

Supporting nurses in general practice



Submission to Health Legislation
Amendment (Midwives and Nurse Practitioners) Bill
2009 and two related Bills:
Midwife Professional Indemnity (Commonwealth
Contribution) Scheme Bill 2009 and Midwife
Professional Indemnity (Run-off Cover Support
Payment) Bill 2009

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Belinda Caldwell
Chief Executive Officer

belinda.caldwell@apna.asn.au

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1. Introduction

The Australian Practice Nurses Association (APNA) was established in 2001 in response to the growing Commonwealth government interest and funding initiatives to encourage more nurse into general practice.

With approximately 9000 nurses now working in general practice, this group of nurses has grown to be a significant provider of primary health care services in the community.

APNA is a professional association run *by* primary health care nurses *for* primary health care nurses. It provides representation, support and professional development for practice nurses at national, state and local levels.

Prior to APNA being formed, there was not a formal support network for nurses working in general practice. APNA was incorporated on the 10th August 2001, and our first National Executive was elected on the 16th August to represent and promote the interests of practice nurses by developing and maintaining networks with key stakeholders. Subsequently we received seeding funding for 3 years from the Department of Health and Ageing in recognition of the need for such an organisation. Whilst now funded primarily by member subscriptions, we continue to administer the Department of Health and Ageing's *Continuing Professional Development for Practice Nurses* (CPDPN) program, comprising provision of over 2000 professional development and postgraduate scholarships to practice nurses as well as development of online learning opportunities.

In 2009, we are now a vibrant and dynamic association with over 1700 members and growing, and regular contact with many more practice nurses through our workshops, website and other activities. We provide nurses with a voice in policy decision making about this fast evolving role, access to range of specific information, resources and education, as well as tools for ensuring general practice nurses practice professionally e.g. CPD program and professional indemnity.

2. Support for ANF submission

In order to focus our submission primarily on nurse practitioners who are or who intend to practice in the general practice setting, we would like to fully commend the ANF submission and it's views on the wider terms of reference of this committee enquiry.

3. Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and related Bills (Midwife Professional Indemnity)

The announcement last May of the proposed legislation allowing patients of nurse practitioners access to the MBS and PBS has been very exciting for our members. Aspiring to the role of Nurse Practitioner in the general practice setting has been extremely hampered by the lack of funding mechanisms to support this role.

We currently have 4 nurse practitioners endorsed working in general practice, with a further 10-15 studying their Masters in Nursing (Nurse Practitioner) degrees. Of note, in this years CPDPN program. We received over 300 applications for Masters in Nursing (Nurse Practitioner) scholarships compared to 2 in the 2008-9 Round. This indicates the intense interest that has been expressed by nurses in these roles. Of further interest to the committee may be that almost all currently endorsed and NP candidates are from rural practices.

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We currently host an email listserve of NPs and NP candidates to harness their views and support them in carving out this new role in primary health care (see attachment A for a secretion of their roles and views on collaboration). This submission provides an overview of their views and concerns regarding the delay in the legislation and the requirement for 'formal collaboration' with medical practitioners.

We urge the committee to consider what is safe and provides the best access for patients to care provided by an NP, which is not overburdened with Red Tape and allows flexibility in the ability of the NP to respond to needs of the community or practice population.

4. Committee considerations

We envision that nurse practitioners will form a key part of general practice and primary health care more broadly. Overseas evidence is crystal clear that nurse practitioners are safe and effective, as well as highly valued by patients. Access, quality of care and effectiveness of care can all be enhanced through care provided by nurse practitioners.

The role of nurse practitioner offers registered nurses in general practice a clinical career path, as opposed to an academic or managerial career path. It provides a regulatory and accountability framework around the more advanced nursing roles already being undertaken.

Teamwork is also shown to be best practice in effective primary health care and we support models that are based on collaboration defined as

'Collaborative Practice is an inter-professional process for communication and decision making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided.'

*Collaborative relationships are based on **provider equality**. The relationships are not hierarchical, nor are they dependent upon the supervision of one professional group by another. Likewise, collaborative practice is neither a "physician replacement" nor "physician extender" model. The model recognizes the strengths and integrity of each of the professional partners' approach to care delivery. Within a shared practice "Nurses practice nursing. Physicians practice medicine." While efforts to provide patients with "shared care" are the essence of the Collaborative Practice model, not all patient encounters require the input of the other discipline. Experienced Family Doctors and Nurses Practitioners quickly learn when an integrative approach is needed and when it is not' (Way, Jones and Busing 2000).*

The proposed amendment to add a requirement for collaborative arrangements with one or more medical practitioners in order to be eligible for an MBS or PBS provider number poses some difficulty for us, if the collaborative arrangement is to be formal in nature. Nurse practitioners working in general practice will always be collaborating with GPs and have all established at least one mentor relationship with a GP in order to obtain their NP endorsement. However, creating 'formal' collaborative relationships has the potential to impose a Red Tape burden on what are already fantastic collaborative relationships.

We are also mindful that many NPs working in primary health care more broadly may not be working in co-location with general practice. And we are not keen to see solutions that work only for general practice *but no other setting*, as this will preclude our members from moving across settings in the future as they apply their skills to other populations in need.

Additional concerns raised have been

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1. if the relationship is proscribed with an individual medical practitioner, what happens to the NP ability to practice when that medical practitioner retires or moves away.
2. collaboration should not be enforced / contractual with one specific medical practitioner but should be appropriate in each situation. For example if an NP visited a private patient in a nursing home for a continence issue or completed a pap for a woman in a GP setting and had to manage the result by referral, the Dr or Health service he/she would collaborate with in the different situations would be different. NPs should not be limited by what one specific Doctor sees as best practice for that patient (this is important for access and advocacy).

The APNA view of a collaborative relationship as defined in the proposed legislation is a model that

1. needs to be flexible enough to be appropriate for co-located and non-co-located nurse practitioner/medical practitioner collaborations,
2. needs to avoid Red Tape burden similar to General Practice Management Plans /Team Care Arrangements and allied health,
3. needs to not restrict access for patients to appropriate care e.g. only see NP on GP referral as does not fit many models
4. supports effective collaboration and improves integration of care

We envisage that NPs who see patients away from the general practice setting could have as an expectation in the MBS that they ask if the patient has a usual GP and provides feedback to patient usual GP with patient consent. Evidence for this in notes could be audited by Medicare in the same way GP audits are done. This however is different to a 'formal' collaborative arrangement.

5. Conclusion

The APNA thanks the committee for the opportunity to be able to provide advice to the Community Affairs Legislation Committee to assist in its deliberations on the impact of the proposed Government amendments to the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills: Midwife Professional Indemnity (Commonwealth Contribution) Scheme Bill 2009 and Midwife Professional Indemnity (Run-off Cover Support Payment) Bill 2009.

Our current and candidate NP members are keen that the passage of the proposed Bills is expedited through the Parliament as soon as possible, to provide them with the certainty that they will be able to fulfil their full potential in the primary health care setting, as well as become a critical part of the primary health care team delivering easily accessible, safe and affordable care.

Appendix A

Examples of current or pending Nurse Practitioners in general practice in their own words

Cassie Holland, Port Macquarie, NSW. In general practice for 14 years, RN 28yrs, certified Diabetes educator, Cardiac care certified, Intensive care certified, OT nurse. Vaccinator, Women's health, Sexual and reproductive, Domestic violence counsellor. Educator and tutor UNSW Rural Medical school. Facilitator and supervisor University of Newcastle medical school. APNA rep on Nurse Practitioner Advisory Group.

Kerrie Duggan, Tasmania GP land for 5 years RN 30 years, ICU, Midwifery, Bachelor of Education, Grad. Cert. General Practice Nursing, Authorised nurse immuniser, supervise undergraduate nurses during primary health care rotation

Colleen McGoldrick, NP, Bundaberg Qld. Was a nurse practitioner in general practice UK before coming out here. Asthma and COPD educator. Winner of 2009 APNA Best Practice Award for Chronic Disease Management.

Sherrie McCaffery, Cootamundra, NSW. General Practice for 6 years - Master Nursing - Advanced Practice, Grad Cert in Rural and Remote, Immuniser, Well Women's Nurse, Domestic Violence counsellor, Wound Care,

Lisa Scholes is the first Nurse Practitioner (NP) to work in general practice in Western Australia. She graduated with a Bachelor of Nursing from Edith Cowan University in 1994, completed a Postgraduate Diploma of Nursing (Clinical Nursing): Gerontology in 1998 and was Director of Nursing at Bunbury Nursing Home (Moran Health Care Group) from 2002-2005. Lisa commenced working as a Registered Nurse (RN) at the Naturaliste Medical Group in 2006, where she is now employed as a NP after completing a Postgraduate Diploma in Clinical Specialisation: Nurse Practitioner at Curtin University of Technology in 2007

Broad description of role/focus

Cassie

Role is defined as Triage nurse. All patients of the Practice are provided with the service if their condition needs to be addressed before the next available appointment.

The majority of these cases currently are flu related or acute gastroenteritis (Both rife in Port Macquarie). Along with acute infectious conditions I also see all cuts, lacerations, burns, wounds etc.

All respiratory, cardiac, and paediatric triages go through me.

I see anything up to 60 patients a day with varying triage levels.

I also run a diabetes clinic, well women's clinic and allergy clinic

Kerrie

as per Cassie except not well women's clinic or allergy clinic

Colleen

Chronic Disease Management is my main role. I see 7 asthma/COPD patients per week, 5 cardiovascular and 4 diabetics all in designated nurse first doctor second clinics. EBM is utilised within the clinic setting.

As well as this I see acute injuries, pap smears, baby immunisation clinics, travel clinics, INR clinics, basically anything that comes through the door.

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All pts usually come through me first for assessment and then priority is dictated from there.

Sherrie

I can see my role in the future when MBS and PBS comes into play that I will manage most INR's, triage, CMA's, pap smears, baby health checks and immunisations. This will lessen the load currently on the GP's in our practice.

Lisa

Role includes chronic disease management, pre-employment medicals, emergency management, women's health and complex wound care.

Key clinical conditions you will be managing and what you would do?

Cassie

Acute respiratory and cardiac conditions are an immediate triage. Immediate assessment at an advanced level and treatment. Doctors are freely available for emergencies but usually take a back seat. I usually manage specialist calls, referrals and ambulance transfers.

All children are assessed by me before a GP is called. The only children I don't see are those brought back for review by their GP's. I am able to phone the local paediatrician for any concerns that the GP's cannot remedy and he is always obliging. The GP's have never yet taken over a consultation from me, they always guide a course of action in a very collaborative discussion.

All foreign bodies, sutures and minor fractures are see by me before being reviewed by the GP's

I see all worker's Comp before the doctors and usually finalise all referrals before being seen.

Kerrie

I won't have finished the NP course until end 2010, so currently still exploring my role, looking at chronic disease management - diabetes, CVD, respiratory, wound management

Colleen

Same as above although my main concerns will lie in CDM clinics, the aim is to change to nurse led consultation and ref. to GP if outside of scope of practice or any deviation from the set protocols. The idea is to review the patients, repeat any scripts or maintenance pathology that is required and liase with GP in case of further ref. to specialist or otherwise.

Sherrie-

Not very productive as a business case at present due to no MBS or PBS numbers - will change come Nov 2010

Lisa

Patients are referred to me by both the GPs and the PNs within our Practice. Referrals can include diabetes management, continence management, women's health and complex wound care, including burn management. Not all consultations involve diagnostic tests or the prescribing of medication but do involve comprehensive assessment, diagnosis, management and education, especially in the area of self-management.

I find that for some patients the care is less fragmented as I can complete both the 'consult room' and the 'treatment room' requirements of the consultation.

How you work with your GP broadly

Cassie

My GP is my clinical mentor for the NP course.

Every day we converse any joint case and during the day we always find time to touch base on

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general issues, staff etc

I work with a team of 6 GP's, but two are foremost in my work. They are the most senior doctors in the clinic and are very comfortable with my myriad of questions
We have daily training sessions with almost every patient we see.

Kerrie

I am struggling with my mentor team, my principal is not actively supportive and my other GP has just resigned - I am looking to build a working relationship with new , experienced GP and then ask if he will take over, What Cassie has sounds awesome - I am so jealous!!

Colleen

We are currently having weekly conferences in regards to the patients we are seeing and discussing their case management. My GP was my mentor and we all have a trust and respect for each others competencies and fields of expertise. We are in the process of completing a study in regards to our CDM set up with the vision of nurse only clinics in conjunction with the Dept of Health and Ageing.

Sherrie

All GP's very supportive and encouraging.

How your role differs from a practice nurse working at an advanced level

Cassie

My work is at a more autonomous level where I make the decisions and the Doctors either agree or disagree.

I never call them into a cons unless I have made a preliminary diagnosis and explored avenues of treatment. At our level I would expect no less. I am not always right so then we discuss in front of the patient alternate diagnoses and treatments. This works very well as the patient sees collaboration and huge respect.

I have to decide on treatment pathways and drug dosages, I am expected to know any reactions and side effects. The doctors listen as I regale to the patients the drug regimens and only correct when they have to.

This system is perfect advanced training for me to improve my scope of practice.

Any gray areas are always valuable learning sessions which we use for our group tutorials.

Kerrie

I am currently working as an advanced practice nurse while studying but would like to take it to the next level when I have a mentor organised -

Colleen

I find this a difficult one as I have always worked at an advanced level and the NP endorsement just confounded and confirmed that this was happening. I have worked with many PN's and been one myself for many years but doing my Masters allows me more autonomy and freedom to extend my practice which is what I needed to grow.

Sherrie

Autonomy and freedom with the full support of my GP's.

Lisa

The title 'Nurse Practitioner' is protected in Australia. This means that a RN needs to be authorised by a State or Territory nurses' registration board in order to be called a 'Nurse Practitioner'.

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NPs are RNs with advanced educational preparation and experience and authorised to practice in an expanded nursing role in their chosen clinical setting. The NP's scope of practice extends beyond that of a RN and is currently seen as the most advanced clinical nursing role.

NPs make complex decisions about what care is needed through assessment and diagnosis (with the ability to order diagnostic tests and prescribe medications) as per approved Clinical Protocol Guidelines.

The Naturaliste Medical Group NP Clinical Protocol Guidelines that the Health Department of Western Australia (WA) has approved are open injury, burns, analgesia and urinary tract infection. Clinical Protocols are only required in WA if the scope of practice involves the prescribing of medications. However, the authorisation of NPs and Clinical Protocol Guidelines requirements presently vary from state to state – hopefully this will change with national registration in 2010.

Collaboration agreements between yourselves and your GPs/medical mentors

Cassie

We don't have a formal collaborative agreement as such, just a huge level of open discretion, proven trust and immediate back up.

I do work within my scope of practice but the GP's want me working as if authorised to ensure that when the time comes for them not to be approving all my requests they will feel very confident that I won't stuff up !!!!!

Colleen

Our main belief is one of team work and collaboration within a work setting.