VICTORIAN NURSE PRACTITIONER PROJECT (VNPP)

PHASE 4

ROUND 4.2 & 4.3

FINAL REPORT

NOVEMBER 2008
Author

This report has been put together by Annette Coutts, Nurse Practitioner Renal Care Model Development Project Officer, Austin Health.

Acknowledgements

The project officer would like to acknowledge the Nurse Practitioner Renal Care Model Development Steering Committee and the assistance with developing the Transitional Model of Care for Renal at Austin Health. The Director of the Medical and Emergency Clinical Service Unit (CSU) and the Medical Director of Nephrology for their commitment to the development of a Nurse Practitioner role in Renal care and the support of all the Nurse Unit Managers (NUM’s).

A big thank you to Nonie Rickard for all the work she did on Austin Health’s Nurse Practitioner Service Plan Development Project Phase 3, Round 6. Melissa Stanley and Marg Morris, Renal Nurse Practitioners St Vincent’s Hospital, for their help in putting me on the right track as well as their support. Also, the Phase 3 Service Plans of the Royal Women’s Hospital and Western Hospital.

Invaluable information obtained from the Nurse Practitioner Renal Care Collaborative and the Nurse Practitioner Stroke Care Collaborative.

GLOSSARY OF TERMS

For the purpose of this report:

Renal Care refers to all treatment, care or management needed for the patient with chronic kidney disease requiring dialysis.

Non-specialist medical (workforce) practitioner refers to registrars, HMO,s and interns
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EXECUTIVE SUMMARY

Austin Health, one of Australia’s leading teaching facilities and medical research centres, has 930 beds across 3 campuses and provides acute tertiary referral services, an extensive range of specialty and super-speciality services, mental health services, and subacute services including aged care, rehabilitation and palliative care.

Austin Health has embraced the concept of implementing the Nurse Practitioner role in service provision. This has caused us to question whether we are currently providing the service in the most patient focussed way and delivering maximal outcomes. The Nephrology Unit has explored the validity of implementing a Nurse Practitioner role in a range of clinical settings throughout renal dialysis. As chronic kidney (CKD) disease has now become a growing and significant public health issue across Australia. CKD contributes to a substantial burden of illness and premature mortality in Australian adults.

The Nephrology Unit, Austin Health took up the challenge to develop a Nurse Practitioner Renal Care Model. A project team was formed with a Project Officer and Executive Lead and Steering Committee to explore a NP Renal Care Role.

The outcome statement for the project was to:

*Develop a service model of care for a Nurse Practitioner role in Renal Care. The model will define the scope of practice, identify the key responsibilities of a NP service in maintenance haemodialysis and how the model of care will be delivered.*

In an effort to gather information about perceived service gaps a focus group was conducted with key renal staff and representatives. The aim of the particular group was to explore, from a choice of 4 areas of renal care, where clinical support would form a process by which the patient and the medical professional’s are cooperatively involved in the patient’s ongoing health care management and quality care.

A number of service gaps were identified in the areas explored including:

- initial referral
- assessment and admission
- managing perceptions and expectations of patients
- inability to provide a vascular review of country patients
- predialysis and the capacity for patient follow-up.

With this in mind, the group then went onto healthy debate about the merits of a Nurse Practitioner in Renal Care, and the concepts discussed were funding, candidate selection, continuing academic focus, medical collaboration and maintaining good patient outcomes.

The top 4 areas of renal care the focus group members identified with service gaps, were then analysed by the undertaking of a SWOT Analysis in an effort to identify the area of renal care, with the most strengths in which to implement the NP Renal Care role.

Some gaps were identified with the current process of patients commencing dialysis in the Central Dialysis Unit and moving onto one of the four metropolitan satellite units. The NP Transition Care Service would help with the patients commencing renal dialysis in the Central Dialysis Unit (CDU). Working collaboratively with nursing staff and develop partnerships with the medical staff. The NP will assist with assessment, consenting for treatment, making referrals for an AV fistula, assisting and
reinforcing nursing staff’s education on modalities and writing dialysis orders and developing clinical management plans. Whilst working with the patient to make choices about their future dialysis needs.

A NP would be able to work closer with the patient, give them the power to make choices about their care and to help the process to flow and decrease the number of medical reasons the patient needs to be transferred back to CDU. This NP role will be an extension of existing services thus, extend capability of the hospital non-specialist medical workforce (medical practitioner).

The model of care is a nursing model of routine renal dialysis care, undertaken by the Renal Dialysis Nurse and medical review, assessment, diagnosis and treatment prescribing in collaboration and partnership with the medical practitioner, nursing staff and patient. It would be expected that the NP would reduce current service gaps with an emphasis on earlier medical treatment and stabilisation of the patient to an improved optimal renal state. The NP with their expert clinical knowledge and extensions to practice would provide substantial assistance and improvement to the patient’s treatment and their path of care. They will not perform the dialysis treatment, but rather, assist with the ordering of treatments and maintenance issues to ensure appropriate care, management and sustaining a quality of life on maintenance dialysis.

A Transition Model of Care for patients, undergoing maintenance dialysis and their families, is the area that the NP scope of practice has been developed. A scope of practice for the NP Renal Care has been clearly set out and formularies for medications, pathology and radiology have been defined. Other areas of the scope of practice are assessment and referral which have also been developed.

The implementation of a Nurse Practitioner tier to the nursing career structure is relatively new and would be a new position for renal care. Evaluating the Nurse Practitioner Role in Renal Care is imperative, in order to comprehensively demonstrate the value of the position and inform the future planning of further advanced practice roles. Therefore, evaluation of the service model and monitoring of the service delivery would be ongoing with changes and improvements made as the role evolves. This will promote establishing the best practice for the NP Renal Care and the Renal Transition Model of Care. A full evaluation framework has been incorporated into the model.

The budget modelling and requirements (as set out in the report) will be based on a Grade 5 Year 2 Clinical Consultant plus on costs and qualification allowances, for the NP candidate. Endorsed NP’s in their first year will be paid as a Grade 6 Year 1, plus on costs and qualification allowances. In their second year of endorsement the salary rate will be that of a Grade 6 Year 2.

Austin Health’s NP Service Plan was adopted for the education of NP candidates to endorsement. Services and resources identified in the service plan such as, the HMO training programme, NP peer support group and Renal Care collaboration will be part of the NP education program.

Supporting the implementation of NP roles in health services has a significant cost barrier as it takes time of the candidate to be endorsed and at a level where they can operate more independently, hence, achieving the improved patient care goals. Previous seed funding provided by DHS has been a key success in the implementation to such roles and has enabled Austin Health to implement a number of NP roles and current candidates. In the current climate it is difficult to see how further implementation will be possible without financial support from DHS.
NURSE PRACTITIONER’S ROLE IN THE TRANSITION MODEL OF CARE

Austin Health’s NP Model of Care for Renal will be a Transition Model of Care. The evolution of the transition will be with the patient commencing dialysis, in the Central Dialysis Unit (CDU), to maintenance renal dialysis in a home or satellite setting.

The model of care is a nursing model of routine renal dialysis care, undertaken by the Renal Dialysis Nurse and medical review, assessment, diagnosis and treatment prescribing in collaboration and partnership with the medical practitioners (nephrologists and non-specialist medical practitioners), nursing staff and patient. It would be expected that the NP would reduce current service gaps with an emphasis on earlier interventions and stabilisation of the patient to an improved optimal renal state. The NP with their expert clinical knowledge and extensions to practice would provide substantial assistance and improvement to the patient’s treatment and their pathway of care. They will not perform the dialysis treatment, but rather, assist with the ordering of treatments and maintenance issues to ensure appropriate care, management and sustaining a quality of life on maintenance dialysis.

The NP will also provide immense support to the nursing staff in their provision of the renal care ordered and education. In saying this, the NP is not a doctor substitute but rather, a complementary service. The NP remains part of a nursing role and a nursing model of care.

Scope of Practice

The scope of practice will:

- Assist the renal management of a designated, specific renal patient population in commencing renal dialysis, in the Central Dialysis Unit (CDU) and satellite units
- The practitioner will reinforce the education provided at the Predialysis Clinic and by the nursing staff about the renal modalities available to the patient
- The NP will be an active member of the Dialysis Unit and so will work throughout the unit areas (CDU and metropolitan satellites)
- Assist patients in the transition to a dialysis satellite or other modalities for training.
- At the satellite, the NP will be responsible for managing within the parameters of specific renal markers the renal dialysis of the patient, defined within the triage criteria (reflected in the inclusion/exclusion criteria listed in each CPG) with the Nurse Unit Manager (NUM). Also, they will provide a constant point of reference for the patient and nursing staff, throughout the patient’s episode of care, for the diagnosis and ordering of treatment as determined by assessments made by the nursing staff.
- Provide opportunities to continue to develop their new skills to manage the changing needs of the renal patient population.

Who

The Endorsed Nurse Practitioner Renal Care - A nurse with expert clinical care in Renal Care and extensions to practice authorised by the NBV or a NP Candidate.

What

A Transition Model of Care for the patient commencing on renal dialysis and moving onto maintenance dialysis in a satellite program. As well, manage the renal wellbeing of maintenance dialysis patients at the four metropolitan Austin Health renal satellites as defined within the triage criteria (reflected in the inclusion/exclusion criteria listed in each CPG) with the Nurse Unit Manager (NUM).
Rational: Improving continuity of care across the renal dialyses spectrum and the delivery of health services.

How
Routine Renal Dialysis Care provided by the NP will involve:

- Referrals to and consultations with the Vascular Access Nurse in relation to the renal nurses assessments of the AV fistula
- Reviewing and ordering dialysis according to the patients Cardiovascular/fluid levels measured by the renal nurse
- Make referrals to the Anaemia Coordinators and order treatments as requested by them
- Order specific renal bone disease pathology tests and assess results. Develop a plan of care including prescribing treatment for low calcium and phosphate levels. Assist the renal nurse with educating the patient about phosphate binders. Any pathology ordered for private patients needs to be countersigned by a Medical Practitioner (NP candidates and Endorsed NP) this is to ensure Medicare payments to the hospital.
- Vaccination history-Hep B, Ab level-order tests yearly and as required
- Writing up and adjusting Haemodialysis Orders as required
- Prescribe routine renal dialysis medications as listed on the Renal Medication Formulary (Appendix 6). For private patients countersigned by a Medical Practitioner. NP candidates need to have everything they are prescribing, countersigned by a Medical Practitioner and both NP Candidates and NP Endorsed need to have any medication outside of the Renal Medication Formulary ordered by a Medical Practitioner.

Amendment to Victorian legislation means endorsed Nurse Practitioners (NP) can prescribe substances for which they have received approval under the Drugs, Poisons and Controlled Substances (DPCS) Act 1981. The Austin Health’s pharmacy website contains guidelines on medication prescribing and dispensing and policies on medication administering. The NP needs to be aware of the guidelines and policies and of the DPCS Regulations governing their prescribing practices. They also need to take steps to minimise the possibility of prescribing errors and be aware of the factors contributing to errors (NBV 2005).

- Undertake patient treatment assessments, diagnosing and order routine renal dialysis pathology tests, electrocardiograms (ECG), fistulograms and duplex ultrasounds in the vascular laboratory. Interpret the results of the tests and develop clinical management plans (NP candidate needs to have tests countersigned by a Medical Practitioner)
  Referral for diagnostic testing is initiated according to criteria defined in the individual CPG’s guiding the NP practices. Diagnostic testing outside the tests stated above is to be ordered by a Medical Practitioner.
- Refer patients to Austin Health’s Emergency Department and Vascular Department (in consultation with the Vascular Access Nurse) only
  Admission occurs as a result of consultation with the Dialysis Consultant Nephrologist/Unit Head for each individual case assessed. The NP may write internal referrals (ED, Vascular Unit) without countersigning by a Medical Practitioner. Referrals for any clinics or external medical specialists (private), the referral must be made by a Medical Practitioner including their provider number.
- It is not usual practice that patients will be discharged from dialysis treatment units so the discharging of patients would not be a function required to be undertaken by the NP Renal Care.
- Provide and authorise Certificates of Absence
- Leadership/Educator
  Patient, renal staff and community
  Self-education and ongoing skills development
- Counselling/Advocacy
  Patient, family and carers
  Psychosocial issues and liaising with the primary nurse
  Support and reinforce the primary nurse’s education and counselling in end of life choices (Respecting Patient Choices-a program of Austin Health)
- Researcher
  Publication-Write about the process of your role implementation
• Administration/Management
  Development and maintenance of Clinical Practice Guidelines (CPG)
  Change management skills and redesign work

When
The Nurse Practitioner Renal Care will work with patients:

1. On commencing renal dialysis in the Central Dialysis Unit and until their renal condition stabilises (as determined by the multidisciplinary team) for transition to a satellite maintenance dialysis program or other renal modality
2. Undertaking maintenance dialysis at the 4 metropolitan satellite units of Austin Health, as defined by the triage criteria with the Nurse Unit Manager
3. Monday to Friday regular work hours; 40 hours inclusive of ADO.

Where
The dialysis units are as follows:

- Central Dialysis Unit (CDU)-Ward 7ND
- Repat Dialysis Unit (RDU)-Heidelberg
- North East Kidney Service (NEKS)-Preston
- Dialysis Training Unit (DTU)-Preston
- Epping Dialysis Unit (EDU)-Epping
## MODEL OF CARE SUMMARY

### PATIENT POPULATION

<table>
<thead>
<tr>
<th>Work Area</th>
<th>Service Need</th>
<th>Inclusion Criteria</th>
<th>Exclusion Criteria</th>
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<tbody>
<tr>
<td><strong>Central Dialysis Unit</strong></td>
<td>Stabilisation of patient commencing renal dialysis</td>
<td></td>
<td>Public &amp; Private patients</td>
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<tr>
<td></td>
<td>Modality education</td>
<td>(NP to establish in consultation with the NUM's)</td>
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<td></td>
<td>Counselling</td>
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<tr>
<td><strong>Repat Dialysis Unit</strong></td>
<td>Routine renal dialysis care</td>
<td>Public &amp; Private patients</td>
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<td></td>
<td>Promotion of renal modalities</td>
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<td>Counselling</td>
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<tr>
<td><strong>North Eastern Kidney Service</strong></td>
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<td>Public &amp; Private patients</td>
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<td>Promotion of renal modalities</td>
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<td></td>
<td>Counselling</td>
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<td><strong>Day Treatment Unit</strong></td>
<td>Routine renal dialysis care</td>
<td>Public &amp; Private patients</td>
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<td></td>
<td>Promotion of renal modalities</td>
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<td>Counselling</td>
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<tr>
<td><strong>Epping Dialysis Unit</strong></td>
<td>Routine renal dialysis care</td>
<td>Public &amp; Private patients</td>
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<td></td>
<td>Promotion of renal modalities</td>
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<td></td>
<td>Counselling</td>
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### SCOPE OF PRACTICE (Applicable to all public (non-billable) patients within Nurse Practitioners defined population)

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Radiology</th>
<th>Pathology</th>
<th>Assessment</th>
<th>Referral</th>
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<tbody>
<tr>
<td>Prescribe from the Renal Nurse Practitioner formulary. PBS/S100 countersigned Heparin Locks.</td>
<td>Request: Duplex ultrasound Fistulogram ECG</td>
<td>Request: U&amp;E, LFT, FBE, Routine Blood Glucose, Albumin Ca, PO4 HbA1c, Lipids-HDL, LDL Post dialysis urea iron studies, Red Cell Folate TIBC PTH B12 Hep B, C, HIV Se aluminium Magnesium TSH, T3, T4 FT4</td>
<td>Advanced assessment of: Vascular access Fluid/Cardiovascular issues Anaemia Bones Vaccination history Hep B Ab level Haemodialysis orders Provide and authorise</td>
<td>Refer to: Vascular Access Nurse Anaemia Coordinator Vascular Unit Austin Health Emergency Department Discharge by consultation with the Multidisciplinary Team Certificates of Absence</td>
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PROJECT ESTABLISHMENT ACTIVITIES

HEALTH SERVICE OVERVIEW

Austin Health, one of Australia’s leading teaching facilities and medical research centres, comprises three hospitals, the Austin Hospital in Heidelberg, the Heidelberg Repatriation Hospital in Heidelberg West and the Royal Talbot Rehabilitation Centre in Kew. It has 930 beds across the 3 campuses and provides acute tertiary referral services, an extensive range of specialty and super-speciality services, mental health services, and subacute services including aged care, rehabilitation and palliative care.

Austin Health employs some 4,500 people and 1456 EFT nurses Div-1, 1057, Div-2 144.3 EFT and Div-3 154.2 EFT, most of whom are employed at the Austin Campus, Heidelberg, Repatriation Campus, West Heidelberg or Royal Talbot Rehabilitation Centre Kew.

Vision, Mission and Values

Vision
Austin Health will be renowned for excellence and outstanding leadership in healthcare, research and education.

Mission
Austin Health is the major provider of tertiary health services, and health professional education and research in the northeast of Melbourne.

Values
Which guide our behaviour:

- **Integrity**—we exercise honesty, candour and sincerity
- **Collaboration**—we work in partnership with others
- **Accountability**—we are transparent, responsible and answerable
- **Respect**—we treat others with dignity, consideration, equality and value
- **Excellence**—we continually strive for excellence
- **Empathy**—we are passionate and empathetic

Nurse Practitioner at the Austin

The development of Nurse Practitioner (NP) roles is relatively new in Victoria with only eight endorsed Nurse Practitioners’ throughout the state. Overall, Austin Health has embraced the concept of implementing the Nurse Practitioner role. The potential implementation of Nurse Practitioners in particular areas have provided the impetus for the discussion, “are we currently providing the service in the most patient focussed way and delivering the maximal outcomes?” The Nurse Practitioner discussion has prompted services to review current delivery models with the view to incorporating Nurse Practitioners as a service provider. Currently, across Austin Health, there is one endorsed Nurse practitioner and four Nurse Practitioner candidates. Austin Health has developed a process to support the development of Nurse Practitioners.

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3 Austin Health 2006-2007 Annual Report

NP Project Phase 4 Round 4.2 Renal Care November 2008
Nurse Practitioner Renal Care

Across Australia, chronic kidney disease (CKD) is a growing and significant public health issue. CKD contributes to a substantial burden of illness and premature mortality in Australian adults. It is estimated that approximately 14% of Australia’s population have some evidence of early stage disease which may progress to them requiring dialysis or renal transplantation. Mortality arising from kidney failure has doubled over the last two decades, with approximately 40 Australians dying annually from the disease and associated co-morbidities such as heart attack and stroke.

The Victorian Government’s renal review in 2005, Renal Dialysis: a revised service model for Victoria, recommended organisations look at a more effective system of delivering maintenance renal dialysis (MD) that is in accordance with the needs of patients and their carers. One of the five recommendations of this review was to aim to:

Provide for an appropriately skilled and prepared MD service workforce including exploration and further extension of renal nurse practitioner models.

The Nephrology Unit, Austin Health has looked at taking up this challenge through the development of a NP Renal Care Model. A project team was formed with a Project Officer and Executive Lead (Executive Director, Ambulatory & Nursing Services) to explore a NP Renal Care Role.

The outcome statement for this project was to:

Develop a service model of care for a Nurse Practitioner role in Renal Care. The model will define the scope of practice, identify the key responsibilities of a NP service in maintenance haemodialysis and how the model of care will be delivered.

A Transition Model of Care for maintenance dialysis patients and their families was chosen in which to develop the Scope of Practice for the NP Renal care.

NP MODEL DEVELOPMENT METHODOLOGY

1. UNDERSTANDING DEMAND AND OPPORTUNITIES

1.1 Service Plans, Projected Demand and Workforce Data

1.1.1 Service Plans

Austin Health services a primary catchment population of 250,000 people covering:
- Darebin-Preston
- Banyule-All (includes Heidelberg and North)
- Nillumbik-All (includes South and Southwest).

Austin Health services a secondary catchment population of 266,000 people covering:
- Darebin-Northcote
- Whittlesea-All (includes North and South)
- Manningham-All (includes West and East).

The major priorities for Austin Health in relation to patient management include (Austin Health Strategic Plan 2005-08 Appendix 1):
- Reduction in the waiting time for elective surgery
- Reduction in the waiting time for outpatient appointments
- Minimising the number of patients waiting longer than 23 hours to be admitted to a hospital bed from the emergency department
- Minimising the time on ambulance bypass

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2 Victorian Nurse Practitioner Project Renal, NP models in Renal and Stroke Care 2008, Phase 4 Funding Rounds 4.2 and 4.3
• Providing an effective interface between the community and the acute hospital to deliver appropriate services and co-ordinate and communicate effectively between health providers.

A series of high-level goals have been developed to guide Austin Health in working towards their strategic priorities for 2007-2008. The table below matches Austin Health’s planning priorities against the strategic goals. A complete 2007-08 Statement of Priorities Austin Health can be found at Appendix 2.

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<th>STRATEGIC GOAL</th>
<th>PLANNING PRIORITIES</th>
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<tr>
<td><strong>PR 1 Delivering the right service well</strong></td>
<td>Continue to identify and make service improvements to enhance flow through all areas of the hospital including outpatients. Strategies to increase uptake of home based haemodialysis. Continue to develop and roll out an integrated risk management system.</td>
</tr>
</tbody>
</table>
| • Providing safe, quality care  
• Improving access to care  
• Delivering appropriate services  
• Streamlining the flow from community through the hospital back to the community | |
| **PR 2 Working through partnership and participation** | Continue to develop cancer services as part of the North Eastern Integrated Cancer Services. Strategies to support and sustain improving care for older people across the whole health service. Establish an after hours GP clinic. |
| • Ensuring patient focused care  
• Promoting consumer participation  
• Planning for service development jointly with key provider, consumer and government partner. | |
| **PR 3 Leading research and education** | Implementing a clinical skills centre. Finalise plans and commence construction of Bioresources facility and Florey Neurosciences Institute. |
| • Providing advanced education and training for clinical staff  
• Building on our reputation as a centre for research excellence  
• Strengthening the Austin Biomedical Alliance | |
| **PR 4 Investing in our staff** | Implementation of an approved organisation wide performance management program. Workforce planning including workforce redesign, succession planning, employee assistance program and return to work support. Undertaking an Employee Opinion Survey. |
| • Planning for a changing workforce demographics, including recruitment and retention  
• Ensuring the provision of professional development opportunities  
• Enhancing our work culture through performance management and feedback for all staff  
• Enhancing internal communication | |
| **PR 5 Building a strong, sustainable future** | Completion of the feasibility study for the Heidelberg Repatriation Hospital Mental Health development and mental health service plan. Completion of final business case for Veterans Mental Health redevelopment. Continuing to plan for the Olivia Newton John Cancer Centre. |
| • Ensuring financial viability  
• Furthering Austin health capital development and master planning  
• Considering Austin health corporate positioning and image | |
| **PR 6 Advancing leadership and innovation** | Planning of an electronic medical record and effective application of information technology. Continue planning and redevelopment of radiology department facilities including angiography suite, computerised Tomography (CT) and mammography services. Establishment of CT service in the Emergency Department. |
| • Fostering clinical and management leadership opportunities  
• Leading advances in service delivery  
• Enhancing information, communication and technology  
• Improving knowledge management capabilities | |
1.1.2 Projected Demand

The projected growth in demand of healthcare services, in Victoria, is 25% growth in this decade which is 3.9% of the population. Of the 25% growth, in demand for health services, the expected number of people requiring Maintenance Dialysis will grow by five to six per cent over the next ten years\(^3\), in Victoria alone.

From Kidney Health Australia a total of 9,182 (446 per million) people were receiving dialysis treatment at the end of 2006. Of this number, 2,378 people started dialysis or had a transplant in 2006, which was an increase of 4% from 2005. The number of people on dialysis increased by 6% from 2005-2006, and has averaged a 6% growth rate per year over the past decade. Although Indigenous Australians represent less than 2% of the national population, they account for approximately 10% of people commencing kidney replacement therapy (dialysis or transplant). The facts state that 1 in 7 Australians over 25 years have at least one clinical sign of existing CKD and 1 in 3 Australians are at an increased risk of developing Chronic Kidney Disease (CKD) in this decade\(^4\).

Factors influencing an increase in the demand for Maintenance Dialysis are:

- Australia’s aging population
- Increase in life span
- Increase in the prevalence of diseases (hypertension, cardiac disease, diabetes etc) leading to Early Stage Renal Failure
- Higher incidence of diabetes amongst the overal population
- Elderly patients are often unsuitable for transplant
- Consumers are better informed about their diagnosis, treatment/care options and have higher expectations about their care.

Trends in Renal Modality\(^5\)

During 2006, there was an increase of 562 (7%) in the total number of dialysis patients in Australia. There were 9,182 patients receiving dialysis at 31\(^{st}\) December 2006 in Australia. The spread of these patients across modalities continues to slowly change. The majority (74%) were out of hospital, that is, 31% were dialysing at home and 43% at satellite units.

The proportion of patients receiving haemodialysis (HD), particularly satellite HD, has steadily increased. Forty three percent of all dialysis patients are receiving satellite haemodialysis, a further 26% hospital based haemodialysis, 9% home haemodialysis, 11% Peritoneal Dialysis-CAPD and APD.

<table>
<thead>
<tr>
<th>Mode of Treatment</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AUST</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HD</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital</td>
<td>1990</td>
<td>2076</td>
<td>2074</td>
<td>2291</td>
<td>2344</td>
</tr>
<tr>
<td>Home</td>
<td>779</td>
<td>778</td>
<td>798</td>
<td>814</td>
<td>876</td>
</tr>
<tr>
<td>Satellite</td>
<td>2709</td>
<td>3026</td>
<td>3343</td>
<td>3662</td>
<td>3941</td>
</tr>
<tr>
<td>Total</td>
<td>5478</td>
<td>5880</td>
<td>6215</td>
<td>6767</td>
<td>7161</td>
</tr>
<tr>
<td><strong>PD</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>APD</td>
<td>620</td>
<td>737</td>
<td>766</td>
<td>814</td>
<td>969</td>
</tr>
<tr>
<td>CAPD</td>
<td>1168</td>
<td>1107</td>
<td>1027</td>
<td>1039</td>
<td>1052</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>1788</td>
<td>1844</td>
<td>1793</td>
<td>1853</td>
<td>2021</td>
</tr>
<tr>
<td>Dialysis Dependent ‘06</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>9182</td>
</tr>
<tr>
<td>Dialysis Dependent ‘05</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>8620</td>
</tr>
<tr>
<td>New Patients 31/12/06</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2378</td>
</tr>
</tbody>
</table>


A reasonable explanation for the change in dialysis treatment, away from home and PD forms of dialysis to haemodialysis in the satellite unit, would be the increasing trend in the age of Australia’s population.

\(^3\) Renal Dialysis: a revised service model for Victoria, 2005
\(^4\) Kidney Health Australia, Kidney & Urinary Fast Facts, 2007
Trends in Age

Forty seven percent of all dialysis patients in 2006 were 65 years and older and 218 patients (2%) were 85 years or more, an increase of 26% from 2005. An increase occurred in all age groups 35 years or older, 10% (176 patients) in the 55-64 year age group, followed by increases of 8% in the groups 25-34 years and 75-84 years with the lowest increases 3% (25 patients) in the 34-44 years group.

As can be seen there is a trend towards patients requiring and undertaking haemodialysis in a higher age group than in the years prior to 2006. Victoria has a higher percentage of patients in the 55-64 age groups than the national average. An explanation for this would be the increasing life span of Australians overall, a higher incidence of diabetes in the elderly and indigenous population, an increase in the prevalence of illnesses leading to Early Stage Renal Failure and the fact that many elderly are unsuitable for renal transplant.

Trends in Australia’s patient characteristics

The age profile of dialysis patients is changing. The highest growth has occurred in the >85 year age group, however, the number of patients in this group is relatively small. There was also a significant increase in the 75-84 age groups.

There are 6 common conditions contributing to early stage renal failure. The proportion of people commencing dialysis with Type 11 diabetes continues to be the most common condition with 29% of new patients having diabetes. This significant increase in diabetic nephropathy fits with the community increase in diabetes and the increased age group.

Other contributing conditions are:

- Smoking
- Lung Disease
- Coronary Artery Disease
- Peripheral Vascular Disease
- Cerebrovascular Disease
**Nephrology Unit**

The Nephrology Unit at Austin Health provides the following services as part of renal care:

- Haemodialysis-home, hospital and satellite
- Peritoneal Dialysis-Continuous Ambulatory and Automated
- Home Haemodialysis-Day-time or Nocturnal.

Other services provided by the Nephrology Unit are:

- Transplantation
- Live Donor Coordination
- Anaemia Coordination
- Vascular Access Coordination
- Predialysis Clinic and Education
- Outpatient Clinics
- Dialysis Technicians and an on-call service
- Research-Clinical Trials
- Medical Training Program.
- Home Dialysis Training Unit and an on-call service.

The Nephrology Unit is a very busy unit, providing an in-centre facility and maintenance dialysis in four metropolitan satellite units. In accordance with the current funding model, Austin Health is designated as a hub and has a range of clinical and support responsibilities to patients dialysing at Bendigo, Echuca, Bairnsdale, Cohuna, Orbost and Omeo. With this structure rural patients benefit by not having to travel to the Austin as frequently to receive care.

As at the year 31 December 2007 the total number of patients dialysing at Austin Health was 423.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Dialysis Patients at 31-Dec-2007</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Hosp</td>
</tr>
<tr>
<td>Austin Hospital</td>
<td>HD</td>
</tr>
<tr>
<td></td>
<td>30</td>
</tr>
</tbody>
</table>


**Need for new initiatives**

Patients will benefit through new initiatives such as delivering maintenance dialysis within a different framework. An example would be incorporating a Nurse Practitioner role into the model of care. It is anticipated that there will be a reduction to the interruption to service delivery. Less interruption to service delivery will also mean fewer requirements to attend the in-centre dialysis unit (CDU) for maintenance dialysis issues. The Nurse Practitioner role would also increase the level of supervision for patients on dialysis and the opportunity to improve clinical outcomes. For satellite dialysis patients, the Nurse Practitioner will provide regular reviews of patients’ renal status at the unit, and check all relevant monthly dialysis and pathology parameters. Medical problems can be dealt with either through liaising with the supervising nephrologists or referral directly to an outpatient clinic for medical review.

The framework would see a reduced burden of care by the three levels of professionals associated with managing the patient on renal dialysis. The NP will relieve the registrar (non-specialist medical practitioner) of responsibility for assessment, diagnosing, monitoring and ordering treatment for the dialysis patient. At the same time, the clinical renal nurse can be more efficient with the patient’s care and management if there is someone who can interpret results and make changes to orders in a timelier manner. The new model would work as a multidisciplinary team of care and management, thus reducing each others load and enhance continuity of care and the renal service.
1.1.3 Work force Issues and Data

Another issue to be considered in the future delivery of health services is the critical shortage of some health professionals, in particular nursing and medical, with many further shortfalls predicted\textsuperscript{6}. The demand for health services is increasing and will continue to rise as the population ages, there is an increase in morbidities, technology and drugs and people’s medical awareness. The current and predicted workforce shortages are well documented. The reasons for the shortages are varied and include the aging workforce, and a preference for part-time work. The average age in all nursing divisions, at Austin Health, has increased over the last three years.\textsuperscript{5} This is in keeping with nurses’ age trends seen throughout Australia.

Joyce, McNeil and Stoelwinder (2006),\textsuperscript{7} in their research to project the future size of the Australian medical workforce predicted a steady growth in the medical specialist workforce, but no growth in the GP workforce, and no real growth in the hospital non-specialist workforce. Their research found medical practitioner’s working hours had fallen from 48.3 hours per week in 1995 to 44.4 hours per week in 2003. Although, there has been an increased number of women in the medical workforce during this time, it was the male doctors working hours that declined by 7.4% and female doctors by 6.4% during this period. The little to no real growth in the hospital non-specialist workforce will continue until 2012, if changes are not made now.

It is time to redesign the way healthcare services are delivered. From a professional perspective, nursing has been at the forefront of negotiating plans for future workforce issues with the implementation of a Nurse Practitioner tier to its career structure. The Nurse Practitioner role provides an advanced route for nursing that allows autonomous practice (within guidelines) and provides a career structure that will keep nurses with considerable experience and expertise in clinical roles.

In 2006, Austin Health saw the endorsement of two nurse practitioners in the Emergency Department and the appointment of a nurse practitioner candidate in Mental Health. A number of other nurses are either completing or have completed the pre-requisite Masters of Nursing qualification and are awaiting the opportunity to take up Nurse Practitioner candidate positions. In 2007 nurse practitioner candidates commenced in the Emergency Department and Neurosurgery.

The implementation of Nurse Practitioner roles in Nephrology, presents an opportunity for the service to review current practice and implement a new service delivery model, with an emphasis on addressing the shortage of medical professionals.

A Nurse Practitioner model that works in partnership with non-specialist medical practitioners and develops collaboration with all areas of medical care would be one way, to help address the extreme shortages of workforce supply and assist the effective delivery of medical care.

1.2 Service Gaps

The Nephrology Unit has explored the validity of implementing a Nurse Practitioner role in a range of clinical settings throughout renal dialysis. In an effort to gather information about perceived service gaps a focus group (Appendix 3) was conducted with key renal staff or representatives. The aim of the particular group was to explore, from a choice of 4 areas of renal care, where clinical support would improve continuity of care. The group took into consideration the following points:

- What the benefits would be?
- What are the current and future gaps?

\textsuperscript{6}Austin Health Nursing Workforce Strategy, January 2008

• What improvements would there be from a patient and service perspective?
• What outcomes could be expected?
• What support would be required to implement in a particular area?
• What impact this might have on other service areas?

The group identified service gaps in 3 areas of renal care:
(The 4th did not present many gaps but was identified, by the group, as an area of a possible NP role)
1. Chronic Kidney Disease Clinic (CKD) (predialysis)
2. Satellite Support
3. Home Maintenance Dialysis
4. Vascular Access (only gap identified was time in accessing country patients)

The actual gaps identified in the areas explored included:

- initial referral
- assessment and admission
- managing perceptions and expectations of patients
- inability to provide a vascular review of country patients
- predialysis and the capacity for patient follow-up.

With this in mind, the group then went onto healthy debate about the merits of a Nurse Practitioner in Renal Care, and the concepts discussed were funding, candidate selection, continuing academic focus, medical collaboration, maintaining optimum health care management and quality of care.

1.3 Areas for Service Implementation

The four areas of renal care identified as service gaps, were then analysed by the undertaking of a SWOT Analysis (Appendix 4) in an effort to identify the area of renal care, with the most strengths in which to implement the NP Renal Care role.

2. SHAPING THE SERVICE MODEL FOR NP’s

Shaping the service is about getting the ground work right and the organisation interested, so as to be able to implement the model and role where and when they are needed. The work to develop the framework for a NP model will take some months, whilst the ongoing work to actually establish roles for NP’s will take, in some cases, years.

2.1 Priority Areas for NP Service Development

Only if funding is/becomes available:

- Within 1-2 years Satellite Dialysis Unit support-Transition Model of Care
- Between 3-5 years Home Maintenance Dialysis
- Greater than 5 years Chronic Kidney Disease Clinic (CKD) (Predialysis Clinic) Vascular Access

2.2 Current Model of Care-Referral to Satellite Unit

After interviews with staff, and patients and analysis of the current service pathway, the model of renal care which would benefit most from including a Nurse Practitioner would involve a transition of care between the in-centre facility and the four metropolitan satellite units. There are four metropolitan satellite units which work independently. Some patients move back and forth between the in-centre facility (Central Dialysis Unit (CDU)) and the satellite units as their medical condition requires. Otherwise, patients move through their dialysis care without any or only minor interruption to the maintenance of their optimum health care management and quality of care.
Current pathway at Austin Health of patients presenting for assessment/treatment of renal failure

The new model will need to challenge some of the current accepted care practices. The NP model should help address some of the transfers back to CDU. There are specific medical conditions in which the patient will continue to be transferred to CDU or ICU, but, then there are some that a NP can diagnose, assess and order treatment for in the satellite unit. With the assistance from a NP in CDU, it would be hoped that they can assist the nursing staff with informing the patient of their options and develop clinical management plans.
The NP Transition Care Service would help with the patients commencing renal dialysis in the Central Dialysis Unit (CDU). They would work collaboratively with nursing staff and develop partnerships with the medical staff. Some patients are too sick that they are unable to attend predialysis sessions or are from private nephrologists so go straight to CDU. The NP can assist with assessment, consenting for treatment, making referrals for an AV fistula, assisting and reinforcing nursing staff's education on modalities, writing dialysis orders and developing clinical management plans. This model will also give the patient the opportunity to make a choice about their future dialysis needs.

The current practice involves all new haemodialysis patients, having at least 3 dialysis runs in the in-centre unit. This is regardless as to whether the patient has a stable base weight and blood pressure. Some patients that pass through the CDU, to commence dialysis, are relatively stable with a stable base weight and blood pressure. These patients could go straight to a satellite unit to commence their dialysis regime. If the treating medical practitioner, states that the patient is medically fit for satellite dialysis the NP could prescribe the dialysis, and then oversee the treatment within their scope of practice. The NP would engage in extended and advanced specialised nursing practice, decision making and order care, thereby, provide a complete episode of care.

There would potentially be an increase in the home and peritoneal dialysis patient numbers as the NP reinforces nurse's education of modalities and the patient has the opportunity to make an
informed choice. This should empower the patient by giving them the authority to make decisions about their own care.
If home dialysis numbers increase, there maybe a need for the current system to be redesigned to create a separate home training unit, with designated staff. This would help address the home training gap. Currently, staff at the Dialysis Training Unit train home patients. This unit is also a satellite dialysis unit.

A NP would be able to work closer with the patient, give them the power to make choices about their care, improve the flow of patients and decrease the number of medical reasons the patient needs to be transferred back to CDU. This NP role will be an extension of existing services, not a medical practitioner’s replacement or to fill nursing staff vacancies, but rather, enhance the hospital non-specialist medical workforces (medical practitioner) work and maintenance of optimum health care management.

2.3 Benefits to Stakeholders

A Stakeholder Analysis (Appendix 5) for the development of the NP Renal Care Role was established at the commencement of the project. Development of partnerships and collaboration with the treatment team (medical, nursing and allied health) will be of benefit to all and can improve communication and the delivery of health care/services for patients commencing on renal dialysis.

Benefits to stakeholders arising from the implementation of the NP service would be many. The benefit, for many stakeholders, is that of someone:8 9 10

- with advanced practice nursing care (NP have extensive nephrology nursing experience)
- who manages the care of patients
- who acts as a senior resource to renal staff, hospital services, patients and families
- authorised to practice by a professional board
- who works in accordance with written and approved guidelines which abide by the Nurses Act
- that collaborates with other health professionals to optimise the patient’s management and care
- that assess, prioritise, manage and evaluate patients on dialysis
- who liaises with medical practitioners regarding treatment regimes and participates in direct and indirect patient care
- that has practice privileges which are protected by legislation
- autonomous and accountable
- that develops clinical partnerships
- has authorised medication and pathology formularies
- that incorporates advanced nursing skills into their assessment, implementation and evaluation of clinical services to patients and families
- who collaborates with stakeholders
- able to take referrals and refer individuals
- who delivers high-quality, client-centred care
- who is a patient advocate
- when outside their scope of practice will refer to appropriate team member
- who will work within a primary health care model
- with good patient communication and listening skills
- who makes patients feel at ease and comfortable to take an active part in their care
- who can do some of the work medical professionals (doctors) do (eg advanced assessments) with patient satisfaction
- who gives more education and information to patients about their illness or condition
- who gives clear explanation to patients about diagnosis and tests

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- that involves patients as partners in their own healthcare
- who will deliver effective and efficient care
- who give patients more choice
- that focus on prevention and early intervention
- that is complementary to medical professionals (doctors) not a substitution role
- who achieves comparable health outcomes and care processes for patients as do doctors
- who is cost-effective in that they are known to order less [inappropriate] tests
- that provides more time and support for patients than doctors can
- Patients do not need to have to wait to be seen, like they do with the doctor

### 2.4 NP’s Role in Service Model of Care

Austin Health’s NP Model of Care for Renal will be a Transition Model of Care. The evolution of the transition will be with the patient commencing dialysis, in the Central Dialysis Unit (CDU), to maintenance renal dialysis in a home or satellite setting.

The model of care is a nursing model of routine renal dialysis care, undertaken by the Renal Dialysis Nurse and medical review, assessment, diagnosis and treatment prescribing in collaboration and partnership with the medical practitioners (nephrologists and non-specialist medical practitioners), nursing staff and patient. It would be expected that the NP would reduce current service gaps with an emphasis on earlier interventions and stabilisation of the patient to an improved optimal renal state. The NP with their expert clinical knowledge and extensions to practice would provide substantial assistance and improvement to the patient’s treatment and their pathway of care. They will not perform the dialysis treatment, but rather, assist with the ordering of treatments and maintenance issues to ensure appropriate care, management and sustaining a quality of life on maintenance dialysis.

The NP will also provide immense support to the nursing staff in their provision of the renal care ordered and education. In saying this, the NP is not a doctor substitute but rather, a complementary service. The NP remains part of a nursing role and a nursing model of care.

#### 2.4.1 Scope of Practice

The scope of practice will:

- Assist the renal management of a designated, specific renal patient population in commencing renal dialysis, in the Central Dialysis Unit (CDU) and satellite units
- The practitioner will reinforce the education provided at the Predialysis Clinic and by the nursing staff about the renal modalities available to the patient
- The NP will be an active member of the Dialysis Unit and so will work throughout the unit areas (CDU and metropolitan satellites)
- Assist patients in the transition to a dialysis satellite or other modalities for training.
- At the satellite, the NP will be responsible for managing within the parameters of specific renal markers the renal dialysis of the patient, defined within the triage criteria (reflected in the inclusion/exclusion criteria listed in each CPG) with the Nurse Unit Manager (NUM). Also, they will provide a constant point of reference for the patient and nursing staff, throughout the patient’s episode of care, for the diagnosis and ordering of treatment as determined by assessments made by the nursing staff.
- Provide opportunities to continue to develop their new skills to manage the changing needs of the renal patient population.

**Who**

The Endorsed Nurse Practitioner Renal Care - A nurse with expert clinical care in Renal Care and extensions to practice authorised by the NBV or a NP Candidate.
What
A Transition Model of Care for the patient commencing on renal dialysis and moving onto maintenance dialysis in a satellite program. As well, manage the renal wellbeing of maintenance dialysis patients at the four metropolitan Austin Health renal satellites as defined within the triage criteria (reflected in the inclusion/exclusion criteria listed in each CPG) with the Nurse Unit Manager (NUM).
Rational: Improving continuity of care across the renal dialyses spectrum and the delivery of health services.

How
Routine Renal Dialysis Care provided by the NP will involve:

• Referrals to and consultation with the Vascular Access Nurse in relation to the renal nurses assessments of the AV fistula
• Reviewing and ordering dialysis according to the patients Cardiovascular/fluid levels measured by the renal nurse
• Make referrals to the Anaemia Coordinators and order treatments as requested by them
• Order specific renal bone disease pathology tests and assess results. Develop a plan of care including prescribing treatment for low calcium and phosphate levels. Assist the renal nurse with educating the patient about phosphate binders. Any pathology ordered for private patients needs to be countersigned by a Medical Practitioner (NP candidates and Endorsed NP) this is to ensure medicare payments to the hospital.
• Vaccination history-Hep B, Ab level-order tests yearly and as required
• Writing up and adjusting Haemodialysis Orders as required
• Prescribe routine renal dialysis medications as listed on the Renal Medication Formulary (Appendix 6). For private patients countersigned by a Medical Practitioner. NP candidates need to have everything they are prescribing, countersigned by a Medical Practitioner and both NP Candidates and NP Endorsed need to have any medication outside of the Renal Medication Formulary ordered by a Medical Practitioner.

Amendment to Victorian legislation means endorsed Nurse Practitioners (NP) can prescribe substances for which they have received approval under the Drugs, Poisons and Controlled Substances (DPCS) Act 1981. The Austin Health’s pharmacy website contains guidelines on medication prescribing and dispensing and policies on medication administering. The NP needs to be aware of the guidelines and policies and of the DPCS Regulations governing their prescribing practices. They also need to take steps to minimise the possibility of prescribing errors and be aware of the factors contributing to errors (NBV 2005).

• Undertake patient treatment assessments, diagnosing and order routine renal dialysis pathology tests, electrocardiograms (ECG), fistulograms and duplex ultrasounds in the vascular laboratory. Interpret the results of the tests and develop clinical management plans (NP candidate needs to have tests countersigned by a Medical Practitioner)
  Referral for diagnostic testing is initiated according to criteria defined in the individual CPG’s guiding the NP practices. Diagnostic testing outside the tests stated above is to be ordered by a Medical Practitioner.
• Refer patients to Austin Health’s Emergency Department and Vascular Department (in consultation with the Vascular Access Nurse) only
  Admission occurs as a result of consultation with the Dialysis Consultant Nephrologist/Unit Head for each individual case assessed. The NP may write internal referrals (ED, Vascular Unit) without countersigning by a Medical Practitioner. Referrals for any clinics or external medical specialists (private), the referral must be made by a Medical Practitioner including their provider number.
• It is not usual practice that patients will be discharged from dialysis treatment units so the discharging of patients would not be a function required to be undertaken by the NP Renal Care.
• Provide and authorise Certificates of Absence
• Leadership/Educator
  Patient, renal staff and community
  Self-education and ongoing skills development
• Counselling/Advocacy
Patient, family and carers
Psychosocial issues and liaising with the primary nurse
Support and reinforce the primary nurse’s education and counselling in end of life choices
(Respecting Patient Choices-a program of Austin Health)

- Researcher
  Publication-Write about the process of your role implementation
- Administration/Management
  Development and maintenance of Clinical Practice Guidelines (CPG)
  Change management skills and redesign work

When
The Nurse Practitioner Renal Care will work with patients:

4. On commencing renal dialysis in the Central Dialysis Unit and until their renal condition stabilises (as determined by the multidisciplinary team) for transition to a satellite maintenance dialysis program or other renal modality
5. Undertaking maintenance dialysis at the 4 metropolitan satellite units of Austin Health, as defined by the triage criteria with the Nurse Unit Manager
6. Monday to Friday regular work hours; 40 hours inclusive of ADO.

Where
The dialysis units are as follows:

- Central Dialysis Unit (CDU)-Ward 7ND
- Repat Dialysis Unit (RDU)-Heidelberg
- North East Kidney Service (NEKS)-Preston
- Dialysis Training Unit (DTU)-Preston
- Epping Dialysis Unit (EDU)-Epping

MODEL OF CARE SUMMARY

PATIENT POPULATION

<table>
<thead>
<tr>
<th>Work Area</th>
<th>Service Need</th>
<th>Inclusion Criteria</th>
<th>Exclusion Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Dialysis Unit</td>
<td>Stabilisation of patient commencing renal dialysis</td>
<td>Public &amp; Private patients</td>
<td>(NP to establish in consultation with the NUM’s)</td>
</tr>
<tr>
<td></td>
<td>Modality education</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Counselling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Repat Dialysis Unit</td>
<td>Routine renal dialysis care</td>
<td>Public &amp; Private patients</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Promotion of renal modalities</td>
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<tr>
<td></td>
<td>Counselling</td>
<td></td>
<td></td>
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<tr>
<td>North Eastern Kidney Service</td>
<td>Routine renal dialysis care</td>
<td>Public &amp; Private patients</td>
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<td></td>
<td>Promotion of renal modalities</td>
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<td>Counselling</td>
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<tr>
<td>Day Treatment Unit</td>
<td>Routine renal dialysis care</td>
<td>Public &amp; Private patients</td>
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<td>Promotion of renal modalities</td>
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</tr>
<tr>
<td></td>
<td>Counselling</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## SCOPE OF PRACTICE (Applicable to all public (non-billable) patients within Nurse Practitioners defined population)

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Radiology</th>
<th>Pathology</th>
<th>Assessment</th>
<th>Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribe from the Renal Nurse Practitioner formulary. PBS/S100 countersigned Heparin Locks.</td>
<td>Request: Duplex ultrasound Fistulogram ECG</td>
<td>Request: U&amp;E, LFT, FBE, Routine Blood Glucose, Albumin Ca, PO4 HbA1c, Lipids-HDL, LDL Post dialysis urea iron studies, Red Cell Folate TIBC PTH B12 Hep B, C, HIV Se aluminium Magnesium TSH, T3, T4 FT4 Vancamycin levels</td>
<td>Advanced assessment of: Vascular access Fluid/Cardiovascular issues Anaemia Bones Vaccination history Hep B Ab level Haemodialysis orders</td>
<td>Refer to: Vascular Access Nurse Anaemia Coordinator Vascular Unit Austin Health Emergency Department Discharge by consultation with the Multidisciplinary Team</td>
</tr>
</tbody>
</table>

### Collaborations and Partnerships

**Partnerships**

This will include:
- Nurse Unit Managers of Renal Care (Dialysis)
- Director of Nephrology, Senior Consultant Nephrologist
- Clinical Director of Medical & Emergency CSU
- Medical Staff (Nephrology)
- Director of Pathology
- Director of Pharmacy
- Director of Radiology

**Collaborations**

This will include:
- Patients/Family members and/or carers
- Emergency Department
- Clinical Nurse Consultants (Vascular Access Nurse, Anaemia Coordinator etc)
- Executive Director Nursing & Ambulatory Services

### 2.5 Succession Planning-Service Continuity and Sustainability

Austin Health has developed a Nurse Practitioner Service Plan which would enable the development of a consistent structure that strategically develops and integrates the new role into existing services.

Austin Health’s organisational commitment to Nurse Practitioner roles has been, and continues to be, actively demonstrated. Austin Health has long-standing and successful Nurse Practitioner initiatives in the Emergency Department, Neurology, Mental Health, and DHS role development initiatives in Stroke and Renal Care.
A nurse practitioner model based on a single individual practitioner is unsustainable and risky. Changes to status or personal circumstances have the potential to jeopardise many years of work. It is imperative that the Nephrology Unit undertake workforce planning through the development of a succession plan to ensure appropriately skilled nurses are available to fill Nurse Practitioner Renal Care positions.

Succession planning is multifaceted. Firstly, the personal and professional challenge to become a Nurse Practitioner is enormous. The candidate must display absolute commitment to the position, to completing a Masters Degree, further education in the nominated specialty and development of higher level clinical skills to fulfil the role. The Nephrology Unit will undertake a number of key considerations to assess this commitment and choosing the right nurse for the Nurse Practitioner Renal Care role. They will consider:

1. A combination of academic, professional and leadership skills
2. The amount of clinical renal experience
3. Performance appraisal reports
4. A rigorous interview process which assesses candidates personal and professional commitment

The funding mechanisms are not available to assist this new designation of nurse. Few organisational supports are available from a financial perspective to assist in the development. Internal and external funding sources would need to be explored. Finding financial resources to employ a Nurse Practitioner Renal Care from existing budgets is challenging, even though Austin Health’s CEO is committed to implementing Nurse Practitioner positions. In developing a role the Nephrology Department will need to explore and secure internal or external funding sources allocated specifically for NP positions.

Should the department establish ongoing funding for a NP position there would need to be a succession plan, to ensure continuity of the position should the partitioner leave the organisation or takes extended leave. The person would need to be replaced by a suitable candidate. If this candidate does not exist within the organisation advertising of the position would go external to the organisation. The NP’s responsibilities would revert back to the medical practitioners until a suitable candidate was employed.

Sustainability of the Nurse Practitioner Renal Care Role is also dependent upon the NP evaluating their role and collecting data that indicates the efficacy of the role on service provision. The NP will need to develop a database of outcome measures.

Some of the changes in service provision that can be measured are:

- Stabilised in the shortest period of time(compare NP to non-specialist medical practitioner)
- Streamline associated interventions
- Quality of treatment
- Patient satisfaction
- Outcome measures specific to the NP Renal Care role
  - Number of CPG’s completed
  - Number of research articles
  - Documentation
  - Case studies
  - Quality of assessments
  - Competency assessment

Role sustainability is also reliant upon the Nurse Practitioner Renal Care being supported by the organisation through their candidacy. This requires an organisational strategy of providing clinical support, professional support and administrative support to develop the role and clinical practice guidelines. The Nephrology Unit have the capacity to provide these services to the NP Candidate and NP Endorsed.
The Nephrology Unit understands strategies to address, research, mentoring, clinical supervision, allocating time to completing research and study time are paramount in terms of the Nurse Practitioner Renal Care role sustainability.

Austin Health has established the following structure which will continue to support the candidate during the endorsement process. They include:

- NP Steering Committee
- NP Candidate Peer Support Group
- Expressions of Interest and Submission processes.

There is quite a commitment required from all key players in the development of NP roles and subsequently NP’s.

### 2.6 Evaluation and Monitoring

The implementation of a Nurse Practitioner tier to the nursing career structure is relatively new and would be a new position for renal care. Therefore, evaluation of the service model and monitoring of the service delivery would be ongoing with changes and improvements made as the role evolves. This will promote establishing the best practice for the NP Renal Care and the Renal Transition Model of Care.

Evaluating the Nurse Practitioner Role in Renal Care is imperative, in order to comprehensively demonstrate the value of the position and inform future planning of further advanced practice roles. Evaluation should be carried out at regular intervals throughout the NP implementation (NP candidacy) stage with changes made according to the results of the evaluations. To evaluate the NP in Renal Care a framework, which is an adaptation of the Nursing Role Effectiveness model developed by Irvine, Sidani, McGillis Hall, (1998)\(^\text{11}\), will be used. It is a conceptual model developed to guide the evaluation of the contribution of nursing in the health care arena. In the model, the achievements of specified outcomes are related to the roles nurses take up in health care with the objective of nursing quality improvement.

The Irvine et al conceptual framework has three major but interrelated components (Figure 1):

- Structure
- Process
- Outcomes

(Explanation of components Appendix 7)

Monitoring of the NP Renal Care service delivery should focus on safety, quality and the timing, of care. Some outcome measures will be context specific but the outcome measures should reflect service delivery rather than the individual NP’s performance.

In monitoring of the service model delivery KPI’s in renal care have been established in line with the Victorian Quality Council’s dimensions of quality (Appendix 8).

The Dimensions of Quality include:

- Access
- Safety
- Effectiveness
- Appropriateness
- Acceptability
- Efficiency

\(^{11}\) Irvine D., Sidani S. & McGillis Hall L. (1998) Linking outcomes to nurses’ roles in health care. *Nursing Economics* 16(2)
Post implementation of the role the NP candidate will be required to undertake research relating to the NP Renal Care service model. The NP would set up a database that outlines the number of patients seen, diagnostic tests ordered, referrals made to other health care professionals, and medications prescribed. Each NP (candidate or endorsed) shall identify potential areas of research to be conducted within the model and include satisfaction surveys and case scenarios.

Staff surveys are useful in collecting information about a range of different components of the role of the Nurse Practitioner. Not only to assess staff’s satisfaction with the Nurse Practitioner role and service delivery, but also identify staff learning needs related to this role and evaluate the effectiveness of the educational program implemented.

Consumer satisfaction is an indication of the quality of care provided by a service and evidence of the efficacy of the system. Consumer satisfaction surveys include the utilisation of questionnaires, telephone calls and measures such as focus groups, individual interviews and case studies. Consumer satisfaction surveys can be administered to:

1. A target population pre and post NP role implementation to measure the degree of change
2. Compare two providers offering comparable service eg the NP or medical practitioner seeing the same type of patients.

Clinical Audit meetings will be established monthly to deal with the review and analysis of the KPI audits, presentation of dialysis case reports and review of NP intervention. There will be ongoing quality improvement both in the service model and the service/care delivery. The Director of Nephrology and the NP’s Clinical Supervisor will be two compulsory members of the clinical audit meeting. The NP Renal Care will develop a Clinical Indicators Audit Form for data gathering and reporting to the Clinical Audit Meeting.
EVALUATION FRAMEWORK

Structural Factors

Patient Population Variables
- Demographics
- Equity and accessibility of care
- Care delivery model
- Patient load

Patient population defined
Criteria for referral developed and documented
Scope of practice expanded
Number undertaken/monitoring of waiting list

Organisational variables
- Organisational policies
- Clinical practice guidelines
- Resource adequacy

Number and range written
Barriers/facilitators to practice identified

Process of Care Delivery

Role Components
- Practitioner
  - NP applies knowledge and skills to assist patients
  - Deal with patients health problems
  - Planning activity

Clinical performance review
Case studies
Self-assessment
Patient assessments, prescribing treatment
Performance appraisal
Competency assessment
Patient & family education

- Educator
  - Staff
  - Care related activities

- Researcher
  - Undertake continual research

- Administrator
  - Documentation

Number of articles complied
Documentation audits

Role Enactment
- Physician extender
- Expanded nursing practice

Outcomes of Care

Quality
- Care/ presentations by the NP
- Related health problems/diagnosis System
- Clinical activity for each event
- Diagnostic/pathology tests ordered
- Medications prescribed
- Referrals made

Timeliness of Care
- Time to stabilise condition
- Time to transfer to optimum location
- Reason for delay in transfer to optimum location
- Consultation time

Cost
- Patient
- Austin Health
- Health Care

Quantity of Care
- Number of occasions of service
- Total number of patients seen

Quality of Care
- Consumer satisfaction
  - Either no decrease or an increase in consumer satisfaction
- Clinical incidents
  - Either no increase or a decrease in sentinel events and clinical incidents
3. PRIMING THE ORGANISATION FOR NP’s

3.1 Executive Lead for NP Role Development
Executive Director of Nursing and Ambulatory Services

3.2 Governance Structures for NP Role Development at Austin Health

In the Round 6 Nurse Practitioner Service Plan Project, a NP Role Development, Austin Health NP Steering Committee was established along with Terms of Reference (Appendix 9). The role of the NP Steering Committee is to create a vision and develop a framework to introduce NP roles and maximise sustainability of these roles at Austin Health. The Steering Committee is a multidisciplinary group. The membership includes:

- Executive Director Nursing & Ambulatory Services
- Deputy Director Nursing & Ambulatory Services
- Executive Director Acute Operations
- Chief Medical Officer
- All Clinical Service Unit (CSU) Directors
- Allied Health Managers
- Clinical Governance Manager
- Medical Directors
- Senior Medical staff
- Nurse Unit Mangers
- Clinical Nursing Education
- LaTrobe University School of Nursing % Midwifery Rep
- Nurse Practitioner Candidate

3.3 Engage Key Stakeholders

The importance of working collaboratively with other healthcare providers, consumers and the community is reflected in Austin Health’s Strategic Priority 2 - Working through partnerships and participation. There is evidence that suggests consumer and community participation can improve the delivery of health care/services.

At Austin Health we have a number of established mechanisms for consulting with key stakeholders. These include:

- Community Advisory Committee
- Primary Care and Population Health Advisory Committee
- Board of Directors
- Bayule Nillumbik Primary Care Alliance (of which Austin Health is a member)
- Austin Health Quality Care Report (distributed annually)
- Hospital Primary Care Liaison Unit
- General Practitioner Liaison Officer
- Department of Human Services

The Austin Health NP Steering Committee has undertaken educating key stakeholders about the role of NP’s. A comprehensive organisational consultation and information process was undertaken to educate nursing, allied health and medical staff about the role of the NP and to encourage them to explore the possibilities’, benefits and challenges for their specialty area.

In order to maintain awareness and promote the role a regular newsletter will be distributed to all nurses in the organisation every three months.

The NP Renal Care will need to ensure the executive management are aware of the benefits of the role and keep staff informed of the NP Renal care progress through:
- Conference Presentations
- Patient Information Brochure (only for those patients the NP is having contact with)
  
  *NP is a protected title, so all NP's must make it clear to the patient/person they are dealing with that they are a NP or NP candidate.*
- Feedback of evaluation findings
- Involvement in committees
- Education seminars
- Present to medical staff at Grand Round
- Post information in ‘WAG’ (Austin Health staff newsletter)
- Community Information Forums

### 3.4 Communication and Marketing Strategy

A communication strategy for the NP Renal Care Role has been developed with the aim to engage and inform key stakeholders and enable successful implementation and sustainable outcomes. The communication strategy (Appendix 10) was authorised by the NP Renal Care Project Steering Committee and has been implemented by members of the Steering Committee and the project team to assist in dissemination of project information during the project.

A number of principles underpin effective communications. The following principles of good communication practice have been built into the communication strategies and include:

- **Who** is the target audience?
- **What** information needs to be communicated?
- **How** should we communicate, that is, what is the most appropriate method of communication?
- **Where and when** should the information be targeted?
- **Why** is the information being disseminated?

Three key messages are central to communicating the role, which will remain simple so that there is a shared understanding of the role and are as follows:

1. The Nurse Practitioner Renal Care Role aims to deliver timely management of the care and treatment patient’s need and manage local capacity and capability for innovation.
2. Front line clinical teams will drive and support the innovations of the Nurse Practitioner Renal Care Role.
3. The methodology will be practical and applicable to Nurse Practitioner Renal Care operational duties.

### 3.5 Staff NP Knowledge Gaps and Strategies to Address

It has been apparent, by the Austin Health NP Steering Committee, there is a lack of understanding across nursing and beyond about this role and its’ responsibilities. The misconceptions need to be clarified to maximise the opportunity for nurses to undertake NP roles. The key finding from consultation was that very few nurses understood the concept of NP, the role of the NP, how enhancing scope of practice could improve service delivery and what was required to become a NP.

The CEO of Austin Health has been involved in the developing of the Nurse Practitioner Candidate positions and is supportive of the concept of the NP.

The Austin Health NP Steering Committee (multidisciplinary committee) has taken responsibility for promoting the role of the NP across the organisation. It has been important that a multidisciplinary team at a senior level meet to discuss the merits, challenges and differing view points about NP’s. The view of Austin Health’s NP Steering Committee is that successful implementation of NP’s requires strong organisational support from senior management.
The committee has taken a phased approach in supporting the NP development

**Phase 1-Organisational Consultation**
- An awareness phase, to educate the staff about the role and the potential of NP’s.

**Phase 2-Establishment and Involvement of the Steering Committee**
- To engage managers in the process of identifying areas suitable for NP’s and to focus upon the potential NP’s have in adding value to their service.

**Phase 3-Development of the Austin Health Nurse Practitioner Framework (support package):**
- To establish support mechanisms to assist the nurse in their development in becoming a NP. These mechanisms include:
  - Role definition
  - A submission framework for specific service, to identify the NP role (Appendix 11a)
  - A clinical supervision program (Appendix 11b)
  - Organisational mentoring (Appendix 11c)
  - Clinical Practice Guidelines (CPG) Format (Appendix 11d)
  - Peer Support Group (Appendix 11e)

### 3.6 Develop Internal Processes

The internal ‘Expressions of Interest’ and ‘Submission’ processes for NP service models, from nurses or Clinical Service Units (CSU), are addressed by the Austin Health NP Steering Committee. The process is outlined in the flowchart (appendix 12a) and submission form (appendix 11), along with a position description specific to the NP Renal Care Role (appendix 12b).

### 3.7 Organisational Structure & Reporting Lines

**Organisational Structure & Reporting Lines for the NP/Candidate Renal Care**

```
CEO

Exec Director
Ambulatory &
Nursing Services

Exec Director
Acute Operations

Chief Medical
Officer

Director of Medical &
Emergency CSU

NP Renal Care
&
NP Candidate Renal Care

Senior Consultant
Nephrolgist-Dialysis

Medical Director
of Nephrology

Academic Supervisor

Clinical Supervisor

Central Dialysis
Unit NUM

Mentor

University Education

CLINICAL SERV I CES

CLINICAL SERVICE UNITS
```
3.8 Budget Modelling

To assist budgeting requirements, for the NP Candidate Renal Care, costing for salary will be based on a RN Grade 5 Y2 Clinical Nurse Consultant salary scale.

Nurse Practitioner Candidate Renal Care as at October 2008

RN G5 Yr 2 Clin Con (ZA8)
$ 77,906 per year
$ 107,204 per year (includes on costs)

plus qualification allowance of $ 61.84 per fortnight for 26 weeks $1,608 $108,812/yr

2 years@ $217,624
or
3 years@ $326,436

Endorsed Nurse Practitioner Renal Care as at October 2008

RN G6 Yr 1 (201-300 beds) ZE8
$ 80,876 per year
$112,873 per year (includes on costs)

plus masters allowance of $68.80 per fortnight for 26 weeks $1,789 $114,663/yr

RN G6 Yr 2 (301-400 beds) ZE9
$ 83,845 per year
$117,025 per year (includes on costs)

plus masters allowance of $68.80 per fortnight for 26 weeks $1,789 $118,814/yr

3.9 Budget Requirements

BUDGET FUNDING REQUIREMENTS-NP Candidate Renal Care
RN G 5 Yr2 Clin Con (ZA8) classification as at 01/10/2008

Pay Rates, EBA Agreements & Rostering Arrangements

Monday to Friday position within normal work hours
Ordinary hours@40 per week (inclusive of ADO) $77,906.40
On costs $29,297.80
Qualification Allowance $ 1,607.84 $108,812

SALARY COSTS-NURSING

Clinical and Non-clinical Time
10 hours of in house clinical development/supervision
1 hour per week Data Collection

4 hours per week for completion of:
Nurse Practitioner Submission
Writing CPG’s
Educating staff about role
Developing evaluation process
**Education, Study leave, Mentoring/Internship (on Job)**
2 hours clinical lecturing for NP Candidates per week
Study Leave as per Nurses EBA

**RECURRENT NON-SALARY COSTS**
1 Renal Conference per year $1,000
Travel Expenses from Austin to 4 satellites (Heidelberg, Preston and Epping) $1,500
Communications:
   Mobile Telephone on Corp Plan @ $10/mth $120 $2,620

**Nursing Costs** $111,432

**SALARY COSTS-MEDICAL**
Medical Senior Specialist Yr 7 (MO24)
(Due to the travelling nature of the NP Renal Care model proposed one session of a Medical Specialist's position needs to be allocated to Clinical Supervision of the NP)
One session per week-4hrs (0.1 EFT) including on costs $21,416
Less lump sum from DHS for academic preparation of candidates $6,000 $15,416

**Clinical and Non-clinical Time**
10 hours of professional lecturing @ $100/hr $100 $100

**NP Candidate Internship**
2 hours clinical lecturing to NP Candidates per week
@ $100/hr $200 $10,400

**Medical Costs** $26,816

**Access Resources and Equipment** (Based on 2008/09)
Office space including desk:
   Chair $250
   Set of draws $250
   Desk Telephone $200
   Desk Top Items-Stationary, Hole Punch, Mouse Pad etc $150
Technology Equipment:
   Laptop Computer $1,832
   Remote Access $250
   Cabling $350
   Printer $140
   Pager local Alphanumeric $155
   Mobile Telephone $172
   (Ongoing billing costs from Nephrology Admin budget)
Employment Advertisement $500
$4,249

**TOTAL COSTS FOR THE NP CANDIDATE RENAL CARE POSITION FOR THE FIRST YEAR** $142,497

**TOTAL COSTS FOR THE NP CANDIDATE RENAL CARE POSITION FOR TWO YEARS** $280,745
excluding EBA increases

**TOTAL COSTS FOR THE NP CANDIDATE RENAL CARE POSITION FOR THREE YEARS** $418,993
excluding EBA increases
BUDGET FUNDING REQUIREMENTS-NP Endorsed Renal Care

YEAR 1
RN G6 Yr 1 (201-300 beds) ZE8 classification as at 01/10/2008

Pay Rates, EBA Agreements & Rostering Arrangements
Monday to Friday position within normal work hours
- Ordinary hours at 40 per week (inclusive of ADO) $80,875.60
- On costs $31,997.65
- Qualification Allowance $1,788.80
?
Research and Consultancy/Non-clinical Time
25% per week of NP’s regular working hours
(10 hours per week)
- Travel Expenses $1,500
- Renal Conference $1,000
- Mobile Telephone Expenses on Corp Plan @ $10/mth $120
?
TOTAL COSTS OF A NP ENDORSED RENAL CARE AT RN G6 YR1 (201-300 BEDS) $114,663

YEAR 2
RN G6 Yr 2 (301-400 beds) ZE9 classification as at 01/10/2008

Pay Rates, EBA Agreements & Rostering Arrangements
Monday to Friday position within normal work hours
- Ordinary hours@40 per week (inclusive of ADO) $83,844.80
- On costs $33,180.20
- Qualification Allowance $1,788.80
?
Research and Consultancy/Non-clinical Time
25% per week of NP’s regular working hours
(10 hours per week)
- Travel Expenses $1,500
- Renal Conference $1,000
- Mobile Telephone Expenses on Corp Plan @ $10/mth $120
?
TOTAL COSTS OF A NP ENDORSED RENAL CARE AT RN G6 YR2 (301-400 BEDS) $118,814

4. PREPARING THE NURSING WORKFORCE

4.1 Identified Staff Interested in NP Renal Care

Nurse Unit Manager Ward 7 North Renal
Renal Clinical Support Nurse
Current Renal Course student
None of the above has started to undertake any NP educational preparation.

4.2 Priority Area

The above staff members would be more than appropriate for the model of care established so the priority for the NP Renal Care Model will be unchanged.

4.3 & 4.5.2 Education Preparation Pathways for Renal Care Candidacy
EDUCATION OF A NURSE PRACTITIONER (NP) RENAL CARE TO ENDORSEMENT
(as defined by the ‘coloured sections’ and taken from the Implementing a NP Flowchart)

EDUCATION

Research NP endorsement requirements. Obtain package from NBV

Liaise with Universities re Masters programs and Pharmacology subject.

Commence academic prep
1. Masters Program
2. Therapeutic Medication Management

Participate in organisational education

Commence strategy to educate staff, pts & stakeholders.

ORGANISATIONAL

Discuss idea with NUM/CSU Director/Medical Director/Head of Unit/Nursing Services

Explore NP role in more detail

Identify organisational mentor

Yes

Establish local multidisciplinary steering committee, to explore role and purpose.

Local steering committee completes/oversees Nurse Practitioner Steering Committee (NPSC)

No

Further groundwork required

Identify difference between NP and Advanced Practice Nurse and decide how extension of scope of practice assists the role.

ROLE DEFINITION

Develop CPG’s

Complete nursing research and act as a role model in clinical field

Define role and complete PD

SUBMISSION

Submission forwarded to Exec Dir Nursing & Amb Services Chairperson NPSC

Receive funding approval for position through CSU Department

Commence role awaiting NBV endorsement

Commence endorsement process with NBV

CONGRATULATIONS
NURSES BOARD ENDORSEMENT
YOU ARE AN ENDORSED “NURSE PRACTITIONER”
PATHWAY TO NP RENAL CARE ENDORSEMENT EDUCATION REQUIREMENTS

EDUCATION

- Research NP endorsement requirements. Obtain package from NBV

- Liaise with Universities re Masters Programs and Pharmacology subject.
  - www.nbv.org.au/web/guest/courses-nurse-practitioner

- Commence academic preparation

- Masters of Nursing (Nurse Practitioner) Program

- Therapeutic medication Management Subject

- Participate in organisational education requirements.

- Commence strategy to educate staff, pts & stakeholders.
  - APPENDIX 10

- Establish formalised mentor & Supervisor program for NP Renal Care
  - APPENDIX 11 b & c

- Submission forwarded to Exec Director Nursing & Amb Services Chairperson NPSC
  - APPENDIX 11a

- Commence NP Renal Care Candidate working towards NBV endorsement

- Commence NP Renal Care Endorsement process with NBV

- Develop CPG’s
  - APPENDIX 11d

- Conduct nursing research and act as a role model in clinical field

- Page 31 & 32

- Page 31

CONGRATULATIONS
NURSES BOARD ENDORSEMENT
YOU ARE AN ENDORSED “NURSE PRACTITIONER”
### 4.4 & 4.5.3 Timeframe to Endorsement

#### TIMELINE FOR THE NURSE PRACTITIONER CANDIDATE RENAL CARE

**AUSTIN HEALTH**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 3mths</td>
<td>Commence NP Renal Care Candidate working towards NBV endorsement</td>
</tr>
<tr>
<td>1.5yrs</td>
<td>Completion of Masters &amp; Therapeutic Medication Management</td>
</tr>
<tr>
<td>2 yrs</td>
<td>Austin Health’s Internship: (from 2008)</td>
</tr>
<tr>
<td></td>
<td><strong>Clinical Supervision</strong></td>
</tr>
<tr>
<td></td>
<td>2hrs/week clinical development</td>
</tr>
<tr>
<td></td>
<td>10hrs/year clinical lecturing</td>
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<tr>
<td></td>
<td>Mentoring Program-Mentor meeting Log</td>
</tr>
<tr>
<td></td>
<td>CPG Development, &amp; staff education (4hrs/week)</td>
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<tr>
<td></td>
<td>Consolidate skills &amp; develop professional portfolio</td>
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<tr>
<td></td>
<td>Clinical Log (Patient Assessment)</td>
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<tr>
<td></td>
<td>Unit record audit (documentation)</td>
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<tr>
<td></td>
<td>Case Review</td>
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<tr>
<td></td>
<td>Competency supervision/Bondy Scale 3 monthly</td>
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<td></td>
<td>Clinical examination of individual’s skills</td>
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<tr>
<td></td>
<td>Developing evaluation &amp; monitoring process</td>
</tr>
<tr>
<td>2.5yrs</td>
<td>Completion of Application: (from 2008)</td>
</tr>
<tr>
<td></td>
<td><strong>Pathway 1, 2 or 3</strong></td>
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<tr>
<td></td>
<td>Nominate category of practice</td>
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<td>Oral examination</td>
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<td>Submit summary of model of care &amp; scope of practice</td>
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<tr>
<td></td>
<td>Provide drug formulary &amp; constructed CPG’s</td>
</tr>
<tr>
<td></td>
<td>2 complex case studies</td>
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<tr>
<td></td>
<td>Evidence of organisational support &amp; professional indemnity</td>
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<tr>
<td>3yrs</td>
<td>Endorsement Process: (from 2008)</td>
</tr>
<tr>
<td></td>
<td><strong>Qualification Assessment</strong></td>
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<tr>
<td></td>
<td>CPG’s, policies</td>
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<tr>
<td></td>
<td>Submission of Portfolio</td>
</tr>
<tr>
<td></td>
<td>Clinical Log</td>
</tr>
<tr>
<td></td>
<td>Competency efficiency</td>
</tr>
<tr>
<td></td>
<td>Recommendation to the Board for Endorsement</td>
</tr>
</tbody>
</table>

**Contact the Nurses Board of Victoria 3 months prior to completion of Masters to ensure expert panel availability.**

**NOTIFIED WITHIN 28 days**

### 4.5 Renal Care Candidacy Model

Refer to ‘Preparing the Workforce’ 4.1 through to 4.5.
The NP candidate will need to develop an individualised education/learning plan based on the NP competencies, the specific scope of practice and their own professional and clinical learning needs.

#### 4.5.1 Support for Educational Requirements

Figure 2 sets out resources from the candidacies educational resources and program that will help them in attaining the requirements to have them prepared for application to NP Endorsement.
The Austin Health NP Internship delivers the educational preparation required:

- Accredited Masters Program
- Clinical Mentor-to assist the NP candidate to orientate themselves to their new role, gain insight into the scope of practice and identify the candidates learning needs. The mentor is an advocate, role model, coach and guide.
- Clinical Supervisor-role is to help develop the candidate’s clinical skill and knowledge base. They will also assess the candidate’s competency standards against the Bondy Scale (Appendix 13) initially, then every 3 months of the internship.
NP candidates would join the Junior Medical Officers Training Program to access clinical educational needs, to record practice, for preparation and presentation and case study experience.

Figure 2
Support for educational preparation requirements

<table>
<thead>
<tr>
<th>STANDARD</th>
<th>COMPETENCY</th>
<th>RESOURCE</th>
</tr>
</thead>
</table>
| 1. Dynamic practice that incorporates application of high-level knowledge and skills in extended practice across stable, predictable and complex situations. | 1.1 Conducts advanced comprehensive and holistic health assessment relevant to a specialist field of nursing practice. | ▪ Health Assessment and Diagnosis (Masters Program)  
▪ Clinical supervision |
|                                                                           | 1.2 Demonstrates a high level of confidence and clinical proficiency in carrying out a range of procedures, treatments and interventions that are evidenced based and informed by specialist knowledge. | ▪ Evidence-Based Guideline Development for Clinical Practice (Masters Program)  
▪ Scope of Practice  
▪ CPG’s  
▪ Junior medical Officer’s Training Program |
|                                                                           | 1.3 Has the capacity to use the knowledge and skills of extended practice competencies in complex and unfamiliar environments. | ▪ Clinical Case Review/Presentations  
▪ Therapeutic Medication Management Course |
|                                                                           | 1.4 Demonstrates skills in accessing established and evolving knowledge in clinical and social sciences, and the application of this knowledge to patient care and education of others. | ▪ Clinical Log  
▪ CPG’s  
▪ Junior Medical Officer’s Training Program |
| 2. Professional efficacy whereby practice is structured in a nursing model and enhanced by autonomy and accountability. | 2.1 Applies extended practice competencies with a nursing model of practice. | ▪ Clinical meetings and tutorials  
▪ X-ray meetings |
|                                                                           | 2.2 Establishes therapeutic links with the patient/client/community that recognise and respect cultural identity and lifestyle changes. | ▪ Presentations to internal/external multidisciplinary forums |
|                                                                           | 2.3 Is proactive in conducting clinical service that is enhanced and extended by autonomous and accountable practice. | ▪ Competency standards assessed 3 monthly against the Bondy Scale |
| 3. Clinical leadership that influences and progresses clinical care, policy and collaboration through all levels of health care. | 3.1 Engages in and leads clinical collaboration that optimizes outcomes for patients/clients/communities. | ▪ Multidisciplinary consultation  
▪ Referral to other unit abilities  
▪ NP Renal Care Collaborative-Bendigo Health |
|                                                                           | 3.2 Engages in and leads informed critique and influence at the systems level of health care. | ▪ Mentoring program  
▪ Clinical supervision  
▪ Post graduate education and staff development  
▪ NP Candidate Peer Support Group |

4.5.4 Collaborative Models

▪ Renal Care Collaboration supported by Bendigo Health  
▪ Austin Health’s NP Peer Support Group  
▪ HMO Training Program
APPENDICES
The next four years

The Austin Health Strategic Plan will consolidate and continue to build our reputation for excellence and outstanding leadership in healthcare, research and education.

Over the next four years we will be working hard to improve access to our services by:

- Further reducing the waiting times for elective surgery
- Reducing the time between outpatient referral and appointments
- Reducing the waiting time in the Emergency Department
- Minimising the number of patients waiting longer than 12 hours in the Emergency Department for a hospital bed and
- Minimising ambulance bypass.

The 2005-08 Strategic Plan is not achievable without the dedication and commitment of all staff. Austin Health strives to attract, retain and value staff by providing professional development and a working environment that is both safe and supportive.

About Austin Health

Austin Health is the major provider of tertiary health services, health professional education and research in the north east of Melbourne. Austin Health is world-renowned for its research and specialist work in cancer, liver transplantation, spinal cord injuries, neurology, endocrinology, mental health and rehabilitation. Austin Health comprises Austin Hospital, Heidelberg Repatriation Hospital and the Royal Hobt Rehabilitation Centre.

During 2005-07, Austin Health's 6,700 staff treated a record 85,875 inpatients and 1.4 million outpatients.

Austin Health prides itself on being a leader in Victorian healthcare and was awarded the Premier's Award for best outstanding Metropolitan Health Service of the Year 2006.

Austin Health

145 Studley Rd, Heidelberg, Victoria

Australia 3084

P.O. Box 63665

Tel 03 9496 5000

Fax 03 9496 4778

A handy guide to Austin Health's Strategic Plan

2005-08
Strategic plan 2005-08

What is the Austin Health Strategic Plan?
The Austin Health Strategic Plan has been developed to give Austin Health future direction. It tells us where the future lies for the health service and how we’re going to get there.
The Austin Health Strategic Plan was developed through extensive internal and external consultation with staff, the community, including community providers; senior management and the Board of Directors. This consultation process culminated in the recognition of six strategic priorities.
Each priority will guide work at every level of the organisation and is critical to the future delivery of services throughout the Austin Health.
In July 2006, Minister for Health Bronwyn Pike, alongside the Austin Health Board of Directors, ratified the strategic plan and committed to the delivery of the 2005-08 strategic plan priorities.
What can you expect from the strategic plan?
The Austin Health Strategic Plan is the driving force behind all that will occur in the health service between 2005-08.

Our priorities
1. Delivering the right services well
We will provide safe, quality care and deliver timely services that serve the needs of our community.

2. Working through partnership and participation
We will work in partnership with our patients, carers, families, the community and other health service providers.

3. Leading in research and education
We will provide excellence in education and training and lead in advancing basic, clinical and applied research through the Austin Biomedical Alliance.

4. Investing in our staff
We will attract, retain and value all of our staff through professional development, ensuring a supportive work environment while seeking to address current and future workforce challenges.

5. Building a strong, sustainable future
We will ensure ongoing financial viability and continue to plan and develop high-class facilities to meet our community’s needs.

6. Advancing leadership and innovation
We will support clinical and management leaders to develop a strong culture of leadership and innovation and explore opportunities for advances in service delivery.

...
2007-08 Statement of Priorities
Agreement between Minister for Health
and Austin Health
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Introduction to 2007-08 Statement of Priorities

Background

The Statement of Priorities is the key accountability agreement between Austin Health and the Minister for Health. This annual agreement ensures delivery of or substantial progress towards the key shared objectives of financial viability, improved access and quality of service provision.

The Statement of Priorities incorporates systemwide priorities and statewide benchmarks set by the government but also allows for locally generated health service/hospital specific priorities. It also identifies performance and activity targets and a small number of measureable Key Performance Indicators. The Statement of Priorities forms the basis of organisational performance assessments throughout the year that are reported on in the Integrated Performance Report. This includes regular monitoring of health service achievement of strategic priorities as well as delivery of priorities aligned to Government policy directions and priorities. The Performance Monitoring Framework strengthens the overall monitoring, analysis and performance evaluation of public health services in a transparent manner.

Government policy directions and priorities

The Victorian Government’s policy directions are addressed in the Growing Victoria Together statement. Underpinning this vision for Victoria to 2010 and beyond is A Fairer Victoria. Central to the Fairer Victoria framework is the combined emphasis on the provision of accessible and affordable universal services for all Victorians, and a parallel focus on targeting support for those in greatest need. A Fairer Victoria 2007 continues investments in areas which have a direct impact on reducing disadvantage.

Key initiatives of the 2007-08 State Budget include funding to:

- expand access to emergency and critical care services
- provide two new surgical centres to help reduce the waiting time for elective and orthopaedic surgery
- expand hospital capacity, including maternity services and other essential services including renal dialysis, chemotherapy, radiotherapy, blood services and ventilation support
- increase the number of outpatient appointments
- expand short stay units, day treatment centres and medi/hotels and treat more people at day hospitals
- equip major hospitals with mental health teams in emergency departments and provide new mental health acute beds
- strengthen the health workforce
- support new health and aged care building projects.

In 2007-08, health services will need to demonstrate their commitment and progress towards implementation of the following policies and directions; HealthSMART Participation policy, Health Purchasing Victoria policy, Metropolitan Health Strategy 2007 - Future Directions, membership of the Health Promoting Hospitals Network, Future Directions for Victoria’s Maternity Services, Better Faster Emergency Care, Elective Surgery Access policy, Integrated Cancer Services strategy, Strengthening Palliative Care policy, Improving Care for Older People policy, Outpatient Services Improvement And Innovation Strategy, Care In Your Community policy, Infection Control Strategy, Strengthening Emergency Management Capability And Capacity Strategy, Medical Equipment Asset Management Framework, and Improving Care for Aboriginal and Torres Strait Islander Patients (ICAP) policy.
Austin Health

Part A: Strategic overview - Draft

Mission statement

<table>
<thead>
<tr>
<th>Vision:</th>
<th>Austin Health will be renowned for excellence and outstanding leadership in healthcare, research and education</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mission:</td>
<td>Austin Health is the major provider of tertiary health services, and health professional education and research in the northeast of Melbourne</td>
</tr>
<tr>
<td>Values:</td>
<td>Integrity: we exercise honesty, candour and sincerity</td>
</tr>
<tr>
<td></td>
<td>Collaboration: we work in partnership with others</td>
</tr>
<tr>
<td></td>
<td>Accountability: we are transparent, responsible and answerable</td>
</tr>
<tr>
<td></td>
<td>Respect: we treat others with dignity, consideration, equality and value</td>
</tr>
<tr>
<td></td>
<td>Excellence: we continually strive for excellence</td>
</tr>
<tr>
<td></td>
<td>Empathy: we are compassionate and empathetic</td>
</tr>
</tbody>
</table>

Service profile and planning priorities

Austin Health is made up of three facilities: the Austin Hospital, Heidelberg Repatriation Hospital and Royal Talbot Rehabilitation Centre.

The Austin Hospital is a major tertiary hospital providing an extensive range of medical, surgical and mental health services including specialist services for spinal and head injuries and delivery of the new youth early psychosis program, respiratory, cancer, neurological disorders including epilepsy and stroke and liver transplantation.

Heidelberg Repatriation Hospital has a significant history of providing health services to veterans and war widows. The Repatriation Hospital amalgamated with the Austin Hospital in 1995. It now focuses on ambulatory care and day surgery, aged care residential care, palliative care, radiation oncology and mental health.

Royal Talbot Rehabilitation Centre provides general rehabilitation services and specialises in spinal and neurological (acquired brain injury) rehabilitation and specialist mental health brain disorders.

Austin Health also provides the following statewide services:

- Victorian Spinal Cord Injuries Services (VSCI)
- Victorian Liver Transplant Unit
- Victorian Respiratory Support Service
- Victorian Weaning Unit
- Child Inpatient mental health service
- Veterans’ mental health service
- Toxicology Service
Austin Health services a primary catchment population of 250,000 people covering:
- Darebin – Preston
- Banyule – All (Includes Heidelberg and North)
- Nillumbik – All (Includes South, Southwest and Balence)

Austin Health services a secondary catchment population of 265,000 people covering:
- Darebin – Northcote
- Whittlesea – All (includes North and South)
- Manningham – All (includes West and East)

Austin Health planning priorities for 2007-2008 include:
- Completion of the feasibility study for the Heidelberg Repatriation Hospital Mental Health development and the mental health service plan.
- Completion of final business case for Veterans Mental Health redevelopment
- Continuing to plan for the Olivia Newton John Cancer Centre
- Continue to develop cancer services as part of the North Eastern Integrated Cancer Service
- Implementation of an improved organisation wide performance management program
- Workforce planning including workforce redesign, succession planning, Employee Assistance program and return to work support
- Undertaking an Inaugural Employee Opinion Survey
- Planning for an electronic medical record and effective application of Information Technology/Informatics solutions to improving patient safety and quality and human resource management.
- Continue to develop and roll out an integrated risk management system, incorporating Business Continuity Management and Code Brown Disaster Planning
- Continue to identify and make service improvements to enhance flow through all areas of the hospital including outpatients
- Participating in Department of Human Services (DHS) Medical Equipment Replacement
- Infrastructure assessment of Mellor Ward at Royal Talbot Rehabilitation Centre
- Update Asset Management Plan for buildings and equipment
- Expending client base for Central Production Kitchen
- Completing Outpatients redesign project
- Implementing a Clinical Skills Centre
- Continued planning and redevelopment of radiology department facilities including angiography suites, Computerised Tomography (CT) and mammography services
- Establishment of CT service in the Emergency Department
- Establishment of an After Hours GP Clinic
- Continued implementation of Health-SMART
- Strategies to increase uptake of home based haemodialysis
- Strategies to support and sustain Improving care for older people across the whole of health service

Major capital developments for 2007-2008:
- Continuation of Health and Rehabilitation Centre including hydrotherapy pool and rehabilitation gym due for completion late 2008
- Finalise plans and commence construction of Bioresources facility and Florey Neurosciences Institute
- Refurbish and opening of the Elective Surgery Centre at Heidelberg Repatriation Hospital
- Continue to refurbish Harold Stokes Building and Lance Townsend Building as funding allows
- Complete Austin Health Strategic Master Plans

**Strategic priorities for 2007-08**

<table>
<thead>
<tr>
<th>Strategic Priority</th>
<th>Deliverables</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Site master planning across the 3 campuses</td>
<td>Complete master planning across 3 sites</td>
<td>30 June 2008</td>
</tr>
<tr>
<td>2 Elective surgery centre refurbishment and opening</td>
<td>Elective surgery centre operational at Heidelberg Repatriation Hospital</td>
<td>30 June 2008</td>
</tr>
<tr>
<td>3 Continuing to provide better access to emergency and elective surgery</td>
<td>Meet DHS access and performance targets</td>
<td>30 June 2008</td>
</tr>
<tr>
<td>4 Planning for medium secure Mental Health facility</td>
<td>Planning completed within agreed timeframe</td>
<td>30 June 2008</td>
</tr>
</tbody>
</table>
| 5 Improve Austin Health cash position | • Meet statement of priority financial targets  
• Generate sufficient capital funds to meet planned equipment and infrastructure needs | 30 June 2008 |
| Continuing to build relationships with Mercy Hospital for Women | • Undertake joint planning for Women's Health services  
• Undertake a shared Business Continuity Planning process in conjunction with the Victorian Managed Insurance Authority (VMIA)  
• Continue to build clinical linkages | 30 June 2008 |
| 7 Implement the Metropolitan Food Services Strategy | Central Production Kitchen operating to planned capacity | 30 June 2008 |
NURSE PRACTITIONER – RENAL CARE FOCUS GROUP

HELD 28TH AUGUST, 2008

In attendance:
Anne Wright - Manager of LOD (Focus Group Facilitator), Annette Coutts – Project Officer Nurse Practitioner, Renal Care (Focus Group Co Facilitator), Jason Payne – Medical & Emergency CSU Project Manager (scribe), Ada Wilcox – NUM Dialysis Training Unit (DTU), Pascal Bisscheroux – Pre Dialysis Coordinator, Sharon Lorman – NUM Renal Dialysis Unit (RDU), Angela Warland – NUM North East Kidney Service (NEKS), Marie Cook – NUM 7 North Central Dialysis Unit (CDU), Maree Ross-Smith – Renal Access Coordinator, Megan Sandiford – Live Donor Coordinator, Katina Aspridis – NUM Epping Dialysis Unit (EDU), Allyson Manley Grant – NUM 7 North, Dr Frank Ierino – Deputy Director Nephrology

Apologies:
Jen Bakker – Anaemia Coordinator, Cameron Hunt – Clinical Nurse Specialist, Peritoneal Dialysis, Dr Peter Mount – Consultant Renal Physician, Dr Matthew Roberts – Renal Physician, Dr Kathy Paizis - Consultant Renal Physician

FOCUS GROUP INTRODUCTION

Thank you all for coming.

I’m Anne Wright, Manager of Learning and Organisation Development (LOD). Also present today is Annette Coutts, Project Officer – Nurse Practitioner (NP) Renal Care, who has organised this focus group, and Jason Payne, Medical & Emergency CSU Project Manager who will take notes from today’s Focus Group. As is the format in all focus groups, we request that only one person speaks at a time so we can capture your thoughts.

Most of you will know, among the various things LOD does, is to facilitate focus groups. As an independent unit and body, we aim to elicit your ideas, encourage you to participate and share your thoughts & experiences.

The aim of this particular Focus Group is to explore with you:

- From a choice of 4 areas, what the best area to introduce a Nurse Practitioner model might be
- And, in doing this, get you to think about such things as:
  - What the benefits would be
  - What the current and future gaps are
  - What improvements would there be from a patient, service and CSU perspective
  - What outcomes could be expected
  - What support would be required to implement in a particular area and
  - What impact this might have on other service areas

In terms of how the session will run, we would first like to give you an introduction on Nurse Practitioners, which Annette will do. Annette will aim to clarify some things, such as what is involved in becoming registered as a NP, what criteria must be met, the scope of a NP once it has been implemented, the NP experience at other hospitals, after which there will then be an opportunity for you to ask a few questions.
We will then move into the focus group component, and I will be asking you a series of questions, eliciting your thoughts and ideas. These will be structured, in order to get you thinking about specific areas, but we will of course, also seek other comments.

Are there any questions at this point?

I’ll now hand over to Annette, who will take us through some of the aspects of Nurse Practitioners.

Take questions after Annette’s presentation.

Annette will present ‘a day in the life of a renal NP’ as no NP was able to attend in person.

Are there any questions at this point?

Summing up, some of the critical success factors, may be:

- Funding
- Candidate selection
- Continuing academic focus
- Medical collaboration
- Are there any others?

I now have a range of questions to put to you, which you might be able to answer easily, or we might need to discuss them a bit and tease them out.

As always with focus groups, we are gathering information, therefore whose idea something was, or even who the people we are speaking with are not important but rather capturing the discussion is the key. Jason will be taking notes as we move through the questions.

The four areas we are looking at are:

1. Home based dialysis therapies
2. Vascular access
3. Pre dialysis
4. Satellite support

QUESTIONS

1. What do you think the current gaps are with:

   - Home based dialysis therapies
     - Initial referrals, getting patients into therapy
     - Determining functional vascular access
     - Encouraging patients to participate in home dialysis (PD, haemodialysis)
     - Not encouraged by all Consultant Renal Physicians

   - Home based dialysis therapies cont...
     - No established consistent criteria to determine patient group to go onto home dialysis
     - No designated Home Training Unit
     - Managing perceptions and expectations of patients
     - Home visitation – level of service not provided on a regular basis rather ‘on call’ only – reactive service rather than planned
     - Current home training exists in a dual Satellite/home training unit not designed for this purpose
- Outsourcing renal technical services vs. in-house

- Vascular access
  - Inability to provide review of country patients pre dialysis
  - Referral base - lack of lead time
  - Ongoing fistula surveillance

- Pre dialysis
  - Early Chronic Kidney Disease (CKD) detection required – potential to improve patient outcomes by delaying progress of renal disease
  - Patient counseling/support
  - Capacity for patient follow-up
  - Lack of clear patient clinical pathway
  - Medication review
  - Opportunity to review patients during all phases of CKD
  - Ongoing comprehensive patient monitoring
  - Medication prescribing
  - Treatment planning
  - Community support

- Satellite support
  - Medication review and potential alteration
  - Coordinating timely Outpatient Department reviews
  - Regular Base Weight review
  - Pathology review - miscellaneous
  - Consistent Medical sign off of patients being transferred to the Satellite Units
  - Clinical support for Satellite Unit Nursing Staff
  - Patient follow up post transfer to Satellite Units (Review 1 week post transfer)
  - Regular patient access review and surveillance
  - Clinic time at Satellite Units each month to review patient treatment plans
  - Review of hypertensive medications

2. What would be some of the benefits of having a NP in:

- Home based dialysis therapies
  - Increasing numbers of patients on home based therapies
  - Improve patient quality of life
  - Financial incentives
  - Decrease pressure on inpatient dialysis services

- Vascular access
  - Legitimising patient referrals
  - Ability to order tests/procedures without seeking Medical signoff – increase efficiencies

- Pre dialysis
  - Early detection of disease progression
  - Slowing disease process
  - Potential to reverse some disease processes
• Ability to order tests/procedures and some medications without seeking Medical signoff – increase efficiencies

• Satellite support
  o Decrease number of patients that ‘bounce back’
  o Continuity of care
  o Increase quality of life

3. If thinking about some of the benefits of the NP role, what would be the types of improvements you could expect for:

• The patient
  o Group agreed that they would be the same patient improvements ‘as above’ plus additional improvements such as;
  o Improve patient safety
  o Streamline patient care so they can potentially return to work

• The Service or CSU
  o Cost savings
  o Decrease clinic numbers
  o Decrease incidence of patient ‘bounce-back’
  o Decrease in Nursing Staff stress
  o Enhancement of Service profile
  o Opportunity for research
  o Improved patient care
  o Increased revenue

• Professional issues
  o The role could support everyone else, Nursing, Medical
  o Nursing staff able to aspire to someone
  o Career progression
  o Teaching/coaching j8nior medical staff/Registrars

4. What support do you think would be required to implement a NP role in Renal Care?
  o CEO support
  o Senior Medical Staff Support
  o Nurse Board Victoria support
  o Colleague support
  o Mentorship role, who provides this?
  o Financial incentives, it was felt that the wage of a NP was not appealing for the responsibility they have
  o Access to study time
  o Financial assistance for completion of Masters Degree
  o Government support

5. What do you think some of the Cost Benefits or Savings would be for a NP in
  o Decreased patient presentations to ED and subsequent inpatient admissions
  o Increased number of patients on home haemodialysis
  o Delaying progression/prevention of diseases – reduced cost to Austin Health and the broader Health Care System
6. When thinking about roles, we tend to think about our current needs, but if we thought about how health care might be delivered in the future, (new drugs & treatment regimes, changing health status, higher patient expectation, more IT infrastructure and savvy, more mobile patients), how do you think these things might impact on a NP Model?
   o New drugs
   o Increased patients on haemodialysis as new treatment modalities have been able to keep patients alive longer
   o Older patients
   o Increased incidence of Type 2 Diabetes
   o Research may impact on role eg: trials in CKD and pre dialysis
   o Increase in patient numbers may be greater than research can keep up with which may delay positive outcomes
   o Patient expectation will change – expect more from technology and the Health Care System
   o Transplantation will not meet patient demand

7. Any other issues?
   • Some general comments were raised, which will impact on patient care over the next few years and into the future. The role of the NP will be integral in meeting some of these identified patient issues. These included:
     o Aging population of renal patients
     o Increased number of patients commencing haemodialysis
     o Decreasing number of Nephrologists to manage patients in the future, as we are not attracting Medical staff to the role. Nephrology Society has identified these workforce issues
     o Advanced treatments and procedures, which improve patient outcomes and keep patients alive for longer
     o Need for some type of ‘step down’ Unit ‘Subacute Unit’ to transition patients before they are allocated to a Satellite Unit
     o Look at restructuring dialysis services to meet future service needs
     o If we are not proactive change will be forced upon us
     o NP and Drs could be symbiotic
     o Renal Bone Disease requires further exploration – probably a coordinator role though. Divergent views and expectations of the need for this role currently exist
### SWOT Analysis
Assessing CKD Clinic-Predialysis

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Early detection of disease progression</td>
<td>• Not currently established</td>
</tr>
<tr>
<td>• Potential to delay patient outcomes by delaying progress of renal disease</td>
<td>• Encroaching on GP’s area</td>
</tr>
<tr>
<td>• Patient counselling/support and link into community supports</td>
<td>• Complex medical care requiring nephrologists intervention</td>
</tr>
<tr>
<td>• Capacity for patient follow-up</td>
<td>• Extreme difficulties with settling blood pressure</td>
</tr>
<tr>
<td>• Create a clear patient clinical pathway and treatment planning</td>
<td>• Much involved with establishing initial diagnosis</td>
</tr>
<tr>
<td>• Medication review and prescribing</td>
<td></td>
</tr>
<tr>
<td>• Ability to order tests/procedures without seeking medical sign off</td>
<td></td>
</tr>
<tr>
<td>• Opportunity to review the patient during all phases of CKD</td>
<td></td>
</tr>
<tr>
<td>• Ongoing comprehensive patient monitoring</td>
<td></td>
</tr>
<tr>
<td>• Potential to delay progression leads to delay in need to start dialysis</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To establish a CKD clinic</td>
<td></td>
</tr>
</tbody>
</table>
## SWOT Analysis
Assessing: Satellite Dialysis

### Strengths
- Staff available immediately for treatment, support and education
- Monthly review by consultant nephrologists
- Organise outpatient appointment as required
- Pathology review
- Identify vascular access problems early
- Arrange transport
- Create social contact/outing for some isolated/older patients
- Another modality for Renal students
- Give antibiotics and blood products (no need to go to hospital)
- Patients dialyse in a non hospital environment
- Able to assess patient’s emotional and social needs
- Know patients ARE dialysing

### Weaknesses
- No chair availability
- Restrictive life style
- Dependence on ambulance/personal transport
- Lack of choice by patient
- Shorter dialysing time leads to decreased wellbeing and poorer blood results
- Inflexibility with treatment and session times
- Dialysing with a large group of patients
- Need to send patients back to hospital when unwell
- Co patients all at different stages of their illness-witness this
- Timely medication and pathology review and alteration
- Need to send back to outpatients for review
- Distance from many patient’s place of residence
- Ongoing dialysis machine maintenance due to number of runs

### Opportunities
- Arteriovenous fistula construction performed months in advance of patients commencing dialysis
- Decrease in costs due to the use of temporary permacath
- Decrease costs associated with treatment/hospitalisation [as patients with AV fistula less likely to be admitted to hospital to maintain function from infection, clotting etc]
- Establish a coordinated Multidisciplinary approach to Vascular Access- Physician, surgeon, nurse and patient
- To prevent thrombosis by early detection and intervention

### Threats
- Loss of funding to the position
- No holiday relief for staff member
<table>
<thead>
<tr>
<th>Good</th>
<th>Difficulties</th>
<th>One thing you would tell someone else, with CKF, about dialysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dialyses 3 times /week for 4 hours</td>
<td>Tell people I am going off to do volunteer work</td>
<td>Feel safer at the unit and have confidence in all the staff there</td>
</tr>
<tr>
<td>I have ‘dodgy’ veins so I cannot needle and there is someone to needle for me</td>
<td>I have never dreaded dialysing or having to go and dialyse</td>
<td></td>
</tr>
<tr>
<td>Life style reasons: Go to the football on weekends and night matches so able to dialyse Mon, Wed &amp; Fri</td>
<td>No longer driving have to have husband drive me in</td>
<td></td>
</tr>
<tr>
<td>You are part of the family (others and staff) only 4 ladies on my shift</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialyses 3 times/week for 5 hours</td>
<td>Do not like getting needled</td>
<td>Absolutely everything is done for you and taken care of</td>
</tr>
<tr>
<td>Nursing staff wonderful, a family, love all the nurse</td>
<td>I panic</td>
<td></td>
</tr>
<tr>
<td>The level of care and how they care for you</td>
<td>Knowing I have had a good weekend so my weight will be up and so going to get told off</td>
<td></td>
</tr>
<tr>
<td>Dialyses 3 times/week for 5 hours</td>
<td>Long-time to sit there (5 hours)</td>
<td></td>
</tr>
<tr>
<td>It is like going to work and not getting paid for it. I see it has my place of employment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is just something I do, it does not worry me</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurses are very helpful</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I enjoy the afternoon drive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Form friendships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialyses 3 times/week for 5 hours</td>
<td>Nothing</td>
<td>More restrictions on your fluids as you do not have the opportunity to dialyse longer and an extra day like you might if did it yourself</td>
</tr>
<tr>
<td>It is just something I do, it does not worry me</td>
<td>No window to look out</td>
<td></td>
</tr>
<tr>
<td>Form friendships</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## SWOT Analysis

**Assessing: Home Maintenance Dialysis**

### Strengths
- Self funding
- Has government approval/backing
- Increased revenue
- Patients can dialysis nocturnally
- Patient maintain job and active lifestyle
- Dialyse longer lead to better outcomes for renal function
- Committed to Austin’s planning priorities—"Strategies to increase uptake of home based haemodialysis"
- Leadership by a NP, have there own clinical load
- Positive support to the patient and families social and emotional issues
- Decrease the strain on ambulance/transport services
- Commitment from Senior Medical staff
- Patients ownership of disease/self management-take control
- Home nocturnal HD can provide more treatment hours at a lower cost than conventional (thrice-weekly) HD
- Positive clinical effects particularly in reducing hospitalisations
- Patients healthier and fewer comorbidities
- Patients develop their own care plan

### Weaknesses
- An need to engage other areas eg HITH, RDNS
- Unable to keep up with the demand
- Getting the elderly to dialyse at home
- Need for am partner or family member to assist with the dialysis
- Part time employment of the consultant nephrologists

### Opportunities
- For those who do not currently home dialyse but would like to
- Free up dialysis spots in satellites
- For a separate home training centre
- Increased supervision of home patient
- Multidisciplinary team approach to home dialysis
- Holistic approach
- Funding for a Nurse Practitioner role
- An injection of DHS/GOV funding as an increase in home dialysis is one of the recommendations from the review
- Opportunity to increase tech service
- Increased numbers of home dialysis to bring us inline with other organisations
- Decrease presentations to ED and decrease readmission
- Decrease outpatient appointments
- More consistent clinical management
- To provide home visitation on a regular basis rather than ‘on call only’. Currently reactive rather than planned
- Outsourcing renal technical services v’s in-house
- Significantly drive down the costs of HD
- Reduced need for erythroid stimulants & antihypertensive meds contributing to lower costs

### Threats
- A block to funding
- Elderly becoming too anxious to want to dialyse at home
- Unable to keep up with demand
- Unable to get anyone to want to dialysis at home
- Patients who live in isolated areas
- Unable to plumb the home
- Unable to increase techs to match demand
- Disruption to utilities
- Water quality by local councils
## PATIENT INTERVIEWS ABOUT HOME MAINTENANCE DIALYSIS

<table>
<thead>
<tr>
<th>Good</th>
<th>Difficulties</th>
<th>One thing you would tell someone considering home dialysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home dialysis 8 years, 8 hrs 4 nights per week</td>
<td>Satellite dialysis 12 months before home dialysis</td>
<td>Encourage the person to give it a go</td>
</tr>
<tr>
<td>In charge of my own care</td>
<td>• Hated having to go into unit everyday</td>
<td>Good to have a carer (another person)</td>
</tr>
<tr>
<td>Can choose days and hours</td>
<td>• Then to wait another hour or more</td>
<td>Confidence will improve</td>
</tr>
<tr>
<td>Alternate days and hours</td>
<td>Satellite unit was disempowering</td>
<td>At first I was not confident but as I learnt more I got confident. It is like when you start to learn to drive and overtime you get better</td>
</tr>
<tr>
<td>No interference to others or from others</td>
<td>Loose connection with Austin renal care, wish DTU could visit more often</td>
<td></td>
</tr>
<tr>
<td>I can eat and drink more</td>
<td>Needling</td>
<td></td>
</tr>
<tr>
<td>DATA Houses-can go on holidays at the houses as have machine. Do not have to go to a hospital</td>
<td>Unable to button hole which would be ideal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Due to scarring husband has to assist with needling</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sleeping sometimes difficult but have had sleeping problems ever since getting sick</td>
<td></td>
</tr>
<tr>
<td>Trained straight to home dialysis 27 years ago</td>
<td>Did have some teething problems</td>
<td>Go for it, you can only try but do give it a good go</td>
</tr>
<tr>
<td>My wife and I spend lots of valuable time together</td>
<td>Puncturing (needling)</td>
<td>You can only try but do try first even if you end up back at the satellite</td>
</tr>
<tr>
<td>Number one good thing is can dialyse on time and day that is suitable for me</td>
<td>Temperamental machine but sorted it out</td>
<td></td>
</tr>
<tr>
<td>It fits our life rather than fitting our life around it</td>
<td>Nothing is dangerous or unmanageable</td>
<td></td>
</tr>
<tr>
<td>Has given wife and I more time and socialisation together</td>
<td>Use to have dialysis in the study. Difficulty isolated from my wife in other parts of the house. Moved into living room</td>
<td></td>
</tr>
<tr>
<td>Wife able to sit and talk with me and we do things together whilst I am dialysing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comfortable and more casual at home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I do not feel like a patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Something in my life I do</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can go on holidays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friends and family sit with me it is part of my life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can change day and work</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Free to go here and there</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If naughty one day can increase rate the next</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NP Project Phase 4 Round 4.2 Renal Care November 2008
<table>
<thead>
<tr>
<th>Home dialysis 12 years</th>
<th>Cannot complain, other than relatives trying to talk us out of doing it at home I cannot complain Some difficulties in the start adjusting to it</th>
<th>Some say cannot do at home because all the things to do but I tell them it is worth a try</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior satellite 6 months</td>
<td>Very convenient Do not have to be at hospital by certain time then by the time you wait and then dialysis it takes all day. At home half the day It suits us and our lifestyle (have no children) It is easier at home, have more time Not stuck to stick a time can organise around when have to take Mum to medical appointments We adapted and it become part of my routine and part of my life Able control dialysis a round fluid retention (weight) Husband does blood pressure and bloods RDNS picks up bloods</td>
<td></td>
</tr>
</tbody>
</table>
**SWOT Analysis**
Assessing: Vascular Access

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Ability to identify tests/procedures required and get medical signoff</td>
<td>• 6-8 week maturing period</td>
</tr>
<tr>
<td>• Timely functional vascular access</td>
<td>• AV fistula needs to be functioning well at the commencement of dialysis</td>
</tr>
<tr>
<td>• Decrease the length of time a patient has a permacath</td>
<td>• Needs assessment by a surgeon skilled in vascular access</td>
</tr>
<tr>
<td>• Early referral and planning decreases catheter use and the consequent risks to health avoided</td>
<td>• Assessment and access well before the anticipated start of haemodialysis</td>
</tr>
<tr>
<td>• Decreased morbidity and mortality with an AV fistula</td>
<td>• Not possible for delayed or late presentations of end-stage renal failure</td>
</tr>
<tr>
<td>• All commencing dialysis have vascular access where possible</td>
<td>• VA problems/issues major cause of hospitalisation for ESRD patients</td>
</tr>
<tr>
<td>• Early detection and maintenance of vascular access problems-prevents thrombosis</td>
<td>• Country patients are unable to be reviewed predialysis</td>
</tr>
<tr>
<td>• Educate and review patients predialysis to ensure functioning AVF</td>
<td></td>
</tr>
<tr>
<td>• AVF is the haemodialysis vascular access of first choice</td>
<td></td>
</tr>
<tr>
<td>• Decrease in infections compared to catheters</td>
<td></td>
</tr>
<tr>
<td>• Prioritise VA clinic and surgery lists</td>
<td></td>
</tr>
<tr>
<td>• On going communication with dialysis nurses and multidisciplinary team</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Arteriovenous fistula construction performed months in advance of patients commencing dialysis</td>
<td>• Loss of funding to the position</td>
</tr>
<tr>
<td>• Decrease in costs due to the use of temporary permacath</td>
<td>• No holiday relief for staff member</td>
</tr>
<tr>
<td>• Decrease in costs associated with treatment/hospitalisation [as patients with AV fistula less likely to be admitted to hospital to maintain function from infection, clotting etc]</td>
<td></td>
</tr>
<tr>
<td>• Establish a coordinated Multidisciplinary approach to Vascular Access-Physician, surgeon, nurse and patient</td>
<td></td>
</tr>
<tr>
<td>• To prevent thrombosis by early detection and intervention</td>
<td></td>
</tr>
</tbody>
</table>
# NURSE PRACTITIONER ROLE DEVELOPMENT RENAL CARE PROJECT

## STAKEHOLDER ANALYSIS

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Impact (impact of project outcome on...)</th>
<th>Involvement (involvement in the outcome)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High</td>
<td>Low</td>
</tr>
<tr>
<td>Nurses Board Victoria</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>CEO</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Austin Executive</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Exec Director Ambulatory &amp; Nursing Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Director Nephrology</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>M&amp;E CSU Director</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>M&amp;E CSU Medical Director</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Renal Satellite NUM’s</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>CDU NUM</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>NUM 7 North</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>DTU &amp; Home Training</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Home Dialysis Consultant Nephrologist</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Dialysis Consultant Nephrologist</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Renal Technicians</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>GAMBRO</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Consumers</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>DHS</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Vascular Access Nurse</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Predialysis Clinic</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Live Donor Kidney Transplant Coordinator</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Registrars</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Interns</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Deputy Director Nephrology</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Pathology</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>ANF</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Medical Education</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Clinical Governance</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Anaemia Coordinators</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>
The Renal Care Nurse Practitioner shall prescribe the following medical drugs in accordance with the Clinical Practice Guidelines (CPG’s) developed for that drug.

A description of assessment and management strategies that shall be undertaken, by the Nurse Practitioner in Renal Care, are to be developed on all prescribed medical drugs endorsed by the Nephrology Unit and Austin Health for use by the Nurse Practitioner Renal Care.

<table>
<thead>
<tr>
<th>Unscheduled</th>
<th>Schedule 2</th>
<th>Schedule 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aluminium Hydroxide</td>
<td>Lignocaine 1%</td>
<td></td>
</tr>
<tr>
<td>Calcium Carbonate</td>
<td>Lignocaine and Prilocaine Cream</td>
<td></td>
</tr>
<tr>
<td>Sodium Chloride 0.9% for Infusion</td>
<td>Prilocaine</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schedule 4</td>
<td>Schedule 8</td>
<td></td>
</tr>
<tr>
<td>Calcitriol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dalteparin and Enoxaparin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Darbepoetin alfa</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enoxaparin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epoetin alfa</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epoetin beta</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heparin Sodium</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B Vaccine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza Vaccine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza vaccine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iron Compounds (Polymaltose)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iron Sucrose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumococcal vaccine (Polyvalent, Pneumovax 23)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clexane</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renagel</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CONCEPTUAL FRAMEWORK DEFINITIONS

STRUCTURE of the organisation
.... refers to characteristics of the patient population and the practice setting. Characteristics of the practice setting include equity and accessibility, the care delivery model including referral criteria, organisational policies, clinical practice guidelines, patient load and the adequacy of resources.

Subsequent evaluation needs:

- Patient population defined
- Scope of practice expanded
- Number and range of CPG's written
- Criteria for patient referral developed and documented
- Monitoring of patient load undertaken
- Barriers to practice identified.

PROCESS of care
.... involves the role functions of the NP and ways to which the role is enacted; that is, how well the NP applies knowledge and skill to assist patients to deal with their health problems. The process of care is evaluated using a variety of methods, some of which are also used as assessment methods during NP candidacy.

Evaluation methods may include:

- Case studies
- Annual performance review/appraisal
- Documentation audit
- Self assessment
- Competency assessment
- Credentialing.

OUTCOMES of care
.... are the end result of both structure and process and are therefore considered to be an ideal measure of quality. Outcome measures also reflect team as much as individual performance. The kPI's are not an absolute measure of quality and therefore should not be interpreted as a conclusive picture of an individual's performance.

These outcomes include the timeliness, quantity and quality of care.

Evaluation:

- Care/presentations seen by the NP
- Related health problems/diagnosis
- Clinical activity for each event
- Diagnostic/pathology tests ordered
- Medications prescribed
- Increased appropriateness of referrals made.

---

### MONITORING OF THE SERVICE MODEL RENAL CARE

<table>
<thead>
<tr>
<th>DIMENSIONS OF QUALITY</th>
<th>OUTCOME/PROCESS MEASURES</th>
<th>AGREED MEASURES</th>
<th>INFORMATION SOURCE</th>
</tr>
</thead>
</table>
| **Access**            | • Time from CDU to optimum place of treatment  
  • Time to transfer  
  • Number of patients seen | • Reduced time to treatment  
  • Reduced time to transfer  
  • Increased number of patients seen in CDU & satellite | Unit clinical stats  
 Unit clinical stats  
 Pivot tables |
| **Safety**            | • Adverse events  
  • Diagnostic tests  
  • Occupational violence | • No increase in adverse events  
  • Pathology in line with unit protocols  
  • Decrease incidence of Occupational Violence requiring/not requiring security attendance | Riskman, clinical governance Audit  
 Riskman audits |
| **Effectiveness**     | • Re-admission to CDU (pts who could have stayed in the satellite for treatment)  
  • Re-presentation  
  • MET/MER calls | • Reduced admissions within 12 months  
  • Reduced presentations to ED  
  • Reduced transfer to ICU | Unit clinical stats Audits |
| ** Appropriateness**  | • Referral criteria  
  • Medications prescribed  
  • AVF problems/thrombolysis | • Patient referral criteria clearly documented  
  • Prescribed in accordance with clinical protocol  
  • Number of patients requiring VA Nurse referral | Document analysis Clinical audit |
| **Acceptability**     | • Patient satisfaction  
  • Satisfaction of referrals  
  • Carer satisfaction | • No decrease in patient satisfaction  
  • Level of satisfaction of referring practitioner  
  • Carer satisfaction with treatment plan | Patient survey/feedback form  
 GP survey  
 Carer survey/feedback |
| **Efficiency**        | • Time to referral  
  • Number of days to stabilise | • New referrals actioned within agreed period  
  • Average number of days | Audit Audit |

NURSE PRACTITIONER STEERING COMMITTEE

TERMS OF REFERENCE

The Nurse Practitioner Steering Committee is a representative multidisciplinary group that reports to the Nursing Advisory committee through its Chair, the Executive Director, Ambulatory and Nursing Services.

1 ROLE

1.1 The role of the Nurse Practitioner Steering Committee is to create a vision and develop a framework to introduce Nurse Practitioner roles at Austin Health.

2 REPORTING

2.1 The Nurse Practitioner Steering Committee reports to the Nursing Advisory Committee through its chair.

3 TERMS OF REFERENCE

3.1 The purpose of the Nurse Practitioner Steering Committee is to:

3.1.1 Provide organisational leadership for the implementation of Nurse Practitioner roles at Austin Health.

3.1.2 Provide a strategic direction for the implementation of Nurse Practitioners at Austin Health.

3.1.3 Oversee the development of the framework of the service/business plan for implementation of Nurse Practitioners at Austin Health.

3.1.4 Undertake an organisational analysis of the potential benefits and challenges.

3.1.5 Identify the organisational changes required to support the implementation of Nurse Practitioners.

3.1.6 Identify initial areas for establishing Nurse Practitioners, considering the potential impact of the role on service delivery such as demand patterns, throughput, length of stay, clinical audit, consumer satisfaction and health outcomes.

3.1.7 Identify the educational support required for Nurse Practitioners.

3.1.8 To identify the challenges that may arise when implementing Nurse Practitioner positions.

3.1.9 Develop guidelines to manage and resolve the challenges associated with the implementation of Nurse Practitioners.
3.1.10 Identify a process to engage / inform consumers in the process.

3.1.11 Identify a mechanism to mentor and provide supervision for Nurse Practitioners.

3.1.12 Explore the funding implications of implementing Nurse Practitioners’.

3.1.13 Establish the process required to evaluate the role.

3.1.14 Establish guidelines for clinical areas wishing to implement Nurse Practitioner roles.

4 EXPECTED OUTCOMES

4.1 For the 12 months from August 2005 to August 2006 the Nurse Practitioner Steering Committee will achieve the following outcomes:

4.1.1 The submission of the business/service plan to DHS.

4.1.2 The development of a strategy to support the implementation of Nurse Practitioners.

5 PERFORMANCE EVALUATION

Submission of Nurse Practitioner Services Plan to DHS by September 2005.

6 MEMBERSHIP

6.1 The following shall constitute the Council:

Chair - Executive Director Ambulatory and Nursing Services

Secretary – Project Officer – Nurse Practitioner

Members –

- Deputy Director Ambulatory and Nursing Services
- Executive Director – Acute Operations
- Manager - Clinical Nursing Education
- CSU Directors or Nursing Delegates – Specialty, Medical and Emergency, Psychiatry, Royal Talbot, Aged and Residential Care, Surgical, Cancer, Spinal and Outpatients, Anaesthetic, Peri-operative and ICU.
- Chief Medical Officer
- Senior Medical Staff Member
- Registrar
- Allied Health Manager
- Clinical Governance Manager
- NP candidate
- Latrobe University School of Nursing & Midwifery
- Nurse Unit Manager (2)
- Chief Executive Officer (ex officio)
- Other nominees as required
7 MEETINGS

7.1 Any person elected or appointed, as a member of the Council is entitled to one vote and in the event of an equality of votes, the Chair shall have the casting vote.

7.2 A quorum consists of a simple majority of voting members.

7.3 The Committee may invite any person to attend a committee meeting in order to facilitate its business. Any person so attending does not have voting rights.

8 MEETING FREQUENCY

8.1 The Nurse Practitioner Steering Committee will meet at least 8 times per year.
MEDICAL & EMERGENCY CSU
NEPHROLOGY UNIT

NURSE PRACTITIONER RENAL CARE ROLE

COMMUNICATION STRATEGY

OCTOBER

2008
1. Introduction

It is essential that a sound communication strategy be developed for the success of the Nurse Practitioner Renal Care Role.

The Nephrology Unit aims to build a model of integration of the Nurse Practitioner role in renal care at Austin Health.

This document sets out the requirements to achieve a highly effective communication strategy that will act as a guide for the Nurse Practitioner Renal Care and our stakeholders.

The Nurse Practitioner Renal Care Role will build upon and integrate current Nurse Practitioner (NP) requirements and implementation in the supervision of patients’ well being and their support in the dialysis arena.

This communication resource will enable all involved in the Nurse Practitioner Renal Care Role to give clear messages for the purpose, the program of work and their involvement and to engage and inform key stakeholders and enable successful implementation and sustainable outcomes.

2. Objectives

The objectives of the communication strategy will be:

- To raise unit and organisational awareness of The Nurse Practitioner Renal Care
- To generate excitement, fun and enthusiasm for redesign, innovation and improvement of patient care delivery in dialysis
- To promote openness, generosity and assistance to demonstrate good practice and change methods
- To assist with the flow of information
- To provide a central point for the stream of information.

3. Key communication principles

Communication principles underpin effective communications. The following principles of good communication practice will be built into the communication strategies.

1. Who is the target audience?
2. What information needs to be communicated?
3. How should we communicate, that is, what is the most appropriate method of communication?
4. Where and when should the information be targeted?
5. Why is the information being disseminated?

4. Program ownership within Austin Health

The Nurse Practitioner Renal Care Role will be led by the NNP or NP Candidate themselves and will operate by a support team from the Nephrology Unit, who will report directly to the Austin Health Nurse Practitioner Steering Committee.

The Steering Committee will provide governance and guidance to the rollout of The Nurse Practitioner Renal Care Role.
The Nurse Practitioner Renal Care and any support team will build strong working relationships with clinical and management leaders.

5. **Monitoring, reporting and promoting role**

The Nurse Practitioner Renal Care will work with key clinical areas to identify need and innovations for the role’s plans and time scales. All clinical areas will drive the changes to reach the project’s aims.

A full report of the Nurse Practitioner Renal Care Role implementation will be completed under the directive of the Clinical Director Medical & Emergency Clinical Service Unit (CSU) and made available to all stakeholders. Throughout the project, occasional progress reports will be presented to the Austin Health NP Steering Committee. The Steering Committee’s communication will be through an agenda and the circulation of minutes to all key NP stakeholders.

Specific innovations, monitoring and reporting will become embedded in the communications and evaluation of the role.

The NP will use a multidisciplinary “implementation team” approach to identify and implement the NP role into the clinical unit. Convene a multidisciplinary team with representatives from nursing, medicine and allied health discipline and management representatives.

### 6. Communication roles and responsibilities

<table>
<thead>
<tr>
<th>Health Service Position</th>
<th>Communication responsibilities</th>
<th>Target Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive NP Lead</td>
<td>Maintain corporate responsibility for raising profile and focus of NP Renal Care role within health service. Chair Steering Committee.</td>
<td>Austin Health Exec., Department of Human Service, Victorian public healthcare system</td>
</tr>
<tr>
<td>Nephrology Director &amp; CSU Director</td>
<td>Maintain project communication strategy. Lead project plans. Lead organisational communication strategy. Identify opportunities for NP's</td>
<td>Stakeholders Nurse Practitioner Clinical Leaders</td>
</tr>
<tr>
<td>Steering Committee</td>
<td>Provide executive lead with inputs for communication. Provide and champion communication and spread of actions. Demonstrate enthusiasm across all areas of the role.</td>
<td>Austin Health Stakeholders</td>
</tr>
<tr>
<td>Nurse Practitioner (Candidate/Endorsed)</td>
<td>Promote Communication of Position Feedback evaluation &amp; monitoring progress.</td>
<td>Clinical Leaders Stakeholders Front line staff Consumers</td>
</tr>
<tr>
<td>Clinical Leaders (eg NUM’s)</td>
<td>Provide and champion communication and spread of actions enthusiasm across clinical stream.</td>
<td>Front line staff (eg clinical staff)</td>
</tr>
</tbody>
</table>

### 7. Key messages

Three key messages are central to communicating the role, which will remain as simple as possible for ease of communication.

1. The Nurse Practitioner Renal Care Role aims to deliver timely management of the care and treatment patient’s need and manage local capacity and capability for innovation.

2. Front line clinical teams will drive and support the innovations of the Nurse Practitioner Renal Care Role.
3. The methodology will be practical and applicable to Nurse Practitioner Renal Care operational duties.

8. **Timelines**

<table>
<thead>
<tr>
<th>Commence NP Renal Care Candidate working towards NBV endorsement</th>
<th>Commence NP Renal Care Endorsement process with NBV</th>
<th>Endorsement Process: Qualification Assessment Expert Oral Examination Recommendation to the Board for Endorsement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5 to 2 years</td>
<td>6 months</td>
<td>Notified within 28 days</td>
</tr>
</tbody>
</table>

(Refer to the more detailed document titled, “Education of a NP Renal Care to Endorsement”)

9. **Communication methods/tools**

The following are the mechanisms that will assist the Nurse Practitioner Renal Care and the Nephrology Unit to impart the roles message to the target audience.

9.1 **Information sessions and consultation**

Information sessions will be held with key clinical and management leaders. Consultation forums will be conducted to:

- Meet the objectives to raise unit and organisational awareness of The Nurse Practitioner Renal Care Role
- Generate excitement, fun and enthusiasm for redesign, innovation and improvement of patient care delivery in dialysis
- The Nurse Practitioner will make presentations to all areas of the hospital and dialysis as to the role of the NP Renal Care and the Model of Care regularly (approximately every 2-3 weeks) throughout the first 3 months then redo every 12 months
- Representation on committees

The Nurse Practitioner Renal Care will share information, knowledge and experiences that impact on the implementation of the role/services. Outline what support is needed from others within renal care and the organisation

Information forums will be promoted via email, business meetings and posters, throughout the Nephrology Unit, to ensure appropriate participation and input.

9.2 **Focus group**

Through consultation with our patients and the community, in the form of focus groups, information will be gathered and communicated
9.3 Presentations
Presentations to the Austin Health Executive and key stakeholders will be communicated periodically throughout the implementation of the role.

Present at Staff Forums, Medical School/Orientation and Lectures

9.3 Issues management
The Nurse Practitioner Renal Care will proactively manage any predictable and non-predictable issues and as required, after consultation with the stakeholders or the management team.

If warranted, a Q&A sheet of the role of the Nurse Practitioner Renal Care will be developed and circulated to ensure all parties are approaching the Nurse Practitioner Renal Care Role in the same way.

10. Budget

Nurse Practitioner Candidate Renal Care
RN G5 Yr 2 Clin Con (ZA8)
$ 77,906.40 per year
$ 107,204 per year (includes on costs)
plus qualification allowance of $ 61.84 per fortnight for 26 weeks $1,608

2 years@ $217,624
or
3 years@ $326,436

Endorsed Nurse Practitioner Renal Care
RN G6 Yr 1 (201-300 beds) ZE8
$80,875.60 per year
$112,873 per year (includes on costs)
plus masters allowance of $68.80 per fortnight for 26 weeks $1,789 $114,663/yr

RN G6 Yr 2 (301-400 beds) ZE9
$83,844.80 per year
$117,025 per year (includes on costs)
plus masters allowance of $68.80 per fortnight for 26 weeks $1,789 $118,814/yr

(Refer to the more detailed document titled, “Budget Funding Requirements”)

12. Evaluation
Sustainability of the Nurse Practitioner Renal Care Role is also dependent upon the NP evaluating their role and collecting data that indicates the efficacy of the role on service provision. The NP will need to develop a database of outcome measures.
Some of the changes in service provision that can be measured are:

- Time to stabilise condition
- Quantity of treatment
- Quality of treatment
- Patient satisfaction
- Outcome measures specific to the NP Renal Care role

The NP Renal Care Service Model will also need to be evaluated and for this The Conceptual Framework for evaluating the Acute Care Nurse Practitioner, developed by Sidani and Irvine (1999), will be used; a Structure, Process and Outcome process.
## APPENDIX 11a

### NURSE PRACTITIONER SUBMISSION

**Part 1**  
**Service Provider Details**

<table>
<thead>
<tr>
<th>Clinical Service Unit/Area of Specialty</th>
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<tbody>
<tr>
<td>Name of Clinical Service Unit</td>
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<tr>
<td>Specialty</td>
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<tr>
<td>Contact Person</td>
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<tr>
<td>Position / Title</td>
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<td>Email Address</td>
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<tr>
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<tr>
<td>Name</td>
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<td>Position/Title</td>
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<tr>
<td>Role in developing NP position</td>
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<td>Telephone Number</td>
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<td>Email Address</td>
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<td>Telephone Number</td>
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<tr>
<td>Email Address</td>
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</table>
Submission

The intention of this submission is to ensure that the implementation of the Nurse Practitioner role has been carefully considered within the multidisciplinary health care team and that nursing has explored the introduction of this role and its inclusion within the overall delivery of optimal patient care. It is essential that the purpose of the position is transparent, with specific outcome criteria to enhance the delivery of patient services.

Completion of a submission to the Nurse Practitioner Steering Committee is required as a pre-requisite to implement a Nurse Practitioner role. The role of the Steering Committee is to assist in the development of Nurse Practitioners across Austin Health and to ensure that the proposed Nurse Practitioner candidate is well supported. The final position approval will be conducted through the customary channels for any department /CSU implementing a new position.

The submission is to be forwarded to Executive Director Ambulatory and Nursing Services/chairperson Nurse Practitioner Steering Committee.

1 Nurse Practitioner role

1.1 Define the Nurse Practitioner role
- Describe the NP model of care. Outline why the NP role has been proposed?
- Describe the added scope of practice and how this will assist service delivery?
- How will this role interrelate with other service providers, including nurses and the broader multidisciplinary team?
- Are there any other NP’s with this clinical specialty? (Victoria, interstate, international)
1.2 Describe the plan to fill the Nurse Practitioner position

- Are there any candidates within the specialty interested in becoming a NP?
- Do they possess the skills and education preparation required for NBV endorsement?
- If not, how would the position be filled?
- How will the role be sustained? (Succession planning for leave replacement and position vacancies)

1.3 Nurse Practitioner reporting structure and responsibilities

- Describe the proposed reporting structure. (may have a professional and operational reporting structure)
- What responsibilities does the manager of the NP undertake to ensure that all team members, nursing and the broader multidisciplinary team are involved in the evolution of the newly developed position?
2. Service Overview
Describe the current service, and its existing structure. Describe how the proposed change of implementing a Nurse Practitioner position will improve the delivery of service outcomes.
3 Service Improvement

- Utilising data (e.g., population trends, health care trends, workforce planning trends, LOS) describe how this role will enhance efficiency and service delivery.
- Are there other alternatives to providing this service?
- What direct benefits will this role add to the service being provided?
4 Evaluation
- Outline the generic KPI’s that will be utilised to assist in evaluating the role and service delivery and describe how these will be measured.

5 Communication structure
- Describe the communication plan with nursing team members, multidisciplinary team, stakeholders, referrers and clients. Communication plan includes formal and informal presentations with nursing team meetings, multidisciplinary team meetings, medical staff, (Consultants, Registrars, Residents, Interns), patients families and significant others. Written publications include brochures, newsletters, and magazines.
  - Formal communication strategies
  - Informal communication strategies
  - Publications
6 Team support
- Does the nursing and multidisciplinary team support this role being implemented?
- What measures are planned to mediate any actual or potential barriers within the team?

7 Copy of Position Description
- Complete and attach a draft Nurse Practitioner position description, utilising the generic Nurse Practitioner Position Description as the core document.

8 Education
8.1 Outline the educational support and strategy required to successfully implement the Nurse Practitioner role.
8.2 Outline the strategy to educate other nurses, medical staff and the multidisciplinary team about the role of the Nurse Practitioner.

9 Mentor
Discuss the support mechanisms for the Nurse Practitioner, including the possibility of a mentor program.
10 Barriers
• Identify major barriers to the implementation of the role and strategies to overcome.

11 Business Case Development
• Through the process of completing a Business Case have any funding sources been identified to support the role?
CLINICAL DEVELOPMENT GUIDELINES

NURSE PRACTITIONER CANDIDATES

May 2006
The role of the Nurse Practitioner is a relatively new phenomenon and currently there are very few role models as there is currently only eight endorsed Nurse Practitioners in Victoria. Given the extension in scope of practice it is essential the nurse has access to a clinical program specific to meeting their educational needs under the guidance of a clinical expert, usually a consultant doctor or Nurse Practitioner.

The expectations of a Nurse Practitioner to extend their scope of practice, usually presents as a major learning curve. Austin Health suggests that a clinical mentor is available to optimise the clinical skills of a Nurse Practitioner Candidate.

The Nurses Board Victoria (NBV) mandates that a Nurse Practitioner Candidate have written support from three clinical mentors, who support the endorsement of the candidate. Each referee is expected to complete a referee verification report covering information relating to advanced clinical assessment, skill level, diagnostic skill and knowledge, pharmacology knowledge, demonstrated competence in medication management and leadership, research abilities and agreed competency standards. It is anticipated that at least one referee would be a medical doctor. Referees must be people who are identified as senior health professionals and multidisciplinary team members who have provided clinical supervision to the applicant and may have been involved in the development of clinical practice guidelines and / or have worked closely with the applicant and are able to verify advanced level of practice and knowledge.

Some Nurse Practitioner Masters courses assist a candidate to develop a clinical internship, however other nurses do not have this opportunity as they are enrolled in generic masters or have completed or not commenced this subject at the time of applying for endorsement.

The focus of the clinical development program is to ensure the Nurse Practitioner Candidate has well developed clinical skills in the areas of advanced clinical assessment, diagnostic skill and knowledge, pharmacology knowledge, demonstrated competence in medication management, research abilities and advanced clinical leadership, to support a successful endorsement process with the NBV.

1. Clinical Supervisor guidelines
The supervisor should be:
   - A clinical expert in the area, either Consultant Doctor or Nurse Practitioner.
   - Available during clinical placement and able to commit to being a mentor for the duration of the internship.
   - Accessible within the clinical environment for teaching and reviewing patients seen by the candidate.
   - Have a good understanding of the Nurse Practitioner model and the extended scope of practice of the role.
   - Able to supervise clinical practice.

2. Clinical Supervisor responsibilities
   - Able to observe the student working clinically and provide thorough critical feedback on their performance in the role.
   - Ensure that a wide range of opportunities for skill development is available.
   - Assess progress of the Nurse Practitioner Candidate against the objectives at regular intervals.

It is intended that the clinical development program will assist in preparation towards the portfolio required for endorsement.
1. **Suggested outline for clinical development**

   **a) Commencement of candidate position**

   The Nurse Practitioner Candidate has been appointed into the role and is about to commence the journey of acquiring the clinical skills and knowledge required to fulfil the role of an endorsed Nurse Practitioner. The candidate will choose their clinical mentor and together will identify skill and knowledge gaps and complete a generic learning plan. The mentor and candidate will work together to complete this plan. It is anticipated the candidate and clinical mentor will meet regularly to review their skill development and learning plan.

   It has been suggested that a generic learning plan is identified for all Nurse Practitioner Candidates to be used as a starting point for the Nurse Practitioner Candidate and Clinical Mentor.

   **Proposed Generic Learning Plan**

<table>
<thead>
<tr>
<th>Medications</th>
<th>Pathology/radiology</th>
<th>Research</th>
<th>CPG’s</th>
<th>Note writing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribing</td>
<td>Normal pathology</td>
<td>Research project</td>
<td>How to write for CPG’s for Austin Health</td>
<td>Expectations Of Nurse Practitioner writing notes in Unit Record</td>
</tr>
<tr>
<td>Common drugs</td>
<td>Common blood tests</td>
<td></td>
<td>Who is required to sign off</td>
<td></td>
</tr>
<tr>
<td>Case scenarios</td>
<td>Effective radiology order writing</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>Common X-rays, Abdo, chest etc.</td>
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</tbody>
</table>

   **b) CPG development**

   In this phase the candidate is in the process of developing the Clinical Practice Guidelines (CPG’s) and therefore defining their extensions in scope of practice. The learning plan will become more specific as the guidelines are being developed, however in this phase the plan will focus on the following areas:

   - Health assessment and diagnostic skills in the specialty area,
   - Interpreting diagnostic and other laboratory tests.
   - Applying pharmacological interventions appropriately including therapeutic effects and adverse events.

   CPG’s are being developed simultaneously with the candidate acquiring knowledge in the clinical setting.

   It is anticipated regular feedback will occur, **preferably every two weeks**.

   **c) CPG completion**

   The CPG’s have been completed and the focus is on gaining the knowledge and skills that underpin the CPG’s. The candidate is expected to have developed an approach to advanced health assessment, considered diagnostic implications, including pathology and radiology, clinical management, referral or discharge planning and documentation and communication. During this phase the candidate will also learn examination skills for each system, interpretation of the results of diagnostic testing, making a diagnosis and procedural skills. The candidate is expected to practice clinically providing direct patient care to the population that fits the Nurse Practitioner scope of practice.
The candidate will practice under the direct and indirect supervision of their clinical mentor as well as other health professionals during this phase. The level of supervision provided will be dependent upon the competence of the candidate managing specific presentations. It will also be dependent on the mentoring clinician’s previous exposure to the candidate. It is expected that the mentor will provide the candidate with guidance regarding the level of supervision required.

**d) Consolidation of skills**

The candidate will focus upon consolidation of their clinical skills and building a professional portfolio to complete the endorsement process. The emphasis will be on total service provision, both clinical and non-clinical.

The candidate will continue to practice clinically under the direct and indirect supervision of a medical consultant or an endorsed Nurse Practitioner. However, the level of direct supervision should be minimal in preparation for endorsed practice. It is important to provide the candidate with an opportunity to simulate endorsed practice to highlight capacity for independent practice.

It is essential the Nurse Practitioner role is seen as evolutionary and therefore the candidate is considering further CPG’s that can be added to enhance the role and care outcomes.

**3. Suggested Assessment strategies**

Work based assessment –

- **Clinical log**
  Each patient the candidate treats will be documented in the clinical log. The clinical log will be the basis of discussion between the candidate and supervisor.

- **Unit Record audit**
  As a quality tool it is important that there are Unit Record reviews, whereby the clinical mentor and candidate review three histories every three months to explore the clinical notes and identify whether adequate documentation has been recorded.

- **Case review**
  It is expected the candidate will complete case reviews presenting their patients assessment, diagnostic tests, clinical findings and diagnosis and treatment plan. Depending on the requirements, this could be completed in conjunction with the clinical log or as a separate review and be a formal presentation to other nurses and medical staff as a mechanism for individual and unit based learning.

- **Bondy Scale**
  The Bondy Scale is a tool to assist identify the degree of supervision required by the candidate. This tool can be used in collaboration with the clinical log, and would be utilised at the commencement of the candidate position and every three months thereafter to assist in making a comparison and documenting progression of candidate’s clinical skills.

- **Clinical examination of individual skills**
  It is anticipated that the CPG’s will be the foundation of the assessment of clinical skills. Specific assessment criteria may be developed to assess the candidate’s knowledge and technique of each of the required skills.

*University based assessment will be required if enrolled in a Nurse Practitioner clinical masters. This proposed clinical supervision program could be adjusted to meet university requirements.*

Acknowledgement

Women’s Health Nurse Practitioner Project Officer – “Clinical Internship Model”
Latrobe University Nurse Practitioner Curriculum
| CLINICAL LOG: | Diagnostics ordered and rationale | Results diagnostics | Working diagnosis/ plan of care
Including: meds/therapies ordered,
Referrals/OPAs & follow-up
Specific instructions (treatments/monitoring) |
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Patient Assessment</td>
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</tbody>
</table>
**TOOL TWO – Case Review**

It is expected the candidate will complete case reviews presenting their patients assessment, diagnostic tests, clinical findings and diagnosis and treatment plan. Depending on the requirements, this could be completed in conjunction with the clinical log or as a separate review and be a formal presentation to other nurses and medical staff as a mechanism for individual and unit based learning.

Detailed Patient Assessment to present to Reviewer and as an open forum if agreed.

<table>
<thead>
<tr>
<th>Patient Assessment</th>
<th>Diagnostic Tests</th>
<th>Clinical findings</th>
<th>Diagnosis</th>
<th>Treatment Plan</th>
</tr>
</thead>
</table>

**TOOL THREE - Bondy Scale:**

Below is the scale that relates to your clinical practice. Your clinical practice may be graded from Independent (I) to Dependent (D). The scale describes the quality of your performance and the level of assistance you require.
<table>
<thead>
<tr>
<th>Grade</th>
<th>Performance Criteria</th>
<th>Quality of Performance</th>
<th>Assistance Required</th>
</tr>
</thead>
</table>
| Independent (I) | Level of clinical practice is of a high and safe standard | - Sound level of theoretical knowledge applied effectively in clinical practice  
                   - Coordinated and adaptable when performing skills  
                   - Achieves intended purpose  
                   - Proficient and performs within expected time frame  
                   - Initiates actions independently and / in cooperation with others to ensure safe delivery of patient care. | Without supporting cues                      |
| Supervised (S)  | Level of clinical practice is of a safe standard but with some areas of improvement required | - Correlates theoretical knowledge to clinical practice most of the time  
                   - Coordinated and adaptable when performing skills  
                   - Achieves intended purpose  
                   - Performs within a reasonable time frame  
                   - Initiates actions independently most of the time and / in cooperation with others to ensure safe delivery of patient care. | Requires occasional supportive cues          |
| Assisted (A)    | Level of clinical practice is of a safe standard but with many areas of improvement required | - Demonstrates limited correlation of theoretical knowledge to clinical practice  
                   - At times lacks coordination when performing skills  
                   - Achieves intended purpose most times  
                   - Performs within a delayed time period  
                   - Lacks initiative and foresight | Requires frequent supportive cues and direction |
| Dependent (D)   | Level of clinical practice is unsafe if left unsupervised | - Unable to correlate theoretical knowledge to clinical practice  
                   - Lacks coordination when performing skills  
                   - Unable to achieve intended purpose  
                   - Unable to perform within a delayed time period  
                   - No initiative or foresight | Requires continuous supervision and direction |
**TOOL FOUR - Mentor Meeting Log:** This is the record of the meetings between the mentor and the student

<table>
<thead>
<tr>
<th>Meeting date</th>
<th>Mentor feedback:</th>
<th>Student feedback:</th>
<th>Objectives set to be included in learning plan:</th>
<th>Signed: Mentor/student</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1:</td>
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<tr>
<td>Week 2:</td>
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<td>Week 3:</td>
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<tr>
<td>Week 4:</td>
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</tbody>
</table>
APPENDIX 1: ANMC Competencies for Nurse Practitioner Competency Framework:

Standard 1: Dynamic practice that incorporates application of high-level knowledge and skills in extended practice across stable, predictable and complex situations

Competency 1.1: Conducts advanced, comprehensive & holistic health assessment relevant to a specialist field of nursing practice

Competency 1.2: Demonstrates a high level of confidence and clinical proficiency in carrying out a range of procedures, treatments and interventions that are evidenced based and informed by specialist knowledge.

Competency 1.3: Has the capacity to use the knowledge and skills of extended practice competencies in complex and unfamiliar environments.

Competency 1.4: Demonstrates skills in accessing established and evolving knowledge in clinical and social sciences, and the application of this knowledge to patient care and the education of others.

Standard 2: Professional efficacy whereby practice is structured in a nursing model and enhanced by autonomy and accountability

Competency 2.1: Applies extended practice competencies within a nursing model of practice.

Competency 2.2: Establishes therapeutic links with the patient/client/community that recognise and respect cultural identity and lifestyle choices.

Competency 2.3: Is proactive in conducting clinical service that is enhanced and extended by autonomous and accountable practice

Standard 3: Clinical leadership that influences and progresses clinical care, policy and collaboration through all levels of health service.

Competency 3.1: Engages in and leads clinical collaboration that optimize outcomes for patients/clients/communities

Competency 3.2: Engages in and leads informed critique and influence at the systems level of health care.

Acknowledgement for tool development
Latrobe University Unit guide – “Clinical Internship for Masters of Nursing Science”
Mentoring Program For Nurse Practitioner Candidates

March 2006
Preamble
The Nurse Practitioner (Nurse Practitioner) role is the pinnacle of clinical nursing. Nurse Practitioner’s are experienced nurses, highly skilled, and academically prepared for their position. Given the early stage of development of Nurse Practitioners in Victoria, most Nurse Practitioner positions are in an evolutionary mode, with Nurse Practitioner candidates expected to lead the way and implement new and untested roles. The formulation of these roles is exciting but brings an expectation of Nurse Practitioner’s having the ability to manage change, organisational dynamics and communicate with senior managers, nurses and doctors across a broad spectrum of departments and specialty areas, to market their new role.

This scenario is exciting and also extremely challenging. The endorsement process to become a Nurse Practitioner with the Nurses Board Victoria mandates the Nurse Practitioner have a clinical mentor. The responsibility of the clinical mentor is to supervise the Nurse Practitioner candidate to ensure they have the appropriate clinical skills to fulfil the extended role.

The Nurse Practitioner Steering Committee supports the notion of Austin Health Nurse Practitioner Candidates having an organisational mentor as well as the mandatory clinical mentor. The organisational mentor would be available to assist the Nurse Practitioner Candidate develop their confidence and skills in fulfilling the role of Nurse Practitioner.

What is mentoring?
“Mentoring is the process that can encourage self efficacy, or the power of belief in the novice that he or she will be able to take on a new role successfully and become a fully participating member of an organisation or profession.” (Hayes 2005)

“A deliberate pairing of a more skilled or experienced person with a lesser skilled or experienced one, with the goal of having the lesser skilled person grow and develop specific competencies.” (Murray 2001)

Mentoring is therefore the development of a relationship between two parties, with the intention of the mentee to develop skills under the guidance of the mentor. Accordingly there must be a willing commitment to the relationship from both parties.

Mentee
In order for the relationship to develop “potential mentees must be enthusiastic, willing to be challenged and guided, willing to relate and share and be clear about what they want in a mentor”.
(Hayes 2005)

Mentor
Qualities of the mentor that assist with the relationship and mentee outcomes include:

- A willing commitment to invest time and resources into the relationship.
- Willingness to share knowledge, interests, values, and beliefs;
- Openness to communication and friendship
- Approachability
- Offering feedback in a positive way and celebrating success
- Providing an environment that encourages growth from mistakes
- Being a competent, confident role model.
- Standing by their mentees in critical situations
- Ability to listen
(Hayes 2005)
**Mentoring relationship**

Mentoring programs are most successful when both parties are willing and able to devote time, energy, and resources to the success of the relationship, when the program is voluntary and when the organisation provides encouragement, support and tangible resources. (Hayes 2005) A mentoring program ideally requires that both expert and novice make a longer time commitment, perhaps for a year. This provides adequate time to develop a relationship, set and meet common goals, and evaluate some accomplishments as well as the relationship itself. This time commitment, in addition to matching of expertise, career needs, and interests, may help potential mentors and mentees to choose to be with one another and allow the potential for mentoring to develop.

**Length of Relationship**

Kram’s research found that mentoring relationships vary in length and proceed through a series of phases. When the protégé is becoming more independent and is approaching a collegial relationship with the mentor, the relationship will be redefined and most likely will end in the formal sense of mentoring. (Learning and Organisation Development 2005)
1. ROLE OF AUSTIN HEALTH NURSE PRACTITIONER MENTOR’S
The role of the organisational mentor would be to support the Nurse Practitioner Candidate and assist in their transition from clinical nurse to Nurse Practitioner, within the context of service delivery changes to enhance patient care.

- Support transition of mentee into the Nurse Practitioner candidate role with a focus on managing change, communicating and involving key stake- holders, understanding and dealing with organisational dynamics and marketing the role.
- Support the mentee to develop the personal and non-clinical professional skills required of a Nurse Practitioner.
- Provide guidance in the submission process to Nurses Board of Victoria?
- Act as a sounding board for challenges that the mentee may be presented with.
- Assist in the reflection process.

2. REQUIREMENTS FOR NURSE PRACTITIONER MENTORS

- Committed to the principles of mentoring.
- Committed to the development of Nurse Practitioners at Austin Health.
- Willing to participate in orientation session for Nurse Practitioner Mentors.
- An experienced management background.
- Experience in change management and introducing new programs.
- A broad understanding of the Austin Health organisational dynamics.
- A well respected staff member across a broad range of disciplines.
- A broad understanding of the clinical area and key players within the area the Nurse Practitioner Candidate is working.
- Highly developed communication and listening skills.

3. GUIDELINES FOR MENTEE TO CHOOSE MENTOR

- Feel comfortable about your choice of mentor.
- Mentor has some understanding of your clinical area, eg coming from a psychiatric area would not choose an acute manager. The mentor’s position has some relevance to your clinical area and broadly understands the key players in your area.
- Mentor must not be your direct report.
- Feel comfortable about the prospect of entering into a mentoring relationship.

Organisational Mentors who have completed the Nurse Practitioner Mentor Program willing to participate as your mentor

Mark Petty – Executive Director Acute Operations
Ann Maree Keenan – Executive Director Nursing and Ambulatory Services
Shane Crowe – Deputy Director Nursing and Ambulatory Services
Leanne Turner – CSU Director Specialty Services CSU
Anne Szysz – General Manager Royal Talbot
Daniel Nichols – Nursing Manager – Mental Health
Bernadette McDonald – Director Surgical CSU
Denis O’Leary – CSU Director Operative Services
Jillian Macloy – CSU Director
Fergus Kerr – Consultant Emergency Department
Rhyl Gould – CSU Director
Eleanor Hughes – Manager Clinical Nursing Education
Jennifer Johns – Medical Director, specialty Services CSU
Chris Hawkins – Nurse Practitioner Candidate Emergency Department
Margaret Ferma – Nurse Practitioner Candidate Emergency Department
Nonie Rickard – Nurse Practitioner Project Officer

Phase 3 Round 6 Nurse Practitioner Service Plan Final Report (September 06)
Nurse Practitioner Project Officer invites staff across Austin Health willing to become Nurse Practitioner mentors. Suitable mentors identified in line with mentor criteria.

Mentor orientation program conducted by LOD

Mentee orientation program conducted by LOD

Participant chooses Mentor on list or identifies own mentor, within guidelines.

Initial meeting with mentor and mentee to discuss and agree to development plan

Learning strategies are identified

Implement development plan

Periodic meetings

Program evaluation
CLINICAL PRACTICE GUIDELINES FORMAT

A requirement of the Nurse Practitioner endorsement process by the Nurses Board Victoria is that Clinical Practice Guidelines (CPG’s) have been developed in consultation with the health care team, documenting the Nurse Practitioners extension in scope of practice.

The purpose of the CPG’s is to define an extension of scope of practice and ensure that best practice principles are applied. That is CPG’s guide clinical practice and is not the sole way of managing a client / patient.

Austin Health has devised a proforma to assist with CPG development, which is attached below.

When developing CPG’s it is important to consider the following:
- Are there local multidisciplinary guidelines already in place to guide practice that can be utilised?
- Have other Nurse Practitioner’s developed CPG’s that could be used and adapted to suit the local organisation?
- That CPG’s guide practice and do not restrict an individual’s decision making.
- Multidisciplinary team members are required to be involved in the process, but do not necessarily have to endorse the documents. At Austin Health the CPG’s are endorsed by the (Executive Director of Ambulatory and Nursing Services, Executive Director Clinical Services and Medical head of Unit).

The N3ET Nurse Practitioners and Clinical Practice Guidelines Position Statement is concerned that “the use of CPG’s by only one member or one discipline in the health care team, such as Nurse Practitioner’s can have contrary effects. The development of discipline specific CPG’s rather that multidisciplinary tools can contribute to fragmentation of care, reinforce traditional roles for health workers and maintain conventional models of delivering services. They consider that CPG’s developed for the multidisciplinary team acknowledge and utilise the overlapping and complementary skill sets of the entire health team.
<table>
<thead>
<tr>
<th><strong>Activity</strong></th>
<th><strong>Outcome</strong></th>
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<tr>
<td><strong>Rationale</strong></td>
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<td><strong>Clinical Alert</strong></td>
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<td><strong>Exclusion Criteria</strong></td>
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<td><strong>Clinical Assessment</strong></td>
<td>Pathological Investigations</td>
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<td>Urgent referral</td>
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<td>Analgesia</td>
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**Name of Guideline**
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<thead>
<tr>
<th><strong>Clinical Management</strong></th>
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<tr>
<td><strong>Medication /Prescription Labelling, storage</strong></td>
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<tr>
<td><strong>Patient Education</strong></td>
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<tr>
<td><strong>Follow Up</strong></td>
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<tr>
<td><strong>Team members communicated</strong></td>
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<td><strong>Author/s</strong></td>
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<td><strong>References</strong></td>
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<td><strong>Key words</strong></td>
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<tr>
<td><strong>Bibliography</strong></td>
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This CPG shall not be regarded as endorsed by Austin Health or available for application until a signature is entered.

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<th>Name</th>
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Date authorised Review Date

| Executive Director of Ambulatory and Nursing Services | Medical Unit Director | Executive Director Acute Operations |
NURSE PRACTITIONER CANDIDATE PEER SUPPORT

Aim
That all Nurse Practitioner Candidates and endorsed Nurse Practitioners are accessible to each other to form a support network to share experiences and learn from each other.

Purpose
Nurse Practitioners are an evolving group of nurses and despite having a variety of clinical backgrounds will share similar challenges and highlights in preparing for their new roles. It is important that Nurse Practitioners learn and support each other through the evolution of their role along with the challenges of the endorsement process.

Issues that may require support
Some of the challenges identified in the literature and discussions with candidates include:

- Role ambiguity with other health care workers including, residents and other nurses.
- Developing a new role and service provision model.
- Endorsement process
- Organisational politics/dynamics
- Clinical Practice Guideline development and organisational approval.
- Balancing the work and demands on Nurse Practitioner time.
- Sharing relevant information appropriate for Nurse Practitioners, eg feedback from NBV endorsement interview, etc.

Suggested format

- Informal monthly meeting to discuss pertinent issues.
- Nurse Practitioner Project Officer to organise first meeting to introduce candidates and identify proposed structure with suggested terms of reference.
- Nursing Administration will advise group of new candidates.
- Endorsed Nurse Practitioner’s chair group until format is reviewed.
EXPLORATION OF IMPLEMENTING A NURSE PRACTITIONER (NP) POSITION (Division One, Three or Four Registered Nurse)

**EDUCATION**
- Research NP endorsement requirements. Obtain package from NBV
- Liaise with Universities re Masters programs and Pharmacology subject.
- Participate in organisational education requirements.
- Commence strategy to educate staff, pts & stakeholders.
- Commence academic preparation

**ORGANISATIONAL**
- Discuss idea with NUM/CSU Director/Medical Director/Head of Unit/Nursing Services
- Explore funding options
- Explore NP role in more detail
- Identify difference between NP and Advanced Practice Nurse and decide how extension of scope of practice assists the role.
- Identify organisational mentor
- Yes
- No
- Further ground-work required
- Establish local multidisciplinary steering committee, to explore role and purpose.
- Local steering committee completes / oversees Nurse Practitioner Steering Committee (NPSC)

**ROLE DEFINITION**
- Establish formalised mentor program for NP
- Develop CPG’s
- Complete nursing research and act as a role model in clinical field.
- Define role and complete PD

**INFORMATION**
- Submission forwarded to Ann Maree Keenan Chairperson NPSC
- Receive in principle agreement for position from NPSC and CSU Director.
- Receive funding approval for position through CSU / Department.
- Commence role awaiting NBV endorsement
- Commence endorsement process with NBV

**CONGRATULATIONS**
NURSES BOARD ENDORSEMENT
YOU ARE AN ENDORSED “NURSE PRACTITIONER”
POSITION DESCRIPTION

POSITION TITLE: Nurse Practitioner Candidate Renal Care
Nurse Practitioner Endorsed Renal Care

REPORTS TO: Professional: Executive Director Nursing & Ambulatory Services
Clinical: Consultant Nephrologist Dialysis Treatment

AWARD: Nurses (Victorian Public Health Sector) Multiple Business Agreement
2007-2011

CLASSIFICATION: Reg Nurse (Division One, Three or Four)
NP Candidate: RN G5 Yr 2 Clin Con
NP Endorsement: RN G6 Yr1 (201 – 300 beds)
RN G6 Yr2 (301 – 400 beds)

PERIOD OF APPOINTMENT: As per contract
Reaccreditation with NBV every 3 years

1. ORGANISATIONAL CONTEXT
Austin Health is one of Victoria’s largest health care providers.

Comprised of Austin Hospital, Heidelberg Repatriation Hospital and Royal Talbot Rehabilitation Centre, Austin Health is a major teaching and research centre with numerous university and research institute affiliations.

Catering to diverse multicultural and veteran communities, Austin Health delivers vital statewide services to Victorians and a vast array of specialty services to the people of Melbourne’s northeastern corridor in a safety-focussed, team-orientated and stimulating work environment.

The new 400 bed Austin Hospital Tower opened mid 2005 and further redevelopment is underway. The Mercy Hospital for Women is located at the Austin Hospital site.

Austin Health Values

The Austin Health values play a critical role in shaping how we operate as an organisation. They influence our performance planning, recruitment, training and development, and relationships with colleagues, work mates, our patients and their relatives and friends. The Austin Health values set standard that we expect all staff to live up to in the way they undertake their duties and responsibilities across the Hospital.

- **Integrity**
  We work in the spirit of collaboration and honesty to build effective working relationships across the whole organisation.

- **Accountability**
  We are transparent, responsible and build trust by fulfilling promises and communicating effectively.

- **Respect**
  We care about others and treat each other with consideration, equality and fairness.

- **Excellence**
  We continually strive to advance patient focused care through innovation, research and effective stakeholder management.
2. LOCAL WORK ENVIRONMENT

The Nurse Practitioner/Candidate Renal Care will be supported by Austin Health and the Medical & Emergency CSU to work in Haemodialysis where there is evidence that the advanced clinical skills of a Nurse Practitioner would enhance patient outcomes within an efficient service model. The Nurse Practitioner role will be implemented across renal care in accordance with the Austin Health Nurse Practitioner service plan.

3. POSITION OBJECTIVE

Background

The Nurse Practitioner [Candidate] Renal Care role is innovative, progressive and patient centred within renal dialysis. The Nurse Practitioner is an integral member of the health care team who practices autonomously but in collaboration and partnership with other health professionals to assess and manage patients within their clinical context using nursing knowledge and skills.

The Nurse Practitioner Candidate Renal Care will be a Registered Nurse who aims to practice at an advanced level and work towards authorisation/endorsement by the Nurses Board of Victoria to use the title “Nurse Practitioner”. Extensions to this role include prescription of medications, referrals to health care professionals, ordering diagnostic investigations, the ability to admit and discharge patients and/or provision of absence from work certificates.

In Victoria a Nurse Practitioner is defined as “a registered nurse educated for advanced practice who is an essential member of an interdependent health care team and whose role is determined by the context in which s/he practices.” www.nursing.vic.gov.au.furthering/practitioner.htm August 2005

Position Objective

The Nurse Practitioner aims to maximise the continuity of care for patients within the renal dialysis arena in accordance with the Nephrology Units and Medical & Emergency CSU objectives. The Nurse Practitioner practises within a multidisciplinary framework to maximise recovery and promote optimum outcomes for patients.

4. POSITION REQUIREMENTS

The Nurse Practitioner Renal Care is directly involved in the provision of expert patient centred clinical care. This extends to the care of family, carers, the community and other health professionals.

CLINICAL CARE

- Conducts advanced, comprehensive and holistic health assessment relevant to renal dialysis nursing practice
- Ability to utilise assessment skills to develop a comprehensive treatment plan, including the need for organ imaging and laboratory studies, diagnostic and therapeutic procedures and prescribing medications that are evidence based and informed by specialist knowledge
- Ability to refer patients to other specialties/specialists as required (Emergency Department, the Vascular Unit, Vascular Access Nurse or Anaemia Coordinator)
- Facilitate admission and discharge planning with medical staff and the multidisciplinary team.
- Frequently will adopt a case management approach to service delivery
- Identify correct/incorrect clinical pathology parameters for Renal Dialysis and action the results as required
- A working level of skills and knowledge required to practice within the area of maintenance dialysis renal care
- Assist the renal dialysis nursing staff in improving the continuity of patient care and reduce service fragmentation
BEST PRACTICE
• Involved in clinical data collection for research, KPI’s and evaluation and monitoring of the role
• Demonstrates a commitment to safety and quality management
• Evaluates NP service delivery in accordance with key performance indicators
• Participates in the development and delivery of specialist research programs
• Adapts and applies related scientific research to clinical area
• Clinical decisions are informed by evidence-based practice

MANAGEMENT
• Documents extension of practice in Clinical Practice Guidelines, which are supported by the multidisciplinary team
• Formulates a sound communication strategy with multidisciplinary team, medical staff, nursing staff, patients and significant others
• Participates in the service planning process to identify future directions for the clinical service to maximise patient outcomes and resource management

ADVOCACY
• Provide a resource and education role to patients, families, General Practitioners and community groups
• Assist with the provision of health promotion activities
• Provides psychosocial support to patient and significant others
• Empower the patient in their dialysis decision making

CLINICAL LEADERSHIP
• Acts as a nursing role model and an expert clinician in the clinical setting
• Assists the development of Renal Dialysis, by assuming a nursing leadership role in specialty clinical groups at State, National or an International Level
• Participates in the development and delivery of Renal Dialysis education programs
• Participates in formal and informal education programs
• Awareness of the latest research literature, equipment and treatment and utilisation of knowledge in practice
• Disseminates clinical practice and research finding via education and publications
• Initiates and conducts nursing research relevant to Renal Dialysis
• Advocate for the development of nurse practitioner practice
• Monitors own practice as well as participating in peer supervision and review

Ensure confidentiality by undertaking not to reveal to any person or entity any confidential information relating to patients and employees, policies, processes and dealings including making public statements relating to the affairs of Austin Health without prior authority of the Chief Executive Officer.

5. KEY SELECTION CRITERIA

Essential:
• Registered Nurse (Vic State Award)
• Endorsed Nurse Practitioner/or working towards NBV endorsement
• Masters post-graduate studies or working towards
• Extensive and recent clinical experience in Renal Care
• Advance level of therapeutic management skills
• Demonstrated excellent collaborative, leadership, teaching, and interpersonal skills
• Well developed communication skills
• Ability to work as a team member and achieve projected goals and targets
• Ability to evaluate practice at an advanced level
• Demonstrated educational skills and basic computer knowledge
• Experience in nursing research and research skills

Desirable:
• Knowledge of case management models and theories
• Experience in change management
• Experience in report writing

6. KEY COMPETENCIES
• Advanced clinical knowledge in Renal Care
• Demonstrated leadership ability
• Advanced interpersonal skills
• Ability to work in a team
• Ability to manage projects and to work autonomously
• Ability to communicate effectively in both written and verbal form
• Experience in the management of change
• Experience in conducting research projects
• Analytical skills
• Computer skills

7. CONDITIONS OF EMPLOYMENT
• Successful completion of reaccreditation with NBV every 3 years

8. PROFESSIONAL PERFORMANCE STANDARD
Nursing Service Standards, Philosophy and Objectives
Organisational Standards, Philosophy and Objectives
Nurses Board of Victoria Regulations
Guide to the Practical Legal Aspects for Nurse Practitioners
Australian Nursing Council Incorporated Competencies and Code of Conduct
Australian Council on Healthcare Standards
Nurses (Amendment) Act 2000
Nurses Act 1993

9. OTHER RELEVANT INFORMATION
Pre-Existing Injury
In accordance with the Accident Compensation Act 1985 (as amended), the prospective employee is required to disclose information of pre-existing injuries and disease suffered by the worker of which the worker was aware which might be affected by the nature of the proposed employment. Failure to make such a disclosure or the making of a false or misleading disclosure may affect the workers entitlement to compensation under Section 82, Sub-section (8) of the Accident Compensation Act 1985 (as amended).

☐ HAVE (Specify: ______________________________) ☐ HAVE NOT
a pre-existing injury which might be affected by the nature of the proposed employment.

Signature: Employee ______________________________  Date: __/__/___
Signature: Manager ______________________________  Date: __/__/___
Review Date:
Austin Health Strategic Priority 4: Investing in Our Staff

We will attract, retain and value all of our staff through professional development, ensuring a supportive work environment while seeking to address current and future workforce challenges.

1. Identify and analyse targeted positions
   - Identify key competencies (ANMC competency standards for the Nurse Practitioner)
   - Review current position description

2. Assess developmental needs of each candidate
   - Gap analysis to determine competencies required

3. Establish individualised development plan for each candidate
   - Formal training
   - Coaching
   - Developmental assignments (eg. project work, committee membership)

4. Establish system to track candidates' progress
   - The Bondy Scale,

5. Competency checklists and development plans are reviewed and assessed 3 monthly to ensure continual development and progress of the NP Renal Care Candidate.

A competency checklist using the ‘Bondy Scale’ to assess the NP’s development needs and areas of competence; to be completed with Clinical Development Supervisor.
<table>
<thead>
<tr>
<th>Competency</th>
<th>Performance Criteria</th>
<th>Bondy Scale</th>
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<tbody>
<tr>
<td><strong>Standard 1</strong></td>
<td><strong>Dynamic practice that incorporates application of high-level knowledge and skills in extended practice across stable, unpredictable and complex situations</strong></td>
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</tr>
<tr>
<td>1.1 Conducts advanced comprehensive and holistic health assessment relevant to a specialist field of nursing practice.</td>
<td>Demonstrates advanced knowledge of human sciences and extended skills in diagnostic reasoning.</td>
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<td>Differentiates between normal, variation of normal and abnormal findings in clinical assessment.</td>
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<td>Rapidly assesses a patient’s unstable and complex health care problem through synthesis and prioritisation of historical and available data.</td>
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<td>Makes decisions about use of investigative options that are judicious, patient focused and informed by clinical findings.</td>
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<td></td>
<td>Demonstrates confidence in own ability to synthesise and interpret assessment information including client/patient history, physical findings and diagnostic data to identify normal and abnormal states of health and differential diagnosis.</td>
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<td></td>
<td>Makes informed and autonomous decisions about preventative, diagnostic and therapeutic responses and interventions that are based on clinical judgement, scientific evidence, and patient determined outcomes.</td>
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<tr>
<td>1.2 Demonstrates a high level of confidence and clinical proficiency in carrying out a range of procedures, treatments and interventions that are evidence based and informed by specialist knowledge.</td>
<td>Consistently demonstrates a thoughtful and innovative approach to effective clinical management planning in collaboration with the patient.</td>
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<td></td>
<td>Exhibits a comprehensive knowledge of pharmacology and pharmacokinetics related to a specific field of clinical practice.</td>
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<td>Selects/prescribes appropriate medication, including dosage, routes and frequency pattern, based upon accurate knowledge of patient characteristics and concurrent therapies.</td>
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<td>Is knowledgeable and creative in selection and integration of pharmacological and non-pharmacological treatment interventions into the management plan consultation with the patient.</td>
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<td>Rapidly and continuously evaluates the patient’s condition and response to therapy and modifies the management plan when necessary to achieve desired patient outcomes.</td>
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<td></td>
<td>Is an expert clinician in the use of therapeutic interventions specific to and based upon, their expert knowledge of speciality practice.</td>
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</table>
Collaborates effectively with other health professionals and agencies and makes and accepts referrals as appropriate to specific model of practice.

Evaluates treatment/intervention regimes on completion of the episodes of care, in accordance with patient determined outcomes.

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<tr>
<th>1.3 Has the capacity to use the knowledge and skills of extended practice competencies in complex and unfamiliar environments.</th>
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<tr>
<td>Actively engages community/public health assessment information to inform interventions, referrals and coordination of care.</td>
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<td>Demonstrates confidence and self-efficacy in accommodating uncertainty and managing risk in complex patient care situations.</td>
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<td>Demonstrated professional integrity, probity and ethical conduct in response to industry marketing strategies when prescribing drugs and other products.</td>
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<td>Uses critical judgement to vary practice according to contextual and cultural influences.</td>
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<td>Confidently integrates scientific knowledge and expert judgement to assess and intervene to assist the person in complex and unpredictable situations.</td>
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<tr>
<th>1.4 Demonstrates skills in accessing established and evolving knowledge in clinical and social sciences, and the application of this knowledge to patient care and the education of others.</th>
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<tr>
<td>Critically appraises and integrates relevant research findings in decision making about health care management and patient interventions.</td>
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<tr>
<td>Demonstrates the capacity to conduct research/quality audits as deemed necessary in the practice environment.</td>
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<tr>
<td>Demonstrates an open-minded and analytical approach to acquiring new knowledge.</td>
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<tr>
<td>Demonstrates the skills and values of lifelong learning and relates this to the demands of extended clinical practice.</td>
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**Standard 2**

**Professional efficacy whereby practice is structured in a nursing model and enhanced by autonomy and accountability.**

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<tr>
<th>2.1 Applies extended practice competencies within a nursing model of practice.</th>
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<tr>
<td>Readily identifies the value intrinsic to nursing that inform the nurse practitioner practice and an holistic approach to patient/client/community care.</td>
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<tr>
<td>Communicates a calm, confident and knowing approach to patient care that brings comfort and emotional support to the client and their family.</td>
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<tr>
<td>Demonstrates the ability and confidence to apply extended practice competencies within the scope of practice that is autonomous and collaborative.</td>
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<tr>
<td>Creates a climate that supports mutual engagement and establishes partnerships with patients/carer/family.</td>
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<tr>
<td>Readily articulates a coherent and clearly defined nurse practitioner scope of practice that is characterised by extensions and parameters.</td>
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<tr>
<td>Standard 3</td>
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<tr>
<td><strong>3.1 Engages in and leads clinical collaboration that optimism outcomes for patient/client/community.</strong></td>
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<tr>
<td><strong>3.2 Engages in and leads informed critique and influence at the systems level of health care.</strong></td>
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<tr>
<td>Influences health care policy and practices through leadership and active participation in workplace and professional organisations and at state and national government levels.</td>
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<tr>
<td>Actively contributes to and advocates for the development of specialist, local and national, health service policy that enhances nurse practitioner practice and the health of the community.</td>
</tr>
</tbody>
</table>

Source: Australian Nursing & Midwifery Council, National Competency Standards for the Nurse Practitioner, 2004