Older Persons Nurse Practitioner
Model of Care

Department of Health Victoria’s VNPP Funding round 4.11 – Nurse Practitioner models (Open Round).

November 2013

Project Officer – Michelle Spotswood
Older Persons Nurse Practitioner Models of Care – Austin Health

Introduction
The Older Persons Nurse Practitioner model of care has been developed in consultation and collaboration with relevant stakeholders to improve clinical outcomes for the older person commonly referred to Austin Health Community Care Programs. The Older Persons Nurse Practitioner will optimise the delivery of quality clinical care to the older person within Austin Health specifically within the Continuing Care Clinical Service Unit.

Austin Health demonstrates recognition and support of innovative role development as evidenced by current employment of 5 Nurse Practitioners in Mental Health, Emergency Department and Neurosurgery. There are 5 Nurse Practitioners Candidates in Stroke, Emergency Department and Cardiac Surgery.

The Older Persons Nurse Practitioner role is maintained within an established nursing framework and structure, and will function in accordance with the Nursing and Midwifery Board of Australia approved National Competency Standards within aged and rehabilitative care. The Older Persons Nurse Practitioner will work autonomously and collaboratively with support and supervision of the nominated mentors in a clinical, managerial and leadership role.

Austin Health will provide the opportunity for a highly skilled registered nurse to extend and expand their current role within the context of aged and rehabilitative care within Austin Health Continuing Care Clinical Service Unit and the community. The candidate will work towards acquiring advanced clinical skills and expert knowledge; including prescribing, requesting and interpreting diagnostic tests, advanced and comprehensive health assessment, and the ability to complete admission/discharge and referral of patients.

Model of Care
The Older Persons Nurse Practitioner candidate will support older persons in the community and the ambulatory care setting by working within both the pre-existing Community Care Programs and providing referral support to the Residential Outreach Service. The Older Persons Nurse Practitioner candidate will, with geriatrician support, provide clinical management to older people using services provided by the Community Care Programs. This service will enable early recognition and interventions relating to clinical concerns improving patient outcomes, alleviating the need for presentation to Austin Health Emergency Department and reduce the number of avoidable acute inpatient admissions.

The proposed model will also improve access for the older person to prompt expert care and knowledge within the home setting during business hours. The Older Persons Nurse Practitioner role will be integrated into both the existing Community Care Programs and Residential Outreach Services by building on current relationships with Residential Aged Care Facilities, General Practitioners, medical consultants, specialist’s services such as geriatricians and palliative care within the community and be complementary of the general practitioner’s clinical practice role, rather than role substitution.

The Older Persons Nurse Practitioner will work with patients and families to allay anxiety, concern and stress related to a change in clinical condition. Patient and family satisfaction will be measured with a short survey.

Project Officer: Michelle Spotswood November 2013
The Older Persons Nurse Practitioner will accept referrals from Community Care Programs to assist with acute changes in condition within the community. Prompt response will provide specialist care within the patient home.

The Older Persons Nurse Practitioner will work 5 days per week. 32 hours clinically with 8 hours for study including clinical case reviews, training and research.

The Older Persons Nurse Practitioner internship will include over 2 years:

- Community Care Programs
- Clinics – falls, memory, continence, pain
- Emergency Department
- Medical Ward – Acute Assessment Unit
- Continuing Care units including Wards 9, 10 & Cognitive Assessment and Management unit
- Residential Outreach Service

At the completion of the candidacy the Older Persons Nurse Practitioner will continue to have access to a Geriatrician for opinion and advice regarding resident triaging and treatment if required. The Older Persons Nurse Practitioner would communicate with the treating General Practitioner the ongoing plan of care.

The Older Persons Nurse Practitioner will be evolutionary and will be explored and tested within the model of care. The model will allow for growth and development to meet the changing needs of clients and the larger community. While the initial focus of the model development will be on strengthening the Community Care Programs and Residential Outreach Services, it is envisaged that this model will see the Older Persons Nurse Practitioner role potentially develop and expand into the broader aged care community to support clients in the chronic disease trajectory within a primary care context. The success of the Older Persons Nurse Practitioner will support and lead to development of additional models of care for Older Persons Nurse Practitioners in the Emergency Department and acute wards specifically related to the management of the older person with delirium and reducing the need and costs of Continuous Patient Observation.

The results of the GAP Analysis identified:

- There is an aging population growth in the northern metropolitan region requiring care.
- Failure of early recognition and response to a change in clinical condition may lead to significant harm to the patient, their family and carers.
- There has been an increase in Emergency Department presentations over the past 5 years from Residential Aged Care Facilities, and continuing to increase as shown in Table 1.
- Delays in Locum/ General Practitioner services causes delayed referrals to Austin Health Emergency Department, leading to delirium while awaiting treatment therefore increase potential of harm to patient and economically the employment of Continuous Patient Observation.
- Despite North Melbourne Medicare Local After-hours pilot participating Residential Aged Care Facilities sent patients to Austin Health Emergency Department. Table 1
shows that in over 200 Emergency department presentations, Residential Outreach Services could have been involved in care potentially reducing need for an admission. Admissions after hours are significant in being over 500 per year.

- An un-well Community Care Programs client at home may wait up to 6 - 8 hours before presenting to Austin Health Emergency Department for treatment. This is due to time spent by a community care worker contacting Austin Health Community Programs Case Manager; the case manager referring to the General Practitioner or geriatrician to visit in the home or patient be escorted to General Practitioner or geriatrician, and then if General Practitioner / geriatrician unavailable being referred to Austin Health Emergency Department.

- Provision of timely clinical management within the home of Community Care Programs clients will expedite treatment, decrease Emergency Department presentations and reduce carer anxiety.

- Reduction in acute presentations to Austin Health Emergency Department will result in a more effective use of ambulance transport services.

- The Austin Health CLINK Program received 583 referrals in 2012/13.

- 1095 referrals of the older person were made to Austin Health Post-Acute Care Programs.

- Limited Advanced Care Planning in the community.

- Lack of co-ordinated Advanced Care Planning affects End of Life care.

- Lack of co-ordinated Advanced Care Planning when End of Life care is required can affect patient and family dis-satisfaction and increase stress, anxiety and depression in surviving relatives.

- There is an increase Length of Stay due to End of Life care being given within the hospital environment and the patient is not transferred to the patients Residential Aged Care Facility. Over 100 patients from residential care Facilities have died each year in the last 3 years Austin Health as shown in Table 1.

- There is an imbalance between a ‘Residential Aged Care Facilities resident’/ patient needs and available resources within the community and Austin Health.

- 46 of 235 patients requiring Continuous Patient Observation were from Residential Aged Care Facilities.

- 6 of 19 deaths of patients requiring Continuous Patient Observation were from Residential Aged Care Facilities.
Table 1: Analysis of each peak winter period and annual presentations over 3 years of Older Persons to Austin Health Residential Outreach Service, Emergency Department and Acute Care Services

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Residential Outreach Service referrals</td>
<td>54</td>
<td>82</td>
<td>437</td>
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<td>423</td>
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<td>Residential Outreach Service could have been involved in business hours (within catchment)</td>
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<td>14</td>
<td>79</td>
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<td>Residential Outreach Service could have been involved after hours and weekends (within catchment)</td>
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<td>60</td>
<td>261</td>
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<td>Presentations to Emergency Department from Residential Aged Care Facilities (including those not in catchment)</td>
<td>446</td>
<td>448</td>
<td>2415</td>
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<tr>
<td>Admission to Acute Care from Residential Aged Care Facilities (within catchment) in business hours (not including dialysis)</td>
<td>52</td>
<td>53</td>
<td>287</td>
<td>49</td>
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<td>Admission to Acute Care from Residential Aged Care Facilities after hours and weekend</td>
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<td>564</td>
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<td>Death in acute care from Residential Aged Care Services (not including sub-acute)</td>
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<td>Families insisting on Emergency Department presentation from Residential Aged Care Facilities</td>
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<td>5</td>
<td>23</td>
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Table 2:

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<td>150</td>
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<td>after hours</td>
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<tr>
<td>Admission in business hours</td>
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<td>75</td>
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<td>125</td>
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<td>Admission after hours</td>
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<td>150</td>
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<tr>
<td>Presentations to ED from RACF</td>
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Table 3:

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<td>500</td>
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The role of the Older Persons Nurse Practitioner Candidate will support the Nursing and Midwifery Board of Australia Nurse Practitioner Standards of Practice and the new National Safety and Quality Health Service Standards.

These will include, but not be limited to:

Assesses using diagnostic capability

- Receive referrals from Community Care Programs and Residential Aged Care Facilities, General Practitioners, nurse clinicians and other specialist services within the community for management of; but not limited to; delirium, infection, falls, pressure injuries, behaviours and psychological symptoms of dementia, medication management and general decline.
- Receive referrals for clinical assessment of acute changes in condition of the Community Care Programs clients.
- Provide advanced holistic assessment, diagnosis, planning and implementation of care; including follow up and referral to other services within the home of the Community Care Programs client.
- Support Community Care Programs with management of delirium, depression and/or cognitive disorders, functional decline, falls, falls with fractures and/or Urinary Tract Infections.
- Assist with admission to Ward 9/ CAM unit from home for the Community Care Programs client. Clinical assessment within the patient’s home will facilitate a smooth admission to the sub-acute sector with potential to reduce acute length of stay and reduce patient and carer anxiety.
- Provide a rounding service to the identified Top 5 Residential Aged Care Facilities to provide complimentary primary care, develop partnerships with care staff and G.P.’s, develop Residential Aged Care Facilities staffs assessment and analytical skills.
- Provide advanced holistic assessment, diagnosis, planning and implementation of care including follow up and referral to other services as required.
- Assist with clinical management of palliative care in Residential Aged Care Facilities by developing strong anticipatory and consistent care regimes.
- Assist with clinical management of end of life care to residents of Residential Aged Care Facilities through access to timely symptom management and anticipatory planning ensuring an organised and co-ordinated approach.
- Allow a natural death to occur within a friendly, home-like and supported location where appropriate.

Plans care and engages others

- Working in partnership with Community Care Programs staff on complex cases while having a caseload themselves.
- Establish and develop relationships between Community Case Management Programs ensuring effective care within the home environment.
- Have the potential to improve social and cultural partnerships with identified Top 5 referring Residential Aged Care Facilities including Directors of
Nursing, care co-ordinators, general nursing and care staff, and visiting General Practitioners.

- Have the potential to establish social and cultural partnerships relationships within the North eastern community for referrals (e.g. attend North Eastern Director of Nursing Network).
- Improve collaborative relationships between Austin Health Emergency Department, Residential Aged Care Facilities and General Practitioners.
- Provide follow-up support to targeted patients newly discharged to Residential Aged Care Facilities to improve the continuum of care for the older person by visiting 1 day after discharge and as required.
- Improve residents, families and carers awareness and engagement of Residential Outreach Service.
- Empower the patient, families and carers by completing an Advanced Care Plan in partnership with patient and families to better inform health care workers of the patient’s wishes ensuring an organised and deliberate approach to End of Life care.
- Provide teleconference support to Community Care Programs staff whilst they are home visiting.
- Develop and support evidence based clinical practice in Residential Aged Care Facilities by providing support, training and review of care, processes and protocols regarding diseases processes relating to aging.

**Prescribes and implements therapeutic interventions**

- Improve access to Community Care Programs to provide case management for the older person, therefore increasing the potential for co-ordinated integrated and collaborative care of the older person ensuring better patient outcomes.
- Ensure all clients referred from Community Care Programs are offered an Advanced Care Plan if there is not one in place.
- Ensure all residents referred are offered an Advanced Care Plan if there is not one in place.
- Provide holistic evidence based support to Residential Aged Care Facilities via a combination of phone advice and visit(s) to Residential Aged Care Facilities with the support of a geriatrician.
- Assist with reduction of acute length of stay by providing new and returning discharges to Residential Aged Care Facilities with ongoing clinical support (e.g. take catheter out tomorrow and trial void at Residential Aged Care Facilities not at hospital).
- Develop and promote research projects that will contribute to advance the body of knowledge in aged care and palliative care nursing, thus enhancing the quality of care to Residential Aged Care Facilities residents at the end of life phase.

**Evaluate outcomes and improves practice**

- Identify patients over 65 with more than 4 admissions per year in category 4/5 and provide case management.
• Act autonomously and collaboratively within the teams working in Community Care Programs, Residential Outreach Service, Residential Aged Care Facilities and with community General Practitioners.
• Promote the role of the Older Persons Nurse Practitioner to Austin Health staff, professional networks and the broader community therefore strengthening partnerships and improving community referrals.
• Provide consultancy and mentoring role to other healthcare providers.
• Engage clinical collaboration with external community services such as local pharmacists and After Hours Locum Deputising services.
• Develop leadership qualities’ working collaboratively with the community Residential Aged Care Facilities, General Practitioners and within the Austin Health Community Programs by providing weekly case conferencing for Community Programs staff to attend and present complex cases for review.
• Work collaboratively with older people, Austin Health Respecting Patient Choices, General Practitioners, Residential Aged Care Facilities and families to improve Advanced Care Plan discussions within the community between older people, their families, carers and their health service providers.
• Influence healthcare policy and practice through active participation in workplace and professional organisations at local, state and national level as requested. Such as Older Persons Nurse Practitioner State Collaborative, North East Valley Division of General Practice Aged Care Interest Group, North Melbourne Medicare Local and the North Eastern Director of Nursing Residential Aged Care Facilities Network.
• Participate in research and quality audits as deemed appropriate by the organisation.

Clinical governance

An Older Persons Nurse Practitioner Steering Committee has been established to develop the Older Persons Nurse Practitioner model of care. The Committee will provide support, guidance and expertise to the candidate and clinical mentors to ensure the candidates learning plan and clinical competencies comply with and meet the Nursing and Midwifery Board of Australia approved National Competency Standards for Nurse Practitioners.

Austin Health Nursing Advisory Council has governance of all advanced scope of practice roles across Austin Health. The role will be implemented once approved by Austin Health Nursing Advisory Council. The role integration will be monitored by Austin Health Nursing Advisory Council.

An Older Persons Nurse Practitioner Clinical Internship Program will provide education, training and mentoring under the supervision of the Medical Director of Continuing Care. The clinical therapeutics component will be supervised by a senior pharmacist. Mentorship will be provided by a group of geriatricians, specialists, organisation and community pharmacists, Austin Health Nurse Practitioners and the Older Persons Nurse Practitioner Collaborative.
Older Person Nurse Practitioner Model Flow Chart

Residential Aged Care Facility or Community Care Programs Case Managers refer to Older Person Nurse Practitioner located within Residential Outreach Service

Older Person Nurse Practitioner candidate gives phone advice or attends resident/patient with supervision of geriatrician

- Informs Resident/Patient of clinical plan
- Informs General Practitioner of clinical plan
- Refers to Hospital In The Home
- Informs Residential Aged Care Facility of clinical plan
- Informs Family of clinical plan
References:

- Nursing and Midwifery Board of Australia: Competencies for Nurse Practitioner Competency framework
- Clinical Information Analysis and Reporting
- Community Care Programs data
- Doing it with us not for us, 2006, Victorian Department of Health (former Department of Human Services).
- The Impact of Advance Care Planning on End Of Life care in elderly patients: randomised controlled trial, Karen M Detering, respiratory physician and clinical leader, Andrew D Hancock, project officer, Michael C Reade, physician, William Silvester, intensive care physician and director BMJ 2010;340:c1345
- National Aged Care Alliance Aged Care Reform Series – Palliative Care
- National Safety and Quality Health Service standards
- Northern Melbourne Medicare Local After Hours Residential Aged Care Facilities Pilot Report
- Northern Melbourne Medicare Local Primary-care type presentations to Public Hospitals Report/ A local in-hours and after-hours population comparison
- Residential Outreach Service referrals by Facility by month by year
- Residential Outreach Service Number of Emergency Department presentations 2009 – 2013
- Residential Outreach Service Outcomes 2008 - 2013
- Victorian Health Priorities Framework 2011-2020

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Executive Director, Ambulatory and Nursing Services