Nurse Practitioner Project: Service Plan Development
Northern Health
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For further information regarding this report please contact:

Julie Considine
Project Officer, Nurse Practitioner Service Plan Project, Northern Health
c/- The Northern Hospital
185 Cooper St, Epping
Victoria, 3076

Julie.Considine@nh.org.au
Executive Summary

Northern Health manages 547 beds and provides health care services to Melbourne’s northern suburbs in acute, sub-acute and community settings. Northern Health has five campuses: The Northern Hospital, Epping (TNH), Broadmeadows Health Service (BHS), Bundoora Extended Care Centre (BECC), Panch Health Service, Preston (PHS), and Craigieburn Health Service (CHS). Northern Health currently has two Nurse Practitioner roles with an Aged Care Nurse Practitioner (ACNP) Candidate at BHS and an Emergency Nurse Practitioner at TNH. Both initiatives have been highly successful and well supported within their respective contexts of practice and have met designated outcome measures within prescribed timeframes, fulfilled reporting requirements and complied with budgets.

The Nurse Practitioner Candidate role is an important transitional role between existing advanced practice nursing roles and Nurse Practitioner. The Nurse Practitioner role complements the care provided by other health care professionals in specific contexts of practice. Nurse practitioners are differentiated from other advanced nursing roles by the use of five extensions to practice: prescribing, initiation of diagnostics (imaging and pathology), completion of absence from work certificates, referring to specialists and admitting and discharging patients. There are still a number of issues related to the use of extensions to practice. For example, the major issues related to prescribing by Nurse Practitioners / Nurse Practitioner Candidates are lack of Pharmaceutical Benefits Scheme (PBS) access for endorsed Nurse Practitioners, and absence of legislative framework to allow for prescribing of medications by Nurse Practitioner Candidates. Ongoing issues related to diagnostic authority are lack of MBS access for endorsed Nurse Practitioners and ordering diagnostics by Nurse Practitioner Candidates. Urgent legislative review and reform is necessary so that legislative frameworks that govern health care provision reflect contemporary health care delivery and do not disadvantage specific health care providers and patient groups.

The development of Nurse Practitioner roles within Northern Health will be an important strategy in the management of increased service demands and workforce shortage projections. Priority areas for implementation of Nurse Practitioner models should be driven by service demand and organisation strategic direction and where possible Nurse Practitioner models should be health service rather than site based. Existing Nurse Practitioner roles that can be further developed within Northern Health are Emergency Nursing and Aged Care Nursing. Priority areas for new Nurse Practitioner models of care within Northern Health are Wound Management, Oncology, Intensive Care Liaison, Diabetes, Neonatal Nursing and Continence.

Education and mentoring of Nurse Practitioner Candidates is pivotal to the success of Nurse Practitioner roles. Nurse Practitioner education falls into two distinct categories: education aimed at preparation for practice as a Nurse Practitioner Candidate and to meet NBV requirements for endorsement as a Nurse Practitioner and education aimed at ongoing professional development for endorsed Nurse Practitioners and to meet the requirements of the NBV review. Key recommendations related to education for Nurse Practitioner Candidates are health service support for university studies using EBA study / exam leave and engagement of organisational support prior to undertaking Master of Nursing (Nurse Practitioner) or related studies. Dedicated training time is also an issue for Nurse Practitioner Candidates. Current models of medical education recommend 1-2 hours per week of dedicated education time. Development of clinical internships to facilitate vocational training is a priority area for nurse Practitioners / Nurse Practitioner Candidates and clinical internships should have state-wide standards to ensure transferability of the Nurse Practitioner roles and organisational confidence. Educational preparation for Nurse Practitioner Candidates should also include formal preparation in areas such as clinical practice guideline development, academic writing, presentation, leadership and change management.

In Victoria, Clinical Practice Guidelines developed by a multidisciplinary team underpin the use of extensions to practice by Nurse Practitioners and are one of the NBV criteria for endorsement as a Nurse Practitioner. Health services should have policies for the
development, approval, implementation and evaluation of Clinical Practice Guidelines. Northern Health Clinical Practice Guidelines should be multidisciplinary and should be developed so they may be used by all independent practitioners managing specific patient groups and an easily accessible repository for all Clinical Practice Guidelines developed within Northern Health needs to be created.

There are a number of barriers to implementation of Nurse Practitioner roles and these barriers may be considered from three perspectives: personal barriers for actual or potential Nurse Practitioners / Nurse Practitioner Candidates, local departmental or organisational barriers and barriers arising from Government and legislative constraints. Evaluation of Nurse Practitioner roles should focus on safety, quality and timing of care. In the absence of established evaluative frameworks and data collection tools, the framework presented in this section will be drawn from the nursing literature and evaluation of specific Nurse Practitioner roles within Northern Health to date: Aged Care and Emergency Nursing. It is important to note that specific outcome measures will be context specific but outcome measures should reflect service delivery rather than individual performance. Evaluation of Nurse Practitioner roles may be considered from two perspectives: i) short term intensive evaluation of new Nurse Practitioner roles and ii) long term evaluation of service delivery in areas of health care in which Nurse Practitioners / Nurse Practitioner candidates work. Each method has different aims which may inform the methods used to collect data and how the data is analysed and interpreted.

Succession planning for Nurse Practitioner roles is an important stage in any Nurse Practitioner program. Succession planning should be multi-faceted and include a career pathway for potential Nurse Practitioner Candidates, structured and reproducible approach to clinical education and clinical supervision / mentorship, and future expansion of scope of practice, rostering considerations to include study leave, non-clinical time for clinical practice guideline development etc., roles of health care professionals from different disciplines in Nurse Practitioner models of care, and human resource and financial planning for long term viability of the Nurse Practitioner / Nurse Practitioner Candidate roles.
1 Introduction

Northern Health manages 547 beds and provides health care services to Melbourne’s northern suburbs in acute, sub-acute and community settings. Northern Health as five campuses:

- The Northern Hospital, Epping (TNH),
- Broadmeadows Health Service (BHS),
- Bundoora Extended Care Centre (BECC),
- Panch Health Service, Preston (PHS), and
- Craigieburn Health Service (CHS).

The Northern Hospital (TNH) is a 262 bed acute facility offering paediatric, obstetric, gynaecological, psychiatric services in addition to general and specialist medical and surgical services. The Northern Hospital has a 10 bed critical care unit, 6 operating theatres and the Emergency Department treats in excess of 68,000 patients per annum.

Broadmeadows Health Service (BHS), Victoria’s first integrated care centre is a 136 bed facility offering a unique mix of general health and community services as well as specialised medical, surgical and therapy services within one location. The inpatient services include Geriatric Evaluation and Management (GEM), Rehabilitation, Palliative Care and Mental Health. Ambulatory services include Aged Care Shared Care (ACSC), Community Therapy Service (CTS), Day Procedure Unit, Specialist Medical Consulting Clinics, Mental Health services and chronic Renal Dialysis Service.

Bundoora Extended Care Centre (BECC) is a 147 bed facility with inpatient aged care, residential care and aged Mental Health services. BECC offers community-based and inpatient services to the elderly, young patients with disabilities and Victorian Veterans. Care provided at BECC aims to assist its clients and carers with quality of life activities that restore function and promote independence.

Panch Health Service (PHS) opened in 2003 and provides a range of services in partnership with Austin Health, Bundoora Extended Care Centre, Darebin City Council, Darebin Community Health, Dental Health Services Victoria, Mercy Hospital for Women and The Northern Hospital. Services include aged and disability services, child and family services, dental services and specialist medical services.

Craigieburn Health Service (CHS) is Northern Health’s newest campus and will open in 2007. CHS was built as part of the Victorian government’s healthcare strategy to provide health services close to where people live. Services provided at CHS will include obstetrics & ante-natal, oncology, paediatrics, diabetes & endocrinology, and allied health services, primary injury and illness clinic, renal dialysis centre, day medical procedures, pathology, radiology and specialist outpatient clinics.

The services provided by Northern Health include medical, surgical, emergency, intensive and coronary care, paediatrics, women’s and maternal health, mental health, aged care, palliative care, and rehabilitation programs. The demographic profile of the community served by Northern Health has grown enormously in recent years and this growth is projected to continue. The diversity of services offered by Northern Health means that many specific patient groups could be managed safely and effectively by a Nurse Practitioner and Nurse Practitioner models of care are an important strategy in the management of increased service demands.

Northern Health has a proven track record in implementation and evaluation of Nurse Practitioner role models of care with successful implementation of the Aged Care Nurse Practitioner role 2002 and Emergency Nurse Practitioner role in 2004. The diversity of these contexts of care and ongoing success of these initiatives highlights the commitment of Northern Health to the Nurse Practitioner role.
2 Background to Nurse Practitioner roles at Northern Health

Northern Health currently has two Nurse Practitioner roles with an Aged Care Nurse Practitioner (ACNP) Candidate at BHS and an Emergency Nurse Practitioner at TNH. The section to follow will provide a historical overview of these roles and a summary of the implementation of these roles in the health service.

2.1 Aged Care Nurse Practitioner

The BHS Aged Care Nurse Practitioner demonstration project began in August 2002. The ACNP role at BHS occurred as part of the DHS funded Aged Care Nurse Practitioner Project that was aimed at establishing the ACNP role within subacute, community and residential aged care facilities as an effective and sustainable model of Aged Care nursing. The development and evaluation of the Aged Care Nurse Practitioner model was guided by a multidisciplinary project team, which ensured the model was based on collaboration with key stakeholders and assisted to clearly define professional roles and boundaries, thus preventing duplication of existing services. The Project Team provided input into the identification of appropriate areas for extended practice and contributed to the development of Clinical Practice Guidelines based upon current evidence ensuring the ACNP’s practice is both up to date and safe.

The ACNP sub-acute model of care was implemented in January 2003 following establishment of the Geriatric Outpatient and Evaluation Clinic (GEOC). Between August 2002 and January 2003 the focus of the demonstration project was upon the implementation of the education program and the development of a suite of Clinical Practice Guidelines based on the common problems of the elderly. Subsequent funding in 2004 enabled further development of the Clinical Practice Guidelines identified for the ACNP. This was completed in 2005.

The ACNP model of care encompasses the patient’s journey across the continuum of care and includes service delivery in sub-acute and ambulatory care settings as well as the patient’s usual residence whether this is a private residence or Residential Aged Care Facility. The ACNP role recognises the need for greater continuity of care across health care settings and the patient’s normal place of residence. This involves access to health care teams, information and health care resources. The ACNP model of care involves; collaboration across disciplines, accepting and making referrals to other health care providers; comprehensive geriatric assessment (CGA); ordering of basic pathology and diagnostic investigations; prescribing from a limited formulary; development of a care plan for initial management (where possible with a focus on prevention); and triaging of patients to appropriate resources including admission to sub-acute services.

The ACNP works both as an independent practitioner with the support of a Specialist Medical Consultant and written procedures and Clinical Practice Guidelines, and inter-dependently with all members of the aged care multidisciplinary team. The model of care is represented in Figure 1.
SUB ACUTE
- Professional input – attendance at ward rounds and case conference
- Comprehensive assessment
- Care planning
- Nursing interventions
- Discharge Planning

GERIATRIC OUTPATIENT EVALUATION CLINIC

REVIEW
- Effectiveness of discharge plan
- Maintenance of gains
- Review of progress
- Further referral
- Review of diagnostic investigations
- Liaison with community providers

COMMUNITY REFERRALS
- Comprehensive geriatric assessment
- Risk screening
- Ordering pathology, radiology tests
- Care planning
- Admission referral

HOME / RESIDENTIAL CARE
- Fast track for review
- Contact with GP and community services
- Potential avoidance of acute admission or presentation to emergency
- Referral
- Early initiation of services
- Admission to acute or sub acute with plan of care initiated

Figure 1: Aged Care Nurse Practitioner Model of Care
A structured education program was designed for the ACNP Candidate and focused on advanced assessment skills with specific reference to the common problems experienced by the elderly. A body systems approach was taken and included pathophysiology, diagnostic tests, interpretation of diagnostic tests and treatment including pharmacological interventions. The education program was mapped out with various health professionals providing tutorials and supervision. Additionally, an ICU Clinical Nurse Educator at St Vincent’s Hospital worked with the ACNPC to review and update comprehensive assessment skills. This approach, while effective, was resource intensive as learning was tailored to an individual ACNP Candidate. For future development and sustainability of the role of Nurse Practitioners in Aged Care, it will be beneficial to build on and link with established educational programs.

Comprehensive Geriatric Assessment is the cornerstone for the extensions to practice in Aged Care. Undertaking a Comprehensive Geriatric Assessment of patients in their home environment and within the GEOC leads to the identification of ailments that are common within the elderly population. Seven common problems of the elderly were identified for the development of the Clinical Practice Guidelines, these included: nutritional issues, continence, dementia and delirium, depression, falls risk assessment, osteoporosis and polypharmacy. The ACNP model of care was implemented incrementally over a three-year period and continues to develop in response to the professional development of the ACNPC, the organisational and patient needs.

### 2.2 Emergency Nurse Practitioner

In April 2004, the Emergency Nurse Practitioner (ENP) role was implemented at TNH. This model was a collaborative model whereby the ENP Candidate works in conjunction with Emergency Physicians. The focus of this ENP model of care was management of minor illness and injury in adult and paediatric patients.

There were wide consultative processes prior to implementation of this role and meetings were held with all key stakeholders (Executive Medical Director, Operations Director, ED Nurse Unit Manager, Directors of Emergency Medicine, Medicine, Surgery, Obstetrics, Pharmacy, Radiology and Pathology) prior to completion of the role submission. Liaison with these stakeholders continued throughout implementation of the role and other groups such as GP liaison and TNH Nurse Unit Manager group were targeted on a needs basis. Prior to implementation of the ENP role, clear lines of reporting (medical and nursing) were established and interim arrangements for extensions to practice that were drafted as part of the original submission were finalised. The ENPC was able to order radiology and pathology, refer to specialists (inpatient and outpatient) congruent with content of Clinical Practice Guidelines however medications ordered by the ENPC were co-signed by Emergency Physicians. One of the negative aspects of these interim arrangements for extensions to practice was that if added to workload of others, in particular emergency physician group.

Government, organisational and local support for ENP role facilitated its implementation. The ENP role at TNH occurred as part of the DHS funded Emergency Nurse Practitioner Project that was aimed at establishing ENPs as an effective and sustainable model of emergency care delivery. Implementation of the ENP role was also supported by NH / TNH Executive, ED Nurse Unit Manager and Director of Emergency Medicine. A structured education program for one ENPC was not feasible on an organisational level so the majority of ENPC education was organised via VENPC with study days on a rotating site basis attended by all ENPCs across Melbourne and later in conjunction with rural ENPS. Study day content was determined on a needs basis and expert clinicians used to deliver study day content (Emergency Physicians, senior physiotherapists, pharmacists, product specialists, specialty specific experts e.g. RVEEH) and recruitment of expert clinicians and study day organisation was resource and time intensive. Medical staff (e.g. Emergency Physician group, radiologists) were extremely supportive of being involved in VENPC study days and providing 1:1 education in the clinical area. Although ENPC attendance at medical staff education was well received, many of the existing medical staff education programs did not meet the needs of ENPCs.
Education of ED medical and nursing staff was pivotal to the successful implementation of the ENP role. Pre-test data showed that although staff were generally supportive of the ENP role, there was poor understanding of the ENP role and requirements to for endorsement as an ENP. Post education data showed significant improvement in attitudes and knowledge related to the ENP role, requirements for endorsement, use of advanced emergency nursing practice and extensions to practice as a function of education. Anecdotal evidence suggests that many staff perceived that they had understood the ENP role when this may have not been the case. Pre-test knowledge surveys highlighted the need for education of medical and nursing staff about the ENP role however access to medical education time was more difficult than access to nursing education time.

In Victoria, it is a requirement that Nurse Practitioner practice is underpinned by evidence-based Clinical Practice Guidelines therefore ENPC is unable to manage specific patient groups until supported by a Clinical Practice Guideline. This requirement raises issues about guideline development, review and endorsement. Positive aspects of Clinical Practice Guidelines development by the ENPC were that theoretical preparation for practice and awareness of evidence / best practice rationales underpinning Clinical Practice Guidelines. Negative aspects of Clinical Practice Guideline development were the significant amounts of non-clinical time required to develop a baseline set of Clinical Practice Guidelines and the ongoing requirements for Clinical Practice Guidelines development to increase scope of practice. Clinical Practice Guideline review and endorsement by other personnel was extremely resource intensive (Emergency Physician mentor / emergency physician group / Directors of Pathology / Pharmacy / Radiology) and lack of high level evidence, conflict between evidence and practice, and differing expert opinions made finalising some Clinical Practice Guidelines difficult. A future issue will be periodic review of Clinical Practice Guidelines and the time required to undertake this process.

The Emergency Nurse Practitioner Project team collaborated with ENP project teams from other organisations to form the Victorian Emergency Nurse Practitioner Collaboration (VENPC). Positive outcomes of this collaboration were facilitation of Clinical Practice Guideline development and review, formation of a peer-support network, forum for discussion about the ENP role and opportunity to share data collection tools / develop common data collection tools.
2.3 Evaluation of Aged Care and Emergency Nurse Practitioner roles

There was rigorous evaluation of the implementation of the Nurse Practitioner roles in both Aged Care and Emergency Nursing. As part of the Aged Care and Emergency Nurse Practitioner projects, the evaluation methods were designed as part of the original project submissions and multiple methods were used to give comprehensive evaluation of roles. Although evaluation of the implementation of the roles is important to ensure that Nurse Practitioner care is safe and effective. The use of multiple evaluation methods was complex and would not be sustainable for long term role evaluation because of personnel, data management and data analysis requirements. It may also be argued that ongoing data collection by Nurse Practitioner Candidates would adversely affect efficiency. Like all clinical research, evaluation of the Nurse Practitioner roles was subject to a number of limitations. The success of data collection was influenced by confounding variables, for example poor response rates, and it may be argued that some outcome measures are not a true representation of the quality of Nurse Practitioner care, for example, patient satisfaction.

A key source of evaluation data for the Nurse Practitioner roles was Hospital Information Systems (HIS). HIS staff were responsive to data needs of the Emergency Nurse Practitioner project and ran reports as requested and emailed Victorian Emergency Minimum Dataset (VEMD) data on a monthly basis. There were a number of difficulties related to data extraction for the Emergency Nurse Practitioner project. For example, it was not possible to extract time between seen by the Triage Rapid Assessment Team and next doctor which would have given a more accurate indication of patient flow. VEMD data required significant manipulation to make data fields meaningful and able to be analysed, for example, time and date fields are presented as numbers rather than times and dates and the accuracy of some information was questionable, for example, delays in data entry may be reflected as prolonged ED LOS for discharged patients when patients may leave the ED but there is delay in completion of discharge paper work.

Tool development and validation expertise and good relationships between members of project team and key stakeholders in other EDs enabled piloting and validation of data collection tools resulting in valid and reliable tools. Publication of data collection tools developed for ENP evaluation in peer reviewed journals increased the profile of the Emergency Nurse Practitioner team at TNH both nationally and internationally. Statistical expertise and experience in the use of statistical software for analyses among the project team negated the requirement for outside statistical support however had these local expertise been lacking, statistical consultation would have added considerable expense to the ENP project. There was a lack of validated data collection tools that met needs of ENP evaluation so most of the data collection tools used to evaluate the Emergency Nurse Practitioner role were developed by the project team. This was resource intensive however collaborative development of data collection tools by the project officer and ENPC increased familiarity with tools to be used. The use of paper based data collection tools meant that data was entered manually into the computer software program: this was also extremely resource intensive. The requirement of ENPC to complete data collection tools for each patient seen limited efficiency of the ENP role in terms of numbers of patients seen per shift.

Wide variation in project commencement dates for the Emergency Nurse Practitioner projects, different evaluation methodologies between ENP project groups and organisational idiosyncrasies made it difficult to have common evaluation methods that would have provided a state-wide perspective of ENP care.
Similarly the ACNP project was implemented across three service settings; sub-acute, residential and community with varying project completion dates and data requirements. This limited the power of collective data analysis and benchmarking and highlights for future consideration the potential benefits of having consistent data requirements across Nurse Practitioner programs. Evaluation of the sub-acute model of ACNP consisted of four phases:

- Phase 1 involved an audit of ACNP activities, and captured patient demographics, referral sources, initial and subsequent contacts, mode of contact and location, presenting problem, assessment, intervention, service referrals and extended practice activities.
- Phase 2 involved health professional surveys to evaluate the role of the ACNP Candidate in the following areas - timeliness, adequacy of information provided, accessibility, appropriateness of referrals, collaborative practices, perceived benefits, disadvantages;
- Phase 3 involved patient interviews to evaluate the role of the ACNP Candidate in the following areas: accessibility and acceptability, quality, appropriateness of service provided, continuity of care, patient / carer perceptions of outcomes.
- Phase 4 involved an interview with the ACNP Candidate.

2.4 Summary

The Nurse Practitioner roles in Emergency Nursing and Aged Care were funded by the Victorian Department of Human Services. Both initiatives have been highly successful and well supported within their respective contexts of practice and have met designated outcome measures within prescribed timeframes, fulfilled reporting requirements and complied with budgets. Both Nurse Practitioner Candidates were the first in their specialties at Northern Health and this had both advantages and disadvantages. Advantages included opportunity to develop a clinical career pathway for nurses, retention of highly skilled nurses in clinical practice, opportunity to extend traditional scope of nursing practice use new skills, knowledge and expertise and opportunity to develop and evolve the Nurse Practitioner role. Disadvantages included lack of role clarity, absence of role models and peer support, need to establish professional boundaries and re-define professional relationships so support from medical and nursing staff was pivotal to the success of Nurse Practitioner roles. Northern Health’s experience in implementing two Nurse Practitioner roles to date has resulted in a comprehensive understanding at various levels of the organization of the requirements of both the Nurse Practitioner role and the strategies that enable its successful implementation, evaluation and sustainability. Inter-professional consultation and collaboration has been vital to the success of the Nurse Practitioner roles that currently exist within Northern Health. Both initiatives have required the support of Northern Health Executive and the Management at each site. Consultation and collaboration with Heads of Departments such as Radiology, Pathology and Pharmacy has been vital to the success of both of these initiatives.
3 Policy frameworks to support Nurse Practitioner roles

Key Recommendations:

- major issues related to prescribing by Nurse Practitioners / Nurse Practitioner Candidates are i) lack of Pharmaceutical Benefits Scheme (PBS) access for endorsed Nurse Practitioners, and ii) absence of legislative framework to allow for prescribing of medications by Nurse Practitioner Candidates.
- major issues related to diagnostic authority are i) lack of MBS access for endorsed Nurse Practitioners and ii) ordering diagnostics by Nurse Practitioner Candidates
- major issues related to referrals are i) failure of MBS to recognise Nurse Practitioners / Nurse Practitioner Candidates referrals to outpatient clinics as valid referrals and ii) inability of Nurse Practitioners / Nurse Practitioner Candidates to lead outpatient care services
- urgent legislative review and reform is necessary so that legislative frameworks that govern health care provision reflect contemporary health care delivery and do not disadvantage specific health care providers and patient groups

3.1 Prescriptive authority

Interim measures for prescription of medications by Nurse Practitioner Candidates are already in place as a result of the Emergency and Aged Care Nurse Practitioner initiatives. These interim processes have been tested over time and have been effective to date. It is anticipated that the interim processes related to prescribing that are already in place could be translated to other contexts of practice as Nurse Practitioner roles are implemented across Northern Health. This policy framework expands on these processes to include policy recommendations about prescription of medications by endorsed Nurse Practitioners.

Background and context

There are two major issues related to prescribing by Nurse Practitioners / Nurse Practitioner Candidates:

i) lack of Pharmaceutical Benefits Scheme (PBS) access for endorsed Nurse Practitioners, and

ii) absence of legislative framework to allow for prescribing of medications by Nurse Practitioner Candidates.

Although endorsed Nurse Practitioners can independently prescribe medications from their specific formulary, current legislation precludes Nurse Practitioners from access to the Pharmaceutical Benefits Scheme (PBS). PBS is a Commonwealth Government system of subsidising prescription medications.1 PBS is governed by Part VII of the National Health Act 1953 and National Health (Pharmaceutical Benefits) Regulations 1960 made under the Act. Approximately 80% of medications in Australia are subsidised under the PBS.2 There are two levels of subsidy: general subsidy and additional subsidies for concession card holders.

The following rules apply for writing PBS prescriptions. PBS prescriptions must:1

- be written by a medical practitioner or dentist,
- be written in indelible form (ink or ball-point pen) in the prescriber’s own handwriting using a standard PBS prescription, or on a computer generated form approved by Medicare Australia,
- record the prescriber’s name and address, the patient’s name, address and entitlement status, and whether the prescription is under the PBS or RPBS,
- completely identify the pharmaceutical benefit by detailing the item, dose, form, strength, quantity and instructions for use,
- indicate where brand substitution is not permitted, and
- be signed by the prescriber and dated (forward or back dating is not permitted).
There are specific arrangements for PBS prescriptions in Victorian public hospitals. PBS access is given to patients attending or discharged from a public hospital. Medical practitioners employed with the public hospital may prescribe the medication. Hospital drug charts used on inpatient units and in the Emergency Department are not PBS prescriptions so if medications are ordered on these charts, there are no PBS implications. Northern Health discharge prescriptions are, however, a PBS prescription. In this instance, only prescriptions completed by registered medical practitioners and dentists approved to work within the PBS will be subsidised. As Nurse Practitioners are not approved for PBS access, PBS prescriptions completed by Nurse Practitioners are dispensed as non-PBS items and the patient is not entitled to the PBS subsidy.

As there are no endorsed Nurse Practitioners at Northern Health at the time of writing this report, the full impact of lack of PBS access is yet to be determined. Evaluative data from implementation of the Emergency Nurse Practitioner role showed that of 367 patients who were discharged from the ED, 52.8% (n = 194) were given advice regarding the use of over the counter analgesic preparations by the Emergency Nurse Practitioner Candidate. Only 16.6% of discharged patients (n = 61) required discharge medications to be prescribed and of these, 62.3% (n = 38) were analgesics and 47.5% (n = 29) were oral antibiotics. These medications are relatively inexpensive and do not result in large financial deficits when dispensed as non-PBS items.

The issue that will remain unresolved until legislative changes enables PBS access by Nurse Practitioners is discharge prescriptions that need to be dispensed by private pharmacists. Nurse Practitioners can complete the prescription however the patient will be charged the full cost of the medication and there will be no PBS subsidy. The other option is to request that these prescriptions be completed by medical staff so that the prescription meets PBS criteria.

There are currently two systems in place at Northern Health to overcome the absence of a legislative framework for prescribing by Nurse Practitioner Candidates. In all cases, prescription of medications is governed by the Clinical Practice guidelines and both systems require high levels of medical support. The Aged Care Nurse Practitioner Candidate at BHS currently consults with general practitioners and / or consultant geriatricians who then prescribe medications or alter existing medication regimes. This has been a successful strategy for the aged care context of practice and there are no PBS implications as the prescription is completed by a medical officer. The disadvantage to this system is that the Nurse Practitioner Candidate does not get practice and preparation at writing his / her own prescriptions.

The Emergency Nurse Practitioner Candidate at TNH prescribed medications in consultation with an Emergency Physician. Patient cases, including medications to be ordered were discussed with the supervising Emergency Physician in a process similar to that undertaken by junior medical staff. This provided opportunity to demonstrate rationale for medications prescribed and ensure safe prescribing patterns prior to medication administration.

Medication orders on Emergency Department Observation Chart (MR62), TNH Drug Chart (MR72) and TNH discharge prescriptions that were to be dispensed by TNH Pharmacy were written by the Emergency Nurse Practitioner Candidate and co-signed by an Emergency Physician. Although the TNH discharge prescription is by definition a PBS prescription, the presence of two signatures negates the validity of PBS script so medications from these prescriptions are currently dispensed as non-PBS items. As discussed previously, most of these medications are oral analgesics and antibiotics.

If discharge prescriptions required dispensing by a private pharmacist, the ENPC discussed the need for the prescription with an Emergency Physician who then completed the prescription as per the PBS criteria. Although there was a process for external prescriptions in place, it was not utilised during the project. These processes were approved by the Director of Emergency Medicine and Director of Pharmacy prior to implementation of the ENP role.
Prescription framework

Prescription of medications by Nurse Practitioners / Nurse Practitioner Candidates is governed by Clinical Practice Guidelines. MIMS on-line and Northern Health drug protocols should be used as primary references for medication recommendations. Other references can be used as indicated. Clinical Practice Guidelines that include prescription of medications should be discussed with the key stakeholders including the Director of Pharmacy (or their nominee) prior to their development. This will give the Director of Pharmacy (or their nominee) an opportunity to consider actual or potential PBS implications. The final Clinical Practice Guideline should be approved by the Director of Pharmacy (or their nominee) and then approved by one of the Northern Health Drugs and Therapeutics Committees. If there are significant PBS implications for specific medications, a possible contingency is that those medications are prescribed by medical staff.

Prior to implementation of Nurse Practitioner Candidate roles, processes for prescribing should be negotiated with supervising medical staff, preferably the Head of Department. Prior to ordering medication, Nurse Practitioner Candidates should formally discuss the patient case with supervising medical staff. This discussion should include the rationale for the medication prescribed and demonstration of appropriate dose, route of administration, frequency of administration, adverse effects, and contraindications.

Following this process, the Nurse Practitioner Candidates can either:
   i) request that supervising medical staff complete the medication orders, OR
   ii) order medications and request that supervising medical staff co-sign the medication order.

Irrespective of which of the above options is selected, medical staff should have the opportunity to review / examine the patient if required prior to administration of medication. Support of senior medical staff and their agreement to complete / countersign medication orders is paramount.

To minimise the potential for drug errors, Nurse Practitioners / Nurse Practitioner Candidates should not administer parenteral medications that they have ordered. If there is the need for Nurse Practitioners / Nurse Practitioner Candidates to administer parenteral medications that they have also ordered, they need to be checked and signed for by a second Registered Nurse (Division 1) or Medical Officer.
3.2 Diagnostic authority

Interim measures for ordering diagnostics by Nurse Practitioners / Nurse Practitioner Candidates are already in place as a result of the Emergency and Aged Care Nurse Practitioner initiatives. These processes have been tested over time and to date, have been effective. It is anticipated that the interim processes related to diagnostic authority that are already in place could be translated to other contexts of practice as Nurse Practitioner roles are implemented across Northern Health. Diagnostic authority is governed by the Medicare Benefits Schedule which refers to ‘treating practitioners’. Under the Health Insurance Act 1973, a ‘practitioner’ is defined as a medical practitioner or a dental practitioner highlighting the need for urgent legislative review and reform so that legislative frameworks that govern health care provision reflect contemporary health care delivery.

3.2.1 Diagnostic imaging

Background and context

Diagnostic imaging services at Northern Health are provided by Symbion Imaging, which is a private provider that has a contract with Northern Health. Diagnostic imaging is defined in the Health Insurance Act 1973 as ‘a procedure for the production of images (for example x-rays, computerised tomography scans, ultrasound scans, magnetic resonance imaging scans and nuclear scans) for use in the rendering of diagnostic imaging services’.3

The major issue affecting ordering of diagnostic imaging by Nurse Practitioners / Nurse Practitioner Candidates is lack of Medicare Benefits (MBS) access for endorsed Nurse Practitioners. Although endorsed Nurse Practitioners can independently order diagnostic imaging within the boundaries of their Clinical Practice Guidelines, current legislation precludes Nurse Practitioners from access to Medicare benefits. Medicare provides access to medical and hospital services for all Australian residents and certain categories of visitors to Australia. Legislation covering the major elements of the Program is contained in the Health Insurance Act 1973.3

Medicare benefits are not payable when medical expenses for the service are paid or payable to a recognised (public) hospital.3 This means that there are no MBS implications requests for diagnostic imaging by Nurse Practitioners / Nurse Practitioner Candidates working in public hospitals (inpatient units, emergency departments or public VACS funded clinics). Orders for diagnostic imaging in this context will be within the boundaries of the Clinical Practice Guidelines. Although there is no legislative requirement that diagnostic imaging requests are in a particular form, legislation does require that diagnostic imaging requests must be:3

- in writing
- contain sufficient information to clearly identify the item/s of service requested including the clinical indication(s) for the requested service
- be signed and dated
- contain the name and address or name and provider number of the requesting practitioner

Responsibility for the adequacy of requesting details rests with the requesting practitioner.3

MBS implications occur when requests for diagnostic imaging fall outside the public hospital system (including requests made in private clinics run by public hospitals). For a valid referral to occur, only the following health care professionals may request diagnostic imaging under the Medicare Benefits Schedule:3

- specialists and consultant physicians can request any diagnostic imaging service, and
- other medical practitioners can request any service except Magnetic Resonance Imaging Services.

Physiotherapists, chiropractors, osteopaths, podiatrists, oral and maxillofacial surgeons, prosthodontists, dental specialists (periodontists, endodontists, pedodontists and orthodontists) are also permitted to order specific diagnostic imaging related to their area of practice. There is no scope for Nurse Practitioners / Nurse Practitioner Candidates to order diagnostic imaging in these contexts.3
There are two processes currently in place for ordering diagnostic imaging by Nurse Practitioners / Nurse Practitioner Candidates at Northern Health. The Emergency Nurse Practitioner Candidate works within the public hospital system so independently completes the imaging requests for plain film x-rays and ultrasounds and these requests are clearly identified with the Emergency Nurse Practitioner Candidate's name and designation. Investigations that expose patients to high levels of radiation (e.g. CT scan) are currently co-signed by an Emergency Physician. All imaging requested by the Emergency Nurse Practitioner Candidate are performed by Symbion Imaging at TNH.

In contrast, the Aged Care Nurse Practitioner Candidate works between the public hospital system and the community. The Aged Care Nurse Practitioner Candidate does not order diagnostic imaging and consults with general practitioners to organise investigations such as CT brain. These investigations are then usually performed by private service providers but MBS implications are negated by completion of the referral by a medical practitioner.

Policy framework

Initiation of diagnostic imaging by Nurse Practitioners / Nurse Practitioner Candidates is governed by Clinical Practice Guidelines. The Royal Australian and New Zealand College of Radiologists (Imaging Guidelines) should be used as a primary reference for diagnostic imaging. Clinical Practice Guidelines that include diagnostic imaging should be discussed with the key stakeholders including the Director of Radiology (or their nominee) prior to their development. This will give the Director of Radiology (or their nominee) an opportunity to consider actual or potential MBS implications. The final Clinical Practice Guideline should be approved by the Director of Radiology (or their nominee). If there are significant MBS implications for specific imaging requests, a possible contingency is that those investigations are ordered by medical staff.

Prior to implementation of Nurse Practitioner Candidate roles, processes for ordering diagnostic imaging should be negotiated with supervising medical staff, preferably the Head of Department and Director of Radiology (or their nominee). There should be opportunity for Nurse Practitioner Candidates to discuss patient cases with supervising medical staff and demonstrate the rationale for imaging requests. When electronic request systems are used, for example, the BOSS system currently used in the Emergency Department at TNH, the level of access given to Nurse Practitioners / Nurse Practitioner Candidates should reflect the content of the Clinical Practice Guidelines.

3.2.2 Pathology testing

Background and context

Pathology tests are defined in the Health Insurance Act 1973 as ‘pathology service means a medical service to which an item of the pathology services table relates’. Many of the same issues described in the section above ‘Diagnostic imaging’ apply to ordering of pathology tests by Nurse Practitioners / Nurse Practitioner candidates.

Again, lack of MBS access for endorsed Nurse Practitioners and ordering pathology tests by Nurse Practitioners / Nurse Practitioner Candidates are major issues. Although endorsed Nurse Practitioners can independently order pathology tests within the boundaries of their Clinical Practice Guidelines, current legislation precludes Nurse Practitioners from access to Medicare benefits. Like diagnostic testing Medicare benefits are not payable when medical expenses for the service are paid or payable to a recognised (public) hospital. This means that there are no MBS implications for pathology tests by Nurse Practitioners / Nurse Practitioner Candidates working in public hospitals (inpatient units, emergency departments or public VACS funded clinics). Orders for pathology tests in this context will be within the boundaries of the Clinical Practice Guidelines.
Although there is no legislative requirement that pathology test requests are in a particular form, legislation does require that pathology requests contain:

- pathology services (or groups of pathology tests) to be rendered using only acceptable terms and abbreviations,
- requesting practitioner's surname, initials, provider number and signature,
- date of request,
- the patient's name and address,
- details of the hospital status of the patient
- details of the person or approved pathology service to whom the request is directed

There are two processes currently in place for ordering pathology tests by Nurse Practitioners / Nurse Practitioner Candidates at Northern Health. The Emergency Nurse Practitioner Candidate works within the public hospital system so independently completes requests for pathology tests within the boundaries of Clinical Practice Guidelines. Pathology requests are clearly identified with the Emergency Nurse Practitioner Candidate’s name and designation. All pathology tests requested by the Emergency Nurse Practitioner Candidate are performed by Network Pathology at TNH which is managed by Austin Health.

In contrast, the Aged Care Nurse Practitioner Candidate works between the public hospital system and the community. The Aged Care Nurse Practitioner Candidate also orders pathology tests however these services are provided by Melbourne Pathology. Again, all pathology requests are clearly identified with the Aged Care Nurse Practitioner Candidate’s name and designation.

Policy framework

Initiation of pathology tests by Nurse Practitioners / Nurse Practitioner Candidates is governed by Clinical Practice Guidelines. The Royal College of Pathologists, Australasia (RCPA Manual 4th edition) should be used as a primary reference for pathology tests. Clinical Practice Guidelines that include pathology testing should be discussed with the key stakeholders including the Director of Pathology (or their nominee) prior to their development. This will give the Director of Pathology (or their nominee) an opportunity to consider actual or potential MBS implications. The final Clinical Practice Guideline should be approved by the Director of Pathology (or their nominee). If there are significant MBS implications for specific pathology requests, a possible contingency is that those investigations are ordered by medical staff.

Prior to implementation of Nurse Practitioner Candidate roles, processes for ordering pathology tests should be negotiated with supervising medical staff, preferably the Head of Department and Director of Pathology (or their nominee). There should be opportunity for Nurse Practitioner Candidates to discuss patient cases with supervising medical staff and demonstrate the rationale for pathology requests. When electronic request systems are used, for example, the BOSS system currently used in the Emergency Department at TNH, the level of access given to Nurse Practitioners / Nurse Practitioner Candidates should reflect the content of the Clinical Practice Guidelines.
3.3 Referral process

Nurse Practitioners and Nurse Practitioner Candidates may make referrals to a range of health care professionals. Processes for referral to both inpatient and outpatient specialists are in place as a result of the Emergency and Aged Care Nurse Practitioner initiatives. These processes have been effective to date and can be extended to include referrals made in other contexts of practice.

3.3.1 Referral to Clinical Nurse Consultants and Allied Health Services

Clinical Nurse Consultants and Allied Health Services accept referrals from nursing staff so these current processes would apply to referrals from Nurse Practitioner (Candidates).

3.3.2 Referral to inpatient registrars

Both the Emergency and Aged Care Nurse Practitioner Candidates currently make direct referrals to inpatient registrars and consultant medical staff. The Emergency Nurse Practitioner Candidate requests assessment for admission from inpatient units as recommended by the Clinical Practice Guidelines. All Emergency Nurse Practitioner Candidate requests for assessment for admission are discussed with the Co-ordinating Emergency Physician prior to referral to ensure appropriate referrals and pre-referral work-up. This process also applies to junior medical staff.

3.3.3 Referral to Community Therapy Services

Community Therapy Services provides outpatient rehabilitation to both centre-based and home-based clients. Treatment programs offer fast-stream therapy, provided by Physiotherapists, Occupational Therapists, Speech Pathologists, Dieticians, Nurses and Psychologists. Also included are Self-Efficacy groups, Stroke Education Groups, Carers’ Groups, Exercise Groups and Hydrotherapy. The Aged Care Nurse Practitioner currently refers to these services.

3.3.4 Referral to Hospital in The Home

HITH currently accepts referrals from the Emergency Nurse Practitioner Candidate. HITH admission criteria are currently supported by policy and HITH admission criteria are the same irrespective of the referring Nurse Practitioner / Medical Officer. Patients admitted into Hospital in the Home must be accepted by an inpatient unit.

HITH currently provides care for private and public patients. Prior to HITH referral of private patients, it must be ascertained if the patient is a self funding private patient or covered by a private health insurance company. If covered by a private health fund the patient may be admitted to HITH as a private patient. If the patient is self funding, they should be admitted to HITH as a public patient to avoid out of pocket expenses. Currently the Emergency Nurse Practitioner Candidate refers to HITH and completes the HITH admission documents.

Policy framework

Referrals to HITH by Nurse Practitioners / Nurse Practitioner Candidates should be made in conjunction with an inpatient unit.
3.3.5 Referral to outpatient clinics

Although both the Aged Care and Emergency Nurse Practitioner Candidates have been referring to outpatient clinics, further refinement of these referral processes is necessary if Nurse Practitioner roles are to be implemented across Northern Health.

Background and context

There are 2 separate issues related to Nurse Practitioners and referral to public hospital outpatient clinics:

i) referral to outpatient clinics by Nurse Practitioner / Nurse Practitioner Candidate to obtain a specialist medical (or multidisciplinary) consultation

ii) referral to outpatient clinics by other health care professionals to obtain a Nurse Practitioner / Nurse Practitioner Candidate consultation

Referral from a primary care physician or inpatient unit is required to attend a hospital outpatient clinic. Outpatient services are typically paid for through hospital or health service budgets but can utilise private medical and allied health specialists on a fee-for-service basis where medical services are funded through the Commonwealth Medicare system. The current structure of outpatient care at Northern Health is a combination of publicly funded and privatised clinics. Public outpatient services are funded through the Victorian Ambulatory Classification and Funding System (VACS) and are a major source of free specialist medical and allied health care. Privatised clinics are run on a fee-for-service basis and the direct cost to patients depends on the billing arrangements of physicians. Currently at TNH, patients attending privatised clinics are bulk billed so do not have out-of-pocket expenses for the consultation. Patients may however incur fees related to diagnostic testing (imaging and pathology) and these fees currently apply to patients seen in private clinics irrespective of the level of practitioner making the referral.

There are two major issues related to referral to specialists in outpatient clinics by Nurse Practitioners / Nurse Practitioner Candidates. First, there is currently no legislative framework that supports referrals to outpatient clinics by Nurse Practitioners / Nurse Practitioner Candidates. A valid referral is defined as a “...request for specialist opinion, investigation, treatment and / or management of a condition...” For a referral to be valid, the referring practitioner must communicate relevant information about the patient to the specialist in writing, the referral must be signed by the referring practitioner, and the specialist must receive the referral on, or prior to, the consultation.

The absence of a legislative framework supporting referrals to specialists may be overcome by interim measures, for example, those tested during the Emergency Nurse Practitioner project. During the Emergency Nurse Practitioner, outpatient referrals were made as recommended in the Clinical Practice Guidelines, and also discussed with and co-signed by an Emergency Physician. Currently there is limited demand for outpatient referrals by the Aged Care Nurse Practitioner Candidate and the majority of referrals in this context of practice are made to Community Therapy Services (see above).

A major risk management issue related to outpatient clinic referrals is follow-up after the specialist consultation. This applies to ALL outpatient referrals irrespective of the level of practitioner making the referral. It is imperative that processes for follow-up after a specialist consultation and review of results of diagnostic tests that may be ordered as part of the specialist consultation are implemented. Typically, follow-up will be provided by the Local Medical Officer or General Practitioner however there may be the need for some health care professionals to be involved in long term patient management and provide specific follow up after the specialist consultation.

There are also legislative limits to Nurse Practitioners having a consultative role as specialists in outpatient clinics. The Health Insurance Act defines clinically relevant professional services as ‘services delivered by a medical or dental practitioner or an optometrist that is generally accepted in the medical dental or optometric profession...’ Currently, the only service providers that are eligible for Medicare payment are recognised
specialists, consultant physicians or general practitioners. The Medicare Benefits Schedule for Allied Health and Dental Services states that allied health services are available “... to people with chronic conditions and complex care needs who are being managed by a medical practitioner under an Enhanced Primary Care (EPC) plan.” Medicare benefits are only available for up to five allied health services per patient, per calendar year. Services may only be provided by the following professional groups: aboriginal health workers, audiologists, chiropodists, chiropractors, diabetes educators, dieticians, mental health workers, osteopaths, physiotherapists, podiatrists, psychologists, occupational therapists and speech pathologists who are registered with Medicare Australia. In order that Medicare Benefits are payable, the patient must be referred to an eligible allied health professional by their GP using an EPC referral form. Services provided by allied health professionals must be personally provided by the allied health professional, be at least 20 minutes in duration and provided to individual patients, not groups. Allied health professionals must provide a written report back to the GP after each service and reports should include details of investigations, tests or assessments performed, treatment provided and future management plan.

The only nursing roles that fit within the current legislative framework are diabetes educators and mental health workers. In order to register with Medicare Australia, Diabetes Educators must be credentialed by the Australian Diabetes Association and mental health nurses must be certified by the Australian and New Zealand College of Mental Health Nurses. Medicare benefits can also apply to persons other than medical practitioners if they are employed or supervised by a medical practitioner and it is this condition of the Medicare Benefits Schedule that covers multidisciplinary clinics. The legislative requirement that nurses practice under the supervision of a medical practitioner would limit nurse practitioner roles in this context.

Policy framework

Referrals to outpatient clinics by Nurse Practitioners / Nurse Practitioner Candidates can be made within the boundaries of the Clinical Practice Guidelines. To comply with Medicare requirements for a valid referral, referrals made to outpatient clinics at Northern Health by Nurse Practitioners / Nurse Practitioner candidates must be co-signed by supervising medical staff. There should also be a clear process for follow-up of after the specialist consult either by the referring team or the patient’s general practitioner.
3.4 Admission and discharge protocols

Admission to Northern Health may include admission to TNH, BECC or BHS. Inter-hospital transfers do not occur between Northern Health sites: patients are discharged from one facility and then admitted to another. The following section will outline current admission and discharge policies which would apply to all personnel admitting and discharging patients from Northern Health including Nurse Practitioners / Nurse Practitioner Candidates.

3.4.1 Admission

Admission to The Northern Hospital (TNH)

Admission to TNH occurs via one of two processes:

i) unplanned (emergency) admissions including admissions via the Emergency Department, outpatients department, consultants with admitting privileges at TNH or transfer from other facilities, or

ii) planned (elective) admission to an inpatient unit.

Emergency admission occurs when patients attend the ED and their condition warrants HITH or inpatient management. Processes for emergency admission of Nurse Practitioner / Nurse Practitioner managed patients have been established and successfully tested during the Emergency Nurse Practitioner project. The Emergency Nurse Practitioner candidate makes direct referrals to inpatient Registrars and / or Consultants, Hospital in the Home and the Short Stay Unit as per Clinical Practice Guidelines. Prior to each referral, the patient case is discussed with an Emergency Physician: this process is the same for junior medical staff making referrals for assessment for admission. Prior to implementation of the ENPC role, referral processes were discussed with the Director of Short Stay Unit, Head of Departments of Medicine, Surgery, Obstetrics and Gynaecology and Paediatrics and Nurse Unit Manager of Hospital in the Home all of whom agreed to this process prior to implementation of the ENP role. If the inpatient unit agrees that admission is warranted a Notice of Admission is completed, the Admitting Officer notified and an inpatient bed arranged.

Expected admissions to TNH occur by elective admission from an elective surgical list. Admission to TNH via this pathway is dependent on elective surgical category (or urgency of procedure), time spent on waiting list, previous cancellations and inpatient bed availability.

A number of patients require admission to TNH from Nursing Homes for replacement of percutaneous endoscopic gastroscopy (PEG) tubes. TNH has an arrangement with local Nursing Homes that all admissions for PEG tube replacement are coordinated by the admitting officer. In hours, the patient is held at the Nursing Home while the admitting officer contacts radiology who book a time for the patient to come in that day for their PEG tube replacement. Out of hours, the procedure is organised for the following morning. If the patient required urgent hydration or medication, the patient will be transferred from the Nursing Home to the Emergency Department for intravenous administration of fluids and / or medications.

Admission to Broadmeadows Health Service (BHS)

The majority of admissions to BHS come from acute care sector (~85%) and the remainder are from the community. Admission to BHS occurs via the Intake Unit which:

- is the single point of entry BHS, and
- provides bed management of the Rehabilitation and Geriatric Evaluation and Management (GEM) Units,

Northern Health has an Aged Care Shared Care program that is a community-based service that provides multidisciplinary assessment and treatment within the patient’s home or residential care facility. Referrals for admission from the community or residential care may be assessed by the Aged Care Shared Care team and then discussed with a consultant geriatrician. If acute assessment and / or intervention is warranted then the patient will be referred to ED. If admission to BHS is needed, the Intake Unit will be contacted.
Admission to BECC

Admission to BECC occurs via the Access Unit. Approximately 80% of admissions to BECC are from acute care settings and 20% are admitted from the community. BECC is only able to accept medically stable patients so if acute assessment and / or intervention is warranted the patient will be referred to ED.

Policy framework

The process for admission is the same, irrespective of the practitioner requesting admission:

- all patients for admission need to be accepted by an inpatient unit and referral for assessment for admission should be congruent with the Clinical Practice Guidelines
- once the inpatient unit has accepted the patient, the Admissions Manager at the specific site should be contacted regarding bed allocation (Admitting Officer at TNH / Intake Unit at BHS / Access Unit at BECC).
4 Development of Nurse Practitioner roles within Northern Health

Key Recommendations:
- priority areas for implementation of Nurse Practitioner models should be driven by service demand and organisation strategic direction
- where possible Nurse Practitioner models should be health service rather than site based
- priorities for further development of existing Nurse Practitioner models of care within Northern Health are Emergency Nursing and Aged Care Nursing
- priorities for new Nurse Practitioner models of care within Northern Health are Wound Management, Oncology, Intensive Care Liaison, Diabetes, Neonatal Nursing and Continence

4.1 Methodology

The complexity of implementing (and evaluating) Nurse Practitioner / Nurse Practitioner Candidate roles can not be under-estimated. Successful role implementation is multifactorial and depends on key stakeholder support and robust processes. Many of these processes and frameworks require development prior to appointment of Nurse Practitioners / Nurse Practitioner Candidates, for example:
- Identify priority areas - organisation strategic direction, service demands, workforce issues
- Engage key stakeholder support
- Form Nurse Practitioner working group / steering committee
- Define patient group and scope of practice
- Develop business plan with initial and ongoing budget considerations
- Prioritise service delivery needs to inform Clinical Practice Guideline development / adaptation
- Identify learning needs of Nurse Practitioner Candidates and plan strategies to meet those needs including allocation of clinical mentor(s)
- Develop evaluation framework that will be applicable over the longer term
- Develop and implement education framework to inform other staff about the Nurse Practitioner role (medical / nursing / allied health)

4.2 Identification of priority areas

Northern Health used two methods to identify priority areas for Nurse Practitioner roles. First, the organisation’s strategic plan and future directions were used to identify areas if increased or changed service demand and therefore inform possible Nurse Practitioner roles. Second, all clinical areas within Northern Health were invited to submit an Expression of Interest for a Nurse Practitioner role in their specific context. The following Nurse Practitioner roles were identified as priority areas for Northern Health:
- i) further development of existing Nurse Practitioner roles
  - Emergency Nurse Practitioner
  - Aged Care Nurse Practitioner
- ii) implementation of new Nurse Practitioner roles
  - Wound Management Nurse Practitioner
  - Oncology Nurse Practitioner
  - Intensive Care Liaison Nurse Practitioner
  - Diabetes Nurse Practitioner
  - Neonatal Nurse Practitioner
  - Continence Nurse Practitioner
4.3 Further development of existing Nurse Practitioner roles within Northern Health

4.3.1 Emergency Nurse Practitioner

Description of the service

The existing Emergency Nurse Practitioner role at TNH has been described in detail in Section 2. The Emergency Nurse Practitioner role will be further developed at Northern Health with the Emergency Nurse Practitioner role to be implemented at CHS as part of the staffing model for the Minor Illness and Injury Clinic and further expansion of the Emergency Nurse Practitioner in the Emergency Department at TNH. The current Emergency Nurse Practitioner Candidate is in the final stages of application endorsement as an Emergency Nurse Practitioner with the Nurses’ Board of Victoria and it is anticipated that another Emergency Nurse Practitioner Candidate will be appointed in 2007. CHS is will be operational in early 2007 and are currently recruiting Emergency Nurse Practitioners / Emergency Nurse Practitioner Candidates to staff the Minor Injury and illness Clinic.

Patient group

The Emergency Nurse Practitioner Candidate at TNH currently manages adult and paediatric patients presenting to the ED with minor illnesses and injuries. In the first year of implementation of the Emergency Nurse Practitioner role, 16 adult and 7 paediatric Clinical Practice Guidelines were developed. In the following 12 months the scope of practice of the Emergency Nurse Practitioner / Emergency Nurse Practitioner Candidate has increased dramatically with the development of an additional 10 adult and 8 paediatric Clinical Practice Guidelines (Table 1).

Table 1: Patients managed by the Emergency Nurse Practitioner / Emergency Nurse Practitioner Candidate

<table>
<thead>
<tr>
<th>Phase 1: 2004-05</th>
<th>Adult patients</th>
<th>Paediatric patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Pain and Inflammation suggestive of Mastitis</td>
<td>Earache suggestive of Otitis Media</td>
<td></td>
</tr>
<tr>
<td>Calf Pain suggestive of Deep Vein Thrombosis</td>
<td>Laceration and Wound Management</td>
<td></td>
</tr>
<tr>
<td>Elbow Injury</td>
<td>Lower Limb Injury (or non use)</td>
<td></td>
</tr>
<tr>
<td>Forearm / Wrist Injury</td>
<td>Minor Burn Injury</td>
<td></td>
</tr>
<tr>
<td>Foot Injury</td>
<td>Plaster of Paris Complication</td>
<td></td>
</tr>
<tr>
<td>Hand Injury</td>
<td>Upper Limb Injury (or non use)</td>
<td></td>
</tr>
<tr>
<td>Knee Injury</td>
<td>Vomiting and Diarrhoea</td>
<td></td>
</tr>
<tr>
<td>Adult patients</td>
<td>Paediatric patients</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>• Blood and Body Fluid Exposure (community)</td>
<td>• Barking Cough</td>
<td></td>
</tr>
<tr>
<td>• Blood and Body Fluid Exposure (staff)</td>
<td>• Ingested or Intra-nasal Foreign Bodies</td>
<td></td>
</tr>
<tr>
<td>• Emergency Contraceptive</td>
<td>• Minor Head Injury</td>
<td></td>
</tr>
<tr>
<td>• Fever and cough suggestive of Pneumonia</td>
<td>• Non-venomous Bite or Sting</td>
<td></td>
</tr>
<tr>
<td>• Non-venomous Bite or Sting</td>
<td>• Symptoms of Minor Allergic reaction</td>
<td></td>
</tr>
<tr>
<td>• Symptoms of Minor Allergic Reaction</td>
<td>• Respiratory Depression post Opiate administration</td>
<td></td>
</tr>
<tr>
<td>• Painless Vaginal bleeding in Early Pregnancy</td>
<td>• Ring Removal</td>
<td></td>
</tr>
<tr>
<td>• Respiratory Depression post Opiate administration</td>
<td>• Wheeze</td>
<td></td>
</tr>
<tr>
<td>• Ring Removal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Viral symptoms of Upper Respiratory Tract Infection</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Service gap analysis**

The Emergency Nurse Practitioner role is an important strategy in the management of increased service demands in the Emergency Department. The Emergency Department at TNH is currently the busiest in Victoria and provides care to over 68,000 patients annually. The importance of the Emergency Nurse Practitioner role may increase as workforce projections forecast both medical and nursing staff shortages. The advantage of this role is that the Emergency Nurse Practitioner is able to provide both nursing care and care that, until now, has been considered beyond the scope of nursing practice and was traditionally considered part of the medical domain. The ability to combine these skills makes Emergency Nurse Practitioners a versatile member of the health workforce. One of the major issues that remains unaddressed for many Emergency Nurse Practitioners is retention of advanced emergency nursing skills such as triage and resuscitation which further adds flexibility to the Emergency Nurse Practitioner role.
4.3.2 Aged Care Nurse Practitioner

Description of the service

The existing Aged Care Nurse Practitioner role at BHS has been described in detail in Section 2 and is underpinned by comprehensive geriatric assessment (Figure 2).

Figure 2: Aged Care Nurse Practitioner Model for Comprehensive Geriatric Assessment

The Aged Care Nurse Practitioner model of care at BHS is a generalist model. There are opportunities for the future development of Aged Care Nurse Practitioner models across Northern Health, for example, Cognitive Dementia and Memory Service (CDAMS) and Residential Care Intervention Program in the Elderly (RECIPE) Ageing of the Australian population is well documented. A recent Australian Society of Geriatric Medicine (ASGM) position statement concluded, that “medical services for all Australians in residential aged care facilities has been a neglected field from all perspectives including policy development, general practice initiatives, data collection, research and clinical guideline development” and that “as a matter of urgency, we now need to develop the process to achieve better outcomes for frail older Australians housed in residential facilities”. The development of the RECIPE Clinical Nurse Consultant (CNC) role towards endorsement as ACNP would enhance access to medication and diagnostics enabling the resident to receive treatment within their usual place of residence and avoid an acute admission or presentation to Emergency Department (ED) at TNH.
It is anticipated that the working group for this Aged Care Nurse Practitioner model would consist of the following key stakeholders:

- Northern Health Site Director(s) of Nursing
- Director(s) of Nursing, Aged Care Facility
- Geriatrician(s)
- Palliative Care Consultant
- General Practitioner(s)
- Representatives from Pharmacy, Pathology and Radiology services
- RECIPE manager
- GP liaison officer
- Aged Care Nurse Practitioner / Nurse Practitioner Candidate
- Expert aged care nurses
- Consumer representatives
- Academic/education representative

Patients who meet the RECIPE criteria would be referred for discharge follow-up by appropriate medical/nursing personnel. The Aged Care Nurse Practitioner working in the RECIPE service will:

- refer appropriate residents to the RECIPE Geriatrician, for example, complex care residents requiring medication management or those with outpatients appointments for medical clinics, that could more easily be conducted at the nursing home,
- review all referred residents for an initial visit and commence Advanced Treatment Planning discussion with patient and family (where appropriate) & development of management plans,
- review residents at their residential care facility in a rapid response capacity, and
- manage and / or refer residents with acute or intercurrent illness.

**Patient group**

The patient group that would be managed by the Aged Care Nurse Practitioner as part of the RECIPE service would meet the current RECIPE inclusion criteria:

- aged greater than 65 years
- admitted into TNH with a medical diagnosis from an aged care facility

OR

- patients in a high-level care facility that require development of a palliative care plan if symptoms can be managed at their facility, regardless of diagnosis (support may be provided to selected patients requiring palliation in low-level facilities)

AND

- lives within a 20 minute drive of TNH
- agrees to participate in RECIPE (either patient &/or family)
- agrees to participate in Advanced Treatment Planning (ATP) & development of a management plan

Table 2 outlines the extensions to nursing practice that may be identified through a Comprehensive Geriatric Assessment conducted by the RECIPE ACNP within the context of her / his role.
<table>
<thead>
<tr>
<th>Comprehensive Geriatric Assessment</th>
<th>Advanced nursing practice</th>
<th>Extensions to nursing practice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nutritional Screen CPG</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Dehydration</td>
<td>• advanced patient assessment</td>
<td>• request and interpret diagnostics (pathology)</td>
</tr>
<tr>
<td></td>
<td>• IV cannulation</td>
<td>• review medications including prescription of medications for symptom management, withholding of medication, prescription of alternative routes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• commencement of intravenous</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• referral to HITH for subcutaneous fluid administration</td>
</tr>
<tr>
<td>• PEG tube replacement</td>
<td>• advanced patient assessment</td>
<td>• referral to TNH for replacement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• commencement of intravenous fluids if indicated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• prescription of alternative routes for medication</td>
</tr>
<tr>
<td><strong>Skin Integrity CPG</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Simple cellulitis</td>
<td>• advanced patient assessment</td>
<td>• request and interpret diagnostics (pathology / microscopy &amp; culture)</td>
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<td></td>
<td>• IV cannulation</td>
<td>• commencement of intravenous / oral antibiotics</td>
</tr>
<tr>
<td>• Simple wound infection</td>
<td>• advanced patient assessment</td>
<td>• request and interpret diagnostics (pathology / microscopy &amp; culture)</td>
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<td></td>
<td>• wound management</td>
<td>• commencement of intravenous / oral antibiotics</td>
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<td></td>
<td></td>
<td>• referral to acute care services if warranted</td>
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<tr>
<td><strong>Continence Assessment CPG</strong></td>
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<tr>
<td>Urinary tract infection</td>
<td>• advanced patient assessment</td>
<td>• request and interpret diagnostics (pathology / microscopy &amp; culture)</td>
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<td>• continence management</td>
<td>• commencement of intravenous / oral antibiotics</td>
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<td>• referral to acute care services if warranted</td>
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<tr>
<td><strong>Respiratory Assessment CPG</strong></td>
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<tr>
<td>• Chest infection management</td>
<td>• advanced patient assessment</td>
<td>• request and interpret diagnostics (imaging / pathology / microscopy &amp; culture)</td>
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<td></td>
<td>• referral to physiotherapy</td>
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<td></td>
<td>• commencement of intravenous / oral antibiotics</td>
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<tr>
<td><strong>Cognitive Assessment CPG</strong></td>
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<tr>
<td>• Behavioural management</td>
<td>• advanced patient assessment</td>
<td>• request and interpret diagnostics (imaging and / or pathology) if indicated</td>
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<tr>
<td></td>
<td>• staff and family education</td>
<td>• prescription of short acting anti-psychotics for symptom control until review and assessment</td>
</tr>
<tr>
<td><strong>Palliation CPG (to be developed)</strong></td>
<td></td>
<td></td>
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<tr>
<td>• Palliative care</td>
<td>• advanced patient assessment</td>
<td>• referral to other services as indicated</td>
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<tr>
<td></td>
<td>• liaison with GP and other service providers</td>
<td>• management of medications for symptom control</td>
</tr>
<tr>
<td></td>
<td>• education / counselling for patient and carers</td>
<td></td>
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<tr>
<td><strong>Nursing Admission/Referral CPG</strong></td>
<td></td>
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</tr>
<tr>
<td>Referral to HITH for IV antibiotics, trial of sub-cutaneous fluids or blood transfusion</td>
<td>• advanced patient assessment</td>
<td>• referral to HITH, TNH</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• request and interpret diagnostics required for HITH admission work-up (imaging / pathology)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• prescribe medications and / or fluids for symptom control and ongoing HITH management</td>
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</table>
**Service gap analysis**

Aged Care Nurse Practitioner would help fill a gap in service delivery from TNH to residential aged care facilities. The plan would be to work in conjunction with the local doctor, aged care facilities, RECIPE Geriatricians and Nurse Consultants from appropriate areas within Northern Health. The position would be based at TNH with an outreach component to nursing homes & hostels within the Northern region.

**Case example**

A resident of a local aged care facility is referred to RECIPE after recurrent presentations to TNH with dehydration due to poor oral intake as a result of end-stage dementia. The Aged Care Nurse Practitioner working as part of the RECIPE team organises a family meeting & develops a management plan for treatment in the nursing home. A referral is made to HITH and the patient is managed with subcutaneous fluids. Once the patient is discharged from HITH, if further support is required the GP or facility staff can contact the RECIPE team for assistance or advice. One month later resident refuses oral intake over two days has a recurrence of acute dehydration. The Aged Care Nurse Practitioner is contacted, visits the aged care facility and conducts a comprehensive patient assessment. The Aged Care Nurse Practitioner liaises with the patient’s General Practitioner and family to discuss management options. Subcutaneous fluids are initiated by the Aged Care Nurse Practitioner and a referral made to TNH HITH so that subcutaneous fluids can be continued in the aged care facility for 48 hours. As a result of patient assessment findings, an MSU is taken and review of the results showed a urinary tract infection. Oral Trimethoprim was prescribed by the Aged Care Nurse Practitioner and the GP consulted regarding the change to this patient’s management plan.

The use of an Aged Care Nurse Practitioner as an extension of the RECIPE team would provide timely interventions in the patients residential care facility and therefore increase access to health care. A secondary outcome of management by an Aged Care Nurse Practitioner is reduction in transfers from aged care facilities to TNH Emergency Department. Decreased presentations to the Emergency Department has a number of benefits: i) improved patient outcomes by decreasing social and cognitive disruption, ii) reduces risk of complications such as falls and nosocomial infections and iii) more appropriate use of Emergency Department services.
4.4 Development of new Nurse Practitioner roles within Northern Health

4.4.1 Wound Management Nurse Practitioner

Description of the service

Northern Health currently provides a range of wound management services, all of which would be augmented by Wound Management Nurse Practitioners. There are chronic wound management services at BECC (integrated with PHS) and BHS with plans for CHS to also provide a chronic wound management service once it is open in 2007. TNH currently provides acute wound care services at the acute wound care clinic (which comprises clinics run by multidisciplinary teams of nurses, plastic surgeons and general surgeons) and the high risk foot clinic (which is largely podiatry led).

A Wound Management Nurse Practitioner model of care will improve both acute and chronic wound services at Northern Health. The Wound Management Nurse Practitioner is a key member of wound management services and as part of an interdisciplinary team will:

- perform wound assessment and treatment planning,
- provide patient (and family) education to promote an understanding of causes of chronic wounds and modify risk factors
- educate patients (and families) about how they may participate in the wound healing process,
- assist with discharge planning to ensure appropriate follow up support,
- provide a link between the patient, community nursing and general practitioners to ensure continuity of care is supported and maintained
- provide follow up care and review as appropriate.

In both acute and chronic wound services, Wound Management Nurse Practitioner(s) will work as part of an interdisciplinary team. The composition of the teams will change with the context of practice. It is anticipated that an acute care wound service will require collaboration between Wound Management Nurse Practitioner(s) and a range of nursing staff (Registered Nurses: Divisions 1 and 2 and Clinical Nurse Consultants), medical staff (Plastic Surgeons and General Surgeons) and allied health personnel (Occupational Therapists, Hand Therapists and Podiatrists). In the context of a chronic wound management service it is anticipated that the Wound Management Nurse Practitioner(s) would work in conjunction with Consultant Physicians, Rehabilitation Physicians, Division 1 and 2 Registered Nurses, Podiatrists, Occupational Therapists and other chronic disease services as appropriate for individual client care.

The Wound Management Nurse Practitioner scope of practice will be underpinned by a series of evidence-based Clinical Practice Guidelines developed using a multi-disciplinary approach. As a result the Wound Management Nurse Practitioner will be able to prescribe from a limited formulary of medications, particularly antibiotics for management of wound infection and analgesics to provide symptom relief. The Wound Management Nurse Practitioner would also have the authority to order diagnostic investigations including blood tests, urine tests, wound cultures and x-rays as indicated.

The need to manage acute and chronic wounds is increasing. Chronic wounds are a significant and increasing financial and health concern: it is estimated that approximately 1 in 100 older people have a chronic wound. The increase in chronic wounds is a reflection of increases in other diseases: for example, the increasing prevalence of diabetes has resulted in an increased prevalence of diabetic foot ulcers. As result of the ‘aging population’ there will be a corresponding increase in age-associated medical problems, including wounds. A recent study of 66 residential facilities (2600 beds) in Melbourne found that 25% of residents have a wound at any given time. Extrapolation of these findings across all residential facilities means there is potential for 30,000 wounds requiring management in Melbourne. Comparison of standard treatment protocols for wound management with a control group who received traditional wound management showed that treatment protocols
resulted in significant cost savings (approximately $83.70 / resident). If these savings were to be expressed across Australia’s 140,000 high care beds then a projected saving over 40 weeks could be in the order of $12 million per year. Best practice wound management in the primary care setting has been associated with improvement in management of chronic wounds. Therefore, the type of wounds being referred to specialty services is growing in complexity.

The Wound Management Nurse Practitioner working group would be comprised of key stakeholders, who may vary depending on the site and context of the Wound Management Nurse Practitioner model of care. It is anticipated that the key stakeholder group would consist of

- Chief Nursing Officer, Northern Health
- Chief Medical Officer, Northern Health
- Northern Health Site Director(s) of Nursing
- Service Clinical Coordinator or Nurse Unit Manager
- Medical staff (e.g. Plastic Surgeons, General Surgeons, Geriatricians, Rehabilitation Physicians)
- Representatives from Pharmacy, Pathology and Radiology services
- Expert wound management nurses from existing Northern Health services
- Consumer representatives

**Patient group**

The patients that could be managed by Wound Management Nurse Practitioner(s) vary between Northern Health sites. Currently TNH is primarily responsible for delivery of acute wound services and logistics would suggest that TNH would continue to provide acute wound care services under a Wound Management Nurse Practitioner model of care. Acute wound services may be provided to TNH inpatients whereby the Wound Management Nurse Practitioner(s) may provide a referral based liaison service and also in an outpatient clinic context where existing services provided would be augmented by Wound Management Nurse Practitioner(s).

There is a wide scope for service delivery by Wound Management Nurse Practitioner(s) at BECC, BHS, PHS and CHS. Service delivery by Wound Management Nurse Practitioner(s) with a focus on chronic wound management at BECC and BHS includes continued service provision in wound management clinics, patients in inpatient wards and an expanded wound management service to include an outreach to patients in local residential facilities. Wound Management Nurse Practitioner(s) at PHS and CHS will deliver care on an outpatient / primary care basis via Specialist Clinics at both sites and the Minor Injury and Illness Clinic at CHS.

**Service gap analysis**

The Wound Management clinics at BECC (which also provides services to PHS) and BHS provide services to the community, BECC and BHS inpatients and residents in local care facilities. Service provision by this clinic is restricted due to lack of availability of medical and nursing staff with specialist wound management skills leading to

- limited hours of operation to provide outpatient services,
- reduced ability to provide an adequate and timely service to inpatient units at BECC / BHS, and
- lack of provision of an outreach service to residents in local residential care facilities.

A Wound Management Nurse Practitioner(s) model of care would expand the services provided to the community, increase community access to wound care services and maximise the number of new patients managed in the Wound Management clinic. Benefits of a Wound Management Nurse Practitioner service for inpatient units include increased access to wound care, decreased length of hospital stay, reduced costs in terms of dressing products and associated materials, and staff education and support to manage wounds appropriately using contemporary wound management practices.
Wound Management Nurse Practitioner(s) in outreach roles may decrease the need for hospitalisation for wound related issues (infection or surgical intervention), decrease medical consultancy costs and medical workload, reduce pain and suffering, and increase quality of life for residents as their wounds are managed in a familiar ‘home’ environment.

The Wound Management Nurse Practitioner role is planned as part of the staffing profile for CHS. Wound Management Nurse Practitioner(s) will augment the services provided by the Minor Injury/Illness Clinic and Specialist Consulting Clinics. CHS will be operational in early 2007 and are currently advertising for a Wound Management Nurse Practitioner / Nurse Practitioner Candidate.

4.4.2 Oncology Nurse Practitioner

Description of the service

As part of the Northern Health strategic plan, day oncology services will be offered at both TNH and CHS. It is anticipated that day oncology services will be offered at CHS in 2008 and currently there is a business case before the Victorian Department of Human Services for the funding of a 12 bed Day Oncology / Day Medical Unit as part of TNH Stage 2B Redevelopment. To meet current (and increasing) demands for oncology services, Northern Health is planning to set up an interim 12 bed Day Oncology / Day Medical Unit using bed capacity within the commissioning of the Stage 2A Redevelopment (April 2007).

It is envisaged that Oncology Nurse Practitioner(s) will play key roles at both TNH and CHS. They will work as part of a team consisting of Medical, Nursing and Allied Health professionals, however the precise composition of the team will be dependent on the types of cancers managed by the oncology service and the site of service provision. The Oncology Nurse Practitioner scope of practice will be underpinned by evidence-based Clinical Practice Guidelines developed using a multi-disciplinary approach. As a result the Oncology Diabetes Nurse Practitioner will be able to prescribe from a limited formulary of medications and it is anticipated that effective symptom management will result in analgesic and anti-emetic medications being a key component of Oncology Nurse Practitioner prescribing. The Oncology Nurse Practitioner will also perform minor procedures such as bone marrow biopsies, order diagnostic investigations including blood tests, and radiological investigations such as x-rays.

Specific elements of an Oncology Nurse Practitioner role will include:
- obtain health history and perform physical examinations
- play a key role in symptom management
- provide ongoing monitoring of health status
- counsel patients (and families) regarding possible treatment options and outcomes
- collaborate and liaise with the oncology team and other health care providers
- refer to doctors or other specialists as indicated

The Oncology Nurse Practitioner working group would comprise the following key stakeholders, all of whom have indicated their support for the Oncology Nurse Practitioner role:
- Northern Health Site Director(s) of Nursing
- Service Clinical Coordinator or Nurse Unit Manager
- Consultant Oncologist
- Representatives from Pharmacy, Pathology and Radiology services
- Consumer representatives
**Patient group**

The patient group are individuals who require cancer services. The Cancer Services Framework for Victoria\(^9\) recommends an integrated model of cancer service delivery that provides population base preventative, screening, diagnostic, treatment, rehabilitation, supportive care and palliative care services. It also recommends clear pathways to a range of well high quality, multidisciplinary, co-ordinated services. The North Eastern Metropolitan Integrated Cancer Service (NEMICS) was established to improve the integration and co-ordination of services in the North East, and Northern Health have committed to participating in this process.

**Service gap analysis**

The need for an Oncology Nurse Practitioner model of care within Northern Health is becoming increasing apparent as demands for cancer services increase dramatically in the area serviced by Northern Health. Approximately 520 patients are diagnosed with Cancer at TNH per year, a 40% increase from 2000-01. Outpatient Oncology attendances have increased by 34% in the last 5 years (1303 in 2000-01 to 1969 in 2005-06). Therefore there is a significant need to provide chemotherapy to patients within Northern Health’s primary catchment area.

Currently, a significant number of Northern Health patients have to be referred to inner city hospitals (primarily Austin and St Vincent’s Hospitals) for chemotherapy services and many of these patients come from outer northern areas. Round trip travel time to the nearest centre, Austin Health for patients residing in the outer North is 50 minutes by car or 2 hours by public transport (train/bus). This creates significant stress for potentially frail, ill and/or socially disadvantaged patients and their families. It is not uncommon for cancer patients to require 10-20 admissions in a year for disease management so specialist services at TNH and CHS will increase access to cancer services.

There is an urgent and unmet need for a growing regional cancer centre in Melbourne’s North. The increasing demand for cancer services and the increasing population in the Northern Health catchment area, indicate a need to develop cancer services beyond what is currently available at Northern Health. The current strategic plan is to establish a Cancer Unit at TNH with the view to supporting the services provided at CHS. Provision of oncology services will be new for Northern Health however it is anticipated that Oncology Nurse Practitioners would play a key role in service delivery at both of these facilities and that the Oncology Nurse Practitioner role will compliment the services provided by the inter-disciplinary team, enhance the scope and versatility of the team and result in delivery of a high standard of cancer care.

**4.4.3 Intensive Care Liaison Nurse Practitioner**

**Description of the service**

TNH has an 18 bed Critical Care Department comprising 10 Intensive Care Unit (ICU) beds and 8 Coronary Care beds (CCU) (4 acute coronary Care beds and 4 telemetry beds). The Intensive Care Unit liaison role is focused on care of patients coming to or leaving the Intensive Care Unit. TNH currently provides an Intensive Care Unit liaison nursing service. Two expert Intensive Care Nurses currently provide 1.4 EFT of Intensive Care Unit liaison over 7 days / week. The role is currently an advanced practice role with three key components:

- facilitates patient transition from Intensive Care Unit to the general wards and maintains continuity of care,
- responds to Intensive Care Unit referrals from general wards to ensure timely assessment and effective interim management of clinically unstable patients, and
- coordinate the acute pain service across TNH.
The Intensive Care Unit liaison nurses also attend and follow-up all Medical Emergency Team calls and Code Blues (cardiac arrest calls) at TNH. The Intensive Care Unit Liaison nurses currently function as part of an inter-disciplinary team. They collaborate with medical and nursing staff from the Critical Care Department and general medical and surgical units, and allied health personnel (social work, physiotherapy and speech pathology). The Intensive Care Unit Liaison Nurse Practitioner role would increase the scope of practice of the current Intensive Care Unit Liaison team and would increase capacity for service delivery. As with all Nurse Practitioner roles, scope of practice will be underpinned by evidence-based Clinical Practice Guidelines developed using a multi-disciplinary approach. As a result the Intensive Care Unit Liaison Nurse Practitioner will be able to prescribe from a limited formulary of medications. Given the current practice of the Intensive Care Unit Liaison nurses, it is anticipated that medications that would be commonly prescribed are those related to symptom relief (analgesics, anti-emetics), and management of acute clinical instability (IV fluids, potassium supplements). The Intensive Care Unit Liaison Nurse Practitioner will also order diagnostic investigations including blood tests, and radiological investigations such as x-rays as indicated.

There are a number of clinical risk issues affecting patients who require Intensive Care Unit management including delays in medical referral to ICU, transfer delays following ICU referral, and increased acuity of patients transferred from ICU to general wards due to an ageing population and a resultant increase in co-morbidities. Early ICU referral and effective interim care on general wards prior to transfer to ICU have been shown to improve patient outcomes. The Intensive Care Unit Liaison Nurse Practitioner roles has been successfully implemented in other health services (Western, Eastern and Bayside Health). Outcomes from these initiatives have included:
- reduction in transfers to intensive care facilities at other hospitals,
- decreased cancellation of elective surgery due to non-availability of ICU/CCU beds,
- increased support for general ward staff to manage patients with complex care requirements,
- decreased admission of elective surgical patients to ICU (at Western Health this fell from 52% in 2001 to 32% in 2004) with no increase in mortality or morbidity,
- decreased hospital length of stay for surgical patients, and
- reduction in ICU readmission rates.

The Intensive Care Unit Liaison Nurse Practitioner working group will have representatives from nursing, medical, allied health, pharmacy, pathology, radiology and organisational management:
- Director of Nursing, TNH
- Nurse Unit Manager, Critical Care Department, TNH
- Director of Critical Care Department, TNH
- Director of Anaesthetics and Acute Pain Service, TNH
- Medical staff (Consultant Intensivists, Medical and Surgical Unit Consultants)
- Clinical Nurse Educators, Critical Care Department, TNH
- Representatives from Pharmacy, Pathology and Radiology services
- Consumer representatives

**Patient group**

The Intensive Care Unit Liaison Nurse Practitioner will provide care for patients in the Critical Care Department at TNH, patients in other inpatient units at TNH, and where required extend follow-up of Critical Care Department patients in the community. The demand for acute health services is growing and will continue to increase as Australia has an ageing population. Approximately 40% of patients admitted to the Critical Care Unit at TNH are admitted via the Emergency Department (ED). ED presentations at TNH have increased steadily over the last decade and continue to increase markedly each year. Increasing service demands in the ED translates to increasing need for ICU care.
Service gap analysis

The Intensive Care Unit Liaison nurses currently provide the following services:
• enable prompt and appropriate care for critically ill patients in general wards,
• decrease ICU and hospital length of stay for patients discharged from ICU,
• improve outcomes for patients discharged from ICU,
• reduce cancellations of elective surgical cases,
• provide counselling & advocacy: ongoing support for patients & their family once discharged from ICU,
• education & support for ward nursing staff when managing patients from ICU,
• improve quality and safety and continuity of nursing care, and
• reduce clinical risk.

The Intensive Care Unit Liaison Nurse Practitioner role will further enhance the service currently provided by the Intensive Care Unit Liaison nurses at TNH by:
• enabling primary response for Medical Emergency Team calls,
• management of critically ill patients prior to and during transfer to ICU,
• co-ordination of nursing management after discharge to the ward from the ICU,
• quality improvement activities including highlighting clinical areas of need,
• research activities including data management and analysis,
• initiation of laboratory and diagnostic testing as indicated,
• prescribing of medications from a limited formulary, and
• direct referral of acutely unstable patients to specialists as required (e.g. the ICU & cardiology team).

Case examples

Earlier in 2006, a 45yo man with an acquired brain injury (since the age of 4) was admitted to ICU at TNH from the Emergency Department following a respiratory arrest. Following discharge from ICU, the Intensive Care Unit liaison nurses were involved with his care in the ward for over 6 months, assisting, supporting & teaching ward staff & family members regarding tracheostomy care. The Intensive Care Unit liaison nurses were also involved in the extensive planning to enable this patient to be discharged home to his family. An education package for the family and carers to explain tracheostomy care follow-up visits to his home were provided by the Intensive Care Unit liaison nurses for 1 week post-discharge. Over 3 months following discharge from TNH, the Intensive Care Unit liaison nurses were still involved in his care: his family contact the Intensive Care Unit liaison nurses with queries and the Intensive Care Unit liaison nurses also organise his tracheostomy tube changes.

The Intensive Care Unit liaison nurses also attend Medical Emergency Team calls and Code Blues at TNH. For patients that require admission to ICU from general wards, the Intensive Care Unit liaison nurses commence monitoring and treatment as ordered until an ICU bed is available. Treatments that may be commenced by the Intensive Care Unit liaison nurses include non-invasive ventilation, inotropes, fluid & electrolyte therapy, infusions. An example of this element of the Intensive Care Unit liaison role is highlighted by a recent MET team call in a general medical unit at TNH. The patient had significant respiratory distress as a result of acute pulmonary oedema and despite intravenous Frusemide and Morphine, topical application of nitrates and high flow supplemental oxygen, the patient's oxygenation remained poor. The Intensive Care Unit liaison nurses commenced non-invasive ventilation on the ward. There was no ICU bed available and until a patient was discharged from ICU, there was no physical bed space either. The Intensive Care Unit liaison nurses stayed with the patient in the medical unit until an ICU bed was available and the patient was transferred to ICU two hours later.
4.4.4 Diabetes Nurse Practitioner

Description of the service

Diabetes mellitus is a chronic disease that carries significant risk of complications such as retinopathy, cataract, glaucoma, neuropathy, nephropathy, diabetic foot ulcers and amputations.\textsuperscript{11,12} Diabetes is the sixth leading cause of death in Australia\textsuperscript{11} and a major cause of chronic disability.\textsuperscript{12} The prevalence of diabetes is increasing in Australia. It is estimated that one million Australians have diabetes and that half of these cases are yet to be diagnosed.\textsuperscript{11} The prevalence of diabetes has almost trebled in the past two decades\textsuperscript{11} as a result of a dramatic increase in lifestyle related Type 2 diabetes.\textsuperscript{11}

The increased incidence of diabetes and diabetes related co-morbidity means that service demands for diabetes management have increased and continue to increase. Patients with diabetes are two to four times more likely to develop cardiovascular disease so prevention of diabetes may also impact on reduction in cardiovascular mortality.\textsuperscript{11} In 1998, almost 64,000 Australians had a diabetes related disability.\textsuperscript{11} The direct cost to the health care system is estimated at $372 million in 1993-94 and when complications of diabetes are factored in, the health care cost of diabetes increased $681 million.\textsuperscript{11}

The Diabetes Nurse Practitioner model of care has been adapted from the Royal Prince Alfred Hospital Diabetes Nurse Practitioner Guidelines - Role and Scope of Practice (pg 10 - 13).\textsuperscript{13} The Diabetes Nurse Practitioner would be instrumental in the management of diabetes but also provide patients with the skills and knowledge to live healthily with diabetes. This is accomplished through direct contact with patients, family and significant others and through support, education, and advice to other healthcare professionals. The Diabetes Nurse Practitioner will assess, co-ordinate care, refer, follow-up and develop management guidelines for use by other staff. He/she will:

- provide a link between patients, Northern Health, GPs, other health care providers and community organizations,
- actively promote diabetes health awareness and primary prevention,
- demonstrate a high standard of professional practice and clinical leadership that incorporates education and research, and
- facilitate research and quality improvement in diabetes management.

There is scope across Northern Health for a number of Diabetes Nurse Practitioners. In the short term, the Diabetes Nurse Practitioner model has been primarily designed as part of service provision at CHS however both TNH and BHS currently provide Diabetes services. It is anticipated that the working group for the Diabetes Nurse Practitioner model would vary slightly according to site and context but would include the following key stakeholders:

- Northern Health Site Director(s) of Nursing
- Service Clinical Coordinator or Nurse Unit Manager
- Consultant Endocrinologist
- Diabetes Clinical Nurse consultants / Diabetic Educators
- Representatives from Pharmacy, Pathology and Radiology services
- Consumer representatives

In the first instance, the Diabetes Nurse Practitioner will be located at CHS. It is envisaged that most services will be provided on this campus, however there is also scope for Diabetes Nurse Practitioner(s) to provide care in the community (home visits), consultant service to inpatients at Northern Health campuses, outpatient services and out-reach services to aged care and residential facilities.

Like all Nurse Practitioner models of care, Diabetes Nurse Practitioner(s) will function as part of an interdisciplinary team and compliment the services provided by Endocrinologists, Diabetes Nurse Educators, Dieticians and Podiatrists. He/ she will also liaise closely with other chronic disease services, as appropriate for individual client care. Diabetes Nurse Practitioner scope of practice will be underpinned by a series of evidence-based Clinical Practice Guidelines developed using a multi-disciplinary approach. As a result Diabetes Nurse Practitioner(s) will be able to prescribe from a limited formulary of medications,
particularly medications used to treat hyperglycaemia and hypoglycaemia (for example, oral hypoglycaemic agents, insulin and glucagon). Diabetes Nurse Practitioner(s) will also have the authority to order diagnostic investigations including blood and urine tests and wound cultures.

**Patient group**

Diabetes (both type I and II) affects patients of all ages. There will be increased service demands in the area of diabetes management as the number of people being diagnosed with diabetes increases as a result of an aging population and increasing obesity. There is an increasing number of children being diagnosed with Type II diabetes as a result of the increased incidence of obesity and these children will require management of their diabetes throughout adult-hood. Effective management of diabetes is paramount as diabetes-related complications further add to the burden of this disease so prevention of complications is in the best interests of patients and health care systems.

**Service gap analysis**

Northern Health currently provides diabetes services at TNH and BHS and will also provide diabetes services at CHS. Both TNH and BHS have diabetes clinics that are run by a multi-disciplinary team consisting of Diabetes Educators (Clinical Nurse Consultants), Consultant Endocrinologists and Endocrinology Registrars and Dieticians. Although both clinics primarily focus on outpatient management of diabetes, clinic teams also provide some services for in-patients. Northern Health does not currently provide any out-reach services for patients in the community or residential care facilities: these services are currently provided by RDNS.

The Diabetes Nurse Practitioner role is planned as part of the staffing profile for CHS. Diabetes Nurse Practitioner(s) would expand the diabetes services already provided by Northern Health, increase community access to diabetes services and maximise the number of patients managed in Diabetes clinics. There may also be scope to provide diabetes services to Northern Health campuses that currently do not offer this service (BECC and PHS). Diabetes Nurse Practitioner(s) in outreach roles may decrease need for hospitalisation for diabetes related issues and decrease medical consultancy costs and medical workload.

Historically, diabetes management has focused on diagnosis and management of diabetes however increasing prevalence of largely preventable type 2 diabetes has resulted in a focus on primary prevention of diabetes in patients with no history of diabetes including:

- diabetes risk factor modification (obesity, diet and physical activity),
- use of multiple strategies with adult populations, and
- use of health promotion strategies rather than drug interventions.

Diabetes Nurse Practitioner(s) may also therefore have a role to play in diabetes prevention.
4.4.5 Continence Nurse Practitioner

Description of the service

A Nurse Practitioner Model in Continence would encompass the following components:

- management of a clinical caseload using advanced practice skills to improve clinical outcomes for clients and carers and work expeditiously with the health care team
- mentoring of Continence Nurse Consultants
- developing a model of service that seeks to offer opportunity for professional development and clinical supervision
- create an environment where the Nurse Practitioner is able to facilitate learning in a range of settings for Continence Nurse Consultants in the acute, subacute, community and residential settings
- create an environment where the Nurse Practitioner is able to facilitate learning for students currently enrolled in continence courses and for nurses who may be interested in working in the continence area
- program development
- develop the BECC Continence Model of Service across different settings to meet the needs of different client groups and different nursing experience
- development of research and other projects
- provision and development of education by involvement in established Continence Promotion Courses
- provision of education packages across all contextual settings (acute, sub-acute, community, residential) for clients, carers and a diverse range of health care providers

It is envisaged that the scope of the clinical assessment skills of the CNC could be enhanced through a program of further intensive education to enable advanced clinical practice and improved outcomes for the client. The following specific additional roles would include:

- prescribing authority for relevant medications such as aperients, antibiotics and anticholinergics,
- ordering of urine tests, pelvic ultrasounds and abdominal X-rays
- referral to Geriatricians, Paediatricians, Gynaecologists, and Urologists

It is believed that development of specific guidelines and strong partnerships with a team of clinical mentors would enable the Nurse Practitioner to act as the first-line contact and implement appropriate interventions expeditiously.

It is anticipated that the working group for the Continence Nurse Practitioner would include the following key stakeholders:

- Northern Health Site Director(s) of Nursing,
- Manager Community Therapy Service
- Geriatrician(s), Paediatrician(s), Urologist(s)
- Nurse Educator
- Continence Clinical Nurse Consultant(s)
- Continence Physiotherapist
- Representatives from Pharmacy, Pathology and Radiology services
- General Practitioner(s)
- Consumer representatives

The group would establish the scope of practice for the Nurse Practitioner, the competency standards required of the incumbent, the protocols to guide decision making and the specialist education required to support advanced practice in these areas. It is envisaged that the Nurse Practitioner would undertake a comprehensive education program involving 4 hours education each week for 26 weeks. Advanced clinical assessment and interpretation of pathology results would be purchased from a General Practitioner, advanced knowledge of the disease associated with continence would be facilitated by education sessions from a geriatrician and pharmacology education would be accessed from a pharmacist.
**Patient group**

There are a number of patient groups who would benefit from a Continence Nurse Practitioner service. Currently the majority of patients referred to the BECC Continence Service are seen by the Continence Nurse Consultant in their home environment or residential facility as patients may be too frail to attend the Continence Clinic or it may be more appropriate to see the patient in their home or residential environment. Children, in particular disabled children are also another group with continence management requirements. A Continence Nurse Practitioner may also manage children in a Clinic environment, at home or at their school or day-care centre.

**Service gap analysis**

Presently the Continence Nurse Consultant provides a high level of service and the relationships between the Continence multidisciplinary health care team at BECC and General Practitioners have already been forged. Observations of current practice highlight that Continence Nurse Consultants often make recommendations that relevant medications be commenced or ceased, that particular tests and investigations be ordered, or referral to Specialist doctors be initiated for patients. At BECC the Continence Nurse Consultant works in consultation with a network of healthcare providers, in particular the patient’s General Practitioner and BECC’s Continence Service.

The benefits to patients, carers and other health care providers such as General Practitioners are significant. The time delay in the provision of care is substantially reduced, and the partnerships with General Practitioners are strengthened. The burden on resources and waiting list for the Continence Service is also addressed because currently patients are required to feed into clinic appointments for medical intervention for specialised interventions. It is hoped that much of the preliminary interventions highlighted above would be carried out by the Nurse Practitioner, leaving outpatient appointments for patients with more complex needs.

**4.4.6 Neonatal Nurse Practitioner**

**Description of the service**

The site of health care delivery will be within the clinical setting with active participation in the transition of children and their families from the acute care setting (inpatient paediatric unit and special care nursery) to their home and community settings. The Neonatal Nurse Practitioner model will encompass care in both acute and home / community settings. The Neonatal Nurse Practitioner scope of practice will include:

- resuscitation, stabilization and ongoing management of children prior to transfer to Neonatal or Paediatric Intensive Care Units. This may include airway management, endotracheal intubation, insertion of peripheral/venous cannulae and limited drug administration
- active involvement in planned (caseload) and unplanned admissions and immediate and ongoing management of children as per department policy/guidelines (assessment, ordering and collecting specific tests and investigations, insertion of peripheral lines, ordering of intravenous/enteral fluids, limited prescribing of drugs treatments specific to conditions such as asthma, gastro management, etc)
- discharge planning and transition into the community for children and families to address acute and chronic care needs (includes discharge examination, complex discharge planning arrangements for paediatric community care, and follow up and referral to other disciplines/specialists)
- support and enhance the professional development of all health professionals in the areas of research, quality improvement activities, publications and the application of evidence based practices to raise the profile of Paediatrics at TNH.
The Neonatal Nurse Practitioner will work as part of a multidisciplinary team health care team who aim to provide family centred care. Therefore the Neonatal Nurse Practitioner will have close partnerships with the nursing, medical and allied health staff and although there will be times when the Neonatal Nurse Practitioner will work independently, collaboration and good working relationships will be paramount to the success of this role.

The funding model for the Neonatal Nurse Practitioner aims to balance funding the Neonatal Nurse Practitioner role within existing SCN and CAHU budgets and not compromising existing staffing deficits. Additional costs associated with implementation of the Neonatal Nurse Practitioner role includes:

- initial ‘one on one’ training and mentorship with an identified member of the medical and allied health team at TNH followed by ongoing mentorship,
- the development of professional links with ‘visiting’ and ‘practicing’ rights at an identified NICU and Paediatric centre of excellence to maintain aspects of clinical practice/expertise with integration of knowledge not available on a daily basis at TNH - ‘one on one’ mentorship needs to be negotiated with a member of the medical team at these units,
- the development of formal professional links with community service providers,
- funding (through scholarships) for existing Masters prepared nurses to undertake the Medication Management Module,
- staff replacement costs for staff member(s) who make the transition to Neonatal Nurse Practitioner Candidate.

It is anticipated that the working group for this Aged Care Nurse Practitioner model would consist of the following key stakeholders:

- Director of Nursing, TNH
- Nurse Unit Managers, Special Care Nursery and Child and Adolescent Health Unit
- Clinical Nurse Educators, Paediatric and Women’s Health
- Director of Paediatrics
- Representatives from Pharmacy, Pathology and Radiology services
- Director of Social Work
- Consumer representatives

Patient group

For the purposes of this document, the term ‘neonatal/paediatric’ refers to newborns, infants and children aged between 0-16 years. Hence the term ‘children’ will be used throughout. The Neonatal Nurse practitioner will provide care to children (and families) in the inpatient paediatric unit and special care nursery at TNH as well as providing home and community-based services after discharge.

Service gap analysis

During the transition of children (and their families) from acute care settings to their home and community settings, discontinuity of care is a major issue. Fragmented care can occur from:

- increased volume of throughput in the paediatric settings,
- increased number of children transferred from tertiary centres for ongoing management and care,
- limited services for ongoing acute and chronic care to support families following discharge from TNH.

Children and families will benefit from a consistent and collaborative approach through a Neonatal Nurse Practitioner to enhance existing services for this patient/client group.
5 Education / mentoring for Nurse Practitioner Candidates

Key Recommendations:
- health services continue to support university studies using EBA study / exam leave
- organisational support is highly recommended prior to undertaking Master of Nursing (Nurse Practitioner) or related studies
- specific education related to Clinical Practice Guideline development should be included in the educational preparation for Nurse Practitioner Candidates
- 1-2 hours per week dedicated education time is recommended for clinical education
- vocational training should be provided via a structured clinical internship
- clinical internship programs should have state-wide standards to ensure transferability of the Nurse Practitioner roles and organisational confidence
- Nurse Practitioner candidates should have formal preparation to improve professional development in areas such as academic writing, presentation, leadership and change management

Education and mentoring of Nurse Practitioner Candidates is pivotal to the success of Nurse Practitioner roles. Nurse Practitioner education falls into two distinct categories:
  i) education aimed at preparation for practice as a Nurse Practitioner Candidate and to meet NBV requirements for endorsement as a Nurse Practitioner
  ii) education aimed at ongoing professional development for endorsed Nurse Practitioners and to meet the requirements of the NBV review processes (currently, the NBV are reviewing Nurse Practitioners at 18 months, 3 years and then every 3 years).

The focus of education for Nurse Practitioner Candidates is often limited to:
- the academic requirements for NBV endorsement including Master of Nursing and Master's level Medications Management Module
- preparation for practice including specific skills acquisition, physiology, pathophysiology, pharmacology, diagnostics and pathology testing

However, it is important to note that educational preparation for Nurse Practitioner Candidates is multifaceted and also comprises:
- development, implementation and evaluation of clinical practice guidelines including literature reviews, evidence searches and appraisal, word processing and document development
- professional activities including academic writing, report writing, public speaking / presentation skills, clinical and professional leadership
- knowledge of contemporary nursing issues including evidence-based practice, clinical risk management, quality and safety, workforce planning and reforms
5.1 Academic requirements

In Victoria, a Master of Nursing and Medications Management module are requirements for endorsement as a Nurse Practitioner. The following Master’s programs are currently endorsed by the NBV:

- Master Nursing Practice, Deakin University, Burwood and Geelong Waterfront Campuses
- Master of Nursing (Nurse Practitioner), Flinders University, Adelaide
- Master of Nursing Science (Nurse Practitioner), University of South Australia, City East campus
- Master of Nursing (Nurse Practitioner), La Trobe University, Bundoora & Bendigo Campuses
- The following medications management modules are approved by NBV:
  - Pharmacology for Advanced Professional Practice, Flinders University, Adelaide
  - Therapeutic Medication Management Unit, Monash University, Peninsula Campus
  - Therapeutic Medication Management Education Program, University of Melbourne
  - Pharmacology for Advanced Practice, University of South Australia, City East campus

Organisational support is vital to meet the Nurses Board of Victoria criteria for endorsement therefore support from key stakeholders should be sought prior to enrolling in a Master of Nursing (Nurse Practitioner). Considerations may include:

- congruence with the proposed Nurse Practitioner model and organisational objectives and strategic plan,
- feasibility of obtaining employment as a Nurse Practitioner Candidate,
- organisational and departmental resources and support should employment as a Nurse Practitioner Candidate be successful,
- potential barriers to successful implementation of the Nurse Practitioner role, and
- potential barriers to successful application for endorsement as a Nurse Practitioner.

Registered Nurses undertaking postgraduate study are entitled to postgraduate study leave and exam leave under the Victorian Nursing EBA. It is recommended that health services continue to support Nurse Practitioner Candidates by the provision of study / exam leave for those undertaking Master’s Degrees.

5.2 Clinical Practice Guideline Development

The development, implementation and evaluation of Clinical Practice Guidelines should be supported by a health service policy framework. A policy framework is detailed in Section 6.

The educational value of the development of Clinical Practice Guidelines (or the rigorous appraisal of existing Clinical Practice Guidelines) should not be underestimated. It is recommended that Nurse Practitioner Candidates appraise the literature / evidence for each Clinical Practice Guideline so that they understand the evidence underpinning the assessment and management of specific patient groups. Knowledge of best available evidence (of lack thereof) has wider implications for Nurse Practitioners / Nurse Practitioner Candidates. Evidence-based Clinical Practice Guidelines define the scope of practice for Nurse Practitioners / Nurse Practitioner Candidates therefore that knowledge of the evidence underpinning the content of the Clinical Practice Guideline (and therefore practice) is pivotal for safe patient care. Further, Nurse Practitioner Candidates are interviewed against their Clinical Practice Guidelines as part of the requirements for endorsement so knowledge of best evidence is an integral part of successfully completing requirements for endorsement. Nurse Practitioners / Nurse Practitioner Candidates function as part of a multi-disciplinary team so knowledge of best evidence / best practice enables Nurse Practitioner Candidates to engage in professional discourse and informed debate about patient assessment and management.
5.3 Educational Preparation for Clinical Practice

Specific education for clinical practice will depend on the scope and context of Nurse Practitioner model of care. Considerations will be:

- acquisition of new skills,
- extension of existing skills sets, and
- appropriate use of extensions to practice.

Factors such as small numbers of Nurse Practitioner Candidates, cost of education, restricted government funding to universities and health services, fragmentation of resources, and distribution of expertise across organisations adversely effects the design and delivery of education programs for Nurse Practitioner Candidates. Inter-organisation collaboration is an effective strategy for Nurse Practitioner Candidate education and consortia approaches to nursing education are well documented. For example, a consortium of 10 universities in Ontario, Canada delivered a primary care nurse practitioner programme to registered nurses throughout the province and a 4 university consortium delivered a Master of Science in Nursing course in Louisiana, USA. To date, reporting of consortia approaches to nursing education have focussed on collaborations between universities however collaboration between health services will be pivotal to sustainable Nurse Practitioner Candidate education. A local level example of a successful consortium approach was that used by the Victorian Emergency Nurse Practitioner Candidates to meet their educational requirements. Thirteen ENPCs from nine EDs formed the Victorian Emergency Nurse Practitioner Collaboration and since the inception of the Emergency Nurse Practitioner Project in mid 2004 have been organising regular study days to meet priority learning needs. Host sites were nominated on a rotating basis and the study day content was determined by the Emergency Nurse Practitioner Candidates and the expertise available at the host site. The study days were then attended by all Emergency Nurse Practitioner Candidates. Study days have been held on a monthly basis since inception of the ENP project (June 2004). Although this collaborative approach to education has been successful to date, more formal arrangements will need to be put in place to ensure a sustainable and planned program for further ENPCs. Ideally, these formal arrangements should be linked to completion of Masters’ studies, application for endorsement and organisational appraisal / credentialing.

There are many aspects of current models of medical training that can be applied to education of Nurse Practitioner Candidates. The National Guidelines for Training and Assessment of Junior Medical Doctors recommend that junior medical staff are provided:

- with appropriate formal education opportunities which are relevant to their needs, and to clinical needs of the hospital, and based on adult learning principles,
- employer provision of structured education programs,
- education time that is ‘protected’ from intrusions from clinical responsibilities, and
- education programs that focus on clinical skills acquisition.

These recommendations are directly applicable to Nurse Practitioner Candidate education. Formal teaching sessions of 1-2 hours per week are recommended for medical staff in their second postgraduate year. This would equate to approximately one study day per month and given the success of this approach for the Emergency Nurse Practitioner Candidate group, 1-2 hours per week of protected education time is an appropriate recommendation for Nurse Practitioner Candidates.

Provision of clinical educators and the nature of personnel providing clinical education is a challenge for education of Nurse Practitioner Candidates. In the absence of a critical mass of Nurse Practitioners, medical staff and staff supporting specific elements of Nurse Practitioner practice (Clinical Nurse Consultants, Allied Health, pharmacists, radiologists / radiographers and pathologists) are currently valuable sources of clinical information for Nurse Practitioner Candidates. It may be further argued even with expanding numbers of endorsed Nurse Practitioners, best use of resources and expertise will mean that these personnel will always have a role in the education of Nurse Practitioner Candidates for clinical practice. Given the increasingly inter-disciplinary nature of health care and the probable evolution of workforce models that challenge traditional professional boundaries, it is imperative that organisations promote an interdisciplinary approach to the clinical
education of health care professionals rather than fee for service arrangements between disciplines.

5.4 Clinical supervision / internship

Clinical mentorship and learning in the clinical environment is pivotal to the safe implementation of Nurse Practitioner roles and will be an adjunct to education for clinical practice described in the section above. A provisional licensure and clinical internship program, akin to the model used by medicine, may be considered as an effective method of education for Nurse Practitioner Candidates. Medical graduates enter the workforce on completion of their medical degree by working as an Intern for a 12 month period, usually in a major public teaching hospital. Full medical registration with State Medical Boards occurs only after satisfactory completion of an Intern year. Postgraduate vocational medical training leading to fellowship of a medical College is required before medical staff can enter into independent private practice under the Medicare system. The AMA recommends that transition into internship can be improved by ensuring medical students have adequate levels of clinical exposure in their undergraduate years, that hospitals conduct comprehensive induction programs for new interns, and interns are provided with appropriate supervision, support and resources. Further, the AMA advocates that clinical teachers need to be valued and rewarded appropriately and educational time needs to be protected for all doctors.

These recommendations readily apply to education for Nurse Practitioners and Nurse Practitioner Candidates. A standardised and consistent approach to clinical internship models is vital to enable transferability of Nurse Practitioner Candidates and organisational confidence in the clinical skills and practice of Nurse Practitioner Candidates. The National Guidelines for Training and Assessment of Junior Medical Doctors recommends state standards and criteria for:

- organisation and administration of the training and education program,
- structure and content of the training and education program,
- supervision of junior medical officers,
- assessment of junior medical officers,
- feedback from junior medical officers about their programs and supervisors, and
- procedures for ongoing evaluation of the training program.

These standards are applicable to clinical internship programs for Nurse Practitioner Candidates.

5.5 Professional development

Two of the Nurses Board of Victoria criteria for endorsement as a Nurse Practitioner require academic and professional development:

- Criterion 4: evidence of involvement and utilisation in research in relation to practice and/or continuous quality improvement projects
- Criterion 5: evidence of leadership in the practice area in which endorsement is sought.

Activities such as utilisation of evidence in practice, involvement in quality or research activities, academic writing and public speaking are often neglected in nursing, with clinical activities taking precedence. It is important that an academic or professional mentor is sought to assist Nurse Practitioner Candidates with these skills. The academic mentor may not have clinical skills in the context of practice in which the Nurse Practitioner Candidate is seeking endorsement however academic writing and presentation skills are transferable across many different contexts of practice. Academic writing skills may also be obtained as part of completion of a Master of Nursing (Nurse Practitioner).

Clinical and professional leadership is often associated with seniority or years of experience and there is often little formal preparation to prepare nurses for leadership roles, particularly in clinical areas. There are often organisation based professional development courses related to leadership, communication and change management however often nurses working in management roles are targeted for participation in these courses.
Courses currently offered by Northern Health that could be utilised by Nurse Practitioner Candidates include:

- conflict and negotiation skills
- communication skills
- leading staff through change
- what makes an intelligent leader
- managing self through change
6 Development and approval of clinical practice guidelines

Key Recommendations:
- A Northern Health policy for the development, approval, implementation and evaluation of Clinical Practice Guidelines is developed
- Northern Health Clinical Practice Guidelines should be multidisciplinary and should be developed so they may be used by all independent practitioners (medical, nursing and allied health) managing specific patient groups
- An easily accessible repository for all Clinical Practice Guidelines developed within Northern Health is created
- There is information sharing of Clinical Practice Guidelines across and beyond Northern Health

In Victoria, Clinical Practice Guidelines developed by a multidisciplinary team underpin the use of extensions to practice by Nurse Practitioners and are one of the NBV criteria for endorsement as a Nurse Practitioner. Clinical Practice Guidelines are: "systematically developed statements to assist practitioners and patient decisions about appropriate health care for specific circumstances". A policy framework related to the development and approval of Clinical Practice Guidelines for use by Nurse Practitioners and Nurse Practitioner Candidates should take into account the following National Nursing and Nursing Education Taskforce Recommendations:
- Clinical Practice Guidelines do not replace clinical judgement and are intended to guide clinical decision making,
- development of discipline-specific Clinical Practice Guidelines can increase fragmentation of care and impede workforce redesign strategies,
- Clinical Practice Guidelines should be multidisciplinary in nature and focus on the care requirements for specific patient groups rather than the health care professional providing the care, (for example, a guideline for management of ankle injury could be used by medical officers, physiotherapists and Nurse Practitioners)
- the AGREE methodology is recommended as a systematic approach to evaluate the quality of existing Clinical Practice Guidelines, and
- development of Clinical Practice Guidelines by a multidisciplinary team increases consistency of care, decreases duplication, and promotes flexible models of care however, it is important to recognise that a nurse or midwife’s practice does not need to be authorised by other disciplines.

6.1 Rationale for organisational processes for guideline review and endorsement

Currently Clinical Practice Guidelines for use by Nurse Practitioners / Nurse Practitioner Candidates are developed by multi-disciplinary teams at local level with site based endorsement processes. The need to establish Northern Health processes for guideline development and endorsement has been recognised within Northern Health to ensure that guidelines across the organisation are consistent.
Health service wide processes for Clinical Practice Guideline development and approval would assist in addressing a number of issues including:

- inconsistencies in minimum requirements for a Clinical Practice Guideline
- lack of implementation and evaluation strategies
- variability and suitability of personnel developing Clinical Practice Guidelines in terms of literature review, database searching and evidence appraisal skills
- Clinical Practice Guidelines developed at local level may not be evidence-based may instead be based on tradition or opinion of key stakeholders in those clinical area. Failure to utilise best available evidence may result in outdated or unsafe practices or unnecessary variation in practice, both of which are significant clinical risk issues.
- Clinical Practice Guidelines that are based on best evidence may have limited uptake because of poor implementation processes
- failure to have a health service wide approach to Clinical Practice Guideline development may result in unnecessary duplication of guidelines, which then raises issues about inappropriate use of resources.

6.2 Clinical practice guideline development

Northern Health Clinical Practice Guidelines should be developed using an evidence-based approach by multidisciplinary teams. Where possible, Clinical Practice Guidelines should be developed so they may be used by all independent practitioners managing specific patient groups. The following National Health and Medical Research Council (NH&MRC) publication should be used as a primary reference for the development of Clinical Practice Guidelines for use within Northern Health: NH&MRC. (1999). A guide to the development, implementation and evaluation of clinical practice guidelines. Canberra: AusInfo.

In addition to the NH&MRC guidelines there are also a number of key references for specific sections of Clinical Practice Guidelines. For example, when diagnostic imaging is required, the Imaging Guidelines from The Royal Australian and New Zealand College of Radiologists are a key reference. Similarly for Clinical Practice Guidelines that require pathology testing, the RCPA Manual from the Royal College of Pathologists, Australasia is an important reference.

The NH&MRC recommends that the following nine principles should underpin the development of Clinical Practice Guidelines:

- processes for developing and evaluating clinical practice guidelines should be outcome focused;
- guidelines should be based on the best available evidence and should include a statement about the strength of recommendations;
- the method used to synthesise the available evidence should be the strongest applicable;
- the process of guideline development should be multidisciplinary and should include consumers;
- guidelines should be flexible and capable to adapting to varying local conditions;
- guidelines should be developed with resource constraints in mind;
- guidelines should be developed, disseminated and implemented taking into account their target audiences;
- the implementation and impact of guidelines should be evaluated; and
- guidelines should be revised regularly.

All Clinical Practice Guidelines developed at Northern Health should use the levels of evidence recommended by the NH&MRC (Table 3). An additional category of ‘expert opinion / consensus’ has been added to allow for areas where the best available evidence currently available is expert opinion or consensus agreement. Recommendations should be based on the highest level of evidence available at the time.
### Table 3: Levels of Evidence (NH&MRC) 22

<table>
<thead>
<tr>
<th>Evidence Level</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Evidence obtained from a systematic review (meta-analysis) of all relevant randomised controlled trials</td>
</tr>
<tr>
<td>II</td>
<td>Evidence obtained from at least one properly designed randomised controlled trial</td>
</tr>
<tr>
<td>III-1</td>
<td>Evidence obtained from well-designed pseudo-randomised controlled trials (alternate allocation or some other method)</td>
</tr>
<tr>
<td>III-2</td>
<td>Evidence obtained from comparative studies with concurrent controls and allocation not randomised (cohort studies), case-control studies, or interrupted time series with a control group</td>
</tr>
<tr>
<td>III-3</td>
<td>Evidence obtained from comparative studies with historical control, two or more single-arm studies, or interrupted time series without a parallel control group</td>
</tr>
<tr>
<td>IV</td>
<td>Evidence obtained from case series, either post-test or pre-test and post-test</td>
</tr>
<tr>
<td>Expert opinion</td>
<td>/ consensus</td>
</tr>
</tbody>
</table>

The NH&MRC acknowledges concern about potential for legal vulnerability if patient care varies from the treatment specified in clinical practice guidelines.22 The NH&MRC states that “Guideline developers are unlikely to be held liable for any negative consequences of implementation of the guidelines, particularly if the processes of preparation and the limitations of the guidelines are clearly described...”22 and recommends the following principles as the minimum legal requirements for Clinical Practice Guidelines:22

- guidelines should be a summary of the evidence,
- guidelines should have an expiry date,
- guidelines should be reviewed by persons independent of the development process,
- acknowledge areas of disagreement in the guidelines, and
- avoid overly prescriptive guidelines so that allowances can be made for management that differs from what is recommended.

Other useful references related to appraisal and clinical application of evidence include:

The process for Clinical Practice Guideline development, implementation and evaluation is summarised in Figure 3.

Figure 3: Clinical practice guidelines flowchart\textsuperscript{22}
7 Expected benefits of Nurse Practitioner roles

Workforce redesign is an important strategy in the management of increasing service demands. The Nurse Practitioner Candidate role is an important transitional role between existing advanced practice nursing roles and Nurse Practitioner. The Nurse Practitioner role complements the care provided by other health care professionals in specific contexts of practice. There are a number of benefits of Nurse Practitioner roles for patients, for Northern Health and for the health care system.

7.1 Patients

The benefits of Nurse Practitioner roles for patients may include:
- improved access to health care,
- alternative model of health care,
- better continuum and less fragmentation of health care,
- increased satisfaction with Nurse Practitioner care, and
- decreased variation in care and an evidence-based approach to health care delivery.

7.2 Northern Health

In addition to the benefits listed above, the benefits of Nurse Practitioner roles for Northern Health may include:
- management of increased service demands,
- recognition and retention of experienced clinical nurses in a clinical roles,
- cost effective, high quality and timely care,
- increased scope of multidisciplinary teams,
- foster working relationships in multidisciplinary teams, and
- structured and evidence based approach to extend the scope of current nursing practice.
Position descriptions have been developed for Nurse Practitioners and Nurse Practitioner Candidates across Northern Health. The aim of development of these documents is to have consistent generic position descriptions that can be used at all Northern Health campuses. It is also worthy of note that the scope of practice of Nurse Practitioners / Nurse Practitioner Candidates will be defined by the context in which they practice and underpinned by evidence-based Clinical Practice Guidelines. Reference to these documents in the position descriptions has negated the need to include context specific clinical detail. The position descriptions are shown in the section to follow.
# Position Description

### POSITION TITLE:
Nurse Practitioner Candidate

### DATE OF EFFECT:
- Created: 1st September 2006
- Reviewed: N/A
- For review: TBC

### TYPE OF EMPLOYMENT:
- 38 hours per week
- Substantive pay rate

### REPORTING TO:
- Director of Nursing
- Medical Director of Service

### ROLES REPORTING TO THIS POSITION:
N/A

### GENERAL RESPONSIBILITY STATEMENT:
Responsible for advanced and extended nursing practice in specific contexts and preparation for endorsement as a Nurse Practitioner with the Nurses’ Board of Victoria.

### LIAISES WITH:
- Operations Director / Nurse Unit Manager
- Other service providers in the service including medical, nursing and allied health staff
1. ORGANISATIONAL INFORMATION

1.1 Introduction

The Northern Health Service provides a diverse range of acute, sub-acute and community health services to the large and diverse population in the regions north of Melbourne. There are four main campuses; Broadmeadows Health Service, Bundoora Extended Care Centre, The Northern Hospital at Epping and Panch Health Service at Preston. Craigieburn Health Service is expected to open early in 2007.

1.2 Strategic Plan 2006-2008

The Strategic Plan for Northern Health includes the following elements -

Mission:

To apply our resources to work with our staff and partners, offering our diverse community excellence in health care.

Vision:

A healthier Northern Community through quality care, prompt access and effective partnerships.

Values:

- We will take a patient centred approach to the provision of care
- We will consult and respond to community views about our organisation and their health needs
- We will care for our patients who come to us at a most vulnerable and fragile time in their lives, giving consideration to their unique situations.
- We will be flexible and responsive to change.
- We will aim continuously to provide better services and we will demonstrate the quality of our services to the community.
- We will look after our colleagues and encourage teamwork ahead of individual achievement in our service.
- We will be accountable for the service we provide.
- We will provide equitable access to health services for our community.
- We will value and encourage evidence-based practice and research which supports it.

Strategic Priorities:

- A Quality Health Service
- An Effectively Staffed Health Service
- A Financially Viable Health Service
- An Integrated Health Service
2. ROLE STATEMENT

Workforce redesign is a key strategy in the management of increased current and projected service demands. The Nurse Practitioner Candidate role is an important transitional role between existing advanced practice nursing roles and Nurse Practitioner. The Nurse Practitioner role complements the care provided by other health care professionals in specific contexts of practice. The Nurse Practitioner Candidate will work as part of a multidisciplinary team to provide high quality care to specific patient / client groups.

The aim of the Nurse Practitioner Candidate role is to prepare the nurse for endorsement as a Nurse Practitioner with the Nurses’ Board of Victoria in the following domains:
- clinical practice
- theoretical and educational preparation
- professional growth and development

In addition to advanced nursing knowledge and skills the Nurse Practitioner Candidate role may include (but is not limited to), referral of patients to other health care professionals, prescribing medications, and ordering diagnostic investigations, admitting and discharging patients / clients. The scope of practice is determined by the context in which the Nurse Practitioner Candidate is authorised to practice.

3. KEY RESULT AREAS and MAJOR RESPONSIBILITIES

Role Specific

Clinical Practice

- Possesses advanced clinical knowledge and skills commensurate with those required to function effectively as a Nurse Practitioner Candidate.
- Practices within a framework of evidence based clinical practice guidelines and appropriately consults with medical staff and other health care professionals as required.
- Demonstrates knowledge of best evidence underpinning scope of practice and clinical practice guidelines
- Performs comprehensive patient assessments and demonstrates skill in the diagnosis and treatment of acute and chronic illness within the specified scope of practice and in collaboration with other members of the multidisciplinary team.
- Demonstrates knowledge related to extensions to nursing practice including pharmaceuticals / prescribing, ordering and interpreting diagnostic tests, referring patients, admitting and discharging patients and completing absence from work certificates.
- Ensures maintenance of accurate, clear and current patient records within the legal and ethical framework.
- Evaluates and accurately documents data required to monitor outcomes and key performance indicators.
- Demonstrates effective communication and promotes collaborative practice with other health care professionals.
- Continues to develop and expand the role of Nurse Practitioner Candidate / Nurse Practitioner.
- Demonstrates sensitivity to the needs of individuals and groups, respecting their values, customs, and beliefs.
- Demonstrates the immediate actions required in any emergency and responds appropriately.

**Education**
- Demonstrates self direction, motivation and commitment to own professional development in order to gain successful and continued endorsement as an Nurse Practitioner with the Nurses’ Board of Victoria.
- Participates in succession planning and is committed to providing educational support, clinical supervision and mentorship to other Nurse Practitioner Candidates.
- Participates in the education and professional development of other staff as required.
- Promotes the Nurse Practitioner role by the education of other health care professionals, patients and the community.
- Demonstrates understanding of evidence based practice, appraisal of research and other literature and principles of clinical application of best evidence.

**Professional**
- Acts as a role model within professional code of conduct, and legal requirements.
- Provides expert nursing knowledge to the multidisciplinary team.
- Demonstrates comprehensive knowledge of the legislative and professional boundaries of the Nurse Practitioner Candidate role.
- Demonstrates an understanding of the requirements of the Nurses Board of Victoria for endorsement and continued practice as a Nurse Practitioner.
- Demonstrates a comprehensive knowledge of standards prescribed by the Australian Nursing and Midwifery Council, Nurses Board of Victoria Guidelines and Northern Health Policies and Procedures.
- Acts as a patient advocate ensuring rights of individuals/groups with the maintenance of optimal standards of quality patient focussed health care.
- Ensures confidentiality of information.
- Builds and / or contributes to collaborative partnerships within and beyond Northern Health.
- Recognises the values of research in contributing to developments in nursing and improved standards of care, by initiating / participating in quality improvement, research and clinical risk management activities.
- Actively promotes the Nurse Practitioner role by participation in professional forums, publication in peer reviewed journals and presentation at local, national and international conferences.

**Management**
- Demonstrates the principles of management in the organisation of patient care within the unit and with other team members.
- Demonstrate knowledge and understanding of current trends and their implications for the Nursing Division, nursing practice and health care.
- Initiate and participate in the development and review of policies, procedures, protocols and clinical practice guidelines.
- Demonstrates advanced managerial and organisational skills
- Participates in multidisciplinary meetings and committees as required.

**General**
Comply with all of the By-Laws, Regulations and Policies that are in place at Northern Health from time to time, including those relating to; Privacy and Confidentiality, Occupational Health and Safety, Performance and Development Management, Harassment in the Workplace.

Comply with all relevant Legislation.

Contribute to quality improvement and sustainability of the organisation by participating in quality activities and ensuring flexibility within the role in order to respond to the changing needs of our customers.

Follow the guidelines provided in the Code of Conduct for staff of Northern Health.

4. SELECTION CRITERIA

Essential
- Registered Nurse (Division 1) with current registration with the Nurses’ Board of Victoria
- Hold Graduate Diploma (or equivalent) in nursing speciality
- Demonstrates commitment to undertake a relevant Master of Nursing (including a mandatory Therapeutic Medication Management module) or working towards same.
- Evidence of commitment to application for endorsement as a Nurse Practitioner by the Nurses Board of Victoria.
- Evidence of advanced clinical skills and knowledge in nursing speciality.
- Demonstrated ability to practice as part of a multidisciplinary team.
- Well developed skills in interpersonal communication, human resource management and change management.

Desirable
- Master or Nursing: Nurse Practitioner (or equivalent)
- Completion of Therapeutic Medication Management module
- Previous experience in advanced practice / extended nursing roles

INCUMBENT STATEMENT

I _____________________________________ have read, understand and accept the above Position (Please print name) Description.

Signed: ................................................................................................. Date:
Position Description

<table>
<thead>
<tr>
<th>POSITION TITLE:</th>
<th>Nurse Practitioner</th>
</tr>
</thead>
</table>
| DATE OF EFFECT:      | Created: 1st September 2006  
Reviewed: N/A  
For review: TBC |
| TYPE OF EMPLOYMENT:  | ZE4 - Grade 6  
38 hours per week |
| REPORTING TO:        | Director of Nursing  
Medical Director of Service |
| ROLES REPORTING TO   | Nurse Practitioner Candidates |
| THIS POSITION:       |                    |
| GENERAL RESPONSIBILITY STATEMENT: | Responsible for advanced and extended nursing practice in specific contexts. |
| LIAISES WITH:        | Operations Director / Nurse Unit Manager  
Other service providers in the service including medical, nursing and allied health staff |
1. ORGANISATIONAL INFORMATION

1.1 Introduction

The Northern Health Service provides a diverse range of acute, sub-acute and community health services to the large and diverse population in the regions north of Melbourne. There are four main campuses; Broadmeadows Health Service, Bundoora Extended Care Centre, The Northern Hospital at Epping and Panch Health Service at Preston. Craigieburn Health Service is expected to open early in 2007.

1.2 Strategic Plan 2006-2008

The Strategic Plan for Northern Health includes the following elements -

Mission:

To apply our resources to work with our staff and partners, offering our diverse community excellence in health care.

Vision:

A healthier Northern Community through quality care, prompt access and effective partnerships.

Values:

- We will take a patient centred approach to the provision of care
- We will consult and respond to community views about our organisation and their health needs
- We will care for our patients who come to us at a most vulnerable and fragile time in their lives, giving consideration to their unique situations.
- We will be flexible and responsive to change.
- We will aim continuously to provide better services and we will demonstrate the quality of our services to the community.
- We will look after our colleagues and encourage teamwork ahead of individual achievement in our service.
- We will be accountable for the service we provide.
- We will provide equitable access to health services for our community.
- We will value and encourage evidence-based practice and research which supports it.

Strategic Priorities:

- A Quality Health Service
- An Effectively Staffed Health Service
- A Financially Viable Health Service
- An Integrated Health Service
2. ROLE STATEMENT

Workforce redesign is a key strategy in the management of increased current and projected service demands. The Nurse Practitioner role complements the care provided by other health care professionals in specific contexts of practice. The Nurse Practitioner Candidate will work as part of a multidisciplinary team to provide high quality care to specific patient / client groups.

In addition to advanced nursing knowledge and skills the Nurse Practitioner Candidate role may include (but is not limited to), referral of patients to other health care professionals, prescribing medications, and ordering diagnostic investigations, admitting and discharging patients / clients. The scope of practice is determined by the context in which the Nurse Practitioner Candidate is authorised to practice.

3. KEY RESULT AREAS and MAJOR RESPONSIBILITIES

Role Specific

Clinical Practice

- Possesses advanced clinical knowledge and skills commensurate with those required to function effectively as a Nurse Practitioner.
- Practices within a framework of evidence based clinical practice guidelines and appropriately consults with medical staff and other health care professionals as required.
- Demonstrates knowledge of best evidence underpinning scope of practice and clinical practice guidelines
- Performs comprehensive patient assessments and demonstrates skill in the diagnosis and treatment of acute and chronic illness within the specified scope of practice and in collaboration with other members of the multidisciplinary team.
- Demonstrates knowledge related to extensions to nursing practice including pharmaceuticals / prescribing, ordering and interpreting diagnostic tests, referring patients, admitting and discharging patients and completing absence from work certificates.
- Ensures maintenance of accurate, clear and current patient records within the legal and ethical framework.
- Evaluates and accurately documents data required to monitor outcomes and key performance indicators.
- Demonstrates effective communication and promotes collaborative practice with other health care professionals.
- Continues to develop and expand the role of Nurse Practitioner Candidate / Nurse Practitioner.
- Demonstrates sensitivity to the needs of individuals and groups, respecting their values, customs, and beliefs.
- Demonstrates the immediate actions required in any emergency and responds appropriately.
Education

- Demonstrates self direction, motivation and commitment to own professional development in order to gain continued endorsement as an Nurse Practitioner with the Nurses’ Board of Victoria.
- Participates in succession planning and is committed to providing educational support, clinical supervision and mentorship to Nurse Practitioner Candidates.
- Participates in the education and professional development of other staff as required.
- Promotes the Nurse Practitioner role by the education of other health care professionals, patients and the community.
- Demonstrates understanding of evidence based practice, appraisal of research and other literature and principles of clinical application of best evidence.

Professional

- Acts as a role model within professional code of conduct, and legal requirements.
- Provides expert nursing knowledge to the multidisciplinary team.
- Demonstrates comprehensive knowledge of the legislative and professional boundaries of the Nurse Practitioner / Nurse Practitioner Candidate role.
- Demonstrates an understanding of the requirements of the Nurses Board of Victoria for endorsement and continued practice as a Nurse Practitioner.
- Demonstrates a comprehensive knowledge of standards prescribed by the Australian Nursing and Midwifery Council, Nurses Board of Victoria Guidelines and Northern Health Policies and Procedures.
- Acts as a patient advocate ensuring rights of individuals/groups with the maintenance of optimal standards of quality patient focussed health care.
- Ensures confidentiality of information.
- Builds and / or contributes to collaborative partnerships within and beyond Northern Health.
- Recognises the values of research in contributing to developments in nursing and improved standards of care, by initiating / participating in quality improvement, research and clinical risk management activities.
- Actively promotes the Nurse Practitioner role by participation in professional forums, publication in peer reviewed journals and presentation at local, national and international conferences.

Management

- Demonstrates the principles of management in the organisation of patient care within the unit and with other team members.
- Demonstrate knowledge and understanding of current trends and their implications for the Nursing Division, nursing practice and health care.
- Initiate and participate in the development and review of policies, procedures, protocols and clinical practice guidelines.
- Demonstrates advanced managerial and organisational skills
- Participates in multidisciplinary meetings and committees as required.
General

- Comply with all of the By-Laws, Regulations and Policies that are in place at Northern Health from time to time, including those relating to; Privacy and Confidentiality, Occupational Health and Safety, Performance and Development Management, Harassment in the Workplace.
- Comply with all relevant Legislation.
- Contribute to quality improvement and sustainability of the organisation by participating in quality activities and ensuring flexibility within the role in order to respond to the changing needs of our customers.
- Follow the guidelines provided in the Code of Conduct for staff of Northern Health.

4. SELECTION CRITERIA

Essential

- Registered Nurse (Division 1) with current registration with the Nurses’ Board of Victoria
- Current endorsement as a Nurse Practitioner with the Nurses’ Board of Victoria
- Hold Graduate Diploma (or equivalent) in nursing speciality
- Evidence of advanced clinical skills and knowledge in nursing speciality.
- Demonstrated ability to practice as part of a multidisciplinary team.
- Well developed skills in interpersonal communication, human resource management and change management.

Desirable

- Previous experience in the Nurse Practitioner role

INCUMBENT STATEMENT

I ___________________________ have read, understand and accept the above Position (Please print name)
Description.

Signed: ____________________________________________ Date:
9 Barriers/constraints to implementation of Nurse Practitioner roles

Key Recommendations:

- Nurse Practitioner / Nurse Practitioner Candidate roles should be service driven and where possible developed from a Northern Health perspective
- Key stakeholder support and educational preparation of health care professionals from all disciplines (medical, nursing, allied health) are pivotal to the successful implementation of Nurse Practitioner / Nurse Practitioner Candidate roles
- Decision-making regarding the implementation of Nurse Practitioner / Nurse Practitioner Candidate roles should be clinical governance model rather than be dependent on decisions by individual stakeholders
- lines of reporting, definition of scope of practice and Nurse Practitioner / Nurse Practitioner Candidate position descriptions should be developed and freely available throughout the organisation
- education of health care professionals from all disciplines (medical, nursing, allied health) are a key factor in successful

There are a number of barriers to implementation of Nurse Practitioner roles and these barriers may be considered from three perspectives: personal barriers for actual or potential Nurse Practitioners / Nurse Practitioner Candidates, local departmental or organisational barriers and barriers arising from Government and legislative constraints. Potential barriers and strategies to overcome these barriers are shown in Table 4.

Table 4: Barriers to implementation of Nurse Practitioner roles and solution strategies

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Solution strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncertainty regarding role sustainability</td>
<td>• service driven model of planning, implementing and continuing Nurse Practitioner roles and key stakeholder engagement in these processes</td>
</tr>
<tr>
<td></td>
<td>• comprehensive strategic, operational and financial should occur planning prior to implementation of Nurse Practitioner / Nurse Practitioner Candidate roles and these plans should include succession planning and long term funding strategies</td>
</tr>
<tr>
<td></td>
<td>• Nurse Practitioner / Nurse Practitioner Candidate roles should be developed, where possible from a Northern Health rather than site specific perspective</td>
</tr>
<tr>
<td></td>
<td>• decision-making regarding the implementation of Nurse Practitioner / Nurse Practitioner Candidate roles should use a clinical governance approach rather than be dependent on decisions by individual stakeholders</td>
</tr>
<tr>
<td>Variability in understanding of the Nurse Practitioner role and requirements for endorsement</td>
<td>• service driven models of implementation of Nurse Practitioner roles</td>
</tr>
<tr>
<td></td>
<td>• development of detailed position descriptions for Nurse Practitioner / Nurse Practitioner Candidate roles</td>
</tr>
<tr>
<td></td>
<td>• rigorous appointment process including submission of curriculum vitae and formal interview</td>
</tr>
<tr>
<td>Expectations of the Nurse Practitioner role (realistic and unrealistic) from colleagues and management</td>
<td>• development of detailed position descriptions for Nurse Practitioner / Nurse Practitioner Candidate roles</td>
</tr>
<tr>
<td></td>
<td>• clear lines of reporting</td>
</tr>
<tr>
<td></td>
<td>• clear definition of scope of practice</td>
</tr>
<tr>
<td></td>
<td>• key stakeholder engagement in implementation process</td>
</tr>
<tr>
<td>Barriers</td>
<td>Solution strategies</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Lack of legislative framework to support use of extensions to practice  | • clearly defined scope of practice  
• clearly defined use of extensions to practice in clinical practice guidelines  
• organisational policies regarding use of extensions to practice by Nurse Practitioners and Nurse Practitioner Candidates  
• lobbying of key stakeholders from State Governments and peak professional bodies for legislative reform |
| Access to specific educational preparation for practice as a Nurse Practitioner / Nurse Practitioner Candidate | • ensure support of key stakeholders  
• clear articulation of departmental / organisational commitment to education for Nurse Practitioner / Nurse Practitioner Candidates (e.g. study leave entitlements, non-clinical time)  
• Nurse Practitioner / Nurse Practitioner Candidate access to suitable departmental / organisational education programs  
• collaborative approach to Nurse Practitioner / Nurse Practitioner Candidate education with other organisations |
| Politically and industrial controversy surrounding Nurse Practitioner roles | • service driven models of implementation of nurse Practitioner roles  
• development of detailed position descriptions for Nurse Practitioner / Nurse Practitioner Candidate roles  
• clear lines of reporting  
• clear definition of scope of practice  
• key stakeholder engagement in implementation process  
• educational preparation of all health care professionals regarding the Nurse Practitioner / Nurse Practitioner Candidate role  
• Nurse Practitioner / Nurse Practitioner Candidates access to human resources education (e.g. conflict resolution, change management, supervision and delegation)  
• allocation of and access to professional mentor(s)  
• funding of Nurse Practitioner / Nurse Practitioner Candidate positions to be shared responsibility between medical and nursing budgets  
• multi-disciplinary approach to clinical practice guideline development and endorsement  
• evidence-based clinical practice guidelines to support clinical decision making  
• departmental commitment to clinical support for Nurse Practitioner / Nurse Practitioner Candidates  
• allocation of, and access to clinical mentor(s)  
• organisational support for, and access to, professional counselling if required  
• clear articulation of departmental / organisational support for post-graduate education (e.g. study leave entitlements, non-clinical time, scholarships) |
| Re-defining relationships with colleagues (medical, nursing and support staff) and role conflict (movement from expert to novice status, retaining a nursing ethos while working under a predominantly medical model). Managing increased responsibility (particularly related to patient discharge, treatment decisions based on interpretation of test results and clinical assessment findings) Cost of postgraduate education |
10 Budget for the implementation of Nurse Practitioner roles

The budget for further development of existing Nurse Practitioner roles or implementation of new Nurse Practitioner roles are considered as part of the organisation’s annual budget cycle. At Northern Health, budgeting for Nurse Practitioner / Nurse Practitioner Candidate roles falls into three subgroups: new models of Nurse Practitioner care, expansion of existing Nurse Practitioner models and upgrading of existing advanced nursing roles.

Pay rates for Nurse Practitioners / Nurse Practitioner Candidates are governed by the Nurses Award (Victorian Health Services). The definitions and corresponding pay rates under this award are shown in Table 5.

Table 5: Definitions and pay rates for Nurse Practitioners / Nurse Practitioner Candidates

<table>
<thead>
<tr>
<th>Definition</th>
<th>Pay rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Practitioner:</td>
<td>• Grade 6</td>
</tr>
<tr>
<td>• a Registered Nurse registered under Division 1, 3 or 4 who has satisfactorily completed a course of study and undertaken clinical experience that, in the opinion of the Victorian Nurses Board, qualifies the nurse to use the title Nurse Practitioner</td>
<td></td>
</tr>
<tr>
<td>Pilot Candidate:</td>
<td>• Grade 5</td>
</tr>
<tr>
<td>• a Registered Nurse registered under Division 1, 3 or 4 who was engaged to commence a Department of Human Services Nurse Practitioner Pilot Project that was approved prior to 1 January 2006.</td>
<td></td>
</tr>
<tr>
<td>Nurse Practitioner Candidate:</td>
<td>• substantive salary</td>
</tr>
<tr>
<td>• a Registered Nurse registered under Division 1, 3 or 4 engaged to undertake a course of study and undertake clinical experience leading to endorsement as a Nurse Practitioner</td>
<td></td>
</tr>
</tbody>
</table>

10.1 New Nurse Practitioner / Nurse Practitioner Candidate roles

A number of new Nurse Practitioner / Nurse Practitioner Candidate roles are required for staffing at CHS: Diabetes, Emergency, Wound Management, and Oncology. These positions have been included as part of the CHS recurrent budget and have therefore been included in the CHS service plan and budget request to DHS.

The Neonatal and Oncology Nurse Practitioner / Nurse Practitioner Candidate roles will be new roles for Northern Health. The process for approval of new positions at Northern Health is completion of an Operating Business Initiative that is submitted to the Northern Health CEO for approval.

Completion of the Operating Business Initiative will include the following considerations:
• details of Nurse Practitioner / Nurse Practitioner Candidate model of care
• purpose and need for Nurse Practitioner / Nurse Practitioner Candidate model of care
• relationship between proposed model of care and organisational goals
• financial statement / budget including changes in salary and potential savings
• key performance indicators
• key outcomes and benefits including service implications and applicability to Northern Health sites.
10.2 Expansion of existing Nurse Practitioner / Nurse Practitioner Candidate roles

The Emergency Nurse Practitioner and Aged Care Nurse Practitioner Candidate roles are currently funded from operational budgets. Northern Health recognises that once endorsed as Nurse Practitioners, there will be a pay increase to RN (Division 1): Grade 6. Expansion of these current roles (for example, appointment of additional EFT) would require CEO approval of an Operating Business Initiative (as described above).

10.3 Upgrading existing advanced nursing roles to Nurse Practitioner

Currently Northern Health has the following advanced nursing roles: ICU Liaison, and Clinical Nurse Consultant in Diabetes, Wound Management, and Continence. Although upgrading these roles to Nurse Practitioner Candidate positions will not incur additional salary costs, upgrading current Clinical Nurse Consultant positions to Nurse Practitioner / Nurse Practitioner Candidate positions is, in essence, creation of a new position and will be subject to CEO approval of an Operating Business Initiative (as described above).
11 Evaluation framework for Nurse Practitioner roles

Evaluation of Nurse Practitioner roles should focus on safety, quality and timing of care. In the absence of established evaluative frameworks and data collection tools, the framework presented in this section will be drawn from the nursing literature and evaluation of specific Nurse Practitioner roles within Northern Health to date: Aged Care and Emergency Nursing. It is important to note that specific outcome measures will be context specific but outcome measures should reflect service delivery rather than individual performance.

11.1 Evaluation framework

The conceptual framework developed by Sidani & Irvine\(^{24}\) (Figure 4) is a useful evaluation framework for nurse Practitioner models of care and although primarily developed to evaluate the Acute Care Nurse Practitioner role, this framework is easily transferable to a variety of contexts. This conceptual framework is underpinned by the Nursing Role Effectiveness Model which was developed to identify and investigate nurse sensitive outcomes.\(^{24}\) The Sidani & Irvine\(^{24}\) conceptual framework has three major but interrelated components: structure, process and outcomes.

![Conceptual framework for evaluating the Acute Care Nurse Practitioner\(^{24}\)](image)

**Figure 4: Conceptual framework for evaluating the Acute Care Nurse Practitioner\(^{24}\)**
11.2 Evaluation of Nurse Practitioner roles within Northern Health

Evaluation of Nurse Practitioner roles may be considered from two perspectives: i) short term intensive evaluation of new Nurse Practitioner roles and ii) long term evaluation of service delivery in areas of health care in which Nurse Practitioners / Nurse Practitioner candidates work. Each method has different aims which may inform the methods used to collect data and how the data is analysed and interpreted.

11.2.1 Short term evaluation of new Nurse Practitioner roles

Short term intensive evaluation of new Nurse Practitioner roles has largely occurred as part of funded projects, is resource intensive, is not sustainable over the longer term, and is contingent on resources and personnel with the skills to undertake detailed evaluative studies. However this type of evaluation has been useful in meeting a number of aims and contributing to the body of knowledge regarding Victorian and Australian Nurse Practitioners. At Northern Health, this type of evaluation occurred during implementation of both the Aged Care and Emergency Nurse Practitioner roles and was undertaken by dedicated project officers over a limited period of time (typically 12 months).

Useful outcomes of these evaluative studies were:
- development and validation of data collection tools for use in the Victorian Nurse practitioner context,
- assessing appropriateness of patient groups for Nurse Practitioner / Nurse Practitioner Candidate management,
- defining scope of practice and appropriateness of use of extensions to practice (prescribing, diagnostics, admission, discharge, referral),
- identifying potential patient groups for Nurse Practitioner / Nurse Practitioner Candidate management,
- testing clinical applicability of Clinical Practice Guidelines, and
- effect of the Nurse Practitioner role on specific aspects of care (for example, timing, length of stay).

Outcomes and methods commonly used in the evaluations conducted to date at Northern Health are shown in Table 6. The approaches that have been used to date include:
- descriptive exploratory approaches,
- pre-test / post-test methods,
- document analysis,
- comparative studies with standard models of practice, and
- case control methods.
Table 6: Evaluative outcomes and measures

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timing of care / patient flow</td>
<td>• waiting time</td>
</tr>
<tr>
<td>data</td>
<td>• treatment time</td>
</tr>
<tr>
<td></td>
<td>• length of stay</td>
</tr>
<tr>
<td></td>
<td>• number of patients seen</td>
</tr>
<tr>
<td>Demand for Nurse Practitioner</td>
<td>• number of patients seen</td>
</tr>
<tr>
<td>model of care</td>
<td>• type of patient seen</td>
</tr>
<tr>
<td>Safety and quality of care</td>
<td>• compliance with clinical practice guidelines</td>
</tr>
<tr>
<td></td>
<td>• assessment of decision making by clinical</td>
</tr>
<tr>
<td></td>
<td>supervisor</td>
</tr>
<tr>
<td></td>
<td>• documentation audit</td>
</tr>
<tr>
<td></td>
<td>• use of extensions to practice</td>
</tr>
<tr>
<td></td>
<td>• adverse events monitoring</td>
</tr>
<tr>
<td></td>
<td>• satisfaction measures - patients / staff</td>
</tr>
<tr>
<td>Cost of care</td>
<td>• cost analysis</td>
</tr>
</tbody>
</table>

There are a number of important considerations when evaluating Nurse Practitioner models of care:
- rigor is not always possible (any research conducted in clinical environments will be subject to confounding variables),
- adequate ‘orientation and lead-in’ time should be considered to ensure that evaluative studies are an accurate reflection of the Nurse Practitioner service,
- timing of care does not reflect quality of care (quicker is not always better),
- avoid unrealistic and unreasonable outcomes (it is not reasonable to expect that Nurse Practitioners alone will decrease waiting times of length of stay), and
- where possible consistent measures should be used.

11.2.2 Long term evaluation of Nurse Practitioner roles

Long term evaluation of new Nurse Practitioner roles is, to date, untested and will present a new challenge for health services. Lack of resources in terms of project personnel would suggest that long term evaluation will be less extensive however it is reasonable to expect that data collected as routine part of patient care and context specific key performance indicators could be used to assess care delivery and performance from organisational or health system perspectives.

11.3 Data collection / audit tools

A number of audit / evaluation tools have been used to evaluate the effect of both the Aged Care and Emergency Nurse Practitioner roles within Northern Health.

Two of the most useful evaluative tools used to date were the ‘Emergency Nurse Practitioner Register’ and ‘The Northern Emergency Nurse Practitioner Staff Survey’ and both were developed and used during evaluation of the Emergency Nurse Practitioner role. These tools have been successfully used in the Emergency Nursing context although they have not been trialled in other areas of practice, the format and information obtained suggests that adaptation to other practice contexts would be relatively simple.25-27 There are also other tools currently under development such as the Nurse Practitioner Workforce Planning Minimum Dataset that may prove to be useful for future initiatives.28

11.3.1 Scope of practice / practice evaluation

Both the Emergency Nurse Practitioner and Aged Care initiatives evaluated Nurse Practitioner Candidate scope of practice. Examples of data collection tools that may be used to evaluate Nurse Practitioner / Nurse Practitioner Candidate practice are the ‘Emergency Nurse Practitioner Register’ (Appendix 1) and the ‘Consultant feedback sheet’ (Appendix 2).
The ‘Emergency Nurse Practitioner Register’ provided information related to the scope of practice and use of extensions to practice by Nurse Practitioners / Nurse Practitioner Candidates. As all Nurse Practitioners / Nurse Practitioner Candidates are governed by the same extensions to practice, only the specifics related to prescribing, diagnostics and referral would need to be amended. This tool would be useful for short term evaluation (6-12 months) of new Nurse Practitioner roles where the scope of practice has not been previously defined and where the frequency and types of extensions to practice is unknown.

11.3.2 Staff Surveys

Staff surveys may be used to identify staff learning needs related to Nurse Practitioner roles, evaluate the effectiveness of education programs for medical and nursing staff and measure staff satisfaction with Nurse Practitioner / Nurse Practitioner Candidate service delivery. Baseline data may be collected prior to role implementation and can be used to identify learning needs and establish areas of knowledge deficits. The same tools can be used to assess the effectiveness of education programs and examine shifts in knowledge and / or attitudes following role implementation and / or education programs. Examples of staff surveys are the ‘The Northern Emergency Nurse Practitioner Staff Survey’ and the ‘Health Professionals Satisfaction Survey’.

11.3.3 Patient surveys

The ‘Patient Satisfaction Survey’ was sourced by the Emergency Nurse Practitioner Project Team from an article by Byrne et al. This tool was adapted with permission from the author for use with adult and paediatric patients who were managed by the Emergency Nurse Practitioner Candidate and traditional ED care.

11.3.4 Nurse Practitioner Datasets

While both the Emergency and Aged Care Nurse Practitioner initiatives collected data, the issue of ongoing data collection to evaluate long term outcomes of Nurse Practitioner roles is currently under development. For example, the Nurse Practitioner Workforce Planning Minimum Dataset that aims to inform workforce planning by collecting data related to the essential activities undertaken by Nurse Practitioners. This dataset was developed under the direction of Australian Institute of Health and Welfare (AIHW) and funded by The National Nursing and Nursing Education Taskforce (N3ET) and Department of Human Services, Victoria and may supersede data collection tools used in local projects. The proposed data to be collected is categorised into four groups (Table 7) which would provide detailed data related to care providers, patient populations, episodes of care, scope of practice and use of extensions to practice.
Table 7: Nurse Practitioner Workforce Planning Minimum Dataset

<table>
<thead>
<tr>
<th>Data Group 1</th>
<th>Data Group 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Work setting and provider</strong></td>
<td><strong>Patient characteristics</strong></td>
</tr>
<tr>
<td>• Workplace type</td>
<td>• Sex</td>
</tr>
<tr>
<td>• Workplace sector</td>
<td>• Date of birth</td>
</tr>
<tr>
<td>• Workplace postcode</td>
<td>• Post code</td>
</tr>
<tr>
<td>• Provider's date of birth</td>
<td>• Indigenous status</td>
</tr>
<tr>
<td>• Provider's postcode</td>
<td>• Language</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data Group 3</th>
<th>Data Group 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health service event</strong></td>
<td><strong>Health problem data</strong></td>
</tr>
<tr>
<td>• Presentation date</td>
<td>• Problem / diagnosis status (new or recurrent)</td>
</tr>
<tr>
<td>• Service commencement time</td>
<td>• Cognitive intervention description</td>
</tr>
<tr>
<td>• Service completion time</td>
<td>• Procedural intervention description</td>
</tr>
<tr>
<td>• Source of referral</td>
<td>• Diagnostic imaging test name</td>
</tr>
<tr>
<td>• Encounter status (new or recurrent)</td>
<td>• Pathology test name</td>
</tr>
</tbody>
</table>

One of the positive features of this document is that it recognise that there may be differences in the ability to record data depending on the context of practice in which the Nurse Practitioner works and that some of the items listed in the Minimum Dataset may overlap with data currently collected by health care services.
12 Sustainability of Nurse Practitioner roles

12.1 Organisational commitment
Northern Health’s organisational commitment to Nurse Practitioner roles has been, and continues to be, actively demonstrated. Northern Health has two long standing and successful Nurse Practitioner initiatives in Aged Care and Emergency Nursing. Northern Health has successfully acquired funding to implement Nurse Practitioner models of care:
- Victorian Nurse Practitioner Project Phase 1: Aged Care Nurse Practitioner
- Victorian Nurse Practitioner Project Phase 2: Aged Care Nurse Practitioner
- Victorian Nurse Practitioner Project Phase 3 Round 5: Emergency Nurse Practitioner
- Victorian Nurse Practitioner Project Phase 3 Round 5: Continuing Nurse Practitioner Models of Practice
- Victorian Nurse Practitioner Project Phase 3 Round 6: Service Plan Development

12.2 Facilitation of NBV application for endorsement
Facilitating Nurses’ Board of Victoria endorsement for Nurse Practitioner Candidates is pivotal to the success of Nurse Practitioner roles across Northern Health in terms of improving service delivery, access to health care, role sustainability and succession planning.

Again Northern Health demonstrated success in supporting Nurse Practitioner Candidates during their candidature and though the Nurses’ Board of Victoria process. The Emergency Nurse Practitioner Candidate is currently in the final stages of application for endorsement. Northern Health has provided a range of resources that actively facilitate Nurses’ Board of Victoria endorsement, for example,
- post-graduate study leave to facilitate completion of academic requirements for endorsement,
- conference leave and subsidy to enable Nurse Practitioner Candidates to present at national and international conferences, and
- provision of written statements of support and references.

12.3 Clinical, professional and academic mentorship
Please refer to Section 5 for a detailed discussion of clinical, professional and academic mentorship for Nurse Practitioner Candidates.

12.4 Succession planning
Succession planning for Nurse Practitioner roles is the next stage in Northern Health’s Nurse Practitioner program. Both of the existing Nurse Practitioner models (Aged Care and Emergency Nursing) at Northern Health are dependent on one full time Nurse Practitioner Candidate. Not withstanding the expertise, hard work and commitment of these Nurse Practitioner Candidates to their roles and the organisation, a model of health care dependent on a single individual practitioner is unsustainable and risky. Changes in health status or personal circumstances have the potential to jeopardise many years of work.

Succession planning should be multi-faceted and include the following considerations:
- career pathway for potential Nurse Practitioner Candidates (for example, development of Clinical Nurse Specialist roles to incorporate elements of advanced practice),
- structured and reproducible approach to clinical education and clinical supervision / mentorship, and future expansion of scope of practice
- rostering considerations to include study leave, non-clinical time for clinical practice guideline development etc.,
- roles of health care professionals from different disciplines in Nurse Practitioner models of care, and
- human resource and financial planning for long term viability of the Nurse Practitioner / Nurse Practitioner Candidate roles.
References

### Appendix 1: Nurse Practitioner Register

**AFFIX PATIENT LABEL HERE**

**GIVEN NAME:** _____________________________

**SURNAME:** _______________________________

**DATE OF BIRTH:** _____ / _____ / _____

<table>
<thead>
<tr>
<th>TIME ARR:</th>
<th>TIME SEEN:</th>
<th>TIME DISCH:</th>
<th>ED LOS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRESENTING PROBLEM:</td>
<td></td>
<td></td>
<td>ATS CAT</td>
</tr>
</tbody>
</table>

**CPG USED:**

<table>
<thead>
<tr>
<th>DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMAGING</td>
</tr>
<tr>
<td>PATHOLOGY</td>
</tr>
<tr>
<td>ED MEDICATIONS</td>
</tr>
<tr>
<td>DISCHARGE MEDICATIONS</td>
</tr>
<tr>
<td>PROCEDURES</td>
</tr>
<tr>
<td>INPATIENT REFERRAL</td>
</tr>
<tr>
<td>DISCH REFERRAL</td>
</tr>
<tr>
<td>PT EDUCATION</td>
</tr>
<tr>
<td>CERTIFICATE</td>
</tr>
<tr>
<td>ED DISCHARGE</td>
</tr>
<tr>
<td>DISPOSAL</td>
</tr>
<tr>
<td>HANDOVER</td>
</tr>
</tbody>
</table>

**COMMENTS**

**Appendix 1: Nurse Practitioner Register**
What degree of supervision was required for the ED NPC to treat this pt?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constant</td>
<td>Minimal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How appropriate were the medications ordered by the ED NPC for this pt?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inappropriate</td>
<td>Very appropriate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How appropriate were the diagnostics ordered by the ED NPC for this pt?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inappropriate</td>
<td>Very appropriate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

How appropriate was the pathology ordered by the ED NPC for this pt?

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inappropriate</td>
<td>Very appropriate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Supervising Physician

__________________________

Signature __________________

Comments

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Appendix 2: Consultant Feedback Sheet for the Aged Care Clinic

Please attach patient label

How would you rate the ACNP’s practice with regard to this patient’s care

<table>
<thead>
<tr>
<th>Assessment of patient</th>
<th>Not sure</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning of patient care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Management of patient care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate referral</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Do you think the Aged Care Nurse Practitioner Candidate has enhanced the care of your patients?

Yes ☐  No ☐

Comments:
________________________________________________________________________________

Do you think the Aged Care Nurse Practitioner Candidate has assisted your practice?

Yes ☐  No ☐

Comments:
________________________________________________________________________________

Would you like to comment on any limitations/disadvantages of the Aged Care Nurse Practitioner role?

Comments:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Have you any suggestions to improve the Aged Care Nurse Practitioner role?

Comments:
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Thank you for your participation.
### Appendix 3: The Northern Emergency Nurse Practitioner Staff Survey

<table>
<thead>
<tr>
<th>ED Nurse Practitioner role</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I have a good understanding of the ED Nurse Practitioner role</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>2. I have a good understanding of how the ED Nurse Practitioner role will function in my ED</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>3. I have a good understanding of which patients are suitable for management by an ED Nurse Practitioner</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>4. I have a good understanding of the ED Nurse Practitioner’s scope of practice</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>5. I have a good understanding of how the ED Nurse Practitioner is different to other senior nurses working in the ED</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>6. I have a good understanding of how the Nurse Practitioner Clinical Practice Guidelines will form the basis for ED Nurse Practitioner’s practice</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Requirements to become an ED Nurse Practitioner</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. I have a good understanding of the educational preparation required to become an ED Nurse Practitioner</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>8. I have a good understanding of the Nurses Board of Victoria requirements for endorsement as an ED Nurse Practitioner</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Advanced emergency nursing practice</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. The ED Nurse Practitioner has the skills and knowledge to provide appropriate emergency care to specific patient groups</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>10. The ED Nurse Practitioner has the skills and knowledge to provide appropriate education to specific patient groups</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>11. The ED Nurse Practitioner has the skills and knowledge to appropriately refer specific patient groups</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>12. The ED Nurse Practitioner has the skills and knowledge to initiate diagnostic imaging</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Extensions to emergency nursing practice</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. The ED Nurse Practitioner has the skills and knowledge to prescribe medications from a limited formulary of drugs</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>14. The ED Nurse Practitioner has the skills and knowledge to refer patients directly to outpatients or specialist clinics</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>15. The ED Nurse Practitioner has the skills and knowledge to write absence from work certificates</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>16. The ED Nurse Practitioner has the skills and knowledge to discharge patients from the ED</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>17. The ED Nurse Practitioner has the skills and knowledge to refer patients to inpatient Registrars for assessment for admission</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>18. The ED Nurse Practitioner will make the ED team more effective</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>19. The ED Nurse Practitioner will improve access to emergency care</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Collaborative practice</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
<th>No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. I am comfortable with being approached by the ED Nurse Practitioner for advice regarding patient management</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
<tr>
<td>21. Emergency Physicians are the most appropriate personnel to supervise / advise the ED Nurse Practitioner regarding patient management issues</td>
<td>☐ 1</td>
<td>☐ 2</td>
<td>☐ 3</td>
<td>☐ 4</td>
<td>☐ 5</td>
</tr>
</tbody>
</table>
Appendix 4: Health Professionals Satisfaction Survey

You have been chosen to participate in this survey as you have either referred a patient to the Aged Care Nurse Practitioner Candidate (NPC) in the Aged Care Clinic or the NPC has referred a patient to you. We are interested to know your perception of this new service. Completion of the questionnaire is voluntary and confidential and will take about 5-10 minutes of your time to complete. Please return the survey in the envelope provided to the Project Officer within 7 days.

Answer only those questions that are relevant to your practice.

General Practitioner ☐ Diabetes Nurse Educator ☐
Physiotherapist ☐ Nurse Unit Manager ☐
Occupational Therapist ☐ Registered Nurse ☐
Dietician ☐
Podiatrist ☐ Other (please specify) ☐

Department: _____________________________________________________________________

1. Complete only if your client has been assessed by the Aged Care Nurse Practitioner Candidate

Has the Nurse Practitioner candidate's response to you been?

Timely: Never ■ Rarely ■ Sometimes ■ Often ■ Always ■
Appropriate/relevant: Never ■ Rarely ■ Sometimes ■ Often ■ Always ■
Well-documented: Never ■ Rarely ■ Sometimes ■ Often ■ Always ■
Professional: Never ■ Rarely ■ Sometimes ■ Often ■ Always ■

Comments………………………………………………………………………………

2. Complete only if you have been referred clients by the Nurse Practitioner candidate. Was the referral

Timely: Never ■ Rarely ■ Sometimes ■ Often ■ Always ■
Appropriate/relevant: Never ■ Rarely ■ Sometimes ■ Often ■ Always ■
Well-documented: Never ■ Rarely ■ Sometimes ■ Often ■ Always ■
Professional: Never ■ Rarely ■ Sometimes ■ Often ■ Always ■

Comments………………………………………………………………………………

3. Did you have any difficulty contacting the Nurse Practitioner Candidate? Yes ☐ No ☐

Comments:

_________________________________________________________________________________________

_________________________________________________________________________________________
4. Has the Nurse Practitioner candidate kept you informed about the following aspects of your patient’s management?

<table>
<thead>
<tr>
<th>Aspect</th>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
<th>N/a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathology:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Progress with presenting problem:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral to other health professionals:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ongoing management:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments: ______________________________________________________________________
________________________________________________________________________________

5. Please comment on any benefits of the Aged Care Nurse Practitioner’s involvement to your patients.
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

Please comment on any benefits of the Aged Care Nurse Practitioner’s involvement to yourself.
Appendix 5: Emergency Nurse Practitioner (Candidate) Patient Satisfaction Surveys
### Patient Survey

<table>
<thead>
<tr>
<th>Statement</th>
<th>Not applicable</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Nurse Practitioner understood why I had come to the Emergency Department.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. The Nurse Practitioner was interested in me as a person.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. The Nurse Practitioner seemed to be very thorough.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. I was less worried about my health after seeing the Nurse Practitioner.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. I will follow the advice of the Nurse Practitioner because I believe it was good advice.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. When I saw the Nurse Practitioner, I felt that I had enough time to discuss things fully.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. I would like to see the Nurse Practitioner again for a similar health problem</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. There were other things I would have liked to discuss with the Nurse Practitioner.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. While I was in the Emergency Department, I was given health education or first aid advice from the Nurse Practitioner.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. My friends / family were allowed to be with me during investigations / treatments.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. I was told who to contact if I needed more help or advice regarding my illness / injury once I was home.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. I was given written instructions about my illness / injury to take home.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. The Nurse Practitioner explained how to take the tablets / medicines prescribed.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. I was informed of how and when to contact my GP (local doctor) about my illness / injury.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. I was told verbally and given written information about my follow up appointment.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. If I was advising a friend, I would recommend the Nurse Practitioner.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Relative / friend details: [ ] Male, [ ] Female

Patient details: [ ] Male, [ ] Female

Date: _____ / _____ / _____

Age _____ yrs

Age _____ yrs

Presenting problem: ____________________________

Relationship to patient: ____________________________

ED discharge Dx: ____________________________
Patient Survey

1. The Nurse Practitioner understood why I had brought my child to the Emergency Department.

2. The Nurse Practitioner was interested in my child as a person.

3. The Nurse Practitioner seemed to be very thorough.

4. I was less worried about my child’s health after seeing the Nurse Practitioner.

5. I will follow the advice of the Nurse Practitioner because I believe it was good advice.

6. When I saw the Nurse Practitioner, I felt that I had enough time to discuss things fully.

7. I would like to see the Nurse Practitioner again for a similar health problem.

8. There were other things I would have liked to discuss with the Nurse Practitioner.

9. While I was in the Emergency Department, I was given health education or first aid advice for my child from the Nurse Practitioner.

10. My child’s friends / family were allowed to be with them during investigations / treatments.

11. I was told who to contact if I needed more help or advice regarding my child’s illness / injury once I was home.

12. I was given written instructions about my child’s illness / injury to take home.

13. The Nurse Practitioner explained how to take the tablets / medicines prescribed.

14. I was informed of how and when to contact my GP (local doctor) about my child’s illness / injury.

15. I was told verbally and given written information about my child’s follow up appointment.

16. If I was advising a friend, I would recommend the Nurse Practitioner.

---

Relative / friend details

Patient details

Date: ____ / ____ / ____

Age ____ yrs  Age ____ yrs  Presenting problem: ____________________

Relationship to patient  ED discharge Dx:

---

Patient survey: ED NP / Child

adapted with permission by J Considine & R Martin - Emergency Nurse Practitioner Project: The Northern Hospital 2004

## Patient Survey

<table>
<thead>
<tr>
<th>Question</th>
<th>Not applicable</th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The Doctor understood why I had come to the Emergency Department.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. The Doctor was interested in me as a person.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. The Doctor seemed to be very thorough.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I was less worried about my health after seeing the Doctor.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I will follow the advice of the Doctor because I believe it was good advice.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. When I saw the Doctor, I felt that I had enough time to discuss things fully.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I would like to see the Doctor again for a similar health problem</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. There were other things I would have liked to discuss with the Doctor.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. While I was in the Emergency Department, I was given health education or first aid advice from the Doctor.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. My friends / family were allowed to be with me during investigations / treatments.</td>
<td></td>
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<tr>
<td>11. I was told who to contact if I needed more help or advice regarding my illness / injury once I was home.</td>
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<tr>
<td>12. I was given written instructions about my illness / injury to take home.</td>
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<tr>
<td>13. The Doctor explained how to take the tablets / medicines prescribed.</td>
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<tr>
<td>14. I was informed of how and when to contact my GP (local doctor) about my illness / injury.</td>
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<tr>
<td>15. I was told verbally and given written information about my follow up appointment.</td>
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<tr>
<td>16. If I was advising a friend, I would recommend the Doctor.</td>
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</tr>
</tbody>
</table>

### Patient details

- **Relative / friend details**
  - 1 Male, 2 Female
  - Date: ____ / ____ / ____
- **Presenting problem**: ______________________
- **ED discharge Dx**: ______________________

### Patient survey: Doctor / Child

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Patient Survey

1. The Doctor understood why I had brought my child to the Emergency Department.
   - Not applicable
   - Strongly disagree
   - Disagree
   - Agree
   - Strongly agree

2. The Doctor was interested in my child as a person.
   - Not applicable
   - Strongly disagree
   - Disagree
   - Agree
   - Strongly agree

3. The Doctor seemed to be very thorough.
   - Not applicable
   - Strongly disagree
   - Disagree
   - Agree
   - Strongly agree

4. I was less worried about my child’s health after seeing the Doctor.
   - Not applicable
   - Strongly disagree
   - Disagree
   - Agree
   - Strongly agree

5. I will follow the advice of the Doctor because I believe it was good advice.
   - Not applicable
   - Strongly disagree
   - Disagree
   - Agree
   - Strongly agree

6. When I saw the Doctor, I felt that I had enough time to discuss things fully.
   - Not applicable
   - Strongly disagree
   - Disagree
   - Agree
   - Strongly agree

7. I would like to see the Doctor again for a similar health problem.
   - Not applicable
   - Strongly disagree
   - Disagree
   - Agree
   - Strongly agree

8. There were other things I would have liked to discuss with the Doctor.
   - Not applicable
   - Strongly disagree
   - Disagree
   - Agree
   - Strongly agree

9. While I was in the Emergency Department, I was given health education or first aid advice for my child from the Doctor.
   - Not applicable
   - Strongly disagree
   - Disagree
   - Agree
   - Strongly agree

10. My child’s friends / family were allowed to be with them during investigations / treatments.
    - Not applicable
    - Strongly disagree
    - Disagree
    - Agree
    - Strongly agree

11. I was told who to contact if I needed more help or advice regarding my child’s illness / injury once I was home.
    - Not applicable
    - Strongly disagree
    - Disagree
    - Agree
    - Strongly agree

12. I was given written instructions about my child’s illness / injury to take home.
    - Not applicable
    - Strongly disagree
    - Disagree
    - Agree
    - Strongly agree

13. The Doctor explained how to take the tablets / medicines prescribed.
    - Not applicable
    - Strongly disagree
    - Disagree
    - Agree
    - Strongly agree

14. I was informed of how and when to contact my GP (local doctor) about my child’s illness / injury.
    - Not applicable
    - Strongly disagree
    - Disagree
    - Agree
    - Strongly agree

15. I was told verbally and given written information about my child’s follow up appointment.
    - Not applicable
    - Strongly disagree
    - Disagree
    - Agree
    - Strongly agree

16. If I was advising a friend, I would recommend the Doctor.
    - Not applicable
    - Strongly disagree
    - Disagree
    - Agree
    - Strongly agree

Relative / friend details
- Male
- Female

Patient details
- Male
- Female

Date: ___ / ___ / ___

Age ____ yrs

Relationship to patient

ED discharge Dx:

Presenting problem: __________________________

Patient survey: Doctor / Adult
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Appendix 6: Aged Care Nurse Practitioner (Candidate) Patient Satisfaction Survey

ACCESS

1.1 Did you have any difficulties in making an appointment with the Hospital to attend the Aged Care Clinic? If Yes, please specify?  
Yes ☐ No ☐

1.2 How long did you have to wait before an appointment was available in the Aged Care Clinic?  
Was this acceptable?  
If not, please specify?  
.........weeks

1.3 Were you visited at home by the Aged Care Nurse Practitioner Candidate, prior to attendance at the clinic?  
Yes ☐ No ☐

1.4 How long did you have to wait before being visited at home by the Aged Care Nurse Practitioner Candidate?  
Was this acceptable?  
If not, please specify?  
.........weeks  
..........days

1.5 Do you think your condition worsened before being visited at home?  
If yes, in what way did it worsen?  
Yes ☐ No ☐

1.6 Do you think being visited at home prior to attending the Aged Care Clinic was of benefit?  
If not, please specify?  
Yes ☐ No ☐

1.7 Did you find the time of day the Aged Care Nurse Practitioner Candidate visited acceptable?  
Yes ☐ No ☐

1.8 Were you able to contact Aged Care Nurse Practitioner Candidate when you needed to?  
If no please explain  
Yes ☐ No ☐

CONTINUITY OF CARE

2.1 Following your home visit was your plan of care clear to you including which health professional you would see next?  
Yes ☐ No ☐

2.2 If the Aged Care Nurse Practitioner Candidate referred you to another health professional (i.e. physiotherapist or occupational therapist), was it clear to you  
- when you had to see them?  
- why you were going to see them?  
Yes ☐ No ☐

2.3 Did the Health Professional know why they were seeing you?  
Yes ☐ No ☐

COMMUNICATION AND INFORMATION GIVING

3.1 Did the Aged Care Nurse Practitioner Candidate listen to your worries and concerns?  
If no, please specify.  
Always ☐ Usually ☐ Sometimes ☐ Never ☐ Not sure ☐

3.2 Did you have enough time to ask questions?  
If no, please specify  
Yes ☐ No ☐

3.3 Did you have any tests done?  
Yes ☐ No ☐

3.4 If you had any tests or treatments at home did the Aged Care Nurse Practitioner Candidate tell you about the tests/treatments in a way you could understand?  
Always ☐ Usually ☐ Sometimes ☐ Never ☐ Not sure ☐
3.5 Were you satisfied with your involvement in the decision making about your care?

3.6 Did you receive enough information about how to manage your condition at home?

3.7 Where relevant, were you linked with local resources?

3.8 Overall what did you think of the care you received from the Aged Care Nurse Practitioner Candidate?

4.1 Do you have any suggestions for improvements to the service?

4.3 As a result of your contact with the Aged Care Nurse Practitioner Candidate at home how would you rate your condition?

4.4 If you required treatment again would you prefer to be visited at home, attend the Aged Care Clinic or go to a different service?

4.5 Following your home visit was it still necessary for you to visit the Aged Care Clinic?

If yes, please complete the questions on the next few pages to tell us your views on your appointment.
**ACCESS**

1.1 Do you think your condition worsened between being visited at home and attending the Aged Care Clinic?  
   If yes in what way did it worsen?  
   Yes [ ] No [ ]

1.2 Did you have any difficulty accessing the Aged Care Clinic in regards to  
   - transport?  
   - getting from transport into the clinic?  
   - hospital signage?  
   If yes, please specify?  
   Yes [ ] No [ ]

1.3 While you were at the clinic did you have any special needs? For example did you have any specific diet, religious or, cultural needs?  
   If yes were they met?  
   Yes [ ] No [ ]

**CONTINUITY OF CARE**

2.1 When you left the Aged Care Clinic was the plan of care clear to you including which health professional you would be seeing next?  
   Yes [ ] No [ ]

2.2 If the Aged Care Nurse Practitioner Candidate referred you to another health professional (physiotherapist or occupational therapist), was it clear to you  
   - when you had to see them?  
   - why you were going to see them?  
   Yes [ ] No [ ]

2.3 Did the Health Professional know why they were seeing you?  
   Yes [ ] No [ ]

**COMMUNICATION AND INFORMATION GIVING**

3.2 In the clinic, did you feel your concerns were listened to by the Aged Care Nurse Practitioner Candidate?  
   If no, please specify  
   Always [ ] Usually [ ] Sometimes [ ] Never [ ] Not sure [ ]

3.3 In the clinic, did you feel your concerns were listened to by the Aged Care Nurse Practitioner Candidate?  
   If no, please specify  
   Yes [ ] No [ ]

3.4 Did you have enough time to ask questions?  
   If no, please specify,  
   Yes [ ] No [ ]

3.5 Did you have any tests done?  
   Yes [ ] No [ ]

3.6 If you had any tests or treatments at the clinic were you told, by the Aged Care Nurse Practitioner Candidate, about the tests/treatments in a way you could understand?  
   If no, please specify,  
   Always [ ] Usually [ ] Sometimes [ ] Never [ ] Not sure [ ]

3.7 Were you satisfied with your involvement about your care?  
   If no, please explain  
   not as much as you wanted [ ] as much as you wanted [ ] more than you wanted [ ]

3.8 Did you receive enough information about how to manage your condition at home?  
   If no please explain  
   not as much as you wanted [ ] as much as you wanted [ ] more than you wanted [ ]

3.6 Did you receive enough information about how to manage your condition at home?  
   If no please explain  
   not as much as you wanted [ ] as much as you wanted [ ] more than you wanted [ ]

3.7 Where relevant, were you linked with local resources?  
   Yes [ ] No [ ]
**PROCEDURAL COMPETENCE**

4.1 Overall what did you think of the care you received from the Aged Care Nurse Practitioner Candidate at the Aged Care clinic?
- Excellent 
- Very good 
- Good 
- Fair 
- Poor 
- Not sure 

4.2 Do you have any suggestions for improvements to the service?

4.3 As a result of your contact with the Aged Care Nurse Practitioner Candidate at the Aged Care clinic how would you rate your condition?
- Better 
- The same 
- Worse 

Please elaborate

4.4 If you required treatment again would you prefer to return to this clinic or go to a different service?
- This service 
- Different service 
- Not sure