Victorian Nurse Practitioner Project
Round 4.13 – Nurse Practitioner Models, Primary and Community Settings: Aged Care and Chronic Disease Management.

Alfred Health
Aged Care Nurse Practitioner Model of Care Report

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**Deliverable 1: Proposed Model of Care**

**Background**

This report will describe the model of care for the implementation of an Aged Care Nurse Practitioner (ACNP) role at Alfred Health.

The Mobile Assessment and Treatment Service (MATS) was introduced in Alfred Health in 2001, and is situated within the Hospital Admission Risk Program (HARP) with an aim of preventing avoidable hospital presentations.

MATS is a rapid response out-reach service providing care to clients in residential aged care facilities (RACF) or to the aged living independently in the community. MATS care is short term and episodic; managing clinical presentations that range from complex geriatric conditions and syndromes to ambulatory sensitive conditions common to a broader demographic. Referrals are received by the MATS intake nurse and triaged according to clinical acuity. Out-reach care is delivered by a Registrar and Nurse team and over-seen by the MATS Geriatrician. Dietetics provides direct care in MATS for the management of clients with Percutaneous Endoscopic Gastrostomy (PEG) tubes in a weekly session.

MATS provides a 24 hour, 7 day a week service. The operational hours are from 8 a.m. to 8 p.m. Monday to Friday and 11 a.m. to 8 p.m. on weekends. After hours and public holidays are staffed by a MATS on-call nurse who supports RACF clinical staff decision making and processes out-of-hours referrals. The MATS Geriatrician is rostered three sessions per week and the Registrars work Monday to Friday from 8am to 8pm. On weekends Emergency Department consultants or on-call Geriatricians provide medical cover and limited out-reach services.

Alfred Health MATS is well established and recognised within the organisation and by Aged Care service providers and General Practitioners in the Alfred Health catchment.

**Nurse Practitioner Roles at Alfred Health and in Aged Care**

In 2004 the first Alfred Health Nurse Practitioner (NP) role was introduced into the Emergency Department. Since this time NP roles have continued to expand into other specialties including sexual health, mental health, pain, multiple myeloma, aged psychiatry and peritoneal dialysis. 11% of the 179* endorsed Victorian NPs have developed their models of care and are employed with Alfred Health (*March 2014 data). Alfred Health has established a Nurse Practitioner Leadership Group that supports and promotes the development of NP candidates and successful implementation of NP models of care.

The Aged Care Nurse Practitioner (ACNP) will expand the range of NP specialties that operate in the organisation. The Aged Care NP role is the second NP role in the Aged Care domain to be developed in Alfred Health following the endorsement of the Aged Psychiatry Mental Health NP. However the ACNP has been an emerging role in the Aged Care Sector more broadly, prompted by the Commonwealth’s 2011 national investment for the development of ACNP roles to improve primary health care access for clients in residential facilities.
Aged Care.

The impacts of an ageing population on health service utilisation are well documented. 13% of the Australian population is aged over 65 years and 1.9% is aged over 85 years while life expectancy for Australians is steadily increasing (Australian Institute of Health and Welfare (AIHW), 2013). While not unavoidable, disability and multi-morbidity become increasingly prevalent with age. Proactively managing the health and wellbeing of the older population is essential to safeguarding quality of life in the elderly and ensuring effective health-resource utilisation (AIHW, 2013).

In 2014 AIHW reported its inaugural study of the movement between hospital and residential care in the older population. It found that 2008-09 9% of hospital admissions were for people from residential aged care, of which 90% were permanent residents. Further to this 1 in 3 admissions to residential care were from a hospital. The likelihood of admission to a RACF rises with age, with a 1% chance for those aged 65-69 years, to a 10% chance for those over 90 years of age. The main conditions leading to hospital admission from respite or a RACF were respiratory or cardiovascular in nature or due to falls related injury (AIHW, 2014).

Identifying a Service Need for the Aged Care Nurse Practitioner

There are approximately 44 residential aged care facilities (RACF) in the Alfred Health catchment, and many more special accommodations services and boarding houses. The number of referrals to MATS increases year on year with 1,232 referrals received in 2014, demonstrating a 71% increase in demand over 4 years for a service that specialises in rapid response health care for the elderly.

An ACNP model of care will address the following organisational imperatives:

Hospital demand management. Aside from the aforementioned increasing demand in MATS, there were over 1,400 presentations from RACFs to Alfred Health’s emergency departments in 2014. In reviewing the data, three broad categories of clients were identified as an appropriate starting point for the development of an ACNP model of care: infection (e.g. respiratory, cellulitis), chest pain assessment and screening and falls management and prevention. The ACNP can have an impact on hospital demand of clients from RACFs that fall into these categories through four mechanisms:

- a hospital avoidance approach through outreach to referrals from RACFs
- the rapid discharge of clients from the ED by providing hospital substituted care
- reducing length of stay in the organisation’s medical wards, by offering care in the community setting and there-by expediting flow
- illness prevention and health promotion by undertaking out-reach medication review, and providing clinical advice and education for clients and carers
Right care, right place, right clinician: Emerging hospital avoidance models such as MATS and the ACNP are well placed to manage a range of health conditions that would traditionally have been managed in the hospital setting. It is often more appropriate to manage the health care needs of the elderly client in a familiar environment than in a busy emergency department or hospital ward. Notably, people admitted to a hospital from RACFs are six times more likely to have a diagnosis of dementia affecting their hospital care, than those admitted from the community (AIHW, 2014). In such cases the value of providing care in an environment that is familiar to the client is significant.

In addition MATS works closely with clients’ usual health care providers and carers, applying a capacity building approach. The ACNP approach reflects changing community needs and takes into account the requirement to continually review our models of care so as to remain contemporary.

Enhancing the capacity of MATS: The ACNP model will enhance the capacity of the MATS medical team to focus on more complex referrals that require Geriatrician level of knowledge and skill. In this way MATS will be better able to respond to the health care needs of the elderly, to provide pre-emptive health assessment, care and referral and to avoid premature hospitalisation and/or institutionalisation. Such an approach further extends to work of MATS beyond RACFs into the community setting. It builds on a long term strategy to reduce avoidable hospital attendance through the early provision of specialised care and to proactively manage clinical and functional decline in an ageing population.

Meeting a Medical service gap in MATS: Medical Registrars are not currently rostered to work in MATS on weekends and public holidays. As a result MATS is reliant upon Medical Consultants (often Emergency Department Consultants) to provide on-call support. However after-hours Medical staff have limited capacity for out-reach visits which impacts upon the responsiveness of the service. The ability to flexibly roster an ACNP to provide some weekend coverage will enhance the responsiveness and sustainability of the MATS service.

Supporting organisational partners: Alfred Health has recently reached agreement with Hammond Care to assume the management of the 4 Alfred Health RACFs. Hammond care plans to modernise and expand these facilities. This transition of services entails a long term shared commitment to provide optimal care for Hammond Care residents including a rapid response service provided by MATS. The ACNP model of care will enhance the responsiveness of MATS for this co-located organisation.

The ACNP model of care is aligned with:
- The Commonwealth’s Aged Care Reforms
- Victorian Health Priorities framework 2012-2022: Metropolitan Health Plan
- Alfred Health’s Strategic Plan 2011-2013 statement of priorities to develop, implement and evaluate new workforce models to support patient care
Governance Structure for Nurse Practitioner Role

A local NP Steering group has been established to develop and oversee the implementation of the ACNP model of care. The Steering group is chaired by the Director of Sub-Acute and Medical Services, Rehabilitation, Aged and Community Care, Associate Professor Peter Hunter.

Other members of the steering group include:

- Clinical Services Director for Rehabilitation, Aged and Community Care; Director of Nursing & Site Coordination
- Senior Nurse Manager of Aged Persons Psychiatric Services
- Director of Community and Ambulatory Services
- Director of Pharmacy
- Clinical Services Development Manager
- MATS Geriatrician
- Community General Practitioner
- Aged Psychiatry Mental Health Nurse Practitioner
- HARP Manager

Other key stakeholders are invited to attend the group as required. These may include Pathologists, Radiologists, Allied Health Professionals, a RACF representative and consumer representative/s.

The Alfred Health has a clinical program based organisational structure and the ACNP role is aligned with the Rehabilitation, Aged and Community Care Program. The ACNP will report to the Director of Sub-Acute and Medical Services, Rehabilitation, Aged and Community Care in relation to clinical practice and to the Clinical Services Director for Rehabilitation, Aged and Community Care; Director of Nursing & Site Coordination for professional scope of practice nursing issues. The local NP steering group will report on progress six monthly to the Alfred Health Nursing Scope of Practice Committee.

Nurse Practitioner Scope of Practice

The ACNP will focus on improving access for clients in RACFs and in the community to specialist gerontic care so as to prevent avoidable hospital admissions. The ACNP model, providing out-reach as part of the MATS service, will address the needs of three clinical cohorts: conditions related to infection (respiratory infection, cellulitis), chest pain assessment and screening, and clients experiencing or at risk of falls including implementation of falls prevention management and assessment and intervention in falls related injury.

The role of the ACNP in assessing and managing the identified patient groups will incorporate the following (including extensions to advanced practice):

- Comprehensive knowledge base and assessment skills to diagnose and treat chronic and complex health conditions, determine differential diagnoses including consideration of the impact of co-morbidities in the elderly population
- Complex decision making
- Ordering of diagnostic tests/pathology and interpretation of results
- Development of acute treatment and management plans informed by evidence based practice and in collaboration with other key interdisciplinary team members involved in the resident's care
- Prescribing (and de-prescribing as required), utilising the ‘Acute and Supportive’ & ‘Care of the Older Person’ formularies
- Generation of referrals to Medical and Surgical Specialists, Specialist Clinics, Cognitive Dementia & Memory Service (CDAMS), Neuropsychology, Aged Person’s Mental Health Services, Continence Services, Allied Health service providers and others as appropriate.
- Admission and referral to health services for treatment and to escalate care, including direct admission to sub-acute services
- Provision of health promotion education to residential care clients, carers/families and residential care facility staff

**Integration of the ACNP into the MATS team and work environment**

The ACNP will be based at The Alfred hospital and will be a full time position; working 8 hour shifts and operating on a rotational roster including weekends. The role will work collaboratively within the MATS team providing outreach clinical care for elderly patients.

The ACNP will engage with a broad range of health care professionals and key stakeholders across the acute, community, residential and primary care sectors to collaboratively plan and implement care of elderly patients under their purview. The role will contribute to team handover meetings and consult with the MATS Geriatrician who will provide the ACNP day to day mentorship and clinical supervision. The ACNP will also lead in the provision of education and up-skilling of facilities staff, clients and carers in the prevention and management of falls.

**Mentorship and Continuing Professional Development (CPD) Arrangements**

The ACNP candidate will be supported by the primary medical mentor and clinical supervisor Associate Professor Peter Hunter. The medical mentor will ensure the ACNP candidate’s clinical skills, knowledge and scope of practice matches the needs of the elderly patients under their care. Secondary medical mentors (MATS Geriatrician and Registrar) will be available to provide clinical support on a day to day basis. The ACNP will also be allocated an NP mentor, who will assist with the development of the role and the model of care. Furthermore the ACNP steering group will provide ongoing direction and support of the role. Additional mentorship and CPD strategies include:

- Attending relevant Geriatric registrar training program sessions
- Establishing close networks with Aged Care Nurse Practitioners in Victoria and the Victorian Older Persons Nurse Practitioner Collaborative
- Membership of the Alfred Health NP Leadership Group for additional support and networking opportunities within the organisation.
- Attending regular aged care seminars and International Conferences to learn about current aspects of treatment, care and management aged care clients.

A structured continuing professional development program (CPD) will be developed for the NP for any areas where their scope of practice is to be extended. The education modules will be based on the Emergency Department NP CPD program at The Alfred.
## Deliverable 2: 5 Year Plan

### Year 1
- NP service model development, appointment of an Aged Care NP (endorsed preferred)
- Development of supervision and mentorship program and commencement of continuing professional development program, as required
- Submission of Stage 2 NP role development application to Alfred Health Scope of Practice Committee for approval
- Formalisation of governance structure for NP role
- Development of NP scope of practice guidelines and NP drug formulary
- Establishment of service evaluation framework

### Year 2
- Annual review against NP service deliverables and development
- Submission of NP Scope of Practice Guidelines and drug formulary for endorsement and approval
- Annual review and succession planning, workforce requirement and model evolution

### Year 3
- Further development of the scope of practice of the NP based on service gaps and client need for e.g.:
  - Assessment and management of Functional Decline and Geriatric Syndromes
  - Coordination of short term, interim palliative care requirements for clients in RACFs

### Year 4
- Scoping the potential for a second NP role in MATS
- Consideration of expansion of the NP role to partner with the Caulfield Hospital Aged Care Assessment Service

### Year 5
- Ongoing review of the service and plans for service evolution
References


