Implementation of Aged & Palliative Care Nurse Practitioner Role
Melbourne Citymission

The Victorian Nurse Practitioner Project Phase 4.7 Funding Round
Deliverables and reporting requirements

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Melbourne Citymission
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"It is only with the heart that one can see rightly; what is essential is invisible to the eye."
- Antoine de Saint-Exupery
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<td>ANMC</td>
<td>Australian Nursing and Midwifery Council</td>
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<td>ERC MCM</td>
<td>Eltham Retirement Centre</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>MCM</td>
<td>Melbourne Citymission</td>
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<td>NMBA</td>
<td>Nursing and Midwifery Board Australia</td>
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<td>NP</td>
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<td>APC NP</td>
<td>Aged and Palliative Care Nurse Practitioner</td>
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<td>NPC</td>
<td>Nurse Practitioner Candidate</td>
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<td>PMC</td>
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<td>RACS</td>
<td>Residential Aged Care Services</td>
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<td>RN</td>
<td>Registered Nurse</td>
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<td>RECIPE</td>
<td>Residential Care Intervention Program in the Elderly.</td>
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1. Introduction
Melbourne Citymission (MCM) is an independent not-for-profit organisation with 156 years of experience of diverse service delivery to the community of greater Melbourne. It’s broad based service delivery range from Employment Services, ABI, Disability Services, Residential Services and Palliative Care but a few. (For a more comprehensive description of MCM service delivery programs refer to VNPP 4.7 Funding Application September 2010). It is within the aged and palliative care setting that the nurse practitioner role is being developed.

Eltham Retirement Centre (ERC)
is located in a semi rural region north east of Melbourne within the Shire of Nillumbik and comprises of:
- 120 residential aged care beds
- 120 Independent Living Units.
- A Day Therapy Centre that provides HACC funded allied services to over 300 clients each year
- An Older Men’s Workshop

The medical care of the residents in ERC Residential Aged Care Service (ERC RACS) is managed by general practitioners. There is varying levels of management with some GPs attending weekly and others attending on a needs basis. However ERC RACS has a good working relationship with general practitioners in the Shire of Nillumbik. Banksta Palliative Care provides specialist outreach palliative care support when this is required by ERC Residential Aged Care Services (RACS) clients.

Palliative Care
Melbourne Citymission Palliative Care (MCM PC) opened in 1981 as the first community based palliative care services established in Victoria. MCM PC is a leader in providing expert symptom management, emotional and practical support to people who have a life limiting illness. This support includes the physical, spiritual, social and cultural support to maximise choice and dignity for clients and families and quality of life.

2. Purpose of the Aged and Palliative Care Nurse Practitioner
There has been a significant change in residential aged care in the past ten years. RACS once promoted a home like environment. Many residents moved into this care, primarily because of loneliness and social isolation, with many living in care for 10 or more years. RACS are no longer able to offer this type of care. RACS are now homes where residents who are admitted usually have multiple co-morbidities, dementia, complex care needs and many entering into the end of life phase. These residents present many challenges for staff, in terms of addressing and managing exacerbation of symptoms, which if not identified early in the illness trajectory often result in a resident presenting to the emergency department awaiting an acute hospital admission resulting in lengthy stays. Staff of RACS often do not have the knowledge or skills required to care for these people.

As the population ages and the market workforce declines, RACS like all business, compete for staff, which also includes general practitioners.

A gap analysis related to medical care of the older person at ERC RACSs was undertaken at the commencement of the project. See appendix 1 for the results of the identified service gaps at ERC RACS.

The purpose of establishing a nurse practitioner role at Melbourne Citymission ERC is to provide the opportunity for a highly skilled registered nurse to extend and expand their current role within the context of aged and palliative care internally and within the expanded aged care community. The candidate will work towards acquiring advanced clinical skills and an expert knowledge to optimise the delivery of quality aged and palliative, particularly end of life care to residents.
3. **Service Model**
The Aged and Palliative Care Nurse Practitioner (APC NP) will be located within ERC RACS’s. The APC NP model of care will be diverse and broad. The model will allow for growth and development to meet the changing needs of the residents and the larger community. While the initial focus of the model development will be on strengthening the palliative approach within ERC’s RACSs, it is envisaged that this project will see the APC NP role potentially develop and expand into the broader aged care community to support clients in the chronic disease trajectory within a primary care context.
The APC NP role is maintained within a nursing framework and structure, and will function in accordance with the Australian Nursing and Midwifery Council (ANMC) National Competency Standards within aged and palliative care. The APC NP will work autonomously and collaboratively with support and supervision of the nominated mentors in clinical, managerial and leadership role.

The ERC RACS Nurse Practitioner role includes but is not limited to:

1. consultation and expert education regarding disease processes related to ageing
2. clinical support to ERC RACSs staff and residents of the community when required
3. application of extended practice competencies within the scope of practice that is both autonomous and collaborative in its approach
4. develop and support evidence based practice within the RACSs and ensure that own practice is evidence based at all times
5. providing ongoing support and education to staff in relation to clinical care and disease processes associated with ageing and palliative care
6. provision of advanced comprehensive holistic assessment, diagnosis, planning and implementation of care including follow up and referral as appropriate
7. support for residents, families and staff: through access to more timely symptom management and anticipatory planning; management of complex care, symptom management of residents requiring care at the end of life, increased likelihood of death at the residents preferred place, better coordinated medical and nursing care, ongoing communication with resident’s and families
8. participation in review of policies and procedures related to aged and end of life care
9. undertaking research and quality audits as deemed appropriate by the organisation
10. leadership and supervision: promoting the role of the Aged & Palliative Care Nurse Practitioner to staff, professional networks and the broader community
11. influence healthcare policy and practice through active participation in workplace and professional organisations at local, state and national level as requested.
12. develop and promote research projects that will contribute to advance the body of knowledge in aged care and palliative care nursing, thus enhancing the quality of care to RACS residents at the end of life phase
13. develop a highly collaborative working relationship with senior staff at ERC RACSs, ensuring a clear and strong role which is complementary, rather than a duplicative of services
14. engage in clinical collaboration in compliance with the National Competency Standards for the Nurse Practitioner with all general practitioners and health care providers who attend ERC RACS’s

The APC NP role will build on current relationships with general practitioners, medical consultants, specialist’s services such as geriatricians and palliative care within the community and acute care settings. This is to ensure
timely access to advanced aged care practice which is integrated with advanced palliative care expertise and complementary of the general practitioner’s clinical practice role, rather than role substitution.

### 4. Key Collaborative Arrangements

The APC NP will enter into collaborative arrangements with general practitioners who attend ERC RACS. The APC NP will receive referrals from general practitioners, nurse clinicians, medical specialists and other health professional to provide care within the ERC RACS or the associated external communities for residents. Following comprehensive assessment, the APC NP identifies the needs and problems and then formulates a plan of management within their scope of practice and structure of collaborative arrangements. See appendix 2 for examples of collaborative arrangement which may be considered with ERC RACS GP’s.

### 5. Scope of Practice

The Aged and Palliative Care Nurse Practitioner (APC NP) will work within the agreed scope of practice for nurse practitioners (NPs) within their employment context.

The APC NP clinical practice is guided by best available evidence based practice principles.

The scope of the individual NPs clinical and prescribing practice is supported by their employer’s clinical governance framework. The ERC APC NP clinical governance structure will ensure that critical elements such as medical, nursing, leadership and management mentorship are incorporated in the APC NP preparation and traineeship. The NPs’ clinical practice as a registered nurse will be guided by the Australian Nursing & Midwifery Council (ANMC) National Competency Standards for the Nurse Practitioner. These are the endorsed standards by the state and territory nursing and midwifery regulatory authorities (NMRA) that provide the framework to assess professional performance and conduct to obtain and retain credentialing to practice as nurse practitioner in Australia.

The role will include:

- referral to and from other health care providers see appendix 3
- a process for residents entering, care and exiting care of the APC NP see Appendix 4
- anticipatory planning and triaging of residents to prevent unnecessary transfer to hospital
- comprehensive holistic assessments of residents and their families when appropriate
- evidence based clinical interventions based on elements from existing and current health protocols such as the *Queensland Health, Health Management Protocol* ¹
- symptom assessment and symptom management practices are in place for all residents in the palliative phase
- ordering of diagnostic investigations
- prescribing of medicines within the approved formulary
- ensuring all residents are offered an advance care plan
- referral to other health professionals
- education and support to staff, residents and families
- participation and regular engagement in professional development activities relevant to advanced practice
- collaboratively working with other health professionals

### 6. Aged and Palliative Care Nurse Practitioner Candidacy and Learning Program

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1. Queensland Health :Nurse Practitioner Palliative Care Health Management Protocol 2010

2.
The role of the APC NP will evolve from a competent and proficient nurse to expert practitioner. The role will be reviewed regularly and adjusted to meet the learning needs of the candidate and the needs of the older person living in ERC RACS.

The potential candidate will be required to undertake the Masters of Nurse Practitioner course whilst working concurrently as an APC NP candidate. It is the discretion of the candidate to opt to undertake the Masters course either at fulltime or part time capacity. However it would be anticipated that the candidate is endorsed as a Nurse Practitioner by mid 2014.

The candidate will be required to use the Australian Nursing and Midwifery Council (ANMC) National Competency Standards for Nurse Practitioner framework to guide and develop their practice and will function in accordance with the (ANMC) National Competency Standards within the Aged and Palliative Care teams.

A professional learning plan – including objectives, competencies, mentorship and evaluation structures and expectations is currently being developed to be ready once a nurse practitioner candidate is appointed.

The curriculum will be dictated by (but not limited to) the university the candidate is enrolled in, when fulfilling academic requirements. Research activities, attendance and participation in forums related to aged and palliative care advanced practice together with the formulation, discussion and management of case studies are essential components of the candidate’s structured study and self learning activities. The core elements of these professional activities are recorded and documented as part of the candidate’s clinical portfolio when applying for endorsement to the Nursing and Midwifery Board of Australia.

Examples of some of the structures and documents being developed as part of this learning plan include:

1. Formulation and ongoing development of the learning plan in consultation and with the support and guidance of the Project Management Committee (PMC)
2. Development of aged and palliative care competencies to guide the Scope of Practice see attachment 1
3. Identification and engagement of clinical and professional mentors see appendix 5
4. Self assessment - the candidate and his/her direct clinical supervisor will undertake a self assessment activity to identify current areas of professional strengths and weaknesses to target learning needs
5. Development of a structure to guide and assess evidence of learning such as take home exams, case studies, diagnostic tests and interpretation, communication and presentation skills
6. A framework for documentation of effective and constructive relationship with nominated clinical mentor
7. Documented evidence of participation in research and quality improvement activities

The primary place of employment of the APC NPC will be within MCM ERC. However MCM ERC is currently exploring external opportunities for a more creative learning model and partnerships within the broader community such as primary care, palliative care and acute care services. It is anticipated that these partnership will further enhance the knowledge of the candidate, as well as build relationships and trust within the community to which his/her services will be provided.

7 Support Framework
The APC NP candidate and endorsed APC NP is accountable to and will report to MCM ERC Manager Aged Care Services. see appendix 6

7.1 Organisational and Clinical Governance Framework
A Nurse Practitioner Project Management Committee will be established to provide support, guidance and expertise to the candidate and the clinical mentors to ensure the candidates learning plan and clinical competencies comply with and meet the ANMC National Competency Standards for Nurse Practitioners.
7.1 Clinical Internship
- The clinical internship will be supervised by a geriatrician, palliative care physician, a palliative care nurse practitioner and a general practitioner
- The clinical therapeutics component will be supervised by a senior pharmacist.

7.1.2 Professional Internship (Management and Leadership)
- The professional internship with be supervised by an external management executive and an endorsed NP and will include:
  - development of leadership and management skills, including communication and relationship building
  - research, analytical and presentation skills
  - support of learning plan
  - development of portfolio for endorsement

7.1.3 Academic
- The academic component of the NPC traineeship will be supported and supervised by the Manager Aged Care Services at MCM ERC
- A Palliative Care Nurse Practitioner from MCM PC will support the candidate with preparation for the requirement for endorsement by NMBA

7.2 Reporting Framework - Project Management Committee
APC NPC will report to and discuss all professional matters with the MCM ERC Manager Aged Care Services. The Nurse Practitioner Project Management Committee will meet bi monthly once the candidate has commenced the academic training and clinical internship. This committee will be chaired by the Manager Aged Care Services and report directly to the Director of Aged and Palliative Care who reports to the Chief Executive Officer.

Issues related to clinical decision making and clinical care will be discussed initially with one of the clinical mentors, depending on the clinical context. The clinical mentor/s will discuss and share concerns as appropriate with the MCM ERC Manager Aged Care Services who will then raise such matters at the Project Management Committee meeting. The MCM ERC Manager Aged Care Services has the authority to raise matters with the Project Management Committee at his/her discretion.
8 Appendices
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**Service Gap Analysis**

**Ageing Population**

A forecast change to the age structure of residents living in the Shire of Nillumbik is no different to the ageing population in general. In 2011 the number of residents > 70 years of age is 3373. It is projected in 2020 the number of residents > 70 years will increase to 5585 - a 58% increase. This ageing population, by definition will increase the demand for palliative care and a palliative approach within aged care.

**Timely Access to Medical Care**

Twenty three (23) general practitioners from 8 practices care for the 120 residents of ERC RAC’s. The range of residents to GP is between 1-14.

Three GP’s visit the RACS’s weekly providing care for 36% (n=43) of the residents. The remaining 64% residents (n=77) are cared for by the remaining 20 GP’s visit the RACs ad hoc or when requested by staff.

Many GPs are unable to attend the RACS when called for an urgent review of a resident, this is primarily due to their own practice obligations. All twenty three GP’s attending the RACS use a locum service for after hours care or when they are unable to attend the RACS. Staff are then required to book a locum visit or transfer the resident to the emergency department of the local hospital.

The large numbers of GPs who do not visit regularly may be a contributing factor to the number of locum visits and to the number of residents transferred to hospital in 2010.

In addition, the past 10 years has seen a significant decrease in the overall number of GP’s providing or involved in cooperative practice coverage of afterhours care. Nationally there has been a decrease from 60% of GP covering care after hours to 48%. *AIHW The BEACH Report 2010*

**Locum Visits**

There has been a significantly high number of locum visits to ERC RAC’s during the period Jan 2010 to Jan 2011. One hundred and sixty three (163) bookings/requests were made for after hours care by RACS staff to the Melbourne Medical Deputising Service during this period. There were 141 actual visits made by the locum service and of these 102 requests made for visits between Monday and Friday.

**Transfer to Hospital**

Thirty four (34) residents were transferred from ERC to hospital in 2010. Six residents were from the nursing home (high level care) and 28 from the hostel (low level care). The circumstance as to why residents were transferred to hospital has not been explored as it is beyond the scope of this project. However it is possible that the higher number of RN staff employed in the high care facility may prevent residents being transferred to hospital as these staff have a higher level of assessment skills compared to the less skilled staff (not RNs) employed in the low level facility.
Ageing Workforce - future service-provider gaps

RACS Workforce
A high percentage of the care staff working at the RACS of ERC are long term employees and many of these employees are > 55 years and/or nearing retirement, which will result in a changing workforce in the near future. It is anticipated that the need for ongoing training, mentoring and support for staff (nursing and personal care workers) will continue to increase because of current level of skill mix and retention rates of the aged care workforce across the industry. Ongoing aged and palliative care staff education and training is of primacy for all stakeholders working in aged care to understand and integrate the palliative approach into routine practices within residential and community services.

GP Workforce
Thirty percent (30%) of GP’s practicing in the Shire of Nillumbik and the surrounding catchment is > 55 years and nearing retirement. "North East Valley Division of General Practice 2011"

There is also less GP’s per 1000 of population compared with neighbouring suburbs. Nillumbik has 0.8 GP’s per 1000 population compared to Banyule which has 2.62 GPs per 1000 population. "Banyule Nillumbik Primary Care Alliance 2010"
Key Collaborative Arrangements

Appendix 2

May include:

- Communication protocols
- Clinical interventions
- Arrangements for initiating pathology & diagnostic testing
- Prescribing arrangements
- Resident consent
- Protocols for referral to other health professional
- After hours care
- Protocols for consultation
- Timely liaison with GP &/or other health professional
- Arrangements for terminating the collaborative agreement
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Referral Pathways

Aged and Palliative Care Nurse Practitioner

- RACS Staff, residents and families
- Residential Outreach RECIPE
- Pharmacist
- General Practitioner
- Community Palliative Care Services
- Hospital post discharge
- Other healthcare professionals
**Nurse Practitioner Aged & Palliative Care Model of Care**

**Entering the Aged & Palliative Care NP Care**
- Referral from staff in collaboration with GP for:
  - Urgent assessment &/or treatment
  - Complex care
  - Anticipatory planning & triaging of residents to prevent transfer to hospital
  - Complex family meetings to discuss care management and strategies
- Referral from GPs & other health professionals
- Referral from Residential Outreach (AH)
- Referral from RECPE (NH)
- Hospital post discharge
- On admission to the RACF
- Family request

**Care Provided**
- Clinical assessment
- Symptom management
- End of life care
- Prescribing & de-prescribing of medicines
- Care as per residents wishes & advance care plan
- Ordering diagnostic tests
- Referral to palliative care physician
- Referral to other healthcare providers
- Geriatric assessments
- Education & support for residents, families, and staff
- Bereavement follow up and referral for family & staff
- Communication with GP, residents, families, and staff

**Exiting the NP Care**
- Symptoms controlled
- Residents condition stable
- Transfer to hospital
- Transfer of care to other healthcare provider
- Resident dies

*Working collaboratively with the residents GP at all times*
9 References

1 AIHW The BEACH Report 2010

2 North East Valley Division of General Practice (Victoria): (2011) Population data and practice & staffing information

3 Banyule Nillumbik Primary Care Alliance: (2010) Demographics & Health Indicators Mapping