AGED CARE NURSE PRACTITIONER

PROJECT REPORT 2012-2013

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Funded by: Victorian Department of Health
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BACKGROUND
In 2012 Southwest Healthcare [SWH] was received funding from the Victorian Department of Health to develop a Model of Care and a Five Year Plan which would support the implementation of an Aged Care Nurse Practitioner [ACNP] role. A Project Worker was appointed to address the core deliverables of this project:

- Internship Plan for ACNP Candidate
- Model of Care & Scope of Practice for endorsed ACNP role
- 5 Year Plan - Support and Governance

Details of the project deliverables, activities, and outcomes are available in the body of this report.

SOUTH WEST HEALTH
South West Healthcare [SWH] provides extensive medical, nursing, psychiatric and allied health services to a large community in the regional City of Warrnambool. Support services and resources are also provided for other hospitals and health-related organisations in the sub-region.

South West Healthcare has a total of 36 aged care beds and 207 acute beds (including 15 acute psychiatric inpatient beds), the organisation services a population in excess of 110,000. South West Healthcare provides a comprehensive range of specialist services from geographically separate campuses located at Warrnambool, Camperdown, Lismore and Macarthur. Services provided include (but are not limited to) acute, rehabilitation, and aged care together with an extensive range of primary and community health services. Acute and Community based Psychiatric Services are provided from the inpatient unit (Warrnambool Campus) and community based mental health teams located in Warrnambool, Camperdown, Portland and Hamilton.

South West Healthcare is committed to providing a comprehensive range of health care services to enhance the quality of life for people in south west Victoria. This includes pursuing an innovative integrated model of care to meet the healthcare needs of increasing numbers of aged persons.

While SWH currently has 11 Geriatric Evaluation and Management [GEM] beds the hospital has to date been relying on visiting gerontologists to support the care provided on this ward. It is anticipated that the services of a resident Gerontologist will be available by the end of 2013.

CONTEXT
Population

The Aged care Nurse Practitioner Project has been initiated in the context of a world-wide increase in the number and percentage of persons in the 65 and over age group.

Locally, in 2011 the proportion of the Warrnambool population aged 65 and over [16%] was higher than both the Victorian [14.2%] and the Australian average [14%].
The number of Warrnambool residents in the over 60 age group increased by 714 between 2001 and 2006 to a total of 6,200, with a further increase of 1,935 projected by 2016. According to Victoria in Future [Department of Planning and Community Development 2012], a population increase of 5% [3,363 persons], in the Warrnambool over 65 cohort, is predicted to occur between 2011 and 2026.

For the purposes of ACNP service delivery, members of the ATSI community aged 45 and over will be included in the category of older persons. According to the Warrnambool Health & Wellbeing Profile [2011], 1.6% of the population of Warrnambool at that time was Aboriginal. This was greater than the Aboriginal percentage of the overall Victorian population of 0.71%. The 2011 Census recorded that of the 496 ATSI persons residing in Warrnambool, 84 [16%] were aged 45 and over.

Hospital Statistics
As is to be expected with an increasing local population, SWH Hospital statistics show that discharges, and therefore admission, have been increasing incrementally over the past 5 years.
As a percentage of these increasing admissions, the number of older persons remains relatively steady. Five Year Discharge Trend figures are shown in the table below.

<table>
<thead>
<tr>
<th>5 Year Discharge Trend</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
</tr>
<tr>
<td>All Patients</td>
</tr>
<tr>
<td>Over 65's</td>
</tr>
<tr>
<td>Over 65's as %</td>
</tr>
</tbody>
</table>

Length of Stay
A 5 year comparison of average bed days for SWH patients aged over 65 and under 66 shows that the average number of bed days for patients over 65 years of age is greater [almost double the length of stay], than for younger patients. This means that in terms of bed days the resources needed to care for a person aged 65 are greater than for those in the under 66 age group. As displayed in the chart below, while the average bed days for over 65's has decreased in the period and shows signs of stabilising at lower levels, the difference in length of stay between age groups remains noteworthy.

AGED CARE NURSE PRACTITIONER [ACNP]
A nurse practitioner is a registered nurse who is educated to function autonomously and collaboratively in an advanced and extended clinical role. The role includes assessment and management of clients using nursing knowledge and skills and may include, but is not limited to, the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations. The scope of practice of the nurse practitioner is determined by the context in which the nurse practitioner is authorised to practice [Gardner et al.(2004) Nurse Practitioner Standards Project, p. 3].
South West Healthcare currently employs several Nurse Practitioners within the Emergency Department, and also a Nurse Practitioner specialising in wound care.

An Aged Care Nurse Practitioner has a key role to play in improving healthcare services to older persons. In addition to offering specialised advance clinical care, the role often aims for a preventative aspect, whereby the number of emergency presentations and inpatient admissions of older persons to hospital/s from Nursing Homes are reduced through intervention by the ACNP. The involvement of an ACNP also has potential in some instances to decrease the length of stay for older persons admitted to hospital.

The Nurse Practitioner role aims to operate collaboratively with, and has the potential to complement, the services of GP’s, Gerontologists, other Aged Care Nursing, Allied Health services, Community Nursing, and other health practitioners/services.

Given the healthcare demands of a growing aged population, it is envisaged that in order to improve SWH services to people over 65 years of age in the general population and members of the ATSI community aged 45 and over, the introduction of an Aged Care Nurse Practitioner to SWH would aim to:

- Increase the availability of specialised clinical care to aged persons in a variety of settings
- Reduce the number of emergency and short term hospital admissions for older people
- Reduce the length of stay for older people admitted to hospital
- Increase the potential for older people to continue to live at home or in low care accommodation for longer periods of time
- Provide specialist consulting and coaching support to existing health and aged care services
- Enhance timely coordinated care through referrals to, and active partnerships with, a range of service providers
- Work with peak groups to identify and address gaps in service delivery to the aged
- Provide case studies and other research to support strategic development of the role, and
- Facilitate the potential use of tele-medicine options for off-site/remote service delivery

**PROJECT OVERVIEW**

In 2012, SWH was successful in receiving funding from the Victorian Department of Health to develop: an ACNP Candidate Internship, a Model of Care, and a 5 Year Plan for the introduction of an Aged Care Nurse Practitioner role.

**DELIVERABLES**

The SWH ACNP Project commenced in October 2012 with the appointment of a part-time [0.4 EFT] Project Worker. The Project Deliverables which are shown in the following table are the same as those outlined in the 2012 Victorian Department of Health Industry Briefing. Completion dates have been adjusted to align with the start time and availability of the SWH Project Worker, and the anticipated recruitment of an ACNP Candidate.
### Project Deliverables

<table>
<thead>
<tr>
<th>Activity</th>
<th>Format</th>
<th>Date Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACNP Model of Care for SWH</td>
<td>Report</td>
<td>28 March 2013</td>
</tr>
<tr>
<td>5 year plan - identifies phased activity to initiate and achieve spread and integration of the model. Key dates/activities to include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Internship plan for ACNP Candidate</td>
<td>Table of key stages, deliverables and dates.</td>
<td>28 March 2013</td>
</tr>
<tr>
<td>- Support plan for ACNP Candidate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Appointment of ACNP Candidate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Anticipated endorsement of Candidate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Anticipated appointment of ACNP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Ongoing governance &amp; support plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Budget acquittal for Model Development</td>
<td>½ page Excel with exec. sign off</td>
<td>April 2013</td>
</tr>
<tr>
<td>Anticipated Confirmation of Candidate appointment</td>
<td>Electronic</td>
<td>Mid 2013</td>
</tr>
<tr>
<td>ACNP Candidate Log</td>
<td>Electronic lodgement using Dept. template</td>
<td>6 monthly (post appointment date)</td>
</tr>
</tbody>
</table>

### ACTIVITY

The work undertaken during the Project was allocated in the following way:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Who</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consult with other organisations with ACNPs or Candidates</td>
<td>Project Worker</td>
</tr>
<tr>
<td>Review other ACNP Models and Evaluation Reports</td>
<td>Project Worker</td>
</tr>
<tr>
<td>Investigate local demand &amp; service gaps</td>
<td>Project Worker</td>
</tr>
<tr>
<td>Convene Project Support Group</td>
<td>Director of Nursing</td>
</tr>
<tr>
<td>Develop Framework for ACNP Model of Care &amp; Scope of Practice</td>
<td>Project Worker &amp; Project Group</td>
</tr>
<tr>
<td>Complete ACNP Model of Care &amp; Scope of Practice</td>
<td>Project Worker &amp; Project Group</td>
</tr>
<tr>
<td>Develop Candidate Internship and Support Plan</td>
<td>Project Worker, Unit Managers, Mentor/s &amp; Project Group</td>
</tr>
<tr>
<td>Complete 5 Year Plan</td>
<td>Project Worker</td>
</tr>
<tr>
<td>Compile all documents into Final Report for Department</td>
<td>Project Worker</td>
</tr>
<tr>
<td>Approve Final Report and submit to Department</td>
<td>Director of Nursing</td>
</tr>
<tr>
<td>Submit Budget Acquittal for Model development to Department</td>
<td>Director of Nursing</td>
</tr>
<tr>
<td>Recruit Candidate &amp; notify Department</td>
<td>Director of Nursing</td>
</tr>
<tr>
<td>Update 5 Year Plan</td>
<td>Director of Nursing</td>
</tr>
<tr>
<td>Implement Internship and Support Plan</td>
<td>Director of Nursing &amp; Project Group</td>
</tr>
</tbody>
</table>
CONSULTATION

To inform the project, consultation included interaction with a range of organisations involved in Aged Care including: a sample of Aged Care Residential Facilities [RACFs] in Warrnambool and Camperdown, ACNP’s and Candidates from a range of rural and metropolitan settings, the Older Persons Nurse Practitioner Collaborative [Victoria], SWH Hospital and Community Service Health Professionals who are frequently involved in the care of older persons, a sample of SWH RACF residents, the SWH ACNP Project Support Group, AHPRA representatives, and the Department of Health Nursing and Midwifery Policy Office. The generous support of these people, groups, and organisations was invaluable.

Stakeholder Surveys

Formal feedback via surveys was sought from: three local RACFS [staff and residents], and Community Services involved with the care of older persons [i.e. Hospital Admission Risk Program, District Nursing, Palliative Care]. The purpose of the surveys was to help define the potential demand, and scope of practice, for an ACNP.

In the context of their own service setting, respondents were asked to list which health care/medical conditions were most likely to lead to older people being admitted to emergency/acute hospital care. The main themes were:

- Falls/injuries
- Infections
- Intravenous treatment
- Heart
- Pain
- End of life
- Urinary Tract Infection [UTI]
- Exacerbation of chronic condition
- General decline

Respondents were also asked in what ways [if any] they thought that intervention and support from an ACNP might assist the service and/or residents. Responses included the following needs:

- Timely diagnosis
- Earlier intervention
- Ability to order tests
- Ability to prescribe
- Intravenous cannulation and treatment
- Reduced demand on GP system
- Greater understanding/application of end of life care
- Avoiding preventable deteriorations
- Links to other services
- Liaison with GPs
- Education & information
- Resident being treated in place
- Reduction of avoidable admissions to Emergency Department
- Referral capacity
- Potential admission rights
- Potential to increase service availability across region
- Quality & benchmarking
- Flexibility of care
An overview of survey results is located Appendix 1.

Hospital Data

Additional quantitative information about emergency admission of older people to SWH Hospital was sourced from SWH Health Information Services.

The table below was compiled from 12 months of SWH Emergency admissions July 2011 – June 2012. It shows the % [in frequency] of the top 14 Diagnostic Related Groupings [DRG’s] for over 65’s by source of admission – Private Home [PH] and RACF [all levels].

The most frequent DRGs were Chest Pain, Arrhythmia/cardiac arrest & Heart Failure, all of which may be considered legitimately acute, and likely to be unavoidable ED admissions.

The remainder of high presenting DRG’s [such as respiratory, kidney, digestive, urinary, and cellulitis], may all be potentially preventable ED admissions. This conclusion aligns with stakeholder feedback about frequent causes of older persons admission to ED, and facets of ACNP service delivery which may have the potential to reduce avoidable admissions. Stakeholder feedback and Emergency DRG data for over 65’s also gives direction regarding the types of treatments and interventions that need to be considered for inclusion to the ACNP Scope of Practice.

<table>
<thead>
<tr>
<th>DRG Description</th>
<th>PH%</th>
<th>RAC%</th>
<th>AB%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cellulitis W/O J64B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dysequilibrium D61Z</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Syncope &amp; Collapse W/O F73B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Digestive W G70A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oesoph &amp; Gastro W/O G67B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney, UTI W/O L63B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Circulatory W/O F60B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injuries W/O X60B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Airways Chronic W/O E65B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Digestive System W/O G70B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory Infections W E62A E62B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Failure W/O F62B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arrhythmia, Cardiac Arrest F76B</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chest Pain F74Z</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
FRAMEWORK
The SWH ACNP Framework was produced collaboratively by the ACNP Project Support Group, and was informed by stakeholder feedback, hospital data, and professional knowledge of the sector. The purpose of the Framework was to guide and underpin the development of the ACNP Model of Care and Scope of Practice.

<table>
<thead>
<tr>
<th>SWH ACNP FRAMEWORK 2013</th>
<th>Summary of Main Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Model of Care</strong>*</td>
<td></td>
</tr>
<tr>
<td>Who are ACNP patients, &amp; where are they located?</td>
<td>ACNP patients = &gt; 65 years of age and &gt; 45 years of age for ATSI, who reside in the Warrnambool District [including RACF’s], Merindah Lodge in Camperdown, or are admitted to/presenting at SWH across continuum of care. Healthcare professionals in other areas of South West District, including Moyne and Corangamite, with clients in the designated age group.</td>
</tr>
<tr>
<td>What are the preferred treatment settings for ACNP patients?</td>
<td>Place of residence, and SWH Hospital, Warrnambool Campus. Consulting with other healthcare professionals via phone and tele-medicine.</td>
</tr>
<tr>
<td>Where would the ACNP role be based?</td>
<td>SWH Hospital [i.e. GEM aged care beds], or/and SWH Community Health.</td>
</tr>
<tr>
<td>Who can refer to ACNP?</td>
<td>All sources [hospital, ambulance, community, family] can refer older persons living [or being treated] within designated locations/region, to ACNP.</td>
</tr>
<tr>
<td>What are the geographical boundaries of the service?</td>
<td>Warrnambool District [including RACF’s], and remote settings such as: Camperdown [SWH RACF Merindah Lodge], Port Fairy, Lismore, and Macarthur. This includes the aspiration to develop tele-medicine consulting to remote health care settings in district.</td>
</tr>
<tr>
<td>What are the hours of service?</td>
<td>0800-1700 Monday to Friday initially, while being mindful of opportunities to review and extend the service in some way to better meet out of hour demand.</td>
</tr>
<tr>
<td>Other?</td>
<td>Have, reinforce, and broadly promote awareness of distinct scope of practice that delineates between ACNP and GP role, and actively build relationships with GP’s and other health professionals. Use Candidacy stage to further assess demand for after-hours / on-call, and opportunities to better meet these needs.</td>
</tr>
</tbody>
</table>

*Review can occur during Candidature once actual demand and capacity are better established.*
MODEL OF CARE, SCOPE OF PRACTICE, CANDIDATE INTERNSHIP & SUPPORT

The SWH ACNP Model of Care and Scope of Practice are drawn from the information and principles documented in the SWH ACNP Framework.

The Candidate Internship and Support Plan is directly relevant to the Model of Care/Scope of Practice, and is intended to be complimentary to the likely course structure for Masters of Nursing studies.

The SWH ACNP Model of Care defines a number of basic elements of service such as:

- The client group – who can be referred to the service?
- What are the hours and base location of the service?
- In what treatment setting/s is the service delivered?
- What are the geographical boundaries of the service?
- Who can refer to the service?

The answers to these questions enabled us to develop not only a Model of Care, but acted as a pathway to developing an appropriate Scope of Practice that will be useful and effective within the chosen Model.

The Scope of Practice will in turn define key aspects of the service such as:

- What specific treatments and services will the ACNP provide, and not provide?
- What drugs and tests will the ACNP be able to prescribe and order?
- Where [if anywhere] will the ACNP be offered admitting rights?
- How will quality assurance be measured and maintained?

The pre-defined Model of Care and Scope of Practice will in turn be used to ensure that the support, education and professional development that occurs during the ACNP Candidate Internship phase is relevant to the projected requirements of the role following full ACNP endorsement.

The logic looks like this:
Details of the Model of Care, Scope of Practice, Candidate Internship and Support are outlined in the following sections of the Report.

**MODEL OF CARE**

Information tabled in the [SWH ACNP Framework](#) depicts a broad generalist Model of Care that encompasses a wide range of treatment settings.

Given the size of population and geographical breadth of the SWH service district, it is apparent that to adequately meet the expressed demand and aspirations for the ACNP role as expressed in the Framework, more than one incumbent will be needed. It therefore seems reasonable to produce a *staged* Model of Care, which can be strategically designed to support [subject to resources], the eventual appointment a second ACNP. This means prioritising treatment locations and clinical activities into those best commenced in Stage 1, and those which can be held over to Stage 2.

Stage 1 will commence following the successful appointment of SWH’s fully endorsed ACNP – potentially in 2015.

Implementation of Stage 2 will be dependent on SWH capacity to appoint a second ACNP [or Candidate] post 2014.

The main differences between Stage 1 and Stage 2 are the treatment settings. Stage 1 includes treatment in the SWH Hospital setting and Warrnambool Residential Aged Care Facilities. Stage 2 broadens to cover non-RACF residents in the Warrnambool community, and looks at the potential for developing an after-hours and/or on call aspect to the ACNP service. To align with the treatment settings, it is anticipated that in Stage 1 the first ACNP appointment will be based in the GEM setting. Depending on learning, demand and resources it is possible that in Stage 2 the second ACNP role will operate from within a Community Health setting.

Following are depictions of stages 1 & 2 of the proposed SWH staged Model of Care, and a related Model of Care table. Details of the specific treatments and services able to be offered by the ACNP are further tabled in the Scope of Practice. The Scope of Practice will apply initially to Stage 1 of the Model, and be reviewed and adjusted as needed prior to commencement of Stage 2.
### South West Healthcare (SWH) Aged Care Nurse Practitioner (ACNP) Model of Care – 2015

#### Stage 1

**HOSPITAL**  
Bed visits & consultation  
- GEM [ACNP Base1]  
- Rehab  
- Emergency  
- Medical Ward [acute episodes]  
- Palliative Care [within GEM]  
- Assessment Support [GEM, ACASS, CADMS, other?]

**NON-HOSPITAL**  
Site visits & remote consultation  
[Referrals from RACFs, GPs, Ambulance, other health professionals]  
- RACF’s – Warrnambool  
  Site visits & phone consultation  
- RACF’s – Campertown & Port Fairy  
  Phone consultation & telemedicine options  
  Community Health Services  
  [e.g. HARP, District Nursing, Allied Health]  
  Phone consultation

#### Stage 2

**HOSPITAL**  
Bed visits & consultation  
- GEM [ACNP Base1]  
- Rehab  
- Emergency  
- Medical Ward [acute episodes]  
- Palliative Care [within GEM]  
- Assessment Support [GEM, ACASS, CADMS, other?]

**NON-HOSPITAL**  
Home/Site visits & remote consultation  
[Referrals from RACF’s, GPs, Ambulance, other health professionals]  
- RACF’s – Warrnambool  
  Site visits & phone consultation  
- RACF’s – Campertown  
  Phone consultation, weekly clinic &/or telemedicine options  
- RACF’s – District  
  Phone consultation  
- SWH Community Health Services  
  [ACNP Base2?]  
  [Palliative Care, HARP, District Nursing, Allied Health etc.]  
  Phone consultation, telemedicine & home visits

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SWH AGED CARE NURSE PRACTITIONER PROJECT FINAL REPORT MARCH 2013 .docx
<table>
<thead>
<tr>
<th>MODEL OF CARE *</th>
<th>Full Rollout</th>
<th>Stage One</th>
<th>Stage 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who are ACNP patients, &amp; where are they located?</strong></td>
<td>ACNP patients = general population &gt; 65 years of age and ATSI community members &gt; 45 years of age, residing in the Warrnambool District [including RACF’s], Merindah Lodge in Camperdown, or are admitted to/presenting at SWH across continuum of care. Offer professional consultation to South West District including Moyne and Corangamite.</td>
<td>ACNP patients = general population &gt; 65 years of age and ATSI community members &gt; 45 years of age, who reside in Warrnambool RACF’s, or are admitted to/presenting at SWH Hospital. Phone consultation to SWH Community Health Services, Merindah Lodge, &amp; other South West District Health Services including in Moyne and Corangamite Shires.</td>
<td>As for Stage One plus: Home visits to age eligible people residing in the general [non-RACF] community of Warrnambool presenting to SWH Community Services, or other healthcare professionals.</td>
</tr>
</tbody>
</table>
| **What are the preferred treatment settings for ACNP patients?** | Place of residence, and Hospital | HOSPITAL  
* Bed visits & consultation  
  GEM [ACNP Base 1]  
  Rehab  
  Emergency  
  Acute  
  Palliative  
  Assessment Clinic  

NON-HOSPITAL  
* Home/Site visits & remote consultation  
  [Referrals from RACF’s, GP’s, Ambulance, other health professionals]  
  RACF’s – Warrnambool  
  Site visits & phone consultation  
  RACF’s – Camperdown  
  Phone consultation & telemedicine options | HOSPITAL  
As for Stage One  

NON-HOSPITAL [ACNP Base 2?]  
* Home/Site visits & remote consultation  
  [Referrals from RACF’s, GP’s, Ambulance, other health professionals]  
  RACF’s – Warrnambool  
  Site visits & phone consultation  
  RACF’s – Camperdown  
  Phone consultation, weekly clinic &/or telemedicine options  
  RACF’s – District  
  Phone consultation  
  Community Health Services  
  [Palliative Care, HARP, District Nursing, Allied Health] |
<table>
<thead>
<tr>
<th>**MODEL OF CARE *</th>
<th><strong>Full Rollout</strong></th>
<th><strong>Stage One</strong> <em>Review to occur during Candidature once actual demand and capacity are better established.</em></th>
<th><strong>Stage 2</strong> <em>Review to occur during Candidature and Stage One once actual demand and capacity are better established.</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Where is the ACNP role based – i.e. main office/workstation?</td>
<td>SWH Hospital [i.e. GEM aged care beds], or SWH Community Health.</td>
<td>ACNP 1 - GEM/Rehab</td>
<td>ACNP 1 - GEM/Rehab ACNP 2 - Community OR ACNP 1 &amp; 2 – GEM/Rehab</td>
</tr>
<tr>
<td>Who can refer in to the ACNP?</td>
<td>All sources [hospital, ambulance, other healthcare professionals, community services, family] can refer older persons living [or being treated] within designated locations/ region, to ACNP.</td>
<td>ACNP can accept direct referrals from within SWH Hospital environment, and Warrnambool RACF’s. Phone consultations accepted from health professionals in Regional South West.</td>
<td>As for stage 1, plus: SWH Community Services; Local Ambulance Service; other Warrnambool healthcare professionals; members of the Warrnambool community.</td>
</tr>
<tr>
<td>Geographical reach / boundaries of the service?</td>
<td>Warrnambool District and broader region including Port Fairy, Camperdown, Lismore &amp; Macarthur. Aspire to develop tele-consulting to remote health care settings across wider district.</td>
<td>Face to face service: Warrnambool Other: Aspire to develop tele-consulting to remote health care settings across wider district.</td>
<td>As for stage 1, <em>plus:</em> Extension of face to face service to include Port Fairy &amp; Camperdown [either by appointment or holding a regular regional clinic.]</td>
</tr>
<tr>
<td>Hours of service</td>
<td>0800-1700 M-F initially, while being mindful of opportunities to review and extend the service in some way to better meet out of hour demand.</td>
<td>Mon – Fri between the hours of 0800-1700</td>
<td>Mon – Fri between the hours of 0800-1700 <em>plus</em> additional after hours and/or on call service to help meet demand</td>
</tr>
</tbody>
</table>
SCOPE OF PRACTICE

The Scope of Practice tables below were developed in consultation with the Project Group, align with the SWH ACNP Framework, and apply to the Stage 1 of the Model of Care which includes clinical practice within the SWH Hospital and RACF settings. The Scope of Practice will be reviewed annually, and in conjunction with any changes to the overall Model including implementation of Stage 2 of the Model of Care.

The Scope of Practice tables include: Summary, Role, Interventions, and drug Formulary.

**SCOPE OF PRACTICE SUMMARY**

<table>
<thead>
<tr>
<th>SCOPE OF PRACTICE</th>
<th>Summary from SWH ACNP Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>What specific treatments &amp; services can the ACNP offer?</td>
<td>Advanced clinical assessment; GEM assessment; order basic tests [pathology &amp; radiology]; prescribe from agreed formulary; specific admission rights [consider for Stage 2 Model]; referral; care and discharge assessment/planning; treatment for non-emergency illness, injury, infection, exacerbated chronic conditions, and end of life care; case management including consultation with [and referral to] GP’s, gerontologist, pharmacist, allied health, aged care nurses, and other health care specialists/providers.</td>
</tr>
<tr>
<td>What should the ACNP Not do?</td>
<td>Emergency treatment, and anything else outside the agreed scope of practice. Repetitive and/or routine work normally allocated to other health professionals.</td>
</tr>
<tr>
<td>Pharmacy: what drugs can the ACNP prescribe from the approved formulary?*</td>
<td>Selections from the approved Nurse Practitioner - Aged Care Drug List, as agreed to and documented by ACNP support group and clinical supervisor. Additional drugs not on the current Nurse Practitioner - Aged Care Drug List [i.e. vitamins], and approved by AHPRA.</td>
</tr>
</tbody>
</table>
**SCOPE OF PRACTICE – ROLE**

<table>
<thead>
<tr>
<th>The ACNP has capacity to treat / provide:</th>
<th>NP will not be referred / treat:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reversible causes of delirium e.g. UTI, constipation, pain, dehydration</td>
<td>Patients undergoing a medical emergency</td>
</tr>
<tr>
<td>• Respiratory &amp; Urinary Tract Infection’s</td>
<td><strong>For example:</strong></td>
</tr>
<tr>
<td>• Chronic &amp; acute pain management</td>
<td>• Myocardial infarction</td>
</tr>
<tr>
<td>• Continence issues both urinary and faecal</td>
<td>• Cerebrovascular event</td>
</tr>
<tr>
<td>• Fungal infections e.g. thrush</td>
<td>• Acute decline in respiratory function</td>
</tr>
<tr>
<td>• Cellulitis without systemic complications</td>
<td>• Loss of consciousness</td>
</tr>
<tr>
<td>• PEG issues – care &amp; education</td>
<td></td>
</tr>
<tr>
<td>• Acute surgical wound management</td>
<td></td>
</tr>
<tr>
<td>• Diagnosis and Suturing of minor wounds</td>
<td></td>
</tr>
<tr>
<td>• Dementia Management strategies</td>
<td></td>
</tr>
<tr>
<td>• Medication review/polypharmacy in consultation with pharmacist</td>
<td></td>
</tr>
<tr>
<td>• Palliative care &amp; symptom management / end of life care</td>
<td></td>
</tr>
<tr>
<td>• Exacerbation of chronic disease</td>
<td></td>
</tr>
<tr>
<td>• Diagnosis and treatment of undisplaced simple fractures</td>
<td></td>
</tr>
<tr>
<td>• IV cannulation</td>
<td></td>
</tr>
<tr>
<td>• GEM assessment</td>
<td></td>
</tr>
</tbody>
</table>

*Note 1: Details of pathology and prescribing are listed in the Interventions section of this document, and in the SWH ACNP Formulary*

*Note 2: While some of the above diagnosis and treatments may be available from other sources [i.e. RN, Continence Nurse, or Wound Nurse NP], they may not be equally or as readily available across all practice settings. To minimise the need for patient relocation and maximise the opportunity for timely and holistic patient care, the ACNP may decide at their own discretion to initiate treatment/s themselves and/or refer on to relevant health care staff/specialists.*
### SCOPE OF PRACTICE – INTERVENTIONS

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Radiology</th>
<th>Pathology</th>
<th>Admission, Referral &amp; Discharge</th>
<th>Prescribing – Pharmacy and Non-pharmacological</th>
</tr>
</thead>
</table>
| • Advanced clinical assessment, E.G.:  
  o Symptom history  
  o Full medical history  
  o Pharmacological history  
  o Drug Allergy history  
  o Family History  
  o ADL/Functional History  
  o Falls history  
  o Psychosocial history  
  o Physical examination  
  ▪ Including mini mental state examination  
  ▪ Geriatric depression scale  
  • Advanced mood & cognitive screening  
  • Identification of health risks  
  • Advance care planning / end of life care  
  • Evaluation of patients adherence and response to plan of care  
  • Conservative pathway management  
  • Blood Pressure Control  | • CXR  
  • AXR  
  • Plain x-rays  
  o Limbs  
  o Pelvis  
  • CT scans [in consultation with Radiologist]  
  • Ultrasound  
  • MRI  | Request  
  • FBE  
  • U & E  
  • Microbiology, culture and sensitivity of urine, sputum, wound swabs and stool  
  • LFT  
  • TSH  
  • CRP  
  • Glucose HBA1C  
  • Iron studies  
  • INR  
  • ESR  
  • Blood Culture  
  • Blood levels for medications e.g. Lithium, Digoxin, Sodium valproate  | Referral to/consultation with:  
  • Geriatrician  
  • Other NP’s  
  • GEM & Inpatient rehab  
  • GP  
  • Emergency Department [from RACF’s]  
  • Medical Ward  
  • Palliative Care  
  • Allied Health  
  • Community Health Services  | Pharmacy:  
  • Prescribe from agreed SWH ACNP Formulary  
  Non-pharmacological - prescribe:  
  • Immunisation  
  • Cannulation  
  • Catheterisation – Male; SP  
  • Fluid replacement  
  • Suturing of minor wounds & wound management  
  • Simple POP  |

Discharge:  
• Facilitate timely discharge from hospital [in collaboration with Discharge Planning Team]  
• Facilitate transfer/referral on from ED [e.g. to GEM bed, or return to RACF for treatment in
Assessment | Radiology | Pathology | Admission, Referral & Discharge | Prescribing – Pharmacy and Non-pharmacological residence

Assessment:

- The potential/rationale for admitting rights [e.g. to GEM and/or HITH] will be reviewed prior to commencing Stage 2 of the Model of Care.

SCOPE OF PRACTICE - FORMULARY

The ACNP Formulary List is predominantly derived from the “Nurse Practitioner – Aged Care” Schedules as listed under the Drugs, Poisons and Controlled Substances Act 1981. Permission for an additional Formulary item [Vitamins] not listed in the current “Nurse Practitioner – Aged Care” Schedule, will be requested from AHPRA. The Formulary will be reviewed annually, and in conjunction with any relevant changes to the Drugs, Poisons and Controlled Substances Act or the SWH ACNP Model of Care.

SWH ACNP FORMULARY LIST

<table>
<thead>
<tr>
<th>SCHEDULE</th>
<th>CLASS</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>ACE inhibitors</td>
</tr>
<tr>
<td>4</td>
<td>Agents used in gout and hyperuricaemia</td>
</tr>
<tr>
<td>3</td>
<td>Antiangina agents</td>
</tr>
<tr>
<td>2, 3 &amp; 4</td>
<td>Antidiarroicals</td>
</tr>
<tr>
<td>2, 3 &amp; 4</td>
<td>Antihistamines</td>
</tr>
<tr>
<td>2 &amp; 4</td>
<td>Antispasmodics and motility agents</td>
</tr>
<tr>
<td>3 &amp; 4</td>
<td>Antiemetics</td>
</tr>
<tr>
<td>4</td>
<td>Antibacterials [skin]</td>
</tr>
<tr>
<td>SCHEDULE</td>
<td>CLASS</td>
</tr>
<tr>
<td>----------</td>
<td>-------</td>
</tr>
<tr>
<td>4</td>
<td>Antiemetics</td>
</tr>
<tr>
<td>4</td>
<td>Antiepileptics [?]</td>
</tr>
<tr>
<td>3</td>
<td>Beta2 agonists</td>
</tr>
<tr>
<td>4</td>
<td>Bisphosphonates</td>
</tr>
<tr>
<td>4</td>
<td>Bronchodilator aerosols and inhalations</td>
</tr>
<tr>
<td>4</td>
<td>Cephalosporins</td>
</tr>
<tr>
<td>2 &amp; 3</td>
<td>Combination simple analgesics &amp; antipyretics</td>
</tr>
<tr>
<td>4</td>
<td>Corticosteroids</td>
</tr>
<tr>
<td>4</td>
<td>Diuretics</td>
</tr>
<tr>
<td>2</td>
<td>Drugs for anaemias</td>
</tr>
<tr>
<td>2 &amp; 4</td>
<td>Drugs for local anaesthesia</td>
</tr>
<tr>
<td>2, 3 &amp; 4</td>
<td>Expectorants, antitussives, mucolytes &amp; decongestants</td>
</tr>
<tr>
<td>4</td>
<td>Glaucoma preparations</td>
</tr>
<tr>
<td>2 &amp; 4</td>
<td>H2 antagonists</td>
</tr>
<tr>
<td>4</td>
<td>Hypoglycaemic agents</td>
</tr>
<tr>
<td>4</td>
<td>Insulin preparations</td>
</tr>
<tr>
<td>4</td>
<td>Macrolides</td>
</tr>
<tr>
<td>4</td>
<td>Nitrates</td>
</tr>
<tr>
<td>4</td>
<td>Nitrofurantoin</td>
</tr>
<tr>
<td>4</td>
<td>Nitroimidazoles</td>
</tr>
<tr>
<td>4</td>
<td>Nonsteroidal anti-inflammatory agents</td>
</tr>
<tr>
<td>4</td>
<td>Oestrogens [topical]</td>
</tr>
<tr>
<td>4</td>
<td>Penicillins</td>
</tr>
<tr>
<td>4</td>
<td>Potassium chloride</td>
</tr>
<tr>
<td>4</td>
<td>Proton pump inhibitors</td>
</tr>
<tr>
<td>4</td>
<td>Quinolones</td>
</tr>
<tr>
<td>4</td>
<td>Sedatives, hypnotics</td>
</tr>
<tr>
<td>4</td>
<td>Statins</td>
</tr>
<tr>
<td>4</td>
<td>Sulfonamides and trimethoprim</td>
</tr>
<tr>
<td>3</td>
<td>Sympathomimetics [anaphylaxis]</td>
</tr>
<tr>
<td>4</td>
<td>Tetracyclines</td>
</tr>
<tr>
<td>SCHEDULE</td>
<td>CLASS</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>2</td>
<td>Topical anorectal medication</td>
</tr>
<tr>
<td>2, 3 &amp; 4</td>
<td>Topical antifungals</td>
</tr>
<tr>
<td>2 &amp; 4</td>
<td>Topical corticosteroids</td>
</tr>
<tr>
<td>2 &amp; 3</td>
<td>Topical oropharyngeal medication</td>
</tr>
<tr>
<td>4</td>
<td>Topical ocular anti-infective preparations</td>
</tr>
<tr>
<td>4</td>
<td>Topical optic medication</td>
</tr>
<tr>
<td>Other</td>
<td>Vitamins</td>
</tr>
</tbody>
</table>
**INTERNSHIP**

The purpose of the two year Internship is to provide high quality clinical experience, education, support, and supervision to the ACNP Candidate prior to applying for Endorsement. The placements within the Internship Plan will align with the main treatment settings outlined in Model of Care. Where possible and practical, the nature and timing of Internship placements will also compliment the study curriculum of the Candidate.

As per Stage 1 of the Model of Care, our initial vision is to establish an ACNP service that addresses the identified healthcare needs of older persons presenting at SWH Hospital, and residing in Residential Aged Care Facilities within the Warrnambool District. Exploring the capacity of the ACNP role to support a range of formal Aged Care Assessment processes is also part of the vision.

A further aspiration is to progress to Stage 2 of the Model of Care, which will enable the ACNP service to be extended to older persons residing in private non RACF homes in Warrnambool, to increase the level of service offered to Camperdown and Port Fairy [either on-site or via tele-medicine], and to potentially offer some after-hours service through the appointment of a second ACNP.

The 2013 Candidate will participate on a total of 5 Placements across the 2 Year Internship period. Internship Plan # 1 is relevant to the Stage 1 Model of Care.

The main treatment settings outlined in the SWH ACNP Model of Care Stage 1 are:

- GEM/Rehabilitation wards;
- Medical & Inpatient Palliative Care Wards;
- Emergency Department & Psychiatric Services;
- Warrnambool RACF’s.

A full copy of the Internship Plan #1 is located at the [Appendix 2](#).

**SUPPORT & GOVERNANCE**

Support and governance for the ACNP Candidate is provided throughout the Internship in the form of planned mentoring and supervision. As listed in the Internship Plan, mentoring includes regular interaction and collaboration with the SWH Geriatrician, Rehabilitation Physician, Pharmacist, Medical Centre GP, ED Nurse Practitioner/s, and other health professionals as required. Unit Managers will provide supervision within each placement.

The ACNP Candidate will have the ongoing support of the Victorian Older Persons Nurse Practitioner Collaborative. Information and advice is also available from the Victorian Department of Health and AHPRA representatives.

As outlined in the 5 Year Plan, the learning outcomes and emerging Candidate needs will be reviewed by the main mentor, Unit Manager, and Project ACNP Support Group towards the end of each placement. Strategic supervision with the Director of Nursing will occur on a 6 monthly basis, and more frequently if required.

It is envisaged that the support relationships and networks formed during Candidacy will continue as needed into the ACNP endorsed stage of practice.
The 5 Year Plan also includes supervision and points of review applicable to implementation of the Model of Care and the endorsed ACNP Role.

5 YEAR PLAN
The 5 Year Plan provides a record of completed Project Deliverables, and serves as a guide for the ongoing work needed to recruit and support ACNP Candidate/s through the Internship phase to full endorsement, and to fully implement Stages 1 & 2 of the SWH ACNP Model of Care.

The plan includes:

- Quarterly reviews of Internship progress and Candidate Support, by the ACNP Project Group
- End of Placement Evaluations with Candidate, Mentor, and Unit Manager
- Management of Placement Transitions by Director of Nursing
- Submission of 6 monthly Candidate Log to Victorian Department of Health
- 6 monthly strategic supervision of Candidate with Director of Nursing
- Annual Review of SWH ACNP Model of Care
- Regular update of 5 Year Plan, and ...
- Other strategic change and evaluation points

It is acknowledged that much can change in 5 years, and many eventualities will not have been anticipated. It is with this in mind that the ACNP Project Group will continue to monitor and update this Plan, plus provide the pivotal support and guidance needed for the ongoing development of the ACNP role/s, and the implementation of Stages 1 & 2 of the SWH ACNP Model of Care.

Change is inevitable, except from vending machines.

- Unknown

A detailed copy of the 5 Year Plan is located at Appendix 3.
APPENDIX 1 – Stakeholder Feedback

<table>
<thead>
<tr>
<th>STAKEHOLDER FEEDBACK RELEVANT TO AGED CARE NURSE PRACTITIONER ROLE in WARRNAMBOOL</th>
<th>RACFs – Lyndoch, Mercy Place, Merindah Lodge</th>
<th>SWH – Community Care [various]</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Question:</strong> What kind of health/medical conditions most commonly lead to residents being admitted to emergency/acute hospital care?</td>
<td><strong>Main themes:</strong></td>
<td>Exacerbation of chronic conditions such as asthma, copd, AF, gout, requiring surgery (bypass surgery), pneumonia; Debility; Heart Failure/CCF; Exacerbation COPD; Falls for investigation; Anemia; carer stress, mental health issues, cardiac failure, general physical decline, COPD, pneumonia; Admission - transfer to medical needed; cancelled services; Acute symptom management and/ or exacerbation of disease; Pr bleeding; S &amp; S TIA/stroke, acopia; Ca oesphagus, COPD, leg ulcer- grafting, cataract; UTI's, wound infections, falls, pneumonia, acopia; Falls, UTI's; Acopia, flare up of chronic medical conditions, and booked surgery.</td>
</tr>
</tbody>
</table>

- Falls/injuries
- Infections
- IV
- Heart
- Pain
- End of life
- UTI
- Exacerbation of chronic condition
- General decline

Sutures or fractures; outpatients clinics; IV antibiotics; ECG's – arterial blood gases; wound consultation; on call Doctor not familiar with resident and wanting To transfer to A & E for further assessment; acute infections requiring UV abs; falls - investigation of injuries following falls; xrays to check for fractures; treatment of fractures; IV therapy for acute infections; surgical interventions [e.g. hip, removal of cancerous growth, bowel obstruction]; infections; delirium due to infection; chest infections; drug toxicity; heart problems; pneumonia; blood transfusion; palliative care / pain management – GP unwilling or unable to attend, or no concept of pain management needs; URTI; #NOF; ACNP who could assess & treat chest infections, prescribe end of life meds etc; residents need to go for further diagnostic assessments & treatments; On call GPs being available for after-hours visits and consultation; Staff to have backup to avoid sending resident to hospital unnecessarily; Easier access to GP’s, ability to orders bloods without waiting for GP; regular review of all residents; More Registered Nurses who can administer the drugs and care needed; Earlier intervention; GP understanding of

What might have prevented the need for these admissions? | **Main themes:** | More GPs, so my clients did not have to come into ED and could be seen by a GP sooner for review and scripts; Early recognition of exacerbations & early implementation of treatments. Ability to see GP without delay...clients require review, but often have to wait several days for an appt. When delay of several days for GP appt, clients then often have to present to the ED; less reliance on the local GP system which is then not available to them when they need it for immediate advice; They only go through ED if they have a new

- Timely diagnosis
- Earlier intervention
- Order tests

ACNP who could assess & treat chest infections, prescribe end of life meds etc; residents need to go for further diagnostic assessments & treatments; On call GPs being available for after-hours visits and consultation; Staff to have backup to avoid sending resident to hospital unnecessarily; Easier access to GP’s, ability to orders bloods without waiting for GP; regular review of all residents; More Registered Nurses who can administer the drugs and care needed; Earlier intervention; GP understanding of
**STAKEHOLDER FEEDBACK RELEVANT TO AGED CARE NURSE PRACTITIONER ROLE in WARRNAMBOOL**

<table>
<thead>
<tr>
<th>Question:</th>
<th>RACFs – Lyndoch, Mercy Place, Merindah Lodge</th>
<th>SWH – Community Care [various]</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(if any) intervention and support</td>
</tr>
<tr>
<td></td>
<td>• Prescribe</td>
<td>from an Aged Care Nurse</td>
</tr>
<tr>
<td></td>
<td>• IV capacity</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Understand end of life care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>end of life care; Div 1 staff deemed competent in IV cannulation; correct staffing levels; doctors doing daily round [when resident ill as they do in acute]; Outside scope of practice of EN’s; More Div 1 Nurses required; earlier diagnosis and provision of antibiotics; more recent and therefore more accurate assessment [ACAS]; so that residents are admitted to area best suited to their care needs; Thorough assessment by Nurse Practitioner – too often assessed by on-call; resident not falling in room; resident not having stroke; nil; not sure; nothing.</td>
<td>symptom otherwise they are admitted directly to the inpatient Palliative Care Unit; maybe nothing as all clients admitted have lots of support in place; Early nursing intervention or GP referral; early intervention, wholistic approach; Early diagnosis; One client told me she didn’t have her walking stick when she fell. Another said she was tired after traveling to Geelong for day - fell that evening; Husband of another client who fell said she should not have been working in the garden (when she fell); Possibly OT assessment and falls and balance clinic input; More GPs, so my clients did not have to come into ED and could be seen by a GP sooner for review and scripts; Early recognition of exacerbations &amp; early implementation of treatments. Ability to see GP without delay...clients require review, but often have to wait several days for an appt. When delay of several days for GP appt, clients then often have to present to the ED; less reliance on the local GP system which is then not available to them when they need it for immediate advice; They only go through ED if they have a new symptom otherwise they are admitted directly to the inpatient Palliative Care Unit; maybe nothing as all clients admitted have lots of support in place; Early nursing intervention or GP referral; early intervention, wholistic approach; Early diagnosis; Client consent to ACAS, community care packages, advanced care planning [i.e. Jamie Fogherty @ SWH], and/or respite care, plus timely professional health care review when there is a flare-up.</td>
</tr>
</tbody>
</table>

In what ways [if any] do you think intervention and support from an Aged Care Nurse

Residents would not have to wait for Doctor to visit; being able to treat residents with dementia in their own setting, decreasing disruption to A & E and the

Prescription of antibiotics, ordering CXR as a diagnostic; Decrease wait time for review of simple conditions, prior to them becoming complex; assist with
<table>
<thead>
<tr>
<th>Practitioner could help your service and / or your Residents?</th>
<th>RACFs – Lyndoch, Mercy Place, Merindah Lodge</th>
<th>SWH – Community Care [various]</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Main themes:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Timely diagnosis</td>
<td></td>
<td>consultancy around aged care issues, especially for those with limited experience. Could link community care with acute; Unknown with HITH, as ages vary and all admissions are for acute reasons; I think they need to have knowledge of the Palliative Approach and how this applies to the Primary Care Provider; Not sure, would this be duplicating HARP service? Greater access, less medical focus approach; Drug chart and time; referrals to appropriate services - early intervention - closer monitoring; Scripts – sooner; Maybe more supportive care education on falls prevention. DNS provide assessment of falls risks and education but still up to client to take on our suggestions; We are not sufficiently big enough to warrant a full time practitioner however having the ability to consult with a practitioner where necessary would be of benefit; Junior Nurse [and those lacking confidence, i.e. in dealing with GPs], using this as a resource to determine earlier on if presenting issue a problem rather than ringing a doctor.</td>
</tr>
<tr>
<td>• Earlier intervention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Order tests</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Prescribe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• IV capacity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reduce demand on GP system</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• End of life care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Avoid preventable deteriorations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Links to other services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Liaise with GPs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Education &amp; information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Resident treated in place</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Reduce avoidable admissions to A &amp; E</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Make referrals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Admission rights to HITH?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Other comments:**

| The NP would best be utilised in the region rather | Would be of great benefit given the fact some clients |
## STAKEHOLDER FEEDBACK RELEVANT TO AGED CARE NURSE PRACTITIONER ROLE in WARRNAMBOOL

**Question:**

- RACFs – Lyndoch, Mercy Place, Merindah Lodge
- SWH – Community Care [various]

### Main themes:

- **Service availability across region?**
- **Relationship with GP’s?**
- **Education**
- **Quality & benchmarking**
- **End of life care**
- **Flexibility of care**
- **Ability to know residents?**
- **Workload?**

than be based solely at SWH Warrnambool; One understands that the acute facility does not want to admit older people into acute beds or to be in the ED; if they can be safely managed in their own home with the support of the GP and DNS for example, but if an older person should be admitted then it is most likely their right; Best outcome for resident, cost effective for acute hospital; Provide a link between AC Facilities. Assist with benchmarking by auditing; Support would realistic be very limited to outside Warrnambool given the population; It would help if ACNP was geared towards gerontics and end of life care. I would welcome an ACNP who could promote palliative care in my facility; I’m sure they would benefit the community greatly by being more available; It would cover the shortage of Doctors in country areas; If they were wise, they would extend the service to a private practice and be available to consult anywhere in the region; Our facility welcomes and encourages all aspects of ongoing education. Advice and support from NP would be very supported and staff would benefit greatly from this supportive role. The continuing improvement of our quality control combined with a broader scope of learning within our facility would be open to a more flexible model of client centred care; NP would not know the residents as well as regular staff; No downside to having access to a NP: Effectiveness depends in part on what they can order, and are GP’s happy to work with them? Will we have good access in Camperdown?

have to wait a number of days sometimes week to be able to see a GP; Acute client assessments required when GP is unavailable, but importantly, chronic condition management and PHC approach to management of these clients. Ability to admit to GEM for chronic & complex clients, to reduce pressure on ED pathway when emergency assessment is NOT required; There are staff at [name] who were undertaking study, may be completed, to obtain a similar role. Preferable the practitioner would have less of a focus on acute care skills, and be generalist and experienced and empathetic to aged care and chronic illness; May be good for support reasons or elderly living alone, patients treated are acute conditions e.g. cellulitis, warfarinisation for DUT, PE & AF; I think it is fantastic and just wish we had someone interested in being a Palliative Care Nurse Practitioner; Often elderly feel they have to be really sick to see the doctor so they ignore early warning signs that could be addressed and prevent a hospital admission; what would be the selection criteria, how would it be implemented, would be possibly huge work load; If able to provide one-on-one education support for more clients i.e.: for falls prevent, importance of exercise, diet etc - the wholistic care. Due to time constraints maybe we as DNS don’t provide this well enough?? maybe we could refer clients to this ACNP, client may only need a couple of visits to provide support of plan - as I write this I feel we (dns) should be doing this but not sure we are as well as could be. I think DNS are great at providing specific care like wound care and technical care, but are we providing best in way of health information to prevent falls and hospital admissions? the ability to
<table>
<thead>
<tr>
<th>STAKEHOLDER FEEDBACK RELEVANT TO AGED CARE NURSE PRACTITIONER ROLE in WARRNAMBOOL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Question:</strong> RACFs – Lyndoch, Mercy Place, Merindah Lodge</td>
</tr>
<tr>
<td><strong>Feedback:</strong> teleconference and consult with a practitioner for regional areas would be beneficial; potentially service residential care for infections or dehydration, and refer to HITH for care e.g. IV fluids IV antibiotics, plus assess and coordinate response to syndromes such as Hoarding/Diogenese [i.e. establish relationship and referral onwards];</td>
</tr>
</tbody>
</table>
# APPENDIX 2 – Internship Plan

## Aged Care Nurse Practitioner Candidate Internship Plan # 1 - South West Healthcare

The purpose of the two year Internship is to provide high quality clinical experience, education, support, and supervision to the ACNP Candidate prior to applying for Endorsement. The placements within the Internship Plan will align with the main treatment settings outlined in Model of Care. Where possible and practical, the nature and timing of Internship placements will also compliment the study curriculum of the Candidate.

As per Stage 1 of the Model of Care, the initial vision is to establish an ACNP service that addresses the identified healthcare needs of older persons presenting at SWH Hospital, and residing in Residential Aged Care Facilities within the Warrnambool District. Exploring the capacity of the ACNP role to support a range of formal Aged Care assessment processes is also part of the vision. A further aspiration is to progress to Stage 2 of the Model of Care, which will enable the ACNP service to be extended to older persons residing in private non RACF homes in Warrnambool, to increase the level of service offered to Camperdown and Port Fairy [either on-site or via tele-medicine], and to potentially offer some after-hours service through the appointment of a second ACNP.

The 2013 Candidate will participate on a total of 5 Placements across the 2 Year Internship period. Internship Plan # 1 is relevant to the Stage 1 Model of Care. The main treatment settings outlined in the SWH ACNP Model of Care Stage 1 are: GEM/Rehab wards; Medical & Inpatient Palliative Care Wards; ED & Psychiatric Services; Warrnambool Residential Aged care Facilities [RACF’s].

<table>
<thead>
<tr>
<th>Intern Prerequisites</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Advanced Practice Registered Nurse – Clinical Nurse Specialist (CNS), Clinical Nurse Consultant and or Care Coordinator.</td>
<td>Consolidation of nursing practice and leadership. Will be on substantive pay while undertaking candidature.</td>
</tr>
<tr>
<td>2. Available to undertake <strong>0.4 EFT Internship</strong> combined with additional 0.3 or 0.4 in other relevant/complimentary nursing role.</td>
<td>Note: average minimum of 0.7 EFT per week needed to gain necessary skills / relevant practice across Stage 1 Care, and provide evidence of hours towards national endorsement requirements of 5000 hours advanced practice over 6 years prior to endorsement application.</td>
</tr>
<tr>
<td>3. Competent Advanced Physical Assessment or equivalent training &amp; education.</td>
<td>Nurse must have established systems based understanding of assessing key clinical features as the basis for advanced training in diagnosis &amp; treatment.</td>
</tr>
<tr>
<td>4. Graduate Diploma Gerontology or other postgraduate qualification</td>
<td>Demonstrated commitment to continuing education on a pathway relevant to advanced care nursing.</td>
</tr>
<tr>
<td>5. Master of Clinical Nursing / Nurse Practitioner ACNP (enrolled and underway )</td>
<td>Completion is an essential component of national endorsement.</td>
</tr>
</tbody>
</table>

**Mentors:** SWH and other available Gerontologists, GEM/Rehab Unit Manager, Psych Services Aged Care Liaison Nurse; Palliative Care Manager, AHPRA staff member, SWH Medical Centre GP, Endorsed ACNPs via Victorian Collaborative, SWH Wound Care NP, ED NP, Pharmacist, Pathologist, Radiologist, ACAS Officer, other appropriate health professionals/specialists as needed.

**Underpinning Policy Framework:** Care for the Older Person
ACNP INTERNSHIP # 1 - SUMMARY

<table>
<thead>
<tr>
<th>Year One</th>
<th>Year Two</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 2 clinical rotations of 24 weeks each at SWH with approved mentor/s.</td>
<td>- 3 Clinical Rotations of 16 weeks each - Two rotations at SWH &amp; One rotation at an external RACF with approved mentor/s.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Placement 1</th>
<th>Placement 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>SWH GEM &amp; Rehab Units</td>
<td>SWH ED &amp; Mental Health Services Liaison</td>
</tr>
<tr>
<td>Date TBC</td>
<td>Date TBC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Placement 2</th>
<th>Placement 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>SWH Medical Ward &amp; Palliative Care</td>
<td>SWH Merindah Lodge RACF</td>
</tr>
<tr>
<td>Date TBC</td>
<td>Date TBC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Placement 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lyndoch Living RACF [external placement]</td>
</tr>
<tr>
<td>Date TBC</td>
</tr>
</tbody>
</table>

- **Learning Objectives and Active Duties**: To ensure appropriate application of Interns current level of ability, plus the creation of learning situations that align with formal study components and contribute to ACNP Endorsement requirements for advanced practice, the Learning Objectives and Active Duties within each placement should wherever possible be confirmed via consultation between Intern, Unit Manager and Mentor.

- **Outcome assessment**: Outcome /competency assessments will be done by SWH Mentors. For external placement, SWH Mentor will also consult with RACF Manager/Mentor.

- **Support**: As per the terms of the Department of Health Nurse Practitioner Support Package Guidelines [2012-13], the Intern will need:
  - Time to undertake the program, and maintain manageable workloads that will include advanced clinical practice
  - Access to suitable supervisors (clinical and professional) and mentors that understand their role and objectives of the Internship
  - Flexible rostering to allow them to meet study requirements and work with/spend time with supervisors
  - Access to library facilities [including online], office equipment, and clinical skills development equipment/simulators etc.
  - Use of support package to cover paid specialist supervision, seminar attendance, roster backfill, and travel costs as appropriate

- **Hours of Work**: The Intern role is an 0.4 position, with hours of work as agreed to by Candidate and Unit Manager/s

- **Annual Leave**: Intern will be entitled to 4 weeks Annual Leave [pro-rata]

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Details of each placement begin on the following page.
Year 1 – Intern Placement 1: Geriatric Evaluation Management (GEM) Unit / Rehabilitation – 24 Weeks

Operational Supervision: GEM/Rehab Unit Manager
Mentor/s: Geriatrician, supported by Rehab Physician and GEM Liaison Nurse

Key Learning Objectives

- Capacity to support a Comprehensive Geriatric Assessment (CGA) and provisional diagnoses based around the Geriatric Syndromes
  - Focus on assessment

Specific medical condition knowledge requirements

- Definition
- Epidemiology
- Clinical Presentation
- Aetiology
- Pathophysiology
- Predisposing / Risk Factors
- Assessment
  - Physical
  - Diagnostic
- Investigations
- Therapeutics
- Prescribing

Learning Outcome Measures

Assessed by Mentor

- Demonstrate 2x Bedside CGA – long case
  1. Taking a history
  2. Systems review
  3. Upper and lower limb neurological
  4. cranial nerves
  5. cognition
  6. cardiac
  7. respiratory
  8. abdominal
  9. musculoskeletal
10. miscellaneous

- Case Presentation at multidisciplinary Meeting
- In service education session to team [including geriatrician] on topic negotiated
- Attendance at seminar series [including OPNP Vic. Collaborative]
- Development and maintenance of Clinical log [using Department of Health template], with weekly mentor review
- Map prospective referral pathways for endorsed ACNP role that will be applicable to GEM/Rehab
- Negotiate attendance at Specialist Hospital/Aged Care clinics [min 1 session / internship]
  1. Falls
  2. Continence
  3. Memory
  4. Pain
  5. Geriatric
  6. Other as applicable

Organisational Duty Responsibilities

Hours of Work: As agreed to by Candidate and Unit Manager

- Respond to GEM referrals in acute through
  - CGA for appropriate referrals
- Internal handover
- Read previous days progress notes
- Check Pathology / Radiology results
- Review medication charts
- Visit current patients
- Further assessment as needed
- Monitor the attainment of goals
- Confer management plans with Geriatric specialist
- Attend ward
- Admission of new patients
- Case conference (1 day / week)
- Alternatively assess acute patients for GEM program
- Skill development
- Other activities as deemed appropriate by the Unit Manager/Geriatrician
**Year 1 – Intern Placement 2: Medical & Palliative Care Wards[Plus related Community PC], & PAC - 24 Weeks**

**Operational Supervision:** Medical Unit Manager

**Mentor/s [to be selected prior to placement]:** from within the Community Palliative Care Team, with support from Physician & PAC delegate

**Key Learning Objectives**

**Medical**

- To independently undertake a CGA, make provisional diagnoses and propose a treatment plan based around the Geriatric Syndromes
- To articulate the recognition, diagnosis and management of Delirium in the acute setting

**Palliative Care**

- To assess symptoms such as pain and nausea and propose a medication and/or management plan
- To assess symptoms related to terminal phase of care and propose a medication and/or management plan
- To articulate whole person care taking all psychosocial issues into account
- To articulate the difference between a Palliative Approach and Specialist Palliative Care
- To learn how to complete Advance Care Planning
- To assist people to develop resilience in the face of death and dying

**Specific medical condition knowledge requirements**

- Definition
- Epidemiology
- Clinical Presentation
- Aetiology
- Pathophysiology
- Predisposing / Risk Factors
- Assessment
  - Physical
  - Diagnostic
- Investigations
- Therapeutics
- Prescribing

**Learning Outcome Measures** - Assessed by Mentor
Medical & Palliative Inpatient Wards
- Demonstrate 2x Bedside Comprehensive Geriatric Assessment (CGA) – long case
  1. Advanced assessment skills as evidenced through GEM/Rehab learning outcome measures
  2. Pharmacotherapeutics
  3. Diagnostics
- Case Presentation at 1 multidisciplinary Meeting
- 1 audit of agreed clinical outcome measures
- 1 Education session to 1 Multidisciplinary team on topic negotiated
- Evidence of leadership in delirium prevention, recognition & management
- Attendance at seminar series
- Development and maintenance of Clinical log [using Department of Health template], with weekly mentor review
- Map prospective referral pathways for endorsed ACNP role that will be applicable to Medical Ward and Palliative Care Inpatient Unit
- Negotiate attendance at Tertiary Hospital clinics x 1 session / internship
  1. Falls
  2. Continence
  3. Memory
  4. Pain
  5. Geriatric

Palliative Care - Generic
- Completion of the Advance Care Planning Course and demonstrate completion of an Advance Care Plan with a patient
- Case Presentation incorporating Whole Person Care [if need be, this activity can cover off the Medical/Inpatient Palliative case presentation listed above]
- Demonstration of use of the Living in Style Kit
- Education of Aged Care Staff in A Palliative Approach using the Aged Care/Palliative Care Tool Kit [if need be this activity can cover off the Medical/Inpatient Palliative Education Session listed above]

Organisational Duty Responsibilities

Hours of Work: As agreed to by Candidate and Unit Manager

Medical
- Attend Medical round with Med 1 VMO (or GP if in partner organisation) identifying patients who require ACNPC interventions
- Read previous days progress notes
- Check Pathology / Radiology results
• Review medication charts
• Develop geriatric plan in conjunction with VMO / registrar / intern / GP
• Individual assessment as required
• Skill development
• Exposure to ACAS activity
• Other activities as deemed necessary by the Unit Manager/Clinical Supervisor

**Palliative Care**
• Attend weekly Palliative Care Multidisciplinary team meetings
• Attend round with Palliative Care Doctor/Physicians
• Review ESAS of each older Palliative Care Patient daily and propose treatment/medication plan
Year 2 – Intern Placement 3: Emergency Department and SWH Mental Health Services- 16 Weeks

Operational Supervision: ED Unit Manager
Mentor/s: Aged Persons Mental Health Consultation Liaison Nurse, with support from Geriatrician, ED Nurse Practitioner and other sources as needed

Key Learning Objectives

- To independently undertake a CGA, make provisional diagnoses and present a treatment plan including pharmacotherapy.
- To independently undertake a CGA, make provisional diagnoses and present a treatment plan including the complex interaction of mental illness
- Under supervision to initiate the treatment plan including any pharmacotherapy, admission or referral.

Specific medical condition knowledge requirements

- Definition
- Epidemiology
- Clinical Presentation
- Aetiology
- Pathophysiology
- Predisposing / Risk Factors
- Assessment
  - Physical
  - Diagnostic
- Investigations
- Therapeutics
- Prescribing
- Diagnosis / Differential diagnosis
- Management / Treatment
- Outcome / Reflective Practice
- Health promotion / Preventative Medicine

Learning Outcome Measures

Assessed by Mentor

- Demonstrate 1x Bedside Targeted Geriatric Assessment (CGA) – long case / short case
- Mental Health and ED Case Presentations at multidisciplinary Meeting
- 1 Education sessions to Multidisciplinary team on topic negotiated
• Development and maintenance of Clinical log with weekly mentor review
• Map prospective referral pathways for endorsed ACNP role that will be applicable to ED and Mental Health Services
• Negotiate attendance at Tertiary Hospital clinics x 1 session / internship
  1. Falls
  2. Continence
  3. Memory
  4. Pain
  5. Geriatric

**Organisational Duty Responsibilities**

**Hours of Work:** As agreed to by Candidate and Unit Manager

• Visit ED & Mental Health Services, identifying patients who require specialised geriatric interventions
• Read previous days progress notes
• Check Pathology / Radiology results
• Review medication charts
• Visit all current older patients
• Further assessment as needed
• Monitor the attainment of goals
• Confer management plans with ED GP/Nurse Practitioner and Liaison Nurse/Psychiatrist as needed
• Admission of new patients
• Skill development
• Other activities as deemed necessary by the Unit Manager & Liaison Nurse
**Year 2 – Intern Placement 4: Merindah Lodge - SWH Residential Aged Care Facility – 16 Weeks**

**Operational Supervision:** Merindah Lodge Nurse Unit Manager

**Mentor/s:** SWH Geriatrician, supported by SWH Pharmacist, GP [to be identified in the local context of Merindah Lodge] other aged care health professionals as needed

**Key Learning Objectives**

- To independently undertake a CGA, make provisional diagnoses and present a treatment plan include pharmacotherapy
- Under supervision to initiate the treatment plan including any pharmacotherapy, bedside diagnostic tests or referral
- Review the potential of tele-medicine as a viable method of service delivery to remote campus

**Specific medical condition knowledge requirements**

- Definition
- Epidemiology
- Clinical Presentation
- Aetiology
- Pathophysiology
- Predisposing / Risk Factors
- Assessment: Physical & diagnostic
- Investigations
- Therapeutics
- Prescribing
- Diagnosis / Differential diagnosis
- Management / Treatment
- Outcome / Reflective Practice
- Health promotion / Preventative Medicine

**Learning Outcome Measures**

Assessed by Mentor

- 1 X Physical examinations with diagnosis & treatment plan including pharmacotherapy & communiqué to GP
- 2 X Full admission
- 1 X Case Presentations at multidisciplinary Meeting
- 1 Education session to Multidisciplinary team on topic negotiated
- Development and maintenance of Clinical log with weekly mentor review
- Map prospective referral pathways and service delivery options for endorsed ACNP role that will be applicable to Merindah Lodge
• Negotiate attendance at Tertiary Hospital clinics x 1 session / internship
  1. Falls
  2. Continence
  3. Memory
  4. Pain
  5. Geriatric

Organisational Duty Responsibilities

Hours of Work: As agreed to by Candidate and Unit Manager

• Respond to RACF referrals through RACF / GP
• Comprehensive geriatric Assessment on Admission to the service
• Read previous days progress notes
• Check Pathology / Radiology results
• Review medication charts
• Visit all current residents
• further assessment as needed
• Monitor the attainment of goals
• Confer management plans with RACF staff / GP / Geriatric specialist as needed
• Skill development
• Review of remote service delivery options
• Other activities as deemed necessary by the Unit Manager/Mentor
Year 2 – Internship Placement 5: Lyndoch Living - Community Based Residential Aged care Facility – 16 Weeks

Operational Supervision: Lyndoch Living Nurse Unit Manager

Mentor/s: SWH Geriatrician, supported by SWH Pharmacist, GP [to be identified in context of RACF work], ACAS team member, and other aged care health professionals as needed

Key Learning Objectives

- To independently undertake a CGA, make provisional diagnoses and present a treatment plan include pharmacotherapy.
- Under supervision to initiate the treatment plan including any pharmacotherapy, admission or referral.

Specific medical condition knowledge requirements

- Definition
- Epidemiology
- Clinical Presentation
- Aetiology
- Pathophysiology
- Predisposing / Risk Factors
- Assessment
  - Physical
  - Diagnostic
- Investigations
- Therapeutics
- Prescribing
- Diagnosis / Differential diagnosis
- Management / Treatment
- Outcome / Reflective Practice
- Health promotion / Preventative Medicine

Learning Outcome Measures

Assessed by Mentor

- 2 X Physical examinations
- 1 X Case Presentations at multidisciplinary Meeting
- Development and maintenance of Clinical log with weekly mentor review
- Map prospective referral pathways for endorsed ACNP role that will be applicable to RACF’s in Warrnambool
• Negotiate attendance at Tertiary Hospital clinics x 1 session / internship
  1. Falls
  2. Continence
  3. Memory
  4. Pain
  5. Geriatric

Organisational Duty Responsibilities

Hours of Work: As agreed to by Candidate and Unit Manager

• Respond to Community / GP / Community Aged Psychiatric referrals
• Update with ingoing patient notes
• Check Pathology / Radiology results as needed
• Visit all clients according to diary
• further assessment as needed
• Monitor the attainment of goals
• Confer management plans with appropriate specialist / GP / psychiatrist
• Admission of new patients
• Skill development
• Attend session/s with Aged Care Assessment Services team
• Other activities as deemed necessary by the Unit Manager or delegate
APPENDIX 3 – ACNP 5 YEAR PLAN

SWH WARRNAMBOOL AGED CARE NURSE PRACTITIONER [ACNP] PROJECT – MARCH 2013

5 Year Plan - 2012-2017

The 5 Year Plan provides a record of completed Project Deliverables, and serves as a guide for the ongoing work needed to recruit and support ACNP Candidate/s through the Internship phase to full endorsement, and to fully implement Stages 1 & 2 of the SWH ACNP Model of Care.

The plan includes:

- Quarterly reviews of Internship progress and Candidate Support, by the ACNP Project Group
- End of Placement Evaluations with Candidate, Mentor, and Unit Manager
- Management of Placement Transitions by Director of Nursing
- Submission of 6 monthly Candidate Log to Victorian Department of Health
- 6 monthly strategic supervision of Candidate with Director of Nursing
- Annual Review of SWH ACNP Model of Care
- Regular update of 5 Year Plan, and ...
- Other strategic change and evaluation points

It is acknowledged that much can change in 5 years, and many eventualities will not have been anticipated. It is with this in mind that the ACNP Project Group will continue to monitor and update this Plan, plus provide the pivotal support and guidance needed for the ongoing development of the ACNP role/s, and the implementation of Stages 1 & 2 of the SWH ACNP Model of Care.

Change is inevitable, except from vending machines.

- Unknown

The Plan begins on the following page.
### SWH ACNP 5 YEAR PLAN – 2012-2017 as at March 2013

<table>
<thead>
<tr>
<th>YEAR</th>
<th>DATE</th>
<th>ACTIVITY</th>
<th>RESPONSIBILITY</th>
<th>METHOD</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>October</td>
<td>Commence ACNP Project</td>
<td>Project Officer</td>
<td>Create Project Brief, Project Plan &amp; Timeline</td>
<td>Done</td>
</tr>
<tr>
<td>2012</td>
<td>October</td>
<td>ACNPC Expressions of Interest</td>
<td>Director of Nursing and Project Officer</td>
<td>Review Expressions of Interest from previous advertising; identify and liaise with potential Candidate/s</td>
<td>Done</td>
</tr>
<tr>
<td>2012</td>
<td>October-November</td>
<td>Desktop research</td>
<td>Project Officer</td>
<td>Review relevant Journal articles and Reports</td>
<td>Done</td>
</tr>
<tr>
<td>2012</td>
<td>October - December</td>
<td>Consult within sector</td>
<td>Project Officer</td>
<td>Meet with a selection of “like” organisations who have appointed an ACNP Candidate and/or an endorsed ACNP. Review Models of Care, Scope of Practice, and outcomes.</td>
<td>Done</td>
</tr>
<tr>
<td>2012</td>
<td>October - December</td>
<td>Investigate local demand and service gaps</td>
<td>Project Officer</td>
<td>Conduct stakeholder surveys and analyse data.</td>
<td>Done</td>
</tr>
<tr>
<td>2012</td>
<td>December</td>
<td>Review Hospital Data</td>
<td>Project Officer</td>
<td>Analyse hospital discharge data for information about: admission numbers, length of stay, source of admission, and diagnoses, for people aged 65 and over.</td>
<td>Done</td>
</tr>
<tr>
<td>2012</td>
<td>December</td>
<td>Convene Project Support Group</td>
<td>Director of Nursing</td>
<td>Bring together an array of key stakeholders to assist in developing the SWH ACNP Framework, Model of Care, Scope of Practice, Candidate Internship and Support.</td>
<td>Done</td>
</tr>
<tr>
<td>2012</td>
<td>December</td>
<td>Brief Project Support Group</td>
<td>Project Officer</td>
<td>Provide Group with: Project overview, summary of stakeholder feedback and hospital data, sample models of care, and Group Agenda/Action Steps.</td>
<td>Done</td>
</tr>
<tr>
<td>2012</td>
<td>December</td>
<td>Develop broad SWH ACNP Framework</td>
<td>Project Officer</td>
<td>Work with Project Group to create a broad Framework that encompasses the identified needs of stakeholders [including SWH], and can be used to stimulate, guide and underpin development of the Model of Care.</td>
<td>Done</td>
</tr>
<tr>
<td>YEAR</td>
<td>DATE</td>
<td>ACTIVITY</td>
<td>RESPONSIBILITY</td>
<td>METHOD</td>
<td>STATUS</td>
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</tr>
<tr>
<td>2013</td>
<td>January</td>
<td>Develop Model of Care</td>
<td>Project Officer</td>
<td>Work with the Project Group to develop a realistic Model of Care that takes into account the attributes of the Framework and the identified stakeholder needs.</td>
<td>Done</td>
</tr>
<tr>
<td>2013</td>
<td>February</td>
<td>Develop Scope of Practice</td>
<td>Project Officer</td>
<td>Work with the Project Group to develop a Scope of Practice that fits the Model of Care.</td>
<td>Done</td>
</tr>
<tr>
<td>2013</td>
<td>February</td>
<td>Develop Internship and Support Plan</td>
<td>Project Officer</td>
<td>Work with the Project Group and Unit Managers to develop an Internship Plan that provides appropriate learning opportunities, support, and clinical pathway toward endorsement for an ACNP Candidate who will also be undertaking Masters of Nursing study.</td>
<td>Done</td>
</tr>
<tr>
<td>2013</td>
<td>March</td>
<td>Finalise 5 Year Plan</td>
<td>Project Officer</td>
<td>Confirm 5 Year Plan with Project Group</td>
<td>Done</td>
</tr>
<tr>
<td>2013</td>
<td>March</td>
<td>Final Project Report for Department of Health</td>
<td>Project Officer</td>
<td>Combine key documents within a Project Report, and submit Project Report to the Department of Health</td>
<td>Done</td>
</tr>
<tr>
<td>2013</td>
<td>March</td>
<td>End of Project Officer role</td>
<td>Project Officer</td>
<td>Handover of ongoing activity to Director of Nursing and Project Support Group for recruitment of 2013 Candidate, and management of 5 Year Plan</td>
<td>Done</td>
</tr>
<tr>
<td>2013</td>
<td>April</td>
<td>Budget acquittal for Model Development Project</td>
<td>Director of Nursing</td>
<td>Submit to the Department of Health on half page excel spreadsheet</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>April</td>
<td>Recruit 2013 Candidate</td>
<td>Director of Nursing</td>
<td>Commence formal recruitment for a 2013 Candidate</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>TBA</td>
<td>Appointment Advice</td>
<td>Director of Nursing or Delegate</td>
<td>Confirm appointment of ACNP Candidate to Department of Health via email.</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>TBA</td>
<td>5 Year Plan</td>
<td>Director of Nursing or Delegate</td>
<td>Update dates in 5 Year Plan to align with key stages of Candidacy</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>TBA</td>
<td>Implement round 1 Internship Placement/s</td>
<td>Director of Nursing or Delegate</td>
<td>2013 Candidate starts round 1 Internship Placement/s</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>TBA</td>
<td>Quarterly review of Internship progress and 2013 Candidate Support Plan</td>
<td>Project Group Representative, clinical supervisor/s and other mentors</td>
<td>Meet with Candidate to discuss Internship and Support needs; make adjustments or other action/s where required.</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>October</td>
<td>Model of Care Stage 2</td>
<td>Project Support Group</td>
<td>Review Model of Care Stage 2, and prepare a plan for second ACNP Candidate [2014] including: recruitment of a 2014 Candidate, and application for funded support package.</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>TBA</td>
<td>6 monthly Log</td>
<td>2013 Candidate</td>
<td>Submit electronic log to Department of Health using Department Template</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>TBA</td>
<td>6 Monthly strategic supervision with 2013 Candidate</td>
<td>Director of Nursing or Delegate</td>
<td>Meet with 2013 Candidate to review Internship and academic progress and discuss Candidate needs.</td>
<td></td>
</tr>
<tr>
<td>YEAR</td>
<td>DATE</td>
<td>ACTIVITY</td>
<td>RESPONSIBILITY</td>
<td>METHOD</td>
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<td>2013</td>
<td>TBA</td>
<td>Evaluate Learning Outcomes from round 1 Placement/s</td>
<td>Operational Manager &amp; Mentor - Placement 1</td>
<td>Meet with 2013 Candidate to review and document learning outcomes</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>TBA</td>
<td>Placement Transition</td>
<td>Director of Nursing or Delegate</td>
<td>Oversee formal arrangements for 2013 Candidate to transition from Placement 1, to Placement 2</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>TBA</td>
<td>Quarterly review of Internship progress and 2013 Candidate Support Plan</td>
<td>Project Group Representative, clinical supervisor/s and other mentors</td>
<td>Meet with 2013 Candidate to discuss Internship and Support needs; make adjustments or other action/s where required.</td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>TBA</td>
<td>Prepare for second ACNP Candidate, to align with Model of Care Stage 2</td>
<td>Project Support Group</td>
<td>Confirm 2014 Candidates; provide information and support for enrolment [if needed]; develop Internship and Support Plan based on Model of Care and learning from current Internship.</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>TBA</td>
<td>5 Year Plan - Update</td>
<td>Project Support Group</td>
<td>Review and update 5 year plan to incorporate 2014 ACNP Candidate activity/needs, including: Internship Plan, mentoring, supervision, support, assessment and reporting activities.</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>TBA</td>
<td>Appoint 2014 Candidate</td>
<td>Director of Nursing</td>
<td>Formal commencement of role</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>TBA</td>
<td>Evaluate Learning Outcomes from round 2 Placement/s</td>
<td>Operational Manager &amp; Mentor – Placement 2</td>
<td>Meet with 2013 Candidate to review and document learning outcomes</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>TBA</td>
<td>Quarterly review of Internship progress and 2013 Candidate Support Plan</td>
<td>Project Group Representative, clinical supervisor/s and other mentors</td>
<td>Meet with 2013 Candidate to discuss Internship and Support needs; make adjustments or other action/s where required.</td>
<td></td>
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<tr>
<td>2014</td>
<td>TBA</td>
<td>Placement Transition</td>
<td>Director of Nursing or Delegate</td>
<td>Oversee formal arrangements for 2013 Candidate to transition from Placement 2, to Placement 3</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>TBA</td>
<td>6 Monthly strategic supervision with 2013 Candidate</td>
<td>Director of Nursing or Delegate</td>
<td>Meet with 2013 Candidate to review Internship and academic progress and discuss Candidate needs.</td>
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</tr>
<tr>
<td>2014</td>
<td>TBA</td>
<td>6 monthly Log</td>
<td>2013 Candidate</td>
<td>Submit electronic log to Department of Health using Department Template</td>
<td></td>
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<tr>
<td>2014</td>
<td>TBA</td>
<td>Placement Transition</td>
<td>Director of Nursing or Delegate</td>
<td>Oversee formal arrangements for 2013 Candidate to transition from Placement 3, to Placement 4</td>
<td></td>
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<tr>
<td>YEAR</td>
<td>DATE</td>
<td>ACTIVITY</td>
<td>RESPONSIBILITY</td>
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<tr>
<td>2014</td>
<td>TBA</td>
<td>Evaluate Learning Outcomes from 2013 Candidate for round 3 Placement/s</td>
<td>Unit Manager/s Placement 3</td>
<td>Meet with 2013 Candidate to review and document learning outcomes</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>TBA</td>
<td>Placement Transition</td>
<td>Director of Nursing or Delegate</td>
<td>Oversee formal arrangements for 2013 Candidate to transition from Placement 3 to Placement 4</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>TBA</td>
<td>6 monthly Log</td>
<td>2013 Candidate</td>
<td>Submit electronic log to Department of Health using Department Template</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>TBA</td>
<td>Quarterly review of Internship progress and 2013 Candidate Support Plan</td>
<td>Project Group Representative, clinical supervisor/s and other mentors</td>
<td>Meet with 2013 Candidate to discuss Internship and Support needs; make adjustments or other action/s where required.</td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>TBA</td>
<td>6 Monthly strategic supervision with 2013 Candidate</td>
<td>Director of Nursing or Delegate</td>
<td>Meet with 2013 Candidate to review Internship and academic progress and discuss Candidate needs.</td>
<td></td>
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<tr>
<td>2014</td>
<td>TBA</td>
<td>Start Transition Planning for 2013 Candidate moving towards fully endorsed ACNP status in April 2015.</td>
<td>DON, Project Group Representative/s, Other?</td>
<td>Meet with 2013 Candidate to: give support for endorsement application; prepare transition plan for 2013 Candidate to move to endorsed ACNP role in 2015; review and update Model of Care Stage 1 [including scope of practice and formulary]; review plan to meet ongoing support needs for endorsed ACNP in 2015.</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>TBA</td>
<td>Evaluate Learning Outcomes from round 4 Placement/s</td>
<td>Unit Manager/s Placement 4</td>
<td></td>
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<tr>
<td>2015</td>
<td>TBA</td>
<td>Placement Transition</td>
<td>Director of Nursing or Delegate</td>
<td>Oversee formal arrangements for 2013 Candidate to transition from Placement 4 to Placement 5</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>TBA</td>
<td>Quarterly review of Internship progress and 2013 Candidate Support Plan</td>
<td>Project Group Representative, clinical supervisor/s and other mentors</td>
<td>Meet with 2013 Candidate to discuss Internship and Support needs; make adjustments or other action/s where required.</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>TBA</td>
<td>Final review of 2013 Candidate Internship, and confirm pathway to fully endorsed ACNP role</td>
<td>Project Group Representative, clinical supervisor/s and other mentors</td>
<td>Project Group and others meet with 2013 Candidate for: final review of Internship; progress report and support for endorsement application; bridging extension of Candidacy role if appropriate while awaiting endorsement; ready for transition to Model of Care Stage 1, and ongoing support plan for endorsed ACNP role.</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>TBA</td>
<td>Final 6 monthly Log</td>
<td>2013 Candidate</td>
<td>Submit electronic log to Department of Health using Department Template</td>
<td></td>
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<tr>
<td>2015</td>
<td>TBA</td>
<td>Appoint 2013 Candidate as endorsed ACNP - Stage 1</td>
<td>Director of Nursing</td>
<td>Appoint fully endorsed ACNP, and oversee formal transition plan to Model of Care Stage 1.</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>TBA</td>
<td>Quarterly review of Endorsed ACNP role and Support Plan</td>
<td>Project Group Representative, clinical supervisor/s and other mentors</td>
<td>Meet with endorsed ACNP to discuss ongoing support needs and take action/s where required.</td>
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<td>Quarterly review of Endorsed ACNP role and Support Plan</td>
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<td>Meet with endorsed ACNP to discuss ongoing support needs and take action/s where required.</td>
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<tr>
<td>2015</td>
<td></td>
<td>6 Monthly strategic supervision with ACNP</td>
<td>Director of Nursing or Delegate</td>
<td>Meet with ACNP to review outputs and support needs.</td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>December</td>
<td>Annual ACNP Evaluation Report</td>
<td>ACNP</td>
<td></td>
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</tr>
<tr>
<td>2016</td>
<td>TBA</td>
<td>Quarterly review of Endorsed ACNP role and Support Plan</td>
<td>Project Group Representative, clinical supervisor/s and other mentors</td>
<td>Meet with endorsed ACNP to discuss ongoing support needs and take action/s where required.</td>
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<td>Quarterly review of Endorsed ACNP role and Support Plan</td>
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<td>TBA</td>
<td>6 Monthly strategic supervision with ACNP</td>
<td>Director of Nursing or Delegate</td>
<td>Meet with ACNP to review outputs and support needs.</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>TBA</td>
<td>Appoint 2014 candidate as endorsed ACNP - Stage 2</td>
<td>Director of Nursing</td>
<td>Appoint fully endorsed ACNP, and oversee formal transition plan to Model of Care Stage 2.</td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>TBA</td>
<td>Quarterly review of Endorsed ACNP role and Support Plan</td>
<td>Project Group Representative, clinical supervisor/s and other mentors</td>
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<tr>
<td>2016</td>
<td>November</td>
<td>Annual Model of Care Review</td>
<td>Project Group &amp; ACNP/s</td>
<td>Review Model of Care including scope of practice and formulary.</td>
<td></td>
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<tr>
<td>2016</td>
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</table>