

# **Nursing Practice and Continuity of Care for the Dual Diagnosis Population**

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# Outline of Presentation

- What is Dual Diagnosis?
- Complexity in Dual Diagnosis
- Continuity of Care Model
- Role of Nursing in Dual Diagnosis and Continuity of Care
- Challenges in Implementation
- Strategies to Enhance Implementation
  - Interprofessional Collaboration and Education
  - Clinical Supervision for Nursing
  - Daily mentoring/support from Nurse Educator

# What is Dual Diagnosis (DD)?

- Dual Diagnosis in Ontario is defined as a developmental disability and mental health needs
- Types of mental health needs vary from a diagnosed mental illness (i.e. bipolar disorder) to behaviour and emotional disturbances (i.e. self-injury, aggression, impulsivity, etc).

# What is Dual Diagnosis (DD)?

- An estimated prevalence of developmental disability in Ontario is between 220,000 and 330,000
- Of that population, it is estimated that upwards of about 85,000 of those individuals will have behavioural, emotional or psychiatric problems
- There is likely a much higher prevalence of mental health issues in the developmental population than general population due to organic, psychosocial and environmental factors

# Complexity in Dual Diagnosis (DD)

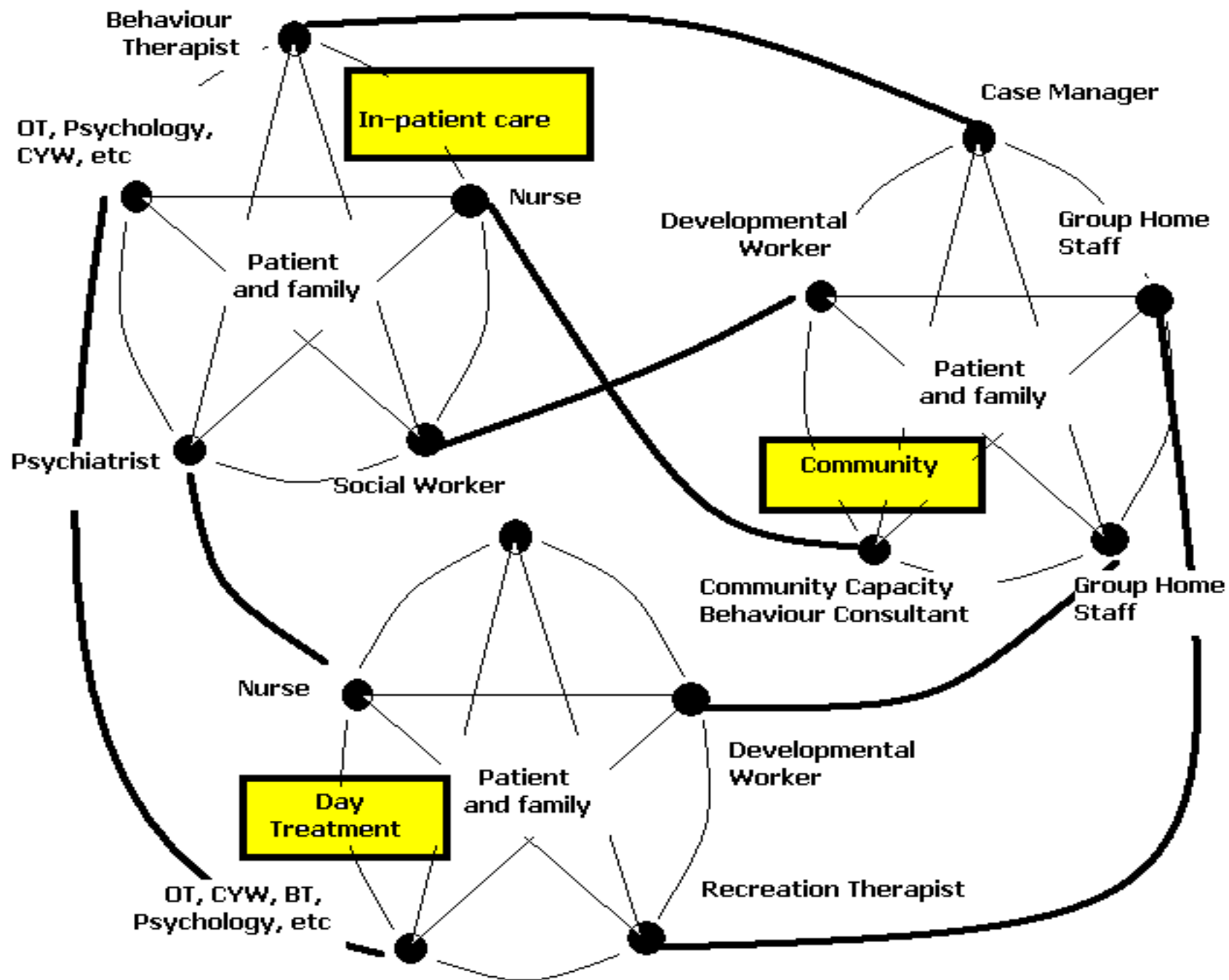
- Diagnostic conundrum
  - Diagnostic overshadowing
  - Over-medicating or jumping to psychiatric diagnosis too soon
- Need for very thorough assessment looking at multiple factors (solving the puzzle)
- Lack of professionals with expertise in dual diagnosis assessment, treatment and ongoing monitoring

# Complexity in Dual Diagnosis (DD)

- High incidence of co-morbid issues
- Lack of funding and availability of community, housing and health services that have experience with this population
- High staff burnout and turnover
- Each client is like a “snowflake” – care delivery requires extensive knowledge of client with effective communication amongst care team

# Continuity of Care Model

- Follows patients from referral, inpatient, outpatient, day program and community/home
- Incorporates ongoing training and support for community care providers
- Emphasis on communication along the whole pathway to ensure that treatment plan developed in hospital or community will follow the individual no matter where they go
- As new information and assessment data arises, there may be changes made to the treatment plan (again, need to ensure that this follows the client)
- Is a **WHOLE** team approach



# The Role of Nursing

- Communicate and collaborate with interdisciplinary staff who follow client in the community or in day treatment re:
  - Treatment planning, implementation and progress of client if they are admitted to inpatient
  - Receiving information from community/day treatment if client needs admission
  - Changes or suggested changes to care plan and behavioural protocols
  - Development and progress of programming for inpatient clients
- This requires enhanced skills, communication and organization

# Nursing Practice Skills in Dual Diagnosis

- Along with regular scope of practice in inpatient mental health, nurses require enhanced skills to work effectively with this population as well as within the continuity of care model:
  - Knowledge of developmental disabilities and related co-morbidities and the impact on communication, mental status (coping/anxiety), ADL's, physical health, etc
  - Extensive crisis management skills including coordination, creativity, and ability to provide debriefing for team and clients
  - Understanding of the roles of multidisciplinary team and how to consult/utilize them
  - Knowledge of programming coordination and implementation
  - Extensive skills in teamwork, collaboration and communication with nursing and interdisciplinary team members
  - Enhanced critical thinking and reflective practice skills
  - Ability to make effective and quick decisions

# Challenges with Implementation For Inpatient Nursing Staff

Nature of clients:

- 24/7 care of clients that can have some problematic behaviours and do not always possess skills to self-soothe or rationalize feelings and behaviours
- Client needs re: interventions for co-morbid issues, assistance with ADL's, recreation and treatment programming can be quite time intensive
- Clients have higher incidences of physical aggression towards staff and co-patients as well as self-injury

# Challenges with Implementation For Inpatient Nursing Staff

## Organizational issues:

- Time intensive assessment and data collection work is required
- Interdisciplinary staff rely on nursing for providing info about clients due to their proximity
- Lack of organizational structures to support communication

## Uneven Skills and History of Staff/Program

- Unprepared for client complexities and organizational demands due to uneven skill balance and education differences among nursing team
- History of health care environment and program

# Strategies to Enhance Implementation of Continuity of Care: IPC/IPE

## Interprofessional Collaboration/Education (IPC/IPE)

- IPC/IPE is the provision of comprehensive health services to patients by multiple health care providers who work collaboratively to deliver the best quality of care in every health care setting
- Sets foundation for support, teamwork and for whole team to become a “we”
- Balancing tasks and process – “culture eats strategy for lunch everyday”
- Need solid leadership that is facilitative and pulls out strengths of staff while also paying attention to accountability

# Strategies to Enhance Implementation of Continuity of Care: IPC/IPE

How?

- Series of IPC meetings with activities that help staff to dialogue about their roles on the team, what each profession does and how they work together to plan and implement care, deals with relational issues - call the “elephants in the room”
- IPE – Clinical teaching program for students that teaches them how to work in interprofessional team, support for student supervisors
- IPE and IPC work in tandem

# Strategies to Enhance Implementation of Continuity of Care: Clinical Supervision

## Clinical Supervision

- Providing effective Clinical Supervision is a foundation of support for nurses

## How?

- Biweekly meetings away from clients with APN and other facilitator (not a part of organization)
- Explore clinical practice through client case discussions
- Talk about the client, who they are, what is their background, how does their disability impact their actions, decisions and behaviours, etc
- Discuss nurses feelings, stresses, and what works and doesn't work and strategize about new approaches and/or best practices

# Strategies to Enhance Implementation of Continuity of Care: Nurse Educator

## Nurse Educator (NE) Role:

- Daily support and mentoring – learning “in the moment”, promotes sustainability of that learning,
- This strategy focuses more on tasks and details but ensures they are promoting health and wellbeing for clients (best practice)

## How?

- NE works with day shift staff as they are providing nursing care to help with problem solving, integration of policies and new tools, get ideas from nurses about what works or doesn't work, uses repetitive and multimodal education strategies

# Synergy!

- All three strategies work synergistically to create a foundation of support, learning and collaboration which will ultimately achieve the goal of continuity of care
- It's about shifting the culture to create better communication, teamwork and clinical care for clients with developmental disabilities and mental health challenges

# Next Steps

- Refining organizational structures that impede communication
- Advocate for centre-wide policies and procedures that more adequately reflect this client population as well as our communication and care planning needs
- Fine tune current communication tools

# References

- A reference list of all articles and research that informed this presentation will be handed out
- For more information contact Gillian May, [gillian\\_may@camh.net](mailto:gillian_may@camh.net)