

Victorian Nurse Practitioner Project

Report of the Nurse Practitioner Implementation Advisory Committee



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Advisory Committee**

December 2001

*Victorian Nurse Practitioner Project: Report of the Nurse Practitioner Implementation
Advisory Committee*

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Foreword

The Nurse Practitioner Advisory Committee submitted this report in December 2001. This report and the associated process of consultation have added significantly to the development and implementation of the nurse practitioner role in Victoria.

The Department of Human Services has carefully considered the recommendations of the Nurse Practitioner Implementation Advisory Committee. This report incorporates departmental responses to each of the recommendations of the committee.

Since this report has been submitted, the Department of Human Services has continued to invest in developing the nurse practitioner role. Achievements include:

- Completion of the Therapeutic Medication Management Module by the University of Melbourne. The education module has been accredited by the Nurses Board of Victoria and is available to universities to offer as a core module in Masters level programs that lead to endorsement as a nurse practitioner.
- Availability and allocation of postgraduate scholarships contributing to subject fees for Masters level programs leading to nurse practitioner endorsement in Victoria. To date 16 scholarships have been awarded.
- Three additional *Victorian Nurse Practitioner Project Bulletins* published.
- Completion and publication of the evaluation of phase 2 demonstration projects undertaken by La Trobe University, titled *Victorian Nurse Practitioner Project: Evaluation of sixteen Phase 2 demonstration projects*.
- Allocation of two additional demonstration project funding rounds following public calls for submissions. Round 3 funding was allocated to four demonstration projects, three in varied aged care settings and one in renal dialysis. Round 4 was allocated to five projects in the areas of maternal and child health, men's health, Aboriginal health (midwifery and women's health) and two projects in mental health.

Implementing the nurse practitioner role and the associated extensions to practice requires further work to develop a consistent national approach to the funding and/or reimbursing clients for these activities. While a national approach is supported, the mechanism is yet to be determined. The options provided in this report will be considered in discussions at a national level.

As Victoria approaches the endorsement of the first nurse practitioners, I commend the Nurse Practitioner Implementation Advisory Committee in submitting this comprehensive report and for their contribution to the implementation of the nurse practitioner role in Victoria.



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Minister for Health



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Hon Bronwyn Pike MP
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Dear Minister

It is my pleasure to submit for your consideration the Report of the Nurse Practitioner Implementation Advisory Committee.

The committee was established in February 2001 following amendments to the *Nurses Act 1993*, creating this new career option for nurses. Those amendments came into effect in November 2001. You requested that the committee consider the best ways to implement the new role of nurse practitioner in light of the legislative requirements and in order to facilitate the extended practices nurse practitioners may need to undertake.

During the course of the committee's deliberations we engaged in a process of broad consultation with the community including nurses, consumers, medical practitioners, radiographers and others. We were gratified by the willingness demonstrated by all stakeholders to collaborate in the development of the nurse practitioner role.

Our recommendations are designed to facilitate the ongoing implementation of the nurse practitioner role. I commend them to you and, on behalf of the committee, thank you for the opportunity to provide advice on this important innovation in the range of care available to respond to the health needs of the Victorian community.

Yours sincerely

A handwritten signature in black ink, appearing to read "M Carter", written in a cursive style.

Meredith Carter
Chairperson
NPIAC

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Acknowledgements

The members of the Nurse Practitioner Implementation Advisory Committee are grateful to those who were coopted for their expertise and to those participating in the multi-faceted consultation process.

This report was prepared for the Minister for Health.

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Executive summary and recommendations

Following the release of the *Victorian Nurse Practitioner Project, Final Report of the Taskforce December 1999*, and in order to progress implementation of the nurse practitioner role in Victoria, the then Minister for Health, the Hon John Thwaites MP, established the Nurse Practitioner Implementation Advisory Committee (NPIAC). Committee membership included nursing, medical, pharmacy, employer and consumer bodies and Department of Human Services' representatives.

The NPIAC examined key implementation issues relating to the extended practices of the nurse practitioner role, including limited prescribing authority, initiation of diagnostics, referral to specialists and admitting privileges. A multifaceted consultation process, development of policy, and evaluation of a number of Victorian nurse practitioner models of practice have occurred concurrently and interactively. Together with the concerns of the Australian Medical Association (AMA), Victoria, and the Royal Australian College of General Practitioners (RACGP) Victoria, they have informed the deliberations of the NPIAC.

The multifaceted consultation process undertaken by the NPIAC involved specialist nursing, medical and employer organisations as well as the broader health care industry. Written submissions were initially invited and followed by a series of forums. One of the forums was co-sponsored by the RACGP (Vic), AMA (Vic) and the General Practice Divisions - Victoria and was held at a time and location to best accommodate doctors. Feedback from the consultation process informed policy development in relation to the extended practices of nurse practitioners and has generally supported the work of the NPIAC and the direction it has taken.

The NPIAC was also involved in selecting 16 Phase 2 nurse practitioner models of practice from 83 submissions. Evaluation of these in terms of feasibility, safety, effectiveness, quality and cost will continue to inform the implementation process.

This report is submitted to the Minister for Health by the NPIAC. It proposes a framework for the development of clinical practice guidelines to support the extended practices of the nurse practitioner role; sets out guidelines for obtaining admitting privileges by nurse practitioners in Victoria; and suggests priority areas of clinical nursing practice for initial implementation. Interdisciplinary and collaborative planning and evaluation should continue to guide practice in relation to the extended practices. However, it is proposed that a feasibility study be undertaken to examine the possibility of a separate funding pool for the reimbursement of consumers of nurses practitioners and that a national approach be taken for the development of corresponding Commonwealth policy.

Department of Human Services response to recommendation 1.

The Department of Human Services accepts the framework for the development of clinical practice guidelines developed by the Nurse Practitioner Implementation Advisory Committee.

The department also proposes to further develop this framework to assist with the development of clinical practice guidelines for nurse practitioners.

Recommendations

Clinical practice guidelines

1. That the Minister for Health accepts the framework for the development of clinical practice guidelines developed by the Nurse Practitioner Implementation Advisory Committee, in line with National Health and Medical Research Council (NHMRC) guidelines, and commends it to the Nurses Board of Victoria for use in the nurse practitioner endorsement process.

Department of Human Services response to recommendations 2, 3 and 4.

The Department of Human Services supports the endorsement of nurse practitioners in categories reflective of the varying contexts of clinical nursing practice in Victoria. The department will continue to work collaboratively with the Nurses Board of Victoria and the nursing profession to expedite the endorsement process in various categories, subject to nurse practitioner candidates meeting the criteria for endorsement.

Department of Human Services response to recommendations 5 and 6.

The Department of Human Services acknowledges the fundamental importance of clinical practice guidelines for nurse practitioners in all contexts of clinical nursing. Funding to support the development of clinical practice guidelines will be available according to government funding and purchasing guidelines. To date, 22 demonstration projects have received additional funding to further refine their clinical practice guidelines. In addition, the department proposes to further develop the framework for the development of clinical practice guidelines into generic documentation to assist with the development of clinical practice guidelines for nurse practitioners.

Areas of clinical nursing practice – initial priorities

2. Recognising that the Nurses Board of Victoria may specify in the endorsement the category or categories of nurse practitioner which the nurse practitioner is qualified to use (Section 8B of the *Nurses (Amendment) Act 2000*), that the following eight areas of clinical nursing practice be considered as initial priorities for implementation:

- wound management
- haematology oncology
- emergency
- primary health care – rural health
- women’s sexual and reproductive health
- paediatric eczema
- diabetes mellitus
- midwifery.

Prescribing rights

3. That the Minister for Health requests that the Nurses Board of Victoria consider and endorse the nurse practitioner areas of clinical nursing practice put forward as implementation priorities by the Nurse Practitioner Implementation Advisory Committee in the initial phase of determining areas of clinical nursing practice for nurses seeking to be endorsed as nurse practitioners with prescribing rights.
4. That the Department of Human Services, the Nurses Board of Victoria and the nursing profession work collaboratively on an ongoing basis to expedite the process for the establishment of categories of nurse practitioner with prescribing rights.
5. That the Department of Human Services considers the request for funding from Australian Diabetes Educators Association Limited, Victorian Branch, to develop clinical practice guidelines, including lists of medications and a specific therapeutic medication management module, in line with the framework endorsed by the Nurse Practitioner Implementation Advisory Committee, and that the context-specific therapeutic medication management modules articulate with the core therapeutic medication management module.
6. In addition to recommendation 5, that the Department of Human Services considers funding other appropriate initiatives to support the development of clinical practice guidelines, including lists of medications and specific therapeutic medication management modules, in line with the framework endorsed by the Nurse Practitioner Implementation Advisory Committee, and that the context-specific therapeutic medication management modules articulate with the core therapeutic medication management module.

Department of Human Services response to recommendations 7, 8 and 9.

The Department of Human Services supports the development of a national approach to funding and/or reimbursing consumers for services such as referral, pathology, radiology or pharmaceuticals initiated by nurse practitioners. The mechanism to fund and/or reimburse the extended practices of the nurse practitioner role is yet to be determined. The options provided in recommendations 7, 8 and 9 will be considered, in the first instance, by the National Nursing and Education Taskforce to be established in 2003-04.

Department of Human Services response to recommendations 10 and 11.

The Department of Human Services supports admitting privileges and processes that promote safe and effective health care for consumers. Evaluation of these processes is supported.

Department of Human Services response to recommendations 12 and 13.

The Department of Human Services accepts the importance of publicly acknowledging the achievements of nurse practitioner demonstration models and disseminating information about the nurse practitioner role and its implementation in Victoria.

Initiation of diagnostics and referral to specialists

7. That the Department of Human Services promotes a national approach for the development of Commonwealth policy associated with nurse practitioners gaining access to the Medicare Benefits Schedule and that the initial approach focus on access to the Enhanced Primary Care Medicare Items.
8. That the Minister for Health, through the Australian Health Ministers' Advisory Council, recommends that the *Health Insurance Act 1973* be appropriately amended for the reimbursement of consumers of nurse practitioner services.
9. That the Minister for Health, through the Australian Health Ministers' Advisory Council, recommends that a feasibility study be undertaken to examine the possibility of a separate funding pool for the reimbursement of consumers of nurse practitioner services and, further, that the Minister for Health offers to auspice the project on behalf of health ministers across Australia.

Admitting privileges

10. That Victorian public health services incorporate admitting privileges for nurse practitioners into existing processes, utilising the generic *Guidelines for obtaining admitting privileges by nurse practitioners in Victoria* as a model, and that clear lines of responsibility and communication be documented as part of this process to promote safe and effective health care for consumers.
11. That the Department of Human Services, in conjunction with the Victorian Healthcare Association Limited, the Private Hospitals Association of Victoria, and the nursing profession, designs and implements a process for the evaluation of admitting privileges in Victorian health services within two years.

General recommendations

12. That the Department of Human Services convenes a public forum at which the minister can acknowledge the achievements of the demonstration projects in developing nurse practitioner models.
13. That the Department of Human Services undertakes a process for disseminating the findings and recommendations of this report, including:
 - a) the framework for the development of clinical practice guidelines
 - b) the principles underpinning ordering of diagnostics and referral to specialists
 - c) guidelines for obtaining admitting privileges by nurse practitioners in Victoria.

1. Introduction

1.1 The Victorian Nurse Practitioner Project

The Victorian Nurse Practitioner Project commenced in July 1998 when the then Minister for Health appointed a taskforce to develop a framework and process for implementing the nurse practitioner role in this state. The work of the Nurse Practitioner Taskforce was informed by extensive consultation with key stakeholders. The 30 recommendations of the taskforce and the rationale underpinning them are detailed in *The Victorian Nurse Practitioner Project: Final Report of the Taskforce* December 1999 ('taskforce report'). The work of the taskforce, along with an initial round of funding for nurse practitioner demonstration projects, constituted Phase 1 of the Victorian Nurse Practitioner Project.

1.1.1 Scope of the nurse practitioner role

The nurse practitioner role is at the apex of clinical nursing practice. The role extends and advances current nursing practice, with a strong foundation in knowledge, skills and competencies, for both population and individual health. It may include prescribing, initiating diagnostics, approving absence from work certificates, referring to medical specialists, and admitting and discharging consumers. It is these extended practices that differentiate the role of the nurse practitioner from other registered nurses.

Suitably experienced and qualified advanced clinical nurses will be eligible for endorsement by the Nurses Board of Victoria (NBV) as a nurse practitioner in a particular category. A 'category' is a defined clinical area of nursing practice. The categories are anticipated to develop over time as the nurse practitioner role evolves.

1.1.2 Phase 1: Consultation

Broad consultation with stakeholders in Phase 1 of the project informed the work of the taskforce. This included forums targeting nurses and the health industry and focus groups targeting consumer representatives. The forums were designed to elicit the views of health care professionals on the process of implementing the role of the nurse practitioner in Victoria. The focus groups considered the potential impact of the implementation of the nurse practitioner role on individuals and communities. A summary of the community consultation process is included as an appendix in the taskforce report.

1.1.3 Phase 1: Nurse practitioner models of practice

In June 1999, funding was provided via a competitive tender process for eight nurse practitioner models of practice (demonstration projects). The models of practice were disparate in nature and included:

- Warrnambool and District Base Hospital: Wound Management Nurse Practitioner
- Peter MacCallum Cancer Institute: Haematology Nurse Practitioner
- Women's and Children's Health Care Network: Paediatric Eczema Nurse Practitioner
- Southern Health Care Network, Monash Medical Centre: Emergency Nurse Specialist

- Central Gippsland Health Service: Primary Care and Emergency Services in a Remote Area
- Barwon Health, Geelong Hospital and Deakin University: Perioperative Nurse Practitioner
- Southern Health Care Network, Community Health Services and Monash University: Well Women's Health Services
- Women's and Children's Health Care Network: Neonatal Nurse Practitioner
A further three existing models of practice were funded to participate in an external evaluation.
- Women's and Children's Health Care Network: Well Women's Nurse Practitioner Role in a Tertiary Women's Health Setting
- Royal District Nursing Service (RDNS): Homeless Person's Program
- Austin and Repatriation Medical Centre and the University of Melbourne: Consultation Liaison Psychiatric Nurse Practitioner.

Evaluation of Phase 1 Nurse Practitioner Models of Practice

Each model of practice participated in an external evaluation process. In addition, the first eight models of practice listed above also undertook an internal evaluation of their model of practice.

The broad evaluation indicators addressed by both processes were:

- feasibility - effectiveness, efficiency, cost-benefit and sustainability of the nurse practitioner role
- access - availability, acceptability, convenience, timeliness, choice and equity issues of the nurse practitioner role
- best practice - use of guidelines based on literature reviews, 'expert' opinion, professional standards, consumer¹ choice, consumer values
- appropriateness - consumer satisfaction, actual versus recommended practices
- cost - professionals' time, supplies, capital, overheads, costs of other services, costs to consumers and their families, indirect costs
- outcomes - symptom relief, complications, consumer satisfaction, physical, psychological and social function, impact on other services
- restrictions/limitations to current practice
- scope for improving and broadening current practice.

Internal evaluation

The overall general findings from the eight nurse practitioner models of practice that were funded to develop, implement and evaluate the role included:

- improved access to health services
- reduction in waiting times
- reduction in length of hospital stay
- improved healing rates

¹ The term 'consumer' has been used throughout this report and is inclusive of patients and clients.

- evidence of safe and effective care
- better continuity and coordination of care
- improvement in quality of life indicators
- improved management of health care
- cost savings due to decreased visits to a health professional
- role acceptability by all stakeholders
- high levels of consumer and carer satisfaction.

External evaluation

A team from the University of Melbourne (School of Postgraduate Nursing and the Program Evaluation Unit of the Centre for Health Program Evaluation) undertook the external evaluation of the 11 nurse practitioner models of practice.

As part of the external evaluation, individual consumer encounter data was collected via a minimum data set and analysed. Stakeholder and consumer perceptions were gathered via surveys and case studies. Each project varied in terms of its stage of development, extended role and the number of nurses involved. A minimum data set was developed against which all projects reported. This included preset variables using drop down menus of information for consistency in data collection and memo fields to allow projects to provide descriptive information reflecting the individual nurse's actual practice.

The models were constrained by legislation in relation to prescribing medications and seeking reimbursement for diagnostic tests ordered and referrals instigated. To accommodate this, most projects established protocols to deal with issues related to diagnostic tests, drugs and referral to other health professionals. Some projects significantly extended the role beyond what it had previously been with the scope of practice depending on contextual factors. Structured education programs were provided in many projects with both classroom and practical teaching being significantly supported by the medical consultants.

Nurses involved in the projects experienced a high level of acceptance by their colleagues and consumers. Their colleagues perceive them as enhancing the profession of nursing and assisting their professional roles. If there is opposition to this, then it was silent, despite various opportunities to state frank views in non-identified surveys and confidential interviews. Consumer perception surveys gave overwhelmingly positive comments about the nurse practitioners' level of care, attention and expertise.

Case study findings indicated that the nurse practitioner role was well received by the variety of health professionals interviewed and that nurse practitioners were valued by consumers. The case studies also identified the value of considering local and contextual factors when setting up projects and the importance of involving key stakeholders in role development and implementation. Of specific note was the mentor relationship between medical consultants and the key nurses involved in the model of practice.

The essentially developmental nature of the projects meant that the Phase 1 external evaluation yielded insights rather than conclusions, and preferable alternatives rather than clear pathways. Further details of the external evaluation, *Victorian Nurse Practitioner Project: Evaluation of eleven Phase 1 demonstration projects June 2000* may be found in the Victorian nurse practitioner website. (<http://www.nursing.vic.gov.au/furthering/practitioner.htm>)

1.2 The Nurse Practitioner Implementation Advisory Committee

In February 2001, the then Minister for Health, the Hon John Thwaites MP, established the Nurse Practitioner Implementation Advisory Committee (NPIAC). Its membership included nursing, medical, pharmacy, employer bodies and Department of Human Services' representatives. The chairperson was Meredith Carter, Executive Director, Health Issues Centre. The terms of reference of the NPIAC are detailed in Appendix 1.

The NPIAC was convened to work through key implementation issues relating to prescribing authority, admitting privileges, initiation of diagnostics and referral to medical specialists. The NPIAC was informed by the work and recommendations of the Nurse Practitioner Taskforce. In addition, the NPIAC was required to consider the dissenting positions of the AMA Victoria and the RCGP Victoria regarding implementation of the nurse practitioner role as outlined in the taskforce report.

The recommendations in this report aim to progress implementation of the nurse practitioner role in Victoria. The consensus reached by the NPIAC and the rationale for the recommendations in relation to each of the extended practices of the nurse practitioner role are detailed in this report.

1.2.1 Policy development

The work of the NPIAC encompassed:

- establishing subcommittees to examine and consult on key policy issues, including limited prescribing rights, initiation of diagnostic imaging and laboratory testing, referral to specialists and admitting privileges
- developing a framework for the funding of further nurse practitioner models of practice (demonstration projects)
- developing recommendations to the Minister for Health on options for incorporating into the Victorian nurse practitioner role the extended practices of prescribing, initiating diagnostics, referral to specialists and admission to hospital.

The membership and terms of reference of each of the subcommittees are detailed in Appendix 2. Each subcommittee met monthly and produced a document for discussion by the NPIAC. Subcommittees were also formed to review and select the nurse practitioner models of practice (demonstration projects), funded as part of Phase 2 of the project, to monitor the external evaluation process of these demonstration projects, and to select a preferred tenderer for the development of a core therapeutic medication management education module.

The establishment and work of the NPIAC in conjunction with the funding of a subsequent round of nurse practitioner demonstration projects constitute Phase 2 of the Victorian Nurse Practitioner Project.

1.2.2 Phase 2: Consultation

A multifaceted consultation process was undertaken by the NPIAC. This involved specialist nursing and medical organisations, as well as the broader health care industry to further inform the work of the committee. Written comments were invited on the extended practices of the nurse practitioner role in the first stage of this consultation process. Subsequent to this, three open consultation forums were held, two in metropolitan Melbourne and one in Bendigo. One of the forums held in Melbourne was co-sponsored by the RACGP (Vic), AMA (Vic) and the General Practice Divisions - Victoria at a time and location to best accommodate doctors.

The forums provided participants with an overview of the Victorian Nurse Practitioner Project and the recently funded nurse practitioner demonstration projects. Participants also had an opportunity to discuss role implementation issues and make further comments prior to the committee finalising its recommendations to the Minister for Health. More than 200 people from a range of clinical perspectives participated in the three forums in addition to the 65 written submissions received. Meetings with several groups, including the Victorian Hospitals Association and the Institute of Radiography, were held to discuss specific issues. A summary of the key themes emerging from this consultation process is provided in Appendix 3.

1.2.3 Phase 2: Nurse practitioner models of practice

The funding of nurse practitioner demonstration projects in a variety of clinical practice areas has formed a key component of the Victorian Nurse Practitioner Project. The objectives of these demonstration projects are to:

- enhance health care delivery
- develop a culture of collaboration and partnership with health care providers and the community
- identify appropriate practice settings for nurse practitioner services
- develop nurse practitioner models that demonstrate efficiency and quality outcomes
- promote the nurse practitioner role within the health care system and the community.

The key selection criteria developed by NPIAC for the demonstration projects were:

- evidence that the proposed nurse practitioner role is advanced and extends current practice
- demonstration of a locally agreed need
- support of, and demonstrated commitment to, the model of practice by employer bodies and an inter-disciplinary team

- evidence that the model is sustainable, including management commitment
- inter-professional collaboration in the refinement of the nurse practitioner model of practice
- cost-effectiveness of the nurse practitioner role.

Nurse practitioner models of practice funded in Phase 1 of the project were invited to apply for additional funding to further refine their model of practice. Four of the models sought and obtained further funding. In addition, a further 16 nurse practitioner models of practice, which were selected from 83 submissions by a nine member selection panel consisting of members of the NPIAC, were also funded in July 2001 to develop, implement and evaluate their model of practice. A summary of each of the newly funded models is provided in Appendix 5.

Local and external evaluations of these models are in progress and will further inform the implementation of the nurse practitioner role. Each of the models of practice will assess whether there is a need for the extended practices and will develop, refine and evaluate their model. They are required to work with other health care professionals and to consult with all relevant stakeholders including professional associations or interest groups related to their context of practice. This might include, for example, the Australia and New Zealand College of Mental Health Nurses and the Australasian College of Physicians where applicable, pharmacy, pathology and radiology personnel as well as general medical practitioners. Depending on the outcomes of each project, the nurse should be ready to seek endorsement as a nurse practitioner from the NBV at the end of the project. In addition, the employer is expected to have gone some way towards developing structures to facilitate the employment of the nurse practitioner.

The external evaluation of the 16 nurse practitioner models of practice was undertaken by the School of Nursing and Midwifery, La Trobe University.

2. Implementing the taskforce recommendations

Implementation of the 30 recommendations contained in the taskforce report is underway. These developments have informed Phase 2 of the Victorian Nurse Practitioner Project and are outlined below.

2.1 Legislative changes

In line with the taskforce recommendations to protect the title ‘nurse practitioner’ and to provide for limited prescribing authorisation for nurse practitioners, amendments have been made to the *Nurses Act 1993*, which pave the way for changes to be made to the *Drugs, Poisons and Controlled Substances Act 1981* (DPCS Act).

2.1.1 Nurses (Amendment) Act 2000

The amendments to the Nurses Act set the scene for recognising advanced clinical nurses practising in an extended role. The *Nurses (Amendment) Act 2000* came into effect in November 2001. The Act protects the title ‘nurse practitioner’ and provides for endorsement as a nurse practitioner on the nurses’ register. It also provides for authorisation of suitably experienced and qualified advanced clinical nurses to prescribe a limited range of drugs and poisons under the DPCS Act.

Section 8(B) of the Nurses (Amendment) Act pertaining to the endorsement of registration for nurse practitioners is detailed in Appendix 4.

The minister will approve regulations under the DPCS Act that authorise prescribing for categories of nurse practitioner when:

The training accredited by the Nurses Board of Victoria (NBV) is of a sufficient standard, and in particular, the course content and clinical practice requirements have been established in consultation with the relevant specialist medical and nursing bodies;

The clinical practice guidelines have been established in consultation with the relevant medical and nursing bodies and all parties are in substantial agreement that these clinical practice guidelines along with the accredited training will support safe prescribing.

2.1.2 Nurse Practitioner Advisory Committee

The amendments to the Nurses Act require the NBV to establish a Nurse Practitioner Advisory Committee (NPAC). This committee will advise the NBV in relation to endorsement of registered nurses in categories of nurse practitioner authorised to prescribe drugs and poisons under the DPCS Act. The function and membership details of the NPAC are detailed in Appendix 4.

The Minister for Health will refer to the Poisons Advisory Committee (PAC)² requests from the NBV for regulations to be made under the DPCS Act to include a new nurse practitioner category and list of drugs. A regulatory impact statement (RIS) process will then follow, providing another opportunity for stakeholders to have input.

² Refer to Appendix 4 for information about the function and membership of the Poisons Advisory Committee.

The RIS process includes public notification and ensures that all comments and submissions are considered before the regulation becomes law.

2.1.3 Professional indemnity for nurse practitioners

Recommendations 22 and 23 of the taskforce report address the issue of professional indemnity insurance for nurse practitioners. Consistent with this, section 4 of the Nurses (Amendment) Act details the discretionary power of the NBV to require evidence of professional indemnity insurance from nurses applying to the board for endorsement as a nurse practitioner. Section 5 requires the professional indemnity insurance arrangements to meet any minimum terms and conditions set out in the guidelines of the NBV.

2.2 Nurses Board of Victoria

In line with the taskforce recommendations (6, 7, 8, 9, 10, 12, 13, 17, 20 and 22) and amendments to the Nurses Act, the NBV was requested by the Minister for Health to:

- develop the criteria for nurse practitioner endorsement, including clinical and educational requirements
- develop transition arrangements for the attainment of the minimal educational requirement of a Master's degree for nurse practitioner recognition and provide exemptions where appropriate
- establish criteria for the assessment of continuing competence of nurse practitioners
- recommend a framework for the development of national standards.

In September 2000, the NBV convened an advisory committee to consider these issues. The *Nurse practitioner: Pre-implementation report*, emanating from the work of this committee, was released by the NBV in December 2001.

2.3 Recognition of the nurse practitioner role

Recommendations 1 to 5 of the taskforce report relate to recognition of the nurse practitioner role. A number of strategies have been adopted to promote a greater understanding of this emerging role. Three editions of the *Victorian nurse practitioner bulletin* have been produced to date. The bulletin promotes consultation and aids participation in the Nurse Practitioner Project by disseminating information on the legislative and policy framework, models of practice and current issues. The Nurse Policy Branch website (www.nursing.vic.gov.au/furthering/practitioner.htm) also informs interested parties about the progress of the nurse practitioner role in Victoria.

2.4 Educational preparation of nurse practitioners

The taskforce made a number of recommendations regarding the educational preparation of nurses seeking endorsement as nurse practitioners. It recommended that the courses developed include both core and context-specific units. Furthermore, it proposed that the core units encompass the extensions to nursing practice, which include prescribing, initiating diagnostic investigations, referring to

medical specialists and admitting to hospital. The taskforce also recommended that the Department of Human Services supports a consortium of universities in the development of appropriate nurse practitioner courses.

Based on the taskforce recommendations, a consortium of universities has agreed on the core components of courses for nurses preparing for endorsement as a nurse practitioner, which include pharmacology, law and ethics, advanced assessment and professional development. Work on the development of context-specific units has also commenced and will be informed by the guidelines for the accreditation of courses leading to endorsement as a nurse practitioner developed by the NBV. These guidelines are contained within NBV's *Nurse practitioner: Pre-implementation report*.

Work on developing a core therapeutic medication management education module, which would be undertaken by all nurses seeking endorsement as a nurse practitioner, has also commenced and is detailed in section 4.3 of this report.

3. Clinical practice guidelines

The NPIAC has formulated a framework for the development of clinical practice guidelines to support the extended practices of the nurse practitioner role. The NHMRC publication, *A guide to the development, implementation and evaluation of clinical practice guidelines* (1999), forms the basis of this framework³. The development of a framework to support the formulation of clinical practice guidelines is in line with recommendation 21 of the Victorian nurse practitioner taskforce report and is also consistent with recommendations 26, 27 and 29 of the report.

Before the Minister for Health approves any regulation under the DPCS Act that authorises prescribing for any category of nurse practitioner, clinical practice guidelines need to be established in consultation with the relevant stakeholders, including appropriate nursing, medical and allied health professionals, consumers and management. All parties are required to be in substantial agreement that these clinical practice guidelines, along with the accredited training, will support safe prescribing.

Clinical practice guidelines are a guide to practice only and the NPIAC is aware that they may not yet have been developed for all specific practice areas. A collaborative process in the development of clinical practice guidelines will ensure that the extension of the scope of practice of registered nurses is introduced in a planned and considered manner and that public health and safety is protected.

Guidelines are viewed as an important link between best available evidence and good clinical practice. They are designed:

- To improve the quality of health care
- To reduce the use of unnecessary, ineffective or harmful interventions, and
- To maximise the chance of benefits for consumers, at an acceptable cost. (NHMRC, 1999).

The NHMRC has identified a number of key factors critical to the success of clinical practice guidelines. These include ensuring that the guidelines are:

- perceived to be useful
- used in clinical decision-making
- fully incorporated in the health care system
- used alongside existing quality assurance activities
- continually evaluated and revised in response to new evidence and consumer feedback
- sufficiently flexible to adapt to varying local conditions and to take account of consumer preferences and values.

The key steps to inform the development of clinical practice guidelines are outlined in Appendix 6.

³ Copies of the NHMRC publication can be obtained through the AusInfo Government Information Bookshops by telephoning 132 447 or at http://www.ausinfo.gov.au/general/gen_hottobuy.htm

The framework to inform the development of clinical practice guidelines to support the extended practices of the nurse practitioner role is detailed on the following page. It is proposed that the framework be recommended to the NBV for use in the endorsement process.

Recommendation

1. That the Minister for Health accepts the framework for the development of clinical practice guidelines developed by the Nurse Practitioner Implementation Advisory Committee, in line with National Health and Medical Research Council (NHMRC) guidelines, and commends it to the Nurses Board of Victoria for use in the nurse practitioner endorsement process.

Department of Human Services response to recommendation 1.

The Department of Human Services accepts the framework for the development of clinical practice guidelines developed by the Nurse Practitioner Implementation Advisory Committee. The department also proposes to further develop this framework to assist with the development of clinical practice guidelines for nurse practitioners.

Framework for the development of clinical practice guidelines

This framework is based on the *Victorian Nurse Practitioner Project, Final report of the taskforce* (December 1999). The establishment of nurse practitioner services in Victoria is to be guided by the principles of collaborative planning and evaluation relevant to the context of practice. It is the responsibility of the employing organisation, in consultation with key stakeholders, to plan services to meet the needs of the local community.

The clinical practice guidelines are to be developed in the clinical setting with relevant stakeholders, including appropriate nursing, medical and allied health professionals, consumers and management. The guidelines should address specific clinical presentations and guide the nurse practitioner in clinical assessment, clinical management, referral processes and clinical evaluation.

Overall, clinical practice guidelines should be credible, useable and of a high standard. They should reflect a holistic model of care and acknowledge the values of consumers. The language used in the guidelines should be accessible. The guidelines should also be publicly available and, in line with community needs, be available in multiple languages.

Clinical practice guidelines shall:

1. Follow the principles outlined in the NHMRC document *Guidelines for the development and implementation of clinical practice guidelines*, including:
 - the process of development should be multidisciplinary, flexible, inclusive of consumers, and adaptable to varying local conditions
 - the development and evaluation of clinical practice guidelines should be outcome-focused and based on the best available evidence
 - they should be evaluated and updated regularly.
2. Specify the extended practices including:
 - details of the particular substances to be prescribed as part of the nurse practitioner formulary
 - diagnostic investigations that the nurse practitioner is authorised to initiate locally
 - referral processes and privileges
 - admitting processes and privileges.
3. Include clearly delineated professional links for consultation and review between the nurse practitioner and appropriate local health practitioners related to the clinical context of practice.

4. Prescribing rights

As outlined in section 2.1.1, the Nurses (Amendment) Act allows for suitably endorsed nurse practitioners to gain limited prescribing rights. A list of drugs will be included in the regulations to be made under the DPCS Act for each category⁴ of nurse practitioner with prescribing rights.

The NPIAC has considered issues and potential barriers that may arise from the implementation of nurse practitioner prescribing rights. It has also considered clinical areas of nursing practice that are priorities for implementation of prescribing rights. In addition, it has examined alternative approaches and processes for the implementation of prescribing rights for nurse practitioners where there are anticipated to be a small number of nurse practitioners in a particular category of practice.

4.1 Background

The taskforce report summarises the literature regarding the benefits and potential risks associated with extending prescribing rights to advanced practice nurses. The benefits identified include: improved consumer care; increased convenience for consumers; improved nurse-consumer relationship; improved collaborative practice; and potential reduction in costs. Some of the concerns identified in the literature include: educational preparation of nurses; risk of polypharmacy and consumer confusion; and potential increase in costs.

Nurses have the authority to prescribe in particular contexts of practice in other countries. A review of these prescribing practices is detailed in the taskforce report. Within Australia, nurses in Queensland are authorised to possess, administer and supply medications according to established drug therapy protocols. With the introduction of the nurse practitioner role in NSW, prescribing by endorsed nurses is supported by a list of drugs and protocols approved by the Director General of Health. In Victoria, the taskforce recommended changes to the DPCS Act to provide for limited prescribing authorisation for nurse practitioners and also recommended that nurse practitioners be authorised to prescribe from a formulary corresponding to the context of practice of the nurse practitioner.

As part of the Phase 1 nurse practitioner demonstration projects, project teams considered the need for prescribing medications and commenced work on developing a list of medications and associated clinical practice guidelines to support prescribing specific to their context of practice. During the life of these projects, protocols were developed to enable nurses to recommend certain drugs with medical supervision.

4.2 Areas of clinical nursing practice

In line with the taskforce recommendations and in order to progress nurse practitioner role implementation, the NPIAC developed selection criteria for use in the initial phase of determining categories of nurse practitioner with prescribing rights. Recognising that the titles for nurse practitioner categories will be specified by the

⁴ As defined in section 1.1

NBV, the NPIAC identified areas of clinical nursing practice which would be initial priorities for implementation. These areas are not intended to be exhaustive. They will need to be reviewed and refined on an ongoing basis as the nurse practitioner role evolves, so as not to unduly restrict the practice of nurse practitioners.

Four key criteria were developed to determine the initial clinical areas of nursing practice that are priorities for nurse practitioner role implementation:

- a well developed model of clinical practice
- a defined list of drugs
- an identified generic specialist association/body relevant to the category of practice
- a Department of Human Services funded project with strong organisational support.

The clinical areas of nursing practice put forward by the NPIAC are predominantly limited to Phase 1 models that are well advanced and have substantially developed a list of drugs and associated clinical practice guidelines for their clinical area of practice. The list of context-specific drugs identified in the Phase 1 models range from one to 34. The concern of the NPIAC was that the role of nurse practitioners not be restricted by geographic location, as per taskforce recommendation 2. This was taken into account in identifying priority areas of clinical nursing practice.

The clinical areas of diabetes mellitus and midwifery were also included in the initial list of priority areas as these models are similarly well developed in relation to defining the scope of the nurse practitioner role, establishing a list of drugs specific to the clinical practice area and developing associated clinical practice guidelines.

To avoid duplicating the work of the NPIAC in specifying initial areas of clinical nursing practice for implementation, the committee agreed to seek the endorsement of the NBV for the selection criteria and areas of clinical nursing practice put forward as implementation priorities by the NPIAC. Any nurse, however, may seek nurse practitioner endorsement from the NBV. The NPIAC recognises the importance of the nursing profession, the NBV, and the Department of Human Services, in particular the Drugs and Poisons Unit, working together on general principles to progress role implementation in relation to prescribing.

The NBV has indicated that it intends to adopt the New Zealand Nursing Council's nomenclature model for determining scopes of practice on an interim basis. This is a two dimensional model which includes scopes of practice on its vertical axis and lifespan or population groups on its horizontal axis. The model allows for nurses/midwives to self-identify their category of practice in their application for endorsement.

The Nurses (Amendment) Act allows for the NBV to specify in the endorsement of a nurse as a nurse practitioner, the category or categories of nurse practitioner recognised by the NBV. A schematic representation of the process for the establishment of categories of nurse practitioner and a list of drugs in regulation along with the process for nurses to seek endorsement as a nurse practitioner with prescribing rights are detailed on the following pages.

Figure 1: Process for determining nurse practitioner categories and associated list of drugs

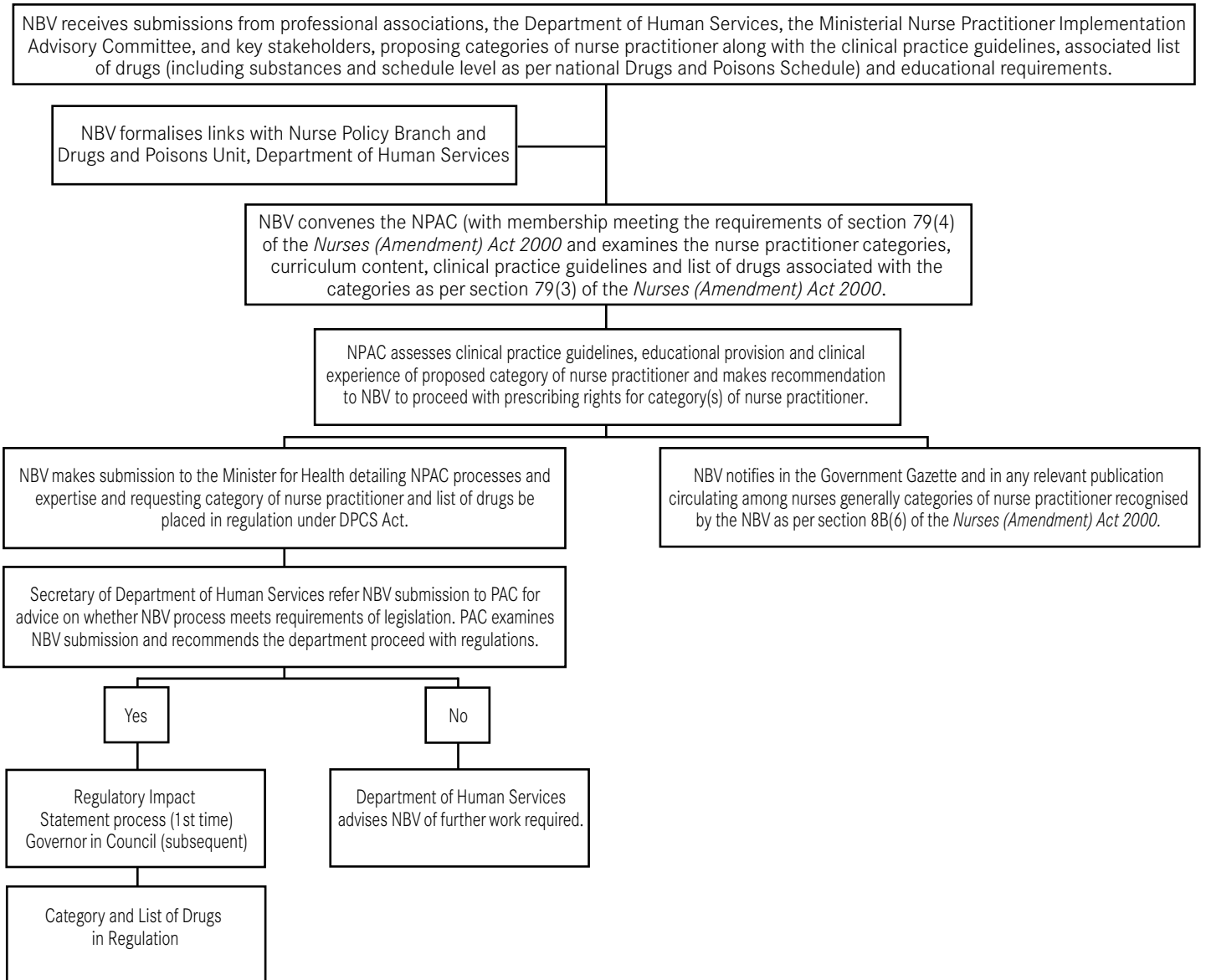
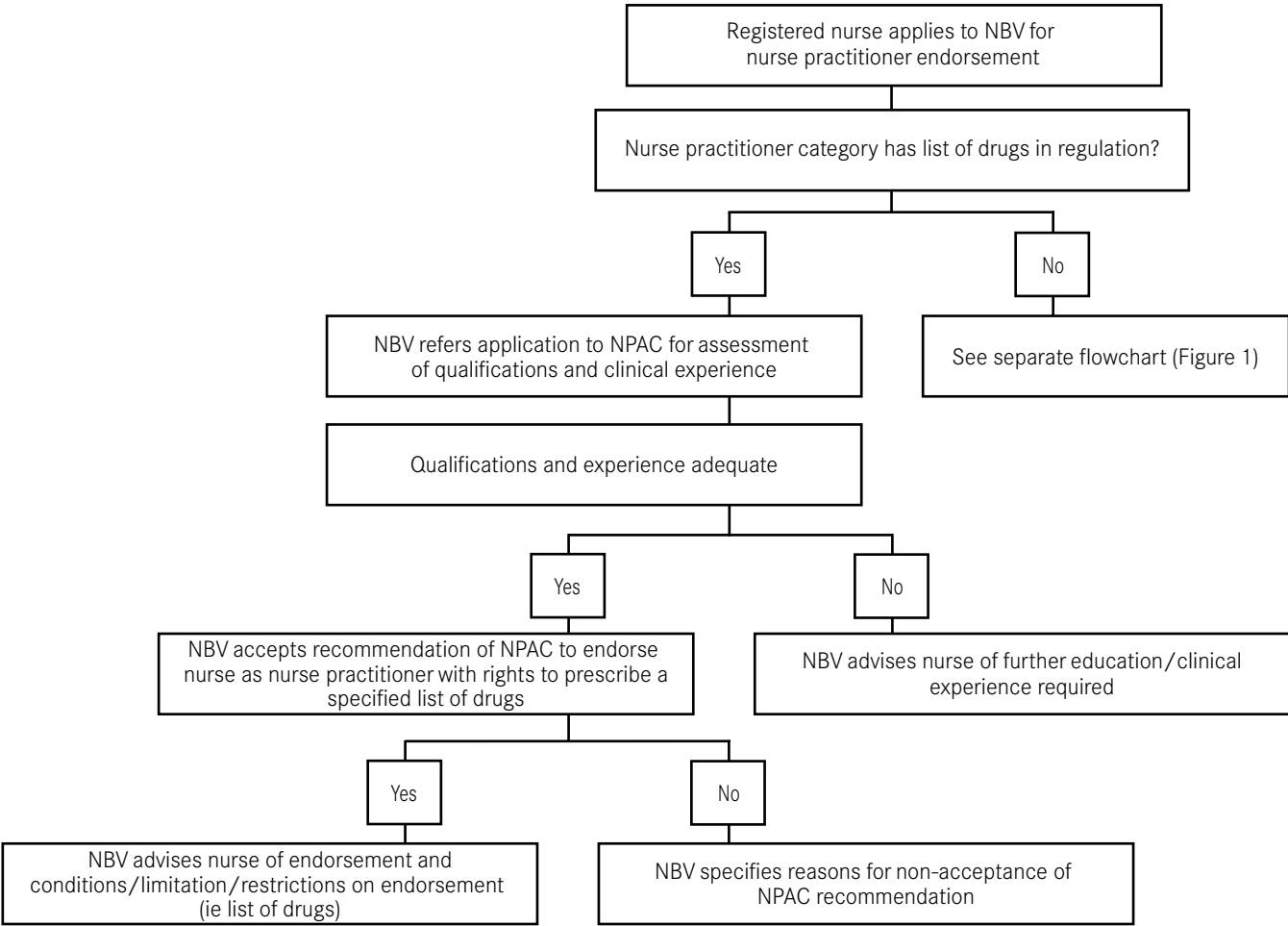


Figure 2. Endorsement process for a nurse seeking endorsement as nurse practitioner with prescribing rights



Recommendations

2. Recognising that the Nurses Board of Victoria may specify in the endorsement the category or categories of nurse practitioner which the nurse practitioner is qualified to use (section 8B of the Nurses (Amendment) Act 2000), that the following eight areas of clinical nursing practice be considered as initial priorities for implementation:
 - wound management
 - haematology oncology
 - emergency
 - primary health care - rural health
 - women's sexual and reproductive health
 - paediatric eczema
 - diabetes mellitus
 - midwifery
3. That the Minister for Health requests that the Nurses Board of Victoria considers and endorses the nurse practitioner areas of clinical nursing practice put forward as implementation priorities by the Nurse Practitioner Implementation Advisory Committee in the initial phase of determining areas of clinical nursing practice for nurses seeking to be endorsed as nurse practitioners with prescribing rights.
4. That the Department of Human Services, the Nurses Board of Victoria and the nursing profession work collaboratively with the nursing profession on an ongoing basis to expedite the process for the establishment of categories of nurse practitioner with prescribing rights.

Department of Human Services response to recommendations 2, 3 and 4.

The Department of Human Services supports the endorsement of nurse practitioners in categories reflective of the varying contexts of clinical nursing practice in Victoria. The department will continue to work collaboratively with the Nurses Board of Victoria and the nursing profession to expedite the endorsement process in various categories, subject to nurse practitioner candidates meeting the criteria for endorsement.

4.3 Therapeutic medication management education module

In line with the recommendations of the taskforce, nurses seeking endorsement as a nurse practitioner must have completed a study program accredited by the NBV that prepares them for the extended practice of prescribing medications. In order to progress the development and subsequent accreditation of appropriate courses of study, the NPIAC has supported the development of a core therapeutic medication management education module applicable to all nurses seeking nurse practitioner endorsement.

The Department of Human Services has contracted the University of Melbourne, School of Postgraduate Nursing and Department of Pharmacology to develop a core therapeutic medication management education module. Once developed, this

module will be submitted to the NBV for accreditation as the core therapeutic medication management post-graduate education module for advanced clinical nurses seeking nurse practitioner endorsement.

The therapeutic medication management education module is intended to build on nurses' and midwives' advanced clinical knowledge about medication administration to assist them to develop core competencies to safely and effectively prescribe and supply medications in defined populations. It is expected that context-specific therapeutic medication management modules will also be developed.

Through consultation with key stakeholders, the NPIAC has been informed of work being undertaken by professional associations in relation to the development of clinical practice guidelines and context-specific education modules. The Australian Diabetes Educators Association Limited has established a process to address the above and identified the costs associated with undertaking this work. The NPIAC considers that the development of clinical practice guidelines and education modules would be facilitated if funding were made available to support such initiatives by relevant professional associations. These initiatives should be in line with Department of Human Services principles relating to quality and continuity of care.

Recommendations

5. That the Department of Human Services considers the request for funding from Australian Diabetes Educators Association Limited, Victorian Branch, to develop clinical practice guidelines, including lists of medications and specific therapeutic medication management modules, in line with the framework endorsed by the Nurse Practitioner Implementation Advisory Committee, and that the context-specific therapeutic medication management modules articulate with the core therapeutic medication management module.
6. In addition to recommendation 5, that the Department of Human Services considers funding other appropriate initiatives to support the development of clinical practice guidelines, including lists of medications and specific therapeutic medication management modules, in line with the framework endorsed by the Nurse Practitioner Implementation Advisory Committee, and that the context-specific therapeutic medication management modules articulate with the core therapeutic medication management module.

Department of Human Services response to recommendations 5 and 6.

The Department of Human Services acknowledges the fundamental importance of clinical practice guidelines for nurse practitioners in all contexts of clinical nursing. Funding to support the development of clinical practice guidelines will be available according to government funding and purchasing guidelines. To date, 22 demonstration projects have received additional funding to further refine their clinical practice guidelines. In addition, the department proposes to further develop the framework for the development of clinical practice guidelines into generic documentation to assist with the development of clinical practice guidelines for nurse practitioners.

4.4 Alternative approaches to prescribing rights

The NPIAC has considered alternative approaches and processes for implementing prescribing rights for nurse practitioners, in particular where there is anticipated to be only a small number of nurse practitioners in a certain category of practice.

As detailed in the taskforce report, rural and remote nurses in Victoria can be authorised to administer medications via a Health Services Permit. The permit applies to a specific health service and allows nurses to administer medications under certain circumstances.

Health Services Permits can also authorise nurses to administer medications in other settings. Under the Royal Children's Hospital Health Services Permit, appropriately skilled nurses are able to administer hydrocortisone cream without the authority of a medical officer. However, they must do so only according to the procedure approved by the Divisional Director of Medicine-Nursing, the Director, Department of Dermatology, and the Network Director of Pharmacy.

The NPIAC considered the value of extending the Health Services Permit mechanism to authorise nurse practitioners employed by an agency that has been issued a Health Services Permit to use, sell and supply scheduled drugs in addition to their authorisation to possess and administer. However, there was not unanimous support from the NPIAC to expand the Health Services Permit. Some concerns were expressed about creating parallel processes for nurse practitioners to obtain prescribing rights. Some committee members also felt that the new legislation should be tested in the first instance. In line with this, the committee supports the streamlining of processes for nurse practitioners to obtain prescribing rights and proposes that such processes be kept open for review.

5. Initiation of diagnostics and referral to specialists

To provide prompt care and treatment, a nurse practitioner may need to initiate diagnostic services and/or refer to medical specialists. The NPIAC has considered issues associated with defining the scope of practice and determining the roles and responsibilities of nurse practitioners in applying these extended practices. In addition, the work of the NPIAC has focused on identifying barriers to implementation and processes for hospitals to consider in relation to nurse practitioners seeking these extended practices.

The recommendations of the NPIAC relating to the extended practices of the nurse practitioner role were informed by the work of the taskforce, the Phase 1 nurse practitioner demonstration projects, and existing legislative frameworks. In relation to the initiation of diagnostics, the recommendations were also informed by existing protocols to support the initiation of diagnostic procedures by nurses and other health professionals in some health settings.

5.1 Barriers identified in Phase 1 demonstration projects

A number of barriers to the initiation of diagnostic procedures and referral to specialists were identified by the project teams in the development of the Phase 1 nurse practitioner models of practice. The barriers included:

- lack of a Medicare Provider Number impeding nurses initiating diagnostics and referring to specialists
- concerns about the costs to consumers for diagnostic procedures ordered by nurse practitioners where no Medicare benefits are obtainable
- required authorisation of diagnostics by medical officers in order to claim Medicare benefits
- duplication of assessments when the consumer also needs to be seen by a medical practitioner to authorise diagnostic procedures and so obtain Medicare benefits
- radiology and pathology providers unsupportive of nurses ordering diagnostic procedures in some settings.

5.2 Consultation

The range of comments received on these issues during the NPIAC consultation process, are summarised in the following paragraphs.

The major barrier to nurse practitioners initiating diagnostic imaging related to access to Medicare benefits. This barrier was also identified with respect to medical specialist referrals. Funding issues generally were considered more complex for nurse practitioners in private practice or in the community, than for those working in a hospital setting.

The consultation also identified concerns of a perceived risk of over-servicing by nurse practitioners, although these concerns are not limited to nurses. The development of guidelines to assist nurse practitioners in the decision-making process and collaboration between nurse practitioners and other clinicians were seen as ways to avoid over-servicing and ensure the consumer is not disadvantaged.

Educating nurse practitioners on the risks and benefits of radiological examinations and the interpretation of results was also considered necessary. Nurses seeking endorsement as a nurse practitioner will need to complete a NBV accredited course in preparation for ordering diagnostic tests.

It was also proposed that radiological investigations should be limited to the context of practice of the nurse practitioner. This would reflect the current practice of podiatrists and other allied health professionals in this area. In addition, the consultation generated a proposal that the range of specialists to whom nurse practitioners might refer consumers should be limited by their scope of practice. The process for determining the breadth of diagnostic tests and referrals potentially required is being undertaken as part of the nurse practitioner demonstration projects.

Attitudinal barriers to nurse practitioners ordering diagnostic tests and referring to specialists were also noted. The availability of professional indemnity insurance was raised in relation to the responsibility resting with the clinician ordering diagnostic tests to obtain the results and take appropriate follow-up action.

5.2.1 Australian Institute of Radiography

The NPIAC consulted with the Australian Institute of Radiography in October 2001. Issues regarding nurse practitioners ordering radiological procedures were considered.

Discussion focused on the importance of nurse practitioners establishing collaborative relationships with radiographers within the clinical setting. It was agreed that guidelines to support nurse practitioners ordering radiological investigations would be initiated by the NPIAC with input from the Australian Institute of Radiography.

5.2.2 Existing frameworks and work in progress

As part of the consultation process, some organisations provided details of existing protocols to support nurse initiated radiological investigations in a number of health services in Victoria. These protocols have predominantly developed in emergency departments where they enable triage nurses to instigate a limited range of X-rays. Protocols to support midwives ordering a limited range of diagnostic tests also exist within some health services. A summary of these protocols is given below.

- **Austin & Repatriation Medical Centre** - triage nurses are able to order some laboratory and radiological tests. Request slips are pre-signed by doctors in some speciality departments allowing nurses to order some tests as per a clinical management protocol.
- **Alfred Hospital** - protocols exist to support nurse initiated X-rays within the emergency department. Clinical indicators and appropriate tests were formulated with senior medical officers and senior radiology staff. Education for the nurses is via a self-learning package. No adverse events have been observed.
- **Angliss Health Service** - nurse initiated investigations and treatment within the emergency department includes ordering X-rays for simple fractures (a medical

officer is required to sign the request slip but not required to validate it clinically); initiating and taking blood gases for consumers with Chronic Obstructive Airways Disease (COAD); inserting intravenous catheter and rehydration of consumers with fluid depletion; commencing oral rehydration therapy of children presenting with dehydration; initiating paracetamol for febrile children; and initiating treatment and analgesia for simple sprains.

- **Box Hill Emergency Department** – protocols exist for triage nurses to make referrals for specific examinations, for example, X-rays of the foot and ankle. The protocol has reportedly decreased consumer waiting times and increased emergency department throughput.
- **Goulburn Valley Health** – midwives are able to initiate tests at initial consumer presentation and following the development of a defined history and initial examination results. Antenatal screening tests include blood group and antibody titre; full blood examination; rubella titre; syphilis; midstream specimen of urine; hepatitis B; iron studies; glucose challenge test; glucose tolerance test; and vaginal swabs for streptococcus and thrush. Reports of test results are sent to both the midwifery clinic and a supervising medical officer.
- **Stawell District Hospital Occupational Health and Medical Screening Service** – all referrals for pathology or radiology made to the Occupational Health and Medical Screening Service are for occupational health monitoring. All referred services are paid for by the employer, therefore, access to Medicare benefits is not required. The occupational health nurse initiates pathology for the purposes of occupational immunisation, biological monitoring (lead and mercury, drug screening) and health promotion (for example, lipid profiles). Initiation of radiology by the occupational health nurse includes routine chest X-rays for the pre-placement and periodical surveillance for mine and asbestos exposed employees. A medical practitioner reviews the results.
- **Victorian Cytology Service (VCS)** – a small numbers of Pap smears are collected by nurses who have a credentialing secretariat user number allocated by the Royal College of Nursing, Australia. In 2000, nurses collected 1.7 per cent of all Pap smears. Under the current Commonwealth-State Public Health Outcomes Funding Agreement, Pap smears are processed by the VCS free of charge.
- **Wangaratta District Base Hospital (WDBH)** – limited diagnostic privileges, including routine ultrasound, are currently appropriated to midwives under the Community Midwife Program. Normal results are forwarded to the midwives to be read, discussed with the woman and filed. Abnormal results are also discussed and appropriate referral consultation with the obstetrician follows.
- **Wodonga Regional Health Service** – nurses are able to initiate limited diagnostic tests (radiology and pathology) in accordance with specific protocols. It is currently perceived that nurses order a greater number of tests than medical interns within this setting. Advice received suggests, however, that further training and experience in ordering diagnostics will lead to more confidence and better practice in this respect.

5.2.3 Breakthrough Collaborative Project

The Breakthrough Collaborative Project has involved the development of processes to support nurse initiated X-rays in emergency departments. The project is supported by the Department of Human Services and involves 18 hospitals throughout Victoria working intensively to reduce waits and delays and improve patient satisfaction in emergency departments.

Factors that appeared to promote the success of teams involved in the project include: overt executive sponsorship; stable staffing; medical and nursing representation and support; Emergency Department Director support; provision and understanding of improvement methodology; understanding concepts of change dynamics and empowerment of nursing staff.

Nurse initiated X-rays and pathology practised according to agreed protocols were powerful drivers in the project. The Breakthrough Collaborative recommended that the nurse practitioner project build on these successes (The Breakthrough Collaborative, reducing waits and delays and improving patient satisfaction in the emergency department, report, June 2001).

5.3 Initiation of diagnostics - definition

To promote clarity about the nurse practitioner role, the NPIAC formulated the following definition.

The initiation of diagnostic investigations specific to a nurse practitioner category of practice encompasses:

- ordering radiological investigations and/or pathology tests following a clinical assessment
- receiving results
- using results to monitor the effects of management strategies
- taking appropriate follow-up action, for example, referral to an appropriate specialist.

5.4 Reimbursement issues

In relation to the reimbursement of diagnostic investigations ordered and referrals to medical specialist instigated by nurse practitioners, key stakeholders participating in the NPIAC consultation process overwhelmingly identified an inability to access Medicare benefits or other sources of funding as a major barrier to the implementation of these extended practices. In seeking to address this issue, the NPIAC, keeping in mind the AMA's continued opposition to consumer access to Medicare rebates for the provision of nurse practitioner services, considered existing legislation pertaining to Medicare benefits, how the legislation applies to other non-medical health professionals, and alternative funding arrangements currently accessed by registered nurses.

5.4.1 Legislation

In Victoria, registered nurses can initiate a written request for diagnostic services

and can directly refer a consumer to a medical specialist. The consumer is, however, unable to claim against Medicare for reimbursement. Amendments to the *Health Insurance Act 1973* would be required for nurse practitioners to access Medicare benefits on behalf of consumers.

The Health Insurance Act details provisions for medical practitioners to obtain a Medicare Provider Number and access Medicare benefits. Provisions also exist for dentists, prosthodontists, chiropractors, physiotherapists and podiatrists to obtain a Medicare Provider Number and order a limited number of items from the Medicare Benefits Schedule (MBS).

Hence, while there are no legislative barriers to nurses initiating diagnostic imaging and pathology, there is no legislative provision for nurses to obtain a Medicare Provider Number. This presents a barrier for consumers accessing Medicare benefits for services provided by nurse practitioners or taking up recommendations such as referrals to a specialist.

The Commonwealth Department of Health and Aged Care has indicated that in order to change Commonwealth legislation (Health Insurance Act), policy changes need to be put in place first. All states and territories need to work together to demonstrate to the Commonwealth the need for change. National lobbying should include the relevant professional and specialist nursing organisations.

Enhanced Primary Care Medicare Items

The possibility of extending the Enhanced Primary Care (EPC) Medicare Items for the reimbursement of nurse practitioner services was considered by the NPIAC. The EPC Medicare Items, included in the MBS in November 1999, are designed to promote collaboration between general practitioners (GPs) and other health care providers as a means of providing better care for health consumers with chronic conditions and also for people over the age of 75 and Aboriginal and Torres Strait Islander people over the age of 55.

The 28 recently introduced Medicare Items cover three areas:

- annual health assessments for elderly Australians aged 75 years and older and Aboriginal and Torres Strait Islanders aged 55 years and older
- care planning for consumers with complex care needs
- case conferencing between GPs and other health and support workers about the care and progress of consumers requiring care from these multiple providers.

(Source: Department of Health and Aged Care, www.health.gov.au)

Collaboration with other health professionals is a key component of the nurse practitioner role. The nurse practitioner demonstration projects have been required to provide detailed evidence of collaboration with other health professionals in developing, implementing and evaluating their model of practice. The NPIAC therefore considered that the EPC Medicare Items should form the focus of the initial approach to the Commonwealth to seek access to Medicare benefits for consumers of nurse practitioner services.

5.4.2 Access to Medicare benefits by non-medical health professionals

The NPIAC sought information from a number of professional associations regarding the processes they adopted to obtain access to Medicare benefits and the educational preparation for their health professionals once access had been obtained.

Podiatrists, chiropractors and physiotherapists are able to obtain a Medicare Provider Number and order a small number of radiological procedures that attract Medicare benefits. The Medicare items are limited to the health professionals' scope of practice. Consumers of podiatry services can access Medicare benefits for radiological procedures of the foot and ankle; those of chiropractors and physiotherapists can currently access Medicare benefits for radiological procedures of the hip joint, pelvic girdle and spine.

The process of podiatrists and chiropractors obtaining access to Medicare benefits involved their professional associations at the national level establishing the potential cost savings if consumers were not required to be examined by their GP for the purpose of ordering X-rays in certain situations. Educational preparation for these allied health professionals to order limited radiological procedures and interpret the results forms part of the under-graduate curriculum.

The NPIAC recognises that for nurse practitioners to gain access to Medicare benefits policy change at the national level is required and all Australian states and territories need to work together to achieve such change.

5.4.3 Alternative funding mechanisms

The NPIAC recognises that innovative arrangements may be required to fund nurse practitioner services and enable consumers to be reimbursed for services provided or ordered by nurse practitioners.

Health Program Grant

The funding arrangements of the VCS were considered by the NPIAC as a potential model for funding future nurse practitioner services. The VCS was established as a joint preventative health initiative between the Government of Victoria and the Anti-Cancer Council of Victoria and receives State and Commonwealth government funding. When the Cervical Screening Program became a national program in 1991, funding from the Commonwealth was via the Health Program Grant (HPG).

The purpose of the HPG was to provide a free Pap screening service for women by medical practitioners to encourage cervical cancer screening and to provide a centre of expertise that would act as a resource for both State and Commonwealth cervical screening programs. As access to female medical practitioners was limited, the State Government decided to fund VCS to provide a free Pap screening service for women by nurses.

In 2000, the Commonwealth decided to fund the Pap screening service for women through a public health outcomes funding agreement and the State Government agreed that funding for the services provided by nurses would continue.

The VCS is an example of an alternative funding structure to support nurses in an expanded role. There is potential for a similar structure to be developed to support the extended practices of the nurse practitioner role.

Separate funding mechanism

The NPIAC proposes that a separate funding mechanism be established for the reimbursement of consumers of nurse practitioner services.

The NPIAC believes that consideration for a separate funding mechanism is warranted due to the anticipated small number of nurse practitioners and the defined scope of their practice. Nurse practitioners in some contexts will provide services in an area previously void of any specialised health services.

The NPIAC acknowledges the importance of undertaking a feasibility study to gather evidence regarding the associated costs and benefits of a separate funding structure. The NPIAC proposes that the Victorian Minister for Health seeks the support of other health ministers throughout Australia to conduct a feasibility study and that the Victorian Minister for Health auspice the project.

5.5 Principles underpinning ordering of diagnostics and referral to specialists

The NPIAC identified a number of key principles, which should inform the development of clinical practice guidelines to support the extended practices of the nurse practitioner role in relation to the initiation of diagnostics and referral to medical specialists.

The key principles are:

- A radiological procedure should not be performed unless the benefits to the consumer outweigh any radiation risks.
- An assessment should be made to determine whether the investigative procedure is needed to diagnose the presenting clinical condition or monitor the outcome of treatment and is based on evidence-based practice.
- Consideration should be given to whether the results of the investigative procedure will influence the management of the presenting clinical condition, that is, the clinical benefit of the investigative procedure.
- Consideration should be given to the costs to the consumer and the community more broadly for undertaking the investigative procedure.
- Establishing mutually supportive relationships with medical specialists, general medical practice and relevant acute and extended care providers is considered essential to ensure continuity of consumer care and to avoid duplication.

The NPIAC proposes that these principles be incorporated into the framework for the development of clinical practice guidelines.

Recommendations

7. That the Department of Human Services promotes a national approach for the development of Commonwealth policy associated with nurse practitioners gaining access to the Medicare Benefits Schedule and that the initial approach focus on access to the Enhanced Primary Care Medicare Items.
8. That the Minister for Health, through the Australian Health Ministers' Advisory Council, recommends that the Health Insurance Act 1973 be appropriately amended for the reimbursement of consumers of nurse practitioners services.
9. That the Minister for Health, through the Australian Health Ministers' Advisory Council, recommends that a feasibility study be undertaken to examine the possibility of a separate funding pool for the reimbursement of consumers of nurse practitioner services and, further, that the Minister for Health offers to auspice the project on behalf of health ministers across Australia.

Department of Human Services response to recommendations 7, 8 and 9.

The Department of Human Services supports the development of a national approach to funding and/or reimbursing consumers for services such as referral, pathology, radiology or pharmaceuticals initiated by nurse practitioners. The mechanism to fund and/or reimburse the extended practices of the nurse practitioner role is yet to be determined. The options provided in recommendations 7, 8 and 9 will be considered, in the first instance, by the National Nursing and Education Taskforce to be established 2003-04.

6. Admitting privileges

Admitting privileges refers to the authorisation of a health professional to admit consumers to health services for procedures and specific care. The NPIAC considered the scope of admitting privileges for nurse practitioners, including:

- the range of facilities and employment status of practitioners
- the roles and responsibilities of nurse practitioners with admitting privileges
- the barriers for the efficient functioning of processes associated with nurse practitioner admitting privileges
- the processes for health services to follow, including credentialing requirements, for nurse practitioners seeking admitting privileges.

6.1 Background - review and consultation

Policies and practices that specify which particular health professional is permitted to admit consumers into health services were identified by the taskforce as a barrier to advanced clinical nurses/midwives contributing to a more responsive and integrated health care service. In line with this, the NPIAC:

- reviewed existing processes and frameworks associated with admitting privileges
- considered the feedback from the consultation undertaken throughout 2001
- review of nurse practitioner models of practice
- considered professional indemnity issues
- reviewed the dissenting positions of the AMA and the RACGP
- consulted with the Victorian Healthcare Association (which represents the interests of the public health care sector)
- considered and applied the NHMRC guidelines in the development of guidelines for obtaining admitting privileges by nurse practitioners in Victoria.

6.1.1 Review of existing processes and frameworks

The NPIAC considered existing processes where nurses have a key role in the admission of consumers to health care facilities for inpatient care.

Wangaratta District Base Hospital

Admitting privileges for community midwives working on the Midwife Care Project (now the Wangaratta Community Midwife Program) have been in place at WDBH since 1996. This is an alternate model of maternity care that aims to be woman-centred, offering choice, continuity and a safe, satisfying birth experience. The midwife is the lead maternity carer seeing women from their booking visit at around 12 weeks through to labour, delivery and postnatal care.

In 1996, the key midwife working on the Midwife Care Project was employed by the Ovens and King Community Health Service and required visiting/admitting privileges to enable her to admit women to hospital when they were in labour. A proposal was submitted to the WDBH Board that recommended a Midwifery Credentialing Committee be established. This committee comprised two

obstetricians, the Director of Medical Services, the Director of Nursing, and the Nurse Unit Manager of Midwifery. The midwife's credentials were approved by the committee and it was recommended that she be granted visiting/admitting privileges. This was approved by the WDBH Board of Management.

Two of the midwives working on the Midwife Care Project were employed by WDBH. They also successfully went through a credentialing process and obtained admitting privileges.

When the project funding and the partnership between the Ovens and King Community Health Service and WDBH concluded at the end of 1998, the midwives working within the community midwifery model of care continued to admit women to hospital and were credentialed by the Director of Nursing, the Nurse Unit Manager and one of the obstetricians.

Consumers of the Community Midwife Program are still admitted under the Community Midwife Program bed card; the DRG is generated and submitted by the Medical Records Department to the Victorian Inpatient Minimum Database (VIMD)/Victorian Admitted Episodes Dataset (VAED); and the hospital is paid a WIES payment for those consumers.

Community Midwife Program midwives have an established credentialing process that currently requires the submission of a curriculum vitae, pathology in-service attendance, peer review using New Zealand Midwives standards, and yearly appraisals using Australian College of Midwives Incorporated (ACMI) competencies.

The community midwife model of care is known as a modified case-load model. Under this model, consumers meet the team of five midwives at some stage throughout the antenatal period and are assured of these 'known midwives' being present at delivery. The role of the midwife changes depending on the level of care needed. Emphasis is placed on collaborative practice between midwives and medical staff. Consumers requiring referral to medical care access obstetricians via established hospital referral procedures. The actual admission of consumers of the Community Midwife Program to WDBH occurs efficiently via liaison with ward staff and medical personnel.

Women's and Children's Health

Advanced clinical nurses in specialised services initiate admission to the Royal Women's Hospital (RWH)/Royal Children's Hospital (RCH) with the documentation 'signed off' by the medical officer according to hospital policy. This is especially relevant to those nurses providing outreach services for consumers with serious illness, who may require multiple and complex intermittent inpatient admissions.

Policies for consumer admissions to hospital include guidelines to assist staff in maintaining effective and accurate health care records.

Consultation with senior nursing staff at the RWH and the RCH identified that formalised admission privileges for advanced clinical nurses was considered to be a progressive step since it would promote accountability and efficiency. It was felt that

enabling equality of admitting privileges will allow the most relevant and qualified practitioner, be it nursing or medical, to facilitate admission. The obtaining of admitting privileges by nurse practitioners is considered to be appropriate for some practice areas and will need to be assessed on an individual basis. It was stressed that nurses with admitting privileges need to be supported by the same legal, professional and structural resources that apply to medical officers and need to hold the same responsibilities.

Royal District Nursing Service - Cystic Fibrosis

The RDNS Cystic Fibrosis Clinical Nurse Consultants are involved with the Cystic Fibrosis/Respiratory Teams within the RCH, the Alfred Hospital and Monash Medical Centre (MMC). A process has been established to facilitate admissions.

If the Cystic Fibrosis Clinical Nurse Consultant is concerned about a consumer's health status, and considers hospitalisation is required, the nurse contacts the consultant physician who then contacts the bed allocation officer to arrange admission. If a bed is available on the Cystic Fibrosis Unit, the consumer is admitted directly to that unit. If there is no bed available on the unit at the RCH, direct admission is arranged via the general medical unit. If no bed is available for adults at the Alfred Hospital and MMC, admission is via accident and emergency.

While the RDNS Cystic Fibrosis home support team (comprised of two nurse practitioner candidates and one physiotherapist) does not provide direct care to consumers as inpatients, their input to the care plan is significant and includes:

- visiting the hospital to provide ongoing psychosocial support to consumers and families
- acting as consultants to ward staff and the hospital cystic fibrosis team to assist with discharge planning and educational requirements for technical aspects of the care, such as Portacaths, intravenous administration via pumps, and blood collection
- weekly participation in multidisciplinary review meetings, providing valuable input into the consumer's home situation
- liaising with the RCH Education Institute regarding a child's school, teacher and progress, to minimise disruption to the child's education
- preparing consumers and their home community for their 're-entry', which includes visits to schools, sports clubs and so on.

The existing processes outlined above, where nurses have a key role in the admission of consumers to health care facilities for inpatient care, informed the deliberations of the NPIAC.

Policies, procedures and by-laws in health facilities

The NPIAC also considered existing policies, procedures and by-laws in health facilities in relation to admitting privileges. Most health facilities have policies, procedures and guidelines in place relating to the services provided by the facility that should be read in conjunction with health services by-laws and *Australian Council on Healthcare Standards (ACHS) accreditation guidelines*.

The ACHS standards cover the care and services provided to consumers and are organised to follow a continuum of care. They also cover the main functions within an organisation that are needed to support the delivery of quality of care. Health care facilities are not obliged to seek or maintain accreditation but the vast majority of those that do seek accreditation do so by way of the ACHS. This program uses health service peers as surveyors and standards are developed and revised in consultation with the industry and its professional bodies. The accreditation program covers all aspects of a facility's operations and the standards apply to hospitals (public or private, small or large), aged care facilities, community health services, day procedures facilities and home and community nursing agencies.

Health service by-laws refer to the internal rules of the health service. The *Health Services Act 1988* defines a 'by-law' as 'a principal regulatory instrument' made by the service, which does not include rules made under a principle regulatory instrument. The Governor in Council, by Order published in the Government Gazette, may declare that any or all of the provisions of the Health Services Act specified in the Order do not apply to a specified health service establishment or class of establishment. The board of management of a health service, however, has powers to carry out its functions, including the power to make, amend or revoke by-laws.

The Health Services Act envisages that all health services have established by-laws for the administration and governance of the service. Within the standard by-laws, reference is made to the Australian Health Care Agreement (Medicare) principles. Reference is also made to matters such as the objects of the service, the power and duties of the board of directors as prescribed by the Act, issues relating to a quorum, voting, disclosure of interest, delegation, seal, the position of the chief executive officer, remuneration and condition of executive and senior appointments, as well as the establishment of committees and other matters. The board must also comply with any direction of the Secretary of the Department of Human Services made pursuant to section 24 (2) of the Act to amend or alter its objects or by-laws or to make new by-laws.

The Health Services Act does not, however, require by-laws to incorporate admitting privileges. Some old style by-laws, which still apply in some rural hospitals, do refer to the appointment and credentialing of medical staff. Such by-laws include the establishment of a medical appointments and privileges committee and a credentials committee. They set out a process for practitioners seeking classification and privileges and processes for dealing with appeals from medical practitioners about credentialing decisions.

The NPIAC considered advice from health services and from the Legal Services and Legislation Review units of the Department of Human Services and agreed that it would be desirable for health services to incorporate admitting privileges for nurse practitioners into existing hospital processes and structures. This would not preclude a health service from entering into arrangements with individual health professionals where the formal processes and structures for granting admitting privileges do not exist.

6.1.2 Feedback from consultation process

The NPIAC also considered feedback relating to admitting privileges for nurse practitioners from the multifaceted consultation process undertaken throughout 2001. This feedback is summarised below according to general themes:

Support for nurse practitioners obtaining admitting privileges

There was general support for the concept of nurse practitioners obtaining admitting privileges and for these admitting privileges to be incorporated within existing systems of health services. It was felt that the same processes for conferring admitting privileges on medical practitioners should apply to the granting of these privileges to nurse practitioners. These processes should aim at ensuring safe practice.

Guidelines

A number of consultation participants indicated that generic guidelines relating to admitting privileges need to be developed and that they should be consistent throughout the state, applicable to all health services, and flexible enough to be adapted to the local needs of specific health services. It was suggested that guidelines should define the scope of admitting privileges, consider endorsement and credentialing processes, identify professional indemnity provisions, and indicate arrangements for nurse practitioners not employed by the health service and for the care of consumers moving between private and public health care facilities.

Lines of communication and responsibility

There was general support amongst consultation participants for the development of clear lines of communication and responsibility relating to the care and treatment planning for consumers admitted by a nurse practitioner. It was suggested that monitoring of interdisciplinary collaboration as the nurse practitioner role evolves might possibly be required.

The example set by WDBH suggests that barriers to the obtaining of admitting privileges by nurse practitioners are surmountable. The NPIAC also agreed with the feedback that nurse practitioners exercising admitting privileges do need to establish clear lines of responsibility and communication that support safe and effective health care for consumers.

6.1.3 Review of the nurse practitioner models of practice

The NPIAC reviewed the outcomes of the Phase 1 funded nurse practitioner models of practice in relation to admitting privileges. Arrangements relating to two of these models are summarised above.

A number of the funded models referred to the need to incorporate admitting privileges as part of the extension of their role. The lack of admitting privileges was considered to be a barrier in their ability to contribute to comprehensive and responsive health care.

The Phase 1 nurse practitioner models that have received continuing funding now have the opportunity to review their need for admitting privileges and to negotiate arrangements relating to admitting privileges with their health service. A number of the Phase 2 models recently funded have also referred to the need for incorporating admitting privileges as part of the extension of their role and will be exploring possible arrangements with the relevant health service.

6.1.4 Consider professional indemnity issues

Matters relating to professional indemnity were raised a number of times during the deliberations of the NPIAC. This issue was highlighted following the withdrawal of indemnity insurance from midwives in private practice by Guild Insurance Limited. Problems obtaining indemnity insurance present a particular barrier to consumers wishing to access the services of nurse practitioners in private practice.

Guild Insurance notified individual policy holders of its decision not to offer a renewal of terms for the insurance from 31 August 2001. This decision seems to be related to factors external to Guild Insurance Limited and the perception in the insurance industry that self-employed midwives exposed the insurers to a similar risk as for obstetricians and gynaecologists. All Australian and overseas insurance companies and brokers were canvassed by the ACMI in its attempts to seek out a willing insurer. A proposal from a potential replacement insurance company is currently being considered.

The Australian Health Ministers' Advisory Committee (AHMAC) has a Medical Indemnity Jurisdictional Working Party that was formed to advise health ministers on possible options for a national approach to law reform to address issues of concern raised by the medical profession about medical indemnity insurance, large damages payouts and increasing litigation. The terms of reference have recently been amended to include consideration of the professional indemnity issues raised by midwives.

This group is compiling information at both a state and national level in order to build an accurate profile of the midwifery services provided within the public health care system and in private practice. Once this information is gathered, the jurisdictional working party will be in a position to provide authoritative advice to health ministers.

While the issue of indemnity insurance for all midwives is beyond the scope of the NPIAC and indeed the Nurse Practitioner Project, it is possible that similar issues may arise for particular nurse practitioner categories.

Possible professional indemnity arrangements for nurse practitioners were discussed in the taskforce report, which recommended that nurse practitioners demonstrate adequate indemnity insurance. In addition to this, the taskforce recommended that a professional indemnity insurance facility for nurse practitioners be provided by the Department of Human Services. The aim was to ensure that the cost of professional indemnity insurance did not limit the implementation of the nurse practitioner role in any area of practice.

Recognising that the minimum terms and conditions for professional indemnity insurance are set out in the guidelines of the NBV, the NPIAC consulted with the Insurance Unit, Finance and Administrative Services Branch of the Department of Human Services on possible professional indemnity arrangements.

Nurse practitioners who successfully apply for positions in the public health care system are indemnified to the extent of \$11.5 million in any one claim under the Department of Human Services insurance program. This will satisfy NBV requirements for registration purposes. A separate policy is not necessary for the nurse practitioner as the Department of Human Services program protects both the corporate (vicarious) liability of the agency and the individual health professional's liability.

For private practice, recent feedback from the insurance market indicates that nurse practitioners (other than those engaged in midwifery services), either on an individual or collective basis (association), will be able to obtain professional indemnity insurance cover from private insurers.

Nurse practitioners looking to engage in private midwifery services need to follow progress on the viability and acceptance of the insurance models developed by commercial insurers for the ACMI or any other developments through AHMAC.

The Department of Human Services provides an insurance facility for rural procedural GPs. The provision of this facility was based on a need for rural and remote communities to have local access to medical services that have become increasingly uneconomic for individual doctors.

If it were substantively demonstrated that nurse practitioners cannot obtain cost-effective professional indemnity insurance cover for their private practice, any proposal to consider arranging an insurance facility within government through the Victorian Managed Insurance Authority, would need to include consultation between senior management within the Department of Human Services and with the Minister for Health.

This cross-divisional consultation process is critical given the recent developments in two key areas:

- The Department of Prime Minister and Cabinet will be hosting a National Medical Indemnity Forum to complement work being performed by AHMAC. It appears that this action has arisen from increasing concerns over the financial viability of medical defence organisations and the level and frequency of medical indemnity cost increases to their members, particularly obstetricians and neurosurgeons. The implications on both accessibility to quality medical services and the flow-on costs to the community have prompted the Prime Minister to intervene. Developments will need to be closely monitored by the Department of Human Services.
- The increasing reluctance of commercial insurers to either provide professional indemnity (and public liability) cover for new and existing risks across a wide range of commercial activities or, if so provided, the economic viability of the premium cost to the purchaser. (The hardening of the insurers' attitudes is not confined to health service providers but across industry and commerce groups in general.)

In respect of health services, there are policy implications for the department as not only nurse practitioners but all other health professionals who provide services in the private sector (for example, physiotherapists) and require professional indemnity insurance for registration purposes, may not be able to secure cover from commercial insurers in the future. The Department of Human Services needs to carefully monitor and develop health strategies to complement any structural changes in professional indemnity provisions that may arise from the review processes to ensure that essential health services for the Victorian community are not compromised.

In the meantime, the NPIAC understands, however, that the department has in place a monitoring strategy on insurance options for nurse practitioners in the commercial insurance market that will alert it to any significant change in insurers' positions towards acceptance and pricing of this risk category.

6.1.5 Review of dissenting positions

The NPIAC took into account the dissenting positions of the AMA and the RACGP as detailed in the taskforce report when considering admitting privileges for nurse practitioners.

The RACGP's main concern is that nurse practitioners should only be implemented in areas of locally agreed need and they should collaborate with medical practitioners.

In relation to admitting privileges for nurse practitioners, it will be up to the employer to determine what arrangements will be entered into with health professionals. Such arrangements constitute a strong indicator of locally agreed need. The role of the nurse practitioner and the development of clinical practice guidelines also reinforce the requirement for consultation and collaboration with other relevant health practitioners (and particularly medical practitioners) as well as with the broader community. This consultation and collaboration will ensure that the range and scope of nurse practitioner services to be provided within a health service are consistent with agreed local need.

The AMA (Victoria) opposed taskforce recommendation 29, which in part proposed that the Department of Human Services facilitate the process for the development of guidelines for nurse practitioners requiring admitting rights.

According to the dissenting position of the AMA (Victoria), admitting rights to hospitals are 'a privilege granted, where the hospital has a demonstrated need, to the most senior members of the medical profession, based on evidence of qualifications and expertise'. The AMA (Victoria) stated:

In larger public hospitals, the medical practitioner is usually appointed to a clinical unit, the members of which have similar professional interests and qualifications. Specialist trainees and other junior doctors are appointed to that clinical unit to provide 24-hour care to its patients, under the direction of the unit specialists. This unit structure establishes clear lines of responsibility and communication, which enhance the likelihood of patients receiving the right care at the right time. This

