Implementation of the Renal Nurse Practitioner Role at Eastern Health

A Dual Model of Care

The Victorian Nurse Practitioner Project Phase 4 Funding Round. Deliverables and reporting requirements.
### Service Provider

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<tr>
<td>Agency Number</td>
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<tr>
<td>Contact Person</td>
<td>Adjunct Professor Penny Newsome</td>
</tr>
<tr>
<td>Position/Title</td>
<td>Chief Nursing Officer - Eastern Health</td>
</tr>
<tr>
<td>Telephone No</td>
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</tr>
<tr>
<td>E-mail Address</td>
<td><a href="mailto:penny.newsome@easternhealth.org.au">penny.newsome@easternhealth.org.au</a></td>
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### Key Project Staff – Project Steering Committee

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<thead>
<tr>
<th>Contact Person</th>
<th>Adjunct Professor Penny Newsome</th>
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<tr>
<th>Contact Person</th>
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<tr>
<td>Position/Title</td>
<td>Program Director, Specialist Medicine and Outpatient Services, Box Hill Hospital Clinical Program Leader Specialist Medicine Eastern Health</td>
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</tr>
<tr>
<td>Telephone No</td>
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<tr>
<td>E-mail Address</td>
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Acknowledgements

The authors would like to thank the following people who have assisted in the preparation of this document by sharing information and experiences in relation to the Renal Nurse Practitioner role.

Ms Jill Farquhar
Renal Nurse Practitioner
Westmead Children's Hospital, New South Wales

Ms Kathy Kable
Renal Nurse Practitioner
Westmead Hospital, New South Wales

Associate Professor Robyn Langham
Director of Nephrology
St Vincent's Hospital, Melbourne

The Renal Nurse Practitioner Collaborative
Victoria

Ms Melissa Stanley
Renal Nurse Practitioner
St Vincent's Hospital, Melbourne

Ms Marie Wintle
Nurse Unit Manager, Outpatient Department
Box Hill Hospital, Melbourne
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1. Executive Summary

1.1 Introduction
Eastern Health (EH) is committed to advancing the nursing profession and is proactive in exploring recruitment and retention strategies that work to provide a quality nursing workforce to service the needs of the community. Development of the EH service plan allowed the organisation to outline a centralised approach to facilitate implementation of the nurse practitioner role into priority clinical areas. These areas include Oncology, Palliative Care, Renal Services, the Mental Health Program and Emergency Departments at all sites including Yarra Ranges Early Response and Referral Clinic.

In 2009 EH applied for and was successful in securing funding to assist in the implementation of a Renal Nurse Practitioner (RNP) role within Eastern Health Integrated Renal Service (EHIRS). This document provides the framework from which the role will be implemented over the next five years and meets the standards as outlined in the Department of Human Services (DHS) document “Deliverables and Reporting May 09 Funding Round”. It should be noted that as a new service, the EHIRS is constantly evolving and as such this document is also fluid. Review of the service gaps and expansion of the RNP role into these gaps has been accounted for in the implementation timeline to ensure provision of care in line with patient growth and requirements.

EH acknowledges that the role of the Renal Nurse Practitioner Candidate on which this document focuses will differ from that of the endorsed RNP. The endorsed RNP's right to extended nursing practice is grounded in professional accountability and responsibility commensurate with the requisite academic qualifications. The RNP role is seen as an important adjunct to the renal care team and not as a replacement for current nursing or medical roles.

1.2 Background
In 2005 EH engaged Healthcare Management Advisors (HMA) consultants to undertake a review of dialysis services for patients requiring renal replacement therapy (RRT) in the Eastern suburbs in response to recommendations made in the document “Renal Dialysis: A revised service model for Victoria” (DHS, 2005) which has ultimately led to the development of the EHIRS and the attainment of level three hub hospital\(^1\) status in March 2009.

The growth of the EHIRS patient population has exceeded expectation\(^2\) and areas for further development within the service have become apparent. Roles that are able to utilise the extended practice boundaries of Renal Nurse Practitioners (RNP) to service these areas was felt to be a logical next step in ensuring EHIRS develops the service in line with contemporary best practice.

As the service grows, so too does the role of the RNP with financial commitment at departmental level to provide for 2.0 EFT over five years as per the EHIRS business plan (Wintle, M. 2007). Two models of care have been developed to reflect this commitment and the changing needs of the patient population. Initially there will be a focus on establishing links with community health care providers within a chronic kidney disease (CKD) model of care, ensuring the ongoing referral of new patients into the service. Expansion into a transplantation model of care will evolve as the need for this service develops. A RNP practising in this role would identify potential transplant candidates from the existing cohort and assist with inpatient and outpatient care following a transplant.

1.3 Project Brief\(^3\)
- To determine existing service gaps\(^4\).
- To define a Model of Care to address the service gap.
- To define the role of the RNP in delivering this Model of Care.

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\(^{1}\) Level three hub hospital provides all renal services excepting for renal transplantation surgery. All pre and post transplant care is provided by the hospital.

\(^{2}\) See appendix 1 – patient growth expected vs actual

\(^{3}\) See appendix 2 – Overview of Project

\(^{4}\) See appendix 3 – Decision Making Framework
• To develop a continuing education and professional development plan that has links with both Nursing and Medical frameworks.
• To provide a realistic framework from which the role can be implemented over a five year period.
• To build in expansion of the role to ensure future model development and sustainability of the RNP role.

1.4 Outcomes
Information sessions were held with key stakeholders to identify service gaps and provide information on the potential roles of the RNP. A model of extended nursing practice within a CKD\(^5\) management framework was developed after gap analysis and stakeholder interviews. The use of a decision making framework\(^6\) was utilised to assist in setting priorities for provision of services. A second model in transplantation care was also defined to ensure expansion of the role within a 5 year timeframe and to reflect the expected changing needs of the patient demographic as the service develops.

A five year implementation plan\(^7\) outlines key dates and timelines to ensure the smooth transition of the roles into the service.

The proposed models secure patients into the EH network enabling the service to be self sufficient by engaging with consumers early on in the CKD pathway. Ongoing relationships with community service providers and demonstrated commitment to providing a robust renal service across the care continuum ensure referral lines are maintained and thus the viability of the EHIRS.

2. Chronic Kidney Disease (CKD) Model of Care\(^8\)

The objective of this Model of Care is to prolong the interval between first diagnosis of kidney disease and commencement of Renal Replacement Therapy (RRT)\(^9\).

This CKD Model of Care meets the Australian Nursing and Midwifery Council (ANMC) 2006 standard which states that the role remains grounded in the nursing profession’s values, knowledge, theories and practice and provides innovative and flexible health care delivery that complements other health care providers. This model will use a case management approach enabling timely referral algorithms and enhanced management of transition into end stage kidney disease care pathways.

This Model of Care allows the RNP to work autonomously but still have a collaborative relationship with the Nephrologist, specialist nurses such as anaemia management and renal access, as well as allied health management streams such as dieticians, social workers and physiotherapists aligned with renal care. Clinical issues can be discussed and decisions made in a shared setting rather than in isolation. Learning and development opportunities in this environment are also plentiful.

Early intervention in the management of kidney disease has been shown to improve outcomes by slowing the progression of the disease. Tight blood pressure control and control of blood sugar levels in the diabetic population are the mainstays of treatment which can maintain kidney health for longer and delay the need for dialysis (CARI guidelines,2005). Management of these areas of early intervention by the RNP will be under the guidance of the Nephrologist and clearly defined Clinical Practice Guidelines (CPG).

2.1 Role and Responsibilities
• Develop relationships with GP practices within EH catchment to ensure referral of patients to CKD service\(^10\).

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\(^5\) CKD: eGFR 30-59ml/min
\(^6\) See appendix 3 – Decision Making Framework
\(^7\) See appendix 4 – Five Year Implementation Plan
\(^8\) See appendix 5 – Chronic Kidney Disease Model of Care
\(^9\) Includes peritoneal dialysis, haemodialysis, no dialysis treatment and transplantation
\(^10\) See appendix 6 – Referral Pathways
• Attend CKD clinic at EH site along with Nephrologist who ideally would be the clinical mentor for the NPC.
• Early education of patient and family as to progression of disease and management of same.
• Advanced nursing practice management of renal patients
• Coordination of referral to specialties involved in the renal care continuum including diagnostic interventions.
• Interpretation of investigations such as pathology and radiology.
• Referral to EH Nephrologist as appropriate thus securing patients into EHIRS and ensuring continued growth of the service.
• Assist in the development of CPG to reflect the scope of practice.
• Medication management of the early symptoms of renal disease under the guidance of the Nephrologist and CPG.
• Coordination of communication with key stakeholders involved in the care of the patient.
• Involvement with professional affiliations to utilise peer support and networking opportunities.
• Participation in non-clinical components of role, incorporating skills such as management and leadership, advanced communication, writing for publication, clinical auditing, report writing and nursing research.

3. Transplantation Model of Care

The objective of this model of care is to ensure that potential renal transplant recipients are identified and managed from across the entire patient population to enable living related, living unrelated or cadaveric transplant where possible. A secondary objective is to ensure coordinated care of transplant recipients in both the pre and post transplant period.

This Transplantation Model of Care meets the Australian Nursing and Midwifery Council (ANMC) 2006 standard which states that the role remains grounded in the nursing profession’s values, knowledge, theories and practice and provides expert, innovative and flexible health care delivery that complements other health care providers. This model will utilise a case management framework ensuring that aligned renal health professional expertise including specialist nurses, medical staff and other allied health care professionals are included in a holistic approach to care delivery.

Renal transplantation offers numerous benefits to patients requiring RRT in comparison to dialysis therapies. (Agar, J. 2003). As well as the social benefits to the patient, cost savings associated with this form of therapy are substantial (Bartlett, S. 1998).

This Model of Care allows the RNP to pro actively seek out potential transplant recipients from both the CKD as well as the dialysis patient population and ensure this avenue of RRT is offered to all patients who fulfill specific criteria.

The RNP will manage the care of this patient cohort under the guidance of the transplant Nephrologist within a clinical setting thus ensuring shared decision making in a collaborative environment. Opportunities for learning within this environment are also plentiful.

3.1 Role and Responsibilities

• Identify potential renal transplant candidates from with the EHIRS.
• Refer to specialists involved in the renal transplantation care continuum.
• Provide pre and post transplant education.
• Refer to diagnostic and interventional care providers.
• Interpret pathology and radiological results.
• Coordinate pre transplant work up for living related/unrelated donors and recipients.
• Coordinate care of patients on the cadaveric transplant waiting list.
• Liaise with transplanting hub hospital regarding potential transplants.

11 Renal Society of Australasia, Renal Nurse Practitioner Collaborative, College of Nurse Practitioners
12 See appendix 9 – Transplantation Model of Care
• Attends renal transplant clinic in conjunction with the transplant Nephrologist.
• Coordinate communication between key stakeholders involved in transplant care.
• Assist in the development of CPG to reflect the scope of practice.
• Participation in non-clinical components of role, incorporating skills such as management and leadership, advanced communication, writing for publication, clinical auditing, report writing and nursing research.
• Involvement with professional affiliations to utilise peer support and networking opportunities.

4. Education, Training and Support Framework
The preparation to become a RNP is grounded in formal education and workplace training, supervision and mentoring. The proposed framework for RNP education and training aims to embrace interdisciplinary learning opportunities between health professionals that include but are not limited to nursing, medical, pathology, pharmacy, radiology and physiotherapy, providing additional teaching and training across traditional health boundaries.

Of prime consideration will be integrating the academic and clinical requirements for endorsement as a RNP. Eastern Health has established links with Deakin University, through the Deakin – Eastern Health partnership. EH also maintains links with a range of other tertiary institutions including Monash and Latrobe Universities as well as RMIT. Employment of a Renal Nurse Practitioner Candidate (RNPC) is conditional upon agreement by the candidate to complete the endorsement process within a two year time frame.

The EH Practice Development Unit (PDU) will provide expertise and support in monitoring the learning plan under the guidance of the clinical mentor. The PDU will also undertake periodic review of the learning plan to ensure compliance to the Australian Nursing and Midwifery Council competency standards.

Three streams of professional development are undertaken by the RNP candidate. These are Clinical internship, Professional Internship and Academic preparation.\(^\text{13}\)

4.1 Clinical Internship
• Internship is supervised by EHIRS Nephrologist.
• Competency and practical skill based as dictated by the individual learning plan.
• Grounded in CPG which are evidence based and reflect current practice.

4.2 Professional Internship
• Supervised by EH professional mentor.
• Development of research and report writing capability.
• Development of leadership, mentoring and education skills.
• Development of endorsement portfolio.
• Achievement of agreed Key Performance Indicators (KPI) to reflect the above.

4.3 Academic Preparation
• Submission of endorsement portfolio.
• Successful completion of Masters level education in the relevant field.
• Oral examination conducted by the Nurse’s Board of Victoria (NBV).

4.4 Key Personnel
Clinical Mentor: designated EHIRS Nephrologist with capability to provide education and feedback to NPC on clinical care issues. Clinical care provided by the NPC is grounded in CPG.

\(^{13}\) See appendix 8 – Education Framework of a NPC within EHIRS
Organisational Mentor: designated EHIRS Operations Coordinator provides overall support, guidance and encouragement to the candidate.

Professional Mentor: designated Director of Nursing provides guidance on professional development such as writing for publication, education, mentoring skill development, public speaking and research opportunities within a nursing framework.

4.5 Reporting Lines
The RNP will report back through two chains of command
- Any operational / professional issues to be resolved with the EHIRS Operations Co-ordinator. Escalation of issue as per appendix 7.
- Any clinical decision based concerns to be discussed with EHIRS Nephrologist. Escalation of issue as per appendix 7.

4.6 Lines of Communication
- Attendance at weekly EH audit meeting.
- Weekly meeting with professional mentor to set clinical and education targets in line with Key Performance Indicators (KPI).
- Weekly audit with clinical mentor or delegate to track patient changes.
- Data collection, information sharing and benchmarking within EH to track patient numbers and assist with service planning and future health care catchments.

5. Next Steps
The EHIRS anticipates that there will be a CKD RNP Candidate positioned within the Department by February 2010. The role of the Transplantation RNP will transition into the service by February 2012. Identification of potential candidates from within the Department has already taken place and an expression of interest for potential candidates will be submitted internally in November 2009. Candidates must commit to completing the endorsement process within a two year timeframe.

It is expected that the delivery of the CKD model of care will result in improved renal health longevity by careful management and early intervention by a competent RNP under the guidance of a Nephrologist and CPG. Cost savings by delaying the need for RRT are well documented (Cass et al, 2006) as well as the personal benefits of delaying the need for treatment to patients which are not so easily quantified. The expansion of the role to include a dedicated transplantation RNP ensures that all potential renal transplant candidates are identified and managed to enable all facets of the renal care pathway to be offered to those patients requiring RRT.

Clear definition of the roles and distinct implementation timelines promote a clinical career pathway and extended learning opportunities for those nurses wishing to base themselves in an advanced practice nursing role whilst still enjoying the benefits of a collaborative and supportive environment inside a joint nursing and medical learning framework.

The EHIRS acknowledges the financial support of DHS in the implementation and future expansion of this role and commits to provide data and information pertaining to the role as a reporting requirement of this support.

6. Appendices

14 See appendix 7 – Reporting Lines
15 See appendix 4 – Five Year Implementation Plan
16 See appendix 4 – Five Year Implementation Plan
Appendix 1 - Patient growth EHIRS (Expected vs Actual)
Appendix 2 – Overview of Project

**WHAT**
- Chronic Kidney Disease Model of Care that is grounded in clinical guidance and professional development based on clinical practice guidelines and KPIs
- Renal Transplantation Model of care that coordinates the care and management of existing and potential kidney transplant patients
- A five year implementation timeline that accommodates for 2.0 EFT Renal Nurse Practitioners within 5 years

**WHY**
- To prolong the interval between first diagnosis of kidney disease and commencement of Renal Replacement Therapy (RRT)
- To ensure potential transplant patients are given the opportunity to benefit from this form of RRT which has distinct advantages over other forms of RRT

**WHO**
- An Advanced Renal Practice Nurse who has completed or is working towards completion of a Masters Degree of Nursing (Nurse Practitioner)
- Successful completion of the medication management module relevant to renal practice

**WHEN**

**HOW**
- Advanced Nursing CPGs guide Chronic Kidney Disease management in a community setting
- A Nephrologist and CPG guided Transplantation clinic
- Early identification of potential transplant recipients
- Clear communication and referral pathways
### Appendix 3 – Decision Making Framework

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**Rating**

1 = not important  
2 = of some importance  
3 = important  
4 = very important  
5 = paramount

**Weighting**

1 = not important  
2 = of some importance  
3 = important  
4 = very important  
5 = paramount

HTS = Home Therapies Service  
CCC = Conservative Care Clinic  
CKD = Chronic Kidney Disease  
MD = Maintenance Dialysis  
Transplant = Transplantation
# Appendix 4 - 5 year Implementation Plan

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<td>Define in-house service agreements</td>
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<td>Identify clinical mentor</td>
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<td>Determine competencies required</td>
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<td>Determine recruitment strategy</td>
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<td>Agree terms &amp; conditions with steering committee</td>
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<td>Recruitment &amp; selection</td>
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<td>Development of data collection tool</td>
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<td>Pre-implementation survey with key stakeholders</td>
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<td>Monthly KPI review with professional mentor</td>
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<td>Post-implementation survey with key stakeholders</td>
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<td>Monitoring effectiveness of NP role</td>
<td>Annual review of Clinical Practice Guidelines (CPGs)</td>
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<td>Annual monitoring review with NP Steering Committee</td>
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<td>Monitoring effectiveness of NP role</td>
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<td>Engagement with professional affiliations</td>
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<td>Recruitment of Renal NP Role Development</td>
<td>Review role to include identified gaps</td>
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<td>Recruitment of Renal NP Role Development</td>
<td>Commencement of 1st Renal NP DCHO Clinic</td>
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<td>Commencement of 2nd Renal NP Transplantation clinic</td>
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Appendix 5 – Chronic Kidney Disease Model of Care
Implementation of the Renal Nurse Practitioner Role at Eastern Health: 2009

Appendix 6 – Referral Pathways

Referral into service

Referral through service

GP refers patients to CKD clinic

Private Nephrologist refers patients to CKD clinic

EHIRS Nephrologist refers patients to CKD clinic

Patient refers self to clinic

Nurse Practitioner CKD clinic

EHIRS Pre-Dialysis CNC

Vascular/General Surgeon

Allied Health

Allied Medical Specialists

EHIRS Nephrologist

EHIRS Access Nurse

Pathology Radiology Diagnostic

EHIRS Anaemia CNC
Appendix 8 - Education and Organisational support framework

Organisational Mentor

Nurse Practitioner Candidate

Professional Internship
- Clinical Practice Guideline Development
- Research and Audit Skills
- Development of leadership and mentoring skills
- Development of Public Speaking and Teaching skills
- Development of endorsement portfolio
- Subscription to Professional affiliations
- Define KPIs to achieve set targets

Academic Preparation
- Successful completion of Master’s level education in the relevant field
- Successful Completion of Therapeutic Medication Management module
- Submission of endorsement portfolio to NBV

Clinical Internship
- Practical Skills based CPG development
- Development of health assessment and diagnostic skills
- Interpretation of diagnostic and laboratory tests
- Clinical case presentation
- Medication Management of Renal Disease as per local agreements
- Co ordination of multidisciplinary referrals
- Co ordination of multidisciplinary communication

Endorsement within 2 year time frame
Appendix 9 - Renal transplantation NP – Model of Care

- Interprets diagnostic and interventional tests
- Provides pre and post transplant education
- Ensures appropriate referral to allied health specialities
- Coordinates communication between key stakeholders
- Coordinates pre transplant work up for living related donors
- Coordinates care for patients on cadaveric waiting list
- Refers to specialists involved in the renal transplantation care continuum
- Refers to radiology and pathology
- Attends renal transplantation clinic in conjunction with renal physician
- Liaises with transplanting hub hospital
- Identification of potential transplant candidates from existing dialysis cohort
- Liaison with CKD NP to identify potential pre-emptive transplant patients
7. References


