teasing out the key issues: What did I think at the time? How did I feel?
- processing the issues: How do the issues relate to practice? What have I learnt?
- summarising the experience: What actions do I need to take? How can I improve my practice?

Learning to reflect in a structured way is important but it should not be used as rigid formula, instead it should be used as a guide. It is also important to recognise that reflection on action, if used properly as a lifelong learning tool, will become more refined over time; it will also enable the nurse to reflect in action and assist them towards being an expert practitioner.

Clinical supervision

Clinical supervision as a reflective practice can be delivered in different ways, including:

- individual supervision;
- group supervision;
- peer group supervision.

Although clinical supervision follows the tenets of structured reflection it can be grounded in a specific model, especially when a mental health nurse is also a therapist, such as a cognitive behavioural therapist. Whichever model is used in clinical supervision, as a professional process it should:

- support practice and enable the nurse to maintain and promote standards of care;
- be a practice-focused professional relationship, involving a practitioner reflecting on practice guided by a skilled supervisor;
- be developed by practitioners and managers according to local circumstances; ground rules should be agreed so that practitioners and supervisors approach clinical supervision openly and confidently, and are aware of what is involved;
- ensure that all practitioners should have access to clinical supervision and each supervisor should supervise a realistic number of practitioners;
- ensure supervisors are adequately prepared with the principles and relevance of clinical supervision that is included in pre- and post-registration education programmes;
- be evaluated locally with a focus on evaluating how clinical supervision influences care, practice standards and the mental health service.

Lifelong learning

To have real value, lifelong learning (which includes continuing professional development) has to have a reflective component. Nurses who are lifelong learners and critically reflective are capable practitioners who:

- know how to learn and reflect continually;
- work well with others and are effective communicators;
- regularly and easily apply themselves to new and unfamiliar situations;
- demonstrate positive values about themselves and others.

Research

Background

Utilising good quality research evidence will assist the mental health nurse in the process of providing a continuous high standard of care with improved care outcomes. To utilise such evidence effectively and appropriately the nurse will need to be competent in the use of research-based evidence. Part of being competent is knowing what evidence is useful and what evidence is not so useful, and also being able to justify the decision taken. It is worth noting that there are

different forms of knowledge, but, in terms of clinical guidelines, scientific evidence is the key form of knowledge used in mental health nursing practice.

Nursing practice utilises different types of knowledge:

- traditional and routine-based knowledge;
- experienced-based knowledge;
- research-based knowledge.

The nurse will not use one source of knowledge exclusively; as an example, research might suggest the nurse should change their practice in a certain way and experience may further modify this change, which then becomes the norm or traditional practice. Research is a systematic way of gaining knowledge where what is already known is either added to, rejected or confirmed. It can assist the nurse in the process of:

- exploring the issues in further depth;
- solving problems;
- providing a strong rationale for change.

Research is generally either quantitative, focusing on measuring cause and effect, or qualitative, which is more concerned with value-laden or subjective issues.

Professional skills

Mental health nurses should:

- deliver care that is responsive to the needs of individuals living with mental health problems and is based appropriately on research evidence;
- ensure their practice is informed by the best available evidence and complies with local and national guidelines;
- recognise the value of evidence in practice and be able to understand and appraise research, apply relevant theory and research findings to practice, and identify areas for further investigation;
- use research-based evidence to assist in improving improve mental health service users care experiences and care outcomes and also to shape future care provision.

Scientific evidence

Scientific evidence (also called quantitative evidence) and approaches take different forms, though the dominate form in mental health nursing practice is the evidence-based form or what is called evidence-based practice (EBP). This means that the clinical-decision-making process is based on the careful use of current and best available

evidence. This evidence can range from testimony from a clinical expert to evidence that is collected through randomised controlled trials (RCTs). The highest quality evidence is collected through the RCT process. It is important to note that this type of evidence is continually being updated and, on this basis, the nurse needs to ensure they too are regularly updated about any changes. This should include checking any relevant clinical guidelines that are based upon EBP, as the guidelines change as the evidence is updated. EBP has number of steps, starting with asking a clinical question such as; What is the best nursing intervention for this condition? The nurse will then move on to:

- identifying the relevant literature;
- assessing the evidence critically; Is it reliable and/or valid?
- applying the chosen evidence to the particular clinical situation;
- evaluating the application of the evidence.

Naturalistic evidence

Naturalistic research (also called qualitative research) investigates experiences and meanings, such as why individuals act in the way they do. The different types of naturalistic research approaches include:

- phenomenology;
- grounded theory;
- ethnography;
- narrative studies;
- case studies.

The most commonly used methods of collecting information for these approaches are:

- interviews;
- narratives;
- case studies;
- focus groups.

Practice evidence

EBP is a dominant approach, although it is important to recognise that scientific knowledge only provides one perspective, which can be a limited way of understanding a service user's mental distress. A better understanding can be engendered through multiple approaches, which might include working with both EBP information and the service user's narrative. By working in this manner, with both scientific and naturalistic knowledge, the nurse has a more holistic understanding of a mental health service user's needs. When working with a service

user's narrative or story it is important that the nurse really listens and pays attention to the purpose, content and tone of the story:

- purpose — what information is contained within the narrative and why is the service user giving you this information?
- content — what does the narrative say about the service user's quality of life?
- tone — is the overall tone positive or negative?

Suicide and self-harm

Background

Managing suicide and self-harm are part of managing risk. The risk-management process should be partnership focused and emotionally intelligent, as the emotions related to harm, whether it be harm to self or others, can be intense and distressing. The mental health nurse also has to recognise that the levels of risk attributed to suicide and self-harm can change quite quickly, and when risk levels increase a service user's freedoms may be restricted which, in itself, can be distressing.

Suicide is a form of self-harm; however, individuals may engage in acts of deliberate self-harm with no intention of committing suicide. It is important to note that individuals who engage in deliberate self-harm are more likely to commit suicide than the general population (Burton 2006). Suicide and self-harm can be categorised as follows:

- suicide — intentionally killing oneself;
- attempted suicide — intentionally trying to kill oneself without success;
- parasuicide — trying to kill oneself and not succeeding, it may or may not be intentional, it may be a suicidal gesture, a cry for help or an act of revenge;
- deliberate self-harm — intentionally injuring oneself; there may or may not be suicidal intent. Acts that have little or no suicidal intent may be a way of coping with emotional and mental distress or a way of communicating distress.

Professional skills

Mental health nurses should:

- recognise and manage suicide and self-harm in a way that is person centred, recovery focused and that protects vulnerable individuals;
- work positively and proactively with individuals who are at risk of suicide and self-harm, using evidence-based models of suicide prevention, intervention and harm reduction to prevent, reduce and minimise the risk;

- manage the risk of suicide and self-harm both independently and as part of a team approach in a way that promotes effective communication, positive risk management and continuity of care across services;
- respond autonomously and appropriately when faced with self-harm and attempted suicide, including seeking help from appropriate individuals when necessary.

Suicide

Since 1961 suicide has been decriminalised in the UK; however the act of assisting someone to commit suicide is still illegal. In other cultures suicide can be viewed as an honourable death in certain circumstances, in the UK, however, the sanctity of life argument holds sway. It is estimated that that the majority of suicides can be linked to a mental disorder such as:

- depression;
- substance misuse;
- personality disorder;
- psychosis.

Suicide is the fourth commonest cause of death in the UK, and it is thought that published suicide rates do not reflect the fact that suicides may well be under-reported. Risk factors for suicide include:

- gender — men are three times more likely to commit suicide than women;
- age — the highest suicide rates are for men between 25 and 45 years old and women over 65 years old;
- whether single, widowed or separated/divorced;
- whether unemployed or retired;
- certain occupations — vets, farmers, pharmacists and doctors;
- social isolation;
- whether a victim of physical or sexual abuse;
- a recent life crisis;
- a history of deliberate self-harm;
- a mental disorder;
- a severe physical illness;
- a family history of suicide or deliberate self-harm.

Hanging is the most common method of suicide for men and poisoning is the most common method for women.

Self-harm

Accurate rates of deliberate self-harm are difficult to ascertain as not everyone who deliberately self-harms will go to hospital or seek medical attention. Within England and Wales it is estimated that there are at least 200,000 hospital admissions or presentations per year for

deliberate self-harm. Self-poisoning and self-injury by cutting are the most common types of deliberate self-harm. Risk factors include:

- age — deliberate self-harm is more common in people under the age of 25;
- gender — deliberate self-harm is more common in women than men;
- a mental disorder;
- substance misuse;
- whether a victim of physical or sexual abuse;
- relationship changes;
- social isolation;
- bereavement;
- unemployment.

Management

When a service user attempts suicide within a mental health ward it is important that staff have the appropriate life-support training and that the equipment is checked regularly and is up-to-date. As this is a medical emergency the paramedics also need to be contacted. When a service user engages in deliberate self-harm the mental health nurse should:

- establish the likely physical risk to themselves and to others;
- de-escalate and control the incident;
- assess the extent of the injury;
- refer the service user for urgent treatment in an emergency department if required;
- provide treatment as required in a respectful and person-centred manner.

Assessment

The assessment of service users who have self-harmed should be part of the risk-assessment process. The following areas should be assessed as part of this process:

- skills, strengths and assets of the service user;
- coping strategies;
- mental health problems;
- physical health problems;
- social circumstances and problems;
- methods and frequency of current and past self-harm;
- current and past suicidal intent;
- depressive symptoms and their relationship to self-harm;
- triggers, specific risk factors and protective factors;
- significant relationships;
- immediate and long-term risks.

Psychological interventions

In the short term the mental health nurse should consider using psychological interventions that help reduce harm, which include:

- reinforcing existing coping strategies that are healthy;
- supporting the service user to develop less harmful ways of coping;
- supporting the service user to develop effective problem-solving skills;
- advising the service user that there is no safe way to self-poison.

In the long term the service user should be offered a psychological therapy; the type of therapy will depend on whether the self-harm co-exists with an underlying mental health condition.

Therapeutic relationships

Background

Therapeutic relationships in mental health nursing should be evidence based, especially when delivering psychological interventions, and they should also respect the narrative of the service user. Mental health nurses are therefore required to build a therapeutic relationship that acknowledges the service user's unique narrative and at the same time delivers positive therapeutic outcomes. The therapeutic use of self is crucial within the process of developing meaningful and positive therapeutic relationships. It is also important to note that the use of self in a recovery-based relationship needs to be underpinned by the mental health nurse's commitment to partnership working.

At times it can become quite easy for the mental health nurse to reconstruct the service user's own experience of mental distress. This can happen for example when an assessment tool is being used which captures the information the mental health nurse needs; however it does not capture the service user's entire story. Having different viewpoints can create conflict within the relationship unless the mental health nurse takes a collaborative approach. In addition, the therapeutic relationship within the mental health field has an element of risk when, for example, risk containment and risk minimisation shape the relationship. Even though the therapeutic relationship is intended to be collaborative and person centred this intention is dependent on the level of risk. The nurse should always look to build therapeutic relationships that are based on true partnership working and, at the same time, value both the service user and their experiences; a person-centred philosophy.

Professional skills

Mental health nurses should:

- build safe therapeutic relationships that are partnership focused, person centred and non-discriminatory;
- use relationship-building skills with mental health service users, including facilitating therapeutic groups;

- use their personal qualities, experiences and interpersonal skills to build recovery-focused relationships;
- be self-aware and know to when to use self-disclosure while maintaining professional boundaries;
- recognise mental distress and be able to respond using therapeutic principles that are underpinned by evidence-based practice.

The therapeutic self

Mental health nurses use a range of strategies in the process of building a therapeutic relationship. These strategies include:

- selecting the right words to use;
- knowing when to talk and when to be silent;
- using the right verbal and non-verbal responses;
- adapting non-verbal communication to suit the situation.

To use these strategies effectively the mental health nurse needs to be self-aware; aware of the impact their self has upon others, and aware of their own thoughts and feelings. They also need to be able to use this knowledge in a positive way when working with service users.

Empathy

It is essential that the mental health nurse is empathetic within the therapeutic relationship. This means that they have to be able to identify with the service user's experiences by being:

- an active listener;
- genuinely interested;
- accepting the person;
- caring and compassionate.

Delivering care

The *No Health without Mental Health* policy document (DoH 2011a) and its accompanying strategy and vision document for mental health nursing (DoH 2011b) highlight the importance of partnership working. The vision document links explicitly to the 6Cs, and within the 'care' element the development of a sustainable and positive therapeutic relationship is viewed as the basis for all the care that the mental health nurse provides. This relationship needs to be:

- grounded in compassion;
- respectful and empathetic;
- skilful and purposeful;
- recovery focused and inclusive.

Professional boundaries

Taking an empathetic approach gives the nurse the opportunity to be more thoughtful about the interventions they deliver, but also on occasion the nurse may self-disclose. As a therapeutic skill

self- disclosure can be a way of fostering collaboration. When using self-disclosure the mental health nurse must remember that, as a nursing professional, there are professional boundaries that they must adhere to in addition to being governed by a professional code of conduct.

Reflective practice

To build therapeutic relationships that have positive outcomes the mental health nurse needs to be able to balance being person centred and collaborative against the demands of being a clinical risk manager. To do this effectively the mental health nurse has to be able to engage in reflective practice, which is a professional requirement as well as an important component of effective clinical decision-making. Reflective practice is a structured and critical process that requires the nurse to re-examine their practice experiences and focus on changing their practice for the better.

Time management

Background

When in the process of delivering care, mental health nurses have to manage their time effectively. Time management is a complex process; it is concerned not only with how the mental health nurse manages their own time as a series of tasks, but also how they manage time pressure emotionally. A nurse who is an expert in a certain intervention may take less time to complete it than someone who is less experienced. This in itself is not problematic; the problem arises if the team expectation is that everyone can complete the intervention in the same amount of time. If a nurse cannot meet this expectation they can feel rushed or they rush to complete the intervention and consequently feel stressed. Another issue is that the delivery of mental health nursing care can be routine focused with tasks planned in advance, but the routine has to be flexible as unexpected issues can arise which have to be dealt with immediately.

Care delivery has become increasingly complex and the mental nurse needs to manage many competing priorities. Managing time focuses on controlling the amount of time and effort spent on a specific task or intervention, including:

- prioritising tasks;
- scheduling the order of tasks to be undertaken;
- planning each task;
- agreeing what needs to be achieved;
- allocating resources to the task;
- delegating when required.

Being systematic can be extremely helpful in managing time but, as health and social care provision can change rapidly, it is important that

this approach is flexible. Prioritisation should be the mediating factor in a flexible approach; for example, writing a care plan might well be a priority before an emergency situation arises on the ward, and then the emergency takes priority. On this basis mental health nurse should:

- be aware of what are priorities and what are not;
- set priorities being aware that they can change;
- deliver care based on those priorities.

Professional skills

Mental health nurses should:

- identify priorities and manage time and resources effectively to ensure that the quality of care is maintained or enhanced;
- prioritise the needs of groups and individuals in order to provide care effectively and efficiently;
- negotiate with others in relation to balancing competing and conflicting priorities;
- prioritise own workload and manage competing and conflicting priorities.

Delegation

When a team is delivering care then tasks need to be allocated, and the person undertaking the task should be the best person for the job. In an ideal situation the team would allocate their own tasks, but usually task allocation falls to the team leader. The appropriate and safe use of delegation can create a sense of time and space; one person does not feel they are doing everything. When delegating tasks the following should be considered:

- Does the person have the right skills and knowledge?
- Are they legally allowed to undertake the task?
- What does the organisation's policy say?
- Who is accountable and responsible?
- Does the person know exactly what they need to do?
- Is delegating the task the best option?

Stress management

The benefit of being a good time manager is that it helps the mental health nurse cope with stress in a healthy way. Stress in itself is not a bad thing; it is usually transient, and at times we all feel a bit stressed. It becomes problematic, however, when the mental or emotional pressure adversely impacts upon an individual's ability to function healthily; in other words an individual may feel unable to cope. People have different stress levels and different ways of coping; it is therefore important for mental health nurses to recognise when they are

stressed and whether stress is having a negative impact upon their ability to cope. Prolonged stress manifests different ways, including:

- sleep problems;
- loss of appetite;
- difficulty concentrating;
- constantly feeling anxious;
- feeing irritable and/or angry;
- having repeating thoughts;
- worrying;
- avoiding certain situations and/or people;
- an increased use of alcohol;
- headaches;
- muscle tension.

Prolonged stress can lead to the individual experiencing emotional exhaustion and, in some cases, leading to a number of mental disorders. To manage stress consider the following activities:

- engage in physical activity;
- engage in something that makes you laugh;
- learn relaxation and/or deep breathing techniques;
- take control of the situation;
- seek support and talk;
- try to find a solution to the problem;
- eat a healthily diet;
- drink plenty of water;
- be mindful.

Values-based practice

Background

All nurses are required to practice ethically, which includes being able to reason ethically. The added dimension for mental health nurses is that they have to also take into account the value-laden nature of mental health practice.

The mental health nurse must know how to act ethically and they must also be able to justify their actions. The need to act ethically is also contextualised by the controlling element of mental health nursing practice whereby the mental health nurse might have the power to restrict a service user's freedoms in some cases. Where there is the power to restrict freedoms there is potential for ethical conflict; for example, a mental health nurse might justify this power on the basis that they are keeping the service user safe, whereas the service user might see this power in a more negative light, as an abuse of power. Where this conflict arises and different values are at play within the therapeutic relationship the conflict needs to be managed in way that is collaborative and recovery focused.

Professional skills

Mental health nurses should:

- be able to understand the importance of values and beliefs and how they impact upon the communication process;
- work within recognised professional, ethical and legal frameworks;
- ensure that decisions about care are shared and in a way that values a service user's experiences;
- recognise and address ethical and legal challenges that arise within the therapeutic relationship.

Ethical theory

In general, ethical theories that influence mental health nursing practice are normative, focusing on what actions are right, what ought to be done, which motives are good, and which characteristics are virtuous; for example:

- consequentialism (also known as utilitarianism) is outcome focused; for the mental health nurse to be ethical their actions need to produce the greatest balance of good over bad;
- deontology (also known as Kantianism) is concerned with duty; without exception the ethical mental health nurse must always do their ethical/professional duty;
- virtue ethics are based on the character of a person; a virtuous mental health nurse will acquire and utilise virtuous traits such as honesty, trustworthiness, cooperativeness and humility;
- principlism is using principles in ethical decision-making, such as do no harm (non-maleficence), act to benefit others (beneficence), respect a person's autonomy and treat people fairly (justice).

Code of conduct

The Nursing & Midwifery Council in the UK requires mental health nurses to follow a professional code of conduct, which is based on four main ethical statements and twenty-five sub-statements (NMC 2015):

- prioritise people;
  - treat people as individuals and uphold their dignity;
  - listen to people and respond to their preferences and concerns;
  - act in the best interests of people at all times;
  - respect people's right to privacy and confidentiality;
- practise effectively;
  - always practise in line with the best available evidence;
  - communicate clearly;
  - work cooperatively;
  - share your skills, knowledge and experience for the benefit of people receiving care and your colleagues;

  - keep clear and accurate records relevant to your practice;
  - be accountable for your decisions to delegate tasks and duties to other people;
  - have in place an indemnity arrangement which provides appropriate cover for any practice you take on as a nurse or midwife in the united kingdom;
- preserve safety;
  - recognise and work within the limits of your competence;
  - be open and candid with all service users about all aspects of care and treatment, including when any mistakes or harm have taken place;
  - always offer help if an emergency arises in your practice setting or anywhere else;
  - act without delay if you believe that there is a risk to patient safety or public protection;
  - raise concerns immediately if you believe a person is vulnerable or at risk and needs extra support and protection;
  - advise on, prescribe, supply, dispense or administer medicines within the limits of your training and competence, the law, our guidance and other relevant policies, guidance and regulations;
  - be aware of, and reduce as far as possible, any potential for harm associated with your practice;
- promote professionalism and trust;
  - uphold the reputation of your profession at all times;
  - uphold your position as a registered nurse or midwife;
  - fulfil all registration requirements;
  - cooperate with all investigations and audits;
  - respond to any complaints made against you professionally;
  - provide leadership to make sure people's well-being is protected and to improve their experiences of the healthcare system.

Ethical reasoning

Ethical theories and the NMC code of conduct should underpin the mental health nurse's ethical reasoning, and using an ethical framework can further assist this process:

1. Recognise the ethical issue/s;
2. Gather the facts and values;
3. Consider the rules;
4. Look at any underpinning moral theories;
5. Consider all options;
6. Make a decision and test it;
7. Act and reflect on the outcome.

Values-based practice

When gathering facts as part of the ethical reasoning process the mental health nurse also needs to gather values. Values-based practice is a process that focuses on dealing with conflicting values rather than outcomes. This process requires the mental health nurse to work with values in a way that resolves ethical conflict and moves the therapeutic relationship forward:

- consider the service user's perspective;
- balance the rules against this perspective;
- preserve the person-centred element of this perspective;
- represent this perspective fully in the decision-making process.