



Nurse Practitioner Project

**Phase Three, Round Six
Service Plan Development**

Final Report

August 2006

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Executive Summary

The Nurse Practitioner role has been slow to take off in Australia. We have only eight NPs in Victoria despite a large scale effort to grow the role and support organisations in placing this new position into their services.

Although many reports have been written in response to the Victorian Department of Human Services Nurse Practitioner projects, this one is unlike others in that if the recommendations are adopted we will see by 2010, around ten Nurse Practitioners endorsed by the Nurses Board of Victoria and working in our organisation with approximately thirty more in the process of candidature.

In developing NP roles at NHW, we must anticipate and respond to the changing needs of our specific community. Wangaratta has an aging population above the national average (Australian Bureau of Statistics 2001, as cited in Quality of Care Report NHW 2005). A critical issue for us will be whether the supply of health professionals can keep pace with demand for our services and whether we have the right skill mix to enhance wellness, prevent disease and respond appropriately to the most likely clinical presentations.

To effect successful change in how we work with our community some strong consensus was required around the key drivers for achievement and the perceived barriers to implementing a new nursing role such as the Nurse Practitioner.

The methodology we employed to achieve this understanding was a combination of extensive stakeholder consultation in the form of presentations and interviews (Appendix 1), a mapping exercise to identify key nursing competencies and discern areas of existing advanced practice (Appendix 2) followed by the Delphi method of consensus building.

Key Findings

1. Changing needs of the Health Care System

The challenges of an aging population and reduced numbers of the rural health workforce were well understood and articulated. Planning for workforce change and development must very much include training and education for the future so we are well placed and prepared.

2. Financial, Educational & organisational support

This was very strong theme. Potential NPs need to feel supported in their role by the executive team and Board of Management. The politics of health should be dealt with at executive level rather than at patient care level.

Studying for a Masters, learning new clinical skills and providing patient care in addition to the roles many nurses' play as partners, parents, caregivers, farmers, business partners and community volunteers needs both financial support and study leave in addition to the EBA provision. The cost in dollar terms and the travel and emotional price of being away from home for study is a major disincentive to take up.

3. The patient, the client, the person

All service development must put the person receiving care at it's centre. The needs of the client should drive change and innovation rather than professional territory protection and expansion.

4. Assaying the service gaps

The introduction of Nurse Practitioners into the health team should be driven by clearly identified service gaps. The system should not be made more complex by the introduction of NPs. The stakeholders in specific clinical areas should agree on the scope of practice.

5. Community needs and partnerships

Our efforts to establish Nurse Practitioners must be inclusive of the continuum of care and the episodic nature of acute hospital admission. NPs crossing the boundaries of the acute and community setting was agreed as being very important to making the role functional. Opportunities for training and education for NPs need to be available for our partners in rural healthcare outside of NHW.

6. Understanding of nursing practice & expertise including scope of practice

A considerable amount of work needs to be done in understanding what nurses do-both within the healthcare sector and into the community. There is not a clear understanding of what the role of the NP is and how it articulates into the broader system of care. Articulating the scope of practice should not be underestimated. It is a difficult process when we try to understand where advanced practice stops and where the need for extended practice begins.

7. Communicating the message

A sophisticated communication strategy to avoid confusion and conflict was seen as a priority in planning for the role.

8. The characteristics of the NP and sustainability of the service.

The personal characteristics of individual NPs were viewed as being as important as their clinical skills. Key attributes included highly intuitive communication skills and being seen as role models and leaders. There was strong consensus around establishing models which provided a sustainable and reliable service. GPs in particular commented that they did not want to see a service where by NPs were only available for very limited hours per week.

9. Interdisciplinary teamwork

The importance of working together as a team- 'Right patient, right professional, right setting.' A 'clever' skill mix to enable the most effective treatment and the best opportunities for health promotion was seen to be more important than hanging onto

traditional hierarchical paternalistic models. Care is needed however to avoid duplication of services.

10. Relationship with doctors

This was a strong and recurring theme in the deliberations. Nurse Practitioners' contribution to patient care should be a critical part of the team approach. It should not substitute for nor diminish the role of the medical practitioner. It should make best use of nursing knowledge & expertise rather than create confusion and boundary protection. Healthcare is not about any one professional group. The desire not to disenfranchise medical practitioners was seen as being very important. Several respondents said that GPs feel quite vulnerable and undervalued in the current healthcare climate. Their concerns need to be listened to and they are keen to play a part in the evolution of the NP role at NHW. Our research showed that individual medical practitioners were less concerned with the politics of their respective colleges and more concerned with the pragmatics of healthcare which they saw as benefiting from the expertise of NPs in the team providing that the NP scope of practice was clear. There appeared to be genuine goodwill between doctors and nurses in discussions on the potential role of NPs.

11. Recruitment & retainment

The Nurse Practitioner role may assist in providing a clear and attractive career path for clinical nurses. The availability of nurses of this calibre may act as a magnet for other skilled workers such as medical specialists and allied health. The availability of NP roles and educational opportunities would establish NHW as a vibrant workplace. Recruitment and retainment of skilled health workers is vital for the broader health and economic viability of our wider rural community.

12. Best value for money

Nurse Practitioners carefully placed in the system were seen as a pragmatic approach to making the health dollar go further provided they did not duplicate existing services.

13. Evaluation of the role

The research participants were clear that the role should be integrated into the same rigorous quality surveillance that other services are subjected to. Additional identification of clear and relevant outcome measures need to be incorporated into the organisation’s existing data collection to reflect the specific effect NPs are having on patient care, rather than an onerous separate evaluation. Each NP role will need to identify their outcome measures specific to their context of practice. The effect of the NP needs to be visible and measurable just as all interventions should be.

14. Government Role

The exclusion of NPs in accessing PBS and Medicare provider status for the treatment they provide outside of a Public Hospital setting is seen a significant barrier to making the role effective particularly given the nature of community based health care and the importance of population health strategies. Frustration remains strong around the role of government and its delay in acting on the recommendations of the Productivity Commissions Report and other reports calling for reform.

15. Service Gaps Identified.

The areas of clinical practice where there were identifiable gaps in service which might positively respond to the introduction of Nurse Practitioner were:

Immediate (Within 3 years)

- 1. Critical care
- 2. Mental Health
- 3. Aged care

Within Five years

- 4. Palliative care
- 5. Oncology
- 6. Wound care

The Emergency Department was also identified as a context for NP practice but has not been put forward at this time due to local issues surrounding the scope of practice of the NP and the viability of key roles and functions within the department should a Nurse Practitioner be introduced.

Key recommendations

1. That Nursing Council is the peak NHW body for evaluating potential NP roles and making recommendations to the DON for approval.

1.1 That NHW adopt a two part submission process (Appendix 3) for proposed NPs in the organisation which is administered through Nursing Council for recommendation for approval to the Director of Nursing. (Appendix 4 & 5)

2. Access to relevant, affordable education which does not tip the scales of life/ work balance and prevents isolation in learning and practice.

2.1 Potential Nurse Practitioner Candidates should have access to Masters level education which is available as much as possible through on line learning with local clinical and academic support. Deakin University is the preferred provider of this program with a co-joint clinical position recommended to support the NP candidates.

2.2A cohort of Nurse Practitioner Candidates should commence their preparation together in order to assist and support each other in learning and to establish some organisational economies of scale in providing clinical mentorship. Ten to twelve students is recommended across three - four clinical areas of practice.

2.3The mandatory Clinical Pharmacology modules should be delivered by video conferencing on site at NHW to the cohort of NP candidates. The University of Melbourne is the preferred provider.

2.4 Potential nurse practitioner candidates at NHW should have access to scholarship support to assist them in their educational preparation for the NP role. This scholarship must include assistance with payment of fees, study leave

in addition to the EBA and provision for clinical mentorship. The candidates should agree to complete their preparation and be ready for endorsement within 3.5 years of commencing the process. The candidate, NHW and the university provider should work together to identify scholarship monies for assistance with fees. Clinical areas at NHW which wish to develop NP positions should budget for study leave in addition to the EBA for their NP candidates for the duration of their studies.

2.5 The Masters program should be linked closely to the clinical context in which the candidate works so that key learning and competencies can meet the rural contextual requirements.

2.6 Inclusive in the Masters program is the development of CPGs and drug formulary specific to each candidate's scope of practice which meets the standard for NBV endorsement.

3. That the relationship between Nurse Practitioners and the medical team be grown and nurtured so that a truly collaborative and therapeutic bond be built which will best serve our local community and provide a sustainable service within our organisation.

3.1 All working parties should include representatives from the medical team. The NEVDGPs and relevant medical colleges should be included in the communication strategy.

3.2 Included in the working parties are representatives from allied health.

4. Involve other local health services to better serve our community rather than just our organisation: Integration and cross boundary roles with reciprocal rights in each workplace.

4.1 In line with its strategic plan NHW should promote opportunities for partnerships with other health service providers to develop Nurse Practitioners together through cooperative mentorship, access to education and promotion of a seamless transition for clients through the acute and community settings. Reciprocal rights need to be established across agencies. Appropriately skilled mentors are scarce resources. They should be shared rather than competed for.

4.2 The working parties should include representation from the community sector and consumers.

5. A professional public relations and communication strategy regarding the role and scope of practice should be budgeted for across the organisation to ensure that there is clarity in both the community and the health team regarding the role of the NP.

6. Establish models of practice for NPs that ensure reliable service delivery, prevent burnout, prevent professional isolation, encourage peer review and support and planned clinical learning opportunities.

6.1 Sole NPs are vulnerable. A minimum of three NPs in each area of clinical need is recommended.

6.2 In defining the scope of practice, care needs to be exercised to prevent creating a role that sets the NP up for an unsustainable work load and the takeover of particular duties because they are no longer desired by other members of the multi disciplinary health team.

6.3 Mentorship and clinical supervision should be planned and budgeted for with mentors included where possible in the early working party deliberations.

6.4 Opportunities for support between NPs in different clinical areas will be enhanced by cohort learning. Where possible core subjects of the Masters program should be taken simultaneously by the NP candidates.

7. Key attributes of the Nurse Practitioner as identified by the Steering Committee should be included in the generic job description for all new NP roles.(Appendix 6)

8. The problem of access to Medicare rebates and the PBS for consumers wishing to access the services of NPs outside of the public hospital setting requires lobbying at a federal level and some exploration of collaborative local solutions.

8.1 Exploration of commonwealth funding opportunities in community based aged care and wound management is a priority. Collaboration with the Northeast Victorian Division of General Practice is recommended to explore possible options within the existing framework of delegated item numbers for specific client services.

9. NPs need to be viewed within the wider context of advanced nursing development and overall workforce redesign. They are not the sole answer to the looming crisis in meeting service demands- they are potentially an important component of this. It is foolish therefore to look at NPs in isolation of the broader objectives of developing the whole health workforce.

Our project has developed well beyond its original purview and has come some way towards implementing key strategic elements of this service plan. NHW is an organisation committed to responding to the needs of the region we serve. It is also committed to providing the resources and support to the staff that are providing these services.

Introduction

This project report forms part of Phase Three, Round 6 of the Department of Human Services Victorian Nurse Practitioner Project.

The objectives of Phase Three are as follows:

- Enhance health care delivery.
- Develop a culture of collaboration and partnership with health care providers and the community.
- Develop nurse practitioner models that demonstrate efficiency and quality outcomes.
- Promote the nurse practitioner role within the health care system and the community.
- Strengthen the capacity of the health system.

Round Six of the VNPP required the development of an organisational service plan to support Nurse Practitioner (NP) roles. Northeast Health Wangaratta commenced work on this project in August 2005.

NHW was well placed to do this, given a background of significant capacity building in its nursing division over the past five to ten years in response to the evolving needs of health care in our rural context. As a result we now have many Division 1 & 3 nurses and midwives who are practicing at an advanced level and who enjoy productive and innovative interdisciplinary relationships. Supporting this is an active program of education and support: a nurse education unit, a Mental Health education and research unit and a system of area based clinical nurse consultants. We have a very successful program with the University of Melbourne for nurses undertaking post graduate studies in Mental Health nursing and the Post Graduate Diploma of Rural Critical Care. This latter program has resulted in 42 nurses from 1996 – 2005 completing the course and working in both our Critical Care Unit and Emergency Department. We recognize and budget for education to grow the expertise of our existing nursing workforce.

NHW has had involvement with the development of NPs since 2002 when it undertook a pilot project with the Community Midwife Program (Haines 2002). Since that time one midwife from that team has been preparing for endorsement with the Nurses Board of

Victoria. Our involvement in this DHS nurse practitioner funded project has meant that significant work has also been undertaken in identifying service areas where patient care could be significantly enhanced by some of our nurses having the extended skills afforded by nurse practitioner.

NHW is located within the Hume Region of Victoria (Figure 1) and has a catchment area of around 28 townships beyond the Rural City of Wangaratta boundaries. This catchment area comprises a total of over 70,000 people. There are over 26,000 people within the city boundaries alone. Information available from the Australian Bureau of Statistics (ABS) Census in 2001 shows the population of Wangaratta is predominantly Australian born.

Further figures from the ABS show that the population of Wangaratta is aging at a rate faster than comparable regions (Table 1). We need to ensure the services that we are planning and developing reflect these needs in the future, not just for the present time.

Information available for the Australian Bureau of Statistics (ABS) census in 2001 shows that the population of Wangaratta is aging at a rate faster than comparable regions .We need to ensure that the services we plan and develop reflect this future need not just our present ones.

Year	0-14 years	15-24 years	25-34 years	35-44 years	45-54 years	55-64 years	65-74 years	75-84 years	85+ years	Total pop.	%population >65 yrs
2001	5629	3164	3183	3882	3726	2831	2179	1532	538	26,664	16 %
2031	4001	2460	2381	3064	3251	3949	4467	3687	1802	29,061	34%

Table 1: Wangaratta Population Forecast (ABS 2001 as amended from Quality of Care Report 2005, NHW)

In comparison, the ABS reports that in 2004 people aged 65 years and over made up 13% of Australia's population. This proportion is projected to increase to between 26% and 28% in 2051 and to between 27% and 31% in 2101, still below the Wangaratta projection of 34 % by 2031. (ABS Population Projections, Australia, 2004 to 2101) <http://www.abs.gov.au/ausstats/abs@.nsf/mf/3222.0> accessed July 30 2006.

Our Health Service.

NHW is a diverse organisation with 527 nurses, 35 VMOs, 23 junior doctors, 20 GPs with admitting rights and 15 additional doctors who admit through the HITH program. There is 91 allied health staff. The total staff of NHW is 1012. The management structure can be seen in (Appendix 9).

Listed below are the clinical services provided to our community:

Acute Services		
Emergency:	Triage Disaster Management	
Critical Care:	Intensive Care Cardiac Care	
Medicine	Renal Dialysis Cardiac Rehabilitation Respiratory Medicine Palliative Care	
Surgery	General Surgery Day Stay Orthopaedics Ear/Nose/Throat Urology Pain Management Theatre/Recovery Stomal Therapy	
Women/Child Services	Newborn Early Motherhood Program General Gynaecology Pregnancy: Childbirth Education	Complicated Pregnancy Community Midwife Program Giving Birth Following Birth Home Midwife visit Home Advice Paediatrics Paediatric Surgery
Cancer Care	Oncology Breast Care Palliative Care	
Medical Imaging	Outpatient Inpatient	
Allied Health	Dietetics Occupational Therapy Physiotherapy Social Work Speech Pathology Podiatry	

	Audiology Pharmacy Continence Service Stomal Therapy Diabetes Education	
Sub Acute Services	Rehabilitation Community Rehabilitation Centre Geriatric Evaluation Allied Health	
Home and Aged care	Nursing Home Home and Community Care Cognitive and Dementia Memory Services District Nursing Older Persons in Hospital Geriatrician Allied Health	
Mental Health	Integrated Primary Mental Health Psychiatry Kerferd Unit Community Psychiatry NECAMS Aged Psychiatry	
Community/ Ambulatory	Community Psychiatry Continence Clinic Stomal Therapy Diabetes Education Post Acute Care Hospital In The Home Palliative Care Allied Health	
Health Promotion	Integrated Primary Mental Health Pit Stop Staff Health	

Table 2: Clinical Services NHW.

Tables 3 & 4 display our service profile and our top ten admission categories:

Table 3: NHW Type of service profile (Quality of Care report 2005, NHW)

	2003-2004	2004 - 2005
Number of patients admitted	14,145	14,316
Patients seen in the Emergency Department	15,817	15,404
Staff employed (total)	1,013	1,064
Patients attending the Community Rehabilitation Centre (CRC)	5,054	5,792
Patients assisted by Thomas Hogan Rehabilitation	291	228
Client visits by home based nursing services	18,948	19,461
Scripts filled by Pharmacy	22,589	
Invoices processed by finance	23,005	22,429
Attendances at medical imaging (X-Ray)	44,420	47,338

Table 4: NHW Top 10 admissions for 2004/2005 (NHW Quality of Care report 2005)

Reason for admission	Number of Admissions
Renal dialysis	1801
Chemotherapy	761
Colonoscopy	215
Normal childbirth	251
Chest pain	225
Knee replacements	121
Gastroscopy	177
Tonsillectomy	101
Acute myocardial infarction	109

Background

This report cannot be read in isolation of the well documented context of the workforce challenges facing healthcare in Australia. The added dimension of rurality amplifies the identified issues of recruitment, retainment and further education and training.

“Australia is experiencing workforce shortages across a number of health professions despite a significant and growing reliance on overseas trained health workers. The shortages are even more acute in rural and remote areas and in certain special needs sectors.

With developing technology, growing community expectations and population ageing, the demand for health workforce services will increase while the labour market will tighten. New models of care will also be required.” (Productivity Commission 2005.)

Duckett (2005) describes the Australian health workforce as being made up of a mixture of separate professions. Each discipline is academically prepared, clinically trained and regulated differently. The disciplines are often characterised by different philosophical standpoints on the delivery of healthcare services and the manner in which they interact with clients, with the community at large and members of the multidisciplinary team with whom they work. Much change to this workforce will be needed in the future to respond to the epidemiological and demographic transition of the Australian population. Duckett (2005) further argues that future workforce planning should not be based on providing more of the same. Rather, the roles of health professionals will need to change and evolve to meet the predicted demand. It is this evolution of practice in response to a changing horizon of health status which underpins the need for the planned and strategic deployment of Nurse Practitioners in our multi disciplinary rural health setting. Australia is not alone in this – other western countries such as the UK face the same challenges (Cowie, 2005, Offredy 2000).

Gardner’s (2005) work which looked at the scope of practice of Nurse Practitioners in the ACT, validated a research-based, iterative process for initial development of nurse

practitioner scope of practice for any Australian specialisation. With this in mind, we decided that the success of implementing Nurse Practitioner roles depended on us seeking out perceptions, presenting accurate information and understanding the context of the evolving role of the nursing workforce and the health workforce in general. Understanding this evolution required a robust process of research and communication of the scope of nursing practice within the multidisciplinary health team.

The literature and our preliminary research indicated considerable confusion about the role of the nurse practitioner; how it differed to an advanced practice nurse and even in fact, how it differed to a practice nurse! Daly and Carnwell (2002) argue that the recent profusion of new nursing roles in the UK has led to much confusion in the minds of health care consumers, employers, nursing practitioners and educationalists regarding the meaning, scope of practice, preparation for, and expectations of such roles. Titles such as Clinical Nurse Specialist (CNS), Nurse Practitioner (NP), Advanced Nurse Practitioner (ANP), Higher Level Practitioner (HLP) and more recently Nurse Consultant (NC) are being adopted in a variety of care settings with little understanding or consensus as to the nature of or differences between such roles.

While there is substantial confusion around nursing nomenclature there is strong agreement that many of our nurses undertake highly complex patient care and provide leadership in case management across a variety of health domains. Fundamental to the success of this project then was a significant amount of work put into explaining what the role of the NP could add to the existing workforce and how it differed from what we already had.

The goals of this Phase Three Round Six project were addressed by:

1. Forming a Steering Committee of nursing leaders who met monthly and advised & supported the project officer.
2. Communication to the staff of Northeast Health, our collaborators and partners and the wider community, information about the nurse practitioner role and how it might contribute to our future health needs. This was

achieved by oral presentations, media releases through the local paper, hospital bulletin and specific target group publications, poster displays and face to face consultations.

(Appendix 1)

3. Identification of the existing nursing competencies and advanced practice roles in our organisation through a mapping exercise whereby all Unit Managers across the organisation were interviewed and asked to list all the nursing competencies from basic through to advanced practices with the associated training and education required to become competent in that skill . This assisted in our understanding of where extensions to practice may be of greatest efficacy to the continuum of care we offer our present and future clients. (Appendix 2)
4. Undertaking a Delphi study to achieve a consensus view of the key drivers for success of Nurse Practitioners in our organisation and the barriers to deploying NPs. The Delphi Panel was also asked identify where gaps in service could be reduced by an introduction of a NP into the service.
5. Organising a NP forum with endorsed NPs addressing key issues around defining scope of practice and their experiences of the role so far. At this forum three existing NPs discussed their journey and current role. We explored the dilemmas faced in defining a scope of practice and discerning the issues around advanced versus extended practice. This forum was attended by nurses, medical practitioners, management and allied health personnel from with in the organisation and across the region.
6. Developing a strategic plan in response to the findings of the project for the establishment of nurse practitioner positions with supporting policy frameworks.

Rationale for the Delphi Study

After consideration of the literature and in preparation for developing a role which enjoys the confidence and cooperation of the whole health team and the client base, the Delphi method of generating consensus was chosen to assist in understanding where we were at and where we should go with developing the Nurse Practitioner role in our organisation. Bowles (1999) describes the Delphi method as a mechanism that has the potential to promote change.

It provides both qualitative and quantitative data on the subject at hand.

Beech (2001) says that the aim of consensus methods such as the Delphi technique is to determine the extent to which experts or lay people agree about a given issue. The Delphi method seeks to overcome some of the disadvantages normally found with decision making in groups or committees, which are commonly dominated by one individual or by coalitions representing vested interests. In open committees individuals are often not ready to retract long held and publicly stated opinions, even when these have been proved to be false. Health services are environments where due to their traditional hierarchical structure are at risk of this phenomena.

The Delphi method has been used widely in health policy research. In the UK the method has been used to better understand the issues there in relation to the role and function of the Nurse Practitioner in the acute and primary care setting. Roberts-Davis and Read (2001) undertook a Delphi study, which was aimed at reaching a consensus of views amongst nurses in clinical practice, educators, purchasers, providers and representatives of statutory and professional bodies on the parameters and competencies desirable for the NP role.

Marsden, Dolan and Holt (2003) used the Delphi approach to generate valuable expert consensus data around Nurse Practitioner deployment and practice.

In combination with community awareness building about the role and function of Nurse Practitioners and followed by more consultation with key groups affected by the implementation of these nurses our Delphi Study has helped to build our response to the five objectives of the Department of Human Services Victorian Nurse Practitioner

Project Phase Three as outlined previously and has acted as a useful vehicle for communication of the issues surrounding implementing NP roles.

Policy Framework to Support the role of NP at NHW.

In order to support, sustain and grow the role of the Nurse Practitioner at NHW our steering committee has adopted a strategy and service plan based on the drivers for success as identified by the Delphi Study, the existing literature and our consultation process.

1. Nurse Practitioner roles at NHW will be driven by the clinical areas not by individuals.
2. Nursing Council is the peak body which endorses and makes recommendations to the Director of Nursing for Nurse Practitioner positions at NHW. Nursing Council will be looking for evidence that the role has a well defined scope of practice, that its development is supported by a multi disciplinary working party, that there are clinical mentors available, that it can be supported within the existing nursing budget, that the proposed candidates meet the desired attributes for a NP position, that there is an educational plan and that there has been some preliminary thinking and planning for the Clinical Practice Guidelines and formulary required.
3. All clinical areas which wish to develop a role for a nurse practitioner must complete the two part submission template and present it to NHW Nursing Council (Appendix 3)
4. Each Service area will have a unique set of clinical practice guidelines and formulary relevant to their particular context. NHW has an existing process for approval of guidelines which the NPs will integrate with. There is no intention for NPs to sit outside existing processes which have been developed for all other members of the interdisciplinary team. All clinical practice guidelines and policies developed for NPs will be in line with the NHMRC and DHS approved Guide to Developing Clinical Practice Guidelines (2006).

5. Solo Nurse practitioner roles should not be supported unless there are compelling reasons why only one NP is needed.
6. NHW acknowledges the hardship involved for nurses undertaking postgraduate studies in concert with work, family and community obligations and will work with the prospective NP candidate to secure scholarship support, offer salary sacrifice provision for fee payment and negotiate study leave over and above the EBA. Each candidate will be assessed for support on an individual basis with consideration given to how many credit points they require, whether they require off campus mentorship and so on. Nurses who are successful in their application to NHW for development as a NP and require assistance with their Masters studies will agree to complete their candidature and be ready to submit to the NBV for endorsement within 3.5 years of commencing their NP preparation.
7. Prescriptive & diagnostic authority will be acknowledged by the NHW Pharmacy committee and our pathology provider upon endorsement with the NBV and subsequent appointment as a NP. Referral processes and admission & discharge protocols are activities which will be detailed within the NPs Clinical Practice guidelines and algorithms. These will be developed by the NP candidates in concert with their service areas, their working parties, appropriate colleges and the university educational provider and in line with the Victorian Government Department of Human Services guide for developing clinical practice guidelines for nurse practitioners in Victoria (2006).

Process for the Development of the NP role in the organisation including time frames

- September 2006:** Workshop and launch of the NHW Nurse Practitioner Service Plan
- October 2006:** Working Parties developing submissions in key clinical areas.
Submissions to Nursing Council for approval to commence NP development (Aiming for 3- 4 successful clinical areas with 3-4 candidates each)
- November 2006** Enrolments in University of Melbourne Pharmacology course
- December 2006:** Enrolment in Deakin Cohort Group or other Masters programs.
- February 2007:** Commence candidature and clinical internship.
Pharmacology course begins
- March – May:** Working parties organising suitable mentors, continued planning for candidature.
- June 2007:** Commence first subject with Deakin
- February 2008:** Second cohort group of NP candidates commence pharmacology
- June 2008:** Possible 3 NP candidates apply for endorsement
Second cohort commence Deakin Masters program
- February 2009:** Third cohort group of NP candidates commence pharmacology
- June 2010:** Approximately 9 nurses apply for endorsement with NBV.
Third cohort commence Deakin Masters program

Priority Areas for establishing the NP role and method for determining those areas.

This service plan has not proposed specific roles and functions of NPs. Rather it has put forward clinical domains of need and developed a framework for the sustainable development of these roles. Only the specific clinical areas will be able to determine the precise role and function of their Nurse Practitioners. The submission template (Appendix 3) leads the working part in this process.

The Delphi Panel was asked to prioritise the clinical areas where they believed gaps in client services would benefit from the introduction of a NP into the multidisciplinary team. In doing this they considered the patient group who would access the NP. They considered the community as a whole rather than NHW in isolation.

Their selections are listed below.

Immediate (Within 3 years)

Critical care

Mental Health

Aged care

Within Five years

Palliative care

Oncology

Wound care

The Emergency Department was also identified as a context for practice but while widely accepted as a logical place for Nurse Practitioner positions in other organisations it has not been put forward at this time due to local issues surrounding the scope of practice of the NP, the concerns of the Division of GPs and the viability of key roles and functions within the department should a Nurse Practitioner be introduced. There remains conjecture here regarding whether a NP in the ED should take on the role of primary care or whether their role is in high acuity emergency care. The Emergency department is a good example of why we need to take into account local conditions and the wider politics of healthcare when considering roles.

The Delphi selections do not eliminate the development of NP models of care in other areas provided the Nursing Council endorsed submission supports their addition to the health team at NHW. It is the aim of the organisation in fact that many roles be developed for NPs but they must be planned in a strategic way. (Appendix 3)

The Delphi selections will however be targeted to commence development of roles in the first instance as described below.

1. Aged Care: Our stakeholders consistently cite aged care as the domain most in need of nurse practitioners. The NE Division of GPs is quick to point out that the GP alone cannot cope with the demands associated with our aging population. GPs are frustrated by the demands on their services for often poorly planned review of residential aged care residents. Likewise residential aged care facilities are constrained by their dependence on GPs to make health status assessments and medication adjustments in a timely fashion. There is a view that a collaborative model with suitably qualified NPs liaising with GPs and a geriatrician could provide a much more pro active service to clients. There is much already written in the literature around NPs in aged care (Gardner 2005, ACT Health 2005, Mezey and Fulmer 2002) being able to respond to changing physical and mental states of community and residential facility based older people and provide timely interventions. The Greensborough Private Nursing Home Nurse Practitioner Project Final Report (2004) study demonstrated that with adequate financial support from the State and Federal Government, the implementation of the NP role in aged care would not only benefit older Australian residents but reduce hospitalisations and support medical practitioners in the provision of quality clinical and medical care.

The ABS profile for age in our region as cited in our most recent Quality of Care report (2005) shows higher than state average in persons over 65 years. Clearly this is a population we need to consider when planning our service provision. In considering roles for NPs in aged care we did not limit our thinking to NHW specific services. While our organisation is a key player in aged care it is not the only service provider in our community. Volunteers, Churches, Community Health, local government, the private sector and the Division of GPs all work with the aged in our community. There is scope

and indeed desire for the development of roles which cross the boundaries of acute inpatient episodes of care, residential settings and home based care. This is hampered by capacity to pay. A Medicare rebate and access to the PBS is not open to clients accessing the services of NPs, which is a disincentive for individuals and private nursing home operators using them. Exploration of the possible use of GP delegated Medicare item numbers has been discussed and needs further exploration.

Despite considerable efforts over recent years, NHW has not been able to recruit a geriatrician to our service. The presence of NPs in our aged care team has been cited as an enticement to a Geriatrician relocating to Wangaratta as care planning and case management of clients could be better managed by a highly skilled team which included NPs. In the interim though, we have to look at alternatives. We have commenced negotiations with a metropolitan based geriatrician who is supportive of the notion of attending our region for clinics and then case managing in partnership with Nurse Practitioners and GPs. We have the IT facilities to manage high quality video conferencing as an adjunct to this. He is also supportive of providing mentorship to NP candidates. This model will be developed further in the next few months.

2. Critical Care: We already have nurses functioning at an advanced level of clinical practice in our CCU. Already our CCU nurses order diagnostic testing and standing orders allow for a high degree of physical assessment and subsequent medication adjustment .The Delphi Study found that in fact nurses in the CCU were perceived as sometimes working outside the usual scope of practice for CCU nurses. While they were perceived as having high clinical competence there was some concern regarding their medico legal status at times. The development of a Nurse Practitioner role in this setting could fall into the category of acknowledging the advanced role already in play and providing some legal boundaries for extension to practice

Fifteen of our current CCU nurses have undertaken METS training and a PAR team is under development. NHW is a key partner in the University Of Melbourne Postgraduate Diploma Of Rural Critical Care. Our nurses who hold this post graduate diploma are in a good position to move onto Masters qualifications. We do not have access to a full time

medical intensivist therefore in order to maintain a high level of patient care a trusting collaborative approach has been developed between the nursing staff and the broader medical team. This is a good basis on which to build a NP role.

In addition to this there is a push in our wider organisation to better support the more junior members of the health team in the general wards particularly overnight and on weekends when the response to patients' deteriorating physiological status can be delayed due to a combination of factors sometimes including the inexperience of nursing staff and or the availability of senior medical officers. Having CCU staff who can leave their unit and respond to situations across the organisation with the capacity to prescribe and or admit immediately to the critical care unit is seen to be a smart use of resources and something which in the long run can be sustained by our ready resource of CCU trained nurses coming through the postgraduate diploma course. Possibly the further development of our existing area based Clinical Nurse Support Consultants (these nurses are CCU qualified) or our after hours nursing supervisor role into NPs would better address this gap. Considerable work still needs to be done by a CCU working party to best determine the scope of practice of a Critical Care Nurse Practitioner. There is in principle however strong support for NPs in this field.

3. Mental Health: Mirroring the experience of CCU and the Community Midwife Program the mental health team at NHW have responded to the changing needs of our community and the increased demands on the medical team by developing the capacity of the nursing and allied personnel so that they are recognised as advanced practitioners. A key role for nurses in mental health is in community interventions and up stream health promotion activities. Many of our community based mental health nurses work at a highly developed level providing specialist advice to consumers, the wider health team and GPs. The application of evidence based interventions by a multidisciplinary team has seen the development of innovative models of care such as our Integrated Primary Mental Health Model. These nurses work in a collaborative model in GP practices through out the region. Coupled with this we have developed a formal support system of education and research in partnership with the University of Melbourne.

The mental health team have identified several areas of practice where the capacity to utilise the extended practices of the nurse practitioner endorsement would lead to more timely and appropriate care for the clients. This view is supported by the regional division of GPs and the consultant psychiatrists. The mental health team are now working in a focused way to define the exact scope of practice for Mental Health NPs in our rural context.

All of the Delphi selections: Mental Health, Critical care, Aged care, Wound care and palliative care have been piloted in some form though the DHS funded nurse practitioner projects across Victoria and shown to demonstrate the need for extension to practice with various recommendations (Victorian Government Department of Human Services 1999, Victorian Government Department of Human Services 2003, 2004) -the exception being oncology. Our situation at NHW is unique from the metropolitan experience in that our oncology nurses work in a unit at NHW geographically isolated from the consultant Oncologists who work in Albury/ Wodonga. The oncology nurses have a strong and collaborative working relationship with the NHW consultant physicians who currently through good will rather than formal process assist the nurses with patient review. The oncology nurses rely on the resident medical staff to prescribe medications. These junior doctors effectively work under the direction of the oncology nurses. These nurses already work as clinical nurse consultants, are highly skilled and practise with an advanced level of autonomy. Our research indicates that endorsement as NPs would enable them to respond to their client needs in a much more evidenced based and process driven fashion.

Understanding Advanced Practice and the Need for Extensions to Practice

This has been a key discussion point in our in our deliberations and will continue to be debated as each clinical area works to define the precise scope of practice of their NPs. Elsom, Happell and Manias (2005) elaborate on this and challenge us quite rightly to discern where the extended practices are really required. At our Nurse Practitioner Forum in March Associate Professor Brenda Happell from the University of Melbourne Centre for Psychiatric Nursing and Research spoke to this topic and placed it firmly on

our agenda. This issue of defining practice and understanding advanced roles is something which creates confusion throughout Australia and is hampering the progression of the profession towards the development of consistent advanced practice roles in Australia argues Jamieson and Williams (2002). We acknowledge that we need to be clear about where the NP role fits within our existing and proposed practice models.

Collaboration with other health services in the development of nurse practitioner roles.

We have had discussions with Ovens and King Community Health Service (O& KCHS) regarding a collaborative approach to assisting with the education of a primary health care NP in the upper reaches of the King Valley and in relation to aged care and chronic disease management through ACASS and our HARP project. Subject to funding we are keen to provide educational support and share some clinical mentoring with NP candidates employed by O&KCHS. Collaboration with the private sector was beyond the initial Terms of Reference of this project however our forums and workshops have included nurses from across all sectors in our region. There would be good opportunities for education if the private and public sector pooled some resources and shared mentors.

In addition to this we are confident that if we build a critical mass of NPs in our organisation they can act as mentors for growing the next wave of NPs here in NHW and in some of the smaller district health services. We aim to build our capacity to provide educational support for the Masters studies and offer opportunities to other regional health services to access this.

**Prospective nurse practitioner candidate/s capacity for development
as a Nurse Practitioner**

As described previously we have a strong field of nurses in CCU, mental health and oncology who have been working in an advanced capacity for some time and many of whom already hold post graduate diplomas. Some staff has local, regional and state

leadership profiles. Many of our prospective NP candidates present their work at state and national conferences. We have an accredited Advanced Physical Assessment skills course running at NHW which many nurses have completed and can gain credit points towards their Masters with.

NHW is now a member of the Rural Health Academic Network (RHAN), University Of Melbourne School Of Rural Health, and through this we will grow our research capacity and offer support to staff such as NPs to undertake research. This is an important resource as our respondents tell us that while our potential NPs are key clinicians who are involved in internal quality activities and the application of existing evidence to practice there is some fear around the NBV requirement for NPs to be involved in what is perceived as higher level research. Organisational capacity for research, training and funding is an important driver for success in this area.

There is no doubt that our pool of prospective NP candidates is not as strong in the aged care sector however we believe that this is more an issue of confidence and access to further education than lack of ability. We are not limiting our thinking to the existing staff profile in our designated aged care settings. Older people belong to all sorts of contexts. We believe that our initial aged care NPs may in fact come from other clinical areas such as acute medical wards or our HARP program and work across service boundaries.

The aged care working party is exploring this and executive is not adverse to the notion of advertising both internally and externally for potential candidates once the scope of practice is determined.

Education and Mentoring Plan for NP Candidates

Fundamental to the development of nurse practitioners at NHW is the acknowledgement of the need for our nurses to be working towards a Masters level qualification and to undertake a clinical internship in preparation for the extended practices inherent in their new role. Our Delphi research has indicated that this is the greatest barrier to nurses taking up the mantle of NP.

For rural nurses at our organisation the tyranny of the distance, the expense of Masters level education both in dollar terms and time away from family and work is a substantive disincentive to them progressing to NP level. Growing Nurse Practitioners in our community requires input from healthcare agencies, the broader community who they serve in addition to the individual nurse. Getting the mix equitable is complex but some balance between individual contribution, scholarship funding, and workplace study time release and community sponsorship needs exploration.

NHW acknowledges that we must address this reality if we are to achieve our Nurse Practitioner objectives.

Local access to and support for appropriate education is the cornerstone of our strategy to incorporate NPs into our multi disciplinary teams across the organisation and into the community and is well supported by our findings and the literature (Murray & Wronski 2006).

Our plan is to build a bank of NPs starting with three in each designated service area, growing that to around forty NPs over 5-6 years in order to provide a sustainable service and provide collegial support. A number of these NPs will be employed by agencies other than NHW however our goal is to service the community not the organisation so we envisage cooperative arrangements that will allow NPs to practice across service boundaries.

We will link closely with a provider university for online Masters Study and work with them for a joint academic appointment to support a cohort of around twelve NP candidates across the three/four identified immediate service areas. Deakin University with its extensive experience in distance education and desire to partner in a large cohort group of NP candidates at NHW has been identified as the partner university. Discussions with the University of Melbourne have identified them as the provider of education in the Clinical Pharmacology component of study, with lectures delivered by video conference to our cohort here in Wangaratta.

Each clinical area where the role is being developed will work with the candidates and the university to identify clinical mentors. We are mindful however that in some domains we do not have the capacity to provide appropriate mentorship. Some buy in of mentorship may be necessary and is planned for in our submission process. (Appendix 3). A successful submission to the Victorian Department of Human Services Nurse Policy Branch has provided funds to accommodate some of the costs involved with mentorship of NP candidates.

NHW can provide the necessary resources for on site learning in terms of skills laboratory, video & teleconferencing, medical library and computer access.

In addition the NP candidates will liaise closely with Deakin University and NHW to develop the CPGs necessary for practice in each domain.

To achieve endorsement in a time frame consistent with our goals, the NP candidates require significant onsite mentorship and organisational support. The incorporation of CPG development and NBV portfolio construction as part of the Deakin Masters program is attractive as it integrates into the Masters what has been a most difficult and burdensome component of preparation for endorsement . In being offered candidature from NHW each nurse will agree to being ready for endorsement application within three and half years.

The success of the project will be built on attracting sufficient scholarship funding to underwrite the costs to our candidates and getting our first cohort of NPs across the line leading on to them providing the next level of mentorship support for subsequent NPs from our organisation and from other health services in our region. To that end we are working in concert with Deakin University to attract both individual scholarships and broader research funds. Our aim is to have our first nurse practitioners endorsed by the NBV in three and a half years, with staged intakes of candidates following through over the next six to seven years, so that by 2010 we would have around forty nurses endorsed or close to endorsement as NPs.

This is a bold and ambitious initiative but our project findings have demonstrated that this has potential not only on a local level but as a model for NP development nationally and is indeed fertile ground for educational and clinical research.

Clinical Practice Guidelines Development including process for organisational approval

As discussed above and described in (Appendices 4, 9 and 10), the development of Clinical Practice Guidelines will be a joint effort by the candidates and their clinical area working party in conjunction with guidance and supervision from the University. The development of CPGs will adhere to the Victorian Government Department of Human Services Guide for Developing Clinical Practice Guidelines for Nurse Practitioners in Victoria (2006) which is inline with the NHMRC guidelines.

Scenario One: The NP candidate is enrolled in Deakin Masters program in which case development of the CPGs is part of the assessed study program. The candidate will be working closely with their unit specific working party and their relevant colleges on this.

Scenario Two: The NP candidate is holding a Masters or equivalent and needs to develop CPGs. This will be according to DHS and NHMRC guidelines and will be jointly developed by the candidate and their working party. (Appendices 4, 9 and 10)

Both approaches will see the finished CPGs being approved by the usual NHW internal approval process (Appendices 4, 9 and 10) which is in line with the DHS process for developing and approving clinical practice guidelines at an organisational level.

Expected benefits to the organisation, community & clients

Organisation

This project has found that NHW would benefit from the addition of NPs into our multi disciplinary teams on several levels:

1 Clinical Governance: Several of our nurses are operating at an advanced level now and have been described as 'virtual' NPs by their peers. Endorsement as a NP with the

accompanying process and structure would recognize the work of these nurses and provide a solid clinical governance framework around their activities.

2. Workplace recruitment & retention: A strong clinical career path with innovative and generous educational opportunities is a lure in attracting and retaining staff to a regional centre such as ours. Our plan to grow a significant cohort of NPs is possibly a unique feature for our organisation. We also believe that our multidisciplinary approach particularly in the community sector will be attractive to allied health and medical staff contemplating work in a rural centre.

“There is compelling evidence for the success of the "rural pipeline" (rural student recruitment and rurally based education and professional training) in increasing the rural workforce. The nexus between clinical education and training, sustaining the health care workforce, clinical research, and quality and safety needs greater emphasis in regional areas. A "teaching health system" for non-metropolitan Australia requires greater commitment to teaching as core business, as well as provision of infrastructure, including accommodation, and access to the private sector. Workforce flexibility is mostly well accepted in rural and remote areas. There is room for expanding the scope of clinical practice by non-medical clinicians in both an independent codified manner (eg, nurse practitioners) and through flexible local medical delegation (eg, practice nurses, Aboriginal health workers, and therapists).

(Murray RB, Wronski I 2006)

3. Patient Flow: Using the right patient, right practitioner, right place philosophy our findings suggest that the introduction of NPs into the organisation will reduce patient wait times, afford more expedient admission and discharge, increase health promotion activities and ultimately provide a more seamless journey for clients accessing our organisation. Again the NP positions piloted across the state already support this view (Victorian DHS 2006, 2004, 2003, 1999)

Community

Rural communities are pragmatic. Often portrayed as people who resist progress the reverse is in fact closer to reality. Our community leaders are very much aware of the need for innovation and change. The evolution of collaborative models of nurse practitioner care is seen by consumers who participated in our research to be a real and tangible way of maintaining quality health services where they are most threatened. While traditionally the GP has been the cradle to grave provider in country towns the community is becoming more aware through their experiences with multidisciplinary teams that this is no longer the case. Our hospital and our regional community is strong in its desire to grow its own skill base, provide local opportunities for its own people and alleviate some of the brain drain of our young and talented to the metropolitan centers.

As part of our community engagement strategy we met with the CEO of 'Champions of the Bush'. This is an independent regional lobby group formed in 2002 with the goal of improving life in regional and rural areas. One of their particular goals is to encourage our young people to return home upon completion of their tertiary studies rather than face a continual drain of young people moving to metropolitan areas. They also lobby for improved health, education, transport and telecommunications in the country. This group has endorsed our plan to work with Deakin University in developing strong scholarship opportunities for our nurses. They see this as an initiative which provides work and educational opportunity to young people wanting to 'come home'.

We have included local government in our nurse practitioner projects to date so they are aware of the positive possibilities of the role. The Wangaratta Community Education Advisory Committee is aware of our endeavors as are significant community leadership groups such as The Alpine Valleys Community Leadership group and the Williamson Foundation. In addition, our NHW community advisory group participated in the Delphi research project and has reported to us their ideas and support for growing the role of the nurse practitioner in our community.

There is no question that the NP role has benefits in addition to direct service delivery from many perspectives to our community. A strong and skilled nursing workforce has the potential to retain and even attract specialist medical services in rural regions as skilled workers look for collegial support.

Clients

The benefits to clients have been well described in the evaluations of the Victorian DHS demonstration projects (2003, 2004, and 2006) and in the national and international literature (Donald, and McCurdy 2002, Gardner and Gardner 2005, Horrocks and Salisbury 2002, Offredy M. 2000). We would expect similar benefits in terms of safety and satisfaction, timeliness of diagnostics and review, appropriateness of referral. As discussed earlier the areas where findings point to clients receiving most benefit in the immediate term are in Aged Care, CCU and Mental Health.

Barriers/Constraints to implementation of the role

Possible Solutions

Our Delphi Study asked participants to identify the key barriers to implementing NP roles. There was strong consensus around the following issues:

Confusion about the role

There is not a clear understanding of what the role of the NP is and how it articulates into the broader system of care. Articulating the scope of practice should not be underestimated. It is a difficult process when we try to understand where advanced practice stops and where the need for extended practice begins.

Solution: A considerable amount of work needs to be done in understanding what nurses do-both within the healthcare sector and into the community. A sophisticated communication strategy to avoid confusion and conflict was seen as a priority in planning for the role.

Financial, Educational & organisational support

This was very strong theme. Potential NPs need to feel supported in their role by the executive team and Board of Management. The politics of health should be dealt with at executive level rather than at patient care level.

Studying for a Masters, learning new clinical skills and providing patient care in addition to the roles many nurses' play as partners, parents, caregivers, farmers, business partners and community volunteers needs financial support and study leave in addition to the EBA provision. The cost in dollar terms and the travel and emotional price of being away from home for study is a major disincentive to take up. Most of our potential NP candidates are at a time in their life where they are paying for or preparing for their children to attend university in metropolitan cities. This is a major financial burden for rural families costing in the vicinity of \$30,000 per year in some instances. Access to postgraduate education is an equity issue if we consider the situation of rural nurses

and the added expense distance contributes to learning compared with access metropolitan nurses have to further education facilities.

Growing Nurse Practitioners in our community requires input from healthcare agencies, the broader community who they serve in addition to the individual nurse. Getting the mix equitable is complex but some balance between individual contribution, scholarship funding, and workplace study time release and community sponsorship needs exploration.

Solution: Provide as much education as possible locally and establish economies of scale with access to resources including mentors and clinical training by organising a cohort of around twelve NP candidates working towards endorsement together. Assisting students to access scholarships and provide study leave in addition to the EBA. Establish a joint position with a University provider to support a cohort learning model. Support strong area based working parties which work in concert with the candidates and the university provider.

Nurse practitioners duplicating existing services

The perception that Nurse Practitioners are seen as another cog in the complex machine that is health care.

Solution: The introduction of NPs into the health team should be driven by clearly identified service gaps. The system should not be made more complex by the introduction of NPs. The stakeholders in specific clinical areas should agree on the scope of practice and then seek to fill the position by developing a NP position rather than the role being developed to match individual candidates.

Clients accessing the Services of NPs outside of the Public Hospital setting

The exclusion of NPs in accessing PBS and Medicare provider status for the treatment they provide outside of a Public Hospital setting is seen as a significant barrier to making the role effective particularly given the growth of community based health care and the importance of population health strategies. Frustration remains strong around

the role of government and its delay in acting on the recommendations of the Productivity Commission Report (2005) and other reports calling for reform.

Our efforts to establish Nurse Practitioners must be inclusive of the continuum of care and the episodic nature of acute hospital admission. NPs crossing the boundaries of the acute and community setting was agreed as being very important to making the role functional.

Solution: Reciprocal rights should be established between agencies and exploration of funding models such as possible use of GPs delegating care through Medicare. Opportunities for training and education of NPs need to be shared with our partners in rural healthcare outside of NHW.

Continued lobbying of federal and state governments to widen access to Medicare and the PBS is vital.

The professional and personal isolation of NPs

The sustainability of any NP service was seen to be contingent upon there being enough NPs to provide a regular and reliable service. GPs were very strong in this view. Burnout and ‘Tall Poppy Syndrome’ was seen to be threats to individual NPs in particular.

Solution: Individual NPs in clinical areas are not supported. A minimum of three NPs in each service area would provide a reliable service and provide collegial support.

Relationship with doctors

This was a strong and recurring theme. The desire not to disenfranchise medical practitioners was seen as being very important by nurses, consumers, doctors', allied health and administrators alike.

Solution: Nurse Practitioners' contribution to patient care should be a critical part of the team approach. It should make best use of nursing knowledge & expertise rather than create confusion and boundary protection. Clear communication of the development of the role, inclusion of medical practitioners on working parties and in the review of guidelines is essential to maintain good will. The research showed that individual medical practitioners were less concerned with the politics of their respective colleges and more concerned with the pragmatics of healthcare which they saw as benefiting from the expertise of NPs in the team. There appeared to be genuine goodwill between doctors and nurses in discussions on the potential role of NPs.

Proposed Budget

Each submission (Appendix 3) to Nursing Council must include a budget for the proposed NP role which includes costs for mentorship, study leave in addition to the EBA and any back fill required. Identification of scholarship sources should also be included.

Funding Options

Funding the Nurse Practitioner role is as much a state of mind as a state of budget. If Nurse Practitioners are truly part of an overall strategy then they should not be viewed as an 'add on' or a special project in the multidisciplinary team. Our findings from this project expressed a view that if the DHS are committed to the growth of the role then this needs to be reflected in funding agreements which incorporate a NP into the broad staffing profile.

Each clinical area wishing to include a NP role into their team needs to survey the educational requirements of their candidates and then explore scholarship options. Funding for the role once the candidate is endorsed must be inclusive in existing staff budgets.

Evaluation Plan

When asked about evaluation processes for any proposed NP roles, the Delphi Panel agreed that the role should integrate with existing organisational clinical measures and quality evaluations. There should not be an overly burdensome process of data collection as NPs had already been demonstrated to be safe and effective in a variety of settings (Offredy 2000, DHS 1999, 2003, 2004, and 2006). In addition to the occasions of service, adverse events and clinical indicators which all services collect some limited specific outcome measures should be identified for each service area to reflect the impact that the intervention of the NP has on the client experience. The ANMC Report (Gardner et al 2004) recommends a mixed methods approach which includes some rich client outcome data.

Process to Ensure Sustainability of the Nurse Practitioner role

Our Education strategy together with our policy of having a minimum of three Nurse Practitioners in a service area is how we propose to ensure that the NP is not just a 'flash in the pan'. Building a Nurse Practitioner role into future recurrent funding budgets and collecting data over time which demonstrates clear population health benefits from the role and publishing these findings will ensure its sustainability. Championing the role and communicating the scope of practice is also paramount for the ongoing success. NHW has maintained a role for a project officer position in the Nursing Administration budget to continue to drive the progress of developing NPs locally.

Conclusion

NHW is an organisation which supports the introduction of NPs into our multidisciplinary teams. We have identified the key drivers for success in achieving their introduction and have come some way to beginning the process of making this happen.

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Ms. Sue Wilson	Manager Nursing Education Northeast Health Wangaratta
Ms. Bernadine Hamer	Manager HARP Northeast Health Wangaratta
Ms. Kerrin Elliott	CNC/NUM Oncology Unit, Northeast Health Wangaratta
Ms. Julie Hancock	CNC/NUM Oncology Unit, Northeast Health Wangaratta
Mr. Brett Johnson	NUM Critical Care Unit, Northeast Health Wangaratta
Ms. Heather Wickham	CNC, Palliative Care Northeast Health Wangaratta

Co Opted Members

Mr. Peter Fahy	Senior Psychiatric Nurse, Northeast Health Wangaratta Senior Lecturer, University of Melbourne.
Ms. Val Goodwin	Clinical Nurse Consultant, Mental Health Education & Research Northeast Health Wangaratta
Ms. Deb Hobijn	Post graduate Education Coordinator, NHW Lecturer, Rural Critical Care University of Melbourne.

Delphi Panel

Ms. Anne Shaw	Consumer Representative
Ms. Janine Holland	Acute Health Program Advisor Department of Human Services, Hume Region.
Mr. Frank Megens	Deputy Director Clinical Services, NHW
Ms. Kerrin Elliott	Oncology Unit, NHW

Ms. Heather Wickham	Palliative Care, NHW
Ms. Bernadine Hamer	Program Manager, HARP, NHW
Ms. Jeanette Dowd	Consumer Representative
Ms. Karen Gunner	CNS, Home Based Nursing, NHW
Ms. Helen O'Donoghue	CNC, Diabetes Education, NHW
Ms. Coral Marks	CNC, Hume Region Palliative Care
Ms. Ann Wearne	CEO, Ovens and King Community Health Service
Ms. Gail O'Donnell	Manager, Ovens and King Community Health Service
Mr. Brett Johnson	NUM, CCU, NHW
Mr. Greg Benton	NUM, Emergency Department, NHW
Mr. Michael Nuck	Manager Mental Health Services, Kerferd Unit, NHW
Ms. Val Goodwin	Mental Health Education & Research, NHW.
Ms. Marianne McKelvie	NUM, Hospital in the Home, NHW
Mr. Paul Crimmin	Manager, Post Acute Care, NHW
Ms. Lia Rigoni	Physiotherapist, NHW
Ms. Carmel Jedanyk	CNC, Thomas Hogan, Sub Acute Rehab Unit, NHW.
Mr. Rob Ryan	NUM, Thomas Hogan, Sub Acute Rehab Unit, NHW.
Ms. Christine Delaney	Manager Residential Aged Care, NHW
Ms. Janet Baker	CNC, Community Midwife Program, NHW
Ms. Deb Hobijn	Educator, Nursing Education Unit, NHW
Ms. Jan Garvey	Educator, Nursing Education Unit NHW
Ms. Tamlyn Gent	Graduate Nurse, NHW
Mr. Gary Croton	CNC, Integrated Primary Mental Health Services

Ms. Jenny Ahrens	Manager, Integrated Primary Mental Health Services
Ms. Norene Branigan	Consumer Representative
Ms. Anne Bell	Consumer Representative
Dr. Desmond Burke	Consultant Anaesthetist, NHW
Ms. Jenny Donnelly	Manager, Ovens and King Community Health Service.
Ms. Rose Purches	CNC, Renal Unit, NHW
Ms. Ally Crimmin	Social Worker, NHW
Ms. Clare Schulz	Health Promotion Worker, NHW
Dr. Alan Randell	Medical Specialist Aged Care & Rehab NHW
Ms. Jill Campbell	ACN, Residential Aged Care NHW.
Ms. Bev Maher	CNS, Home Based Nursing, NHW
Ms. Naomi Kerr	Graduate Nurse, NHW
Ms. Lois Foley	Patient Services Manager, NHW
Dr. John Elcock	Director Medical Services, NHW
Ms. Monika Samolyk	CNC, Nurse Educator, NHW
Mr. Peter Lee	CNC Paediatrics, NHW
Ms. Anne Hiskins	CNS Paediatrics, NHW
Dr. Gill Perriment	NEVDGP
Dr. Amah Shah	NEVDGP
Dr. Les Bolitho	Consultant Physician, NHW
Ms. Renee Murtagh	CNS, Community Psychiatry, NHW
Mr. Jurgen Hemmerling	Manager Community Psychiatry, NHW

Glossary & Acronyms

ACAS: Aged Care Assessment Service

Advanced Practice Nurse: Advanced practice nursing defines a level of nursing practice that utilises extended and expanded skills, experience and knowledge in assessment, diagnosis, planning, implementation and evaluation of the care required. An advanced practice nurse is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the features of which are shaped by the context of the health service in which the practice is based. Nurses practising at this level are educationally prepared at post-graduate level and may work in a specialist or generalist capacity. However, the basis of advanced practice is the high degree of knowledge, skill and experience that is applied within the nurse-consumer relationship to achieve optimal outcomes through critical analysis, problem solving and accurate decision-making.

Advanced practice nursing forms the basis for the role of the nurse practitioner. (RCNA 2006)

CPG: Clinical Practice Guidelines

EBA: Enterprise Bargaining Agreement

Extended practice: Defines the level of nursing that draws upon advanced nursing practice knowledge and skill in conjunction with legislative provisions that enable the nurse to deliver a health service that encompasses a complete episode of care to clients/patients. This nursing care is autonomous and collaborative and determined by the health-service needs of clients in specific populations. (ANMC 2005)

HARP: Hospital at Risk Program

HITH: Hospital in the Home

Glossary (cont)

NP: Nurse Practitioner

METS: Medical Emergency Team

NEVDGP: Northeast Victorian Division of Genral Practice

NHW: Northeast Health Wangaratta

O&KCHS: Ovens and King Community Health Service

PAR: Patient at Risk

VMO: Visiting Medical Officer

List of Appendices

1. List of Presentations, publications and consultations
2. Nursing Competency Report
3. Submission Template
4. Establishing a NP in a Clinical Area Flow Chart
5. Nursing Council Guide to Approving Nurse Practitioner Applications
6. Communication Strategy
7. Generic Job Description
8. NHW Management Structure
9. Process for developing and approving clinical practice guidelines at an organizational level.
10. Approval Process for Clinical Practice Guidelines for Nurse Practitioners at NHW.

APPENDIX 1

List of Presentations and Consultations

DHS Objective:

Promote the role within the health care system and the community

1. Meeting & presentation to Ovens and King Community Health Service October 18th 2005
2. Presentation to Medical Staff Group October 19th 2005
3. Mobile Poster Display – Hospital wide.
4. Presentation to NHW Consumer Group October 21st 2005
5. Meeting with NEVDGPs November 8th 2005
6. Presentation to Probus November 17th 2005
7. Meeting with NUM - Palliative Care 22nd November 2005
8. Hume Region Palliative care team November 25th 2005
9. Presentation to Nursing Council November 22nd
10. Meeting with NUM – Critical Care 23rd November 2005
11. DHS Workforce Planning Day- November 29th 2005
12. Meeting with NUM : Hospital in the Home November 30th 2005
13. Presentation to Nursing Executive
14. Meeting With Renal Dialysis – November 30th 2005
15. Presentation to NHW Executive Group December 5th 2005
16. Meeting with Emergency Department NUM - December 6th 2005
17. Meeting with Corporate Business Analyst Dec 6 2005
18. Meeting with GP Consultant Aged Care December 8th
19. Letter to Dean Clinical School of Medicine, University of Melbourne School of Rural Health.
20. Poster Presentation at University of Melbourne Rural Health Conference -December 13th 2005
21. Article published in Base Bulletin
22. Meeting with Education Unit- December 14th 2005
23. Presentation to Community Midwife Program- December 14th 2005
24. Meeting with NUM & CNC - Sub acute December 19th
25. Meeting with Manager – Home Based Nursing December 20th 2005
26. Meeting Manager Psychiatry Services - January 2nd 2006

27. **Presentation to combined Home Based Nursing Services January 4th 2006**
28. **Meeting with Residential Aged Care Christine Delaney -January 6th 2006**
29. **Meeting with Integrated Primary Mental Health Team January 3 2006**
30. **Meeting with Allied health – January 23rd**
31. **Presentation to Paediatric Ward February 9th 2006-08-16**
32. **Presentation to Community Psychiatry Team February 10th 2006.**
33. **Presentation to Pharmacy Committee**
34. **Meeting with Mental Health Education & Research Team March 5th 2006.**
35. **Presentation to Zonta Club March 2nd 2006**
36. **Nurse Practitioner Forum, Gateway Hotel Wangaratta March 31st 2006**
37. **Presentation to Aged Psychiatry Team June 7th 2006**
38. **Presentation to ANZ College of Mental Health Nursing June 23rd 2006**
39. **Presentation to NHW Board June 29th 2006**
40. **Northeast Division of GPs Board Meeting June 29th 2006**
41. **Rotary Inner Wheel Presentation**
42. **Presentation to Champions of the Bush June 24th**
43. **PRAXIS article published.**
44. **Presentation NHW Clinical leadership team, August 15th 2006**

APPENDIX 2:



Nursing Division

Competency Project Report

February 2006

Barbara Sanders
RN Div1, C.C.Cert

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Executive Summary of Nursing Division Competency Project

Background

In any organisation of size, there exists a huge pool of experience and skills. However, it is sometimes difficult to identify which personnel have the skills and knowledge to deal with particular issues. Concomitant to this, it is sometimes difficult for an individual to have their skills appreciated by the organisation of which they are a part.

The decision by Director of Nursing Christine Giles to address these issues resulted in Northeast Health Nursing Division undertaking a project starting in late 2005. The first part of the project involved identification of what competencies existed in the division. Including in this identification was looking at what the requirements are to attain competency in each of those skills. Once the data was collected, ways to improve accessibility to the data needed to be looked at.

Working Definition for the Project

The first task was to try to get a handle on what a competency is. This is made more difficult because there does not seem to be an agreed definition in the literature. After much reading, and discussion with colleagues, it was decided that for the purposes of this project, a competency would be a clinical skill, and/or a body of knowledge which is an extension of the skills and knowledge which a nurse has (or should have) when he/she graduates.

Identification of Nursing Division Competencies

This stage consisted of interviews involving the Nurse Unit Managers (NUMs) or their delegates, from all areas of the organisation. Utilising their knowledge was essential to the success of the project. The Nursing Council delegates were also informed of the project. Helen Haines, Nurse Practitioner Project Officer, has been an important resource person. Valuable contact was made with the staff of the Nurse Education Unit.

Early in the course of the project, it became quite clear that generally the NUMs had a firm grip on the skill level and mix of the staff in their areas. Other individuals with specific responsibilities (for instance the Basic Life Support educators of an area) also had clear knowledge of which of the staff in a particular area are up to date in their training.

A very clear, but not entirely surprising, message coming from this data collection is the breadth and depth of knowledge and skills existing in the staff of the nursing division.

In total, this project has identified about 120 competencies/clinical skills currently in use across the division. At present about 10 of these are organisation wide, such as proficiency in caring for a patient with a Peripherally Inserted Central Catheter

(PICC) in situ and No Lift training. There are mandatory competencies, such as BLS certification, and Fire Training. Some are intensely area specific, such as those involved in perinatal care. Many of the skills, including their accompanying knowledge base, need refreshing on a regular basis, other skills, if practised, are deemed to be life long attainments. Classification of staff can influence who is eligible to pursue certain competencies – for example, Registered Nurses (Division 2) may pursue a Medication Endorsement; Midwives may attain the skill of perineal suturing.

There are specialist areas in the hospital, where staff may pursue post-graduate education, hence attaining a qualification which gives them a knowledge base and the skills to care at a more autonomous level for patients. Alternatively, a staff member working in such an area may work towards acquiring some of the skills and knowledge needed to function in that speciality area, with supervision. Two examples are CCU and Paediatrics.

Attainment of Competencies

Group One

Competencies are attained through several different mechanisms. Some (the simpler tasks) are acquired by informal teaching – “see one, do one, teach one”. Examples of such things are nasogastric tube insertion; venipuncture; catheterisation. There are others, presently informal, where there may be benefit accrued if a change to a more formal approach was made – arguable examples are: CPAP use; Hickman/Porta Cath/Infusaport management; PICCO monitoring.

Group Two

To attain skills in the next grouping, some reading, or viewing of AV material, or lectures, (provided internally) together with being taught the actual skill involved is required. Also, there is either a theoretical or practical assessment of varying complexity. For instance, for IV cannulation, a log is kept by the aspiring RN of successful cannulations. For Paediatric drug calculations – a drug calculation quiz must be completed successfully.

Group Three

The next grouping of skills will involve (again provided internally) some reading, or viewing of AV material, or lectures, together with a more formal assessment process, involving theoretical as well as practical aspects. Examples of this group of skills are anaphylaxis management; PICC line management; tri-age co-ordinator (Community Psychiatry).

Group Four

The fourth grouping of skills involves externally provided written information or lectures, together with theoretical and practical assessment. This may take the form of a one or more day short course, or may involve a post-graduate university qualification.

There are a few competencies provided by external agencies, but for which there is no formal assessment, for instance the CTG workshop for midwives.

Facilitation of Access to the Data

The next step of the project was to facilitate the translation of the local knowledge of the NUMs into a format that can be more universally accessed. Many steps along this route have been taken already by Kevin Vaughan, as he has set up a Microsoft Access based database. Access is a powerful database engine, and can be individualised to allow the user(s) to perform queries on, among other things: staff training; dates for renewal; individual staff member's attainments. This database at present contains about a dozen of the current competencies, and is used for tracking staff attainments in those competency areas.

The administrator(s) of the database can also program in permissions, so that only staff with a relevant need to use particular information are able to do so. For instance, the NUM of Ward A cannot explore the data pertaining to staff of Ward B. This is a useful ability in light of the need for privacy protection.

It would appear that not all of the users are utilising the database to the full extent of its capabilities. A way to deal with this would be the provision of training in query and report generation. This would need to be looked at in terms of resources available.

Issues Arising from the Project

While not strictly within the purview of the project, several issues arose which it would be useful to pursue.

- The discussion in the nursing literature about competencies and how one assesses them, while not within the scope of this project, should be referred to when future competencies or clinical skills packages are being devised.
- Training of staff developing competencies needs to occur

Recommendations Arising from the Project

- Add the identified current competencies to the database already set up by Kevin Vaughan, including dates of attainment and re-do where applicable
- Facilitate access to the database for relevant staff
- Train relevant staff members to fully utilise the database, developing skills in generating queries and reports in Access
- Provision of nursing educator hours, whether on a unit basis or organisation wide, to allow development of competencies identified as lacking, and necessary; amalgamation of duplicated competencies; and reworking of those competencies needing a more formal footing

Results of the Data Collection

The table over the next several pages contains the data on actual, current competencies, as obtained from interviews with stakeholders, and discussed at a meeting on February 3rd 2006.

Key to Data

First column - name of the skill/competency

Second column - whether the skill is mandatory in that area
Y or N

Third column - at what intervals does the skill need to be re-assessed
A - lifetime, if practiced
B - yearly
C - 2 years
D - 3 years

Fourth Column - what is required to attain the skill
1 - shown, practiced
2 - internal, written information/lectures; shown, practiced; no or informal or self assessment
3 - internal, written information/lectures, theory exam, prac exam
4 - external, written information/lectures, theory exam, prac exam
4a - external, written information/lectures, no formal assessment

Fifth column - which staff members are eligible to attain the skill - i.e. Div1, Div2, Midwife
Div1
Div2
Div3
Midwife
All
All# - different assessment and responsibilities for Div1 and Div2

Current Competencies

The tables over the next several pages contains the data on actual, current competencies, as obtained from interviews with stakeholders, and discussed at a meeting on February 3rd 2006.

	MAND	INTERVAL	LEVEL	PERSONNEL	AREA
Venipuncture		A	1	All	Org Wide
Hand Hygiene	Y	B	2	All	Org Wide
Fire training	Y	B	2	All	Org Wide
No Lift	Y	B	2	All	Org Wide
IV cannulation		A	2	Div1	Org Wide
BLS	Y	B	3	All	Org Wide
Pain package	Y	D	3	All#	Org Wide
PICC package	Y	B	3	All#	Org Wide
Extinguisher training	Y	D	4	All	Org Wide
MERN		A	4	Div2	Org Wide

All# Div1 and Div 2 packages differ

PICCO monitoring		A	1	Div1	CCU
Ventilator management		A	1	Div1	CCU
Long line placement		A	1	Div1	CCU
CPAP use		A	1	Div1	CCU
Arterial stab		A	2	Div1	CCU
ALS	Y	B	3	Div1	CCU
MET		D	4	Div1	CCU
ICU/CCU certif/dip		A	4	Div1	CCU

Arterial stab		A	1	Div1	A&E
A & E Pain package	Y	A	3	Div1	A&E
ALS	Y	B	3	Div1	A&E
Triage		A	3	Div1	A&E
pathology ordering & x-ray ordering - extensions of triage competency					

Neonatal Venipuncture		A	1	All	1E midwifery
Antenatal Clinic		C	2	Midwife‡	1E midwifery
Breast Feeding		B	2	All	1E midwifery
Sterile H2O inj in labour		A	2	Midwife	1E midwifery
Peri suturing		A	4	Midwife	1E midwifery
Comm. Midwife Program		C	4	Midwife‡	1E midwifery
Lactation Consultant		A	4	All	1E midwifery
Neonatal Resusc.		C	4	Midwife	1E midwifery
Emergency care in obstetrics		D	4	Midwife	1E midwifery
CTG workshop		B	4a	Midwife	1E midwifery
Sexual health counselling		D	4a	Midwife	1E midwifery
Genetic counselling		C	4a	Midwife	1E midwifery

‡ includes path and US ordering

‡Includes everything in ANC competency

Grad Cert Stomal Therapy		A	4	Div1	Stomal Therapy
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	MAND	INTERVAL	LEVEL	PERSONNEL	AREA
Pain Package		D	3	Div1	Pain M'Ment
Grad Dip Pain		A	4	Div1	Pain M'Ment
Respiratory course		A	3	Div1	GW medical
Cardiac Course		A	3	Div1	GW medical
Physical Assessment		A	3	Div1	GW medical
Palliative Care Course		A	4	Div1	GW medical
Catheterisation		A	1	Div1	1E surgical
NGT		A	1	Div1	1E surgical
Physical Assessment		A	3	Div1	1E surgical
Hickman		A	1	Div1	GW paediatric
Porta Cath		A	1	Div1	GW paediatric
Infusaport		A	1	Div1	GW paediatric
Fluid Management		A	1	Div1	GW paediatric
Paediatric Cannulation#		A	1	Div1	GW paediatric
Paediatric Psychiatric Awareness		A	2	All**	GW paediatric
Paediatric Drug Calculations		A	3	Div1	GW paediatric
Paed. Asthma Management		C-D	3	All**	GW paediatric
Post Grad Paed. course		A	4	Div1	GW paediatric
					#Supervision of MOs
PEG tube care		A	1	Div1	HBNS
Supra pubic catheter		A	1	Div1	HBNS
Baxter infusers		A	1	Div1	HBNS
Catheterisation		A	1	Div1	HBNS
Peritoneal Dialysis		A	1	Div1	HBNS
Syringe driven medication		B	2	Div1	HBNS
Anaphylaxis	Y	B	3	Div1	HBNS
Driver Safety	Y	A	4	Div1	HBNS
Syringe drivers		A	1	Div1	Aged Care
Grad cert/dip gerontic nursing		A	4	Div1	Aged Care
Hickmans		A	1	Div1	Oncology
Porta Cath/Infusaport		A	1	Div1	Oncology
CAD pumps		A	1	Div1	Oncology
Venesection phlebotomy		A	1	Div1	Oncology
R/O PICC		A	1	Div1	Oncology
Path ordering		A	2	Div1	Oncology
Anaphylaxis		B	3	Div1	Oncology
Chemo Certif		A	4	Div1	Oncology
Breast care		B	4	Div1	Oncology
palliative Care		A	4	Div1	Oncology
Lymph oedema m'ment		A	4	Div1	Oncology
Cert IV Training		A	4	All	Oncology
Defibrillation		B	3	Div1	Theatre
Scope cleaning					Theatre
level1		A	3	All	Theatre
level2		A	4	All	Theatre

	MAND	INTERVAL	LEVEL	PERSONNEL	AREA
Rehab certificate		A	4	Div1	Rehab
Rehab certificate		A	4	Div2	Rehab
Gerontic Certificate		A	4	Div1	Rehab
Catheterisation		A	1	Div1	X-ray
Triage Co-ordinator		A	3	Div3/Div1MH	Comm. Psych
Mobile Support team		A	3	Div3/Div1MH	Comm. Psych
ECAT		A	3	Div3/Div1MH	Comm. Psych
TRAAM (aggression man'ment)		B	3	Div3/Div1MH	Comm. Psych
Drug and Alcohol Interventions		A	4	Div3/Div1MH	Comm. Psych
Early Psychosis intervention		A	4	Div3/Div1MH	Comm. Psych
Debriefing		A	4	Div3/Div1MH	Comm. Psych
Men's Behavioural Change		A	4	Div3/Div1MH	Comm. Psych
BASIC SKILL SET					
Set up machine		A	1	All	Dialysis
Gain access - needle or CVC		A	1	All	Dialysis
On and Off Dialysis		A	1	All	Dialysis
Disinfection machine		A	1	All	Dialysis
Documentation		A	1	All	Dialysis
ADVANCED SKILLS					
Path - order and interpret		A	4	Div1	Dialysis
Dialysis prescription		A	4	Div1	Dialysis
Anti-coagulant		A	4	Div1	Dialysis
Anaemia management		A	4	Div1	Dialysis
Ideal weight assessment		A	4	Div1	Dialysis
Fluid management		A	4	Div1	Dialysis
Education - staff, patients, GPs, allied health		A	4	Div1	Dialysis
Medication review		A	4	Div1	Dialysis
Communication with other units, nephrologists		A	4	Div1	Dialysis
Advanced physical assessment skills		A	4	Div1	Dialysis
Recognition of co-morbidities		A	4	Div1	Dialysis
Management of the water filtration system		A	4	Div1	Dialysis
M'ment complications of dialysis - patient		A	4	Div1	Dialysis
- machine		A	4	Div1	Dialysis
Basic Renal Nursing course		A	4	Div1	Dialysis
Post Grad Renal Certif		A	4	Div1	Dialysis
HIV/HepC Counselling		A	4a	Div1	Infection Control
Nurse Immunisation		A	4	Div1	Infection Control
Mantoux testing		D	4	Div1	Infection Control
Catheterisation		A	1	Div1	Continenence
Supra Pubic catheter care		A	1	Div1	Continenence
Continenence Nursing		A	4	Div1	Continenence
Diabetes Education Course		A	4	Div1	Diab. Ed.
Credentialling		D	4	Div1	Diab. Ed.

Competencies Identified as Needed

Outlined below are the competencies which have been identified as desirable, as obtained from interviews with stakeholders, and discussed at a meeting on February 3rd 2006. Some of the skills are already practiced, but perhaps are not taught on a formal basis; some may have been formally taught previously, but would benefit from being refreshed on a regular basis.

Barriers exist which impede the development of new competencies, and the administration of current ones. The major perceived barrier is not enough allocated education hours, and in some areas, lack of a staff member with any allocated staff education time at all. Another barrier is the willingness (or otherwise) of staff to undertake study towards competencies, particularly if the competency attainment process is seen as unwieldy, and unrealistically complex.

CCU

Pathology ordering - is under development

IV fluid ordering - is under development

A&E

Paediatric cannulation

Paediatric - assessment and management in A & E

GW Medical

Trache care

GW MAPS

12 lead ECG

Rhythm interpretation

Physical Assessment

ALS

GW Paediatric

Paed Pain Management - is under development

Kerferd - most are done on an informal basis, and are currently being put on a formal basis

Mental Health Act Provisions

Phone Triage Skills

Therapeutic Interventions

Level 3 TRAAM (includes restraint, seclusion, escort)

ECT

Risk Assessment

Mental Health Status Assessment

Theatre

Perhaps done on an "area" basis, ie Anaesthetics; Scouting, Scrubbing; Recovery.

sterilisation procedures

decontamination procedures

Difficult Airway

LMA insertion

Malignant hyperthermia management

Loan kits

1E Surgical

Traction
UWSD

DSU

Currently no staff with formal pain package - being rectified
IV cannulation - need to access existing packages
Pre-Admission Clinic - with path ordering (protocol driven)
- also ?Physical assessment course be pre-requisite for running PAC

Rehab

Physical assessment course, specifically from a gerontological aspect

Aged Care

Dementia Care
Chest Pain Management - aiming to avoid unnecessary A&E admissions
PEG
Wound Management
Pain Management
TRAAM

Organisation wide

Medication Competency - ?utilise existing post-graduate package; or ?yearly math calculations
Mental Health First Aid
Drug and Alcohol issues
Preceptoring
Middle Management
TRAAM - is under development
Wound Management
UWSD
Protocol driven pathology ordering
Protocol driven x-ray ordering
CPAP - available, not yet "rolled out"
Catheterisation - learning package, male and female included
Some form of "train the trainer"
Computer literacy
SAD
PEG Care
Stoma Care

Glossary of Terms

ALS	Advanced Life Support
BLS	Basic Life Support
CPAP	Continuous Positive Airway Pressure (non invasive ventilation assistance)
CTG	Cardio-Toco-Gram
CVC	Central Venous Catheter
MERN	Medication Endorsed Registered Nurse (Div 2)
MET	Medical Emergency Team
NGT	Naso-Gastric Tube
PEG	Percutaneous Entero-Gastrostomy
PICC	Peripherally Inserted Central Catheter
PICCO	Peripheral Continuous Cardiac Output
SAD	Semi-Automatic Defibrillator
TRAAM	Tiered Response to Aggression/Anger Management
UWSD	Under Water Seal Drainage

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This project would have been much more difficult without the help I have received from all the NUMs and educators in the organisation.

I would particularly like to thank Helen Haines, Nurse Practitioner Project Officer, for her support and encouragement.

A big Thank You to Margie O'Connor and Ellen Hudson, for helping me with all my questions, and to Lee Peck for her minute taking

APPENDIX 3: Submission for a Nurse Practitioner Role

PROCESS

These documents are to be developed by or in collaboration with the Unit Manager relevant to the application.

Stage 1: Expression of Interest.

A brief document requesting a recommendation from Nursing Council to the DON seeking approval to develop a Nurse Practitioner role in a particular clinical area.

Once approved by Nursing Council, Stage 2 is then undertaken.

Stage 2: Full Plan for Nurse Practitioner Role

Only to be undertaken upon approval of Stage 1 from Nursing Council.

An electronic copy of the submission must be sent to Nursing Council at least 2 weeks before the next scheduled meeting. The key contact person must be available to speak to the submission at Nursing Council. Notification of approval or disapproval will be given within one month post presentation at Nursing Council.

Queries to be directed to Nurse Practitioner Project Officer:

Ms. Helen Haines

Northeast Health

Wangaratta

VIC 3677

Tel: 03 57 220 058

E: Helen.haines@nhw.hume.org.au.

STAGE 1: Expression of Interest

All criteria are mandatory. Please confine your responses to the area provided. This document is not intended to be onerous. Dot points are acceptable. Our intention is that clinical areas flag their interest in the Nurse Practitioner role and seek support from Nursing Council before undertaking the more extensive planning required for stage two. NHW is committed to Nurse Practitioners becoming an important part of our multidisciplinary teams.

Please note that only submissions put forward by a clinical area which meet selection criteria will be supported. Individuals applying for Nurse Practitioner roles without the prior support of their NUM and clinical team will not be successful.

Key Contact Details

Clinical Area	
Name of Person Completing Submission	
Position/Title	
Nursing Unit Manager Signature	
Phone/FAX	
Email	
Date	

Criteria	Response
1. There is a demonstrable need	
1.1 Why should a Nurse Practitioner Role be developed in your clinical area?	
1.2 What data/ information is there to support the need for this change to the personnel in your existing multidisciplinary team? i.e. <ul style="list-style-type: none"> • Findings from the existing literature, NHW Delphi Study etc. • Hospital data i.e. waiting lists, delayed admission &/or discharge 	
2. There is a clearly definable scope of practice	
2.1 Target patient population or client profile	

<p>2.2 Extensions to practice that would be used:</p> <table border="0"> <thead> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>• Prescribing</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>• Initiation and follow up of diagnostics</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>• Referral to medical specialists</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>• Admitting & discharging privileges</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>• Approval of Absence from Work Certificates</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table> <p>Describe any other proposed advanced clinical skills currently not in the existing nursing scope of practice?</p>		Yes	No	• Prescribing	<input type="checkbox"/>	<input type="checkbox"/>	• Initiation and follow up of diagnostics	<input type="checkbox"/>	<input type="checkbox"/>	• Referral to medical specialists	<input type="checkbox"/>	<input type="checkbox"/>	• Admitting & discharging privileges	<input type="checkbox"/>	<input type="checkbox"/>	• Approval of Absence from Work Certificates	<input type="checkbox"/>	<input type="checkbox"/>	
	Yes	No																	
• Prescribing	<input type="checkbox"/>	<input type="checkbox"/>																	
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• Referral to medical specialists	<input type="checkbox"/>	<input type="checkbox"/>																	
• Admitting & discharging privileges	<input type="checkbox"/>	<input type="checkbox"/>																	
• Approval of Absence from Work Certificates	<input type="checkbox"/>	<input type="checkbox"/>																	
<p>3. There is demonstrated support for the role from key stakeholders</p>																			
<p>3.1 Who would you invite to join your Multidisciplinary Working Party?</p>																			
<p>3.2 Have you discussed the role with these people?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>																		

6. Education requirements have been considered	
6.1 Are the potential candidates eligible for the NHW scholarship scheme? (See Appendix 4 for reference -do not submit this document)	Yes <input type="checkbox"/> No <input type="checkbox"/>
6.2 Have potential clinical mentors been identified who could assist Nurse Practitioners in your area to develop their extended skills?	Yes <input type="checkbox"/> No <input type="checkbox"/>
6.3 Do you think there would be a need to second mentorship from outside the organisation?	Yes <input type="checkbox"/> No <input type="checkbox"/>
6.4 Do you think there might be a need to pay some/ all of the clinical mentors for their time?	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Any other comments or information?	

Thank-you for completing Stage 1 Expression of Interest.

Please send a hard copy and electronic copy to:

Northeast Health Nursing Council

Submission for a Nurse Practitioner Role

Stage 2: Full Plan for Nurse Practitioner Role

This document will be completed by the Working Party which has been formed in the clinical area wishing to have Nurse Practitioners in their multidisciplinary team. All criteria are mandatory. Letters or statements of support may be attached as deemed important. Please add more paper as you see necessary.

Working Party Contact Details

All members of the working party are required to sign this document. Please circle lead contact person

Clinical Area:

Date:

Name	Position/ title	Telephone	Email	Signature

Criteria	Response
1. There is a demonstrable need	
<p>1.1 How could the existing health service be enhanced or new services be provided to meet organisational needs or the needs of a particular patient group?</p> <ul style="list-style-type: none">• How will it benefit your clients?• How will it benefit the Multidisciplinary team?• How will it benefit the Nursing profession?	

2. There is a clearly definable scope of practice

2.1 Please describe the scope of practice ensuring that you address the following points:

- What will the NPs do that is different to what nurses already do in your area and what other members of the health team do?
- Include how the NPs will demonstrate:
 - Leadership
 - Engagement in continuous quality improvement
 - Clinical research and developing evidence based practice at
NHW

Criteria	Response
<p>2.2 Are there other existing models for Nurse Practitioners in clinical areas such as yours?</p> <p>If so, have you contacted them?</p> <p>If you answered 'yes', what learning can you gain from the experience of these other models?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>2.3 Are there existing local, state, national or international Clinical Practice Guidelines and formularies that you can use or modify?</p>	<p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>

3. Demonstrated support for the role from key stakeholders

3.1 Please describe how you have brought the people you need on board to assist you in developing this role?

- The nursing team in your area
- Medical practitioners (consultants & GPs)
- Allied health
- Consumers
- Relevant colleges

3.2 Do you need assistance with communicating the new role to stakeholders?

Yes

No

4. Budget	
4.1 The role can be funded and sustained within the existing clinical unit budget.	<p>Please attach budget include:-</p> <ul style="list-style-type: none"> - Mentors Clinical teaching - Study leave above EBA - Any Back fill required - Travel
5. There are Potential Nurse Practitioner candidates in your Clinical area.	
5.1 Please list the names of your Nurse Practitioner Candidates and attach their applications with scholarship support applications where applicable.	<i>(Appendix B)</i>
6. Education requirements have been considered	

<p>6.1 Study leave has been considered with provision to back fill where necessary.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	
<p>6.2 Please list the clinical mentors you have approached so far.</p>	<p>Name</p>	<p>Clinical Skill</p>
<p>6.2 NHW plans to provide information and orientation to the mentors around the vision and goals of the Nurse Practitioner initiative.</p> <p>Describe how the mentorship team could operate to ensure the appropriate level of support and clinical supervision is provided to candidates</p> <p>How will you as the working party steering this project support the work of the mentors?</p>		
<p>6.3 Do these mentors need payment for some/ all of their clinical time?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	

7. Problem Solving	
<p>7.1 Please describe any specific issues that you anticipate may challenge the success of your Nurse Practitioner development?</p> <p>What strategies will you put in place to address these issues?</p>	
8. Other Comments	

Thank-you for completing Stage 2
Please send a hard copy and electronic copy to: **Northeast Health Nursing Council**
You will be contacted soon after with dates for your oral presentation of the submission to council.

Desirable Attributes for Nurse Practitioner Candidates

Minimum Clinical Experience

- Has a minimum of 3-5 years clinical experience in their specialty clinical area

Existing Clinical Leadership Qualities

- Has a conceptualisation of the Nurse Practitioner role that is patient centered and within a nursing model of practice.
- Has membership in their professional body and relevant college
- Has a strong history of participation in ward activities, policy development quality measures
- Has a strong record of participation in professional development activities both within and beyond that provided by NHW
- Has a high personal and professional standard as demonstrated by work history of excellence in performance review and testimony of referees.
- Would be seen as a role model by others
- Is recognised by their peers and supervisors as a 'go to ' person for clinical advise or supervision
- Is recognised by their peers and supervisors as willing to 'go the extra mile' for the benefit of the client, other members of the health team and the wider organisation?

Existing or Potential Professional Leadership Qualities

- Understands the importance of a 'Scope of Practice' and can work within the agreed boundaries of this.
- Has presented at a relevant conferences or submitted abstracts, posters
- Has undertaken or is undertaking formal or informal research activities: ie literature reviews, journal club, audits etc.
- Is active in organising ward based in service education or other forms of professional development.

Communication Skills

- Has a personal style that staff and clients feel comfortable in approaching
- Can articulate a scenario in a manner that is understood by people of varying skill levels and backgrounds.
- Has a sense of humour
- Can engage others in new initiatives and maintain their enthusiasm
- Can manage conflict in a constructive manner.
- Is a strong link in the interdisciplinary chain
- Can communicate with confidence in a variety of forums.

Personal Skills

- Has the capacity to be critically reflective and insightful
- Is persistent
- Is committed to excellence in themselves and others.
- Has an understanding and sensitivity to the political dimension of developing the Nurse Practitioner role and an ability to promote the role in a positive manner.
- Has a focus on best patient outcomes within a multidisciplinary team
- Can demonstrate a strong sense of accountability for decision making
- Understands their limitations and seeks help or training to address them

Educational Capacity

- A clinically relevant Masters level of nursing education or working towards **or:**
- Has existing relevant Post Graduate Diploma and willing to undertake Masters **or:**
- Keen and willing to enrol into a relevant Masters program
- Has the capacity to undertake post graduate studies and see them through to completion
- May be interested in participating in the NHW/ Deakin scholarship agreement

References

Gardner G, Carryer J, Gardner A, Dunn S 2006. Nurse Practitioner competency standards: Findings from collaborative Australian and New Zealand research . *International Journal of Nursing Studies, Volume 43, Issue 5, Pages 601-610*

Gardner GCJ, Dunn S, Gardner A. 2004. Report to the Australian Nursing and Midwifery Council: Nurse Practitioner Standards Project. In. Edited by Council ANaM. Dickson ACT: Queensland University of Technology.

Application for candidature as a Nurse Practitioner at NHW

Please attach your CV to this application. You may add extra paper to this application if you require it.

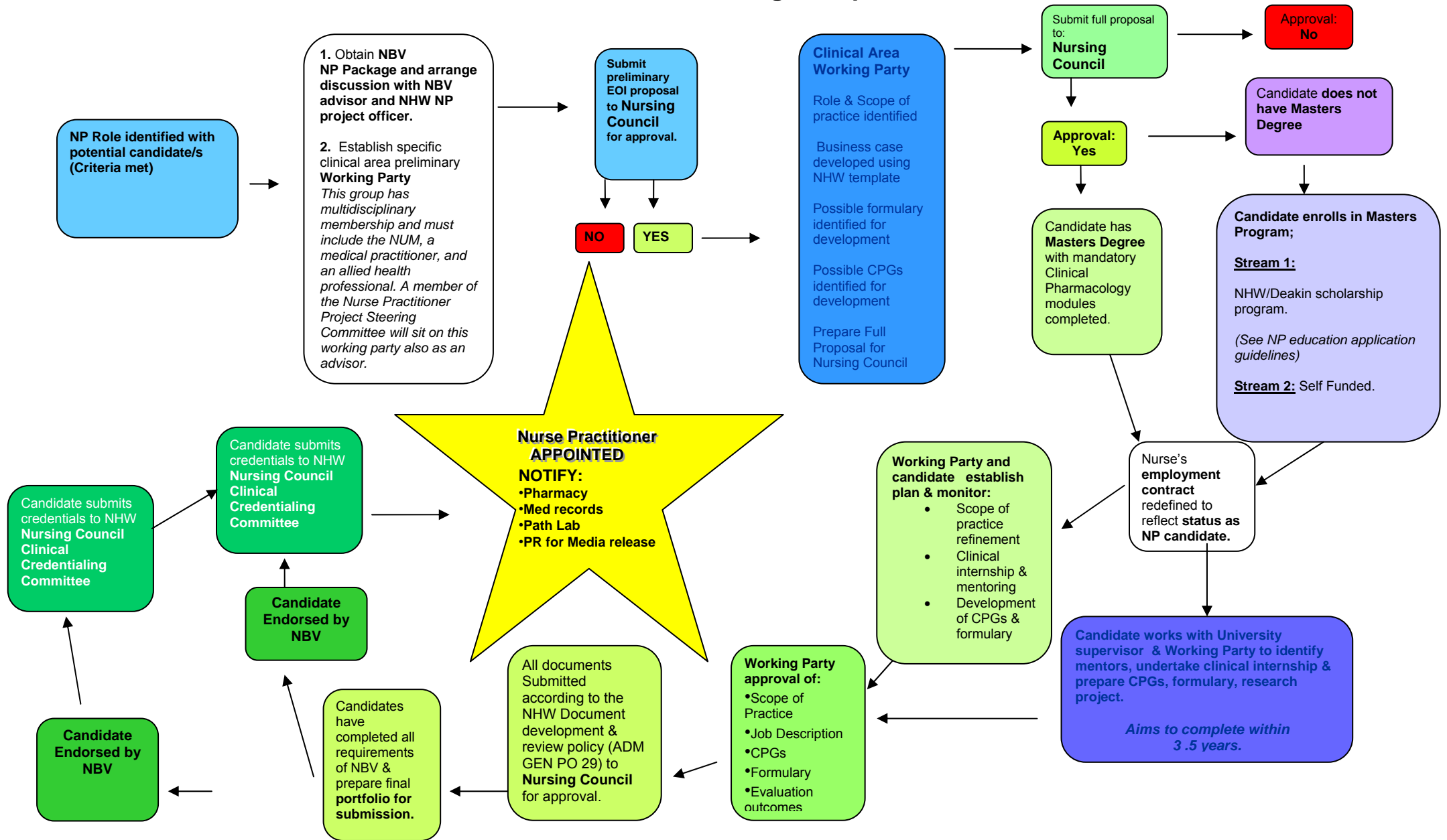
Name	
Address	
Telephone & Email	
Clinical Area	
Educational Qualifications	
Years of experience in specialist clinical area.	
Names & contact details of 3 professional referees with whom you have recently worked.	

**What do you see as your scope of practice as a Nurse Practitioner?
Please include the following in your answer:**

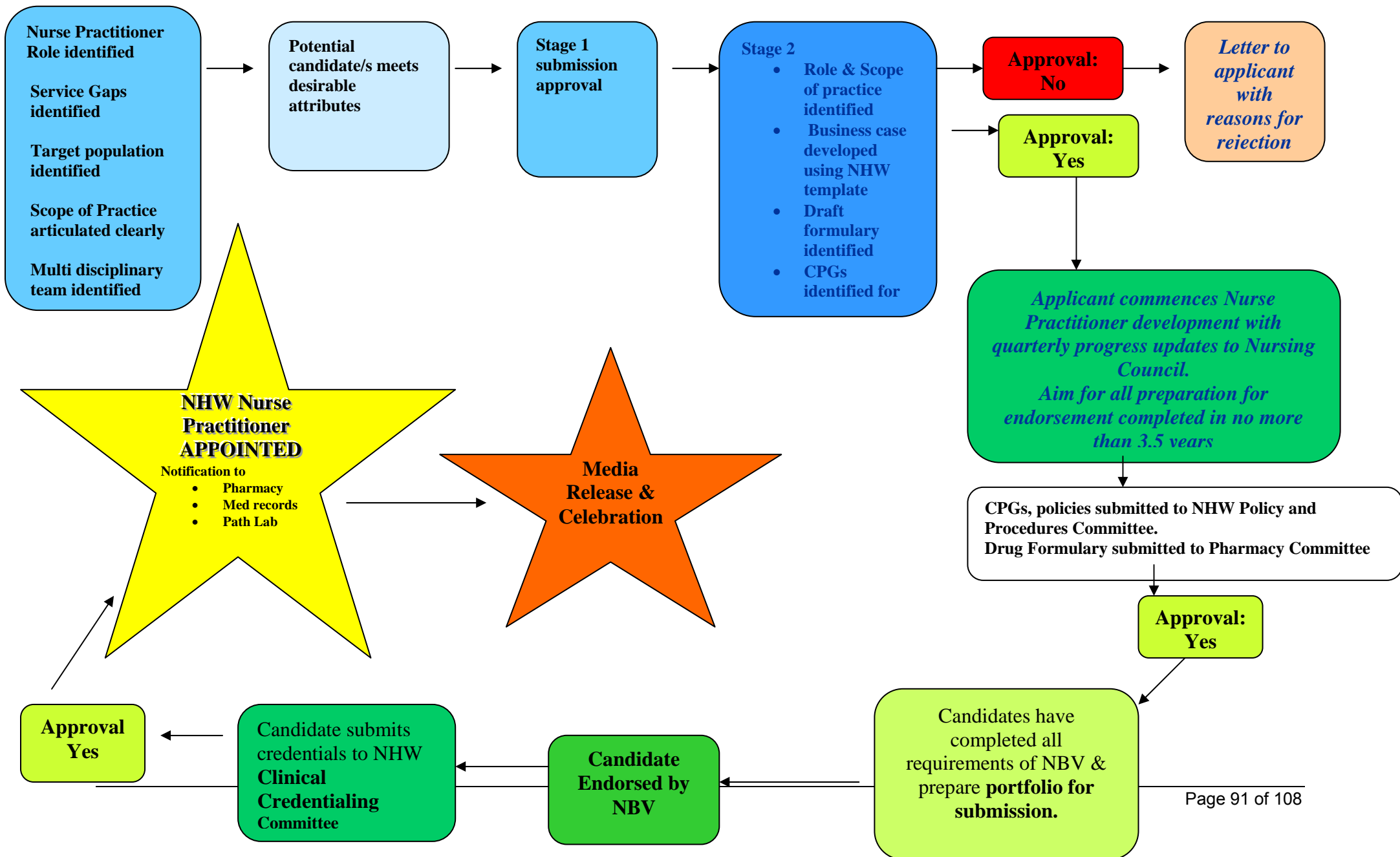
- **Who are your clients?**
- **What extensions to practice would you require?**
- **What areas of practice would you need mentorship in?**
- **What difference would you being a Nurse Practitioner make to patient care.**

<p>Level of tertiary education required to achieve Masters level i e:</p> <ul style="list-style-type: none"> • Full Masters enrolment • Have some credit points already • Just need pharmacology component 	
<p>Clinical and Professional Leadership Activities.</p> <p>Please describe any ward, hospital, state or national activities you are currently involved in or have been involved in which contribute to the knowledge base and quality outcomes for clients and colleagues in your clinical area.</p>	
<p>Why do you wish to be a Nurse Practitioner?</p>	

APPENDIX 4: Guide for Clinical Units Wishing to Implement Nurse Practitioner Roles



APPENDIX 5: Nursing Council Guide to Evaluating Nurse Practitioner Applications at NHW



APPENDIX 6:

Communication strategy to be developed in concert with Deakin University & NHW (Due for commencement in September 2006)

APPENDIX 7:



POSITION DESCRIPTION



DATE OF EFFECT:

TITLE: **Nurse Practitioner (insert specific area of practice)**

TYPE OF EMPLOYMENT: **Full Time/ Part Time**

DIVISION / DEPARTMENT: **Nursing (Insert Specific Department)**
Describe scope of Practice here

ACCOUNTABLE TO: **Divisional Director of Nursing**

DIRECT REPORTS: *Insert Appropriate name here*

LIAISES WITH: Nurse Unit Manager
Clinical Director of Medicine
Clinical Nurse Consultants
Medical Staff
Nursing Staff
Allied Health Staff
Community Health Agencies and their staff
Clients and their significant others

PREREQUISITES: **Registration with the Nurses Board of Victoria as a Division 1, 3 or 4 nurse with endorsement to practice as a Nurse Practitioner.**

Northeast Health - Wangaratta is a busy regional hospital of 200 beds and is the major referral facility for the greater part of North Eastern Victoria with an emergency department, critical care unit, obstetrics and gynaecology, paediatrics and specialised aged care, rehabilitation and psychiatric services.

Our Purpose

To meet the healthcare needs of our community by working collaboratively with individuals, the community, other service providers and funding bodies.

Our Values

Integrity
Compassion
Excellence

ROLE RESPONSIBILITIES

The following sections form the basis of the appraisal document and provide consistency in the quality standards expected of each employee. A position description should accompany this appraisal.

1.1.1 CODE OF BEHAVIOUR

1.1.2 FOR STAFF AT NORTHEAST HEALTH WANGARATTA

1.1.1.1

1.1.1.2 *Caring about what we do*

We Will:

- Treat people equally
- Honour confidentiality
- Respect and uphold the rights of others

1.1.1.3 *Caring about those we serve*

We will:

- Exercise openness and fairness in our dealings with others
- Strive to provide the highest level of service

1.1.1.4 *Demonstrating Professionalism*

We will:

- Acknowledge our limitations
- Be willing to seek advice
- Maintain professionalism in all our interactions

1.1.1.5 *Leading by Example*

We will:

- Use our knowledge and skills to perform our duties to the best of our ability
- Cultivate and maintain relationships that support the goals of the organisation

1.1.1.6 *Supporting each other*

We will:

- Seek to resolve conflict rapidly and constructively
- Foster a safe, healthy and creative environment

Encouraging Innovation

We will:

- Value our interest in entrepreneurial activities
- Channel our creativity into tangible initiatives

Respecting Difference

We will:

- Recognise and tolerate individual differences in others, including gender, spiritual values, sexual preferences, age, disability and culture.

Communicating Openly and Honestly

We will:

- Communicate courteously
- Discuss differences in a clear and calm manner.
- Refrain from using behaviours that are abusive, intimidating or patronising.

1.1.3 ROLE STATEMENT *[Inc responsibilities, key activities & quality outcomes of an employee in a specific role. Consider the skills & attributes current or previous incumbents possess in this role which enables them to perform the job successfully. Consider the "team fit".]*

The Nurse practitioner is a registered nurse who has acquired the expert knowledge base, complex decision making-making skills and clinical competencies for extended practice.¹The

¹ International Council of Nurses, <http://icn-apnetwork.org/>

Nurse Practitioner role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations. The Nurse Practitioner role is grounded in the nursing professions values theories and practice and provides innovative and flexible health care delivery that complements other health care providers. The scope of practice of the Nurse Practitioner is determined by the context in which the Nurse Practitioner is authorized to practice.²

Insert Specific clinical role statement here also

Responsibilities:

Insert specific responsibilities here.

² Australian Nursing and Midwifery Council (2003), Report to Australian Nursing and Midwifery Council, Nurse Practitioner Standards Project, Queensland University of Technology.

Under the umbrella of the Code of Behaviour for staff of Northeast Health Wangaratta. The primary responsibilities relate to the four strategic goals of Northeast Health Wangaratta.

- i.) Providing Quality Healthcare Services for Our Community
- ii.) Achieving Business Sustainability as a Foundation for Growth
- iii.) Building a Dynamic and Capable Organisation
- iv.) Working in Partnerships

The role of **Nurse Practitioner** assists and promotes these strategies by ensuring duties are performed with legislative compliance:

- Policies and procedures of Northeast Health Wangaratta
- Quality Activities
- Occupational Health and Safety Act
- Drugs, Poisons and Controlled Substances Act 1981
- Nurses Act 1993, Nurses (Amendment) Act 2000
- Drugs Poisons and Controlled Substances Act 1981
- DPCS Regulations 1995
- Information Privacy Act 2000
- Guide to DPCS Regulations 1995
- Privacy Act 1988 (Cth)
- Health Records Act 2001
- Health Records Regulations 2002
- Health Services Act 1988
- Mental Health Act 1986
- Therapeutic Goods (Victoria) Act 1994

Nurse Practitioners at NHW must practice at an advanced level within the specific scope of practice in the provision of high quality, culturally sensitive patient care in partnership with patients, and their significant others and other members of the multi disciplinary team.

This requires the following ANMC Nurse Practitioner Competencies.

ANMC Nurse Practitioner Competency Framework

Standard 1

Dynamic practice that incorporates application of high level knowledge and skills in extended practice across stable, unpredictable and complex situations.

Competency Performance Indicators

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

- a. Demonstrates advanced knowledge of human sciences and extended skills in diagnostic reasoning
- b. Differentiates between normal, variation of normal and abnormal findings in clinical assessment
- c. Rapidly assesses a patient's unstable and complex health care problem through synthesis and prioritization of historical and available data
- d. Makes decisions about use of investigative options that are judicious,

patient – focused and informed by clinical findings

e. Demonstrates confidence in own ability to synthesise and interpret assessment

f. Makes informed and autonomous decisions about preventative, diagnostic and therapeutic responses and interventions that are used on clinical judgment, scientific evidence and patient –determined outcomes

Competency Performance Indicators

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

a. Consistently demonstrates a thoughtful and innovative approach to effective clinical management planning in collaboration with the patient/client.

b. Exhibits a comprehensive knowledge of pharmacology and pharmacokinetics related to a specific field of clinical practice

c. Selects/prescribes appropriate medication, including dosage, routes and frequency pattern, based upon accurate knowledge of patient characteristics and concurrent therapies

d. Is knowledgeable and creative in selection and integration of both pharmacological and non-pharmacological treatment interventions into the management plan in consultation with the patient/client

e. Rapidly and continuously evaluates the patient/client's condition and response to therapy and modifies the management plan when necessary to achieve desired patient/client outcomes

f. Is an expert clinician in the use of therapeutic interventions specific to, and based upon, their expert knowledge of specialty practice

g. Collaborates effectively with other health professionals and agencies and makes and accepts referrals as appropriate to a specific model of practice

h. Evaluates treatment/intervention regimes on completion of the episode of care, in accordance with patient/client outcomes

Nurses Board of Victoria October 2005 Approved by Board 17 November 2005 9

Competency Performance Indicators

1.3 Has the capacity to use the knowledge and skills of extended Practice competencies in complex and unfamiliar environments

a. Actively engages community/public health assessment information to inform interventions, referrals and coordination of care.

b. Demonstrates confidence and self-efficacy in accommodating uncertainty and managing risk in complex patient care situations

c. Demonstrates professional integrity, probity and ethical conduct in response to industry marketing strategies

d. Uses critical judgments to vary practice according to contextual and

cultural influences

e. Confidently integrates scientific knowledge and expert judgment to assess and intervene to assist the person in complex and unpredictable situations.

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

a. Critically appraises and integrates relevant research findings in decision making about health care management and patient interventions

b. Demonstrates the capacity to conduct research/quality audits as deemed necessary in the patient environment

c. Demonstrates an open minded and analytical approach to acquiring new knowledge

d. Demonstrates the skills and values of lifelong learning and relates this to the demands of extended clinical practice

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

Competency Performance Indicators

2.1 Applies extended practice competencies within a nursing model of practice

a. Readily identifies the values intrinsic to nursing that inform nurse practitioner practice and an holistic approach to patient/client/community care

b. Communicates a calm, confident and knowing approach to patient care that brings comfort and emotional support to the client and their family

c. Demonstrates the ability and confidence to apply extended practice competencies within a scope of practice that is autonomous and collaborative

d. Creates a climate that supports mutual engagement and establishes partnerships with patients/carer/family

e. Readily articulates a coherent and clearly defined nurse practitioner scope of practice that is characterized by extensions and parameters

2.2 Establishes therapeutic links with the patient/client/community that recognize and respect cultural identity and lifestyle choices

a. Demonstrates respect for the rights of people to determine their own journey through a health/illness episode while ensuring access to accurate and appropriately interpreted information on which to base decisions.

b. Demonstrates cultural competence by incorporating cultural beliefs and practices into all interactions and plans for direct and referred care

c. Demonstrates respect for differences in cultural and social responses to health and illness and incorporates health beliefs of the individual/community into treatment and management modalities

Competency Performance Indicators

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

- a. Establishes effective, collegial relationships with other health professionals that reflect confidence in the contribution that nursing makes to client outcomes
- b. Readily uses creative solutions and processes to meet patient/client/community defined health care outcomes within a frame of autonomous practice
- c. Demonstrates accountability in considering access, clinical efficacy and quality when making patient-care decisions
- d. Incorporates the impact of the nurse practitioner service within local and national jurisdictions into the scope of practice
- e. Advocates for expansion to the nurse practitioner model of service that will improve access to quality, cost-effective health care for specific populations

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

Competency Performance Indicators

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

- a. Actively participates as a senior member and/or leader of relevant multidisciplinary teams
- b. Establishes effective communication strategies that promote positive multidisciplinary clinical partnerships
- c. Articulates and promotes the nurse practitioner role in clinical, political and professional contexts
- d. Monitors their own practice as well as participating in intra- and interdisciplinary peer supervision and review

Competency Performance Indicators

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

- a. Critiques the implication of emerging health policy on the nurse practitioner role and the client population
- b. Evaluates the impact of social factors (such as literacy, poverty, domestic violence and racial attitudes) on the health of individuals and communities and acts to moderate the influence of these factors on the specific population/individual
- c. Maintains current knowledge of financing of the health care system as it affects delivery of care
- d. Influences health care policy and practice through leadership and active

participation in workplace and professional organizations and at state and national government levels

e. 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.

Key Duties:

The primary activity of the **Nurse Practitioner (insert specific area of practice)** is to *insert scope of practice*

This includes:

-

Outcomes:

These are measurable results derived from the above key duties.

-

RISK ASSESSMENT / JOB ANALYSIS

Northeast Health Wangaratta provides a safe working environment for staff as part of the process Risk Assessments have been carried out and this position could include some or all of the following.
(Please mark those that apply to this position).

Aspects of Normal Workplace	Frequency		
	Occasionally	Regularly	Continual
1.1.1.6.1.1.1 Work Environment <ul style="list-style-type: none"> • Work office hours with the possibility of extended hours • Work in a team environment and at times independently • Work in locations geographically separated from main facility • Working off site which may include clients homes • Clinical Area for the management of patients • Traveling or Driving in cars on a regular basis 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
1.1.1.6.1.1.2 Work Activity <ul style="list-style-type: none"> • Manage demanding and changing workloads and competing priorities • Undertake administrative tasks including intensive computer keyboarding work, filing, writing, concentrating for long periods of time (regular, daily basis) • Sitting at the computer for extended periods of time • Sitting in meetings for extended periods of time • Use of technology including photocopiers, telephones including mobiles, fax, overhead projectors, televisions, video, electronic whiteboards • Undertake manual handling of equipment (eg, lifting, pulling, pushing, moving, transferring, twisting) on a daily basis • Patient Handling (<i>No Lift Program operates throughout NHW</i>) • Exposure to Substances (<i>Protective equipment & procedures in place to prevent contact</i>) 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<u>Work relationships</u> <ul style="list-style-type: none"> • Work within a team environment • Professional interaction with medical nursing and admin staff • Interact with colleagues and other hospital staff • Members of the public • Patients and relatives 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<u>Training</u> <ul style="list-style-type: none"> • Emergency Procedures • Fire & Evacuation • Duress Alarm Training • Manual Handling • CPR Cardiopulmonary Resuscitation • BLS Basic Life Support • No Lift 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

1.1.2 ANNUAL APPRAISAL

The Appraisal will include:

- **Employee's Summary Comments on Performance over the past 12 months**
 An annual Appraisal ensures an employee has the opportunity to reflect on their achievements over the previous year and the challenges and opportunities they have encountered during that time.

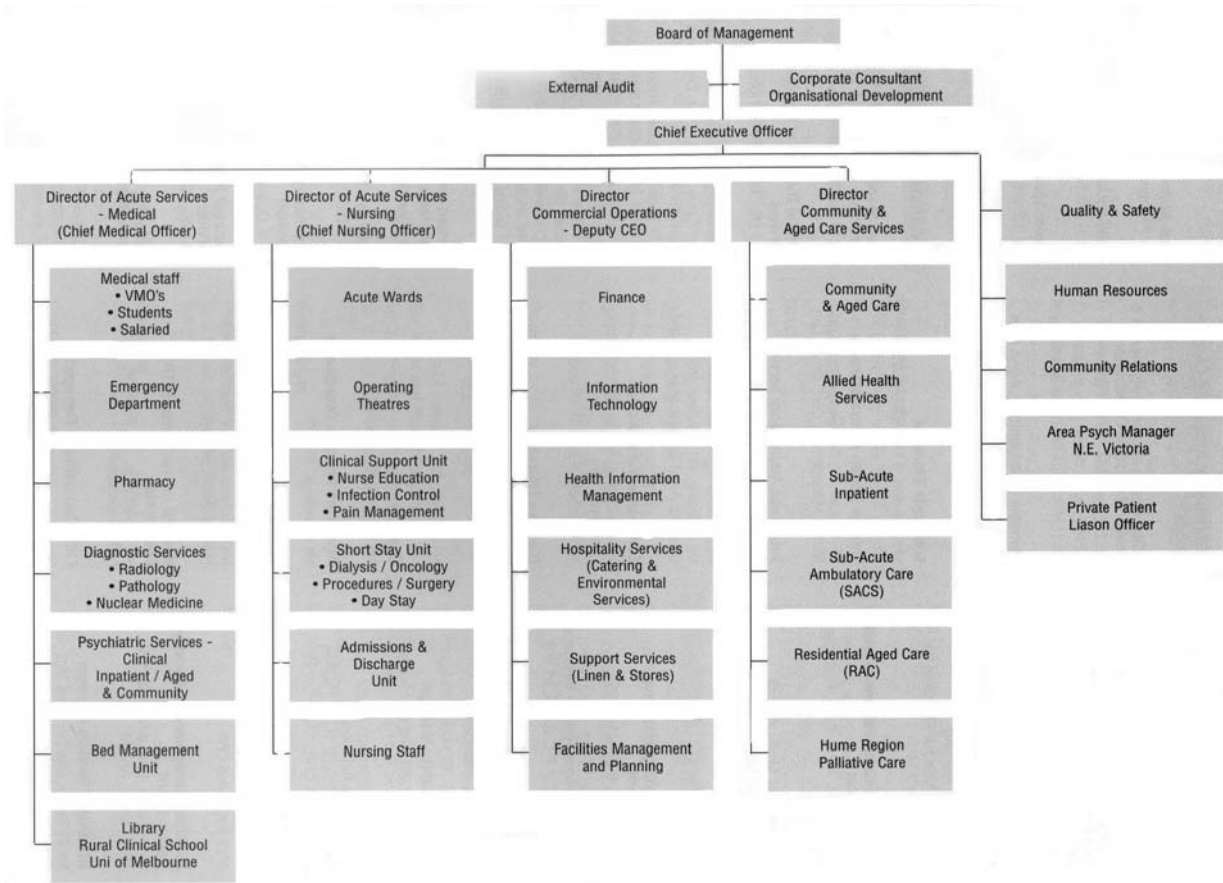
- **Compulsory Workplace Training.** These are compulsory requirements and indicate attendance and competency for legal and OH&S compliance.
- **Annual Training and Development Plan** that details specific job training courses and developmental experiences that are to be undertaken prior to the next annual review.
- **Career Development and Education Plans** that identify broad developmental and educational opportunities associated with long-term career development.
- **Summary Comments** allow the employee and their manager the opportunity to separately summarise overall performance for the year. The senior manager is not required to be involved in this process unless issues are raised that may be in dispute.

As the occupant of this position, I have read and understand the above position description.

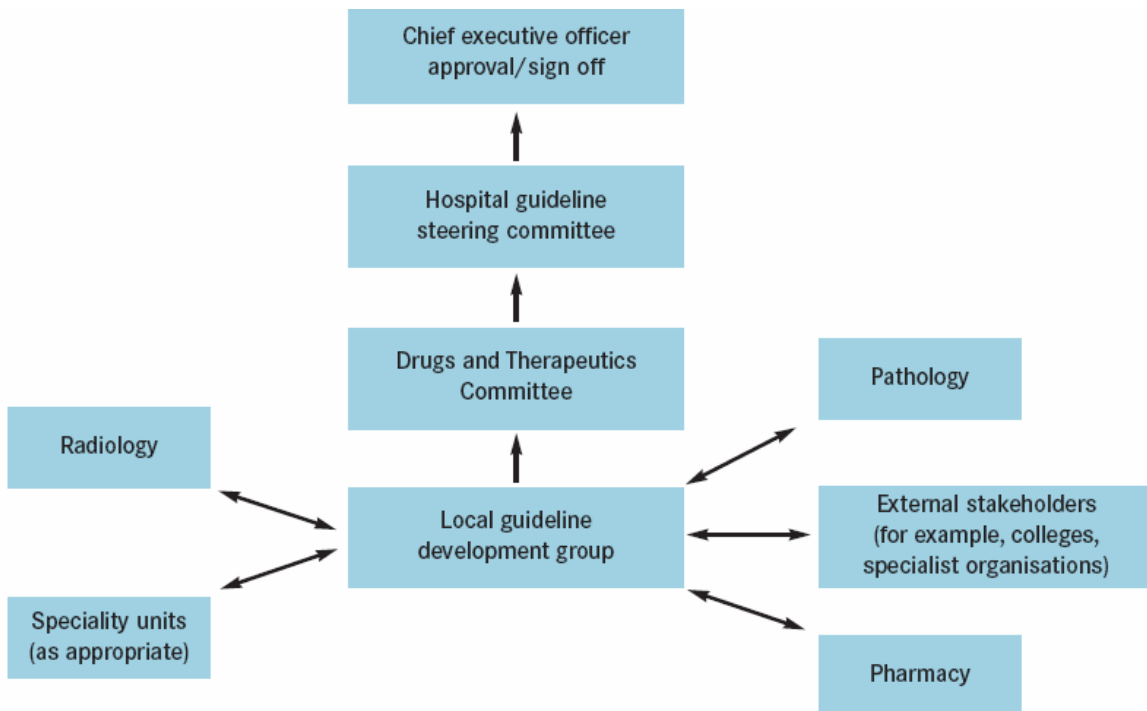
Name: [please print]

Signature: **Date:**

APPENDIX 8: NHW Management Structure



APPENDIX 9: Process for developing and approving clinical practice guidelines at an organisational level.



Ref: Victorian Government Department of Human Services June 2006. A guide for developing clinical practice guidelines for nurse practitioners in Victoria

APPENDIX 10:

Approval Process for Clinical Practice Guidelines for Nurse Practitioners at NHW

