

**NSW Nurses and Midwives' Association**

**Mental Health Members Survey Report**

**October 2017**



## Background

The New South Wales Nurses and Midwives Association (NSWNMA) is the registered union for all nurses and midwives in New South Wales. The membership of the NSWNMA comprises all those who perform nursing and midwifery work. This includes Assistant in nursing (who are unregulated), Enrolled Nurses, Registered Nurses and Midwives at all levels including management and education.

The NSWNMA has approximately 62,500 members and is affiliated to Unions NSW and the Australian Council of Trade Unions (ACTU). Eligible members of the NSWNMA are also deemed to be members of the New South Wales Branch of the Australian Nursing and Midwifery Federation.

Our role is to protect and advance the interests of nurses and midwives and the nursing and midwifery professions. We are also committed to improving standards of patient care and the quality of services in health and age care services.

We welcome the opportunity to make a submission to the Legislative Assembly Inquiry into the Management of Health Care Delivery in NSW.

This submission is authorised by the Elected Officers of the New South Wales Nurses and Midwives' Association.

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## Introduction

Patient safety and staff safety has always been a priority of the NSWNMA and our members, along with evidence based clinical practice that provides best care for the individual. Seclusion and restraint events hold many risks and appropriate measures to help reduce the number of seclusion and restraint episodes will also reduce the exposure of clients and staff to the associated risks.

Seclusion is ultimately about safety. It is usually only a small number of high risk clients that are involved in most seclusion episodes. Seclusion and restraint is predominantly used to manage risk of harm to others.

We believe that where there is an increased level of seclusion and restraint use in NSW mental health units, it cannot be seen in isolation from the underlying problems within mental health service in NSW.

The NSWNMA holds the view that the use of seclusion and restraint can be reduced in NSW, but only with the right support and resources in place. Seclusion must remain an option and necessary last resort to ensure optimum safety in NSW mental health facilities.

Systemic issues within the mental health services have been created by inadequate funding of the public mental health services over many years (since the implementation of deinstitutionalisation).

Even though mental health funding is supposed to be 'protected' and spent on mental health, 'leakage' to other areas of health have occurred (Auditor-General's report Performance Audit, Mental Health workforce, NSW Health 2010). This has forced Local Health Districts (LHDs) to create budget saving at the expense of evidenced based best practice to ensure optimum safety of clients and staff. The impact of this tight fiscal strategy is now having an impact on clinical outcomes in mental health services.

The NSWNMA conducted a survey of mental health members, this survey highlights the effects of long term unrealistic budget constraints, a non-specialised and inexperienced mental health workforce, with a poor retention of senior mental health qualified nurses. This has resulted in critical levels of safety for clients and staff, with less than ideal and costly outcomes for clients of mental health services.

LHDs have resorted to a 'genericisation' of senior nursing management positions in mental health services. The removal of specialty criteria for mental health experience and qualifications as a requirement for mental health nursing positions in mental health services when advertising for staff has meant that mental health nurses at the clinical level are being managed by those with no or a very limited mental health nursing background.

A lack of leadership by government, along with restrictive budget constraints has led to mental health services being poorly resourced. Given the new employment profile of a non-specialised and inexperienced mental health workforce, with the difficulty of retaining senior mental health qualified nurses, the level of safety for clients and staff is now approaching a critical level.

A summary of the relevant survey questions and their respective responses are outlined in this document for your information. The survey comments provided by respondents have been de-identified and included in their raw, unedited form to preserve the honest intention of those responses.

The survey went out to approximately 2500 members with 340 completing the survey. This gives a response rate of approximately 13.6% of the NSWNMA mental health membership.

Some of the main themes that have strongly come through from the survey are:

- Safer nursing staff numbers, with appropriate staff rostering and skill mix.
- Lack of Mental Health Intensive Care (MHICU) beds across the State, with High Dependency Unit (HDU) beds or Observation (Obs) beds

having to fill the role of MHICU beds, with less funding than MHICU beds but often with the same patient acuity.

- More mental health qualified staff.
- More access to mental health education for nursing staff new to the mental health work force, especially at the clinical level.
- The inappropriate employment of AiNs in the acute mental health sector.
- Poor retention of senior staff to mentor nursing staff new to the mental health work force.
- Better career structure for mental health nursing with the employment of staff to management positions that clearly display the necessary mental health nursing skills and knowledge required in their role.
- Excessively high levels of time required for documentation which directly impacting on the time with patients. This is a workloads issue that can only be remedied with more nursing staff.
- Lack of consultation with nursing staff on many levels.

This report is provided to inform the Legislative Assembly Inquiry into the Management of health Care Delivery in NSW of the many issues faced by the mental health nursing workforce in NSW.

## Survey Response Data and Comments

### Q1 What is your current employment position in mental health?

| Position                | %     |
|-------------------------|-------|
| Enrolled Nurses         | 9.12  |
| Registered Nurses 61.76 | 61.76 |
| CNS                     | 10.59 |
| NUMs                    | 5     |
| CNC                     | 5     |
| Managers                | 3.48  |
| CNE/NE                  | 1.47  |
| NP                      | 0.29  |
| Other                   | 3.19  |

The survey respondents included a cross section of the clinical workforce.

### Q2 Your gender

Gender spread for participants was male at 30.38% and female at 69.62%.

### Q3 Approximately how many years' experience in mental health nursing do you have?

| Years   | %     |
|---------|-------|
| 0       | 2.06  |
| 1 - 2   | 11.5  |
| 3 - 5   | 12.39 |
| 5 - 10  | 22.71 |
| 10 - 20 | 24.78 |
| 20 - 30 | 11.21 |
| 30+     | 15.34 |

It can be seen from the table below that the majority of participants have a considerable number of years' experience, with 74% of participants having 5 years or more mental health experience.

#### **Q4 What sector are you primarily employed in?**

Almost all (97.63%) employed in the public mental health service sector

#### **Q5 In what clinical area do you predominantly work?**

| Clinical area                           | %     |
|-----------------------------------------|-------|
| Acute Adult                             | 48.38 |
| Rehabilitation                          | 10.6  |
| Community MH services                   | 7.37  |
| MHICU                                   | 6.72  |
| Specialist MH Services for Older People | 4.42  |
| Child and Adolescent MH                 | 4.42  |
| ED                                      | 3.24  |
| PECC                                    | 2.65  |
| Forensic                                | 1.47  |
| HDU/Obs                                 | 2.95  |

The largest clinical area represented was acute adult mental health units with a reasonable spread across other clinical areas.

#### **Q10 Does your facility ever have trouble accessing MICU or PICU beds when required?**

| Difficulty accessing MHICU or PICU beds | %     |
|-----------------------------------------|-------|
| Always                                  | 23.01 |
| Often                                   | 27.61 |
| sometimes                               | 27.91 |
| Never                                   | 4.6   |
| Not sure                                | 8.28  |
| N/A                                     | 8.59  |

The majority of respondents (78.53%) indicated that they sometimes/ often/ always have trouble accessing Mental Health Intensive Care (MHICU) beds when needed for highly disturbed patients. Only a very small number (4.6%) never had an issue (which would closely correspond to the number of respondents working in MHICUs). The remainder were either not sure or it was not applicable.

There are only 62 MHICU beds across the State. MHICU beds are in extremely short supply across the State and are always in very high demand, waiting times can often be up to weeks at a time (if a bed does become available).

MHICU beds catered for the:

*“most disturbed mental health patients who are unable to be cared for safely within Local Health Districts (LHD) acute care options”, “MICUs are tertiary level units funded at the highest level of funding of any mental health service in NSW to allow a level of staff to safely stabilise a person’s condition.”*  
*...“HDU and Obs beds are not tertiary-level services nor are they funded by the Ministry of Health at the same rate as MHICU Services”.*

(Correspondence from Mr Peter Carter, Acting Director Mental Health Drug and Alcohol Office, 17th June 2015).

It is estimated that there are a further 270 HDU/Observation beds across NSW Mental Health services. These HDU/Obs beds are not NSW Health funded at the same high level as MHICU beds. HDUs and Obs units often perform the same function as MHICU beds by having to manage highly disturbed clients, usually for extended periods of time.

The HDUs and Obs units are underfunded and under resourced to cope with highly aggressive clients, but are required to act as de facto MHICU/PICU beds requiring a higher use of seclusion to manage high risk clients.

**Q11 If so, why (you may choose more than one option)**

| Why is there difficulty accessing MHICU or PICU beds | %     |
|------------------------------------------------------|-------|
| Long wait for available beds when needed             | 60.06 |
| Lack of cooperation between areas                    | 37.42 |
| Lack of communication between areas                  | 26.42 |
| Distance to beds                                     | 24.53 |
| Transport coordination between Ambulance and Police  | 30.5  |
| Other (please specify)                               | 16.35 |
| Not Applicable                                       | 14.47 |

Problems accessing beds included long wait times (60.06%), lack of co-operation between LHDs (37.42%), or transport co-ordination issues with ambulance and police (30.5%). Other issues lack of communication between areas (26.42%) and distance to beds (24.53%).

The geographical location of rural mental health HDUs and Obs units in NSW leaves them exposed when required to manage high risk patients. Due to the distance and associated risks with transferring clients to approved MHICUs, rural HDUs and Obs units can often be required to manage this type of client for extended periods.

This has an impact on risk and the rates of seclusion at these rural sites. As HDUs and Obs unit beds are underfunded and under resourced to cope with highly aggressive clients, requiring a higher use of seclusion to manage high risk clients, as seclusion is often the only safe option available when managing highly disturbed mental health patients.

Some of the survey respondent's comments include:

*"Have never been informed about the possibility of accessing MICU or PICU beds. Have never been told which hospital would take our very unwell patients. We manage everyone ourselves. We just have to manage all types of patients here from 80 year old frail patients with depression to young aggressive males with ice induced psychosis".*

*"We do not have a MICU or PICU beds available in our LHD, such would most definitely assist in reducing seclusion and restraint episodes."*

*"No such facilities exists in Northern NSW LHD, being non-metropolitan"*

*"Patient would have to hit a staff member to be accepted first. Despite a patient's history of assaulting staff, an assault would need to occur first to be accepted".*

*"Staffing issues including lack suitably experienced staff"*

*"Constantly refusing request to be transferred"*

*"We are just expected to deal with whoever is admitted"*

*".. aggressive or clients extremely psychotic have to be in seclusion or special care areas over the weekend or after hours. Often takes a long process for a decision to be made and lots of back and forth issues. Not a straight forward process."*

There needs to be an immediate increase of funding for more MHICU beds and units across the State, to reduce the exposure of clients and staff to the risks associated with managing very high risk clients within under resourced mental health units, especially units isolated by distance from any supporting MHICU. There also needs to be a consistent referral process to streamline timely access to MHICU beds.

#### **Q12 importance of recruit and retain qualified and experienced staff for mentoring new staff.**

99.7% of respondents felt it was very important/important to recruit and retain qualified and experienced staff for mentoring new staff.

#### **Q13 What do you think would help recruit and retain nurses in mental health? (You may chose more than one option)**

| Help recruit and retain nurses in mental health          | %      |
|----------------------------------------------------------|--------|
| Safer skill mix of rostered staff                        | 76.11% |
| More mental health qualified staff                       | 66.96% |
| More access to mental health education                   | 59.29% |
| Requirement for all staff to be trained in mental health | 58.70% |
| Better career structure for mental health nursing        | 53.39% |

Respondents were asked to provide feedback on how this could be achieved:

*"Safer skill mix is just the tip of the iceberg (the first 80% of our problem) -but we dont even have that. Senior staff are simply burning out - and for what! A slap in the face from management – no thanks. who would wanna stay for*

*this. Most senior staff in my workplace are either retiring early (6 in the last 6 months, most established and promising staff are not returning from extended leave, 5 in the last 6 months, and those of us who are still here are looking for employment options elsewhere. My workplace has become ridiculous and dangerous. We are already in a senior staff shortage and only getting worse."*

*"Increased staff to patient ratio when the ward has more complex and difficult clients who are either at significant risk to others or to themselves. more resources or close down some beds when there's not enough staff"*

*"Staffing levels are most relevant. Even when they meet the levels suggested it doesn't take into account the acuity of some situations."*

*"Safer staff ratios in community settings. Better remuneration in community settings."*

*"There is only so long that people can put up with endless abuse, violence, physical assaults, working understaffed, being made to work overtime, being bullied by management, working with wards over census etc. It's not an attractive place to work!"*

*"Better understanding from management that safe patient care is not always about saving money. They want safe patient care that costs nothing."*

*Better management. The ones in this LHD are more interested in the budget and covering up problems than looking after their staff and therefore, the mental health patients.....Having done general nursing and then mental health - it is obvious that mental health nurses carry more risks in the course of their work and should be remunerated appropriately. This may also help to attract more staff to this field of nursing. I don't know if this is a state-wide thing, but locally it seems that the increase in the NGO sector has led to a stagnation/decrease in public mental health services. Of concern is that the NGOs are usually employing less qualified staff and I have personally witnessed problems resulting from this."*

*"people are just burning out, it's a high risk environment, you face abuse and aggression daily, and management doesn't care, you get injured and you get very little support, you earn the same money working in a much less stressful environment, with less responsibility , why would mental health be attractive??"*

*"More resources in terms of permanent staff. The service is far too reliant on casual staffing numbers. We are chronically underfunded and under-resourced. This leads to safety issues, staff burnout, lack of time available for clinical supervision / support...and a host of other problems. It makes an already-difficult job just that much harder..."*

*"An interest by management to retain experienced staff and not use new grads for 12 months and cease their employment and get the next lot of new grads."*

*"Safe staffing levels. Stop management cutting costs."*

*"Improving the safety of the workplace for the staff. Very dangerous and challenging employment with minimal regard for the safety of the nurses. Intensive mentoring of student nurses interested in mental health, intensive mentoring in the New Graduate Program and Intensive Mentoring of new nurses that have not had a lot of experience of mental health. I believe this will result in more confidence for the nurse and increased retention of the workforce. In my unit the Nursing Office frequently place an unsafe skill mix in the IDAT (Involuntary Drug and Alcohol Treatment) unit resulting in regular staff and patients being placed at risk due to unsafe and experienced practices".*

*"Too many AIN's with little or no mental health education"*

*"Management who are willing and able to respond to concerns from staff about skill mix, adequate staffing, inappropriate admissions and aggression".*

*"Structured mentoring programs for new graduates"*

*"Better leadership"*

*"Allowing part time employees or job share to maintain highly skilled senior nurses. Our casual pool is more skilled then the ward staff.*

*NSW Health to adopt the provisions of the Anti-Discrimination Act, and employ MALE staff / more male staff for high acuity wards.*

*they really need to be trained in Mental Health nursing before they come on the units, as many of us who were specically trained as RPNs are retiring."*

*"More flexibility in employment hours. Many fulltime staff I work with feel a 0.8 roster would allow for much better work/home balance & assist in minimising burnout, however our LHD is rigid & insists on primarily full time hours."*

*"Many of my nursing friends & colleagues are nearing retirement or have retired within the last 2 years. ALL report a frustration that their experience is not valued on the floor and that they are not listened to. There appears to be a 'flat' model in place among registered nurses where someone who has minimal experience is listened to over those who have decades of experience..... If positions are advertised (not always), others do not go to the effort of making an application as it is obvious well in advance who has been lined up for the position. I think all appointments above RN level should be vetted by a NSW Health state-wide office that checks appointees actually have the requisite experience for the position they are being proposed for."*

*"More male nurses"*

*"Less tolerance of violence, safer work places, more backing from executive level"*

*"Increase safety measures and staffing ratios."*

*"More male staff recruitment,"*

*"Prioritising not only patient safety but also staff safety from management  
Better nurse patient ratios"*

*"Management team that actually don't bully their own staff around seclusion  
"Safer staffing levels"*

*"Safety for staff which is the least concern as it stands now"*

**Q15 Do you have nurse to patient ratios/Nursing Hours Per Patient Day (NHPPD) in your place of work?**

50% of respondents had Nurse Patient Ratios.

27.8% respondents do not have Nurse Patient Ratios.

21% were unsure

**Q16 When your employer advertises for nursing positions in mental health, do they always specify that mental health qualifications and/or MH experience is required?**

38.35% of respondents reported that LHDs do not.

29.5% reported LHDs do.

32% were unsure.

**Q17 Should only appropriately qualified and experienced mental health nursing staff 'special' (1:1) acutely unwell mental health patients?**

92% of respondents strongly agreed/agreed with this statement. This is now part of the new 'Engagement and Observation Policy Directive' from NSW Health, PD2017\_025.

**Q18 Should nursing staff rostered to do 'specials' (1:1) always be rostered in addition to the normal nursing numbers?**

94.1% of respondents strongly agreed/agreed with this statement.

**Q19 Do you always have an appropriate skill mix of nursing staff rostered for the acuity of patients to reduce seclusion and restraint?**

| Appropriate skill mix of nursing staff rostered for the acuity of patients | %     |
|----------------------------------------------------------------------------|-------|
| Always                                                                     | 3.25  |
| Often                                                                      | 13.31 |
| Sometimes                                                                  | 60.95 |
| Never                                                                      | 14.79 |
| Unsure                                                                     | 3.85  |
| N/A                                                                        | 3.85  |

60.95% have appropriate skill mix sometimes with 14.79% reporting never having an appropriate skill mix rostered for the acuity of patients to reduce seclusion and restraint. That's a total of 75.74% of respondents that can have dangerous levels of staff skill mix for patient acuity on the ward. Only 16.56% often or always have an appropriate skill mix rostered for the acuity of patients to reduce seclusion and restraint.

**Q20 Do you always have appropriate nursing staff numbers for the acuity of patients to reduce seclusion and restraint?**

| Appropriate nursing staff numbers for the acuity of patients | %     |
|--------------------------------------------------------------|-------|
| Always                                                       | 4.14  |
| Often                                                        | 18.05 |
| Sometimes                                                    | 54.14 |
| Never                                                        | 14.79 |
| Unsure                                                       | 3.85  |
| N/A                                                          | 5.03  |

54.14% sometimes and 14.79% never have appropriate nursing staff numbers for the acuity of patients to reduce seclusion and restraint. A total of 68.93% of respondents indicated that on occasions lack the nursing staff numbers to reduce seclusion and restraint for the acuity of patients.

Only 18.05% often and 4.14% always have appropriate nursing staff numbers for the acuity of patients to reduce seclusion and restraint (22.19%).

This leaves 68.93% of respondents at high exposure to foreseeable risk.

**Q21 Do you have unfilled staff positions or vacancies at your place of work?**

81.12% have unfilled nursing positions at their place of work.

Only 5.9% of respondents indicated that they are staffed to full capacity.

**Q22 Are you always staffed according to the rostered numbers?**

20.35% indicated that they are always staffed to the rostered numbers.

64.9% are not always staffed to the rostered numbers.

*"Overtime is utilised to cover shortfalls which leads to additional work stress and burnout. The overworking of staff also limits the capacity of staff to work with compassion and empathy".*

*"they try but in country areas keeping staff and enough staff is a huge problem"*

*"Mostly but there are many gaps & many staff have left due to our situation with cutting staff so sometimes we don't have the full compliment"*

*"Nearly always by numbers. However it is a 'bums on seats' approach and it seems anyone will do to make up the required numbers for a shift. Especially is someone rings in Sick, usually the vacancy is filled by the cheapest staff first (AIN or rehab assistant is available). It appears the priority is to replace the RN with the cheapest available staff rather than like-for-like. When this is commented on, the NUM often says that was all she could get, but later, talking to people, it turns out RNs off duty were never rung."*

**Q24 Are unregulated workers (such as AINs/HSAs) rostered to replace nursing staff (e.g. ENs and RNs) when absent?**

50.61% of respondents indicated yes, some of the comments included:

*"Yes. AIN's all the time. And on every shift including night shift. Especially on the weekends/public holidays in order to save money."*

*"Makes it unsafe yet cost effective for the health department"*

*"AIN's can only do basic nursing care, they can't do medications. It's unfair for the other RN/EN staff working on the floor. They should replace the right discipline"*

*"its becoming a very regular occurrence now"*

*"Not where I currently work but prior to this position you could end up having 3-4 AINS on one shift"*

*"This happens far too often, especially on the afternoon shifts and weekends when the ratios are always adjusted anyway".*

*"Often unable to access staff or AIN is booked due to staffing confusion. At times OT is refused to fill this position. The AIN in our unit usually ends up doing a significant skill- visual observation. Often they have never worked in the unit before or with MH clients. So this puts the clients and the AIN at significant risk".*

*"ALL THE TIME SOMETIMES 2 ON EACH SHIFT"*

*"This is unacceptable in my opinion as it puts experienced staff & the unregulated staff & the patients at risk"*

*"AIN'S replace EN's at times. Very difficult for EN and RN when rostered on with AIN as their scope of practice is so limited. Puts greater workload on EN and RN staff. They do not have appropriate level of knowledge to work in acute setting. Unsafe for them and other staff and patients"*

*"They cost cut"*

*"Usually when RN is off will be replaced by EN or AIN"*

*"This is done despite having qualified mental health nurses putting their names down as available for overtime."*

*"They are used for budget purposes. A RN is always on but EN's and AINs are used the same"*

*"This is very frustrating, especially when there are 1:1 specials, and management are still trying to replace RNs with AINs, which leaves 2 RNs to look after 19 psychiatric patients. It isn't right!"*

*"There are no AINs in my MHICU ward and the staff fought hard to achieve this."*

*"Sometimes from Agency and they do not know what to do and the nurse in charge with a patient load of six has to teach them and also do intake"*

*"They seem to be first choice as they are cheaper. It especially puts on additional strain on the Nurse-in-Charge and other shift members when someone cannot do medications for their own patients."*

*"to conduct specials and observe first hour of seclusions"*

*"Ains or casual pool are the cheaper option and that is how staff is replaced if at all"*

**Q25 How often are you asked to work overtime shifts per week?**

| Number of times per week | %     |
|--------------------------|-------|
| none                     | 15.93 |
| One                      | 21.53 |
| Two                      | 15.04 |
| Three                    | 14.16 |
| Four                     | 7.08  |
| Five                     | 3.5   |
| Six                      | 1.47  |
| Seven                    | 7.37  |
| N/A                      | 13.86 |

This indicates that just over 50% respondents are being asked to work from one to three extra shifts per week. One must assume that the high amount of overtime nursing staff are being asked to work is directly a result of the high number of vacancies that are not being filled (see Q21, 81.12% have unfilled nursing vacancies at their work place). Working these extra shifts often creates fatigue in nursing staff and places them at risk of work health and safety (WHS) issues.

**Q26 What issues do you find that affect your workload? (able to choose more than one answer)**

| Issue that affect your workload                  | %     |
|--------------------------------------------------|-------|
| Excessive documentation                          | 75    |
| Acuity of patients                               | 75    |
| Inexperienced Staffing                           | 70.54 |
| Staff specialising (1:1) out of rostered numbers | 47.62 |
| Other                                            | 27.08 |
| Agency staffing                                  | 17.26 |

Comments as follows:

*"documentation related to Observation & Engagement Policy is crippling us. we now have no time at all to spend with patients. management and Medical staff seem unable to come to agreement as to how patients are classified. Where we frequently had possibly 1/2 the ward as Care Level (second hourly obs), now all our patients are Care Level 4 newly classified to be sighted every hour. Coupled with the Leave monitoring Policy where entries have to be documented when they leave the unit and again when they return. Generally leave is of 30 mins duration. You sometimes just finish the outgoing leave and they are back. in our unit this happens 3 times on an A shift. Some doctors only allow 15 mins leave. It is simply un doable."*

*"Under staff"*

*"Staff vacancies - lack of recruitment, and too many staff rostered leave at same time. Leave never back filled"*

*"Moving experienced staff from our ward to cover absences on other MH wards..then we get an AIN or casual staff as replacement (or sometimes no replacement at all). staff that do not want to work with obs patients. Especially those on overtime or staff from other MH wards that have been moved to our ward. They mostly avoid obs area like the plague. And I'm being serious. This means shift after shift you are forced to work mostly with the obs pts."*

*"Non replacement of staff when on planned or extended leave"*

*"working short staffed"*

*"TOO MUCH PAPER WORK!!!! (electronic now EMR) NOT ENOUGH TIME with Pts"*

*"Excessive community caseloads"*

*"vacant positions"*

*"Low staff morale leading to increased turnover of staff, deficits in staffing. Increasing number of junior/ new staff leading to unsafe patient care"*

*"Lack of resources. We often are invited to participate in process improvement initiatives - but no additional staffing is offered to backfill in this regard. This ultimately means trying to 'do more with less' - and it is a real problem. Many staff become resentful and/or burnt out, as they are already giving so much."*

*"Lack of retention from experienced staff due to burnout and assaults."*

*"Cost cutting leads to poor staffing levels. Senior management is ineffective and out of touch with workplace. Culture of arrogance."*

*"More time is spent on documentation then caring for the patient, not to mention answering phones, allowing visitors and patients in and out of the ward"*

*"Needing to attend to clerical duties. Recently told by admin officer "the night staff can do some clerical work" instead of performing nursing duties. Constantly having to answer phone calls during the day making the nursing staff a receptionist for allied health team and medical officers. In my unit I could be better utilised performing nursing duties which I am trained to do in face to face engagement. There is a poor medical coverage on the weekend, placing the medical and psychiatric conditions at risk which I believe is a reason for increased seclusion. This has been identified by the Medical Director of our unit. Our unit is a dual diagnosis unit for approx 98% of the patients."*

*"Patient to staff ratio unsafe on open ward, unrealistic expectations from hospital to adequately care for these patients"*

*"its all about saving money and budgets"*

*"Strong, young, often substance-induced aggressive male patients"*

*"Inadequate planning for after hours (weekends/evenings/nights) in terms of admissions and transfers of inappropriate or highly aggressive patients"*

*"When consumers are escorted by staff to outside appointments or when transferred to general hospital. This sometimes can remove a staff for almost half a shift and sometimes a majority of the shift"*

*"Poor managerial decisions and support of the workforce"*

*"Management's philosophy, that patients are to be 'served' by Nursing Staff. That patients are always 'right' with any complaints. Therefore Nursing Staff are required to spend more time with 'demanding' / 'entitled' / 'delusional' patients, and usually disregard staff discretion on how to manage such patients."*

*"This is for community: unable to get clients into hospital, discharged from hospital too early, unrealistic expectations of what community staff can actually do, staff off sick or on leave are not replaced, constantly following up with what the Community managed organisation staff are doing or not doing. Unsupported by other areas with clients who have co-morbidities, waiting for hours with clients in ED to get admitted to MHU. Mountains of documentation."*

*"shortage of staff"*

*"Being experienced you always have to work with the most aggressive agitated patients and have inexperienced people work with you in your team. You have to manage them and the patients. It takes a toll on you and I understand why experienced people are leaving. You feel your safety is at risk. There are too many inexperienced people working at once it is impossible to mentor people to teach them what is safe practice"*

*"Role merging as way of reducing wage bills."*

*"working down staff"*

*"Demands higher than capacity. No replacement staff when going for annual leave."*

*"Chronic understaffing"*

*"Continuously working under staffed"*

*"Insufficient staff numbers and not enough trained staff. Eg RN ratio too low"*

*"These days everything is computerised, we spend more time on computers than with patients. Male nursing staff are used as security officers as females don't jump in restraints leaving me staff vulnerable to injuries. When females are scared to work in mental health..why employ? Excessive documentation to fetch funding and immense pressure to get patients out of seclusions for better statistics which in turns endangers staff safety."*

*"Consistently over-census" (too many patients for the number of beds)*

*"Staff skill mix"*

**Q27 Do the managers/NUMs at your place of work have a mental health nursing qualification and/or experience?**

| Managers/NUMs have a mental health nursing qualification and/or experience? | %      |
|-----------------------------------------------------------------------------|--------|
| Yes                                                                         | 54.73% |
| No                                                                          | 7.99%  |
| Some                                                                        | 24.85% |
| Not sure                                                                    | 12.43% |

Due to the different disciplines or minimal mental health nursing experience some upper managers have, this can impact on the care of patients and the efficient running of the ward due to the lack of understanding around clinical management and safety of patients. It is difficult to provide clear leadership when you don't fully understand the nursing care your team needs to provide.

Comments included:

*"NUMs are all mental health trained. Senior management are not necessarily mental health trained."*

*"NUM does not have a lot of experience in mental health. NUM's positions being given to younger, inexperienced RN's. Can become awkward when NUM is attempting to assert their authority but then having to take guidance and advice from experienced ward staff. Not good leadership when staff aware they know more than NUM."*

*"the site manager was a social worker, now will be an OT, the overall operations manager for MNCLHD is a social worker"*

*"I believe so, I find NUM's not only do they need to be qualified, also should have experience in leadership which of I am not sure that they do, in the past the NUM's have been well experienced in leadership"*

*“Yes, but sometimes only minimal on-the-floor experience before they got away from front-line nursing and started climbing the ladder. Lack of solid on-the-floor experience often shows in decisions that are made and what is prioritised.”*

**Q28 Do you feel that you are supported by your managers and senior manager when required to use seclusion to minimise risk of violence against staff, other patients and visitors?**

| Supported by your managers | %     |
|----------------------------|-------|
| Well supported             | 15.68 |
| supported                  | 30.47 |
| Neutral                    | 18.05 |
| Poorly supported           | 20.71 |
| Unsupported                | 8.28  |
| N/A                        | 6.8   |

46.14% of respondents felt well supported/supported, with 18.05 neutral. 28.99% felt poorly supported or unsupported.

**Q29 Do your senior managers practice a no blame culture towards staff and focus more on systems improvements?**

| No blame culture | %     |
|------------------|-------|
| Always           | 13.43 |
| Sometimes        | 49.55 |
| Rarely           | 27.16 |
| Never            | 9.85  |

13.43% of responded felt their senior managers always practiced a no blame culture. Nearly 50% only sometimes and 27.16% rarely practice a no blame culture towards staff and focused more on systems improvements.

Comments as follows:

*lately, there seems to be a big blame culture with staff, and staff don't feel supported, and staff feel they will be punished for doing their job a patient goes to seclusion because they are aggressive, yet management want them out of seclusion to keep the stats low, not because they are settled, and when someone is aggressive, staff are afraid to restrain a patient, for fear they will be labelled over zealous and have the police called due to excessive force*

*“Senior managers place high demands on staff and place all liability on staff when things go wrong.”*

*They accept only the good and blame others for the bad results.”*

*"Focus on blaming others whilst accepting no accountability. Ministry also extremely out of touch and dismissive."*

*"I have been accused of being punitive towards a patient when he was punching the glass of the office and threatening harm towards staff. No deescalation techniques were successful or redirection. This person was intoxicated and not amenable to any other nursing intervention other than seclusion which was successful for a short time where he was moved to a MHICU."*

*"Seclusion procedures are criticised by senior managers and nursing staff on the floor."*

*"They always find faults and blame individual staff members without acknowledging the effort or the potential outcome that was avoided by having to seclude a patient"*

*"Adequate, experienced nursing numbers on wards reduces seclusion. Senior management know this."*

*"There is a culture of blame and our acting clinical coordinator has asked me why I didn't walk away when a patient was attempting to hit us and then attempted to pick up a chair to hit us with. There were other patients that were also at risk and we had no choice but to seclude someone. I am anti seclusion and will try every de-escalation option available. It is often the case that you come on to a situation that has been allowed to escalate as staff are inexperienced and won't approach people with aggression, then you are left to deal with the situation. Then asked what did you do to cause it. I have never in 30years had a debrief after an aggressive incident and I have seen a patient kill another patient."*

*"Senior managers in the ward are supportive. Managers with a more administrative position enforce blame culture"*

*"Unfortunately the Last replacing Unit nursing Manager was transferred to another ward, whom brought the staff together, was delight to work with, was positive, plus progressive with the systems improvements for staff and clients, up until I went on holidays, on returning from holidays there will be another replacing unit manager again will be replaced by the permanent unit manager, returning from another placement'*

*"As in Charge you are blamed if anything goes wrong. Little or no recognition for what you do well"*

*"NUM very supportive senior management never."*

*"Staff are Pressued to remove patients out of seclusions against staff advise"*

**Q30 Do you feel confident that your senior managers are approachable and you will be fully supported when making clinical decisions for patient care?**

| Senior managers are approachable | %     |
|----------------------------------|-------|
| Always                           | 18.86 |
| Sometimes                        | 47.31 |
| Rarely                           | 24.85 |
| Never                            | 8.98  |

33.81% felt their senior managers were rarely (24.85%) or never (8.98%) approachable.

Comments as follows:

*"Our managers both NUMs & top management are on the dark side so we can't trust them"*

*"Mostly, yes. I think they actually do a pretty good job, considering how difficult working in MH often is. However, I think there are certain policies (i.e. smoking) where staff input is given little regard. I think in such cases, ideology is given precedent over practical reality and clinician safety. The 'zero tolerance' smoking policy has led to more aggressive incidents than anything else I have witnessed - and NRT is an absurd mitigation strategy for most clients I have worked with."*

*"Listened to issue discussed with outcome always in favour of senior manager outcome. High pressure work environment and pressure from Ed, ADON and Executive. Not an ideal work environment to attract let alone retain staff."*

*"Manger will listen and try to support. NUM is obstructive, uneducated and out of his depth and is there to be the yes man and replies with bullying and intimidation."*

*"In about 80% of cases the senior managers will support me in making clinical decision. It has been my experience that some feel threatened by information/actions."*

*"The num is fantastic, the people about her not so much"*

*"Senior management are never on the wards. There is no relationship between them and frontline nursing staff. There are no "grand rounds" in mental health."*

*"For my current manager, always."*

*"Most need to practice their communication skills and remember we are the ones keeping the hospital running. We are not appreciated or valued enough. We are often spoken to in disrespectful, rude tones and they love nothing more than catching you leaving your workplace 5 minutes early, while never noticing all the times you come in 15 minutes early. Far too petty and authoritarian - hard to imagine successful companies treating their employees this way."*

*"NUMs are generally very good. Senior management at the hospital is not always so."*

*"Not infrequently I felt criticism for maintaining safety. It is more important to admit for KPI in ED. Therefore we constantly have High acuity with little supportive staffing"*

*"I feel that staff are disempowered and there is a lack of support around clinical decision making. As a NUM1, I sit on the incident review committee and I feel that it is currently a "tick the box" process that tends to focus on whether the paperwork is filled out correctly, rather than looking at ways that we can reduce or prevent the incidences, particularly in relation to aggression"*

*"Senior managers tend to be distal to the clinical environment and sometimes demonstrate a poor practical understanding of front-line issues"*

**Q31 If you work in community mental health services, do you feel your patient case load is able to be managed safely?**

This was not applicable to 79.4 % of respondents. Of the remaining 20.6%

Only 7.16% felt their patient case load was able to be managed safely.

13.43% felt their patient case load was unsafe.

If we take 20.6% response rate as the total (100%) then 13.43% equates to 65.19% of community nursing staff believing their patient case load was unsafe.

**Q32 In your community mental health service, do allied health staff (including Social Workers and Occupational Therapists) case manage clients on complex medications?**

| Allied health staff case managing clients on complex medications | %     |
|------------------------------------------------------------------|-------|
| Yes                                                              | 52.82 |
| No                                                               | 10.26 |
| Unsure                                                           | 36.92 |

52.82% of respondents report non-nursing mental health professionals, such as allied health staff, are managing clients on complex medication regimes. These non-nursing professional do not possess the required understanding of the medications side effects, complications or management protocols in regard to these complex medications (for example clozapine). Our members are gravely concerned that this is not best practice and could lead to a relapse of a patient's condition, possibly leading to seclusion on readmission, or worse, to a fatal outcome due to poor medication management, which could have been avoided.

**Q33 Do you agree or disagree that the time it takes to complete documentation has significantly reduced your face to face time with patients?**

The majority of respondents 95.83% agree (20.83%) or strongly agree (75%) that the time it takes to complete documentation has significantly reduced face to face time with patients? If staff workloads are significantly increasing then more staff are required and nursing number need to be increased.

**Q34 When was the last time you completed face to face de-escalation training?**

| De-escalation training completed | %     |
|----------------------------------|-------|
| Less than 1 year                 | 40.42 |
| 1 to 2 years                     | 25.75 |
| 2 to 3 years                     | 10.48 |
| 3 years or more                  | 14.67 |
| Never                            | 8.68  |

It is encouraging that 40% of respondents report having training in the last 12 months. Unfortunately, nearly one quarter of respondents (23.35%) have had no refresher in the last 3 years or no training at all.

**Q35 Do you report all episodes of aggression (including physical and verbal) as per your local policy?**

| Report all episodes of aggression | %     |
|-----------------------------------|-------|
| Don't know how to report          | 1.49  |
| Don't have time                   | 61.19 |
| Reporting is discouraged          | 14.43 |
| Reporting won't make a difference | 63.68 |
| Someone else's responsibility     | 1.99  |
| Other                             | 27.86 |

49.7% of respondents reported they report all episodes of aggression as per their local policy. But an almost equally large proportion 47.02% do not. There appears to be a gross under reporting of aggression and abuse towards nursing staff at the clinical level.

The NSW Health 'zero tolerance' policy has been ineffectual in reducing aggression in the work place with complete lack of support by management to ensure a zero tolerance approach as required by their policy from the Ministry. The no smoking policy has markedly increased the amount of aggression directed at nursing staff. Nursing staff should not be subjected to or expected to tolerate the high levels of the aggression (including verbal) they have reported experiencing every day (to the point that they no longer have the time to report such incidents). This constant level of chronic abuse takes a toll on the health of the individual over time. This can only contribute to the 'burnout' reported by nursing staff.

This is a work health and safety issue that needs addressing. No one should expect to be constantly abused as part of their work and abuse of this nature should never be seen as acceptable and part of the profession of being a mental health nurse. The Ministry could be seen as negligent in its duty to protect its staff from ongoing constant abuse from patients and those at the local LHD level also have the responsibility to not ignore this WHS issue by dismissing this constant abuse as "part of the job".

Comments as follows:

*"Violence/aggression is so prevalent that it frequently escapes notice. Floor staff frequently expect that such documentation will be attended by the ICS or senior nurse on duty."*

*"Who has time to complete the stupid IIMs reports. They take 10 minutes or more each and I could easily do 10 a day, no problem. Sorry but teh IIMs system is deliberately designed to discourage reporting. Also, who follows up on it, we NEVER get feedback, EVER. Yet our managers discourage reporting anonymously "as it makes it hard for us to give you guys feedback" says my NUM. If we're stuck with the IIMs system then make it auto load my workplace, the time and date etc."*

*"Only report physical aggression never verbal as would always be reporting"*

*"The threshold for what is considered "aggression" is unfortunately SO high. A lot of episodes do not get documented because it is the daily norm. Someone shouting obscenities and threatening to kill you and your family is a normal day at the office."*

*"Too many episodes"*

*"Physical aggression always reported. Verbal aggression is daily basis. This isn't reported due to the time it takes to iims same. Plus, if we reported every verbal incident we would seriously be reporting it several times a shift.. for each staff member. The culture of MH has normalized the verbal aggression. We see it as a normal part of the job. Which is so so wrong. Management and the Drs should speak to those voluntary pts who are verbally rude and aggressive to staff but they do not. So pts continue to treat staff like crap as there are no consequences."*

*"Management sees it as an inconvenience to them if you report verbal aggression at any time and find it irritating to even do their part on physical aggression IIMS all physical aggression is reported however daily verbal abuse is often and due to time constraints and nothing really being done about this is more times than not left unreported, I thought we had a no tolerance policy, what a joke that is, sounds and looks good on paper, reality is what can we do about it????"*

*"The feeling of the nurses is that verbal aggression is so common that we put up with it and seems to be just a part of mental health. Only really serious threats are reported to management and an IIMS done."*

*"If we reported all verbal aggression we would never be away from the computer."*

*"At times and when it is a more difficult population on the unit, if we reported every verbal incident the time would not permit much else"*

*"The effective management of aggression is part of the MHN's role. If I ever felt unsafe or personally threatened I would definitely make a report. To a degree aggression comes with this specialist role."*

*"It depends on the level of violence. If it's just verbal abuse I will put that in their report, anything else would be IMMS'd"*

*"Too many small incident at all times"*

*"Most verbal aggression goes unreported as it is stated by management that's the nature of mental Health"*

*"I think we have a higher tolerance to aggression than we probably should"*

*"So many smaller aggression incidents would spend the shift completing incidents"*

*"It becomes a regenerative feedback loop. The more time I spend off the floor, the more paperwork gets generated (incidents increase). At some point, you have to become very judicious about how often you document these episodes...or there will be even MORE of them to document! It's madness. Filling out an entire IIMS report often takes so long that additional ones are generated in the meantime. There needs to be an easier way. The current tools are far too cumbersome. In addition, I have seen far too little in terms of response to these reports - so there appears to be very limited value in taking the time to submit them. I think nursing staff would be far more likely to take the time to submit them if they felt that they had any real impact on preventing future incidents from occurring. Sadly, that doesn't really appear to be the case."*

*"Time constraints. Never get feedback, no debriefings and nothing changes. So I tend to only report extreme violence or restraints/seclusion's."*

*"IIMS reported seem to make no difference. No feedback on outcome of reported incidents. Nursing colleagues in other disciplines do not comply with policies and are seemly not heald to account for non adherence."*

*"become desensitized over the years especially for verbal aggressions and threats of violence. Management unsure of how to handle this situation."*

*"Verbal aggression occurs continually, it would be impossible to report all accounts and attend to work load."*

*"Verbal aggression is not reported as senior managers do not consider it aggression."*

*"On occassions of reporting issues the reply has been finger pointing and blaming the nurse for incidents and is very degrading."*

*"I would be submitting multiple reports in clinical files, handover sheet, and IMMS if I were to reflect the sheer volume of incidents of threats & verbal abuse throughout the shift in the PICU. This in turn reduces my opportunity to nurse patients and deescalate the potential for further physical aggression and or self-injury."*

*"I feel I work in a culture that minimises these acts due to the poor mental health of the child. We often justify the aggression in the context of their mental health and their developmental stage, especially verbal aggression. And often at the expense of the impact on the nurse or staff member"*

*"There are too many verbals to report It is common practice - unless first aid is required reporting is not to be done."*

*"There is so much aggression and abuse, it is seen as normal."*

*"I have had an experienced where after making reporting my manager finds more blame and sends a message to staff that you should have done this and that instead of how can we improve. No meeting even held to discuss about the reporting or again for improvement. Being in that situation discourages me to report."*

*"Verbal aggression is viewed as part of the working environment. If all episodes of patient aggression were to be documented the nursing staff would have no time to do anything else."*

*"If we were to do that we would be reporting incidences every 10 mins..working in intensive environment we get abused almost continuously..thanks to no smoking policy."*

*"so frequent, I think I've become desensitised and accepted it's part of my work environment"*

*"Over time have become desensitised to some verbal aggression"*

**Q39 Have you ever been too afraid to use seclusion, even when you thought seclusion was necessary for the safety of others?**

| Afraid to use seclusion | %     |
|-------------------------|-------|
| Frequently              | 2.95  |
| Sometimes               | 24.19 |
| Rarely                  | 17.4  |
| Never                   | 39.53 |
| N/A                     | 15.93 |

A total of 56.57% of respondents, indicated rarely (17.4%) or never (39.53%) had been too afraid to use seclusion. Comments as per below:

*"Seclusion is being made irrelevant but at the expense of staff and pt safety."*

*"Managers strongly discourage the use of seclusion, and often step in to "manage" the situation in order to keep their seclusion statistics favourable, which jeopardises the safety and wellbeing of other patients and staff."*

*"it really depends on what manager is on duty at the time"*

*"It is less about fear than it is about having the adequate resources available. When you have two nursing staff on during a night shift, and no security immediately available (if available at all), seclusion is barely even an option without putting people at VERY serious risk. (And yet, they recently REDUCED the number of night staff on our adult unit....)"*

*"No seclusion in our unit. We sometimes have to empty one ward, to enable one aggressive patient to be on his own in the 8 room ward"*

*"Usually this means taking a nurse usually with limited experience to special the client in seclusion which in turn affects the unit especially if the acuity is high."*

*"Discouraged, documentation problematic, time consuming, culture of blame & often ridiculed, "finger pointing" as individual skills to de-escalate come into question."*

*"Criticism by management and ministry about statistics whilst failing to provide appropriate environment to reduce seclusion. These people should be held to account including chief executive and minister"*

*"Due to the NUM intimidating and bullying mentality due to statistics and how it will look on the them personally as managers. Also the level of violence confronting staff to be able to enter to seclude the patient is often too high and unsafe."*

*"I personally haven't But of late alot of colleagues have been afraid to seclude in fear of senior nurse managers casting judgment from a distance."*

*"Policies already exist to discourage seclusion and therefore risk is regularly transferred to the next shift."*

*"seclusions was and is the last resort but with all the negative attention it has gained we are often a bit late doing it"*

*"Even though I am criticised for it I believe safety of staff and patients comes first"*

*"Active policy to not seclude or to end seclusion asap in our service. This has led to many more incidents of aggression between patients and staff and co-patients. There has been a lot of assaults since then and a lot of staff attrition"*

*"It is increasingly apparent that nurses are hesitating and doubting themselves when restraint and seclusion become possibilities,"*

**Q40 How often have you felt threatened or witnessed verbally threatening or assaultive behaviour from a patient towards yourself, staff or another patient in the last month?**

| felt threatened or witnessed verbally threatening or assaultive behaviour | %     |
|---------------------------------------------------------------------------|-------|
| Daily                                                                     | 27.08 |
| More than 4 times week                                                    | 22.62 |
| Less than 4 times week                                                    | 14.88 |
| More than 4 times month                                                   | 11.9  |
| Less than 4 times month                                                   | 13.39 |
| Not at all                                                                | 10.12 |

More than 64% of respondents witnessed or experienced aggression in the last week, with nearly half this number (27%) on a daily basis.

**Q41 Do you always have the time to provide the care you would like to provide to your patients?**

| Time to care | %     |
|--------------|-------|
| Yes          | 10.68 |
| No           | 69.44 |
| Sometimes    | 19.88 |

Nearly 70% of respondents (69.44%) indicated that they do not have the time to provide the care they would like to provide to patients. This must have an effect on the care provided in the long term. One wonders about the cost efficiencies that could be gained through the employment of more staff to achieve safe efficient and effective care provision.

The themes from the comments include excessive documentation requirements, poor skill mix/ poor staffing levels and acuity of patients.

There were 9 pages of comments (83.5% responding to this question) with a small sample of comments as below:

*"Lots of paper works to complete."*

*"We have too many paper works, online and emr documentations which do not provide quality time for care of patients"*

*"Huge increase in level of documentation required-a unilateral decision made by senior management as a direct result of critical incidents occurring in*

*OTHER facilities. Lack of computer entry points confines nursing staff to the staff station."*

*"Staffing"*

*"Way to much paperwork to be done"*

*"Poor staffing level. More documentations."*

*"excessive workload understaffing poor skill mix"*

*"Unskilled staff, too many jr staff, paperwork, documentation, stress, aggression and violence"*

*"Documentation. There is just so much of it. Nurses are being made accountable for every little thing. Why can't pts take more responsibility for what they do on the ward? Senior managers and Drs are so scared of litigation by pts that we nurses can't even do our jobs anymore. We haven't progressed at all. Ask any senior ward nurse and they'll tell you that things were better in the old days.. 5-10yrs ago."*

*"Increase workloads increased documentation"*

*"Not enough time and poor skill mix"*

*"staffing levels are too low and there is too much paperwork and check lists to attend to."*

*"Poor staffing skill mix and not enough time"*

*"the workforce has changed, everything is on computer now, there aren't enough computers to access, the nursing model has changed and staff aren't sure what to do anymore, staff are leaving in droves, so casuals fill in the gaps, but our job isn't as simple as taking blood pressure, but casuals aren't around consecutively to build rapport with patients, so the patients frequently go to the regular staff for all their care needs, thus burning out the regulars, while the casuals have easy cruisey days, the doctors want experienced staff for interviews and reviews, the patients want regular staff to attend to their needs, managers want regular staff to get things done on the floor, but the work force has limited regular staff now and we are burning out and finding jobs elsewhere, which is leaving the regular staff in the mental health wards at higher risk"*

*"Documentation. Enabling Unescorted ground leave to access lockers (provided by management to keep cigarettes and tobacco) to smoke. This involves escorting patients from unit, returning to unit and documenting for each patient where they are going, why, what they are wearing, mental state, time due back, who they are with and if relatives have been notified. On return from leave patients are checked/searched and any contraband is removed."*

*The documentation is then repeated including search results. On a morning shift this process occurs 3 times. Accessing computers"*

*"too much paperwork to complete.. far too much and more shit just keeps coming our way.. Have you the new care levels what a fucking joke.."*

*"In my role I have more flexibility than the floor nurses who certainly do not always have time to care as they might wish too or the most unwell patients get the attention and those who sit back and are quiet miss out. Behavioural issues often take precedence"*

*"Despite improved ratios, such is the high risk of our patients of harm to self and others, that staff are required to be vigilant not only of our allocated patients, but to the unit as a whole. A lot of time also is used by paperwork-type tasks, minimising time for the care that we would like to provide to our patients."*

*"Resourcing issues, and allied health staff who are infrequently present on the unit (many work part-time). We also have a large number of staff on secondment to other units, or on disability leave due to burnout or illness. We also have very high rates of sick leave. This all impacts our capacity to spend time with the clients - as the staff who remain are often seriously over-tasked."*

*"Documentation and staff ratios"*

*"Time constraints from import of Documentation, doctors demands, aggressive incidents, inadequately skilled staff, skill mix issues, at times poor concept and practice of team work."*

*"too much documentation and told we need to earn money for activity based funding and book cars to go out, so far less time seeing patients, most time spent in the office, paperwork is excessive"*

*"This is dependent upon many variables, such as: acuity of the ward, staffing mix, too much documentation, patient escorts being removed from staffing numbers. etc."*

*"Some patients take more time and effort just to make it through the day and others are neglected. High patient to nurse ratios. Specials within numbers. Understaffed. Too many casual staff etc"*

*"Limited time, patient to nurse ratio, documentation needing to be done, especially if there are admissions, discharges, tribunals, doctor's reviews, etc...."*

*"Too much bloody paperwork. The documentation that is required each shift is not necessary and is often doubling up in one way or another. The system needs streamlining and staff education is required to level the playing field so that everyone knows what to do, how to do it, why to do it and the outcome of completing all the bloody paperwork."*

*“Too much paperwork including double documenting, and increased patient loads when we are short staffed including when we have specials”*

*“Pressure to limit duration of care and discharge”*

**Q43 Do you agree or disagree that more education for staff new to mental health, (face to face education, not just online training modules) would help assist in reducing seclusion and restraint use in mental health?**

| More education for staff new to mental health | %    |
|-----------------------------------------------|------|
| Strongly agree                                | 57   |
| Agree                                         | 28   |
| Disagree                                      | 7.99 |
| Strongly disagree                             | 0.89 |
| Unsure                                        | 5.03 |

85% of respondents believe that they do not have the necessary qualified staff numbers to reduce the use of seclusion and restraint at their facility with 57% strongly agreeing and 28% agreeing.

**Q44 Do you think that your facility currently has the qualified nursing staff numbers necessary to reduce seclusion and restraint?**

| Qualified nursing staff to reduce seclusion and restraint? | %     |
|------------------------------------------------------------|-------|
| Yes                                                        | 18.64 |
| No                                                         | 57.99 |
| Unsure                                                     | 16.57 |
| N/A                                                        | 6.8   |

Nearly 60% of respondents believe that they do not have the necessary qualified staff numbers to reduce the use of seclusion and restraint at their facility.

**Q45 Do you agree or disagree that restrictive budget measures have had a negative impact on the care provided to mental health patients?**

| Budget measures have had a negative impact | %     |
|--------------------------------------------|-------|
| Strongly agree                             | 72.92 |
| Agree                                      | 16.07 |
| Disagree                                   | 2.68  |
| Strongly disagree                          | 0.89  |
| unsure                                     | 7.44  |

88.99% of respondents indicated that they strongly agree (72.92%) or agree (16.07%) that restrictive budget measures have had a negative impact on the care provided to mental health patients. This is the opinion of clinicians at the clinical interface of patient care that have experienced the changes that restrictive budget constraints have created in the mental health sector over time.

**Q46 What extra resources do you think are needed at your facility to safely reduce the use of seclusion?**

This was an open question with 11 pages of responses (83.5% response rate) with some of the comments as below:

*"Nurses"*

*"Extra rooms where patients could be safe alone to give themselves timeout that will not necessarily means seclusion Safe place to express anger that will not get anybody hurt"*

*"Education"*

*"Increased clinical staff. Appropriately qualified CNEs. Appropriately qualified and experienced security staff. A review of the anti-smoking policy including consultation with consumers. Formalisation of senior/middle management staffing. Greater visibility of middle/senior management at ward level."*

*"More staff"*

*"Staff on acuity not numbers"*

*"More male staff needed. Need use regular staff."*

*"Staff patient rations, an end to NHPPD, acknowledgement of the difficulties acute MH wards operate in, the burden on staff and appropriate staff numbers and education"*

*"Experienced Staff"*

*"Adequate staffing plus good skill mix"*

*"More male staff"*

*"More experienced nursing, allied health and security staff. More quality face to face training by well qualified CNE's."*

*"An extra staff member on the morning/afternoon shifts and/or a ward clerk would enable nursing staff to spend more face to face time with the clients and therefore hopefully reduce escalation and need for seclusion/restraint in acutely unwell clients."*

*"Our one room is not appropriate for seclusion ... used for every other presentation due to bed Demands"*

*"Staff skill"*

*"Better staff to patient ratios"*

*"Face to face training. recruitment of experienced staff in mental health"*

*"Additional staff time in rosters to allow for staff to develop ward programs which produce quality interactive engagements. Nursing staff should have time to develop groups and engagement strategies and evaluate these, outside of nursing duties. Nursing staff should have protected time to have clinical supervision and reflect on their practice, learn from when situations have resulted in seclusion and restraint with a senior clinical colleague"*

*"More staff especially nurses. I work in the community so have many allied health staff"*

*"We need to have an HSA on night duty. Most of our seclusion occurs at night due to reduced nursing numbers and lack of support. We also need another OT or Diversional Therapist or dedicated Activities Nurse as boredom and lack of meaningful activity is one of main causes of aggression on our unit. Also need to have another nurse on the Evening shift as the nurse in charge has a full patient load and is also very busy with incharge duties. Their patient's don't receive the care they should have and the incharge does not have time to engage with their patients as they would like to."*

*"Increased MH experienced staff, correct skills mix and better nurse patient ratios"*

*"More qualified ie. RNs"*

*"more space to separate individuals with disturbing/ intrusive behaviour"*

*"more low stimulus areas, sensory zones"*

*"adequate skilled mental trained staff"*

*"more qualified RNs"*

*"more staff qualified and with experience in Mental Health"*

*"An appropriate ED and PECC environment for MH consumers. Commencement of MHN's to do the ED specials (currently attended 100% by agency security guards). A secure, safe smoking area for ED MH consumers who are held involuntary."*

*"skills mix"*

*"More experienced staff."*

*"I do not feel any EXTRA resources would reduce seclusion. The higher acuity of patient being admitted to the ward due to ICE use and various other substances has increased the unpredictable nature of patient. Patient's are being admitted to the ward quickly from Emergency due to their need to get patients through a timeframe."*

*"Seclusion is only used at our facility when absolutely necessary it is not done lightly & often police have to be involved due to the violence of the patient. It's all very well to say less seclusion when you don't actually work there. Like the Richmond Report that worked well didn't it (not!) people not working in the area thinking things can be changed so easily. Try being threatened by a violent patient & see how you feel"*

*"Meaningful activities. Quiet space. Decent buildings/ interiors"*

*"We could have resources to the sky, but that would be unlikely to reduce the number of drugintoxicated, antisocial people being admitted to the picu. I can't think of any alternative resources we could effectively use to safely reduce risk for people being aggressive to self/others due to treatment-resistant psychosis, or psychotic mania, who also lack the insight to cooperate with therapeutic care, medications."*

*"More qualified staff, 25 positions down at present time."*

*"More experienced staff especially if we require patients to be specialised or if the ward is unsettled"*

*"More careful analysis of patient interactions and strategies, which requires more technical rigor therefore time and skill."*

*"Adequate staffing, senior staff employed to support and develop clinical staff who do not have a patient load. Hands on allied health staff who provide diversional therapies but who are independent clinicians and do not utilise nursing staff time to provide same"*

*"I see this less as a matter of resources than an issue of admitting patients who are clearly inappropriate for the particular space. Hint: Stop admitting forensic patients into environments that are not adequately staffed for that purpose. It makes for an incredibly dangerous situation for all involved - including the patients".*

*"Reduction of beds in Observation area. 8 acute pts in small area is impossible to manage. Increased staff when very high acuity. An after hours manager that can support, debrief, organise, liase with junior Drs who are unsure and inexperienced on how to manage highly aggressive pts and assist with difficult pts."*

*"More highly trained mental health staff"*

*"Full complement of qualified and experienced staff. Support and the appearance from executive would go along way in supporting staff."*

*"Better communication with entire Mental Health Team. Less restrictions regarding patients being medicated as most clients are under medicated even with aggression incidents. Education of mental health workers regarding physical health monitoring so doctors won't feel afraid to medicated and risk patient having respiratory depression. Adequate skill mix on every shift. Don't include specials in nurse numbers as the staff left are generally casuals with limited experience. Incentives for Mental Health staff to remain in mental health. Greater protective laws for assaults against health care workers, disregarding the fact whether the aggressor is intoxicated with substances as the bruises still swell up at the end of the day. Mandatory debrief sessions by out sourced clinical psychologists for staff affected by abuse from patients."*

*"Greater number of staff for 1 to 1 interaction with patients"*

*"Contemporary facilities not 40 year old buildings and better staffing levels with relevant skills."*

*"LESS MANAGEMENT AND MORE REGISTERED NURSES PER SHIFT LESS PAPERWORK"*

*"The acuity of our patient is never taken into account. We are basically a dual diagnosis unit combining mental health, drug and alcohol and multiple physical events that require nursing time. Nursing numbers are only taken on patients in units. Weekend coverage and after hours coverage is very poor."*

*"Retain more senior staff.. how? Support them... trust them in decision making. Bugger trying to look good in statistics... nurses are getting injured both physically and psychologically.. then they lose this sort of nurses. Dog eats dog. All because of documentations forced down our throats"*

*"Extra staffing and not relying on AINS to be staffing numbers. More face to face training"*

*"Enough number of staff. Experienced staff. Good skills mix. More programs for mental health consumers. Managers to stop transferring consumers to another mental health unit for the sake of making an available bed as it disrupts the mental state of the consumer. We have consumers who have been in that situation deteriorated became aggressive and was secluded."*

*"Most of the clients I have seen go into seclusion were extremely violent and drug affected , it is not just training , it is more staff , security presence as well. Our security at [REDACTED] that Work in Mental Health are excellent . No one feels safe, many of my colleagues have had terrible injuries. Often clients admitted should have been in custody . Management have a different agenda."*

*"PICU or MH ICU provision. Use of technology to monitor vital signs & thereby reduce need to wake patients. More humane, less austere HDU environment - along the lines of Marie Bashir Mental Health unit in Sydney (Metropolitan = better resources), although they have a PICU. Provision of comfortable areas/seating in HDU where agitated patients can relax & not be disturbed by yelling/screaming/banging patients, especially at night; somewhere that they could listen to relaxation music or meditation exercises safely - wireless headphones would be good. HDU is very antiquated & uninviting."*

*"If nursing staff had more time to spend with the patients with higher staff to patient ratios - I believe restraint/seclusion would be greatly reduced. On night duty we have 4 staff to 28 patients. If there is a 1:1 special (in numbers), this becomes 3:27. We are needing to rely on hospital security for restraints/seclusions overnight, due to the poor staffing. This can further aggravate patients as the security can be intimidating. However, for staff safety it is often the only option. Greater deescalation, self defence training and more frequent restraint training would be beneficial too, as staff often get trained once, then refresher courses years later."*

*"Backfill if staff to attend training, more funding to support staff to attend specific specialised MH training, scholarships for staff to complete post grad education"*

*"Increased staff numbers. Staff released off the floor to attend mental health education. Increased budget for education delivery. Increased supervision and debriefing of staff. Smoking areas for inpatients within mental health facilities."*

*"Experienced staff with mental health training Experienced Security staff on the floor OT and resources Smart design of actual unit Team building days Education regularly Humane conditions for inpatients- taps that work, access to soap and appropriate hygiene. Access to nutritional food. Access to coffee and tea/ herbal tea options in a humane way."*

*"For a high acuity ward, our seclusion and restraint numbers are quite low. However, the majority of our consumers who require seclusion and restraint are under the influence of drugs, particularly ice. There is a push to get consumers out of emergency so they come to the ward acutely intoxicated and usually undermedicated. We also have a few patients with complex emotional dysregulation who are admitted extremely regularly for "containment". Multiple of my staff members have been injured and reported this to the police but whenever there have been court cases, the court sends them in for psychiatric assessment. These consumers are in integrated support programs but the staff there are lacking training and send them to hospital and soon as the consumers are distressed, they are sent to hospital."*

*"We only secluded in our HDU when a patient is a physical threat to others. Seclusion episodes in the main are brief - less than 12 hours. One aspect that concerns me in our service is that it is a medical decision to unseclude not a nursing decision."*

*"More staff & less isolation. Nurse to patient ratio needs to be lower for adolescents - at least 1:2 -, as the young people need much more 1:1 time than the adults. It is not appropriate that adolescent units continue to be run as for adults. I have frequently been called away from a distressed adolescent to deal with other matters, which can lead to increasing agitation in a patient."*

**Q47 NSW Health just released a new 'Engagement and Observation in Mental Health Inpatient Units' Policy (PD 2017\_025). Do you agree or disagree that the workload on nursing staff would significantly increase when trying to comply with the new 'Engagement and Observation in Mental Health Inpatient Units' Policy?**

| PD 2017_025). would significantly increase the workload on nursing staff | %     |
|--------------------------------------------------------------------------|-------|
| Strongly agree                                                           | 50.88 |
| Agree                                                                    | 15.29 |
| Disagree                                                                 | 3.24  |
| Strongly disagree                                                        | 1.82  |
| Unsure                                                                   | 8.82  |
| Not aware of the new policy                                              | 20.59 |

With this policy having already rolled out across LHDs it is surprising that 20.59% of respondents are not aware of it.

66.17% of the remaining 79.41% responders that are aware of it strongly agree or agree that this policy would significantly increase the workload on nursing staff.

**Q48 In your experience, how long do you think it would take to therapeutically engage with a patient, be able to observe and assess the patients mental state and then document the assessment, including risk assessment, in the patient's notes?**

| Time to engage observe assess and document as per policy | %     |
|----------------------------------------------------------|-------|
| 1 to 5 minutes                                           | 1.47  |
| 5 to 10 minutes                                          | 6.47  |
| 10 to 15 minutes                                         | 11.18 |
| Greater than 15 minutes                                  | 80.88 |

The extra work load required can be seen once we examine the full extent of what the 'level 2' observation entails within the context of purposeful observation and all that is involved.

Just over 80% of those surveyed estimated that it would take more than 15 minutes to therapeutically engage with a patient, be able to observe and assess the patient's

mental state and then document the assessment, including risk assessment, in the patient's notes as per the new policy.

If a patient was on 'level 2 observations' (15 minute observations), then their time would be observing and documenting for the whole shift, with no time for any other activities.

The estimation of the time taken to complete the nursing observation is informed by our members working at the clinical level and for one patient only. This does not include any interruptions to the nurse while complying with the observation policy directive or other nursing actions for any other client.

The nurse cannot be distracted by any other issues or it will impede their ability to ensure they are able to complete the observation as outlined in the policy directive. Having any other patients would mean that they would have no ability to maintain the frequency and remain committed to complying with each and every observation. Managing level 2 observations would severely impact on the nurse's ability to therapeutically engage with any other patients under their care due to the 15 minute interruptions.

The time taken to safely monitor two patients on Level 3 observations (30 minute observations) by one nurse and complete the nursing observation as required in this policy directive would also leave no time for any other activities during this hour.

**Q49 Do you agree that it will require substantially more nursing staff than you have currently rostered to comply with the new Engagement and Observation Policy?**

| Require substantially more nursing staff than to comply with the new Policy (PD2017_025)? | %     |
|-------------------------------------------------------------------------------------------|-------|
| Strongly agree                                                                            | 56.05 |
| Agree                                                                                     | 18.29 |
| Disagree                                                                                  | 2.95  |
| Strongly disagree                                                                         | 0.59  |
| Unsure                                                                                    | 5.9   |
| Not aware of the new policy                                                               | 16.22 |

16.22% of respondents indicated they are not aware of the new policy.

74.34% of the remaining 83.78% of responders that are aware of it strongly agree or agree that this policy would significantly increase the workload on nursing staff. Without the resource of extra nursing staff, to comply with this policy would be impossible and to expect nursing staff to comply with this policy, would in effect be setting them up for failure, place nursing staff in an impossible position, creating an unacceptable risk to patient safety and to the nurses professional registration.

**Q50 Thank you for taking the time to complete the survey. Do you have any other comments or suggestions that you would like to add?**

*"The new policy means well however, did not consider the workload it would give to staff who are on the floor. Whoever made this policy obviously hasn't been working with patients at all."*

*"This system is completely broken. I don't like seclusion, I don't like putting patients in seclusion, it's NEVER used as a first line treatment. It is used only when that patient is a risk to their own safety or the safety of others and all other possible avenues have been exhausted. People simply do not understand the struggles that are faced on the wards, we are stretched beyond what is humanly possible, with unreasonable expectations coming from above. The number of assaults will rise dramatically if seclusion were to be abolished. A lot of patients are admitted with comorbid drug dependence, greatly complicating matters. A lot of patients do not have any care, concern or respect for anyone. This makes mental health units extremely dangerous, volatile places to work."*

*"Only that I do hope that the current environment in MH changes for the better and changes soon. Otherwise, I predict a mass exodus of qualified, experienced staff who are now nearing burn out and are already searching for their way out of MH.. I know as I'm one of them."*

*"I don't think things will improve any time soon as a matter of fact I think there is worse to come. I feel sorry that the patient's are going to be caught up in it. Today's Mental Health Care is far from what I loved. And even further away from how I felt when I left University. Mental Health back then was the only thing I could have ever wanted to do when I was a newly registered nurse"*

*"Seclusion is often the safest option to maintain a safe environment for other patients as well as staff I think the trauma aspect is over stated Why not look at how to reduce the trauma of seclusion rather than just trying to reduce seclusion eg move away from the seclusion room being like a gas chamber"*

*"There needs to be a statewide policy on pregnant women not being required or expected to participate in seclusions and restraints, or care for violent and aggressive patients. I nearly lost my baby early this year due to having to participate in a restraint."*

*"I feel that there are times when seclusion is the only answer for the safety of all concerned. And that it should not be totally abolished."*

*"im tired of mental health being the poor cousin to health in general, hospitals are being rebuilt, modified, increased beds and new equipment provided, yet mental health gets very little, all the big mental health hospitals except one has been shut down, instead each hospital has a satellite unit attached, with poor funding or resources provided by the parent hospital mental health is an after thought for most area health services , with the mental health unit having*

*to adhere to general hospital policy and practises, that in no way help mental health services provide adequate care to mental health patients, we get funded the least, the stats say that mental health affects 1 in 5 people now, and there is a big media and education push for the public to address mental health issues, yet we aren't resourced or funded accordingly, people are turned away from admission if there are no beds, but we still cant adequately care for the patients we have. often discharging them early to accommodate pressure of beds, the government is focusing of community mental health, but all the patients I deal with, state that its so hard to engage the community sector, cause they have huge case loads already its a case of the hospital discharging to the community to create beds, but the community bring patients to hospital cause they are too unwell to mange in the community, and the poor patient is stuck in a revolving cycle of getting shafted from one service to another, without either service really helping the root cause also.... people affected by drugs and ice, aren't mentally ill, they are drug affected, we are wasting precious resources of mental health budget on patients who are only really mentally ill while they are under the influence of drugs, why are we referring these [people to community mental health services, when we should be referring them to drug and alcohol services??? that's because drug and alcohol services are way under funded too, and the system makes it easy for people who abuse substances, to coordinate and choose there own care, because there aren't any locked rehab units, its a voluntary service, yet people with mental illness don't get the same choice the government wants mental health patients to go private, but in the current economic climate, who can afford \$250 psychiatrist consultations, the only way to see a psychiatrist is to admit yourself to hospital, then you get referred to the community, but if you go to the community first, the waiting list is months long, or you get refused service the mental health system is broken!!!!!!"*

*"Mental health patients need to go to a specialised unit not be brought to ED. Smaller hospitals are not staffed up...TECs avoid assessments psychiatrist will not accept MY pt until medically cleared...its so difficult to get gain the pts co operation for ECG never mind bloods. It's not fair on the pt when we have very sick pts including children being sworn at and threatened it watching staff be threatened. Skilled trained experienced RNs in a mental health facility should be able to medically clear pts with skilled MO in Mental Health. In appropriate settings maintaining privacy for the or and safety for the staff."*

*"I hope these surveys have a positive impact and improve mental heath nursing"*

*"CORE values include consultation. This has not happened and staff are being told "you'll just have to do it"."*

*"The nurses are always the ones who are asked to do more and more work. Allied Health and the MOs don't ever seem to be involved in doing the increasing documentation that is required. They also complain if ever asked to do anything extra and just don't do it. I can understand why they have implemented the new policy, to try to increase engagement with patients. There are some nurses who do just stay in the nurses station and observe*

*patients through the windows and this is bad and needs to be improved. However the nurses just can't be asked to do more and more work with no extra resources."*

*"The Service I work in seems to be concerned about "numbers and dollars" than improved clinical service delivery. There is poor compliance with MoH and LHD policies and a tendency for "quick fixes" and "Convenience before Compliance" with disregard for "EBP" Quality and safety"*

*"I'm sick of being addressed as being the problem, State MH Services. When it has been ongoing lack of funding of services. Now any concern expressed about NGO led services is interpreted as you putting up barriers for consumers to get a service. Rather than genuine concern for their care."*

*"More practice Less bureaucracy/ paperwork More Face to Face Training Prevention & Mgt of Violence/ Aggression Training should be MANDATORY & more REGULAR, eg every 3-6 mths: I've had 2 in 9 yrs."*

*"Nursing related workload issues are not only about nursing staff related issues. The PECC unit particularly is dominated by the medical model, has poor overall medical coverage and actually adds to the nursing workload not takes away from it."*

*"Seclusion & restraint is a necessary component of managing violent & aggressive patients. Reducing its usage will put staff & others at serious risk."*

*"It can take more than an hour to engage with a patient & do all of the above it could take up to 3 hours depending on the patient. 15 mins is doing their obs & giving them their paperwork to do"*

*"I would not work in my unit (picu), nor my hospital, if seclusion was unavailable. I regard the safety of myself, my colleagues and my patients of utmost importance priority over a patient's discomfort in regards to seclusion. I resent that seclusion is portrayed as a punishment, it is not. It is a very useful and valid therapeutic tool giving a patient time away from stimulation and exacerbating influences, allowing them to self soothe as much as they can in safety. I concede that it would not be a pleasant experience for anyone, but to contain the extreme risk a patient poses to themselves and others, I think that it is far preferable than the alternative of manacling a patient to a bed, and/or injecting a patient with multiple antipsychotic/ tranquilisation medications that could either endanger their lives or are simply ineffective if the patient is drug-resistant. I have never known an instance when seclusion was the first option used by staff to reduce extreme risk from a patient, it is always the last option in an exhaustive process to effectively treat a person for their risks to themselves or others. In my unit, several staff have been seriously injured after being attacked by psychotic and antisocial patients. If there were no seclusion rooms available, the alternative, in the face of threat, is to simply open the doors and let them go rather than to risk injury to ourselves or our other patients."*

*"There is a significant shortage of skilled and senior nursing staff currently, this is due to staff not being supported and provided with opportunities to further their career, staff get burnt out and leave, causing not only shortages but an increase in junior and new staff which in turn causes an increase in aggressive incidents and seclusion due to staffs inability to manage challenging behaviors"*

*"Please consider the mental Health needs of children & Young people who are presenting in higher numbers with high levels of acuity & distress & their families"*

*"Upper management should have more of a clue on a floor level issues and to take into account staff issues"*

*"We do everything we can to reduce seclusion and restraint on our unit - and we have been extremely successful in this regard. Having the right staff makes a tremendous difference. However, limitations of our current infrastructure could be improved significantly. People are doing the best they can with what they have available...but it is often not enough - and staff are paying the price in terms of attrition rate. It is an incredibly difficult job, and I do not always feel that staff have the support they require to stay in the job for the long haul. It is very unfortunate, because we lose a lot of real talent and experience when people burn out. But this health service often seems to 'keep the boilers lit' on the bodies of its nursing staff. Some of the most committed and talented people I have ever met have been crushed beneath the wheels of this machine. Frankly, I think it's tragic."*

*"Upper managers are unsupportive and are always trying to cut money and services to the inpatient unit. They blame the staff for issues that are occurring in the unit. Any restraints or seclusions are frowned upon. Yet they seem to have no idea of the verbal abuse and aggression that mental health nurses are subjected to every shift. The money allocated to mental never seems to make it to the inpatient unit to provide quality nursing care and patient outcome. Way to many managers all trying to protect their jobs. Resources OTs in Observation areas. The unit has limited resources. Everyone is focused on seclusion and restraint. The nurses are leaving at a rapid pace. No nursing staff means no one to work in the unit. Then what the carers and advocates are going to manage the highly aggressive patients."*

*"Are we working from a safety perspective for both patients, consumers, staff and they public? Is staff experience being considered? Have recently received a please explain via executive concerning a Seclusion event. Felt like big brother event."*

*"pressure now on employing cheaper staff eg new grad SW and ots, nurses are too expensive and devalued, NGOs are taking over and activity based funding is too much pressure, we now lie and exaggerate our contacts to earn the service money and the pressure to do so is great. In community most managers are Social Workers and our line management is unclear, I feel*

*Nurses in community will be non existant in a few more years and even now we are becoming deskilled. We write reports ( never trained to do this) enforse CTOs and difficult psychopath clients and now being asked to run drug and Alcohol groups ( not in our scope) as well as pressure to keep up hours on the computer to earn funding. Mental health services are in crisis and lack of qualified staff, beds and Dr shortage impact severely on patient care. NGO services are not equipped to deal with mentally ill clients and now mental health includes everything so the chronic mentally ill are severely neglected"*

*"Action needs to be taken to hold WSLHD and ministry accountable for current unsafe situation. Too many tragedies without consequence."*

*"Managing the ice epidemic in mental health facilities has impacted on this specialty. It has and will continue to increase seclusion rates due to the extreme violence and behaviours requiring what others Police would require tazers, batons, handcuffs, guns to maintain their safety. For nurses there is no other way to be manage these clients safely other than seclusion/restraint with strong doses of medication until the toxins are excreted. Bad behaviour can not be controlled with medications alone and at times seclusion is the only resort for the patients own time out from the world and time to reflect and self regulate themselves and their behaviours therapeutically."*

*"Management do not monitor fatigue and burn out. Nurses are unheard. Poor staff retention. Staff willing to go part time refused hence increased resignations. Staff are blamed for decision making. In charge nurses not supported. Ward it short staffed. Too many eens with no experience in MH"*

*"In the ED we rarely use seclusion but it does occur occasionally. To be honest the occasions when it is used is often in response to pts. who have presented or been brought to Ed under the influence of drugs or alcohol and are aggressive/ highly aroused. The use of seclusion in ED ( in my experience) occurs when there are no security staff available to manage the pts aggression. It is also worth noting that in ED pharmaceutical restraint is most often used and the person is sedated and managed in resus. As the pt can be closely monitored in this environment we have resources the staff on inpt units do not. Pts. who have been unmanageable in Ed without sedation are often then transferred to the inpt unit whilst sedated. In this circumstance it must be very difficult for the inpt staff to manage the pt who will potentially wake in a different environment with little recollection of how they got there. I imagine under these circumstances the risk to staff would be high and the use of seclusion may in fact be the only safe way to assess how the person is feeling when the sedation wears off."*

*"More money for the budget. Less managers. A DON that actually knows and cares for his staff. The government needs to look at the damage, drug use is doing to our society and the impact of the unpredictable behaviour and violence that has increased and impacts the use of the restraint and seclusion. Staff have the right to feel safe at work at all times. The patients are not charged with assault in relation to the injury inflicted on staff."*

*"MH nursing needs a proper and appropriate skill mix in order to properly manage and engage with mental health patients. They really need to be empathetic to the requirements of patients and colleagues"*

*"Key words of Therapeutic Engagement should also include meeting some personal needs. This will often require lengthy periods longer than 15 minutes to provide satisfactory nursing care."*

*"Will this survey make a difference to NSW Mental health or is this just another exercise in futility"*

*"Fix the mental health system and management setup so that nurses and patients can give and get the best care possible"*

*"Nurses are burned out from the negative environment in which we work. None of us are getting any younger (extreme aggressive incidents are increasing) and hence injuries during restraint and seclusion are increasing."*

*"Our unit has been in crisis due to understaffing/poor skill mix for months. This has led to many staff leaving/poor staff morale and burnout. Seclusion and restraint have been reduced but more because of lack of staff available to safely carry it out than anything else, so this is not good therapeutic practice for the patient needing containment nor for the other patients adversely affected by the aggressors behaviour"*

*"Seclusion is always the last resort for us nurses however, the safety of others (patients, staff) comes first. It is not an easy job for nurses to seclude someone, it's a lot of hard work. But having said that, extra work does not matter if you know the other patients are safe as well as the staff. Seclusion is due to acuity not numbers."*

*"Every bloody jack and joe wants to do a bloody project to look good.. who are they asking to complete such crap??? NURSES. WE DONT HAVE TIME OR STAFFING FOR THIS PILE OF CRAP. And they dont improve our working life..or workload. STOP!! STOP!! STOP!!! Doing projects. Put the money in staffing. I work in Rehab and forensic ward.. i have been in charge and had 10 patients allocation too. Rehab there is no RATIO.. IT DOES NOT EXIST.. HAD ENOUGH OF IT.. THEN I GET GIVEN AIN.. AND I HAVE FULL APPOINTMENTS IN THE DIARY... THEN THEY EXPECT US TO HELP WITH ECT CLINIC.. THEN RUN A REHAB FOCUSED WARD... STUFF IT. COME TO MY WARD... THIS RUINS WARD MORAL!"*

*"SMOKING ( or rather NO smoking ) has been THE BIGGEST cause of physical aggression in acute Mental Health Units. BEFORE the punitive law was enacted, Nurses had far less issues with aggression in acute units."*

*"How can Nursing be effective when no-one feels safe ? We don't even get clinical supervision, even after requesting it in writing"*

*"Pop psychology concepts have no place in dealing with acutely psychotic drug affected patients. Current Worker's Compensation is extremely ineffective in dealing with the needs of injured nurses."*

*"Im an RN, not a security guard. I don't think I would be able to work in Acute Mental Health if seclusion rooms were removed. They have saved me and my colleagues, and other patients multiple times from drug addicted and aggressive patients who are often dumped in mental health by doctors who have no understanding of mental health units, and without proper medication. There are occasions I have heard of where nurses in other states have misused seclusion or restraint, but in my three years it has only ever been for the safety of the patient, other patients, or staff. As much as I hate restraining/secluding patients, and the trauma it can cause for them, sometimes we simply have no other option."*

*"mental health nursing need to return to being a speciality, nurses need to be fully trained before they hit the floor. 20 years ago I could spend 6 out of 8 hours counselling and being with my patients now with all the paperwork and such I'm lucky to have 3 hours and that is if we are fully staffed."*

*"We are losing good staff due to burning out. We really need a shake up of the system to appreciate and support the nurses rather than blaming them all the time"*

*"Mental health units are a specialty area, just like intensive care or coronary care, surely when staff are employed in these areas they are well qualified. Same with mental health, nursing staff that are employed in these areas should be well qualified. Senior nursing management not NUMs should be supportive of staff. There are NUM's currently employed that have NO experience in acute admission psych wards but know how to manipulate and before you know it, they have climbed up the ladder like there is no tomorrow. Senior management making ridiculous decisions without consulting staff that deal with violence and aggression on daily basis. However, if a staff member is assaulted, they are quick to point the blame on the staff, especially when the staff member have been around for a long time. NURSES NEED SUPPORT NOT CRITICISM. Patients are becoming more aggressive due to drugs that are becoming an epidemic and endemic."*

*"Restraint and seclusion is necessary and taking people out of seclusion early on the orders of a person who doesn't understand the risks in an individual case is a massive risk to safety of all and reduces staff confidence I working in these areas. Management gives no support and actually treats nurses with contempt and assume the worst"*

*"The drive to reduce seclusion has to be balanced by an awareness of the number of patients presenting who are regular illicit drug users - especially 'Ice' users. Poor frustration tolerance, hairtrigger reactions, combined with no-smoking, no cell phone policies and medical staff risk-averse to granting leave for smoking is an explosive mix."*

*"We need more staff and more modern facilities with safe design. The newer hospitals are more safe i think. Eg RNSH has a safe back escape from the nurses station and high fences to prevent escape. Plus the common activity areas are in sight of the nurses station. Would be good to have seperate ward for D&A patients from other patients with higher staffing as they tend to be more aggressive and try to bring substances in."*

*"The ideal that RN's are professionally recognised and considered to have equal input within a multidisciplinary team remains a work in progress. RN's with many years experience are still considered to have a custodial role re. ongoing management and care planning for patients in their care. Having a real say in terms of dictating care pathways remains a myth. A culture of noninclusiveness in relation to primary decision making within a MDT remains problematic, and as a result nurses become professionally muzzled, frustrated and burnt out- despite being front line care 24-7."*

*"Scholarship and training opportunities for new staff not just new grads in mental health nursing would help. I'd love to get fulltime employment in MH but as a mature age generalist nurse without specific MH training I see all new positions go to new grads or experienced staff. I work fulltime in another area. Im in a position where I cant study for a Post grad in MH without being employed in the field but a i cant get work without a qualification"*

*"I believe that the systems in place and being constantly extended to report and manage restraint and seclusion events is deliberately complex and time / resource hungry in order to make it impractical and too difficult to implement to make it less attractive as a clinical option. Staff are / will avoid using appropriate interventions to avoid the complex protocols and in doing so will ultimately put themselves, their colleagues and patients at increased risks."*

*"Myself and others have stated that should the seclusion policy be removed then we will find other jobs. We will not put our own safety at risk."*

*"Not enough accountability or consequences for patients that are aggressive verbally or physically. They seem to think it is their right to abuse and even state I'm a mental health patient and I'm right your wrong. Programs like excellence every patient every time if complaints go in the patient is right your wrong and it goes on your file against you despite having other staff witness the abuse or threats or violence of the patient. [REDACTED] executive bully and intimidate their staff and get away with it over and over even have workcover issues of bullying upheld AVO's against them and they still get to stay and hold their positions and continue to bully."*

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