ACMHN Response to Consultation questions:

# Registered Nurse Accreditation Standards Framework – moving to five standards

Thank you for providing the Australian College of Mental Health Nurses (ACMHN) with the opportunity to provide feedback in response to *Consultation Paper 2: Review of the Registered Nurse Accreditation Standards Framework*.

The ACMHN has provided feedback on the following:

- The extent to which the draft accreditation standards cover the required knowledge, skills and attitudes to ensure that the new graduate meets the Registered Nurse Standards for Practice (Nursing and Midwifery Board of Australia, 2016
- Additional criteria that should be included
- The structure and/or content of the draft standards
- The extent to which the Draft Accreditation Standards address the use of simulated learning
- Whether any additional criteria should be included in the Accreditation Standards
- How the Accreditation Standards can support the use of health informatics and health technology
- Whether the draft standards capture the learning outcomes required to ensure quality professional learning experiences in entry-to-practice nursing programs
- Other issues that should be considered – scope of practice

We are happy to be contacted should there be any further enquiries.

Yours sincerely

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# ACMHN Feedback

### *Question 1*

**Do the draft accreditation standards cover the required knowledge, skills and attitudes to ensure that the new graduate meets the Registered Nurse Standards for Practice (Nursing and Midwifery Board of Australia, 2016)? Please provide an explanation for your answer.**

With one in four people experiencing a mental illness at some point in their lives, nurses in all healthcare settings are frequently presented with people with mental health care needs in the course of their everyday work. Furthermore, according to the World Economic Forum report, *The Global Economic Burden of Non-communicable Diseases* (2011), mental health will account for the greatest lost economic output of all non-communicable diseases by 2030. The World Economic Forum estimates that the direct and indirect costs of mental illness amount to 4 per cent of GDP, more than that of cancer, diabetes and chronic respiratory disease combined.

Despite mental health fast becoming the leading burden of disease in Australia, many nursing students only receive a unit or a couple of lectures on mental health, with little or no relevant mental health clinical practice experience over the course of their three year undergraduate nursing course (Happell et al, 2015). This pattern across Australian undergraduate nursing programs has been well documented (Happell et al, 2015; Happell & Gaskin, 2013; Wynaden, 2012; Moxham, McCann, Usher, Farrell, & Crookes, 2011; Birks, Al-Motlaq, & Mills, 2010; Happell, 2010; McCann, Moxham, Usher, Crookes, & Farrell, 2009; Warelow & Edward, 2009;), yet to date, an effective solution has not been implemented.

Furthermore, recommendations calling for mental health to be given greater priority in Australian tertiary nursing education programs date back to as early as 1993 with the Burdekin Report and follow through to the 2008 reports: '*Mental Health Workforce: Supply of Mental Health Nurses*' and '*Final Report : Mental Health in pre-registration nursing courses-Supply of Mental Health Nurse Education Taskforce'*; as well as more recently in the National Mental Health Commission Report: '*The National Review of Mental Health Programmes and Services' (2014).*

In fact the ACMHN has recently become aware that some tertiary institutions are continuing to substantially reduce their existing coverage of mental health content, even though the existing coverage is already significantly misaligned with the current burden and prevalence of disease attributable to mental illness. The College is also frequently receiving reports that where mental health content is being taught, it is not uncommon for it to be delivered by nursing academics who themselves are not qualified or experienced mental health clinicians, therefore raising significant questions about the quality of the learning experience. The ACMHN has recently been informed of a situation in which the mental health theoretical content is delivered by a midwife with no specific qualifications, training or experience in mental health (this has specific implications for Standard 3.11).

This issue of teaching quality is significant and evident across a range of areas. It has direct implications for Standards 2.2 and 3.3, as a high quality teaching and learning experience and competence of new graduates in mental health is not being achieved where it is being taught by someone whose own knowledge, qualifications and experience in mental health are not so far removed from that of the students they are teaching.

The College also hears from nurses who have not worked in mental health saying that they feel ill-equipped and lack the confidence to respond to co-occurring mental health needs of their patients who are seeking treatment for other (physical) health concerns. If this is indeed reflective of the feelings of nurses who are not working in mental health settings, the potential ramifications for the nursing workforce that actually becomes employed in mental health settings – and the safety of the public – cannot be understated.

Incorporating mental health as a discrete and required topic throughout the Standards also provides an opportunity to address the issue of diagnostic overshadowing by better equipping the nursing workforce with appropriate knowledge, skills and experience in mental health. Diagnostic overshadowing has been identified as a significant issue for people experiencing mental illness, in which they are more likely to receive sub-standard health care, or miss out on treatment entirely for what are significant and legitimate physical health concerns, because their physical symptoms are attributed to their mental illness. This has been identified as factor contributing to the 20 year life expectancy gap between people with serious mental illness and the general population. Evidence suggests this type of diagnostic overshadowing can be in part addressed by addressing the prevailing mental health stigma and lack of knowledge, training and experience in mental health among the health workforce (*Equally Well*, *Physical health and Mental Illness*; Roberts, R., 2017).

Nursing graduates are entering mental health settings having had very minimal exposure to mental health content and for many, having that very limited content delivered by academics who themselves have had little or no exposure to mental health content or relevant clinical experience. One way in which the potential consequences for public safety and care quality are evident is through the extensive reviews and research into the use of seclusion and restraint practices in mental health settings. Various inquiries and research projects have revealed a significant correlation between the level of qualifications, training and skills of the nursing workforce and the incidence of seclusion and restraint use (ACMHN, 2017; NSW Ministry of Health, 2017; Melbourne Social Equity Institute, 2014).

Nurses in general are geographically well dispersed, creating enormous potential to increase access to mental health services across Australia, including in rural and remote locations. However, this is dependent on whether the nursing workforce are provided with the knowledge and skills to undertake mental health stepped-care responses appropriate to their scope of practice. Given the growing need in the community, effectively harnessing the nursing workforce to better respond to mental health needs across all healthcare settings represents an opportunity for improving the lives and health outcomes for Australians experiencing mental illness.

Strengthening the requirements in relation to mental health in the Nursing accreditation standards also creates an opportunity for the undergraduate nursing curriculum to accurately reflect the now well documented intricate relationship between mental and physical health. This is crucial for improving the overall health and wellbeing of the community. In order to achieve this, nurses in all healthcare settings must be equipped with the knowledge, skills and attitudes to identify and respond to both the impact of mental health on physical health outcomes; and the strong, bi-directional correlation between physical health and mental health, for the people in their care.

Clinical placements in mental health are also an area which the Standards should seek to address. Quality clinical placements in mental health (Happell and Gaskin, 2013) and clinical mental health placements that veer from the traditional 'acute' mental health setting (Patterson et al, 2017) have been associated with nurses' increased clinical confidence in mental health. Furthermore, Patterson et al (2017) concluded that a unique mental health placement, such as recovery camp, may positively affect undergraduate nurses' clinical confidence in the areas of communication with people experiencing mental illness, knowledge of psychotropic medications and mental health education and promotion. Such outcomes have important implications for all nurses, regardless of where they become employed, when they graduate, and more importantly, for the health and safety of the community.

Research has revealed that nursing students are commonly overseen during clinical placements in mental health settings by clinical coordinators and supervisors who are not qualified or experienced mental health clinicians (Happell and Gaskin, 2013). Furthermore, another issue that has recently come to the attention of the ACMHN is that students are being allocated 'mental health' clinical placements which are in fact more traditional aged care placements and do not reflect a specific focus on mental health, nor does it provide the student with supervision from a mental health nurse.

Despite the wide range of potential benefits and implications for the quality of nursing practice, clinical placement quality in Australia in mental health is highly variable. This substantial variability in placement quality has direct implications for the safety of the public, Standard 1.6 *('Students are supervised and assessed by appropriately qualified and experienced registered nurses during professional experience placements"*) and Standard 2.2 ("*The governance structure for the provider and the school conducting the program ensure academic oversight of the program and promotes high-quality teaching and learning experience for students and the competence of new graduates"*).

Additionally, the ACMHN has been made aware of nurses often completing their clinical placement prior to having completed any relevant theoretical learning at university to support that placement. The potential risks arising from this – for both public safety and the quality of the placement for the student as a worthwhile learning opportunity – are further exacerbated by the frequency in which students on mental health placements are often not supervised by a nurse with experience and sound working knowledge/training in mental health.

There is a need for the Standards to more explicitly reference mental health as a discrete topic/priority area and a required disciplinary learning outcome (as per Standard 3.5). It is not sufficient for mental health to be referenced in Standard 3.3 as needing to be "integrated throughout the program', particularly given:

- Evidence and reports of significant gaps in coverage and mental health needs being overlooked and not treated as of equal importance to physical health needs.
- Evidence that the comprehensive nursing education program offered in Australia has specific adverse impacts on the nursing care in relation to mental health, as well as recruitment of nurses into mental health settings (Hemingway et al, 2016; Edward et al, 2015).
- Reports from nursing graduates themselves saying they feel underprepared and ill-equipped to respond to the growing mental health needs of the community.
- Reports of nursing schools further reducing the mental health content in their undergraduate nursing programs and categorising traditional aged care placements as "mental health" placements.
- Prevailing mental health stigma (including professional stigma – from both undergraduate nursing students and also nursing academics).

It is also worth noting that greater exposure to both theoretical content and increased length and quality of clinical placements has been associated with nurses having reduced stigmatizing attitudes and being more open to considering mental health as an important part of their practice (Happell and Gaskin, 2013).

**ACMHN Recommendation:** Standard 1: Safety of the Public – The ACMHN recommends amending Standard 1.3 to "Students are adequately prepared before providing care *to respond to both physical and mental health needs* of care recipients as part of the program."

**ACMHN Recommendation:** Standard 1: Safety of the Public – 1.6 - The ACMHN recommends this be more explicit than the requirement for a registered nurse when it comes to professional experience placements in mental health. The quality of the learning experience is being compromised – with direct implications for the safety of the public – as a result of students being supervised by a nurse working in a mental health setting who themselves has had little or no experience and training in mental health. The longer term solution of course is that the nursing workforce in mental health settings will be ultimately be equipped with the appropriate knowledge and skills in mental health to effectively supervise nursing students during professional placements in mental health.

**ACMHN Recommendation:** Standard 2: Governance – The ACMHN recommends also explicitly referencing mental health under Standard 2.5. For example – "There is relevant input to the design and management of the program from external representatives of the nursing profession including Aboriginal and Torres Strait Islander peoples, *mental health clinical academics* and other relevant stakeholders."

**ACMHN Recommendation:** Standard 2: Governance – The ACMHN recommends incorporating responding to emerging health priorities under Standard 2.6. For example – **"**Mechanisms exist for responding within the curriculum to contemporary developments in health professional education in a timely and effective manner*, with particular consideration given to contextual factors arising from existing and emerging health priorities*."

**ACMHN Recommendation:** Standard 3: program of Study – The ACMHN recommends that mental health be identified in Standards 3.3 and 3.5 as a discrete topic/priority area and required disciplinary learning outcome of the undergraduate nursing program (as per Standard 3.5).

### *Question 2:* Are there any additional criteria that should be included?

As indicated in the recommendations above, there are some specific areas of the Accreditation Standards in which mental health should be included as an additional criteria. This is crucial to ensuring that all graduates, regardless of where they undertake their studies, enter healthcare settings with the necessary knowledge, skills and attitudes to identify and appropriately respond to both the mental and physical health needs of the people in their care. There is now indisputable evidence of the intricate relationship between mental health and physical health (*Physical health and mental wellbeing: evidence guide*, NSW Mental Health Commission, 2016). All nurses therefore have a responsibility for identifying and responding to mental distress or mental illness in order to achieve the best possible overall health and wellbeing outcomes for their patients.

Furthermore, a lack of exposure to mental health as an undergraduate has also been found to influence nurses' decisions not to pursue a career in mental health (Happell et al, 2014).

### *Question 5:* Please provide any other feedback about the structure and/or content of the draft standards.

In addition to the above recommendations, the ACMHN also recommends an amendment to Standard 2.2 to align the Standards with what is a widely accepted standard across the broader health sector:

**ACMHN Recommendation:** Standard 2: Governance – The ACMHN recommends amending Standard 2.2 to also explicitly reference the input of (both mental and physical) health consumers and carers.

### *Question 7:* Simulated learning
### Should the proposed definition of simulation be adopted for the RN Accreditation Standards?

The ACMHN supports the current position regarding the minimum practice hours (800) remaining exclusive of simulated learning. It is important to reserve this decision until there is an established evidence base around the effectiveness of simulated learning relative to traditional clinical experience.

The ACMHN also accepts the proposed definition of simulation but to ensure it is not left open to subjective interpretation, recommends adding the additional clarification supplied in the glossary of the Draft Accreditation Standards, which provides a range of clear, tangible examples of simulation and briefly outlines what simulation aims to achieve in the clinical learning environment:

"*Simulation is a technique, not a technology, to replace or amplify real experiences with guided experiences that evoke or replicate substantial aspects of the real world in a fully interactive manner. Simulated learning involves activities using patient simulators, including devices, trained persons, lifelike virtual environments, and role-playing. These experiences strengthen, mimic or replace real-life clinical situations. Simulated learning aims to enable students to reason through a clinical problem and make decisions, without compromising patient wellbeing*. "

### *Question 8:* Health informatics and health technology
### How can the accreditation standards better support the inclusion of health informatics and digital health technologies in entry-to-practice nursing programs?

In the context of supporting the inclusion of health informatics and digital health technologies, it is important that the standards seek to ensure that all nurses are educated about:

- Implications for privacy and sharing and storing of sensitive information, which may differ depending on the particular platform/technology, how it is being used and by whom.
- Scope and appropriate use of technology in the clinical setting and how this may differ depending on individual clinical indictors/presentations. For example, someone with altered mental/cognitive state who is in distress may not be able to accurately complete a short assessment questionnaire on a tablet device, while in other cases the use of the tablet for a person with impaired mental/cognitive state may be very effective and assistive.
- Awareness of potential future implications of particular types of detailed mental health information being entered into a person's ehealth record for the individual receiving care, such as in relation to their eligibility for health or other personal insurance, or fitness for work (e.g. for defence and emergency personnel etc) – particularly where the information contained in the ehealth record relates to their mental health. It is important that the nursing workforce – together with the broader health workforce – are aware of their role and is equipped with the knowledge and skills to assist with informing the public about how their health information may be used and stored, by whom etc.

### Question 9: Quality professional experience

### Do the draft standards capture the learning outcomes required to ensure quality professional learning experiences in entry-to-practice nursing programs?

It is the view of the ACMHN that the Standards in their current form are significantly more focused on learning inputs rather than being explicitly linked to the subsequent learning outcomes for nursing students. E.g. Recommendation 2.6: – Rather than ***"****Mechanisms exist for responding within the curriculum to contemporary developments in health professional education in a timely and effective manner."*

A more outcomes focused approach could be to amend this to say something such as: *"The student learning experience is supported by a curriculum that contains mechanisms for responding to contemporary developments in health professional education in a timely and effective manner".*

### Question 10: Are there any other issues that should be considered?

Scope of practice is increasingly becoming a significant issue with direct implications for quality and safety of healthcare and nursing practice. Increasing pressure on services to "do more with less" as a result of finite budget allocations and despite the growing demand for care is fuelling a growing reliance on the engagement of nursing students, enrolled nurses and assistants in nursing to manage resource limitations. It is therefore important that the Accreditation Standards acknowledge this tension and seek to clearly articulate adherence to appropriate scope of practice and supervision of nursing students on clinical placement.

### Conclusion

As the largest clinical health workforce in Australia, it is imperative that the Registered Nurse Accreditation Standards clearly and deliberately communicate requirements relating to the coverage of mental health to ensure nurses are equipped with the appropriate knowledge, skills and clinical experience to respond to what will soon represent the largest burden of disease in Australia. Specifically, this should include incorporating mental health into the Accreditation Standards as a required disciplinary learning outcome; specifying that registered nurses with training and experience in mental health nursing are delivering theoretical content and supervising students on mental health placements and requiring that clinical placements are directly relevant to the learning outcomes the placement aims to achieve.

Thank you again for the opportunity to provide feedback. We are happy to be contacted if you require further information.

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