



Community Health Nurse Practitioner  
Project 2005-06  
Final Report

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Department of Human Services, September 2006

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On behalf of Alexandra District Hospital



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The Board of Management at Alexandra District Hospital, for their support of the concepts and their vision for nursing in small rural health services.

The project steering team who provided input included Ms Heather Byrne (CEO/DON), Ms Debbie Skinner-Louis (Nurse Practitioner candidate), Dr Greg Louis (General Practitioner), Ms Denise Fiddes (Gribbles Pathology), and Ms Melinda Jackson (Hospital Pharmacist).

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*The Department of Human Services,*

*Nurse Policy Branch*



## Executive Summary

In September 2005 Alexandra District Hospital successfully secured grant funding from the Department of Human Services (DHS) Nurse Policy Branch. The funding was allocated for:

### 2.2 Nurse Practitioner Project Funding

*“The development of a business/service plan that provides a framework for the introduction of sustainable nurse practitioner roles within the organisation.*

*Please note: The funding is not intended for the development of nurse practitioner candidates or models of practice.”*

#### **Project Aim:**

The creation of an **accepted, appropriate, functional and sustainable model** for implementation of a rural Community Health Nurse Practitioner at Alexandra District Hospital.

#### **Strategy:**

The project team firstly clarified the models objectives and scope giving consideration to the services that could practically be offered and the potential of a market for these services. It was considered that any Nurse Practitioner model suitable for Alexandra District Hospital required congruence between the skills of individual nurse/s, the needs of the organisation and a conducive funding environment.

It is also considered that to assess the strategic potential of any model, a detailed analysis of both the internal and external environments needed to be undertaken. This defined the demonstrated areas of community need, areas of potential market competition, the barriers to successful model implementation and that which could act as an enabler.

The external analysis informed us about threats and opportunities, the internal analysis informed us about strengths and weaknesses and a force field analysis has provided us with knowledge about the ultimate effects that the driving and restraining forces may have on the proposed model. This information additionally assisted in the development of a risk management plan.

Use of the AVICTORY model then gave the project team information about the Hospital’s ability to accommodate the project. Retrospectively, the benefits of this analysis would have been greater had it been undertaken prior to the lodging of the initial submission. However practically this was not possible due to competing organisational needs and constraints.

Strategy cont.

Timing  
Budget  
Outcome requirements



## AVICTORY

### Project (internal) Environment Analysis

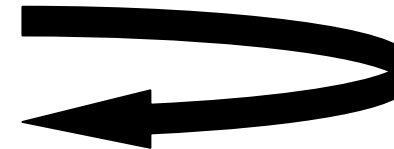
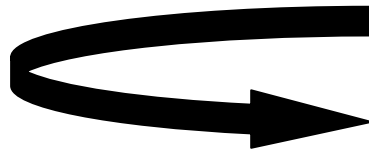
- Tangible resources
- Intangible resources

### Industry Analysis

- Threat of new entrants
- Bargaining power of suppliers
- Bargaining power of buyers
- Threat of substitute products
- Rivalry amongst competition

### External Environment Analysis

- Demographic
- Economic
- Political / Legal factors
- Sociocultural factors
- Technological factors
- Global issues



### Stakeholder clarification

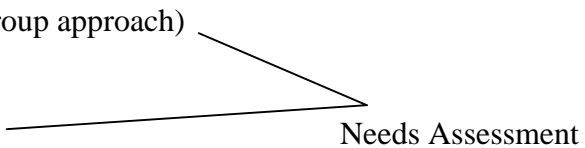
Pharmacy  
General Practitioner  
Pathology provider  
Consumers

### Risks

### Scope

### Capabilities & Core Competencies

## Target Identification

- Stakeholder group
  - Needs assessment (nominal group approach)
  - Community
- Population Health data
- 
- Needs Assessment

A nominal group approach was used to clarify stakeholder group needs. Stakeholders were brought together, and the requirements and scope of the project were reiterated. Each member was given individual time to table with the project coordinator what they saw as their group's priority needs. All the needs were collated and needs statements were established.

As the Shire of Murrindindi is geographically so large and is made up of such diverse population groups with a wide range of health needs, four different sources of public health data was used to establish priorities.

1. The Murrindindi Municipal Health Plan, ( 2004-2007)
2. DHS Burden of Disease (1996)
3. North East Victorian Division of General Practice, episodes of care and disease prevalence data (2000)
4. Lower Hume Primary Care Partnership health profile statistics (2005)

The stakeholder group using their own needs list presented qualitative data regarding community disease prevalence and used a needs analysis matrix to prioritise findings. A great deal of common thinking emerged between the groups represented making goal setting relatively straight forward.

## **Methodologies**

### Acceptability

- Focus groups
- Individual interviewing of stakeholder group leaders
- Goal attainment scaling

### Appropriateness

- Service mapping against population health statistical data
- Examination of Health Data

### Functionality

- Focus groups
- Individual interviewing of stakeholder group leaders
- Sign-off on scope of practice document
- Proposed framework satisfaction survey (key stakeholder groups)

### Sustainability

- Cost analysis
- Work force analysis

### **Project Evaluation**

Internal review consisted of quarterly monitoring using:

- Key performance indicator achievement scales
- Steering Committee review of project progress against milestones
- Continuous reporting on risk analysis

### **Peer review consisted of**

Monitoring using

- Quarterly progress presentation meeting with grant recipient group and the Department of Human Services project officer.
- Recommendations reported to the Steering Committee for consideration.

### **External review**

It is anticipated that external review will be provided via formal feedback on submitted framework.

### **Findings**

The proposed model is feasible for a small rural health service such as Alexandra District Hospital. It provides flexibility and sustainability because it can accommodate one practitioner who holds a number of specialist qualifications or several practitioners who hold one qualification.

The model is financially viable if a service operates under a flexible funding system which allows the conversion of funding between health care streams.

However, the model also requires time and sustained energy and resource allocation focused on the building of partnerships between the Hospital, the Nurse Practitioner, the General Practitioner (GP) and the community. Without GP endorsement particularly, the model cannot be fully implemented.

## **2. Introduction**

### **The Service**

Alexandra District Hospital is a small rural health service in north east Victoria incorporating 30 acute care beds, (Medical and Surgical) and an extensive range of allied and community health services

The Hospital is one of 67 agencies in Regional Victoria designated as a small rural health service, which affords it flexibility in the allocation of funding to the Acute Health, Sub Acute Health and Primary Health service areas.

The facility operates under a General Practitioner (GP) Medical Model, with local General Practitioners providing an on call service roster to the two local Hospitals in the Shire. As is the case with many rural areas, the viability of the Hospital's services are constantly challenged by the ability to attract and retain GPs to the area.

### **Corporate Vision, Mission and Major Goals.**

Alexandra District Hospital recognises the following organisational statements.

#### **Vision**

*Excellence in Rural Health Care*

#### **Mission**

*Provision of quality integrated health services that meet the needs of our community*

#### **Goals**

Alexandra District Hospital is committed to:

- 1. achieving consumer, community and staff satisfaction*
- 2. providing best practice health care*
- 3. developing a mutually informed, health focussed community*

4. *becoming the leading agency in the Hume region in the introduction of information technology for the enhancement of service provision*
5. *improving current performance status in all areas of Human Resource Management in accordance with the EQUIP criteria*
6. *converting all under utilised funding to address two of the health priority areas in our community*
7. *promoting a low risk environment for employees, the community and the organisation*
8. *redevelopment of the Alexandra District Hospital site*
9. *maintain profitability*
10. *maintain current accreditation status*

### **3. Background and History to the Nurse Practitioner (NP) Role in the Service**

Much has been written about the NP role and without a doubt it remains a highly contentious and non mainstream entity. However rather than expending resources on the rediscovery of generic understandings around which much has been written, this project will focus specifically on implications, practicalities and possible outcomes of embedding a NP model within the structure of Alexandra District Hospital servicing the eastern Murrindindi Community.

Initial consideration of the concept began informally and has evolved over time. Health care providers (both private and public) living within the small community of Alexandra have long debated the possibilities of such a model. However it was not until 2003-04 that these discussions became more formalised.

The Department of Human Services at this time introduced a flexible funding and accountability model that changed the way small rural health services funding was provided. As a small rural health service, Alexandra District Hospital was able to convert funding between program areas to enable appropriate, locally based, care provision in service areas relevant to community needs.

This change provided organisations such as the Hospital with the option to tailor service delivery around area based needs and hence has enabled the creation of a community focussed, sustainable service mix.

Coinciding with this development was awareness by the CEO/DON of service gaps that were impacting on the organisation as well as other health and aged care services in the area. These gaps were resulting in issues such as the development of diabetes and respiratory disease related complications that resulted in hospital admission and extended lengths of stay, and unmanaged incontinence which not only had a considerable effect on personal lifestyle but also contributed to other health issues such as falls related injury.

In addition to these known opportunities, (and as a result of the Hospital's close relationship with local General Practitioners and their practice nurses), an experienced nurse with post graduate training and aspirations to provide better health care to individuals in an ambulatory setting was identified.

Overlaying these enabling factors and providing ADH with the confidence to consider a nurse practitioner role, is the strength of the relationship between the Hospital and the local General Practitioner group. These vital relationships are fundamental to the successful implementation of any change to service delivery and require considerable time and effort to establish and maintain. Forged over the years, these partnerships have required a recognition by the Hospital that General Practices are private businesses that need to be economically viable and personally tenable for the General Practitioner and his/her family.

As such the opportunity for development of the nurse practitioner role has arisen from favourable funding conditions, demonstrated need and existence of a potential candidate as well as willingness by the Hospital to allow time for the building of relationships that are fundamental to the success of such an arrangement.

## **4. Policy Framework**

### **4.1 Prescriptive and Diagnostic Authority**

#### **4.1.1 Prescriptive Authority:**

Alexandra District Hospital recognises the funding restrictions associated with Commonwealth control of medications on PBS and the unlikelihood of change to this legislation in the near future.

The Hospital also recognises the intense value of interdependent care but also is cognisant of the need for one primary care coordinator (or gate keeper). As such, the Nurse Practitioner role outlined in this document has rights restricted to the alteration of medication dosages in consultation with the client's General Practitioner. However, the Nurse Practitioner may commence and discontinue pharmacological therapy in circumstances where the client is a hospital inpatient (in which case the Hospital carries the cost of the drug) and the client is referred to the practitioner by the admitting GP. In the event of the model being actualised, this level of prescriptive authority would require recognition and endorsement by the local General Practitioner group.

#### **4.1.2 Diagnostic Authority:**

Pathology, radiology and ultrasound services at Alexandra District Hospital are provided by external providers. As such, diagnostic tests provided in the inpatient setting are billed to the Hospital, and those provided in an ambulatory care setting are billed to the individual (Medicare rebates apply).

Therefore, the Nurse Practitioner could order diagnostic tests for both inpatient clients and Hospital ambulatory care clients. Again this level of diagnostic authority would



require recognition and endorsement by the local General Practitioner group should the model be implemented.

#### **4.2 Referral Processes**

The preferred referral pathway is via the Service Coordination (SCOTT) tool currently in use in public health services across the state. The limitations of this tool however are two-fold.

1. At the time of writing, this tool is not available electronically and as such its use has been restricted primarily to the ambulatory care setting.
2. The tool has not been widely adopted by the General Practitioner group and as Alexandra District Hospital operates under the GP model of care, there is no way to enforce its use by referring GP's.

Alternate referral pathways that have already been established include:

- A Medical Director software based referral tool
- Hard copy templates
- Letters on Practice letterhead
- Self referral via community health intake worker

#### **4.3 Admission and Discharge Policy:**

In recognition of the value of interdependent care and the need for a primary care coordinator (or gate keeper), an agreement will exist between the admitting nurse and the referring General Practitioner. The Nurse Practitioner will then facilitate admission and liaise with the treating doctor regarding care requirements. This agreement will state that should the client's care be complicated by issues beyond the Nurse Practitioner's scope of practice, the client is to be transferred to the bed-card of the GP Visiting Medical Officer who then takes over as the primary care provider.

Additionally, upon discharge the client is referred back to their local GP for ongoing management and community based prescribing of medications and further diagnostic testing as required. The Nurse Practitioner will be involved in community managed care as requested.

## 5. Role development process inc. timeframes

**Aim: Creation of an Accepted, Appropriate, Functional and Sustainable model for implementation of a Nurse Practitioner at Alexandra District Hospital.**

<b>Goal The Nurse Practitioner model is <i>accepted</i> by all stakeholders</b>				
<i>PROJECT OBJECTIVE</i>	<i>TIMEFRAME</i>	<i>MEANS OF VERIFICATION</i>	<i>ASSUMPTIONS</i>	<i>MAJOR TASKS</i>
To overcome the negative implications of the crossing of professional boundaries and potential overlapping of scope of practice between the NP and the other health care providers.	12 months.	<p>Established agreed upon areas of role delineation as outlined in the nurse practitioner role description, competency requirements and associated policy documents that have been endorsed by the Nurses Board of Victoria.</p> <p>Endorsement of the above by all potentially effected health care providers and their representative body.</p>	Role clarity and an assurance that the role poses no legal risk to external practitioners will increase the acceptance of this new function within health care.	<ol style="list-style-type: none"> <li>1. Undertake a thorough examination of the relationship between interlinking roles giving consideration to individual personalities and work patterns.</li> <li>2. Engage with all potentially effected health care providers and their local representative body.</li> <li>3. Establish and achieve endorsement of a clear policy framework that can be used to guide practice.</li> <li>4. Establish and achieve endorsement of a position description which outlines scope of practice and lines for professional liaison, adheres to NBV professional practice standards and organisational protocols and provides for individual professional accountability.</li> </ol>

<b>Goal The Nurse Practitioner model is <i>appropriate</i> to the health care needs of the community</b>				
<i>PROJECT OBJECTIVE</i>	<i>TIMEFRAME</i>	<i>MEANS OF VERIFICATION</i>	<i>ASSUMPTIONS</i>	<i>TASKS</i>
The Nurse Practitioner model will address and research needs associated with some or all of the top 5 health needs of people living in the Eastern Murrindindi Shire.	3yrs.  (Data collection must be statistically significant)	The Nurse Practitioner model addresses health issues associated with three out of five of the top health priorities in Eastern Murrindindi.  Admission rates to Alexandra District Hospital for complications associated with chronic disease will decrease.  Lengths of stay at Alexandra District Hospital for complications of chronic disease will be decreased.	The role can only be considered appropriate if it addresses the dominant health needs of the local community.	Identification of the top 5 health needs of the eastern Murrindindi community using current health needs data.  Recruitment of a Nurse with the required skills / provision of specialist training for an appropriately experienced nurse.

<b>Goal The Nurse Practitioner model is <i>functional</i></b>				
<i>PROJECT OBJECTIVE</i>	<i>TIMEFRAME</i>	<i>MEANS OF VERIFICATION</i>	<i>ASSUMPTIONS</i>	<i>TASKS</i>
The Nurse Practitioner model will function successfully within both a public and private business framework and a multidisciplinary setting.	3 yrs.  (Data collection must be statistically significant)	<p>The Nurse Practitioner is subcontracted to a General Practice clinic 1 day per week.</p> <p>The Nurse Practitioner will demonstrate accommodation of both a clinical, educative and research function in the Hospital as well as the community setting.</p> <p>Growth is demonstrated in client service utilisation rates.</p> <p>Growth of GP based referrals for both inpatient and outpatient services is demonstrated.</p>	Role functionality is dependent upon local health industry and consumer acceptance.	<p>Negotiation of subcontracting arrangements and development of guidelines for this agreement.</p> <p>Development of referral tools for endorsement of both the Hospital and external referral sources.</p> <p>Inclusion of educative and clinical key performance indicators in the Nurse Practitioner’s position description.</p> <p>Collection of baseline data regarding local client numbers and level of current service utilisation.</p>

<b>Goal The Nurse Practitioner model is sustainable</b>				
<i>PROJECT OBJECTIVE</i>	<i>TIMEFRAME</i>	<i>MEANS OF VERIFICATION</i>	<i>ASSUMPTIONS</i>	<i>TASKS</i>
The Nurse Practitioner model at Alexandra District Hospital is economically and practically sustainable.	3 yrs.	<p>The Hospital is able to recruit a suitable Nurse Practitioner candidate.</p> <p>The Hospital is able to meet the financial commitments of a Nurse Practitioner model of care.</p> <p>The Hospital is committed long term to the ongoing education of potential Nurse Practitioners who will maintain the viability of the position within the service structure into the future.</p> <p>The Nurse Practitioner candidate is able to access required education to achieve endorsement.</p> <p>The registered Nurse Practitioner is able to access ongoing education to maintain their competency status.</p>	Access to affordable and appropriately qualified staff is essential to the successful implementation of the model.	<p>Employment of a current or potential Nurse Practitioner candidate.</p> <p>Cost analysis of inpatient service provision versus community based services for the considered disease categories.</p> <p>Development of a succession planning structure aimed at service maintenance.</p> <p>Organisational incorporation of a budgetary provision for the achievement of credentialing and the maintenance of qualifications and competencies.</p>

## **6. Priority Areas**

### **6.1 Service Description**

The proposed model operates as a rural community health nurse incorporating a variety of specialist areas. These areas would be chronic respiratory disease (including asthma) management and education, and diabetes education (incorporating chronic wound management).

The incumbent's would work primarily in the Alexandra District Hospital's integrated health service setting, providing both in-patient and ambulatory care services. Additionally however, the incumbent/s would be subcontracted to provide a regular clinic within the General Practice and aged care settings. It is envisaged that such arrangements would augment cross collegial care provision and the implementation of truly interdependent partnerships.

The scope of the role/s includes:

- Client education / consultation
- Community education
- Staff / peer education
- Nursing assessment and chronic disease review with implementation of an ambulatory care based management plan.
- Wound management (both inpatient and ambulatory care).
- Spirometry
- Prescription of supportive medications (taken from an approved limited formulary of medications).
- Manipulation of current medications for review clients.
- Diagnostic pathology
- Diagnostic imaging
- Research

## 6.2 The client group

Murrindindi Shire covers 3889 sq. km and is located 100km north east of Melbourne. Total Population is 13,823 (as of June 30<sup>th</sup> 2003). Review of DALY rates for the area (Municipal Public Health Plan 2004-2007, Murrindindi Shire Council, 2004), Dept. Human Services Burden of Disease data (1996), morbidity comparison data presented by the NEVDGP (2000), and Lower Hume Health Profile data (2005) all point to the following as the primary causes for years of life lost in:

### a) Males in the Murrindindi Shire:

- Cardiovascular disease
- Unintentional road traffic accidents
- Lung cancer
- Chronic respiratory disease
- Stroke
- Chronic obstructive pulmonary disease (COPD)
- Intentional injuries including suicide
- Cancer colon, rectum and prostate

(Additionally, the Asthma DALY rate is higher than the Victorian average)

### b) Females in the Murrindindi Shire:

- Cardiovascular Disease
- Breast Cancer
- Stroke
- Cancer colon / rectum
- Chronic obstructive pulmonary disease
- Unintentional road and traffic accidents
- Cancer lung
- Peripheral vascular disease
- Neurological and sensory disorders

## Non Physical Disorders

- Number of child protection notifications in the eastern side of Murrindindi (2002-03) was 54 with 68% of notifications substantiated.
- Mental Health separations in the NE Victorian Division are lower than State average with the exception of Alcohol, Drug and other Psychoses. However separation rates rose significantly in the period between 1991-92 and 1998-99.

### Acute Sector Data:

Ambulatory Care Sensitive Conditions (ACSC) are defined as **“those (conditions) for which hospitalisation is thought to be avoidable if preventative care and early disease management is applied usually in the ambulatory care setting” (Department of Human Services, Victoria, 2004).**

ACSC’s admission rates for Lower Hume 1997-98 to 2001-02 show a pronounced increase over the surveyed period. (Lower Hume PCP Health Profile 2005, p54).

The top ten ACSC’s requiring hospitalisation for the Lower Hume PCP in 2001-2002 include:

1. Diabetes complications (highest incidence and greatest contributor of bed days)
2. Chronic obstructive pulmonary disease
3. Congestive cardiac failure
4. Asthma
5. Dental Conditions
6. Angina
7. Dehydration & gastroenteritis
8. Ear nose and throat infections
9. Cellulitis
10. Pyelonephritis

### Conclusions:

Review of population health data for the Murrindindi Shire reveals a number of potential areas of practice in which a Nurse Practitioner could have a significantly positive influence. The areas of highest priority include cardiovascular disease, respiratory disease (in particular asthma and COPD) and management of diabetes complications.

Whilst locally based capability exists to provide all these services currently, investigation of a sustainable cardiac nursing model has been deemed by the project team as unachievable at this time.

As noted above, the stand out issues according to current disease prevalence and impact data are cardiovascular disease, respiratory disease (in particular asthma and COPD) and diabetes complications. However, being a small rural health service set in a remote area limits the organisation's internal capacity to address all areas. As such these priorities must be considered within the context of available human resources.

### **Asthma, Respiratory Disease Management, Diabetes, Chronic Wound Management & Continence:**

Alexandra District Hospital currently employs a Division 1 Nurse with qualifications and significant expertise in asthma management and education, diabetes management and education, chronic wound management, continence nursing, sexual health and who is also a registered Pap Test provider.

The Nurse also has significant expertise in general practice management and hence established links with the GP community and the North East Victoria Division of General Practice.

She is currently enrolled in a Master of Nursing program and has research, academic and teaching expertise all of which offer the potential for NP candidature in the near future.

This Nurse is committed to a clinically based career path, with a rural health research focus and as such is available for consideration as a NP.

Although confinement of such expertise to a single staff member may appear to be unsustainable, the training requirements for these specialist areas are within the capability of a small rural health service such as ADH. Additionally, scope exists for the nurse practitioner to oversee the practise of others acting as a mentor for future NP candidates.

## **6.2 Service Gap Analysis**

### **Respiratory Nursing**

#### **a) Chronic Obstructive Pulmonary Disease (COPD)**

COPD has a significant indirect effect on any community both economically and in terms of allocation of limited resources. The impact of COPD in rural and remote communities is particularly significant. The Australian Lung Foundation statement (1999 p.9) notes that "the challenges facing COPD sufferers in rural, remote and indigenous populations were of particular concern... as the financial burden of hospital care, doctors and medicines is substantial".

COPD also creates enormous burdens for both the sufferer and their families. It increases work absenteeism sometimes forcing early retirement, and can contribute significantly to feelings of low self-esteem and depression. Improving the overall

quality of life for sufferers of COPD can result in a reduction of the number of individual admissions to Hospital (Australian Lung Foundation 1999).

#### **b) Asthma Management**

According to the North East Victorian Division of General Practice Health Profile Report (2000), asthma separation rates for Murrindindi were higher than for both the Division and for Victoria. Additionally, the same document states the following “Murrindindi had the highest percentage of asthma deaths compared to other shires of the division, which was considerably higher than that of the division and the state” (North East Victorian Division of General Practice Health Profile Report 2000,p.22)

Previously there was no service available to asthma sufferers which could assist to address the connectedness and education issues that exist across the Murrindindi Shire. Busy General Practitioners provided these clients only source of support and education, and no service existed to provide for the broader community.

It is particularly in the areas of holistic assessment, education, and community based support that the Nurse Practitioner is able to offer a new dimension to the care of those with chronic respiratory disease that focuses on self management and quality of life improvement.

#### **c) Diabetes Management**

Alexandra District Hospital (ADH) carries significant numbers of long stay clients who are admitted as a result of poor illness self management and complications resulting from their diabetes and in particular, chronic diabetic ulcers.

A community health nurse based care structure again offers additional services to the client with diabetes. Like respiratory disease management, under a nurse practitioner model, a proactive care approach focuses on disease management planning, education, prevention and / or early management of complications and avoidance of hospitalisation.

#### **d) Continence**

DHS funded continence management services are provided by an out of area provider based in a neighbouring shire one hour away. The service is HACC funded and has at times had 12 months waiting time. Concerns regarding access to this service have been brought to the attention of the Hospital by local aged care service providers who site poor continence management as a major contributor to falls in the elderly. (Falls carry very high mortality and morbidity rates).

A locally based continence nurse now offers immediacy in service provision in a situation where the sufferer is significantly socially incapacitated by their health issue. Additionally, the service has the potential to reduce incontinence associated falls and hence positively impacts on mortality and morbidity rates.

## 7. Education and Mentoring Plan

The breadth of the role requires attainment of formal educational qualifications as well as ongoing formal learning and peer and collegial mentoring.

### A. Required qualifications

#### (Diabetes and chronic wound management)

- Cert. Diabetes Education and Health Care
- Cert. IV Workplace Training and Assessment
- Master of Nursing (Nurse Practitioner)
- Graduate Certificate in Wound Care

#### (Respiratory Nursing)

- Certification by Asthma Victoria as a qualified Asthma Educator
- Cert. IV Workplace Training and Assessment
- Emergency Asthma Management Trainers Certificate
- 5 day Respiratory Nursing Course
- 2 day Spirometry workshop
- Master of Nursing ( Nurse Practitioner)

#### (Continence)

- Graduate Certificate in Advanced Clinical Nursing – Continence
- Master of Nursing (Nurse Practitioner)

### B. Ongoing Learning

#### (Diabetes and chronic wound management)

##### *Credentialing requirements*

- Education 16 credit points per annum
- Professional and community involvement 10 credit points per annum
- Professional responsibility and accountability 10 credit points per annum
- Mentoring 5 credit points per annum
- Membership Australian Diabetes Educators Association

#### (Respiratory Nursing)

- Membership Victorian Asthma Educators Association
- Attendance – Lung Health Course (annually)

#### (Continence)

- Membership Continence Foundation of Australia
- Attendance – Continence update (annually)

### **C. Peer and Collegial Mentoring**

- Weekly clinics within a GP setting. (service agreement includes case conferencing opportunities)
- Attendance at professional body meetings with an expectation of networking and information sharing

## **8. Process for the Development of Clinical Practice Guidelines including organisational approval**

### **Definitions:**

#### **8.1 Competency Standards: (Competencies)**

Competency standards are standards of practice set by the profession for its members and society. The Australian Nursing Council (ANC) competency standards are the core standards, which it is expected will be demonstrated by all nurses. The standards take account of the contemporary role of the nurse, which covers clinical practice, management of care, counselling, supervising, mentoring and research. They provide a benchmark for nurses in daily practice. (Nurses Board of Western Australia – Professional Portfolio, 2004)

#### **8.2 Clinical Practice Guidelines / Scope of Practice**

“A scope of practice/clinical guidelines is required by law to provide a framework to guide the clinical practice of the Nurse Practitioner. An infringement of the approved guidelines may constitute “professional misconduct or unsatisfactory professional conduct” under the Nurses and Midwives Act 1991”.  
<http://www.health.nsw.gov.au/nursing/npract.html>

#### **8.3 Process for the Development of Clinical Practice Guidelines / Scope of Practice including organisational approval**

1. The Nurse Practitioner is deemed competent by ADH Director of Nursing in accordance with the ANC competency standards
2. Using the NHMRC publication, *A guide to the development, implementation and evaluation of clinical practice guidelines* (1999), the Nurse Practitioner defines their scope of practice using an evidenced based approach and in accordance with NBV requirements and ADH policy.
3. The guidelines demonstrate consideration of the local health needs of people, and the level of competence and experience of the NP
4. The guidelines / scope of practice and competencies are submitted to the ADH Continuum of Care Committee and undergo Executive, Peer, Medical, Pharmacological, Allied Health, Consumer and Board review.
5. The approved guidelines are signed by all members of the review panel
6. A signed copy is sent to the Principal Nurse Adviser, Nurse Policy Branch (DHS)

## **9. Expected benefits to the organisation, community and clients of the establishment of the role.**

### **Asthma Management**

#### Short term outcomes:

- Addressing the immediate education and support needs of asthma sufferers in the Murrindindi Shire and thereby assisting these individuals to take responsibility for the management of their condition.
- Development of clear communication pathways between the sufferers, the treating GP, associated health care professionals and key stakeholders eg: schools, work places and carers that will be used to support the individual's ability to manage their own condition.
- Provision of a community education program aimed at responding to an asthma crisis thus ensuring the safety of sufferers living in a rural community.

#### Long term outcomes:

- Reduction of acute care admissions
- Increased use of asthma action plan
- Increase GP's knowledge of asthma education plan
- Incorporation of emergency asthma management training as part of emergency education
- Maintenance of health professionals skills and knowledge
- Promotion of the three plus plan

### **Continence**

#### Short term outcomes:

- Enhancement of the client's self care ability and confidence to independently manage their disease

#### Long term outcomes:

- Improved inpatient / residential care management resulting from applied learning and mentoring of non specialist nurses
- Improvement in quality of life for clients
- Reduction of demands on local GP services
- Reduced admission rates and length of stay resulting from continence related falls
- Further enhancement of the GP / Hospital relationship through provision of mutual support and access to affordable nursing expertise

## **Diabetes Management (including chronic wound management)**

### Short term outcomes:

- Addressing the immediate education and support needs of diabetes sufferers and assisting these individuals to take responsibility for the management of their condition.
- Development of clear communication pathways between the sufferers, the treating GP, associated health care professionals and key stakeholders eg. schools, work places and carers that will be used to support the individual's ability to manage their own condition.
- Enhancement of the client's self care ability and confidence to independently manage their disease.

### Long term outcomes:

- Reduction of diabetes related complications
- Reduction of acute care admissions for diabetes related illness
- Increased GP knowledge of diabetes management strategies
- Improved inpatient / residential care management resulting from applied learning and mentoring of non specialist nurses
- Improvement in quality of life for clients
- Reduction of demands on local GP services
- Reduced admission rates and length of stay of individuals with diabetes suffering chronic wounds.
- Further enhancement of the GP / Hospital relationship through provision of mutual support and access to affordable nursing expertise



<b>Accountability Objective</b>	<b><i>The NP, in consultation with the CEO/DON, will provide both outpatient and inpatient service to clients who require a range of specialist nursing interventions.</i></b>
<b>Key Result Area 1</b>	<b>Continuum of Care</b>
<b>The NP, will demonstrate excellence in service outcomes.</b>	
<b>Associated Key Performance Indicators</b>	<ul style="list-style-type: none"> <li>1.1 Monitors compliance with relative statutory requirements, and codes of practice.</li> <li>1.2 Expertly applies advanced practice competencies.</li> <li>1.3 Acts as a role model for primary health practice and holistic care.</li> <li>1.4 Assists the Charge Nurse, in review of staff competence and educational needs concerning all specialist practice and policy.</li> <li>1.5 Ensures incidents regarding clinical practice are accurately documented and investigated at the time of the incident and that both the CEO/DON and the Charge Nurse is informed.</li> <li>1.6 Demonstrates a thorough knowledge of primary health and related performance targets.</li> <li>1.7 In liaison with the senior management team, reviews systems and processes as they relate to primary health and implements changes and education programs as appropriate.</li> <li>1.8 Accurately documents Primary Health initiatives in accordance with Hospital guidelines.</li> <li>1.9 Adheres to all aspects of confidentiality in regards to patients, staff and personnel.</li> <li>1.10 Practices within NP policy and clinical practice guidelines.</li> <li>1.11 Contributes constructively to a multidisciplinary approach to patient care.</li> </ul>

<b>Key Result Area 2</b>	<b>Leadership and Management</b>
<b>The NP, in liaison with the CEO/DON, will ensure congruence between implementation of the Hospital's Primary Health Strategy and population health objectives.</b>	
<i>Associated Key Performance Indicators</i>	<ul style="list-style-type: none"> <li>2.1 Demonstrates commitment to the objectives of Alexandra District Hospital.</li> <li>2.2 Demonstrates vision, flexibility, creativity and the ability to plan strategically.</li> <li>2.3 Acts as a resource person to all staff on issues of disease and disability management and prevention.</li> <li>2.4 Seeks opportunities to attend meetings / conferences that enhance professional practice.</li> <li>2.5 Regularly reviews work practices to minimize clinical and organisational risks</li> <li>2.6 In consultation with the CEO/DON conducts practice reviews to measure program outcomes and assess potential risks.</li> <li>2.7 Mentors new NP candidates.</li> <li>2.8 Builds effective relationships with staff and colleagues to enhance patient outcomes.</li> <li>2.9 Actively promotes the NP role.</li> <li>2.10 Influences health care policy through participation in both regional and state forums.</li> </ul>
<b>Key Result Area 3</b>	<b>Human Resources Management</b>
<b>The NP will model professional excellence.</b>	
<i>Associated Key Performance Indicators</i>	<ul style="list-style-type: none"> <li>3.1 Demonstrates competency in the application of clinical practice guidelines.</li> <li>3.2 Maintains a professional portfolio (as required by the Nurses Board of Victoria) whilst pursuing endorsement.</li> <li>3.3 Builds and maintains own clinical competence and credentials.</li> <li>3.4 Provides information relating to the role for all new staff.</li> <li>3.5 In cooperation with the CEO/DON facilitates organisational training for issues relating to specialist areas of practice.</li> <li>3.6 Complies with Hospital directives in regard to the Hospital's code of conduct.</li> </ul>

Key Result Area 4	Information Management
<p><b>The NP will enhance customer service and management of services through appropriate administration of information accessed via both computer based and manual systems.</b></p>	
<p><i>Associated Key Performance Indicators</i></p>	<ul style="list-style-type: none"> <li>4.1 Adheres to the Hospital's confidentiality policy.</li> <li>4.2 Seeks out and disseminates best practice information appropriately for use in service delivery and management.</li> <li>4.3 Ensures all documentation is complete and accurate and is sufficiently detailed and legible to enable continuity of care, evaluation, education and medico-legal integrity.</li> <li>4.4 Reviews internal processes to ensure that information is managed effectively to enhance patient care and reduce clinical risk.</li> <li>4.5 Seeks opportunities to develop ways of enhancing communication with hospital customers (internal and external)</li> <li>4.6 Actively participates in the enhancement of the organisation through submissions and publications.</li> <li>4.7 Initiates, leads and participates in clinical research based activities.</li> <li>4.8 Applies relevant research to practice and policy development.</li> <li>4.9 Assists others in the evaluation of research data.</li> </ul>

<b>Key Result Area 5</b>	<b>Safe Practice and Environment</b>
<b>The NP will be responsible for ensuring a safe environment for clients and staff through adherence to organisational OH&amp;S and risk management policies.</b>	
<i>Associated Key Performance Indicators</i>	<p>5.1 Actively participates in the review of risk management procedures as detailed in the Policy and Procedures Manual.</p> <p>5.2 Ensures compliance with Occupational Health and Safety regulations in accordance with the requirements of the role. (ref: OHS policy and procedure manual, employee and management responsibilities)</p> <p><b>Resources</b>  Victorian WorkCover Authority at <a href="http://www.workcover.vic.gov.au">www.workcover.vic.gov.au</a>  National Occupational Health and Safety Commission at <a href="http://www.nohsc.gov.au">www.nohsc.gov.au</a></p> <p>5.3 Is committed to the further development and implementation of organisational risk management strategies.</p>
<b>Key Result Area 6</b>	<b>Improving Performance</b>
<b>The NP will actively participate in the Hospital Quality Improvement Program. This will include the development of quality measures to meet optimal patient, staff and resource outcomes within a multidisciplinary team.</b>	
<i>Associated Key Performance Indicators</i>	<p>6.1 Develops evidence based clinical practice guidelines in collaboration with other members of the multidisciplinary care team.</p> <p>6.2 Demonstrates a capacity for critical reflection.</p> <p>6.3 Leads best practice activities in areas of clinical expertise.</p> <p>6.4 Actively participates in annual review of policies, procedures and standards of designated area.</p> <p>6.5 Demonstrates responsibility in ensuring work practices are measured and monitored for improved patient care.</p> <p>6.6 Understands the EQUIP Accreditation concept.</p>

**Agreement** I have read, understood and agree to comply with this position description.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## 11. Barriers, constraints and opportunities

### Industry analysis

#### 1. Threat of new entrants

**Threats:** Development of a Medical Practitioner assistant's role (The Australian 12/8/06)

**Opportunities:** Absolute cost advantage within a primary health setting.

**Solutions:** The role is developed in consultation with the General Practitioners. Additionally adequate time and resources are allocated to the building of interdependent relationships that show both economical and professional advantage to both the private practice and the publicly funded health service.

Of Note: A trial by Laurant et al (2004) showed that adding nurse practitioners to general practice teams did not reduce the workload of the GP, implying that NPs were used as supplements rather than substitutes to care provided by the GP.

#### 2. Bargaining power of suppliers

**Threats:** Government regulation regarding provider number access and access to the Medicare Benefits Schedule and Pharmaceutical Benefits Scheme. The potential for NPs scope of practice to be governed by a Medical Practitioner (Karvelas and Cresswell The Australian 11<sup>th</sup> Apr. 2006)

**Opportunities:** The Nurse Practitioner can capitalise on the Hospital's buying power and the Department of Human Services (DHS) standardised supply systems.

**Solutions:** The Nurse Practitioner works collaboratively with the General Practitioner, accepting the requirement for a single 'gate keeper' role to care. The Nurse Practitioner is able to therefore prescribe within the Hospital setting (those medications within the approved scope of the NP) but does so within a shared care framework, enabling the GP's treatment regime to dovetail with the NP's once the client returns to the community setting.

#### 3. Bargaining power of buyers

**Threats:** Client loyalty to the GP community

**Opportunities:** Potential to increase service access to low income families and individuals in a community health / ambulatory care setting.

**Solutions:** The subcontracting of the Nurse Practitioner to the General Practice clinic will facilitate access to the role by clients traditionally being cared for only by their GP.

#### 4. Threat of substitute products

**Threats:** Development of the role in such a way as to be used to substitute GP care provision.

**Opportunities:** A Nurse Practitioner offers full women's health assessment as opposed to a single item consultation. As a public service, time does not have the same income implications.

**Solution:** The Nurse Practitioner service is created to compliment rather than compete with General Practitioner services.



### **5. Rivalry amongst competition**

**Threats:** Individual business interests have the potential to threaten the Hospital's good relationship with the local GP community.

**Opportunities:** Low concentration of competitors exists. Increased public awareness of women's health issues and an ageing population has created industry growth and demand. The NP model offers service differentiation for those wanting to see a female or a non GP. Additionally, it offers low fixed business costs, low exit barriers and has a lack of diversity in competitors.

**Solution:** As previously stated, GP involvement in the development of the model is vital.

## **External Analysis**

### **Macro Environment Force Analysis**

#### 1. Demographic

**Threats:** Lack of transport to local area creates issues of access.

**Opportunities:** Ageing population

Geographical isolation leads to a shortage of GPs

Small highly dispersed population – three sites and service mobility.

**Solution:** The NP model offers a portable community based model of care that can be easily made available to all areas of eastern Murrindindi.

## 2. Economic

**Threats:** Excessive demand may result in the service being unable to meet demand

**Opportunities:** Many in the community have a small disposable income, high levels of social disadvantage.

**Solution:** Waiting lists will be managed internally and (should the demand exceed capacity) consideration will be given to the further conversion of funding enabling model expansion.

## 3. Political / Legal

**Threats:** The AMA are fundamentally opposed to the NP model (amavic.com.au, 1999)

There is national inconsistency in requirements and timeframes for registration.

A potential change in state government results in altered funding patterns in health.

**Opportunities:** Move by State Government toward increasing ambulatory care framework.

The implementation of a Small Rural Health Service funding model.

**Solutions:** Alexandra District Hospital continues to be committed to the provision of area based services and the development of the Nurse Practitioner role by the Victorian Nurse Policy Branch.

Additionally, however it remains cognizant of the vital importance of good working relationships with locally based doctors whose opinions of the Nurse Practitioner model may not necessarily align with those opinions expressed by the AMA.

In both instances, open and transparent communication is a key factor to the success of this proposal.

## 4. Socio cultural

**Threats:** Mobile workforce

**Opportunities:** Increasing health consciousness. Client has a role in decision making  
Need for flexibility in work arrangements

**Solutions:** The model incorporates opportunity for the sustainable development and potential expansion of the role through ongoing education and training of potential NPs.

## 5. Technological

**Threats:** Inadequate IT infrastructure, limited access to medical technology.

**Opportunities:** Global communication systems are linking staff and clients with the latest information and resources.

**Solutions:** Alexandra District Hospital maintains its commitment of resources to the expansion of IT infrastructure and the use of this technology to facilitate video linkage with specialist health services.

## 6. Global

**Threats:** Ageing of population

**Opportunities:** Changing economic conditions affect health funding

**Solutions:** Alexandra District Hospital continually scans the external environment in an effort to anticipate and proactively address issues as they arise.

## **12. Financial Considerations**

### **Models – Cost analysis**

Review of population health data for the Murrindindi Shire reveals three potential areas of practice in which a nurse practitioner could have a significantly positive influence. These areas included continence management, respiratory disease management (in particular asthma and COPD) and management of complications of diabetes.

An internal environmental analysis identified potential viability to the concept of implementing two of the three priority areas with the presence of strong financial and human resource capacity appropriate to these.



Respiratory Health Management.

Review of Alexandra District Hospitals Cost model reports – (Department of Human Services 2005) reveals the following costs associated with inpatient management of all respiratory disorders for 2003-04.

<u>Item</u>	<u>Cost</u>
Average length of stay	<b>10.26</b>
Average cost per client	<b>\$933</b>
Total organizational cost for 112 clients	<b>\$104,496</b>

An ambulatory care model based on the use of a Nurse practitioner would assume the following associated setup and ongoing costs.

<u>Item</u>	<u>Cost</u>
<b>Required post graduate clinical qualifications:</b>	
Qualified Asthma Educator Certified by Asthma Victoria	<b>\$550.00</b>
Cert. 1V Workplace Training and Assessment.	<b>\$900.00</b>
Emergency Asthma Management Trainers Certificate	<b>\$330.00</b>
5 day Respiratory Nursing Course	<b>\$785.00</b>
2 day Spirometry workshop	<b>\$605.00</b>
Required academic qualifications	
Master of Nursing (Nurse Practitioner)	<b>\$3,847.00</b> <b>(Commonwealth subsidized places until 2007)</b>
<b>Credentialing requirements and associated costs</b>	
Emergency Asthma Management Trainers Certificate (renewable every 3yrs).	<b>(Budget): \$5000.00</b>
10 professional development points accrued annually.	
Membership Australian Asthma and Respiratory Educators Association.	<b><u>\$ 140</u></b>
<b>TOTAL EDUCATIONAL AND CREDENTIALING COSTS</b>	<b><u>\$12,157</u></b>
<b>ONGOING STAFF COSTS</b>	
<b>Practitioner Wages</b>	
ZA8 base wage per day (1 day per week)	<b>\$14680.64</b>
On costs @25%	<b>\$ 3670.16</b>
	<b><u>\$18,350.80</u></b>

**Diabetes Health Management.**

Review of Alexandra District Hospitals Cost model reports – (Department of Human Services 2005) reveals the following costs associated with inpatient management of diabetes mellitus 2003-04. Note: No data is available specific to the number of admissions for management of diabetes complications however ACSC data for the LHPCP (2001-2002) shows diabetes complications as being the greatest contributor of bed days for the ACSC group.

<b><u>Item</u></b>	<b>Cost</b>
Average length of stay	<b>13.5</b>
Average cost per client	<b>\$877.25</b>
Total organisational cost for <b>40</b> clients.	<b>\$35,090.00</b>

An ambulatory care model based on the use of a Nurse practitioner would assume the following associated setup and ongoing costs.

<b><u>Item</u></b>	<b>Cost</b>
<b>Required post graduate clinical qualifications:</b>	
Gd. Cert Diabetes Education and Health Care	<b>\$3,890.00</b>
Cert. 1V Workplace Training and Assessment.	<b>\$900.00</b>
Required academic qualifications	
Master of Nursing (Nurse Practitioner)	<b>\$3,847.00</b>
<b>Credentialing requirements and associated costs</b>	<b>(Budget): \$5,000.00</b>
Education 16 credit points per annum	
Professional and community involvement 10 credit points per annum	
Professional responsibility and accountability 10 credit points per annum	
Mentoring 5 credit points per annum	
Membership Australian Diabetes Educators Association	<b><u>\$ 16.50</u></b>
<b>TOTAL EDUCATIONAL AND CREDENTIALING COSTS</b>	<b><u>\$13,653.50</u></b>
<b>ONGOING STAFF COSTS</b>	
<b>Practitioner Wages</b>	<b>\$14680.64</b>
ZA8 base wage per day (1 day per week)	<b>\$ 3670.16</b>
On costs @25%	<b><u>\$18350.80</u></b>

**Continence Management.**

“Bladder or bowel control problems (incontinence) is one of the biggest health issues in Australia, affecting approximately 2 million people across all aged groups. It affects people socially, emotionally, physically, mentally and economically (Chiarelli, 2002). Incontinence in the majority of older adults is amenable to improvement and often cure, irrespective of the underlying condition (Fonda and Benvenuti, 2002).

The total annual cost of urinary incontinence among community dwelling Australian women is estimated to be \$710 million (Doran and Chiarelli, 2001). This estimate does not include the cost of incontinence within institutions, or experienced by men. It is estimated that the long-term care of nursing home residents with incontinence is estimated to be \$47,000 each, or \$450 million per year (Steel and Fonda, 1995). Although there is no figure which combines the costs in the community and institutions for both men and women, the above estimates suggest that such a figure would exceed \$1 billion annually”. (Continence Foundation of Australia July 2003)

An ambulatory care model based on the use of a Nurse Practitioner would assume the following associated setup and ongoing costs.

<u>Item</u>	<u>Cost</u>
<b>Required post graduate clinical qualifications:</b>	
Post Graduate Diploma – Nursing Science in Urological and Continence Nursing.	<b>\$3,846.00</b>
Required academic qualifications	<b>\$3,847.00</b>
Master of Nursing (Nurse Practitioner)	<b>(Commonwealth subsidized places until 2007)</b>
<b>Credentialing requirements and associated costs</b>	
23.5 CNE professional development points accrued annually.	<b>\$ 5,000.00</b>
Membership Continence Foundation of Australia	<b><u>\$ 80.00</u></b>
<b>TOTAL EDUCATIONAL AND CREDENTIALING COSTS</b>	<b><u>\$12,773.00</u></b>
<b>ONGOING STAFF COSTS</b>	
<b>Practitioner Wages</b>	
ZA8 base wage per day (1 day per week)	<b>\$14,680.64</b>
On costs @25%	<b>\$ 3,670.16</b>
	<b><u>\$18,350.80</u></b>

## **13. Evaluation**

### **Acceptability**

#### **Component 1**

Key stakeholder evaluation pre and post implementation.

12 months post implementation, using a nominal group approach, the stakeholders views of the NP model's ability to address the formally developed needs statements will be elicited. Collated data will be compared with that collected during the pre implementation study.

#### **Component 2**

Partnership analysis

Using the Vic Health Partnership Analysis Tool (2003, [www.vichealth.vic.gov.au](http://www.vichealth.vic.gov.au)), the viability of established relationships both pre and post model implementation will be examined.

### **Appropriateness**

#### **Component 3**

Scope of practice

An examination of the candidate's clinical practice both pre and post model implementation will be undertaken. These observations (conducted over a two day period) will be used to determine if the scope of practice has been extended as a result of model implementation. Additionally, it will enable the examination of actual practice scope thus identifying ongoing service gaps and overlaps.

### **Functionality**

#### **Component 4**

Health Outcomes

A randomized sample of clients would be asked to be part of a pre and post care health outcomes analysis. The clients would be asked questions pertaining to their health status, abilities, number of intervention episodes and hospitalizations, knowledge of their disease and its management and levels of satisfaction.

### **Quality of Service Delivery**

#### **Component 5**

A client satisfaction survey would be provided to all clients using the service. This survey would be used to obtain information regarding the client's perceptions of services prior to and following implementation. It is anticipated that results would provide both qualitative and quantitative data.

### **Sustainability**

#### **Component 6**

Economic Evaluation

Respiratory disease management and diabetes management costs would be evaluated against Alexandra District Hospital Cost Analysis data reports (Department of Human Services).

The economic implications of improved continence management is more difficult to assess due to the lack of baseline data. However, in partnership with Darlingford Upper Goulburn Nursing Home, a pre and post model implementation analysis of the cost of continence aids will be undertaken. The expectations of this being that costs for pads will decline as individual continence improves.

## **14. Sustainability**

As previously noted, model sustainability is one of the four key objectives of the project. As such the model is inclusive of a plan to target potential candidates for education and training, offering opportunity for acute care staff to work with the NP gaining experience in one or all of her specialty areas.

Additionally, it is envisaged that the financial viability of the model will be ensured by capitalising on the organisation's ability to convert funding to ambulatory care based service provision.

### **References**

Commonwealth Govt. (2004) Drugs Poisons and Controlled Substances (Nurse Practitioner and Miscellaneous Amendments) Regulations.

<http://www.amavic.com.au> (1999) Dissenting view. Nurse Practitioner Taskforce.

Godleman Sharon, (2005) Meeting The Community Needs: Exploring the role of the Nurse Practitioner in Rural Victoria. Seymour Hospital.

<http://abc.net.au> (6/3/03) Health Matters Features

[www.health.nsw.gov.au/nursing/npract](http://www.health.nsw.gov.au/nursing/npract)

Adam Creswell, (2006) Call for assistants. The Australian 12/8/06.

<http://www.nnnet.gov.au>

Miranda GTH Laurant, Rosella PMG Hermens, Joze C. C Braspenning, Bonnie Sibbald, & Richard PTM Grol (2004) Impact of Nurse Practitioners on workload of general practitioners: randomized controlled trial. BMJ 2004; 328;927.

Parnell S., & Hart C. (2005) Health's Changing Face adds to Doctor Shortage. The Australian 12/11/05



Victorian Government, Dept. Human Services (1999) Victorian Nurse Practitioner, final report of the task force. Melbourne.

Victorian Government, Dept. Human Services (2001) Victorian Nurse Practitioner Project, Report of the Nurse Practitioner Implementation Advisory Committee, Melbourne.

Murrindindi Shire Council, (2004), Municipal Public Health Plan 2004-2007

Dept. Human Services, Burden of disease data (1996)

North East Victorian Division of General Practice (2000) Morbidity comparison data

Lower Hume Primary Care Partnerships (2005) Lower Hume Health Profile data