Stroke Nurse Practitioner Model Development
2008

Victorian Nurse Practitioner Project
Phase 4 Round 4.2
# Part 1 - Service Provider Details

## Service provider

<table>
<thead>
<tr>
<th>Name of Service Provider</th>
<th>Austin Health</th>
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<tbody>
<tr>
<td>Agency Number</td>
<td></td>
</tr>
<tr>
<td>Contact Person</td>
<td>Ann Maree Keenan</td>
</tr>
<tr>
<td>Position/Title</td>
<td>Executive Director Ambulatory &amp; Nursing Services</td>
</tr>
<tr>
<td>Telephone Number</td>
<td>03 9496 52479</td>
</tr>
<tr>
<td>Facsimile No</td>
<td>03 9459 2821</td>
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<tr>
<td>E-mail Address</td>
<td><a href="mailto:Ann.keenan@austin.org.au">Ann.keenan@austin.org.au</a></td>
</tr>
</tbody>
</table>

## Endorsement by

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Name of Authorised Officer (Print)</td>
<td>Dr Brendan Murphy</td>
</tr>
<tr>
<td>Title/Office Held</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>Date</td>
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1. Author:
This report has been compiled by Louise James, Stroke Nurse Practitioner Model Development Project Officer, Austin Health

2. Rationale for choice of template:
At Austin Health the completion of a submission to the Nurse Practitioner Steering Committee is required as a pre-requisite to implement a Nurse Practitioner role. The role of the steering committee is to assist in the development of Nurse Practitioners at Austin Health and to ensure that the proposed candidate is well supported. The final position approval will be conducted through the customary channels for any department/Clinical Services Unit implementing a new position. I have chosen to use these template headings to ensure organisational considerations have been taken into account. Although there is overlap not all of Austin’s template headings meet the requirements for the Department of Human Services final report so other subheadings have been included.

3. Acknowledgements:
- Leanne Turner: Director-Specialty Services Clinical Services Unit
- Associate Professor Helen Dewey-Head of Inpatient Stroke
- Nonie Rickard-Austin Health’s Nurse Practitioner Project Officer and author of Nurse Practitioner Service Plan 2006
- Katy Fielding, Manager Nurse Workforce Policy & Programs, Nurse Policy Branch, DHS
- Michelle Thomas-Nurse Policy Officer, Nurses Board of Victoria
- Members of the Stroke Nurse Practitioner Collaborative
- Members of the Stroke Nurse Practitioner Model Development Project Officers collaborative: Elizabeth Mackey (Melbourne Health), Jill Dunn (St Vincent’s Health), Anne-Marie Watson (Alfred Health), Deanna O’Donnell (Eastern Health)
- Multidisciplinary team- Austin Health Acute/Subacute Stroke Care Unit
- Senior Medical Team Neurosciences
- Members Senior Nurses meeting
- Heads of Department Pathology, Radiology and Pharmacy
- Melbourne Ambulance Service
- Ann Maree Keenan- Executive Director Ambulatory and Nursing Services
- Shane Crowe-Deputy Director Ambulatory and Nursing Services

4. Barriers to Project Establishment:
A resignation of the previous project officer delayed the start of this project.
5. Executive Summary:

Austin Health is participating in the Department of Human Services Victorian Nurse Practitioner Project Phase 4 Round 4.2. The aim of this project is to develop a model of service delivery for a Stroke Nurse Practitioner with an emphasis on meeting service gaps in the care of stroke patients.

The Stroke Nurse Practitioner role has been carefully considered. The July 2008, Nurse Policy Branch offer of funding to support projects to develop Nurse Practitioner models in stroke care in public health services and provide policy focus for development and implementation of Nurse Practitioner roles has assisted our health services in developing this model.

The proposed Stroke Nurse Practitioner model and role for implementation is expected to change as time progresses. The model will need to be redefined with the employment of a Stroke Nurse Practitioner candidate.

The Acute Stroke Team has coalesced as a discrete team and worked collaboratively with disparate staff groups within the hospital and externally to achieve a successful result for patients presenting with stroke to Austin Health. The approach and outcomes achieved by the Acute Stroke Call Page operationalise the overall Austin Health Vision – ‘...excellence and outstanding leadership in healthcare, research and education’ and correspond with its values. The addition of a Stroke Nurse Practitioner role to the Acute Stroke team will continue to contribute to the growth, culture and values of Austin Health through ongoing collaboration, innovation, partnership and excellence in patient care.

In 2006 Austin Health completed the Nurse Practitioner Service Plan Report conducted under DHS Victorian Nurse Practitioner Project Phase 3 Round 6. This service plan was devised to ensure organisational support and commitment to the implementation of Nurse Practitioner roles. It is obvious that Austin Health as an organisation is well positioned to support a Stroke Nurse Practitioner candidate; it will be the second Nurse Practitioner model within the Neurosciences. There is strong medical support for the new model and a high level of support at an executive and clinical services unit level. The model development has seen extensive communication to all key stakeholders which will need to continue during its evolution.

The model addresses the service gaps experienced by stroke patients in the Emergency Department and Stroke Prevention Outpatient Clinic. Whilst posing an exciting career opportunity for nurses with the possibility of further roles evolving over time as service demands.
6. Introduction and description of Austin Health Service:

Austin Health, one of Victoria’s largest metropolitan health care providers is a 920 bed major teaching and research hospital affiliated with the University of Melbourne. Austin Health is world-renowned for its research and specialist work in many areas including neurosciences and has provided comprehensive stroke care services for many years. Stroke Care Units were first introduced in mid 1970’s. Austin Health had the first stroke unit in Australia established in 1978. (‘Strategies to improve outcome after stroke’ Editorials MJA Vol 178 7 April 2003)

Its vision is “that Austin Health will be renowned for excellence and outstanding leadership in healthcare, research and education”.

“In the last financial year, 2007–08, Austin Health’s services, profile and activity have all continued to grow at a remarkable rate and our most pressing challenge remains the demand for our world-class health care”. (Austin Health’s CEO Dr Brendan Murphy-Annual Report 2007/2008)

During 2007-08, 57,000 people presented at the Austin’s Emergency Department (ED) Austin’s 6,400 staff treated a record 85,670 inpatients and 152,520 outpatients. (Annual Report 07/08, Austin Health Pivot tables 07/08).

Most stroke patient admissions (58%) are from the Austin Health’s primary catchment area of Banyule, Darebin and Nillumbik statistical local areas (SLAs), with 24% from the secondary SLAs and 18% from the tertiary catchment area.

The major diseases that Austin Health patients present with, in order of morbidity and mortality burden are:

- Cardiovascular disease
- Cancer
- Respiratory illness
- Mental illness and disability
- Diabetes Mellitus
- Dementia and Parkinson’s disease

(Department of Human Services Burden of Disease 1996 – Local Government Areas and Regions of Victoria)

Each of these major disease groups is noted by DHS as areas for growth to 2016-2017.

Austin Health employs approximately 4,500 (Nurses) people and 1732 EFT nurses Div-1, 1583 EFT, Div-2, 149 EFT, most of whom are employed at the Austin Campus, Heidelberg, Repatriation Campus, West Heidelberg or Royal Talbot Rehabilitation Centre, Kew. (Austin Health workforce and recruitment statistics June 2008).
The Australian health care industry including Austin Health continue to face the challenges of providing high quality, integrated health care to a growing and ageing population with increasingly diverse needs and expectations, within limited resources. Trends effecting health care include: a projected growth in demand for nearly all types of services, but particularly services in the community, a decline in the availability of out of hours and bulk billing general practitioner services, an ageing population, with an expected 25% growth in this decade to 3.9% of the population and an ongoing increase in the use and cost of medical technology. (Austin Health Annual Report 2004/05).

In 2006, Austin Health participated in the Department of Human Services (DHS) The Victorian Nurse Practitioner Project (VNPP) Phase 3 Round 6. The aim of this project was to develop a service plan to implement Nurse Practitioners (NP’s) in the organisation with an emphasis on role sustainability and feasibility. A project officer was appointed and a multidisciplinary steering committee established to support and guide the work of the project. The steering committee was a vital component to the success of the project in working through the myriad of issues associated with these roles including the cultural change component necessary. The achievements of this service plan development are relevant to the current Stroke Nurse Practitioner (SNP) model development project. The work already completed to prepare the organisation has paved the way for the development of a SNP at Austin Health. Several other NP models are already implemented in ED, mental health and neurosurgery.

In its service plan development, other health system issues that have been considered and remain consistent to the development of a SNP model include the ageing of the workforce and emerging staff shortages in most professional areas. Consumers are increasingly better informed about their diagnosis and health care treatment options and have high expectations about their care.

Austin Health has been funded to convene the SNP Collaborative. The collaborative has been well attended with representatives from many other health services in Victoria, DHS Nurse Policy Branch and the Nurses Board of Victoria (NBV). The group will collectively advise the department and NBV on an appropriate formulary for the area of SNP clinical practice. The SNP Collaborative is intended to be a self-directed forum, responsive to the individual and collective needs of the SNP candidates.

Overall, Austin Health has embraced the concept of implementing the NP role.
7. Understanding demand and opportunities

At a local level Austin Health provides high quality patient care to the community and veterans and has achieved national and international recognition in many fields. Austin Health provides many specialist services including stroke.

According to Austin Health’s Strategic Plan 2005-2008 the major priorities in patient management include:

- Further reducing the waiting times for elective surgery;
- Reducing the time between referral and outpatient appointments;
- Reducing the waiting time to be seen in the ED;
- Minimising the number of patients waiting longer than 12 hours to be admitted to a hospital bed from the ED, and;
- Minimising the time on ambulance bypass.
- Providing an effective interface between the community and the acute hospital to deliver appropriate services and co-ordinate and communicate effectively between health care providers.

The Victorian DHS directions for your health system; Metropolitan Health Strategy (2003), provides the overarching framework within which the Austin Health strategic plan was developed. This Strategic Plan addresses the key policies, strategic directions and enablers of change outlined in the Metropolitan Health Strategy.

A series of high-level strategic goals have been developed to guide Austin Health in working towards our strategic priorities. The goals reflect the issues raised through the environmental analysis and those identified by Austin staff through an internal consultation process and are in line with the mission statement and values of Austin Health.

**PRIORITY 1 Delivering the right services well**  
**GOALS**  
- Providing safe, quality care *
- Improving access to care *
- Delivering appropriate services
- Streamlining the flow from the community through the hospital back to the community

**PRIORITY 2 Working through partnership and participation**  
**GOALS**  
- Ensuring patient focussed care *
- Promoting consumer participation
- Planning for service development jointly with key provider, consumer and government Partners

**PRIORITY 3 Leading research and education**  
**GOALS**  
- Providing advanced education and training for clinical staff *
- Building on our reputation as a centre for research excellence
- Strengthening the Austin Biomedical Alliance
PRIORITY 4 Investing in our staff *
GOALS
• Planning for a changing workforce demographic, including recruitment and retention
• Ensuring the provision of professional development opportunities
• Enhancing our work culture through performance management and feedback for all staff
• Enhancing internal communication

PRIORITY 5 Building a strong, sustainable future
GOALS
• Ensuring financial viability
• Developing and expanding fundraising opportunities and capabilities across the organisation
• Furthering Austin Health capital development and master planning
• Considering Austin Health corporate positioning and image

PRIORITY 6 Advancing leadership and innovation
GOALS
• Fostering clinical and management leadership opportunities *
• Leading advances in service delivery
• Enhancing information, communication and technology
• Improving knowledge management capabilities

The strategic plan provides the appropriate framework for the implementation of NP roles Austin Health, particularly in relation to priorities * in 1, 2, 3, 4 and 6.

The implementation of a SNP role presents an opportunity for Austin to review current practice and implement a new service delivery model, with an emphasis upon service continuity and overcoming existing service gaps. There is high level of support for the role at a senior level including that of the Chief Executive Officer (CEO), which assists us to overcome the challenges sometimes experienced in introducing NP roles. The organisation has advanced support structures for Nurse Practitioner Candidates (NPC’s), developed in the DHS 2006 Nurse Practitioner Phase 3 Round 6 Project, which allowed for development of a service plan for sustainability and feasibility of NP roles.

In Victoria the majority of NPs currently work in ED’s. At Austin Health we currently have two endorsed NP in the ED and further candidates in Emergency, Neurosurgery and Mental Health. Currently, there is a high level of interest from a range of clinical areas in implementing candidate positions, including stroke, cardiac, medical, renal, surgery and ICU.

There is evidence for support of a SNP role in Austin Health’s Specialty Services Clinical Service Unit (CSU) Quality Business Plan (QBP) (January-December 2008). The speciality services CSU has approximately 500 EFT and an operational budget of $43 million and comprises the following units / departments:
• Victorian Respiratory Support Service (state-wide service)
• Victorian Ventilation Weaning Unit (state-wide service)
• Respiratory & Sleep Medicine including the Sleep and Respiratory Laboratories
• Cardiology including the Cardiac Catheterisation and Cardiodiagnostics Laboratories
• Neurology including Stroke and Epilepsy Units and the Neurodiagnostics Laboratory
• Neurosurgery
• Thoracic Surgery
• Cardiac Surgery
• Ophthalmology including Orthoptics
• Vascular Surgery including the Vascular Laboratory
• Neuropsychology
• HARP Chronic Disease Program including Medication Alert and Cardiac COACH programs

The CSU has already supported the development of a Neurosurgery NP candidate role so is well placed to support a Stroke Nurse Practitioner candidate (SNPC).

The Strategic goals set to guide Austin Health are incorporated into the specialty services CSU QBP 2008. They describe key improvements activities which support the implementation of a SNP to meet the service gap in patient management as described in Austin Health’s Annual Report 2007/2008. See extract from QBP below:

**Table 1. KEY IMPROVEMENT ACTIVITIES FOR 2008**

<table>
<thead>
<tr>
<th>Title of the activity</th>
<th>Improvement area, opportunity or issue</th>
<th>Projected outcomes/improvements</th>
<th>Project timeframe</th>
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<td>Implementation of nurse practitioner roles</td>
<td>Implementation of neurosurgery nurse practitioner role</td>
<td>Development of clinical practice guidelines Endorsement obtained from Nurses Board Victoria DHS funding obtained and implement project</td>
<td>July 2008</td>
<td>1,4</td>
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**STRATEGIC PRIORITY 1**
**DELIVERING THE RIGHT SERVICES WELL:** We will provide safe, quality care and deliver timely services that serve the needs of our community

**STRATEGIC GOALS**
• Providing safe, quality care
• Improving access to care
• Delivering appropriate services
• Streamlining the flow from the community through the hospital back to the community

**Table 2 STRATEGIC PRIORITY**

<table>
<thead>
<tr>
<th>Desired Outcome</th>
<th>Strategy/Action</th>
<th>Performance Indicator/ Measure</th>
<th>Responsibility</th>
<th>Expected end date</th>
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<tr>
<td>Improve neurosurgical patient care through the implementation of a nurse practitioner role</td>
<td>Develop clinical practice guidelines Develop formularies for radiology, pathology, pharmacy and neuro lab test orders Obtain endorsement from Nurses Board Victoria</td>
<td>CPGs developed and implemented Formularies developed Endorsement as NP from Nurses Board Victoria approved</td>
<td>A Scanlon / G Fabinyi A Scanlon / G Fabinyi A Scanlon</td>
<td>Feb 08 Feb 08 June 08</td>
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STRATEGIC PRIORITY 4
INVESTING IN OUR STAFF: We will attract, retain and value all of our staff through professional development, ensuring a supportive work environment while seeking to address current and future workforce challenges

STRATEGIC GOALS
- Planning for a changing workforce demographic, including recruitment and retention
- Ensuring the provision of professional development opportunities
- Enhancing our work culture through performance management and feedback for all staff
- Enhancing internal communication

Table 3 STRATEGIC PRIORITY

<table>
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<tr>
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<th>Performance Indicator/Measure</th>
<th>Responsibility</th>
<th>Expected end date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of nurse practitioner role framework in cardiac and stroke units</td>
<td>Develop DHS stroke nurse practitioner project funding submission</td>
<td>Submission developed and funded</td>
<td>L Turner / H Dewey / L James</td>
<td>May – June 08</td>
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<td>Develop framework for cardiac chest pain nurse practitioner role</td>
<td>Framework developed</td>
<td>Cardiac model care steering group</td>
<td>June – Dec 08</td>
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<td></td>
<td>Completion of Victorian Nurse Practitioner Project Phase 4 Round 4.2</td>
<td>Model Developed and submitted to DHS</td>
<td>L James</td>
<td>November 2008</td>
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</table>

The SNP role is consistent with Austin Health’s plans to increases its strategic investment in workforce role redesign, focusing on roles which extend scope of practice for non-medical professionals, with an objective of becoming a recognised leader in this area. (Austin Health’s Strategic Plan refresh 2006-2008)

The Austin Health Nursing Workforce Strategy was developed as a responsive document, which provides an overview of the nursing workforce challenges, highlights successful strategies and provides direction for the Nursing Advisory Committee for 2008.

It acknowledges the demand for health services is increasing and will continue to rise as technology develops, the population ages and community expectations increase. The current and predicted workforce shortages are well documented. The reasons for the shortages are varied and include the ageing workforce, an increasing reliance on overseas trained health workers, and a growing preference for part-time work.

Austin Health’s 2007 Nursing Workforce Plan delivered increased numbers of nurse practitioners/ nurse practitioner candidates across a range of clinical practice areas. A documented key strategy to be implemented in 2008 is the expansion of Nurse Practitioner roles. In 2007 Austin Health experienced its highest nursing shortfall since the 2002 recruitment campaign with a 60 EFT shortfall in September. This shortfall has since reduced to 40 EFT in December due to a number of successful recruitment strategies. This experience along with the complexity of the workforce challenges requires Austin Health to maintain a sustained multi-pronged and innovative approach to both recruitment and retention. According to the Nursing Workforce
strategy 2008, Austin Health is committed to the introduction of NP roles operating at the peak of nursing practice. The NP role provides a career pathway for clinical nurses that recognise their expertise and clinical leadership. The introduction of NP roles provides an advanced route for nursing that allows autonomous practice (within guidelines and collaboration within a multidisciplinary team) and provides a career structure that will keep nurses with considerable experience and expertise in clinical roles. Whilst Austin Health recognises that there are many challenges in introducing NP roles it is well placed to address these given the high level of support for the role at a senior clinician and management level including that of the CEO.

Austin Health became a clinical school of La Trobe University in 2001. The model for the Clinical School is that academic staff are based at Austin Health. La Trobe University commissioned an independent review of the clinical school in 2006. The recommendations of this review have been released. There are a number of recommendations being pursued including joint appointments and increased participation in nursing research. The proposed SNP model would include involvement in nursing research. Austin Health also has a strong affiliation with the National Stroke Research Institute (NSRI) located on the Repatriation campus of Austin Health with progress underway to have it relocated to Austin Campus; this provides further organisational support for nursing research in stroke. The NSRI uses a mail merge to inform stroke team members of current accessible grants. The NSRI has great capacity for mentorship within nursing research. There are a number of researchers employed at the NSRI who have previously been stroke specialist nurses at a clinical level.

The NSRI, Brain Research Institute, and Howard Florey Institute will merge to become the Florey Neurosciences Institute (FNI). Austin Health’s current head of Neurology Professor Geoff Donnan has been appointed as the new Director of FNI from January 2009. As a Professor of Neurology and clinical neurologist this appointment reinforces Austin Health’s commitment to integrating clinical practice with research as FNI will be a most important part of research life with strong clinical engagement with clinical services.

The national and international profile of the Austin research community continues to grow. Over 700 Austin researchers and postgraduate students receive in excess of $25 million each year in external research funding. To bring together, in one integrated function, the diverse research groups on campus, we are very pleased that the Austin Lifesciences Office for Research has now secured funding and been established. Austin Lifesciences will support the diverse specialties investigated at Austin Health, including cancer, neurosciences, transplantation, heart disease, hypertension, immunology, vaccines, endocrinology, sleep disorders and many more. (Austin Health Annual Report 2008).

Maintaining strategic links between research, education and clinical care will be a key objective for Austin Health. In addition, Austin Health has identified an opportunity to distinguish itself and sustain its future workforce through active implementation of new workforce roles across all professions.
This SNP role is proposed because the acute stroke and TIA patient workload via the ED at Austin Health is considerable and continues to grow (547 admissions in 04-05, 705 in 05-06, 727 in 06-07, and 711 in 07-08). There are huge numbers of Transient Ischaemic Attack (TIA) patients seen in Stroke Prevention Outpatient Clinic 765 in 04/05, 730 in 05/06, 596 in 06/07 and 510 in 07/08. (Austin Health outpatient Pivot tables). Even though there has been a decrease in the number of outpatient attendances, the volume of patients reviewed is still high there are still opportunities for the NP role to address existing service gaps. The decreasing numbers may be indicative of effective evidenced based secondary prevention therapies that the SNP can continue to practice.

Austin Health is genuinely committed to innovation, service improvement and work force planning to ensure that patients are provided with outstanding care. Clearly a workforce shortage is inevitable and Austin Health has been very proactive in exploring initiatives to overcome this challenge.

In order to protect itself and position itself well for the future Austin Health has developed a workforce sustainability plan that reflects the National Health Workforce Strategic Framework released in April 2004 at the Australian Health Minister’s conference. The changing health workforce environment is creating new challenges for planning care delivery into the future.

Austin Health has particularly focused on the strategy of maximising staff potential that is demonstrated through the Enhanced Scope of Practice Division 2 Program. Similarly the introduction of four NP roles at Austin Health, with the likelihood for a further three roles recognises the clinical expertise of nurses and the benefit they have to enhancing patient care.

There major purpose beyond their clinical skills is for their capabilities to enhance the patient continuum between services and respond to patient needs in a timely manner.

At Austin Health advanced physiotherapy clinical practice roles are well established in the Neurosurgery and Orthopaedic outpatient clinics which further illustrate the commitment to workforce redesign.
Regional:

Currently, 5% of Austin Health’s activity relates to non-metropolitan Victorians. Austin Health wishes to work with the DHS as part of a statewide strategy to improve access by rural and regional Victorians to tertiary hospital services. (Austin Health’s Strategic Plan Refresh 2006-2008)

Establishing Stroke Units in appropriate hospitals is a key recommendation of the Victorian Stroke Strategy (Recommendation 12) described in further detail in next section of report. The evidence for this recommendation is well established and is documented in the National Health and Research Council (NHMRC) endorsed Clinical Guidelines for Acute Stroke Management published by the National Stroke Foundation (NSF), as well as the Cochrane library meta-analysis of models of organised stroke care.

Austin Health is internationally recognised for its clinical leadership in stroke care. The stroke unit staff are frequently called upon to offer expert advice and support to other facilities in the management of stroke. Austin Health adopts a ‘hub and spoke model’ in supporting other stroke services in regional Victoria to set up and developing their stroke services. Austin Health Acute Stroke Service has hosted many international, national and regional visitors, which reaffirms its leadership role in stroke patient care. A SNP role would complement Austin Stroke Service clinical leadership status and support to other Stroke Services.

There are 173 public and private health services that provide acute stroke care in Victoria in 2005/2006: 67 are in Melbourne and 106 are in rural areas. Of these 117 are public health services that include 28 in Melbourne and 89 in rural areas. (Stroke Care Strategy for Victoria p.27). It is reasonable that the Melbourne based Hospital’s with their increased infrastructure help support rural stroke services in setting up evidenced based stroke services.

Austin Health’s Strategic Report highlights the role that Austin Health plays in supporting the interest of selected rural and regional health services in receiving educational and clinical support through formalised partnerships and other collaborations using sophisticated telecommunications links. The ‘Victorian Stroke Clinical Network Committee’ (VSCN Committee) whose role is to oversee the implementation of recommendations made in the Victorian Stroke Care Strategy is working in collaboration with the NSRI and Department of Health in NSW to apply for NHMRC partnership grant to allow for telemedicine between city and rural hospitals in the management of stroke patients. The SNP may be able to utilise this medium of communication to assist rural settings in establishing stroke units and manage patients as a clinical nursing leader.

State-Wide:

The Victorian Government supports advanced practice nursing roles such as NPs as an important component of building a responsive, skilled and appropriate workforce to meet the needs of the Victorian community. There have been previous DHS ‘phases’ of funding under the VNPP in

Victoria supporting increases in the number of nurses obtaining endorsement by the NBV as a NP.

In 2007, the Stroke Care Strategy for Victoria (the Strategy) was released. Nurse Policy Branch, DHS has collaborated with Programs Branch to support the implementation of the Strategy through a targeted round of funding for NP projects. The strategy makes 28 recommendations to improve the delivery of public acute and sub-acute stroke services in Victoria over the next five
to 10 years in support of an integrated state-wide approach to care of people within stroke. The
government has committed $5 million over three years to implement the recommendations.
Implementation of these recommendations is being overseen by the VSCN Committee. Austin
Health is well represented on this network.

This SNP model proposal aligns well with the Stroke Care Strategy (Recommendations 1, 3, 5, 6,
10 and 22) and contemporary stroke management. Recommendations 1 & 3: The available
scientific literature supports the notion that transient ischaemic attack (TIA) and stroke are
medical emergencies as the short-term risk of recurrence is very high over the next days and
there is a number of highly effective stroke prevention strategies e.g. carotid endarterectomy for
symptomatic high grade stenosis. It is therefore essential that patients presenting with TIA or
minor stroke are assessed urgently and secondary prevention strategies rapidly instigated. At
Austin Health, the vast majority of patients with TIA present via the ED. A substantial proportion
of patients are admitted for monitoring and investigation but many are assessed in the ED and
discharged after commencement of secondary prevention measures. The establishment of this
NP position will facilitate evidence-based and rapid assessment and management of patients
presenting to Austin Health with TIA. As noted above, the workload of the stroke service
continues to grow and this role will assist with unmet patient demand. Quality evidence-based
care of patients with TIA and stroke is dependent on a high skill base within a hospital's ED. The
NP role will include education and liaison with ED staff, particularly nursing staff with
responsibility for triage. ED triage staff practice is fundamental to rapid assessment of stroke
patients and for delivery of intravenous thrombolysis to eligible patients.

Recommendations 5 & 6) The need for rapid follow-up of patients with TIA in a TIA/neurovascular clinic is highlighted in Recommendation 3. The NP role will include education and management of patients seen in the TIA clinic (Recommendation 22). The NP role will include responsibility for data collection, and performance monitoring, fundamental to development and maintenance of quality, evidence-based care (Recommendation 10). These are consistent with the high level of clinical leadership required of the SNP.

Recommendation 26 of the strategy "Increasing the capability of the workforce, through ongoing
education, training and professional development, will improve and enhance provision of stroke
care". "The underpinning theme of any workforce-related recommendation should be to
encourage/enable training and education that can be embedded in continuing professional
development" and is supported in the proposed SNP role.

The Better Skills, Best Care Strategy (DHS 2005b) describes the provision of quality services in
any setting as using the right people in the right place at the right time with the right skills to
deliver quality of care to patients. It is suggested to achieve such a goal will take consideration
of how to best use available skills and exploring how "work might be reorganised to minimise
duplication of effort and make best use of available staff"; and how "new roles can be developed
to meet current and evolving patient needs"(page 90 Stroke Care strategy for Victoria).

It is reported in the DHS report "Your health - a report on the health of Victorians 2005", that
"Cardiovascular disease was responsible for almost 18 per cent of the total disease burden in
Victoria in 2001, or 60,389 DALYs in males and 54,664 in females. Over 75 per cent of this
attributable burden is due to mortality. Ischaemic heart disease and stroke are the major
contributors, accounting for 53 per cent and 29 per cent of the cardiovascular disease burden
respectively".
Nationally:

There are several recently released national papers that influence and impact upon the development of NP in our health care system. Australia’s Health Workforce, Productivity Commission Research Report (2005) is a report recognising problem’s at the centre of the nations health system and has made many recommendations relating to their findings.

Major findings include a complex system for health professional registration, with over 90 bodies nationally responsible for accrediting health professionals. The report indicated there is currently a medical focus in providing health care and suggested that other health care workers such as nurses, physiotherapists, speech pathologists, be able to access the Medicare rebate system. Access to health services in rural areas can be limited and it was recommended that exploration of funding from federal and state health budgets would be beneficial. It was also suggested to establish an independent advisory council to look at health workforce numbers and funding as currently there are critical shortages of some health professionals particularly in rural areas, with many further shortfalls predicted.

The National Nursing and Nursing Education Taskforce (N³ET) was established in response to the National Review of Nursing Education Report. The intention of the taskforce was to develop a more consistent approach for nursing nationally. It has been found, there is great diversity between states and territories not only for qualifications and accreditation, but also for scope of practice of different nursing roles. This taskforce was hoping to make recommendations of how consistent data collection across the country can be developed to evaluate the roles. Essentially the time is right for the implementation of NP’s. From a political perspective it has been recognised at a national policy level that it is time to redesign the way services are being delivered and from a professional perspective nursing has been well represented at a national level with the as the N³ET Task force, Royal College of Nursing and from DHS Nurse Policy Branch at a state level.

According to the Australian Institute of Health and Welfare (AIHW) 2006 report ‘How we manage stroke in Australia’, stroke is a significant health problem:

- In 2003 around 346,700 Australians had had a stroke at some time in their lives.
- Each year there are about 40,000–48,000 stroke events among Australians.
- Stroke claimed 9,006 lives in 2003, nearly 7% of all deaths.
- In 2003 about 282,600 Australians with stroke had a disability and in around 146,400 of these people the disability resulted from their stroke.

Allocated expenditure for cerebrovascular disease amounted to $896 million in2000–01, which is 1.8% of total health system expenditure (AIHW 2004b). Aged care homes accounted for half of the funds allocated to cerebrovascular disease and hospitals accounted for 40%".

"Despite the lack of actual data on incidence trends, we can expect that the ageing of the Australian population will drive an increase in the number of strokes in the future unless incidence rates fall by 2–3% per year. There is ample scope to intervene to reduce the incidence of stroke with primary and secondary prevention measures" (AIHW 2006 report ‘How we manage stroke in Australia’, page 43). See website for full report: [http://www.aihw.gov.au/publications/cvd/hmsa/hmsa.pdf](http://www.aihw.gov.au/publications/cvd/hmsa/hmsa.pdf)
8. Summary of Stroke Nurse Practitioner Model:

What is a Nurse Practitioner?

In the State of Victoria, a NP is a nurse with an endorsement on their general registration. The NBV has adopted the Australian Nursing and Midwifery Council’s definition of NP: "A nurse practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The 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 profession’s values, knowledge, 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 authorised to practice.” (Australian Nursing and Midwifery Council, 2004)

A NP candidate (NPC) is a Registered Nurse under division 1, 3, or 4 engaged to undertake a course of study and clinical experience leading to endorsement as a NP paid at their substantive rate (Australian Industrial Relations Commission 2006).

As the senior nurse in the Acute Stroke Team (AST), the SNP will take the lead role in the initial assessment, investigation, management and education of patients with acute stroke and TIA presenting to the ED. The proposed NP will perform a standardized clinical assessment (including history and examination using the National Institutes of Stroke Scale Score); instigate acute investigations according to existing stroke care protocols e.g. CT and MR imaging, carotid duplex ultrasound, ECG, and blood tests; triage for alteplase therapy and institute standard orders e.g. aspirin therapy, IV therapy, allied health team referral. The NP will also fill a key liaison role between ED and stroke unit staff, providing expert advice and continuing education to ED and stroke unit staff utilising evidenced based practice. In addition, the NP role will include audit and monitoring responsibilities.

This role is proposed because 1) the acute stroke and TIA patient workload via the ED at Austin Health is considerable and continues to grow (547 admissions in 04-05, 705 in 05-06, 727 in 06-07, 711 in 07-08); 2) much of the assessment, investigation and management of patients with stroke and TIA is ‘per protocol’ and can be readily performed by an experienced stroke nurse; 3) The Austin Hospital has a number of skilled and experienced stroke nurses who are currently unable to exercise their full clinical potential and have limited options for clinical career advancement. An example of this is evident in relation to the existing Stroke Liaison Nurse role. Currently, the Stroke Liaison Nurse provides considerable clinical support to the Stroke Intern for the day-to-day management of acute stroke patients. However, this nurse’s knowledge and skills remain under utilised and underestimated.

The added scope of practice will include independent assessment of patients, the ability to order investigations and institute management including prescription of medications. The existing nurse roles of patient and staff educator will be enhanced. The NP role will improve the efficiency of assessment and management of stroke and TIA patients in the ED and lead to further quality improvements in the Austin Acute Stroke Service. This role will provide a stronger link between nursing staff based in the ED and nursing staff based in the Stroke Unit. The NP would join the other members of the multidisciplinary stroke team as the nurse and work closely with stroke interns, stroke registrars and neurologists. The redesign of stroke services to include a role for a SNP will involve a shift of some medical duties, therefore meeting the continued growth in the stroke service. There is currently an unmet patient demand particularly relating to stroke...
patient follow up following a TIA and subsequent discharge from hospital. This care includes the need to monitor diagnostic results and arrange further patient care which would be performed by the NPC and address this gap in stroke patient care delivery. Ideally the SNP would include a 4-day a week service for follow up of TIA patients.

Internationally there have been Stroke Nurse Practitioners in United States, United Kingdom and Canada for the last 40yrs; the model that most align to Austin’s proposed model is that of the ‘Foothills Medical Centre’ in Calgary, Canada. The Stroke Nurse practitioner role in Canada was initially developed in response to cutbacks in medical residency programs and increasing complexity of patients. (Journal of Neuroscience Nursing, Sept 2006. Vol 38, Number 4 Supplement). It is important to remember when comparing SNP models internationally that they are not always regulated roles. There is even diversity in legislation relating to NP’s across Australia. Victoria is the only state to use the term endorsed, the term authorised is used in other states of Australia. There is work in progress to develop a national consistency for NP endorsement/authorisation when national registration of health professionals is implemented in July 2010. All nurse registration authorities in Australia have adopted the ANMC definition and competency standards. There have been 300 NP’s in Australia since the 1990’s. The first endorsed NP in Victoria was in 2004.

Across Australia there are currently no endorsed Stroke Nurse Practitioners. In Victoria a Stroke Nurse Practitioner candidate has just been employed at Northern Hospital in Melbourne with other potential candidates at RMH and Austin Hospital have expressed interest in similar roles. In Victoria the majority of NPs currently work in Emergency Departments, there are currently 44 endorsed Nurse Practitioners from 15 categories with 19 of these employed in ED. The DHS provided targeted funding to health services to assist in the establishment of ED NP roles. (Nexus NBV November 2008, Vol 16, Issue 2). At Austin Health we currently have two endorsed NP in the ED and further candidates in Emergency, Neurosurgery, Mental Health and Liver Transplant. Similar to stroke services, renal services are participating in the Victorian Nurse Practitioner Project Phase 4 Model development.

<table>
<thead>
<tr>
<th>VNPP Funded Services</th>
<th>Stroke Facilitators co-located</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austin Health</td>
<td>-</td>
</tr>
<tr>
<td>Alfred Health</td>
<td>-</td>
</tr>
<tr>
<td>Eastern Health</td>
<td>-</td>
</tr>
<tr>
<td>Melbourne Health</td>
<td>-</td>
</tr>
<tr>
<td>Northern Health</td>
<td>Linda Francis</td>
</tr>
<tr>
<td>St Vincent's Health</td>
<td>-</td>
</tr>
<tr>
<td>Western Health</td>
<td>Adele Mollo</td>
</tr>
<tr>
<td>Peninsula Health</td>
<td>Marlena Klaic</td>
</tr>
</tbody>
</table>

9. Are there other alternatives to providing this service?

It is evident that the acuity of the hospital inpatients is increasing and the nature of the workforce is changing, therefore the way we optimise service delivery is essential. NP’s are one of many important workforce initiatives that can assist Austin Health meet these challenges. It is well documented that NP’s enhance service delivery particularly to increase care co-ordination, provide a patient centred approach and strong clinical leadership.

Stroke and TIA are conditions of older age (median age of first stroke in Australia is 79 years). The vast majority of patients with stroke require hospital admission for management in an organized, multi-disciplinary stroke unit. Patients with TIA require expert assessment and urgent
investigation on the day of presentation as the 7 day risk for stroke following TIA is as high as 30% for some patients. Given that the Australian population is rapidly ageing and there is little evidence that stroke incidence is appreciably declining, we can expect continued increased presentations to the ED with stroke and TIA in coming years. Currently, across Australia, same day separations for stroke account for 9% of the total and the median length of stay for stroke is 8 days (AIHW 2006). There is considerable scope to reduce length of hospital stay for patients with TIA or minor stroke with more rapid assessment and investigation, commencing in the ED. The proposed NP would be instrumental in improving efficiency of care. Given the current workload for the stroke service and the expectation that this will increase in coming years, the alternative will be to increase medical staffing within the stroke service. The proposed NP is an important alternative to this option by providing continuity of service via a single individual. The proposed duties in this new position are also well within the capabilities of a nurse practitioner and the creation of such a position will enhance the career opportunities for stroke nurses. It is worth noting the proposed model does not promote Nurse Practitioners as doctor substitutes but clinical leaders in their field. The role would mean a substitute of some tasks to fill a gap in service need, not a substitute of a profession. Ultimately it’s about providing the best care at the best time by the best professional.

There are existing variations in the management of the TIA patient group with a proportion of patients hospitalised and others discharged from hospital, creating remaining “deficiencies of care”. The implementation of the stroke NP role would create increased capacity to provide assessment of patients 1 – 2 weeks following presentation to hospital with a TIA. This group of patients represents a significant “unmet” patient demand.

The proposed model of service delivery could not be achieved by a Stroke Clinical Nurse Consultant or Liaison Nurse as the role demands the expanded scope of practice to independently assess, order investigations, and prescribe within a collaborative team. The SNP would be part of the future of quality, professional person centered care in Australia as highlighted at the Australian Nurse Practitioner’s Conference 2008.

10. Plans to fill the Stroke Nurse Practitioner position:

The implementation of the NP role requires careful consideration and planning to ensure the role would enhance service delivery, along with a suitable candidate who is academically and clinically prepared for the role. The Steering Committee convened in the service plan phase in 2006 commenced with developing a flow chart to identify the pathway of how to become a NP. This chart has been used to educate potential staff about the complexities of becoming a NP and to ensure that all issues are considered and agreed before proceeding along this pathway. The flow chart is divided into three main areas, academic preparation, role definition and service and organisational requirements. (See attached Flow Chart –Appendix 1) This flow chart highlights the complexities of the potential NPC working simultaneously with the organisation to identify and fund the role, and the University to meet the academic requirements of the position.

It is a requirement of Austin Health that the SNPC would need to complete the Austin Health’s template for submission of a proposed role. After sign off from the area manager and team members involved this submission is forwarded to the steering committee for review. The review focuses upon ensuring that the position is funded, evaluation criteria are robust and it is evident that the service will benefit by the new care delivery model. The Steering Committee also provides an organisational overview and ensures the NP role is aligned with strategic objectives. This current final report has covered all Austin submission criteria that would allow the SNPC to refine the role with any new changes that arise between now and the commencement of the role.
Expression of interests will be managed as per Austin Health’s recruitment policy through the Human Resources department. The role will be advertised internally to give Austin Health staff first priority. The position would be strongly promoted amongst Neurosciences nurses at various nursing forums and ward meetings. The position would be advertised to all staff via the internal employment circular which provides a copy of position description, contact person and due dates for submission of applications. Please see Appendix 2 for draft of SNPC proposed position description.

The Health Practitioners Registration Act Vic 2005 came into effect on 1 July 2007 (replacing the eleven separate health practitioner registration Acts, including the Nurses Act). The change provides a more responsive, transparent, efficient and accountable regulatory framework for health professionals in Victoria. (Australian Nurse Practitioner Association National-ANPA Report 2008)

The title of nurse practitioner is a protected title under the Health Professions Registration Act 2005. Only nurses who have successfully completed the NP endorsement process are entitled to call themselves NP’s.

In the state of Victoria, the Australian Nursing and Midwifery Council’s (ANMC) National Nurse Practitioner Competency Standards are used to assess an applicant’s eligibility for endorsement as a NP, for ongoing assessment once endorsed, and for assessment of practice in regards to professional conduct.

The standards are not viewed in isolation, but are an extension to the core standards for registered nurses and midwives, and the advanced nursing practice competency standards.

There are 3 competency standards for nurse practitioners that define nurse practitioner practice as it differs from other advanced practice roles.

These standards are defined by nine competencies each with specific performance indicators. (See Appendix 3 for competency framework)

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

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

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


As per the ‘Process for Nurse Practitioner Endorsement’ document published by the NBV 2008 the minimum requirement for endorsement is:

1. Current Victorian registration as a Division 1, 3 or 4 nurse;
2. Completed ‘Masters of Nurse Practitioner’ or Completed a Masters assessed as equivalent in
3. Completed ‘Therapeutic medication management module’.

Austin Health has a potential candidate working within the stroke speciality that has started a Masters of Advanced Nursing Practice at University of Melbourne this year. The potential candidate plans to complete a minor thesis next year (looking at Stroke NP, prescribing and secondary prevention) and in 2010 will complete the pharmacology modules and advanced assessment subjects. On successful completion the applicant would then be eligible to apply for endorsement in 2011. This new position would therefore need to be filled as a SNPC during this time. Anticipated time of candidacy is included in the Position Description. At the commencement of the candidate’s position an expected time frame to become endorsed will be discussed and documented, between candidate and manager as well as a mentoring and support plan.

The candidate’s plans for academic preparation fit with the areas of priority outlined in the proposed model in meeting deficits in current service to stroke patients.

The NBV has responsibility under Section 135 of the Health Professions Registration Act 2005 to approve courses, which provide qualifications, which lead to endorsement in the protected title of NP. See web address below that confirms the list of approved education providers for NP. [www.nbv.org.au/web/guest/courses-nurse-practitioner](http://www.nbv.org.au/web/guest/courses-nurse-practitioner)

### Table 6. Nurse Practitioner Courses:

<table>
<thead>
<tr>
<th>Education Provider</th>
<th>Campus</th>
<th>Course Name</th>
<th>Accreditation Expiry Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deakin University</td>
<td>Burwood and Geelong Waterfront</td>
<td>Master Nursing Practice</td>
<td>January 2011</td>
</tr>
<tr>
<td>Flinders University</td>
<td>Adelaide</td>
<td>Master of Nursing (Nurse Practitioner)</td>
<td>April 2009</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pharmacology for Advanced Professional Practice</td>
<td>April 2009</td>
</tr>
<tr>
<td>La Trobe University</td>
<td>Bundoora &amp; Bendigo</td>
<td>Master of Nursing (Nurse Practitioner)</td>
<td>July 2009</td>
</tr>
<tr>
<td>Monash University</td>
<td>Peninsula campus</td>
<td>Therapeutic Medication Management Unit</td>
<td>June 2010</td>
</tr>
<tr>
<td>University of Melbourne</td>
<td>Parkville</td>
<td>Therapeutic Medication Management Education Program</td>
<td>October 2013</td>
</tr>
</tbody>
</table>

This applicant would need to follow pathway 2 as described in the NBV Process for Nurse Practitioner Endorsement document, which includes the completion of equivalency of qualification document.

Pathway 2
Applicants under this pathway are required to:

- Complete an application form for Pathway
- Nominate the category of practice
- Make payment of fee
- Sit an expert panel oral examination
- and provide the following documentation:
  - A certified copy of the academic transcript of a Masters of NP commenced prior to 2009 or a copy of the letter from the NBV granting equivalency of Masters qualification
  - A certified copy of the academic transcript of an approved Therapeutic Medication Management Module.
- Curriculum Vitae

Including academic transcripts for post-registration qualification(s) in the area of clinical specialty; a detailed work history; professional profile and at least two professional referees who have worked with the applicant in their current role.

- A summary of the model and scope of practice as a NP;
- A list of the drugs that the applicant is going to prescribe according to their scope of practice;
- Detailed documentary evidence that demonstrates the applicant meets the ANMC national competency standards for NP;
- At least two complex case studies that evidence the applicant’s practice at the NP level;
- Evidence of organisational support and professional indemnity insurance coverage from the employing organisation;

The applicant will be notified of the outcome of the endorsement within 28 days of the Board’s consideration of the exert panel recommendation.

NP’s are endorsed under a particular category. Each category has a list of drugs approved by the Minister of Health. A NP can prescribe any drugs from this list that are within their individual scope of practice. A SNP would practice under the Neurological Care Category. Please see Appendix 5 for SNP proposed medication formulary.

11. Role Sustainability:

The stroke NP is expected to ultimately take on a clinical leadership role within the multidisciplinary stroke service and work closely with staff in ED and Outpatients as well as in the acute stroke ward.

Registered nurses who wish to expand their scope of practice are responsible for acquiring and maintaining current knowledge and competence.

NP’s were described at the Australian Nurse Practitioners Association (ANPA) 4th Annual Conference (Nov 2008) as “self directed, collaborative health care practitioners”. A nurse who desires to become a SNP must have absolute commitment to the position, drive to implement change, commitment to complete the NBV professional requirements to be endorsed and
sustain the role, collaborative self support groups will need to be developed with other SNP’s/SNPC’s from a speciality perspective and also with the cohort of NP’s from other specialities at the Austin Health. The stroke NP role will be the second NP role in neurosciences at Austin Health. This established NPC role in neurosurgery, will create a valuable peer support framework.

The Head of Inpatient Stroke Service at Austin Health is committed to actively mentor, develop and support the stroke NP.

Austin Health’s affiliation with the NSRI is a great resource for the SNP to utilise when they prepare research papers/presentations at conferences surrounding the development of the SNP role and implementation of a new service. This research will be derived from the data collected to evaluate the introduction of the new role and service delivery.

The organisation has advanced support structures for NPC’s, developed in the 2006 NP Phase 3 Round 6 Project to guide. These structures include an organisational mentoring model, clinical supervision processes, pharmacy, radiology and pathology involvement and understanding of the process, clinical practice guideline templates, and organisational pathways to approve clinical practice guidelines. All of these structures help with the sustainability of the role and provide incentives for potential candidates to begin the rigorous and extensive task of SNP as a career choice.

DHS funding in the form of targeted NP scholarships are available to assist the SNPC with academic preparations for endorsement as described in the table below. This financial assistance will help part way to reimburse the cost and effort involved. It would be important for sustainability that access to these scholarships is available after 2009.

**Table 7. NP Scholarships**

<table>
<thead>
<tr>
<th>Funding element</th>
<th>Available funding</th>
<th>Funding purpose</th>
</tr>
</thead>
</table>
| Targeted NP Scholarships         | up to $6,000 per nurse | NP scholarships are offered as part of the NPB postgraduate scholarship program (each semester) for nurses undertaking courses of study that lead to endorsement as a NP. In 2008-09, priority weighing will be given to NP scholarship applications from nurses employed at public health services:  
  • whose area of practice is stroke, renal (and Mental health or Drugs), or  
  • who are employed as an NP candidate at a health service that is funded for NP models in Stroke or Renal care development |

All SNPC are encouraged to apply for scholarships under the Nurse Policy Branch Scholarship Program (refer [www.health.vic.gov.au/nursing](http://www.health.vic.gov.au/nursing)). Applications for top up grants of $2000 will also be considered under the Stroke Post Graduate Scholarships grants being offered to Nursing and Allied Health by DHS Victorian Stroke Clinical Network as a contribution to individuals who are undertaking post graduate studies relevant to the area of acute and subacute stroke care.

The availability of these grants help to fulfil Recommendation 26 of the Victorian Stroke Care Strategy "Increasing the capability of the workforce, through ongoing education, training and professional development, will improve and enhance provision of stroke care". "The underpinning theme of any workforce-related recommendation should be to encourage/enable training and education that can be embedded in continuing professional development". And also Austin
Health’s strategic priority of “investing in our staff” and “fostering clinical leadership opportunities”.

There is already an experienced group of senior nurses in the neurology team, very supportive and excited by the prospect of implementing a SNP. In addition to the proposed SNP role, there is a fulltime stroke nurse consultant role (Grade 4) and a Neurology / Epilepsy nurse consultant position (Grade 5) in place which provides a strong senior nursing career structure in neuroscience. This experienced group would ensure that the SNP would be part of a nursing team with advanced nurses and other nurses working together within the larger multidisciplinary team and should attend all relevant nursing meetings. It is important in the promotion of the new service delivery that nurse practitioners are not seen as separate from the body of nursing. This group of experienced nurse provides potential candidates for the SNP role within the stroke specialty.

These skilled and experienced stroke nurses are unable to exercise their full clinical potential and have limited options for clinical career advancement. An example of this is evident in relation to the existing Stroke Liaison Nurse role. Currently, the Stroke Liaison Nurse provides considerable clinical support to the Stroke Intern for the day-to-day management of acute stroke patients. However, this nurse’s knowledge and skills remain underused and underestimated. One of the senior nurses was awarded with a Victorian State Nursing Excellence Award in 2007 in the category developing professional nursing practice. This award was received for her role in influencing the way in which the whole organisation now responds to those patients presenting with stroke, across the continuum from their presentation and treatment in the Emergency Department to establishing a nurse led risk assessment process in the Stroke Prevention Clinic. A role such as this is the ideal platform for expansion of scope of practice as a SNP.

The development of a SNP Model to meet patient demand also allows for an extended scope of practice as a career path to keep experienced nurses in clinical practice as an attractive, stimulating alternative to education or management. The stroke liaison role will continue with the introduction of the SNPC role. The Stroke Liaison role allows for development of clinical expertise in Stroke, which is ideal preparation for the ultimate progression to a SNP role.

Part of succession planning is the endorsed SNP mentoring potential candidates to encourage them to follow in this ‘clinical practice’ career prospect and supporting them to undertake the necessary academic qualifications. To lead by example and promote the clinical leadership role as attractive, positive and giving recognition to an advanced knowledge base.

The introduction of NP roles provides an advanced route for nursing that allows them to practice autonomously (within guidelines) and collaboratively providing a career structure that will keep nurses with considerable experience and expertise in a clinical role. Austin Health’s NP Steering Committee has taken the opportunity to educate nurses about the new career pathway and have Communicated with all of the nurses involved in post-graduate clinical specialties along with the Graduate Nurse Years to promote such roles.

The Austin Hospital has been funded to convene the SNP Collaborative, which will encourage the development of networks to support in sustaining such roles.

12. Nurse Practitioner reporting structure and responsibilities; Engaging key stakeholders

Organisational responsibilities for supporting a newly developed position were achieved in the 2006 NP project to develop a service plan. The project achieved the aim of developing structures that included an organisational mentoring model, clinical supervision processes, pharmacy,
radiology and pathology involvement and understanding of the process, clinical practice guideline templates, and organisational pathways to approve clinical practice guidelines. Communication with other relevant medical units such as cardiology, neurosurgery and general medicine has taken place in the development of the SNP model.

The steering committee was a vital component to the success of the project in working through the myriad of issues associated with these roles including the cultural change component necessary. The key successes of the project were to prepare the organisation for nurse practitioner roles and included the development of a template that is completed and submitted to Austin Health Nurse Practitioner Steering Committee (See Appendix 6).

It is acknowledged that NP positions have organisational implications and therefore requires total organisational support. Austin Health’s NP Steering Committee is comprised of key organisational players including Medical Director, CSU Directors, Director of Ambulatory and Nursing Services, Executive Director of Nursing and Ambulatory Services, Nurse Managers, Nurse Education Manager, Nurse Educators and supports the development of NP roles. The committee was established during the NP project and continues to monitor and support the implementation phase. This committee meets on a needs basis upon receipt of a NPC application. This application constitutes an outline of the role, plan to fill the role, key stakeholders involved, reporting structure, projected service improvements, business case development, communication structure and position description. Essentially this framework encourages the candidate and the clinical team to ensure a comprehensive approach has been undertaken prior to the implementation of the position.

Professional Structure for reporting:
The executive team, driven by the CEO and Executive Director of Ambulatory and Nursing Services are passionate and supportive of the implementation of SNP roles. At a local level the implementation of the SNP is driven by the Head of In-patient Stroke Services, Associate Professor Helen Dewey and the Specialty Services CSU Director Leanne Turner who has a Neuroscience nursing background. The stroke team are innovative and committed to quality care, which can be seen by the inclusion of this service being highly commended in the 2007 Victorian Public Health Care Awards for their early recognition and response in stroke patients. Associate Professor Helen Dewey is committed to the development of the stroke service and perceives this nursing role as instrumental to the improvement of the stroke service and will be the clinical mentor. Leanne Turner was actively involved in the development of the Neurosurgery NP role at Austin Health and is committed to the potential for SNP’S to enhance existing service delivery models and address existing gaps in patient care delivery. The NP would report to the Head of Inpatient Stroke Services about professional matters and to the Director – Specialty Services CSU about operational matters. Similarly to any role within the stroke team a yearly performance appraisal now referred to as work planning & review would occur according to Austin Health’s policy which promotes professional and personal growth. Ultimate responsibility will be to the Executive Director Ambulatory and Nursing Services. Obviously the SNPC/SNP has a responsibility to patients.

13. Managers responsibility in communicating the newly evolved position:
The managers of the proposed NP will undertake that all the relevant team members within and external to the Stroke Service are informed about plans to develop this new position and have every opportunity for input and comment at each stage of the development process. The regular meetings of the Stroke Unit, Neurology Department, Neurology SMS, Specialty Services CSU, Acute Stroke Care Working Group and Neurology ward nursing staff afford potential
opportunities for discussion and comment.

The Head of Inpatient Stroke Service at Austin Health will actively mentor, develop and support the stroke NP. Associate Professor Helen Dewey as the proposed Clinical Supervisor and Leanne Turner as the Clinical Service Director have been crucial to the development of the SNP model and have been the front runners in preparing the multidisciplinary team. The manager would be initially responsible to link the Stroke Nurse Practitioner candidate into these forums and then allow the candidate to begin networking and establishing themselves within the stroke team in a clinical leadership position.

14. Communication structure

Informal Communication Strategies:

The existing Stroke Liaison Nurse coordinates a monthly meeting with the multidisciplinary stroke team as a forum for service improvement and to discuss any business/updates that has an effect on the stroke service. Monthly stroke statistics (length of stay, treatment times, patient separations, safety outcomes Alteplase, and clinical trial data) are collected by the Stroke Liaison Nurse and presented. Protocols and policies are initiated and reviewed and pending stroke education sessions advertised. Stroke Team Members who attend include: Clinical Service Unit Director; Stroke Consultants, Nurse Unit Manager of Acute Stroke Unit; Associate Nurse Unit Managers; nurses acting in charge; Stroke Liaison Nurse; Stroke Registrar; Stroke Intern; Dietician; Speech Pathologist; Occupational Therapist; Neuropsychology; Physiotherapy; Stroke Research nurses; Stroke Research fellows; Pharmacist; Social worker; Clinical Psychology; Quality Coordinator; Care Coordinator; Rehabilitation Consultant; Rehabilitation Registrar; Visiting students from all disciplines and visiting colleagues. As key stakeholders it has been this team that has doubled as a steering committee for the development of the service delivery model and role. Out of session feedback and correspondence is conducted via email. Until the appointment of a SNP project officer, the sharing of information was managed by the Stroke Liaison Nurse reporting back to the stroke team via a mail merge which includes a broader plethora of stroke interested clinicians based at other campuses and the NSRI.

Leanne Turner and A/Prof Helen Dewey have communicated to medical staff at various senior medical staff meetings whose members include: Medical director of CSU, neurologists/neurosurgeons within the CSU including stroke consultants. The specialty CSU director SNP project officer have reported updates at the Senior Nurses meeting held monthly, whose members it is envisaged will provide mutual peer support to a SNP candidate as experienced advanced nurses. Leanne Turner chairs the meeting. The members include: Stroke, Cardiology, Vascular, Epilepsy, Neurosurgery, Ophthalmology and Respiratory Liaison Nurses; Nurse Unit Managers/Clinical Support Nurses from these specialties, and Quality Coordinator of the CSU.

As Head of Inpatient Stroke Associate Professor Helen Dewey has communicated extensively with the six consultants which rotate on a monthly basis through Stroke ward service, all are very supportive and have been involved in the evolution of the SNP role, this has assisted in overcoming the challenges sometimes experienced in introducing NP roles where there can be negative attitudes from medical colleagues.

Meetings with heads of department from Pharmacy, Pathology and Radiology have occurred with the CSU Director and SNP project officer to discuss the proposed model with these relevant stakeholders. Correspondence via email inviting feedback from the allied health Heads of Department in Speech Pathology, Dietetics, Physiotherapy, Neuropsychology, and Occupational Therapy as managers of key stakeholders have also taken place.
Melbourne Ambulance Service (MAS) have been communicated with as part of the evolution of the model development. Correspondence via email to Kevin Masci the Executive Manager Operations, Operational Standards and Improvement, MAS. Kevin has distributed information on the proposed model for wider comment amongst appropriate staff at Ambulance Victoria. Kevin is part of Austin’s Acute Stroke Working Group, which meets on a needs basis. Its members include Stroke consultants, Radiologist, Radiology Technician, Stroke Research Nurses, Stroke Liaison Nurse, Representative from MAS, and ED Clinical Nurse Consultant with an interest in stroke and are chaired by the Head of Inpatient Stroke. This group will reconvene on issues relating to the evolution of the SNP, as each member is a key stakeholder.

Communication with heads of department and Nurse Unit Managers from Austin Health’s ED and Outpatients has been crucial in the evolution of the role as this model directly impacts on the service delivery of these departments. This communication would need to advance further once the candidate is employed. Outpatients are particularly supportive of the role as they are exploring opportunities for NP models currently including nurse led clinics.

It is the responsibility of the SNPC, the Head of Inpatient Stroke and the CSU Director to facilitate opportunities with all of these working groups throughout the evolution of the newly developed position. The SNPC would be welcomed into all of these existing forums as part of the team who provides stroke care at Austin Health.

Austin Health’s Nursing newsletter ‘Nursing News’ distributed to all Austin Health Nurses, featured a write up about the proposed SNP role with contact details of the project officer for further information. See Appendix 7. The SNPC could continue to use this as a forum to communicate to all Austin Health Nurses.

To network with stroke clinician’s interstate the SNPC could make use of the existing mail merge with NSW, co-ordinated by the State Manager Stroke Services New South Wales. Interest in SNP models has already requested by colleagues in NSW via this medium.

Clients: Consumer feedback would need to be sought via specific focus groups. Austin Health’s Consumer Participation Support Officer is keen to be involved in guiding this process to be conducted professionally according to hospital policy and to have the greatest impact. Austin Health has a great example to follow in the ‘Young Adult Diabetes Service’ (YADS) consumer discussion group. YADS was a new Young Adults Diabetes Service being established at Austin Health for 15 – 25 year old young people with Type 1 diabetes. To make sure that the YADS clinic was developed with a youth-friendly approach, the clinicians involved sought input from potential clients of the service to help design and direct how the service should operate. Feedback was obtained by holding a Snack and Chat session for interested youth (aged 15-25 years), and/or parents of adolescents with type 1 diabetes. The session ran for 1 ½ hours, and provided an opportunity to come along and share the good, bad and ugly experiences of attending ‘regular’ diabetes clinics at Austin Health or other health services. The group explored how the new YADS clinic could best work for young people with diabetes. Details of the Snack and Chat session were advertised by an invitation sent to clients that had attended the ‘regular’ diabetes clinic at Austin and was coordinated by the Diabetes Clinical Nurse Co-ordinator. Light refreshments and car parking costs were included as incentives for attendance.

This approach could be easily adapted by the Stroke Nurse Practitioner to gain access to stroke clients who have attended the Stroke Prevention Clinic. It could be conducted in a staged approach were information is shared on and consumer feedback given on:

- Understanding the role of a Stroke Nurse Practitioner.
- Development of a brochure to describe the role that can be used to educate patients and significant others in suitable language.
• Feedback on the Stroke Nurse Practitioner Service
• Development of the Nurse Practitioner Satisfaction survey.

Austin Health’s Consumer Participation Support Officer has plans to develop an organisational wide policy for payment of participants on Austin Health consumer participation committees. Austin Health has a Consumer and Community Policy updated earlier this year which would need to be adhered to in the process of consumer involvement. The aim of the Austin Health Consumer and Community Participation Policy is to ensure that consumers are involved in the planning, implementation and evaluation of Austin Health services. Consumer and community participation is fundamental to ensure that Austin Health services are responsive to the needs of individuals and achieve the best possible outcomes. The Stroke Nurse Practitioner could also utilise the Austin Health Community Advisory Committee in setting up the group.

This same approach can be adapted to apply to Melbourne Ambulance Service Officers and their Consumers assisted by MAS ‘Executive Manager Operations, Operational Standards and Improvement’ and to General Practitioners via Austin Health’s GP Liaison Officer.

The next step is to inform current Austin Health stroke patients and their significant others about the potential new role by the distribution of the Victorian Stroke Clinical Network’s Consumer newsletter updating them on the Victorian Stroke Care Strategy recommendations which includes discussion on Stroke Nurse Practitioner Models in Victoria. A copy of the Clinician focused newsletter has also been circulated to all key stakeholders in an effort to keep them updated with the progress of the Victorian Stroke Care Strategy implementations. SNP roles are reported on in this newsletter.

It would be important to inform consumers of relevant websites for up-to-date information on legislation in which the SNP will practice under. This could include making available the Australian Nursing and Midwifery Council (ANMC)–National Competency Standards for NP which the SNPC/SNP would practice under. And the Health Practitioners Registration Act Victoria 2005 which is the regulatory framework for health professionals in Victoria.

**Formal communication strategies:**
There is enormous potential for formal communication and publication of the new service delivery model and the impact of a SNP implementation in utilising existing forums as listed below:

**Austin Health:**
- Staff Open Forum
- Grand Round
- Aged Care Grand Round
- Neurosciences Seminar-National Stroke Research Institute
- Stroke Research Meeting-National Stroke Research Institute
- Nurse Unit Managers Meeting
- Acute Stroke Unit Senior Nurses Meeting
- Specialty Services CSU-Senior Nurses Meeting
- Acute Stroke Care Working Group
- Veterans Working Group-Repatriation
- Royal Talbot’s Neurology Team Meeting
- Quality Coordinator Network
- ‘Road show’ to each unit within Austin that is impacted by implementation of Stroke Nurse Practitioner.
- Specialty meetings-Neurology, Neurosurgery, General Medicine, Cardiology, Radiology,
Pathology, Pharmacy.

Locally:
- Rotary Organisations
- Victorian Stroke Support Network
- Melbourne Ambulance Service
- Victorian Stroke Clinical Network

Nationally/Internationally:
- Stroke Society of Australasia-Nursing Symposium/SMART strokes
- Australian Nurse Practitioner Association Conference
- European Stroke Conference
- World Stroke Congress
- National Quality and Safety Conference

Publications:

Austin Specific:
- Austin Nursing News
- Austin’s weekly newsletter-Week at a Glance
- Develop Information Brochure for patients/relatives on the SNP role.

Locally:
- Heidelberg/Preston Leader
- Victorian Stroke Clinical Network Newsletter-Health Facilities and Consumers

National/International:
- Australasian Neurosciences Journal
- Australian Nurses Federation Magazine
- National Stroke Foundation Publications
- International Journal of Stroke-Edited by Professor Geoff Donnan – Director Neurology at Austin Health.

15. Austin Health Acute Stroke Service Overview
The evolution of NP’s in clinical service models such as a SNP at Austin Health will assist in meeting service delivery objectives.

The Acute Stroke Care Unit at Austin Health Ward 6 East is part of the Specialty Services CSU. It is located on the Neurology Ward 6E of the Austin Tower which includes beds for Stroke, Neurology, Epilepsy, Endocrinology, Dermatology and Rheumatology Units. The Acute Stroke Unit has 4 monitored beds and 9 beds located within the same ward with one portable monitor available when required. There is capacity to flex up or down depending on the numbers of stroke patients that require admission. It is Austin Hospital Admission Policy that all acute stroke patients presenting through the ED are managed on the Acute Stroke Unit. Patients that have a stroke whilst an inpatient on other units is also prioritised to be transferred to the Acute Stroke Unit unless concurrent medical or surgical problems are best managed in another specialised area.

Stroke Care Units were first introduced in mid 1970’s. Austin Health had the first stroke unit in Australia established in 1978. However, not until 1993 was it evident that management in a stroke care unit reduced morbidity and mortality compared with general ward management and, more recently that patients treated in physically discrete units have better outcomes than those who are dispersed in different locations and rely on mobile stroke teams. The stroke model of
care adopted by Austin Health is evidenced based practice. It is Grade ‘A’ level ‘one’ evidence as per the Clinical Guidelines for Acute Stroke Management 2007 that all stroke patients should be treated in a comprehensive stroke unit with an interdisciplinary team.

According to the Stroke Services Framework Model Austin Health’s Acute Stroke Unit is a Category A Service Model. The Stroke Services Model Framework was developed to provide guidance about where stroke units should be located. In the original model (2002) hospitals were categorised using three criteria: access to 1) neurosurgery; 2) brain (CT) imaging; and 3) intensive care or high dependency units, however feedback indicated that some of these criteria were not relevant. The Stroke Services Model has been updated using a systematic approach that included a literature review, expert consultation, and analytic piloting using data from the 2007 National Stroke Audit. This resulted in a simplified approach to categorising hospitals that was based upon (1) access to brain (CT) imaging; (2) the number of stroke patients admitted per year; and (3) urban or rural location (see Table 3 of the model framework). Although defined differently, these categories maintain the A, B, C, D classification.

Austin Health’s Acute Stroke Care Unit can be classified as ‘Acute-semi intensive (Short stay, close physiological monitoring, limited rehabilitation)’ as per the National Stroke Unit Program (NSUP). Strongest evidence for stroke unit care is in comprehensive stroke units where rehabilitation can be provided for up to several weeks (Stroke Unit Trialists’ Collaboration 2007). Austin’s Stoke patients are transferred to rehabilitation facilities located on Royal Talbot and Repatriation Campus’s. Austin’s Acute Stroke Care Unit is participating in ‘A Very Early Rehab Trial’ (AVERT) which is NHRMC funded trial conducted from NSRI. AVERT is the largest ever trial conducted worldwide to investigate the introduction of rehabilitation in the first 24hrs post stroke to improve outcome. Earlier mobilization and earlier rehabilitation often results in improved functional outcomes for patients and overall reductions in their length of stay in the acute and sub-acute settings.

Austin’s multidisciplinary team is made up of Stroke Consultants (EFT-1.5) which includes the Head of Inpatient Stroke, Stroke Registrar (1 EFT); Stroke Intern (1 EFT); Nurses who specialise in stroke care (42 EFT for whole ward with 1-4 nurse to patient ratio) ; Stroke Liaison Nurse(1.EFT); Dietician(0.2 EFT for ward and 0.1 EFT for Stroke Prevention Clinic); Speech Pathologist(1.EFT); Occupational Therapist(1-EFT); Neuropsychologist (0.2 EFT); Physiotherapist (0.7 EFT) ; Pharmacist (0.7 EFT); Social worker (1-EFT); Clinical Psychologist (EFT 0.2); Care Coordinator (0.7 EFT).

**Acute Stroke Unit Model Staffing Facts:**
- Trainee Neurology Registrar allocated to Stroke patients only-rotate 4monthly.
- Stroke Intern-rotate every 5-10 weeks.
- Stroke patients are admitted under a dual bed card. That is a Stroke Unit bed card and a medical unit who is admitting for the day-these units see stroke patients daily and provide expert medical advice. The Stroke Unit remains the parent unit.
- Full time Stroke Liaison Nurse Position.
- Physiotherapy and Occupational Therapy see all stroke admissions as a blanket referral
- All other disciplines attend Interdisciplinary stroke team meeting but are referred to see stroke patients on a needs basis. Interdisciplinary Team meetings are held every Monday morning at 11am as part of the consultant ward rounds where all team members are expected to join. The nurse working in the area joins the round when their specific patients are being seen to receive and provide up-to-date information. A more formal team meeting is held on Wednesday’s at 10am.
- Daily handover is given to a smaller section of the interdisciplinary team-all nursing staff,
the Stroke Liaison Nurse, Physiotherapist, Occupational Therapist, Pharmacist, Social worker and Care Coordinator and any students from these disciplines. The nurse in charge also hands over to the Ward Clerk and PSA staff.

As Austin Health is a tertiary hospital often complex stroke patients are transferred from areas in Melbourne that don’t have a Stroke Unit or from rural areas. The majority of strokes/TIA are admitted via ED as per the Protocol. In January 2005, the Acute Stroke Team (AST) was established. It is available 24-hours per day/seven days per week to facilitate the assessment and rapid management of hyperacute stroke patients who may be eligible for intravenous rtPA (alteplase thrombolysis) therapy for ischaemic strokes, or alternative acute therapies for haemorrhagic stroke. The team’s focus is to reduce permanent brain damage through rapid recognition, diagnosis and treatment of stroke - ‘time saved is brain saved’.

Requiring cooperation within the immediate multi-disciplinary team Acute Stroke Team (AST) and extensive cooperation with a wider multidisciplinary team (ED, Radiology, Switchboard, Pathology, MAS) to achieve its goals, the AST and wider team have demonstrated strong teamwork, persistence and dedication to achieve successful patient outcomes (See evaluation section for specific outcomes).

The AST is activated by Austin ED staff via an emergency call to Switchboard following ambulance pre-notification of an acute stroke patient en route to ED or when a patient meeting the specified criteria presents to ED.

The immediate response team (AST) consists of the stroke registrar, stroke intern, stroke liaison nurse, stroke trials nurse, stroke fellow and Head of Inpatient Stroke services (with a slightly reduced team after-hours and at weekends). However, crucial to the success of the AST is the wider multi-disciplinary team which includes:

- MAS (pre-notification of ED)
- ED staff (rapid assessment by medical & nursing staff /rapid request for AST activation)
- Switchboard staff (rapid activation of AST via paging system)
- Radiology staff (prioritisation of stroke as a medical emergency for CT Brain)
- Pathology staff (rapid processing of blood specimens).
- Ward nurses activated to rapidly transfer the patient from ED to the Acute Stroke Unit.

While waiting for the AST, patients are managed in ED according to the Hyperacute Stroke Management protocol (urgent workup including CT scan cannula insertion and blood tests). Following CT confirmation and meeting specific hyperacute stroke criteria, patients are ‘streamed’ into appropriate treatment modalities.

Early recognition, diagnosis and treatment permits earlier transfer from ED to the Acute Stroke Care Unit where ongoing care is provided by the specialist neurology-trained nursing, medical and allied health staff as mentioned above. This team continues assessment, management and discharge planning.

The team provides the AST service on an on-call basis after-hours and weekends, which is in addition to their previous and next day non-AST workloads. With no additional resources available to the team for education and training of other staff in stroke recognition and management, or for evaluation and feedback of AST/patient outcomes, AST members undertake these important components in addition to their normal workload, again underlining the commitment and dedication of team members. The introduction of a SNP role will help to alleviate some of the workload required to keep this system running smoothly with increasing numbers of stroke patients being admitted via ED. This SNP role will provide a stronger link between nursing staff based in ED and nursing staff based on the ward. The NP would join the
other members of the multidisciplinary stroke team as a senior member and work closely with stroke interns, stroke registrars and neurologists. Collaborations with the wider multidisciplinary team will be crucial to the success of the SNP joining the AST, particularly in role delineation.

The fully implemented SNPC role will include the ordering of specific radiology and pathology diagnostic tests in addition to prescribing specific medication according the approved formulary and specified evidenced based clinical practice guidelines. It is not necessary according to the latest thinking from NBV for a candidate to develop specific Clinical Practice Guidelines (CPG) for their role. CPG should be treatment based not profession based. The candidate will develop detailed stroke clinical practice guidelines if the stroke steering committee deems it necessary. The Clinical Guidelines for Acute Stroke Management released by the NSF in 2007 will form the basis of practice for the SNPC. They would operate within the guidelines of the already existing stroke protocols that are used by the AST. These protocols are based on the national guidelines and agreed upon at a local level. And include:

- Protocol for assessment investigation and management of ischemic stroke.
- Protocol for management of intracerebral haemorrhage.
- Alteplase (rTPA) protocol for acute ischaemic stroke.
- Eligibility criteria for Alteplase (rTPA) for acute ischaemic stroke.
- Checklist for Alteplase (rTPA) for acute ischaemic stroke.
- Dosing schedule for Alteplase (rTPA) for acute ischaemic stroke.
- Inpatient stroke protocol.
- Warfarin dosing
- IV GTN protocol
- Driving post stroke protocol
- Carotid stenting protocol
- Neurological observations protocol
- Neurology Guidelines for GP’s-Is it TIA or Stroke?
- Survival Guidelines for Stroke Prevention Outpatient Clinic.
- TIA Emergency Department Guidelines.

The Neurosurgery Nurse Practitioner Candidate at Austin Health has developed CPG according to Austin Health’s policy; these are examples that the SNP candidate could adapt to the stroke speciality if the steering committee thought it necessary.

- Requesting for Pathology.
- Pathology Formulary
- Neurosurgical Inpatient management.
- Formulary of Radiology Investigation.
- Requesting an Organ Imaging.
- Neurosurgery/Neurology-Formulary of Drugs.
- Provision of certification supporting absence from work or study.
- Request for neurodiagnostics.

The stroke service at Austin Health was highly commended in the 2007 Victorian Public Health Care Awards for their early recognition and response in stroke patients. Stroke outcomes are closely associated with the time to treatment interventions. Service outcomes can only improve with the introduction of this clinical leadership position, especially as a component of the role will include auditing and monitoring responsibilities.

The total skill base in stroke nursing will increase following the implementation of a nurse practitioner candidate position. The role will include close liaison with ED, which will also increase the general nursing skills of others involved in the provision of acute stroke patient care.
care. Continuity of patient care is also provided through the nurse practitioner candidate position when compared to the position of stroke intern in which junior medical staff rotate through the stroke unit every 5-10 weeks and Stroke Registrars rotating 4 monthly.

The NP would work as a senior member of the multidisciplinary stroke team, providing acute stroke initial assessment skills in the ED. The SNP would assess and manage patients according to existing protocols. They would work independently within this role but be a senior member of the stroke team with frequent interaction with registrar and consultant staff. They would have a shared workload with Stroke registrar based on the case load of the day. The SNP would report to the Stroke Consultant on ward service and the Head of Inpatient Stroke as their clinical supervisor. The SNPC would not be expected to see complex cases that they did not feel competent to manage; as confidence and competence grows they could take on such cases with discretion from clinical supervisor.

Service review and innovation are a focus at Austin Health. A major outpatient reform service improvement project is well underway focussing on reducing fail to attend rates, reduce waiting times for patients and increase the clinic patient discharge rates, the introduction of a SNP will assist in meeting this service improvement. The SNP role encompassing admission and discharge from ED will be complimented by follow up of TIA patients in both a SNP TIA led clinic and at the already existing Stroke Prevention Outpatient Clinic.

There are variations in the management of the TIA patient group with a proportion of patients hospitalised and others discharged from hospital, creating remaining “deficiencies of care”. At Austin Health, the vast majority of TIA present via the ED. A substantial proportion of patients are admitted for monitoring and investigation but many are assessed in the ED and discharged after commencement of secondary prevention measures to be followed up in Stroke Prevention Outpatient Clinic which has considerable wait times.

The implementation of the stroke NP role would create increased capacity to provide assessment of patients 1 – 2 weeks following presentation to hospital with a TIA in a SNP led clinic. This would facilitate evidenced based rapid assessment and management of patients presenting to ED with TIA. The stroke NP would have an independent patient load relating to TIA patient follow-up after discharge from ED. The model involves a shift of some medical duties, therefore meeting the demand of continued growth in the stroke service. The introduction of this role would circumvent some of the load on Stroke Prevention Outpatient Clinic, follow up of diagnostic results and further arrangement of care could be conducted by the SNP in a nurse led clinic. For example if a TIA is seen after hours or over the weekend and discharged home the SNP would see that patient on the next available working day to instigate investigations and secondary prevention in a timely fashion. The use of the Neurosciences Consulting room available in the Neurodiagnostics area which has access to secretarial support, phone, sphygmomanometer, scales and computer with hospital systems to review pending results. This consulting room is collocated with the Acute Stroke Unit Ward 6 East. The patient would be seen again by the SNP for follow up on investigations and secondary prevention measures with liaison to GP.

The role at Stroke Prevention Outpatient Clinic would include providing expert patient advice in relation to risk factor modification and liaison with GPs. With the added scope of practice and required academic preparation the SNP has expertise to triaging and managing TIAs, they could therefore work as an additional staff member in this clinic in response to the increased workload. This clinic is one afternoon a week, so would fit within the proposed working week which allows for educational requirements.

The stroke NP is expected to ultimately take on a clinical leadership role within the multidisciplinary stroke service and work closely with staff in ED and Outpatients as well
as in the acute stroke ward to improve outcomes. As part of a collaborative team it is expected that the SNP would need to hand over patients not discharged home to the other stroke members to continue assessment, management and discharge planning.

Overall higher staffing levels are required because of new stroke developments; the SNP role is ideally suited. New developments:

- Increased admissions to ED.
- New evidence for TIA management requiring rapid assessment.
- New demands on acute stroke assessment.
- New evidence for secondary prevention strategies.

**Table 8. A provisional time table for SNPC:**

<table>
<thead>
<tr>
<th>Time</th>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
</tr>
</thead>
<tbody>
<tr>
<td>Am</td>
<td>ED- Clinical Supervision</td>
<td>ED- Clinical Supervision</td>
<td>Case presentations with Neurology trainee’s Radiology meeting Education (SNPC) Roaming locations with SNP collaborative</td>
<td>Join Neurology Registrar training if relevant topic ED</td>
<td>University (SNPC)</td>
</tr>
<tr>
<td>Pm</td>
<td>Stroke Prevention Clinic Outpatients Department Mentoring time with clinical supervisor (30 minutes)</td>
<td>Nurse Led TIA Clinic 6 North Mentoring time with clinical supervisor (30 minutes)</td>
<td>Monitoring and auditing responsibilities Own Office</td>
<td>Nurse Led TIA Clinic 6 North</td>
<td>University (SNPC)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Mentoring time with clinical supervisor (30 minutes)</td>
<td></td>
</tr>
</tbody>
</table>

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### Table 9. Summary Stroke Nurse Practitioner / Candidate Expansions in Scope of Practice

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Pathology</th>
<th>Radiology</th>
<th>Referrals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribed from agreed Stroke Nurse Practitioner formulary as approved by NBV and Minister for Health. See Appendix for proposed Formulary.</td>
<td><strong>Request</strong>&lt;br&gt;U&amp;E’s&lt;br&gt;FBE&lt;br&gt;Coagulation Screen&lt;br&gt;CRP&lt;br&gt;MSU&lt;br&gt;Fasting Glucose/Cholesterol&lt;br&gt;Lipid Profile</td>
<td><strong>Request</strong>&lt;br&gt;CT&lt;br&gt;MRI&lt;br&gt;Carotid Doppler&lt;br&gt;Transcranial Duplex&lt;br&gt;Chest Xray- NGT placement</td>
<td>• Neurology Unit&lt;br&gt;• Epilepsy Unit&lt;br&gt;• Neurosurgical Unit&lt;br&gt;• Neurodiagnostics&lt;br&gt;• Cardiology Unit&lt;br&gt;• Endocrine Unit&lt;br&gt;• Renal Unit&lt;br&gt;• Psychiatry&lt;br&gt;• Intensive Care Unit&lt;br&gt;• Acute Aged Care Services&lt;br&gt;• Medical Units&lt;br&gt;• Orthopaedic Unit&lt;br&gt;• Orthotics&lt;br&gt;• Clinical Pharmacology&lt;br&gt;• Allied Health&lt;br&gt;• Dietetics&lt;br&gt;• Occupational Therapy&lt;br&gt;• Physiotherapy&lt;br&gt;• Social Work&lt;br&gt;• Clinical Psychology&lt;br&gt;• Neuropsychology&lt;br&gt;• Speech Pathology&lt;br&gt;• Clinical Trials&lt;br&gt;• General Practitioners</td>
</tr>
</tbody>
</table>

**Enhanced Staff and Patient Education role as a clinical leader**

**Stroke Prevention Clinic**
- Follow up of investigations ordered from ED and ability to initiate further orders
- Patient and family education, both verbal and written information.
- Risk factor modification—initiating secondary prevention measures
- Liaison with GP

**Cardiology**
- **Request**<br>ECG<br>Holter Monitor<br>Transthoracic Echocardiogram<br>TOE

When a pathology or diagnostic test is ordered it is the responsibility of the one who requested it to follow up the result.

The endorsed SNP is autonomous with legal accountability and responsibility in an advanced clinical role. When endorsed the SNP is an experienced nurse but a beginner NP. After providing evidence to the board of competence according to approved academic and clinical preparation, the SNP will practice under the ‘National Competency Standards for the Nurse Practitioner’ (Australian Nursing and Midwifery Council (ANMC)’s 2004 “National Competency Standards for the Nurse Practitioner” (p 2-4). See website [http://www.anmc.org.au/professional_standards/index.php](http://www.anmc.org.au/professional_standards/index.php)

In relation to prescribing medications the SNP completes the ‘Therapeutic Medication Module’ as part of academic preparations and has practiced under clinical supervision within a SNPC role leading to endorsement. The endorsed SNP is legally liable and fully responsible for Diagnosis and Prescription of medications on the approved list for their category of endorsement and according to their scope of practice. In order to prescribe safety within guidelines the endorsed SNP will practice under their category of endorsement and operate under:
• Health Professions Registration Act (HPRA).
• Drugs, Poisons and Controlled Substances Act (DPCS).

To avoid a medication misadventure below are some recommended online resources available to the SNP as per the Pharmacy Board of Victoria Registrar Stephen Marty:
• Australian Medicines Handbook
• Therapeutic guideline series-Cardiovascular.
• DHS website-Drugs and Health Professionals-Link to Legislation
• Clinicians Health Channel.

Please see Appendix 5 for the proposed Medication Formulary-Stroke yet to be approved by the Minister for Health. The NBV will work with the SNP collaborative to come to agreement on a Stroke specific list to be approved by the Minister for Health. Austin Health’s Director of Pharmacy and the stroke steering committee has been consulted to assist in the development of this list. Clinical Governance and the hospital’s Therapeutics’ Committee will need to approve the SNPC individual formulary.

17. Priority areas for NP service development to be begin implementation:
• Within 1-3 years
• Between 3-5 years
• Greater than 5 years

The introduction of NP roles provides an advanced route for nursing that allows them to practice autonomously (within guidelines) and provide a career structure that will keep nurses with considerable experience and expertise in a clinical role. The candidate’s plans for academic preparation fit with the areas of priority outlined in the proposed model in meeting deficits in current service to stroke patients.

The role will need to be refined with key stakeholders once the SNPC has been employed. It is envisaged that as the SNPC grows in confidence and competence they will be ready for presentation to the board for endorsement within a reasonable time frame of 1-3yrs. It is reasonable that as the endorsed SNP develops professional confidence and without the pressure of academic preparations that within 3-5 yrs they could expand their role to include an increased presence on the Acute Stroke Care Unit, maybe helping out with ward rounds in the day to day management of stroke. It is envisaged that an endorsed SNP would have flexibility to be employed to cover more days of the week, with potential for after hours and weekend cover if required. The educational requirements could be reduced to one day per fortnight, with a SNP collaborative meeting once a month as per the example of ED NP’s.

There is enough scope of practice for a second Stroke Nurse Practitioner Position to meet with ‘deficiencies of care’ and to allow for cover for leave entitlements and succession planning. It is reasonable to expect that within 1-3 yrs the promotion of the Stroke Nurse Practitioner model will influence other nurses to being their academic preparation for succession planning purposes. A redesign of the stroke service may include an increased capacity for SNP roles at all areas through the stroke patient’s continuum of care.

Greater than 5 yrs might see several SNP working autonomously but collaboratively branching into community or rural aspects of stroke care.
### 18. Implementation Milestones for the next 12 months

**Table 10. Shows implementation milestones and anticipated outcome over next 12 months.**

<table>
<thead>
<tr>
<th>Description of Activity</th>
<th>Anticipated Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential SNPC has begun academic preparations, equivalency documentation preparation prepared for NBV</td>
<td>The nurse is committed to a SNP role, academic preparations fit with Nurses Board of Victoria granting equivalency of Masters qualification</td>
</tr>
<tr>
<td>Gain sign off from Area Manager and Stroke Team involved in submission of proposed role template</td>
<td>Submission sign off from Area Manager and Stroke Team</td>
</tr>
<tr>
<td>Submit Austin’s Template for proposed role to Austin Health’s NP steering committee for review</td>
<td>The review agrees that the position is funded, evaluation criteria are robust and it is evident that the service will benefit by the new care delivery model. The Steering Committee also provides an organisational overview and ensures the Nurse Practitioner role is aligned with strategic objectives.</td>
</tr>
<tr>
<td>SNPC position advertised using updated position description</td>
<td>Promote role in Neurosciences and externally advertise.</td>
</tr>
<tr>
<td>Expressions of Interest processed as per hospital policy</td>
<td>Expressions of Interest processed and SNPC interviewed.</td>
</tr>
<tr>
<td>SNPC interviewed</td>
<td>SNPC selected</td>
</tr>
<tr>
<td>SNPC begins work-NP Steering committee reconvened</td>
<td>SNPC has organisational support</td>
</tr>
<tr>
<td>Promotion of SNPC role with all key stakeholders and throughout the organisation</td>
<td>All key stakeholders and the organisation are up-to-date with implementation of the SNPC role</td>
</tr>
<tr>
<td>Education, clinical supervision and mentoring begin; SNPC has identified mentors/champions and gaps in learning identified.</td>
<td>The SNP has support from the organisation and multidisciplinary team as well as management. Peer support and mentoring in place. Gaps in learning addressed. SNPC is getting exposure to case study presentations to build confidence for later presentation to the board.</td>
</tr>
<tr>
<td>Collaborations with other Austin Health NP and with SNP within Victoria develops further</td>
<td>The SNP has peer support and utilises access to other networks which employ SNPC.</td>
</tr>
</tbody>
</table>
The SNPC begins their professional portfolio from early on in preparation for endorsement. The SNPC develops a professional portfolio from early on in preparation for endorsement. Data Collection evaluation the model and the role. This data analysis forms the basis for a research paper and feedback to all key stakeholders including consumers.

**19. Stroke Nurse Practitioner Clinical Development**

The expectations of a NP to extend their scope of practice, usually presents as a major learning curve it is essential the nurse has access to a clinical program specific to meeting their educational needs under the guidance of a clinical expert, usually a consultant doctor or NP. As there are no endorsed SNP in Australia the clinical supervision will need to come from a consultant doctor. Austin Health suggests that a clinical mentor is available to optimise the clinical skills of an NPC. In this case the Head of Inpatient Stroke Service at Austin Health will actively mentor, develop and support the SNPC in a clinical supervisory capacity.

The NBV mandates that a NPC present a detailed work history; professional portfolio and at least two professional referees who have worked with the applicant in their current role and who support the endorsement of the candidate. Each referee is expected to complete a referee verification report covering information relating to advanced clinical assessment, skill level, diagnostic skill and knowledge, pharmacology knowledge, demonstrated competence in medication management and leadership, research abilities and agreed competency standards. It is anticipated that at least one referee would be a medical doctor. Referees must be people who are identified as senior health professionals and multidisciplinary team members who have provided clinical supervision to the applicant and may have been involved in the development of clinical practice guidelines and / or have worked closely with the applicant and are able to verify advanced level of practice and knowledge.

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

The focus of the clinical development program is to ensure the NPC has well developed clinical skills in the areas of advanced clinical assessment, diagnostic skill and knowledge, pharmacology knowledge, demonstrated competence in medication management, research abilities and advanced clinical leadership, to support a successful endorsement process with the NBV. The SNPC would not apply for endorsement they have completed all the academic requirements: until the role is established and the candidate is confident and competent to practice at the level outlined in the ANMC competency standards.

**1. Clinical Supervisor guidelines:**

The supervisor should be:

- A clinical expert in the area, either Consultant Doctor or NP.
- Available during clinical placement and able to commit to being a mentor for the duration of the internship.
- Accessible within the clinical environment for teaching and reviewing patients seen by the candidate.
- Have a good understanding of the NP model and the extended scope of practice of the role.
- Able to supervise clinical practice.
2. **Clinical Supervisor responsibilities:**
   - Able to observe the student working clinically and provide thorough critical feedback on their performance in the role.
   - Ensure that a wide range of opportunities for skill development is available.
   - Assess progress of the NPC against the objectives at regular intervals.

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

**Suggested outline for clinical development as per Austin Health’s Nurse Practitioner Service Plan 2006:**

a) **Commencement of candidate position**

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

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

**Table 11. Proposed Generic Learning Plan**

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

b) **Clinical Practice Guidelines (CPG’s) development if required by Steering Committee:**

In this phase the candidate is in the process of developing the CPG’s and therefore defining their extensions in scope of practice. The learning plan will become more specific as the guidelines are being developed, however in this phase the plan will focus on the following areas:
• Health assessment and diagnostic skills in the specialty area,
• Interpreting diagnostic and other laboratory tests.
• Applying pharmacological interventions appropriately including therapeutic effects and adverse events.

CPG’s are being developed simultaneously with the candidate acquiring knowledge in the clinical setting using the existing approved Stroke protocols.

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

C) CPG completion
The CPG’s have been completed and the focus is on gaining the knowledge and skills that underpin the CPG’s. The candidate is expected to have developed an approach to advanced health assessment, considered diagnostic implications, including pathology and radiology, clinical management, referral or discharge planning and documentation and communication. During this phase the candidate will also learn examination skills for each system, interpretation of the results of diagnostic testing, making a diagnosis and procedural skills. The candidate is expected to practice clinically providing direct patient care to the population that fits the SNPC scope of practice.

The candidate will practice under the direct and indirect supervision of their clinical mentor as well as other health professionals during this phase. The level of supervision provided will be dependent upon the competence of the candidate managing specific presentations. It will also be dependent on the mentoring clinician’s previous exposure to the candidate. It is expected that the mentor will provide the candidate with guidance regarding the level of supervision required.

d) Consolidation of skills
The candidate will focus upon consolidation of their clinical skills and building a professional portfolio to complete the endorsement process. The emphasis will be on total service provision, both clinical and non-clinical. The candidate will continue to practice clinically under the direct and indirect supervision of the Head of Inpatient Stroke. However, the level of direct supervision should be minimal in preparation for endorsed practice. It is important to provide the candidate with an opportunity to simulate endorsed practice to highlight capacity for independent practice.

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

3. Suggested Assessment strategies as decided by the SNPC and the clinical mentor:
Work based assessment –

• Clinical log-see Appendix 9
Each patient the candidate treats will be documented in the clinical log. The clinical log will be the basis of discussion between the candidate and supervisor.

• Unit Record audit-see Appendix 10
As a quality tool it is important that there are Unit Record reviews, whereby the clinical mentor and candidate review three histories every three months to explore the clinical notes and identify whether adequate documentation has been recorded.

• Case review- see Appendix 11
It is expected the candidate will complete case reviews presenting their patients assessment, diagnostic tests, clinical findings and diagnosis and treatment plan. Depending on the requirements, this could be completed in conjunction with the clinical log or as a separate review and be a formal presentation to other nurses and medical staff as a mechanism for individual and unit based learning.

- **Bondy Scale- see Appendix 12**
  The Bondy Scale is a tool to assist in identifying the degree of supervision required by the candidate. This tool can be used in collaboration with the clinical log, and would be utilised at the commencement of the candidate position and every three months thereafter to assist in making a comparison and documenting progression of candidate’s clinical skills.

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

*University based assessment will be required if enrolled in a Nurse Practitioner clinical masters.*

*This proposed clinical supervision program could be adjusted to meet university requirements.*

**Acknowledgement:**
Austin Health’s Nurse Practitioner Service Plan Development Project 2006
Women’s Health Nurse Practitioner Project Officer – “Clinical Internship Model”
Latrobe University Nurse Practitioner Curriculum

**Existing educational opportunities for the SNPC/SNP to attend include:**
Registrar training sessions
- Australasian Brain School-Wednesday pm- When learning is stroke specific.
- Victorian Neurology Training-Thursday am- When learning is stroke specific.
- Neurological Case Presentations-the SNPC could build up to presenting in this forum in preparation for endorsement.
- Radiology Meeting-Wednesday am (Neurologists/Vascular surgeons/Radiologists discuss imaging of stroke patients, the SNPC could have imaging from his/her specific patients reviewed in this forum.
- Strokes ward rounds.

The SNP Collaborative is working together with subcommittee members of the Victorian Stroke Clinical Network; Professor Chris Bladen (Director, Eastern Melbourne Neuroscience, Chairman Division of Medicine, and Head of Stroke Boxhill Hospital) and Associate Professor Peter Hand (Deputy Director of Neurology and Co-Head of Inpatient Stroke Care Unit Royal Melbourne Hospital) to develop an education framework to meet the gaps in knowledge of SNPC.

The proposed series of lectures which is to be refined as gaps become apparent includes:
- Brain imaging interpretation-CT, MRI, CTA, CTPerfusion.
• Clinical Scenarios including education on Alteplase Administration.
• Secondary Prevention-TIA clinics and working with GP’s.
• Systems approach to medications.
• Documentation of clinical assessments including admission and discharge essentials.

The SNPC also discussed the use of mock interview panel similar to the structure used by NBV during exam panel to become endorsed; it is recommended that during this oral exam that the candidate takes control and volunteers as much information when presenting case studies. The SNPC needs to become an expert at describing the model and their role within the model pitched to a range of audiences. The collaborative provides a great practice environment for public speaking.

The SNP Collaborative candidates have also been invited to participate in education session being developed as part of the ‘Medical Education Project’ subcommittee of the Victorian Stroke Clinical Network. These sessions are aimed at providing up-to-date evidenced based stroke education to medical interns across regional and metro sites via teleconferencing. Dr Alistair Wright General Physician, Warragul Hospital is chairing the subcommittee and will keep the SNPC in the loop as this medium for communication evolves.

20. Mentorship and the Stroke Nurse Practitioner:

Given the evolutionary mode of SNP models in Victoria, the SNPC will cross uncharted territory in managing change, organisational dynamics and communication across a broad spectrum of departments at Austin Health and to external key stakeholders. The endorsement process to become a NP mandates the NP have a clinical mentor for support. The NP steering committee at Austin Health supports the need for NP candidates to have an organisation mentor as well as the mandatory clinical mentor to assist in the transition from candidate to endorsed NP. Some university courses also recommend the need for a university ‘academic mentor’.

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

Mentee
In order for the relationship to develop “potential mentees must be enthusiastic, willing to be challenged and guided, willing to relate and share and be clear about what they want in a mentor”. (Hayes 2005)
Diagram 1. Illustrates the factors that feed into the need for a clinical mentor.

Acknowledgement: Geraldine A. Lee Nurse, Practitioner Masters program coordinator La Trobe University, Melbourne

Austin Health has guidelines for NP mentor Program (see Appendix 13) which discusses the role of Austin Health NP mentors; Requirements for NP mentors; Guidelines for mentee to choose mentor; And organisational Mentors who have completed the NP mentor Program willing to participate as a mentor. It is appropriate that the SNPC may have a number of different mentors from a range of departments in the organisation depending on the knowledge gap.
21. Evaluation of the Stroke Nurse Practitioner Service Model:

The evolution of NP’s in clinical service models such as a Stroke Nurse Practitioner at Austin Health will assist in meeting service delivery objectives.

Given that a team of health professionals specialising in stroke delivers service to stroke patients, it is difficult to evaluate the SNP’s exclusive enhancement of service delivery. However it is recommended that a range of data be collected to highlight the effectiveness of this role. It is important for a nurse acting at a senior nursing level be confident within their scope of practice and open to critique just like any other health professional.

The stroke service at Austin Health was highly commended in the 2007 Victorian Public Health Care Awards for their early recognition and response in stroke patients. Stroke outcomes are closely associated with the time to treatment interventions. A collaborative approach was undertaken with the Austin Health ED, Acute Stroke Unit and the MAS, with the aim to reduce delays in diagnosing and treating stroke. Since its implementation the Acute Stroke Team (AST) has achieved more rapid assessment of acute stroke patients, decreased the time taken to confirm the diagnosis with a brain scan, increased the number of patients eligible to receive clot-busting treatment and decreased the length of hospital stay for stroke patients. The whole organization now responds to those patients presenting with stroke, across the continuum from their presentation and treatment in the ED to establishing the Stroke Liaison Nurse into a risk assessment process in the Stroke Prevention Clinic.

AST success is most clearly demonstrated through the improved patient outcomes described under ‘Quality Outcomes’ below. It has now become standard care for patients presenting to Austin Health with suspected acute stroke. Further evidence of AST’s success is seen in ‘flow-on’ effects such as the improved profile of stroke in patients, the improved overall management of TIA patients, capacity building of acute stroke expertise, the infrastructure developed for acute trials and future acute therapies, and the work undertaken with the Acute Stroke Care Working Group including discussion of acute stroke issues within Austin Health (involves General Medicine, MAS, ED, Stroke, Radiology & 6-East) and the revision of existing/development of new protocols for patient care (e.g. tpa, acute stroke, ICH). Work with this group has helped build teamwork, cooperation, morale and camaraderie.

Quality Outcomes

First 12 Months of Operation (Jan-Dec 2005):

- 225 (34%) of 663 patients presenting with stroke or TIA were referred to AST:
  - 153 (68%) of these were stroke or TIA / 10% ICH
  - 27 patients received alteplase compared with 11 in 2004 pre-AST (60% increase)
  - 21 patients recruited to acute trials
- More rapid assessment of all acute stroke patients:
  - Decreased ‘door to CT’ time (diagnosis with CT confirmation)
  - Decreased ‘door to Stroke Care Unit’ time
  - Decreased LOS (pre-AST median=6 days; post-AST= 3 days)
  - Increased number of eligible patients treated with alteplase (60% increase as above)

These quality improvements have continued since with results presented at several hospital forums every year. In 2006 35 patients were thrombolysed. In 2007 45 pts were thrombolysed with the median door to needle time of 62 minutes and best door to needle time was 26 minutes. So far this year 34 patients were thrombolysed with the median door to needle time of 51 minutes. The best time this year happens to be the same as last year 26 minutes.
The tools for data collection have improved and can be very easily adapted to include specific data for patients seen by the SNPC/SNP. This year a new system has been piloted and went live in May 2008. This new system allows for the collection of data on all stroke patients and not just those patients seen when an AST page is activated. Austin stroke team are in the process of working with Information Technology (IT) to refine the layout/contents of the form and generate an electronic report. This is made possible, as it is part of Austin Health’s hospital network computer system ‘Trak Health’, so once a UR number is entered it is easy to drill into the departmental form where some patient information has already translated over, reducing duplication.

See Appendix 14 for current layout of ‘Acute Stroke Form’ and the fields of data collected. Please note the field ‘Seen by Stroke Nurse Practitioner’ which would allow for report to be generated on data for those patients seen specifically by SNPC/SNP against the overall impact on service delivery.

**Table 12.** Key Performance Indicators (KPI’s) for SNP Model of Care incorporating SNPC/SNP services:

<table>
<thead>
<tr>
<th>Dimensions of Quality</th>
<th>Outcome/Process Measures</th>
<th>Agreed Measures</th>
<th>Information Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>• Onset to arrival time</td>
<td>• More rapid assessment of acute stroke patients</td>
<td>-Acute Stroke Form Data as produced by Trak Health report-can be selected to collect data for any length of time-days/week/months/years. Includes retrospective data pre/post new model of care implemented. Data on numbers of patients seen by SNP consultation time is generated by this form.</td>
</tr>
<tr>
<td></td>
<td>• Time to patient review.</td>
<td>• Decreased the time taken to confirm the diagnosis with a brain scan</td>
<td>-Trak Health also collects data, including waiting times, length of stay, DRG, principle diagnosis, specific procedure and Outpatient waiting times. The database is able to group specific DRG’s together.</td>
</tr>
<tr>
<td></td>
<td>• Door to CT brain</td>
<td>• Increased the number of patients eligible to receive Alteplase therapy</td>
<td>-Safe Implementation</td>
</tr>
<tr>
<td></td>
<td>• Time to treatment</td>
<td>• Decreased the length of hospital stay for stroke patients in ED.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Door to Acute Stroke Unit</td>
<td>• Decrease in time taken to transfer patient from ED to Acute Stroke Unit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Time to first appointment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of patients reviewed by SNP in TIA and Stroke Prevention Clinic.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Effectiveness | • 3mth Rankin grading post alteplase  
• Global outcome at 7 days and 3mths post stroke | • Improved patient outcomes | -SITS database  
- Provision of expert advice to other services. |
| Efficiency | • Reduced waiting times  
• Adherence to NSF guidelines for management of TIA | • Improved overall management of TIA patients | - Trak Health collects data on Outpatient waiting times by DRG.  
- NSF 'acute stroke audit' 2007, to be repeated in 2009.  
- Cost per patient DRG is collected in the clinical costing unit.  
- Adherence to NSF guidelines for management of TIA could need to be collected separately by review of the existing electronic discharge summary system on the Stroke Database. |
| Appropriateness | • Thrombolysed  
• Adherence to NSF guidelines and Stroke Unit | • % of patients thrombolysed | -SITS database  
- Consultation activities adhering to NSF guidelines/stroke |
Protocols

unit protocols would need to be collected separately by review of the existing electronic discharge summary system on the Stroke Database.

<table>
<thead>
<tr>
<th>Acceptability</th>
<th>Protocols</th>
<th>- Nurse Practitioner Patient Satisfaction Survey—see Appendix 8, could be adapted apply to carers and multidisciplinary team -Backfill of leave and succession plan developed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptability</td>
<td>• Patient satisfaction</td>
<td>• No decrease in patient satisfaction</td>
</tr>
<tr>
<td>Acceptability</td>
<td>• Team satisfaction</td>
<td></td>
</tr>
<tr>
<td>Acceptability</td>
<td>• Carer satisfaction</td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td>• Adverse Events</td>
<td>• No increase in adverse events when benchmarked for safety in delivery of Alteplase</td>
</tr>
<tr>
<td>Safety</td>
<td></td>
<td>-SITS database -Risk Man tool - Adverse events data collated by Clinical Governance accessible via database.</td>
</tr>
</tbody>
</table>

Austin Health Departments that have agreed to be involved in assisting Nurse Practitioner Candidates identify and collect data include:

- Nursing Informatics,
- Clinical Costing Unit,
- Health Information Management,
- Clinical Governance and
- La Trobe University.

As data is already collected using these information sources, it is possible for the SNP to generate retrospective data before the commencement of the new model of service delivery and SNPC role.

It is possible for the endorsed SNP to compare quality outcomes over time from when they began as a SNPC until endorsement to demonstrate efficiency. Just as important is the demonstration of no increase in adverse events. The whole concept behind the development of this SITS database is to measure the safe delivery of Alteplase. Using this database the SNPC can track their individual delivery of alteplase therapy in acute stroke. Gathering data can form the basis of a research paper and ‘tell the story’ of better outcome for clients.

Further IT support is available if needed for KPI collection or presentation from the NSRI Data Manager who has been involved in the development and update of AVERT Online (“A Very Early Rehabilitation Trial” with international recruitment whose principle investigator is based at NSRI). AVERT Online is a web based clinical trial randomization and trial management system for AVERT Phase 3. This Data Manager has also been responsible for designing Case Report Forms using TELEform (Elite version 9®) for AVERT Phase 2.

The Data Manager could be utilised as a resource when developing presentations, which need to be delivered at an excellence standard and for nursing research endeavours.
Potential available grants to conduct model evaluation and the SNP contribution:

NBV Ella Lowe Grant – Value $50,000 (1 per year) – is now open for the purpose of conduct researching, education or program evaluation in any clinical setting that has the potential to lead to better patient outcomes for research conducted in Victoria.

Eligibility:

Available to Division 1 nurses who propose to conduct research, education or program evaluation in any clinical setting that has the potential to lead to better patient outcomes.

Grants are not available for research projects undertaken as part of studies toward an academic award. A researcher may hold no more than two NBV grants over a three-year period as Chief Investigator A.

For requests to fund part of a project with other funding being sought for the remainder of that project, the Board must be confident that if it does fund a part of the project that it is independent of all other parts and will be completed in its own right.

June Allen Fellowships - NOW OPEN

Purpose:

The purpose of the Fellowships is to enable registered nurses who are directly or indirectly involved in clinical practice in any clinical setting, including aged care, mental health and the community, to undertake activities that will enhance nursing practice. (Enhancements may include changes to practice, validation of practice, policy development and the like.)

The Fellowships will be awarded to assist the development of innovative approaches to enhancing nursing practice. Each Fellowship application will be reviewed on the individual proposal. Examples of possible funding needs include but are not limited to:

- supporting overseas or interstate experts to visit the clinical setting in Victoria;
- small clinically based projects by individuals or groups;
- mentoring in clinical practice;
- professional education including small modules and seminars (not leading to an award, e.g. postgraduate qualifications);
- observational visits by the applicant; and
- facilitation of teaching groups.

Value:

A total amount of $20,000 is available annually. The Board's preference is to fund up to 10 Fellowships, each of $2,000. The number and amount of each Fellowship will be at the discretion of the Nurses Board of Victoria. Funding is normally for a 12-month period.
Eligibility: Nurses registered with the Nurses Board of Victoria who are practising in Victoria.

Method of selection: All applications are reviewed by the Nurses Board of Victoria.

Requirements of the fellowships:

Successful applicants will be required to prepare a written report on the activity and its effect on nursing practice. The report is to be received by Nurses Board of Victoria within 12 months of the allocation of the Fellowship funds. A statement of expenditure must accompany the report. Projects of one year’s duration will require a progress report at six months.

Submission closing date:

Applications open Monday 3rd November 2008 and close Friday 6th February 2009.

Paid study leave is supported by Austin Health in accordance with the leave policy.

22. Barriers in implementation of the role and strategies to overcome

Barriers outlined in Austin’s 2006 NP Service Plan still remain relevant; however advances have been made on several fronts.

Table 13. Shows barriers in implementation of the role and strategies to overcome them.

<table>
<thead>
<tr>
<th>Major barriers to the implementation of the role</th>
<th>Strategies to overcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resistance from nursing staff as nursing roles change</td>
<td>• Respect every nursing position. Promote that NP’s are nurses and not separate from the body of nursing. SNPC should include themselves in all Nursing meetings so they do not miss out on nursing communication.</td>
</tr>
<tr>
<td>Financial disincentive for potential NP’S required to complete a Masters degree,</td>
<td>• Increase in number of scholarships available.</td>
</tr>
<tr>
<td>Financial rewards for NP position not enough incentive to complete the process of endorsement</td>
<td>• Increase in number of scholarships available.</td>
</tr>
<tr>
<td></td>
<td>• The Minister for Health has approved the redesign of the endorsement process with has created clarity. National registration of NP in 2010 will also create clarity to demystify the endorsement process to alleviate some of the anxiety provoked surrounding endorsement.</td>
</tr>
<tr>
<td><strong>Ability of clinical managers to redesign services to accommodate implementation of NP roles</strong></td>
<td>• Development of service plans has created organisational support for NP’s led at the executive level. This combined with model development of the specialty and the SNP collaborative has created further incentive to undertake the rigorous and extensive process to endorsement.</td>
</tr>
<tr>
<td><strong>Too few NP’s to provide role certainty of sustainability</strong></td>
<td>• DHS funding for SNP model development project officer to engage key stakeholders.</td>
</tr>
<tr>
<td><strong>Availability of resources to provide the education and clinical support to develop the clinical skills of the NP.</strong></td>
<td>• Increase in the numbers of NP/NPC now employed at Austin Health and with 44 NP endorsed across Victoria there is a cohort of peer support and enthusiasm has grown.</td>
</tr>
<tr>
<td><strong>Nurses not always practiced at promoting self.</strong></td>
<td>• Increase in number of scholarships available. SNP Collaborative building momentum to link networks and pool resources. SNP collaborative model utilises shared resources to support the educational preparation of NP.</td>
</tr>
<tr>
<td><strong>NP do not currently have access to</strong></td>
<td>• Keep talking—Promotion within the organisation to raise awareness of the role. The SNPC will need to find creative ways to promote the role and become confident in their contribution to a holistic approach to health care.</td>
</tr>
<tr>
<td>• Medicare Benefits Scheme (MBS).</td>
<td></td>
</tr>
<tr>
<td>• Pharmaceutical Benefits Scheme (PBS).</td>
<td>• Part of leadership role is to set the vision and navigate barriers to implementation.</td>
</tr>
<tr>
<td>Nurses do not have provider numbers.</td>
<td>• SNPC remains positive about their contribution and presents at as many forums as possible to promote the role.</td>
</tr>
<tr>
<td></td>
<td>• SNPC does not discount what their role brings to the stroke patient but encouraged to become an expert at articulating the SNP role.</td>
</tr>
<tr>
<td></td>
<td>• Access to publication grants via NSRI and other sources.</td>
</tr>
<tr>
<td></td>
<td>• Access to paid study leave via Austin Health leave policy.</td>
</tr>
<tr>
<td></td>
<td>• The SNP may need to be politically active to advocate on behalf of patients to help bring about change to allow NP to access to MBS and PBS.</td>
</tr>
</tbody>
</table>
| | • PBS/MBS access—evolving role at a
<table>
<thead>
<tr>
<th>Role delineation (Allied Health/Stroke Registrar) shift in some workload can create a sense of disturbance.</th>
<th>• Steering committee has a role to negotiate role boundaries; respect all disciplines for their contribution to stroke service delivery. Communication that the implementation of the SNPC role may involve a substitute of tasks not a substitute of profession. They are not doctors or doctor replacements.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opposition from other health professionals. Stroke Registrars had concerns they will have less exposure to Stroke's in ED and Alteplase which makes the registrar training so interesting.</td>
<td>• Communication that the SNP is part of the solution to Australia’s health care crisis but does not want to be characterised as &quot;super nurse&quot; or seen as any more 'special' than any other member of the stroke team.</td>
</tr>
<tr>
<td>• Steering committee has a role to negotiate role boundaries; respect all disciplines for their contribution to stroke service delivery. Communication that the implementation of the SNPC role may involve a substitute of tasks not a substitute of profession. They are not doctors or doctor replacements.</td>
<td>• Shared skill sets are an advantage in meeting the gap in providing holistic patient care.</td>
</tr>
<tr>
<td>• Communication that the SNP is part of the solution to Australia’s health care crisis but does not want to be characterised as &quot;super nurse&quot; or seen as any more 'special' than any other member of the stroke team.</td>
<td>• Despite published articles by the Australian Medical Association. The Stroke Medical Team is very supportive of the proposed model and can help to mediate barriers.</td>
</tr>
<tr>
<td>• Shared skill sets are an advantage in meeting the gap in providing holistic patient care.</td>
<td>• Although anecdotally hospitals with NP may be seeing improved outcomes more efforts need to be made to document the impact that NP have in improving outcomes; and in showing that the roles provide integrated care, are safe and cost neutral. SNPC/SNP needs to research and publish their evaluation and contribution to the service delivery model.</td>
</tr>
<tr>
<td>• Despite published articles by the Australian Medical Association. The Stroke Medical Team is very supportive of the proposed model and can help to mediate barriers.</td>
<td>• The Australian Nurse Practitioners Association (ANPA) has a role to circulate published materials and educate the public.</td>
</tr>
<tr>
<td>• Although anecdotally hospitals with NP may be seeing improved outcomes more efforts need to be made to document the impact that NP have in improving outcomes; and in showing that the roles provide integrated care, are safe and cost neutral. SNPC/SNP needs to research and publish their evaluation and contribution to the service delivery model.</td>
<td>• Potential to survey other professions within the interdisciplinary team to get communication lines open of actual or potential barriers as the role evolves.</td>
</tr>
<tr>
<td>• The Australian Nurse Practitioners Association (ANPA) has a role to circulate published materials and educate the public.</td>
<td>• The SNPC will need time with mentor/clinical supervisor to reflect back any criticisms from colleagues. This will allow for professional growth.</td>
</tr>
</tbody>
</table>
23. Business Case Development:
Identify budget/funding requirements and strategies to meet options with consideration given to the following:

- Clinical and non-clinical time
- Education, including study leave and costs associated with mentoring/internship arrangements.
- Access resources, equipment
- Travel expenses
- Pay rates, EBA agreements and rostering arrangements that relate to the anticipated service model (e.g. is it to be an after hours service?)

NP’s are paid by their employer in accordance with the applicable industrial relations agreements.

For the 09-10 financial year

**Option 1**
-seek executive approval to partly redirect a recurrent neurology medical staff saving of $60,000 to support the implementation of this part time role (4 days per week) with the remaining $10,700 to be funded from a reduction in stroke intern / stroke registrar overtime - total $70,700 including salary oncosts.

Grade 4 RN YX11 classification with qualification allowance and 14% salary oncosts $70,700 p.a.

**Option 2**
-seek executive approval to partly redirect a recurrent neurology medical staff saving of $70,700 to support the implementation of this part time role (4 days per week).

Grade 4 RN YX11 classification with qualification allowance and 14% salary oncosts $70,700 p.a.

**Option 3**
-seek executive approval to partly redirect a recurrent neurology ward nursing EFT saving of $35,500 to support the implementation of this part time role (2 days per week).

A reduction to 2 days per week would involve a role limited to the outpatient stroke prevention clinic and patient follow-up, without the inpatient and ED components.

Grade 4 RN YX11 classification with qualification allowance and 14% salary oncosts $35,500 p.a.

**Notes**
No public holiday, weekend or evening penalty shift allowances are applicable for this Stroke NP candidate position.
A nursing qualification allowance has been included.
- the paid weekly hrs worked by the Stroke NP candidate includes dedicated non clinical time
- paid education related leave will be supported in accordance with the nurses award provision
- a computer will be purchased for the stroke NP and they will have access to the Neurology department resources
- travel expenses will be reimbursed in accordance with Austin Health policy
## Stroke Nurse Practitioner Project Expenditure

<table>
<thead>
<tr>
<th>Classification</th>
<th>Classification</th>
<th>Hrly rate</th>
<th>Weekly hrs</th>
<th>Qual allow</th>
<th>Salary Oncosts</th>
<th>Total cost</th>
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<tr>
<td>Project officer 1 (June-July only)</td>
<td>ZJ7</td>
<td>$37.19</td>
<td>24</td>
<td>$363</td>
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<td>Project officer 2 (Aug-Nov)</td>
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<td>Secretarial support</td>
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<td>Senior neurologist input - 4 VMO sessions</td>
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<td>$127.90</td>
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<td>Stationery/office set up/phone/carparking</td>
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<td>Computer purchase for project officer</td>
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<td><strong>Grand total</strong></td>
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<td></td>
<td><strong>$34,927</strong></td>
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### Notes:
24. References


Austin Health’s Annual Report 2004-2005

Austin Health’s Annual Report 2007-2008

Austin Health’s Nurse Practitioner Service Plan Development Project-Phase 3, round 6 Final Report-Sept 2006

Austin Health Nursing Workforce Strategy –Executive summary January 2008

Austin Health’s Nursing Workforce Plan 2007

Austin Health Outpatient Pivot tables

Austin Health’s Strategic Plan 2005-2008

Austin Health’s Speciality Services CSU QBP 2008

Austin Health’s Strategic Plan Refresh 2006-2008

Austin Health Victorian Stroke Nurse Practitioner Rounds 4.2 and 4.3 Submission -May 2008

Austin Health Workforce and recruitment statistics June 2008


Australian Industrial Relations Commission 2006


Donnan, G et al ‘Strategies to improve outcome after stroke’ Editorials MJA Vol 178 7 April 2003


National Health Workforce Strategic Framework April 2004


Nurses Board Victoria Publication ‘Nexus’ November 2008, Vol 16, Issue 2


The Victorian Department of Human Services Directions for your health system; Metropolitan Health Strategy (2003).
25. Glossary

Acronyms and Glossary:

AVERT- A Very Early Rehab Trial
ANMC- Australian Nursing and Midwifery Council
ANPA- Australian Nurse Practitioners Association
CEO- Chief Executive Officer
CPG- Clinical Practice Guidelines
CSU- Clinical Service Unit
CTA- Computerised Topography Angiogram
CT- Computerised Topography
DHS- Department of Human Services
ED- Emergency Department
GP- General Practitioner
MRIA- Magnetic Resonance Imaging Arteries
MRI- Magnetic Resonance Imaging
NBV- Nurses Board of Victoria
NHMRC- National Health Medical Research Council
NIHSS- National Institute Health Stroke Scale
NSF- National Stroke Foundation
NSUP- National Stroke Unit Program
NPC- Nurse Practitioner Candidate
NP- Nurse Practitioner
SLA- Statistical Local Areas
SNPC- Stroke Nurse Practitioner Candidate
SNP- Stroke Nurse Practitioner
TIA- Transient Ischaemic Attack
The Strategy - Stroke Care Strategy for Victoria

VCSN - Victorian Stroke Clinical Network

VNPP - Victorian Nurse Practitioner Project
Appendix 1. EXPLORATION OF IMPLEMENTING A NURSE PRACTITIONER POSITION (Division One, Three or Four Registered Nurse)

**EDUCATION**
- Research NP endorsement requirements.
- Obtain package from NBV
- Liaise with Universities re Masters programs and Pharmacology subject.
- Commence academic preparation
- Participate in organisational education requirements.

**ORGANISATIONAL**
- Discuss idea with NUM/CSU Director/Medical Director/Head of Unit/Nursing Services
- Explore funding options
- Explore NP role in more detail
- Identify difference between NP and Advanced Practice Nurse and decide how extension of scope of practice assists the role.
- Establish local multidisciplinary steering committee, to explore role and purpose.
- Local steering committee completes / oversees Nurse Practitioner Steering Committee (NPSC) submission.
- Develop CPG’s
- Complete nursing research and act as a role model in clinical field.
- Define role and complete PD

**ROLE DEFINITION**
- Identify organisational mentor
- Further ground-work required
- Establish formalised mentor program for NP
- Submission forwarded to Ann Maree Keenan Chairperson NPSC
- Receive in principle agreement for position from NPSC and CSU Director.
- Receive funding approval for position through CSU / Department.
- Commence role awaiting NBV endorsement
- Commence endorsement process with NBV

**CONGRATULATIONS**
**NURSES BOARD ENDORSEMENT**
**YOU ARE AN ENDORSED “NURSE PRACTITIONER”**
Appendix 2 POSITION DESCRIPTION

POSITION TITLE Stroke Nurse Practitioner Candidate

REPORTS TO
Professional – Executive Director Ambulatory & Nursing Services
Operational – Director Specialty Services Clinical Services Unit and Head of Inpatient Stroke

AWARD/AGREEMENT/CONTRACT
Registered Nurses Award

POSITION TYPE e.g. Registered Nurse Div 1, Occupational Therapist Gr1, etc.
Registered Nurse Division 1
Grade 4B (YX11 Year 1, YX12 Year 2)

HOURS PER WEEK
4 days per week, part time (days negotiable)

1. ORGANISATIONAL CONTEXT

Austin Health comprised of Austin Hospital, Heidelberg Repatriation Hospital and Royal Talbot Rehabilitation Centre, is one of Victoria’s largest metropolitan health care providers is a 920 bed major teaching and research hospital affiliated with the University of Melbourne. Austin Health is world-renowned for its research and specialist work in many areas including neurosciences and has provided comprehensive stroke care services for many years.

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

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

Austin Health Values

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

**Our Values:**

**Integrity**

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

**Accountability**

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

**Respect**

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

**Excellence**

- We continually strive to advance patient focused care through innovation, research and effective stakeholder management.

2. **LOCAL WORK ENVIRONMENT**

Nurse Practitioners are supported by Austin Health to work in clinical specialties where there is evidence that the advanced clinical skills of a Nurse Practitioner would enhance patient outcomes within an efficient service model. Nurse Practitioners will be implemented across the organisation in accordance with the service plan.

The Acute Stroke Care Unit at Austin Health Ward 6 East is part of the Specialty Services Clinical Service Unit (CSU). It is located on the Neurology Ward 6E of the Austin Tower which includes beds for Stroke, Neurology, Epilepsy, Endocrinology, Dermatology and Rheumatology Units. The Acute Stroke Unit has 4 monitored beds and 9 beds located within the same ward with one portable monitor available when required. There is capacity to flex up or down depending on the numbers of stroke patients that require admission. It is Austin Hospital Admission Policy that all acute stroke patients presenting through the Emergency Department are managed on the Acute Stroke Unit. Patients that have a stroke whilst an inpatient on other units is also prioritised to be transferred to the Acute Stroke Unit unless concurrent medical or surgical problems are best managed in another specialised area.

The majority of strokes/TIA are admitted via ED as per the Protocol. In January 2005, the Acute Stroke Team (AST) was established. It is
available 24-hours per day/seven days per week to facilitate the assessment and rapid management of hyperacute stroke patients who may be eligible for intravenous rtPA (alteplase thrombolysis) therapy for ischaemic strokes, or alternative acute therapies for haemorrhagic stroke. The team’s focus is to reduce permanent brain damage through rapid recognition, diagnosis and treatment of stroke - ‘time saved is brain saved’.

Patients seen by the stroke service are followed up at the stroke Prevention Clinic located at the Outpatients Department of the Repatriation Campus.

3. POSITION OBJECTIVE

Background
In the State of Victoria, a nurse practitioner is a nurse with an endorsement on their general registration.

The NBV has adopted the Australian Nursing and Midwifery Council’s definition of Nurse Practitioner.

“A nurse practitioner is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The 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 profession’s values, knowledge, 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 authorised to practice.”

Australian Nursing and Midwifery Council, 2004

A NP candidate is a Registered Nurse under division 1, 3, or 4 engaged to undertake a course of study and clinical experience leading to endorsement as a NP paid at their substantive rate (Australian Industrial Relations Commission 2006).

Position Objective

The Nurse Practitioner aims to maximise the continuity of care for patients within a designated clinical specialty in accordance with the department/CSU objectives. The Nurse Practitioner practises within a
multidisciplinary framework to maximise recovery and promote optimum outcomes for patients.

4. POSITION REQUIREMENTS

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

CLINICAL CARE

• Conducts advanced comprehensive and holistic health assessment relevant to specialist field of nursing practice.
• Ability to utilise assessment skills to develop a comprehensive treatment plan, including the need for organ imaging and laboratory studies, diagnostic and therapeutic procedures and prescribing medications that are evidence based and informed by specialist knowledge.
• Ability to refer patients to other specialties as required.
• Facilitate admission and discharge planning with medical staff and the multidisciplinary team.
• Frequently will adopt a case management approach to service delivery.
• Outpatient care
  • Nurse led TIA clinic
  • Stroke Prevention Clinic
• Inpatient
  • Other Specific clinical skills to be determined by nursing and multidisciplinary clinical teams to maximise clinical outcomes for the patients and their families.

BEST PRACTICE

• Involved in clinical data collection as necessary.
• Demonstrates a commitment to quality management.
• Evaluates NP service delivery in accordance with key performance indicators.
• Participates in the development and delivery of specialist research programs.
• Adapts and applies related scientific research to clinical area.
• Clinical decisions are informed by evidence based practice.

MANAGEMENT

• Practices within the already existing evidenced based Stroke Protocols. Documents extension of practice in Clinical Practice Guidelines which are supported by the multidisciplinary team when deemed necessary to define scope of practice.
• Formulates a sound communication strategy with multidisciplinary team, medical staff, nursing staff, patients and significant others.
• Participates in the service planning process to identify future directions for the clinical service to maximise patient outcomes and resource management.

ADVOCACY
• Provide a resource role to patients, families, General Practitioners and community groups.
• Assist with the provision of health promotion activities.
• Provides psychosocial support to patient and significant others.

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

Generic
• Abide by Austin Health corporate policies and practices as varied from time to time.
• Participate in Austin Health work planning and review performance appraisal program as required.
• Undertake not to reveal to any person or entity any confidential information relating to patients and employees, policies, processes and dealings and not to make public statements relating to the affairs of Austin Health without prior authority of the Chief Executive Officer.
• Participate in the emergency incident response activities, as defined within the Emergency Response Manual, as and when required, at the direction of management.

5. KEY SELECTION CRITERIA
Essential for Performance of the Position

- Division 1 Registered Nurse (current Vic State Award)
- Post-graduate (Neuroscience) qualification
- Working towards an approved “Masters of Nurse Practitioners” Qualification OR a Masters assessed as equivalent *
- Evidence of safety and competency whilst working towards an approved “Therapeutic Management Module”*
- A minimum of 5 years stroke nursing experience
- Extensive and current clinical experience in Stroke
- Advance level of stroke clinical knowledge and therapeutic management skills
- Demonstrated excellent collaborative, leadership, teaching, and interpersonal skills.
- Ability to evaluate practice at an advanced level.
- Demonstrated ability to formulate and implement new models of patient care
- Commitment to patient focused care
- Demonstrated educational skills at a tertiary level
- Basic computer knowledge
- Highly developed writing and documentation skills.
- Database creation and data entry
- Experience in nursing research and research skills
- Critical thinking skills and the ability to work autonomously.
- Open, flexible and innovative.
- Demonstrated knowledge of nursing professional standards and legal/ethical requirements. In particular the Australian Nursing and Midwifery Council “National Competency Standards for the Nurse Practitioner” * summarised as:
  1. Dynamic practice that incorporates application of high-level knowledge and skills in extended practice across stable, unpredictable and complex situations.
  2. Professional efficacy whereby practice is structured in a nursing model and enhanced by autonomy and accountability.
  3. Clinical leadership that influences and progresses clinical care, policy and collaboration through all levels of health service.

- Commitment to nursing as a profession- through professional associations, publications, conference presentations and ongoing
- Commitment to research and its application in practice

* Nurses Board of Victoria” Process of Nurse Practitioner Endorsement” September 2008
Desirable but not essential for Performance of the Position:

- Knowledge of case management models and theories
- Experience in change management
- Experience in report writing

6. OTHER RELEVANT INFORMATION

Pre-Existing Injury
Prior to any person being appointed to this position it will be required that they disclose full details of any pre-existing injuries or disease that might be affected by employment in this position.

7. DOCUMENT REVIEW DETAILS

Date Position First Documented: November 2008

Date of this Position Description Review: Date: ____/____/____

Signature of Manager: ____ Date: ____/____/____

Signature of Employee: _____ Date: ____/____/____
Appendix 3

ANMC Competencies for Nurse Practitioner Competency Framework:

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

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

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

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

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

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

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

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

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

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

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

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

Acknowledgement for tool development
Latrobe University Unit guide – “Clinical Internship for Masters of Nursing Science”
Appendix 4 – Nurses’ Board of Victoria – Pathways to Endorsement

There are three pathways to Nurse Practitioner endorsement:

**Pathway 1**
Nurse has completed a NBV approved Master of Nurse Practitioner Commenced 2009 onwards

**Pathway 2**
Nurse has completed a NBV approved Master of Nurse Practitioner Commenced prior to 2009

Nurse has completed a Masters not approved specifically for the purpose of endorsement as a NP

**Pathway 3**
Nurse has completed a Masters program and has worked as an independent prescriber overseas (excluding New Zealand)

Nurse has been authorised as a NP under other Australian state, territory or New Zealand legislation

For more information on the pathways to endorsement see the “Process for Nurse Practitioner Endorsement” on the Nurses Board of Victoria’s website [http://www.nbv.org.au/web/guest/np-become](http://www.nbv.org.au/web/guest/np-become)
# Appendix 5

## NURSE PRACTITIONER - STROKE

### PROPOSED FORMULARY

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<th>Drug Name</th>
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<th>Schedule</th>
<th>Drug Name</th>
<th>Route</th>
<th>Schedule</th>
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<td>Anticoagulants/antithrombotics/antiplatelets</td>
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<td>Calcium Channel Antagonists</td>
<td>Oral</td>
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<tr>
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<td>Oral</td>
<td>S2</td>
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<td>S4</td>
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<td>Heparin Injection BP (DBL)</td>
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<td>S4</td>
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<tr>
<td>Enoxoparin sodium (Clexane)</td>
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<td>S4</td>
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<td>S4</td>
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<td>Alteplase (t-pa)</td>
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<td>Antihypertensives</td>
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<td>Hypolipidaemic agent</td>
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<td>Glyceryl trinitrate</td>
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## Appendix 6
AUSTIN HEALTH NURSE PRACTITIONER SUBMISSION

### Part 1
Service Provider Details

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<tr>
<td>Position/Title</td>
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<tr>
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<tr>
<td>Email Address</td>
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<td>Telephone Number</td>
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<tr>
<td>Telephone Number</td>
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<tr>
<td>Email Address</td>
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Appendix 6 cont...

Austin Health Nurse Practitioner role-Submission template

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

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

1.3 Nurse Practitioner reporting structure and responsibilities
Describe the proposed reporting structure. (May have a professional and operational reporting structure)
What responsibilities does the manager of the Nurse Practitioner undertake to ensure that all team members, nursing and the broader multidisciplinary team are involved in the evolution of the newly developed position?

2. Service Overview
Describe the current service, and its existing structure. Describe how the proposed change of implementing a Nurse Practitioner position will improve the delivery of service outcomes.

3. Service Improvement
Utilising data (e.g. population trends, health care trends, workforce planning trends, LOS) describe how this role will enhance efficiency and service delivery.
Are there other alternatives to providing this service?
What direct benefits will this role add to the service being provided?

4 Evaluation
Outline the generic KPI’s that will be utilised to assist in evaluating the role and service delivery and describe how these will be measured.
Appendix 6 cont.....

5 Communication structure
Describe the communication plan with nursing team members, multidisciplinary team, stakeholders, referrers and clients. Communication plan includes formal and informal presentations with nursing team meetings, multidisciplinary team meetings, medical staff, (Consultants, Registrars, Residents, Interns), patients families and significant others. Written publications include, brochures, newsletters, and magazines.

- Formal communication strategies
- Informal communication strategies
- Publications

6 Team support
Does the nursing and multidisciplinary team support this role being implemented?
What measures are planned to mediate any actual or potential barriers within the team?

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

8 Education
8.1 Outline the educational support and strategy required to successfully implement the Nurse Practitioner role.

8.2 Outline the strategy to educate other nurses, medical staff and the multidisciplinary team about the role of the Nurse Practitioner.

9 Mentor
Discuss the support mechanisms for the Nurse Practitioner, including the possibility of a mentor program.

10 Barriers
Identify major barriers to the implementation of the role and strategies to overcome.

11 Business Case Development
Through the process of completing a Business Case have any funding sources been identified to support the role?
Appendix 7

Nursing news

Stroke nurse practitioner model update

In 2007, the Stroke Care Strategy for Victoria (the Strategy) was released. DHS is supporting the implementation of the strategy through a targeted round of funding for NP projects under Victorian Nurse Practitioner Project. In July 2008, Nurse Policy Branch offered funding to support projects to develop NP models in stroke care in public health services.

Louise James is currently working in a project role to develop a Stroke Nurse Practitioner Model.

Brief overview of proposed model:

- It is envisaged that as a senior member of the Acute Stroke Team, the NP would take the lead role in the initial assessment, investigation, management and education of patients with acute stroke and transient ischaemic attack (TIA) presenting to the Emergency Department (ED). The proposed NP will perform a standardized clinical assessment (including history and examination using the National Institutes of Stroke Scale Score); instigate acute investigations according to existing stroke care protocols e.g. CT and MR imaging, carotid duplex ultrasound, ECG, and blood tests; triage for alteplase therapy and institute standard orders e.g. aspirin therapy, IV therapy, allied health team referral.

- The model proposed would see the NP fill a key liaison role between ED and stroke unit staff, providing expert advice and continuing education to ED and stroke unit staff. In addition, the NP role will include audit and monitoring responsibilities and plans to improve efficiencies by monitoring the follow up of TIA patients.

For any further information or comments please email Louise James.
### NURSE PRACTITIONER PATIENT SATISFACTION SURVEY

**DRAFT**

Please circle most appropriate response

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Nurse Practitioner understood why I had come to see them</td>
<td></td>
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<tr>
<td>2. The Nurse Practitioner was interested in me as a person</td>
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<tr>
<td>3. The Nurse Practitioner seemed to be very thorough.</td>
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<tr>
<td>4. I was less worried about my health after seeing the Nurse Practitioner</td>
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<td>5. I will follow the advice of the Nurse Practitioner, because I believe it is good advice.</td>
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<tr>
<td>6. When you saw the Nurse Practitioner did you have enough time to discuss things fully?</td>
<td>Yes</td>
<td>No</td>
<td></td>
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<tr>
<td>7. Would you like to see the Nurse Practitioner again for a similar health need?</td>
<td>Yes</td>
<td>No</td>
<td></td>
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<tr>
<td>8. Are there other things you would have like to discuss with the Nurse Practitioner?</td>
<td>Yes</td>
<td>No</td>
<td></td>
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<tr>
<td>If yes what other things would you have like to discuss?</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>9. Were you given any health education or advice for the Nurse Practitioner?</td>
<td>Yes</td>
<td>No</td>
<td>Not applicable</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 8 cont.....

10. Were you informed who to contact if you needed more help or advice regarding the illness/injury when you were at home?
   - Yes
   - No
   - Not applicable

11. Were you given written instructions about the illness/injury to take home with you?
   - Yes
   - No

12. Did the Nurse Practitioner explain how to take the tablets/medicine prescribed?
    - Yes
    - No
    - Not applicable

13. Were you told verbally and given written information about a follow-up appointment?
    - Yes
    - No
    - Not applicable

14. If you were advising a friend, would you recommend the Nurse Practitioner?
    - Yes
    - No

Appendix 9

TOOL ONE – CLINICAL LOG

<table>
<thead>
<tr>
<th>CLINICAL LOG: Patient Assessment</th>
<th>Diagnostics ordered and rationale</th>
<th>Results diagnostics</th>
<th>Working diagnosis/ plan of care Including: meds/therapies ordered, Referrals/OPAs &amp; follow-up Specific instructions (treatments/monitoring)</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>
Appendix 10
TOOL TWO – Case Review

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

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

<table>
<thead>
<tr>
<th>Patient Assessment</th>
<th>Diagnostic Tests</th>
<th>Clinical findings</th>
<th>Diagnosis</th>
<th>Treatment Plan</th>
</tr>
</thead>
</table>
### TOOL THREE - Bondy Scale:

Below is the scale that relates to your clinical practice. Your clinical practice may be graded from Independent (I) to Dependent (D). The scale describes the quality of your performance and the level of assistance you require.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Performance Criteria</th>
<th>Quality of Performance</th>
<th>Assistance Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent</td>
<td>Level of clinical practice is of a high and safe standard</td>
<td>☐ Sound level of theoretical knowledge applied effectively in clinical practice</td>
<td>Without supporting cues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Coordinated and adaptable when performing skills</td>
<td></td>
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<td></td>
<td></td>
<td>☐ Achieves intended purpose</td>
<td></td>
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<td></td>
<td></td>
<td>☐ Proficient and performs within expected time frame</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>☐ Initiates actions independently and / in cooperation with others to ensure safe delivery of patient care.</td>
<td></td>
</tr>
<tr>
<td>Supervised</td>
<td>Level of clinical practice is of a safe standard but with some areas of improvement required</td>
<td>☐ Correlates theoretical knowledge to clinical practice most of the time</td>
<td>Requires occasional supportive cues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Coordinated and adaptable when performing skills</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Achieves intended purpose</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Performs within a reasonable time frame</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Initiates actions independently most of the time and / in cooperation with others to ensure safe delivery of patient care.</td>
<td></td>
</tr>
<tr>
<td>Assisted</td>
<td>Level of clinical practice is of a safe standard but with many areas of improvement required</td>
<td>☐ Demonstrates limited correlation of theoretical knowledge to clinical practice</td>
<td>Requires frequent supportive cues and direction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ At times lacks coordination when performing skills</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Achieves intended purpose most times</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Performs within a delayed time period</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Lacks initiative and foresight</td>
<td></td>
</tr>
<tr>
<td>Dependent</td>
<td>Level of clinical practice is unsafe if left unsupervised</td>
<td>☐ Unable to correlate theoretical knowledge to clinical practice</td>
<td>Requires continuous supervision and direction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Lacks coordination when performing skills</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Unable to achieve intended purpose</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ Unable to perform within a delayed time period</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>☐ No initiative or foresight</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix 12

**TOOL FOUR - Mentor Meeting Log:** This is the record of the meetings between the mentor and the student.

<table>
<thead>
<tr>
<th>Meeting date</th>
<th>Mentor feedback:</th>
<th>Student feedback:</th>
<th>Objectives set to be included in learning plan:</th>
<th>Signed: Mentor/student</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1:</td>
<td></td>
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<tr>
<td>Week 2:</td>
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<td>Week 3:</td>
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<tr>
<td>Week 4:</td>
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</tbody>
</table>
Appendix 13

**AUSTIN HEALTH GUIDELINES FOR NURSE PRACTITIONER MENTOR PROGRAM**

1. **ROLE OF AUSTIN HEALTH NURSE PRACTITIONER MENTOR’S**
   The role of the organisational mentor would be to support the Nurse Practitioner Candidate and assist in their transition from clinical nurse to Nurse Practitioner, within the context of service delivery changes to enhance patient care.
   
   - Support transition of mentee into the Nurse Practitioner candidate role with a focus on managing change, communicating and involving key stakeholders, understanding and dealing with organisational dynamics and marketing the role.
   - Support the mentee to develop the personal and non-clinical professional skills required of a Nurse Practitioner.
   - Provide guidance in the submission process to Nurses Board of Victoria?
   - Act as a sounding board for challenges that the mentee may be presented with.
   - Assist in the reflection process.

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

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

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

- Mark Petty – Executive Director Acute Operations
- Ann Maree Keenan – Executive Director Nursing and Ambulatory Services
- Shane Crowe – Deputy Director Nursing and Ambulatory Services
- Leanne Turner – CSU Director Specialty Services CSU
- Anne Szysz – General Manager Royal Talbot
- Jillian Macloy – CSU Director-Medical and Emergency
- Fergus Kerr –Director Emergency Department
- Rhyl Gould – CSU Director-Cancer, Spinal and Outpatients
- Eleanor Hughes – Nursing Coordinator operating suites, Austin Campus
- Jennifer Johns – Medical Director, specialty Services CSU
- Margaret Ferma – Nurse Practitioner Candidate Emergency Department
- Nonie Rickard – Nurse Practitioner Project Officer
## ACUTE STROKE FORM

<table>
<thead>
<tr>
<th>Field</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stroke</strong></td>
<td></td>
</tr>
<tr>
<td>Date of Stroke</td>
<td></td>
</tr>
<tr>
<td>Known/Unknown:</td>
<td></td>
</tr>
<tr>
<td>Time of stroke onset</td>
<td></td>
</tr>
<tr>
<td>Known/Unknown:</td>
<td></td>
</tr>
<tr>
<td>Did the stroke occur during sleep?</td>
<td></td>
</tr>
<tr>
<td>Date of triage:</td>
<td></td>
</tr>
<tr>
<td>Triage arrival time:</td>
<td></td>
</tr>
<tr>
<td>BSL (mmol/L):</td>
<td></td>
</tr>
<tr>
<td>AST call:</td>
<td></td>
</tr>
<tr>
<td>Date of AST call:</td>
<td></td>
</tr>
<tr>
<td>Time of AST call:</td>
<td></td>
</tr>
<tr>
<td>Arrived by Ambulance?:</td>
<td></td>
</tr>
<tr>
<td>Stroke team arrival time:</td>
<td></td>
</tr>
<tr>
<td>Location of Patient:</td>
<td></td>
</tr>
<tr>
<td>Seen by Stroke Nurse Practitioner</td>
<td></td>
</tr>
<tr>
<td>AST activation by:</td>
<td></td>
</tr>
<tr>
<td>Who attended AST call:</td>
<td>Stroke registrar, Stroke consultant, Clinical Trials nurse, Stroke Liaison nurse</td>
</tr>
<tr>
<td>AST Diagnosis:</td>
<td></td>
</tr>
<tr>
<td>AST protocol deviation?:</td>
<td></td>
</tr>
<tr>
<td>What was protocol deviation?:</td>
<td></td>
</tr>
<tr>
<td>Clinical trial?:</td>
<td></td>
</tr>
<tr>
<td>CT time:</td>
<td></td>
</tr>
<tr>
<td>Intracranial hemorrhage?:</td>
<td></td>
</tr>
<tr>
<td>Treated with tPA?:</td>
<td></td>
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<tr>
<td>tPA bolus dose (mg):</td>
<td></td>
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<tr>
<td>tPA infusion dose (mg):</td>
<td></td>
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</tbody>
</table>

**Audit Trail**

- [Print](#)
- [Update](#)