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Gerace, A., Muir-Cochrane, E., O'Kane, D., Couzner, L., Palmer, C., & Thornton, K. (2018). Assistants in nursing working with mental health consumers in the emergency department. *International Journal of Mental Health Nursing*, 27(6), 1729–1741. <https://doi.org/10.1111/inm.12477>

which has been published in final form at

<https://doi.org/10.1111/inm.12477>

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**Assistants in nursing working with mental health consumers in the emergency  
department**

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**Authorship statement:** All authors listed meet the authorship criteria according to the latest guidelines of the International Committee of Medical Journal Editors, and all authors are in agreement with the manuscript.

## **Abstract**

Nursing students, regardless of setting, require skills in working with people with mental health issues. One way to provide students with learning opportunities within the context of limited undergraduate mental health content and lack of mental health placements is through employment as assistants in nursing (AIN). The purpose of the study was to investigate the use of AINs employed in an emergency department in South Australia to supervise (continuous observation) mental health consumers on inpatient treatment orders. Twenty-four participants took part in the study, with AINs ( $n = 8$ , all studying in an undergraduate nursing programme), nurse managers ( $n = 5$ ), and nurses ( $n = 11$ ) participating in semi-structured interviews. Data were analysed using thematic analysis. Themes focused on (i) the AIN role, their practice, boundaries or restrictions of their role, and the image consumers have of AINs; (ii) learning through experience, where the AIN role was a practical opportunity to learn and apply knowledge obtained through university studies; and (iii) support, which focused on how AINs worked with nursing staff as part of the healthcare team. Overall, participants believed that AINs played an important role in the ED in supervising consumers on involuntary mental health treatment orders, where their unique role was seen to facilitate more positive consumer experiences. The AIN role is one way for nursing students to develop skills in working with people with mental health issues.

**Keywords:** assistants in nursing, clinical experience, emergency department, mental health consumers, nursing workforce.

## **Introduction**

Nurses require skills in the accurate assessment and treatment of people with mental health conditions in all settings, as well as experience in forming and maintaining therapeutic relationships. In Australia and internationally, mental health nursing faces an ageing workforce and difficulty in retention of mental health nurses, and the number of graduates choosing to work in mental health settings is not commensurate with the need for such skills and competencies (Care Quality Commission, 2017; Health Workforce Australia, 2014). Exposure to clinical environments during undergraduate study is identified as a means of fostering mental health competencies, increasing preparedness to work with people with mental illness, and as having the potential to influence nursing students' consideration of mental health as a career choice (Happell 2008a,b; Henderson *et al.* 2007). Ideally, this should occur during clinical placements, although student reports vary as to the duration and quality of these clinical experiences (Happell *et al.* 2015). Another way students gain experience and exposure to mental health nursing work is by seeking employment outside of their studies as assistants in nursing (AIN) in hospital settings.

This qualitative study examined the perceptions and experiences of undergraduate nursing students employed as AINs in an emergency department (ED) to work with mental health consumers. The study also explored the experiences of health professionals working with these staff, as well as how working as an AIN, from the perspective of AINs and health professionals, can increase mental health knowledge for nursing students, preparation for nursing practice or choice to work in mental health, and more positive consumer experiences.

## **Background**

In 2015, 6.87% of registered and enrolled nurses working in Australia, or 1 in 15 employed nurses, were working in mental health (Australian Institute of Health and Welfare, 2016c). However, data from 2014 reveal that the mean age of employed mental health nurses was 46.9 years, with 60.47% 45 years and older and only 3.07% being <25 years of age (Australian Institute of Health and Welfare, 2016b). There are a number of identified challenges in recruiting and retaining new graduates to the

profession. These include lack of exposure to mental health content in undergraduate nursing programmes, limited opportunities for student clinical experience in mental health settings, graduate preferences and perceptions of greater career possibilities in other nursing specialities, and level of support (e.g. preceptorship and transition support) provided once qualified (Happell 2008a; Hayman-White *et al.* 2007; Stevens *et al.* 2013). Experience in the clinical setting during education is particularly important to student nurses as it provides opportunities to challenge negative perceptions of mental health work and consumers (Happell 2008a).

Students in Australia undertake a comprehensive undergraduate nursing degree (registered nurses (RNs)) with specialization in mental health undertaken through completion of an accredited postgraduate diploma or master's programme (Australian College of Mental Health Nurses, 2017). This means that regardless of mental health training, graduates can practice in mental health settings (McAllister *et al.* 2014). Moves towards comprehensive nursing programmes and generalist approaches in Australia and internationally have been met with critique that such training focuses on biomedical approaches rather than specialist skills and competencies involved in mental health care (Happell & Cutcliffe 2011; Hemingway *et al.* 2016; McKeown & White 2015). Both undergraduate students (Wynaden *et al.* 2000) and senior staff (McAllister *et al.* 2014) have expressed concerns regarding nursing students being prepared to work with mental health consumers. Happell (2008b) found that nursing students' exposure to mental health clinical placements increased preparedness to work in mental health settings. However, in a review of the literature, Happell *et al.* (2015) reported variability in both mental health clinical placement availability and length of placement. Some nursing students seek part-time employment while undertaking their studies in healthcare settings such as nursing homes (Happell 2002; Rochford *et al.* 2009). Another way students may gain clinical experience in mental health care is through their employment as AINs in hospital settings.

In Australia, AINs working in inpatient settings are typically second- and third year university undergraduate nursing students or are required to hold a Certificate III (awarded through completion of a vocational tertiary education course undertaken through a technical and further education (TAFE) institution; Australian Nursing and

Midwifery Federation (SA Branch), 2018; Department of Health and Human Services, Tasmania, 2011; Government of Western Australia, Department of Health, 2013; NSW Department of Health, 2009; State of Victoria, Department of Health and Human Services, 2015). For example, in New South Wales, AINs are required to have a Certificate III, be undertaking an undergraduate nursing programme at second or third year, or have equivalent experience/qualification (Cleary *et al.* 2012b). Other similar roles in Australia and overseas are given titles such as Health Care Assistants (HCAs), Unlicensed Assistive Personnel (UAPs), and Personal Care Assistants (PCAs) (Browne *et al.* 2013). However, it is important to note that depending on the role and setting, varying educational qualifications are required, and that this study involved only AINs undertaking university undergraduate tertiary education.

Within hospital settings, AINs are employed across departments to perform basic direct care tasks within a specified role and under the supervision of RNs (Algozo & Peters 2012). Although specific tasks differ according to their employer defined role and setting, duties performed include visual and physical observation, talking to or reassuring consumers and their families, bed making, and assisting with hygiene, toileting, ambulation, and feeding (Cleary *et al.* 2012b; Furåker 2008; Marshall 2006; Thornley 2000).

A potential advantage of employing AINs is that they are able to perform basic, yet vital aspects of care, and in doing so free up nursing staff to perform advanced clinical, technical, and administrative tasks (Browne *et al.* 2013). Another advantage is the provision of increasingly holistic care; with AINs able to spend time interacting and listening to consumers, aspects of care RNs may have to forego in order to perform other duties (Browne *et al.* 2013).

Providing AINs with experience in observation, which was the main role of AINs in this study, under the direction of nursing staff, has the potential to contribute to their learning experience of mental health. Well-developed observation and supervision, interaction, and communication skills are especially important to mental health nurses working in EDs, which are a point of entry for care and admission to inpatient mental health services (Australian Institute of Health and Welfare, 2016a; Knott *et al.* 2007). Although common practice with mental health consumers, periods of supervision have been perceived by consumers as intrusive and a form of punishment, resulting in a

lack of privacy, feelings of imprisonment, and a perceived lack of acknowledgement and empathy from the staff member observing them (Cardell & Pitula 1999; Manna 2010; O'Brien & Cole 2004). Continuously observing consumers (or 'specialling') is a nursing intervention requiring intuition, skill, and experience (Hamilton & Manias 2008; Rooney 2009). However, while supervision is not intended to be therapeutic in nature, therapeutic benefit may be experienced from the observer's behaviour and attitude along with the relationships developed between consumers and the staff supervising them (Cardell & Pitula 1999; Jaworowski *et al.* 2008). Communication, rapport, and interpersonal skills not only help to prevent nurse–consumer conflict, violence, and aggression, but contribute to more positive consumer and family experiences (Gabrielsson *et al.* 2016; Gerace *et al.* 2018; Luck *et al.* 2009).

The present examination of AINs working with mental health consumers in a role focused on continuous observation was driven by the paucity of studies on AINs working with inpatient mental health consumers and, to our knowledge, no work in the ED setting. Research has largely focused on medical–surgical units, nursing home settings or utilized samples consisting of AINs employed in a range of clinical areas (Algozo & Peters 2012; Chow & Miguel 2010). In these studies, AINs report the development of core skills such as critical thinking and decision-making confidence, and ability to engage in clinical tasks such as constant observation (Algozo & Peters 2012; Rooney 2009). While nursing staff may initially have concerns regarding increased supervisory workload, feeling they may be replaced by these staff and that quality of consumer care will suffer, this initial reluctance largely decreases once AINs are introduced to the setting (Chow & Miguel 2010; Meek 1998). However, regarding implications for consumers, research has indicated that a decrease in proportion of RN staffing or the time spent with consumers is accompanied by an increase in adverse events such as medication errors and mortality (Aiken *et al.* 2011; Duffield *et al.* 2014; Twigg *et al.* 2012), with Browne *et al.* (2013) concluding that 'correct balance of RNs to AINs' (p. 543) is integral to consumer safety.

In an Australian study that investigated the perceptions of AINs working in New South Wales inpatient mental health settings, participants conceptualized their role as involving rapport and a 'person-centred' approach, as well as assisting and freeing

staff to complete other duties by undertaking tasks such as basic observation and assisting consumers in activities of daily living (ADLs). AINs reported some misunderstandings from staff and by AINs themselves, regarding the scope of their role, as well as frustrations with role limits such as lack of use of their observation notes and documentation by staff. However, AINs derived satisfaction and confidence from meeting the needs of staff, acceptance and mentoring by staff, and being provided with the opportunity to develop practical skills. AINs identified educational needs in handover, documentation, assessment and management skills, and understanding of mental health and pharmacology.

Theoretical examination supports these findings, with Cleary *et al.* (2012a) positing that working as an AIN provides opportunities to directly interact with people with mental illness, develop realistic expectations of recovery, and practice skills such as communication; with positive workplace experiences likely to influence recruitment into mental health nursing. In another Australian study (New South Wales) utilizing a sample of 50 RNs working in a specialist mental health acute care, recovery, and extended recovery service, RNs were satisfied with AINs' skills in physical and close observations, bed making, and assisting in ADLs, although less so regarding interaction with consumers, writing notes, and assessing and reporting mental status changes to staff (Cleary *et al.* 2012b).

### **Study site**

The study site ED was located in a South Australian metropolitan public teaching hospital. At the time of the study, the 24-hour ED service had 42 beds. In the ED, hospital policy dictated that a staff member continuously supervise people on mental health inpatient treatment orders.

The hospital took an innovative approach to these consumers who required supervision with the introduction of their Additional Patient Supervision (APS) model. Prior to the introduction of the model, security guards or RNs supervised these consumers. Under the new model, following risk assessment by a mental health clinician, consumers were assigned: (i) a security guard, if considered to be high risk of danger to themselves or others; (ii) an AIN, if considered lower risk (referred to as

continuous visual observation); or (iii) less frequently, a nurse (clinical specialising). Security guards are expected to provide surveillance only, rather than engaging with consumers in the way that AINs or health professional staff do. Level of supervision is reassessed regularly in accordance with changes in a consumer's health status. AINs usually supervise the same consumer for their entire shift (with regular breaks) or as long as the consumer is in the ED. The hospital policy was underpinned by the Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement (Government of South Australia, Department of the Premier and Cabinet, 2013), which identified the role of AINs in clinical environments as being in 'such nursing care and procedures that assist them in their learning capacity to develop the competencies required to achieve the qualification in which they are enrolled' (p. 50).

The hospital policy was to employ only AINs who were completing an undergraduate degree, rather than those with a Certificate III or equivalent qualification/experience (participants in the study by Algosó & Peters 2012, were also students). While AINs were students, the AIN role was *not* part of their education (e.g. a clinical placement) and all were employed by the hospital separate from their completion of their degree. The AIN works within a hospital defined policy regarding the scope of their role. Within their primary role of continuous visual observation of mental health consumers on inpatient treatment orders to maximize safety, AINs engage with consumers, provide assistance with ADLs, monitor and document consumer behaviour, and communicate with the mental health team and RNs regarding presentation and behaviour. AINs could also work across various clinical settings within the hospital, such as with consumers at risk of falls, those requiring help with ADLs, and those with dementia. However, in the ED, the AINs *only* work with mental health consumers.

Prior to commencing their role, AINs participate in an orientation to the hospital setting followed by an induction specific to the ED as well as a specific introduction to caring for mental health consumers. AINs work under the supervision of a RN who regularly checks in with the AIN, sets tasks, and assesses the consumer at least every hour. AINs are required to document the consumer's behaviour every 15 min, with the RN signing off on this documentation every hour. Mental health nurses and medical officers monitor risk and need to change supervision level, and provide education to AINs through inclusion in interview and assessment, and monitoring their interactions.

Mental health nurses are present in the ED if AINs require assistance or are concerned about their consumers. Each AIN is provided with a personal alarm for use if they require urgent assistance.

This study builds on previous research through investigating the use of AINs in the ED setting. Specifically, the study investigates AINs' perceptions and experiences of supervising consumers on inpatient treatment orders, multidisciplinary staff perceptions regarding working with AINs, and both groups' perspectives of how the process of supervising consumers can contribute to consumer management and AINs developing skills in mental health practice.

## **Method**

### **Design**

The study was of a qualitative design. Potential participants were informed of the study via electronic newsletters, emails, and project information sheets placed in the ED. Participants were required to be currently working in the study site ED and employed as an AIN (having worked a minimum three shifts) or other health professional. The hospital ethics committee granted ethical approval to complete the study.

The sample consisted of AINs ( $n = 8$ , six female), registered or enrolled nurses ( $n = 8$ ), mental health nurses ( $n = 3$ ), and nurse managers ( $n = 5$ ). AINs were aged between 23 and 43 years ( $M = 29.63$ ,  $SD = 6.65$ ), and nursing staff and management were aged between 23 and 55 years ( $M = 41.69$ ,  $SD = 12.02$ ). AINs, who were required to be second- or third-year undergraduate students, had been working in the AIN role between eight months and two years, with four working in the role for 1 year, three for 2 years, and one for 8 months; this means that the participants were in the later part of their nursing degrees. Nursing staff were experienced in consumer care with a range of 2 to 46 years in their profession ( $M = 18.91$ ,  $SD = 13.33$ ).

## **Data collection**

Participants took part in individual, semi-structured face-to-face ( $n = 23$ ) or telephone ( $n = 1$ ) interviews. Table 1 includes areas covered in the interviews and example questions.

[Insert Table 1 about here]

## **Analysis**

Interview length averaged 35 min. Interviews were audiotaped and transcribed verbatim. A thematic approach as described by Braun and Clarke (2006) was used to analyse the data. At least two of the researchers read and reread each transcript while concurrently making preliminary notes and interpretations. This was followed by formation of initial codes and categories. The research team met to discuss codes and preliminary themes, which the team then further developed into higher order and subordinate themes. In the results, staff are denoted as an AIN, nurses (N), mental health nurses (MHN), or managers (M) and a participant number.

## **Findings**

Three themes emerged from the data analysis: the AIN role (consisting of three subthemes: AIN practice, boundaries of the AIN role, and image of AIN); learning through experience; and support.

### **The AIN role**

Managing risk and safety, particularly with consumers under inpatient treatment orders, is of primary importance in the ED. In this context, AINs perceived their role in the ED as having a core focus on risk and safety, in particular preventing aggression and absconding: 'So it's all about keeping people safe really' (AIN7). AINs were seen to occupy a unique role between direct nursing care and limited interaction more characteristic of a guard's role. An AIN explicitly described their role with reference to

space, 'I do try to tell them [consumers' families] about my role that it is an intermediate, it's not the direct care and it's not too distant' (AIN1). A manager provided a complementary description of AINs, 'it's that bridge; it's not just someone sitting at the end of the bed' (M4).

This unique role was expressed in the subthemes: 'AIN practice', 'Boundaries of the AIN role', and 'Image of the AIN'.

### *AIN practice*

Within their core role of maintaining safety, AINs could both supervise *and* engage with consumers, providing undivided attention. This was a unique role to that of security guards, who were said to engage minimally with consumers given their role had an emphasis on surveillance rather than engagement; as well as nursing staff, who were focused on clinical tasks, which left less time for undivided attention to consumers. Key tasks of AINs involved 1–1 interaction, attending to needs, diversion, providing structure, providing a 'therapeutic' environment, helping consumers stay calm, and providing information to medical and nursing staff.

Talking and, more often, listening were part of the AIN role based on a judgement of how much 1-1 interaction the consumer desired, as directed by mental health nursing staff, the RN, and the AIN's reading of consumer notes: 'Some people like to chat and...they'll say "come closer and we'll chat"...and some don't like to chat' (N3). The length of time AINs stay with consumers (anywhere from 2 to 8 hours) meant that undivided time could be given to them, 'you have the time to listen [which] I think is a big thing, it's not like "oh just wait, I've got to go and do this and come back"' (AIN7).

Interacting with consumers, providing them with something to do (e.g. playing cards, providing magazines, and writing paper) and providing structure (e.g. encouraging consumers to have breakfast and shower) allowed diversion and stimulation within the confines and boredom of the ED:

... especially with the consumers who are aggressive or have a history of violence..., keeping them occupied and keeping them company, I think it helps them to settle (AIN2)

Participants believed that in occupying an 'in-between' role, AINs could develop rapport. Even with consumers where rapport was difficult due to their wanting to leave or their symptoms (e.g. mania), there was still the possibility of connection, 'they [AINs] still sit there and listen to them, which for a client actually means quite a lot, it's quite significant for them to actually feel like they're being listened to' (MHN2).

Just as AINs were careful about use of physical space and interaction, they engaged carefully with sensitive issues, 'I'm always very careful with what I say just because I'm not qualified to deal with some of the issues that they disclose to me' (AIN5). They did acknowledge that while the best course of action, rapport could be compromised, particularly as consumers may not know the difference between AINs and nurses:

... if you're constantly having to say 'that's something for you to address with the doctors', or 'that's something you can talk to with the mental health nurses' and shutting them down then it [rapport] doesn't always happen. (AIN4)

The potential for AINs to develop rapport was juxtaposed with the role of the guard, who had a main focus on safety, 'they [AINs] have been employed to actually assist us in...not only the surveillance it's also to develop a therapeutic relationship with them...a security guard is there purely to protect property and staff' (M1). The focus on safety, but not engagement, characteristic of guards had implications for the ways in which guards connected with consumers:

... we'll certainly tell them [guards] that this consumer is not allowed to do that, but if you say the consumer's detained and whenever the consumer will want to walk out of the cubicle just to say something or do whatever they go, 'Get back in there, get back in there, don't come out' [gruff voice], instead of saying, 'Hey mate, what's the matter, what's going on?' they'll be, 'No, don't do that' [gruff voice]. (MHN1)

AINs had an important role to play in calming consumers and noticing escalation, 'I find as well if you're talking to them when you're listening to what they're saying you can also pick, you know, are they starting to escalate a bit, are they starting to get a little bit agitated' (AIN5). AINs were also seen to be more equipped than guards in noticing escalation in behaviours or deterioration in consumers due to their previous education and hospital training, which allowed more timely feedback to staff.

In most cases, AINs felt guided by other staff regarding how to interact with consumers, and staff felt it was important to provide this guidance, 'some people if they're a little bit back-offish, intimidated or if they're quite paranoid I would say to them [AINs], "sit as far back as possible to give them some space and [so] you're not quite in their face" (N3). However, AINs did acknowledge there was room for improvement:

There's a little box on the paperwork that is supposed to be filled out by the mental health nurses with a handover and some instructions which is rarely done as well unless there's something particular. I think it would be nice if they...would be able to come and say 'this is how I want you to be with this consumer' instead of leaving it up to you to figure it out you know an hour into the shift after you've tried a few different things, if they say 'you need to be firm with this consumer', or 'this person responds better if you chat to them'. (AIN4)

While the AIN role involved many tasks within their practice, AINs were seen to have specific boundaries to their role.

### *Boundaries of the AIN role*

The AIN role, referred to by the hospital as a scope of practice, was seen to be clear and defined. Most AINs did not feel pressured to perform outside their role, particularly as staff developed understanding of what AINs could and could not do. However, the perceived role boundaries were referred to as 'a point of contention' (N1).

There was an understanding that from a legal perspective, AINs could not engage in certain nursing tasks, but frustration was experienced because as nursing students they often had skills from their study and clinical placements to perform nursing observations and other tasks (e.g. BSL/BGLs). At the time of the study, the scope of the role was to be expanded to include observations and BSL/BGLs. This was seen to have the potential to increase nursing skills, 'it's giving them a purpose, it's leading up to them leaving third-year student and stepping into white uniforms' (N3).

Despite this, participants felt that AINs could work to provide quality care within their unique role, 'you've [clinical staff] got this other hat on. But the AIN have just got the AIN hat, which is nurturing and supporting' (M1). It was stressed that while regular checking on AINs could add to workload, this was needed and offset by AINs being able to provide observation and interaction, 'they take a bit of stress off of you and are able to focus on that consumer and really give them the attention that they need while we're able to run around and do other things' (N8).

The AIN role could also be influenced by the image they projected to consumers through their uniform, demeanour, and practice.

### *Image of AIN*

Participants felt that AINs shared the image consumers likely had of nurses and the qualities they represent, such as being approachable, caring, more willing to build rapport, and empathic. Indeed, participants felt that consumers might not know the difference between AINs and nurses, 'No, I don't think they do because we're dressed as nurses and most of us we wear a fob watch and we sit there with our notes and we look different to a security guard, and what else could we be?' (AIN4). By contrast, guards were highly visible and easily identifiable by their uniform, with little confusion about their identity or role within the department. In particular, participants felt consumers and their families would associate guards with power, authority, and control, 'they would probably feel like they've done something wrong if they've got a guard staring at them' (AIN3).

Participants believed that AINs may be better able to calm consumers and prevent a crisis due to nurses and, by extension, AINs, not being associated with control: 'sometimes that [presence of a guard] feeds into people's behaviour, negative behaviours, it can really fire up their behaviour' (MHN3). It was also seen as potentially problematic to assign guards to consumers with previous trauma, whereby this could lead to the supervised consumer feeling intimidated, threatened, or that they are being punished, 'we have consumers who are quite placid but are obviously in distress who are cowering inside a cubicle because they have what they perceive to be a policeman standing outside' (AIN4). However, some participants identified situations where having a male guard rather than an AIN was seen to be crucial. Such events usually involved consumers whose risk of absconding had been assessed as high or who had a history of threatening behaviour. Guards were deemed better able to manage themselves because of their size and the image they portrayed as being strong and in control in times of crisis.

Risk assessment by mental health nurses to decide appropriate levels of supervision was therefore considered paramount, incorporating consumer need, safety and availability of staff, and regular reassessment to manage any clinical deterioration.

## **Learning through experience**

Working as an AIN was seen as a valuable transitional space into the nursing profession. Foundational knowledge and previous experience (e.g. university study, clinical placements, AIN orientation) was important for providing a base to their practice, but often learning was seen to occur through practical experience and experiential learning in the ED, 'we had a great orientation...but there's only so much that you can say without actually being there in front of a person and having that responsibility' (AIN 4).

AINs initially doubted their expertise, even after completing an induction programme, 'I was so nervous [during] my supernumerary shift, I remember questioning the ear off of my other AIN' (AIN1). Over time, their confidence in keeping themselves and others safe, autonomy (e.g. in judging space and conversation), and awareness of the skills they developed in assessing risk and noticing escalation increased.

I've said to nurses that are sitting there 'this person is starting to get agitated' and you can tell the body signs; they're pacing, they're frustrated, you can pick up on all those little indicators which I think you learn to look for them over time, it comes with experience. (AIN7)

AINs in particular were conscious of their skill development over time and their increasing capacity to assess with accuracy the behaviours of people under their observation. This enabled them to intervene early or alert the mental health team and RNs to potential problems; the other staff also noticed this. As the AINs became more experienced in the role, they became more confident to ask for support and to communicate with other members of the nursing team. They also took responsibility for themselves and self-assessed their practice and their needs. The role was seen to have provided AINs with skills and experience that would benefit their future work as nurses. Staff found opportunities to educate AINs regarding assessment, noticing changes in behaviour, as well as to the nature of mental health issues:

... when [AINs] think they're just sitting there looking at a consumer, documenting every 15 minutes it can be very boring let's face it but I try to do a journey with them to say look you actually sitting there and watching that consumer and then letting us know they're escalating, like they're starting to pace, and letting us know that we can put in actions that can prevent escalation which will increase their journey to wellness quicker. (M1)

AINs felt that their employment was beneficial because it had provided them with transferrable skills in caring for people experiencing mental health issues, which they could apply both when working as an AIN in other areas of the hospital and in their future nursing careers:

We don't have many, as many mental health consumers in the other wards like in ED but when we do...I know what to do, I know how to handle them because I've been doing it in the ED. (AIN2)

Some AINs reflected that because of their experience, they would pursue a mental health nursing career. However, this was not the overwhelming response of AINs. Regardless, they realized the benefit of the experience. Working as part of a team and having one's skills recognized was seen to improve transition to practice and position AINs competitively for future employment.

## **Support**

Given the unique role occupied by AINs, who work in a potentially risky environment but are not qualified nurses, having support from nurses and other staff, from guards, and within the AIN group was seen as useful.

Several challenges were identified specific to the provision of mental health care in the ED context that could affect AINs. One issue involved the appropriateness of assigning inexperienced, mostly young, staff members to 1-1 interaction with consumers who may be unpredictable, confused, or presenting a risk of harming themselves or others. Because of these issues, the introduction of the AINs to the ED was met with initial reluctance among nursing staff:

My biggest concern was the AIN group are the most junior profession of junior staff member within the hospital and they were going to be put with the most challenging consumers that we actually have in the whole hospital, and I thought, 'how are they going to cope?' (M2)

Participants attributed these challenges to larger issues regarding whether EDs are appropriate environments for consumers who are acutely unwell. Noise, constant activity, lighting, delays in treatment, boredom, and even prohibition of smoking were viewed as being detrimental to the well-being of these consumers:

Mental health consumers are stuck in the department for four or five days at a time, and then you're stuck in this little box and you can't get out...there's a multitude of factors that can escalate a consumer. And then the AINs have to deal with that and try and pass it on to us as well. It's a very big role. (N4)

Participants acknowledged the potential for violence and, more often, verbal aggression while supervising consumers, and so there were many layers of support set up to ensure safety.

The RNs and mental health nursing teams were viewed as distinct groups with separate but overlapping roles, and each offered important support. RNs regularly

interacted with the AIN and checked on consumers at least every hour. They referred to 'stepping in' and taking over with consumers if they felt it necessary. The MHNs saw their role as providing overall support to the AINs through leadership and guidance on how to care for people with mental illness. Clinical support and guidance were provided to AINs by the AIN coordinator (who provided opportunities for AINs to discuss their clinical experiences) and MHNs, but this was not formalized debriefing or clinical supervision. Participants acknowledged the safety that AINs felt from having guards in the vicinity, particularly if consumers were agitated or considered at risk of aggressive behaviour:

... sometimes I think no-one's watching at all and then you realise that actually guards...know exactly what's going on and same with Mental Health...sometimes there's support behind the background that you're just not quite aware of. (AIN1)

Generally, AINs felt well supported in the ED and carrying their duress alarms also helped them to feel safe. When an incident occurred (e.g. requiring a security or Code Black team), AINs ceased providing supervision and observed the skills used for deescalation by mental health clinicians from a safe distance. The mental health clinicians and AIN coordinator would subsequently discuss the event with the AIN.

AINs acknowledged the peer support they received from one another. More experienced AINs were conscious of mentoring less experienced staff, 'now I'm more [one] of the longer standing ones, [I feel] more protective of the newer ones' (AIN1). It was strongly agreed there were many more supports available to AINs working within the ED compared with being placed in general units where there were few staff accessible, no guards immediately available, and where duress alarms were not carried.

Beyond the support from fellow AINs, RNs, mental health nurses, and guards, through experience and interaction with staff, AINs became important parts of the hospital team:

Even recently there was an EN [enrolled nurse] who was on a special in EECU [Emergency Extended Care Unit] and came out and said 'I can't cope, send one of the AINs in because they know what they're doing in regards to wandering consumers', so that was quite cool to hear. (AIN5)

## **Discussion**

AINs were seen to occupy a unique role between professional nursing care and a more distant approach to supervision of mental health consumers. Staff believed that AINs contributed to more positive consumer management, as well as being provided with clinical experience that would help them move towards becoming a qualified nurse. Through their focus on maintaining safety, AINs provided support and empathy, monitored and addressed needs, and assessed changes indicating potential risk to consumers and others. It is important to note that AINs in this study were all undergraduate nursing students who were experienced in the role and in the later part of their nursing degrees, and so the findings cannot be generalized to AINs with other qualifications or training. The study was also a small qualitative design in one hospital emergency department.

Within their observation role, AINs reported that they had time to engage with consumers, which is a core component of mental health nursing (Dziopa & Ahern 2009), but may be difficult for nurses to accomplish in the busy clinical environment. Spending time with consumers leads to relationship enhancing (e.g. trust) and treatment outcomes (Bee *et al.* 2008). Similarly, quotidian and phatic chat are effective in building rapport and trust between nurses and consumers (Burnard 2003). AINs were in a position to notice subtle changes in consumer presentation before aggressive physical behaviour had occurred. Participants raised concerns that guards may not notice changes indicative of escalations or agitation and that their focus on containment could actually drive some escalation.

It is encouraging that AINs were seen to demonstrate some assessment skills during their interactions with consumers, as other studies report that AINs (Cleary *et al.* 2012b) and nursing students in general (McAllister *et al.* 2014) did not meet staff expectations regarding communication, interaction skills, and mental status assessment. Such competencies are vital, particularly for AINs working in mental health settings, as they are more likely to spend their direct time in conversation with consumers than those AINs in other departments (Furåker 2008). While interaction with students should not replace time with qualified mental health nurses, it is likely that consumers benefit from uninterrupted time with AINs (Cleary *et al.* 2012a).

Similar to other studies, AINs perceived their role and function to be limited (Algozo & Peters 2012; Cowan *et al.* 2015). However, AINs provided examples where they were able to build on skills such as communication, noticing escalation, and clinical assessment. Unlike AINs in other studies (Cowan *et al.* 2015), the AINs in this study reported minimal pressure to work outside of their prescribed role.

For qualified health professionals, consumer interaction with AINs provided opportunity to engage in more specialized duties. However, adequate ratios of qualified nursing staff to AINs are essential to enable necessary supervision and delegation of tasks to ensure safety of both consumers and staff. Balance is essential to ensure that AIN supervision does not replace interaction between consumers and nursing staff, or be used 'as a knee-jerk reaction to a workforce shortage' (Cleary *et al.* 2012a, p. 70). Indeed, increased time with consumers is related to higher work satisfaction (Bee *et al.* 2006; Browne *et al.* 2013), indicating the importance to nurses of spending time with the people for whom they provide care.

AINs felt that the role increased preparedness to work with people with mental health issues. Indeed, it has been posited that the lack of clinical training in undergraduate nursing could be met through the use of AIN programmes (Algozo & Peters 2012), exposing students to a future career pathway in specialized mental health nursing. However, intention to pursue a specialized career in mental health nursing was mixed (see Stevens *et al.* 2013). This suggests that the AIN role is unlikely on its own to increase the mental health nursing workforce. Regardless, AINs reflected on skills they developed that will be of use in their future work in the ED environment and/or other areas of inpatient care.

AINs reported feeling safe and supported by health professionals, guards, and other AINs. Multiple factors are important to maximizing effectiveness of the introduction of AINs into the hospital setting and in positively impacting their learning experience, including degree of staff acceptance, hospital culture (e.g. degree of collaboration), ability to absorb unit culture and acceptance as a part of the team, structured and quality supervision and positive role models, and AIN ability to manage workload (Cleary *et al.* 2012a). Similarly, positive role modelling is important as AINs learn from, and often adopt the same approach as the nursing staff who are supervising or working with them (Meek 1998). It was acknowledged by some AINs that information given in handover or documentation could be better. In addition, debriefing following adverse events was often informal. This suggests that regular clinical supervision and more structured debriefing, which is particularly beneficial for nurses early in their careers (Cleary *et al.* 2012a), could be more formally integrated into supervision.

### **Limitations**

It is a limitation that only eight AINs (~40% of AIN employed at the hospital), all of whom were relatively experienced in the role and were in the later part of their nursing degree, volunteered to participate in the study. Further, the consumer voice was not part of this study, and guards were not interviewed due to their management declining participation. Both of these groups would provide unique perspectives on the experience of being supervised and providing supervision in EDs, respectively. As mentioned, this study examined the work of AINs who are undergraduate students, and cannot be generalized beyond those staff working towards a nursing qualification.

### **Conclusion**

Overall, study participants saw AINs as playing an important role in supervising consumers on involuntary mental health treatment orders in the ED, with this experience seen to contribute to the development of skills required in mental health nursing. ED environments were viewed as particularly stressful places for persons experiencing mental health issues (Gerace *et al.* 2014; Shattell *et al.* 2014), and staff viewed the use of AINs as contributing to improved consumer management in this setting.

### **Relevance for clinical practice**

In order to maximize their utility, hospitals should provide AINs with regular refresher training on core aspects of their role, as well as regular, formal supervision and debriefing opportunities. The study also identifies a need to provide security staff with training and resources to increase awareness and recognition of increasing consumer arousal and distress. Finally, we suggest that it is important to consider ways in which universities and hospitals could collaborate to provide increased clinical exposure to nursing students, such as through AIN programmes, in order to increase, if not recruitment to mental health nursing, student competence in working with people experiencing mental health issues.

### **Acknowledgements**

This research was supported by funding from Northern Adelaide Local Health Network and Flinders University (Flinders University Collaborative Research Grants Scheme). The views expressed here do not necessarily reflect those of Northern Adelaide Local Health Network. The authors would like to thank the Northern Adelaide Local Health Network project team: Vanessa Owen, Executive Director of Nursing and Midwifery and Clinical Governance Service; Andrew McGill, Director of Nursing; Gwen Rowan, Nurse Educator; Tina Cockburn, Nurse Educator; Julie Turner, Nurse Consultant Mental Health; Ian Rowbottom, Emergency Department Information System Administrator; and Deb Lewington, Nurse Unit Manager, Emergency Department; as well as Candice Oster for useful comments on an earlier version of the manuscript.

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Table 1. Topic areas covered and example interview questions

Topic	Example(s)
Reasons for choosing to work as an AIN	Why did you decide to take on the role as an AIN?
Understanding of the AIN role	What do you understand the role/purpose of AINs in the ED to be?
Day-to-day routine in the ED	What is your day-to-day routine when you are supervising a consumer?
Interaction between AINs and consumers and their families	<p>How has the introduction of AINs impacted on nurses' workload/day-to-day routine?</p> <p>Do you find that you are able to develop rapport with the consumer?</p> <p>How do consumers/consumers' families respond to AINs?</p>
Perceived advantages and disadvantages in having an AIN/guard supervise a consumer	<p>Do you think there are any advantages/disadvantages of having AINs supervise consumers rather than security guards?</p> <p>How do consumers react to the presence of an AIN to supervise them? Is this different to a nurse or guard supervising them?</p>
Impact on nursing workload/day-to-day routine	How has the introduction of AINs impacted on nurses' workload/day-to-day routine?
Perceptions of safety and support for AINs while supervising consumers	What supervision do you receive when working as an AIN in the ED?

Perceptions of training provided and skills needed and developed in the role

Do you feel the training provided has adequately prepared you for your AIN duties?

Do the AIN you have worked with have adequate skills to perform their duties?

Future work as a nurse

Does your work in the ED with mental health consumers make you want to pursue a career in mental health nursing?

Does your AIN work increase your confidence/skills when engaging with mental health consumers?

What has working as an AIN taught you about your future practice as a nurse?

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