Victorian Nurse Practitioner Project

Phase 4 Round 4.1

Rural Health Services

Wimmera Health Care Group Nurse Practitioner Service Planning

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ACRONYMS

CPGs	Clinical Practice Guidelines
DHS	Department of Human Services
GP	General Practitioner
GPS	Grampians Psychiatric Services
LGA	Local Government Area
MBS	Medical Benefit Scheme
MH NP	Mental Health Nurse Practitioner
NP	Nurse Practitioner
NPC	Nurse Practitioner Candidate
NBV	Nurses Board of Victoria
PBS	Pharmaceutical Benefits Scheme
RN	Registered Nurse
VNPP	Victorian Nurse Practitioner Projects
WHCG	Wimmera Health Care Group

ACKNOWLEDGEMENTS

Wimmera Health Care Group Nurse Practitioner project team gratefully acknowledge the following people and organisations for their support and collaboration:

The Board and staff of WHCG

Professional bodies including West Vic Division of GPs and executive staff from health care groups in this region for their collaboration

Northeast Health Wangaratta: Special thanks to Helen Haines and the Mental Health Nurse Practitioner Candidates.

VNPP round 4 reports published on the DHS site

DHS Nurse Policy Branch, the Nurse Practitioner Collaborative and the Nurse Board of Victoria

EXECUTIVE SUMMARY

The Nurse Practitioner (NP) project for rural health services has been a significant opportunity for Wimmera Health Care Group to re-think models of care, scopes of practice and funding models to address issues related to the care of clients/ patients with mental health issues and concerns. The concern around lack of access to care for people with mental health issues has been a long standing and very public issue in this community. Less public but none the less significant, has been the associated risks for this organisation as it has no gazetted mental health inpatient beds - and therefore limited capacity to manage mental health clients in crisis particularly out of office hours.

Whilst NP projects have been rolling out across Victoria for a number of years, there is a dearth of awareness by the nursing profession, particularly in western Victoria, where this project took place. Given this starting point, much of the project revolved around raising levels of understanding about the role and how the role could enhance the health care services for this community.

This project focused on describing the new role and shaping a model of practice that address the identified gaps but also a model shaped to work in the context of this rural city community. Undertaking the project has also provided an impetus for change and provides nurses with an opportunity to consider an extended clinical career path. It also provides them with the opportunity to develop and shape a model of care to areas of need in their community such as mental health care; and to start planning for this professional model.

A major barrier to implementation of a nurse practitioner model to the organisation is the absence of an existing service to substitute and the inflexible nature of funding streams to the existing WHCG programs that would receive most benefit from this type of expertise.

WHCG Board and Executive are committed to the introduction of NP models. The next step will be to recruit a candidate with the required knowledge and skills to address the identified areas of need and to work with the candidate and to work with stakeholders to develop organisational procedures and policies to support the expansions to practice.

PROJECT ISSUES

This project was undertaken in conjunction with the Rural Northwest Health Nurse Practitioner Project. The project officer was originally recruited for the WHCG and after commencing that project, was engaged to undertake the RNH project as well. The early thinking was these projects would be similar, however it became evident that even though the physical distance is approximately 60 kilometres, the demographics and role of these health care groups varies considerably.

Prior to the commencement of this project, issues had long been identified around timely access to appropriate mental health services for this community. In reference to WHCG however, it had not been possible to address this identified need primarily because the organisation is not funded to provide psychiatric inpatient services: In this region, Grampians Psychiatric Service is the funded provider and the nearest gazetted inpatient beds are located in Ballarat 200 kms away. As has been noted in this report, WHCG "…is not an approved mental health service and does not have the resources [trained mental health workers and physical layout]…" WHCG and GPS are co-located,

however they have separate Boards of Governance, accountabilities and roles. In identifying mental health services as the area for NP prioritisation, it has not been possible within the scope of this project to plan how this position would be resourced, nor to directly address the significant level of collaboration required between these organisations to make this position functional.

A very low level of awareness and understanding about the NP role in the health care services and the general community resulted in a great deal of the project time spent on working with stakeholders, formally and informally, through out the project duration. We believed it was important that stakeholders grasped how the NP role would function in their community and that it's purpose is to fill gaps improve access and compliment existing health services rather than compete with them. It is this level of engagement and understanding that underpins organisational change and the potential success of this project.

UNDERSTANDING LOCAL DEMAND AND OPPORTUNITIES

Introduction to Wimmera Health Care Group

Wimmera Health Care Group (WHCG), based in the Local Government Area of Horsham Rural City has campuses in Horsham and Dimboola. Located with in the Victorian Government Department of Human Services region of Grampians, WHCG services the Local Government Areas (LGAs) of Horsham Rural City and the sub region of the Wimmera incorporating the shires of Hindmarsh, West Wimmera and Yarriambiack. Covering 21,000 square kilometres this sub region has a population of around 36,314 persons, with dry-land broad acre farming the predominate industry. The population is predominately Anglo-Saxon and Australian born and includes a small indigenous population of 1.2% (ABS, 2006).

Located 3.5 hours drive and 360 kms northwest of Melbourne, the rural city of Horsham with a population of 13,000 people, is the central hub of the Wimmera region as the main provider of retail, community and government services. Horsham's, Wimmera Health Care Group is the major health service provider for the Wimmera region. The principal campus located in Horsham has a range of services including inpatient care (80 registered acute beds), ambulatory care, residential care (70 nursing homes beds and 36 hostel beds), community, allied and health promotion programs. The Dimboola campus provides an integrated 30-bed facility, comprising acute, low and high care aged residential accommodation and a range of community, allied and health promotion services.

Demographic profile of this community

Horsham Rural City LGA: In the 2006 Census there were 18,492 persons usually resident in Horsham Rural City (RC): The median age was 39 years compared with 37 years for persons in Australia with 17% of the population aged 65 years and over compared to the Victorian state average of 12.6%.

Hindmarsh LGA: In the 2006 Census, there were 6,039 persons usually resident in Hindmarsh: The median age was 39 years, compared with 37 years for persons in Australia and 23% were persons aged 65 years and over compared to the Victorian state average of 12.6%.

West Wimmera LGA: In the 2006 Census, there were 4,260 persons usually resident in West Wimmera: The median age was 43 years, compared with 37 years for persons in Australia and 21% were persons aged 65 years and over compared to the Victorian state average of 12.6%.

Yarriambiack LGA: In the 2006 Census, there were 7,522 persons usually resident in Yarriambiack: The median age was 45 years, compared with 37 years for persons in Australia and 23% were persons aged 65 years and over compared to the Victorian state average of 12.6%.

In summary, this sub-regions population is aging with the median age of persons in the Wimmera being 43 years compared with 37 years for persons in Australia. Overall, 16.75% of the Wimmera's population is over 65 years of age, compared to the state average of 12.6%. Projections reveal that by 2016 the LGA's of Hindmarsh, West Wimmera and Yarriambiack will each have between 40-51% of their population aged 70 or more, whilst Horsham RC's projection is 10-20% (ABS, 2004 cited in DHS, 2005).

Of further note is the difference within this region: While Horsham RC's population grows, Yarriambiack and West Wimmera have the largest population declines for the state and have among the highest percentages of aging population. Population projections are significant as the age structure of the population changes much of what we now take for granted. For example, by 2016 with approximately 30-40% of the Wimmera's population over 65, 30-40% of the population will be retired and identify as having at least one chronic illness. Income patterns, production and the available workforce will change with a lesser proportion of the population employed.

Health status of this community

Australia's Health 2008 provides the following national information:

> Of the total burden of disease, 2003 data revealed cancers were the leading contributor (19% of total Disability Adjusted Life Years), followed by cardiovascular disease (17% of Disability Adjusted Life Years), mental disorders neurological and sense disorders (13% of Disability Adjusted Life Years) and chronic respiratory diseases (7%). For cancer and cardiovascular disease, the majority of Disability Adjusted Life Years were due to deaths, where as Years Lived with a Disability was more important for mental disorders and neurological and sensory disorders.
>
> Mental disorders were the leading contributors to the non-fatal component of the disease burden (Years Lost due to Disability) accounting for 24% of the non-fatal burden of disease in Australia in 2003. Neurological and sense disorders were responsible for another 19% of Years Lost due to Disability. This latter category was dominated by dementia and hearing loss.

Your health: A report on the health of Victorians (DHS, 2005) notes the Wimmera region Burden of Disease has cardio vascular disease, cancers and injuries accounting for 73% of total mortality burden. In line with national findings, mental disorders and neurological conditions contributed most to the non fatal burden and were the 3rd leading cause of ill health in Victoria after cancer and cardio vascular disease.

Wimmera Ambulatory Care Sensitive Conditions (hospital admissions that could have been avoided through primary health care) revealed that Diabetes complications were the leading cause of admissions in 2003-4, followed by dental disease, angina, dehydration, gastro-enteritis and COPD.

Service profile

Wimmera Health Care Group is the major specialist referral centre, providing emergency and critical care services for the region. The Horsham campus is the major sub regional referral centre for obstetrics, and acute specialist medical and surgical services. The hospital plays an important role in education and training and provides clinical training and experience for students and recently graduated doctors, nurses and allied health professionals.

Inpatient and Outpatient service programs include obstetrics, peri natal care, paediatrics, general medicine, general surgery, emergency and anaesthetics. Clinical services include intensive/coronary care, dialysis and chemotherapy units.

Residential Care programs include low care hostel accommodation and high care nursing home accommodation for frail aged including many people with senile dementia as well as people requiring respite care and slow stream rehabilitation.

Home Care programs supports aged and disabled persons and those living with a terminal illness to live at home through the provision of support and maintenance services. Programs included District Nursing, Hospice Care Services, chronic disease management, respite care, aged care assessment as well as community aged care services.

Community Health and Health Promotion Programs involve community intervention and community support programs such as the Continence Advisory Service, Family Planning Clinic and community health nurses.

In 2007/08 Wimmera Health Care Group treated over 10,300 inpatients, 16,113 emergency patients and provided in excess of 123,000 outpatient services (WHCG Annual Report, 2007-2008)

Data 2007-2008

Average Patient Age: 53.5

Top 10 Admissions by DRG code:

Admit for dialysis
Chemotherapy
Dental extraction and restoration
Neonatal admission >2499
Other colonoscopy same day
Other factors influencing health status SD
Lens procedures SD
Vaginal delivery
Gastroscopy SD
Other skin subcutaneous and breast procedure

In this 12 month period, Chemotherapy episodes rose from 657 to 1017, an increase of 360 episodes; and admit for renal dialysis increased from 926 to 1011, an increase of 85 episodes.

Top 10 presentations: Emergency Department

Results only
Viral infection
Removal of orthopaedic device or change of plaster

Abdominal / Flank pain/cramps / Intestinal Colic
Issue of repeat script
Attention to or removal of surgical dressings
Attendance for follow-up (includes injections)
Muscle and musculoskeletal pain / Myalgia
Aftercare following surgery

Workforce

Nurses in Victoria: A Supply and Demand Analysis 2003–04 to 2011–12 documents characteristics of the existing nursing workforce, workforce trends, and projections of supply and demand, noting;

> The Victorian nursing workforce is predominately female, ageing, work part time, and are highly mobile. The average age increased from 38.6 yrs in 1995-6 to 41.2 years in 2002-3 - an increase of .4 years per year. Projections estimate ageing of the workforce will continue. Projections = 43.6 by 2008.

Reports in general consistently reveal that the demand for health workforce services will continue to escalate due to external influences such as changing demographics, an ageing population, growing community expectations and developing technology. Concurrently, studies reveal that the nursing workforce and more broadly the health workforce will continue to become more constricted, resulting in increasing shortages of health professionals to meet demands.

WHCG generally maintains a full compliment of registered nurses with a strong spread of skills and experience. Currently there are two physician positions vacant along side a number of vacancies for allied health staff. Other areas of shortage were securing medical locum coverage of registrars holiday leave for emergency and obstetrics. (Junior doctors and registrars come on rotation from RMH so the staffing of junior doctors is not an issue; in fact, this was seen as a positive as these rotations provide a constant supply as well as training and experience for junior medical staff).

Overall, WHCG has difficulty with recruitment and retention of an appropriately skilled medical specialist and allied health workforce: a workforce shortage that will be exacerbated as the demand for healthcare workers is predicted to rise. The report Australia's Health Workforce notes the skills of many health workers are not being used to full advantage, largely "…because of various systematic impediments that prevent competencies being fully developed, assessed, recognised and utilised." The commission urged efficient and effective utilisation of the existing scarce workforce resource based on the guiding principle that "… services should be delivered by staff with the most cost effective training and qualification to provide safe quality care" (Productivity Commission, 2005, p.14).

Undertaking this Victorian Nurse Practitioner Project provided the organisation with the opportunity to identify gaps in the provision of services to their community; and to consider expanding the scope of practice of a highly skilled and experienced RN to address the gap.

> A Nurse Practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The Nurse Practitioner role includes assessment and management of clients using Nursing knowledge and skills and may include but is not limited to, the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations. The Nurse Practitioner role is grounded in the nursing profession's values, knowledge,

theories and practise and provides innovative and flexible health care delivery that complements other health care providers (Australian Nursing & Midwifery Council, 2006).

Gap Analysis

A review of WHCG strategic plan and Role and Function Statement (2007) identified areas of growth and/or unmet demand: -

Paediatrics: A Base Hospital should provide a specialist paediatric service although low numbers of paediatric admissions make this task difficult.

Emergency Department: Is classified as a Regional Trauma Centre. It is expected that patient numbers will continue to increase, raising the possibility of attracting a part-time Emergency specialist.

Hospital in the Home and Home care services: With increasing pressure on the number of available acute beds it is envisaged that the Hospital in the Home program will continue to expand.

Community Health: There will be increasing focus on and demand for rehabilitation, care management such as Community Rehabilitation programs and chronic disease self-management programs.

Psychiatric Care: The existence of a Community Psychiatric Service in the Wimmera has opened up a large area of previously unmet demand. The Health Care Group is committed to expanding psychiatric services as far as practicable to enable the management and care of clients with moderate psychiatric conditions and avoid the need for such patients to be transferred out of the Wimmera for inpatient services.

The identified areas of growth were in emergency, hospital in the home, community health and psychiatric care.

Projections of growth are due in part to:

1. changing community demographics, in particular, the aging population;
2. morbidity and mortality patterns such as the increasing incidence of certain diseases within the population generally and more specifically, within the Wimmera population (related to ACSC's, Burden of disease, WHCG statistics - profile and projections); and
3. changing government policy with a shift in focus from individuals being treated with disease, to re-orientation of health care to maintaining healthy populations, improved management of chronic illness and keeping people in their homes.

Organisational unmet need and risk

The strategic plan identified psychiatric care as an area of unmet need in the community while clinical risk audits identified a significant area of risk related to the care of patients presenting and being cared for with mental health issues. The issues noted in these clinical risk audits are predominately, though not exclusively, related to the emergency department.

Three issues related to patients with mental illness were identified in audits undertaken by the WHCG Clinical Risk Manager:

1. A risk to patients. "This organisation is not an approved mental health service; it does not have the resources [trained mental health workers and physical layout] to care for

recommended psychiatric patients…”. This lack of resources increases the risk of self-harm by recommended psychiatric patients in the care of Wimmera Health Care Group.”

2. A risk to staff. “A number of recommended psychiatric patients are extremely aggressive in their behaviour and provide an occupational health and safety risk to our staff.”
3. “Long delays in transferring recommended psychiatric patients to an approved mental health service by Ambulance Victoria increases these risks for Wimmera Health Care Group”.

The strategic plan also noted:

- The existence of a Community Psychiatric Service in the Wimmera has opened up a large area of previously unmet demand.
- The Health Care Group is committed to expanding psychiatric services as far as practicable to enable the management and care of clients with moderate psychiatric conditions and avoid the need for such patients to be transferred out of the Wimmera for inpatient services.

Other risks identified included:

- The inability of staff to deal appropriately with patients experiencing mental health issues and psychiatric illness. This expressed concern includes patients who are recommended but is broader, including patients who present and/or are admitted with varying diagnosis related to mental illness or aggressive behaviour. Inability may be related to various factors including: inadequate staffing, lack of knowledge, lack of specific procedures, lack of specific infrastructure i.e. ‘safe room’.

Local Opportunities

The background leading to WHCG exploring NP roles evolved from opportunities raised by DHS to support the development of a comprehensive service plan for the strategic and sustainable deployment of NPs at WHCG. The needs analysis provided the opportunity to consider and develop innovative models of practice that take full advantage and enhance the skills and competencies of the existing health workers to meet the needs of this community. The potential of a NP role to address each need/gap was considered by exploring the following:

- Does the area identified have the potential to change to a NP model: I.e. is it substantive in terms of there being adequate work to make a position economically and professionally sustainable?
- Would the community benefit from the role of a NP?
- Would there need to be an extension of the nurses’ role to address the gap or is there scope for extended practice to provide enhanced outcomes?
- Would a NP model potentially complement / build on existing services, build / extend service capacity, address service gaps at local level?

Those identified issues that could be addressed through changed service provision, such as a Nurse Practitioner model were:

- Mental health care and risk to mental health clients: Care of persons with mental health issues presenting to emergency and those admitted to Oxley ward.

- Emergency department: Increasing presentations specifically in category 4 & 5.
- Aged care: The need to tailor services to meet the needs of an aged population and the need to have access to specialised knowledge for caring for the aged.
- And the shift in focus to maintaining healthy populations, improved management of chronic illness, and keeping people in their homes. This shift provides opportunities for rural health care services to proactively re think models of care and service provision.

SHAPING THE SERVICE MODEL FOR NPS

Prioritising Nurse Practitioner development

Prioritisation of the potential areas for NP service development identified from an in-depth understanding of the local demographics, service profile, risks and opportunities were: 1) mental health 2) aged care 3) emergency and 4) primary care-chronic disease management.

Other potential opportunities were models such as palliative care, midwifery, sexual health, rural remote, continence management, diabetic management and community health-chronic disease management, arising from staff currently working in speciality areas/ undertaking masters level qualifications who expressed interest in the NP role.

What is the gap?

Given the clinical risk audits, statements in the strategic plan, and public concern surrounding care for persons presenting with mental health [illness], this area was of the highest consideration by the Nurse Practitioner Working Party.

Currently there are no specific services or appropriate professional infrastructure for clients presenting to the WHCG emergency department with a mental health illness or mental health issues such as anxiety. However, as a sub regional health care facility there were 16,000 presentations to the ED in 07-08. Of these, 397 were coded as having a primary diagnosis of mental health disorder and a further 33 were coded as presenting with a secondary diagnosis of mental health issues. In addition, some patients with a less serious mental illness were admitted to have medications titrated or modified. Further, due to the incidence of mental disorders and the incidence of co-morbidities between mental illness and other diseases such as heart disease and diabetes in the general population, it is reasonable to surmise that many patients admitted for medical or surgical reasons have co-existing mental health issues.

The burden of disease studies reveal the incidence of mental disorders, with mental illness estimated to be responsible for 13% of the total burden of disease in Australia, placing it third as a broad disease group after cancers and cardiovascular disease; and accounting for almost one-quarter (24%) of the total disability burden for all diseases (AIHW, 2008). The report Australia’s health 2008 also highlights the frequency and significance of co-morbidity involving more than one mental illness, or at least one mental illness and one or more physical illnesses; and evidence alluding to a direct causal link between mental illnesses and physical ill health. Beyond Blue note that 1 in 5 people will have depression at some time in their life; 43% of Australians with a mental disorder have a chronic illness; and having a chronic illness puts a person at greater risk of developing depression.

Despite the increasing impact on the health of our population due to mental health concerns, as this report has illustrated, there are no specific organisational services or appropriate professional infrastructure to provide mental health services and care for clients of WHCG.

The need to provide timely, accessible and appropriate care for people who experience mental illness as either a primary or a secondary diagnosis is significant. In order to lower the incidence and increasing severity of depression and other 'low level - high frequency' presentations; to address the nexus between depression and chronic illness; and to eliminate the need for recommended clients to experience long periods of physical restraint that further exacerbating levels of agitation; appropriate interventions must take place.

Figure One Proposed Model of Care

- **1.1 Identified service:** Mental health (MH) Nurse Practitioner (NP)
- **1.2 Therapeutic need**: To provide accessible, appropriate, timely and comprehensive care for clients of WHCG and the community of this sub-region with mental health issues/illness
- **1.3 Why a Nurse Practitioner?** Due to the high incidence of Mental Illness and a sub regional facility with no [internal] mental health service and low-level knowledge of mental health care within the organisation, a MH NP, acting within their scope of practice can
  - Provide a collaborative practitioner to address the therapeutic need.
  - Order & interpret a pre-determined range of diagnostic tests and interpret results
  - Prescribe a pre-determined range of medication to ensure timely treatment is commenced and to maintain continuity of medication
  - Recommend, admit and transfer clients to enhance timely appropriate treatment
  - Develop a consultation role to other members of the multidisciplinary team
  - Mentor and deliver ongoing staff education (nursing, medical, allied health) to build up the knowledge, understanding and evidence base of caring for clients with mental health issues/illness

2 What consumer groups? (Target population)

Clients with

- mental health concerns
- mental illness or
- mentally disordered presentations
- …primary or secondary diagnosis including
- Behavioural and emotional disturbances
- Substance abuse
- Psychosocial issues

Includes low level presentations such as borderline personality disorders and anxieties

Where?

Who present at emergency or are admitted) to WHCG

(in-patient/out-patient/ambulatory care)

3 Scope of practice

Advanced assessment

Diagnostics

Therapeutic interventions

Advanced technical skills

4 Clinical governance Framework

Clinical Practice Guidelines

Organisational policies

Organisational procedures

Out

Referrals:

- GPS specialist staff ie psychologist, psychiatrist, community nurses; and private specialists
- GP's

Admission: GPS acute beds

Discharge

Transfer: GPS acute inpatient

Proposed model of care: Mental Health Nurse Practitioner (Refer to Figure 1)

1.1 Identified service: Mental Health (MH) Nurse Practitioner (NP)

1.2 Therapeutic need is to provide accessible, appropriate, timely and comprehensive care for clients of WHCG and the community of this sub-region with mental health issues/illness

1.3 Why a Nurse Practitioner*?*

Due to the high incidence of Mental Illness and a sub regional facility with no [internal] mental health service and a low-level of mental health expertise within the organisation, a MH NP, acting within their scope of practice, can

- Provide a collaborative practitioner to address the therapeutic need (1.2)
- Order & interpret a pre-determined range of diagnostic tests and interpret results
- Prescribe a pre-determined range of medication to ensure timely treatment is commenced and to maintain continuity of medication
- Recommend, admit and transfer clients to enhance timely appropriate treatment
- Develop a consultation role to other members of the multidisciplinary team
- Mentor and deliver ongoing staff education (nursing, medical, allied health) to build up the knowledge, understanding and evidence base for caring for clients with mental health issues/illness.

Benefits

A Mental Health NP model will build and enhance service capacity of WHCG by providing timely, appropriate and accessible mental health care assessment and services for WHCG clients and their community.

This model builds mental health services in WHCG with NP working in Emergency Department but also, importantly, throughout the acute and ambulatory care sectors and across clients' continuums of care. The integrated delivery of mental health care within WHCG will increase the availability and quality of mental health care services for the Wimmera community. A further outcome of providing accessible, appropriate and timely care will be the increased opportunity to provide early detection and treat, high prevalence yet 'low level' mental health issues as well as diminishing those previously documented risks to recommended clients, other clients and staff, thereby addressing the identified service gaps at the local level.

Service capacity is enhanced as a MH NP model will provide evidence based practice along side formal education, informal participatory education, mentoring and support to the health care team, enhancing the knowledge and appropriate care that all staff provides for clients with a mental health issue or illness.

Ideally, two MH NPs would be appointed to increase the services' availability to the community and improve sustainability of this role. It will also be important that there is collaboration and a high level of integration between WHCG and GPS to support the services and the NPs.

There are two specific target groups

- *Those presenting with 'high prevalence - low level' mental health issues.*

Anecdotally, these clients often frequently present, typically for other reasons such as chest pain or anxiety. After organic causation is excluded, they are discharged because "…they don't meet the criteria to be serviced by GPS". The need here is to detect low level mental health issues early and offer appropriate and timely services and referral.

- *Those who are admitted in Emergency Department and recommended.*

The risks to all parties have been documented. The need is to provide high level mental health practice and services for these people, to avoid exacerbation of agitation/symptoms, and to decrease as far as possible the risk to these clients themselves, to other clients and to staff whilst they await transfer to an appropriate facility.

Benefits for clients

- Enhanced access to mental health care services
- Timely and appropriate treatment - thus decrease frustration, agitation and aggression cycle
- Early detection and treatment to limit exacerbation of illness
- Improved levels of care - clients not falling through the gaps and /or frequent representations to seek help
- To have mental health issues assessed and managed and ongoing care planned.
- Increased continuity of care across the continuum i.e. ED»inpatient»community

Benefits for the Community

- Enhanced access and quality of mental health care to the sub-region to meet the needs of the community - gap addressed
- More efficient health care delivery: The prevention of hospital admission, more timely provision of health care, improved co-ordination of patient care, improved access to health services etc.
- Improved liaison and coordination of care with community service providers, especially GPs

Benefits for the organisation

- Mental health services integrated within WHCG general health services across all areas
- Improved organisational understanding and links between GPS and WHCG
- Opportunity to address and rethink models of care, organisational structures and utilisation of funding, given workforce issues and unmet service needs of the community
- Opportunity to focus on the early identification and treatment, more timely provision of health care, improved co-ordination of patient care, improved access to health services etc. for the target population
- Increased opportunities for interdisciplinary and organisational collaboration to improve client outcomes and service delivery. This model develops collaboration between GPS, WHCG, specialists, medical practitioners, nurses, community health providers and others.
- Decrease adverse events and risks for clients and staff [risk addressed]
- Improve emergency department flow through [organisational capacity increased]

- Decrease in number of transfers to Ballarat [saving money, time and decreasing client dislocation]
- Increased capacity of existing staff, services and medical practitioners
- Provision of increased clinical and professional leadership for nursing staff in clinical areas
- Increased emphasis on the implementation of evidence based practice through the development of NP clinical practice guidelines
- Encouragement and support of increasing nursing research and quality improvement activities
- Development of a clinical path for nurses with significant experience and expertise who wish to continue to deliver clinical care
- Enhance the recruitment and retention of nursing staff

Timothy Wand, a clinical nurse consultant in mental health liaison concludes that "[T]he Mental Health Liaison Nurse service has the potential to considerably enhance the coordination and continuity of care between general hospital and mental health services by placing an emphasis on minimal waiting times for patients, clinical expertise and mental health promotion (2003)."

Clinical governance frameworks

Clinical governance frameworks will be developed for each area of expanded scope of practice identified; for admitting to WHCG and GPS acute; discharging from WHCG; referring to allied health, GP's, medical specialist, psychologist and psychiatrists; prescribing; and ordering diagnostics. These have not been developed within the scope of this project. Note is made here of consideration for clinical governance frameworks in relation to prescriptive and diagnostic authority related to external legislation and non-reimbursement.

Prescriptive and diagnostic authority

It is highly probable that the NP role will commence as a NP candidate and that candidacy will continue for approximately two years. In view of this, alongside impending changes with forth coming national registration of Health Professionals and foreseeable changes to Pharmaceutical Benefits Scheme[1] (PBS) prescribing rights, it is not expedient to address policy for NP prescribing at this time. A NP candidate will commence, discontinue and review pharmacological therapy in conjunction with each client's GP. As the NP role is new to WHCG, this procedure will also support the NPs development of pharmaceutical knowledge and provide time for organisational change.

Prescribing:- Prior to a candidate seeking authorisation, organisational policy and procedures will be developed in conjunction with key stakeholders including a medical practitioner and pharmacy

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[1] There are specific arrangements for PBS prescriptions in Victorian public hospitals. PBS access is given to patients attending or discharged from a public hospital. Medical practitioners employed with the public hospital may prescribe the medication. Hospital drug charts used on inpatient units and in the Emergency Department are not PBS prescriptions so if medications are ordered on these charts, there are no PBS implications. Northern Health discharge prescriptions are, however, a PBS prescription. In this instance, only prescriptions completed by registered medical practitioners and dentists approved to work within the PBS will be subsidised. As Nurse Practitioners are not approved for PBS access, PBS prescriptions completed by Nurse Practitioners are dispensed as non-PBS items and the patient is not entitled to the PBS subsidy. (Northern Health, 2006, p.15)

representatives to provide prescribing rights for NPs in relation to the authorising bodies predetermined range and the individual NPs scope of practice and competence.

If legislative changes to PBS do not eventuate prior to a candidate seeking authorisation, WHCG will consider contingencies such as

- requiring NPs to have scripts signed by a medical practitioner;
- covering the cost of NP scripts supplied from WHCG pharmacy;
- developing a memorandum of understanding will local pharmacies to fill NP scripts and bill WHCG who would then cover this cost.

Whilst there is the potential for clients who present a NP script at a pharmacy to bear additional cost themselves, **this is not recommended**. The relationship between mental illness, the incidence of co-morbidities, these people being a vulnerable population, inability to pay and the heightened risk of non-compliance - would further disadvantage this population.

Ordering diagnostics:- Prior to a candidate seeking authorisation, organisational policy and procedures will be developed in conjunction with key stakeholders to support the NP candidate's development of competency in relation to ordering and interpreting diagnostics; and to consider the intricacies of Medical Benefit Scheme (MBS) reimbursement for procedures ordered by the NP.

Clinical Practice Guidelines

Clinical Practice Guidelines (CPGs) will be developed by the NP candidate as part of their academic education and 'internship' and submitted to the organisation for approval. A number of CPG's for Mental Health NPs have previously been developed. These are:

NSW Health, Sydney West Area Health Service, Nepean Hospital Clinical Practice Guidelines, Nurse Practitioner Mental Health (August 2005) and

NSW Health, Sydney West Area Health Service, Auburn & Westmead Hospitals Clinical Practice Guidelines, Nurse Practitioner Mental Health (July 2004, Reauthorised August 2007).

These CPGs can be adapted to meet the identified needs of WHCG and the NPs scope of practice, cyclically reviewed and updated to ensure they reflect current evidence based practice guidelines and research.

Sustainability

Sustainability of the initial NP role developed in this project will need to address and monitor the following recommendations:

1. Partnership development with GPS to provide mentoring, support internship and prevent isolation of a NP who would be a sole mental health specific worker at WHCG. This would include collaboration and integration between WHCG and GPS to provide mental health care services to the Wimmera community.
2. Collaboration within the sub region to develop a cohort of NPs. It is recommended that Nurse Practitioner recruitment and retention across the region be actively supported through the development of a sub regional NP collaborative. Initially, all organisations will need to take active roles in the development and support of a collaborative, whilst in time, the collaborative

should become a leadership and development responsibility of the regions NPs. Each employing organisations will need to support NPs role in the collaborative.

3. Engagement of the whole organisation with area managers championing NP roles to ensure the role is supported, has clarity and is understood and appreciated within the broader organisational context. Previous NP reports have consistently noted that the NP role is often not clear nor understood by other health professionals. It is imperative that establishing NP roles involves ongoing attention to organisational change; championing the role; and developing clear policies and procedures and clear lines of accountability and responsibility to guide the expansions to practice.
4. To shape and monitor the role to ensure the NPs
   - accessibility to the target population across emergency departments, acute wards, residential and community settings;
   - client load is manageable; and the
   - provision of care can be planned and managed across the continuum of care within a nursing model of care (ensuring the NP role is not dominantly focused on trouble shooting).
5. To support and/or provide for the NP candidates and endorsed NPs educational needs including professional development, clinical education, clinical supervision and internship.

The organisation will accept responsibility to

- seek out and engage an appropriately qualified mentor to support the candidates development (in conjunction with the NP candidate);
- ensure professional mentoring is effective (in conjunction with the NP candidate);
- provide non clinical time and rostering consideration to support internship, educational requirements, professional mentoring and professional development during candidacy and after endorsement (i.e. 1 day/week or fortnight);
- support an appropriate level of ongoing professional development, maintenance of competence and up-to-date Evidence Based Practice (EBP) including conference leave and support to present at conferences.

Appendix 5 provides information on what is involved in an internship

Succession planning

The organisation commits to:

- The development and active support of a clinical career pathway for registered nurses from novice to advanced practice.
- Actively support NPs recruitment across the sub region and to develop a NP collaborative as a sub regional responsibility.
- The ongoing development of NP models in areas of identified need/service enhancement (and related fiscal commitment) through the WHCG strategic plan.
- Give due consideration to developing NP models where opportunities arise based on service need/enhancement.

- That the completion of this project, a NP working party is maintained to
    a. drive this project and the planned mental health NP model forward;
    b. engage stakeholders in the development of the NP role;
    c. provide ongoing organisational support to the development of NP candidates;
    d. develop policies and procedures related to evolving NP models;
    e. consider expressions of interest applications.

Evaluation and responsiveness of NP roles

An evaluation framework has not been developed with in the scope of this project, however examples of evaluation have been drawn from prior Victorian and National NP reports and are documented here as resources for this organisation.

> The evaluation of Nurse Practitioner roles may be considered from two perspectives: i) short term intensive evaluation of new Nurse Practitioner roles and ii) long term evaluation of service delivery in areas of health care in which Nurse Practitioners/Nurse Practitioner candidates work (Northern Health, 2006, p.5).

Northern Health notes three levels of evaluation:

Phase 1 Involves an audit of NP (NPC) activities, capturing patient demographics, referral sources, initial and subsequent contacts, mode of contact and location, presenting problem, assessment, intervention, service referrals and extended practice activities.

Phase 2 Involves health professional surveys to evaluate the role of the NP (NPC) in the areas of timeliness, adequacy of information provided, accessibility, appropriateness of referrals, collaborative practices, perceived benefits and disadvantages;

Phase 3 Involves patient interviews to evaluate the role of the NP (NPC) in the following areas: accessibility and acceptability, quality, appropriateness of service provided, continuity of care, patient / carer perceptions of outcomes.

Phase 4 Involves an interview with the NP (NPC).

Appendix 4 should be referred to for further information on evaluation. NOTE: Whilst some of the recommendations on evaluation are drawn from Aged Care NP models, these are transferable and will only require minor adaptations to the scope of practice and local context. Our thanks go to those many VNPP reports that have been accessed.

Evaluative activities ought to be based on the key aspects of service provision; of accessible, appropriate, timely, quality and safe care. Appendix 4 provides a list of measurable that may be appropriate to use.

Accessibility to appropriate care would be indicated by an increase in the number of target group clients 1) seen, 2) given appropriate treatment and 3) follow up rates of high frequency low-level mental health presentations.

Timeliness of care would be indicated by a decrease in time waiting to be 1) seen and 2) followed up. Need to collect base line data such as target population and time waiting to be seen in Emergency Department and to continually collect data in ongoing cycles.

Quality of service would be indicated by client satisfaction and indication of care based on up-to-date evidence based practice. Base line data needs to be collected for target population, type of treatment received and the appropriateness and satisfaction with treatment. Client satisfaction will also be indicated by a decrease in community angst re mental health issues and access to care and by undertaking client satisfaction surveys.

Safety would be indicated by a decrease in aggressive episodes related to clients with mental health issues (adverse events).

Peer satisfaction and collaboration (Drs, GP's, allied health, pharmacy) will be undertaken through peer review and feedback (see Northern Health recommendations in appendix 4)

Quantity of clients seen would be indicated by 1) the number of clients followed up from different sectors 2) the number of complete cycle of care and 3) numbers of discharges or moves to longer cycles.

PRIMING THE ORGANISATION

A small project team, relative to the size of the organisation was established at the of the project in late July 2008 and met monthly.

NP working party

Director of Clinical Services, Don McRae

Staff Development Officer, Jeremy Akker

Nurse Practitioner Project Worker, Janet Hall

Engaging the workforce

In order to build engagement, collaboration and consultation with local stakeholders to support implementation of the NP role, a communication strategy was developed and implemented.

Informal and formal meetings were held with nursing staff, at a variety of levels, across the Horsham and Dimboola campuses. These included one to one meetings, small groups in clinical areas and scheduled nurses' forums. Formal meetings to consult and inform were held with internal WHCG stakeholders such as the executive and doctors; and external stakeholders such as PCP executive and West Vic Division of GPs. All significant meetings are listed below.

When the model and scope of practice evolved, this Mental Health Nurse Practitioner model was presented and discussed with WHCGs Board. In addition, a further forum inviting key stakeholders is planned for February with NBV and DHS nurse policy branch speaking on expanding scopes of practice and NP roles.

Presentations and discussions about the role of NPs and model development

August	WHCG Clinical Risk manager
	NUM Oxley ward
	NUM emergency

September	Aged care nurse consultant
	Wimmera Primary Care Partnership Executive
	WHCG executive meeting
	Yandilla ward senior staff
	WHCG Nursing administration meeting
	West Vic Division of GPs
	Yandilla ward staff meeting
	Dimboola campus manager
	Hospice staff meeting
October	Dimboola campus nursing staff team meeting
	Oxley ward staff meeting
	Operating suit-day procedure unit staff meeting
November	Grampians Psychiatric Services staff meeting
	HARP staff meeting
	WHCG Doctors
	West Vic Division of GPs
	WHCG Quality Coordinator
	WHCG nurses forum
	Grampians Community Health Centre: CEO
	Dunmunkle Health Service: CEO
	Stawell Regional Health Service: Director of Clinical Services and NP project worker
December	WHCG Board
	WHCG Pharmacy manager

Many informal discussions took place with various health professionals, in particular with nurses who expressed interest and sought further information about the NP role. Other informative meetings included the:

DHS Nurse Policy Branch - NP Collaborative phone conferences

DHS Nurse Policy Branch – Nurse Practitioner models in aged care forum

Nurse Practitioners: A solution for the future. National Conference 2008 of the Australian Nurse Practitioners Association

NBV information session on becoming a NP

Internal process

Submit/receive expression of interest: Refer to appendix 6

Position Description: Refer to appendix 7

Budgetary considerations

Prior to establishing budget projections, the various components to be included in budget projections are considered and the responsibilities of various parties in preparation for a NP candidate clarified.

Applicant	**Organisation**
Education	Policy framework model of care
Clinical experience	Professional indemnity
Research	Employment agreement
Leadership	Individual formulary

Education components

Academic education, clinical education and practice, ongoing professional development, research activities, quality assurance activities as well as developing and updating clinical practice guidelines, (here in referred to as CPGs) are all integral components of advancing and maintaining the clinical and professional skills required for a Nurse Practitioner. These activities therefore must be factored in to the educational needs and support required as well as position descriptions and funding models for NPCs and NPs.

- Academic requirements – study days and exam leave to undertake and complete NP programs within agreed upon time schedules.
- Education related to ongoing professional development including clinical, management and leadership skills.
- Rostered non clinical time for ongoing activities including
  - CPG development and updating
  - Working with the NP project officer or designated staff member on policy development
  - Undertaking research, quality assurance and evaluation programs
  - Internship involving clinical teaching and mentorship (medical, pathology and diagnostics related to expanded scope of practice knowledge and skills) such as attending 1:1 education sessions with clinical specialists on a regular basis.

Developing budget projections requires allocating time to each area of development; a precarious calculation as this region has no prior experience with NP candidates and there are no standard guidelines. Various VNPP reports provide a guide.

Eastern Health and Northern Health VNPP reports note that clinical internship component should include at least 2 hours/ week of direct clinical education "protected" from the intrusion of clinical responsibilities - related to the mentoring component. VNPP for Bendigo Health and Bendigo

Community Health Services 2006-2008 notes this organisation allocates a day a month as a paid rostered study day for NP candidates.

Internship component

It is a limitation of this specific project that only minimal attention has been given to developing and mapping an internship. Located in appendix 5, learning's from existing reports inform the discussion on internships and mentoring.

To provide an internship, WHCG will need to obtain mentoring support from VMO's with specialised training in mental health and specialists, such as those who work for GPS. Consideration will need to be given to a developing formal contracts or MOUs that include WHCG NP mentoring; and wether this essential mentoring and support is encompassed by the partners collaboration .

Budget projections:

Two year internship costs (1 EFT)

Base salary of candidate based on substantive salary of Grade 4, Year 2	$141,000
plus 25% on-costs	$35,200
Education support for conference leave, research etc	$10,000
Specialists supervision $100/hour x 2 hours/week x 48 weeks	$12,000
Cost of fees for masters program	
Cost of pharmaceutical unit	

Recurrent costs

[2]Base salary of NP Year 1	$78,326
Plus 25% on-costs	$19,581
Education support for conference leave, research etc	$10,000
Specialists supervision $100/hour x 2 hours/week x 48 weeks	$12,000

Organisations can apply to DHS Nurse Policy Branch for funding support for internship costs for 2009. Individual nurses scholarships can be applied for through the Royal College of Nursing Australia at www.rcna.org.au.

Substantive salary: It is noted that in accord with the EBA, a NP candidate is paid at their substantive salary. However, whilst a candidate is expected to be working at advanced practice/ nurse consultant level, this may not be reflected in their substantive salaried position. Given the risk of a discrepancy between expected level of performance and a substantive position, it may be advisable to consider this aspect so pay levels reflect performance expectations, such as grade 4 year 2 as used in NPC budget calculations.

[2] Salary is based on 9-5, Monday to Friday, however the gap analysis identified out of hours as the critical time when mental health clients were recommended and needed to wait with out appropriate mental health care for transfer to Ballarat. Additional funds will need to be allocated to cover 'on call, out of hours, and shift work'.

Financial barriers: As these budget projections demonstrate, the establishment of a NP role is a considerable cost to a medium sized organisation such as WHCG. While WHCG runs programs such as Acute inpatient, Emergency, Hospital Admission Risk, Linkages and Community Health that all have mental health components, it does not have a discrete line of funding for mental health. To create a budget for a NP model of Mental Health care would require contributions from all the programs at WHCG who would benefit from the model however, the funding guidelines are not always flexible enough to allow such innovation across programs. A joint venture between WHCG and Grampians Psychiatric Services might also be feasible, but other issues surrounding governance and line management exist when sharing resources between organisations. Extensive consultation with the relevant organisations and government departments will be required to address these barriers.

PREPARING THE NURSING WORKFORCE

Whilst NP projects have been rolling out across Victoria for a number of years, there is a dearth of awareness by the nursing profession, particularly in western Victoria, where this project took place. Given this starting point, preparing the nursing workforce has been a significant aspect with much of the project revolving around raising levels of understanding about the NP role and how the role could enhance health care services for this community.

Numerous formal and informal discussions and forums took place with nurses. Their response to this project and nurse practitioner roles and models has been enthusiastic and inspiring. There are a number of highly experienced RNs across various areas of practice in the organisation, who have or are currently undertaking masters level studies and who wish to choose a clinical career path.

From an organisational perspective however, seeking to develop and plan for the implementation of a MH NP model when the organisation does not have discreet mental health funding, has created limitations for this project. Within the scope of this project for example, expressions of interest from potential nurse practitioner candidates could not be sought and candidacy could not be mapped. Decisions related to funding the model, sourcing appropriate clinical education and clinical supervision, the level of collaboration required between WHCG and GPS; and lines of reporting are issues that must be developed prior to this model being enacted.

WHCG Board and Executive are committed to the introduction of NP models. Progress will necessitate development related to:

- WHCG and GPS collaboration or possibly a joint venture
- Funding for this mental health service
- Recruitment of a candidate with the required knowledge, skills and professional interest to address the identified areas of need
- Keeping the NP momentum rolling.

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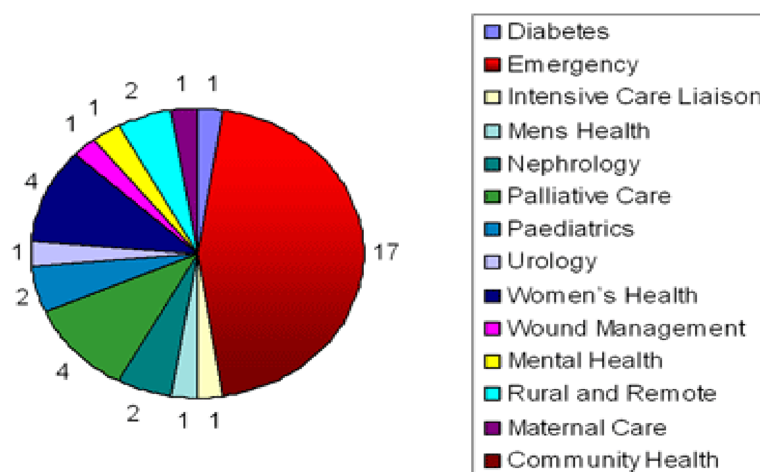
APPENDIX 1 Communication strategy flyer

Overview of the Nurse Practitioner (NP) Projects WHCG and RNH

For further information contact Jan Hall 03 53 819052

The objectives of the VNPP Phase 4 Round 4.1 projects are to:

- Assist rural health services to develop service plans for nurse practitioner services that are strategic, sustainable and integrated with broader health service direction.
- Ensure plans for NP services are aligned with relevant existing organisational, local/regional and state wide service plans and/or workforce plans.
- Facilitate collaboration between health services in the development and implementation of NP models, and
- Build engagement, collaboration and consultation with local stakeholders to support the NP role.



In Victoria there are over 35 NPs endorsed and working in these areas.

What is a Nurse Practitioner?

A Nurse Practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The Nurse Practitioner role includes assessment and management of clients using Nursing knowledge and skills and may include but is not limited to, the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations. The Nurse Practitioner role is grounded in the nursing profession's values, knowledge, theories and practise and provides innovative and flexible health care delivery that complements other health care providers. The scope of practice of the Nurse Practitioner is determined by the context in which the Nurse Practitioner is authorised to practise (*Australian Nursing & Midwifery Council, 2006).*

How does this role differ from advanced practice roles?

The basis of advanced practice is the high degree of knowledge, skill and experience that is applied within the nurse-patient/client relationship to achieve optimal outcomes through critical analysis, problem solving and accurate decision making. Advanced practice nursing forms the basis for the role of nurse practitioner, however:-.

- ***NP is a regulated title***

  NP includes areas that are not part of the traditional nursing repertoire

- ***Legislative provisions enable aspects of NP practice such as prescribing, referral, and admitting privileges to health care facilities***

This independent authority differs from many advanced practice roles where there may be delegation or dependant function such as initiating a limited range of medications based on a protocol that has been approved by another health professional who has authority to prescribe (N^3ET, 2006).

The core role and practice standards for the NP build upon existing standards of advanced practice nursing and relate to three core areas:

- **Dynamic practice** that incorporates application of high level knowledge and skills in extended practice across stable, unpredictable and complex situations.
- **Professional efficacy** whereby extended practice is structured in a *nursing* model and enhanced by autonomy and accountability.
- **Clinical leadership** that influences and progresses clinical care, policy and collaboration through all levels of health service. The nurse practitioner is a clinical leader with a readiness and an obligation to advocate for their client base and their profession at the systems level of health care.

Opportunities for the profession of nursing and nurses

- Utilise enhance and/or legitimise nursing skills knowledge and competencies
- Encourage advancement of nursing skills knowledge and competencies
- Provide a clinical career path for nursing; providing the opportunity to extend your nursing skills knowledge and competencies
- Scholarship opportunities are established for NP candidates

Opportunities for the community

- Fill gaps in regional health needs
- Improved access to care and improved client outcomes (i.e. if service not currently provided or is enhanced)

Opportunities for health care organisations

- Opportunity to address and rethink models of care, organisational structures and modes of delivery, and utilisation of funding, given changing population demographics and workforce issues.

Examples of extended practice may include: Prescribing, referral to specialists, ordering diagnostic tests and admitting privileges to health care facilities.

APPENDIX 2 Pathways to becoming a NP in Victoria

This section is extracted from the Nurses Board of Victoria (NBV) web site http://www.nbv.org.au

Qualifications

A completed Masters of Nurse Practitioner, or equivalent, is the minimal level of education required for endorsement as a Nurse Practitioner.

NBV Approved Masters of Nurse Practitioner Programs and Therapeutic Medication Management Units for potential Nurse Practitioners

Equivalence

If you have a Masters qualification in another discipline, and extensive professional experience to meet the ANMC National Competency Standards for Nurse Practitioners, the Board will consider granting equivalence of qualification. To apply for equivalence refer to the NBV website

Categories of nurse practitioners

Each nurse practitioner applicant must select a category as approved by the Minister of Health under section 13(ba) of the Drugs, Poisons and Controlled Substance Act 1981.

List of approved nurse practitioner categories include diabetes emergency Intensive Care Liaison Men's Health Nephrology Palliative Care Paediatrics Urology womens health, rural and remote, mental health, wound management Maternal Care Community Health Young People's Health with 40 nurses currently registered as NPs under these categories in Victoria

NBV notes that categories allow for:

- A logical, clinical basis for enabling prescribing by nurse practitioners;
- Reflection of areas of practice rather than the individual's scope of practice, specific job setting, or job title;
- Assessment of nurse practitioner applications;
- Dispensing of medications prescribed by nurse practitioners.

Nurse Practitioners and prescribing

Nurse Practitioners (NP) who are endorsed by the Nurses Board of Victoria are legally able to prescribe (supply) medicines to clients/patients according to a defined list. In Victoria, the authority to prescribe (supply) is limited to a category of NPs and a list of drugs approved by the Minister for Health.

Each nurse endorsed as NP will have the category identified on their NBV practicing certificate/card (and on their NBV register) and this identifies the list they can prescribe from. The lists of drugs for each approved category can be found on the NBV website (www.nbv.org.au).

NP Competencies Refer to Australian Nursing and Midwifery Council Nurse Practitioner Competencies located at http://www.anmc.org.au/docs/Publications/Competency%20Standards%20for%20the%20Nurse%20Practitioner.pdf

APPENDIX 3 Overview of Benefits

(Reference: Western Health 2006 p. 31 –41)

Timely management of patient problems

Service currently not provided/or GAP

Improved outcomes for clients in areas that have a GAP in service provision

Increased consumer satisfaction

Reduced waiting times

Reduced costs

Increased patient throughput

Reduced inpatient admissions

Outcomes (measurable)

Timeliness of treatment

Improved access to health services and treatment

Time to travel

Time to discharge

Improved outcomes

Increased support provided

Quality of treatment

- Patient satisfaction
- Interdisciplinary satisfaction
- Improved community links / intra department communication
- Reduced adverse events / aggressive behaviour incidents

Quantity of treatment

- Number of patients seen
- Number of referrals received
- Number of referrals made
- Number of diagnostics ordered
- Number of medications prescribed

Cost of treatment

- Prevention of hospital admission
- Decreased hospital admission (I.e. prenatal treatment is optimised)
- Decreased admissions to ICU
- Decrease costs for ambulance to transfer between hospitals (ICU liaison)
- Decrease length of stay for inpatients
- Reduced presentations to ED (Chronic pain management NP Aged care NP)
- Reduced complications

APPENDIX 4 Evaluation examples

Evaluation

Northern Health Phase 1-4 detailed in the body of the report

The National Aged Care NP Trial Final report, vol.1-Evaluation report p.8-10 also considered evaluation of the Aged care NP role:

Resident/consumer views on the following were canvassed

- quality of the service provided by the NPC including the consumer's experience, choice and values;
- the ongoing feasibility of the NPC role;
- access to the Nurse Practitioner-like service;
- appropriateness of the Nurse Practitioner-like service provided;
- outcomes, including consumer experience, symptom relief, complications, consumer satisfaction, educational value and unexpected outcomes; and
- scope for improving and broadening current practice of the NPC.

Key stakeholder views on the following were sought regarding:

- quality of the service provided by the NPC;
- feasibility of the NPC role;
- access to the Nurse Practitioner-like service;
- appropriateness of the Nurse Practitioner-like service provided;
- collaborative practice including the identification of professional roles and boundaries, participation in case conferencing, referrals to and from other health care workers, initiation of care plans and health professional experience;
- outcomes including impact on other services;
- scope for improving and broadening current practice of the NPC; and
- the sustainability and the cost-effectiveness of the NP model of practice.

Collaborator questionnaire: The various nursing, medical and allied health care professionals who participated in interdisciplinary collaborative care with the NPCs were asked to complete a structured postal questionnaire. This included information about the evolving collaborative relationships between the roles and functions of the nursing and medical/allied health professions, their different foci and any overlap of activities The purpose … was to establish the level of collaboration experienced by those who worked with the individual NPCs.

Economic Evaluation: One of the main purposes of a project such as this is to evaluate the cost-effectiveness of the NP model vis-á-vis the current model with its pre-existing services delivered by medical officers and nurses (with a more limited role in delivery of these services). This study included a simple cost-benefit analysis of the NP model, which, under our assumptions, was consistent with a 'cost effectiveness' analysis. Using budget information contained in the individual project reports, in combination with data extracted from an Economic Evaluation questionnaire (Appendix XII), conclusions were drawn about the overall cost-effectiveness of the Nurse Practitioner model.

APPENDIX 5 Internship & Mentoring

Eastern Health Service Plan Development report (p.29-30):

A clinical internship forms the basis of a discipline specific education and training program that will allow NPCs to advance, in a timely manner, towards endorsed Nurse Practitioner status. A framework for a clinical internship therefore needs to be adequately resourced, competency based, relevant, and to meet the needs of each candidate.

The clinical internship is best developed by a multidisciplinary team, with input from the NPC, and should be aligned with the academic preparation of each candidate. The focus of the clinical development program is to ensure that the NPC has well developed clinical skills in the areas of advanced clinical assessment, diagnostic skill and knowledge, pharmacology knowledge, demonstrated competence in medication management, knowledge of treatment options, research abilities and advanced clinical leadership, and to assist in preparing the portfolio to support a successful endorsement process with the NBV.

For example, the NP [NPC] would meet monthly with a senior pathologist to discuss issues relevant to the diagnostic tests they are ordering. This offers a learning opportunity to review the previous month's requests and results and other Pathology issues.

[It is also worth noting that whilst students undertaking a Nurse Practitioner Master's courses will have access to a framework for a clinical internship]. Candidates who are undertaking a generic Masters may not have access to this resource and will need to utilise a framework that provides clinical education and training tailored to their specific discipline, that is relevant to meets their needs and advances them towards endorsed status in a timely manner.

Mentoring

Eastern Health (p.30-31) notes: "Mentoring is the development of a relationship between two parties, with the intention of the mentee to develop skills under the guidance of the mentor. Accordingly, there must be a willing commitment from both parties".

The clinical mentor should be:

- A clinical expert in the area, either Consultant Doctor or NP. A NP may elect to seek mentorship from more than one clinical expert, for example a medical consultant and additionally a pharmacist or radiologist.
- Available during clinical placement and able to commit to being a mentor for the duration of the internship.
- Accessible within the clinical environment for teaching and reviewing patients seen by the student.
- Have a good understanding of the NP model and the extended scope of practice of the role.
- Able to provide clinical supervision.

Clinical Mentor responsibilities include:

- Able to observe the student working clinically and provide thorough critical feedback on their performance in the role.
- Ensure that a wide range of opportunities for skill development is available.
- Objectively assess progress of the NPC against the training objectives at regular intervals.

- The clinical supervisor will assist the NPC to develop the advanced clinical skills, competencies and knowledge required to fulfil the role of an endorsed NP. The Clinical mentor and candidate will complete a learning plan and will work together throughout the candidature to complete it.

APPENDIX 6 Expression of interest - NP Role

An expression of interest in a NP role is a two-stage process

Stage 1 Expression of interest for a NP role

This may be an opportunistic interest for example by a nurse with an expressed interest in this clinical career path; or need identification by health professionals within the organisation. Stage 1 should be completed by addressing the questions as comprehensively as possible.

NOTE:-The completion and *approval* of Stage 1 expression of interest is a *prerequisite* to proceeding to stage 2.

Stage 2. Submission for a Nurse Practitioner role

To be completed only *at the invitation* of the Nurse Practitioner Steering Committee *after written confirmation of approval to proceed to stage 2.*

Stage 1. Expression of interest

Prior to submitting 'Stage 1 expression of interest', there is an expectation that information has been accessed and understood pertaining to

Nurse Practitioner education, preparation and roles

Nurses Board of Victoria (NBV) information on becoming a Nurse Practitioner - education, application and endorsement processes from www.nbv.org.au

Nurse Practitioner national competency standards and performance indicators by the Australian Nursing & Midwifery Council (ANMC) from www.anmc.org.au

These resources provide information that will enable you to appreciate the requirements of becoming a NP as well as giving you insight required to complete this document.

STAGE 1 EXPRESSION OF INTEREST TEMPLATE

Name of Service	
Expression of interest completed by	
Position/Title	
Phone/Fax	
Email address	
Date	
Signature	

For the proposed Nurse Practitioner model, please provide dot point information to address the following (approximately 2 pages):

a. Provide a brief outline of the current service/model of care

b. Describe the need and target group. This should detail how existing health services will be enhanced **or** new services will be provided to meet the needs of a patient group **or** address a service gap.

c. Detail the proposed role of the Nurse Practitioner/s in the clinical setting as part of the multidisciplinary team

d. Note those extensions to practice that may be required/utilised.

   i. Prescribing
   ii. Initiation and follow up of diagnostics
   iii. Referral to medical specialists
   iv. Admitting and discharge rights
   v. Approval of absence from work certificates

e. Describe any other proposed advanced clinical skills not in the existing nursing scope of practice

f. Discuss the anticipated benefits of the NP role including improved service access, cost-effectiveness, timeliness of service provision etc.

g. What support is there is from key stakeholders (the multidisciplinary team) for the introduction of this role?

Thank you for completing the Stage 1 *Expression of interest*

Please submit in electronic and hard copy to The Director of Nursing and Community Services.

Date to be reviewed by Nurse Practitioner Working Party ....

Response & Feedback provided to applicant by ....

(Chair of NP Working Party to provide written feedback within two weeks of scheduled meeting. Attach feedback to this form, sign and date above.)

STAGE 2. EXPRESSION OF INTEREST TEMPLATE

Stage 2 is only to be completed by *invitation after written confirmation of approval to proceed to stage 2* by the Nurse Practitioner Working Party.

Name of Service	
Expression of interest completed by	
Position/Title	
Phone/Fax	
Email address	
Date	
Signature	

1. THERE IS A DEMONSTRABLE NEED

1.1 Describe the existing model of care for the clinical area.

1.2 Describe how existing health care services could be enhanced or new services provided, to meet the needs of a patient group, or an organisational need, or to address a service gap? Examples of anticipated benefits need to include improved service access, cost-effectiveness, timeliness of service provision, client satisfaction etc.

1.3 What data/information is there to support the requirement for this change to the health care service?

1.4 In what ways is a Nurse Practitioner the most appropriate health professional to provide this service?

1.5 How would patient/organisational outcomes of the new/expanded service and Nurse Practitioner role be evaluated? Include details of key performance indicators that would be crucial for the new role, and examples of data that would be collected and analysed as part of the evaluation.

2. THERE IS A CLEARLY DEFINABLE SCOPE OF PRACTICE

2.1 What would be the role of the Nurse Practitioner in the clinical setting?

Your response needs to address:

a) the scope of practice

b) the patient presentations to be seen/target patient population

c) the extensions to practice that would be required/utilised:

- prescribing
- initiation of diagnostics
- referral to medical specialists

- admitting and discharging privileges
- approval of absence of work certificates

d) the proposed reporting structure

2.2 How would the Nurse Practitioners' scope of practice be linked to Clinical Practice Guidelines?

2.3 How would the Nurse Practitioner function within a multidisciplinary team? In your response, consider what opportunities there would be for both autonomy and collaboration.

2.4 What changes to the current model of care would be required to implement this Nurse Practitioner role? In your response, consider the impact on any existing roles.

2.5 Are there any other Nurse Practitioner Models in an equivalent clinical area? If so, please provide details, and comment on useful learnings that are applicable to your proposed model?

3. THERE IS DEMONSTRATED SUPPORT FOR THE ROLE FROM KEY STAKEHOLDERS

3.1 What evidence is there of:

- Nursing (including clinical staff, Nurse Manager, Director of Nursing & Community Services)
- Medical (including clinical staff)
- Multidisciplinary
- Executive (including Director of Nursing & Community Services/ Chief Executive Officer)
- Consumer support for the introduction of this Nurse Practitioner role?

3.2 What specific multidisciplinary input is available to collaborate in the development of the Nurse Practitioner role, within the revised model of care?

4. THE ROLE CAN BE FUNDED WITHIN THE EXISTING UNIT BUDGET.

4.1 What strategies would allow for funding the Nurse Practitioner/s within the existing budget?

In addition to ongoing funding for the role, there needs to be consideration of the requirement for:

- The 12 month candidature for the Nurse Practitioner/s
- The need for non-clinical time for education/training and the development of Clinical Practice Guidelines, which may be a minimum of one non-clinical day per week for the initial 12 months. (Note: – if the candidate is eligible for 4 hours of study leave per week for the 26 weeks of the academic year, this will be factored in as part of the allocated non-clinical time)
- Any additional resources such as equipment or work facilities for either clinical or non-clinical components of the role.

5. THE REQUIREMENTS FOR AN EDUCATION PROGRAM AND OTHER REQUIRED RESOURCES HAVE BEEN IDENTIFIED.

5.1 What would be the educational requirements of the Nurse Practitioner Candidate that would enable/support extensions to current practice?

Please give consideration to:

- Health Assessment

- Diagnostic Testing
- Prescribing
- Documentation

5.2 What would be the relevant multidisciplinary input into the required education?

5.3 Are you aware of any existing relevant educational programs (internal and/or external) that could be accessed by the Nurse Practitioner Candidate? For example – there may be existing registrar education programs that could have useful components (sub region/region).

5.4 Is there a team of medical consultants to take on the role of clinical mentorship? It is expected that this would require at least 2 hours per week of one to one teaching and supervision of the candidate, in addition to providing direct clinical support on a day–to-day basis.

- If possible, please specify consultants who have indicated their willingness.
- Describe how the mentorship team will operate to ensure the appropriate level of support and clinical supervision, and how the model will be incorporated within the existing service.

6. THERE IS POTENTIAL FOR A SUITABLE NURSE PRACTITIONER CANDIDATE

6.1 Are there any potential Nurse Practitioner Candidates who have:

- A clinically relevant Masters level of nursing qualification (or working towards)
- Completed the therapeutic medication management module at an approved university (or working towards)
- A commitment to seek endorsement by the Victorian Nurse's Board as a Nurse Practitioner
- A minimum of 3 - 5 years clinical experience post specialist qualification, and evidence of working at a level of advanced practice in the clinical area

6.2 If there is no suitable internal candidate, what potential is there to externally recruit a suitable candidate?

7. OTHER CONSIDERATIONS

7.1 Are there any other ways (not already described) in which the Nurse Practitioner role may impact upon:

- Patients
- The Nurse Practitioner Candidate
- Nursing Staff
- Other disciplines, including existing training commitments for other health professionals
- Your clinical area

Other departments/clinical areas?

Describe what you anticipate some of the implications may be.

7.2 Any additional comments or information:

Thank you for completing the Stage 2

Please submit in electronic and hard copy to ....

Date to be reviewed by Nurse Practitioner Working Party ....

Response & Feedback to applicant by ....Date...

The Chair of the NP Working party will provide a written response within two weeks following the next scheduled meeting.

APPENDIX 7 Position Description

POSITION DESCRIPTION

Position Title:	*Mental Health Nurse Practitioner*
Position Number:	*(to be completed by Human Resources)*
Classification	*NP Candidate - substantive salary: NP Endorsed – Grade 6*
Award:	(eg Nurses-Victorian Health Services-Award 2000)
Department:	(eg Oxley)
Reports to:	*Director of Clinical Services*
Hours:	(eg as per rotating roster including weekends and public holidays)

1. ORGANISATIONAL INFORMATION

1.1 Mission Statement

We are committed to achieving the best health for all the Wimmera.

1.2 Vision Statement

To be the best provider of rural health services in Australia.

1.3 Our Values

- We are responsive to the health needs of the community.
- We believe that our customers are entitled to quality health care that respects their dignity, beliefs and rights regardless of their cultural, spiritual or socio-economic background.
- We recognise our customers' total needs in order for them to achieve optimal health and wellbeing.
- We are committed to continuous quality improvement.
- We deliver quality health services that are value for money.
- We care for the wellbeing and encourage the ongoing development of our staff whom we recognise as our most valuable resource.

2. PURPOSE OF POSITION

A Nurse Practitioner[3] is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The Nurse Practitioner role includes assessment and management of clients using Nursing knowledge and skills and may include but is not limited to, the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations. The Nurse Practitioner role is grounded in the nursing profession's values, knowledge, theories and practise and provides innovative and flexible health care delivery that complements other health care providers.

The core role and practice standards for the NP build upon existing standards of advanced practice nursing and relate to three core areas:

- Dynamic practice that incorporates application of high level knowledge and skills in extended practice across stable, unpredictable and complex situations.
- Professional efficacy whereby extended practice is structured in a nursing model and enhanced by autonomy and accountability.
- Clinical leadership that influences and progresses clinical care, policy and collaboration through all levels of health service. The nurse practitioner is a clinical leader with a readiness and an obligation to advocate for their client base and their profession at the systems level of health care.

The NP candidate role aims to prepare the nurse for endorsement as a NP with the Nurses Board of Victoria in these domains.

The primary purpose of the Mental Health Nurse Practitioner position is to provide accessible, appropriate, timely and comprehensive care for clients of WHCG and the community in this sub-region with mental health issues/illness across the continuum of care[4].

The focus of this service is to provide mental health care services to clients of WHCG with 'low level' mental health presentations who are unable to access psychiatric services and clients in the emergency department who are 'recommended'; and to provide mentoring, leadership and education to all WHCG staff, in the care of persons experiencing mental health issues/illness.

The Mental Health Nurse Practitioner, acting within their scope of practice, will

- Provide a collaborative practitioner to address the therapeutic need.
- Order & interpret a pre-determined range of diagnostic tests and interpret results
- Prescribe a pre-determined range of medication to ensure timely treatment is commenced and to maintain continuity of medication
- Recommend, admit and transfer clients to enhance timely appropriate treatment

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[3] Australian Nursing and Midwifery Council (ANMC) (2006). National Competency Standards for the Nurse Practitioner. Accessed July 2008 from http://www.anmc.org.au/docs/Publications

[4] Continuum of care is the provision of care that includes primary level care beginning with the promotion of good health and keeping people healthy and at home; secondary level care, focused on the early detection of disease and prompt response; and finally tertiary level care which focuses on timely intervention to treat disease and limit any progression. The continuum of care encompasses the principles of improving, maintaining and enhancing health, wellbeing and quality of life for the population.

- Develop a consultation role to other members of the multidisciplinary team
- Mentor and deliver ongoing staff education (nursing, medical, allied health) to build up the knowledge, understanding and evidence base of practice for caring for clients with mental health issues/illness

3. KEY SELECTION CRITERIA

3.1 Essential *(list criteria)*

- Division 1 & or 3 Registered Nurse holding registration with Nurse Board Victoria or eligible for same
- Post Graduate Qualifications relevant to specialty area (mental health or related field)
- Minimum 3-5 years post graduate experience in the defined specialty area deemed relevant to the NP category for which endorsement will be sought (mental health nursing)
- Unit in Pharmacology in advanced clinical practice (Flinders) OR Therapeutic medication management Unit/Education program (Monash/ Melbourne) or equivalent OR willingness to undertake same
- Masters in clinical specialty (Mental Health) OR willingness to undertake same OR willingness to undertake Masters of Nursing (Nurse Practitioner).
- NP credentialing with relevant professional nursing organisation OR working towards same.
- Highly developed communication, liaison, interpersonal and negotiation skills.
- Demonstrated ability and willingness to work within a multidisciplinary service delivery framework
- Sound advanced level clinical knowledge, skills and experience
- Strong leadership skills and the demonstrated ability to lead a team
- Demonstrated working knowledge and understanding of relevant Mental Health Acts and legislation

3.2 Desirable *(list criteria if applicable)*

- Membership of professional nursing organisation
- Competence in utilising computer technology
- Experience in undertaking quality assurance and/or research projects
- Experience in developing and delivering education
- Current drivers licence and ability to undertake travel across the Wimmera region

4. PERFORMANCE MANAGEMENT *s)*

4.1 Pre-employment Check

In accordance with current legislation, the Employee must be willing to undertake a police check, with ongoing employment dependant on a satisfactory check.

4.2 Review

A performance review will occur after commencement of this position and annually. It will be based on the duties and responsibilities outlined in this position description.

4.3 Equal Employment Opportunity

WHCG is committed to equality of employment opportunity. The Employee will agree to adhere to the Equal Employment Opportunity policies and practices of the Health Service. Discriminatory practices, including sexual harassment, are unlawful. The WHCG will not tolerate discriminatory behaviour and any such conduct may lead to the invoking of the Disciplinary Policy and Procedure, which may result in termination of employment.

4.4 Confidentiality

Any private and health information obtained in the course of employment is confidential and should not be used for any purpose other than the performance of the duties for which the person was employed. The Employee is bound by the Information Privacy Act 2000 and the Health Records Act 2000 and shall be required to sign a statement on commencement of employment agreeing to comply with WHCG Privacy Policies.

4.5 KEY RESPONSIBILITIES / PERFORMANCE INDICATORS

Performance Objectives	***Performance Indicators***
Service Delivery To provide accessible, appropriate, timely and comprehensive care for clients of WHCG and the community in this sub-region with mental health issues/illness across the continuum of care. Service provision may include triage, health assessment, treatment and care	

planning, implementing the plan and ongoing management, discharge planning and referral to other health professionals and community agencies; for clients in the emergency department, acute wards and ambulatory care settings. **STANDARD 1** **Dynamic practice that incorporates application of high-level knowledge and skills in extended practice across stable, unpredictable and complex situations** **Competency 1.1** Conducts advanced, comprehensive and holistic health assessment relevant to a specialist field of nursing practice	**1.1 Performance indicators** ● Demonstrates advanced knowledge of human sciences and extended skills in diagnostic reasoning ● Differentiates between normal, variation of normal and abnormal findings in clinical assessment ● Rapidly assesses a patient's unstable and complex health care problem through synthesis and prioritisation of historical and available data ● Makes decisions about use of investigative options that are judicious, patient focused and informed by clinical findings ● Demonstrates confidence in own ability to synthesise and interpret assessment information including client/patient history, physical findings and diagnostic data to identify normal and abnormal states of health and differential diagnoses ● Makes informed and autonomous decisions about preventive, diagnostic and therapeutic responses and interventions that are based on

Competency 1.2 Demonstrates a high level of confidence and clinical proficiency in carrying out a range of procedures, treatments and interventions that are evidence based and informed by specialist knowledge	clinical judgment, scientific evidence, and patient determined outcomes **1.2 Performance indicators** ● Consistently demonstrates a thoughtful and innovative approach to effective clinical management planning in collaboration with the patient/client ● Exhibits a comprehensive knowledge of pharmacology and pharmacokinetics related to a specific field of clinical practice ● Selects/prescribes appropriate medication, including dosage, routes and frequency pattern, based upon accurate knowledge of patient characteristics and concurrent therapies Is knowledgeable and creative in selection and integration of both pharmacological and non-pharmacological treatment interventions into the management plan in consultation with the patient/client ● Rapidly and continuously evaluates the patient/client/'s condition and response to therapy and modifies the management plan when necessary to achieve desired patient/client outcomes ● Is an expert clinician in the use of therapeutic interventions specific to, and based upon, their expert knowledge of specialty practice ● Collaborates effectively with other health professionals and agencies and makes and accepts referrals as appropriate to specific model of practice ● Evaluates treatment/intervention regimes on completion of the episode of care, in accordance with

	patient/client determined outcomes
Competency 1.3 Has the capacity to use the knowledge and skills of extended practice competencies in complex and unfamiliar environments	**1.3 Performance indicators** ● Actively engages community/public health assessment information to inform interventions, referrals and coordination of care ● Demonstrates confidence and self-efficacy in accommodating uncertainty and managing risk in complex patient care situations ● Demonstrates professional integrity, probity and ethical conduct in response to industry marketing strategies when prescribing drugs and other product. ● Uses critical judgment to vary practice according to contextual and cultural influences ● Confidently integrates scientific knowledge and expert judgment to assess and intervene to assist the person in complex and unpredictable situations
Competency 1.4 Demonstrates skills in accessing established and evolving knowledge in clinical and social sciences, and the application of this knowledge to patient care and the education of others	**1.4 Performance indicators** ● Critically appraises and integrates relevant research findings in decision making about health care management and patient interventions ● Demonstrates the capacity to conduct research/quality audits as deemed necessary in the practice environment ● Demonstrates an open-minded and analytical approach to acquiring new knowledge ● Demonstrates the skills and values of lifelong learning and relates this to the demands of extended clinical

STANDARD 2 **Professional efficacy whereby practice is structured in a nursing model and enhanced by autonomy and accountability**	practice
Competency 2.1 Applies extended practice competencies within a nursing model of practice	**2.1 Performance indicators** ● Readily identifies the values intrinsic to nursing that inform nurse practitioner practice and an holistic approach to patient/client/community care ● Communicates a calm, confident and knowing approach to patient care that brings comfort and emotional support to the client and their family ● Demonstrates the ability and confidence to apply extended practice competencies within a scope of practice that is autonomous and collaborative ● Creates a climate that supports mutual engagement and establishes partnerships with patients/carer/family ● Readily articulates a coherent and clearly defined nurse practitioner scope of practice that is characterised by extensions and parameters
Competency 2.2 Establishes therapeutic links with the patient/client/community that recognise and respect cultural identity and lifestyle choices	**2.2 Performance indicators** ● Demonstrates respect for the rights of people to determine their own journey through a health/illness episode while ensuring access to accurate and appropriately interpreted information on which to base decisions ● Demonstrates cultural competence by incorporating cultural beliefs and practices into all interactions and

Competency 2.3 Is proactive in conducting clinical service that is enhanced and extended by autonomous and accountable practice	plans for direct and referred care ● Demonstrates respect for differences in cultural and social responses to health and illness and incorporates health beliefs of the individual/community into treatment and management modalities **2.3 Performance indicators** ● Establishes effective, collegial relationships with other health professionals that reflect confidence in the contribution that nursing makes to client outcomes ● Readily uses creative solutions and processes to meet patient/client /community defined health care outcomes within a frame of autonomous practice ● Demonstrates accountability in considering access, clinical efficacy and quality when making patient-care decisions ● Incorporates the impact of the nurse practitioner service within local and national jurisdictions into the scope of practice ● Advocates for expansion to the nurse practitioner model of service that will improve access to quality, cost-effective health care for specific populations
STANDARD 3 **Clinical leadership that influences and progresses clinical care, policy and collaboration through all levels of health service**	
Competency 3.1 Engages in and leads	**3.1 Performance indicators**

clinical collaboration that optimise outcomes for patients/clients/communities	● Actively participates as a senior member and/or leader of relevant multidisciplinary teams ● Establishes effective communication strategies that promote positive multidisciplinary clinical partnerships ● Articulates and promotes the nurse practitioner role in clinical, political and professional contexts ● Monitors their own practice as well as participating in intra- and inter-disciplinary peer supervision and review
Competency 3.2 Engages in and leads informed critique and influence at the systems level of health care	**3.2 Performance indicators** ● Critiques the implication of emerging health policy on the nurse practitioner role and the client population ● Evaluates the impact of social factors (such as literacy, poverty, domestic violence and racial attitudes) on the health of individuals and communities and acts to moderate the influence of these factors on the specific population/individual ● Maintains current knowledge of financing of the health care system as it affects delivery of care ● Influences health care policy and practice through leadership and active participation in workplace and professional organisations and at state and national government levels ● Actively contributes to and advocates for the development of specialist, local and national, health service policy that enhances nurse practitioner practice and the health of the community
Training and Development • Recognises the need for ongoing	• Demonstrates evidence of ongoing

commitment to personal and professional development • Keeps informed about current clinical practice and research in mental health care • Maintains competence	education • Attends all mandatory training sessions as deemed necessary for the position. • Completes mandatory competencies • Maintains Mental Health Nurse Practitioner credentialing with relevant professional body • Maintains up-to-date evidence based practice clinical practice guidelines
Occupational Health and Safety • Ensures compliance with Workcover regulations and other occupational health and safety legislation / initiatives • Maintains current knowledge of WHCG emergency procedures	• Recognises the need for self care and acts to promote same) • Attends annual fire and evacuation training • Reports any incidents / matters which affect the health and safety of the work environment
Organisational Improvement • Embraces the WHCG's Mission, Vision and Value statements to direct work practices • Contributes to achieving the WHCG Strategic Plan) • Promotes a quality culture within the organisation highlighting the values of customer service • Acts to positively promote WHCG both internally and externally) • Delivers prompt and courteous culturally appropriate services	• Participates in annual development of a quality plan • Identifies achievements and outcomes annually for reporting in department business • Seeks feedback from clients of service and follows up all related complaints • Actively contributes to the accreditation program • Treats patients/clients, families/carers and colleagues with respect and dignity at all
Risk Management • Complies with the WHCG risk management policy • Participates with the implementation of strategies to reduce risks / potential risk in the work setting) • Identify potentially harmful	• Reports any identified or potential risks *(common to all position descriptions)* • Keeps informed about WHCG policies and procedures • Complies with all relevant legislation) • Participates in critical incident

situations arising from caring for clients with mental health issues/illness, within the general hospital setting	reviews including sentinel events. • Implements remedial actions in response to potentially harmful situations arising from caring for clients within the general hospital setting
Information Management • Liaises and communicates with all departments and employees (as required by the position) • Maintains appropriate communication channels • Completes documentation (as required by the position) • Utilises effective written and verbal communication methods • Ensures medical records are maintained and kept safely and utilized in accordance with legislative requirements, WHCG policy and procedure and the Australian Standards for Medical Records • Collect and provide data as required within the Health Service agreed targets and Key Performance Indicators (KPI's)	• Attends scheduled committee and other meetings as required. • Provides verbal/written reports to committee meetings and as identified • Provides data related to targets and KPI's

6. VERIFICATION *(common to all position descriptions)*

INCUMBENT STATEMENT

I ___________________________________ (Incumbent Name) have read, understood and agree to comply with the above Position Description.

Signed: _______________________________ (Incumbent)

Signed: _______________________________ (Manager

Date: ____/____/____

(Original to be placed in personal file; photocopy to incumbent)

7. REVIEW OF POSITION DESCRIPTION *(common to all position descriptions)*

This position description will be reviewed annually, when the position becomes vacant or as deemed necessary.

Date Issued: January 2009

Last Date Reviewed:

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