St Vincent’s Hospital
Melbourne

Nurse Practitioner Project
Palliative Care Consultation Service
Implementation Report

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Executive Summary

In April 2009, the Department of Health invited health services to apply for funding ($45,000) under the Victorian Nurse Practitioner Project Round 4.4, to explore the potential for a Nurse Practitioner Palliative Care (NPPC) within their organisation. St Vincent’s Hospital (STV) Melbourne was one of six metropolitan services who were awarded funding for this project.

The key DoH deliverables of the NPPC project are:

- Description of the service model incorporating a NPPC role
- NPPC 5-year service model plan
- Prepare to appoint and support a NPPC at STV

STV Palliative Care Service Plan identified that the role of a NPPC should be explored within the Palliative Care Consultation Service (PCCS). This is supported by members of the STV Nursing Executive through the Nursing Strategy, of which the development of the nurse practitioner (NP) role across the organisation is integral. STV was the first health service to support renal NP candidates with the outcome of two NPs established within renal services. STV has undertaken one previous project to explore the scope of practice for NPs in stroke and submitted a proposal to scope the role in oncology and mental health, in addition to this NPPC project.

Scope of Practice

The STV NPPC model will be relevant across the continuum of care, with particular emphasis on provision of service to marginalised groups including the indigenous and homeless population who attend STV and Correctional Health, all of whom have their own unique, complex and diverse needs.

The NPPC will enable a smooth transition of care for patients with complex needs at key points along the continuum, developing an enhanced liaison role between the community, general practitioner (GP), patient and family by:

- Establishing, organizing, and resourcing the NPPC role
- Integration with relevant ambulatory care specialist clinics including chronic disease, oncology and correctional health services, with the aim of developing nurse led clinics within five years
- Develop a discharge planning liaison role for patients going home or to a residential aged care facility, including provision of an outreach visit where community services or GPs are unable to visit in a timely manner
- Improving quality of life outcomes in the management and support of indigenous patients, the homeless and other vulnerable patient groups
- Implementing and coordinating structured palliative care education programs to meet the needs of patients, families and carers, in addition to those of medical, nursing and allied health staff
- Being integral to the ongoing development of the PCCS
- Participating in research to promote and implement best practice in palliative care nursing

STV Executive is committed to enhancing the services of the PCCS for the benefit of patients, families and carers and sees enormous potential in the NPPC model. Securing adequate funding for the NPPC model remains the key challenge. The initial starting EFT will be 0.5. Furthermore it is recommended that a minimum of two NPCs be appointed to maintain continuity of care and long term integration and
sustainability of the role. This report and five year plan outlines the service model for the PCCS NP at STV. The plan is a living document which will evolve along with the project over time.

1 Background
Contemporary palliative care practice is based on the model developed by Dame Cicely Saunders in the late 1960s. The discipline of palliative care continues to evolve, encompassing both cancer related and chronic diseases, and with potential for patients to be referred where relevant at any stage on their illness trajectory. At the same time, the scope of practice and role of palliative care nursing has undergone enormous development, with opportunities for specific postgraduate education, career path opportunities and the subsequent emergence of the NP role. Clarity in defining the NP role, including purpose of role, scope of practice and educational requirements ensures transparency and provides a framework for services to adapt to the needs of their individual requirements.

2 Description of the current Palliative Care Consult Service Model
STV provides a comprehensive range of acute and sub acute health services to metropolitan and regional Victoria. These services include surgical, medical, oncology, haematology, palliative care, aged care, correctional health and mental health. In 2008, a total of 53,999 in-patients were treated and 364,232 outpatients attended STV.
Caritas Christi Hospice (CCH), STV clinical palliative care service, has been providing quality care over the past 70 years and is considered a national leader. CCH provides a range of interdisciplinary clinically based palliative care services including the PCCS across 19 STV campuses. The PCCS is located within the acute care services at Fitzroy and has been providing consultation services for over 10 years. The service is available office hours Monday-Friday 08.30-17.00. The current role of the PCCS is to review patients in non designated palliative care beds with cancer related and chronic disease diagnoses. In addition, the service offers a weekly physician run palliative care outpatient clinic. Close relationships with metropolitan, regional and rural community palliative care services have been integral to the function of PCCS. The current PCCS model comprises of an interdisciplinary team including a part time physician, registrar and a Clinical Nurse Consultant (CNC).

3 Service Access Point
In 2008, the PCCS received 721 internal patient referrals predominantly from the acute areas of STV. Referrals are made primarily by medical staff either by fax or direct phone call. These referrals are triaged as to urgency by either the CNC or registrar. Usual practice is for all new referrals to be seen within 24 hours of the receipt, by both the registrar and the CNC and palliative care recommendations made. Ongoing patient and/or family reviews occur on a daily basis. In circumstances where the CNC reviews a patient independently, recommendations are made and the treating unit doctors contacted for medication orders. Delays are occasionally experienced when referring unit doctors are not immediately available to write up the medication orders. The PCCS often initiates family meetings with the treating teams for the purpose of introducing palliative care, discussing goals of care including care options and in particular issues relating to discharge planning, end of life care and frequently there are many complexities surrounding these issues.
The PCCS provides a triage/referral service to other palliative care services both externally and internally to STV. For community referrals the PCCS completes the relevant service’s referral form with detailed information regarding the patient and makes follow up phone calls to ensure coordinated care. Referrals are also made by PCCS to other palliative care units, and to metropolitan and regional hospitals with or without palliative care specific beds. Transfers are facilitated to CCH inpatient beds at Kew and Fitzroy.

4 Aim
The purpose of the current project is to scope the role of a NP specific to the PCCS at St Vincent’s Hospital (Melbourne).

5 Method

A mixed methods design was employed to undertake the needs analysis to address the project deliverables. A steering committee of key stakeholders was convened to support the project (page 2). The methods included:

1. A literature review to establish national and international guidelines and trends
2. Audit of current PCCS practice
3. Gap analysis: the PCCS clinical personnel presented patient journey case studies and identified strengths and opportunities for improvement associated with each
4. Semi structured interviews: a questionnaire was developed to guide interviews with key stakeholders identified by the steering committee and included clinicians, service managers, liaison officers, NPs and two key community palliative care services clinicians. Wider consultation across STV campuses, as identified by the key stakeholder group, included with project officers, clinical nurse consultants and a general practitioner (GP)

6 Outcomes

6.1 Literature Review

The demand for palliative care services has escalated due to an ageing population, greater likelihood of people living with multiple medical morbidities for long periods of time, consumer demand for high quality healthcare, the cost of healthcare and the promotion of integrated and coordinated patient management plans having risen (1). Accordingly there is increasing urgency to develop a skill base amongst healthcare professionals to meet these needs. Establishing NP roles is one possible response to this increasing demand. The literature in this area is very limited with just one pilot project examining feasibility in Australia (2). In this report the importance for requisite standards for education, clinical symptom assessment and communication skills were emphasized (2). Suggested skills for a palliative care NP include: ability to undertake comprehensive patient assessment and develop appropriate management plans; competence with educating staff, patients and families; and an ability to conduct research (1).

The benefits of the establishment of NPs have received some attention. A study exploring the activities of a palliative care NP concluded that the primary benefits of the role were symptom management, education and counselling for the patient and family, coordination of care and ensuring continuity of care (3). Others have described NPs as reducing hospitalisations, length of stay and emergency department attendances (1). An American study which compared questionnaire responses of 607 NPs with those of a broader group of health professionals found that 86% of the NPs with their specific NP education were more confident initiating discussion about end of life care with patients and families (3).

Ongoing support and mentorship for NPs is acknowledged as a critical component to the success of the role. A recent UK survey identified that despite their educational preparation to prescribe from an extended formulary, only half the NPs (88 of 168) were actually prescribing (4). One of the main reasons cited was inadequate medical mentoring. The NP role is seen as a key component to coordinated healthcare between acute, home and long term care settings.

6.2 Service audit

An audit of 100 PCCS patients referred in 2008 revealed that 66% of referrals were for patients who had a cancer diagnosis, 34% had a chronic disease diagnosis and of the total, 8% of referrals had both. Of the 100 audited referrals, 44% of patients reported more than 2 symptoms and 86% required more than 2 interventions by the PCCS. For the source of referrals to PCCS [Appendix 1; figures 1, 2, 3] and for the
management undertaken by PCCS [Appendix 1; figures 4, 5, 6]. The mean time spent reviewing a patient was 119 minutes and the average number of visits was 3.65 per patient.

6.3 Gap Analysis

The needs identified from the gap analysis included: a presence in the emergency department for frequent attendees; attendance in chronic disease and cancer related clinics; nurse led ambulatory clinics; case manage complex palliative patients; to facilitate smooth transition of care provide an outreach visit to patients home or Residential Aged Care Facility (RACF); a role in education; more timely assessment; prescribing medications as per formulary and consider a role in Correctional Health.

6.4 Interviews

Thirty one face to face interviews were conducted. The interview questions (Appendix 2) focused on identifying the respondents' level of knowledge of the role of the current PCCS and potential for a NP. Due to the relative newness of the NP role many interviewees required a generic overview of the role including that a NP provides a comprehensive nursing service utilizing a broad range of expert knowledge and skills, and has the ability to work autonomously. The data were analysed to identify recurring themes and issues associated with PCCS and NP role.

Opportunities for NP role

Many interviewees recognized that nurse practitioners offer an excellent opportunity to broaden the access points for patients who may not be well served by traditional models of health care. In addition, the NP could facilitate the appropriate transfer of knowledge to clinicians and patients especially in an era of advancing technology, increasing the volume of research and literature. The NPPC could enable a smooth transition of care for patients with complex needs at key points along the continuum; developing an enhanced liaison role between the community, GP, patient and family. There was unanimous agreement that communication between the PCCS and acute, sub acute, community services and GPs is pivotal in increasing seamless transition of care. The NPPC could facilitate this. Over 75% stated that NPPC would be uniquely placed to take a lead role in providing palliative care across ambulatory care specialist clinics including chronic disease, oncology and STV Correctional Health Services. The majority (82%) of those interviewed were of the opinion that education was currently delivered in an ‘ad-hoc’ manner to all levels of staff including doctors, nurses and allied health and a more structured approach was required. The Koori Liaison Officer identified a role for a nurse with advanced skills in caring for the indigenous patients who attend STV as culturally they require continuity and must have time to develop trust in order to facilitate more timely and sensitive care to meet their diverse needs.

Awareness and uptake of current PCCS

This analysis identified that although 96% of respondents were aware of the PCCS and 87% were satisfied with the responsiveness and assistance provided by PCCS, few were cognizant of the suite of services offered. Sixty-seven percent were not aware that the service could be utilized for symptom management of patients with chronic medical conditions. Although, they reported that the PCCS had impacted positively on patient outcomes, it was apparent that the PCCS was not being utilized to its full potential throughout STV campuses.

Barriers/Limitations

Ninety percent felt that the most significant barrier to the NP role is the ‘culture’ within STV and transitioning from a medical model would take time. The majority felt that the development of the role would be limited as NPs are not currently afforded Medicare provider numbers. In addition, it will take time for the NP role to be understood and recognized.
7 Key Aspects of the NPPC Role

Information gathered via the literature review, audit, gap analysis and interviews were integrated to identify key aspects of the NPPC role which will facilitate seamless transition from acute and subacute care to the community and promote close liaison with GPs and other service providers.

- To develop and implement a triage tool to stream patients with complex care needs to the NP and clearly define what constitutes ‘complex care’
- Case manage patients with complex needs
- Discharge planning liaison role for patients going home or to a RACF, provision of an outreach visit where community services or GPs are unable to visit in a timely manner
- Integration with relevant ambulatory care specialist clinics including chronic disease, oncology and Correctional Health with the view to establishing nurse led clinics within these services
- Establish a role for enhancing palliative care services for the indigenous population of STV in conjunction with the Koori Liaison Officers by delivering the most comprehensive and integrated care in the Metropolitan area
- Establish a regular service to transition care at STV St Georges Hospital subacute and aged care services for symptom management of palliative care patients with cancer and chronic medical conditions
- Establish a role in the management of vulnerable homeless patients presenting at STV to improve quality of life outcomes
- Providing a framework for more strategic education by the PCCS
- Participate in research to promote and implement best practice in palliative care

8 Key Responsibilities

- Provide patients with advanced clinical assessment and treatment under the mentorship of the medical consultant and utilizing applicable Clinical Practice Guidelines (CPGs)
- The NP will develop a comprehensive care plan unique to each patient and family including communication and liaison with relevant interdisciplinary team members, community services and GPs
- The NP will facilitate family meetings and adopt a lead role in discharge planning particularly in facilitating clients with multiple complex needs
- The NP will provide care including diagnostic, prescription and dose authorization as per the designated formulary identified for the scope of practice for a NPPC in the PCCS at STV
- The NP will be involved in the development of quantifiable measures of success that demonstrate improved outcomes for patients using this model
- The NP will take a lead role in structuring and initiating patient and family education
- The NP will provide education and mentorship to staff less experienced in palliative care
- The NP will undertake and participate in research and translate research into practice thus leading change in clinical practice.

9 Accountability

It is anticipated that NP candidates will be working towards endorsement by the Nurses Board of Victoria (NBV) within 3 years of appointment, gaining the appropriate qualifications and developing practice expertise within a professional and clinical mentor framework. Individual nurse practitioner palliative care candidate (NPPCCC) education and mentorship needs will be identified early in candidature.
Clinical mentorship is essential; Dr Mark Boughey, Director of Palliative Medicine and Dr Jennifer Philip, Deputy Director of Palliative Medicine STV have agreed to lead the clinical support for STV NPPC candidates. Non clinical time of at least 20% for the purpose of professional development has been embedded into the NPPC position description. Ongoing education of nursing staff at STV is supported by study and exam leave while peer support for candidates will be provided by the Nursing Education Department and the Centre for Palliative Care Education and Research Nurse Practitioner Collaborative at STV.

Succession planning to ensure sustainability of the NP role is fundamental to the model. Initial scoping of the project at STV has identified the need for two NPs. STV will continue to actively review funding opportunities to support two NPPC in full EFT positions which will ensure sustainability of the role over time. It is important that the NP role is structured to maintain both high levels of clinical case load and commitments to professional development, education and research. Therefore it is recommended that a 1 EFT NP will have one nonclinical day/week as a NPC, and one nonclinical day/fortnight once an endorsed NP. The initial NPC appointment will be at 0.5 EFT with the objective of increasing EFT as soon as practicable.

Given the scope of practice described in the NPPC model, the incumbents will have reporting lines for clinical decision making, professional and operational management. Reporting lines will include to the Director and Deputy Director of Palliative Medicine and Director of Nursing/ Operations Manager CCH.

A governance structure is being developed to oversee the implementation of the NP model and support/mentor/educate the development of the NPC. A key recommendation is that the position description (PD) is reviewed by the NPC in conjunction with their operational manager and medical mentors leading up to attaining practitioner status, ensuring the PD remains relevant to ensure clinical and professional relevance to this emerging role.

10 Recruitment

Recruitment has commenced for a 0.5EFT NPC. A PD has been developed and STV recruitment processes are underway with appointment expected by mid November.

11 Summary

In conclusion this project has provided key insights into the potential role of a NP in the PCCS. The project findings have demonstrated that there is potential for significant improvement in patient outcomes with particular emphasis on early involvement in care pathways and to areas of care that have had limited access to the current service. In particular the NP role will target the palliative care needs of patients with chronic diseases, patients in correctional health, homeless and indigenous patients and in transitional residential aged care. The successful implementation of the NP into the PCCS will be achieved through effective communication with all stakeholders and sustained support by the nursing executive. The steering committee remains hopeful that funding will be established to implement this important model.
11 References

12 Bibliography
1. STV Annual Report (2007-8)
2. STV Strategic Plan 2005-2010
3. STV Health Melbourne Stroke NP project (2008) final report of the project
Appendix 1

**Fig 1: Total referral to PCCS per unit**

Key:
- GMA: General Medicine A
- GMB: General Medicine B
- GMC: General Medicine C
- GEM: Geriatric Evaluation Management
- APS: Acute Pain Service
- Cardio: Cardiothoracic
- Rehab: Rehab Fitzroy
- Gasto: Gastrointestinal
- Upper: Hepatobilary/Upper
- GI: Gastrointestinal
- Haem: Haematology
- Neuro: Neurosurgery
- Ortho: Orthopaedics
- ESCF: End Stage Cardiac Failure
- ESRF: End Stage Renal Failure
- ENT: Ear, Nose & Throat
- COPD: Chronic Obstructive Pulmonary Disease
- SGH: St Georges Hospital
Fig 4: Management issues in cancer related patients referred to PCCS

Fig 5: Management issues - non-complex chronic disease patients
Fig: 6 Management issues - complex chronic disease patients
Appendix 2

Stakeholder Questions

1. Within your area, describe how you see the current role and function of the PCCS.

2. In light of your response to question one how well does the PCCS fulfill this role/is there scope to improve the service that is provided? E.g. do you have palliative care education needs that currently are not being addressed?
   a) If yes, please describe

3. Within your service are there areas that a nurse with advanced clinical skills in palliative care could be of benefit (please describe)? E.g.:
   a) Is there a role for the Palliative Care Nurse Practitioner (PCNP) in assisting with discharge planning in your service? (E.g. to follow up post discharge where the GP is not able to see patients within a specific timeframe? Or where there is a delay in availability of a community palliative care service particularly to residential aged care facilities?
   b) Is there a role for a PCNP in OPD in malignant/Non malignant clinics?
   c) (E.g. Nurse led clinic? /Early referral/Education)
   d) Is there a role for a PCNP in reducing lengths of stay/admissions in your area?
   e) Is there a role for a PCNP to facilitate in communication with family/carers?

4. What do you perceive as barriers to implementing the PCNP role within your area?

5. Could you see the PCNP role evolving and developing in your service?

6. Do you have any other comments regarding the PCNP in the PCCS?

7. Is there anyone else that you would recommend that I should speak with?
Appendix 3

5 Year Indicative Plan for the Palliative Care Consultancy Service Nurse Practitioner Model

NPPC Year 2 continued
- Planning/developing/establishing the NP role in achieving efficiencies in the management of the vulnerable homeless patients presenting at STV
- Sustain and expand a role in providing primary education delivery in association with the PCCS to patients/families and carers in addition to those of nursing and allied health staff
- Develop and establish partnerships with other departments and health services developing nurse practitioner roles both internally at STV and externally.

Deliverables
- Impact of the Nurse Practitioner Model Key performances and data

NPPC Year 1
- Recruitment
  - Establishment of a key role in support of development of the PCCS by participating in development and data
  - Recruitment of key performance indicators (KPIs) for performance evaluation and benchmarking of the service and NP role.
  - Development of monitoring plan to communicate the position and model to St Vincent’s Hospital (STV)
- Evaluation
  - Map the appointment of NP’s in the Palliative Care Consultancy Service (PCCS) at STV
  - Review Professional development of the Nurse Practitioner within three years of appointment
  - Monitor clinical time allocation up to twenty percent will be a component of the role

Monitored assists Monday-Friday 08.30-17.00
- Finalize scope of practice
- Continue involvement with the Centre for Palliative Care Education and Research Nurse Practitioner
- Identify and establish a support network with other NPs working within STV
- Develop and establish strategic partnerships and co-operation with the PCCS
- Develop and establish partnerships with other departments and health services developing nurse practitioner roles both internally at STV and externally.
- Sustain role in improving the palliative care service to the indigenous patients of STV in conjunction with the Koori Liaison Officers
- Continue involvement with The Centre for Palliative Care Education and Research Nurse Practitioner
- Continue involvement with the Centre for Palliative Care Education and Research Nurse Practitioner
- Continue involvement with The Centre for Palliative Care Education and Research Nurse Practitioner
- Review Clinical Practice Guidelines (CPGs) to support the role
- Development of role
- Monitor and develop role in the Aboriginal health centre in Nicholson Street Fitzroy as needed.

NPPC Year 3
- Recruitment
  - Partnership learning, vision including second NPC, preparation for endorsement and engagement in Masters of Nursing and advanced NP in PCCS
  - Recruit second endorsement of second NPC by end of their 3rd year
  - Recruitment/development of RNPs involved in the PCCS role
- Identification of Key Role
  - Development of role as a key role
- Planning/development of RNPs involved in the PCCS role
  - Implement key role into roles of RNPs involved in the PCCS role
- Recruitment/development of RNPs involved in the PCCS role
  - Implement key role into roles of RNPs involved in the PCCS role
- Development of Role
  - Development of role in conjunction with the Centre
  - Identify and establish a support network with other NPs working within STV
  - Finalize scope of practice
- Evaluation
  - Evaluation of role and performance indicators within the first 12 months
  - Evaluation of role and performance indicators within the first 12 months
  - Evaluation of role and performance indicators within the first 12 months

NP Year 4
- Identification of key role
  - Demonstrate leadership in palliative care by actively promoting advanced nurse practice across disciplines
- Development of Role
  - Development of role in conjunction with the Centre
  - Development of role in conjunction with the Centre
  - Development of role in conjunction with the Centre

NPPC Year 2
- Plan develop and establish a role in the Aboriginal health centre in Nicholson Street Fitzroy as needed
- Sustain role in improving the palliative care service to the indigenous patients of STV in conjunction with the Koori Liaison Officers
- Integration into all ambulatory specialized clinics including chronic disease/ oncology and Correctional Health
- Planning/development/establishing the role of ‘case managing’ complex patients presenting at STV
| NP Year 5 | **Development of Role**  
|---|---|
|   | ▪ Expand nurse led clinic at Correctional Health  
|   | ▪ Provide Nurse led palliative care ambulatory clinic at SVH  
|   | ▪ Benchmark NP role in palliative care consultation services  
| **Evaluation** | ▪ Evaluate attendance at the Aboriginal Health Centre in Nicholson Street Fitzroy as need indicates  
|   | ▪ Mentoring  
| **Sustain consolidated role seven days/ week 08.30-17.00** |