NURSE CLINICS IN AUSTRALIAN GENERAL PRACTICE

Planning, Implementation & Evaluation

australian medicare local alliance

Connecting health to meet local needs

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FOREWORD

The Australian health care system faces ongoing challenges which may impact the ability to provide safe, effective and accessible health care that meets the needs of our communities. As the population ages and with continuing advances in technology and increasing consumer expectations, health care organisations are rethinking how better health care can be provided, and by whom. Recent changes to policy and funding have allowed enrolled and registered nurses, nurse practitioners and Aboriginal Health Workers to play a crucial and extended role in primary health care.

The role of the general practice nurse in Australia has rapidly evolved and expanded during the past decade, and primary care has changed as a result. Almost sixty three per cent of Australian general practices now employ at least one general practice nurse as a member of the multidisciplinary health care team, and the number continues to rise. Patients, as well as primary health care providers, have benefited significantly from the greater contribution that nurses can make in the general practice environment.

Access for nurse practitioners to the Medicare Benefits Scheme and the Pharmaceutical Benefits Scheme has also encouraged nurses to work in general practice in increasingly expanded roles. Furthermore, the introduction of the Australian Government funded Practice Nurse Incentive Program (PNIP) in January 2012 has provided eligible general practices with access to incentive funding to support the overall employment of general practice nurses, and also to encourage an expanded level of practice which may include health promotion, illness prevention and chronic disease management.

This resource will assist general practice nurses to develop their role to provide high quality patient care services in general practice, and equip them with the tools they may need to continue to do so. It provides a framework and practical approach to the planning, implementation and evaluation of nurse-led clinics and other models of nursing care in general practice.

I invite you to use this resource to continue to further expand the nursing role in general practice.

Dr Rosemary Bryant

Rosemary Bryant

CHIEF NURSE AND MIDWIFERY OFFICER

ACRONYMS

AAPM	Australian Association of Practice Managers
ACoN	Australian College of Nursing
AIRC	Australian Industrial Relations Commission
AML ALLIANCE	Australian Medicare Local Alliance
AHP	Aboriginal Health Practitioners
AHW	Aboriginal Health Worker
AMS	Aboriginal Medical Service
ANMC	Australian Nursing & Midwifery Council
APHCRI	Australian Primary Health Care Research Institute
APHRA	Australian Health Practitioners Regulation Authority
APNA	Australian Practice Nurses Association
AUSDRISK	Australian Type 2 Diabetes Risk Assessment Tool
BMD	Bone Mineral Density
CKD	Chronic Kidney Disease
CLMHN	Consultation Liaison Mental Health Nurse
CMA	Comprehensive Medical Assessment
CPD	Continuing Professional Development
EFT	Equivalent Full Time
EGFR	Estimated glomerular filtration rate
EN	Enrolled Nurse
GPNNT	General Practice Network Northern Territory
GP	General Practitioner
GPMP	General Practice Management Plan
GPN	General Practice Nurse
GPV	General Practice Victoria
HbA1c	Glycosylated haemoglobin
HMR	Home Medicines Review
MBS	Medicare Benefits Schedule
MHN	Mental Health Nurse
NH&MRC	National Health and Medical Research Council
NMBA	Nursing and Midwifery Board of Australia
NP	Nurse Practitioner
NPC	Nurse Practitioner Candidate
NT	Northern Territory
OATSIH	Office for Aboriginal & Torres Strait Islander Health
PDSA	Plan, Do, Study, Act
PD	Position Descriptions
PIRS	Patient Information Record System
PM	Practice Manager
PNIP	Practice Nurse Incentive Program
PIP	Practice Incentives Program
RACGP	Royal Australian College of General Practitioners
RMMR	Residential Medication Management Review
RN	Registered Nurse
SEHR	Shared electronic health record
SMART	Specific, measurable, attainable, realistic, timely
SMS	Short messaging service
TCA	Team Care Arrangements
WHS	Workplace Health and Safety

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CONTENTS

INTRODUCTION P1

01

P2 1.1 Models of nursing care in general practice
P5 1.2 Clinical governance
P5 1.3 The RACGP Quality Framework
P6 1.4 Structure of the resource
P9 1.5 How to use this resource
P9 1.6 Conclusion

PATIENT FOCUS P11

02

P11 2.1 Patient-centred care
P14 2.2 Population health
P15 2.3 Health literacy
P16 2.4 Cultural competence
P17 2.5 Resources
P18 2.6 Considerations
P18 2.7 Conclusion

PROFESSIONALISM P19

03

P20 3.1 Registration of health professionals
P21 3.2 Codes of ethics and professional conduct
P22 3.3 Leadership and teamwork
P24 3.4 Clinical handover
P25 3.5 Quality and safety
P26 3.6 Resources
P27 3.7 Considerations
P27 3.8 Conclusion

KNOWLEDGE AND INFORMATION MANAGEMENT P29

04

P30 4.1 Data, information and knowledge
P32 4.2 Quality improvement
P33 4.3 Essentials for improving data quality
P33 4.4 Electronic tools for improving data quality
P34 4.5 Clinical audits
P36 4.6 Recall and reminders
P36 4.7 Management of health information
P37 4.8 Health identifiers
P38 4.9 Resources
P38 4.10 Considerations
P38 4.11 Conclusion

5 COMPETENCE P39

05

P40 5.1 What is a general practice nurse?
P43 5.2 Scope of practice
P46 5.3 Competency standards
P48 5.4 Mentoring and clinical supervision support
P50 5.5 Continuing professional development
P51 5.6 Evidence-based practice
P53 5.7 Clinical referral pathways
P54 5.8 Resources
P54 5.9 Considerations
P54 5.10 Conclusion

CAPACITY P55

06

P56 6.1 Human resource management
P56 6.2 Employment models
P57 6.3 Position description
P57 6.4 Induction of staff to new model of care
P57 6.5 Professional indemnity insurance
P58 6.6 Physical facilities
P59 6.7 Consultations
P60 6.8 Infection control
P60 6.9 Occupational health and safety
P61 6.10 Resources
P62 6.11 Considerations
P62 6.12 Conclusion

FINANCING P63

07

P63 7.1 Practice Nurse Incentive Program
P64 7.2 Business case/plan
P67 7.3 Operational plan
P70 7.4 Resources
P71 7.5 Considerations
P71 7.6 Conclusion

CASE STUDIES P73

08

P74 8.1 Jessica Danko RN - Musculoskeletal clinic in general practice
P78 8.2 Michelle Cordes RN - Chronic disease management clinic model of patient care
P83 8.3 Gisborne Medical Centre, Victoria
P87 8.4 Nicole Yates RN - Diabetes clinic in general practice
P92 8.5 Patrick Street Clinic (PSC), Ulverstone, Tasmania
P97 8.6 Mental Health Clinic, Southeast South Australia
P101 8.7 Beth Amega RN, MNurs (Nephrology) - Danila Dilba Kidney Health Program
P105 8.8 Marion Goodman, RN - Lifestyle Modification Clinic
P111 8.9 Bundall Medical Centre, Gold Coast, Queensland
P115 8.10 Sandy Anderson- Baarlinjan Medical Clinic

EVALUATION P119

09

P120 9.1 The evaluation cycle
P121 9.2 Conducting the evaluation
P121 9.3 Literature review
P122 9.4 Evaluation design
P123 9.5 Collect data
P127 9.6 Data analysis
P129 9.7 Discuss findings and make an action plan
P130 9.8 Implement action plan
P130 9.9 Re-evaluate
P131 9.10 Resources
P131 9.11 Conclusion

1 INTRODUCTION

As the burden of chronic disease increases and the need for complex medical care in Australia's ageing population increases, it is important that general practices continue to improve patient access to health care. It is also vital that general practices are well prepared to meet increased workload demands while providing quality patient care.

The introduction of the Commonwealth-funded Practice Nurse Incentive Program[1] (PNIP) in January 2012 has provided Australian general practices with access to incentive funding to support both the overall employment of general practice nurses (GPNs) and their work at an expanded level of practice. It provides general practices with opportunities to review and expand how nursing work is organised within their establishment, and to better employ and/or expand their existing nursing workforce. For an increasing number of general practices, the GPN plays a key role in the collaborative organisation and delivery of many services. GPNs add another dimension to the quality of primary health care service delivery by enabling broader access to primary health care for all Australians.

The process of identifying new ideas and restructuring what GPNs do and how nursing care is organised may assist general practices to maximise quality care, patient safety and patient outcomes in a financially sustainable manner. Expanded GPNs roles may include health promotion, illness prevention and contribution to the management of chronic disease and the introduction of nurse clinics.

This resource aims to assist all practice staff to gain a sound understanding of factors to consider in order to expand the nursing role in a systematic and sustainable way such as a nurse clinic. The practice staff team may include general practitioners (GPs), practice managers (PMs), registered nurses (RN) enrolled nurses (EN), nurse practitioners (NPs), other health professionals such as Aboriginal health workers (AHWs), and reception staff. Information is provided to guide anyone with an idea or concept as to how GPNs could enhance patient care services or quality improvement activities and

management. The material in this resource may assist general practices to develop, implement and evaluate clinical and professional aspects of a nurse clinic as a nursing model of care. It also will assist general practices to consider the financial, quality and logistical elements that need to be addressed if new models of care are to be successful and sustainable. The nurse clinic model of care, as an example of advanced nursing practice, will be further discussed below.

This resource supports the Commonwealth's program of Primary Health Care Reform in Australia[2]. It is based on information provided from a variety of international and national research and discussion papers, and experience from Australian general practice. The experiences of Australian, New Zealand, United Kingdom, European and Canadian medical practices have also been considered to inform the many different ways of organising, re-organising and integrating nursing within Australian general practice[3,4,5].

1.1 MODELS OF NURSING CARE IN GENERAL PRACTICE

Although models of nursing care in general practice have not been widely researched, debated or particularly well understood[6], the health reform agenda in Australia offers an opportunity to consider new models of care to meet future needs. More than 60%[7] of practices employ at least one nurse and this is expected to expand under the PNIP. Nursing capacity across all general practices enables them to develop systems, or ways of working, that meet the needs of the patients, the practice and the nurses. Collectively these are known as models of nursing care and nurse clinics are an example. Consumers have indicated that they support health care reforms including nurse clinics, with 84% of those surveyed in an Australian health survey indicating they would support nurse clinics[8].

Evidence suggests that GPN roles are varied, ranging from conducting clinical tasks that are delegated by the GP, through to collaborative nurse practice models where the GPN may participate in advanced and/or independent practice[9]. Advanced nursing care is generally provided by nurses with many years of experience and postgraduate education in specific nursing practice areas. Nurses in advanced roles may work autonomously and initiate the care process, as well as collaborate with other health care professionals[10]. Advanced nursing roles may be used to meet 'demands from communities for diverse options in health care, improved service access and increased flexibility in models of health care delivery' [11]. (Refer to section 3.1).

The models of nursing care used to date appear to be shaped by factors such as professional interests, general practice structure, employment arrangements, qualifications of the GPN, the business nature of the practice, and the needs of the local population[12]. Models of nursing care enabling GPNs to work to the full extent of their scope of practice need to be further developed and based on best practice, be fiscally viable and improve sustainable patient outcomes based on population needs[13]. Examples of existing roles for

GPNs in Australian general practice that could be described as models of care include:

- **chronic disease management –** GPNs operating clinics including for diabetes[14], cardiovascular disease [15] and respiratory disease[16]. These involve GPNs engaging in patient assessment and monitoring, patient and home-carer education, health promotion and general aspects of disease management. The role also includes liaison with the GP, and via the GP to medical specialists, other health professionals and health and welfare services
- **direct clinical care services** – e.g. immunisation or wound care delivered in the practice treatment room
- **management of quality systems and processes** – e.g. preparing general practices for regular accreditation or coordinating infection control and risk management
- **outreach services** – including home visits to high-risk patients and workplace visits
- **wellness clinics** – focusing on such areas as health maintenance or weight regulation
- **assessment services** – including undertaking health assessments of individuals
- **care coordination.**

Once a general practice decides to employ a GPN, review the nursing role, and/or develop a new nursing model[17] such as a nurse clinic, the following areas may be considered:

- A clear definition of what the model consists of, with interventions and strategies being informed by the practice's patient population, baseline data and evidence of need.
- Practice nurse activities that are accountable and acceptable to patients and other health professionals.
- Consistency within the model that grounds what the GPN does in theoretical considerations and evidence-based practice.
- Outcomes that are measurable and key performance indicators that reflect both process and outcome measures.
- Clear documentation, with individual patient plans meeting identified practice requirements as well as patient needs.
- The model operates within a clear clinical governance structure, with effective practice systems to minimise risk, ongoing monitoring, and changes to the model planned as a result of reflection.
- The model takes into account the business orientation and structure of the practice.

There is limited evidence about the effectiveness of the models of nursing care that have been developed in Australia, with most of the research conducted overseas. Although the above models of care are seen in Australian general practice, the evaluation component needed to provide evidence of effectiveness is not widespread.

This resource is aimed particularly at nurse clinics; however, it is applicable to all of the models of care described above and will assist in providing evaluation to support nursing care on a practice and potentially a Medicare Local level.

It is acknowledged that not all GPNs want to work at an advanced level. For those who wish to extend their skills and knowledge to support an expanded practice, an understanding of how they can do this in a safe, lawful and professional manner will be beneficial.

1.1.1 NURSE CLINICS

There are many definitions of nurse-led care, particularly in the overseas literature. Hatchett [18] describes nurse-led care as a continuum of practice, ranging from the GPN having delegated authority to make decisions regarding patient care at one end of the spectrum, to being responsible for all care provided, including clinical assessment, treatment and management of patients undifferentiated by need.

The definition of nurse-led care in the Australian context, however, is patient care that is 'primarily coordinated by nursing staff with support from the general practice team' [19]. This model is still in an emergent stage in this country. After a review of the international literature for the purposes of this project, the following definition of a nurse clinic has been developed[20].

Definition:

- A clinic where the nurse is the primary provider of care for the patient and has their own patient case load. Accountability and responsibility for patient care and professional practice remain with the nurse.
- The nursing services provided are holistic and patient-centred, and are provided in collaboration with a general practitioner. Collaboration includes, but is not limited to, the initial determination of which patients are appropriate to attend a nurse clinic in general practice, through to nurses seeking advice regarding patients who require care which falls outside their scope of practice.
- Nursing care in this context includes, but is not limited to, health education, promotion and disease prevention, and psychological support such as listening to and discussing patients' concerns. It also includes the provision of clinical care and monitoring patients' health conditions. The level of care provided varies and is determined by the scope of practice of each nurse. This ranges from basic nursing assessment and treatment for specific diseases or injuries in close collaboration with the general practitioner, to the provision of advanced nursing care at nurse practitioner level, which includes physical assessment, nursing diagnosis, ordering of diagnostic investigations and prescription of medicines.
- The level to which a nurse can admit or discharge patients from the clinic, receive referrals and refer to other health care professionals is also determined by the scope of practice of each nurse.
- A nurse clinic is not limited to a particular organisational configuration defined by time or space. For example, an immunisation clinic will include children attending for immunisations at different times and, at times, in different rooms. Attendance at a diabetes nurse clinic could include patients attending at individual times, in whichever clinic room the nurse is using at that time, or a group of patients attending a nurse diabetes education clinic together in a designated clinic room.

The above description highlights the variability and scope of any nursing care provided in the general practice context and recognises that planning and implementation of a nurse clinic or other nursing model of care is complex.

1.2 CLINICAL GOVERNANCE

A vital concept that underpins all provision of health care services is clinical governance. Throughout this resource it is assumed that adherence to clinical governance principles will guide the planning and implementation of a nursing model of care. Clinical governance is described by the RACGP as 'a framework through which clinicians and health service managers are jointly accountable for patient safety and quality care'[17].

Developing a system of clinical governance is an extremely useful tool in planning, as application of clinical governance principles is highly recommended to ensure systems and procedures are appropriately designed, thereby ensuring safety for all, quality services and processes, and clinical excellence. Clinical governance covers all aspects of a general practice, including services provided by medical, nursing and any other practice personnel. When a nursing model of care is being considered, it is vital this is done within the comprehensive framework of the practice's clinical governance principles, as this is a pathway to ensure delivery of excellence in patient services.

Factors underpinning clinical governance[21] include:

- risk management
- clinical effectiveness
- education, training and continuing professional development
- use of information
- staffing and staff management
- clinical audit
- patient/service user and public involvement.

General practices should strive to continue to improve the patient's experience and provide patient care that is informed by evidence-based research reflecting good clinical governance.

1.3 THE RACGP QUALITY FRAMEWORK

The RACGP Quality Framework provides 'a tool to facilitate systematic analysis of the general practice environment in terms of the quality of care'[22]. The general practice, as the setting of care environment, is discussed in relation to processes associated with six quality domains that assist in the provision of safe and high quality care and services. The quality domains that structure this framework are:

- **patient focus** – practitioners work with the patient in a relationship of mutual respect and understanding to enhance the quality of patient care
- **professionalism** – good patient care is underpinned by ethical principles of doing good, avoiding harm, respect for patients and equitable use of resources. In striving for continuous improvement, reflection and openness to critical evaluation are important
- **knowledge and information management** – good health care depends on the health team having the right knowledge and information about their patient in an efficient and timely format
- **competence** – the combined capability of the appropriately trained and skilled health care team to provide competent delivery of clinical care
- **capacity** – supports in place to provide sustainable, high quality, accessible patient care services
- **financing** – funding mechanisms that allow high quality care through provision of adequate resources, and providing affordable, accessible health care.

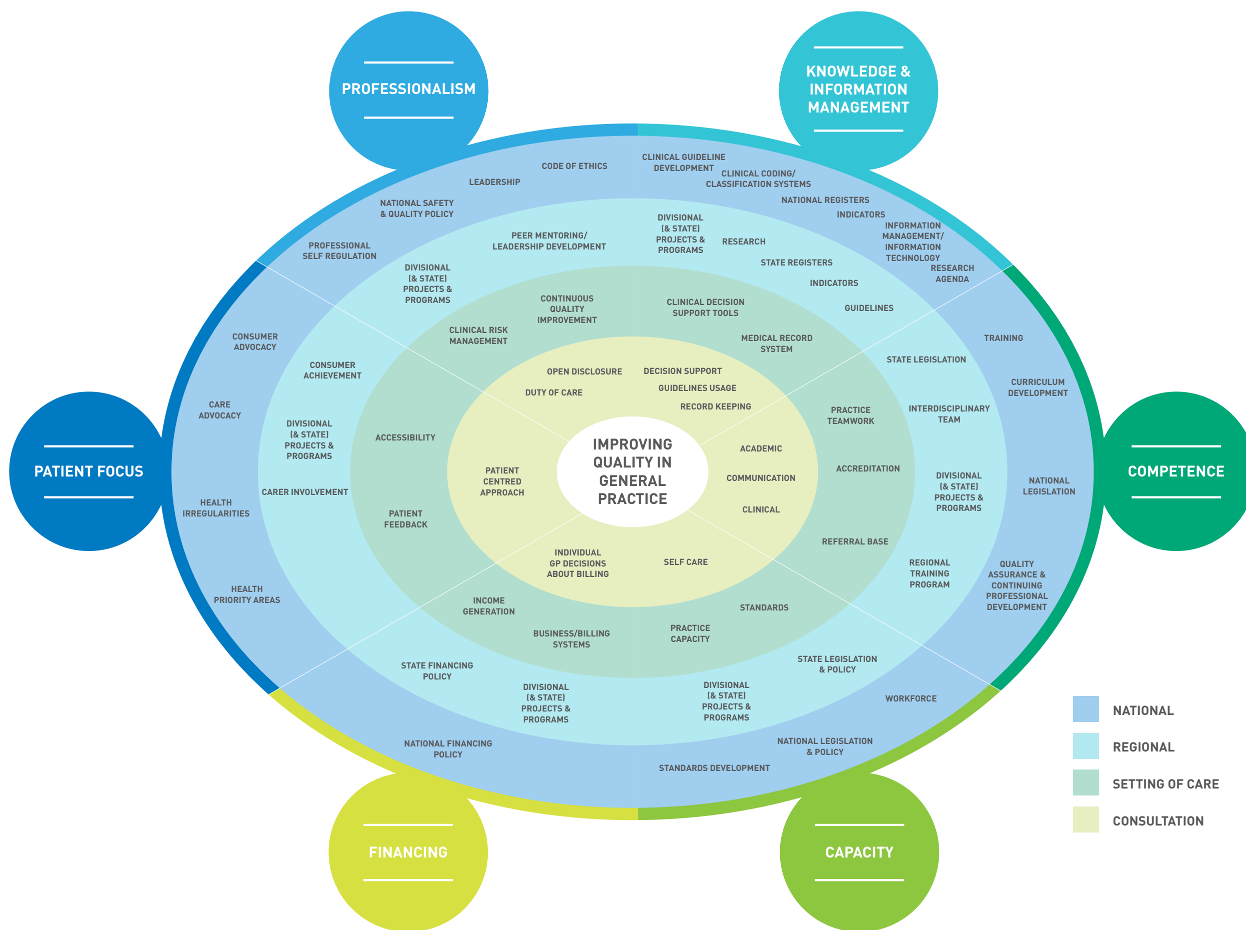


Figure 1.1 Demonstrates the Quality Framework at setting of care level, which is the level at which a nurse clinic is set.

1.4 STRUCTURE OF THE RESOURCE

This resource is divided into three (3) sections: planning, implementation and evaluation. These stages have been recognised as crucial elements in development of innovative models of care[23] such as those needed to meet the widespread nature and demands of chronic disease care in the future. Figure 1.2 outlines the framework for nurse clinics in Australian general practice

To ensure a nurse clinic meets quality standards, all sections are referenced to the appropriate RACGP 'Standards for general practices'[24] and the competencies for the Advanced Registered Nurse[25], which have informed the development of this resource. References to the Australian Safety and Quality Framework for Health Care 2010[26] have also been included where applicable.

FRAMEWORK FOR NURSE CLINICS IN AUSTRALIAN GENERAL PRACTICE

This framework for the planning, implementation and evaluation of nurse models of care in general practice is based on the Royal Australian College of General Practitioners quality framework for general practice.

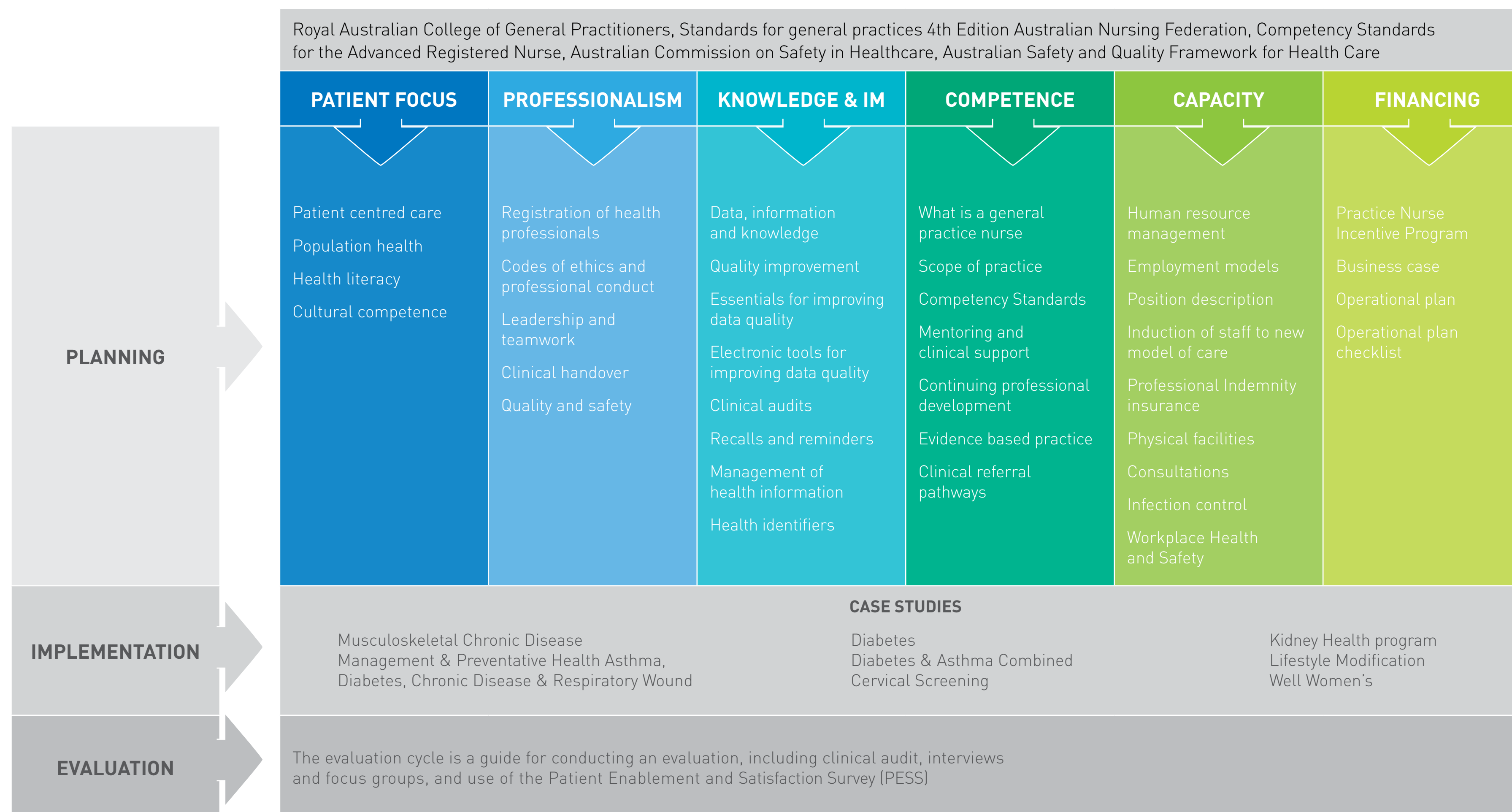


Figure 1.2 This framework for the planning, implementation and evaluation of nurse clinics in general practice is based on the Royal Australian College of General Practitioners quality framework for general practice.

SECTION A. PLANNING

This section is informed by the RACGP's Quality Framework[27], which is evidence based, comprehensive, relevant and already familiar to many GPs. All the domains of the quality framework have been used to cover aspects of nursing care fundamental to providing care in general practice. They are:

- patient focus
- professionalism
- knowledge and information management
- competence
- capacity
- financing

Within each domain are listed those elements that contribute to the general practice context. Each domain will outline the aspects that are recommended to be in place before implementation of nurse clinics, and will be examined in detail.

SECTION B. IMPLEMENTATION

This section highlights a range of innovative examples of how some GPNs provide nursing care. The models, presented in case studies, range from GPNs and NPs participating in primary health care activities such as health assessments, to others focusing on preventing illness and promoting wellness.

SECTION C. EVALUATION

The purpose of providing health care is to improve and enhance the quality of life for people who are in a state of ill-health. In order to know that the care provided is achieving this aim it is important for health care professionals to observe and measure the way in which it is provided and the health outcomes for patients who receive this care. By doing this, the quality of care and services can be improved, resulting in further enhanced health and quality of life for the community.

This section provides practices with a tool to guide the evaluation of individual nursing models of care. Links to resources that support different aspects of evaluation are included. Over time, data may be compared and aggregated with groups of practices to provide more evidence of effective nursing care in Australian general practice.

1.5 HOW TO USE THIS RESOURCE

It is acknowledged that every general practice in Australia is different. The diverse ways GPNs can contribute to patient care or other services will vary significantly between practices and is based on location, resources available and the practice population of the practice considering a new model of care. To allow for flexibility this resource has been developed as an 'ideas bank' rather than a one-size-fits-all prescription. It is a framework for thinking, and supports decision making and the application of solutions. It is important that this resource is not seen as an exhaustive manual, rather practices can extract what is relevant, useful and helpful to them.

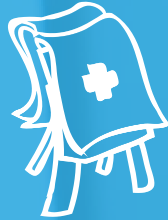
Both initiation and sustainability of new nursing models of care operating within a general practice are contingent on business and quality related considerations. Many great new ideas don't make it beyond the 'discussion' phase because important aspects of the idea have not been considered.

These materials provide a comprehensive planning resource that can be applied to improve any new or existing nursing model of care. Working through each section of the resource and applying each of the concepts to the proposed model of care will help test the idea's viability so that time and money are not wasted with insufficient planned implementation of ideas.

These materials are designed so the reader can focus on one or more areas of information that are of particular interest; however it is recommend that, all the areas are covered to ensure a comprehensive approach and to take advantage of GPNs' skills. At the end of each section is a list of considerations which may be useful in planning your nurse clinic.

1.6 CONCLUSION

Formalising advanced nursing practice and models of care within general practice are ways in which individual practices can respond to the demand for general practice services and utilise available funding. It is hoped this resource will assist and stimulate you to change and further develop the roles of nurses within your general practice in a way that improves patient safety, quality of care and fiscal sustainability.



SECTION A: PLANNING

This section is designed to assist general practices in developing and planning a nurse clinic. It is informed by the RACGP's Quality Framework[28] as previously discussed. The quality domains that general practices may like to consider when planning a nurse clinic model of care are:

- patient focus
- professionalism
- knowledge and information management
- competence
- capacity
- financing

Each domain will now be examined in detail.

2 PATIENT FOCUS

RELEVANT RACGP STANDARD

2.1 Collaborating with patients: Our practice respects the rights and needs of patients.

Criterion 2.1.2 Patient Feedback: Our practice seeks and responds to patients' feedback on their experience of our practice to support our quality improvement activities

In order to provide a sustainable service it is essential to ensure that the outcome matches the requirements of the person seeking the service. In the case of health care it is likely that patients will attend, be reliable and accept responsibility for their behaviour if the practice is providing services that meet their requirements. Patients' needs vary, as do those of the practice and our communities. To achieve optimum health status it is important to look at cultural, social, physiological and economic aspects of the patients in your community.

2.1 PATIENT-CENTRED CARE

Although it is recognised that most general practices operate as small businesses, their aim is that all staff will provide all patients with appropriate, effective, efficient and safe care.

Health care is centred on the needs of patients and this should be uppermost in the minds of nurses when planning and implementing any nursing care to patients in general practice.

Definition:

Patient centred care is 'an approach to the planning, delivery and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients and families'[29]

The dimensions of patient-centred care that are widely accepted include[30]:

- **respect for patients' preferences and values**
- **emotional support**
- **physical comfort**
- **information communication and education**
- **continuity and transition**
- **coordination of care**
- **the involvement of family and friends**
- **access to care.**

The focus on health care providers in public and private sectors to increase their awareness of patient-centred care is intensifying, and is supported by many national initiatives including the Australian Charter of Healthcare Rights (Figure 2.1) and the Australian Safety and Quality Framework for Health Care. Recommendations from the Australian Commission on Safety and Quality in Health Care[31] suggest that 'organisational systems and processes are designed to be patient-centred' and policies and procedures are in place for engaging patients, families, and carers in their own care[32].

The research focusing on communication and collaboration between patients and providers in the area of patient-centred care and outcomes in general practice indicates that patient centred care has been associated with better adherence to treatment regimens, greater patient satisfaction and greater patient enablement[33].

When planning to introduce a nurse clinic into the general practice context, consideration of the dimensions of patient-centred care need to be considered as part of the overall framework and how this is best achieved in the context of your practice to achieve patient satisfaction and enablement.

AUSTRALIAN CHARTER OF HEALTHCARE RIGHTS

The Australian Charter of Healthcare Rights describes the rights of patients and other people using the Australian health system. These rights are essential to make sure that, wherever and whenever care is provided, it is of high quality and is safe.

The Charter recognises that people receiving care and people providing care all have important parts to play in achieving healthcare rights. The Charter allows patients, consumers, families, carers and services providing health care to share an understanding of the rights of people receiving health care. This helps everyone to work together towards a safe and high quality health system. A genuine partnership between patients, consumers and providers is important so that everyone achieves the best possible outcomes.

Guiding Principles

These three principles describe how this Charter applies in the Australian health system.

1 Everyone has the right to be able to access health care and this right is essential for the Charter to be meaningful.

2 The Australian Government commits to international agreements about human rights which recognise everyone's right to have the highest possible standard of physical and mental health.

3 Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects these differences.

For further information please visit www.safetyandquality.gov.au

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

What can I expect from the Australian health system?

MY RIGHTS	WHAT THIS MEANS
Access	
I have a right to health care.	I can access services to address my healthcare needs.
Safety	
I have a right to receive safe and high quality care.	I receive safe and high quality health services, provided with professional care, skill and competence.
Respect	
I have a right to be shown respect, dignity and consideration.	The care provided shows respect to me and my culture, beliefs, values and personal characteristics.
Communication	
I have a right to be informed about services, treatment, options and costs in a clear and open way.	I receive open, timely and appropriate communication about my health care in a way I can understand.
Participation	
I have a right to be included in decisions and choices about my care.	I may join in making decisions and choices about my care and about health service planning.
Privacy	
I have a right to privacy and confidentiality of my personal information.	My personal privacy is maintained and proper handling of my personal health and other information is assured.
Comment	
I have a right to comment on my care and to have my concerns addressed.	I can comment on or complain about my care and have my concerns dealt with properly and promptly.

2.2 POPULATION HEALTH

RACGP
STANDARD

1.3 Health promotion and prevention of disease: Our practice provides health promotion and illness prevention services that are based on patient need and best available evidence.

There is clear evidence that Australia has population groups who experience health inequities, unequal access to health services and poorer health outcomes, for example:

- people with a disability
- Aboriginal and Torres Strait Islander people
- people with low socioeconomic status
- people from culturally and linguistically diverse communities
- people who are same sex attracted and transgender people
- people with chronic disease
- people who are homeless
- refugees and those who have experienced torture and war trauma
- people experiencing the long term impacts of natural disasters and prison populations[34].

Population health focuses on addressing the health and wellbeing of a population, as opposed to providing care or treatment of an individual[35]. It is characterised by identifying the health needs of a defined population and delivering health services that address the underlying factors that contribute to the health and wellbeing of the population[36].

The aim of population health is to improve the overall health of a population by implementing strategies that promote health and wellbeing, prevent illness and injury and reduce health inequalities[37].

Major strategies to improve population health include the National Cervical Screening Program and the National Immunisation Program – both aimed at providing preventive health care to population groups. The programs provide an opportunity for GPNs to contribute to population health activities that improve the health of local communities.

Definition:

The World Health Organisation defines 'health' as *'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'*[38].

The Australian Institute of Health and Welfare articulates *'the study of population health is focused on understanding health and disease in community, and on improving health and well-being through priority health approaches addressing the disparities in health status between social groups'*[39].

Determinants of health include *'the range of personal, social, economic and environmental factors which determine the health status of individuals or populations'*[40].

Population health and nurse clinics in general practice When planning a nurse clinic in general practice it is important to consider adopting a population health approach. Addressing the needs of the wider patient population will provide for a more effective and efficient approach to providing health services to the patient population[41].

One of the key roles of Medicare Locals is to identify where local communities are missing out on services they might need and to coordinate services to address those gaps[42]. In order for practices to provide services to meet the needs of their communities a comprehensive understanding of patient needs is required at a

local, regional and practice level. More information on regional population health needs is available from your Medicare Local.

A population health approach in general practice will help practices to identify and understand the needs of the wider patient population. Practice software system and tools (such as the Practice Health Atlas and Clinical Audit Tool) have the capability to support general practice to identify health priorities in the patient population. Health priorities can be classified into three groups:

1. population group priorities, such as Aboriginal and Torres Strait Islander peoples
2. age group priorities, such as 45-49-year-olds
3. disease group priorities, such as smokers and pre-diabetic patients [43].

Classifying priorities will help define the targeted health priority group for the nurse clinic. It will also enable general practice to decide which health priority group will achieve best use of resources while improving the overall health outcomes for the defined population.

It is important to identify and understand the underlying factors contributing to the health of the defined population to ensure the needs of the population are being met. Once a health priority group has been defined, the next step is to identify strategies to meet the needs of the defined patient population [44]. Depending on the health priority group identified, the population health approach to address the needs of that defined population will differ.

Reviewing patient data, population health data sources and undertaking an analysis of relevant evidence-based research are effective methods in identifying established strategies to address the needs of the health priority group [45].

Some examples of population health strategies in general practice include: patient education, preventative screening, immunisation and other interventions that promote and support healthy lifestyle and behaviours.

2.3 HEALTH LITERACY

RACGP STANDARD

1.2 Information about the practice: Our practice provides sufficient information to enable our patients to make informed decisions regarding their care.

Criterion 1.2.3 Interpreter and other communication services: Our practice provides for the communication needs of patients who are not proficient in the primary language of our clinical team and/or who have a communication impairment.

It is reported that up to nine million Australians have inadequate health literacy [46] including people from indigenous communities and those for whom English is a second language. In practical terms this means that a large number of people attending general practices, and some who attend to receive nursing care, have limited ability to manage their health and navigate the health system.

Definition:

Health literacy *'includes knowledge about health and health care, the ability to find, understand, interpret and communicate health information; and the ability to seek appropriate care and make critical health decisions, including skills to comprehend and act on social and economic determinants of health'* [47].

In order to make the health decisions most appropriate for themselves, patients need to be able to obtain, process and understand basic health information and health services[48]. The implications of low health literacy include a patient not understanding written material, inability to read labels on food, medicines or posters, misunderstanding what a health professional tells them about their condition and its management, and limited use of health services. Health literacy is a determinant of health and is a predictor of a range of health related outcomes across a variety of health conditions and population groups[49].

Having determined which population group the nurse clinic aims to target, it is important to have the required skills, knowledge and resources to ensure the clinic is patient-centred. Thought needs to be given to the health literacy of this group. Interventions that assist health literacy include[50]:

- simple and engaging written materials
- use of interactive multimedia
- enhanced interpersonal communication at the patient-provider level
- raising awareness among health care staff.

In our multicultural society it is important that all practice staff be aware of the problem of low health literacy and consider ways to ensure that information provided is done so in a format that patients can understand easily.

2.4 CULTURAL COMPETENCE

RACGP STANDARD

2.1 Collaborating with patients: Our practice respects the rights and needs of patients.

Criterion 2.1.1 Respectful and culturally appropriate care: Our practice provides respectful and culturally appropriate care for patients.

In 2009 approximately 25% of Australian residents were born overseas. Countries with the highest representation in this group include the United Kingdom, New Zealand, China, India and Italy, with the proportion of immigrants from Asia and Africa rising[51]. Furthermore, 2.6% of the Australian population are Indigenous peoples[52].

Definition

Cultural competence *is a set of congruent behaviours, attitudes and polices that come together in a system, agency or among professionals enabling that system, agency or those professionals to work effectively in cross-cultural situations*[53].

In order to improve service delivery, including that offered by nurse clinics, to patients from culturally and linguistically diverse backgrounds, it is useful to consider a framework for cultural competence. The domains include:

- **organisational values** – demonstrating that cultural competence is a core value of the organisation
- **governance** – embedding cultural competence in the organisation's policies, procedures and goals so that a consistent and responsive approach is maintained
- **planning, monitoring and evaluation** – for example, patients from diverse cultural groups participate in informing the practice of cultural aspects important to health care delivery
- **communication** – supporting the effective and culturally appropriate exchange of information between the practice and its patients and between staff members. This includes the use of interpreters and ensuring that patients understand the written materials provided
- **staff development** – equipping staff with the attitudes, knowledge and skills needed to deliver culturally competent services. This may include access to training, and cultural competence incorporated into position descriptions
- **services and interventions** – a patient's health status will improve if the health care professionals can integrate culture into clinical care.

Living in diverse communities as we do, thought needs to be given to ensuring that all people have access to health care and are adequately supported by practice staff to achieve this.

2.5 RESOURCES

- Australian Charter of Healthcare Rights:
  www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-01
- About the Australian Charter of Healthcare Rights: A guide for health care providers:
  www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/PriorityProgram-01
- Medical Board of Australia – Good medical practice:
  www.medicalboard.gov.au/Codes-Guidelines-Policies.aspx
- The population health in general practice resource kit, developed by the Central Highlands General Practice Network:
  www.chgpn.com.au/general-public-area/population-health/population-health-kit
- The Public Health Information Development Unit:
  www.publichealth.gov.au
- Australian diabetes map:
  www.ndss.com.au/Australian-Diabetes-Map
- Practice health atlas:
  www.healthatlas.org.au
- PEN clinical audit tool:
  www.clinicalaudit.com.au
- Canning tool:
  www.canningdivision.com.au
- The Centre for Culture, Ethnicity and Health:
  www.ceh.org.au
- Promoting refugee health: A guide for doctors and other health care providers caring for people from refugee backgrounds: www.foundationhouse.org.au
- Caring for refugee patients in general practice: A desktop guide:
  www.foundationhouse.org.au
- My heart my family our culture: Resources for Aboriginal people from the National Heart Foundation:
  www.heartfoundation.org.au/information-for-professionals/aboriginal-health/Pages/default.aspx
- Health literacy universal precautions toolkit:
  www.ahrq.gov/qual/literacy
- Closing the GAP: Indigenous chronic disease package:
  www.health.gov.au/tackling-chronic-disease
- Toolkit for indigenous service provision:
  www.fahcsia.gov.au/sa/indigenous/pubs/healing/toolkit_service_provider/Pages/default.aspx
- Australian Indigenous Health Infonet www.healthinfonet.ecu.edu.au/
- RACGP National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people
  www.racgp.org.au/aboriginalhealth
- Aboriginal Resource and Development Services Inc www.ards.com.au/www.ards.com.au/health.htm
- Breaking down the Barriers: Australian Commission on Safety and Quality in Health Care
  http://www.blueshadowgroup.com/clients/BDTB/Start.html

2.6 CONSIDERATIONS

When planning the proposed nurse clinic practices may wish to consider the following key points and questions relating to the patient focus domain.

- What are the patient and family needs of your practice population?
- How does your practice promote healthcare rights to patients attending your practice?
- How will a nurse clinic improve care to patients attending the clinic?
- What health conditions are priorities for your practice for current and future health care needs?
- Are patients able to access the healthcare (chronic condition management as well as prevention) they require to maintain good health?
- Who are the key people in your practice and your community who will have an interest in the establishment of a nurse clinic in your practice, and how will you engage with them?
- What resources will you have available to assist patients to find, understand, interpret and communicate health information?
- What behaviours, attitudes and policies does your practice have in place to support patients attending your clinic from culturally diverse backgrounds?
- How will you evaluate patient satisfaction with the nurse clinic?
- Does your practice record Indigenous status for all patients?

2.7 CONCLUSION

The diversity of the Australian population brings great benefits to our communities and at the same time creates challenges in the provision of equal access to health services that meet their needs. With the increase in multidisciplinary health teams, larger practices, an ageing population and alternative service provision such as nurse clinics, it is important to maintain a focus on ensuring all health professionals, including administration staff, are aware of the challenges of providing patient-centred and culturally appropriate care to such a diverse population.

3 PROFESSIONALISM

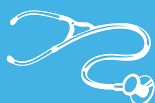
In planning a nurse clinic, it is most important that patients are being cared for by legally registered, professionally accountable and clinically competent staff who can consistently administer safe, reliable and high quality care[54].

Definition

Professionalism can be defined as the *competence and skill expected of a professional*; however; it can also encompass attitudes and values pivotal in providing high quality service to others through one's work. The RACGP discusses professionalism within the context of the principles and quality of service that underpin good patient care[55].

This section will provide an outline of the national nurse registration requirements, professional standards, codes of professional and ethical conduct and educational requirements that assist nurses to provide professional, accountable and responsible nursing practice.

3.1 REGISTRATION OF HEALTH PROFESSIONALS



RACGP STANDARD

3.2 Education and training: Our practice supports and encourages quality improvement and risk management through education and training.

Criterion 3.2.1 Qualifications of general practitioners: All GPs in our practice are appropriately qualified and trained, have current Australian registration and participate in continuing professional development

Criterion 3.2.2 Qualifications of clinical staff other than medical practitioners: Other members of our clinical team are appropriately qualified and trained, have relevant current Australian registration and participate in continuing professional development.

General practices are encouraged to confirm that nurses are appropriately registered with the Nursing and Midwifery Board of Australia (NMBA) and that they provide evidence of basic competence and demonstrated professional nurse behaviour. The NMBA has defined and documented the national registration requirements and professional standards that nurses, midwives and nurse practitioners must meet in order for their registration to continue. Nurses are required to meet the following standards in relation to continuing professional development, criminal history, English language skills, professional indemnity insurance, recency of practice and endorsement (these can be accessed from the NMBA)[56]:

- Nursing and Midwifery Continuing Professional Development Registration Standard
- Nursing and Midwifery Criminal History Registration Standard
- Nursing and Midwifery English Language Skills Registration Standard
- Nursing and Midwifery Professional Indemnity Insurance Arrangements Registration Standard
- Guidelines for Professional Indemnity Insurance Arrangements for Midwives
- Nursing and Midwifery Professional Indemnity Insurance Arrangements Registration Standard
- Nursing and Midwifery Recency of Practice Registration Standard
- Nursing and Midwifery Endorsement Nurse Practitioners Registration Standard
- Registration Standard for Endorsement for Scheduled Medicines for Midwives
- Registration Standard for Eligible Midwives
- Nursing and Midwifery Endorsement Scheduled Medicines Registered Nurses Registration Standard.

An online query to the Australian Practitioners Health Regulation Authority (APHRA) will assist general practices to determine the registration status of nurses legally able to practice. It does not apply to practitioners on the non-practising register, or those with a condition that stops them from practising, or where their registration is suspended. It also outlines endorsement of registration and identifies practitioners with additional qualifications and specific expertise. The current endorsements for nursing and midwifery are for scheduled medicines, supply scheduled medicines (rural and isolated practice), scheduled medicines for nurse practitioners, and eligible midwives.

All Aboriginal and Torres Strait Islander health practitioners and students are now required to be registered with the Aboriginal and Torres Strait Islander Health Practice Board of Australia. Practitioners must meet nationally consistent registration standards and be adequately qualified to be able to practise. Mandatory standards include continuing professional development, criminal history, English language skills and professional indemnity insurance and recency of practice.

3.2 CODES OF ETHICS AND PROFESSIONAL CONDUCT

Nurses as members of the general practice clinical team, are legally required to abide by the Code of Professional Conduct for Nurses in Australia[57] and the Code of Ethics for Nurses in Australia[58]. These minimum standards of ethical and professional nurse conduct are expected to be upheld while acting in a professional capacity, in order to ensure the 'good standing' of the profession. The 'good standing' of the profession alludes to the fact that nursing has been recognised for a number of years as one of the most trusted professions by Australians. The 2011 Ray Morgan Image of Professions Survey[59] found that 90% of Australians aged 14 and over rate nurses as the most ethical and honest profession – the 17th consecutive year since nurses were first included on the survey in 1994.

Professional boundaries[60] have been documented to guide nurses in maintaining a therapeutic and professional relationship with their patients and others they deal with in their practice. These, along with the codes of ethics and professional conduct documents, outline the guiding principles for safe professional practice. In addition, organisations such as the Australian Diabetes Educators Association have set codes of professional conduct expected of nurses working in settings such as general practice[61].

The supervision requirements of enrolled nurses by registered nurses as the primary supervisor are clearly documented and outlined[62]. **Direct or indirect supervision by a registered nurse is required;** however, this arrangement may not be formalised and, at times, there may be confusion in regards to the role and scope of enrolled and registered nurses. It is therefore important that supervision of enrolled nurses is in place and is clearly understood by all involved, and that an agreement to undertake the supervision role has been established and documented by all parties.

3.3 LEADERSHIP AND TEAMWORK

RACGP STANDARD

1.5 Continuity of care: Our practice provides continuity of care for its patients.

Criterion 1.5.1 Continuity of comprehensive care and the therapeutic relationship: Our practice provides continuity of comprehensive care to patients.

3.1 Safety and quality: Our practice is committed to quality improvement.

Criterion 3.1.3 Clinical governance: Our practice has clear lines of accountability and responsibility for encouraging improvement in safety and quality of clinical care.

4.1 Practice systems: Our practice demonstrates effective human resource management.

Criterion 4.1.1 Human resource system: Our practice supports effective human resource management

RELEVANT ANF COMPETENCY STANDARD FOR THE ADVANCED REGISTERED NURSE

Domain 3: Leads Practice.

Competency Standard 8: Leads and guides the nursing team to promote optimum standards of care.

There is growing evidence that team work enhances health outcomes for patients, particularly those with chronic disease[63]. A diabetes nurse clinic is an example whereby GPNs generally work as collaborative health care team members in providing educational and clinical support to patients[64].

Effective collaborative teamwork and the strategies to facilitate a team approach to patient care in general practice has informed and been embraced by many general practices. The general practice team is recognised by the RACGP as 'all those who work in the practice, both administrative and clinical' whereas the 'clinical team' refers to those members of the practice team who provide clinical care to patients[65] . Depending upon the nursing model of care under consideration for your practice, the general practice team members may be broader than the GP, GPN and receptionist located in the practice (micro team), but may also include local partnerships with allied health professionals, social workers, school nurses, AHWs, district nurses and other welfare and support agencies (external team).

When initiating a new model of care, all staff members within the general practice need to be actively engaged, including administrative and support staff. This ensures that the new GPN model of care has the right combination of motivated and supportive people on board[66] . A discussion with all practice staff regarding the importance of the model for providing quality patient care outcomes can promote a just, open and supportive general practice culture.

In the planning stage it is important to take into account systems needed for, and ways to develop, the optimal team environment so that positive teamwork between professionals involved in the nurse clinic can be a reality. Proudfoot et al (2007) found that a positive team 'climate' is a predictor of job satisfaction of team members and is also linked to patients' greater satisfaction with their care[67]. A nurse clinic which is not supported by health care professionals located within or external to the practice may fail if it is reliant upon referrals by these health professionals.

It is recommended that strategies to augment team building are considered during the planning stage. These may include:

- conducting regular and effective team meetings to facilitate relevant discussion
- sharing practice news and communication between team members
- documenting shared goals or a common sense of direction
- ensuring good organisational and information systems in relation to the proposed nursing model of care.

Considerations such as the identification of staff roles and responsibilities, availability and contact details of the nursing and general practice team are recommended to inform the booking of appointments. Billing and recall and reminder systems need to be identified and allocated to the nominated staff team member. Having the right combination of people in the team can facilitate effective collaboration and professional accountability. It can also nurture respect for, understanding of, and appropriate use of each team member's knowledge and skills.

The appointment of a clinical leader who will give strong and identified leadership is recommended[68,69] The designated clinical leadership role will vary depending upon the nature of the model of care. It may be a GP working collaboratively with other members of the team and assigning the care coordination role to a nurse practitioner, or GPN who undertakes an advanced nursing role within the practice. An effective leader will empower the clinical team and assist to create a supportive, open yet critically questioning environment that 'will help to ensure that the ethos and day-to-day delivery of clinical governance is integral in clinical service[70].

Some practices may formalise and document the team members' roles and responsibilities in position descriptions (refer to section 6.3), and diagrammatically represent these in an organisational chart. Others may wish to assess and review their practice team's effectiveness[71] and identify related issues in order to plan strategies that may help implement the nursing model of care under consideration.

The development of clinical protocols (refer to section 5.6) or practice policies and procedures will guide effective multidisciplinary team care and could include documented clinical guidelines, roles and responsibilities of each team member (including supervision), training and CPD requirements. It is important that these are accessible to all staff involved in the clinic, as they can also be beneficial in professional education and in the induction process of new staff.

3.4 CLINICAL HANDOVER

RACGP STANDARD

1.5 Continuity of care: Our practice provides continuity of care for its patients.

Criterion 1.5.2 Clinical handover: Our practice has an effective clinical handover system that ensures safe and continuing healthcare delivery for patients.

Criterion 1.5.3 System for follow up of tests and results: Our practice has a system for the follow up and reviews of tests and results.

1.6 Coordination of care: Our practice engages with a range of relevant health and community services to improve patient care.

Criterion 1.6.2 Referral documents: Our referral documents to other healthcare providers contain sufficient information to facilitate optimal patient care.

AUSTRALIAN SAFETY AND QUALITY FRAMEWORK OF HEALTH CARE

3. Organised for safety.

Patients now have access to many health care providers, both within the practice and externally through various organisations that deliver health care. This requires constant handover or transfer of information between providers, organisations and patients.

Definition

Clinical handover has been defined as *'the transfer of a patient or a group of patients' care to another person or professional group on a temporary or permanent basis'*[72].

Failure or inadequate handover of care is a major risk to patient safety and a common cause of serious adverse patient outcomes. It can lead to delayed treatment, delayed follow-up of significant test results, unnecessary repetition of tests, medication errors and increased risk of legal action.

Clinical handover has been recognised as a high risk area for patient safety[73]. Ensuring accountability and continuity of patient care is essential for all health providers, including nurses.

Clinical handover of patient care occurs frequently in general practice – within the practice, to other members of the clinical team, and to external care providers. For example, GPs may handover certain aspects of a patient's care to a GPN and/or credentialed diabetes nurse educator either employed within or outside the practice. However, factors such as holiday relief and the part-time nature of the general practice workforce need to be taken into account and actioned accordingly to ensure the provision of effective clinical handover of patient care at all times. Clinical handover communications can be via face-to-face, written, telephone and/or electronic means.

The development of a clinical handover policy in general practice is recommended[74]:

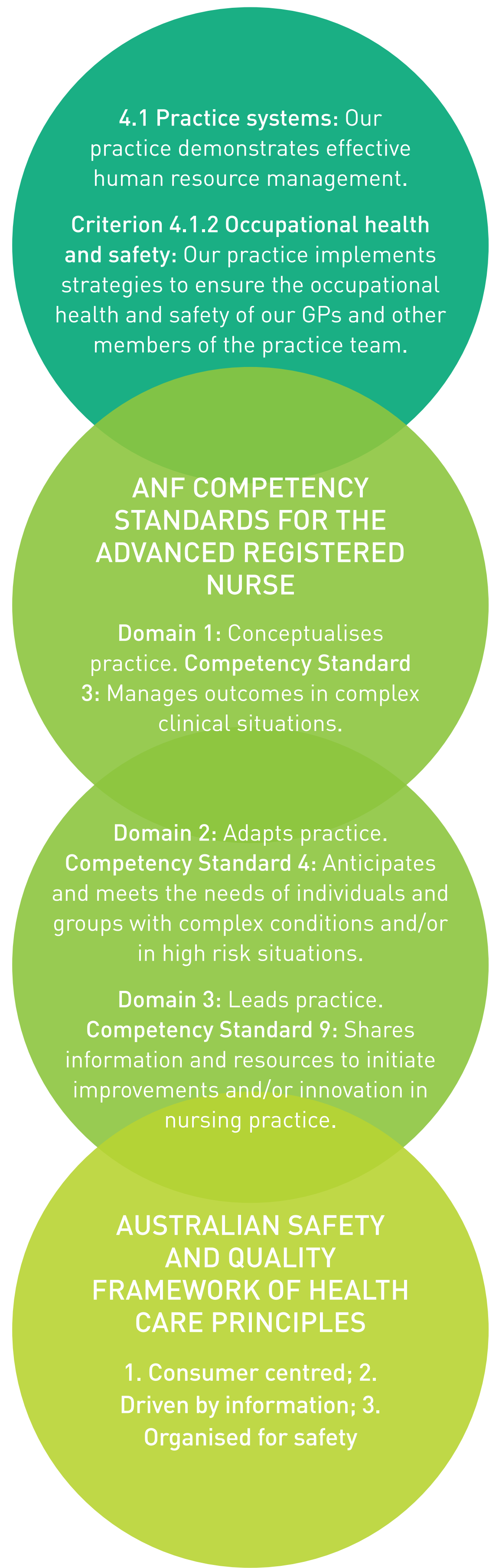
- as an integral part of a practice clinical governance system
- to ensure timely, formal clinical handover with services that provide care outside normal opening hours
- to ensure an accurate, consistent and timely handover of patient information between GPNs and GPs and other health professionals located within the practice or external to the general practice setting.

Discussion and thought directed toward developing a documented clinical handover system may be facilitated within the general practice by asking:

- who should be involved?
- when should it take place?
- where should it occur?
- how should it happen?
- what needs to be handed over[75]?

It may also include an outline to cover the handover of care of patients to another person in the event of an absent clinical team member. Many practices have a 'buddy' system whereby a 'buddy' follows up results and correspondence or continues the care of patients on behalf of an absent colleague.

3.5 QUALITY AND SAFETY



The provision of safe and high quality patient care in general practice ensures that risks to patients, visitors and staff are minimised. This has implications for how the general practice is run and how staff work[76] . A general practice is legally required to assess and control health and safety risks of the practice; therefore it is recommended that a risk assessment of actual and potential hazards (including clinical risk) be conducted in the planning stage of the nursing model of care. This will allow for proactive identification of risks and for strategies to be put into place to reduce the likelihood of near misses and mistakes occurring. Allocation of clinical risk management responsibility to a nominated person in the practice is recommended, and any delegation of this responsibility to other team members should be supported by documentation in staff position descriptions.

Following are some broad areas into which general practice risks and strategies may be categorised[77] .

Clinical knowledge and skills

- Maintaining current knowledge and practice
- Working within own scope of practice
- Reporting unsafe practices that may be occurring
- Documentation in clinical records
- Clinical equipment use, maintenance and storage
- Clinical waste disposal
- Clinical procedures
- Manual handling
- Dealing with fatigue

Communication

- Building a trusting and honest professional relationship with other members of the health care team and patient
- Communicating effectively between all health professionals, practice staff and patient[78]
- Ensuring informed patient consent

Systems

- Complaints management
- Monitoring of patient tests and referrals
- Infection control procedures
- Appointment booking process – cancellation, failures to attend
- Creating a safe physical space[79]

Some other examples of risks that may require a management plan include:

- nursing service not fully booked
- high patient demand, but no appointments available
- workforce shortage

A fundamental part of embarking on any project is an assessment of any risks that may put the project in jeopardy. For this reason an assessment of anticipated risks will allow planning to incorporate strategies to overcome any anticipated problems.

3.6 RESOURCES

- The Nursing and Midwifery Board of Australia www.nursingmidwiferyboard.gov.au
- Australian Nursing and Midwifery Accreditation Council www.nursingmidwiferyboard.gov.au/Accreditation.aspx
- Australian Practice Nurses Association www.apna.asn.au
- Australian College of Nursing www.rcna.org.au
- Australian Safety and Quality Framework for Health Care www.safetyandquality.gov.au
- Australian Government Business: Risk assessment template www.business.gov.au/Information/Pages/businessgovauplanningtemplates.aspx
- Victorian Quality Council Safety and Quality in Health: Promoting effective communication among health care professionals to improve patient safety and quality of care www.health.vic.gov.au/qualitycouncil/downloads/communication_paper_120710.pdf

- Safe Handover: Safe patients guidance on clinical handover for clinicians and managers – AMA www.ama.com.au/node/4064
- The Australian Commission on Safety and Quality in Health Care (ACSQHC). The OSSIE guide to clinical handover improvement. www.safetyandquality.gov.au/publications-resources/publications
- The team approach to diabetes in general practice: A guide for practice nurses: RACGP www.racgp.org.au/Content/NavigationMenu/ClinicalResources/RACGPGuidelines/Diabetesmanagement/DiabetesPracticeNursesGuide.pdf
- Team health check: Australian Primary Care Collaboratives www.apcc.org.au/images/uploads/Team_Check_100517%5b1%5d.pdf
- Australian Practice Nurses Association: CPD Portal
- Mentoring fact sheets for nurses in general practice: University of South Australia www.health.gov.au/internet/main/publishing.nsf/Content/A894BBCC1EFDF07CCA257070002F45D4/$File/mentor.pdf

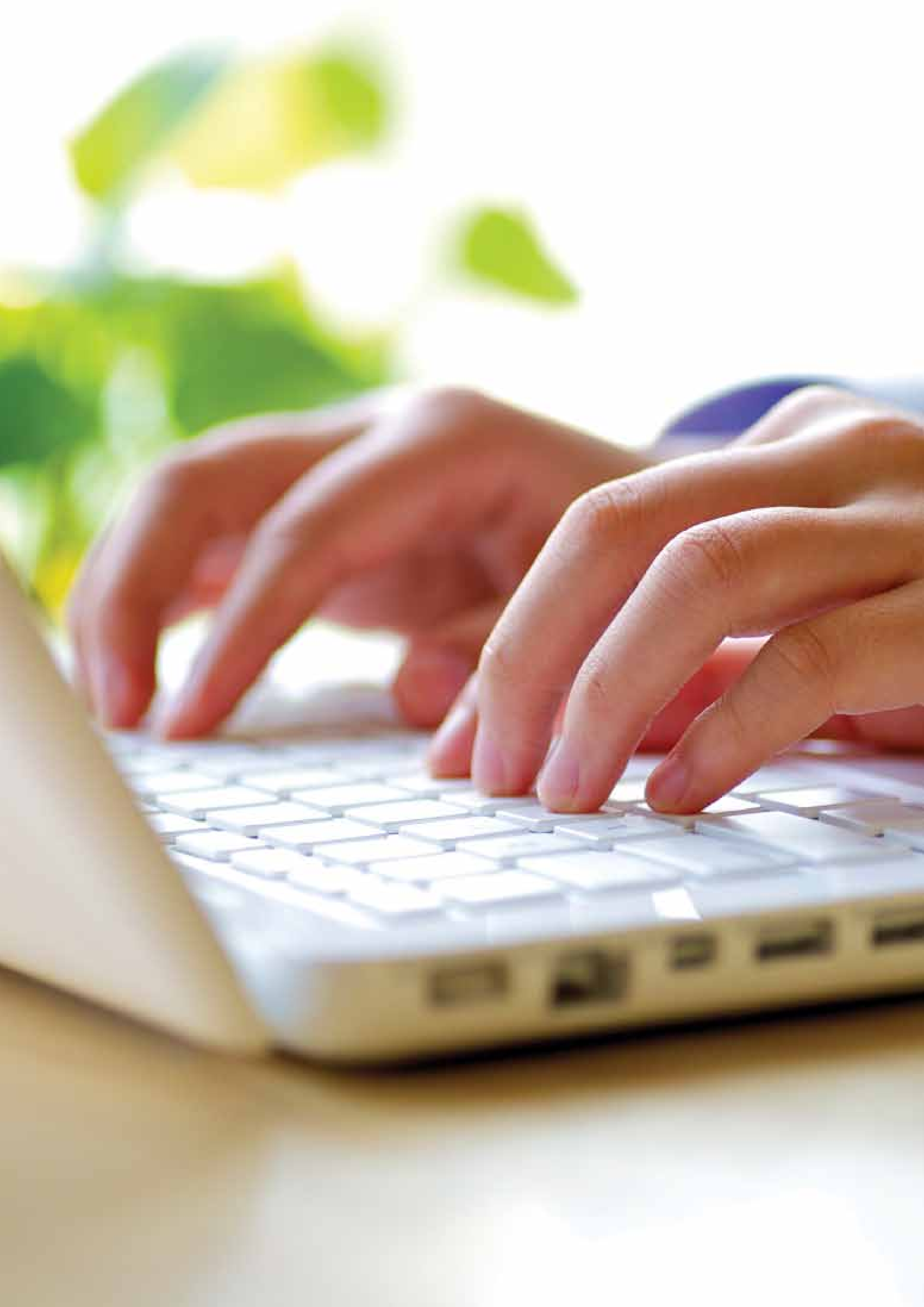
3.7 CONSIDERATIONS

Following are some key points and questions relating to professionalism that practices may wish to consider when planning a nurse clinic.

- Determine professional expertise required to provide professional, high quality nursing care within the new model.
- Have you sighted and obtained copies of staff resumes, registration and appropriate employment checks?
- Do GPNs have documented evidence of professional checks required, such as working with children, and police checks?
- Establish clear and agreed role definitions of each team member including tasks (clinical, managerial, information management and technology).
- Have possible demarcation-related issues between team members been anticipated?
- How will the professional identity of each team member be preserved and respected?
- Has a team leader and/or lead clinician been identified? How is this person going to engender a positive team spirit within the clinic?
- Does the practice have a documented policy outlining arrangements for reporting of abnormal pathology results during working hours and after hours to the patient's GP?
- What systems are in place for documenting unsafe practices or 'near misses'? Who is responsible for analysing these?
- How can patient safety be ensured?
- Have potential risks been identified, and strategies to avoid or minimise them been identified and implemented?

3.8 CONCLUSION

When planning a new nursing model within general practice it is vital to ensure that staff are suitably qualified, registered and working within ethical and professional boundaries. The importance of GPNs being educated and mentored, and the need for clinical supervision, has been outlined. The importance of developing a leader to support an effective interdisciplinary team has been discussed in ensuring provision of safe quality patient care and risk management in general practice.



4 KNOWLEDGE & INFORMATION MANAGEMENT

RACGP STANDARD

1.7 Content of patient health records: Our patient health records contain sufficient information to identify the patient and to document reason(s) for visit, relevant examination, assessment, management, progress and outcomes.

Criterion 1.7.3 Consultation notes: Each of our patient health records contains sufficient information about each consultation to allow another member of our clinical team to safely and effectively carry on the management of the patient.

The electronic collection, use and management of client and system data for clinical and administrative decision-making is crucial to the current and future success of health care systems[80]. Health care organisations are increasingly involved with and dependent on data. Health care decisions are driven by the analysis of data, therefore the quality of data is paramount.

Data is collected at multiple points of contact with patients. It starts when patient demographic details are recorded at reception and continues through clinical assessment and ongoing management processes.

Data quality is a key element of clinical governance and implies a shared responsibility to follow a systematic approach to maintaining and improving quality of patient care. Clinical governance applies to all who deliver care, including nurses, nurse practitioners, Aboriginal health workers, midwives and other members of the practice team. All health professionals have a critical role to play in collecting data accurately at the point-of-care.

Safe and effective health care is dependent on patient data being useful, accurate, accessible, consistent and current. Identifying patients in specific population groups, delivering evidence-based care, providing accurate referrals, ensuring continuity of care and measuring health outcomes – all depend upon accurate data.

The emergence of a shared patient health record (PCEHR) further highlights the need for data to be accurate, machine readable, accessible and of a quality to share with other care providers. Patient health information, formerly collected for use primarily between the patient and the clinician, may now potentially be shared across the whole health sector. It is the responsibility of all staff to ensure that information entered into the patient health record is accurate and comprehensive as this will ultimately impact on the PCEHR.

4.1 DATA, INFORMATION AND KNOWLEDGE

The terms data, information and knowledge are frequently used for overlapping concepts.

Data is considered as raw facts, generally stored as characters, words, symbols, measurements or statistics, and requires processing before it becomes information and knowledge[81].

Data on its own carries no meaning. It is raw material from which information is constructed via processing or interpretation. This information in turn provides knowledge on which decisions and actions are based.

Data can include clinical information, patient demographics, billing information and service delivery statistics The terms 'data' and 'information' are often used interchangeably; however, 'data' is used in research to indicate a sense of control in information collection[82]. In general practice the primary source of data is through direct clinical care delivery to patients. Figure 4.1[83] shows the process that data goes through to become information that can be used in decision making at the practice level.

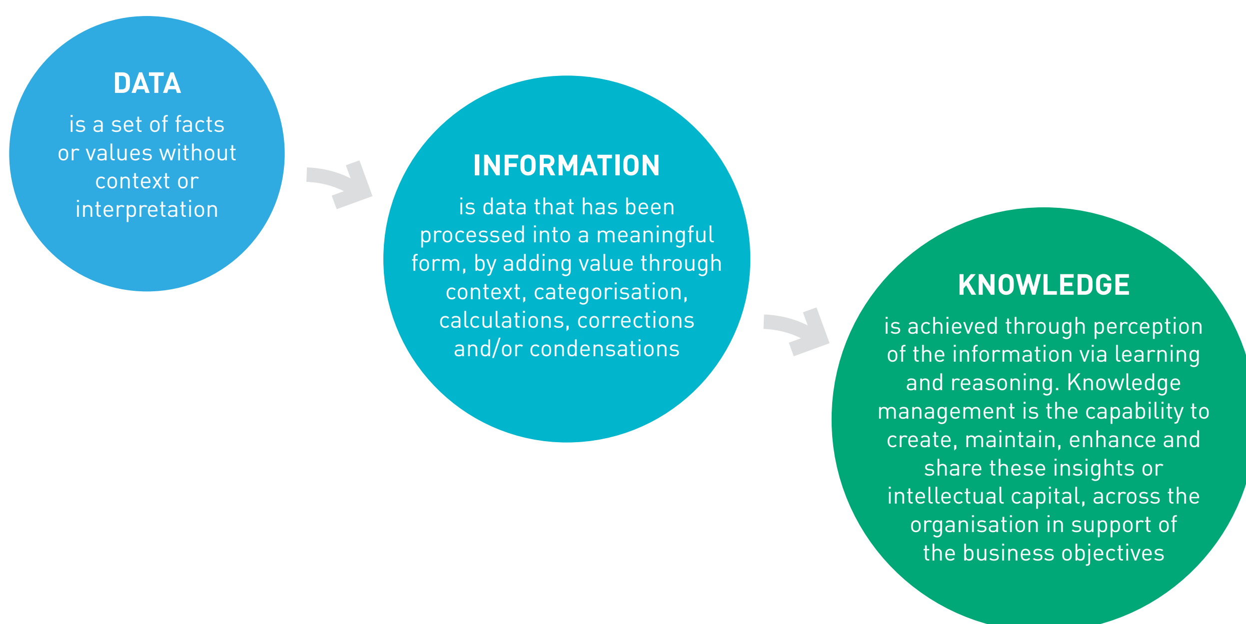


Figure 4.1: Data to information pathway model. Source: General Practice Queensland[84]

There are many tools and frameworks that detail how to define data quality. The Australian Bureau of Statistics' seven dimensions of data quality are[85]:

1. Institutional environment – where was it collected?
2. Relevance – who is it about?
3. Timeliness – is it current and valuable?
4. Accuracy – is it useful and meaningful
5. Coherence – is it consistent and comparable?
6. Interpretability – is it understandable?
7. Accessibility – can I access it?

The clinical information held within health records is relied upon to accurately reflect a patient's health status, and the delivery of quality health care is an information-dependent process. The driving force behind good quality data is ultimately to support patient safety through appropriate clinical management based on the best information available – high quality information means better patient care and better safety[86]:

- high quality data is meaningful, accurate and consistent
- poor quality data affects patient safety and quality of care
- maintaining consistent data quality is a challenge and requires a solution.

All clinical desktop systems are designed to hold information and knowledge about the patients that we provide care for. This is collectively called a clinical information system. It is essential that data that is used to base clinical treatment decisions on is of a high quality.

The health sector is slowly moving from a traditional paper medical record system to an electronic health record system. Paper records were designed around a folder for each patient (indexed by patient name or number) in which were filed all the documents related to that patient. This system had many disadvantages, including:

- possibility of errors due to transcription, illegibility and misfiling
- difficulty in managing the mass of multiple and lengthy documents
- inability to share and/or exchange data with other health care providers
- inability to mine or aggregate the data to better understand the health of patients individually or collectively.

Electronic health records offer many advantages:

- health information is more easily retrievable
- health information is grouped into data sets that are more easily accessed and interpreted
- transcription errors are reduced due to data being electronically transferable
- health information is searchable and summarised
- data may be used beyond the original purpose, for example – education, research, quality improvement, clinical knowledge, quality assurance, performance management.

Health care providers need to embrace the responsibility of data governance. This means that those who enter or use data are accountable for the quality of the information and the manner in which it is applied to clinical care and quality improvement.

Improving the quality of data will reduce the potential for medical error, improve collaboration throughout the health care systems and facilitate better patient care across the health sector. The quality of data in computer-based patient records is often found to be low, with patients incorrectly registered or data items inaccurately recorded or not recorded at all.[87] Estimates put poor data quality at up to 5%, which results in 10% revenue cost to make corrections, repeated work and data cleansing.[88] For this reason data cleansing, which is a process of correcting inaccurate information, is a fundamental process to be undertaken by all practice staff in order to improve the quality of information stored in the practice.

4.2 QUALITY IMPROVEMENT

A practice culture of quality improvement will encourage the measurement of the efficiency, viability and effectiveness of services delivered. A continuing quality improvement model will ultimately contribute to good patient care, health care planning and service delivery.

There are five phases in a quality improvement cycle, and all quality improvement activities start with a problem or question[89] . These phases are best viewed as a continuous cycle of activity (Figure 4.2) and incorporate the practice aspects of communication, organisational governance, culture and data.

1. What is the question or problem?

This involves identifying the potential problem area, e.g. were appointment times available for the nurse clinic when the patient needed them?

2. What can we improve?

Existing processes are evaluated to identify problems or opportunities for improvement, e.g. patients attending the nurse clinic are surveyed to ascertain their level of satisfaction with appointment scheduling.

3. How can we achieve improvement?

Improvement can be achieved by determining potential interventions, defining performance measures, implementing interventions and monitoring progress of the improvement. For example, patients attending the nurse clinic may be offered additional appointments at an alternative time.

4. Have we achieved improvement?

Evaluating the impact of interventions on the performance measures will determine if improvement has been achieved, e.g. conduct a focus group or repeat the survey at a specified time to assess the impact of additional alternative appointments.

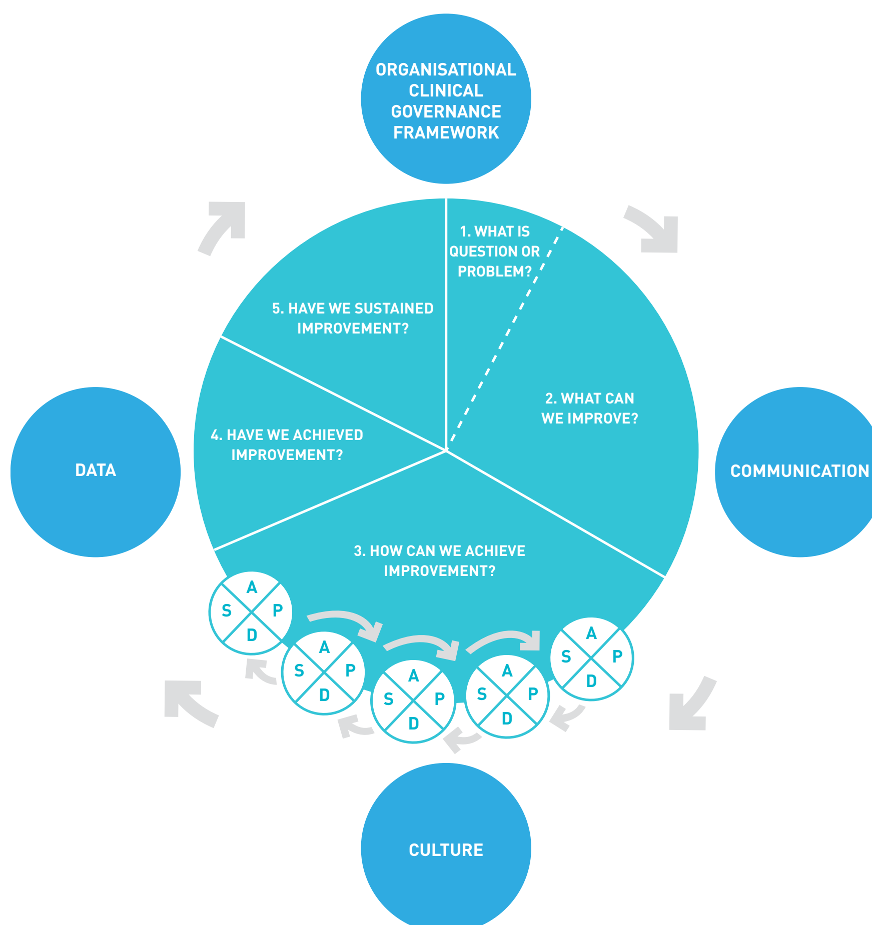


Figure 4.2: Adapted from 'A guide to using data for health care quality improvement, June 2008 Victorian Quality Council' page 8. Source: http://www.health.vic.gov.au/qualitycouncil/downloads/vqc_guide_to_using_data.pdf

5. Have we sustained improvement?

This involves monitoring and refining interventions as well as providing feedback to ensure the improved processes are integrated into health care delivery. For example, analyse the survey and provide feedback to practice staff and patients, and continue monitoring the clinics at regular intervals.

Data is fundamental to all of these phases. Some examples of where it can assist are:

- target appropriate use of health care services
- support better use of medicines
- support best practice patient care
- changing work practices
- streamline practice business management
- improve the management of complex health needs
- evaluate effectiveness of clinical processes
- benefit research.

The above process may indicate the need for a nurse clinic or, having established one, may be used for continuous improvement in the service offered to patients.

4.3 ESSENTIALS FOR IMPROVING DATA QUALITY

General Practice Queensland has identified eight essential components for improving the quality of data. Although these relate to divisions supporting practices, the elements for successful improvement of data quality can apply to practices[90].

1. Relationship management
2. Leadership and change management
3. Data collection and cleaning
4. Training
5. Communication
6. Patient registers
7. Health planning
8. Feedback

Improving data quality is not the sole responsibility of one staff member and requires a long term practice approach to achieving and maintaining quality data.

4.4 ELECTRONIC TOOLS FOR IMPROVING DATA QUALITY

There are electronic tools that are available for practice staff to use to identify gaps in patient data and to find patients with identified health risks. Details on these tools can be obtained from your Medicare Local.

4.5 CLINICAL AUDITS

A widely accepted definition of clinical audit is: 'a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change'[91]

Clinical audit is principally the systematic measurement of practice – whether of diagnosis, care or treatment – against agreed standards and then responding to the outcomes of this measurement to ensure that all patients receive quality care to the same standard[92]. Clinical audits:

- provide assurance of **compliance** with clinical standards
- identify and **minimise** risk, waste and inefficiencies
- **improve** the quality of care and patient outcomes[93]

As discussed in the introduction to this resource, clinical audit is an integral part of clinical governance and it is important to emphasise that it can be carried out by any practitioner, including nurses, involved in the treatment of patients. It is not restricted to the work of doctors[94].

Although many GPNs find it a new concept to apply a clinical audit process to their nursing practice, it has been a part of nursing practice since the days of Florence Nightingale. As the famous nurse of the Crimean War, Nightingale is known as a pioneer of clinical audit. In 1854 she arrived at the British medical barracks in Scutari, Turkey, to find unsanitary conditions and high mortality rates among injured or ill soldiers. She and her team of 38 nurses began to document the cause of death of injured British soldiers and were able to demonstrate that many were dying from preventable diseases such as typhus, cholera and dysentery – and not from wounds sustained in battle.

Nightingale oversaw the introduction of strict sanitary routines and improved standards of hygiene to the hospital and equipment (including the establishment of laundry facilities in British field hospitals). Following these changes the soldier mortality rate in British hospital barracks fell from 40% to 2%, a result which helped overcome resistance from British doctors and officers to her procedures. This methodical approach is recognised as one of the earliest programs of outcomes management. Nightingale's early clinical audit demonstrated that audit can have considerable impact on improvements to patient outcomes[95,96].

4.5.1 WHY DO WE DO IT?

Clinical audit is a valuable tool to ensure continued high standards of care, along with quality improvement within the audited model of care. It can provide a wide array of data/information useful to inform the quality improvement process. For example, it can highlight such diverse factors as clinic attendance, blood results following a particular treatment or details on provision of prescriptions.

Clinical audit can also be used to investigate a specific issue or problem within a practice, and to showcase the performance of the practice or clinic[97].

Figure 4.3: Clinical audit cycle[98]
Source: www.bolton.nhs.uk/Library/your_career/clinical_audit/Clinical_Audit_Cycle_Fig_1.jpg

4.5.2 HOW DO WE DO IT?

The clinical audit cycle is used to conduct clinical audit. While there are variations on the model in Figure 4.3, all clinical audits use the same basic steps. The following expands on each of the components of the cycle.

1. **Choose a topic/objective:** The objectives of a clinical audit depend on the problem or issue needing attention. These issues may have been noticed due to feedback from patients and partner agencies.

2. **Criteria and standards:** Once the objectives have been established and the problem identified, the criteria – or what we want to achieve from the audit – can be developed from national standards and guidelines, such as those from the RACGP. The criteria define what is being measured in the audit and ensure that measurements are objective. The criteria will help establish the group to be included (for example, diabetes patients), any exceptions, the period during which the criteria applies, and practice personnel involved in the clinical audit.

3. **Data collection:** The data needed to address the topic of the audit may be available from a computerised clinical information system. In other cases it may be necessary to collect data manually. In either case, considerations need to be given to what data will be collected, where the data will be found and who will do the data collection. Ethical issues must also be considered – all staff and patient confidentiality must be ensured.

4. **Data analysis:** The data are then analysed against the criteria and standards set for the audit. Following analysis it is possible to ascertain how well standards are being met or identify where standards are not being met.

5. **Implementing change:** Once the results of the audit have been established and disseminated, an agreement must be reached about the recommendations for change. An action plan will need to be developed and refined and this will involve establishing those responsible, a timeline and the cost. The action plan may involve refinement of the audit tool, particularly if measures used are found to be inappropriate or incorrectly assessed[99].
6. **Review:** The last part of the clinical audit cycle is to review the outcome of changes implemented through the entire process in order to answer the question – have we made things better?

4.6 RECALL AND REMINDERS

RACGP STANDARD

1.5 Continuity of care: Our practice provides continuity of care for its patients.

Criterion 1.5.3 System for follow up of tests and results: Our practice has a system for the follow up and review of tests and results.

Recall systems are a process to make sure patients receive further health advice on matters of clinical significance. Information management systems that support clinical care, e.g. recall and reminder systems, have a strong association with quality of care[100].

Further studies have demonstrated that a system that incorporates a recall and reminders process can increase the number of return visits and improve overall healthcare including better outcomes in chronic disease. Furthermore, recall reminder systems facilitate the management of disease states according to guidelines and can be cost effective[101].

4.7 MANAGEMENT OF HEALTH INFORMATION

RACGP STANDARD

4.2 Management of health information: Our practice has an effective system for managing patient information.

Criterion 4.2.2 Information security: Our practice ensures the security of our patient health information.

For patient health information to remain secure, consideration needs to be given to the various ways health information is accessed, stored and shared. Policies need to be developed that will include the following:

Risk assessment

An important element in ensuring effective information security is to undertake a risk assessment and this will be informed by the pre-existing practice policy.

Staff roles and responsibilities

All staff have a responsibility to understand and undertake the policies of the practice to ensure health information is secure and managed appropriately.

Setting access controls and management

For nurses providing a range of care models, access to systems will be required such as internet, clinical desktop systems and prescribing software. Access to these systems should be consistent with the authorisation and responsibilities outlined in their position description. For example, nurse practitioners will need password access to prescribe.

Passwords need to be managed according to practice policy and thought should be given to the following:

- change passwords at regular intervals
- do not disclose your password to anyone or allow others to use your log-in
- passwords need to be 'strong', that is, a mixture of alphabetic and numeric characters, lower and upper case.

Business continuity and disaster recovery plans

Continuous practice operations rely on a safe, secure and stable electronic environment. This is important with the introduction of e-health initiatives and new methods of information transfer to the wider health care community such as pathology and radiology providers, pharmacies and public hospitals.

Practice policies and procedures

Provide information to all staff on the protocols to manage computer information and security. This includes nurses who may be contracted to deliver nursing care within the practice and who use practice hardware and software.

Documentation

It is important to maintain a record of nursing care and treatment received by patients, although there is no specific legislation to this effect[102]. Documentation should happen at the time of the event – when it is likely to be most accurate – and should be chronological.

Backup

Human error, software malfunction or failure can sometimes impact on information retention. For this reason regular backup of all information and software is vital.

Staff internet and email usage

The use of the internet is encouraged to improve access to information, such as evidence-based guidelines. Email is also a useful tool to assist nurses to access information, communicate with colleagues and reduce isolation. Use of internet and email can pose a security risk, however, and this should be considered.

Virus and email threats

Viruses can be transmitted directly through email spam and have the capacity to corrupt, destroy or even steal data for unauthorised purposes. For this reason it is important to have appropriate virus software to protect all information. Nurses need to appreciate the potential impact of insufficient computer protection.

Laptops, USBs, tablets, notebook PCs

Portable devices are used increasingly and this may include nurses using laptops as part of home visits, workplace visits and aged residential aged care facilities. Security of the information stored on these devices is paramount and needs to be considered.

Increasingly the method of communication between health care providers will be electronic, including via email and secure messaging systems. Nurses require an understanding of the availability, delivery risks and benefits of these forms of communication as they will increasingly dictate the way in which health care and communication is delivered.

4.8 HEALTH IDENTIFIERS

Enhanced electronic communications are soon to be phased in with the introduction of the Personally Controlled Electronic Health Record. This requires using a system where the individual health provider, the health organisation and the patient will be clearly identified by a 16-digit number. This enhances machine-to-machine communication. The three identifiers are:

- Healthcare Provider Identifier-Individual (HPI-I) – for all registered health professionals
- Healthcare Provider Identifier – Organisation (HPI-O) – for all organisations where health care is provided
- Individual Healthcare Identifier (HI) – for all patients who seek health care in Australia.

As providing care in a nurse clinic is likely to necessitate referral and transfer of information, nurses need to ensure that they are familiar with the opportunities and safeguards that technology provides.

4.9 RESOURCES

- Computer and Information Security Standards (CISS): www.racgp.org.au/CISS
- RACGP Standards for General Practices (4th edition): www.racgp.org.au/standards
- National E-Health Transition Authority: www.nehta.gov.au
- eHealth: www.ehealthinfo.gov.au/patient-journey
- Video consultations in general practice: www.racgp.org.au/telehealth
- The Royal College of Psychiatrists: www.rcpsych.ac.uk/pdf/clinauditChap1.pdf
- RACGP A guide to developing a clinical audit for osteoporosis: www.racgp.org.au/Content/NavigationMenu/educationandtraining/Educationmodules/msk/MSK_ClinicalAuditGuide.pdf
- Clinical Audit Support Centre: www.clinicalaudittools.com
- Healthy for Life Toolkit- Section 3 Clinical Auditing http://www.health.gov.au/internet/h4l/publishing.nsf/Content/servtoolkit-1

4.10 CONSIDERATIONS

Following are some key points and questions relating knowledge and information management that practices may wish to consider when planning a nurse clinic.

- How well do you understand the capacities of your clinical software and do you know how to use it?
- Does the nurse have access to the internet?
- Does the nurse have a log-in and password?
- Does the nurse practitioner have access to electronic subscribing?
- Do the nurse and staff understand their individual responsibilities with regards to keeping health information secure, ensuring quality of clinical information and contributing to the patient file?
- Is access to patient health information managed appropriately in terms of passwords, security from viruses, managing the internet usage of staff, and disaster recovery plans in case of loss of patient data?
- Do staff understand their responsibility around data cleansing?
- What electronic tool will you use to monitor and evaluate the outcomes of the nurse clinic?

4.11 CONCLUSION

The management of data and patient information is vital in the ongoing improvement of quality care for the patient. Patient data needs to be accurate, current and secure. Careful planning and policy around the use and responsibility of staff in their clinical software and internet usage will support this. It is especially important to have workable systems of data, staff internet use and patient information in place as we move into the era of health identifiers and personally controlled electronic health records.

5 COMPETENCE

As the health system moves its focus from acute care to chronic care in order to cope with the increasing prevalence of chronic disease, many members of the health care workforce will come into contact with patients as they journey through the system.

Definition

Competence is *the combination of demonstrated skills, knowledge, attitudes, values and abilities that underpin safe, effective and/or superior performance in a profession or occupational area*[100].

All workers, including reception and administration staff, have the ability to influence patient care. The World Health Organisation[104] recommends that the entire workforce expand their skills to include the following five basic competencies:

1. **Patient-centred approach** – includes interviewing and communicating effectively, assisting changes in health-related behaviours, supporting self-management, and using a proactive approach
2. **Partnering** – with patients, other providers and communities
3. **Quality improvement** – measuring care delivery and outcomes, learning and adapting to change, and translating evidence into practice
4. **Information and communication technology** – including designing and using patient registries, using computer technology, and communicating with partners
5. **Public health perspective** – including population-based care, systems thinking, working across the care continuum, and working in primary healthcare-led systems.

As a specialist profession, nursing requires competencies that are nursing specific and that ensure that the care provided is of the highest standard.

It is recognised that nurses can only demonstrate competence in general practices that use resources effectively and develop systems and structures to achieve goals of sustainable patient outcomes[105]. This is often referred to as organisational competence. The provision of an environment for the GPN to demonstrate competence in skills, knowledge, values and abilities is important and is supported by such factors as provision of a room or space to conduct nursing duties, having adequate supplies and functioning equipment, and a realistic workload for the individual GPN.

It is recognised that GPNs can only demonstrate competence in general practices that use resources effectively and develop systems and structures to achieve goals of sustainable patient outcomes[102]. This is often referred to as organisational competence. The provision of an environment for the GPN to demonstrate competence in skills, knowledge, values and abilities is important and is supported by such factors as provision of a room or space to conduct nursing duties, having adequate supplies and functioning equipment, and a realistic workload for the individual GPN.

5.1 WHAT IS A GENERAL PRACTICE NURSE?

The general practice nursing workforce can potentially include any of the following categories of nurses. These terms may be somewhat confusing for other members of the general practice team who may not have an understanding of the professional role, accountability and competencies of each nurse.

Definitions

A ***general practice nurse,*** *'commonly referred to as a practice nurse, is a registered or enrolled nurse working in a general practice setting'*[106]. A nurse practitioner, mental health nurse or midwife working in a general practice setting may also be referred to as a GPN.

A ***registered nurse*** *'demonstrates competence in the provision of nursing care as specified by the registering authority's licence to practice, educational preparation, relevant legislation, standards and codes, and context of care'*[107].

A ***nurse practitioner (NP)*** *is a 'registered nurse who is educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The nurse practitioner role includes assessment and management using nursing knowledge and skills. The role may include, but is not limited to, the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations. The role is grounded in the nursing profession's values, knowledge, theories and practice, and provides innovative and flexible health care delivery that complements other health care providers'*[108].

A ***nurse practitioner candidate*** is a nurse who has been appointed by an employer to become a NP. *The AIRC has determined that a NP candidate is: A Registered Nurse engaged to undertake a course of study and undertake clinical experience leading to endorsement as a nurse practitioner*[109].

An ***enrolled nurse*** is an *'associate to the registered nurse who demonstrated competence in the provision of patient-centred care as specified by the registering authority's licence to practise, educational preparation and context of care'*[110].

Advanced registered nurses *'are experienced, knowledgeable and competent nurses, who use evidence for practice, take responsibility for complex situations, show leadership in clinical and professional settings, contribute to effective team work, and focus on improving the health of individuals and groups'*[111] . An advanced registered nurse would:

- be prepared for evidence-based practice through **post registration qualifications/education**
- be an active member of the nursing profession
- accept responsibility for complex situations which may encompass clinical, managerial, educational or research contexts
- demonstrate leadership and initiate change
- practise comprehensively as an interdependent team member
- practise outside of single contexts or episodes of care
- have particular breadth or depth of experience and knowledge
- focus on outcomes for individuals and groups[112].

Examples of advanced registered nurses may include nurses with clinical specialty qualifications such as credentialed diabetes educator, nurse pap test providers or mental health nurses. The Aboriginal health worker (AHW) may be the 'advanced practitioner' employed in the general practice because of their cultural and local knowledge, and understanding of Aboriginal patients' views and responses to mainstream health care.

The Supporting Advanced Nursing Development and Sustainability in General practice (SANDS) project has recently developed the following definitions of advanced registered and enrolled nurses:

The advanced registered nurse in general practice uses post graduate education and broad experience in general practice to make evidence based decisions, often in complex situations. As a member of the general practice team, the advanced registered nurse in general practice has the ability to initiate positive change towards direct patient care and outcomes, health promotion, leadership, management, education and research. The advanced registered nurse in general practice has an active role in progressing the nursing profession as well as general practice service provision and redesign, responsive to community needs.

The advanced enrolled nurse in general practice uses post enrolment education and broad experience in general practice to provide a high level of direct patient care and health promotion. As a member of the general practice team the advanced enrolled nurse in general practice can undertake a greater scope of delegated responsibility and can practice with more indirect registered nurse supervision. The advanced enrolled nurse in general practice acts as a leader for other enrolled nurses and a resource for others in general practice.

Sometimes confusion arises between nurses working at advanced levels. Table 5.1 compares the advanced practice nurse and the nurse practitioner roles. Please note that in this context the table refers to all nurses working at an advanced level and is not restricted to the general practice context.

Table 5.1: Comparisons between advanced practice nurse and the nurse practitioner roles[113]

ADVANCE PRACTICE NURSE (BASED ON THE STRONG MODEL)	NURSE PRACTITIONER (BASED ON ANMC NP COMPETENCY STANDARDS 2006)
SERVICE MODEL	
Consultant, clinician Broad Based service profile	Direct clinical care Focused clinical service
ROLE PARAMETERS / STANDARDS	
Direct comprehensive care - highly developed skills and knowledge to inform service coordination, care delivery and direction of care Support of systems - optimising patient / resident / clients' utilisation of, and progression through, a health service Education - patient / resident / clients', communities, clinicians and students Research - creating and supporting a culture of inquiry Professional leadership - professional activity and dissemination of expert knowledge to the public and profession No national consistency for practice standards	Dynamic practice - highly developed skills and knowledge for direct clinical practice in complex environments. Monitors and adopts evidence base for practice Professional Efficacy - autonomous practice that includes diagnostics, prescribing medication, request for diagnostic tests and referral to other health professionals. Promotes and engages a nursing model of practice Clinical leadership - critique and influence at systems level of health care. Promotes and engages in collaborative team-based practice Conforms to the ANMC National Competency Standards for the Nurse Practitioner
LEGISLATIVE STRUCTURE	
The title is not protected	The title is protected
EXTENDED PRACTICE	
Highly develop autonomous practice profile as an RN within the requirements of Nursing and Midwifery Practice Acts Education requirement - Post graduate level	Endorsed to practice as nurse practitioner with legal provision to diagnose, prescribe medication, order diagnostic tests and refer to other health professionals Education requirement - Master level

Ref: Glen Gardner, Anne Chang, & Christine Duffield (2007) Making nursing work: breaking through the role confusion of advance practice nursing: **Journal of Advanced Nursing 57(4), 382-391**

5.2 SCOPE OF PRACTICE

ANF COMPETENCY STANDARDS FOR THE ADVANCED REGISTERED NURSE

Domain 2: Adapts practice.

Competency Standard 6: Seeks out and integrates evidence from a range of sources to improve health care outcomes.

Competency Standard 7: Safely interprets and modifies guidelines and practice to meet the health care needs of individuals and groups.

ANF COMPETENCY STANDARD FOR THE ADVANCED ENROLLED NURSE

Competency standard 2.1: Practices using specialised or more comprehensive knowledge and skills

Competency standard 2.3: Assists in providing care individuals and groups with complex conditions

Competency standard 2.4 Uses comprehensive assessment to make reliable clinical decisions

Nursing care that can be provided in general practice is diverse and can be provided by a range of nursing professionals. For this reason it is imperative that the practice team understand the scope of practice for each nurse employed.

Definition

The scope of practice for any individual nurse or midwife is defined as those activities which the nurse is educated, competent and authorised to perform[114]. It is the responsibility of the individual nurse to identify their own scope of practice through self-assessment and then work within that scope[115]. The scope of clinical practice of each nurse is also informed by the context of practice in which they work.

It is important to realise that registered (and enrolled) nurses, as qualified licensed professionals, are accountable and responsible for their own actions and decisions[116].

The general practice setting provides opportunities, at times, for GPNs to participate in and apply advanced practice nursing skills and knowledge, and to practise more autonomously. The scope of clinical practice of each team member should therefore be explicitly identified, defined and clearly articulated, as should the scope of the general practice in providing the nursing care.

While the national regulatory authority, the Nursing and Midwifery Board of Australia (NMBA) does not define a nurse's scope of practice[117] – as it is self-regulated – they have provided the National Framework for the Development of Decision-Making Tools for Nursing and Midwifery Practice (2007) as a guide for self-reflection[118]. This is further referred to in the discussion below.

Nurses working in general practice have varied and diverse roles that are governed by a number of factors including the local practice population health needs in which they work. An understanding of working within one's individual professional scope of practice is a component of demonstrating competency. The registered nurse working in health care settings such as general practice will:

- seek clarification when questions, directions and decisions are unclear or not understood
- undertake decisions about care that are within scope of competence without consulting senior staff
- raise concerns about inappropriate delegation with the appropriate registered nurse
- demonstrate accountability and responsibility for their own actions within nursing practice
- assess consequences of various outcomes of decision making
- consult relevant members of the health care team when required
- question and/or clarify interventions which appear inappropriate with relevant members of the health care team[119].

The scope of practice for nurses may continually change as they seek education and gain experience. It is therefore important to ensure that the practice team are aware of the scope that any nurse conducting a nurse clinic has, so that expectations of the care provided are realistic and achievable.

5.2.1 ENROLLED NURSE SUPERVISION

Further to the definition provided in section 5.1, it is a legislative requirement that enrolled nurses working in general practice are supervised by registered nurses.

'The supervision may be direct where the registered nurse is present or indirect where the registered nurse is easily contactable but does not directly observe the activities. The level of supervision required depends upon a number of factors including: the skills and knowledge of the enrolled nurse: the acuity and stability of the person receiving the nursing care and the complexity of the nursing care being provided[120].'

At all times, the enrolled nurse retains responsibility for his/her actions and remains accountable in providing delegated nursing care. Supervisory arrangements by the registered nurse are in addition to those provided by an employer such as a GP, or practice manager.

5.2.2 PRACTICE SCOPE

Nurse practitioners and specialist clinical nurses such as diabetes, asthma and wound management educators are encouraged to document their scope of practice as a nursing health care professional employed in a designated general practice. This document will outline the roles, functions, responsibilities, activities and decision-making capacity that they are educated, competent and authorised to perform based on their agreed clinical role within the practice. For example, a nurse practitioner with a clinical specialty in wound management has a broader scope of practice and higher level of autonomy than other nurses in this clinical area.

The scope of practice of any nurse practitioner working in general practice should be documented and templates are available[121] to facilitate this process. It is encouraged that information such as medication prescribing arrangements and procedural activities relevant to working in a specific general practice be documented.

Pressure for some GPNs who work in professional isolation to work outside their scope of practice may arise[122]; however; it is important that this does not occur and that nurses are not asked to complete tasks beyond their identified scope of practice.

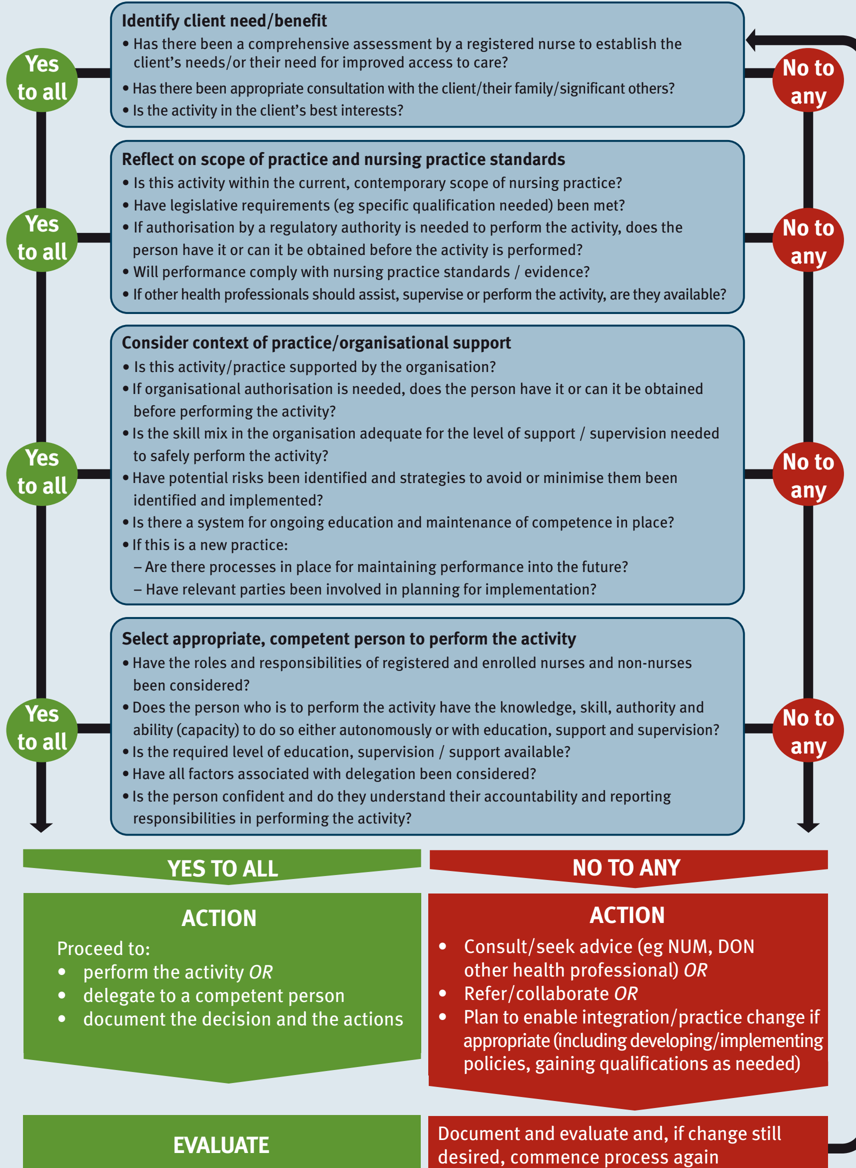


Figure 5.1: Nursing practice decisions summary guide[124].
Permission to use granted by the Nursing and Midwifery Board of Australia

5.2.3 NATIONAL FRAMEWORK FOR DECISION MAKING

A national framework for decision-making by nurses and midwives[123] has been developed, along with associated tools. These aim to guide nurses working in a variety of practice settings to make safe nursing practice decisions, determine delegation and supervision responsibilities, and enable them to work to their full and potential scope of practice. Figure 5.1 is used to assist nurses in safe decision making and can be used in the general practice context by all nurse categories regardless of their level of education and experience.

5.3 COMPETENCY STANDARDS

RACGP STANDARD

3.2 Education and training: Our practice supports and encourages quality improvement and risk management through education and training.

Criterion: 3.2.1 Qualifications of general practitioners: All GPs in our practice are appropriately qualified and trained, have current Australian registration and participate in continuing professional development.

Criterion: 3.2.2 Qualifications of clinical staff other than medical practitioners: Other members of our clinical team are appropriately qualified and trained, have relevant current Australian registration and participate in continuing professional development.

ANF COMPETENCY STANDARDS FOR THE ADVANCED REGISTERED NURSE

Domain 1: Conceptualises practice: Competency Standard 2: Uses health and/or nursing models as a basis for practice.

Domain 2: Adapts practice: Competency Standard 4: Anticipates and meets the needs of individuals and groups with complex conditions and/or in high risk situations.

ANF COMPETENCY STANDARDS FOR THE ADVANCED ENROLLED NURSE

Domain 2: Provision of clinical care: Competency standard 2.1 Practices using specialised or more comprehensive knowledge and skills.

Competency standard 2.3: Assists in providing care to individuals and groups with complex conditions.

GPNs not only require professional registration to practice, but also have the skills, knowledge and attitudes required to competently provide safe and quality patient care.

There are a number of competency standards that outline national minimum standards of practice that must be met to capably and legally carry out the specific clinical requirements for the registered and enrolled nurse. It is the responsibility of the individual nurse to be aware of the applicable competency standards that govern their particular role within the general practice. For those nurses who choose to expand their role, the advanced registered nurse competency standards may apply.

The following competency standards are available:

- National Competency Standards for Nurses in General Practice[125]
- National Competency Standards for a Nurse Practitioner[126]
- National Competency standards for Registered Nurses and Enrolled Nurses[127]
- Competency Standards for the Advanced Enrolled Nurse[128]
- Competency Standards for Advanced Registered Nurse[129]
- National Competencies for Diabetes Educators[130]
- National Standards for Nurse Pap Providers[131]
- Standards of Practice for Respiratory (COPD) Educators[132]
- Standards of Practice for Asthma Educators[133]
- Palliative Care Nurse Standards[134]
- Specialist Breast Care Standards[135]
- Wound Care Competency Guidelines for Health Professionals[136]
- Critical Care Specialist Nursing Competency Standards[137]

5.3.1 THE AUSTRALIAN NURSING AND MIDWIFERY COUNCIL (ANMC) CONTINUING COMPETENCE FRAMEWORK[138]

GPNs are encouraged to undertake a regular self assessment and evaluate their nursing practice against competency standards relevant to their role. The process of self reflection on the nursing role, along with the responsibilities in the general practice, will assist in not only identifying the standards against which a GPN's practice can be evaluated, but also assist in identifying the learning needs required to demonstrate continued competence to practice.

There are a number of resources and templates available to assist GPNs in the process of determining continuing competency[139] such as a self assessment tool, sample professional development plan, and guidance on developing a professional portfolio.

General practices, as employers of GPNs, may consider utilising the relevant competency standards to inform the development of positions descriptions and performance assessment tools for GPNs (refer to section 6.3).

5.4 MENTORING AND CLINICAL SUPERVISION SUPPORT

RACGP STANDARD

2.1 Collaborating with patients: Our practice respects the rights and needs of patients.

Criterion 2.1.3: Presence of a third party: The presence of a third party observing or being involved in clinical care during a consultation occurs only with the prior consent of the patient.

Competency Standard 13: Facilitates education of individuals and groups, student, nurses and other members of the health care team.

Competency Standard 14: Acts as a resource for other nurses and members of the health care team.

Competency Standard 15: Provides nursing as a resource to others through their capacity to practice outside single contexts and episodes of practice.

Mentoring, clinical supervision and/or medical support[140] are important factors for GPNs to consider when planning a nurse clinic. Mentoring can also occur when less experienced GPNs require a buddy to support them in their role within the practice. Some GPNs may be at risk from professional isolation, such as those working in a small or solo practice, or in a remote area. GPNs working in these situations may benefit from a mentor or clinical support person. The identification of an appropriate mentor for newly employed or existing GPNs, as a strategy to further develop the skills required in the provision of effective and quality patient care, may prove beneficial.

Mentoring *is a voluntary professional relationship and both the mentor and person being mentored need to be freely willing to participate*[141]. For example, a nurse conducting a women's health clinic may benefit from an ongoing professional mentoring relationship with another team member such as an experienced nurse Pap provider.

Clinical supervision is generally referred to as a formal technique for professional development that may be useful to GPNs in conducting nursing care. Clinical supervision provides a time for reflection on experiences and for problem-solving with the support of a more experienced clinician. Clinical supervision supports individuals in assuming responsibility for their own practice and fosters developmental and evaluative practice for safe and effective care[142].

The establishment of clinical supervision in general practice is an important part of clinical governance. This notion may not be as formalised and structured as in other clinical settings such as mental health. However, this notion is slowly extending into the Australian general practice setting[143], especially as more nurse practitioners are being employed. Meeting with a skilled supervisor in the workplace can provide GPNs with a confidential, quiet time and place to reflect and 'unpack' a clinically related issue or problem that may be impacting upon their nursing practice, further develop their skills and knowledge, and improve patient care. They can then develop an appropriate and responsive action plan to meet their needs.

5.5 CONTINUING PROFESSIONAL DEVELOPMENT

Continuing Professional Development (CPD) is defined as the *'means by which members of the profession maintain, improve and broaden their knowledge, expertise and competence and develop the personal and professional qualities required throughout their professional lives'*[144]. GPNs must have a commitment to ongoing learning. The broad range of skills and knowledge that GPNs have, in order to competently provide quality patient care, is supported by compulsory participation in CPD, endorsed by the NMBA CPD standard.

The NMBA CPD standard outlines the **minimum** CPD requirements to maintain registration as a registered nurse or midwife[145]. GPNs working in general practice are reminded to be aware of these requirements, such as:

- having documented evidence of 20 hours or more of continuing nursing professional development per year
- an additional 10 hours per year in education in relation to their particular endorsement if applicable
- participation in updates such as cardiopulmonary resuscitation on an annual basis.

There are a number of professional development activities that GPNs working in general practice can undertake and these are outlined by the Australian Practice Nurses Association (APNA)[146] . These activities include:

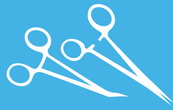
- keeping a practice journal or reflecting on feedback
- acting as a preceptor/mentor/tutor
- writing or reviewing educational materials, journal articles, books
- active membership of professional groups and committees
- developing policy, protocols or guidelines
- working with a mentor to improve practice
- undertaking undergraduate or postgraduate studies which are of relevance to the context of practice and
- undertaking relevant online or distance education.

When proposing a nurse clinic, it is also important to determine the skill mix and role requirements associated with the proposed model. An assessment of the education and training needs should be actioned accordingly. Self reflection is also encouraged to assess individual education and training needs to ensure that knowledge levels and skill are aligned to the provision of evidence-based patient care. It is most important that nurses working in general practice are able to access quality and relevant CPD from reputable education providers[147,148]. Allowing time for staff to engage in professional development activities, associated with the nurse clinic, will need to be factored in as a planning consideration.

As the definition of advanced practice requires post graduate education, for those nurses responsible for patients in an autonomous or independent manner, the authors recommend post graduate education is undertaken to ensure the level of decision making and analysis required to work at this level.

In order for all staff, to be able to work effectively in their assigned role, continuing professional development is vital. There are resources available in a range of formats; more details are available from your Medicare Local or view the resource section.

5.6 EVIDENCE-BASED PRACTICE



RACGP STANDARD

1.4 Diagnosis and management of health problems: Our practice provides health promotion and illness prevention services that are based on patient need and best available evidence.

Criterion 1.4.1: Consistent evidence based practice: Our practice has a consistent approach for the diagnosis and management of conditions affecting patients in accordance with best available evidence.

ANF COMPETENCY STANDARD FOR THE ADVANCED REGISTERED NURSE

Domain 1: Conceptualises practice. Competency Standard 1: Uses best available evidence, observations and experience to plan, conducts and evaluate practice in ways which incorporate complexity and/or a multiplicity of elements.

Domain 2: Adapts practice. Competency Standard 6: Seeks out and integrates evidence from a range of sources to improve health care outcomes.

Competency Standard 7: Safely interprets and modifies guidelines and practice to meet the health care needs of individuals and groups.

Domain 3: Leads practice. Competency Standard 10: Fosters and initiates research based nursing practice.

A focus on evidence-based practice is a cornerstone of clinical governance. The difference between what we know from the best available research evidence and what actually happens in current practice may be at odds. For example, there is evidence that smokers are more likely to quit smoking if they receive advice on smoking cessation from their GP. Generally, GPs are aware of the smoking status of two-thirds of their patients but of these, only half of patients who smoke actually receive cessation advice or counselling[149].

Awareness of the best available evidence and implementing best practice based on that evidence is recommended. The use of clinical guidelines and protocols can facilitate the provision of evidence-based best practice, clinical effectiveness and quality patient outcomes.

Definitions

Clinical guidelines and protocols are *'systematically developed evidence-based statements which assist health professional in making clinical decisions about appropriate and effective care for their patients with specific conditions'*[150].

5.6.1 CLINICAL GUIDELINES

The use of clinical guidelines helps to support the nursing care decision-making process and provides a consistent approach with other clinical members of the team in the provision of patient care. It may be beneficial to conduct a literature search in the planning stage to review best practice, current guidelines and protocols specific to the clinical care that is being developed within the general practice, and to assist in education and inform discussion by all members of the team. The use of clinical templates that are attached to clinical guidelines may prove beneficial as well as the development of local protocols that may guide history taking and data collection if applicable.

GPNs are encouraged to review evidence-based best practice and current clinical guidelines applicable to the nurse clinic being proposed and suggest to all members of the clinical team that they be used, if not already, to guide provision of team-based clinical care.

The format of a clinical guideline may be determined by a particular aspect of care or condition it addresses and also by the relevant patient population. Sometimes the guidelines may give a broad objective for care and criteria set out for its achievement. Alternatively a guideline may provide greater detail and specific information about the patient's condition and treatment options.

To unpack this further, the practice may like to consider developing clear guidelines and develop practice protocols about what you could do, who could be seen without a GP's input, when a GP needs to be involved, development of simple, as well as more complex, decision support systems and how to deal with them if relevant and required.

It is important that the clinical guidelines and locally developed protocols are accessible to all health professionals involved in the patient care and that nursing decision support tools are utilised. This will have implications and application for induction and education of new clinical team members to the new nursing model of care.

There are many best practice clinical guidelines that GPNs can access on the prevention, diagnosis and management of certain diseases. These include some of those commonly used from the Australia's Clinical Practice Guidelines Portal[151].

Links to specific clinical guidelines:

- Guide to management of hypertension 2008: Heart Foundation www.heartfoundation.org.au/SiteCollectionDocuments/HypertensionGuidelines2008to2010Update.pdf
- Diabetes Management in General Practice Guidelines for Type 2 Diabetes: RACGP www.racgp.org.au/Content/NavigationMenu/ClinicalResources/RACGPGuidelines

- Guidelines for preventative activities in general practice (the red book) 7th edition 2009: RACGP www.racgp.org.au/redbook/index
- Putting Prevention into Practice (the green book) 2nd edition: RACGP www.racgp.org.au/guidelines/greenbook
- The medical care of older persons in residential aged care facilities (the silver book) 4th edition: RACGP
- SNAP: A population health guide to behavioural risk factors in general practice: RACGP www.racgp.org.au/guidelines/silverbook
- Abuse and violence: working with our patients in general practice: RACGP www.racgp.org.au/guidelines/abuseandviolence
- Clinical guidelines for Musculoskeletal Diseases (OA, RA, JIA, OP) RACGP www.racgp.org.au/guidelines musculoskeletaldiseases
- Clinical Guidelines for Stroke and TIA Management: A quick guide for general practice. RACGP www.racgp.org.au/guidelines/stroke
- Chronic Kidney Disease (CKD) Management in General Practice: RACGP www.racgp.org.au/guidelines/ckd
- The Australian Immunisation Handbook: Australian Government Department of Health and Ageing www.health.gov.au/internet/immunise/publishing.nsf/content/handbook-home
- Guidelines for the management of acute coronary syndromes 2006: The Heart Foundation of Australia & Cardiac Society of Australia and New Zealand www.heartfoundation.org.au/SiteCollectionDocuments/acs-guidelines-mja-summary.pdf
- Smoking cessation guidelines for Australian general practice: RACGP www.heartfoundation.org.au/SiteCollectionDocuments/acs-guidelines-mja-summary.pdf
- Physical activity recommendations for people with cardiovascular disease: National Heart Foundation of Australia www.racgp.org.au

5.6.2 PRACTICE PROTOCOLS

Local protocols are usually detailed descriptions of the steps taken to deliver specific evidence-based care or treatment to patients in a given setting, such as general practice. These may include decision support systems for local services, resources and staffing, and may integrate the care provided by multidisciplinary teams.

5.7 CLINICAL REFERRAL PATHWAYS

Clinical pathways are structured, multidisciplinary team plans of care that are developed to improve the continuity and coordination of multidisciplinary team patient care. Clinical pathways support the implementation of clinical guidelines and protocols. They provide a coordinated and integrated patient care framework that can guide 'clinicians through the identification of interventions and measurable outcomes along a timeline'[152]. They can provide GPNs with a structured guide on patient care that includes the decisions to be made, provision of patient or patient group care for a particular condition. For example, a nurse practitioner working in a general practice could have a clinical referral pathway for patients who attend their clinic but whose care falls outside their scope of practice.

5.8 RESOURCES

- Competency Standards: The Nursing and Midwifery Board of Australia www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines.asp
- Australian Nursing and Midwifery Accreditation Council www.studentweb.usq.edu.au/home/w0031419/Site2/web%20links/ANMC.htm
- Australian Practice Nurses Association www.apna.asn.au
- 'Expanding your practice' education module: www.amlalliance.com.au/medicare-local-support/nigp/current-projects/orientation-and-training
- International Nurses Day 2012 – Closing the Gap from Evidence to action: www.icn.ch/publications/2012-closing-the-gap-from-evidence-to-action/
- Australia's Clinical Practice Guidelines Portal: www.clinicalguidelines.gov.au/index.php

5.9 CONSIDERATIONS

The following points relate to competencies that practices may wish to consider in planning a new nurse clinic.

- Does the practice team have core competencies needed to work with patients with chronic disease?
- Determine professional expertise and skills required to provide quality nursing care.
- Are there gaps in nurses' skills, knowledge and qualifications – does their overall competency meet competency standards?
- Is professional supervision, mentoring or professional support required by the nurses?
- How will this be determined, and how will these needs be met?
- How can the practice support nurses keeping up to date with new research and best practice and continuing professional development?
- Are relevant evidence-based clinical guidelines being utilised?
- Have relevant policies and procedures been documented?
- Do local protocols need to be developed?
- Does the practice have a documented referral arrangement policy that describes how and when patients are referred to you and other health professionals?
- Does the referral document (including relevant clinical notes) to allied health or other services have sufficient information?
- Have local referral protocols been developed with local providers, i.e. team care arrangements?

5.10 CONCLUSION

Nurses' competence will depend on their role and responsibilities, experience and educational qualifications. It is important therefore that they are competently prepared to provide the specific nursing care that is being planned for the practice, in order to facilitate the provision of safe and quality patient care. It is the responsibility of the individual GPN to be aware of competency standards that are relevant to their practice, and the importance of GPNs working within their scope of practice has been highlighted.

The use of evidence-based guidelines has been discussed as a guide to assist GPNs to support the nursing care decision-making process and provide a consistent approach with other health professionals in the team in the provision of quality patient care.

6 CAPACITY

The RACGP quality domain 'capacity' highlights certain factors that need to be considered in the planning stage of any nursing model of care that supports quality service provision.

Definition

Capacity describes what is essential for sustainable, high quality, accessible patient care services. The components or elements of this domain include a workforce that is trained and equitably dispersed throughout Australia, services to provide care, and the facilities and organisation to support the delivery of competent clinical care[153.]

At the practice level, planning and establishment of processes and systems are needed to ensure a safe and effective working environment for patients, staff and GPs.

Planning for safe, high quality processes and systems will be discussed under the following categories:

- Human resource management
- Physical amenities
- Infection control
- Workplace Health and Safety

6.1 HUMAN RESOURCE MANAGEMENT

RACGP STANDARD

4.1 Practice systems: Our practice demonstrates effective human resource management.

Criterion 4.1.1 Human resource system: Our practice supports effective human resource management.

Criterion 4.1.2 Occupational health and safety: Our practice implements strategies to ensure the occupational health and safety of our GPs and other members of the practice team.

A practice is encouraged to have a robust human resource management system to support the provision of quality clinical nursing care. The identification of a team leader is recommended. This person will have responsibility for staff recruitment, performance and patient feedback management, and have direct input to the nurse clinic. The team leader is likely to be the practice manager. A review of existing policies and procedures may highlight those that are in need of development to support the nurse clinic being proposed. For example, if the nursing service is being conducted out of normal operating hours, there may be a need for a specific policy and procedure or an extension to one already documented that addresses security arrangements and other issues related to this (refer to section 6.9).

It may also be necessary to review existing employment options that suit patient needs and provision of care.

Human resource management templates, such as those for employment applications, positions descriptions, selection criteria checklist, interview questions and induction checklists, are accessible in the Nursing in General Practice Recruitment and Orientation Resource[154] produced by the AML Alliance.

6.2 EMPLOYMENT MODELS

Several factors may influence the decision of a practice in regard to the desired employment model of nursing care. For example, a practice may recognise that existing nursing staff members do not have the qualifications and experience required to conduct a diabetes or respiratory nurse clinic. They may therefore consider contracting the services to clinical nurse specialists such as a credentialed diabetes nurse educator consultant or respiratory nurse consultant, for a number of sessions per week to meet patient demand or directly employ the nurse as an employee. Others may opt for a combination employment model, directly employing the nurse for generalist duties, but as an independent clinical nurse specialist for advanced roles. They may be employed on a casual, fixed, full- or part-time basis.

There are advantages and disadvantages related to each of these employment models discussed[155,156,157], and may have implications in relation to professional indemnity, workers' compensation, superannuation, payroll tax, sense of practice control over the nursing care provided, financial concerns, and professional development responsibilities. It is suggested, therefore, that practices and nurses have an informed awareness and understanding of the employment model that is being planned and which is relevant to them.

Regardless of the practice preferred model of employment, it is recommended that during the planning phase, the practice determines the role and responsibilities for each team member (refer to section 3.3). This may include recruitment of patients; appointments; responsibility of patient

recalls and reviews; billing; and development of templates. Determining 'who does what' is important as this may vary within each practice team documented in the individual team member's position description (refer to section 6.3). This highlights the importance of the 'whole of practice' approach to systematic provision of patient care.

6.3 POSITION DESCRIPTION

It is recommended that position descriptions (PDs) accurately reflect all team members' roles, responsibilities, accountability, communication, continuing CPD opportunities and working relationships. PDs are essential documents outlining the role of all team members and provide the basis for effective teamwork and provision of safe patient care. They are also used to facilitate discussion when conducting a performance appraisal. PDs need to be regularly reviewed to ensure accuracy.

For a position description template that can be adapted to your needs, please refer to the Nursing in General Practice Recruitment and Orientation Resource[158] produced by the AML Alliance.

6.4 INDUCTION OF STAFF TO NEW MODEL OF CARE

Participation in an induction program is vital to ensure that GPNs (existing and newly employed) are introduced, welcomed and integrated into the team. They need to be provided with the knowledge of the proposed day-to-day operations, not only of the practice, but also of the specific nursing role they will undertake. Important information such as referral pathways, infection control, Workplace Health and Safety, privacy and confidentiality of patient health information is explained in detail and, ideally, documented. Induction programs should also include opportunities for GPNs to network with their peers, participate in local network meetings, raise awareness of educational and mentoring opportunities and discuss provision of clinical supervision as relevant.

For a staff induction program that can be adapted for your needs, please refer to the Nursing in General Practice Recruitment and Orientation Resource[159] produced by the AML Alliance.

6.5 PROFESSIONAL INDEMNITY INSURANCE

Since 2010 it has been a requirement of the Nursing and Midwifery Board of Australia that nurses have professional indemnity insurance[160] that covers the conduct of their practice and it is documented in their professional portfolio.

APNA outlines potential civil liability claims that could affect GPNs working in general practice and include clinical or non-clinical-related events such as an adverse or unexpected outcome for a patient; or an error or omission while providing professional services; breach of patient confidentiality; or libel and slander to name a few[161]. A number of organisations provide professional indemnity insurance to their members, such as the ANF, APNA and the Australian College of Nursing (ACoN). GPNs are encouraged to ensure that their individual professional indemnity insurance or practice insurance covers their role and responsibilities within and outside of the practice, for example when conducting home visits. APNA has developed a question and answer sheet that may be beneficial in increasing your understanding and awareness of related issues[162].

6.6 PHYSICAL FACILITIES

RACGP STANDARD

5.1 Facilities and access

Criterion 5.1.1 Practice facilities: Our practice facilities are appropriate for a safe and effective environment for patients and the practice team.

Criterion 5.1.2 Physical conditions conducive to confidentiality and privacy: The physical conditions in our practice support patient privacy and confidentiality.

Criterion 5.1.3 Physical access: Our practice provides appropriate physical access to our premises and services including access for people with disabilities or special needs.

5.2 Equipment for comprehensive care

Criterion 5.2.1 Practice equipment: Our practice has access to the medical equipment necessary for comprehensive primary care including emergency resuscitation.

Determining the scope and nature of care being provided, the frequency of the service, the targeted population needs, and the projected patient outcomes will facilitate informed decisions regarding other important physical factors that need to be considered. These include determining the number, size and types of rooms – including waiting room, consultation room, toilets, hand washing facilities, storage rooms for hazardous material and appropriate equipment such as that needed for emergency resuscitation. Other factors include: accessible car parking; disability and wheelchair access; identification of equipment required; practice design to ensure patients' confidentiality; ensuring auditory and visual privacy; and safety-related issues such as adequate lighting, controlled ambient temperature, and the need for height-adjustable beds. These factors may also influence the overall practice decision to renovate existing premises or relocate some aspects of patient care to other nearby practice satellite sites to accommodate the physical amenity needs of the planned nurse clinic.

In the event that nursing care is conducted at a practice satellite site, the management of effective communication between the two practice sites may warrant further discussion and development. This may have operational implications regarding access to patients' electronic clinical records, appointment scheduling, recalls and reminders, and development of disease registers. There may also be implications for staff and practice public liability insurance requirements.

The design and layout of furniture required to conduct the nursing service needs careful planning. For example, a round table and chairs may be better suited for a credentialed diabetes nurse patient consultation than a consultation room with a bed.

6.7 CONSULTATIONS

RACGP STANDARD

1.1 Access to care: Our practice provides timely care and advice.

Criterion 1.1.1 Scheduling care in opening hours: Our practice has a flexible system that enables us to accommodate patients' clinical needs.

Criterion 1.1.2 Telephone and electronic communications: Patients of our practice are able to obtain timely advice or info related to their clinical care by telephone and electronic means (where in use) where a GP determines that this is clinically safe and that a face-to-ace consultation is unnecessary for that patient.

Criterion 1.1.3 Home and other visits: Regular patients of our practice are able to obtain visits in their home, residential aged care facility, residential care facility or hospital, both within and outside normal opening hours where such visits are deemed safe and reasonable.

Criterion 1.1.4 Care outside normal opening hours: Our practice ensures safe and reasonable arrangements for medical care for patients outside our normal opening hours.

Development of a responsive and flexible appointment system that accommodates patients' and GPs' needs, including access to care, requires careful planning and will require thoughtful consideration of some of the following factors:

- the nature of the service proposed – for example, longer consultations or walk-in appointments
- development of strategies in events such as staff illness to ensure continuity of care
- development of procedures in relation to visiting patients in their homes
- development of procedures for care of patients outside working hours
- culturally appropriate care provision (refer to section 2.4).

The availability of appointments to suit the needs of the consultation is an important factor in providing a patient-centred approach to nursing care and needs to be considered when planning a nurse clinic.

6.8 INFECTION CONTROL

RACGP STANDARD

5.3 Clinical support processes: Our practice has working processes that support safety and the quality of clinical care.

Criterion 5.3.3 Healthcare associated infections: Our practice has systems that minimise the risk of healthcare associated infections.

Adequate infection control is a fundamental component of the provision of safe and effective patient care. In planning to provide a safe, high quality nursing care, infection control must be considered. Apart from having a written policy regarding infection control for the nurse service, having a team member who is responsible to coordinate infection control is advisable. Key elements in health care associated infection control include[163]:

- immunisation for staff members[164]
- transmission based precautions
- sharps injury management
- blood and body substance spills management
- hand hygiene
- cleaning of both clinical and non-clinical practice areas
- sterilisation of equipment
- waste management, including storage and disposal
- access for patients and staff to personal protective equipment.

In planning a specific service involving the risk of transmission of infection, specific protocols may need to be developed, for example, influenza clinics that were operational during the H1N1 pandemic outbreak.

6.9 WORKPLACE HEALTH AND SAFETY

RACGP STANDARD

3.1 Safety and quality: Our practice is committed to quality improvement

Criterion 3.1.1 Quality improvement activities: Our practice participates in quality improvement activities.

4.1 Practice systems: Our practice demonstrates effective human resource management**.**

Criterion 4.1.1 Human resource system: Our practice supports effective human resource management.

Criterion 4.1.2 Occupational health and safety: Our practice implements strategies to ensure the occupational health and safety of our GPs and other members of the practice team.

5.3 Clinical support processes: Our practice has working processes that support safety and the quality of clinical care.

Creating a safe work environment is not only a critical planning consideration, but is also legislated requirement governed by state/territory and federal law. Organisations, including general practices, are required to provide a safe working environment that helps to protect the safety, health and welfare of employees and reduce workplace injury and illness. Workplace health and safety (WHS) measures may also provide protection for patients and other individuals who are not employed, but are present within a general practice[165].

In order to provide a safe environment, the following measures are suggested[166]:

- development and maintenance of safe systems of work, and a safe working environment
- consultation with employees regarding safety
- provision of protective clothing and equipment if necessary, for example for cryotherapy or chemotherapy
- provision of information and training for employees
- adequate facilities for employees and contractors (such as clean toilets, cool and clean drinking water, and hygienic eating areas)
- adequate and well maintained first aid facilities
- external motion lights for after hours.

Safety during clinic opening hours is one key WHS consideration which has implications for workforce capacity and staff rostering. It is important that staff members are never working alone for their own safety and that of patients – whether they are working within normal practice opening hours or involved in a nurse clinic held after hours.

Staff health and wellbeing is an important consideration and can be supported in different ways, for example with a plan to reallocate patients when there is an unexpected absence by a team member. Planning can help to ensure that staff members do not get overwhelmed by workload and staff should feel supported. Other capacity issues to do with WHS relate to the provision of safe equipment that protects both the team members and their patients.

The capacity to provide a safe environment for patients and health workforce needs to be considered carefully when planning any new nurse model of care. It is important that all employees and contractors understand their obligation to follow WHS policies and procedures, ensuring they work in a safe manner that does not jeopardise their safety or that of those around them[167].

6.10 RESOURCES

- Nursing in General Practice Recruitment and Orientation Resource: Australian Medicare Local Alliance: www.amlalliance.com.au/medicare-local-support/nigp
- RACGP: A design workbook for architecture in general practice and primary care www.racgp.org.au/rebirthofaclinic
- RACGP: General Practice – a safe place: tips and tools: www.racgp.org.au/gpsafeplace
- RACGP: The RACGP Infection Control Standards for Office-based practices www.racgp.org.au/infectioncontrol
- South Eastern Health Providers Association http://sehpa.com.au/resources/accreditation
- Australian Commission on Safety and Quality in Health Care – Infection control modules for clinical staff www.infectionprevention.e3learning.com.au/
- Safework Australia www.safeworkaustralia.gov.au/sites/SWA/Pages/default.aspx

6.11 CONSIDERATIONS

The following key points and questions relate to competencies that practices may wish to consider in planning a new nurse model of care.

- Will your clinic conduct home visits or treat patients in another facility?
- Is there an expected busy or peak period requiring recruitment of more staff and resources? How can this peak time of patient demand be managed?
- Identify and finalise insurance requirements, e.g professional indemnity, public liability, workers compensation.
- What rooms are required and how much space is needed? e.g. consultation, treatment room, storage of equipment and supplies, waiting room.
- Have you identified and determined the quantities of all the equipment and supplies?
- Are the information management and technology (IMIT) systems in place to cover appointment scheduling, patient histories, referral tracking, tracking of test results, recall and reminder systems and other clinical software considerations?
- How will patients get in contact with you during normal operating hours and out of hours?
- How many sessions a week/fortnight are required to meet patient demand? How long will the consultations be? Is there any flexibility in length of appointments?
- Are hand washing and hazardous waste disposal facilities required?
- Determine WHS risks (conduct a risk assessment).
- How are consulting or treatment rooms set up so that they provide security for team members, i.e. have you considered duress alarms and safe furniture placement?
- How can a safe working environment be ensured? What systems will you have in place to provide this? For example, in the event that a patient becomes threatening.

6.12 CONCLUSION

When planning the introduction of a new nursing model of care it is vital to determine the capacity of the practice to implement and sustain the service. Having effective human resources management and appropriate physical facilities, may potentially impact upon the practice capacity and nursing staff's ability to provide quality health care. WHS obligations, the procurement, storage and maintenance of equipment and supplies, infection control and waste management are equally important capacity related considerations.

7 FINANCING

Many good ideas on reorganising nursing work fail to eventuate because the general practice's financial viability and sustainability were not properly considered.

General practices considering introducing a nurse clinic that is high quality, sustainable, adequately resourced and financially viable to the practice, patients and community are encouraged to analyse financial elements contributing to the cost of that service[168].

Elements that may need review include: expected revenue, costs, and available funding mechanisms that can be formalised in the development of a business case. In some practices this may be the responsibility of the practice manager; in others it may require input from other members of the practice team.

While it is acknowledged that GPNs' expertise in budgeting and finance may vary widely and that they may not necessarily participate in the process of preparing a business plan, it is important that GPNs have an understanding of the business case that underpins the model of care they are involved in developing and/or implementing.

This section provides links to comprehensive and detailed financial templates. Practices may extract what is applicable and useful, and adapt a template according to their individual practice needs.

7.1 PRACTICE NURSE INCENTIVE PROGRAM

The Practice Nurse Incentive Program (PNIP) that came into effect in January 2012 is a simplified single funding stream administered by the Department of Human Services (DHS) that aims to provide general practices with opportunities to review and further expand how they organise nursing work. Additionally, this funding provides an opportunity for general practices to expand their existing nursing workforce. Calculations for payment are specific for each practice.

The Australian Practice Nurses Association (APNA) has developed a business case for an enhanced practice nurse role under the PNIP[169], and a guide that will assist practices to address the impact of this funding on practice revenues. It also provides examples of opportunities for the practice to work differently to improve the financial position and sustainability of the practice.

7.2 BUSINESS CASE

ANF COMPETENCY STANDARD FOR THE ADVANCED REGISTERED NURSE

Domain 3: Leads practice

Competency Standard 12: Contributes to development of nursing knowledge, standards and resources through active participation at the broader professional level.

ANF COMPETENCY STANDARD FOR THE ADVANCED ENROLLED NURSE

Domain 3: Management of self and others

Competency Standard 3.3: Acts as a resource to others in an area of clinical practice

Definitions

While the terms 'business case' and 'operational plan' are often used interchangeably, the following definitions underpin this resource:

- **A business case** must be developed to initiate the project. The business case involves an analysis of costs and benefits associated with the proposed activity. A business case is required where sign-off by a sponsor or funds provider is needed. This usually involves getting approval for funding. A thorough business case will allow informed decisions to be made and appropriate resourcing to be provided[170].
- An **operational plan** is generally developed to implement an approved business case. (Refer to the operational plan in section 7.3.)

The development of a business case is a strategy to formalise your ideas in a strategic and logical manner to ensure that planning considerations have been addressed and can be presented to the general practice management for consideration. The business case, as a planning tool, is a statement of intent outlining the key business elements associated with the proposal. An operational plan can then be developed to specify how the proposal in the business plan will be implemented.

A comprehensive, systematic approach, supported by the development of a business case and operational plan, will help to identify all components of the nurse clinic and ensure that it is adequately resourced and funded. Ideally the plan will be tailored to meet the requirements of your practice and the needs of the proposed nurse clinic.

The business case sets out the rationale and justification for the nurse clinic to show that it has been well considered and, importantly, is financially viable. A business case will identify how the planned activity will affect costs and revenue. Other aspects of the business, such as improved patient health outcomes, should be clear and specific[171]. Developed systematically, the business case can help identify potential pitfalls, assist in managing risks, and establish viability and sustainability.

7.2.1 PRACTICE INFORMATION AND MARKETING STRATEGY

RACGP STANDARD

1.2 Information about the practice: Our practice provides sufficient information to enable our patients to make informed decisions regarding their care.

Criterion 1.2.1 Practice information: Our practice provides patients with adequate information about our practice to facilitate access to care.

Criterion 1.2.2 Informed patient decisions: Our practice gives patients sufficient information about the purpose, importance, benefits, risks and possible costs associated with proposed investigations, referrals or treatments, to enable patients to make informed decisions about their health.

Criterion 1.2.4 Costs associated with care initiated by the practice: Our practice informs patients about the potential for out-of-pocket expenses for health care provided within our practice and for referred services.

The business case needs to include basic information regarding what benefits the new nurse clinic will provide to both patients and the practice. It will detail who you will be targeting, or who are the expected 'customers', and provide some demographic information about the identified target group.

It is important to develop a marketing strategy as part of the business case. It does not have to be complex, but some planning and thought directed towards the most effective marketing strategies will be beneficial. Conducting a brainstorming or ideas generating session with key members of the practice team who have a local knowledge and understanding of the practice population profile (and data) may generate some effective strategies. Ensuring that the nursing role and other health professionals' roles and responsibilities are understood, and that patients know what to expect from the new nurse clinic, is essential. When developing effective marketing strategies, factors such as the provision of culturally appropriate resources (refer to section 2.4) may need to be taken into account to ensure informed consent of patient care, or to explain 'out of pocket' expenses.

The practice may find it beneficial to communicate extensively with patients, other members of the general practice team and allied health professionals directly involved with patient care. Without the support of a team approach, the GPN's role may be undermined and the success of the nursing model of care in general practice may be jeopardised. Methods of communication can include[172]:

- posters in waiting rooms
- leaflets for anyone to take
- personalised letters to patients identified from disease registers developed within the practice.

Other strategies include practice newsletters, phone recordings, information in recall and reminder letters, and local newspaper advertising.

It must be noted that adopting these strategies does not necessarily guarantee success in all practices. Some consideration on the most effective

strategies to recruit or target the particular patients who may benefit from the new nurse clinic needs to be given. A thorough knowledge and understanding of your practice patient population, such as social and demographic related information and clinical data extracted from data collection tools or disease registers, may help inform and identify a successful, targeted marketing strategy.

Regular review of marketing strategies will be required to ensure that the nursing model of care is fully operational and providing an optimal service. A fully booked appointment schedule, excellent patient attendance rates and good referral of patients from other health care professionals are some criteria to assist in the review process.

7.2.2 DEVELOPING A BUDGET

The Department of Human Services provides a broad overview of public and private sector funding in Australian general practice that can inform the development of the business case.

By searching Medicare Benefits Schedule (MBS) Online[173], you can also identify claimable and relevant item numbers and explanatory notes that will assist in the development of the business case.

General practices are encouraged to 'think outside the square' and explore opportunities within their State and Territory to access alternative funding.. For example, a practice may be interested in registering as a LIFE Taking Action on Diabetes Program provider with Diabetes Australia Victoria; their GPN could then, as facilitator, conduct lifestyle modification programs for patients who have been identified at high risk of developing diabetes. There is remuneration to the provider and also the facilitator for the provision of this education[174].

A link is provided in the resource section to a budget and other finance templates. This may act as a prompt and guide to document potential start-up costs and profit and loss forecasts.

7.2.3 BUSINESS CASE GUIDE

A business case does not need to be complex. It may be useful to present proposed nursing practice improvements on a business case template based on headings identified in 'Developing a business case for an enhanced practice nurse role under the PNIP: A guide for general practice' developed by the APNA or the 'Nurse Practitioners in Primary Care –Benefits for your practice' developed by the AML Alliance. These are both listed in the resource section.

Only include relevant business case aspects and delete any that are not applicable. Once completed, the business case provides a detailed document for discussion and can facilitate the approval and decision-making process by management. It is recommended that a budget be developed as a component of the business case to give the general practice a financial overview, with details of the predicted income and total expenditure to implement the model of care.

7.3 OPERATIONAL PLAN

An operational or implementation plan may not be considered necessary for a business case; however, if required, it provides details and outlines responsibilities associated with implementation of the proposed nurse clinic. This can help to ensure that the business case is realistic and cost effective.

The operational plan can include the following detail:

Clarification of the objectives of the nurse clinic

Objectives of the clinic should be very clear and set out what you want to achieve by implementing the nurse clinic. Objectives need to be SMART – Specific, Measurable, Achievable, Realistic and Time-bound.

Spell out specific objectives in both the business case and the operational plan in order to maintain the focus of activities and tasks required to achieve these objectives.

Assignment of the key tasks that need to be undertaken for the model of care to be implemented

This section details what must be accomplished to achieve your objectives. Each implementation stage and task associated with the nurse clinic should be clearly identified so that roles, responsibilities and accountability of each member of the health care team are clearly assigned and understood by all. Tasks should be plainly stated as it is important to avoid any blurring of professional boundaries.

Assignment of deadlines to these tasks

Each task should be paired with an appropriate and realistic timeframe for completion, taking into account factors such as time, patient demand and the workload on other health team members.

Charting progress in reaching goals and milestones

The operational plan also includes tools to measure performance and progress towards the achievement of overall objectives of the nurse model of care. The identification of key performance indicators, or other quality indicators designed to capture and provide feedback (qualitative and/or quantitative), to monitor the progress of the nurse clinic is essential in the planning stage. How are you going to know that this model of care is making a difference and improving patient outcomes? For example, will you be monitoring patients' HbA1c levels to determine improvement over time in a diabetes nurse clinic? Other indicators such as a reduction in the percentage of patient non attendances for diabetes management appointments may also be used.

Monitoring the progress of the nurse clinic is important to ensure the activities are carried out in a timely fashion, and enables a quick review and adjustment if necessary. The following operational plan checklist has been developed based on RACGP quality domain considerations, and may be useful in your practice.

7.3.1 Nurse Clinic operational plan checklist

RACGP QUALITY FRAMEWORK DOMAIN	CONSIDERATIONS	WHO IS RESPONSIBLE	TIMELINE
Patient focus	• Ascertain population health statistics		
	• Undertake study of cultural diversity and awareness		
	• Patient rights		
	• Access		
	• Planning		
	• Feedback		
Professionalism	**Human resources**		
	• Check professional registration		
	• Codes of ethics, conduct and professional boundaries		
	Leadership and teamwork		
	• Clarification of objectives and aims		
	• Clarification of team roles		
	• Communication systems		
	• Mentoring and teaching provisions		
	• Clinical handover		
	Quality and safety		
	• Clinical support for team leader		
	• Clear clinical supervision for team		
	• Clinical guidelines		
Competence	**Staff competency**		
	• Check staff competencies against competency standards		
	- National competency standards		
	- ANMC Continuing Competence Framework		
	• Assess scope of practice		
	- Of individual team members		
	- Of practice as a whole		
	- National framework for decision making		
	• Mentoring and clinical supervision		
	- Supervision of enrolled nurses		
	• Plan for continuing professional development		
	Evidence-based practice		
	• Use of clinical guidelines		
	• Development of practice protocols		
	• Establish coordinated referral pathways		

RACGP QUALITY FRAMEWORK DOMAIN	CONSIDERATIONS	WHO IS RESPONSIBLE	TIMELINE
Knowledge management and information technology	• Data quality		
	• Practice profile/quality improvement tools		
	• Information security		
	• Recalls/reminder systems		
Capacity	**Model of care**		
	• Determine model of care, frequency of service, other		
	• Off-site activities		
	• Ascertain staff needed		
	Human resource management/models of employment		
	• Position description		
	• Recruit or contract staff		
	• Insurance		
	• Induction		
	• Links/networks with other agencies		
	Physical amenities		
	• Space		
	- Consultations		
	- Treatment		
	- Storage		
	- Privacy		
	- Fit out		
	• Resources		
	- Clinical equipment		
	- Other supplies		
	Infection control		
	Workplace health & safety		
	• Systems to provide a safe working environment for staff		
	- Normal working hours		
	- After hours		
	- Off site		
	- Adequate breaks		
	- Staff support		
	- Infection control		

7.4 RESOURCES

Some of the resources presented here are quite comprehensive and may require accounting or management knowledge and experience. However, they are included because they provide guidance on what to include in a business or marketing strategy. While some of these templates may well constitute 'overkill' on certain nurse models of care, it is advised that, as with the rest of this resource, you use the parts that are relevant and achievable for you, your experience and the needs of both your practice and the nurse model of care being introduced.

- Department of Human Services PNIP Payment Calculator: Ready Reckoner www.medicareaustralia.gov.au/provider/incentives/pnip/calculator.jsp
- MBS Online: www.mbsonline.gov.au
- Australian Practice Nurses Association www.apna.asn.au
- A Tool Kit for Employing Nurses in General Practice: Queensland Urban Divisions Nursing in General Practice (Queensland Urban Divisions NIGP) Group: www.gpqld.com.au/content/Document/3%20Programs/07_NiGP/Qld%20Divisions%20Resources/Urban%20Workgroup/Urban_Workgroup_Employment_Toolkit_Final.pdf
- Nurse Led Clinics General Practice Chronic Disease Management: Melbourne East GP Network: www.iemml.org.au/sites/default/files/chronic-illness-nurse-led-iemml-20120518.pdf
- Nurse Practitioner Business Models and Arrangements: Government of Western Australia, Department of Health, Nursing and Midwifery Office: www.nursing.health.wa.gov.au/docs/reports/Business_Models_Arrangements.pdf
- Australian Government Business Initiative p23-28: www.business.gov.au/Information/Pages/businessgovauplanningtemplates.aspx
- Developing a Business Case for an enhanced practice nurse role under the Practice Nurse Incentive Program (PNIP): www.apna.asn.au
- Before and after the Practice Nurse Incentive Program: www.amlalliance.com.au/medicare-local-support/nigp
- PNIP information sheets: www.amlalliance.com.au/medicare-local-support/nigp
- Nurse Practitioners in Primary Care :Benefits for your practice: www.amlalliance.com.au
- Australian College of Nurse Practitioners: www.acnp.org.au

7.5 CONSIDERATIONS

The following key points and questions relate to the business case and operational plan, and may be useful in planning for the new nurse model of care.

- Provide an overall summary of the business case containing the main justifications for the proposed nurse model of care.
- How was the need identified? What is the evidence supporting this? (Is there supporting evidence from the practice demographics, practice population health profile or practice PIP summary?
- Who are your target group of patients? What are the boundaries of the nurse clinic e.g. professional, services offered? What or who will be excluded if applicable?
- Develop SMART Objectives – that is, Specific, Measurable, Achievable, Realist and Time bound
- What are the deliverables and patient outcomes? How will these address the needs that have been identified?
- How will the clinic be promoted and marketed to potential patients, general practice team and allied health professionals?
- Identity and develop relevant resources, i.e. patient information sheet.
- Consider other options (such as home visits, or a clinic on a different site).
- Have you undertaken a strengths, weakness, opportunities, threats (SWOT) analysis?
- What resources will be needed to implement the clinic? Human resources, technology, equipment, materials?
- Develop a budget of anticipated set-up and implementation costs.
- What funding is required? What is available? How will finance requirements be met?
- How will financial controls be implemented and followed?
- What resources will be needed to implement the clinic? Human resources, technology, equipment, materials?

- Develop a budget of anticipated set-up and implementation costs.
- What funding is required? What is available? How will finance requirements be met? Will the clinic be a 'fee-for-service' operation?
- How will financial controls be implemented and followed?

7.6 CONCLUSION

Financing is a major consideration in planning for delivery of a new nurse model of care – how will it be funded, what income will be received, and what are the associated costs for staffing and resources? It is vital to be realistic about the workforce, equipment and supplies necessary for implementation, and also to be aware of MBS items or programs that can be accessed to provide funding, and any other sources of funding that may be available privately.

Preparing a business case is a way of thoroughly preparing for the new model of care. It provides a justification for your plans to present to decision makers and should include a clear description of the proposed model of care, potential patients, business strategies including marketing, and a realistic budget. There are many business case templates available, but you need to tailor these to suit your proposal and to ensure you have covered all areas.

Developing an operational plan provides a way to implement an approved business plan. The operational plan provides more information and details of the day-to-day running of the nurse clinic care and a template has been developed that may assist in this process.

SECTION B: IMPLEMENTATION CASE STUDIES

8 CASE STUDIES

The following section contains 11 case studies of innovative nurse clinics that are being conducted in Australian general practices. The case studies are primarily written by the GPN who is responsible for implementing the nurse clinic in their practice, and are presented in line with the RACGP Quality Framework domains underpinning this resource. While formal evaluation of the nurse clinics has not been undertaken to a large extent to date, the case studies highlight the diversity in the GPN role and the many different ways that nursing work is organised in general practice. This knowledge may inform planning, implementing and evaluation of general practice nurse clinics in the future.

The following case studies are included:

1: Musculoskeletal

2: Chronic disease management and preventative health (patient health assessments)

3: Asthma, diabetes, chronic disease, respiratory nurse

4: Diabetes

5: Diabetes/asthma combined; cervical screening and wound

6: Mental health

7: Kidney health program

8: Lifestyle modification

9: Well women's

10: Wound

11: Koori women's cervical screening program

CASE STUDY 1: JESSICA DANKO RN

Musculoskeletal Nurse Clinic

Medicaid Family Medical and Accident Centre, Ballarat, Vic

BACKGROUND

In 2011 Jessica Danko was awarded the RACGP Best Practice award for her work in musculoskeletal care and the Australian General Practice Accreditation Limited (AGPAL) Award for Quality Improvement by the Australian Practice Nurses Association (APNA). Jessica works at Medicaid Family Medical and Accident Centre and has been responsible for setting up a musculoskeletal initiative with Dr. Attila Danko, her employer. Jessica suffers from arthritis and has a comprehensive understanding of the many factors that can affect management of the condition, and a great deal of empathy for people with this condition who deal with pain on a daily basis.

'Living in a town like Ballarat, often patients know I have had the hip surgery. This has been an unexpected advantage as I am able to show rehabilitation by example.' – **Jessica Danko**

Jessica explains her experience in the process of setting up a nurse clinic model of care and although an unstructured approach was taken, the process is aligned with facets of the RACGP quality framework domains.

PATIENT FOCUS

To begin with I was sent direct referrals from the GP in the practice, and also used the Clinical Audit Tool (CAT) to recruit patients. I used both the bone disease and osteoarthritis CAT disease filters to find eligible patients. I recruited active patients who are regular attendees of the practice. I then created and mailed out an introductory letter describing the new service. Patients were invited to call to make an appointment with the GP and GPN. A register was kept to identify those patients who responded and attended and those who had not. This was recorded in the patient notes.

Our initiative to give better quality care to those suffering a musculoskeletal condition has already had positive feedback. Patient testimonials include:

'You have changed my life!'- Patient

'I can't believe the change in my husband, his mood is better, and he is so much easier to live with.'- **Patients wife.**

Using health coaching techniques and motivational interviewing, the patient and I work toward realistic achievable goals. An opportunity is given for the patient to identify gaps in knowledge in a supportive non-judgemental environment. Education is given regarding the condition, pharmacological and non-pharmacological pain management, healthy living and prevention activities that are age appropriate.

COMPETENCE

I use clinical practice guidelines extensively in the nurse clinic including those from the RACGP. Organisations such as Ballarat & District Division of General Practice, APNA, Arthritis Victoria , Osteoporosis Australia and the Chronic Pain Association of Australia have proven invaluable in providing accurate and relevant information.

As a result of my commitment to the better management of arthritis I founded the Pelvic Instability Association and remain its president.

In order to streamline referral pathways I had a number of networking meetings and conversations with local services that have relevance to musculoskeletal health. For example, I had a meeting with a large local allied health group that offers physiotherapy, exercise physiology, podiatry and psychology. Other extensive conversations have occurred with multiple service providers in Ballarat and in particular the local public rehabilitation hospital that offers a variety of programs such as hydrotherapy. I have made connections with pharmacists and various medical professionals with an interest in arthritis. I approached Arthritis Victoria and requested improved access to information for people with arthritis in regional Victoria. We also discussed the possibility of me becoming a Musculoskeletal Health Educator or Ambassador with Arthritis Victoria.

The most common referral is to physiotherapy and podiatry; however, other referrals have been made to specialists, psychologists, exercise physiology, hydrotherapy, aids and equipment, social work, optometry and hearing services.

PROFESSIONALISM

Support from practice staff has been instrumental. For this initiative to work, it required negotiation between the nurse, GP, practice manager and practice staff on how to identify clients who may suffer musculoskeletal disease. In particular the assistance of a staff member with expertise in using the CAT and templates was valuable.

KNOWLEDGE AND INFORMATION MANAGEMENT

All of the General Practice Management Plan (GPMP) records are kept centrally for easy access for review follow-up. A review is offered at three-to-six months either by letter or phone. To decrease the rate of missed appointments we offer a text message reminder service to all patients having a GPMP, Team Care Arrangement (TCA) or review. All of these new systems were implemented as the practice operates on a non-appointment based system for GP consultations.

FINANCING

Implementing change in our practice has happened gradually following my employment as the first practice nurse. We needed to create a proposal, identify obstacles and develop a plan that was evaluated and altered as needed. The aim of our proposal was 'To improve the management of patients with chronic musculoskeletal conditions using chronic disease management (CDM) principles.' As the sole general practice nurse I realised that our initiative could only occur on a small scale. The methodology for this was the 'plan, do, study, act' (PDSA) cycle of continuous quality improvement. The business case included the ability for the practice to bill for an increased number of GPMP-721, TCA – 723 and GPMP & TCA Review-732 item numbers through a systematic and organised approach.

The musculoskeletal nurse clinic increased our chronic disease item billings substantially and proved financially beneficial to the practice.

EVALUATION

Utilising the pain assessment tools allowed us to evaluate the patient's pain at each review and consultation. This showed us that most our patients were experiencing less pain, and increased mobility and activity levels.

We have made gradual changes toward utilising the RACGP Guidelines on Musculoskeletal Diseases more within our initiative. Through evaluation we realise that we still have a long way to go to achieve optimal practice. In the future I would like to evaluate our service via a patient feedback form during review appointments and via mail.

KEY MESSAGES

- Patients appreciate a patient-centred approach to charting, describing and understanding their pain. This encouraged better self management of their pain management
- Develop a business case
- Evidence-based resources and memberships of professional organisations have been vital in overcoming the professional isolation experienced as a solo practice nurse.

CASE STUDY 2: MICHELLE CORDES RN

Chronic Disease Management Clinic
Preventative health clinic
Harding Street Medical Centre, Coburg, Vic

BACKGROUND

Michelle Cordes is an experienced registered nurse employed at the Harding Street Medical Centre in Coburg, an inner city suburb of Melbourne, Victoria. The Harding Street Medical Centre employs 13 GPs. In 2010 Michelle initiated chronic disease management (CDM) and preventative health clinics in this general practice: "I just got in and started doing it...' She is now described as the practice's CDM and preventative health GPN.

The following story in Michelle's words provides an overview of the practice journey in setting up chronic disease and preventative health clinics and the nurse's role and responsibilities in the nurse clinic model of care.

'We are constantly working to improve our practice and provide our patients with the knowledge and assistance to improve their own health, better patient outcomes and better patient care. Participation by our practice in the Australian Primary Care Collaborative Program (APCC) also encouraged the most effective utilisation of all general practice team members' roles and subsequent responsibilities in the provision of safe and quality patient care. While our primary focus is on patient care and improving patient outcomes, participation in the APCC indirectly provided us with and reinforced the financial aspects of the model... there is now an increase in Medicare benefit item numbers claimed.' – **Michelle Cordes**

PATIENT FOCUS

We offer a chronic disease management clinic to patients with the following conditions- diabetes, cardiac, arthritis, chronic obstructive pulmonary disease (COPD).

Preventative health clinics are offered for age 40-49 diabetic risk assessments; age 45-49 health checks; 4-year-old health checks; home health assessments over 75; comprehensive medical assessments and intellectual disability health assessments. Preventative health clinics were also implemented for the 50-60 age group to identify patients who had not previously been assessed, or who were identified with chronic disease, and/or needed to be followed up because of family history for example.

CAPACITY

Two nurses are employed to conduct these clinics (1.1 equivalent full-time); however, there is concern that this model of care may not continue to meet the increased demand generated by the resulting diagnoses of chronic disease from these health assessments, particularly in the 50-60 age group. Staffing levels are continually monitored and reviewed to ensure that capacity continues to meet patient demand, with more nurses to be employed in the future. All patients are seen for a one-hour appointment. We see approximately six patients per day, or forty-two a week. Attending patient numbers are increasing as news about the clinics spreads.

The practice has 9,351 active patients and runs six consulting rooms. Due to insufficient space in January 2011 it was decided to obtain new premises off-site to accommodate clinic work, and a second nurse was employed. With nurses performing all these assessments, more available appointments have been created for patient access to the GPs.

Missed appointments are followed up and are rescheduled accordingly; however, after three missed appointments we do not pursue follow-up. The patients are contacted by reception staff via SMS the night before their appointment as a reminder to attend.

PROFESSIONALISM

The patient-focused nurse clinic was supported in the initial stages by practice principal Dr Paul Day.

Despite some initial resistance, all the GPs now support the nurse clinics, and issues related to a lack of understanding of the nurse's role and the care planning process have been resolved. The GPs, GPNs working in the treatment room, receptionists who are aware of the nurse roles, and the CDM and preventative health GPN all participate in the referral of eligible patients to the CDM clinic. All patients with an AUSD RISK above 12 are invited to attend the preventative health clinic. They are now regularly referring patients.

The CAT is used to monitor quality improvements and help create registers, and also to identify eligible patients. These patients are invited to make an appointment or they can self-refer directly to the clinic.

KNOWLEDGE AND INFORMATION MANAGEMENT

The model has improved patient care and health measurement outcomes such as blood pressure, height, weight, body mass index, and an increase in recording health information such as allergies, smoking status, social and family history. There is now better coding of patients' diseases and diagnosis with the development of patient disease registers. Patients are also requesting recalls and follow up.

FINANCING

To market the clinic we have a Powerpoint presentation running in the waiting area advising patients of our preventative health clinics and educating them on the need and benefits of attending this nurse clinic model of care. This has resulted in an increased awareness within the practice community and has also resulted in more patients self-referring into the CDM and preventative health clinics. Prompts are also placed in the patient clinical notes advising GPs that a preventative health assessment is recommended. These prompts are initiated by identifying high-risk individuals.

GPNs in the clinics provide ongoing education and support, monitor all measures and pathology, conduct GPMPs, arrange TCAs, initiate recalls and conduct reviews of GPMP and TCAs. The following MBS Item numbers are being claimed generally: 721, 723, 732, 703 – 707 (usually 707) and 10997.

EVALUATION

Audits using clinical software audits are conducted regularly. Patient disease registers have been developed and the following clinical measures have shown improved clinical patient outcomes.

Coronary heart disease:

- In November 2009 15 patients were identified with CHD – in June 2012 there were 127 patients.
- In November 2009 the unrecorded smoking rate was at 71%; the June 2012 rate was 30%.

Diabetes:

- Nov 2009 cholesterol rate recorded: 26% - in Dec 2010 cholesterol rate recorded: 77%
- Nov 2009 unrecorded HBA1c levels: 69% - in June 2012 unrecorded HBA1c levels 16%.

Chronic Obstructive Pulmonary Disease (COPD):

- Nov 2009 influenza vaccine given within last 12 months: 10% - in Dec 2010 influenza vaccine given within last 12 months: 64%.

Diabetes prevention:

- AUSDRISK forms completed as at June 2012 – 748.

KEY MESSAGES

From lessons learnt, the following strategies are recommended to assist with the planning and implementation process related to this model of care:

- Work with GPs initially who want to participate; the remainder will participate when they see the benefits. Set realistic goals and be able to measure improvements.
- Ensure all staff are aware of what it is you are trying to achieve, include reception staff as they are the first and last people the patient sees when attending the consultation with the GP.
- Ensure all team members have the same ideas on improving patient outcomes and patient care.
- Continue to monitor and conduct clinical audits, as the clinic model of care continues to constantly evolve. Ensure that patient service delivery is continually being reviewed to meet patient needs and clinical outcomes.
- Hold regular staff meetings with all team members to encourage effective and open communication.
- Take small steps; acknowledge that not everyone shares your passion or understands your vision of this nursing model of care.
- All registers are only as good as your data entry. Ensure and allow time for data cleaning and clinical audits before you start your clinic. Start with one project and gradually grow from there.
- Plan, Do, Study, Act: Quality Improvement methodology is effective and is used to assess outcomes.
- Recognise that this clinic model of nursing care is a work in progress and constantly evolving.
- It is important to have the support of the whole practice for the nurse clinic. Any initial resistance and issues related to a lack of understanding of the nurse's role and the care planning process need to be resolved as a practice team.
- The CAT is used to monitor quality improvements, help create registers and identify eligible patients.
- Marketing is essential. Appointment reminders are sent out via SMS, and missed appointments are followed up and rescheduled.

CASE STUDY 3: GISBORNE MEDICAL CENTRE VICTORIA

Nurse clinics:

- Respiratory (Asthma)
- Diabetes
- Nurse (Chronic disease)

INTRODUCTION

Gisborne is an expanding rural Victorian town with a population of 6,300. The Gisborne Medical Centre (GMC) opened 25 years ago and now employs 19 GPs, nine nurses and 16 administration staff. The practice offers a range of services including pathology, consultant specialists and allied health providers.

Nurse clinics began in 2003 with an asthma clinic, followed by the diabetes clinic. More recently GMC introduced a clinic for patients with hypertension, coronary vascular disease, hyperlipidemia and osteoarthritis. Nurse clinics are conducted Monday to Friday and run concurrently.

PATIENT FOCUS

GMC nurse clinics were set to address the increasing numbers of patients attending the practice and to offer support to the GPs in providing comprehensive care to all patients. Data indicates that the number of attending patients is growing, and the number of patients with diabetes has increased by more than 100% since the diabetes clinic began in 2004.

The practice has responded to patient need for flexible access to services by increasing the number and type of clinics, as well as the times they are available. As a response to patient need, the services provided by the clinics have changed; the asthma clinic now incorporates COPD and has been renamed the 'respiratory' clinic, and a nurse clinic focusing on chronic conditions has started. The clinics now provide access to a broad range of patients who require assistance with ongoing management, education and support for their medical conditions.

GMC regularly surveys patients about their nurse clinic experience. Patient feedback indicated that patients preferred more patient-centred language, and the practice responded by incorporating this into its patient information and marketing materials. Patients also indicated that they preferred the chronic diseases clinic to be named the 'nurse clinic'; a change GMC promptly made. Anecdotal feedback has informed GMC that patients like the one-on-one interaction of the nurse clinic model, feel 'listened to' and enjoy the extra time the clinic allows to provide education and update.

CAPACITY

The ability of GMC to run clinics has happened slowly and progressed over the years. Two full-time equivalent designated nursing positions are devoted to nurse clinics, which are separate from treatment room duties. GMC now has a purpose-built facility which has further facilitated nurse clinics. The practice design incorporates a treatment room, doctors' rooms, nurses' consulting rooms, staff training/meeting room and offices for the general manager and administrative staff.

GMC clinics are fully booked three-to-four months in advance. The practice keeps 'urgent' appointment times available for patients who have newly diagnosed conditions and need education in the early stages. An evening nurse clinic will begin shortly to assist patients unable to attend during normal working hours.

COMPETENCE

GMC has a commitment to ensuring that all staff have the education they need to perform their jobs competently. Just as GPs undertake ongoing education, the nursing staff are encouraged to undertake professional development in a range of areas to support their work in the clinics. This includes training on specialties such as diabetes education or spirometry, and attendance at Division network meetings is encouraged. We constantly look to other examples of best practice. Administration staff are also encouraged to seek education in areas that improve their interaction with patients, organisational ability and computer skills.

PROFESSIONALISM

On reflection, GMC considers one of the major ingredients to success in implementing nurse clinics is the ability for staff to communicate well and work as a team. The practice has a communication plan that outlines meetings planned for the next 12 months to foster communication. All staff are expected to attend the appropriate meetings and are informed of activities within the practice, including any changes or issues that require solutions.

'It is important to listen to all ideas and acknowledge staff contribution.'

Good leadership is acknowledged by GMC as imperative in facilitating smooth operation of the practice. In addition to three practice principals, GMC also has a general manager who implements strategic operations and oversees routine systems and processes. There are team leaders for the nursing team, the administrative team and the chronic disease team. All leaders meet regularly with their staff, are responsible and accountable for their areas and are paid accordingly. Their roles and responsibilities are written into their position descriptions.

All administrative staff are familiar with opportunities for patients and for the practice. Having a sound knowledge of the MBS criteria enables them to identify patients eligible for home medicines review (HMR), health assessments, residential medication management review (RMMR), comprehensive medical assessment (CMA), GPMP, TCAs and those patients who may benefit from attending a nurse clinic.

The doctors complement this staff role by referring patients to clinics and confirming patient eligibility.

'Having a quality improvement culture has changed the way we think.'

KNOWLEDGE AND INFORMATION MANAGEMENT

The practice is completely computerised and no paper files are kept on site. All documentation in the patient files is electronic, as are the scripts and pathology reports. Most patient education material used in the nurse clinics is printed from electronic file as required by the nurses.

All nurses have their own password to the clinical software and are able to update histories, including medications. This saves the time of medical staff, is essential in maintaining accurate records and helps ensure health summaries are accurate.

Practice policies and procedures are readily available for staff to reference, via the intranet. A practice calendar ensures that when staff are away, all other staff are informed.

The use of medical software and a clinical audit tool enables GMC to constantly refine its disease registers and identify patients 'at risk'.

FINANCING

Although all nurse clinics must be financially viable, GMC considers that there are other reasons why a practice might choose to implement a nurse clinic. These include job satisfaction and work/life balance for all staff. Having the clinics allows the GPs to 'do what they do best': to provide medical care to patients.

'In gauging success, we look at the big picture'

To assist in maintaining efficiency, all nurses are required to meet specific key performance indicators (KPIs) and these are determined for each clinic and measured monthly. Staff must demonstrate that clinic time is used efficiently either as patient consultation, planning, referral or quality improvement activities.

It is the responsibility of the designated administrative staff to ensure that a log is kept of each patient attending the clinic journey – when they are seen, what was billed, when a review is due and so on. This ensures that no patients fall through the gaps and all billing is accurate and completed. Although staff initially saw this as burden, they now approach it as a rewarding record of their thoroughness, persistence and contribution to the team.

KEY MESSAGES

The elements of success that GMC believes are essential to implement nurse clinics are:

- relationships between staff being based on good communication
- listening to ideas and suggestions
- having a culture of quality improvement in the practice
- engaging all staff when implementing change.

CASE STUDY 4: NICOLE YATES RN

Diabetes Clinic
Interchange General Practice, Canberra

BACKGROUND

Nicole Yates is a registered nurse employed by the Interchange General Practice in Canberra. For the past six months she has run a diabetes nurse clinic at the practice. The decision to initiate the clinic was an extension of patients' need and the particular interest of both the medical director of interchange and Nicole as a GPN.

'It is a personal interest of mine to be involved in diabetes [care], but it's also a matter of opportunities I had when I worked in the hospital to do training in this area and to also work with people with diabetes.' – **Nicole Yates**

PATIENT FOCUS

There are no formal review or feedback systems in place for the clinic; however, any complaints by patients are reported to the practice manager.

CAPACITY

Initially the diabetes clinics were held fortnightly on Tuesdays 9am–1.30pm and allowed one hour per patient. Waiting times escalated to two months so weekly clinics were recently introduced and are now held every Tuesday. Appointment duration has been reduced from one hour to 45 minutes and as a result the waiting period for patients has reduced to one week.

When the clinic first started, the doctors referred lists of patients to the clinic. The clinic now has of a register and patients with high HbA1cs (glycosylated haemoglobin) who access the clinic by invitation letter or phone call from the GPN. Nicole arranges all the appointments, recall of patients and checking of billing. The reception staff assist by also booking in patients who respond to a letter of invitation from Nicole

'Initially I had a receptionist booking some appointments, but it proved confusing for me to know who had been contacted and who had been missed. We now have a system where I handle all the patient invitations and bookings, but still request help from the reception/administration staff from time to time.'

The clinic requires access to a doctor's room and as there is currently no designated nurse office a room is booked for the clinic each week. The practice has plans to renovate and extend the building in order to provide designated nurses' rooms for clinics. The resources involved in running this clinic include protected time away from other duties along with support of the administration staff. The GPN runs the clinic and the medical director provides leadership to the staff.

COMPETENCE

Nicole Yates is a RN with considerable experience in nursing people with diabetes. Nicole has worked in the Renal Services Unit and Hospital in the Home at The Canberra Hospital, involving the care of patients with diabetes. Nicole has experience at another medical centre, running diabetes clinics.

'I believe my role in the clinic is to gather together information, coordinate care and monitor patient outcomes. I'm not a dietitian or a credentialed diabetes educator, so it's not my job to offer specialised advice; rather it's my job to point the patient in the right direction for that advice. As a RN who has some training and experience, I am able to give some dietary information and diabetes education, but I always follow the guidelines and information that comes from either my training or reliable sources. I closely follow the Diabetes Management in General Practice guidelines from Diabetes Australia.'

Nicole has continued to undertake ongoing education in the area of diabetes management. This includes wound management and health coaching courses and CPD is ongoing. The health coaching course completely changed the way Nicole interacts with diabetic patients, and she highly recommends it to improve nursing care of patients with diabetes.

PROFESSIONALISM

The medical director is very supportive of the clinic and encourages other staff to be supportive. In order to engender acceptance and support of the clinic, a meeting was held in the initial stages to inform the whole team. There is regular communication between staff involved in the clinic, and it is discussed at quarterly practice meetings.

'I feel that any registered nurse can assist with care planning for a diabetic patient; however, what the patient gets out of it depends on how much experience and knowledge the nurse has, and especially how much interest they have.'

During 2011 Nicole and the practice manager became involved in the Improvement Foundation's 'Diabetes Prevention and Management Wave', which is part of the APCC.

KNOWLEDGE AND INFORMATION MANAGEMENT

Originally the administration manager extracted details of the number of completed diabetes cycles of care, and care plans, and found that the number completed was very low. This was done using Interchange's clinical software for data extraction, and then establishing a patient register and disease register. In terms of quality improvement tools, Interchange also has useful clinical software programs for this purpose. The practice initially used commercial clinical templates to create care plans for patients, but has since developed its own:

'These (care plans) include, at a minimum, all areas we would like to address for our diabetes patients like vitals, podiatry/feet, eyes education and a dietary advice and referral. To develop the template I used knowledge gained in my previous workplace, along with the Diabetes Australia recommended guidelines.'

FINANCING

'The office manager and I, with the support of the medical director, planned the diabetes clinic. There is no business plan, as the clinic I work for is largely based on an altruistic view of patient care. The Medical Director has encouraged GPs to embrace the diabetes nurse clinic, as it will benefit the patients, and generate enough income to continue to provide this nursing service.'

The practice accesses MBS item numbers 721,723, 732 and 10991 to finance the nurse clinic.

EVALUATION

Although the diabetes nurse clinic is in its early days at the Interchange Practice saw the following results in the six weeks from December 2011 to January 2012:

- 2.3% increase in the number of patients with HbA1c less than/equal to 7%
- 0.8% decrease in the number of patients with HbA1c greater than 7% but less than/equal to 8%
- Decrease in the number of patients with HbA1c of greater than 8% but less than/equal to 10%
- No change in patients with HbA1cs over 10%

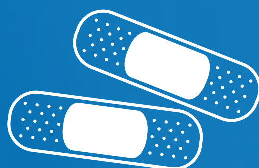
To date the clinic has had around 30 reviews of patients in the diabetic clinic, and another 60 patients have commenced on new care plans.

'I had the benefit of having a doctor and practice manager who knew the ins and outs of running a service, which resulted in a very efficient system. Outcomes, however, were not measured, and our system was largely based on creating care plans opportunistically."

We are creating a questionnaire to send to our clinic diabetes patients to evaluate the clinic."

KEY MESSAGES

- Agree on an aim for the clinic and meet regularly to discuss progress and keep all staff informed.
- Ensure patient records are accurate and create a diabetes register.
- Allow adequate time for each patient consultation.
- Focus on good patient care rather than just making an income.
- The development diabetes care plan template ensures all issues are addressed
- The difficulties in setting up this clinic revolved around understanding our clinical software and care plans, and being able to accurately extract information from our clinical software.
- Have a good knowledge of local allied health service providers including costs.
- Provide education to all staff including the GPs in areas of identified gaps in knowledge.



CASE STUDY 5: PATRICK STREET CLINIC

PSC

ULVERSTONE TASMANIA

- Diabetes and asthma combined clinic
- Cervical screening clinic
- Wound clinic

Patrick Street Clinic (PSC) Ulverstone, Tasmania

INTRODUCTION

The Patrick Street Clinic in Ulverstone, Tasmania, has run nurse clinics in general practice for the past 10 years. Nine nurses work at the clinic, all part time. The clinics were introduced long before the introduction of practice nurse item numbers and have run successfully for many years. A diabetes and asthma combined clinic is conducted twice a week, a cervical screening clinic is conducted weekly and a wound clinic conducted each Monday morning.

Services provided at the nurse clinics include:

- diabetes annual complication screening (managing database, recall, education, checking compliance, electrocardiogram clinical measurements, screening questions)
- asthma review (managing database, recalls, education, checking compliance and technique, screening questions, clinical measurement, spirometry – pre and post)
- immunisation clinics (managing database, recalls, National Immunisation Program schedule)
- Pap smear clinic -(managing database, recall, history taking, screening questions, Pap smear and follow-up)
- health checks (four-year-old, 45-49-year-old, 75-year-old)
- wound clinics and ulcers (assessment, management including choice of dressing)
- pathology collection
- triage of acutely unwell patients and weekend clinics.

PATIENT FOCUS

Although there has not been a planned approach to ensure the clinics are patient-centred, the attendance of carers is encouraged in all nurse clinics.

A package of written information is provided to all patients newly diagnosed with diabetes attending the diabetes clinic. Patients are referred to the clinic by the GPs and all are encouraged to attend. The information and care provided at this time is agreed upon by the entire practice team. In 2005 there were 279 patients and in 2012 there were 455 patients on the diabetes register.

CAPACITY

All the nurse clinics are overseen by Sharon Brain, the nurse team manager. Sharon has previous experience in a management role and leads the nursing team into a cohesive group able to support the practice in the delivery of safe, efficient and accessible health care.

Due to the increasing numbers of patients and the fluctuating numbers of general practitioners working in the clinic, the capacity to provide consulting rooms to nurses conducting clinics remains a struggle for Patrick Street. All the practice nurses rotate working at our satellite clinic.

"It's good for them to be able to adapt to different environments, and the other clinic is usually slightly quieter which gives them time to complete other tasks such as recalls. – Nurse team leader"

Because of the time and effort in establishing the nurse clinics, sustainability is important. Investing in the education and training of the practice nurses working at Patrick Street is seen as fundamental to establishing and maintaining clinics as well as retention of nursing staff in an area that has workforce shortages. Any new staff are selected on their existing capability but also their ability and willingness to undergo further education and training.

One of the major elements to our team is our administrative assistant. Wendy's role is to contact patients, make appointments, arrange pathology, and confirm patient appointments the day before. Our appointments are 30 minutes with the nurse and 30 minutes with the GP who does the GPMP. Sharon does the recalls and Wendy works closely with her. Our outcomes for diabetes SIP put us at nearly 59%.

The cervical screening clinic is run each Wednesday. It is a nurse-only clinic and the patients are not seen by a GP. The appointments are 20 minutes. Three of the nurses have undergone training in this area and work in this clinic. The nurses check results from their own patients and, if normal, send the patient a letter. All abnormal results are followed up with the doctor and through the usual recall system. Patients pay a fee of $21 to see the nurse for this clinic.

November 2011 results show nurses had performed around 1700 Pap smears and that was nearly 59%. The most recent 2012 results are 1505 Pap smears and that puts us at just over 59% as well. Achieving the outcome payment has become more

difficult now, with the increase to 65%, even though that does not take into account the patients who no longer need one or have them performed at Family Planning (or elsewhere).

"There are several important aspects of our process: the administration is taken care of by (administrative assistant) Wendy, freeing the nurses to concentrate more on clinical care, and the receptionists play an important role in knowing the skills of each nurse, the billing and the process". – **Nurse team leader**

COMPETENCE

PSC has a budget for continuing professional development which includes all staff. We use this to ensure that all nurses are competent to provide the care that they do. Generally the clinic decides on the type of care provided and then matches the skills of the nurses. We encourage nursing staff to act as preceptors and have students come to the clinic for clinical placements. All nine nurses who work in the practice have access to CPD and we now have three nurse immunisers, three nurses trained to perform Pap smears supported by this practice.

PROFESSIONALISM

One of the major components of our nurse clinics is the ability to be consistent. This is sometimes difficult, but consistency in our processes, information to patients, billing, education and general approach is critical to success.

Communication is another key component to success. Team meetings are held between the nurses and the doctors, and we have quarterly whole-of-practice meetings with all staff.

All clinics have a written policy and procedure document that outlines how they are run and the responsibility of all staff involved. This acts as a reference point for all staff and helps maintain a consistent approach, especially for any new staff coming into the clinic: they can see exactly how the clinics run.

KNOWLEDGE AND INFORMATION MANAGEMENT

PSC maintains a Diabetes Register that is updated every few weeks with completion of the cycle of care, and a major update is conducted yearly. The Diabetes Register is cross-checked using the medical software and pathology lists to maintain its accuracy. We also use the Practice Health Atlas, CAT and medical software to assist in the identification of patients who we think would benefit from attending the nurse clinic. We use standard shortcuts in the medical software to assist with documentation.

FINANCING

Because most of our clinics were introduced before the practice nurse MBS item numbers, our clinics do not rely on them to be financially viable. The viability for our clinics comes from the Practice Incentives Program (PIP), diabetes and asthma item numbers and using the 10997 nurse item number. Patients attending the cervical screening clinic have always paid a small fee and will continue to do so. Patients attending the wound clinic are still seen by the GP. We have a three-tiered system for charging a minimal fee for dressing products, and in the future there will be a charge for all wound dressings.

The strengths of the nurse clinics conducted at the Patrick Street Clinic are that we have consistency of people, process and information. Clinics allow patients to talk at length about what is important in their health care.

EVALUATION

We evaluate our nurse clinics by receiving verbal feedback. Undertaking a more formal evaluation process such as a clinical audit or a patient survey is probably something that we would be interested in doing in the future. Conducting nurse clinics is an interactive process, with regular reviews discussed at planning meetings and small changes made as needed. This ensures all clinics meet the needs of the patients, the medical staff, the nursing staff and the clinic.

KEY MESSAGES

We have traditionally used our own forms for the cycle of care completion, and still use our own shortcut for that, but a while back decided to get all the doctors to complete the annual cycle of care in the blood pressure software as well. A few of them find that this software does not address all the things they wish to record, but if they don't use the template it makes it harder to audit the system for these specific aspects of care. Still a work in progress!

The strength of the collaboration with nurses here at PSC is an egalitarian structured approach to avoid duplication and wasteful effort between nurse and doctor tasks. We are close to achieving streamlined clinics where time and resources are saved, while ensuring a more systematic engagement with each task for the benefit of patients. This involves a coordinated approach to all aspects of the collaboration from database management, recalls, and clinical tasks during the patient visits. We value initiative highly and are always open to innovation and improvement if these add value and improve efficiency.

The success of the nurse integration can be attributed to competent planning by the nurse in charge, with ever vigilant attention to detail and pestering of the medical team to get things right. Without this persistent effort any system would gradually decay. – **Dr. John Fisher**

CASE STUDY 6: MENTAL HEALTH CLINIC SOUTHEAST SOUTH AUSTRALIA

PATIENT FOCUS

The mental health clinic in this case study was initiated by the partners of the medical practice as a response to the pressure on the mental health resources and services available to their patients in the southeast area of South Australia. There were some existing difficulties with referral pathways and they felt that there was not a team approach to their patients' mental health care. Due to resource constraints, mental health services were obliged to see only the most acute and difficult cases, which left patients with high prevalence disorders (such as anxiety or depression) with few options for specialist treatment. There was also an element of concern that GPs could not provide the time necessary within normal consultations to address patients' mental health issues without impacting on the waiting times of all patients. At one time the waiting time for GPs in this general practice was six weeks.

Patients were not specifically involved in the design of the Mental Health Clinic; however, the clear need for it is evidenced by attendance during the past four years. There are few mental health care options in the area.

Ann McElroy, a credentialed mental health nurse, runs the mental health clinic and has done so for the four years it has been in operation. Ann estimates that around 30% of patients who present to the mental health clinic have mild to moderate depression or anxiety, with another 15% presenting with moderate to severe depression and/or anxiety that may have necessitated hospital admission, either locally or in Adelaide. Other patients have stress related conditions or have had a recent crisis. Approximately 20% present with a significant mental illness including bipolar affective disorder, schizoaffective disorder, schizophrenia and complex presentations involving alcohol and other drugs.

Patients are referred by their GP to the clinic. Some people have also just asked to attend the clinic and the GPs have facilitated this.

CAPACITY

Ann is contracted to the general practice to run the mental health clinic, and works four days per fortnight. The practice approached Ann when it attracted funding for the mental health clinic. She had worked with the practice doctors over many years as a RN at the local hospital and then as consultation liaison mental health nurse (CLMHN) to six small hospitals in southeast SA.

Ann's role as the CLMHN has helped her to build an extensive network of contacts, and this has helped the mental health clinic to access additional services as needed by individual clients, carers and family members.

Ann has a personal administrative assistant (PA) whom she describes as 'worth her weight in gold'. The PA is provided by the clinic and she handles appointment schedules and juggling things when Ann's time needs to be freed up for unforeseen circumstances (part and parcel of mental health care). Besides the administrative staff

being available, Ann can also use all the practice's equipment. All other needs are met by the practice, including designated room. Recent extensions to the building will result in a purpose-designed room that has been 'de-medicalised' for the clients.

Appointments are made for either 30 minutes or a full hour and Ann decides how many patients to see each day and it took about two months to get appointment numbers up. Over the past four years clients have rarely had to wait more than four weeks for an initial visit. Clients turn over depending on their original need for referral and there have been many return patients. Others might be referred to other more suitable agencies or other health professionals.

PROFESSIONALISM

'In the clinic I see the GPs, [general practice] clinic nurses and office staff as part of my team and they treat me as part of their teams.'

'I am an adult mental health nurse; however; I have found my practice expanding into youth (aged 15 and over) I also feel confident dealing with older persons because new criteria means it is almost impossible to get services for this group from the appropriate agency [so we see them in the mental health clinic here].' – **Ann McElroy**

Ann is a credentialed MHN and works on her own in the Mental Health Clinic. There is good support for the mental health clinic from doctors and other colleagues and Ann has only received positive feedback from the doctors, medical students, registrars, clinic nurses and office staff. The partners have regular meetings, to which Ann contributes as required and the practice also has a monthly training meeting at which short education sessions to office and nursing staff are presented around mental health care.

'I expected there might be some barriers to teamwork but have never had any problems. The practice has a conflict resolution policy but we have never had to resort to this. The Mental Health Clinic also uses the policy and procedures manual developed by the practice. I believe a team care approach is a great way to promote nursing.'

FINANCING

Planning for the financial viability of the nurse clinic was done by the partners of the practice. They submitted the original application and approached Ann to run the clinic.

Funding for the mental health clinic comes from the Australian Government under the Mental Health Nurse Incentive Program, which requires a credentialed mental health nurse to be employed. One benefit of this type of funding is that clients do not have any gap payment for attendance at the mental health clinic.

EVALUATION

Any complaints by patients are handled by the practice manager. Ann and her clinical supervisor are developing a feedback mechanism for clients when they are discharged. Ann hopes to have a consumer feedback questionnaire in place this year which will form another important part of ongoing monitoring and evaluation of the work of the clinic.

KEY MESSAGES

'For me the strength of the clinic has been the degree of autonomy I have had to run the clinic, but with the support of the doctors who are always on hand. It has been a real team approach. It is a collaborative way of working and I think offers nurses an alternative model of working in a collegiate manner rather than as an employee.'
Ann McElroy- Credentialed mental health nurse

CASE STUDY 7: BETH AMEGA RN

MNurs (Nephrology)
Danila Dilba Kidney Health Program
Darwin, Northern Territory

PATIENT FOCUS

In 2007 it was identified that chronic kidney disease (CKD) and renal dialysis were increasing dramatically in the Northern Territory. The Australian Government provided funding through the Office for Aboriginal and Torres Strait Islander Health (OATSIH) to establish four renal nurse care co-ordinators in existing Aboriginal Medical Services (AMSs) throughout the Northern Territory. One of these centres was at the Danila Dilba Health Service (DDHS) in Darwin.

Commencing in 2008, officially the program has two very broad key objectives:

1. To educate the staff, clients and community about kidney health and to give case management to stage 4 and 5 renal clients who often have complex needs and multiple co-morbidities
2. To delay the progression of CKD so that the patient never requires dialysis.

During the first six months the priority was to identify clients within the greater Darwin area. This covers a radius of 120km around Darwin.

CAPACITY

Initially Beth worked with an AHW in clinics in two different areas in Darwin, and mobile clinics in urban communities. They concentrated on the education of staff, GPs, AHWs, nurses, families and clients, teaching them how to identify and reduce the risks and the damage from CKD.

In November 2009 it was identified that when renal dialysis patients relocated to Darwin they did not have any primary health care, and so they were being managed at the hospital emergency department when they were in crisis. At that time General Practice Network Northern Territory (GPNNT), Renal Services and DDHS joined forces to develop a primary health care project for dialysis patients. This increased Beth's chronic patient load from 30 to 120. A designated part-time GP was appointed to assist Beth to manage these patients. GPNNT helped the team with a PDSA (plan, do, study, act) model which helped them to work through problems with shared care and communications, as these dialysis patients were not linked through the NT electronic shared care system. This created problems in accessing information so a paper-based referral system and a documented communications pathway were put in place.

In 2010 Beth and her team established a twice-weekly chronic disease clinic for the CKD and dialysis patients. In one clinic patients are reviewed first by the AHW, then the nurse, then the GP or nephrologist. These consultations take up to one-and-a-half hours and generate four-to-six referrals. With the support of the GP, AHW and nephrologist, Beth is able to also see patients in an AHW/nurse only clinic and refer them as required. This improved the efficiencies of the team and patient outcomes.

Health education is still a priority in this nurse clinic. Once a week, clinics are held where whole patient comprehensive consultations are carried out using the multidisciplinary team approach.

The AHW takes:

a. the 'general story'

b. acute observations

c. immunisations – fluvax, pneumovax, ADT, HepB (renal dosing)

d. foot check

e. urine and blood specimens

Beth (NP candidate):

a. General renal history ('where are they on their journey?')

b. Discuss the self management areas, encourage cessation of smoking, weight control, diabetes management, hypertension, sexual health, women's business, men's business

c. identify any acute issues

d. start the Shared Care Management Plan.

The general practitioner reviews all of the previous observations, checks vision, and hearing, ensures current medications are correct and completes the GPMP. The GP also follows up on any home medications review and other referrals.

Attendance to appointments has improved, which has a significant impact on the clinic and patient health outcomes. There is also a lot of time taken in reporting, checking results, and assessment of results and recalls.

Beth also runs a weekly nurse clinic where she can see 'at risk patients'.

The Kidney Health Program runs on a level playing field where Beth works autonomously. She is able to run the clinic with the full support of a visiting private nephrologist, part-time GP and AHW. Beth is the team leader who, working with the AHW, does all of the preliminary work with the patient to establish the diagnosis, decide on the plan of treatment and once this has been reviewed by the GP or nephrologists, they carry it out and follow up on the patient with education, preventative care, disease management and support for patient and family.

COMPETENCE

Beth Amega is a an RN with a Graduate Certificate in Remote Health Practice and Masters of Nursing (Nephrology). In 2010 Beth was awarded a Churchill Fellowship. Beth's current position is a Nephrology Nurse Practitioner (candidate) at DDHS, Darwin.

Beth was appointed to lead this DDHS clinic and at this stage she did not realise how important her work and vision would be. She had been working as a public health nurse in chronic disease management in the preventable chronic disease area and held the renal portfolio for the NT Department of Health. She had firsthand knowledge of the problems with CKD in the Indigenous communities of the Northern Territory. Beth applied for the job on the proviso that she could have a free hand to set the clinic up as a nurse practitioner.

PROFESSIONALISM

The nurse clinic model that she used in 2008 continues today, working in collaboration with an AHW, a GP and a visiting nephrologist. Working with a part-time AHW made it culturally acceptable for Beth to go out to the community to visit clients with declining renal function.

In 2012, along with her current patient base, Beth receives referrals from nephrologists, GPs and RNs from various clinics.

During the next two years the AMS plans to mirror this successful nurse-led clinic approach into other chronic disease areas. As an endorsed nurse practitioner in 2013, Beth is ideally experienced to mentor other practice nurses as they establish these new nurse clinics.

KNOWLEDGE AND INFORMATION MANAGEMENT

The DDHS uses a clinical software system which allowed Beth to access all of the estimated glomerular filtration rate (EGFR) results for CKD staging.

Beth targeted abnormal results and checked the patients' clinical records to see how they were being managed. If the patient had a primary doctor and was being managed that was fine; if they did not have a regular GP Beth initiated a home visit.

Electronic Patient Information Record Systems (PIRS) with the NT- wide Shared Electronic Health Record (SEHR) have been vital in the establishment and effectiveness of this clinic. These computer programs allow results to be viewed, information to be shared and management plans to be maintained and acted upon for a large number of itinerant or relocating clients.

FINANCING

Beth says that if she can stop one patient a year from going on to the next stage to dialysis, then this pays her wage for a year.

KEY MESSAGE

'I think that this case study represents a classic model of a nurse established and led clinic. This clinic runs smoothly, efficiently and there is an improvement in lifestyle for the patient and family by management of CKD. This clinic has made a significant contribution to reducing the progression, morbidity and mortality from CKD in the indigenous community'. – **Beth Amega**

CASE STUDY 8 & 9: BARTON LANE PRACTICE TAMWORTH NSW

Lifestyle Modification Clinic – Marion Goodman, RN

Well Women's Clinic – Jude Collier, RN

INTRODUCTION

Tamworth, in northern New South Wales, has a population of 50,000 and is a major regional centre. For the past six years Barton Lane Practice has conducted nurse lifestyle clinics focusing on prevention of lifestyle-related chronic disease, both primary and secondary. Five years ago they successfully implemented a nurse well women's clinic.

1. LIFESTYLE MODIFICATION CLINIC CASE STUDY

PATIENT FOCUS

Seventy percent of patients presenting to a general practice have some form of preventable lifestyle related disease or co-morbidity such as obesity, Type 2 diabetes, cardiovascular disease, depression and some cancers so the Barton Lane Practice in Tamworth decided to set up a nurse clinic to address these. Lifestyle consultant GPN Marion Goodman identified a need for further intervention to assist patients to enhance their health and wellbeing, and to promote patient self management to prevent or reduce the burden of lifestyle-related chronic disease.

All general practitioners and nurses recognise these issues. They discuss the need for lifestyle change with the patient and an appointment with the lifestyle consultant nurse is offered.

To assist patients with self management, a clinic folder has been developed and is used by the patient to monitor their progress. It has been devised using a lifestyle checklist that addresses matters such as physical activity, weight, nutrition, smoking, alcohol, stress and sleep. Over time, the record of patient information, combined with short and long term SMART (specific, measurable, achievable, realistic, timely) goal setting, will assist in overcoming barriers to change and improve patient self management and problem solving.

CAPACITY

Marion conducts three nurse clinic sessions of five hours duration each week. The need for lifestyle change is usually raised by the patient's doctor and an appointment to see Marion is then offered. The initial two or three appointments are usually 40 minutes and subsequent follow-up appointments are 20 minutes.

For care planning, 40-49-year old health checks and Aboriginal and Torres Strait Islander health checks, one hour is allocated per appointment. Up to 10 patients can be seen in one session. Posters are placed around the practice waiting room walls to promote healthy lifestyle to all patients attending the clinic.

The popularity of such a program has meant a waiting/cancellation list is now in place. At this stage there is a six-week waiting time to attend the lifestyle nurse clinic.

COMPETENCE

Marion became a registered nurse in 1975. She has a great interest in assisting patients to live their best life and to reduce the burden of lifestyle related chronic disease. Being employed part time at The Barton Lane Practice in Tamworth for 24 years, Marion has built up a trusting and respectful relationship with all staff.

Marion is also a Level 3 Certificate IV personal trainer. A special interest in the field of lifestyle medicine, however, is important. Furthermore, by completing many workshops relating to lifestyle medicine – such as those conducted online Southern Cross University, the Heart Foundation, APNA and the RACGP – Marion has been able to continue to increase her skills and expertise in this field. Other education includes becoming a Lifestyle Modification Program facilitator for the Reset Your Life Lifestyle Modification Program for the prevention of Type 2 Diabetes.

Receiving a scholarship to undertake a Masters degree in Applied Science/ Lifestyle Medicine has enhanced Marion's skills and to date she has qualified for a Post Graduate Certificate. Being able to disseminate the learnings gained at Barton Lane Practice has occurred through Marion presenting at conferences relevant to lifestyle medicine.

To ensure accuracy and consistency of information provided to patients, an evidence-based approach is maintained. This involves the use of resources and clinical practice guidelines made available by organisations such as the Cancer Council, RACGP, Diabetes Australia, Nutrition Australia, beyondblue and the National Health and Medical Research Council (NH&MRC).

If the needs of the patient are beyond the scope of Marion's practice they are referred back to their GP, who may then refer them to an appropriate health professional (mostly through TCA if a chronic condition exists and a care plan is in place).

PROFESSIONALISM

Being a new concept, initially, the Lifestyle clinic was daunting for the practice and its manager. Organising patient appointments, working out time needed, ensuring the clinic was financially viable and identifying patients at risk was challenging. All practice staff now assist in the smooth running of the lifestyle clinic and it is now fully supported by the practice team.

A monthly meeting with the principal partner at the practice is held to discuss any problems or plan improvements. Regular staff meetings are held. All staff and practice nurses attend a monthly clinical meeting with the medical staff. Experience has shown that conflict can happen if there is not a good understanding of roles and responsibilities of all staff members; however, most problems can be overcome eventually.

KNOWLEDGE AND INFORMATION MANAGEMENT

Recall and reminder systems are used to ensure that patients don't get lost in the system. A reminder via short messaging service (SMS) is generated by the computer the day before an appointment and if no mobile is available then a courtesy call is made to the patient. A recall list is printed monthly to check patients who may be overdue for review – either for lifestyle follow-up or care planning review. Before the patient leaves, a follow-up appointment is made to keep them engaged with the program.

FINANCING

As a practice decision in the planning phase of the clinic, all patients were bulk billed so the clinic was accessible and financially affordable to all patients. The PNIP has provided funding to the practice to assist with the nurse clinic viability.

The other forms of financial viability come from health checks, care planning and reviews.

- 45-49 year old health assessment (once only)
- 40-49 year old health check (three-yearly)
- MBS Item numbers 701,703,705,707
- MBS item number 715 Aboriginal & Torres Strait Islander Health Assessment:
- GPMP 721 and GPMP Review 732
- GPN Item number 10997

To date the lifestyle clinic has run on a cost recovery basis, with some additional income generated to the practice. Barton Lane Practice has three full-time equivalent practice nurses: the PNIP supports employment of two full-time equivalent practice nurses.

EVALUATION

In 2008 a clinical audit showed that just over 70% of patients who had attended the lifestyle clinic for at least 12 months had made significant changes to their lifestyle as measured by weight loss. Nearly 27% of patients had lost 5% or more weight. Further auditing is ongoing.

KEY MESSAGES

- All members of the practice team can work together to enhance the health and well being of our patients.
- There is always room for improvement.
- Not all patients attending the clinic will necessarily continue in the program; however, the patients who have continued have made gradual, positive lifestyle change.
- General practice provides ongoing continuity of care that is both credible and sustainable to specifically identified populations at high risk.

2. WELL WOMEN'S CLINIC CASE STUDY

I am Jude Collier and I run the nurse-led Well Women's Clinics at Barton Lane Practice in Tamworth.

PATIENT FOCUS

Initially women were hesitant to attend nurse-led clinics, but with education patients are now very accepting of what nurses are capable of. Having 30 minutes with each patient allows time to cover multiple facets of women's health. After five years, I am now seeing women for 'repeat business', with a general comment being how good it is to have a female attend 'female issues'.

CAPACITY

I run three, four-hour clinics per fortnight with 30-minute appointments. With three clinics per fortnight, I am seeing up to eight women per session – which is the maximum appointments available. Unlike GP appointments these can easily rescheduled within one month when required.

COMPETENCE

I initially completed the Well Women's Health Screening course and now do any updates that are available. Also, getting to know allied health professionals locally gives me a great referral base. One of my favourites here is a physio who specialises in incontinence and pelvic floor tone. There is no point in gathering the information from patients if there is no help for them! I am constantly self-assessing my Pap technique and specimen collection. Like everything in this industry I find the more I learn the more I need to know and to know my limitations and any issues and concerns that I find are quickly referred to the GPs who then treat as required.

Education, assessment and information are a huge part of these clinics including breast health and self-examination, safe sex practices, chlamydia screening and pelvic floor tone/incontinence assessment.

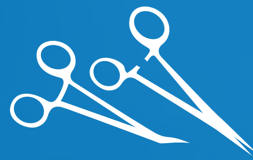
Barton Lane Practice has six RNs who have each focused on a specialty. This has enabled us to be focused and well informed in our area in preference, which is an advance on knowing a little about everything.

PROFESSIONALISM

GPs here now regularly suggest to patients to book in for a Pap as their time constraint doesn't allow them to tend to multiple issues during a single appointment. The GPs are supportive of the Well Women's clinics and are happy to share their knowledge and ideas.

FINANCING

Since the introduction of PNIP funding in 2012 my clinics are now fully funded. Prior to this, it was a user pays system with a $20 out of pocket fee.



CASE STUDY 10:

BUNDALL MEDICAL CENTRE GOLD COAST QUEENSLAND

WOUND CLINIC

INTRODUCTION

Bundall is a suburb on the Gold Coast with a population that includes a significant number of elderly, retired people and, like society in general, it has a rising incidence of diabetes. In addition, the area around the clinic has several residential aged care facilities.

The Bundall Medical Centre is a purpose-built practice which opened in June 2011. The accredited practice offers a range of services such as pathology, consultant and allied health providers, and is a private billing clinic. GPs can bulk bill where they determine that it is appropriate.

As a new clinic Bundall Medical Centre is in a privileged position of being able to set up models of care that are appropriate for the local community. The aim of the wound clinic is to provide medical and nursing care to patients with chronic and persisting wounds only, after a minimum of six-to-eight weeks treatment by their usual doctor has failed to heal the ulcer.

To date 85% of referrals have been for venous leg ulcers. The practice also conducts chronic disease clinics which are coordinated by nurses employed for this purpose.

PATIENT FOCUS

As a population containing significant numbers of elderly people, it was identified in a major public health report on the Gold Coast that many elderly patients were presenting to the emergency department with chronic venous leg ulcers.
Dr Stephen Yelland, a GP with a special interest
in wound management and an active member of the Australian Wound Management Association, has undertaken the task of setting up a wound clinic that will help address this identified need in the local community. By using a collaborative approach between the practice, the GP, the practice nurses and a nurse consultant, it is envisaged that this model will add capacity to the practice and meet patient needs both at a practice level and for the wider community.

Even in its infancy, the practice has received positive feedback from patients about the wound management clinics. Here are some examples:

'I have learned a lot from the clinic and I can manage on my own when I get small ulcers.'

'After three visits my wife has a better outlook, she no longer sees herself as needing to come three times a week for a very long time. Her quality of life has improved and she can now drive again.'

CAPACITY

To cater for the local community, the practice has extended business hours from 7am until 6pm and GPNs provide nursing care and support to the GPs every day.

Because the practice has been purpose built, all the amenities needed to provide a wound clinic to patients are available. The practice is completely computerised, has a large treatment room with five beds, two procedure rooms and additional waiting areas for patients attending the wound clinic. The practice owns a Doppler machine and pays a fee for the use of other specialised equipment provided by the clinical nurse specialist. All staff are aware of the clinic and although still in the planning process, all staff support the aims of the wound clinic.

Although all clinics are presently conducted on site, future plans include visits to residential aged facilities to teach staff as well as provide clinical care.

COMPETENCE

Bundall Medical Centre has a commitment to ensure that all staff providing wound care have the education they need in order to be able to perform their jobs competently. The nursing staff are encouraged to undertake professional development in a range of areas that support their work in the clinic and this is supplemented by mentoring and clinical supervisions from Cheryl, a clinical nurse consultant. Cheryl is an experienced nurse who has worked in the area of wound care for many years including providing a consultant wound management service to a vascular surgeon and working at the Gold Coast Hospital. Visits are made twice weekly to Bundall Medical Centre to provide advanced clinical wound management care to patients.

Because of her experience and education in the specialised field of wound management, Cheryl is able to make a comprehensive assessment of each patient's wound. This includes performing a Doppler study to determine ankle brachial index (ABI) and to identify any underlying cardiovascular disease. At the same appointment Cheryl will outline a plan for management for the patient and this is then confirmed after consultation with Dr Yelland who will oversee the patient's journey through the wound clinic.

Assistance is given by the GPNs, who may be required to see the patient between wound clinic appointments. All practice nurses are being trained to undertake some of the clinical care provided.

In the future, the patients will be able to access hyperbaric therapy from a local provider, as necessary.

PROFESSIONALISM

In order to make changes at a practice level and to improve the quality of care, an evidence-based approach is taken wherever possible. Getting all staff to embrace change is difficult and experience at Bundall has shown that medical staff will respond to change if it is based on scientific evidence. Level I evidence clearly indicates that compression will facilitate wound healing, and the treatments offered in the wound clinic, such as vacuum assisted compression (VAC), is new technology that supports this.

KNOWLEDGE AND INFORMATION MANAGEMENT

The practice has been completely computerised. All nurses have their own password to the clinical software and are able to update histories including medications. The clinical software has been used to identify patients and create a wound registry and in this process time has been spent on ensuring that patient data is accurate and diagnoses are coded correctly.

In order to be able to manage the potential number of patients that will attend the wound clinic, the practice has developed policies for patient referral. This includes criteria for internal referrals from GPs within the practice and a policy for patients referred from other general practices in the area. A policy for reception staff has also been written to ensure all staff are familiar with the process and the roles and responsibility of each member of the team.

Documentation in the patient files is electronic, as are the scripts, pathology and the appointment system. A digital photo is taken of all wounds at the onset of treatment and after each ultrasonic debridement or VAC treatment, and these are uploaded to the patient files.

For patients referred externally, communication between the wound clinic and the patient's usual doctor will also take place and a recall and reminder system is in place.

FINANCING

As a private billing clinic, Bundall Medical Centre requires that the costs of running the clinic are covered. Before external referrals are accepted, patients are required to have a GPMP in place by their own GP and a fee is to be paid to Bundall Medical Centre for treatment including ongoing costs for dressings.

As a GP providing a specialised service, Dr Yelland is able to be nominated as a Provider in any Team Care Arrangement (TCA) and charge for a review of the TCA.

The cost of the vacuum assisted closure dressings is able to be recouped by the patient in most cases through their private health insurance. There is an MBS fee for ultrasound debridement and Doppler studies.

The wound consultant is contracted to attend the clinic each week and is paid a fee per service. The cost of consumables is covered by both the patient and the clinic.

Bundall Medical Centre has made a commitment to meet the needs of the local community in an innovative way and encourages input from advanced nursing practice to achieve its aim. The collaborative nature of this venture is based on a respectful, trusting relationship between the medical and nursing staff. Although in its infancy, the demand for such a clinic has already been demonstrated and over time its outcomes will be measurable in both patient quality of life and reduction in hospital visits and admissions.

KEY MESSAGES

The elements that we feel are essential to implement the wound clinic are:

- a proven identified local need of the community
- team work among GPNs, GPs, administrative staff and other agencies
- evidence-based practice.

CASE STUDY 11: SANDY ANDERSON BALLARAT VIC

Baarlinjan Medical Clinic, Ballarat & District Aboriginal Cooperative
Koori Women Cervical Screening Program

BACKGROUND

Sandy Anderson is a 2012 APNA award winner (Best Practice Nurse Award for Sexual Health) and works in sexual health as a primary health care nurse at the Baarlinjan Medical Clinic at Ballarat and District Aboriginal Cooperative (BADAC).

Sandy, a RN, joined the clinic specifically to take on a role in women's sexual health and in particular the Baarlinjan cervical screening program. Before joining the clinic Sandy worked in another service providing outreach services to BADAC for women for many years, so she had a pre existing relationship with some of the clients.

PATIENT FOCUS

The Baarlinjan Medical Clinic has a rapidly growing patient base. As of early March 2012 there were 389 women aged between 20-70 on the records, 208 of whom were Aboriginal or Torres Strait Islander people. Many of the non indigenous women have Koori partners and are therefore also considered part of the indigenous community.

At the beginning of 2011, of the 310 women eligible for cervical screening, 168 identified as being of Aboriginal or Torres Strait Islander origin. Of the 310 women eligible for screening, 59% had no pap test history recorded. Of the 33% of women with Pap tests recorded, 27% were under screened (that is, it had been more than two years since their last test.)

Of the eligible Aboriginal or Torres Strait Islander women, 52% had no recorded Pap test history, only 38% had one Pap test recorded and of those 27% were under screened.

To improve women's sexual health screening, a permission form was developed to obtain women's permission to track both their Pap test and breast screen history. This was necessary so clinic nurses and doctors could provide informed and appropriate follow up care. This was an opportunity to start a conversation about Pap tests through a range of contacts when women attended the clinic such as for blood tests or new patient screenings. This conversation was also incorporated into the Aboriginal or Torres Strait Islanders health assessments and into 45-55 health assessments.

The Baarlinjan Team provided considerable consultation on the best way to approach the discussion of cervical screening from a cultural perspective and so it was decided that only the nurses, who are all women, would commence the conversations regarding sexual health screening with women.

All of this work to build a picture of the sexual health of the women would not have been possible without the responsiveness of both the Victorian Cervical Cytology Registry (VCCR) and Central Highlands and Wimmera BreastScreen. Both organisations responded to many single requests for histories to be found and for the VCCR to fax individual client records. Due to the transient nature of a proportion of the Koori community this process took some additional work in order to access screening history from other states.

KNOWLEDGE AND MANAGEMENT

Regardless of which staff members had the initial conversation with women, they all had an expectation that there would be a follow-up call or letter informing them about their screening status. Recall lists of women who did not have a cervical screening recorded, provided an opportunity for clinic staff to connect to women by phone and seek their verbal permission to access their screening history.

PROFESSIONALISM

Currently there are five doctors, four of whom are women, and two cervical screening nurses employed at Baarlinjan Medical Clinic. Of the nurse cervical screening providers one is Aboriginal and one non-indigenous, providing additional choice for women.

This newly developed system has only been fully implemented for six month with a whole-of-team approach and it was only possible due to the commitment of the whole Baarlinjan team. As always, the Pap test engagement provides an opportunity for chlamydia testing and for breast screening for appropriate ages.

FINANCING

To market the clinic articles were distributed in the BADAC community newsletter and education was provided through opportunities such as a Koori women's health day to meet with the Koori women at Budja Budja in Halls Gap. The use of simple quizzes and other fun activities have been the most welcome education strategies

EVALUATION

In early March 2012 the eligible women's population had reached 389, of whom 208 identified as being of Aboriginal or Torres Strait Islander origin.

Of the eligible women, 50% had a Pap test recorded, 73% had been screened in the past two years and the 'no Pap-test recorded' number had dropped from 52% in 2010 to 40%. Of the Aboriginal or Torres Strait Islander women, 63% had a Pap test recorded (up from 38% in 2011) and 73.3% of those had been screened in the last two years.

KEY MESSAGES

- understanding the cultural and gender sensitivities around sexual health and using a 'softly, softly' approach to educate and encourage women to participate.
- The whole-of-team approach has also contributed to the success of this program, with doctors and nurses at the Baarlinjan clinic, along with the wider BADAC staff, being involved and supportive of the work.

SECTION C: EVALUATION

9 INTRODUCTION

The purpose of providing health care is to improve and enhance the quality of life for people who are in a state of ill-health, and to prevent the onset of disease for those at increased risk. In order to know that care provided is achieving this aim, it is important for health care professionals to observe and measure the structure and processes of care provision and the health outcomes for patients who receive this care. An evaluation is a systematic approach, which uses evidence-based criteria to measure how well a program of care achieves its purpose and aims. As a result of an evaluation, any or all aspects of the program can be changed to improve health care delivery and then further monitored to assess the impact of these changes.

The following *evaluation cycle* provides a guide for the evaluation of nurse clinics in Australian general practice. It is followed by a description and discussion of each step in the process.

9.1 THE EVALUATION CYCLE

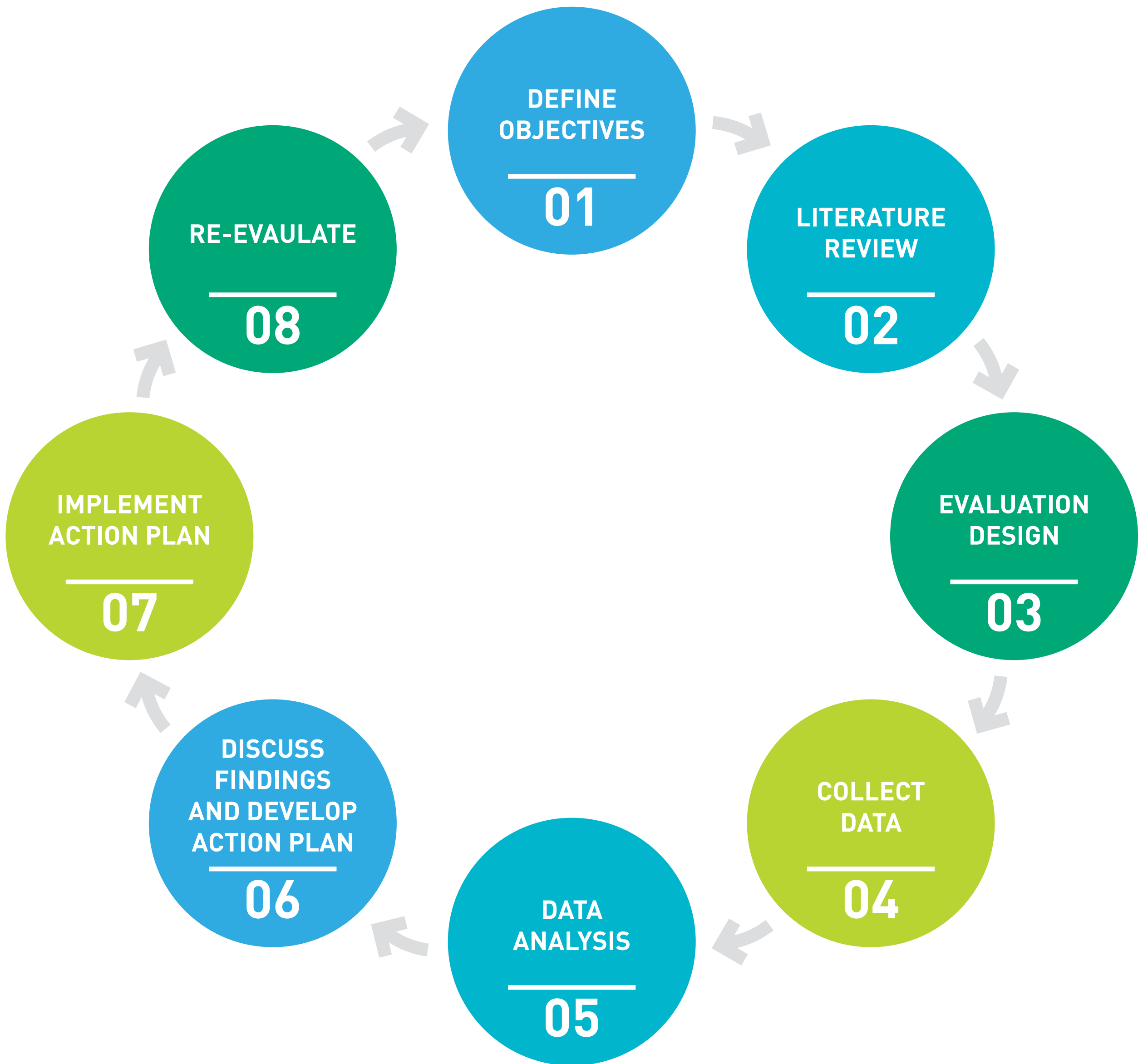


Figure 9.1: Adapted from Chambers & Wakly, 2005, The audit cycle[176]

The Royal Australian College of General Practitioners (RACGP) has developed standards for general practices, which include 'practice services', the 'rights and needs of patients', 'safety, quality improvements and education', 'practice management' and 'physical factors'. These standards provide a helpful benchmark against which to evaluate these aspects of the health care service being provided [177].

9.2 CONDUCTING THE EVALUATION

Before conducting an evaluation, the reasons for doing so must be clear. If the nurse clinic is a relatively new initiative or the practice would like to evaluate its effectiveness to justify its continuance an evaluation can be useful if the area is of high risk, high volume, high cost or has caused concern[178].

The evaluation team should meet to plan the process and objectives. The team can include the nursing staff, a general practitioner, the practice manager and, if possible, a patient representative. Reception staff might be included in meetings to discuss any role they play, such as handing out patient experience surveys or collecting data from patients' records.

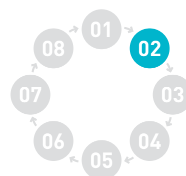
Be sure when setting the objectives of the evaluation that they are Simple, Measurable, Achievable, Realistic and Timely (SMART)[179]. The objectives need to be relevant and easy to understand. Some worthwhile objectives are:

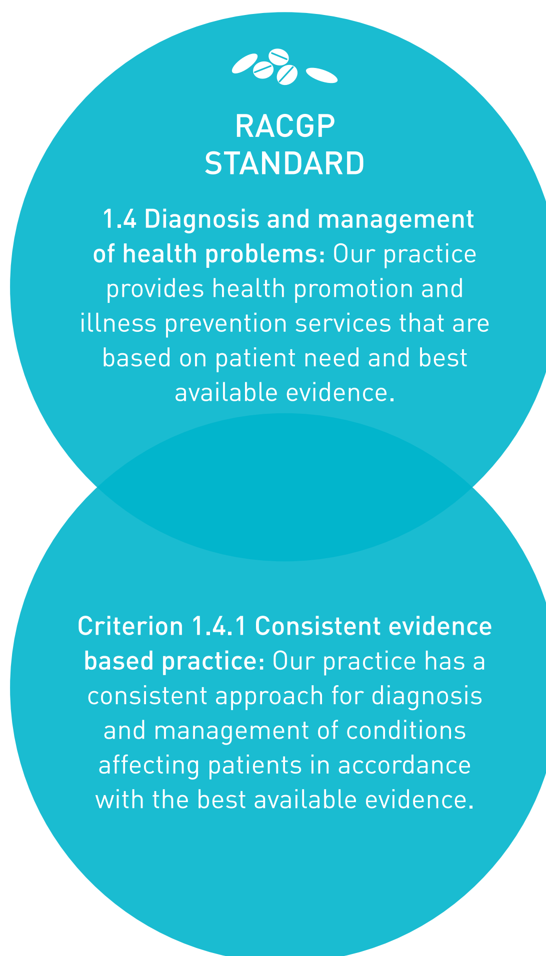
- assessing whether agreed standards are being met
- monitoring patient adherence with recommended treatment or advice
- improving clinical effectiveness
- staff satisfaction, recruitment and retention.
- changing inadequate current practice

The clinic's objectives and target health outcomes should have been identified when planning the clinic (refer to section 2.2).

Remember: Your main aim is always to improve patient care.

9.3 LITERATURE REVIEW





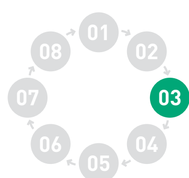
An evaluation must be based on current, evidence-based practice and guidelines. A review of the literature is the best way to determine the most up-to-date evidence. RACGP Standard 1.4.1 discusses the use of evidence-based practice and provides a comprehensive list of resources that indicate best practice and can be used in the development of your practice evaluations[180]. This list is comprehensive and includes guidelines from a range of peak national bodies:

The National Health and Medical Research Council of Australia: http://www.nhmrc.gov.au/guidelines

The Royal Australian College of General Practitioners: http://www.racgp.org.au/guidelines

These guidelines provide measurable evidence-based objectives, which you can use as specific criteria for measuring patients' outcomes of nursing care.

9.4 EVALUATION DESIGN



The design of the evaluation will be dependent on the resources available, such as time, staff skills and funds. It is during this meeting that aspects of the evaluation such as the sample will be discussed (see Box 1).

BOX 1: SAMPLE

The **population** refers to the whole group of patients you are interested in evaluating, for example all patients who attend the women's health clinic. Unless this population is very small, it is difficult to include every patient, so you might need to select a sample of patients who attend this clinic. A highlight is a smaller number of people who are chosen to represent the larger group. Two ways of doing this are:

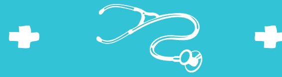
1. Simple random sampling: select a group of patients at random from those who attend the clinic. It is best to have someone who does not know the patients to do this.

2. Systematic sampling: select every nth (e.g. 5th) patient from the list of those who attend the clinic.

Be careful when determining what information you wish to collect. A small amount of meaningful and clearly defined information is better than a large amount of general information, which can create complexity of analysis and interpretation.

Different types of information will reflect different aspects of the way in which care is provided. Evaluation of the structure of care includes examining things such as the office space, equipment and resources, and the clinical competence of staff (including knowledge and training). Evaluation of care processes refers to what is done to patients and how it is done. This includes how easy it is for patients to obtain an appointment with a nurse, the clinical protocols and guidelines used to guide care, patient recall and reminder systems, and waiting times. 'Health outcomes' refers to the impact of health care on patients, including improvements and adverse outcomes[181]. This can be measured in terms of patient satisfaction and experience, clinical outcomes, and access to health care.

Discussing how the evaluation will be performed is important to determine who has responsibility for different aspects of the evaluation. The team will need to be aware of the time-frame during which the evaluation will be conducted and their roles. It is important to consider who will collect information and how, so as to minimise the introduction of bias (see Box 2). For example, the reception staff might be responsible for giving surveys to patients. Specific team members will be responsible for information analysis, while others will be responsible for putting the findings together and feeding them back to the team. In a small general practice, one person might be responsible for most aspects of the evaluation; however, meeting with other members of the team will ensure that they are aware of the task being undertaken and the time required for the evaluation.



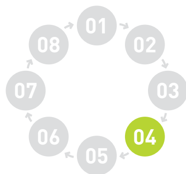
BOX 2: BIAS

Bias refers to the ability to influence or prejudice the results of the evaluation. There are a number of ways that bias can be introduced to the evaluation, so it is important to be careful in the design stage. For example:

- o If a nurse chooses to survey only patients who have recovered from their illness, the results of the evaluation will be more favourable than if patients with a variety of outcomes are included.
- o A nurse conducting a clinic obtains consent and provides patient experience surveys to all patients. These patients may feel obliged to complete the surveys, but at the same time be reluctant to provide any negative feedback for fear of causing offense and possibly compromising their treatment as a result.

It is therefore important that surveys and any related consent forms are provided to patients by reception staff, or by someone who does not have a role in the provision of care for that patient.

9.5 COLLECT DATA



Now that you have decided what information you wish to collect and who will collect it, you may need to pilot the collection of information to see how it works out and solve any problems that arise. This ensures that the information you are collecting measures what it should, and the way you are collecting it works. Minor errors, which could potentially diminish the effectiveness of the evaluation, can be identified during this process. The information discovered during the 'pilot evaluation' can help you to improve the design, before starting the real evaluation[182].

Decide if the information collection is retrospective (information collected in the past), concurrent (information being collected at the same time of the evaluation) or prospective (information expected to be collected in the future)[183]. For example, you might collect information before a program of care is introduced (retrospective) and plan to collect information in the future (prospective), to compare patient outcomes before and after the program of care.

All information must be valid and accurate. It should be readily available, for example on your computer system or obtainable from patients. You might not have time or resources to track down information that is hard to locate[184].

An awareness of the need for ethical conduct when collecting information from patients is important (See Box 3).

There are a number of methods of collecting data, including survey, clinical audit, interviews and focus groups. These will now be discussed in turn.

BOX 3: EVALUATION OR RESEARCH?

It is important to differentiate between an evaluation and research. An evaluation looks at the quality of care being provided, with the aim of determining if objectives are being met. Research is about discovering new knowledge, such as what type of care is best to deliver. Similar methods are used in both circumstances; however, an evaluation usually does not require approval from a local human research ethics committee, whereas research usually does. If there is uncertainty regarding this, seek advice from either the RACGP or the NHMRC (below).

- The RACGP National Standing Committee – Research (NSC-R) available at: www.racgp.org.au/nsc/research
- It is important to be aware of the ethical principles related to conducting an evaluation in any health setting. The National Health and Medical Research Centre's (NHMRC) National Statement on Ethical Conduct in Human Research is a comprehensive resource which discusses the values, principles and considerations specific to health research. This statement is available at: www.nhmrc.gov.au/_files_nhmrc/publications/attachments/e72.pdf

9.5.1 PATIENT EXPERIENCE

RACGP STANDARD

2.1 Collaborating with patients: Our practice respects the rights and needs of patients.

Criterion 2.1.2 Patient feedback: Our practice seeks and responds to patients' feedback on their experience of our practice to support quality improvement activities.

The RACGP Patient Feedback Guide provides information about obtaining patient feedback via surveys, interviews and focus groups, and may prove helpful.

9.5.2 SURVEY

The Patient Enablement and Satisfaction Survey (PESS) was developed by The Australian Primary Health Care Research Institute at the Australian National University specifically for use in Australian general practice. This survey measures patient satisfaction and enablement. Based on surveys developed and validated in other settings[185,186], it was refined specifically for the Australian general practice setting with the assistance of nurse clinic patients, nurses and general practitioners.

The PESS measures patients' perceptions of the following in terms of their experiences and outcomes of nursing care: affective support; provision of information; decisional control; technical competency; access; professionalism; time; overall satisfaction; and enablement.

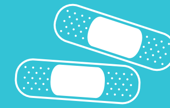
A survey is a simple and cost-efficient method of gaining feedback from patients. Surveys can

be either mailed to patients or provided directly by reception staff. The way in which surveys are provided to patients, and to which patients they are provided, needs to be discussed when designing the evaluation. A copy of the survey and supporting materials can be downloaded from the AML Alliance website.

9.5.3 INTERVIEWS AND FOCUS GROUPS

Another method of obtaining information regarding patients' experiences of health care and health outcomes is through interviews (face-to-face or telephone) and focus group discussions (See Box 4.). These provide qualitative information which, when considered together with information obtained through survey and clinical audit, can provide a valuable insight into patients' and/or their families' experience of the health care they have received.

There are several factors to consider when planning interviews and focus groups. Box 4 outlines some of these factors.



BOX 4. CONDUCTING INTERVIEWS WITH PATIENTS

An interview can be described as a 'conversation with a purpose'. Interviews provide a good opportunity to gain patients' personal accounts of their experiences and feelings in regard to their health and the care provided. It is important that someone other than the nurse responsible for the clinic interviews patients to avoid bias (Box 2). This will ensure that the patient feels free to discuss issues as they arise. Ideally, someone independent of the practice should interview patients. Practically, this might be difficult to arrange in terms of finding an appropriate independent person to conduct interviews or focus groups, and paying that person. The practice manager may be a feasible option. These are the sort of issues that need to be discussed as a team. More information about conducting interviews is available at: www.managementhelp.org/businessresearch/interviews.htm

Conducting focus groups with patients

'A focus group is a data collection procedure in the form of a carefully planned group discussion ... in order to obtain diverse ideas and perceptions on a topic of interest in a relaxed, permissive environment that fosters the expression of different points of view, with no pressure for consensus' (reference OMNI).

More information about conducting focus groups is available at:

www.omni.org/docs/focusgrouptoolkit.pdf

www.eiu.edu/~ihec/Krueger-FocusGroupInterviews.pdf

9.5.4 CLINICAL AUDIT

An audit of patients' records can provide information regarding the treatments provided and results of treatment such as blood results (e.g. HBA1c, INR and cholesterol levels) and other measurements such as weight. An audit can also provide information such as clinic attendance and provision of prescriptions. This quantitative information is valuable as an adjunct to information gained through patient surveys and process evaluation. It is important to take into account the security of patient information when collecting data for clinical audit and the Standard above clearly describes the obligations of the practice in regard to this.

9.5.5 NURSE SATISFACTION

The nurses' perception of the nurse clinic is vital to its ongoing success. Traditionally, nurse satisfaction is measured using surveys or interviews. Some factors associated with nurse satisfaction are autonomy, the capacity to deliver quality nursing care, relationships with colleagues, relationships with patients, pay, and an ability to input into the operation of the workplace[187,188] Measuring nurses' perceptions within the general practice setting might be difficult. General practice by nature is a private enterprise, and often the nurses' employer is a general practitioner. Therefore, expressions of dissatisfaction might be perceived to threaten the nurses' job security and relationships with colleagues and employers.

Another way to consider nurses' opinions or attitudes about the operation and outcomes of nurse clinics in Australian general practice is to ask nurses to self-appraise their satisfaction with the following aspects:

- capacity to deliver quality nursing care
- level of autonomy
- collaborative relationship with other nurses and general practitioner/s
- relationship with the practice manager and reception staff
- capacity to input into the planning of care in the general practice
- working conditions: pay, hours of work, rostering
- physical environment and/or structure of the clinic (see Box 5)
- availability and suitability of clinical guidelines/protocols.

Other questions can refer specifically to the structure and processes of care provided. For example, questions regarding clinical guidelines and protocols (processes of care) can include:

- How easy is it to navigate the protocol software?
- Are the guidelines/protocols current and evidence-based?
- How efficient is the system of data entry? Is there one system or does data need to be entered into more than one system?

Ideally, areas identified as sources of dissatisfaction can be discussed with the team and/or colleagues where appropriate as a first move to improve nurse satisfaction and working conditions.

Nurses might identify some barriers and enablers to the provision of care. Some examples of structural barriers to the optimum delivery of nursing care are described in Box 5.

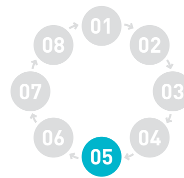
Having identified the problem some discussion with the team may be necessary to resolve the issues and provide solutions that will ensure sustainability of the nurse clinic.

BOX 5.
EXAMPLE OF STRUCTURAL BARRIERS TO THE SUCCESS OF A NURSE DIABETES CLINIC

The nurse diabetes education clinic has been arranged to occur every Friday morning, as this is the only time that a room was available for this clinic when it started.

- o The day and time of this clinic might coincide with another clinic that participants would also like to attend.
- o Your community has a large population with specific cultural and religious commitments on a Friday. For this cultural reason the day and time of this clinic might be unsuitable for this patient population.
- o The room available for this clinic can only accommodate four people, whereas there are 10 patients who would like to attend these education sessions.

9.6 DATA ANALYSIS



The way that data is analysed depends on the methods used to collect it. When using the Patient Enablement and Satisfaction Survey (PESS), scoring will be done in accordance with the instructions provided. Analysis of patient clinical audit data will be determined by the team. It is important to remember that data needs to be analysed as an aggregate as opposed to individually. Resources that are helpful for this stage of the evaluation are provided in the resource section at the end of this document.

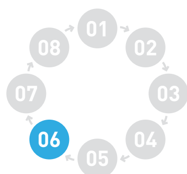
An evaluation based on a variety of information and using different methods provides the most useful information. This is then combined to create a comprehensive picture of the outcome of a health program. This is referred to as **triangulation**, which means 'using more than one approach to answer the same question'[189]. Triangulation improves confidence in the findings and can increase understanding of the outcomes. Box 6 provides an example of how results, when combined, can provide a complete picture of what is happening for a patient.

BOX 6. TRIANGULATION – THE BIG PICTURE

Patients attending a chronic disease clinic complete a Patient Enablement and Satisfaction Survey (PESS). Overall the results indicate that some patients are not satisfied with some aspects of their care, including access to the clinic and time spent with the nurses. The results of these patients' surveys also indicate that their level of enablement in understanding and managing their chronic disease has not been as high as others. On its own, this gives information on the outcome in terms of satisfaction and patient enablement. However, a clinical audit of the patients' records reveal less than expected clinical changes indicating improvements for a number of patients. An evaluation of the processes regarding how patients access the nurse diabetes clinic finds that many patients had difficulty making appointments for the clinic due to the time of day it was conducted. Also, due to the short amount of time available to conduct this clinic, the nurses had made shorter appointment times to accommodate a larger number of patients.

This **triangulation** of data provides a comprehensive picture of these patients' experience of the nurse chronic disease clinic. It also provides enough information for changes to be made to improve access to this clinic in the hope of improving health outcomes. These changes might include either changing the time or day that the clinic is conducted, or opening up a second clinic time, or increasing appointment times to enable improved opportunities for patient education.

9.7 DISCUSS FINDINGS AND MAKE AN ACTION PLAN



The findings of the evaluation and their implications can be discussed with the team. The potential for change and improvements, and how these can be implemented, can be determined. Quality improvement requires more than an individual approach. The greatest success will be achieved if a team approach is taken to reforming and redesigning clinical work structure and processes[190].

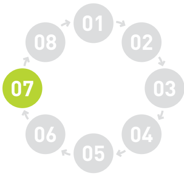
Using the information collected, a plan for clinical design and/or re-design can be made, including how to implement and further evaluate this plan. Examples of action plans are provided in Box 7.

BOX 7. ACTION PLAN EXAMPLES

1. A nurse **smoking cessation clinic** runs every Monday at 10am. A number of the practice's older patients would like to attend but have difficulty getting there at that time of day. One solution might be to run a second clinic later in the day, or the practice might be able to link in with the local community transport service to assist patients with transport to this clinic.

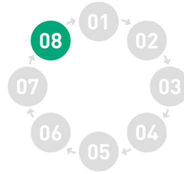
2. A **sexual health clinic** started 12 months ago. Initially the clinic was popular, but over time the number of patients attending declined. Evaluation findings reveal that patients were satisfied with most aspects of the clinic, but had serious concerns about their privacy due to its location in a three-bed treatment room. While curtains provided a level of privacy, patients considered this inadequate. The team meets and discusses the availability of a private consulting room. As a number of GPs work part-time, there is one room available one afternoon each week. Use of this room for the sexual health clinic will provide privacy, but will reduce the number of patients that can be seen in one clinic session. The team decides to try this solution. At the same time, this frees up the treatment room, enabling another nurse to treat other patients there. How to maximise the use of the treatment room is also discussed by the team.

9.8 IMPLEMENT ACTION PLAN



Those responsible for implementing the action plan will need to be clear on their individual and shared responsibilities. Changes might need to be communicated to patients and other staff. The team meeting is a good place to get this process started. Meeting individually with team members to discuss changes and roles is also helpful. Putting the action plan in writing and distributing it among staff for comment and feedback is another approach that can facilitate the implementation process. Two approaches to implementation are presented in Box 8.

9.9 RE-EVALUATE



The team will want to re-evaluate the program of care if changes have been made as a result of your initial evaluation. When planning to re-evaluate you will need to consider what changes have been made and how long it might take for these changes to make measurable impact on health outcomes. This is part of an ongoing approach to the evaluation of quality and safety of health care provision (see Box 9).

BOX 8. IMPLEMENT THE ACTION PLAN – EXAMPLE

1. The practice manager contacts the local community transport service to determine if they have the capacity to transport patients to the **smoking cessation clinic**. Reception staff are provided with the transport service's contact details to give to patients as required.

2. Information about the changed times and location of the **sexual health clinic** is emailed to all practice staff. The reception staff are told individually so that they can inform patients and take bookings appropriately. The changed use of the treatment room is communicated to all staff, so that patients can be appropriately referred for treatment.

BOX 9. RE-EVALUATE – EXAMPLE

1. When re-evaluating the **smoking cessation clinic**, in addition to data regarding patients who have ceased smoking, you could consider how many more patients are attending the clinic and if a second clinic is a better or additional option. You might also want to contact the community transport service and ask how the arrangement is working for them.

2. In addition to re-evaluating the **sexual health clinic**, you might consider planning an evaluation of the clinic now being conducted in the treatment room instead of the sexual health clinic.

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- Patient Enablement and Satisfaction Survey (PESS) www.amlalliance.com.au
- Patient Enablement and Satisfaction Survey (PESS) How to www.amlalliance.com.au
- Patient Enablement and Satisfaction Survey (PESS) Example PESS www.amlaalliance.com.au
- National Health and Medical Research Guidelines www.nhmrc.gov.au/guidelines

9.11 CONCLUSION

Always keep in mind that the main aim of nursing care is to enhance the health and quality of life for patients and the community. Evaluation performed with the goal of improving the safety and quality of this care is one way of achieving this. The evaluation cycle described provides a deliberate and organised approach to assess the quality of care and services provided by nurses in the Australian general practice setting. It is important to use this tool as a guide only. The approach to evaluation might differ from one setting to another depending on the availability of staff, funding, resources and space.

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