DEVELOPMENT OF A UNIT RESOURCE MANUAL

FOR NEWLY HIRED AND CASUAL NURSES ON J4D

By © Andrea C. Wright

A report submitted to the School of Graduate Studies in partial fulfilment of the

requirements for the degree of

Master of Nursing

Faculty of Nursing

Memorial University of Newfoundland

January 2021

St. John’s, Newfoundland and Labrador

Abstract

Background: In today's healthcare setting, it is commonplace for nurses to be displaced to other units as a means to relieve nursing staffing shortages (Bitanya, 2020). Within the Mental Health and Addictions Program (MHAP) at Eastern Health, the casual nurses float to a variety of sites within the program. Although the majority of policies are the same throughout the MHAP, various units have distinct ways of fulfilling daily routines and procedures. This is particularly true for J4D, which is the only provincial mental health unit for children and adolescents with mental health concerns. The orientation period for casual nurses working on the adolescent unit is minimal. They receive a total of two (12 hour) shifts. The low number of orientation shifts coupled with the loss of the nurse educator has created a disconnect between what casual nurses need to know in order to function effectively and what they actually receive during the orientation period. **Purpose:** The purpose of this practicum project was to develop a unit resource manual containing pertinent and unit specific information for casual and newly hired nurses that work on J4D. **Methods:** A literature review was conducted that identified several key learning needs for nurses new to mental health. Findings from the literature review revealed that nurses in a variety of specialty areas, including mental health, need a comprehensive orientation period. Consultations were conducted to determine explicitly what information and material must be included in the resource manual. Casual nurses working in the MHAP, senior nurses employed on J4D, the patient care facilitator and manager were consulted through the use of informal interviews. **Results:** A resource manual for J4D was developed and includes topics such as general unit functioning procedures, information on patients with eating disorders and their specific protocols, and unique practices specific to the unit. A crossword puzzle was created to review and check the casual nurses' knowledge base following their use of the resource. **Conclusion:** The resource manual is designed to be used as a reference guide to familiarize casual nurses working within the MHAP with the day-to-day workings, routines and practices on the J4D unit. Having this resource manual available on the unit will provide casual nurses with a quick reference designed to ultimately improve their ability to function effectively on the unit and provide optimal patient care.

Key words: casual nurses, mental health nurse or psychiatric nursing, nurse floating, newly hired nurses, orientation or in-service training, unit resource manual.

Acknowledgements

First, I would like to say a special thank you to my practicum supervisor, Paula Kelly, of the Faculty of Nursing at Memorial University of Newfoundland. Your unwavering support, professional guidance, and constructive feedback throughout this project has made this a very positive and rewarding experience.

I would also like to thank my parents, Ellen and Kevin, for always supporting me and encouraging me to pursue higher education. You are truly the best parents and inspire me to be the best mom I can be to my darling son, Jayden. I hope that someday he will also come to realize the value and importance of continuing education.

Last but not least, thank you to my fiancé, Ricky. You never stopped believing in me and motivated me to pursue this degree. I truly could not have done this without you and your extra support throughout the past few years.

Table of Contents

Introduction

The Janeway is the sole paediatric hospital within the province of Newfoundland and Labrador. It is located in St. John's and provides tertiary care to children throughout the province ranging from newborn to adolescents up to the age of 18 years. The child and adolescent psychiatric unit at the Janeway (J4D) falls under the umbrella of the Mental Health and Addictions Program (MHAP) within Eastern Health. This program also encompasses adult psychiatric facilities including: The Waterford Hospital, The Health Science Psychiatry unit, as well as 4SW, which is located within the newly opened St. John's long-term care facility.

There were 34 casual nurses within the MHAP during the initiation of this practicum project in the winter semester 2020. Although many of the policies for the program are the same, each unit has a distinct and unique way of carrying out routines and procedures. This is particularly true for J4D, which is the only provincial mental health unit designated for a child and adolescent population. A unique feature of the program is that both the Health Sciences adult psychiatric unit and J4D are the only two units that admit patients with eating disorders. However, the protocol for such patients differs significantly amongst the two units. For example, patients with eating disorders on J4D follow a specific eating disorder protocol whereas patients on the adult Health Sciences psychiatric unit follow a significantly different treatment plan. The casual nurses find it difficult to remember the differences in the protocols for both units. Furthermore, a specific policy aimed at the care of children and adolescents with eating disorders does not currently exist. J4D does have a reference binder for the care of patients with eating disorders, however, it is at least 10 years old and needs to be updated.

Additionally, the length of orientation for casual nurses that work on J4D is problematic. While the total length of orientation to units within the MHAP is nine weeks in total, only two

shifts are designated for orientation to J4D. During those two days, the casual nurse on orientation is co-signed to a nurse permanent to J4D. Depending on the acuity of the unit, the casual nurse on orientation may obtain experience in caring for a variety of patients, including those diagnosed with an eating disorder, substance-induced psychosis, or adjustment disorders. However, there are times during the two-day orientation in which opportunities to care for such patients does not occur due to a low unit census. Further, casual nurses being comfortable with the in-charge role is also precarious. This is partly due to the fact that the casual nurses working in the Mental Health and Addictions program float to at least ten units, in which they may be assigned to J4D one day and then not work there again for several months. Regrettably, there have been instances on J4D when only casual nurses are working on the unit, having to take the in the charge role. Some of the casual nurses have voiced they are uncomfortable with this, as they are not familiar enough with the unit due to lack of casual shifts on the unit. Finally, when the clinical nurse educator for J4D retired a couple of years ago, her full-time position was not replaced. One of the roles central to this position was to orientate nurses new to J4D, including casuals. The absence of a clinical nurse educator specific to J4D has left a significant void in the orientation process on the unit.

Based on the key issues outlined above, in consultation with the program manager for J4D, it was felt that a resource manual for newly hired nurses and casual nurses for J4D would be highly beneficial. The resource manual for J4D will provide the casual and newly hired nurses with essential information they require when working on the unit. In doing so, having this information readily available and presented in an organized manner will provide casual nurses with the vital day-to-day information related to unit descriptions and functioning along with explanations as to how to accomplish specific roles and responsibilities.

Objectives

The main goal of the practicum project was to develop a unit resource manual containing relevant unit information for casual nurses and newly hired nurses working on J4D. The purpose of the resource manual is to assist casual and newly hired nurses to become more knowledgeable with respect to the day-to-day functioning of the unit. The learning objectives for the practicum include:

1. Assess and identify the learning needs of casual and newly hired nurses working on J4D as they relate to the day-to-day functioning of the unit. More specifically, provide information which will assist casual and newly hired nurses to understand and be familiar with various roles and responsibilities as they relate to the unit itself and the care of patients.

2. Develop a resource manual that aides in the orientation of casual and newly hired nurses who work on the Child and Adolescent Psychiatric Inpatient Unit at the Janeway Hospital.

3. Demonstrate advanced nursing practice competencies via research, leadership, and collaborative activities.

Overview of Methods

An integrative literature review and consultations were conducted to attain the objectives of this practicum project. Databases such as Cumulated Index to Nursing and Allied Health Literature (CINAHL), PubMed, Psychological Information (PsychInfo) and Google Scholar were utilized to conduct the literature review. Key search phrases include: “mental health nurse”, “psychiatric nurse” and “learning needs”, “educational needs” and “new nurse”, “new nursing graduate” and “transition” and “orientation”. Search parameters were set to encompass only articles that were written in English. To ensure more current literature was included, articles that

were published prior to 2005 were not used in the review. The Public Health Agency of Canada (PHAC) Critical Appraisal Toolkit (PHAC, 2014) was utilized to critique quantitative research articles. Qualitative articles were evaluated using the Joanna Briggs Critical Appraisal Checklist Questionnaire for Qualitative Research (2017). Consultations were held with several newly hired casual nurses for the MHAP, four senior nurses on J4D, as well as the patient care facilitator and unit manager. A telephone interview was also conducted with the clinical leader of development for the Garron Center, which is the psychiatric unit for children and adolescents at the Isaak Walton Killam (IWK) Hospital in Halifax, Nova Scotia. This provided valuable insight into the orientation process for newly hired and casual nurses to a unit that serves a population similar to that of J4D.

Summary of the Literature Review

A principle aim in healthcare is to support individuals in reaching their full potential, which encompasses mental wellness. Patients in the mental health setting are cared for by numerous specialized staff, involving psychiatrists, psychologists, nurses, and social workers. Within Canada, nurses constitute the largest portion of health professionals (CIHI, 2016), and mental health nurses have a notable role on the interdisciplinary team. Mental health nurses have various accountabilities, including: forming therapeutic relationships with patients, administering prescribed medications, closely monitoring patient surveillance levels, and ensuring the safety of patients with suicidal thoughts or self-harming behaviors. Considering that mental health nursing is viewed as a specialty area, it necessitates a specialized body of knowledge in order to deliver safe and proficient care. Nurses who are new to this specialty, whether newly graduated or senior in their careers, are anticipated to experience distinct learning needs.

Undoubtedly, when a student nurse undergoes the transition to a practicing nurse, it can be a significantly unsettling period, particularly when moving from an academic to professional environment. (Dellasega et al., 2009; Manning & Neville, 2009; Walsh, 2015; Zinsmeister & Schafer, 2009). The phrase "transition shock" (Boychuk Duchscher & Windey, 2018, p.228) was coined to describe this experience. The College of Registered Nurses of Newfoundland and Labrador (CRNNL) recognizes "transition shock" (CRNNL, 2018) for new nurses, and advocates for a coordinated transition period which facilitates an uneventful shift from student to professional nurse. Considerable orientation, including preceptorship and mentorship programs, can help accomplish this. Additionally, the CRNNL (2018) recommends the use of other formal supports, such as the opportunity to connect with peers, mentors, and preceptors for new nurses during the first six to nine months after they are hired (CRNNL, 2018). Consequently, it is essential that organizations implement an extensive orientation and pertinent learning resources that focus on the precise educational needs of nurses as soon as they start their careers.

The literature review was conducted to identify the learning needs of nurses in the specialty of mental health, as well as explore the experiences of new nursing graduates transitioning to practice. From the review, it became apparent that there is a scarcity of research available on the learning needs of mental health nurses. This was apparent as only six of the research studies were published since 2006 and recognized some aspect of the educational requirements of this population. This gives credence to the fact that there is a need for more research to be conducted on this topic in the future. The distinct learning needs for nurses new to the specialty of mental health were recognized as further information on the psychopathology of mental illness (DeSchiffart Marcogliese & Vandyk, 2019; Inoue et al., 2017; Waite, 2006; Walsh, 2015), specific medications used in the treatment of mental illness (DeSchiffart

Marcogliese & Vandyk, 2019; Prince, 2011; Waite, 2006), and the particular care associated with patients who experience behaviors related to their mental illness, such as suicidal ideation and aggressive tendencies (DeSchiffart Marcogliese & Vandyk, 2019; Peternelj-Taylor Woods; Prince & Nelson, 2011; Walsh, 2015).

In contrast, the subject of transitioning from student nurse to practicing nurse has been studied quite extensively in the literature. There were ten research articles retrieved from the literature review on this topic, of which, the majority were quantitative descriptive studies, and are inherently weak in design. As a result, there is a need for future research on the topic that utilizes stronger design methods. The literature proposes that nurses working in diverse specialties, including mental health, require an adequate orientation (Murphy & Janisse, 2017; Peltokoski et al., 2015; Zinsmeister & Schafer, 2009), a devoted preceptor (Clipper & Cherry, 2015; Peltokoski et al., 2015; Laschinger et al., 2016; Williams et al., 2018; Zinsmeister & Schafer, 2009), support from various healthcare team members (Cleary et al., 2009; Laschinger et al., 2016; Leong & Crossman, 2016; Zinsmeister & Schafer,2009), and inclusion programs for new graduates (Cleary et al., 2009; Dyess & Parker, 2012).

From the literature review, it was apparent that undergraduate nursing programs do not provide adequate learning opportunities for students during their mental health rotation; and as a result, there is a dire need for extensive orientation that fulfils the learning requirements of nurses new to the specialty of mental health. The literature review also emphasized the importance of supporting the transition process of new graduate nurses by addressing their specific learning needs and providing guidance when needed.

Summary of Consultations

Consultations were crucial in the process of developing the resource manual, and necessary in order to examine the existing orientation process for nurses who are new to the specialty of mental health. The consultations also provided an awareness of key types of information the casual nurses new to the MHAP and senior nurses on J4D believe is essential in providing the best possible care to patients on J4D and their families. Consultations took place in early March 2020, prior to the Covid-19 pandemic, and were conducted via informal interviews. Several of the new casual nurses were interviewed in a quiet location at the Waterford Hospital, while four senior nurses from J4D, along with the patient care facilitator and manager were interviewed separately on the unit. On one occasion, one of the senior nurses on J4D was consulted via telephone. Before the informal interviews were conducted, the nursing staff and manager of J4D were aware of the objectives of the practicum project. All participants consented to participate in the project and felt the resource manual would be very beneficial to newly hired nurses on J4D, as well as casual nurses within the MHAP that occasionally work on the unit.

The casual nurses indicated that the classroom orientation for the MHAP is uninteresting and lengthy, at approximately two weeks in duration. Conversely, they spoke of how the unit orientation on certain units (including J4D), is only two shifts, and as a result, they do not receive sufficient time to learn unit specific functions. Similarly, senior nurses from J4D reached the consensus that perhaps the newly hired nurses for J4D and casual nurses should be provided with a longer orientation. They voiced concern that when the clinical educator for J4D retired a few years ago, her position was not replaced. In turn, this left a void in the orientation process for nurses new to the unit. The casual nurses also expressed concern that the classroom education does not provide information on the care of patients with eating disorders, which is a fairly

common diagnosis on J4D and the Health Sciences adult psychiatric unit. The resulting information indicated that a reference manual for newly hired and casual nurses that work on J4D would be an invaluable resource for this cohort.

The clinical leader of development at the Garron Center at the IWK revealed that all casual nurses hired for the unit receive the standard orientation, which is composed of eight 12-hour shifts. During the new hires' initial shift, they are paired with a clinical mentor, who is a senior nurse from the unit. Their morning usually consists of attending patient report and rounds, while the remainder of the day is spent reviewing patient charts, unit practices, policies, IWK intranet, and a hospital tour. The remaining seven shifts are spent with an assigned preceptor on the unit. During this time, patient assignments are deliberately made to ensure the new hires obtain a variety of experiences and opportunities for new learning.

Summary of the Resource

As a result of the literature review, consultations, and Knowles' Principles of Adult Learning Theory, a unit resource manual for newly hired and casual nurses that work on J4D was developed. The content of the resource manual includes topics that were identified by the newly hired casual nurses and senior nurses from J4D as being imperative to the day-to-day functioning of the unit. The first section of the resource manual provides an overview of unit guidelines specific to J4D, and includes topics such as: patient belonging and surveillance checks, patient bedtimes, J4D staffing ratio, staff break-times, inpatient and outpatient staff psychiatrists, and the J4D hospital school.

A description of the secure area versus the seclusion room on J4D was also included in the manual. This section provides guidance on what to do when a patient displays aggressive tendencies, as the newly hired and casual nurses felt that this was a grey area during their

orientation period. Although the majority of adult units within the MHAP have a designated seclusion room, J4D is the only unit that contains a secure area. While a program-wide policy exists for placing a patient in a seclusion room, there is no policy at present for the use of the secure area. Circumstances that may lead to a patient being placed in either the secure area or seclusion room were provided in the resource manual along with examples in which case each choice would be utilized.

Information related to therapies available to patients on J4D, such as art and music therapy, are also discussed in the manual. A description of both programs, including their potential benefits for patients and the referral process is included. Additionally, there are two separate sections in the manual that entail the admission and discharge process for patients on the unit.

The largest section of the resource manual is devoted to information on providing care for patients with eating disorders. Within the MHAP, J4D and the Health Sciences Psychiatric Unit are the only two units that admit patients with eating disorders. At the Health Sciences Psychiatric Unit, patients with eating disorders are admitted voluntarily and seek independent treatment for their illness. However, adolescents with eating disorders on J4D oftentimes present to the Janeway ER accompanied by their parents due to medical instability and inadequate nutritional intake. As previously mentioned, there is no education provided during classroom orientation on patients admitted with this diagnosis at present, and the two units differ significantly with respect to their treatment plans for this population. Undoubtedly, this can be a source of confusion for casual nurses within the MHAP that have to work on both units. Topics in this section include: adolescent medicine team staff, admittance criteria for patients with eating disorders, common tests and procedures ordered for patients with eating disorders on J4D,

time limits for meals and snacks, helpful tips for staff when providing meal support, distraction techniques that patients with eating disorders may find beneficial, and useful websites.

Knowles' Adult Learning Theory (1984) was incorporated during the development of the resource manual in order to support adult learning principles, which encompass self-directed learning. One of the central principles of Knowles' theory that was incorporated into the development of the unit resource manual is the notion that adult learners feel the need to actively participate in the development and planning phases of learning. This is essential in order to feel engaged during the experience (Knowles, 1984). Knowles' proposition towards attaining a rewarding educational experience was reached by collaborating with the newly hired casual nurses and senior nurses from J4D throughout the consultation process. Additionally, Knowles (1984) believed that adults must be active in the assessment phase of their learning. To integrate this principle into the project, a crossword puzzle was developed and is located at the end of the resource manual for J4D. The newly hired and casual nurses for J4D will be able to test the knowledge they learned from the resource manual by completing the crossword puzzle in an enjoyable and non-stressful manner. Examples of 'clues' included in the crossword puzzle are: "This type of vital sign is commonly ordered for patients with eating disorders and an ultrasound of the heart".

Advanced Nursing Practice Competencies

The Canadian Nurses Association (CNA) provides a description of primary competencies that serve as a reference point for advanced practice nurses in relation to their practice (CNA, 2019). As outlined by the CNA (2019), it is essential that advanced practice nurses are capable of developing and applying research so they can be adept in practice. The implementation of the

research and leadership competencies in the development of this unit resource manual for casual and newly hired nurses displays relevant utilization of these competencies.

Research

Research can be defined as "generating, synthesizing and using research evidence to advance nursing practice" (Canadian Nurses Association [CNA], 2019, p.23). According to the Canadian Nurses' Association (2019), conducting and incorporating research is essential to advanced nursing practice. In the practicum project, relevant research and literature were utilized to assist in the creation of the resource manual and provided supportive evidence for some of the modules in the manual. Conducting the extensive literature review provided credible literature, including quantitative and qualitative studies, as well as grey literature. These various types of literature assisted in the development of the resource manual that is evidence-based. It is hoped that the implementation of the resource manual will improve client care, as the casual and newly hired nurses will be more knowledgeable of the functioning of the unit as a result of the implementation of the manual.

Leadership

Advanced practice nurses are viewed as leaders in their respective areas of work, and viewed as advocates for diversity by implementing modern and efficient ways of practice, which ultimately has positive impacts on the care received. They also encourage professional growth, lifelong learning, and a multidiscipline approach in the workplace (Canadian Nurses Association, 2019). The resource manual will provide standardized information for J4D that provides specific directions as to functioning at the unit level and assist casual and newly hired nurses to

understand and be familiar with various roles and responsibilities as they relate to the unit itself and the care of patients.

Next Steps

The final draft of the resource manual for casual and newly hired nurses of J4D was completed in mid-December 2020. The goal is to place a print a copy of the resource at the main nursing station on J4D. By doing this, the goal is to increase the orientees' awareness of the manual and avail of it once they start working on the unit. Additionally, a copy of the reference manual will be e-mailed to the clinical nurse educators for the MHAP with the purpose of incorporating it into the reference manual. The clinical educators will be able to incorporate the reference manual for J4D into the orientation.

Plans for evaluation of the resource include conducting a survey between May-June 2021 aimed at the casual and newly hired nurses on J4D, and permanent nurses from the unit. The intent of the survey will be to address the resource and its functionality. Namely, sections of the resource users found helpful, impractical, and topics they believe should be modified, revised, or improved. The survey will also explore whether the users require additional topics, not currently included in the manual.

The clinical nurse educators for the MHAP will be contacted by the end of January 2021 and the key findings from the consultations held with the casual nurses will be shared. It is important to note that classroom education during orientation contains no information regarding the care of patients with eating disorders. This is significant, because it is a common diagnosis for patients admitted to J4D and the Health Sciences adult psychiatric unit. Once orientation is completed, the nurses do not feel adequately prepared to safely care for this

population. It is hoped that by sharing this important finding, eating disorders will be included in the education portion of orientation for the MHAP.

Conclusion

It is clear that nurses working in various specialty areas have distinct learning needs, and nurses working in mental health settings are no different. Furthermore, it is apparent new nursing graduates undergo a significant transition when leaving their student role to that of practicing nurse. A resource manual for casual and newly hired nurses on J4D was developed through the integrative literature review and key consultations with casual nurses from the MHAP and senior nurses from the unit. The resource manual for J4D will act as a quick reference guide for casual and newly hired nurses on the unit and provide information on specific day-to-day functions of the unit. As a result, it is hoped that the resource manual will assist the casual and newly hired nurses to provide safe, competent, and compassionate care for the patients of J4D, and their families. Additionally, it is optimistic to think that there will be changes made to the MHAP orientation for nurses as a result of invaluable feedback received from the casual nurses that participated in the consultation portion of this project.

References

Boychuk Duchscher, J., & Windey, M. (2018). Stages of transition and transition shock. *Journal for Nurses in Professional Development, 34*(4), 228-232.

Canadian Institute for Health Information. (2016). Regulated nurses. https://secure.cihi.ca/free_products/regulated-nurses-2016-report-en-web.pdf

Canadian Nurses Association. (2019). Advanced nursing practice: A national framework. Retrieved from https://cna-aiic.ca/-/media/cna/page-content/pdf-en/advanced-practice-nursing-framework

Cleary, M., Matheson, S., & Happell, B. (2009). Evaluation of a transition to practice program for mental health nursing. *Journal of Advanced Nursing, 65(4), 844-850.*

Clipper, B., & Cherry, B. (2015). From transition shock to competent practice: Developing preceptors to support new nurse transition. *Journal of Continuing Education in Nursing, 46*(10), 448-454.

College of Registered Nurses of Newfoundland and Labrador. (2018). Transition to practice for newly licensed RNs. https://www.arnnl.ca/sites/default/files/documents/PS_Transition_to_Practice_for_Newly_Licensed_RNs.pdf

Dellasega, C., Gabbay, R., Durdock, K., & Martinez-King, N. (2009). An exploratory study of the orientation needs of experienced nurses. *The Journal of Continuing Education in Nursing, 40*(7), 311-316.

DeSchiffart Marcogliese, E., & Vandyk, A. (2019). Mental health nurses' knowledge of entry-to-practice competencies in psychiatric care. *The Journal of Continuing Education in Nursing, 50*(7), 325-330.

Dyess, S., & Parker, C. G. (2012). Transition support for the newly licensed nurse: A programme that made a difference. *Journal of Nursing Management, 20(*5), 615-623.

Inoue, M., Del Fabbro, L., & Mitchell, M. (2017). Assessing the educational needs of mental health nurses working in an adolescent inpatient psychiatric ward in Japan. *Journal of Child & Adolescent Psychiatric Nursing, 30*(4), 181-185.

Joanna Briggs Institute. (2017). Critical Appraisal Checklist for Qualitative Research.

https://joannabriggs.org/sites/default/files/2019-05/JBI_Critical_Appraisal-Checklist_for_Qualitative_Research2017_0.pdf

Knowles, M. (1984). The modern practice of adult education: From Pedagogy to Androgogy. Chicago, IL: Associated Press, Follett Publishing Company. https://pdfs.semanticscholar.org/8948/296248bbf58415cbd21b36a3e4b37b9c08b1.pdf.

Laschinger, H. K. S., Cummings, G., Leiter, M., Wong, C., MacPhee, M., Ritchie, J., Wolff, A.,

Leong, Y. M. J., & Crossman, J. (2016). Tough love or bullying? New nurse transitional experiences. *Journal of Clinical Nursing, 25,* 1356-1366.

Manning, L., & Neville, S. (2009). Work-role transition: From staff nurse to clinical nurse educator. *Nursing Praxis in New Zealand, 25*(2), 41-53.

Murphy, L. J., & Janisse, L. (2017). Optimizing transition to practice through orientation: A quality improvement initiative. *Clinical Simulation in Nursing, 13,* 583-590.

Peltokoski, J., Vehviläinen-Julkunen, K., & Miettinen, M. (2015). Newly hired nurses' and physicians' perceptions of the comprehensive health care orientation process: A pilot study. *Journal of Nursing Management, 23*(5), 613-622.

Peternelj-Taylor, C., & Woods, P. (2019). Saskatchewan provincial correctional nurses: Roles, responsibilities, and learning needs. *Journal of Correctional Health Care, 25*(2), 177-190.

Prince, A., & Nelson, K. (2011). Educational needs of practice nurses in mental health. *Journal of Primary Health Care, 3*(2), 142-149.

Public Health Agency of Canada. (2014). Infection prevention and control guidelines: critical appraisal toolkit. http://www.phac-aspc.gc.ca

Waite, R. (2006). The psychiatric educational experiences of advanced beginner RNs. *Nurse Education Today, 26,* 131-138.

Walsh, A. (2015). Are new mental health nurses prepared for practice? *Mental Health Review Journal, 20*(2), 119-130.

Williams, F. S., Scott, E. S., Tyndall, D. E., & Swanson, M. (2018). New nurse graduate residency mentoring: A retrospective cross-sectional research study. *Nursing Economics,*

36(3), 121-127.

Zinsmeister, L. B., & Schafer, D. M. (2009). The exploration of the lived experience of the graduate nurse making the transition to registered nurse during the first year of practice. *Journal for Nurses in Staff Development*, *25*(1), 28-34.

Appendix A: An Integrative Literature Review

The Development of a Unit Resource Manual that Assists in the Orientation of Newly Hired Nurses and Casual Nurses to the Child and Adolescent Psychiatric Inpatient Unit at the Janeway Hospital

Andrea C. Wright

Master of Nursing

Faculty of Nursing

Memorial University of Newfoundland

St. John's, Newfoundland and Labrador

The World Health Organization (2018), states that mental wellness is characterized by an individual who is fully cognizant in recognizing their own potential, can handle the everyday pressures experienced in life, and are able to meaningfully contribute to society. According to Health Canada, one in three Canadians will be affected by mental illness throughout their lifetime (Government of Canada, 2019). Mental illness is known to cause changes in an individual's thought or mood processes - the results of which can severely impact a person's quality of life and day-to-day functioning (National Center for Biotechnology Information, 2020). There are many different types of mental illness, including: mood disorders, schizophrenia, anxiety disorders, personality disorders, eating disorders, gambling, and substance dependency (Government of Canada, 2019). It is important to note that mental illness knows no bounds, crosses all socioeconomic boundaries and affects people of all ages – including youth. It is estimated that 10 to 20% of Canadian youth will experience a mental illness (Canadian Institute for Health Information [CIHI], 2020). According to Children's Mental Health Ontario (2020), Canada is ranked third in the industrialized world for youth suicide rate. Based on this, the role of the mental health nurse in assisting youth achieve their full potential in mental wellness should not be underestimated.

One of the main goals in healthcare is to assist individuals in achieving their full potential, which includes mental wellness. Mental health patients are cared for by various specialized hospital staff, including psychiatrists, psychologists, nurses, and social workers. Nurses make up the highest number of health professionals in Canada (CIHI, 2016), and mental health nurses play a significant role on a treatment team. They have many responsibilities, such as: forming therapeutic relationships with patients, administering prescribed medications, closely monitoring patient surveillance levels, and ensuring the safety of patients with suicidal thoughts

or self-harming tendencies. Since mental health is a specialty area of nursing, it requires unique and specialized knowledge in order to provide safe and competent care. Nurses, both newly graduated and experienced, who are new to this area are likely to have unique learning needs.

The transition from student nurse to a licensed and practicing nurse is a considerably challenging time, especially when shifting from an academic to professional setting (Dellasega et al., 2009; Manning & Neville, 2009; Walsh, 2015; Zinsmeister & Schafer, 2009). Roles, responsibilities, relationships with interdisciplinary team members, and role performance differ considerably. The term "transition shock" (Boychuk Duchscher & Windey, 2018, p.228) describes this process. The College of Registered Nurses of Newfoundland and Labrador (CRNNL) acknowledges this "transition shock" (CRNNL, 2018) and, as a result, supports and suggests an organized transition period to allow for a smooth shift from the role of student to practicing nurse. This can be achieved through a substantial orientation, which includes preceptorship and mentorship programs. Furthermore, the CRNNL (2018) advocates for additional formal supports, such as the option to connect with peers, mentors, and preceptors for new nurses during the first six to nine months after they are hired (CRNNL, 2018). Therefore, it is imperative that agencies provide a comprehensive orientation program along with appropriate educational resources that address the specific knowledge needs of nurses as soon as they begin their employment. This is particularly vital for nurses hired into specialty areas, such as mental health programs.

This paper will provide a comprehensive integrative literature review, examining the challenges of transitioning from student nurse to practicing nurse, with special attention paid to the unique learning needs of new mental health nurses. This review will assist in the development of a resource manual for new casual nurses on the child and adolescent psychiatry

unit (J4D) at the Janeway Children's Hospital in St. John's, Newfoundland and Labrador. Knowles' Adult Learning Theory (1980) and Benner's Novice to Expert Theory (1982) are examined and are the two theoretical frameworks that will guide this practicum project.

Background

Located in St. John's, NL, The Janeway Children's Hospital is the only pediatric hospital in the province. It provides tertiary-level care to children from newborns to 18 years of age. J4D is the Child and Adolescent Psychiatric Unit at the hospital, which is part of the Mental Health and Addictions Program of Eastern Health. Other psychiatric facilities in the program provide psychiatric care to adults, including: the Health Sciences Psychiatry Unit, the Waterford Hospital, and the recently opened St. John's long-term care facility. Out of all hospitalizations at the Janeway in 2014-2015, 18.2% were due to mental health and addictions-related concerns (NLCHI, 2017). Youth requiring admission to the psychiatric unit are admitted to J4D for care. The unit has a total of eight inpatient beds, which are used mainly by adolescents with anxiety and depressive disorders, substance-induced psychosis, unspecified psychotic disorders, adjustment disorders, and eating disorders. From 2014-2015, there were a total of 80 admissions to J4D, with an average length of stay of 16.4 days (Newfoundland and Labrador Centre for Health Information [NLCHI], 2017).

Because J4D is such a specialized unit, it is imperative that all nurses working there are knowledgeable with respect to the various types of adolescent mental health conditions. Further, nurses must be skilled in the implementation and maintenance of specific treatment plans related to individual patient diagnoses. A number of changes have occurred which have significantly impacted the nursing staff working on this unit. Over the last five to ten years, a number of permanent nurses have retired from J4D and the Mental Health and Addictions Program as a

whole. As a result, a number of casual nurses were hired to fill the gaps. At present, there are 34 casual nurses within the Mental Health and Addictions Program, who are required to float between the ten different units within the program. It is not uncommon to find casual nurses working on the unit. Apart from J4D, all of the other units care for adults and older adults. The total length of orientation for the Mental Health and Addictions program is six weeks with only two days dedicated to J4D. The remaining time is devoted to adult in-patient orientation. It is important to note that if the patient census is low during the two days of adolescent orientation, casual nurses may not acquire the necessary experience required for youth who are admitted with mental health issues. Another change that has impacted J4D is that of the clinical educator. Since the nurse who held this position retired, the role has been phased out, leaving J4D without its own designated clinical educator. This is significant because the clinical educator was responsible for organizing and providing orientation to all nursing staff hired to work on the unit.

A unique feature of J4D and the Health Sciences Psychiatry Unit is that they are the only two inpatient units that admit individuals who have eating disorders. However, the treatment protocol for adolescents and adult patients is vastly different and both units have diverse ways of approaching care for these conditions. This can cause problems for casual nurses who work in both adult and adolescent areas. For example, patients with eating disorders are given different amounts of time to complete their meals and snacks on both units. It maybe easy for casual nurses to become confused by the time protocol allotted for patients on J4D and the adult Health Sciences Psychiatry Unit. In addition, there is no set policy on J4D relating to protocols on how to care for patients with eating disorders and how they eat. A binder related to the care of patients with eating disorders exists as a reference for nursing staff, but it needs to be updated, as it is at least ten years old.

The Canadian Nurses' Association ([CNA] CNA, 2020) has designated mental health nursing as a specialty area. The Canadian Standards for Psychiatric-Mental Health nursing are set by the Canadian Federation of the Mental Health Nurses' ([CFMHN] CFMHN, 2014). There are a total of seven standards relating to knowledge of care for individuals, families, communities and the healthcare system. Standard 3, in particular, accentuates the importance of the role of the Registered Nurse (RN) in forming therapeutic treatment plans for patients. It states that the RN "Administers and monitors therapeutic interventions" (CFMHN, 2014, p.9). One of the ways in which new RNs can attain this standard of practice would be through a sound orientation program, where they are able to attain a concrete knowledge base and gain experience in caring for this population.

Interestingly, in the provinces of British Columbia, Alberta, Saskatchewan, and Manitoba, there are Registered Psychiatric Nursing (RPN) programs for students interested exclusively in mental health nursing. Programs range from a diploma in Psychiatric Nursing to a Bachelor's Degree in Psychiatric Nursing. Similar in length to the Bachelor of Nursing (BN) Degree, The Bachelor of Psychiatric Nursing (BPN) degree is a four-year program (Registered Psychiatric Nurse Regulators of Canada, 2020). These programs are separate from generalized nursing school programs; students that graduate and successfully complete their examinations earn the designation of Registered Psychiatric Nurse ([RPN] Registered Psychiatric Nurse Regulators of Canada, 2014). Another difference is the licensure exam that students must write. Whereas BN students write the National Council Licensure Examination (NCLEX), RPNs write the Registered Psychiatric Nurses of Canada Examination ([RPNCE] Registered Psychiatric Nurse Regulators of Canada, 2014).

In contrast, Newfoundland and Labrador has no requirements for hiring in terms of specialized education for mental health nursing. In the Bachelor of Nursing program at Memorial University of Newfoundland (MUN), students obtain 36 theory hours in mental health, 24 hours of seminar, and 96 hours of clinical (MUN, 2020). The mental health clinical takes place on adult psychiatric units, and students do not receive any clinical time on the child/adolescent psychiatric unit. Therefore, students are not given the opportunity to experience caring for patients in this cohort. Whether the nurse is a new graduate or new to mental health nursing, they may have limited knowledge and it is important to determine their learning needs.

Nurses working in mental health here in NL can also complete a Mental Health Nurse Certification program offered by the Canadian Nurses' Association (CNA). Those who wish to become certified through the CNA study on their own time and write the certification exam at a time set by the CNA, usually offered twice per year (CNA, 2020). Once successful in passing the certification exam, nurses earn the title of Certified Practicing Mental Health Nurse (CPMHN). Although achieving the designation of CPMHN further expands a nurses' knowledge base in the specialty area, it does not necessarily secure a nursing position on a mental health unit. This is due to the fact that within the NL nursing system, seniority usually takes precedence over certification credentials. Therefore, it would not be uncommon for a nurse who has worked 20 years in areas other than mental health to be awarded a position on J4D versus a nurse who has worked exclusively in mental health and has the CPMHN designation.

After consultation with the program manager of J4D and appreciating the issues outlined above, it was decided that a resource manual addressing the learning needs of casual nurses was necessary. Therefore, the purpose of this practicum project is to develop a resource manual for J4D. Specifically, the manual will provide and assist casual nurses with the essential information

they need when caring for adolescent inpatients and outline the required roles, responsibilities, and other duties related to the specific day-to-day functioning of the unit.

Integrative Literature Review

Search Methods and Inclusion Criteria

A literature review was conducted by searching the online databases of the Cumulative Index of Nursing and Allied Health Literature (CINAHL), PubMed, Psychological Information (PsychInfo), and Google Scholar. Search phrases include: “mental health nurse”, “psychiatric nurse” and “learning needs”, “educational needs” and “new nurse”, “new nursing graduate” and “transition” and “orientation”. Search parameters were set to encompass only articles that were written in English. To ensure current literature was included, articles that were greater than ten years old were not included in the review.

A total of 16 articles met inclusion criteria and are included in the literature review. Quantitative research articles were critiqued utilizing criterion from the Public Health Agency of Canada (PHAC) Critical Appraisal Toolkit (PHAC, 2014). Qualitative articles were evaluated using the Joanna Briggs Critical Appraisal Checklist Questionnaire for Qualitative Research (2017). The majority of articles related to the learning needs of mental health nurses were qualitative. Most articles relating to the transition of new graduate nurses into practice were quantitative descriptive studies and mainly weak in design.

Specific Learning Needs of Mental Health Nurses

Specialty nursing practice adds to and builds upon the knowledge base of general nursing practice. It is aimed towards particular areas of nursing (Australian Nursing and Midwifery Federation, 2016). The CNA (2020) proposes that nursing specialties promote the amplitude of

specialized nursing knowledge and outline a wide array of specialty nursing areas such as critical care, neonatal, community health, and oncology. Mental health nursing is also one of the specialty areas which requires further graduate and focused education.

A total of six research studies met inclusion criteria related to the learning needs of mental health nurses (DeSchiffart Marcogliese & Vandyk, 2019; Inoue et al., 2017; Peternelj-Taylor & Woods, 2019; Prince & Nelson, 2011; Waite, 2006; Walsh, 2015). Key learning needs identified were: education specific to mental illness, psychiatric medications, and caring for patients with suicidal ideation and aggressive tendencies.

Education specific to mental illness. Mental health nurses from five of the six studies expressed a desire for further education related to specific mental illness (DeSchiffart Marcogliese & Vandyk, 2019; Inoue et al., 2017; Peternelj-Taylor & Woods, 2019; Prince & Nelson, 2011; Waite, 2006). Participants in studies by both Waite (2006) and Prince and Nelson (2011) voiced they would like more information on schizophrenia and bipolar disorder. In DeSchiffart Marcogliese and Vandyk's (2009) cross-sectional study, Registered Nurses (RNs) and Registered Practical Nurses (RPNs) indicated a desire to learn more about borderline personality disorder, postpartum depression and addictions.

Psychiatric Medications. While psychiatric medications are important in the treatment of certain mental health conditions, they can cause undesirable side effects and at times adverse effects (National Institute of Mental Health, 2020). Some notable adverse effects of certain psychiatric medications include lithium toxicity, serotonin syndrome and tardive dyskinesia (National Institute of Mental Health, 2020). It is important for nurses to be knowledgeable about the potential adverse effects of psychiatric medications, as they can be serious and, in rare instances' life threatening. Mental health nurses in three of the studies claimed they needed

further education related to psychiatric medications (DeSchiffart Marcogliese & Vandyk, 2019; Prince, 2011; Waite, 2006). Waite (2006) concluded that nurses must be aware of the indications and side-effects of psychiatric medications and their adverse effects. Participants in the study expressed that as students, they were not permitted to administer medications to patients and did not feel prepared for practice upon graduation. DeSchiffart Marcogliese and Vandyk (2019) found nurses preferred education related to newer psychiatric medications, including the adverse effects of specific atypical antipsychotics, monoamine oxidase inhibitors, and lithium. Prince (2011) conducted a mixed-methods study and found 27% of participants felt "little confidence" (p.145) in giving specific psychiatric medication advice to patients.

Caring for patients with suicidal ideation and aggressive tendencies. Suicide is a significant concern for Canadian youth and is the second leading cause of death for 10 to 19 year olds in Canada (Government of Canada, 2016). The Department of Health Canada (2016) notes that out of the 4,000 people that die by suicide every year, over 90% were living with a mental health concern. Many mental health nurses do not feel adequately prepared to care for patients with suicidal ideation (DeSchiffart Marcogliese & Vandyk, 2019; Peternelj-Taylor & Woods, 2019; Prince & Nelson, 2011). Prince and Nelson (2011) conducted a study that explored the learning needs of practice nurses in the mental health setting. They also examined the types of care the practice nurses deliver to patients living with mental illness. Researchers discovered 54% of nurses believed that caring for patients experiencing suicidal ideation was a priority learning need. Likewise, Peternelj-Taylor and Woods (2019) identified 94% of Registered Nurses (RNs) and Registered Practising Nurses (RPNs) felt that suicide assessment is very important to their professional practice; a potentially life-saving component for patients experiencing mental health concerns. Nurses believed they required more education on

conducting suicide assessments. DeSchiffart Marcogliese and Vandyk (2019) conducted a cross-sectional study that explored the mental health-related expertise and learning needs of RNs and RPNs working within inpatient psychiatry. It was revealed that the RNs and wanted to know more about caring for patients with suicidal ideation.

Violence in the workplace is a key concern in the healthcare setting, particularly amongst nurses (Heckemann et al., 2015; Spector et al., 2014). Mental health areas are not immune to such displays. Patients admitted to mental health areas occasionally present with violent outbursts that include a range of manifestations, such as verbal aggression and threats to physical violence, including bodily assault (Bock, 2011 and Schablon et al., 2018, as cited in Isaiah et al., 2019). Most often, these behaviours can be attributed to young age, involuntary admission, past incidents of self-destructive behaviours and history of substance use (Bowers et al., 2006, as cited in Binil et al., 2017). Regardless of the underlying cause, mental health nurses identified the management of patients demonstrating violent outbursts as an urgent learning need (DeSchiffart Marcogliese & Vandyk, 2019; Walsh, 2015).

Walsh (2015) conducted a phenomenological study examining how prepared students are for entering into mental health nursing practice, including mental health nursing students, mental health nurses and nurse lecturers. A key finding was the challenge of managing aggression demonstrated by mentally ill patients. In particular, student nurses felt unprepared to care for patients exhibiting aggressive behaviours. Nurse lecturers interviewed in the study stated this specific type of nursing care is challenging to teach in both classroom and clinical settings. Managing aggressive behaviours in the clinical setting is challenging for students, and nursing staff in the study voiced the fear of injury to the student nurses if they took part in the de-escalation interventions.

Transition of New Nurses into Practice

The transition of new nurses into practice is a topic that has been extensively explored throughout the literature (Cleary et al., 2009; Clipper & Cherry, 2015; Dinmohammadi et al., 2013; Dyess & Parker, 2012; Leong & Crossman, 2016; Murphy & Janisse, 2017; Peltokoski et al., 2015; Laschinger et al., 2016; Williams et al., 2018; Zinsmeister & Schafer, 2009). The literature identified numerous factors of importance for nurses transitioning into practice, such as the importance of promoting patient safety and clinical competency, decreasing job attrition, and increasing morale (Dyess & Parker, 2012; Murphy & Janisse, 2017; Williams et al., 2018). Key themes identified in the literature that influence the factors listed above include the following: the importance of an adequate orientation, the benefits of having a preceptor or mentor, the influence of interdisciplinary team members on the transition process, and the impact of transition programs.

Importance of adequate orientation. Zinsmeister and Schafer (2009) identified that the orientation process to clinical areas was instrumental in the smooth transition from graduate nurse to professional nurse. Newly graduated nurses were followed during their initial six to twelve months of being hired into the practice setting. Although the total length of orientation they received was not specified, participants remarked it was individualized and helped them learn the essential knowledge of what is expected of them in their clinical workplace. Peltokoski et al. (2015) conducted a cross-sectional study of newly hired nurses and physicians and found that the length of orientation impacted their satisfaction in their new professional roles. More than half (53%) of participants indicated an orientation period of less than four days, 24% had five to ten days, and 13% had greater than 25 days of orientation. Orientation longer in duration was strongly correlated with a thorough orientation process.

The value of having a comprehensive orientation was also supported in the mixed-methods study by Murphy and Janisse (2017). A total of 521 new nurses took part in a re-structured orientation program that involved the introduction of simulation and experiential learning. Results were compared to 749 nurses who participated in the original orientation program. Nurses expressed more positive feedback regarding the newly updated orientation. They appreciated the hands-on practice in a non-threatening atmosphere attained through the use of simulation. They felt the revised orientation program instilled them with greater self-confidence and as a result, believed they were more equipped for practice in the general clinical areas.

Transitioning from student role to professional role and the benefits of having a preceptor. Professional socialization is the latent manifestation of values, beliefs, commitments, and professional duties that are central to all professions (Dinmohammadi et al., 2013). With respect to nursing, professional socialization is an intricate and dynamic process that begins as a student and continues throughout one's nursing career. It is an important component of lifelong learning (Weis & Schank, 2002; Wolf, 2007; as cited in Dinmohammadi et al., 2013). Perhaps the most influential factor that was evident in the literature with respect to the successful transition of new nurses into practice was guidance from a preceptor (Clipper & Cherry, 2015; Peltokoski et al., 2015; Laschinger et al., 2016; Williams et al., 2018; Zinsmeister & Schafer, 2009). Nursing preceptors help with the orientation of new nursing graduates or nurses who are new to a clinical area to the professional work environment (Sanford & Hart Tipton, 2016). Part of the role of the nursing preceptor is to provide knowledge and experience to new nurses in a non-threatening atmosphere. They are instrumental in helping new nurses refine clinical skills and facilitating professional socialization (Dillon, Borda, & Goodin, 2012).

Clipper and Cherry (2015) conducted a mixed-methods study on two groups of nurses to provide details on the implementation and appraisal of the effects of a preceptor program on new nurses starting to practice. The first group consisted of 62 new nurses with preceptors who did not receive formalized preceptor training, while the second group was composed of 76 new nurses with preceptors who underwent a specialized preceptor training program. Survey question results indicated preceptors were instrumental in helping develop collegial work relationships and the promotion of a positive work environment, (p = 0.038) and helping to ease the transition from student nurse to independent practising nurse (p= 0.016). The group of nurses whose preceptors had formalized training had a higher retention rate following one year of employment (89.5%) versus (82.7%) for the group with untrained preceptors. Similarly, Zinsmeister and Schafer (2009) conducted a phenomenological study and found eight out of nine of the nurses interviewed detailed the benefit of having a preceptor during their transition period and claimed the preceptors were invaluable to the learning process during this time.

Peltokoski et al. (2015) explored the influence of a preceptor on newly hired employees. In particular, having a designated preceptor had a positive effect on the new employees' overall level of contentment in the workplace setting. Williams et al. (2018) conducted a cross-sectional study on 3,484 new nursing graduates to determine the impact that mentoring in a group setting versus an individualized atmosphere had on the transition to practice. The new graduates were divided into two different groups: nurses that were mentored individually and nurses that were mentored in a group setting. Findings revealed nurses who received individual mentoring rated the experience as being beneficial in the transition to work setting, helped with professional development and stress management. Additionally, nurses also had a lower turnover rate (leaving their place of work) if frequent contact with their mentor was available.

Laschinger et al. (2016) conducted a cohort study and sent 3743 surveys to newly graduated nurses across Canada at two points in time (Time 1 was from November 2012 to March 2013 and Time 2 was from May 2014 to July 2014). A total of 406 new nurse graduates responded to both of the surveys. Ninety percent of participants expressed having a preceptor when hired on various units of the hospital (medical-surgical; critical care; maternal-child; and mental health) was advantageous in easing them into their new role as professional nurses.

The support of other healthcare professionals during the transition process. The influence of interdisciplinary team members on nurses transitioning to the health care team was also significant (Laschinger et al., 2016; Leong & Crossman, 2016; Zinsmeister and Schafer, 2009). Laschinger et al. (2016) reported that new nurses experienced incivility from interdisciplinary staff, such as supervisors, co-workers, and physicians. In their first year of practice, 41.9% of new nurses experienced rudeness from physicians, followed by 31% from co-workers and 24% from their supervisors. Leong and Crossman (2016) conducted a grounded-theory study and explored the effects of bullying and negative behaviours on the transition experience of new nurses. Findings from this study indicate that new nurses were often subjected to bullying and criticism from experienced nurses and in some instances physicians. These negative experiences impacted their decision as to whether they stayed at the current workplace, or left altogether. The bullying behaviours also had a detrimental emotional impact on new nurses and contributed to: low self-esteem, anxiety, stress, depression, and a sense of disempowerment. Zinsmeister and Schafer's (2009) qualitative study investigated the transition period experienced by new nurses and uncovered how an optimistic and positive work culture had a positive influence on new nurses' transition into a practising role. One of the key

components related to this specific work culture was that new nurses felt they could openly ask for guidance from senior nurses without feeling ridiculed for doing so.

Integration of an inclusion program for new graduates. Two studies explored the impact a specific transition-to-practice program had for new graduates (Cleary et al., 2009; Dyess & Parker, 2012). Cleary et al. (2009) examined new nurses' attitudes towards a one-year transition to practice curriculum with respect to mental health nursing. The curriculum consisted of five weeks of theory and four three-month clinical placements in various psychiatric specialty areas. Results indicated that out of all participants, 96% felt that the curriculum aided them in honing their mental health nursing skills, 98% expressed that they obtained a better comprehension of the role of the mental health nurse post-curriculum, and 95% indicated that they would endorse the curriculum to other nurses.

Dyess and Parker (2012) conducted a quantitative study of 109 new nursing graduates who had taken part in the Novice Nurse Leadership Institute (NNLI) program for ten months. The aim of the program was to support the transition of new nursing graduates into the practice setting. The content of the program centered on further developing participants' clinical skills, as well as fostering coping and leadership skills. Participants did not rate the effectiveness of the program specifically. However, findings showed 80% of participants remained at their initial place of employment. This is significant, as 65% of new nurses who did not take part in the NNLI program left their initial place of employment.

Literature Review Summary

From the literature review, it is evident that mental health nurses require further education and additional training related to various forms of mental illness, psychiatric

medications, and the effective care of patients with suicidal ideation and those who demonstrate aggressive behaviors. It is also apparent how undergraduate nursing programs provide inadequate learning opportunities for undergraduate students during their mental health course; and therefore, there is a critical need for comprehensive orientations that address the educational requirements of new mental health nurses. The literature review also demonstrates nurses working in specialty areas such as mental health require adequate orientations, dedicated preceptors, support from other healthcare professionals, and transition-to-practice programs for new graduates. Therefore, it is important to support the transition process by addressing nurses' specific learning needs and provide guidance when needed.

Theoretical Framework

From the literature review it is clear that recent graduates and nurses new to the mental health area have specific learning needs. Therefore, Benner's Novice to Expert Model (1982) and Knowles' Adult Learning Theory (1980) will be used to guide the development of the orientation resource manual for new nurses orientating to J4D.

Benner's Novice to Expert Model

In Benner's Novice to Expert Model (1982), nurses transition through a total of five stages, beginning at the *novice* level and gradually moving to the final *expert* stage with time and experience. At the beginning of an individual's nursing career, they are considered *novice*, as they do not have sufficient experience or the knowledge base to safely work in their clinical area. With time and acquisition of knowledge and skill development, nurses move to the second stage, termed *advanced beginner*. During this stage, they still require adequate support, but have a deeper breadth of knowledge and skills than in the *novice* stage. In the third stage, nurses are

deemed as *competent* and have worked in their respective area for two to three years. At this point, nurses can conceptualize specific nursing interventions and appreciate the potential consequences of such. Next, nurses move to a *proficient* stage, whereby they are able to visualize clinical situations as a whole, and enlist all components that are significant in providing patient care. Finally, nurses reach the *expert* stage. At this level, they have a vast comprehension of the majority of clinical scenarios. In turn, this allows for quick decision-making and problem-solving skills.

Since the majority of casual nurses orienting on J4D are new to the Mental Health and Addictions Program, the resource manual will be written from the viewpoint of a nurse in the *novice* stage of Benner's (1982) model. This will give new nurses to J4D the opportunity to build on the knowledge and skills that are essential to working on the child and adolescent psychiatric unit. Over time, the casual nurses will gain work experience and build their levels of competence. This will guide their transition from the *novice* stage at a personalized rate (Benner, 1984).

Self-Directed Learning and Knowles' Adult Learning Theory

Self-directed learning was defined by Knowles (1975) as "a process in which individuals take the initiative without the help of others in diagnosing their learning needs, formulating goals, identifying human and material resources, and evaluating learning outcomes" (p.18). Knowles's Adult Learning Theory (1980) is based on andragogy, which is the art and science of adult learning (Teaching Excellence in Adult Literacy, 2011). According to Knowles (1980), andragogy is comprised of several main premises. First, adults must be active in the planning and assessment of their learning. Second, adults can reflect on prior experiences to form the groundwork for learning activities. Third, adults are drawn to learn about topics that have

applicability to their social roles. Fourth, adult learning is problem-centered. (Teaching Excellence in Adult Literacy, 2011). These main principles of Knowles's Theory will guide the creation of an orientation manual for new casual nurses on J4D. This theory will build upon the new casual nurses' previous learning experiences from nursing school and previous work experiences for the nurses that are not new graduates but are new to the specialty area.

Because there is no specific clinical educator for J4D, one of the main ways that the new casual nurses' learning needs can be addressed is through this self-directed learning. Since the resource manual is proposed to be used as a self-directed learning guide and will be incorporated in the process of educating casual nurses on J4D, it is imperative to establish whether or not this method of learning can help achieve the intended outcome of assisting the new casual nurses learn their required roles and responsibilities while working on the unit.

Studies pertaining to self-directed learning have demonstrated mainly positive outcomes. For example, Kerr et al. (2020) enlisted twelve BN students in their final year of nursing to take part in a qualitative descriptive study. The aim of their study was to examine the nursing students' attitude towards a self-directed learning laboratory, which was created to facilitate learning and assist in readiness for practice in the clinical setting. Participants indicated that the self-directed learning lab was an area that they felt safe and was a non-judgmental environment. Due to the welcoming environment, the students returned to the lab for practice on multiple occasions and reported an increase in confidence levels when they entered the clinical setting.

Taylor et al. (2009) utilized a self-directed learning program that was created to instruct nurses on how to communicate with patients about spirituality. A total of 201 nursing students and nurses participated in their study. A pretest-posttest pre-experimental design was employed to assess nurses' knowledge prior to and upon completion of the program. Significant differences

were found when comparing the before and after tools that assessed attitude, ability, spiritual experience, and knowledge. The results suggest that self-directed learning was an effective learning method for nurses and nursing students.

Likewise, Gega, et al. (2007) also utilized self-directed learning (computer-based) to compare it to traditional teaching methods. They employed a randomised controlled trial (RCT) to determine whether or not computer-assisted self-directed learning or traditional teaching methods were more effective in educating student nurses on exposure therapy regarding phobias and panic. A total of 92 nursing students participated in the study and results indicated that the computer-assisted learning was comparable to traditional learning methods with respect to knowledge acquisition. As no preparation or instruction time was required on the teacher's behalf, the self-directed learning method was a logical instructional approach to use.

Similarly, Considine, Botti, and Thomas (2005) enlisted 88 emergency room (ER) nurses to take part in a quasi-experimental study on the effect of a self-directed learning package on their knowledge of assessment of oxygenation and the use of supplemental oxygen. There were a total of 37 ER nurses in the control group, and 51 in the experimental group. Nurses in the experimental group received a self-learning package on the use of supplemental oxygen and assessment of oxygenation, while nurses in the control group did not. Study results indicated that nurses in the experimental group demonstrated increased knowledge on the topic compared to those in the control group.

Although self-directed learning has many advantages, there are also disadvantages associated with this type of learning. One of the main challenges that can present is an individual's lack of readiness when participating in self-directed learning. Alharbi (2018) conducted a comparative study to differentiate the self-directed learning readiness scores

(SDLR) of 191 traditional and bridging undergraduate nursing students. All participants in the study completed the self-directed learning readiness scale and results for both traditional and bridging students indicated low SDLR scores; thus, the importance of readiness for self-directed learning is essential.

Similarly, Yuan et al. (2012) conducted a cross-sectional study of 536 Chinese nursing students to assess their preparedness for self-directed learning. The SDLR scale was utilized to assess their preparedness. Out of the sample, 62.3% of participants demonstrated a high level of SDLR, while 37.7% had a low score. The more senior nursing students in the study had higher SDLR scores than the newer students. Again, this accentuates the importance of determining the readiness of individuals when utilizing self-directed learning as a learning method.

Conclusion

A commitment to continuing education is a component that is critical to many professions, including nursing. This is especially true for student nurses transitioning to the practice setting and nurses new to specialty areas, such as mental health. It is evident from the literature review that these populations experience unique learning needs. Casual nurse hires new to the Mental Health and Addictions Program at Eastern Health, specifically J4D, are likely to experience similar distinct learning requirements. They need further education on the information they believe is fundamental when caring for patients and their families on J4D. Self-directed learning, which incorporates principles of adult-learning, will assist the new casual nurse hires in learning the essential unit information in a way that most favourably suits their educational needs. The unit resource manual will hopefully become a valuable addition to providing pertinent education to the new casual hires.

References

Alharbi, H. A. (2018). Readiness for self-directed learning: How bridging and traditional nursing students differs? *Nurse Education Today, 61,* 231-234.

Australian Nursing and Midwifery Federation. (2016). Nursing specialty. http://anmf.org.au/documents/policies/P_Nursing_specialty.pdf

Benner, P. (1982). From novice to expert…The dreyfus model of skill acquisition. *American Journal of Nursing*, 82, 402-407.

Binil, V., Sudhakar, C., Hedge, S., & Ravishankar, N. (2017). A review of violent behavior among patients admitted in psychiatric setting. *Medical-Legal Update, 17*(2), 237-242.

Boychuk Duchscher, J., & Windey, M. (2018). Stages of transition and transition shock. *Journal for Nurses in Professional Development, 34*(4), 228-232.

Canadian Federation of Mental Health Nurses. (2014). Canadian standards of psychiatric-mental health nursing. https://live-cfmhn.pantheonsite.io/wp-content/uploads/2019/05/2014-Standards-of-Practice-Final.pdf

Canadian Institute for Health Information. (2020). Child and youth mental health in Canada – Infographic. https://www.cihi.ca/en/child-and-youth-mental-health-in-canada-infographic

Canadian Institute for Health Information. (2016). Regulated nurses. https://secure.cihi.ca/free_products/regulated-nurses-2016-report-en-web.pdf

Canadian Nurses' Association. (2020). Certification Nursing Practice Specialties. https://www.cna-aiic.ca/en/certification/get-certified/certification-nursing-practice-specialties

Canadian Nurses' Association. (2020). CNA Certification Program. https://www.cna-aiic.ca/en/certification

Children's Mental Health Ontario. (2020). Key facts and data points. https://www.cmho.org/education-resources/facts-figures

Cleary, M., Matheson, S., & Happell, B. (2009). Evaluation of a transition to practice program *for mental health nursing. Journal of Advanced Nursing, 65(4), 844-850.*

Clipper, B., & Cherry, B. (2015). From transition shock to competent practice: Developing preceptors to support new nurse transition. *Journal of Continuing Education in Nursing, 46*(10), 448-454.

College of Registered Nurses of Newfoundland and Labrador. (2018). Transition to practice for newly licensed RNs. https://www.arnnl.ca/sites/default/files/documents/PS_Transition_to_Practice_for_Newly_Licensed_RNs.pdf

Considine, J., Botti, M., & Thomas, S. (2005). Effect of a self-directed learning package on emergency nurses' knowledge of assessment of oxygenation and use of supplemental oxygen. *Nursing and Health Sciences, 7*(3), 199-208.

Dellasega, C., Gabbay, R., Durdock, K., & Martinez-King, N. (2009). An exploratory study of the orientation needs of experienced nurses. *The Journal of Continuing Education in Nursing, 40*(7), 311-316.

DeSchiffart Marcogliese, E., & Vandyk, A. (2019). Mental health nurses' knowledge of entry-to-practice competencies in psychiatric care. *The Journal of Continuing Education in Nursing, 50*(7), 325-330.

Dillon, K. A., Barga, K. N., & Goodin, H. J. (2012). Use of the logic model framework to develop and implement a preceptor recognition program. *Journal for Nurses in Staff Development, 28*(1), 36-40.

Dinmohammadi, M., Peyrovi, H., & Mehrdad, N. (2013). Concept analysis of professional socialization in nursing. *Nursing Forum, 48*(1), 26-34.

Dyess, S., & Parker, C. G. (2012). Transition support for the newly licensed nurse: A programme that made a difference. *Journal of Nursing Management, 20(*5), 615-623.

Gega, L., Norman, I. J., & Marks, I. M. (2007). Computer-aided vs. tutor-delivered teaching of exposure therapy for phobia/panic: Randomized controlled trial with pre-registration

nursing students. *International Journal of Nursing Studies*, *44*(3), 397-405.

Government of Canada. (2019). Mental illness. https://www.canada.ca/en/public-health/services/chronic-diseases/mental-illness.html

Government of Canada. (2016). Suicide in Canada: infographic. https://www.canada.ca/en/public-health/services/publications/healthy-living/suicide-canada-infographic.html

Heckemann, B., Zeller, A., Hahn, S., Dassen, T., Schols, J., & Halfens, R. (2015). The effect of aggression management training programs for nursing staff and students working in an acute hospital setting. A narrative review of current literature *Nurse Education Today, 35*(1), 212-219.

Inoue, M., Del Fabbro, L., & Mitchell, M. (2017). Assessing the educational needs of mental health nurses working in an adolescent inpatient psychiatric ward in Japan. *Journal of Child & Adolescent Psychiatric Nursing, 30*(4), 181-185.

Isaiah, O. O., Lawal, A. B., Oluseyi, A. O., Adeolu, E., & Oluwamuyiwa, O. (2019). Experience and attitude of psychiatric nurses toward inpatient aggression in a Nigerian psychiatric hospital. *International Journal of Caring Sciences, 12*(3), 1547-1560.

Joanna Briggs Institute. (2017). Critical Appraisal Checklist for Qualitative Research. https://joannabriggs.org/sites/default/files/2019-05/JBI_Critical_Appraisal-Checklist_for_Qualitative_Research2017_0.pdf

Kerr, D., Ratcliff, J., & Walter, R. (2020). Undergraduate nursing student perceptions of directed self-guidance in a learning laboratory: An educational strategy to enhance confidence and workplace readiness. *Nurse Education in* Practice, *42*, 1-6.

Knowles, M. (1984). The modern practice of adult education: From Pedagogy to Androgogy. Chicago, IL: Associated Press, Follett Publishing Company.

Laschinger, H. K. S., Cummings, G., Leiter, M., Wong, C., MacPhee, M., Ritchie, J., Wolff, A., Regan, S., Rheaume-Bruning, A., Jeffs, L., Young-Ritchie, C., Grinspun, D., Gurnham, M. E., Foster, B., Huckstep, S., Ruffolo, M., Shamian, J., Burkoski, V., Wood, K., & Read, E. (2016). Starting out: A time-lagged study of new graduate nurses' transition to

practice. *International Journal of Nursing Studies, 57*, 82-95.

Leong, Y. M. J., & Crossman, J. (2016). Tough love or bullying? New nurse transitional experiences. *Journal of Clinical Nursing, 25*, 1356-1366.

Manning, L., & Neville, S. (2009). Work-role transition: From staff nurse to clinical nurse educator. *Nursing Praxis in New Zealand, 25*(2), 41-53.

Memorial University of Newfoundland. (2020). *University calendar: Bachelor of nursing (collaborative) program.* https://www.mun.ca/regoff/calendar/sectionNo=NURS-0230

Murphy, L. J., & Janisse, L. (2017). Optimizing transition to practice through orientation: A quality improvement initiative. *Clinical Simulation in Nursing, 13*, 583-590.

National Center for Biotechnology Information. (2020). Information about mental illness and the brain. https://www.ncbi.nlm.nih.gov/books/NBK20369/

National Institute of Mental Health. (2020). Mental health medications. https://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml

Newfoundland and Labrador Centre for Health Information. (2017). Mental Health and Addictions Programs Performance Indicators. https://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml https://www.nlchi.nl.ca/images/Mental_Health_and_Addictions_Programs_Performance_Indicators_2017-04-17.pdf

Peltokoski, J., Vehviläinen-Julkunen, K., & Miettinen, M. (2015). Newly hired nurses' and physicians' perceptions of the comprehensive health care orientation process: A pilot study. *Journal of Nursing Management, 23*(5), 613-622.

Peternelj-Taylor, C., & Woods, P. (2019). Saskatchewan provincial correctional nurses: Roles, responsibilities, and learning needs. *Journal of Correctional Health Care, 25*(2), 177-190.

Prince, A., & Nelson, K. (2011). Educational needs of practice nurses in mental health. *Journal of Primary Health Care, 3*(2), 142-149.

Public Health Agency of Canada. (2014). Infection prevention and control guidelines: critical appraisal toolkit. http://www.phac-aspc.gc.ca

Registered Psychiatric Nurse Regulators of Canada. (2020). Registered psychiatric nurse education. www.rpnc.ca/rpn-education

Registered Psychiatric Nurse Regulators of Canada. (2014). Registered psychiatric nurse entry-level competencies. http://www.rpnc.ca/sites/default/files/resources/pdfs/RPNRC-ENGLISH%20Compdoc%20%28Nov6-14%29.pdf

Sanford, P. G., & Hart Tipton, P. (2016). Is nursing preceptor behavior changed by attending a preceptor class? *Baylor University Medical Center Proceedings, 29*(3), 277-279.

Spector, P.E., Zhou, Z. E., Zhiqing, E., & Xin, X. C. (2014). Nurse exposure to physical and nonphysical violence, bullying, and sexual harassment: A quantitative review. *International Journal of Nursing Studies, 51*(1), 72-84.

Taylor, E. J., Mamier, I., Bahjri, K., Anton, T., & Petersen, F. (2009). Efficacy of a self-study programme to teach spiritual care. *Journal of Clinical Nursing, 18*(8), 1131-1140.

Teaching Excellence in Adult Learning. (2011). Adult Learning Theories. https://lincs.ed.gov/sites/default/files/11_%20TEAL_Adult_Learning_Theory.pdf

Waite, R. (2006). The psychiatric educational experiences of advanced beginner RNs. *Nurse Education Today, 26,* 131-138.

Walsh, A. (2015). Are new mental health nurses prepared for practice? *Mental Health Review Journal, 20*(2), 119-130.

Williams, F. S., Scott, E. S., Tyndall, D. E., & Swanson, M. (2018). New nurse graduate residency mentoring: A retrospective cross-sectional research study. *Nursing Economics, 36*(3), 121-127.

World Health Organization. (2018). Mental health: Strengthening our response. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-

response.

Yuan, H. B., Williams, B. A., Fang, J. B., Pang, D. (2012). Chinese baccalaureate students' readiness for self-directed learning. *Nurse Education Today, 32*(4), 427-431.

Zinsmeister, L. B., & Schafer, D. M. (2009). The exploration of the lived experience of the graduate nurse making the transition to registered nurse during the first year of practice. *Journal for Nurses in Staff Development, 25*(1), 28-34.

Appendix B

Literature Summary Tables

Author	Participants/Methods	Results	Comments
Authors: Peltokoski et al. (2015) **Design:** Cross-sectional (Quantitative) **Purpose:** To investigate the orientation of recently employed nurses and physicians and gain their perspective about the orientation process. Also, to examine the relationship amongst the several facets of a thorough orientation program and background variables.	**N:** 182 participants **Country/setting**: Finland; One university hospital and one central hospital. **Group 1:** Of the 182 participants, 145 were RNs and 37 physicians. -Age range 22-54 years. -97 of the participants worked at a central hospital, while the remaining 85 at the university hospital. -85% of respondents were female. -150 of participants held temporary positions. -69 (or 38%) of participants had less than 1- year experience in specialized healthcare, and 74 (41%) had 1-5 years of experience. **Data collection**: Mailed questionnaires were distributed between May 2009-June 2010. -RNs and physicians at the two hospitals were sent the questionnaire if they had worked in a permanent or temporary posting for at least 3 months from May 2009 or later. -Questionnaires contained cover letters, as well as prepaid and pre-addressed envelopes and were given to the hospital units by the chief researcher. 401 questionnaires were	**Characteristics of the orientation** -53% of participants approximated they received 4 days or less for orientation; 24% received 5-10 days and 13% received 25+ days. -Contentment with the orientation received was ranked at moderately low, mean=7.5; range 4-10 (4='the worst' and 10='the best'). -An affirmative impression was felt for the Hospital Professional Practice Environment, mean=7.9, range:5-10. **Comprehensive orientation process in hospital settings** -None of four subscales received the desired score of 4 or greater. 'Goals and responsibilities' received highest score, mean=3.45, 'Standardized content' had a mean=2.99; 'Implementation' mean=2.94, and 'Evaluation'=2.64. -Findings indicated when an RN or physician had a designated preceptor, moderate and strong relationships were established for the 'Goals and responsibilities' subscale, P=0.000. -RNs commitment to the organization was markedly greater than physicians', P=0.007. -Length of orientation demonstrated a positive, yet somewhat weak relationship with 'Goals and	**Strength of Design:** **Weak (descriptive)** **Quality**: **Low** **Issues:** -Study took place in limited geographical area (two hospitals in Finland). -It is unclear if the researcher(s) was trained in data collection procedures. There was no mention of missing or inaccurate data. -The *orientation process evaluation* instrument was used for the first time in this study. -The self-selection of participants could have potentially created biased outcomes.

	distributed in total, with 182 returned, for a response rate of 45%. -*The orientation process evaluation* was a newly-designed instrument which aimed to measure the participants' perceived thoroughness of the orientation program. It had a total of 54 items and answers were on a five-point Likert-type scale. -The cronbach's alpha for *the orientation process evaluation* was deemed as good, at 0.87.	responsibilities' subscale, P=0.036. -Results surmise that the application of the orientation is being programmed to match each employees' unique needs. -Orientation for nurses more coordinated than that of physicians', P=0.015.	

Authors: Laschinger et al. (2016) **Design:** Cohort study (Quantitative) **Purpose:** First, to examine the variables that affect recent RN graduates' smooth transition into their new positions in the hospital environment. Second, to explore the factors that influence job gratification and attrition rates during a one-year time frame in the beginning of their career.	**N:** 406 **Country/setting:** Canada **Time 1:** (November 2012-March 2013). -Mean age of participant 27.68 years -Mean number of years as RN 1.17 -Mean length of orientation 5.06 weeks -Mean number of preceptors 2.52 **Time 2:** (May-July 2014). -Mean age of participant 29.23 years. -Mean number of years as RN 2.65 **Data collection:** During first period of data collection (November 2012-March 2013), eligible RNs across Canada were sent a letter detailing the study, the study questionnaire, a pre-paid return envelope and $2 gift card to their primary residence. A reminder was mailed out at four weeks after primary survey was sent. Another survey package was sent to those who did not respond to the initial survey four weeks later. During the second period of data collection (May-July 2014), a follow-up survey was mailed out to the RNs that completed the initial survey. -*Nursing Work Index-Revised* was one of the instruments used to collect	-Authors state 1020 RNs completed survey at Time 1, but at Time 2, only 406 returned a completed survey -90% of participants thought that their preceptor greatly aided their transition to practice setting. -Disrespect was most often experienced from physicians (41.9%) instead of co-workers (31%) or supervisors (24%). **Retention Outcomes:** -RNs experienced great job satisfaction, with a mean of 4.05 at Time 1, and 3.98 at Time 2. -Current thoughts of job turnover were not high, with a mean of 2.33 at Time 1 and 2.43 at Time 2. Career attrition rates were lower again, at 1.71 for Time 1 and 1.85 for Time 2.	**Strength of Design:** **Moderate** **Quality: Low** **Issues:** -Poor response rate for Time 2 (39.8%) -The use of self-report questionnaires may lead to social desirability bias on behalf of participants. -Did not provide information on if assessors were trained in data collection methods.

	data on support in the work environment. A standardized questionnaire was employed to discern key study variables.		

Authors: Cleary et al. (2009). **Design:** Cohort study (Quantitative) **Purpose:** To examine nurses' attitudes towards a one-year transition to practice curriculum with respect to mental health nursing. Also, to assess its affect on their discerned comprehension and self-assurance.	**N:** 44 **Country/setting:** Australia **Sample Demographics:** -33 women (75%) and 11 men (25%). -15 (34%) were <30 years old. -5 (11%) were between 31-40 years old. -23 were > 41 years old and one participant did not indicate his/her age. -21 (48%) had previously worked in mental health, while 2 (4.5%) had previously worked in community mental health. **Data collection:** -Data were retrieved at the beginning of the curriculum and once it was finished, one year later. **-Curriculum consisted of:** i) Five weeks of theory, which is presented over one week time-frames throughout the course ii) Four three-month clinical placements in various psychiatric specialty areas: child and adolescent, acute adult, psychogeriatric, drug health, rehabilitation and recovery, and hospital community services.	**Comprehension, Self-Assurance and Self-Concept Post-Program** -Participants felt that they had greater comprehension ($P < 0.01$) and self-assurance ($P<0.01$) after the curriculum in each area excluding information technology and teamwork ($P<0.05$). **Evaluation of the Curriculum** -23/44 (52%) of participants felt the curriculum was better than they had anticipated, 15/44 (34%) felt it was as they thought it would be, and 6/44(14%) felt it was worse than they had imagined it would be. -42/44 (96%) of participants felt that the curriculum aided them in honing their mental health nursing skills. -43/44 (98%) of participants obtained a more sound comprehension of the role of the mental health nurse post-curriculum. -42/44 (95%) indicated they would endorse the curriculum to other nurses.	**Strength of Design: Moderate** **Quality**: **Medium** **Issues:** -Relatively small sample size. -Limited geographical area (one large mental health service in Australia). -Potential for bias, as those who participated were driven to further their knowledge base in mental health nursing.

	Study instruments included: i) a survey modified from prior studies, which sought information on participant demographics, as well as the participants' hopes of the curriculum and sense of contentment with present clinical supports. The survey also assessed the participants' comprehension and self-assurance on 20-items related to mental health nursing. ii) The Nurses' Self-Concept Questionnaire (NSCQ). The Cronbach's alpha for the knowledge aspect is 0.82 and 0.95. for general self-concept.		

Authors: Leong & Crossman (2016). **Design:** Grounded-theory (Qualitative) **Purpose:** To examine the transition process of new nurses into the work setting as in their first year of practice.	**N:** 31 (26 new nurses and 5 preceptors). **Country/setting:** Five hospitals in Singapore. **Sample Demographics:** -24/26 female; 2/26 male -6/26 between the age of 19-20 years -19/26 between the ages of 21-25 -1/26 between the age of 26-30 -3/26 worked on a high dependency ward -4/26 worked in ICU -14/26 worked in med-surge -1/26 worked on neurology -1/26 worked on obstetric/gynecology -3/26 worked in OR **Data Collection:** -New nurses were recruited via an awareness session that was held during the end of their nursing training. -An invitation to participate was also provided to the nursing students' preceptors.	-New nurses were routinely subjected to ridicule from more experienced nurses. -Scolding from experienced nurses and physicians towards the new nurses was not uncommon. -Many new nurses remained quiet with respect to the bullying that occurred. -As a result of bullying behaviors, many new nurses experienced emotional distress, including decreased self-esteem, anxiety, and depression. -Discouraging questions and comments towards new nurses inhibited their learning experiences.	**Strengths:** -Open-ended questions allowed participants to freely discuss their unique experiences. -Only one researcher conducted the interviews. **Limitations:** -Relatively small geographical area, thus limiting generalizability.

	-One researcher conducted semi-structured interviews, which were recorded and transcribed verbatim. -Interviews took place on the participants' days off and were held in a location chosen by the participant i.e: hospital canteen or Starbucks café. The majority were an hour in length. -New nurses also submitted journals of reflection regarding their perspectives on the transition process.		

Authors:	**Data collection:**	**Acquisition of Clinical Skills:**	**Strength of Design:**
Dyess & Parker (2012). **Design:** Uncontrolled Before-After (Quantitative) **Purpose:** -To assess the efficacy of a collective program that supports recently graduated RNs.	-The sample consisted of 109 new RNs who took part in the Novice Nurse Leadership Institute (NNLI) program from 2006-2009. -Data was collected at the initial start of the NNLI program, and additionally at the 19th session. The project director distributed survey questionnaires to the participants. Once survey questionnaires were distributed to the RNs, the project director left the room to give privacy and an envelope was available for finished surveys, ensuring confidentiality. -**Study instruments:** i) Nursing Evaluation Competency Assessment (NECA). This measured the technical and psychosocial skills of new RNs. Cronbach's alpha = 0.94 pre-program and 0.93 post-program. ii) Student Leadership Practices Inventory (SLPI). Used to evaluate five aspects of leadership skills amongst the new RNs. Cronbach's alpha was 0.94 pre- and post-test. **N: Group 1 = 41 (Untrained Preceptors)** **Group 2 = 18 (Trained Preceptors).** **Country/setting:** Texas, United	-Significant differences found with respect to culmination of skill acquisition including four of the subscales: i) planning and evaluation $P<0.001$, ii) member of the discipline $P<0.001$, iii) leading care $P<0.001$ and iv) patient care $P<0.05$. **Leadership competencies:** -Significant differences were found for several of the subscales, including: *Model the way* $P < 0.05$, *Inspire a shared vision* $P < 0.05$, *Challenge the process* $P <0.01$, and *Encourage the heart* $P < 0.05$. **Retention:** -Virtually all of the 2006 NNLI participants are still practicing nursing. -87/109 (80%) have stayed at their initial place of employment. This is compared to a 65% retention rate for RNs that did not take part in the NNLI program. -6/109 (5.5%) left their job due to disappointment with their work conditions.	**Low** **Quality**: **Medium** **Issues:** -Authors of study note it cannot be generalized, as it took place in a southeastern region of the United States and RNs in that jurisdiction might not be representative of a larger population. -Not all new RNs had the opportunity to take part in the NNLI program; only RNs chosen by their employer were selected to take part in the NNLI program. -Potential for social desirability bias, as data was self-reported. -Possibility of bias with respect to retention, as the authors note the international job climate may not have been favorable for one to leave a sound place of employment for.

	States. **Sample Demographics:** **Group 1:** -Age range 21-50 years old -18 (43.9%) between the ages of 21-25 years. -23 (56.1%) had an Associate degree in nursing -16 (39%) had a Baccalaureate degree in nursing. - 2 (4.9%) obtained their Baccalaureate degree in nursing as a second degree. -One-Year retention rate 82.7%. **Group 2:** -Age range 21-35 years. -9/18 (50%) of participants were between the ages of 21-25 years. -2 (11.1%) had an Associate degree in nursing. -7 (38.9%) had a Baccalaureate degree in nursing. -9 (50%) obtained their Baccalaureate degree in nursing as a second degree. -One-Year retention rate 89.5%.		

	Data collection: - The survey was sent online via e-mail to a total of 138 new RNs (with <1 year of experience) across seven acute care hospitals. The first group were 62 new RNs that had an untrained preceptor, while the second group were 76 RNs that had preceptors who had completed a specialized training program. The online-survey was accessible for 30 days. A total of three e-mails were sent to participants as reminders to complete the survey. A final reminder was sent via postcard to all participants. -**Study instruments:** -An investigator-developed survey (based on the principles of Transition Shock theory). The survey had 16 items, with seven demographic questions and 8 questions that used a Likert scale. One question was open-ended (qualitative in nature) and sought to examine the new RNs overall thoughts on the orientation and transition period. -The survey instrument had a Cronbach's alpha of 0.954		

Authors: Clipper & Cherry (2015). **Design:** Mixed-Method (researchers focused mainly on quantitative data, with only one qualitative question asked.) **Purpose:** To provide details on the execution and appraisal of the effects of a preceptor program on new RNs starting to practice.	**N:** 9 -All RNs included in study had been working for a minimum of 6 months, but not greater than 1 year. **Sample Demographics:** -Age range 22-38 years. -3 participants held a Bachelor's degree in nursing, 5 had an Associate's degree, and 1 had a diploma in nursing. **Country/setting:** The United States (East Coast). **Data collection:** -Participants were interviewed at their workplace in a discrete area. The interviews were conducted by a few data collectors and a standardized open-ended approach was employed. -There were 6 semi-structured interview questions in total. -Each interview took place either before the participant's shift, or afterwards. -Data analyzed by two of the researchers via methods suggested by Miles and Huberman (1994).	**First-Year Retention:** - The collected data proposes that new RNs that had a trained preceptor (Group 2), had a marginally increased 1-year retention rate of 89.5% versus the 82.7% for Group 1. **Survey Results:** -There were two questions on the survey in which findings were considered significant: "My preceptor helped me develop collegial working relationships and promote a positive work environment in my new unit department" P=0.038 and "My preceptor took adequate time with me to ensure a smooth transition from my role as a student nurse to that of an independent, professional nurse" P=0.016. RNs In Group 2 scored these two questions considerably greater than RNs in Group 1. -Overall, both groups had favorable ratings for their preceptors, illustrating that having a preceptor in general is worthwhile.	**Strength of Design: Weak** **Quality**: **Low** **Issues:** -Limited geographical area in which the study took place. -Poor response rate (42.8%). -Relatively small sample n=59, limiting generalizability of results. -Possibility of social desirability bias from self-report questionnaires.

Authors: Zinsmeister & Schafer (2009). **Design:** Phenomenological (Qualitative) **Purpose:** To obtain perspective on the transition period experienced by new RNs.	**N:** Group A=6 Group B=8 **Sample Demographics:** **Group A:** -All RNs between the ages of 30-40 years. -Participants had an average of 8 years of general nursing practice and 1.5 years of child/adolescent mental health experience. **Group B:** -Five participants over the age of 50 years, and the remaining three in their 30-40's. -Participants had an average 26 years of general nursing practice and 5.5 years of child/adolescent mental health experience. **Country/setting:** An adolescent psychiatric ward in Japan. **Data collection:** -Nominal group technique (NGT) and focus group discussions were incorporated to ascertain the learning needs of the group. The length of focus groups were 1.5 hours for Group A and 2 hours and 9 minutes for Group B. -RNs were divided into two separate	-A total of 5 themes were found to positively impact the transition experience of new RNs: *supportive work environment, positive preceptor experience, comprehensive orientation process, sense of professionalism,* and *clarity of role expectations.*	**Strengths:** -An open-ended approach in conducting interviews allowed the participants to freely answer and express their unique lived experiences. **Limitations:** -Small sample size of 9 participants limits the generalizability of the study. -The interviews were carried out by more than one data collector. This may have limited the congruency of the process of data retrieval. -The researchers note that the interviews were fairly brief (approximately 30 minutes) for this type of research methodology. -Interviews took place between 6 to 11 months after the start of the RNs' careers. The RNs that were interviewed later on in the start of their career may have experienced more role clarity than those with less practice.

	groups based on their age and number years of nursing experience. -One participant in each of the two groups took notes to aide the researcher. -Data were initially recorded in Japanese and later translated to English. A bilingual academic in the United Kingdom confirmed the translation.		

Authors: Inoue et al. (2018). **Design:** Focus-Group (Qualitative) **Purpose:** -To examine the educational needs of adolescent mental health nurses in Japan.	**N:** 87 for initial questionnaire and 41 for focus-groups. **Country/Setting:** England **Sample Demographics for Questionnaire:** -Sample consisted of 42 third year mental health nursing students, 39 mental health nurses, and six nurse lecturers. -No other demographic information was provided. **Data Collection:** -A total of 150 questionnaires were sent to a convenience sample of RNs with the local Mental Health Trust, 150 were given to a convenience sample of third year mental health nursing students, and 13 questionnaires were given to mental health lecturers that were part of the researchers' institution. -The 39 mental health RNs were recruited via an e-mail invitation to take part in the study; the 42 nursing students were recruited from an e-mail invitation, as well as candid invitations to student groups. The six nurse lecturers were sent an e-mail looking for their support in taking part. **Focus Groups:**	**Group A:** -Learning area ranked as greatest need was child/adolescent mental illness and disorders. -Learning need with second highest ranking was dealing with families. **Group B:** -Top learning need was the same as Group A (child/adolescent mental illness and disorders). -Second greatest learning need was education on children/adolescents with developmental disorders.	**Strengths:** -All staff RNs (n=18) informed of study and had an equal chance to participate, thus avoiding gatekeeper bias. **Limitations:** -Limited generalizability due to small sample and limited area (one adolescent psychiatric ward in Japan). - Possibility of glorification of experience accounts due to group setting. -Primary researcher worked on the unit. Although it was stated "all attempts were made to reduce the possibility that she brought her own beliefs…" (p.182), it was not explained how these attempts were made.

	-Participants of the focus group were given a list of components of care from the questionnaire in which nurses were most self-assured of. -A total of nine focus groups occurred, with a mean of four to five participants per group. -Four focus groups took place with the third year mental health nursing students, four groups with the mental health RNS and one with the lecturers. -Transcription of the data occurred by listening to the audio recordings of the focus group dialogue. This took place using Interpretive phenomenological analysis (IPA) by Smith et al. (1999).		

Authors: Walsh (2015). **Design:** Phenomenological (Qualitative) **Purpose:** To examine how well-prepared students are for entering into mental health nursing practice.	**N:** 29 RNs and RPNs participated. However, one of the questionnaires was not analyzed due to numerous missing data. **Sample Demographics:** -20 (71.4%) of participants identified as RNs; 3 (10.7%) as RPNs; 1/ (3.6%) as "other" and 4 (14.3%) chose not to disclose. -No information on age or gender of participants was provided. **Country/Setting:** Ontario, Canada; an inpatient mental health unit at a tertiary care hospital. **Data Collection:** -Survey kit was comprised of a letter of invitation, the survey, a return envelope and $5 enticement. -E-mail reminders were sent at weeks 2, 4, and 5. -Study took place over a 6-week timeframe. -Posters were placed in noticeable areas during the 6-week timeframe and were written in both English and French. -Drop boxes were made available for completed surveys. **Study Instrument:**	**Questionnaire Data:** -Third year nursing students and new RNs felt most confident in the realm of interpersonal relations. They had less confidence in areas such as dealing with victims of childhood sexual abuse, dealing with aggressive behaviors, and giving emergency life support. -Other noted areas of difficulty included working with individuals with personality disorders, learning disabilities, and dealing with individuals who exhibit suicidal behavior. **Focus Group Data:** -Researcher noted all focus groups used the phrase "thrown into the deep end" to describe the difference in levels of support received as a student vs. the lack thereof as a new RN. -Four main themes emerged from the data from the focus groups: i) *"The transition from student to registered nurse is difficult"* *ii) "The importance of learning from experience"* *iii) "Violence and aggression is difficult to manage"* *iv) "Working effectively with victims*	**Strengths:** -Only one researcher conducted the interviews. **Limitations:** -Relatively small sample from the same geographical area, which limits generalizability. -The researcher taught some of the participants of the study, which questions power relationships. -Possibility of glorification of experience accounts due to group setting.

	-Researchers created their own self-assessment tool based on the *Entry-to-Practice Mental Health and Addiction Competencies for Undergraduate Nursing Education in Canada* (Canadian Association of Schools of Nursing [CASN] and Canadian Federation of Mental Health Nurses [CFMHN], 2015). -The tool had a total of 37 items and answers were on a 5-point Likert scale. Total scores ranged from 37-185.	*of sexual abuse or those who have a diagnosis of personality disorder is difficult"*	

Authors: DeSchiffart Marcogliese & Vandyk (2019). **Design:** Cross-sectional (Quantitative) **Purpose:** -To evaluate and determine the mental-health related expertise and learning needs of RNs and RPNs in inpatient psychiatry. Also, to establish how this population takes part in continuing education (CE).	**N:** 15 **Sample Demographics:** -4 (26.7%) of participants were in 19-29 year age group. -4 (26.7%) were in 30-40 year age group. -6 (40%) were in 41-51 year age group 1 (6.7%) was in 52+ year age group. -12 (80%) were employed full-time -2 (13.3%) were employed part-time -1 (6.7%) did not specify their employment status. -4 held a Bachelor's degree in nursing, while 11/15 held an Associate's degree. -None of the RNs had greater than one year of experience working in mental health. -All participants were female. **Country/Setting:** The United States. **Data Collection:** -Purposeful sampling used. -Mental health facilities within 60 miles of researchers' home were notified of study details. -Participants were interviewed from	**Learning Needs:** -Assortment of self-determined learning needs identified, but majority were related to the care of specific patient groups, including: patients with aggressive or violent behaviors, substance-related needs, borderline personality disorder, postpartum depression, dementia, and suicidal thoughts. -Support on how to effectively educate patient families, as well as members of the LGBTQ community was also identified. -Participants also expressed need for further information on psychiatric medications, de-escalation techniques, dialectical behavior therapy, mindfulness-based cognitive behavioral and stress reduction therapy, and the legal rights of patients. **Past and Preferred Learning Styles:** -Most of the preferred learning techniques were via in-service training during work hours, as well as self-directed reading. -Group discussions and formal peer-to-peer presentations were identified as the most unpopular learning techniques.	**Strength of Design: Weak (descriptive)** **Quality**: **Medium** **Issues:** -Small sample size and geographical area limit the generalizability of the findings. -Psychometric properties of the instrument created by the researchers were not appraised. -Possibility of social desirability bias due to self-reporting. -$5 incentive offered

	July-October 2002 at a location chosen by them. -Colaizzi's (1978) approach was employed for the procedural process. -Interviews were coded and semi-structured in nature. The majority lasted about 45 minutes. -Interviews were audio-recorded and notes were taken to describe "affective, contextual, and verbal material" (p.135). -The majority of interview transcriptions were finished within one week and subsequently mailed to participants for appraisal.		

Authors: Waite (2006). **Design:** Phenomenological (Qualitative) **Purpose:** -To examine the perspectives of advance beginner mental health RNs and how their education helped them adjust to their new jobs.	**N:** 52 **Sample Demographics:** -36 general practices that employed PNs were involved in the study. -All participants were female. -87% European and 13% Maori -Majority of participants were between the ages of 40-59 years. -Average number of hours worked was 27/week in a private physician's office. -46% of sample had postgraduate qualification. **Country/Setting:** Tairawhiti and Hawkes Bay regions of New Zealand. **Data Collection:** -Each general practice in the area was telephoned to determine the numbers of PNs working at the facility. Survey packages were then mailed to general practices that had mental health PNs. -PNs had a two-week timeframe to complete their surveys. A reminder was sent via mail to all participants, since the response rate was <50%.	**Significance of Patient Interactions:** -RNs felt that in nursing school, they did not have enough quality time to spend with patients; the focus was usually on their one patient to collect information for their project. -Usually only assigned one patient per time. **Quality of clinical assignments for educational purposes:** -RNs felt that role-playing in the educational setting was beneficial in refining their therapeutic communication. **Psychopathology of illnesses:** -RNs note as students they wish they had more education on the underlying pathophysiology of psychiatric disorders -Want the ability to create therapeutic bond with patients during mental health rotation instead of task-focused care like in other clinical rotations. **Therapeutic responses:** -Need for more awareness or education for students of the inappropriate comments sometimes made by patients. This will aide in	**Strengths:** -The semi-structured interview allowed participants to freely offer their perspective without interference from researcher. -Only one researcher conducted the interviews. **Limitations:** -Small sample and limited geographical area potentially limit generalizability of study findings.

		decreasing the initial shock value of the comments. **Professional boundaries:** -The importance of maintaining professional boundaries between the nurse-patient relationship is paramount. **Value of treatment teams:** -The need for more educational experience collaborating with interprofessional teams, as the RN plays an important role in them. Treatment teams are paramount in the mental health setting. **Challenges of psychopharmacology:** -Critical to know the pharmacology of psychiatric medications and their potential side-effects. -Non-compliance an important issue in mental health vs. other settings.	

Authors: Prince & Nelson (2011). **Design:** Mixed-Method (main focus on quantitative data) **Purpose:** To determine the learning needs of practice nurses (PNs) in the area of mental health. Also, to examine the types of care they deliver to patients with mental health issues.	**N:** 52 **Sample Demographics:** -36 general practices that employed PNs were involved in the study. -All participants were female. -87% European and 13% Maori -Majority of participants were between the ages of 40-59 years. -Average number of hours worked was 27/week in a private physician's office. -46% of sample had postgraduate qualification. **Country/Setting:** Tairawhiti and Hawkes Bay regions of New Zealand. **Data Collection:** -Each general practice in the area was telephoned to determine the numbers of PNs working at the facility. Survey packages were then mailed to general practices that had mental health PNs. -PNs had a two-week timeframe to complete their surveys. A reminder was sent via mail to all participants, since the response rate was <50%.	**Practice nurse work in mental health:** -Adults were most frequently seen population, followed by older adults 65+ years. -Children experiencing mental health concerns were not seen as often as adults. -PNs with degrees had higher self-assurance in carrying out work-related interventions than those that did not have degrees (p=0.05). -37% of PNs used screening tools in their practice. However, only one PN felt comfortable in using them. -78% of PNs had knowledge pertaining to referral to specialist services. Yet, only 24% knew how to conduct the referrals. **Education needs:** -The topic with the highest educational need was suicidal ideation (54%). - About 1/3 of PNs felt that out of the varying types of mental illness, schizophrenia was the one they felt they required more knowledge in. -Suicidal ideation and bipolar disorder were also often mentioned as topics needing further education	**Strength of Design: Weak** **Quality: Medium** **Issues:** -Low response rate (36%). -Potential bias to participate, as participants had incentive to win $100 restaurant gift-card. -Study does not name specific instruments used; content validity assessed by nurses, but no numerical values provided. -Limited generalizability due to sample size and geographical area.

		in. -Obstacles to continuing education were: having to attend sessions outside of work time, no PN relief to cover while absent, and difficulty obtaining access to study due to rural area. -Many felt education received in nursing school did not adequately prepare them for dealing with patients with mental illnesses.	

Authors: Peternelj-Taylor & Woods (2019). **Design:** Mixed-Methods (researchers focused on quantitative data) **Purpose:** - To obtain awareness about the role of nurses in correctional facilities in Saskatchewan and explore their educational needs.	**N:** 33 **Sample Demographics:** -15 (45.5%) of participants were RNs and 14 were RPNs (42.4%). 3 (9.1%) identified as both RN/RPN and 1(3%) as other. -26 (78.8%) of participants were female and 7 (21.2%) male. -Mean age of sample was 39.18 years. -15 (45.5%) participants worked full-time hours, while 17 (51.5%) worked part-time. -Average length of experience working as a nurse was 12.75 years, with an average of 8.65 years worked in correctional nursing. -29 (87.9%) participants worked in adult correctional facility, as opposed to 4 (12.1%) who worked with youth. **Country/Setting:** Correctional facilities in Saskatchewan, Canada. **Data Collection:** -Nurses working in correctional facilities in SK(n=95) were sent invitations to take part in the study. -Two questionnaires (described below) were disseminated and completed online. Researchers sent recurring reminders to complete the	**Learning Needs Assessment:** - 94 % of participants ranked suicidal assessment with the highest degree of importance, followed by 88% of participants regarding mental health assessment and self-harm assessment. - With respect to the section special populations, inmates with mental illness were categorized as “very important” by majority of participants.	**Strength of Design: Weak** **Quality: Medium** **Issues:** -Reliability and validity of the instruments used in the study were not mentioned. -Small sample size and limited area limits the generalizability of the results. -Low response rate 34.7%.

	surveys. **<u>Study Instruments:</u>** -The Learning Needs Assessment (originally created by the College of Nursing, University of Saskatchewan). -The Staff Questionnaire (originally used in the Nursing in Secure Environments project).		

Appendix C: Consultations Report

The Development of a Unit Resource Manual that Assists in the Orientation of Newly Hired Nurses and Casual Nurses to the Child and Adolescent Psychiatric Inpatient Unit at the Janeway Hospital

Andrea C. Wright

Master of Nursing

Faculty of Nursing

Memorial University of Newfoundland

St. John's, Newfoundland and Labrador

Following completion of the literature review on the learning needs of new mental health nurses, it is apparent they have unique learning requirements related to the care of patients experiencing mental illness. The literature suggests that nurses new to the specialty of mental health insist on further education on the psychopathology of mental illness (DeSchiffart Marcogliese & Vandyk, 2019; Inoue et al., 2017; Waite, 2006; Walsh, 2015), particular medications used to treat mental illness (DeSchiffart Marcogliese & Vandyk, 2019; Prince, 2011; Waite 2006), and the specific care associated with patients experiencing behaviors related to their mental illness. For example, behaviours such as suicidal ideation and aggressive tendencies are the most common behaviors described by the new nurses (DeSchiffart Marcogliese & Vandyk, 2019; Peternelj-Taylor & Woods, 2019; Prince & Nelson, 2011; Walsh, 2015).

Generally, recent graduate nurses experience unique learning needs related to the transition from nursing school environment to the clinical workplace setting. This is especially significant for newly hired nurses into the mental health specialty program. The literature suggests that a comprehensive orientation (Murphy & Janisse, 2017; Peltokoski et al., 2015; Zinsmeister & Schafer, 2009), assignment of a preceptor or mentor (Clipper & Cherry, 2015; Laschinger et al., 2016; Peltokoski et al., 2015; Williams et al., 2018; Zinsmeister & Schafer, 2009), positive treatment from interdisciplinary team members (Cleary et al., 2009; Laschinger et al., 2016; Leong & Crossman, 2016; Zinsmeister & Schafer, 2009), and transition-to-practice programs including extra clinical time and curriculum materials for new nursing graduates (Cleary et al., 2009; Dyess & Parker, 2012) all support a positive transition of nurses into the mental health workplace. The development of this self-learning educational resource manual for newly hired casual nurses working on J4D will aim to provide the necessary education to meet their learning needs and should ultimately improve patient care outcomes. Prior to the commencement of the practicum project, consent was obtained from the unit manager of J4D and is included in Appendix D.

Objectives of the Consultations

This practicum project was created to develop a resource manual for casual nurses that work on J4D. Consultations are a vital component in the development of the resource manual and necessary to review the current orientation process of nurses new to the specialty of mental health. Additionally, the consultations offered insights into the specific information the new casual nurses believe is fundamental in order to work and care for patients and families on J4D. A variety of professionals from J4D, including the manager, patient care facilitator, and several senior nurses, were also consulted in order to establish important topics they believe must be included in the resource manual. The clinical leader of development at the Garron Center, located at the Izaak Walton Killam (IWK) Hospital in Halifax, Nova Scotia, was also contacted with the intention to gather and obtain valuable insights into the details of their orientation process for new nurses. Patients admitted to the Garron Center have diagnoses similar to those seen on J4D. All individuals involved in the consultations were informed that their participation was voluntary and no identifying information would be disclosed in the report.

Setting and Sample

Two groups of point-of-care nurses from J4D were consulted for their opinion on topics they believe are pertinent to the development of the resource manual. The two groups include four permanent nurses, as well as the patient care facilitator, all of whom have worked on the unit for a minimum of three years. Two nurses from each side of the schedule were included to ensure representatives from entire nursing staff were consulted. The unit manager was also consulted. Consultations with the nursing staff from J4D took place on the unit, as well as via telephone. Consultations with the casual nurses from the Mental Health and Addictions Program

(MHAP) who had graduated within 18 months or less, or those new to the mental health specialty, took place in a quiet area at the Waterford Hospital. The clinical leader of development for the Child and Adolescent Psychiatric Unit at the IWK was consulted via telephone.

Current Orientation for the Mental Health and Addictions Program in NL

During consultations, casual nurses were asked to describe their current orientation to the MHAP. Presently, orientation consists of two weeks of classroom learning, which takes place Monday to Friday, and nine weeks of clinical orientation to the six different units within the program. During the classroom training, the new casuals learn about various topics such as: mental health exams, psychotropic medications, psychosis, bipolar disorder, and caring for suicidal patients. However, there is no specific education pertaining to the child and adolescent population and no information provided on patients with eating disorders. On the majority of the units, the casuals receive three orientation shifts and two on J4D. They also attend a one-day therapeutic crisis intervention (TCI) seminar, a two-day applied suicide intervention skills training (ASIST) workshop, and a one-day seminar on gentle persuasion approach (GPA).

Feedback from the casual nurses indicates they find the classroom education sessions to be uninteresting, monotonous, and time-consuming. They attributed this to the fact that the majority of classroom orientation involves daily PowerPoint presentations with information read verbatim from the slides. They also described orientation offered on some of the units as being too short. The casual nurses felt that the orientation on J4D is too short, as it is the only unit in the MHAP that provides care for children and adolescents. As a result, they feel they require more experience in providing care for this population. Conversely, orientation to adult acute care units such as E3A and W3A at the Waterford Hospital were described as sufficient by the casual

nurses. These units admit patients with similar mental health diagnoses and the casual nurses are given a total of three days orientation on each unit.

Senior nurses from J4D are often assigned to complete orientation shifts on the unit with the new hires. The casual nurses described their orientation was chaotic, especially during times when the acuity level was high on J4D. They also voiced that they often did not have the opportunity to attend rounds with the psychiatry and eating disorder teams. They believe attending these rounds would add to their orientation by giving them opportunities to interact with various interdisciplinary team members and discuss the treatment plans for patients they are assigned to care for.

Current Orientation for the Garron Center

A telephone consultation with the clinical leader of development at the Garron Center was also conducted. The unit has a total of 14 inpatient beds where children and adolescents from 5 years of age up to 19 years are admitted. The common types of diagnoses seen include adjustment disorders, mood disorders, schizophrenia/psychosis, bipolar disorder, eating disorders, substance use, anxiety disorders, emotional/behavioral disorders, developmental disorders, personality disorders, and obsessive compulsive disorder (OCD). The number of admissions for 2019 was approximately 250, but in previous years admissions have been between 300-400 patients. Casual nurses are hired specifically for the Garron Center and are not required to float to adult mental health facilities. All nurses, whether part-time, full-time, or casual, receive the same orientation. The orientation includes one-day of online training, which orientates them to the IWK organization and outlines center-wide frameworks. The next five days consist of classroom training, with center-wide orientation provided on the second day and program specific education on the third day. Program specific education includes an overview of

the MHAP, model of care, trauma informed care, stigma, safety, suicide risk assessment policy and documentation tool. The fourth day is a general nursing orientation, which is center-wide for all nurses who are new to the IWK, while the last two days focus on specific education related to mental health and addictions orientation. New nurses learn about topics such as a mental status exam, adjustment disorders, non-suicidal self-injury, psychosis, psychotropic medications, cognitive behavioral therapy (CBT), adolescent development and substance abuse.

Casual nurses hired at the IWK receive the standard unit orientation, which is a total of eight 12-hour shifts. However, the clinical leader of development remarked that they are flexible with orientation. If a nurse feels they require more shifts in order to feel comfortable on the unit, they are generally granted the extra time. During their first shift, the nurse new to the unit is paired with a clinical mentor; an experienced nurse from the unit who is not given a patient assignment. The new staff member attends morning report and rounds. The remainder of the day is focused on reviewing charts, unit practices, policies, IWK intranet, making sure passwords work, and a unit and hospital tour. During days two to seven, the new nurse hires are paired with a preceptor on the unit. An accountability document is provided in order to guide them and their preceptor in tracking what topics need to be addressed during the shifts. A learning needs assessment is also completed by the new hires at the beginning of orientation and shared with their preceptor. Patient assignments are deliberately made to ensure the new hires experience as much variety and opportunity for new learning.

Topics for the Resource Manual

First, both casual and experienced nurses voiced that the casual nurses experience confusion related to the use of the secure area and seclusion room on J4D. It is not clear to them when to use one versus the other and they require further education on how to make an

appropriate decision related to the use of these rooms. The two rooms on J4D cause confusion for the casual nurses as other units in the MHAP have only seclusion rooms that are reserved for patients demonstrating aggressive or harmful behaviors.

Consultations with the nursing staff also revealed their need for specific and focused education surrounding the care of patients with eating disorders. Currently, when casual nurses are assigned to care for patients with this condition they receive no prior training or specialized courses. In fact, because their orientation shifts to the unit are so few, it is possible they will not care for such a patient until they begin working their casual shifts. The casual nurses voiced how this is concerning and problematic to patient care and safety. They described how they feel uncertain and not equipped to care for this patient population. Suggestions were made to address these issues through the use of videos and other learning techniques in the resource manual.

Additionally, the casual nurses disclosed that they are uncertain of the pass protocol and the appropriate visiting age for visitors of patients on J4D. One of them remarked that on one particular shift, there were only casuals working on the unit and they were unsure of the visitation policies. It was recommended by the casual nurses to include information pertaining to passes and visitation in the resource manual.

Furthermore, the nursing staff expressed the need for information about the interdisciplinary team members and the various types of programming that are carried out on the unit. The casuals remarked that due to the numerous interdisciplinary teams who work on J4D, a picture of each person, a description of their professional role, and their contact information should be included in the resource manual. They felt that this could serve as a dual purpose, as it would enhance safety on the unit and the casual nurses would also have a visual identification of staff.

Finally, the casual nurses remarked that they are unfamiliar with the admission and/or discharge process relating to patients on J4D. As the orientation for casual nurses is two days long, many of them do not have the opportunity to experience admitting or discharging patients. Although there are admission kits containing all the necessary documents on the unit, casual nurses did not seem to be aware of them. Therefore, it was suggested that a copy of an admission bundle and checklist for admissions and discharges be included in the resource manual.

Conclusion

It became evident during the consultations that there are numerous insufficiencies relating to the classroom and unit orientation for casual nurses working on J4D. Many of the casual nurses felt a sense of uncertainty and discomfort when assigned to work on the unit. Several recommendations were provided from the casual nurses and seasoned nurses of J4D as to what topics should be included in the resource manual. Findings of the consultations helped to identify the learning needs of casual nurses in the MHAP specifically as they relate to J4D. It is hoped that the creation of the resource manual will address and target the learning needs of the casual nurses in order to assist them to become more confident and comfortable when assigned to work on the unit.

References

Cleary, M., Matheson, S., & Happell, B. (2009). Evaluation of a transition to practice program *for mental health nursing. Journal of Advanced Nursing, 65*(4), *844-850.*

Clipper, B., & Cherry, B. (2015). From transition shock to competent practice: Developing preceptors to support new nurse transition. *Journal of Continuing Education in Nursing, 46*(10), 448-454.

DeSchiffart Marcogliese, E., & Vandyk, A. (2019). Mental health nurses' knowledge of entry-to-practice competencies in psychiatric care. *The Journal of Continuing Education in Nursing*, *50*(7), 325-330.

Dyess, S., & Parker, C. G. (2012). Transition support for the newly licensed nurse: A programme that made a difference. *Journal of Nursing Management*, *20(*5), 615-623.

Inoue, M., Del Fabbro, L., & Mitchell, M. (2017). Assessing the educational needs of mental health nurses working in an adolescent inpatient psychiatric ward in Japan. *Journal of Child & Adolescent Psychiatric Nursing*, *30*(4), 181-185

Laschinger, H. K. S., Cummings, G., Leiter, M., Wong, C., MacPhee, M., Ritchie, J., Wolff, A., Regan, S., Rheaume-Bruning, A., Jeffs, L., Young-Ritchie, C., Grinspun, D., Gurnham, M. E., Foster, B., Huckstep, S., Ruffolo, M., Shamian, J., Burkoski, V., Wood, K., & Read, E. (2016). Starting out: A time-lagged study of new graduate nurses' transition to practice. *International Journal of Nursing Studies*, 57, 82-95.

Leong, Y. M. J., & Crossman, J. (2016). Tough love or bullying? New nurse transitional experiences. *Journal of Clinical Nursing*, 25, 1356-1366.

Murphy, L. J., & Janisse, L. (2017). Optimizing transition to practice through orientation: A quality improvement initiative. *Clinical Simulation in Nursing*, 13, 583-590.

Peltokoski, J., Vehviläinen-Julkunen, K., & Miettinen, M. (2015). Newly hired nurses' and physicians' perceptions of the comprehensive health care orientation process: A pilot

study. *Journal of Nursing Management*, *23*(5), 613-622.

Peternelj-Taylor, C., & Woods, P. (2019). Saskatchewan provincial correctional nurses: Roles, responsibilities, and learning needs. *Journal of Correctional Health Care*, *25*(2), 177-190.

Prince, A., & Nelson, K. (2011). Educational needs of practice nurses in mental health. *Journal of Primary Health Care*, *3*(2), 142-149.

Waite, R. (2006). The psychiatric educational experiences of advanced beginner RNs. *Nurse Education Today*, 26, 131-138.

Walsh, A. (2015). Are new mental health nurses prepared for practice? *Mental Health Review Journal*, *20*(2), 119-130.

Zinsmeister, L. B., & Schafer, D. M. (2009). The exploration of the lived experience of the graduate nurse making the transition to registered nurse during the first year of practice. *Journal for Nurses in Staff Development*, *25*(1), 28-34.

Appendix A

Health Research Ethics Authority Screening Tool

	Question	Yes	No
1.	Is the project funded by, or being submitted to, a research funding agency for a research grant or award that requires research ethics review board? → No		
2.	Are there any local policies which require this project to undergo review by a Research Ethics Board?		✓
	IF YES to either of the above, the project should be submitted to a Research Ethics Board. **IF NO** to both questions, continue to complete the checklist.		
3.	Is the primary purpose of the project to contribute to the growing body of knowledge regarding health and/or health systems that are generally accessible through academic literature?		✓
4.	Is the project designed to answer a specific research question or to test an explicit hypothesis?		✓
5.	Does the project involve a comparison of multiple sites, control sites, and/or control groups?		✓
6.	Is the project design and methodology adequate to support generalizations that go beyond the particular population the sample is being drawn from?		✓
7.	Does the project impose any additional burdens on participants beyond what would be expected through a typically expected course of care or role expectations?		✓
LINE A: SUBTOTAL Questions 3 through 7 = (Count the # of Yes responses)			
8.	Are many of the participants in the project also likely to be among those who might potentially benefit from the result of the project as it proceeds?	✓	
9.	Is the project intended to define a best practice within your organization or		✓

	practice?		
10.	Would the project still be done at your site, even if there were no opportunity to publish the results or if the results might not be applicable anywhere else?	✓	
11.	Does the statement of purpose of the project refer explicitly to the features of a particular program, Organization, or region, rather than using more general terminology such as rural vs. urban populations?	✓	
12.	Is the current project part of a continuous process of gathering or monitoring data within an organization?		✓
LINE B: SUBTOTAL Questions 8 through 12 = (Count the # of Yes responses)			
	SUMMARY **See Interpretation Below**	**3**	**9**

Highlight the Appropriate Interpretation:

- If the sum of Line A is greater than Line B, the most probable purpose is **research**. The project should be submitted to an REB.
- If the sum of Line B is greater than Line A, the most probable purpose is **quality/evaluation**. Proceed with locally relevant process for ethics review (may not necessarily involve an REB).
- If the sums are equal, seek a second opinion to further explore whether the project should be classified as Research or as Quality and Evaluation.

These guidelines are used at Memorial University of Newfoundland and were adapted from ALBERTA RESEARCH ETHICS COMMUNITY CONSENSUS INITIATIVE (ARECCI). Further information can be found at: http://www.hrea.ca/Ethics-Review-Required.aspx.

Appendix B

Recruitment E-mail

Dear Casual Nurses,

My name is Andrea Wright and I am completing my Master of Nursing degree at Memorial University. As part of my practicum project, I am developing a resource manual that aides in the orientation process of the casual nurses that work on J4D. I am sending this e-mail today to kindly ask if we can meet in person for consultations on what you think should be included in the resource manual. The consultations should take no longer than 10-15 minutes of your time. Consultations can take place on either J4D, or at the Waterford Hospital; whichever location works best for you. If meeting in person is not an option at this time, your feedback via e-mail would also be appreciated.

Please respond to this e-mail by March 12th, 2020 to set up a time for consultations. All information shared is strictly voluntary and will remain confidential.

Thank you in advance for your time.

Sincerely,

Andrea Wright BNRN

J4D

Appendix C

Questions to Nurses on J4D:

What are some of the key questions casual nurses have asked while working on the unit?

What did you find most helpful when you started working on J4D?

Have there been any issues when solely casual nurses have worked on the unit?

What would you like to see included in the resource manual?

Questions to Casual Nurses:

What are some of the challenges (if any) you have experienced while working on J4D?

What information do you feel is essential for casual nurses working on J4D?

What resources have you found helpful when working on J4D?

Identify any learning needs you have experienced when working on J4D.

What issues (if any) have you experienced when caring for patients on J4D?

What would you like to see added to the resource manual?

How is it different caring for adolescents with mental illness as compared to adults?

What do you require to help you when going about your day on J4D?

Appendix D: A Unit Resource Manual for Newly Hired and Casual Nurses on J4D

Andrea C. Wright

Master of Nursing

Faculty of Nursing

Memorial University of Newfoundland

St. John's, Newfoundland and Labrador

J4D Unit Resource Manual

Retrieved from:
https://www.123rf.com/photo_47519757_stock-vector-light-bulb-idea-creative-concept-doodle-sketch-hand-draw-background-business-brainstorming-infograph.html

Table of Contents

Welcome to J4D!

- The Janeway is the provincial children's hospital for Newfoundland and Labrador. Any child within the province requiring psychiatric attention is transferred to the Child and Adolescent Psychiatric inpatient unit, J4D, for care. Therefore, children from anywhere in the province use the facilities.

- J4D has a total of 8 inpatient beds and admits children and adolescents up to the age of 18 years with mental illness.

- Children often experience mental health conditions related to but not limited to the following: anxiety and depressive disorders, substance-induced psychosis, unspecified psychotic disorders, adjustment disorders and eating disorders.

Retrieved from: https://www.needpix.com/photo/1445191/welcome-lobster-font-calligraphic-text-title-gradient-colorful-illustration

General Unit Guidelines

- Parents and grandparents of patients are welcome to visit at anytime during daytime hours except during school (the hours for school can be found on p.12 in this manual). Parents may also stay overnight with the patient if they wish. Other relatives, such as siblings, aunts and uncles, or cousins may visit from 1100H to 2100H.

- There have been instances in the past whereby friends of patients have provided illicit substances to the patient while visiting on the unit. This clearly causes problems for patients, families, and others. In order to prevent this from re-occurring, friends of patients are not permitted to visit on the unit. However, if a patient is provided with passes to go off the unit and their parent/guardian is agreeable, they may meet up with their friend within hospital grounds. Patients must be accompanied and supervised by their parent or guardian at all times during the pass.

- No electronics with recording capabilities are permitted out of respect for patient and staff confidentiality. This includes patient cell phones. On admission, patients are asked to either give their cell phone to their parent or guardian for safe-keeping while they are in hospital, or it can be stored in the J4D medication room (which is locked). However, patients are welcome to use the unit telephones at the nursing station from 0800 to 2200H. Phone use outside of these hours is at the discretion of the nursing team. Outside of school hours, patients may be able to use the computer at the Child Youth Care Workers (CYCW) station under the supervision of J4D staff.

- As per Eastern Health J4D Mental Health & Addictions program policy (275H-JWPS-260), bathroom use for all patients must be supervised. This is important as it helps to ensure patient safety, especially if they have a history of self-harm or suicidal gestures. Patient privacy is maintained by keeping door ajar. When bathrooms are not in use, they are to remain closed (doors lock automatically).

- Patients may bring in snacks from home and store in the kitchen. However, patient food is to be retrieved by nursing, as patients are not permitted in the kitchen area.

- If patients wish to socialize with co-patients, they may do so in lounge areas, as they are not permitted in other patients' rooms.

- On admission to unit and when returning from a pass off the unit, patient's belongings are checked for any harmful objects or substances (as per Eastern Health policy 275H-CPC-170). If any are found, they are removed and either given to patient's parents to take home, or stored on the unit until patient is discharged.

- No sharps (razors, pencil sharpeners, paper clips, scissors) are kept in patient rooms. They are to be stored in patient's belongings bin inside CYCW office. If a patient wishes to use any of the objects listed above, it is at the discretion of staff and patient must be supervised by staff. Please ensure sharps are returned after use.

- No phone use after 2200H, with the exception of extenuating circumstances, such as if a patient is feeling unwell or to help console a young child who may be missing their parents.

- Routine observation checks are completed every 15 minutes and involve nursing or CYCW staff physically visualizing each patient on the unit.

Patient Bedtimes

- Sleep hygiene is a term used to describe behavioral and environmental strategies that foster healthy sleep. Such behaviors include refraining from caffeine intake in the evening, routine exercise, a quiet environment before going to bed, and a routine sleep schedule (American Academy of Sleep Medicine, 2020).

- In order to promote positive sleep hygiene practices for patients on the unit, the following bedtimes are encouraged:

  - 2 to 4 year olds: 2000H
  - 5 to 8 year olds: 2030H
  - 9 to 10 year olds: 2100H
  - 11 to 12 year olds: 2130H
  - 13 to 15 year olds: 2200H
  - 16 to 18 year olds: 2300H

Retrieved from: https://pixabay.com/illustrations/sleep-smiley-tired-bed-good-night-2001207/

- At the discretion of nursing staff, patients may be granted an extra 30 minutes before going to bed on Monday, Friday and Saturday HS. If a patient is behaving inappropriately (i.e: resulting in placement in the secure area or seclusion room), routine bedtime will be followed.

- Nursing staff can apply discretion to patient bedtimes during special events, such as sporting or concerts on TV, or a patient's birthday.

J4D Staffing Ratio

- Typically working on a **day shift**, there are either 2 RNs and 1 CYCW, or 3 RNs. During weekdays (Monday-Friday), the patient care facilitator (PCF) is also present on the unit.

- On **nightshift,** there are generally 3 RNs scheduled.

- These ratios are for when the acuity on the unit is status-quo, i.e: there are no patients on constant observation and no patients in the secure area or seclusion room. If the acuity on the unit is high or patients are on constant observation, extra staffing is likely needed.

- However there are times when you may be scheduled to work on J4D, but be floated to HSC Adult Psychiatry unit. For example, if the acuity on J4D is low (i.e: only one or two patients on the unit, none of whom require constant observation or placement in the

secure area or seclusion room), casual staff are expected to take turns floating to the Health Sciences Adult Psychiatric Unit when the unit manager or site clinical coordinators determine it to be necessary.

Breaktimes

- As per the Registered Nurses Union of Newfoundland and Labrador (RNUNL[RNUNL, 2016]), registered nurses are entitled to the following breaks for a 12-hour shift:
  - 15 minutes during the AM and 15 minutes in the afternoon.
  - 30 minutes for lunch.
  - 30 minutes for supper.

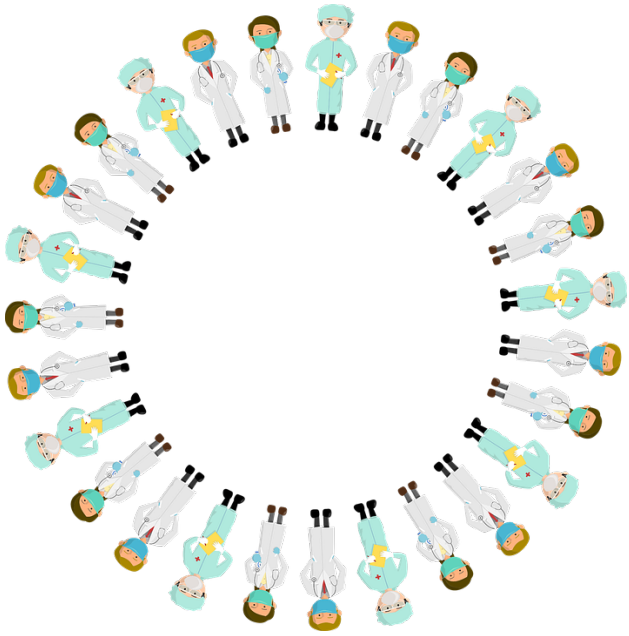
Retrieved from: https://www.needpix.com/photo/1743498/break-time-out-background-interruption-rest-wood

- In the event that J4D is understaffed or acuity on the unit is high and staff cannot relieve each other for breaks, the nurse in charge may call the mental health and addictions site clinical coordinator at 777-3696 to request staff from HSC adult psychiatry to relieve for breaks. If this is not possible, it is recommended J4D nursing staff document missed breaks in the payroll binder located in the blue “Payroll Requests” binder located inside of the nursing station, and request either banked time or pay in lieu of a missed break.

Inpatient Staff Psychiatrists

- Although J4D is a relatively small inpatient unit, there are a total of eight child and adolescent psychiatrists that work with and care for both the inpatient and outpatient population.

- Dr. Weldon Bonnell
- Dr. Richard Elcock
- Dr. Tina McWilliam
- Dr. Rajiv Rajan
- Dr. Chantel Reid
- Dr. Christine Snelgrove
- Dr. Kim St. John
- Dr. Leslie Wheeler



Retrieved from: https://pixabay.com/vectors/doctor-physician-frame-medical-5010719/

- Listed below are the office phone numbers for the psychiatrists' secretary if nursing staff need to contact them during their office hours:

  - Secretary for Dr. Bonnell and Dr. McWilliam: 777-4121

  - Secretary for Dr. Rajan and Dr. White: 777-4476

  - Secretary for Dr. Reid and Dr. Wheeler: 777-4224

  - Secretary for Dr. St. John, Dr. Snelgrove, and Dr. Elcock: 777-4197

- When patients are admitted to the unit they are cared for by the on-call psychiatrist and usually remain under their care for the entirety of their stay.

- <u>The nine inpatient psychiatrists also have outpatient clinics</u>. If a patient from their outpatient practice is admitted, they are generally cared for by their attending psychiatrist.

- When it is necessary for nursing staff to contact a psychiatrist regarding a patient's care (from 0830 to 1630H Monday to Friday), check first and determine whether a resident is involved in their case. If so, call the resident first. If there is no resident involved with the care, contact the attending psychiatrist.

- Outside of office hours (evenings and nights, or on weekends), it is usually the resident on-call paged first with any questions or concerns.

- The on-call schedule for psychiatric residents and staff psychiatrists can be found inside the J4D nursing station on the wall beside the main computer. It is clearly labeled and is posted on a monthly basis.

J4D Hospital School

- School is an important aspect of any child's development. However, when they are admitted to hospital school, learning and social interactions can be interrupted. The Janeway recognizes the importance of school and has in place short-term interventions for children who are out of school for medical reasons. Although instructions on each subject for all grades cannot be provided, the Janeway can offer lessons in four main subject areas, including: English, Mathematics, Science and Social Studies. These are offered so that patients are able to continue with their academics during admission and to also aid with the transition of returning to their local school.

Retrieved from: https://pixy.org/4247998/

- Provides short-term academic interventions for children who are admitted to hospital and therefore unable to attend their local school.

- New patients to J4D spend 24 hours on the unit prior to attending school to give them time to settle on the unit and ensure that their behavior is appropriate and conducive to a learning environment (i.e: no psychosis or acts of violence on the unit).

- The hospital school is staffed from 0815H to 1515H Monday to Friday.

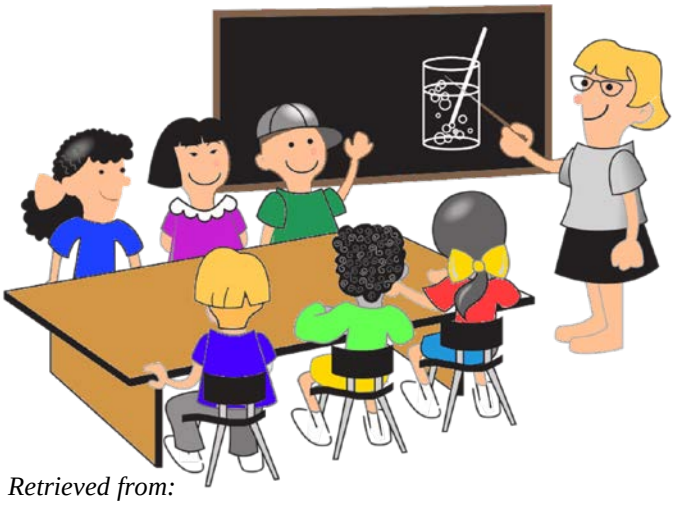
- All patients attending J4D school, which is located down the hall from the staff break room, must be escorted to and from the ward by their assigned teacher or nurse.

- It is the responsibility of nursing staff to ensure that patients are prepared, organized, and are at the front nursing station by 0930H during weekdays (except at 1100H on Tuesdays due to psychiatry rounds) for the teacher to escort them to class.

- The teacher escorts the patients back to the unit at 1040H for recess and meets them at the front nursing station at 1100H to bring them back to class. The teacher also escorts the patients back to the unit at lunchtime (1200H) and when class is over (see J4D school instructional hours on p.14 for daily school schedule).

Meet the Teachers!

- Jill Cluney, M.Ed (Guidance), J4D principal
- Kim Davis, M.Ed (Curriculum), intermediate/secondary
- Jacinta Gaulton, M.Ed (Leadership), intermediate/secondary



Retrieved from: https://www.needpix.com/photo/600301/blackboard-boys-chalkboard-children-classroom-desk-females-girls-kids

J4D School Instructional Hours:

- Monday 0930H to 1200H and 1300H to 1450H
- Tuesday 1100H to 1200H and 1300H to 1450H
- Wednesday 0930H to 1200H and 1300 to 1350H
- Thursday 0930H to 1040H and 1300H to 1450H

Music Therapy

Friday 0930H to 1200H and 1300 to 1350H

Retrieved from: https://thenounproject.com/term/music-therapy/1250229/

- Music therapy is offered to all Janeway inpatients on Medicine, Psychiatry, Surgery and PICU who may be interested in participating.

- It is also offered to Janeway outpatients in the areas of Child Development, Medical Daycare, Psychiatry, and Rehabilitation.

- Music therapy is “a discipline in which credentialed professionals use music purposefully within therapeutic relationships to support development, health, and well-being. Music therapists use music safely and ethically to address human needs within cognitive, emotional, musical, physical, social, and spiritual domains” (Canadian Association of Music Therapists, 2016).

- Music therapists receive special training which enables them to assess their patients and create a treatment plan that has goals, objectives and an evaluation of treatment.

- Any patient on J4D that is interested in music therapy can be referred to the program. If a patient is interested in music therapy, a standard consultation form must be completed by the patient's attending physician or resident and placed on the patient's chart. Nursing staff also notify the music therapist of the referral via telephone.

Some examples of goal areas include:

- ✓ fine and gross motor movement
- ✓ muscle strength and mobility
- ✓ motor coordination skills
- ✓ communication
- ✓ self-expression
- ✓ emotional expression
- ✓ learning of new skills
- ✓ speech and language

- ✓ focus and attention span
- ✓ self-esteem
- ✓ relaxation
- ✓ pain management
- ✓ socialization
- ✓ sensory stimulation

- Music therapy sessions on J4D most often take place in an individual setting, but can also occur in group or family settings. The music therapist usually meets with referred patients either in the patient's room, or in the lower lounge on the unit (Room number 4J334). The music therapy sessions occur on weekdays generally outside of school hours.

- Sessions include:
    - ➢ Singing
    - ➢ Instrument playing
    - ➢ Composing
    - ➢ Improvising

- Moving to music

- Susan LeMessurier Quinn is the accredited music therapist (MTA) for the Janeway. She can be contacted at 777-4805.

Art Therapy

- Art therapy is the healing practice of creating art within a professional relationship (Canadian Art Therapy Association, 2020).

  - Art therapy has many benefits, including:

    - Promoting a heightened sense of self-awareness and awareness of others.

    - Providing a means to cope and work through difficult experiences.

Retrieved from: https://upload.wikimedia.org/wikipedia/commons/1/17/Art_as_Therapy.jpg

    - Advancing problem-solving skills.

    - Shining insight and perspective on various experiences.

    - Improving concentration (Canadian Counselling and Psychotherapy Association, 2012).

- If a patient is interested in art therapy, a standard consultation form must be completed by the patient's attending physician or resident and placed on the patient's chart.

- Bev King is the art therapist for J4D. She can be contacted at 777-4618

Inpatient Psychology

- Depending on individual circumstances and at the discretion of the psychiatry team, patients admitted to J4D may be referred to the psychologist on the unit.

- Dave Jeans is the clinical psychologist for inpatients of J4D. His secretary may be reached at: 777-4020.

- If the patient's psychiatrist or resident refers the patient to psychology, they fill out a consultation form requesting same. Nursing staff notify Dave's secretary of referral via telephone.

Retrieved from: www. https://thenounproject.com/term/psyche/11424/

Seclusion Room and Secure Area

- The secure area on J4D is located at the back of the unit (4J310) and consists of a hallway, which also holds a patient bedroom and patient bathroom. The seclusion room is a singular room just around the corner from the secure area. The seclusion room has a blue mat in which the patient may lie or sit on, but there are no other objects and there are no windows.

- The secure area on J4D is less restrictive than seclusion, as it is an actual hallway and the patient has their own bedroom.

- As per Eastern Health policy (PRC-080), least restrictive measures are attempted as the first line of intervention when a patient's behavior places them at an increased risk of harm to self or others. Least restrictive measures may include distraction, verbal de-escalation, or administration of PRN medications.

- However, in some instances, least restrictive measures may not be effective, or a patient's behavior may escalate quickly, such as suddenly striking out physically at staff or co-patients, or self-

injurious behavior without any prior indication. In these situations, a patient may have to be placed in the secure area or seclusion room on J4D.

- There is no actual Eastern Health policy on the use of the secure area on J4D. However, the following situations are **examples of behavior** that would constitute **placing a patient in the secure area:**

  - If a patient is disrobing on the unit and refusing to put clothes back on.

  - When a patient is demonstrating aggressive behavior while being assessed in the emergency department but have since calmed, this patient could be placed in secure area on admission as a precaution. Generally, the time-frame for this would be 12 to 24 hours, in order to give adequate time to ensure no aggressive tendencies are present.

  - If a patient is throwing items/objects or yelling on the unit and is not re-directable, i.e: not able or willing to listen to staff members' attempts to calm or de-escalate their behavior.

  - When a patient was in seclusion and seclusion is discontinued, they may first be placed in the secure area to ensure their behavior is appropriate before being integrated back to the main unit.

- Nursing staff can place a patient in the secure area. However, it is important to ensure the patient's psychiatrist is aware and obtain a directive for this when it occurs. If it is after hours, the psychiatry resident on-call should be notified. The patient's parents or

guardians should also be made aware of the situation as soon as possible.

- The patient is placed on constant observation with one Eastern Health staff and one member of security. In some instances, more security may be needed. For example, if a patient in secure area displays aggressive behaviors towards self or others, extra staff is likely needed to escort the patient to the seclusion room until their behaviors are settled.
- Daily ongoing assessment is required when patients are in the secure area. In consultation with the psychiatrist, nurse, and patient, a decision will be made as to whether the patient is ready to be integrated back to the main unit. When that decision is made, be sure to obtain a written directive from the patient's psychiatrist.

- There are times when the seclusion room is needed. However, this is as a **last resort**. Some of the more common types of diagnosis experienced by patients that are placed in the seclusion room include: substance-induced psychosis, psychosis not otherwise specified, and patients with personality disorders. Behavior that constitutes **placing a patient in seclusion** includes but is not limited to:

- Overt acts of aggression towards staff, other patients, or self, including: hitting, kicking, biting etc.

- The patient is also placed on constant observation with one Eastern Health staff member and one member of security.

- When patient is placed in seclusion room, the patient's psychiatrist is to be notified during working hours. If after hours, the psychiatry resident on-call should be notified.

- The patient's parents or guardians should also be made aware of the situation as soon as possible.

- The patient will remain in seclusion until their behavior settles. However, physician assessment for continuation of seclusion is monitored more closely than when a patient is in secure area. If a patient is certified under the Mental Health Care and Treatment Act (2014), they are to be assessed every four hours (a patient may be certified on admission to the unit, or they may need to be certified at a later point in time during their admission). If the patient is not certified, they are to be assessed within an hour of being placed in seclusion.

- Directives from the physician are required to discontinue seclusion for a patient. The physician must also indicate whether or not they want the patient to remain on constant observation, or change the patient's level of observation to close. If not written, then be sure to ask and have them clarify their directive.

- Nursing staff should refer to the Eastern Health Seclusion Policy on the intranet: 275H-JWPS-290 when a patient is placed in seclusion. This policy also indicates which paperwork is required to be completed when a patient is placed in seclusion, such as the restraint assessment and constant observation behavioral checklist. These documents can be found in the filing cabinet at the nursing station on J4D, or may be retrieved from the Eastern Health intranet under "forms" and then searching for the applicable documents.

Admissions to J4D

- Patients being admitted to J4D are generally admitted by the psychiatrist on-call through the Janeway ER department. On occasion, patients may also be directly admitted from their outpatient psychiatrist's office.

Retrieved from: https://thenounproject.com/term/chart/126553/

- When the patient is ready to be brought to J4D from Janeway ER, nursing staff from J4D go to Janeway ER and escort patient to unit.

- On admission, ensure the following physician orders are written on the patient's order sheet:

  - ✓ Level of surveillance while on unit
  - ✓ Diet
  - ✓ Activity level
  - ✓ Admitting diagnosis
  - ✓ Depending on whether or not the patient has had recent bloodwork drawn, there may be orders requesting bloodwork.
  - ✓ If a patient admits or is suspected of substance use, a urine sample may be ordered.

- Admission paper work is tremendous. Therefore, admission bundles have been developed for the convenience of nursing staff. They are stored in the nursing station, located in a black mailbox on the wall next to the computer. The admission bundles generally contain all of the required paperwork when completing an admission, including:

  - ➢ Admission Checklist

- Aftercare Information Sheet
- Consent forms (for art therapy, pet therapy, release of information, school information). If a patient is 16 years of age or older, they can sign their own consent forms. Patients under the age of 16 must have their consent forms filled out by their parent or guardian.
- Consultation Forms
- Discharge Summary
- Little Schmidty Fall Risk
- Medication Order Sheets and Medication Kardex
- Nursing Anger Management form
- Patient Belongings Sheet
- Patient Kardex
- Patient Order Sheets
- Progress Notes
- Psychiatric Nursing Assessment
- Social Work Screening
- Vital Signs Record

- **Attention:** Ensure carbon copies of patient medication directives are torn off and either placed on the wall next to the pneumonic tube system for pharmacy staff to pick up, or they can be sent to the pharmacy using the pneumonic tube system by placing the order in a tube and pressing “132” for pharmacy and then “send”.

Discharging Patients from J4D

- Although the length of admission varies for each patient on the unit, one of the main goals for each patient is to discharge them with the appropriate support services put in place. Discharge planning occurs the moment a patient is admitted and continues throughout their stay.

- Before a patient is discharged, ensure there is a physician directive written on the patient's order sheet for discharge.

- If a patient needs a prescription for medication, ensure it is filled out and signed by the patient's physician or resident.

- Fill out the patient's Aftercare Information sheet and write down all follow-up appointments that are applicable. Review this with patient/parents and have them sign the sheet where indicated. Ensure patient/parent is given the yellow copy of the Aftercare sheet.

- Ensure patients belongings sheet is checked and return any belongings to them that were placed in the medication room or CYCW office during admission. This may include:

  - Medications or cell phone/chargers (usually stored in J4D medication room)

  - Patient toiletries (stored in the CYCW office)

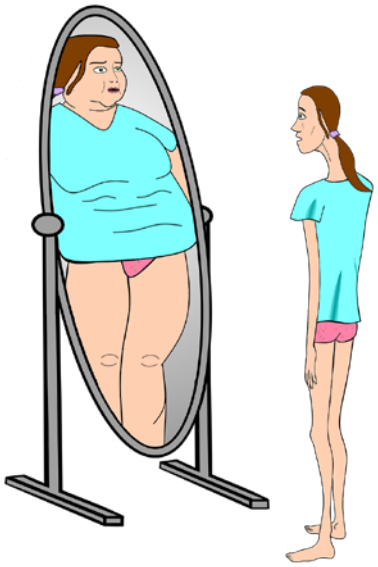
  - Food items brought in by patient/family (stored in J4D kitchen).

- When patient has left unit, ensure nursing staff complete patient Document Interventions on Meditech. When they are completed, discharge patient from Meditech.

- Notify housekeeping staff of patient's discharge so that patient's room/bed can be cleaned. Housekeeping staff can be reached by dialing 777-0900 and selecting option 3.

- If after 1600H on the weekdays, or during weekends, notify the site clinical coordinator for Mental Health and Addictions at 777-3696 to ensure they have accurate patient count.

Eating Disorders



Retrieved from: https://pixabay.com/illustrations/bulimia-anorexia-nervosa-4049661/

- Characterized by significantly altered eating habits.

- Usually start in adolescence and women are ten times more likely to develop an eating disorder than men (Stats Canada, 2015).

- According to Stats Canada (2015), the prevalence of anorexia nervosa among young females is 0.04% and 0% for males. The

prevalence of bulimia nervosa in young females is 0.3% and 0.2% in young males. Although binge eating disorders occur most frequently across the lifespan, anorexia and bulimia are more debilitating.

Types of eating disorders:

- Anorexia Nervosa
- Binge Eating Disorder
- Bulimia Nervosa
- Avoidant Restrictive Food Intake Disorder (ARFID)

Anorexia Nervosa

- Many individuals with this type of eating disorder experience difficulties with their body image and have an extreme fear of becoming obese. The fear does not dissipate in spite of weight loss (National Eating Disorders Association, 2018).
- Individuals with anorexia nervosa oftentimes restrict their food and caloric intake and experience significant weight loss or inadequate weight gain in children (National Eating Disorders Association, 2018).
- Excessive exercise, purging via vomiting and laxatives, as well as binge eating can also be experienced by individuals

with this disorder (Anxiety and Depression Association of America [ADAA]).

- Approximately 20-30% of individuals with anorexia will attempt suicide (Stats Canada, 2015).

- It is believed that 5% to 20% of individuals with anorexia will ultimately die due to complications from the disorder (Stats Canada, 2015).

- It is one of the most prevalent psychiatric illnesses experienced by young women (Stats Canada, 2015) and is the most common type of eating disorder seen on J4D.

Binge Eating Disorder

- Characterized by frequent or ongoing episodes of eating large portions of food; in many instances, the food is eaten very fast, leading to feelings of physical discomfort (National Eating Disorders Association, 2018).

- During the episode of binging, the individual may feel a sense of loss of self-control (National Eating Disorders Association, 2018).

- Feelings of anguish and guilt are commonly experienced once the binge is over.

- As per the National Eating Disorders Association (2018), Diagnostic criteria include:

- Eating much larger portions of food than most individuals would consume in the same time-frame (i.e: within a two-hour period).

- Feelings of loss of self-control (cannot stop eating or control the portion of food consumed).

- Binging occurs usually a minimum of once weekly for at least 3 months.

- Individuals with binge eating disorder do not engage in inappropriate compensatory measures, such as purging, as is seen in cases of bulimia nervosa.

ARFID

- Individuals with Avoidant Restrictive Food Disorder restrict the amount and/or types of food they eat. However, they do not experience any negative thoughts about body image or fear of becoming overweight (National Eating Disorders Association, 2018).

- They do not eat enough calories to grow and develop sufficiently, which results in impairment of body functions.

- Individuals may not eat due to sensory attributes of food, or they may experience fears of choking or swallowing certain foods.

Bulimia Nervosa

- The individual experiences frequent episodes of binge-eating. Similar to individuals with a binge-eating disorder, symptoms of Bulimia Nervosa include two of the following criteria:

- Eating much larger portions of food than most individuals would consume in the same time-frame (i.e: within a two-hour period).

    - Feelings of loss of self-control (cannot stop eating or control the portion of food consumed [National Eating Disorders Association, 2018]).

- Unlike individuals with a binge-eating disorder, individuals with Bulimia Nervosa participate in continual compensatory mechanisms to stop themselves from gaining weight, such as: self-inflicted vomiting, laxative abuse, fasting, and/or extreme exercise (National Eating Disorders Association, 2018).

- Such behaviors usually occur at least once/week for three months.

J4D Eating Disorder Program

- There are two inpatient beds allocated for patients with eating disorders on J4D. If there aren't any beds available on the unit, patients with eating disorders are admitted to J4 Medicine.

- In some instances, patients that are not medically stable may initially be admitted to J4 Medicine or Pediatric ICU (PICU) and transferred to J4D when they become medically stable. Conversely, if a patient is on J4D and becomes medically unstable, they may have to be transferred to J4 Medicine or PICU.

- The parameters for transfer to Medicine or PICU include the following:

    - A sustained heart rate of less than 35 beats/minute.
    - A systolic blood pressure of less than 76 mmHg.
    - An orthostatic blood pressure decrease of greater than 25 mmHg.
    - Moderate to severe metabolic abnormalities (significant electrolyte changes) at the discretion of the attending physician.
    - Prolonged QTc interval on EKG (at the discretion of the attending physician).

- Any questions pertaining to patients with Eating Disorders are directed to the adolescent medicine team (**not psychiatry**). The on-call resident for the adolescent medicine team may be reached by dialing "0" for the operator and requesting that they page the adolescent medicine resident on-call to either 777-4406 or 777-4488.

- When possible, Rooms 4J346 and 4J323 are allocated for patients with Eating Disorders. These two rooms are closest to the nursing station and are best suited for patients that need to be "in view" after meal support (discussed later).

Meet the Team!

- Dr. Zahra Alebraheem, M.D. Office Phone # (secretary) 777-4963

- Dr. Anna Dominic, M.D. Office Phone # (secretary) 777-4963

  - Dr. Alebraheem and Dr. Dominic are two of the physicians for the Adolescent Eating Disorder Program. They care for both inpatients and outpatients with eating disorders.

- Amy Kendall (RSW, MSW) Phone # 777-4889

  - Amy is a Registered Social Worker and provides individual counseling to patients with eating disorders and their families on both an inpatient and outpatient basis. Amy usually meets with patients in the program at least once per week.

- Tanya Martin (R.D) Phone # 777-4326

  - Tanya is the Registered Dietician for the Adolescent Eating Disorder Program. Part of her role includes selecting appropriate nutrition for patients with eating disorders and creating daily food menus for them during their admission. Tanya also provides education on the importance of adequate nutrition to inpatients as they progress to Stages 3 and 4, and to outpatients as well. Parents/Guardians are also involved in the education on nutrition and meal planning at home.

Miranda Pond, M.Sc (Clinical Psychologist) Phone # 777-4482

- Miranda is the clinical psychologist for the Adolescent Eating Disorder Program. She also provides individual counseling to patients and their families on both an inpatient and outpatient basis. Miranda usually meets with patients in the program at a minimum of once per week.

Orthostatic *Vital Signs*

Retrıevea ʃrom: https://pixy.org/472388/

- Generally obtained every 4 hours while patient is awake.
- Ensure the patient is lying flat on their bed for 5 minutes, with arms and legs straight by their side. Once the 5 minutes is up, obtain their blood pressure and radial pulse manually (count for a full minute).
- After the patient's vital signs have been obtained while lying down, instruct the patient to stand with arms by their sides for 2 minutes. Once the 2 minutes are up, obtain their blood pressure and radial pulse manually (once again, for a full minute).

- The patient's temperature is usually taken once every 4 hours while awake as well.

Pulse Gap

- Calculated by obtaining the difference of patient's lying and standing pulse.

  Example: A patient's radial pulse while lying down is 46 and their radial pulse while standing is 112.

  - 112-46=  66

  - The patient would have a pulse gap of 66.

- The patient's pulse gap is also charted on their vital signs record and is calculated each time the orthostatic vital signs are taken.

- Cardiac monitors are stored in the treatment room (4J343) on the unit.

- Electrodes for applying to the patient's skin can be found in the J4D medication room (4J351).

- A physician from the adolescent medicine team will write the directive on patient's order sheet if they want the patient to be on a cardiac monitor. Generally, eating disorder patients on Stage 1 of the Eating Disorder Protocol ([EDP] described in detail further on) are on continuous cardiac monitoring and their heart rate is recorded on their vital signs record hourly at night (i.e: 2400, 0100H, 0200H, 0300H, 0400H, 0500H, 0600H).

- When a patient progresses to Stage 2 of the EDP, continuous cardiac monitoring is usually discontinued, and they are ordered cardiac monitoring only during the night (i.e: when they settle to bed until 0730H).

- Parameters for a patient's high and low heart rate are ordered by the doctor on patient's order sheet and then set on the cardiac monitor. Commonly, the low setting is <35 bpm and high is >120.

- If a patient's heart rate is at a prolonged rate of <35 or >120, notify adolescent medicine physician of same.

- If unfamiliar with setting the parameters on the cardiac monitor, or unsure of how to connect a patient to it, nursing staff from J4 Medicine can be contacted for assistance (777-4384 or 777-4342).

Intake and Output

- Usually ordered to be monitored for patient's on Stages 1-3 of the EDP.

- The physician will write a directive for the minimum and maximum amount of fluid intake and write same on the patient's order sheet, which is also written in the patient's kardex. E.g: Min=2100mls, Max=3500mls.

Retrieved from: https://www.amazon.com/Specimen-Collection-Unit-QTY-1/dp/B002ZUCVP0

- It is important to take note of a patient's fluid minimum and maximum needs to

ensure that not only do they receive enough fluids throughout the day, but that they do not go over the maximum ordered amount.

- All fluids and food eaten during the day are recorded on the patient's intake and output record, as well as food intake record.
- Urine hats for measuring urine output are stored in Medication Room on J4D (4J351).

Weight Monitoring

- Daily weights are usually obtained for all patients with eating disorders throughout their admission.
- Directives for weight monitoring will be written on the patient's order sheet by the physician.
- The weight of patients with an eating disorder is taken in the AM (Generally ~ 0700H). Ensure the patient voids first.

Retrieved from: https://www.globalindustrial.ca/p/medical-lab/scales/floor/industrial-bench-floor-scale-330-lb-x-0-1-lb?infoParam.campaignId=T9F&gclid=EAIaIQobChMIvK3X_-LB7AIViI7ICh1rqwFYEAkYAiABEgK1J_D_BwE

- Patients may keep on their underwear, but remove all other clothing items and jewelry and put on a hospital gown.

- The scale for measuring patients' weight is located in the Treatment room, 4J343.

- On the weight scale, ensure "kilograms" is selected, as this is the default weight measurement.

- The patient is to step onto the scale backwards, so they are unable to see their current weight and are not to be told how much they weigh (unless otherwise specified by physician).

- Patient's weight gets recorded on the patient's vital sign record, which is recorded near the bottom of the page.

Common Tests Ordered for Patients with Eating Disorders

- There are several tests that are commonly ordered for patients with eating disorders during their admission to J4D/J4 Medicine.

- The physician will write directives for the following tests (if indicated) on the patient's order sheet.

Bloodwork

- Usually, daily bloodwork is ordered for patients with eating disorders during the first seven days of their admission. The attending physician may order it for longer if abnormalities continue, or they may order it for a shorter time frame.

Retrieved from: https://commons.wikimedia.org/wiki/File:Vacutainer_blood_bottles.jpg

- Entered in Meditech for 0800H and collected by lab technician.

- Normally, bloodwork is entered by patient's assigned nurse on night shift, prior to the AM that it is collected.

- Common bloodwork ordered for patients with eating disorders includes:

  - CBC
  - Electrolytes
  - Extended Electrolytes (Ca, Mg, Phos)

Bone Mineral Density

- The nurse assigned to the patient receiving this test is responsible for entering the order in Meditech.

- To enter this test in Meditech, go to:

  - Order Entry, then "Enter Care Orders"

- Category: DINM
- Procedure: NMAPPT

Echocardiogram

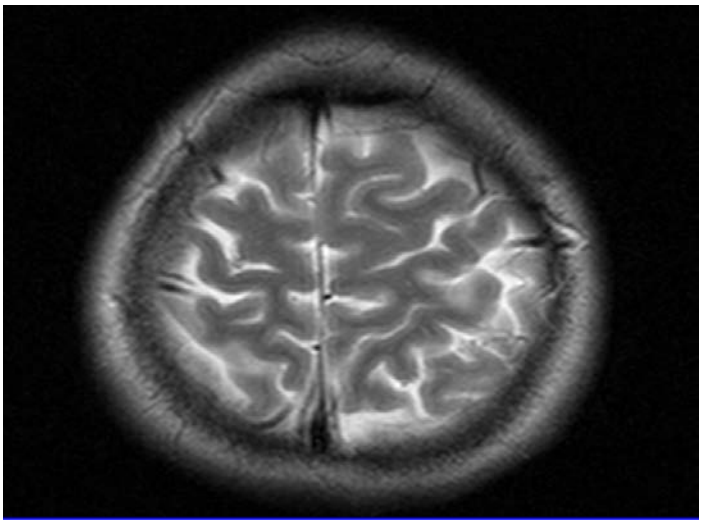
- Normally performed by the cardiac technician at the Janeway. However, it is the assigned nurse's responsibility to ensure the test is entered in Meditech.
- It is completed in the Cardiology department (3rd floor of the Janeway).
- To enter this test in Meditech, go to:
  - Order Entry, then "Enter Care Orders"
  - Category: ECGD
  - Procedure: ECG
  - Ordering Site: J
- The phone number for the Janeway Cardiology department is 777-4581.

Brain MRI

- To request this test, a doctor from the adolescent medicine team will fill out the “Request for Magnetic Resonance Imaging (MRI)” form.

- Once the form is completed, it is faxed by a nurse or wardclerk to the Janeway MRI department for booking.

- When bringing a patient to their MRI appointment, please ensure that the Diagnostic Imaging Program Magnetic Resonance Procedure-Patient Screening Form is filled out. Copies of this form can be found in the filing cabinet on J4D, or from the Eastern Health intranet.



Retrieved from: https://commons.wikimedia.org/wiki/File:MRI_brain_surface_normal.jpg

Urine for Specific Gravity

- Collected from patient's first AM void (generally collected ~0700H prior to taking patient's daily weight and vitals).

- To enter this test in Meditech, go to:

  - Order Entry, then "Enter Care Orders"

  - Category: LAB

  - Procedure: URINAP

Eating Disorder Protocol

- Collected in urine bottle, which can be found in J4D Med-room cupboards, Rm # 4J351.

- The Eating Disorder Protocol (EDP) for J4D encompasses four stages.

- Each stage of the protocol (described below) is a general guide to the treatment and restrictions that encompass each stage. However, the patient's physician may decide to alter certain aspects of the stages at their discretion.

- Generally, when patients are first admitted to the unit, they are placed on Stage 1 of the protocol. They then progress throughout the remaining stages during the remainder of their admission.

- Most patients with eating disorders are admitted to J4D for four to six weeks.

- Patients on Stage One and Two of EDP are permitted to have a landline and TV in their rooms due to restrictions on activity level. Once a patient progresses to Stage Three, the landline and TV are removed from their room and they are encouraged to avail of same in lounge areas if they wish.

Stage One

- Patient is on bedrest with bathroom privileges. When patient is weighed in the AM, or has to go for any procedures or tests, they are to go via wheelchair.

- Continuous cardiac monitoring (for heart rate only).

- Urine for Specific Gravity collected daily with first AM void.

- Daily weights (0700H).

- Patient may have sponge-bath at bedside. It is at the discretion of the physician whether or not to order sit-down showers for patients. When a sit-down shower is indicated, it is generally no longer than 10 minutes. Shower chair can be found on the unit and is stored in one of the bathrooms.

- Patients with eating disorders are encouraged to use the washroom before meals and snacks, as they are not permitted to use the washroom for 1-hour post-meals and snacks. As per J4D unit rules, the patient's bathroom door is to be left ajar whenever they wish to avail of it. Staff must remain outside of the bathroom door.

- Dietician selects meals and snacks for patient (menus are usually completed a couple of days in advance and are placed on the front of patient's chart).

- Nursing staff or CYCW to check patients' food items at snack and mealtimes against the patient menu to ensure that food items are correct.

- Prior to admission to hospital, mealtimes are often a significant source of stress for the patient and their family. Therefore, nursing staff or CYCW provide all meal/snack support for patient during this stage. If a patient's parent/family member is visiting during meal or snacktime, they are asked to leave during this time and may return once the patient is finished eating.

- Patient not permitted to attend J4D school at this stage.

Requirements to Move to Stage Two:

- ✓ Patient must be gaining at least 1.0 kilogram per week.

- ✓ A heart rate of greater than 45 bpm during the daytime sustained for at least 48 hours.

- ✓ A temperature of at least 35.5°C.

✓ Patient must be metabolically stable.

Stage Two

- Cardiac monitoring is usually discontinued during the daytime, but still ordered for overnight heart rate monitoring (same recorded q.hourly on patient's vital signs sheet).

- Patient on "couch-rest", but may get out of bed to tend to ADL's.

- Patient may have "sit-down" showers for a maximum of ten minutes; one per day.

- Urine for specific gravity on first AM void.

- Daily weight in AM.

- Patient to eat all meals and snacks in upper lounge area. Nursing staff or CYCW still provide meal support during this stage and patient continues to be required to be "in view" for 1-hour post-meals and snacks.

- Nurse or CYCW on J4D to continue to check patient's meal tray against menu on chart to ensure it is correct.

- Patient may walk to upper lounge for meals and snacks at medicine team's discretion.

- Medicine team may order walks around unit for the patient.

- Patient may start doing some school work in their room.

Requirements to Move to Stage Three:

- ✓ Patient must gain at least 1.0 kilogram/week.
- ✓ Patient's heart rate must be sustained at least 50bpm during the day and 45bpm overnight for 48 hours.

- ✓ Patient's temperature must be a minimum of 35.5°C.

- ✓ Stable v/s, including a heart rate gap of less than 35 beats/minute; systolic blood pressure change of less than 20mmHg; blood pressure greater than 80/45 mmHg for at least 48 hours.

Stage Three

- Daily weight in AM.

- Urine for specific gravity with first AM void.

- Patient may have showers standing up, but they are to remain brief (i.e: no longer than 10 minutes). As per agency policy, patient is still to be monitored with door ajar and staff supervising outside of bathroom door.

- May attend J4D school.

- Accompanied passes may be ordered for patient by attending physician. Usually, patient is at least 80% of minimum weight for health for passes to occur.

- Patient continues to eat meals and snacks in upper lounge. Meal support may involve patient's family members during this stage, at the discretion of the adolescent medicine team.

- Patients are still required to remain "in-view" for 1-hour post-meals and snacks.

- Patient meal trays are checked by nurses or CYCW against patient menu to ensure all items are correct.

Requirements to Move to Stage Four:

- ✓ Patient must be at least 80% of minimum weight for health, or gain a minimum of 1.0 kg/week if ≤ minimum weight for health.

- ✓ Patient's temperature must be at least 35.5°C.

- ✓ A sustained heart rate of at least 50 bpm during the day and night for 48 hours.

- ✓ Heart rate gap of less than 35bpm; systolic B/P change of less than 20mmHg and a B/P of at least 80/45 sustained for 48 hours.

Stage Four

- Patient may be on daily weights, or the frequency of weights may be decreased at the discretion of the attending physician.

- Urine for specific gravity often discontinued by this point, but not always.

- Patient may continue to have stand-up showers, but they are to remain brief and monitored as per agency policy.

- Patient to attend J4D school.

- Patient to have meals in upper lounge on J4D with family or staff. Passes may be ordered by the attending physician to allow patient to eat meals in cafeteria with family where appropriate.

- During this stage, parents of the patient commonly bring in prepared meals from home for themselves and patient so that they can eat together and prepare for eating together again on discharge. The meals are discussed beforehand in consultation with Tanya, R.D.

- Nurses or CYCW on J4D continue to check patient's meal tray against menu on chart to ensure it is correct.

- Patient **<u>does not</u>** have to be in-view for 1 hour post-meals anymore.

- Weekend and overnight passes for the patient are ordered at the discretion of the attending physician and are to be accompanied by parent/guardian. Passes are usually decided on a weekly basis during team rounds so that the team, patient, and their family are able to prepare and plan for same.

Time Limits for Meals & Snacks

<u>Breakfast</u>

- Usually starts between 0800-0830H.
- Patient has 30 minutes to complete breakfast meal.

AM Snack

- Usually starts between 1000-1030H.
- Patient has 30 minutes to complete AM snack.

Retrieved from: https://www.needpix.com/photo/1559881/hourglass-time-sand-run-out-transience-transient-amount-of-time-minute-clock

Lunch

- Usually starts between 1200-1230H.
- Patient has 45 minutes to complete lunch meal.

PM Snack

- Usually starts between 1500-1530H.
- Patient has 30 minutes to complete PM snack.

Supper

- Usually starts between 1700-1730H.
- Patient has 45 minutes to complete supper meal.

HS Snack:

- Usually starts between 2030-2100H.

- Patient has 30 minutes to complete HS snack.

Meal/Snack Replacements with Ensure

- It is common for patients with an eating disorder to struggle with completing all of their meals and snacks, especially during the beginning of their admission.

What to do when a patient refuses to eat all of required nutrition?

- If a patient on the eating disorder protocol refuses to eat their meal or snack (or portions of their meal or snack), they are to be supplemented with Ensure (stored in J4D patient kitchen).

- **1 ml of Ensure is equivalent to 1 calorie.**

- If less than half of meal is eaten = full meal replacement with supplemental equivalents.

- Half of meal eaten = replace the uneaten portion with half the meal supplement equivalents.

- Over half of meal eaten = replace the uneaten portion with half the meal supplement equivalents.

- ***Example:*** meal equivalent to 2 equivalents (500 calories)

  - If patient eats **less than half**, then replace with 2 Ensure

  - If patient eats **half**, then replace with 1 Ensure

  - If patient eats **over half** to three quarters, replace with 1 Ensure.

What to do when a patient refuses to drink Ensure?

- Sometimes, despite much encouragement and support from staff, patients with eating disorders refuse to drink the Ensure supplement.

- If this happens during dayshift, nursing staff can notify the patient's attending physician or medicine resident that the patient has refused to complete their meal and is refusing to drink Ensure as well. The Adolescent Medicine team will then decide what measures to take. If it occurs on night shift, make sure to pass it along in report to oncoming day staff.

- Occasionally, patients with eating disorders may have to receive Eat the discretion of the patient's attending physician.

Helpful Tips for Providing Support

- ✓ Eat with the patient during meals and snacks when possible.

Retrieved from: https://www.pxfuel.com/en/free-photo-efclz

- ✓ Remove wrappers from patient's food that contains nutritional information on it.

- ✓ Model normal eating behavior, such as eating all of the food on your plate, not cutting your food into very small pieces, not taking very small bites or stalling.

- Refrain from eating or drinking any diet products when providing meal support. If a staff member does have a diet food or drink, it should be removed from packaging or poured into a cup so it is not visible.

- Avoid commenting negatively or positively on a patient's appearance (Etienne-Ward, 2016).

- Do not discuss topics such as dieting or weight in front of patients with eating disorders (Etienne-Ward, 2016).

- Helpful video: https://keltyeatingdisorders.ca/recovery/meal-support/

- The Adolescent Medicine Team encourages parents/guardians of patients with eating disorders to watch the above video (especially before they start providing meal support to their child on the unit).

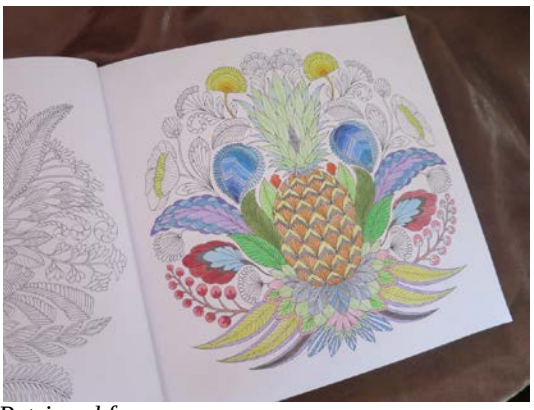
- It is also recommended new casual nursing staff watch the video to help understand how to provide support during meal times.

Distraction Techniques

- These are aimed at taking a patient's mind off some of the bothersome or troubling thoughts they are having in relation to their eating disorder. Engaging in distraction techniques is an important strategy, as patients with eating disorders often experience bothersome thoughts relating to their self-image and food intake, particularly after mealtime (Etienne-Ward, 2016).

- Some techniques that patient may find helpful include:

  - Using a journal to write down thoughts
  - Listening to music
  - Coloring or drawing
  - Talking to a friend or family member



Retrieved from: https://www.flickr.com/photos/waldopepper/28235923594/

- Watching a movie or TV show

- Working on a puzzle

Helpful Websites

- Eating Disorder Foundation of Newfoundland and Labrador: www.edfnl.ca

- HOPE Program (NL) Description: https://mha.easternhealth.ca/children-and-youth/eating-disorder-services/hope-program/

- National Eating Disorder Information Centre: www.nedic.ca

- National Eating Disorder Association: www.nationaleatingdisorders.org

- Eating Disorder Education Organization: www.edeo.org

References

American Academy of Sleep Medicine. (2020). Healthy Sleep Habits. Retrieved from: https://www.sleepeducation.org/essentials-in-sleep/healthy-sleep-habits

Anxiety and Depression Association of America. (2020). Eating Disorders. Retrieved from: https://adaa.org/understanding-anxiety/related-illnesses/eating-disorders

Canadian Art Therapy Association. (2020). What is Art Therapy? Retrieved from: https://www.canadianarttherapy.org/what-is-art-therapy

Canadian Association of Music Therapists. (2016). About Music Therapy. Retrieved from: https://www.musictherapy.ca/about-camt-music-therapy/about-music-therapy/

Canadian Counselling and Psychotherapy Association. (2012). Psychological Benefits of Art Therapy. Retrieved from: https://www.ccpa-accp.ca/psychological-benefits-of-art-therapy/

Etienne-Ward, D. (2016). Tips for Providing Meal Support. Retrieved from:

https://bodymatters.com.au/tips-providing-meal-support/

Mental Health Care and Treatment Act. (2014). Retrieved from: https://www.assembly.nl.ca/legislation/sr/statutes/m09-1.htm

National Eating Disorders Association. (2018). Information By Eating Disorder. Retrieved from: https://www.nationaleatingdisorders.org/information-eating-disorder

Registered Nurses Union of Newfoundland and Labrador. (2014). Collective Agreement. Retrieved from: rnunl.ca/app/uploads/2016/04/NLNU-2012-2016-Provincial-Agreement-1.pdf

Statistics Canada. (2015). Section D- Eating Disorders. Retrieved from: https://www150.statcan.gc.ca/n1/pub/82-619-m/2012004/sections/sectiond-eng.htm