Victorian Nurse Practitioner Project

Phase 4 Round 4.1

Nurse Practitioner Rural Service Planning

West Gippsland Healthcare Group

Rawson Service Model
Index

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1.1 **Executive Summary**

The focus of this report has centred on the feasibility and sustainability of a Rural Remote Nurse Practitioner position at the Rawson Community Health Centre.

This process involved the formation of the WGHG Nurse Practitioner Steering committee that has overseen the project. After thorough researching of existing Nurse Practitioner (NP) positions within Victoria the current nursing model at Rawson was examined to determine if an extension to the scope of nursing practice could address identified services gaps to the local communities.

There is an in principal support by WGHG for the position of a Rural Remote Nurse Practitioner based at the Rawson site. The position would be an extension to the scope of practice of the current nursing position. A Nurse Practitioner would address many of the service gaps identified within the community. There would be:

- a reduction in after hours presentations to local Emergency Departments from Rawson;
- reduced time to appropriate treatment;
- reduced cost of treatment for patients;
- reduced hospital admissions.

The final recommendation to create the position is contingent on allocation of additional resources.

There would not be an increased EFT for nursing at the Rawson site, the potential Nurse Practitioner Candidate currently based at Rawson would continue at a 0.8 EFT (four day week). While the remaining day would not be covered by a Nurse Practitioner many of the service gaps identified in this report would be addressed if the proposal for Rural Nurses to supply medications was instigated. The current close collaboration with visiting General Practitioners would continue and be enhanced.

Two measures to address the service gaps could be implemented without extending the current scope of practice to an NP position, these measures would also ease the transition from the current position to an NP. Specifically these measures are:

- An electronic pharmacy imprest system be instigated at Rawson that is linked to patient notes. All prescribed and supplied medications would be recorded to ensure continuity of supply and monitoring of prescribing patterns.
- That Rawson CHC be given the same recognition as Bush Nursing Centres in relation to remote nursing practice, and have access to Rural Ambulance Victoria training.
- That the proposal for Victorian rural nurse to supply a restricted range of medications based on the Queensland DTP model, be adopted in Rawson.

Additional recommendations from this report are:

- A proposal be developed for additional funding from Department of Human Services to support the NP position for 3 years.
- NP’s be given access to the Medicare Rebate Scheme and Pharmaceutical Benefit scheme to ensure that patients treated by NP’s are not financially disadvantaged, specifically in Rural and Remote settings.
- A submission be made to the federal Minister of Health requesting that in Rural and Remote settings “A Medicare item be made available to GPs for remote collaborative case management of a patient with a rural remote NP” This item would reimburse the professional input of both practitioners and would recognise the context of remote practice. An item number should also be extended to NP’s who assist with case management of a GP’s patient in the community.
Conflict of Interest Disclaimer

This report was funded through the Victorian Nurse Practitioner Project Phase 4 Round 4.1 “Nurse Practitioner Rural Service Planning”. This project officer for this report, Alan Lowe, is employed as Nurse Manager at the WGHG Rawson site. He is undertaking a Masters degree in Remote Health Practice (Nursing) and has expressed interest in seeking endorsement as a Nurse Practitioner if the current position at Rawson was extended to encompass a Nurse Practitioner role. The report’s findings have been overseen and endorsed by the Director of Community Services, Director of Nursing and Midwifery and Chief Executive Officer.

2.1 Introduction

This report has written for the West Gippsland Healthcare Group with funding from the Victorian Nurse Practitioner Project Phase 4 Round 4.1 “Nurse Practitioner Rural Service Plan”.

For the purposes of this report the following definition of a Nurse Practitioner is used:

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 practice 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 practice. (Australian Nursing and Midwifery Council, 2006).

All references to the model proposed in this report should be read in context of this definition. The term Nurse Practitioner (NP) is a protected title in Victoria, and can only be used by nurses endorsed to practice by Nurses Board Victoria (NBV), although national registration is expected by 2010.

The model proposed is specific to the context of Rural Remote Nursing and will be based at the Rawson Community Health Centre. The structures, process of “expression of interest”, and NP candidature endorsement described in this report would be applicable to any NP position sought within the WGHG.

The key stakeholders who have helped shape this report for the NP model proposed at Rawson are:

1. Communities of Erica, Rawson Walhalla and surrounds
2. West Gippsland Healthcare Group
3. Moe Medical Group
4. Nursing staff Rawson CHC

This report has not discussed or entered into debate regarding the merits of an NP role. The research and evidence resolved the position of Nurse Practitioner some years ago. This report has been written with the understanding that the:

- role of nurse practitioner exists.
- position of NP has broad community support, both locally and internationally.
- significant impediment for Nurse Practitioner positions is legislative and funding support for access to both the Pharmaceutical Benefits Scheme (PBS) and Medicare (see attachment 1 “Consensus statement”).
3.0 Background

3.1 West Gippsland Healthcare Group

Our Vision:

To improve the health and wellbeing of our community.

Our Mission:

West Gippsland Healthcare Group is committed to the provision of high quality, integrated health care that meets the changing needs of individuals and our community.

West Gippsland Healthcare Group provides acute medical and surgical, obstetric, emergency, community and aged care services, primarily in the Shire of Baw Baw, approximately 100 kms east of Melbourne.

West Gippsland Healthcare Group comprises a number of sites. They are Baw Baw Health and Community Care Centre, Community Health Centre in Warragul, Community Services Centres in Trafalgar, Cooinda Lodge Aged Care Nursing Home, Rawson Community Health Centre, Andrews House Aged Care Nursing Home, Warragul Linen Service and West Gippsland Hospital.

West Gippsland Healthcare Group's history dates back to 1888 when the community established a hospital to service the area between Melbourne and Sale. West Gippsland Healthcare Group has health service delivery responsibilities across a mixture of rural, urban residential and agricultural areas located within the Shire of Baw Baw, and draws clientele from the peripheral east and west of the shire. The Group services a primary catchment population of approximately 40,000. The administrative headquarters are located at West Gippsland Hospital in Warragul, the largest town in the West Gippsland area.

West Gippsland Healthcare Group enjoys close links with other healthcare providers including the Ambulance Service, general practitioners, residential aged care providers, the Baw Baw Shire, other public and private hospitals and a range of other healthcare professionals in private practice.

West Gippsland Healthcare Group has full accreditation status from the Australian Council on Healthcare Standards, ISO and HACC.

3.2 Rawson Community Health Centre

Rawson township is situated some 40km north of the Latrobe Valley towns of Moe and Traralgon in the foothills of the Great Dividing Range 165 kms to the east of Melbourne. It is in an area dominated by vast tracts of state forest and national parks in the Thomson, Tyers and Aberfeldy rivers catchment area. The townships of Aberfeldy, Erica, Moondarra, Rawson and Walhalla are serviced by the Rawson CHC.

The dominant industries have been forestry, potato and beef farming although tourism is now a major employer within the local townships. The tourism industry is based around the old gold mining town of Walhalla plus outdoor recreation in the surrounding forests, rivers and ski fields.
The Rawson Community Health Centre was established in 1977 to service the health needs of the workforce employed to build the Thomson Dam constructed 17 km north east of Rawson. The township of Rawson was built by the Melbourne and Metropolitan Board of Works (MMBW), later to become Melbourne Water. The Community Health Centre building was funded by the MMBW and administered by the Moe Community Health Centre until the completion of the Thomson Dam. In 1984 the buildings were purchased from the MMBW and the centre was then fully funded via DHS grants. The amalgamation of Latrobe Valley CHCs formed the Latrobe Community Health Service (LCHS) in 1995 with the Rawson CHC being one of its many sites. Following council redistributions and amalgamations Rawson along with the surrounding townships of Erica and Walhalla were incorporated into the Baw Baw Shire. In January 1997 management of the Rawson Centre passed from LCHS to WGHG which better reflected its position within the Baw Baw Shire, but the historic close links to Latrobe Valley based health providers still remain in place. The closest hospital, Latrobe Regional is 40 km away with the nearest pharmacy 35 km away in Moe. Radiology and pathology services are also located in Moe, Morwell and Traralgon.

A private medical practice from Moe provides two GP sessions per week, currently Wednesday and Friday mornings, although absences are not covered so there are a number of weeks where there is one session only per week and occasional weeks were no session is provided. GP services are also located in the Latrobe Valley towns of Morwell, Traralgon and Moe where appointment waiting times have increased significantly in recent years.

Patient Demographics* of Rawson CHC

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<tr>
<td>&gt;89</td>
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<td>16</td>
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</tbody>
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*Sourced from “Medical Director” patient management software. These figures are 2006 based and are sourced from clients registered at the Rawson Community Health Centre.

4.0 Rural Models

4.1 Current Rawson Model

The nursing model at the Rawson Community Health Centre is a generalist rural remote nurse, currently a Monday to Friday service. The continuum of care ranges across the life span from antenatal to palliative care services. There is not a 24 hour Health service in Rawson. However, provision is made for prearranged funded visits for Hospital in the Home, Post Acute Care and Palliative Care Clients. Despite there being no after hours service nurses do respond to critical emergency situations when contacted.

The centre has one full time community nursing position that is currently job shared on a 4 day to 1 day basis. A relief nurse is occasionally employed for extended leave periods. The nursing position of rural generalist comes with the expectation that services are delivered in the following service areas:
- District Nursing Service (home visits)
- Clinic practice
- Palliative care
- Emergency care
- Counselling services
- Health promotion
- Community development

A discussion paper (Jan 2008) for the Canadian Association for Rural & Remote Nursing describes the characteristics of a typical Rural & Remote nursing practice. These characteristics are evidenced in the day-to-day practice at Rawson:

- Autonomy of practice and decision making and independence with an awareness of limitations (Scharff, 2006).
- Significant responsibility that can be overwhelming (MacLeod, 1998).
- Ability to be nimble and responsive in dealing with issues as a consequence of communication patterns and role independence (Shellian, 2002).
- The “ace” and “pinch hitter” concept – having to perform complex tasks competently but infrequently (Scharff, 2006).
- Expert generalist with a wide range of advanced knowledge and ability (Bushy, 1999; Scharff, 2006) and strong broad base clinical knowledge and practice in multiple clinical areas simultaneously (Shellian, 2002; Scharff, 2006).
- Underestimated complexity (MacLeod, Kulig, Stewart, & Pitblado, 2004) and flexibility with limited support (Eldrige & Jenkins, 2003).
- Ability to be culturally safe and relevant in nursing care.
- Ability to utilize technology to maximize nursing care and enhance outcomes for patients/clients.
- Required to take on activities and components of care that are characteristically done by other health care professionals in urban areas (i.e. respiratory therapy, pharmacy).
- Expectation of the addition of certain aspects of care that would commonly be classified as physician responsibilities and the requirement that this expectation is supported by appropriate delegation, education and practice setting requirements.
- Understanding and integration of community capacity, community assets, politics and intersectoral collaboration (Shellian, 2002).
- Ease of intersectoral collaboration as a consequence of necessity and the ability to mobilize a wide variety of services and supports to “get the job done”.
- Creative mobilization of resources that may or may not exist on site (MacLeod, 1998).
- Ability to adjust nursing care based on community demographics and needs.
- Confidentiality and trust for patients as people you know or even perhaps family members.

4.2 Victorian Remote Area Nurse Scope of practice

The scope of practice and setting of the Rawson CHC is very similar to Bush Nursing Centres (BNC). There are 14 such BNCs in Victoria. The Rawson CHC was classified as a Remote Area Centre when the first phase of “Emergency Guidelines for Remote Area Nurses” was introduced in 1995. After completion of the requisite training the Rawson Community Health nurse was recognised as a designated Remote Area Nurse (RAN). In the Victorian context this was defined as:

“a Remote Area Nurse is defined as a Registered Nurse working in a particular rural community which is isolated from medical support and other health care resources”.  

Emergency Guidelines for Nurses 1992 Health Department Victoria
Following the initial training there was little follow up or support for designated nurses who were not employed by BNCs. The Bush Nursing association had been the key driver behind the development and acceptance of the “Emergency Guidelines” the ‘designated’ status was removed in 2003 putting RANs in a legal limbo. The nature and scope of practice had not changed but the legal support behind the guidelines had. In 2005 Rural Ambulance Victoria (RAV) took over the training of RANs. Following successful completion of the RAV course RANs are accredited to use the Remote Area Nurses Guidelines 2008/2009. This seemingly is limited to nurses working in Bush Nursing Centres. Apart from being “out of the loop” there is no reason why nurses working at the Rawson CHC should not again pursue accreditation for RAN status; Rawson is as isolated in 2008 as it was in 1995.

The initial acceptance of the Emergency guidelines was one of the earliest examples in Victoria of nurses being able to legally operate in an expanded role without prior approval from a doctor, albeit in a very limited set of scenarios. Historically the practice had been to deal with the emergency first and worry about the legal implications later. Eventually common sense prevailed and there was acceptance that experienced trained nurses in these remote settings were skilled professional and capable of dealing with emergencies. They however, needed legislative legal support.

4.3 Health Services Permit Conditions

Health Service Poisons Permit “Obtain Poisons Or Controlled Substances For The Provision Of Health Services”

A Permit to “Obtain Poisons Or Controlled Substances For The Provision Of Health Services” enables the purchase, obtaining and use of the poisons and controlled substances which are the subject of the permit, in accordance with the ‘Drugs, Poisons and Controlled Substances Act 1981’. The holder of the permit must comply with the current Poisons Control Plan that has been approved by the Department of Human Services, and have delegated a Responsible Person/s for overseeing compliance with the Plan. Health services with a valid permit may obtain, store and use schedule 2, schedule 3, schedule 4 and schedule 8 drugs for therapeutic purposes.

General Dealers License

‘Licence as a General Dealer in Poisons” – A license to sell or supply schedule 2 poisons may be granted if the business premises are situated at least 25 kilometers distance away by the shortest practicable road from the nearest premises in which a pharmacist conducts a pharmacy in an open shop. A General Dealers License permits the holder to sell or supply by retail poisons or controlled substances included in schedule 2, schedule 5, schedule 6 or schedule 7 of the ‘Drugs, Poisons and Controlled Substances Act 1981’. The holder of a license is subject to the same conditions as a permit. Health services with a valid license may sell or supply by retail schedule 2 poisons, only from the premises in which they are stored.

The Rawson CHC has a ‘Licence as a General Dealer in Poisons” which enables specified nurses employed at the CHC to sell and supply Schedule 2 poisons. A Permit is also held to “Obtain Poisons Or Controlled Substances For The Provision Of Health Services”, both of these are held under the “Drugs, Poisons and Controlled Substances Act 1981 (No.9719)” Paragraph (g) of the CHC’s permit states that a nurse must:

(i) ascertain the therapeutic need for any Schedule 2 poison; and
(ii) make an accurate record in retrievable form of the details of the sale or supply of any Schedule 2 poison. Such record must include the name and address of the patient, the name and quantity of the Schedule 2 poison, and the date of supply.
The following clauses from the Health services permit limits:

“(b) The purchase, obtaining and use of the poisons or controlled substances which are the subject of this permit must be strictly in accordance with the “Drugs, Poisons and Controlled substances Act 1981” and the regulations made hereunder.”

and later states:

“(g) Despite Condition (b), in an emergency where contact with a medical practitioner is not practical, a nurse may administer a Schedule 4 poison or a Schedule 8 poison, if during the previous twelve months the nurse demonstrated competence in physical assessment skills relevant to the condition for which the schedule 4 poison or schedule 8 poison is administered.”

Therefore in an emergency situation the permit allows appropriately trained nurses who are unable to make contact with a medical practitioner for specific treatment orders, to administer S4 and S8 medications without such orders. This needs to be clarified in light of the recent suggestions that only those employed in Bush Nursing Centres can be classified and accredited as RANs.

**Recommendation 1**

A recommendation of this report is that the Rawson CHC be given the same recognition as BNCs in relation to remote practice, and have access to the RAV training.

### 5.1 Sustaining Rural Emergency Services

The Victorian Government has recently released a discussion paper called “Sustaining rural emergency services: Proposal for nurses to supply medicines.”

“It is proposed that Victorian legislation be amended to allow suitably trained RNs who are employed in rural health services (including BNCs) in Victoria to supply a limited range of scheduled medicines to patients who present to these services. Supply of medicines by nurses would be according to state-wide drug treatment protocols that have been approved for use in Victoria and adopted and applied by the local health service facility.”

Initial indications are that submissions have been largely supportive of the proposal.

The proposal is based on the Queensland model “Drug Therapy Protocol” (DTP) It is anticipated that the Queensland model would be adapted to reflect Victorian practice. This proposal allows for more scope of practice for supply of medications than in the Emergency Guidelines for RANs but does not allow for the autonomous prescribing rights that NPs have. NPs have an approved ministerial list of drugs which attaches to the NP regardless of where they work. The proposal to supply medications relies on facility based protocols (Health Management Protocol – HMP) that draw on a state-wide list of DTPs.

If the proposal for nurses to supply medicines was adopted in Victoria this would address some of the service gaps identified at the Rawson CHC. There would be a significant improvement in access to timely treatment with resultant improved outcomes. After hours care will still remain an issue as there is at present no opportunistic after hour’s service offered at Rawson. There may however be a reduction in after hour’s presentations if patients are able to consult with the nurse during hours knowing that they can be managed locally for most conditions. There is some anecdotal evidence that patients do not present to the CHC during hours because of the assumption that due to restrictions on the nurse’s scope of practice they will be required to travel for definitive treatment regardless of being seen at the Rawson CHC.
 Recommendation 2

This report supports and recommends that the proposal for Victorian rural nurses to supply medication be adopted and based on the Queensland DTP model.

5.2 Emergency Presentations

As with nearly all rural health services, patients who present in an emergency to the Rawson CHC are triaged by a nurse. Well over 90% of presentations occur while the nurse is the sole health professional, and unless there are multiple trauma presentations most have treatment commenced in a timely manner. With little or no professional support in an emergency a situation can become overwhelming, especially with multiple trauma such as in motor vehicle accidents. Using the Australasian Triage 1-5 Scale all category 1, 2 and most category 3 presentations would necessitate an immediate ambulance transfer. Patients are generally taken to Latrobe Regional Hospital although on occasions are transported to West Gippsland Hospital. The wait time is for an ambulance is generally 45 minutes although 1 hour is not uncommon. Apart from basic airway and circulation management it is during this critical time that skilled interventions by a nurse practitioner would benefit the outcome, some of the extended practice interventions may include:

- peripheral cannulation and commencement of IV fluid replacement.
- interosseous access for fluid replacement or medication route.
- needling a tension pneumothorax.
- commencement antithrombolytics in suspected AMIs.
- administering adrenaline for anaphylaxis.

The following taken from “Emergency care minimum requirements framework” DHS discussion paper sets the minimum standards for emergency resuscitation and stabilisation of patients at all public health services, many of these are advanced practice skills.

- Assessment
  - Triage including mental health triage
  - Comprehensive patient assessment

- Airway management
  - Airway management techniques including laryngeal mask airway
  - Cervical spine immobilisation with rigid collar
  - Administration of oxygen

- Breathing support
  - Bag valve ventilation
  - Decompress a tension pneumothorax using a needle decompression or ‘pneumocath’
  - Management of a sucking chest wound
• Circulation support
  – Semi-automatic or automatic external defibrillation
  – Peripheral intravenous cannulation and therapy including intravenous fluid replacement
  – Interosseous needle insertion
  – Provision of first line emergency medication including thrombolysis

• Ongoing management
  – Management of mental health emergencies
  – Initial management of patient while awaiting further assistance or transfer

• Initiating transfer
  – Initiate the appropriate transfer protocol
  – Prepare patient and patient information for transfer

Given that these are minimum requirements of public health services then as a consequence nursing staff at Rawson should be expected to have adequate training and support mechanisms in place to ensure provision of these minimum standards. Some of these minimum standards are at an extended scope of practice commensurate with a NP model.

5.3 Acute and Opportunistic Presentations

Emergency presentations make up a very small, but never the less crucial, component of remote rural practice. Far more common are opportunistic acute presentations that can provide dilemmas for rural and remote nurses on a daily basis. There are limitations on a remote nurses scope of practice to diagnosis and provide optimal timely treatment for many presenting conditions, the inability to commence and supply appropriate medications is of most concern. Common acute presentations are:

• UTIs
• Skin infections
• Chest infections
• Eye infection
• Trauma requiring simple suturing
• Otitis media
• Throat infections
• Emergency contraception
• Allergy
• Asthma
• Medical certificate requests

The NP model proposed at Rawson would see an extension to the existing scope of practice to enable appropriate treatment of these conditions. The model assumes that current nursing staff or future staff would undertake the NP endorsement process, that there would be no increase in nursing EFT and there is little change in population.
Presently the health services permit does not allow any supply and administration of medicines in acute situations without the express order of a medical practitioner. In the above presentations this delays treatment, and necessitates lengthy trips out of town for consultations with GPs, if an appointment can be arranged. If no GP appointment can be found patients are advised to present to A& E departments or wait until an after hours clinic opens. This delays optimal treatment and investigations for many hours and often causes inappropriate A&E presentations.

A Nurse Practitioner based at Rawson would be able to initiate timely treatment, investigations and follow up referrals. A vast majority of presentations could have treatment completed without the need for the patients to leave the community, those requiring follow up GP appointments could be seen at the Rawson Centre. Case management discussions between GPs and a Nurse Practitioner, with patient consent, are enhanced at the Rawson CHC with the current practice of shared patient files using the software program Medical director.

6.0 General Practitioner Collaboration

The DHS has been quite proactive in supporting general practice collaboration; the following quote is taken from the DHS position statement Working with General Practice, 2007.

“We are all aware that Victoria’s health system is facing an increasing demand for service. The challenge of meeting this demand is driving both the Commonwealth and the State governments to develop strengthened community based models of care with a focus on prevention, early intervention for those recently diagnosed with a chronic illness, and intensive coordinated care for those with complex care needs.

The Victorian Government recognises that successful partnerships between State funded services and general practice are integral for the provision of coordinated care, particularly for those who need care from multiple providers, such as those in transition between acute and community settings and vulnerable groups who may find it difficult to access the required range of health services without support”

Hon Daniel Andrews MP Minister for Health

and from the same document is the following position statement:

The Department of Human Services, wherever practicable, will seek to bring departmental and general practice developments together to promote and enhance effectiveness and efficiency in the integration of health care in Victoria. General practice and State-funded services cannot provide the most effective health care in isolation.

Rawson CHC and the local community have been proactive in retaining a visiting GP service to the local community. The collaborative approach has seen the retention of a 2 session per week service when many similar size and even larger communities have struggled to retain any visiting GP services. This has been largely achieved through the community’s willingness to contribute to a voluntary membership to offset the administrative costs to WGHG. Also community approaches to the local Baw Baw Council were successful in gaining an ongoing contribution from the council to WGHG for provision of health services to the local community; this funding recognises the efforts made by the community in support of the Rawson CHC and the community development work undertaken by the Rawson CHC. This collaborative approach extends to the GPs whose patients are either bulk billed or charged only slightly above rebate rates.
A strong collaborative approach to patient management exists between the visiting GPs and nurses based at Rawson; this approach has been ongoing for some 30 years. The excellent IT infrastructure at Rawson has enabled remote login to patient files that are shared from a central data base with the visiting GP service. Both GPs and nurses can review and case manage online and this extends to after hours access of these files. In the event of an IT shutdown patient files remain accessible via a full backup and functional copy of Medical Director software on a laptop which can be later uploaded back to the central server during the backup process.

The Nurse Practitioner model proposed for Rawson would expand on this collaborative approach to patient management. The existing GP sessions would continue while at other times patients could consult with the NP. The majority of those consultations would not require the patients to travel for further treatment, thus ensuring continuity and improved treatment compliance. Clinical support and case review could be provided by the GP to the NP as the case notes are shared remotely. This would lead to improved patient outcomes and reduce numbers presenting to A&E departments.

Because of the extended waiting times at A&E departments and difficulty in obtaining GP appointments there is a well grounded perception amongst people from outlying rural regions that it may not be worth the time and effort of travel to present for treatment. Consequent delays in treatment result in poorer outcomes and can lead to unnecessary hospital admissions. Examples of this are:

- Cellulitis
- Otitis media
- UTIs

Timely diagnosis and treatment by a NP at Rawson would reduce the likelihood of hospital admission that could result from delays in diagnosis and treatment.

7.0 Identifying the Service Gaps

Rawson CHC has for 32 years provided the communities of Erica, Rawson and Walhalla with a well resourced and respected primary care health service. During construction of the Thomson Dam this was a 24 hour 7 day a week service that had an EFT of 7 nurses. The past 20 years has seen that EFT fall to 1 EFT with a Monday to Friday 9 to 5 service. There has been numerous informal requests for an after hours medical service to be reinstated at Rawson. The view of current management and nursing staff is that an opportunistic after hours service would not be viable at Rawson because:

- **Staffing.** The ability to staff such a service is problematic; it would require at least a roster of three nurses rotating who resided close to Rawson.
- **Cost and need.** The cost of providing an after hours service would add somewhere between $30,000 to $50,000 per annum for the limited number of consultations. Neither is viable or sustainable.
- **Alternatives.** A limited after hours service is offered at Moe and this combined with the state Government funded “Nurse On Call” is providing a service that fulfils many of the after hours consultation requirements.
- **Emergency Situation.** In the rare critical emergency situations, nursing staff who reside close to Rawson, are contacted and do respond if appropriate.
- **Funded after hours consultations.** PAC, HITH and palliative care patients can be seen after hours by appointment. These visits are funded on fees for service.

A community survey was conducted for this report, with the return rate representing approximately 10% of the local population (of the 27 respondents 19 were completed on behalf of families). The results demonstrated strong support for the proposed NP model. The was also a strong preference for treatment and consultations in their own community and confidence in a NP to provide that treatment. However there was some concern regarding costs that nurse initiated diagnostics and prescriptions may incur, these concerns would be addressed if NPs were given access to the PBS and MBS.
The continuing concern for residents has been the necessity to travel (80km round trip) for GP appointments. Delays in seeking treatment, because of the travel and difficulty in getting appointments, does lead to after hour’s consultations as patients adopt a “wait and see if it gets worse attitude”. Residents are well aware of the limitations on nursing scope of practice and will travel to the Latrobe Valley for treatment when GPs are not available at Rawson (GPs are only available at Rawson for morning consultations on Wednesday and Friday). There is much frustration expressed by residents who feel that the skills and knowledge base of the existing nursing staff is under utilised because of restrictions on scope of practice.

Those patients who travel to the Moe Medical Centre for GP visits will often present subsequently for ongoing management at the Rawson CHC, this is simplified by access to their case notes by logging in directly to the Moe Medical Groups central server.

Residents who consult with GPs in other practices and towns will often be required to travel back for review of their treatment or for diagnostic results. Many of these reviews could be accomplished by a NP at Rawson in collaboration with the patients GP. This would save unnecessary travel, save time and reduce costs for the patient. It would also free up invaluable GP appointments, reduce waiting times and reduce needless ED presentations.

At present there is no mechanism by which a GP can be reimbursed for professional advice sought for remote patients being cared for by rural nurses. A grey legal area exists where it is uncertain as to the extent to which a GP is legally responsible for advice offered to a nurse for a client that the GP may not be physically involved in the care of. With improved technology has come the means to remotely log in to a patient file. This has improved the ability to collaborate on treatment. The GP is relying on the information provided by the nurse is both knowledgeable and accurate. In this situation there should be a mechanism by which both professionals are adequately reimbursed.

A Medicare item that reimburses for professional collaboration with a remote NP would overcome this anomaly. This approach could assist with the acceptance the NP position by the Australian Medical Association who may be appeased if there was a financial recognition of the collaborative model of care in remote rural areas.

There is a precedent for such a collaborative approach as GPs can involve a number of allied health disciplines in an Enhanced Primary Care Plan for some chronic conditions. Allied health professionals are reimbursed through the Medicare system for consultations provided to these patients. These care plans rely on a collaborative team approach. Similarly nurses in rural areas often provide after care and ongoing management of chronic conditions for GP patients. A Medicare item that reimburses for this ongoing management should be available for remote NPs.

### Recommendation 3

This report recommends that a submission is made to the National Health Reform Commission requesting that in Rural and Remote settings.

“A Medicare item be made available to GPs for remote collaborative case management of a patients with a rural remote NP”.

This item would fund the professional input of both practitioners and would recognise the context of remote practice; an item number should also be extended to NPs who assist with case management of a GPs patient in the community remote from the GPs practice.
8.0 **Rawson Rural Remote Nurse Practitioner Model**

8.1 Proposed model

The NP model proposed at Rawson would build on the current Victorian Rural Remote nursing model as described. Although working as a sole practitioner it would continue and expand the collaborative approach that exists presently with the visiting GPs. This could also be expanded to other Latrobe Valley based GPs. The Rawson Rural and Remote NP will provide primary health care in a remote setting across the continuum of the life span.

The advanced and extended clinical role of the Rural and Remote NP will include autonomous:

- **Prescribing and supply of medications.**
- **Ordering of both pathology and radiology diagnostics.** The referral for radiology would have a limited role in trauma presentations but should remain an option. There is no radiology equipment at Rawson so therefore patients have to travel to the Latrobe Valley for radiology, and any subsequent treatment would usually be managed by a specialist. If a patient presents to the NP at Rawson with a possible fracture much time can be saved for the patient if they could be referred directly for imaging rather than having to present at ED and wait for a consultation and then for the imaging request.
- **Referral to other health professionals.** Although consultations with clients occur at an isolated location IT infrastructure allows for close collaboration with other health professionals with both immediacy and on an ongoing basis.

Initiation of treatment by the NP would be targeted to common acute presentations that at present require patients to travel for consultations and treatment such as:

- Minor trauma including suturing lacerations
- Otitis media
- Tonsillitis
- Conjunctivitis
- Medical certificates
- Skin infections
- Respiratory infections
- Soft tissue injuries
- Burns not requiring immediate hospital admission but needing analgesia and antibiotic cover
- Urinary tract infections

In the short to medium term the position will not see an increase in current nursing EFT at Rawson. In the event of no suitably endorsed NP being available the nursing position would continue with its current scope of practice, although that scope of practice may be extended if the proposal for rural nurses to supply medicine is endorsed in the future.

Day to day case management of chronic conditions, such as diabetes, could be better managed in close collaboration with the patients and their GP at an extended clinical level commensurate with a NP model. This may include:

- **Interpreting and responding to pathology and radiology diagnostic reports.**
- **Pain management** (e.g. commencement pain management in palliative care clients).
- **Medication reviews** and monitoring adverse reactions(e.g. following the commencement of new medications by the patients GP).

The mechanisms are essentially in place for a NP to generate requests and referrals. Medical Director, the patient software currently used at Rawson, has the capacity to generate referrals, diagnostic requests and medical certificates and could be adapted to reflect the NP model.
8.2 **NP Prescribing**

A NP would prescribe and supply from items stocked at the Rawson CHC. Pharmacy items stocked at Rawson are supplied through the pharmacy facility located within the WGHG. To provide a reliable stock supply, systems would need to be in place to ensure continuity of supply. The current ad hoc system of keeping adequate supplies while minimising out of date stock would need to be improved to reflect the prescribing practises of a NP. An imprest system that monitors both stock supply levels and expiry dates would address this. This could be implemented immediately independently of implementing a NP role.

**Recommendation 4**

*This report recommends a pharmacy imprest system is instigated immediately at Rawson utilizing a spreadsheet software system that can be cross referenced with patients to allow for monitoring of prescribing patterns. This would link to WGHG pharmacy to provide ongoing optimum supply levels.*

Pharmacy items supplied to patients will be costed using the same system as the West Gippsland Hospital for after hours supply of pharmaceutical items. However if a patient was to present a NP generated prescription to a community based retail pharmacy then the script would be treated as a private script and outside the PBS.

It is anticipated that the most common S4 scripts would be for antibiotics which would require immediate dispensing, these are not particularly expensive items and pricing should have minimal impact on the patient Supply of S3 items would be charged at retail prices so there is no incentive to treat the CHC as a defacto retail chemist. We have at present a good working relationship with a Latrobe Valley retail chemist, patients are able to bring their own scripts to the CHC which are then taken as a batch order to that chemist for dispensing and picked up from the CHC by the patients later on that same day. This service will continue as the only prescribed items dispensed from the CHC will be those that are NP initiated and require immediate dispensing.

8.3 **Nurse Practitioner Diagnostic Referrals**

Lack of access to MBS rebates for NP initiated referrals limits the effectiveness and relevance of both radiology and pathology diagnostics. Despite being able to prescribe medications and order diagnostics at State level NPs are effectively locked out of both PBS and MBS at a federal level by not being issued with provider numbers. Although there have certainly been positive statements which indicate that this anomaly may be removed it is doubtful that could be achieved within 2 years. The health reform commission is not due to report until 2009 and if this was recommended and accepted it would take some time to enact.

Because of the need to travel to the Latrobe Valley or Warragul for radiology diagnostics there is limited scope for NP referrals. Most of these patients would require consultations with GPs, although collaboration with the patients GP to prearrange radiology requests would alleviate the financial consequences of an NP initiated request and also reduce waiting times and needless appointments. After viewing and discussing results the GP may decide to refer the patient back to the NP for ongoing management, this would commonly occur where diagnostics have shown no fracture in trauma presentations.
With pathology diagnostics patients may be willing to pay private fees for NP initiated requests as most specimens are taken at the CHC and patients would not be required to travel, thus saving time and costs involved with travel. Pathology specimens are currently transported from Rawson three times per week; it would be unusual that a specimen could not be transported within 24 hours with most specimens arriving within hours at a laboratory. In presentations such as UTI or skin infection where treatment can be commenced while waiting on microscopy cultures and sensitivities many patients would elect to pay privately for these tests if it meant immediate treatment and not having the travel and time constraints to get identical treatment. Rawson is currently online for diagnostic pathology results, urgent test results can be downloaded to a patient file within hours of the test being taken when the specimen is transported to the lab.

8.4 Clinical Practice Guidelines (CPGs)

There has been a long history of CPGs and protocols being used to regulate and ensure safe practice in rural and remote Australia. In central and northern Australia the CARPA Standard Treatment manual provides evidence based protocols that are used by all health professionals, be they medical, nursing or indigenous health workers, working in that environment. Similarly in rural and remote Queensland the Primary Clinical Care Manual is used.

Although there is some concern that the autonomous practice of NPs’ is restricted by CPGs it is recommended that CPGs be developed for the Rawson NP position. WGHG has a well developed system of policy and guidelines pertaining to clinical practice. As the Rawson NP would be a new position WGHG needs to be assured of appropriate clinical governance, a system which ensures the highest possible safety and quality of clinical care.

The development of CPGs for the Rawson NP model would be undertaken by the NP candidate with review and endorsement, by the Nurse Practitioner Steering committee. Input would be sought from GPs, WGHG Nurse Advisory Council, pharmacists and clinicians relevant to each individual CPG.

8.5 Accountability and Role Evaluation

The Rawson NP would operate on a day to day basis as a sole practitioner in an isolated setting which would complicate the process of peer review, evaluation and accountability for the role. The Rawson CHC is in the Community Services Division of WGHG with the Rawson nurse manager reporting directly to the Director of Community Services. Despite the significant distance of 75km between centres it is a system that has worked well, recent IT upgrades have significantly improved communication flow between WGHG sites.

With the complex clinical nature of the rural and remote NP practice a formalised reporting line to the director of Nursing, Medical Director and head of pharmacy would be appropriate as in the instance of adverse incidents or complex case management.

The close collaboration that already exists with visiting GPs will provide a good framework for clinical practice review and case management. The Moe Medical Group are accredited for medical student supervision and have expressed willingness to fulfil this important clinical practice and case management review role with the NP.

From a WGHG perspective the new expanded role would need to demonstrate patient care that is safe, efficient and effective. The specific outcomes measured would be:

- Timeliness of treatment
- Quality of treatment
- Quantity of treatment
- Treatment costs- to patient and organisation
Procedures and policies are already in place at WGHG that capture adverse events and incidents in the clinical setting, and as such no new reporting mechanisms are required to isolate those incidents for the NP position. Patient satisfaction surveys would provide further evidence of quality of treatment.

**Recommendation 5**

*It is recommended that to assist peer review, education and research the Rawson NP presents selected case reviews on a six monthly basis to the WGHG Nursing Advisory committee. This would be reviewed 2 years after commencement of the NP position.*

### 9.1 Career Path and Workforce Planning

In 2002 the average age of Div 1 nurses in rural Victoria was 43 years and was growing by 4 years each year. In small isolated centres it is not uncommon to find nurses who have worked more than 25 years in the one position, as indeed is the case at Rawson. This has a two fold effect. It produces low staff turnover, but also limits opportunities for graduate nurses to get a foothold and experience in some of these dynamic positions. In the next ten years many of the nurses who work in Victoria’s remote centres will be retiring and there needs to be in place a nursing workforce with appropriate skills to takeover these positions. The current remote area nurses in Victoria have vast experience but many do not have the academic grounding for NP endorsement. Once past 50 years of age the rigors and expense of a masters course are a daunting task but these nurses should be encouraged and supported to if they wish to pursue NP endorsement.

It is somewhat surprising that only 2 Rural Remote NPs have so far been endorsed in Victoria. Both these positions have a close association on a daily basis with GPs and in effect have supported the GP practices. No NP has been endorsed to work in locations that are both professionally and geographically isolated. This may reflect the difficulty with the generalist nature of a remote NP and it also reflects the problems faced by remote nurses tackling the academic requirements.

The most common NP position in Victoria is an Emergency Department (ED) NP. They are fulfilling an important role which is in effect a “clearing house” role. Many presentations to ED are category 4 and 5. The scope of practice has been framed around these presentations. There is a genuine concern that these nurses who are highly skilled in emergency and critical care are not utilizing those skills sufficiently.

The skills required to work as a generalist rural nurse should be gained by both experience and a sound educative process. Universities are now offering undergraduate nursing courses with a rural emphasis, such as Monash Gippsland’s’ Bachelor of Nursing /Rural Health Practice. Post graduate courses that prepare for remote practice are offered at Flinders University and provide solid grounding for any Australian remote health practice.

An ideal career path culminating in endorsement as a rural remote NP at Rawson could comprise of:

1. **Undergraduate:** Bachelor Nursing /Rural Health Practice.
2. **Graduate Year:** Provincial hospital with emphasis on ED.
3. **Post graduate employment in rural health facility. Commence and complete Grad Cert Rural Health Practice.**
4. **Employed isolated facility. Complete RAV emergency RAN training. Complete training to be accredited as Rural Nurse for supply of medicines.* Complete Grad Diploma Remote Health Practice.**
5. With 5 years experience commence Masters Remote Health Practice. Apply for Nurse Practitioner Candidure. Complete Masters within 2 years. Seek endorsement as Rural Remote NP.

6. Endorsed as Remote NP. Process has taken 10 years.

(* All nursing staff at Rawson will be provided with the opportunity to be accredited to supply medications if the proposal for “Rural Nurses to Supply Medications” is accepted. This would address the significant problem of timely access to medications that currently exists for residents).

The reality is that not many nurses would take the ideal path, a metropolitan trained and experienced nurse who undertook the relevant post graduate remote health practice courses would also be in position to attain a Rural Remote NP position after appropriate experience in a rural setting.

10.1 Nurse Practitioner Position Description

A generic Nurse Practitioner position description is attached. This has been modified from the Bayside Health model.

11.1 Budget Implications

The significant obstacle in the introduction of an NP position at Rawson is the budgetary implications. In raw dollars terms there is a salary differential of $12,548.64 between the current classification of year 2 Grade 4B and year 2 NP, with other factors such as leave loading and superannuation it would approach $13,000 pa.

Currently there are no funding arrangements made by DHS to reflect the increased salary entitlements of NPs. The impact of employing a NP on a department’s budget within an organisation can be significant. The annual budget for the Rawson CHC is $150,000, an increase of $13,000 would be a see a 9% increase in the overall budget for the centre. There is little for scope for reducing expenditure as salaries make up most of the centres expenditure. There is also little scope for increasing income. To raise income by $13000 pa the CHC would need to increase revenue by $65 per day for 200 days the centre is open. Fees that can be charged to clients at CHC’s are limited by the DHS fees policy for Primary Health Programs. The fees set for clinical nursing consultations are currently:

- Low income ................................................................. $8
- Middle income .......................................................... $12
- High income ............................................................. full cost recovery

Most patients attending Rawson CHC are either low income or middle income, and there no fees charged to children from low income families.

There has been in place for some years at Rawson CHC an annual voluntary subscription. Those who opt to join are not charged clinical nursing fees. Even if this scheme was ceased it is doubtful that any extra income would be raised given the levels of income in the district. The subscription also give residents a real sense of ownership and belonging to the CHC. The community in turn is very generous in raising funds for equipment.

The scope for raising funds from local industry or other groups is limited, especially as the funding would need to be ongoing. The logging industry has diminished significantly and local tourism has struggled since the bushfires of 2006 and 2007. Seeking funds from the tourism industry is problematic in that there would be an expectation of an after hours service as this is when a tourist is most likely to present for treatment, a service that is not available at Rawson.
Because of the limited options to increase income and reduce expenditure in small rural locations this report recommends that during the first three years of any new NP position that extra funding is allocated to reflect those increased costs. This would amount to $13000 pa for this particular model. It is acknowledged that there has been substantial support to develop NP positions, including significant financial support, from the DHS Nurse Policy branch. If there is a demonstrated need, a well planned model and suitably experienced nurses, then financial support for rural locations are warranted for the first three years.

If the NP was given access to the Medicare Rebate Scheme this could provide a significant level of funding that would reduce the impact of increased costs associated with the employment of an NP.

12.1 Priming the Organization

WGHG currently does not have any NP positions within the organization. The executive from both nursing and management have actively supported the concept of NPs within the organisation and this report has initiated the priming of the organisation to develop NP models that are both sustainable and address demonstrated service gaps.

The sustainability needs to be demonstrated from both a budget and workforce view. There is little point in creating an NP position that cannot be sustained financially or is left unfilled due to workforce shortages or lack of support for candidates. Therefore any proposed NP position within WGHG needs to put through a rigorous evaluation process to ensure the positions sustainability and effectiveness. This report has focussed specifically on the Rawson CHC with a Rural Remote NP model that had been identified for some years as a model that could address perceived service gaps at Rawson. Regardless of the outcome of the proposal for an NP position at the Rawson CHC, WGHG will now have in place the structures and mechanism for development of NP positions within the organisation.

- A Nurse Practitioner Steering Committee has been formed (see Terms of reference attachment 1) and will meet quarterly.
- Expression of Interest forms A & B have been adapted from Western Health (see attachment 3 & 4).
- NP documents and information with links have been created on the WGHG intranet site for nursing staff to access.

With structures now in place department heads can develop a business case for a NP position within their own department. The process of completing EOIs A and B provide a platform to build each case by:

- identifying a gap in the service
- determining if a NP would resolve the gap
- identifying potential candidates
- examining budgetary impacts
- engaging key stakeholders

From a nursing workforce perspective the introduction of NP positions within an organisation demonstrates to current and future nursing staff that clinical excellence is valued within that organisation. Clinical specialists will have a defined path to the pinnacle of clinical excellence of an NP. Similarly if positions of NP are not offered or supported then ultimately excellent clinical staff will be lost to the organisation and possibly to nursing as well.
There are also concerns from an organisation that much time, effort and financial resources can be directed at a NP position with no guarantees that upon endorsement staff will not be coaxed to other institutions or that the NP candidate does not complete the arduous endorsement process.

WGHG has in place sound policy regarding support for ongoing education of it’s’ staff. Given the complexities and requirement of the candidature and endorsement process a review of this policy that reflects those demands should be undertaken by the WGHG Nurse Practitioner Steering Committee.
Section 2

Attachments

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CONSENSUS STATEMENT

Advanced registered nurse and nurse practitioner role in primary health care

This Consensus Statement reflects the position of the Australian Nursing Federation, the Australian Practice Nurses Association, the Australian College of Nurse Practitioners, the Royal College of Nursing, Australia and the Australian College of Mental Health Nurses in relation to the role of the advanced registered nurse and nurse practitioner in primary health care.

Primary health care, as identified in the 1978 international Treaty of Alma Ata, recognises the inseparability of health from the social, environmental and economic factors that affect human life.

It is characterised by a focus on the promotion of health and the prevention of illness, according to principles of equity, access, and community empowerment, and achieved by care delivered by multidisciplinary teams. It differs from the Australian concept of “primary care”, familiar to most Australians as a trip to their General Practitioner. Primary care is better described as a “first contact” care, involving “a single service or intermittent management of a person’s specific illness or disease condition in a service that is typically contained to a time-limited appointment”.¹

The health reform agenda in Australia offers a unique opportunity to consider an alternative model of primary health care that extends beyond the services of a general practitioner to a multidisciplinary model to offer comprehensive primary health care services.

The current system of primary care funding in Australia creates serious barriers to effective health promotion and chronic disease management, and is limiting its effectiveness in terms of equity, access and value for money. Major reform is needed to achieve a model of care that is based on the best available evidence, is efficient and cost effective and provides for positive patient outcomes and sustainable service delivery models.

Expanding the role of nursing in primary health care is increasingly being identified internationally as essential to achieving improved population health outcomes and improving access to primary health care services. An expanded role for nurses enables services to focus on the prevention of illness and health promotion, and offers an opportunity to improve the management of chronic disease as well as reduce demand on the acute hospital sector.

For registered nurses and nurse practitioners to work to the full scope of their practice in the delivery of primary health care services in Australia, professional and legislative barriers to their practice must be overcome.

Registered nurses are autonomous health care professionals who provide care in collaboration with other health professionals and individuals requiring nursing care. Legislation and regulation guide nursing practice. Registered nurses, as qualified licensed professionals, are required to be accountable and responsible for their own actions. As such nurses are entitled to identify the nursing care which they are educated, competent and authorised to provide. Nurses are held accountable for their practice by the nurse regulatory authorities, whose role is to protect the public, as is the case for all other regulated health professions.

As regulated health professionals, registered nurses are not ‘supervised’ nor do they provide care ‘for and on behalf of’ any other health care professional. Nurses acknowledge that all health care is a collaborative endeavour focused on positive outcomes for individuals and groups.

Advanced registered nurses are prepared for evidence-based practice through post registration education, and accept responsibility for complex situations, which may encompass clinical, managerial, and educational or research contexts. They provide leadership, initiate change and practise comprehensively as an interdependent member of the team. These nurses have particular breadth and depth of experience and knowledge in their field of practice. Where appropriate, these advanced registered nurses may seek authorisation or endorsement as a nurse practitioner.

The nurse practitioner role is differentiated by their extended practice in the areas of advanced clinical assessment, prescribing, referral and diagnostics. Whilst there are around 300 authorised or endorsed nurse practitioners in Australia approximately half of these nurses are employed in nurse practitioner positions and even less are practising to the full scope of their role. Some of the restrictions on nurse practitioner practice are the inability for patients to receive subsidised medicines if prescribed by a nurse practitioner (as distinct from a medical practitioner) or rebates from Medicare for nurse practitioner services, limiting their practice and reducing patients’ access to affordable, high quality health care.

Advanced registered nurses and nurse practitioners are ideally placed to deliver primary health care in Australia. Nurses in primary health care will not replace other health professionals but will (and do) provide a unique service that they are already well prepared and qualified to offer. This will enable the community to access a level of primary health care that is currently not available to the Australian population.

The legal capacity of professional nurses to make autonomous decisions needs to be acknowledged at policy level by facilitating access to publicly funded primary health care services and medications provided by nurses.

There is urgent need and immense benefit in reforming primary health care in Australia to fully utilise the expert and effective role of nurses. There is a strong potential not only to deliver improved health outcomes for the community, but also to positively impact national productivity through the utilisation of nurses - the largest professional health workforce in the country.
**Stage 1:** Discussion about the proposed role by a representative from the clinical area with their Division Director.

Criteria that will need to be addressed for the Expression of Interest Form A can be accessed from the Intranet NP site.

**Stage 2:** Completed Expression of Interest (Form A) Brief submission to give an idea of proposed model.

*Submitted to:* Director of Nursing and Midwifery for review then presented to Executive, if approved, then:

*Reviewed by:* West Gippsland Health Group Nurse Practitioner Steering Committee

*Note:* West Gippsland Healthcare Group Nurse Practitioner Steering Committee meets quarterly (meeting dates advertised on the Nurse Practitioner Intranet page)

**If Approved**

**Stage 3:** Invitation to Complete a Formal Submission (Form B) for a Nurse Practitioner Role

Detailed document addressing all identified criteria for a Nurse Practitioner Model. Signatures of all key players required to ensure submission is supported, fits within the strategic plan and is financially viable.

*It is an expectation that all key players will be consulted, and agreement reached regarding the proposed model, during the development phase.*

*Submitted to:* Director of Nursing and Midwifery

*Reviewed by:* NP Steering Committee

**If Approved**

**Stage 4:** Work Begins on Developing a Model

*Supported:* at a local level

*Overseen:* by a Steering Committee
POSITION:  Endorsed Nurse Practitioner

DEPARTMENT:  Rawson Community Health Centre

CLASSIFICATION:  Nurse Practitioner Year 1: Grade 6 Year 1 (201 – 300 beds)
Nurse Practitioner Year 2 and thereafter: Grade 6 Year 2 (301 – 400 beds)

DEPARTMENT CODE:  LO140

QUALIFICATIONS:  Academic
Current endorsement by the Nurse’s Board of Victoria as a Nurse Practitioner.
Completed an approved Masters Qualification relevant to the area of practice. Completed an approved Therapeutic Medication Management Unit.

Experience
Evidence of competent utilisation of extensions to advanced nursing practice according to approved Clinical Practice Guidelines in the clinical area.

ACCOUNTABLE TO:  Director Community Services
Director Nursing – Professional Nursing Functions
Medical Director- Clinical Functions

POSITION SUMMARY:  This position will provide the Site and Practice management of the Rawson site as well as a Clinical Practice role at Rawson within the Scope of Practice of the approved Nurse Practitioner role.

Is a registered nurse who has acquired the expert knowledge base, complex decision making skills and clinical competencies for expanded practice. The Nurse Practitioner is an integral member of the health care team who practices autonomously but in collaboration with other health professionals to assess and manage clients within their clinical context using nursing knowledge and skills. Extensions to Scope of practice include prescription of medications ordering diagnostic investigations, direct referral to other health care professionals, provision of absence from work certificates.

ROLE RESPONSIBILITIES

Service Management

Responsible for the site management of Rawson Community Health Service including facilities and staff.

5. Clinical Practice

Demonstrates excellence in advanced clinical nursing practice. Delivers patient centred care and operates within a nursing model of holistic practice. Maintains a focus on best patient outcomes. Demonstrates competency within the scope of relevant, current and evidence based Clinical Practice Guidelines as they are developed, including:

- Conducting advanced comprehensive patient assessment.
- Initiating and interpreting appropriate diagnostic tests.
- Formulating diagnoses and management plans.
- Performing and demonstrating comprehensive understanding of appropriate therapeutic procedures, treatments and interventions including medication prescription as part of the management plan.
- Facilitating appropriate referrals.
- Providing patient education.
- Communicating patient management plans to all relevant members of the health care team, including the GP.
- Evaluating client assessment and management on completion of the episode of care and taking appropriate action.
- Documenting episode of care.

Uses critical judgement to vary practice according to contextual and cultural influences. Recognises limits to own practice and consults appropriately. Identifies potential adverse outcomes and implements proactive strategies to achieve risk minimisation. Actively engages community/public health information to inform interventions, referrals and coordination of care.

6. Leadership

Acts as a positive role model for all staff in a manner that is consistent with the values, standards and policies of the organization. Demonstrates leadership qualities such as vision, openness, flexibility and integrity. Builds effective and collaborative relationships with patients, colleagues and other stakeholders to achieve best practice and ensure optimal outcomes for patients. Actively promotes the NP role and advanced nursing practice through activities such as presenting at WGHG department meetings, local working groups, committees and/or special interest groups. Builds partnerships with other departments and health services developing Nurse Practitioner roles. Provide clinical leadership and clinical supervision across the WGHG nursing network. Develops mentorship skills and works towards mentoring staff and new NP candidates.
Participates and facilitates organisational committees/working groups as required. Influences and manages organisational change as appropriate.

7. **Research, Evaluation & Quality Improvement**

Monitors processes and outcomes of clinical care provided by the Nurse Practitioner.
Critically appraises and applies relevant research to the development and promotion of evidence based practice.
Develops and maintains evidence based Clinical Practice Guidelines with multidisciplinary input.
Develops and pursues an evaluation strategy for the Nurse Practitioner role in the clinical area.
Leads and contributes to quality improvement and best practice activities that evaluate current practices in the clinical area.
Initiates, leads and participates in research projects/activities in the clinical area.

8. **Education/Training and Professional Development**

*Provides education in the clinical discipline*

Participates in the education of nursing staff and other health professionals through role modelling and facilitating the exchange of knowledge to improve patient outcomes.
Provides in-service education as appropriate and as requested.
Delivers patient education.
Assists other staff in the development and implementation of patient education.
Promotes a clinical environment conducive to learning.

*Supports the professional development and learning of other staff*

Demonstrates clinical leadership in the area of specialty.
Shares knowledge of research, education and clinical practice issues and information gained from professional activities.
Assists, develops and supports colleagues in the area of research.
Facilitates special interest groups or other forums as relevant to the clinical discipline or local needs.

*Ongoing commitment to professional development and learning*

Develops and maintains own clinical development and competence.
Maintains professional portfolio as a record of ongoing clinical activity and competence.
Actively participates in professional development and continuing education, conferences, seminars and professional groups at state, national and government levels.
Remains informed of current literature.
Presents and publishes at/in appropriate professional conferences and journals.
Develops strong collegial links and partnerships with other nurse practitioners.
Knowledge/Skills/Abilities

Extensive advanced knowledge of clinical specialty area.
Peer recognition as a leader within clinical field.
Knowledge of research methods and processes, the ability to generate own research, as well as the ability to analyse and interpret existing data.
High level interpersonal and communication skills across a broad range of health professionals.
Ability to work both autonomously and collaboratively.
Demonstrated ability to be self motivated and innovative.
Capacity for critical reflection.
An understanding of the political sensitivity of developing the Nurse Practitioner role.
PART A – EXPRESSION OF INTEREST FORM

WEST GIPPSLAND HEALTHCARE GROUP EXPRESSION OF INTEREST NURSE PRACTITIONER ROLE

EXPRESSION OF INTEREST FORM PART A

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1 BRIEF OVERVIEW OF THE PROPOSED MODEL

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

2 REASON FOR PROPOSING A NEW MODEL

Describe the current service and its existing structure i.e. process of care, providers etc.
Outline the current gaps in the service and how these gaps were determined?
Describe from an individual and an organisational perspective why the model has been proposed.
### 3 AIM/OBJECTIVES
Describe how the proposed Nurse Practitioner model will improve the delivery of service outcomes.

### 4 OUTCOMES
State the expected outcomes of the new role.

### 5 PREPARATION AND SUPPORT
- List who was consulted in the design of the proposed nurse practitioner model and the rationale for involving them at this stage.
- Outline the support from key stakeholders for the introduction of this model eg. Medical staff, nursing management, allied health.
- Identify the divisional and clinical staff that will provide a clinical support team for the nurse practitioner candidate.
- Outline the discussions held with potential clinical support team members.

### 6 PROJECTED FINANCIAL IMPACT OF THE NURSE PRACTITIONER SERVICE
- List the projected costs incurred with implementing this service eg: wages, office equipment, and other operating costs.
- What cost benefit do you perceive this initiative will have compared with what currently exists eg: Decreased length of stay, reduction on waiting times etc.,
PART B – DETAILED SUBMISSION FORM

WEST GIPPSLAND HEALTHCARE GROUP

NURSE PRACTITIONER

PART B
SUBMISSION CRITERIA

NURSE PRACTITIONER SUBMISSION

PART B

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<td>Name of person completing the submission:</td>
<td></td>
</tr>
<tr>
<td>Position / Title</td>
<td></td>
</tr>
<tr>
<td>Phone number(s):</td>
<td></td>
</tr>
<tr>
<td>E-mail address:</td>
<td></td>
</tr>
<tr>
<td>Date submitted:</td>
<td></td>
</tr>
</tbody>
</table>

INTRODUCTION

The aim of Part B Nurse Practitioner submission is to provide a more in-depth analysis of the proposed model that demonstrates the role has been carefully considered with the multidisciplinary health care team and can demonstrate an improvement in patient care delivery by WGHG.

Completion of this detailed submission to the Nurse Practitioner Steering Committee is required as a pre-requisite to implement a Nurse Practitioner role within WGHG. The Committee’s role is to ensure there is in place a process which identifies and clarifies the Nurse Practitioner role within West Gippsland Healthcare Group and endorses Clinical Practice Guidelines for the clinical setting that allows for expansion and extension to practice. This submission forms an integral part of the process.

Applicants will be notified of the Nurse Practitioner Steering Committee’s decision.
<table>
<thead>
<tr>
<th>1 BRIEF OVERVIEW OF THE NURSE PRACTITIONER MODEL.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Briefly describe the proposed role of the Nurse Practitioner in your clinical setting.</td>
</tr>
<tr>
<td>Your response needs to include the scope of practice including the extensions to practice and the patient population group this will impact on.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2 REASON FOR PROPOSING THE NURSE PRACTITIONER MODEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Detail the gaps within the existing health care services.</td>
</tr>
<tr>
<td>What evidence/data is there to support the requirement for this change to the health care service (eg population trends, health care trends, workforce planning trends,)?</td>
</tr>
<tr>
<td>Describe how this model will enhance the existing health care service.</td>
</tr>
<tr>
<td>What do you expect the impact of the model will have on all relevant stakeholders?</td>
</tr>
<tr>
<td>Will the model demonstrate improvements in resource efficiency? (financial, time, productivity, resource savings)</td>
</tr>
<tr>
<td>In what way is a Nurse Practitioner the most appropriate health professional to provide this service?</td>
</tr>
<tr>
<td>Does any other health professional currently provide services that may be adversely affected by this proposal?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3 OUTLINE THE SUPPORT FOR THE NURSE PRACTITIONER ROLE FROM KEY STAKEHOLDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>List who was consulted in the design of the model and the rationale for involving them.</td>
</tr>
<tr>
<td>Outline the support for this Nurse Practitioner role from medical, nursing, allied health, executive team and consumers.</td>
</tr>
<tr>
<td>Are there any perceived barriers to implementing this role? If so, provide details of how these barriers will be overcome.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4 IMPACT OF THE NURSE PRACTITIONER MODEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>What impact will the proposed model have on your unit/service/setting within WGHG?</td>
</tr>
<tr>
<td>Could the model be translated to other settings within WGHG or collaborate with other organisations?</td>
</tr>
<tr>
<td>What do you perceive the impact of introducing the model will be on stakeholders?</td>
</tr>
<tr>
<td>What systems or structures are in place to sustain the innovation?</td>
</tr>
<tr>
<td>What are the projected costs to the organisation?</td>
</tr>
<tr>
<td>Are there any funding sources that you are aware of which will support the role?</td>
</tr>
</tbody>
</table>
## 5 Outline the Education Program for the Intended Nurse Practitioner Model

Outline the educational support and strategy required to successfully implement the Nurse Practitioner role.

What would be the relevant interdisciplinary input into the required education? What indication is there that this will be available?

Are you aware of any existing relevant educational programs (internal and/or external) that could be accessed by the Nurse Practitioner Candidate?

Is there a team of medical consultants or endorsed nurse practitioners to take on the role of clinical mentorship? If possible please specify medical consultants/endorsed NPs who have indicated their willingness to mentor/supervise you. Describe how mentoring team will operate to ensure the appropriate level of support and clinical supervision.

## 6 Implementing the Nurse Practitioner Model

Outline the proposed reporting structure and the EFT required?

Outline the strategy to be used to implement the new model to WGHG. This needs to include a list of ‘clinical’ project team members who will assist the candidate in implementing the model.

The project team must include management representatives from a range of disciplines including nursing, medical and pharmacy.

A project team will need to be established to support the candidate in implementing the nurse practitioner role. What are the projected timelines for implementation of the model?

## 7 Describe the Recruitment Strategy for the Nurse Practitioner Position

Are there any candidates within the specialty interested in becoming a Nurse Practitioner?

Do they possess the education preparation required for NBV endorsement? (e.g., a clinically relevant Masters level of nursing qualification (or working towards), completed the therapeutic medication management module approved by the NBV (or working towards))

Is the candidate able to demonstrate an active involvement in research, publication, presentations, and quality improvement projects?

If not how will the position be filled?
<table>
<thead>
<tr>
<th>8 EVALUATION OF THE NURSE PRACTITIONER MODEL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outline the outcome measures that will be utilised to assist in evaluation of the role on patient outcomes and service delivery.</td>
</tr>
<tr>
<td>Does the proposed model demonstrate improvements in resource efficiency? (e.g. time, resources, productivity, financial savings etc.)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9 SUSTAINABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>What systems or structures are in place or needed to sustain the model?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10 OTHER CONSIDERATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there any other ways (not already described) in which the Nurse Practitioner role may impact upon patients, staff, departments etc.</td>
</tr>
<tr>
<td>Any additional comments or information?</td>
</tr>
</tbody>
</table>
## Signatures of Key Project Staff

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
<th>Role / functions to be performed</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Divisional Director</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
<th>Role / functions to be performed</th>
<th>Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clinical Service Director</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
<th>Role / functions to be performed</th>
<th>Signature</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
<th>Role / functions to be performed</th>
<th>Signature</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
<th>Role / functions to be performed</th>
<th>Signature</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
<th>Role / functions to be performed</th>
<th>Signature</th>
</tr>
</thead>
</table>
1. Rawson Nurse Practitioner proposal

Thank you for undertaking this short survey. We value your time and comments. This is a completely anonymous survey and your input will help the Rawson Community Health Centre continue to provide an innovative health service that matches the needs of the community while best utilizing available resources.

We are proposing to increase the range of services available to the community by the appointment of a Nurse Practitioner. A nurse can only become a Nurse Practitioner (NP) when he/she has at least five years experience in their chosen specialty, has gained a Masters level of education in a relevant nursing field and is endorsed by the Victorian Nurses Board.

There would be no increase in the hours of operation or in the number of nurses, but there would be an increase in the number of services the Nurse Practitioner can provide.

The Nurse Practitioner will be able to do a limited number of things that only a General Practitioner (Doctor) normally does such as prescribe medications, order pathology and radiology tests, write medical certificates and provide referrals to other health professionals. However, because it is a Nurse Practitioner and not a General Practitioner (Doctor) who prescribes the medications or orders pathology or radiology tests, these medications and tests are not currently covered by Medicare or Prescription Benefits Scheme (PBS) and will result in a larger cost back to the client. There may however be savings for the client in not having to travel to see their GP or wait at outpatients if no GP appointment is available.

The model being proposed for Rawson is a Rural Remote Nurse Practitioner. The GPs who currently provide sessions at Rawson would continue to do so, but at other times patients would be able to consult with a Nurse Practitioner.
2. Default Section

1. Are you answering this survey on behalf of
   - Self only
   - Partner and self
   - Couple with children
   - Self and children

2. What services do you currently use or have you used in the past year at the Rawson CHC?
   - Nursing services
   - GP
   - Both nursing and GP services
   - None

3. The following conditions could be treated by a Nurse Practitioner at Rawson CHC. Have you or member of your family had to travel to the Latrobe Valley or experienced a delay in treatment of more than one day while waiting for a Doctors appointment at Rawson in the past 12 months for any of these conditions?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Self</th>
<th>Other Family Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 Chest infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Kidney or Bladder Infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Minor cut requiring stitches</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Minor eye trauma (e.g. flash burn)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 To get a medical certificate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 Emergency contraception</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 Ear Infection (otitis media)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Skin infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Strained/sprained joint</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Conjunctivitis (eye infection)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Thinking about question 3 would you or members of your family see a Nurse practitioner for treatment of any of those conditions?
   - No to all
   - Yes to all
   - Yes to some

If yes to some which ones (use numbers corresponding to condition):
5. If you decide to see a Nurse Practitioner for treatment how important are each of the following

<table>
<thead>
<tr>
<th>Being seen at my local medical centre</th>
<th>Extremely important</th>
<th>Important</th>
<th>Not sure</th>
<th>Not important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of prescribed medication</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost of seeing the Nurse Practitioner</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost of the pathology or radiology test ordered</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting time</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Being able to complete treatment at my local Nurse Practitioner being able to discuss my treatment with my usual GP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Do you agree or disagree with the following statements

<table>
<thead>
<tr>
<th>Nurse Practitioners would be a good option for the Rancow CHC.</th>
<th>Agree</th>
<th>Disagree</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>I would be confident to be treated by a Nurse Practitioner.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seeing a Nurse Practitioner would save me time and travel.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I will be willing to pay for prescriptions not covered by the Prescription Benefit Scheme (PBS).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I will be willing to pay for pathology and radiology tests not covered by Medicare.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am willing to pay something to the cost of the additional services a Nurse Practitioner can provide.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am willing to use the Nurse Practitioner if the cost was the same as going to a GP (Doctor).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am willing to use the Nurse Practitioner even if the cost was more than going to a GP (Doctor).</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am willing to use the Nurse Practitioner for prescribing medications if the cost was the same as if a GP had prescribed the medications.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am willing to use the Nurse Practitioner for referrals to Radiology and Pathology if the cost was the same as if a GP had referred me.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Your thoughts are welcome
7. What would you be prepared to pay as an extra fee to consult with a Nurse Practitioner. Current non member fees for nursing services are $6.50 concession and $10.00 non concession.

- [ ] $5.00 extra on member and non member costs
- [ ] $10.00 extra on member and non member costs
- [ ] $15.00 extra on member and non member costs
- [ ] Other

Comments:
### Nurse Practitioner

**1. Are you answering this survey on behalf of?**

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self only</td>
<td>26.0%</td>
<td>8</td>
</tr>
<tr>
<td>Partner and self</td>
<td>37.0%</td>
<td>10</td>
</tr>
<tr>
<td>Couple with children</td>
<td>20.0%</td>
<td>8</td>
</tr>
<tr>
<td>Self and children</td>
<td>3.7%</td>
<td>1</td>
</tr>
</tbody>
</table>

Answered question: 27

### 2. What services do you currently use or have you used in the past year at the Rawson CHC?**

<table>
<thead>
<tr>
<th>Response</th>
<th>Percent</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing services</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>GP</td>
<td>11.1%</td>
<td>3</td>
</tr>
<tr>
<td>Both nursing and GP services</td>
<td>88.9%</td>
<td>24</td>
</tr>
<tr>
<td>None</td>
<td>0.0%</td>
<td>0</td>
</tr>
</tbody>
</table>

Answered question: 27

Shipped question: 0
3. The following conditions could be treated by a Nurse Practitioner at Rawson CHC. Have you or member of your family had to travel to the Latrobe Valley or experienced a delay in treatment of more than one day while waiting for a Doctor's appointment at Rawson in the past 12 months for any of these conditions?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Self</th>
<th>Other Family member</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>0. Chest infection</td>
<td>85.7% (6)</td>
<td>28.0% (2)</td>
<td>7</td>
</tr>
<tr>
<td>1. Kidney or bladder infection</td>
<td>0.0% (0)</td>
<td>100.0% (2)</td>
<td>2</td>
</tr>
<tr>
<td>2. Minor cut requiring stitches</td>
<td>66.7% (2)</td>
<td>66.7% (3)</td>
<td>3</td>
</tr>
<tr>
<td>4. To get a medical certificate</td>
<td>44.4% (4)</td>
<td>60.7% (3)</td>
<td>9</td>
</tr>
<tr>
<td>5. Emergency contraception</td>
<td>0.0% (0)</td>
<td>100.0% (1)</td>
<td>1</td>
</tr>
<tr>
<td>8. Ear infection (otitis media)</td>
<td>69.0% (3)</td>
<td>40.0% (2)</td>
<td>5</td>
</tr>
<tr>
<td>7. Skin infection</td>
<td>59.0% (1)</td>
<td>59.0% (1)</td>
<td>2</td>
</tr>
<tr>
<td>6. Strained/sprained joint</td>
<td>0.0% (0)</td>
<td>100.0% (4)</td>
<td>4</td>
</tr>
<tr>
<td>9. Conjunctivitis (eye infection)</td>
<td>50.0% (1)</td>
<td>100.0% (2)</td>
<td>2</td>
</tr>
<tr>
<td>3. Minor eye trauma (e.g. flash burn)</td>
<td>0.0% (0)</td>
<td>100.0% (3)</td>
<td>3</td>
</tr>
<tr>
<td>XX. None of the above</td>
<td>100.0% (9)</td>
<td>55.0% (5)</td>
<td>9</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Response Count: 28

4. Thinking about question 3, would you or members of your family see a Nurse practitioner for treatment of any of those conditions?

<table>
<thead>
<tr>
<th>Response</th>
<th>Response Percent</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>No to all</td>
<td>0.0%</td>
<td>0</td>
</tr>
<tr>
<td>Yes to all</td>
<td>81.5%</td>
<td>22</td>
</tr>
<tr>
<td>Yes to some</td>
<td>18.5%</td>
<td>5</td>
</tr>
</tbody>
</table>

If yes to some which ones (use numbers corresponding to condition): 4

Response Count: 27

Excluded question: 0

A DHS Nurse Policy Funded Project 42
6. If you decide to see a Nurse Practitioner for treatment how important are each of the following:

<table>
<thead>
<tr>
<th>Item</th>
<th>Extremely important</th>
<th>Important</th>
<th>Not sure</th>
<th>Not important</th>
<th>Rating Average</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being seen at my local medical centre</td>
<td>74.1% (26)</td>
<td>22.2% (0)</td>
<td>0.0% (0)</td>
<td>3.7% (1)</td>
<td>1.33</td>
<td>27</td>
</tr>
<tr>
<td>Cost of prescribed medication</td>
<td>33.3% (0)</td>
<td>51.9% (14)</td>
<td>7.4% (2)</td>
<td>7.4% (2)</td>
<td>1.89</td>
<td>27</td>
</tr>
<tr>
<td>Cost of seeing the Nurse Practitioner</td>
<td>37.0% (10)</td>
<td>46.1% (13)</td>
<td>3.7% (1)</td>
<td>11.1% (3)</td>
<td>1.59</td>
<td>27</td>
</tr>
<tr>
<td>Cost of the pathology or radiology test ordered</td>
<td>44.4% (12)</td>
<td>37.0% (10)</td>
<td>11.1% (2)</td>
<td>7.4% (2)</td>
<td>1.91</td>
<td>27</td>
</tr>
<tr>
<td>Waiting time</td>
<td>44.4% (12)</td>
<td>61.9% (14)</td>
<td>0.0% (0)</td>
<td>3.7% (1)</td>
<td>1.88</td>
<td>27</td>
</tr>
<tr>
<td>Being able to complete treatment at my local centre</td>
<td>76.1% (28)</td>
<td>22.2% (0)</td>
<td>0.0% (0)</td>
<td>3.7% (1)</td>
<td>1.33</td>
<td>27</td>
</tr>
<tr>
<td>Nurse Practitioner being able to discuss my treatment with my usual GP</td>
<td>90.8% (21)</td>
<td>10.2% (5)</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>1.10</td>
<td>28</td>
</tr>
</tbody>
</table>

answered question: 27

skipped question: 0
6. Do you agree or disagree with the following statements

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree</th>
<th>Disagree</th>
<th>Not sure</th>
<th>Response Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Practitioners would be a good option for the Rawson CHC.</td>
<td>100.0% (27)</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>27</td>
</tr>
<tr>
<td>I would be confident to be treated by a Nurse Practitioner.</td>
<td>100.0% (27)</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>27</td>
</tr>
<tr>
<td>Seeing a Nurse Practitioner would save me time and travel.</td>
<td>96.3% (25)</td>
<td>0.0% (0)</td>
<td>3.7% (1)</td>
<td>27</td>
</tr>
<tr>
<td>I will be willing to pay for prescriptions not covered by the Prescrip...</td>
<td>93.3% (19)</td>
<td>18.5% (5)</td>
<td>22.2% (0)</td>
<td>27</td>
</tr>
<tr>
<td>I will be willing to pay for pathology and radiology tests not covered ...</td>
<td>24.7% (11)</td>
<td>25.9% (7)</td>
<td>33.3% (9)</td>
<td>27</td>
</tr>
<tr>
<td>I am willing to pay some of the cost of the additional services a Nurse ...</td>
<td>92.3% (24)</td>
<td>3.3% (1)</td>
<td>0.0% (1)</td>
<td>26</td>
</tr>
<tr>
<td>I am willing to use the Nurse Practitioner if the cost was the same as ...</td>
<td>92.6% (25)</td>
<td>3.7% (1)</td>
<td>3.7% (1)</td>
<td>27</td>
</tr>
<tr>
<td>I am willing to use the Nurse Practitioner even if the cost was more th...</td>
<td>93.3% (19)</td>
<td>22.2% (6)</td>
<td>18.5% (5)</td>
<td>27</td>
</tr>
<tr>
<td>I am willing to use the Nurse Practitioner for prescribing medications ...</td>
<td>92.6% (25)</td>
<td>3.7% (1)</td>
<td>3.7% (1)</td>
<td>27</td>
</tr>
<tr>
<td>I am willing to use the Nurse Practitioner for referrals to Radiology an...</td>
<td>92.6% (25)</td>
<td>0.0% (0)</td>
<td>7.4% (2)</td>
<td>27</td>
</tr>
</tbody>
</table>

Your thoughts are welcome 3

answered question 27

skipped question 0
7. What would you be prepared to pay as an extra fee to consult with a Nurse Practitioner. Current non member fees for nursing services are $6.00 concession and $10.00 non concession.

<table>
<thead>
<tr>
<th>Response</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>$5.00 extra on member and non member costs</td>
<td>48.1%</td>
<td>13</td>
</tr>
<tr>
<td>$10.00 extra on member and non member costs</td>
<td>33.3%</td>
<td>9</td>
</tr>
<tr>
<td>$15.00 extra on member and non member costs</td>
<td>11.1%</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>7.4%</td>
<td>2</td>
</tr>
<tr>
<td>Comments?</td>
<td></td>
<td>4</td>
</tr>
</tbody>
</table>

Answered question: 27
Skipped question: 0
### NP Salary Projections

#### Nurse Practitioner Candidates

A Registered Nurse registered under division 1, 3 or 4 engaged to undertake a course of study and undertake clinical experience leading to endorsement as a nurse practitioner. A registered nurse engaged as a nurse practitioner candidate (as defined) shall be classified and paid their substantive salary. (Australian Industrial Relations Commission 2006)

#### Year 1 Nurse Practitioner

<table>
<thead>
<tr>
<th>Grade 6 201-300 beds - (Public sector award)</th>
<th>3.25%</th>
<th>3.25%</th>
<th>3.25%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Salary/week (1)</td>
<td>$1,506.30</td>
<td>$1,555.30</td>
<td>$1,605.80</td>
</tr>
<tr>
<td>Quals allowance (7.5%)</td>
<td>$68.80</td>
<td>$71.00</td>
<td>$73.30</td>
</tr>
<tr>
<td>Total weekly rate base + qualifications allowance (2)</td>
<td>$1,575.10</td>
<td>$1,626.30</td>
<td>$1,679.10</td>
</tr>
<tr>
<td>Annualised base + quals</td>
<td>$81,905.20</td>
<td>$84,567.60</td>
<td>$87,313.20</td>
</tr>
<tr>
<td>Leave loading</td>
<td>$1,054.41</td>
<td>$1,088.71</td>
<td>$1,124.00</td>
</tr>
<tr>
<td><strong>Annualised (base, quals + leave loading)</strong></td>
<td>$82,959.61</td>
<td>$85,656.31</td>
<td>$88,437.20</td>
</tr>
</tbody>
</table>

#### Year 2 Nurse Practitioner

<table>
<thead>
<tr>
<th>Grade 6 301-400 beds - (Public sector award)</th>
<th>3.25%</th>
<th>3.25%</th>
<th>3.25%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Salary/week (1)</td>
<td>$1,561.60</td>
<td>$1,612.40</td>
<td>$1,664.80</td>
</tr>
<tr>
<td>Quals allowance (7.5%)</td>
<td>$68.80</td>
<td>$71.00</td>
<td>$73.30</td>
</tr>
<tr>
<td>Total weekly rate base + qualifications allowance</td>
<td>$1,630.40</td>
<td>$1,683.40</td>
<td>$1,738.10</td>
</tr>
<tr>
<td>Annualised base + quals</td>
<td>$84,780.80</td>
<td>$87,536.80</td>
<td>$90,381.20</td>
</tr>
<tr>
<td>Leave loading</td>
<td>$1,093.10</td>
<td>$1,128.70</td>
<td>$1,165.40</td>
</tr>
<tr>
<td><strong>Annualised (base, quals + leave loading)</strong></td>
<td>$85,873.90</td>
<td>$88,665.50</td>
<td>$91,546.60</td>
</tr>
</tbody>
</table>

#### Grade 4B Year 2 Rawson Classification

<table>
<thead>
<tr>
<th>Base Salary/week</th>
<th>Quals Allowance (7.5%)</th>
<th>Weekly rate plus qual allowance</th>
<th>Annualised base + quals</th>
<th>Leave loading</th>
<th>Annualised (base, quals + leave loading)</th>
<th>Difference year 1 practitioner</th>
<th>Difference year 2 practitioner</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,368.60</td>
<td>$68.80</td>
<td>$1,437.40</td>
<td>$74,744.80</td>
<td>$958.00</td>
<td>$75,702.80</td>
<td>$7,256.80</td>
<td>$10,171.10</td>
</tr>
<tr>
<td>$1,413.10</td>
<td>$71.00</td>
<td>$1,484.10</td>
<td>$77,713.20</td>
<td>$989.20</td>
<td>$78,162.40</td>
<td>$7,493.90</td>
<td>$10,503.10</td>
</tr>
<tr>
<td>$1,459.00</td>
<td>$73.30</td>
<td>$1,532.30</td>
<td>$79,679.60</td>
<td>$1,021.00</td>
<td>$80,700.60</td>
<td>$7,736.60</td>
<td>$10,846.10</td>
</tr>
<tr>
<td>$1,506.40</td>
<td>$75.70</td>
<td>$1,581.80</td>
<td>$82,253.60</td>
<td>$1,054.50</td>
<td>$83,308.10</td>
<td>$8,004.90</td>
<td>$11,214.30</td>
</tr>
</tbody>
</table>

**Notes:**

1. Source: Nurses (Victorian Public Health Sector) MBA 2007-2011 - Schedule B - The following salaries will become payable to Employees from the first pay period.
2. Projects based on allowance for Masters Degrees as this is the minimum NBV educational requirement.
3. Salary projections may not include all provisions an individual NP may be entitled to.
4. Excludes penalty rates

Prepared by Nurse Policy Branch.
Date: 1/03/2008
For more information about this data, please contact Nurse Workforce Policy & Programs section (03) 9096 6922.
References and Acknowledgements

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