Victorian Nurse Practitioner Project

Phase 4, Round 4.1
Final Report
Feb. 2009
Prepared for Echuca Regional Health

By

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Donna Sherringham, Deputy Director of Nursing (to Oct 2008)
Matt Sharpe, Director of Primary Care
Dr Westwood, Director of Medical Services
David Thompson, Director of Finance
All Nurse Managers
Norma Oliver, Diabetes Educator
Chris Turner, Chief Pharmacist
Jodie Clarke, Pathology Services Manager
Hayden Reid, Acting Manager Imaging Services
Neva Atkinson, Koori Liaison Officer
Rosemary Lewandowski, Human Resources Principal
Michele Gray, Payroll Supervisor
Jenni Webster, Health Information Manager
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2. Executive Summary

In March 2008, Echuca Regional Health (ERH) was successful in securing funding from the Department of Human Services (DHS) as part of the Victorian Nurse Practitioner Project (VNPP). This particular round of the state-wide project targeted rural and remote health services and the aim was to explore the potential to introduce the Nurse Practitioner role within such organisations. Although only a short term feasibility study, the project is an important step in the strategy to manage increased service demands and health professional workforce shortage issues.

The changing demographics of the Australian population, particularly in aged care and chronic health are reflected at a local level within the ERH catchment area. The increasing difficulties in recruiting nursing and medical staff to rural areas means that healthcare providers need to review existing workforce and service delivery models to ensure they are able to meet future health needs of their community.

Nationally, the need to maximize the skills and expertise of the available workforce has been highlighted by the Productivity Commission, citing the Nurse Practitioner (NP) role as a model of care for the future.

Over the past 8 years, through previous rounds of the VNPP, the DHS has accumulated sufficient validated evidence to promote the Nurse Practitioner role as a practice model which;

- improves health service access
- provides greater diversity in services
- increases flexibility in models of health care delivery
- manages and coordinates health care provision efficiently and effectively.

Consultation with key stakeholders, has identified a number of areas where there is considerable potential to develop Nurse Practitioner roles at ERH.

Importantly, the project has highlighted many existing organisation wide factors vital to supporting future developments and ensuring successful outcomes.

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1. Australian Bureau of Statistics - ABS Census 2006 (and updates); DSE, Victoria in Future 2004
These factors include:
- NP role is consistent with the strategic direction of the organisation\(^4\)
- executive level support
- demonstrated problem solving approach by key staff
- enthusiasm of departmental managers and nursing staff to consider NP roles
- some existing nursing staff are already suitably qualified and willing to be considered as potential NP candidates
- existing excellent working partnerships with local General Practitioners.

A new senior nursing management team at ERH also creates an opportunity for review of existing structures within the nursing division and of the organisational governance structures needed to support the introduction of new roles. This will ensure quality and risk are appropriately and adequately managed. However, it is important that the governance structures are in place before NP candidates are appointed to help manage the change process and increase the chances of success. Whilst some advanced nursing practices can be introduced relatively quickly, a NP implementation plan will be a long-term proposition (3-5 years).

It is clear that the Nurse Practitioner role is a collaborative one with strong foundations in evidence based advanced clinical practice. The role will compliment the care provided by other health professionals, enhancing the services provided by ERH to its local communities. However, the model of care requires an on-going commitment of resources focused on strengthening partnerships with General Practitioners, other health care professionals and the community to ensure ERH achieves value for money from the role in terms of patient outcomes, enhanced professional skills and staff recruitment and retention.

A number of recommendations have arisen from this project, both at state level and at organisational level. These are contained within the body of the report and are summarised at the end in section 7.

---

\(^4\) ERH Strategic Plan 2008-2011; Strategic Directions 1, 3, 5.
3. Introduction

The following profile is intended to give a snapshot of the rural environment in which Echuca Regional Health must operate and the challenges that arise from such an environment. This is an important point, as most NP service models currently operate within metropolitan health services.

3.1 Community Profile

Echuca is situated in the Shire of Campaspe approximately 200kms north of Melbourne. It is a river border town with Moama, NSW. The combined catchment areas for the Shire of Campaspe and Murray Shire serve an estimated 38,931 people. The Aboriginal population, at approx 1.8%, is higher than the state average. The main industries across the Shire include dairy farming; beef cattle; tourism; food processing; cereal & rice crops; tomatoes & other vegetable crops; sheep/wool; aquaculture; floriculture and viticulture. It is an area popular with holiday makers and retirees, which impacts significantly on local service demand and staff recruitment.

The population of Campaspe Shire is expected to increase by 18% over the next 25 years. In the same period Murray Shire’s population is expected to increase by 40%. The greatest projected change, similar to the rest of Victoria, will be an increase in the aged population. However, Echuca is predicted to also have growth in the younger age groups.

The DHS latest report on the burden of disease confirms that compared to the rest of Victoria, the local community has:

- A higher rate of cancer for both male and females.
- A higher rate of cardiovascular disease.
- A higher rate of diabetes for males.

---

6 www.localgovernment.vic.gov.au – Campaspe Shire Council
7 Australian Bureau of Statistics - ABS Census 2006 (and updates); DSE, Victoria in Future 2004
8 DHS - Victorian Burden of Disease Study, June 2005
3.2 Organisational Profile

Echuca Regional Health (ERH) is a public hospital in its 126th year of community service. It is an expanding multi-service rural health service offering a full range of services including Acute, Aged Care and Community Health (Appendices 1 & 3). The hospital treats over 8,000 in-patients annually, with 15,000+ emergency attendances and 300+ births. ERH sits within the DHS Loddon-Mallee Region. Pathology, Radiology and Pharmaceutical services are provided on site.

ERH employs 575 staff (338.73 EFT), making it one of Echuca's largest employers. The health service has an operating budget of $44 million and returns in excess of $30 million each year to the local community in salaries, wages and purchases from local businesses⁹.

To meet the challenges of an expanding population base and high rates of chronic disease, ERH plans to focus primary and preventive health initiatives on reducing cardiovascular disease, cancer, diabetes and chronic respiratory disease, whilst maintaining and further developing acute and aged care services, placing high priority on quality, consumer focused service delivery¹⁰.

ERH is committed to ensuring that services provided in the future, will meet the needs of the changing community and ensure a sustainable and secure future for local health services. This is reflected in the Purpose and Guiding Principles of the service and the Strategic Plan, revised in 2008 (Appendix 2).

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⁹ Echuca Regional Health – Annual Financial Report June 2008
¹⁰ Echuca Regional Health – Annual Report, June 2008
3.3 Performance Profile

Over the last financial year, service demand has increased significantly\(^\text{11}\);

- Patient separations increased by 15%
- The number of Emergency Department attendances increased by 7%
- The number of patients over the age of 65 years increased by 12.4%
- Cancer support services patients increased by 35%
- Palliative care patients increased by 35%
- Chemotherapy patients increased by 57%
- Medical day unit attendees increased by 11%

The rise in separations is mainly due to increased day surgery, day medical activity and a 100% increase in renal dialysis facilities. This has lead to a 5% reduction in the average acuity of inpatient separations, but a similar reduction in average length of stay has been identified.

The growth in primary and continuing care services has resulted in new services being developed to meet increasing demand, including; the Hospital Admissions Risk Program (HARP), the Transition Care Program (TCP) and the After-Hours Clinic\(^\text{12}\).

\(^{11}\) Echuca Regional Health – Annual Report, June 2008
\(^{12}\) Echuca Regional Health – Annual Report, June 2008
3.4 Human Resources Profile\textsuperscript{13}

3.4.1 Nursing Staff

Nursing staff form the greatest labour category. The majority of nursing staff live within the catchment area and it is estimated that over 50% of nursing staff are connected to local agri-businesses. Therefore, they provide a stable workforce, with low staff turnover. The majority of nursing promotions are internal. Whilst nurses do move into the area, it has been recognised that these are largely older nurses, preparing for retirement, who wish to work on the casual bank only. Consequently, positions may be vacant for many months. Nursing ratios are met through staff working extra hours and with casual bank staff.

3.4.2 Medical Staff

Like most other rural and regional hospitals, ERH is affected by the increasing shortage of Australian trained medical graduates. As a result, international medical graduates (IMGs) are employed. This presents a number of challenges, such as appropriate level of supervision initially, lack of understanding of the Australian health care system, language and cultural issues. ERH provides a supportive learning environment for the IMGs and provides continual support and supervision for Interns in the Emergency Department. To date there has been a 100% pass rate for all graduates who have sat their clinical exams.

Table 1: Staffing Profile

<table>
<thead>
<tr>
<th>Labour Category</th>
<th>June 2008 Full time equivalent</th>
<th>June 2008 Head Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>157.6</td>
<td>238</td>
</tr>
<tr>
<td>Administration and Clerical</td>
<td>21.7</td>
<td>23</td>
</tr>
<tr>
<td>Medical Support</td>
<td>29.9</td>
<td>39</td>
</tr>
<tr>
<td>Hotel and Allied Services</td>
<td>123.5</td>
<td>169</td>
</tr>
<tr>
<td>Medical Officers</td>
<td>1.1</td>
<td>2</td>
</tr>
<tr>
<td>Hospital Medical Officers</td>
<td>10.4</td>
<td>11</td>
</tr>
<tr>
<td>Sessional Medical Officers</td>
<td>0.1</td>
<td>5</td>
</tr>
<tr>
<td>Ancillary Support Services</td>
<td>1.9</td>
<td>2</td>
</tr>
</tbody>
</table>

The increasing shortage of nursing and medical staff will be a continuing challenge for rural health services and is likely to only be addressed by service re-design. The NP role is a vital part of that re-design.

\textsuperscript{13} Echuca Regional Health – Annual Report, June 2008
4. Project Establishment

Although funding for the project was awarded in March 2008, due to recruitment difficulties, a Project Officer was not appointed until May 2008, when a local external consultant was engaged.

As the project was essentially a feasibility study, a small Steering Group was set up to manage the project. The group consisted of;

- Executive Director of Nursing
- Deputy Director of Nursing
- Training Manager
- Project Officer

It was acknowledged that if the organisation was to proceed with the development of Nurse Practitioner roles, a larger, multidisciplinary group would be necessary to ensure adequate and appropriate governance on an on-going basis.

The Project Officer was required to undertake all of the project tasks and had direct access to all Steering Group members for advice and support.

Outside of the organisation, the Project Officer was a member of the ‘Victorian Nurse Practitioner Project (VNPP) Phase 4 Round 4.1 Rural Nurse Practitioner Service Planning Collaborative’, hosted by the DHS. This group met at workshops and communicated via teleconferences set up by the DHS. This enabled the group to discuss common issues and share information and resources. This proved to be an invaluable resource and prevented duplication of work.

Locally, the Project Officer maintained close liaison with Project Officers at Kyabram & District Health Services and Rochester & Elmore District Health Services, which were also part of the VNPP. This also prevented duplication of work as the geographical boundaries of all 3 health services overlapped and information obtained by one Project Officer was often required by the others. It was an emerging theme of the project, that collaborative working is an essential factor for successful outcomes, particularly in the rural setting.
5. Summary of Key Issues

5.1 Understanding Local Demand and Opportunities

To understand local demand issues and opportunities for the development of NP roles, it was necessary to gather a wide variety of quantitative and qualitative data and consult with key stakeholders.

5.1.1 Data Collection

In terms of data collection, the project ran during the period of time that the organisation’s Annual Report was being prepared. Much of the data was therefore already being collected and could be relatively easily harvested without the need to set up new systems or significantly increase the workload of staff. The data reviewed included:

- Clinical Indicators
- Human resources data
- Activity data for the service
  - Separations
  - Diagnostic related groups
  - Emergency Department attendance figures

Additional community profile data was obtained from:

- Shire of Campaspe Council\(^{14}\)
- Murray Shire Council\(^{15}\)
- Campaspe Primary Care Partnership\(^{16}\)

\(^{15}\) Murray Shire Profile - [www.murray.nsw.gov.au](http://www.murray.nsw.gov.au)
\(^{16}\) Shire of Campaspe - Municipal Public Health Plan 2006 – 2009 and Community Profile
5.1.2 Statistical Results

The following charts and tables show some of the results of the data review, clearly indicating:

- a growth in service demand across a range of service areas
- increasing number of patients over 60 years of age

Table 2: Separations last 5 years

<table>
<thead>
<tr>
<th>Year</th>
<th>Separations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003/04</td>
<td>10,000</td>
</tr>
<tr>
<td>2004/05</td>
<td>11,000</td>
</tr>
<tr>
<td>2005/06</td>
<td>12,000</td>
</tr>
<tr>
<td>2006/07</td>
<td>13,000</td>
</tr>
<tr>
<td>2007/08</td>
<td>14,000</td>
</tr>
</tbody>
</table>

Table 3: Separations by Top 10 Diagnostic Related Groups – last 2 years

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Renal Dialysis</td>
<td>1,756</td>
<td>1,400</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Chemotherapy</td>
<td>466</td>
<td>273</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>Colonoscopy</td>
<td>322</td>
<td>293</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>Newborn greater than 2499 grams</td>
<td>285</td>
<td>291</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>Other factors influencing health</td>
<td>223</td>
<td>114</td>
<td>-</td>
</tr>
<tr>
<td>6</td>
<td>Lens procedures</td>
<td>178</td>
<td>147</td>
<td>8</td>
</tr>
<tr>
<td>7</td>
<td>Red Blood Cell Disorders</td>
<td>176</td>
<td>166</td>
<td>5</td>
</tr>
<tr>
<td>8</td>
<td>Normal Vaginal Delivery</td>
<td>168</td>
<td>164</td>
<td>6</td>
</tr>
<tr>
<td>9</td>
<td>Gastroscopy</td>
<td>160</td>
<td>153</td>
<td>7</td>
</tr>
<tr>
<td>10</td>
<td>Anal and stomal procedures</td>
<td>155</td>
<td>105</td>
<td>-</td>
</tr>
</tbody>
</table>
Table 4: Emergency Department Attendances – last 5 years

<table>
<thead>
<tr>
<th>Year</th>
<th>Emergency Department Attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003/04</td>
<td>13,000</td>
</tr>
<tr>
<td>2004/05</td>
<td>14,000</td>
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<tr>
<td>2005/06</td>
<td>15,000</td>
</tr>
<tr>
<td>2006/07</td>
<td>16,000</td>
</tr>
<tr>
<td>2007/08</td>
<td>17,000</td>
</tr>
</tbody>
</table>

Table 5: Patient Age Profile – last 5 years

<table>
<thead>
<tr>
<th>Year</th>
<th>Patient Age Profile</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003/04</td>
<td>1,000</td>
</tr>
<tr>
<td>2004/05</td>
<td>2,000</td>
</tr>
<tr>
<td>2005/06</td>
<td>3,000</td>
</tr>
<tr>
<td>2006/07</td>
<td>4,000</td>
</tr>
<tr>
<td>2007/08</td>
<td>5,000</td>
</tr>
</tbody>
</table>

Table 6: Primary Care and Community Based Services Activity – last 2 years

<table>
<thead>
<tr>
<th>Department</th>
<th>2006/2007</th>
<th>2007/2008</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Patients Treated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer Support</td>
<td>357</td>
<td>482</td>
<td>35%</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>1327</td>
<td>1797</td>
<td>35%</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>270</td>
<td>425</td>
<td>57%</td>
</tr>
<tr>
<td>Medical Day Unit</td>
<td>408</td>
<td>454</td>
<td>11%</td>
</tr>
</tbody>
</table>

Echuca Regional Health – VNPP, Phase 4, Round 4.1 – Final Report Feb 2009
Echuca Regional Health provides services for a large geographical area, including cross border localities in NSW\textsuperscript{17}.

Table 7: Separations by Top 20 Localities

<table>
<thead>
<tr>
<th>Top 20 Localities</th>
<th>Separations 2007/2008</th>
<th>Separations 2006/2007</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Echuca</td>
<td>5,496</td>
<td>4,776</td>
<td>59.1%</td>
<td>59.2%</td>
</tr>
<tr>
<td>Moama</td>
<td>1,416</td>
<td>1,312</td>
<td>15.2%</td>
<td>16.2%</td>
</tr>
<tr>
<td>Rochester</td>
<td>515</td>
<td>373</td>
<td>5.5%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Deniliquin</td>
<td>361</td>
<td>227</td>
<td>3.9%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Tongala</td>
<td>167</td>
<td>168</td>
<td>1.8%</td>
<td>2.1%</td>
</tr>
<tr>
<td>Kyabram</td>
<td>133</td>
<td>111</td>
<td>1.4%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Lockington</td>
<td>116</td>
<td>122</td>
<td>1.2%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Nathalia</td>
<td>111</td>
<td>92</td>
<td>1.2%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Cohuna</td>
<td>80</td>
<td>49</td>
<td>0.9%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Eaglehawk</td>
<td>60</td>
<td>10</td>
<td>0.6%</td>
<td>0.1%</td>
</tr>
<tr>
<td>Gunbower</td>
<td>56</td>
<td>69</td>
<td>0.6%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Torrumbarry</td>
<td>45</td>
<td>38</td>
<td>0.5%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Tongala</td>
<td>37</td>
<td>39</td>
<td>0.4%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Barham</td>
<td>29</td>
<td>27</td>
<td>0.3%</td>
<td>0.3%</td>
</tr>
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<td>13</td>
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</tbody>
</table>

\textsuperscript{17} Echuca Regional Health – Annual Report June 2008
5.1.3 Key Stakeholder Consultation

A considerable part of the project activity involved direct discussions with key stakeholders with the aim of;

- Identifying current models of care
- Identifying if advanced nursing practices were already being utilised
- Identifying service gaps
- Gauging level of interest/support for NP roles
- Identifying potential NP candidates
- Identifying potential barriers to implementation of NP roles (real and perceived)
- Determining potential solutions to barriers
- Raising awareness of NP role and endorsement process
- Introducing Expression of Interest forms
- Identifying potential funding sources
- Identifying suitable mentors and clinical supervisors for NP candidates
- Determining if current governance structures would be adequate to support NP roles
- Determining what level of educational support NP candidates and endorsed NPs would require.

Face to face interviews were conducted with a wide range of ERH key personnel. Stakeholders external to the organisation included; Murray Plains Division of General Practice, University of Melbourne School of Rural Health, Medical Consultants, Campaspe Primary Care Partnership, Shire of Campaspe, Njernda Aboriginal Health Clinic, Viney Morgan Aboriginal Health Clinic. Where it was not possible to meet directly, telephone contact was made to ensure a wide range of views were sought. The response from all contacts was positive and encouraging for future partnership working.

A major stakeholder group is the local General Practitioners (GPs). They were informed of the project via the Murray Plains Division of General Practice (MPDGP) and invited to comment. A seminar was held for local GPs; guest speakers included a representative of the Nurses Board of Victoria and two Nurse Practitioners from local health services. A written review of the seminar was circulated by the MPDGP, for those GPs unable to attend.
Community groups were not approached during the project as there were no local meetings scheduled during the lifetime of the project and it was not considered necessary to set up community groups solely for the VNPP feasibility study. A significant community consultation had been carried out previously by the Shire of Campaspe, which included consumer views on local health service provision\textsuperscript{18} and this was reviewed as part of the project.

\textsuperscript{18} Shire of Campaspe – Municipal Public Health Plan, Community Consultation, Nov 2005
5.1.4 Barriers and Constraints

Through the consultation process, it was evident that there were a number of challenges to be addressed;

i. Confusion and Misunderstandings about the Nurse Practitioner Role.

Within the organisation and amongst external parties, there exists a range of views and perceptions regarding the NP role, scope of practice and endorsement process. This has led to anxiety and scepticism as to the purpose and efficacy of the role. This issue is not isolated to ERH and has been identified previously.¹⁹

The solutions to this challenge include;

- Promoting the role internally via ward meetings, newsletter articles and guest speakers
- Promoting the role externally, in particular to GPs and other health professionals, explaining not just how the role benefits patients, but how it may also assist them in managing workload
- Expose nursing staff to networks and forums including;
  - Royal College of Nursing, Australia
  - Australian Nursing Federation
  - Nurses Board of Victoria
  - Australian Nurse Practitioner Association
- Continuing consultation with key stakeholders

Recommendations

State Level

DHS & NBV should continue to promote the role and endorsement process as widely as possible to minimise confusion, promote the collaborative aspects of the role and engage other health professionals in debate as to how the role can help manage workload as part of the overall health care team.

Organisational Level

ERH should conduct a local promotion campaign to inform and educate key stakeholders about the NP role to alleviate anxieties and foster support for the role.

¹⁹ Bayside Health – Nurse Practitioner Service Plan Development Project, June 2006
ii. Recruiting Nurse Practitioner Candidates

It was evident that ERH had a number of nursing staff who were interested in the NP role and some who were already in a position to commence a candidacy. Due to the confusion around the role and the endorsement process, these staff were slow to come forward. Anxieties were expressed regarding course fees, remuneration, superannuation and job security. In an area where over 50% of nursing staff are connected to the local agri-businesses, it is likely that they may provide the only stable income in the household and the risks to them of embarking on the long road to NP endorsement should not be underestimated. Although the Enterprise Bargaining Agreement (EBA) stipulates that NP candidates are paid their substantive salary and endorsed NPs are paid at Grade 6, this does not address the considerable financial outlay to undertake education at a Masters level.

Recommendations

State Level
DHS, RCNA & NBV should continue to work together to lobby state and commonwealth governments to provide sponsorship opportunities for nurses to complete the educational requirements for NP.

Organisational Level
ERH should ensure that;

- remuneration and human resource issues are adequately addressed in position descriptions and contracts of candidacy
- study leave, clinical supervision and mentorship arrangements are clearly identified in a NP education framework
- nurses are actively encouraged to apply for scholarships
- departmental managers identify potential NP candidates through the performance appraisal process and formulate a development plan
5.2 Shaping the Service Model for Nurse Practitioners

Stakeholder consultation identified potential for the development of NP roles in the following service areas;

- Emergency department
- Diabetes management
- HARP
- Women’s Health
- Men’s Health
- Aged Care

Based on service demand, support mechanisms and availability of potential NP candidates, it was determined that the Emergency Department, Diabetes and HARP proposals would be discussed further with Department Managers and that written Expressions of Interest would be drawn up for those areas.

5.2.1 Expressions of Interest

Expression of Interest (EOI) forms were adapted from those developed in a previous round of the VNPP. These forms were used as a basis to collate the information relating to the current service model and the proposed changes to introduce a NP model of practice. A completed EOI form is included in this report (Appendix 4).

To support the proposals for change, guidance was sought from local health services where NP models of care were already in place. Goulburn Valley Health in Shepparton was extremely supportive, providing professional advice, documentation and ‘in principle’ offers of clinical supervision and mentorship for NP candidates and joint education opportunities.
5.2.2 Proposed Service Models
From the EOI proposals, models of practice were determined for all three service areas. The model was adapted from the Goulburn Valley Health Emergency Department model.\(^{21}\)

5.2.3 Emergency Department
The NP role within emergency departments is well documented, evaluated and researched and is in fact the field in which the largest numbers of NPs work.\(^{22}\) Implementing a NP role in the Emergency Department of ERH has the potential to improve clinical indicators through re-defining the patient journey. The emergency department has 2 nursing staff that have already completed their masters’ degree and are interested in pursuing the NP model.

Proposed Emergency Nurse Practitioner service model:

\(^{21}\) Goulburn Valley Health – Emergency Nurse Practitioner Model of Care 2007
\(^{22}\) Nurse Board of Victoria - www.nbv.org.au
5.2.4 Diabetes Management

The Diabetes Educator role at ERH is well established and considerable patient benefits were identified by converting this role to that of NP. A nurse was identified who has completed the Diabetes Educator course and is interested in pursuing the relevant education in preparation for a NP role in the future.

Proposed Diabetes Nurse Practitioner service model:
5.2.5 HARP/Better Care Older People

The Hospital Admission Risk Program (HARP) commenced at ERH in April 2008. The aim of the Program is to assist people with chronic and complex diseases, which cause frequent admissions to hospital or regular presentations at the Emergency Department, to self manage their condition and improve their lifestyle. Access to the Program is limited to people over 65 years of age, or 45 years of age for indigenous people. Introducing a NP role to this team has the potential to significantly enhance the efficacy of the team. Two nurse members of the team have expressed an interest in pursuing the relevant education in preparation for a NP model.

Proposed HARP/Better Care Older People Nurse Practitioner service model:

- [Flowchart diagram]
  - Client meets inclusion criteria at initial referral
    - Yes: Admitted onto NP caseload
      - Patient assessed by NP
        - Yes: Exclusion Criteria Found
          - Referred to GP, Consultant or other service as appropriate
        - No: Multidisciplinary Management Plan initiated by NP
          - Multidisciplinary Management Plan implemented & monitored by NP
            - Review / Referral / Discharge

Echuca Regional Health – VNPP, Phase 4, Round 4.1 – Final Report Feb 2009
5.2.6 Service Model Evaluation

Evaluation of the NP service model is integral to the model, in order to assess the appropriateness and efficacy of care provided, to assess the value for money of the model and to inform the future planning of other advanced practice nursing roles.

Any evaluation framework should focus on safety, quality and timing of care with the aim of providing adequate data to ensure valid results and must measure not only outcomes of care\(^{23}\) but also the care processes and structural factors\(^ {24}\).

The data collection should focus upon aspects of the service most directly affected by NP activities. It is essential to have a comparison, so data should be collected as a baseline measure prior to the change in service delivery.

Where possible, data already collected within the service should be utilised and any data collection specifically related to the NP service model should contribute to the organisation’s overall risk and quality programs. Evaluation methodology of any NP service model must recognise that a range of factors influence patient outcomes, including the fact that the NP does not work in isolation, but as a member of a collaborative, multidisciplinary team.

Health services with existing NP service models are willing to share their evaluation frameworks and these can be adapted to local needs.

Care should be taken however, to ensure that the NP service model is not subjected to a level of evaluation any greater than any other new service development. Discussions with current NPs suggests that their role is zealously evaluated and re-evaluated to the point where the continual evaluation itself undermines the value of the evaluation framework, as it gives the impression that the results are not valid or that the service is not safe - yet.

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Recommendations

State Level
DHS should offer research grants to enable comprehensive research to be carried out on new service models.

Organisational Level
ERH should conduct comprehensive baseline data collection within the service areas prior to the introduction of any new service model. The data collection should relate to areas of the service that would be impacted on by the NP role and the intended Key Performance Indicators (KPIs) of the role. The baseline audits should feed into existing risk and quality programs.

Any evaluation framework should include parameters to identify when evaluation of the NP service model is sufficient to determine quality, safety and efficacy of the role. Once this has been achieved, no greater level of evaluation need be applied other than relevant quality and risk measures, in line with service KPIs, Clinical Indicators and industry standards. Previous pilot studies and rounds of the VNPP have produced a wealth of data and validated research\(^\text{25}\) and care should be taken not to ‘over-evaluate’ the NP role.
5.2.7 Barriers and Constraints

There are a number of challenges to introducing the proposed service models;

i. Access to Provider Numbers

The current PBS/MBS system does not recognise the role of NP and therefore NPs cannot access provider numbers. This means that their legal prescribing rights are constrained and patients cannot reap the benefits of this aspect of care.

There are a number of solutions to this challenge, including;

- Organisational protocols which enable the NP to prescribe medications which can be dispensed by the ERH pharmacy and have access to medications from the NP Formulary out of hours. This option is supported by the ERH Chief Pharmacist.

- Agreements with local pharmacies to dispense medications from a NP prescription to the patient at PBS rates. This would prove complicated due to the wide area that ERH patients come from.

NP roles and service models are not currently recognised by TAC, Work Cover or many health insurance schemes. This means that the service model is only available to public patients, limiting access to the service. This issue can only be changed through Federal changes to the Medicare system and is beyond the control of ERH at a local level.

### Recommendations

#### State Level

DHS, NBV, RCNA, ANF and other nursing bodies should continue to lobby state and commonwealth governments to support appropriate changes to Medicare to enable NPs to deliver care within their legal sphere of practice.

#### Organisational Level

ERH should establish local protocols which facilitate the service model and enable the NP to deliver care to the fullest extent of their scope of practice, within the constraints of the current health care system.
ii. Clinical Practice Guidelines

The service model is underpinned by Clinical Practice Guidelines (CPGs). The development of the CPGs is a vital component of the service model to:

- Manage risk and quality
- Define the scope of practice of the NP within the service model
- Clarify role responsibilities within the health care team
- Confirm NP diagnostic and prescriptive authority
- Confirm referral processes
- Confirm admission and discharge protocols

As there are a number of NP service models within the state, there is a considerable wealth of knowledge that ERH can draw upon. Goulburn Valley Health has already shared CPGs for the Emergency and Diabetes service models. The HARP/Better Care Older People service model can draw from the Aged Care CPGs developed by the Canberra Hospital, ACT\(^{25}\) and the East Gippsland Primary Health NP CPGs\(^{26}\).

Currently, however, CPGs appear to be written only in relation to the NP role. It would be useful in terms of integrating the NP role and raising the standards of care overall, to develop the CPGs as a multidisciplinary care pathway.

<table>
<thead>
<tr>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>State Level</strong></td>
</tr>
<tr>
<td>DHS should continue to encourage health services to share CPGs and facilitate forums to encourage consistency.</td>
</tr>
</tbody>
</table>

| **Organisational Level** |
| ERH should utilise the CPGs already developed in other areas, adapt as necessary and implement as multidisciplinary guidelines. As the timescale for the introduction of NPs at ERH is in the longer term, consideration should be given to the appointment of a project worker to review & develop CPGs. This role could be undertaken by prospective NP candidates in rotation. |

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\(^{25}\) Canberra Hospital Nurse Practitioner Clinical Practice Guidelines Aged Care, Sept 2006

iii. Nurse Practitioner and Workforce Redesign

Through consultation, it is apparent that the role of the NP is seen as a potential solution to a myriad of workforce and workload issues. It is clear that in some instances, the NP service model will improve quality of care and service delivery. However, the NP role in isolation will not resolve many of the complex workload issues in healthcare. Any changes to service plans based on NP models of care must be viewed within a broad context of workforce planning and service redesign.

The role of the NP is also clouded by debates as to whether the NP is counted as part of the nursing ratios. It must be remembered that the NP role is primarily a nursing role and must therefore be a part of the nurse ratios. What does need to be taken account of when designing NP service models, in relation to establishment numbers, is the increased level of non-patient contact time inherent in the NP role. This includes dedicated time for study leave, clinical supervision, mentoring, delivering education in-house, clinical audit and research.

**Recommendations**

**State level**

DHS should continue to promote the value of workforce planning and assist organisations to conduct workforce planning activities. On-going consultation should be maintained with workforce unions in relation to NP roles, nurse/patient ratios and enabling flexibility within the EBAs to facilitate workforce redesign to the benefit of patients and staff.

**Organisational Level**

ERH has already identified workforce planning as a major human resources objective within the current Strategic Plan. This will be a large piece of work and should consider the development of NP service models as only one of many potential service redesign options.

Re-design options involving NP roles, must include the allocation of resources to support the non-patient contact time within the NP role.
5.3 Preparing the Organisation for Nurse Practitioners

The key elements of this aspect of the change process fall into 4 broad areas:

- Governance structures
- Human Resources
- Funding
- Sustainability

5.3.1 Governance Structures

To ensure risk is adequately managed and quality of care is delivered, organisational governance structures must be robust, but flexible enough to facilitate changes in practice. As the service models proposed are primarily nursing focussed, the responsibility for a policy framework to support the development of NP roles must lay with the Nursing Division, under the leadership of the Executive Director of Nursing (EDoN). The framework must link easily with organisation wide risk and quality governance structures and should focus on the development of any advanced nursing practice, not just NP practice. It is evident that many aspects of service delivery may be improved through the development of advanced nursing practice, in line with the NBV Scope of Nursing & Midwifery Practice Guidelines.27

The policy framework to support the NP role at the local level should include:

- A process for initiating discussions on developing advanced nursing practices within a clinical area, e.g. expressions of interest (stage 1)
- A process for submitting plans to implement advanced nursing practice roles, e.g. expressions of interest (stage 2)
- Validation of CPGs
- Confirmation of prescriptive and diagnostic authority of NP
- Referral processes
- Admission and discharge protocols
- Educational framework

27 Nurses Board of Victoria – Guidelines: Scope of Nursing & Midwifery Practice, Jan 2007

Echuca Regional Health – VNPP, Phase 4, Round 4.1 – Final Report Feb 2009
Current governance structures within the Nursing Division at ERH are not adequate to meet the needs of an evolving service. The recent changes within the nursing executive team at ERH provide a timely opportunity to review those structures and processes to establish a structure which will meet current needs and adapt as the service evolves.

Previous VNPP reports contain detailed flow charts and recommendations for the appropriate structures, processes and committees. As this round of the VNPP is a feasibility study, such recommendations fall outside the remit of the project and could potentially pre-empt the outcome of the review planned by the EDoN and her team.

**Recommendations**

**State Level**

DHS should continue to facilitate networks which will enable nursing leadership teams to share ideas and resources and offer support to participants to implement change.

**Organisational Level**

The EDoN and her team should conduct a review of existing nursing governance structures as already planned and ensure that changes to these structures are adequate to facilitate and support the development of advanced nursing practice and NP roles in the future.
5.3.2 Human Resources
Given the number of concerns raised by nursing staff in connection with contractual obligations, job security, remuneration and superannuation, the role of the Human Resources Department is a vital part of the change process. The Human Resources Department is also integral to the workforce planning activities.

To prevent misunderstandings and allay anxieties, robust position descriptions and contracts of employment will be necessary. This will:

- Confirm selection criteria for NPs
- Clarify issues surrounding salary during candidacy
- Confirm contractual obligations during the candidacy period
- Facilitate the transition from NP candidate to Endorsed NP
- Protect the organisation from risks associated with extended candidacy periods

Once again, many examples of position descriptions and contracts of employment are available for information. Draft position descriptions for NP candidates and Endorsed NPs are included in appendices 5 & 6.

---

**Recommendations**

**State Level**
DHS should continue to consult with nursing bodies and unions to ensure contractual arrangements are consistent with industrial relations legislation.

**Organisation Level**
ERH Human Resources Department should support Departmental Managers with workforce planning activities, performance reviews and position description development.
5.3.3 Funding
The significant costs associated with the NP role are;

- Funding the position
- Clinical education
- Clinical supervision and mentorship fees
- Course fees
- Non-patient contact time
- Administrative costs; audit, research, education delivery

These costs vary depending on;

- Whether the position is new or conversion of an existing role
- Substantive salary of NP candidate
- Length of candidacy period, impacting on level of clinical education and supervision required
- Fees of clinical supervisors and mentors
- Course fees

Currently, most NP candidates are responsible for their own course fees and most clinical supervisors and mentors provide their time and expertise at little or no cost. This results in an ad-hoc support system which devalues the role of the clinical supervisors and mentors. The education package for NP candidates needs to be appropriately funded to ensure quality and recognise the importance of the education.
i. **Implementation Costs**

Due to the variables already identified it is only possible to offer an estimate of costs to implement a NP service model. The example given below relates to the Emergency Department service model;

<table>
<thead>
<tr>
<th>Item</th>
<th>Comment</th>
<th>Costs</th>
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<tbody>
<tr>
<td>Salary</td>
<td>Substantive salary is paid during candidacy. Once endorsed, salary scale rises, incurring an additional final cost, based on current costs of G3 Y2, including on costs and operational costs.</td>
<td>$25,648 per annum, per EFT</td>
</tr>
<tr>
<td>Study leave</td>
<td>NP candidate will require 1 day per week for up to 3 years. Although study leave is included in the overall salary costs, this is non patient contact time and constitutes the cost of backfilling the position to maintain continuity of service. Study leave will continue after endorsement, to maintain NP endorsement, but this will be reduced, possibly by half, but the NP hourly rate will be increased.</td>
<td>$11,561 per annum</td>
</tr>
<tr>
<td>Clinical Supervision &amp; mentorship</td>
<td>It may be necessary to pay for this service from appropriate health professionals. An estimated requirement of 4 hours per month for up to 3 years is at a cost of $100 per hour. This cost may be off-set by candidate obtaining a DHS NP Education Package.</td>
<td>$4800 per annum</td>
</tr>
<tr>
<td>Diagnostic tests</td>
<td>It is difficult to estimate how many tests might be ordered by the NP and what additional costs may be attributed to the hospital service.</td>
<td></td>
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<tr>
<td>Course Fees</td>
<td>There will be individual costs for each NP candidate in relation to course fees. This cost could be reduced by the candidate obtaining a Commonwealth or other scholarship.</td>
<td>$20,000 – $30,000 (to individual)</td>
</tr>
<tr>
<td>The estimated additional cost of developing a NP role in ED including on costs and operational costs, but excluding course fees</td>
<td></td>
<td>$16,500 per annum per EFT during candidacy</td>
</tr>
<tr>
<td>The estimated final costs of implementing NP roles in ED including on costs and operational costs.</td>
<td></td>
<td>$33,044 per annum, per EFT, recurring</td>
</tr>
</tbody>
</table>
Each departmental manager will need to prepare a business case to support the development and implementation of any NP role. The significant costs need to be balanced against potential benefits to the organisation. These benefits will vary from department to department.

In rural areas where nurses often work part time and work to supplement the income from farming or horticultural family businesses, it can be difficult to find nurses who are able to commit to the personal and financial costs of further education to reach advanced nursing practice standards. Whilst costs may be regained in the long term, following endorsement, the initial outlay is prohibitive. Costs of education and clinical supervision may be offset through Commonwealth, DHS and other grants.

The costs to the organisation lies mostly in salary costs, non-patient contact time costs and clinical supervision costs. As the candidacy period may be up to 3 years, benefits to the organisation may not be seen for some time. Implementation of NP service models must therefore be seen as an investment. Benefits may include;

- Reduce service gaps and fragmentation
- Increasing continuity across the continuum of care
- Increased emphasis on holistic care
- Enhanced access to services
- Provision of greater range of care options
- Decreased waiting times
- Enhanced discharge planning
- Reduced repeat attendances/admissions
- Improved patient satisfaction
- Improved staff satisfaction
- Enhanced recruitment & retention of staff
ii. **Funding Options**

The significant costs may be funded from a variety of options:

- Course fees may be subsidised through scholarships and grants
- Clinical supervision and mentorship may be funded through DHS Education Packages
- Income may be generated once the NP is endorsed and able to provide clinical supervision and mentorship to other NP candidates
- Income may be generated by student placements, supervised by the NP
- Income may be generated by paid research, undertaken by the NP
- A NP service model may result in savings which can be channelled back into funding the role
- Conversion of existing roles such as Clinical Nurse Specialist or Clinical Nurse Consultant roles, requiring only top-up funds
- Use of funds for existing unfilled nursing positions within the nursing budget
- Use of funds within the Department. This may mean using funds from a combination of nursing and medical budgets
- Seeking additional funding through DHS programs or projects such as HARP/Better Care Older People
- Workforce redesign and associated revised models of care may elicit saving which can be utilised to fund NP positions.

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**Recommendations**

**State Level**

DHS should continue to make scholarships and grants available and lobby Commonwealth Government and other bodies to do the same. Consideration should be given to funding the implementation of NP roles in high priority areas.

**Organisation Level**

ERH Executive Team should explore opportunities for;

- the reconfiguration of existing roles
- the reallocation of existing funds
- potential external funding sources.
iii. **Sustainability**

The key to building sustainability for Nurse Practitioner roles at ERH lies in; adequate planning, consultation, securing funding streams, establishing robust governance structures and providing an educational framework.

Adequate planning cannot be underestimated as the foundation to successful outcomes. The development of NP roles should not be hurried in response to political or professional imperatives.

Consultation is not a one-off exercise, but needs to be ongoing, as already identified in sections 5.1.3 & 5.1.4.i. This will be a major element of any new service plan and needs to be adequately accounted for in terms of allocation of time and resources.

Securing funding streams has already been addressed in section 5.3.3.ii

Governance structures have been addressed in section 5.3.1.

An education framework is essential to building sustainability of Nurse Practitioner roles in the rural setting and needs to be developed with considerable thought as to the needs of the individuals and ERH. This will be discussed further in the next section.

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### Recommendations

**State Level**

DHS, whilst promoting NP service models and encouraging rural health services to develop such models, should be wary of being seen to promote the roles as a political imperative and cognisant of the barriers and constraints faced by rural health services. In particular, the DHS must acknowledge the extended timeframes which are applicable to the rural setting.

**Organisational Level**

ERH has many opportunities in respect of NP roles and new service models. Extended timeframes are recommended to ensure the vital groundwork is carried out. This will enhance the chances of success and sustainability. Consideration should be given to the appointment of a project worker to undertake this groundwork.
5.4 Preparing the Nursing Workforce

During the project, it was evident that there was considerable interest in and support for NP service models. Nursing staff were identified who already met the minimum education requirements as stipulated by the NBV\textsuperscript{28}. Other nurses were interested in the role and were at various stages of the education process, including not yet enrolled on relevant courses.

As previously stated there was confusion and misunderstanding about the role and the development of models of care in particular. Concerns were also expressed as to how the nurses could gain advanced practice skills and the required clinical supervision and mentorship. To ensure consistency and minimise risks, the NP service plan needs to be underpinned with an education framework.

5.4.1 Education Framework

ERH already has an active Education Department, which is capable of supporting nurses to develop advanced practice skills prior to considering NP roles. It was not felt however, that the department had the relevant expertise or adequate resources to provide the additional clinical training, supervision and mentorship required by NP candidates.

The education framework needs to incorporate the following elements;

- Self assessed learning needs for proposed extension to scope of practice
- Key stakeholder suggestions for learning needs of the role/individual NP candidate
- Identification of in-house education opportunities
- Tertiary education opportunities
- Local/regional/ state wide and national education opportunities
- Prescribing and diagnostic testing learning needs and educational requirements in relation to context of practice
- Identification of appropriate teachers, supervisors and mentors
- Assessment criteria
- Timeframes for completion of education program
Health services already operating NP service models have established education frameworks. The framework developed by Austin Health\textsuperscript{29} was highlighted by the DHS as a benchmark model. The framework was reviewed by the ERH project Steering Group and is indeed comprehensive and highlights the huge commitment required by the organisation to support the NP roles. The framework can be adapted to suit local requirements.

Goulburn Valley Health, University of Melbourne School of Rural Health and individual Medical Consultants have offered ‘in principle’ support to the education program.

\begin{center}
\begin{tabular}{|l|}
\hline
\textbf{Recommendations} \\
\textbf{State Level} \\
DHS should continue to offer education package support and facilitate educational opportunities for NP candidates, endorsed NPs and Health Services. Consideration should be given to fully funding education in priority areas. \\
\hline
\textbf{Organisational Level} \\
ERH should formulate an educational framework which; \\
\begin{itemize}
\item Links to the governance structures
\item Facilitates individual learning plans
\item Identifies appropriate teachers, supervisors and mentors for; \\
\hspace{1cm} o Clinical skills
\hspace{1cm} o Research
\hspace{1cm} o Leadership
\item Outlines assessment criteria
\item Assists the NP candidate to gather evidence for the NBV endorsement process \\
\end{itemize}
\hline
\end{tabular}
\end{center}

\textsuperscript{28} Nurse Board of Victoria – Nurse Practitioner Information Sheet 2  
\textsuperscript{29} Austin Health – Round 6 Nurse Practitioner Service Plan Final Report, Sept 2006
5.4.2 Change Management

The development and implementation of NP service models will be an exercise in change management. With a new Strategic Plan adopted in 2008 (Appendix 2) and a new nursing management team in place from January 2009, there will be a number of changes for staff. A co-ordinated change management plan needs to be adopted based on the principles of consultation, planning and evaluation.

Recommendations

The Nursing Division should work collaboratively to develop a change management plan specific to NP service models, which feeds into an organisation wide change management plan.
6. **The Next 12 Months**

The next 12 months should be considered as a planning stage for ERH. A number of activities need to be undertaken to prepare the organisation and the nursing staff for service changes in the future.

### 6.1 Action Plan

<table>
<thead>
<tr>
<th>Item</th>
<th>Action</th>
<th>Outcome</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance Structures</td>
<td>EDoN to review nursing governance structures</td>
<td>A structure which will facilitate development of advanced nursing practice roles is implemented</td>
<td>6-9 months</td>
</tr>
<tr>
<td>Education</td>
<td>Education Manager to review current education programs to ensure advanced nursing skills are catered for</td>
<td>Education program incorporates educational requirements for advanced nursing practice skills</td>
<td>3-6 months</td>
</tr>
<tr>
<td>Consultation</td>
<td>Communication strategy to be devised</td>
<td>Communication strategy in place</td>
<td>3 months</td>
</tr>
<tr>
<td>Change Management</td>
<td>Change management plan to be devised by Nursing Division</td>
<td>Change management plan in place</td>
<td>4-6 months</td>
</tr>
<tr>
<td>Education Framework</td>
<td>To be adapted from existing models</td>
<td>Education framework for NP candidates in place</td>
<td>6-9 months</td>
</tr>
<tr>
<td>Advanced Nursing Practices</td>
<td>Departmental Managers to review clinical skills required and identify opportunities to develop advanced nursing practice skills</td>
<td>Advanced nursing practices identified and education and implementation plan agreed</td>
<td>6-9 months</td>
</tr>
<tr>
<td>Human resources</td>
<td>NP position description and contracts to be drawn up</td>
<td>Agreed position descriptions and contracts in place</td>
<td>6 months</td>
</tr>
<tr>
<td>Funding</td>
<td>Executive Team to consider funding options</td>
<td>Funding stream identified</td>
<td>9-12 months</td>
</tr>
<tr>
<td>Workforce planning</td>
<td>Workforce planning exercise to be conducted organisation wide</td>
<td>Workforce planning exercise completed and organisation wide workforce plan drafted</td>
<td>12+ months</td>
</tr>
<tr>
<td>NP candidates</td>
<td>Recruit NP candidate for Emergency Dept</td>
<td>NP candidate in post</td>
<td>12 months</td>
</tr>
<tr>
<td>Project Worker</td>
<td>Remaining VNPP funds to be utilised to support this role</td>
<td>Project worker identified and project plan initiated</td>
<td>3-6 months</td>
</tr>
</tbody>
</table>
6.2 Maintaining the Momentum

Given the potential lengthy timeframes for implementation of NP service models (3-5 years), ERH faces a challenge in maintaining the enthusiasm and interest of staff and other key stakeholders.

Potential strategies include;

- Raising awareness of the NP role and future plans, internally & externally
- Communication updates, both internal and external, through newsletters and existing communication forums
- Tapping into educational opportunities which will support advanced nursing practice and the NP role e.g. NBV workshops, University of Melbourne free research training, NP conferences and study days
- Involving prospective NP candidates in on-going activities connected with the planning groundwork

**Recommendations**

**State Level**

DHS should continue to give the NP service models a high profile over an extended period of time and support health services with education, training and networking opportunities.

**Organisational Level**

Consideration should be given to the identification of a project worker (utilising the remaining VNPP funds), to continue to promote the NP role and contribute to an implementation plan by;

- Developing & maintaining a communication strategy
- Undertaking essential planning activities
- Reviewing CPGs
- Adapting the Austin Health Education Framework
- Channelling enquiries from potential NP candidates
- Assisting Departmental Managers to prepare nurses with individual learning & development plans
7. Summary and Recommendations

In summary, the VNPP has been successful at ERH, as it has identified potential options for the development of advanced nursing practice and proposed 3 NP service models for consideration.

The feasibility study is however, only the beginning. It is a long and arduous journey from the current position to a new service plan, both for the organisation and for individual nurses. It is a journey worth taking in view of the benefits to the organisation, the nurse and the local community.

Consideration now needs to be given to the recommendations, not just at local level, but at state level also. Even if ERH decides not to commit to the implementation of the proposed NP service plans, there are valuable recommendations which will impact positively on the current service plans.

The NP service models offer only one alternative to current workforce and service delivery models. Should they be implemented at ERH exciting changes will have been set in motion. Even if the recommendations are not adopted, ERH will at least have started a healthy debate and review of current service delivery. This is line with its Guiding Principles and Strategic Plan.
7.1 Recommendations State Level

i. DHS & NBV should continue to promote the role of NP and endorsement process as widely as possible to minimise confusion, promote the collaborative aspects of the role and engage other health professionals in debate as to how the role can help manage workload as part of the overall health care team.

ii. DHS, RCNA & NBV should continue to work together to lobby state and commonwealth governments to provide sponsorship opportunities for nurses to complete the educational requirements for NP.

iii. DHS should offer research grants to enable comprehensive research to be carried out on new service models.

iv. DHS, NBV, RCNA, ANF and other nursing bodies should continue to lobby state and commonwealth governments to support appropriate changes to Medicare to enable NPs to deliver care within their legal sphere of practice.

v. DHS should continue to encourage health services to share CPGs and facilitate forums to encourage consistency.

vi. DHS should continue to facilitate networks which will enable nursing leadership teams to share ideas and resources and offer support to participants to implement change.

vii. DHS should continue to consult with nursing bodies and unions to ensure contractual arrangements for NPs are consistent with industrial relations legislation.

viii. DHS should continue to make scholarships and grants available and lobby Commonwealth Government and other bodies to do the same. Consideration should be given to funding the implementation of NP roles in high priority areas.

ix. DHS, whilst promoting NP service models and encouraging rural health services to develop such models, should be wary of being seen to promote the roles as a political imperative and cognisant of the barriers and constraints faced by rural health services. In particular, the DHS must acknowledge the extended timeframes which are applicable to the rural setting.
x. DHS should continue to offer education package support and facilitate educational opportunities for NP candidates, endorsed NPs and Health Services. Consideration should be given to fully funding education in priority areas.

xi. DHS should continue to give the NP service models a high profile over an extended period of time and support health services with education, training and networking opportunities.

xii. DHS should continue to promote the value of workforce planning as assist organisations to conduct workforce planning activities. On-going consultation should be maintained with workforce unions in relation to NP roles, nurse/patient ratios and enabling flexibility within the EBAs to facilitate workforce redesign to the benefit of patients and staff.
7.2 Recommendations Organisational Level

i. ERH should conduct a local promotion campaign to inform and educate key stakeholders about the NP role to alleviate anxieties and foster support for the role.

ii. ERH should ensure that;
   - remuneration and human resource issues are adequately addressed in position descriptions and contracts of candidacy
   - study leave, clinical supervision and mentorship arrangements are clearly identified in a NP education framework
   - nurses are actively encouraged to apply for scholarships
   - departmental managers identify potential NP candidates through the performance appraisal process and formulate a development plan

iii. ERH should conduct comprehensive baseline data collection within the service areas prior to the introduction of any new service model. The data collection should relate to areas of the service that would be impacted on by the NP role and the intended Key Performance Indicators (KPIs) of the role. The baseline audits should feed into existing risk and quality programs.

iv. Any evaluation framework should include parameters to identify when evaluation of the NP service model is sufficient to determine quality, safety and efficacy of the role. Once this has been achieved, no greater level of evaluation need be applied other than relevant quality and risk measures, in line with service KPIs, Clinical Indicators and industry standards. Previous pilot studies and rounds of the VNPP have produced a wealth of data and validated research and care should be taken not to 'over-evaluate' the NP role.

v. ERH should establish local protocols which facilitate the service model and enable the NP to deliver care to the fullest extent of their scope of practice, within the constraints of the current health care system.
vi. ERH should utilise the CPGs already developed in other areas, adapt as necessary and implement as multidisciplinary guidelines. As the timescale for the introduction of NPs at ERH is in the longer term, consideration should be given to the appointment of a project officer to review & develop CPGs. This role could be undertaken by prospective NP candidates in rotation.

vii. ERH has already identified workforce planning as a major human resources objective within the current Strategic Plan. This will be a large piece of work and should consider the development of NP service models as only one of many potential service redesign options. Re-design options involving NP roles, must include the allocation of resources to support the non-patient contact time within the NP role.

viii. The EDoN and her team should conduct a review of existing nursing governance structures as already planned and ensure that changes to these structures are adequate to facilitate and support the development of advanced nursing practice and NP roles.

ix. ERH Human Resources Department should support Departmental Managers with workforce planning activities, performance reviews and position description development.

x. ERH Executive Team should explore opportunities for;
   - the reconfiguration of existing roles
   - the reallocation of existing funds
   - potential external funding sources.

xi. ERH has many opportunities in respect of NP roles and new service models. Extended timeframes are recommended to ensure the vital groundwork is carried out. This will enhance the chances of success and sustainability. Consideration should be given to the appointment of a project worker to undertake this groundwork.
xii. ERH should formulate an educational framework which;
   - Links to the governance structures
   - Facilitates individual learning plans
   - Identifies appropriate teachers, supervisors and mentors for;
     - Clinical skills
     - Research
     - Leadership
   - Outlines assessment criteria
   - Assists the NP candidate to gather evidence for the NBV endorsement process

xiii. Nursing Division should develop a change management plan specific to NP service models, which feeds into an organisation wide change management plan.

xiv. Consideration should be given to the identification of a project worker to continue to promote the NP role and contribute to an implementation plan by;
   - Developing & maintaining a communication strategy
   - Undertaking essential planning activities
   - Reviewing CPGs
   - Adapting the Austin Health Education Framework\(^\text{30}\)
   - Channelling enquiries from potential NP candidates
   - Assisting Departmental Managers to prepare nurses with individual learning & development plans

\(^{30}\) Austin Health – Nurse Practitioner Service Plan Development Project, Final Report, Phase 3, Round 6, Sept 06
8. Appendices

Appendix 1; Echuca Regional Health Facilities & Services

Acute Hospital Facilities
67 Acute beds
- Medical
- Surgical
- Haemodialysis
- Obstetric
- Palliative Care
- Paediatric
- Community Rehabilitation
- High Dependency Unit

Residential Aged Care
Glanville Village Aged Care Service
- 65 High Care Beds
- 10 Low Care Beds
- 5 Transitional Care Program Beds

Services Provided
- Aboriginal Liaison Officer
- After Hours Clinic
- Ambulatory Services Unit
- Antenatal Classes
- Asthma Education
- Cardiac Rehabilitation Program
- Chemotherapy/Cancer Support Services
- Community Liaison Officer
- Community Rehabilitation Centre
- Dental
- Diabetes Education
- Dietetics
- Discharge Planning
- District Nursing Services
- Drug and Alcohol Counselling
- Education Department
- Emergency Department
- Family/General Counselling
- Finance
- Glanville Village Aged Care Service
- Hospital Admission Risk Program
- Health Promotion
- Infection Prevention and Control
- Meals on Wheels
- Occupational Therapy
- Palliative Care
- Pathology
- Peri-operative Unit
- Pharmacy
- Physiotherapy
- Pre-Operative Clinic
- Primary Care Services
- Quality and Safety Unit
- Radiology
- Renal Dialysis Unit
- Social Work
- Speech Pathology
- Transition Care Program
- Volunteers
Appendix 2;
Purpose, Guiding Principles and Strategic Plan

**Purpose** - ‘Helping everyone to be and stay healthy’

**Guiding Principles**

- **Respect and Honesty** - Treat people with dignity and be truthful
- **Inclusion** - Include everyone
- **Empathy and Compassion** - Understand other people’s needs and feelings
- **Excellence and Best Practice** - Aim high
- **Access and Equity** - Open to everyone – same for all
- **Commitment and Accountability** - Work hard, be loyal and responsible for own actions

**Strategic Plan 2008-2011**

<table>
<thead>
<tr>
<th>1. Provide services that meet community need.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Demonstrate a commitment to enhancing the health and well being of our community. Continually review services to ensure they are consistent with our identified needs, demographic profile and supported by Department of Human Services policy directions.</td>
</tr>
<tr>
<td>1.2 Expand the capacity of medical services.</td>
</tr>
<tr>
<td>1.3 Implement strategies that will support and acknowledge the importance of General Practitioners at Echuca Regional Health.</td>
</tr>
<tr>
<td>1.4 Expand and develop Primary and Continuing Care services.</td>
</tr>
<tr>
<td>1.5 Improve consumer awareness and staff knowledge of how to access services available at Echuca Regional Health.</td>
</tr>
<tr>
<td>1.6 Work in partnership with other health providers to develop services and enhance clinical care.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Promote community engagement.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Build sustainable relationships with our community and achieve effective consumer consultation.</td>
</tr>
<tr>
<td>2.2 Provide activities to better link the health service and community.</td>
</tr>
</tbody>
</table>
3. **Focus on quality, safety and financial viability.**

3.1 Develop an integrated approach to continuous improvement in quality, safety and risk management.

3.2 Develop effective systems by which patients are admitted, managed and discharged.

3.3 Manage our resources to ensure long term financial sustainability.

4. **Provide services in a culturally appropriate manner.**

4.1 Develop, implement and maintain a strong cultural awareness programme.

4.2 Strengthen relationships with the local indigenous community.

4.3 Ensure staff and consumers have access to interpreter services, appropriate foreign language pamphlets and assisted with multilingual signs.

5. **Improve recruitment and retention of staff.**

5.1 Establish an organisation-wide workforce plan.

5.2 Establish Echuca Regional Health as an employer of choice.

5.3 Establish Echuca Regional Health as a Centre of Excellence in education, professional development and training.

5.4 Establish a process and structure by which local Medical Practitioners will be an essential component of medical teaching.

5.5 Increase the number of indigenous employees at Echuca Regional Health to closely reflect the percentage of the population that they represent in the Echuca-Moama community.

6. **Provide efficient buildings, plant and equipment.**

6.1 Develop a new master plan.

6.2 Develop a plant and equipment upgrade and replacement program including budget projection.

6.3 Establish a facility for accommodation and education of tertiary health students.

7. **Promote environmentally responsible practices.**

7.1 Develop, implement and continually monitor a plan that reduces the organisation’s environmental impact.

8. **Provide efficient and effective Information, Communication and Technology (ICT).**

8.1 Provide information systems to improve the quality and safety of care.

8.2 Enhance information systems to improve the management and use of resources.

8.3 Ensure our people are equipped with appropriate ICT infrastructure and skills to carry out their roles effectively.
Appendix 3;
Echuca Regional Health - Organisational Chart
Nurse Practitioner proposed area of practice: Diabetes Management

Name of person completing the submission: Kim Turner
Position / Title: Project Officer
Phone number(s): 0437 461368
E-mail address: Start2FinishConsulting@hotmail.com
Date submitted: 10.11.08. Updated 16.12.08

1 BRIEF OVERVIEW OF THE PROPOSED MODEL

- Briefly describe the role of the Nurse Practitioner in the clinical setting, including the expansions/ extensions to practice that will be utilised. This will need to include an outline of the intended practice setting and the patient population.

Patient population; all existing & newly diagnosed diabetic clients over the age of 17y, within the geographic catchment area of Echuca Regional Health and in receipt of care as a public patient.

Exclusions; Clients under 17y will be directly referred to GV Health as per current arrangements. Private patients will receive care as per current arrangements.

Practice setting; primary care.

NP role; in collaboration with other relevant health practitioners and as part of an agreed diabetes management plan, to manage on-going care needs of people with diabetes; including education, diagnostic testing, results interpretation, initiation & maintenance of treatment/care plans, insulin adjustments, referral to other agencies/professionals. In addition, deliver staff education & training; undertake clinical audit & research provide clinical leadership in the field of diabetes nursing.

Expansion of Practice;
- Advanced clinical assessment of client
- Authorise diagnostic tests e.g. HBA1C
- Interpretation of results
- Initiation of appropriate actions & treatment/care plans, including insulin adjustment
- Prescribe medications
- Initiate direct referrals e.g. podiatrist, dietician
2 REASON FOR PROPOSING A NEW MODEL

- Describe the current service and its existing structure i.e. process of care, providers etc.
- Outline the current gaps in the service
- Describe from an individual and an organisational perspective why the model has been proposed.

Current Service; Diabetes Educator takes referrals from GPs and Hospital. Patients may self refer, but this is not common. All paediatric cases are referred to GV Health. Service provision is largely centred on client education, to enable better self management.

Gaps in Service;
- Not all newly diagnosed cases are referred to the Diabetes Educator and education program is not therefore always initiated promptly, or sometimes at all.
- Diabetes Educator is not currently able to authorise diagnostic tests, meaning patients have to make a further visit to their GP for authorisation of tests. A particular issue is the 3 monthly HBA1C test, which some patients are not routinely having done, resulting in inconsistent care management plans.
- Insulin adjustments can only be made by the Diabetes Educator after authorisation by the GP.
- It is necessary for patients to attend further visits with their GP in order to obtain referrals to some health practitioners.
- The current post holder is due to retire in approx 3 years and a succession plan is not yet in place.

Reason for proposal; Expansion of the current role and changes to the service plan, would enable;
- earlier access to education for newly diagnosed patients
- increased number of clients receiving 3 monthly HBA1C testing
- prompt referral to other agencies/health professionals
- prompt adjustment of insulin if required, without needing to obtain authorisation from GP
- prompt treatment of associated health problems
- collaborative & effective formal care/treatment plans
- reduced repeat attendances at GP clinics for authorisation of tests and referrals

3 AIM/OBJECTIVES

- Describe how the proposed change of implementing a Nurse Practitioner position will improve the delivery of service outcomes.

Redeveloping the Diabetes Educator role to that of Nurse Practitioner, would improve delivery of service outcomes, by;
- Contributing to Strategic Plan, items 1.4, 1.5, 1.6, 3.1, 3.2
- Improve knowledge & skills of nursing staff in acute service areas in relation to diabetes management
- Earlier collaborative treatment/care plans will help to minimise risk and complications for patients
- Ability to authorise diagnostic tests and act on results would help to manage health problems as they arise for the patient and minimise complications
- Ability to refer directly to other practitioners would ensure prompt assessment & treatment of arising health needs and minimise risks for patients
- Contribute to the wider health service by reducing repeat visits to GP for authorisation of tests of referrals
- Ability to offer education to all newly diagnosed diabetics would enhance their self care abilities and enable them to better manage their condition, reducing visits to GP and/or Emergency Dept and hospital admissions
- Assisting departmental succession planning
4 OUTCOMES

- State the expected outcomes of the new role.

The expected outcomes of the new role are:

- Increased number of newly diagnosed diabetics seen by Nurse Practitioner
- Increased number of patients who routinely have 3 monthly HBA1C test completed
- Increased number of patients with formal collaborative care/treatment plan in place
- Reduced number of repeat patient visits to GP for authorisation of tests and referrals
- Reduced delays in the service, whilst waiting for authorisation to adjust insulin if required
- Satisfaction with service provision expressly stated by consumers
- Increased number of self referrals to service
- Increased number of referrals from acute hospital services

5 PROJECTED FINANCIAL IMPACT OF THE NURSE PRACTITIONER SERVICE

- List the projected costs incurred with implementing this service e.g. wages, office equipment, and other operating costs.
- What benefit do you perceive this initiative will have compared with what currently exists e.g. Decreased length of stay, reduction on waiting times etc.

Costs:

1. Salary – NP candidate is paid substantive salary during candidacy period. Once endorsed, salary scale rises over 2 years, incurring an additional final cost of approx $8000 per annum per EFT, based on salary scale of current post holder (including on-costs and operational costs). It may be possible to off-set some salary costs during candidacy period, as candidates are likely to be on a lower yearly pay point that the current post holder.

2. Study leave – candidate may require 1 day per week for up to 3 years at a cost of approx $13,800 per annum based on salary scale of current post holder (including on-costs and operational costs). Whilst this cost is already included in the basic salary cost, it is non-patient contact time and would be the cost of backfilling the position to maintain continuity of service. Once endorsed, the NP will still require study leave in order to maintain endorsement, but this will be at a reduced level, possibly halved.

3. Clinical Supervision & mentorship – it may be necessary to pay for this service from appropriate health professionals. An estimated requirement of 4 hours per month for up to 3 years at a cost of $100 per hour, = $4800 per annum. This cost may be off-set by candidate obtaining a DHS NP Education Package.

4. Diagnostic tests – it is difficult to estimate how many tests might be ordered by the NP and what costs may be attributed to the hospital service as a result.

5. There will be individual costs for each NP candidate in relation to course fees. These currently range from $20,000 – $30,000 to complete the Master’s degree. This cost could be reduced by the candidate obtaining a Commonwealth or other scholarship.

- The estimated costs of developing and implementing a NP role is approx an additional $20,000 per annum per EFT, recurrent, over current service costs (not including course fees).

Benefits:

- Cost benefits will not be directly attributable to the Primary Care department and are more likely to be reflected in the potential savings of other areas of the public health service e.g. reduced repeat visits to GP and reduced hospital admissions due to improved self care.
- Improved liaison and coordination of care with community service providers, especially General Practitioners
- More efficient health care delivery: prevention of hospital admission, more timely provision of health care, improved co-ordination of patient care, improved access to health services etc
- Increased opportunities for interdisciplinary collaboration to improve client outcomes and service delivery
- Increased emphasis on the implementation of evidence based practice through the development of NP clinical practice guidelines
- There are qualitative benefits in relation to retention of staff, professional development opportunities, internal promotion opportunities, recruitment of new staff and succession planning.
6 POTENTIAL NURSE PRACTITIONER CANDIDATES

- Are you aware of any current nursing staff suitably qualified and interested in such a role?
- What timeframe do you think is appropriate for your proposal? E.g. 2-3 y, 3-5 y

Potential Candidates; 2 staff have recently undertaken the diabetes educator course and could be further developed and encouraged to undertake a NP candidacy. One nurse is particularly interested, but in the longer term, due to study commitments.

Clinical Supervision/Mentorship; GV Health has Diabetes Nurse Practitioner position in place and has, in principle, agreed to support future development of role at ERH by sharing Clinical Practice Guidelines, providing clinical supervision & mentorship and placement with Nurse Practitioner at GVH. The current Diabetes Educator is a huge resource and could contribute significantly to the NP Candidate education program. In addition, Dr Esther Brigante, Endocrinologist, has also agreed in principle to contribute to an education program, if suitable, mutually agreeable timetabling and remuneration can be confirmed.

Timeframe;

- Introduction of advanced practice e.g. pathology tests & insulin adjustments, could be implemented within 6 months
- Preparation for NP candidate position, involving organisational adjustments to governance structures, 6-9 months
- NP Candidate in place, may be dependent on whether candidate position can be funded prior to retirement of current post holder, 18-24 months
- Endorsed practitioner in post, depending on educational status of NP candidate, 4-5 years.
Appendix 5;
Position Description Nurse Practitioner Candidate (Generic)

DESIGNATION: NURSE PRACTITIONER CANDIDATE
REPORTS TO: UNIT/DEPT MANAGER
DATE: XXXX

Purpose of Position

- Within an action research framework to trial and define the role of Nurse Practitioner in Echuca Regional Health (ERH) XXXX Department.
- To work towards attaining Nurse Practitioner status by meeting the Nurses Board Victoria endorsement requirements.

Key Activities

1. Specific Responsibilities

- To provide care to a selected group of patients within a framework of approved clinical practice, Clinical Practice Guidelines, Education Framework, ERH policies and procedures, in collaboration with relevant medical staff and the Nurses Board of Victoria Scope of Practice Guidelines and the Australian Nursing & Midwifery Council Nurse Practitioner Competency Standards.
- To collaborate with other like services to develop evidence based clinical practice guidelines and medication formulary to enable implementation of the extended role.
- To work collaboratively with the nursing management and education teams to:
  - define the role of the Nurse Practitioner in the XXXX Department
  - utilise change management strategies to integrate the extended roles of nursing practice in the XXXX Department
  - communicate with and engage key stakeholders in the process of integrating the new nursing role
  - participate in relevant internal and external committees and working parties
  - assist with evaluation of the new role
- To collaborate with other health services to develop evidence based clinical practice guidelines and medication formulary to implement the extended role.

- Establish effective, collaborative and professional relationships with patients, members of the multidisciplinary team and other stakeholders to ensure an integrated approach to patient care across the continuum of care
- Actively promote the Nurse Practitioner role by participation in professional forums, publication in peer reviewed journals and presentation at local, national and international conferences.
2. Organisational Responsibilities

- To practice within the Purpose and Guiding Principles of ERH
- Act in accordance with all relevant external legislation & internal ERH requirements that relate to this position and the organisation
- Participate in team/departmental meetings and other organisational meetings as required
- Participate in staff development and training as required
- Maintain accurate records, statistics and reports as needed
- Participate in service development as required
- Act as a clinical leader and role model
- Act as an advocate for staff and peers, supporting and encouraging them to take responsibility for the care they provide

Position prerequisites

Essential

- Current registration with the Nurses Board of Victoria as a RN Division 1
- Working towards Masters of Nurse Practitioner or equivalent (including a mandatory Therapeutic Medication Management Module)
- 3-5 years clinical experience post specialist qualification and evidence of working at a level of advanced practice in the nursing field in which endorsement is to be sought
- Commitment to apply to the NBV for endorsement as Nurse Practitioner in the relevant nursing field
- Demonstrated knowledge of Nurse Practitioner professional standards, legal and ethical requirements
- Well developed clinical, analytical and problem solving skills
- Proven commitment to the development of learning, teaching and research orientated work environment
- Demonstrated ability to exercise judgment, discretion and decision making in the clinical area
- Excellent communication and interpersonal skills, including the ability to develop networks and work collaboratively
- Current Advanced Life Support competency
- Satisfactory Police Check and Working with Children Check (as necessary)

Desirable

- Graduate Diploma (or equivalent) in nursing specialty
- Medium to High level IT skills in Outlook, Microsoft word and Excel
- Eligible for membership in the Australian Nurse Practitioner Association (or equivalent)

Award

- In accordance with the Nurses (Victorian Health Services) Award, 2008.
- Substantive salary payable
**Hours**

- A minimum of 24 hours per week.

**Performance Appraisal**

- After the three (3) month probationary period
- Annually thereafter, unless required earlier as part of the individual learning and development plan

**Occupational Health & Safety**

Each employee has the right to a safe working environment and s/he should advise the supervisor of any risk or condition likely to result in accident or injury. Each employee has the responsibility to take reasonable care of their own health and safety and to cooperate with the ERH OH&S policies and to participate in appropriate safety education and evaluation activities.

**Infection Control**

Each employee has a responsibility to minimise exposure to incidents of infection/cross infection of residents, staff, visitors and the general public. This minimisation can be most effectively achieved by all staff adhering to the policies and procedures as set out in ERH Infection Control Manuals.

**Disaster or Emergency Responsibility**

Echuca Regional Health is the principal regional health provider in the event of disaster and emergency. The occupant of this position understands and acknowledges that he/she may be required to work as assigned if requested to meet the ERH responsibilities in a disaster or emergency situation.

**Quality Improvement**

Each employee has a responsibility to participate and commit to ongoing quality improvement activities using the EQuIP (Evaluation and Quality Improvement Programme) model.

**Workplace Harassment & Bullying**

Echuca Regional Health adopts and applies the Victorian State Government Code of Conduct. Each employee has the right to a work environment free from any form of workplace harassment and bullying. From an employee’s orientation and throughout their employment, each employee must apply ERH policy and participate in education and training.

**ERH Policies & Procedures**

Echuca Regional Health policies and procedures are fully set out in the ERH clinical and corporate policy manuals located on the ERH intranet. It is the responsibility of each employee to familiarise themselves with these policies.
Health Promotion

Echuca Regional Health adopts the principles of health promotion and encourages all employees to embrace the organisation’s health promotion plan and activities. In the performance of their role, each employee has a responsibility to support health promotion principles and practice in general and to participate in any health promotion programs run by their unit/department.

Confidentiality Policy

Each employee has a responsibility to comply with the ERH Confidentiality Policy as it is a condition of employment. Any breach of the Confidentiality Policy will result in disciplinary action and/or dismissal and a possible fine under the conditions of the Health Services Act (Vic).

Key Selection Criteria

KSC1 Demonstrated ability to conceptualise a Nurse Practitioner role that is patient centred and within a nursing model of practice

KSC2 Demonstrated high level skills and experience in the relevant nursing field (minimum 3 years)

KSC3 An understanding of and sensitivity to the political dimension of the Nurse Practitioner role and an ability to promote the role in a positive manner

KSC4 Ability to meet deadlines, schedules, set goals/objectives as required

KSC5 Sound appreciation of the key concepts of advanced nursing practice and change management

KSC6 Tertiary qualifications in specialty nursing field including;
- Post Graduate certificate/diploma in speciality nursing field
- A clinically relevant Masters level qualification (or working towards or willing to enrol on course)
- Therapeutic medication management module (or working towards or willing to enrol on course)

KSC7 Ability to collect data and write reports

KSC8 Excellent interpersonal and communication skills

KSC9 Ability to operate in an environment of change

KSC10 Ability to work as part of a team as well as independently and autonomously

Authorised by ________________________________
(Executive Director)

Date Reviewed _______________________________

Adapted from position descriptions of;
Bendigo Health Care Group
Kyabram & District Health Services
Goulburn Valley Health

Dec 2008
Appendix 6;
Position Description Nurse Practitioner (Generic)

DESIGNATION: NURSE PRACTITIONER (insert field of endorsement)
REPORTS TO: UNIT/DEPT MANAGER
DATE: XXXX

Purpose of Position

- To deliver patient care in an extended scope of practice, including:
  - assessment and management of clients using nursing knowledge and skills
  - the direct referral of patients to other health care professionals
  - prescribing medications
  - ordering diagnostic investigations
  - collaborative partnerships with other health care workers and organisations

Key Activities

1. Specific Responsibilities

- To provide care to a defined group of patients within a framework of approved clinical practice, in collaboration with relevant medical staff, within ERH policies, procedures, Clinical Practice Guidelines, Nurses Board of Victoria Scope of Practice Guidelines and Australian Nursing & Midwifery Competency Standards for Nurse Practitioners.
- Prescribe medications and other treatments within the specified scope of practice.
- Initiate and interpret diagnostic and radiological tests specific to the scope of practice.
- From within the specified scope of practice refer patients to other health professionals as necessary.
- Evaluate the effectiveness of the client’s response to the clinical case management and take appropriate action.
- To collaborate with other health services to maintain evidence based clinical practice guidelines and medication formulary to facilitate the extended role and continue to develop and expand the role of Nurse Practitioner in the clinical area of expertise.
- Act as a positive role model and provide expert nursing knowledge to the multidisciplinary team and be accountable and responsible for advanced levels of decision-making.
- Establish effective, collaborative and professional relationships with patients, members of the multidisciplinary team and other stakeholders to ensure an integrated approach to patient care across the continuum of care.
- Actively promote the Nurse Practitioner role by participation in professional forums, publication in peer reviewed journals and presentation at local, national and international conferences.
- Provide education services in the specified clinical discipline including acting as clinical supervisor / mentor for Nurse Practitioner Candidates.
- Undertake research and development and continuous improvement activities to meet specified clinical nursing needs.
2. **Organisational Responsibilities**

- To practice within the Purpose and Guiding Principles of ERH
- Act in accordance with all relevant external legislation & internal ERH requirements that relate to this position and the organisation
- Participate in team/departmental meetings and other organisational meetings as required
- Participate in staff development and training as required
- Maintain accurate records, statistics and reports as needed
- Participate in service development as required
- Act as a clinical leader and role model
- Act as an advocate for staff and peers, supporting and encouraging them to take responsibility for the care they provide

**Position prerequisites**

**Essential**

- Current registration with the Nurses Board of Victoria as a RN Division 1 and endorsement as a Nurse Practitioner
- Masters of Nurse Practitioner or equivalent (including a mandatory Therapeutic Medication Management Module)
- Demonstrated knowledge of Nurse Practitioner professional standards, legal and ethical requirements
- Well developed clinical, analytical and problem solving skills
- Proven commitment to the development of learning, teaching and research orientated work environment
- Demonstrated competence in exercising judgment, discretion and decision making in the clinical area
- Excellent communication and interpersonal skills, including the ability to develop networks and work collaboratively
- Current Advanced Life Support competency
- Satisfactory Police Check and Working with Children Check (as necessary)

**Desirable**

- Graduate Diploma (or equivalent) in nursing specialty
- Medium to High level IT skills in Outlook, Microsoft word and Excel
- Eligible for membership in the Australian Nurse Practitioner Association (or equivalent)
- TAA40104 Cert IV in Training and Assessment

**Award**

- In accordance with the Nurses (Victorian Health Services) Award 2008
- Registered Nurse Grade 6

*Echuca Regional Health – VNPP, Phase 4, Round 4.1 – Final Report Feb 2009*
**Hours**

- XX hours per week as negotiated.

**Performance Appraisal**

- After the three (3) month probationary period
- Annually thereafter, unless required earlier

**Occupational Health & Safety**

Each employee has the right to a safe working environment and s/he should advise the supervisor of any risk or condition likely to result in accident or injury. Each employee has the responsibility to take reasonable care of their own health and safety and to cooperate with the ERH OH&S policies and to participate in appropriate safety education and evaluation activities.

**Infection Control**

Each employee has a responsibility to minimise exposure to incidents of infection/cross infection of residents, staff, visitors and the general public. This minimisation can be most effectively achieved by all staff adhering to the policies and procedures as set out in ERH Infection Control Manuals.

**Disaster or Emergency Responsibility**

Echuca Regional Health is the principal regional health provider in the event of disaster and emergency. The occupant of this position understands and acknowledges that he/she may be required to work as assigned if requested to meet the ERH responsibilities in a disaster or emergency situation.

**Quality Improvement**

Each employee has a responsibility to participate and commit to ongoing quality improvement activities using the EQuIP (Evaluation and Quality Improvement Programme) model.

**Workplace Harassment & Bullying**

Echuca Regional Health adopts and applies the Victorian State Government Code of Conduct. Each employee has the right to a work environment free from any form of workplace harassment and bullying. From an employee’s orientation and throughout their employment, each employee must apply ERH policy and participate in education and training.

**ERH Policies & Procedures**

Echuca Regional Health policies and procedures are fully set out in the ERH clinical and corporate policy manuals located on the ERH intranet. It is the responsibility of each employee to familiarise themselves with these policies.
Health Promotion

Echuca Regional Health adopts the principles of health promotion and encourages all employees to embrace the organisation’s health promotion plan and activities. In the performance of their role, each employee has a responsibility to support health promotion principles and practice in general and to participate in any health promotion programs run by their unit/department.

Confidentiality Policy

Each employee has a responsibility to comply with the ERH Confidentiality Policy as it is a condition of employment. Any breach of the Confidentiality Policy will result in disciplinary action and/or dismissal and a possible fine under the conditions of the Health Services Act (Vic).

Key Selection Criteria

KSC1 Demonstrated ability to practice within a Nurse Practitioner role that is patient centred and within a nursing model of practice

KSC2 Demonstrated high level skills and experience in the relevant nursing field

KSC3 An understanding of and sensitivity to the political dimension of the Nurse Practitioner role and an ability to promote the role in a positive manner

KSC4 Ability to meet deadlines, schedules, set goals/objectives as required

KSC5 Sound appreciation of the key concepts of research and change management

KSC6 Tertiary qualifications in specialty nursing field including;
- A clinically relevant Masters level qualification
- Completed the therapeutic medication management module
- TAA40104 Cert IV in Training and Assessment or equivalent (or willing to undertake)

KSC7 Evidence of experience in collection of data and report writing

KSC8 Excellent interpersonal and communication skills with all levels within the organisation

KSC9 Ability to operate in an environment of change

KSC10 Ability to work as part of a team as well as independently and autonomously

Authorised by ________________________________

(Executive Director)

Date Reviewed _______________________________

Adapted from position descriptions of;
Bendigo Health Care Group
Kyabram & District Health Services
Goulburn Valley Health

Dec 2008
**Appendix 7;**

**Common Abbreviations**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ANF</td>
<td>Australian Nursing Federation</td>
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<tr>
<td>ANMC</td>
<td>Australian Nursing &amp; Midwifery Council</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
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<tr>
<td>CPGs</td>
<td>Clinical Practice Guidelines</td>
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<tr>
<td>DHS</td>
<td>Department of Human Services</td>
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<tr>
<td>DOCS</td>
<td>Director of Clinical Services</td>
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<tr>
<td>EOI</td>
<td>Expression of Interest</td>
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<tr>
<td>ERH</td>
<td>Echuca Regional Health</td>
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<tr>
<td>EDoN</td>
<td>Executive Director of Nursing</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>HARP</td>
<td>Hospital Admissions Risk Program</td>
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<tr>
<td>IMG</td>
<td>International Medical Graduates</td>
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<tr>
<td>KPIs</td>
<td>Key Performance Indicators</td>
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<tr>
<td>MPDGP</td>
<td>Murray Plains Division of General Practice</td>
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<tr>
<td>MBS</td>
<td>Medical Benefits Scheme</td>
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<tr>
<td>NBV</td>
<td>Nurses Board Victoria</td>
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<tr>
<td>NP</td>
<td>Nurse Practitioner</td>
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<td>NPC</td>
<td>Nurse Practitioner Candidate</td>
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<td>NUM</td>
<td>Nurse Unit Manager</td>
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<tr>
<td>PBS</td>
<td>Pharmaceutical Benefits Scheme</td>
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<td>PD</td>
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<tr>
<td>RCNA</td>
<td>Royal College of Nursing Australia</td>
</tr>
<tr>
<td>TOR</td>
<td>Terms of Reference</td>
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<td>TCP</td>
<td>Transitional care Program</td>
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<tr>
<td>VNPP</td>
<td>Victorian Nurse Practitioner Project</td>
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## Service Provider Details

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<thead>
<tr>
<th>Name of Service provider</th>
<th>Echuca Regional Health</th>
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<tbody>
<tr>
<td><strong>Address</strong></td>
<td>9 - 27 Francis Street, Echuca, Victoria, 3564</td>
</tr>
<tr>
<td><strong>Contact Name</strong></td>
<td>June Dyson</td>
</tr>
<tr>
<td><strong>Position</strong></td>
<td>Executive Director of Nursing</td>
</tr>
<tr>
<td><strong>Telephone</strong></td>
<td>03 5485 5038</td>
</tr>
<tr>
<td><strong>Email</strong></td>
<td><a href="mailto:jdyson@erh.org.au">jdyson@erh.org.au</a></td>
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### Report endorsed by:

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<tr>
<td><strong>Name</strong></td>
<td>Michael Delahunty</td>
</tr>
<tr>
<td><strong>Position</strong></td>
<td>Chief Executive Officer</td>
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<tr>
<td><strong>Date</strong></td>
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### Report Prepared by:

<table>
<thead>
<tr>
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<th>Start2Finish Consulting</th>
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<tbody>
<tr>
<td><strong>Name</strong></td>
<td>Kim Turner</td>
</tr>
<tr>
<td><strong>Telephone</strong></td>
<td>0437 461368</td>
</tr>
<tr>
<td><strong>Email</strong></td>
<td><a href="mailto:Start2FinishConsulting@hotmail.com">Start2FinishConsulting@hotmail.com</a></td>
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