Business Plan

Nurse Practitioner Position in Mental Health of Older Person's Service



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Table Of Content

Executive Summary

This is a business case to gain long term funding to employ a Nurse Practitioner for systematic support and intervention for residential aged care residents in the Otago region who are experiencing a mental health related issue. Ultimately the proposal is about acknowledging that we need additional capacity in the system for this population. This is in keeping with Health of Older People strategy and Te Kokiri the Mental Health strategy within a population based approach. The purpose is prevention of admission to hospital and facilitating continuous quality care thorough the health care system and its various settings to ensure people remain as well as possible in their community setting for as long as possible. It is aimed at reducing current gaps between sectors in Mental Health Services for Older People, by improving access to care through a more responsive service with a high degree of continuity of care, while achieving cost savings through reduced admission rates and length of stay.

The investment proposed in this case is 1.0FTE Psycho-geriatric Nurse Practitioner position. The costs of employing a Nurse Practitioner would be offset by utilising an existing FTE vacancy. Further savings will be potentially realised though reduced bed day stays and bed closures as bed usage decreases.

Background

The Nurse Practitioner Role

Whilst Nurse Practitioner positions are relatively new in New Zealand they are well established in other countries, for example the United States of America and Canada. There is no evidence to show that Nurse Practitioner services are detrimental to consumer care. Numerous peer-reviewed journal articles and studies on Nurse Practitioners have been published over the last 50 years, including government reports (Ministry of Health 2002). The research clearly supports the positive and cost-effective contribution of the Nurse Practitioner role for patients, employers and purchasers of health care services. In the late 1990s the New Zealand Government recognised the potential that existed within the experienced nursing workforce and realised the potential the Nurse Practitioner could play in delivering the Government's priorities for health (Ministry of Health 2002, NZ Health Strategy). One of the significant advantages of Nurse Practitioners is that they have the capability to lead service delivery and deliver services across the traditional boundaries of specialties and settings.

The Ministry of Health now considers Nurse Practitioner roles will be an integral part of the sustainable health care workforce, providing a comprehensive range of services to particular populations. It believes there are excellent opportunities for Nurse Practitioner services to become embedded in the health and disability service delivery environment. Amongst the Nurse Practitioner positions now well-embedded within District Health Boards (DHBs), there is a variety of different kinds of employment arrangements emerging. The Ministry of Health's website (Ministry of Health 2006) outlines case studies identifying different Nurse Practitioner positions and arrangements. These case studies show how Nurse Practitioners have the potential to assist with improving the health of New Zealanders and reducing the burden of illness and chronic disease.

The development of the Nurse Practitioner role in New Zealand is based on some of the following guiding principles:

- Nurse Practitioners work towards health gain to address and reduce inequalities and inequities in health.
- The role of the Nurse Practitioner is centred on patient and population needs and improving health outcomes.
- Population health status will drive the provision of Nurse Practitioner services
- It is acknowledged that development of the role of the Nurse Practitioner challenges the traditional boundaries of nursing practice. Whilst the role of the Nurse Practitioner will mostly complement the role of other health professionals it will inevitably overlap in some areas. This will enable substitution between groups to occur and thus promote efficiency and flexibility in the use of valuable resources (Ministry of Health 2002).

Nurse Practitioner roles are most likely to develop in areas where there are gaps in service delivery. Because of the advanced and additional skills within the Nurse Practitioner role (see appendix 1), which include the incorporation of some skills which have been considered exclusive to the domain of medicine for many years, collaborative Nurse Practitioner roles will develop in areas where there are shortages of medical staff and consultants.

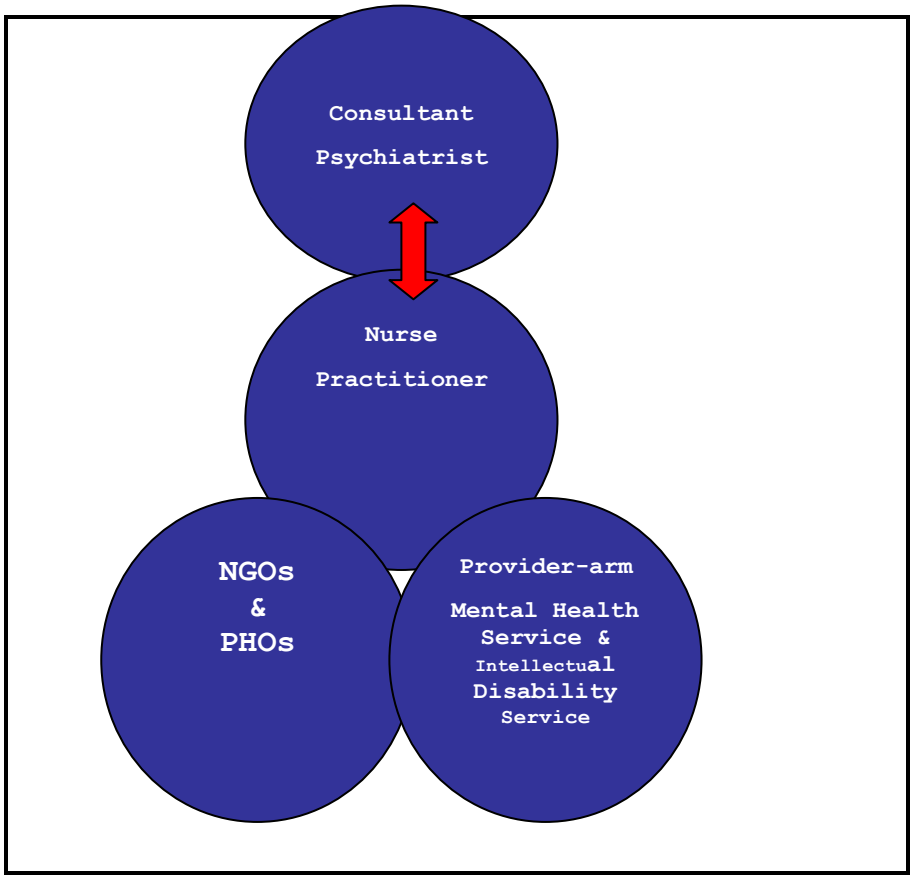
ODHBs Mental Health Services Nurse Practitioner Strategy

The Otago District Health Board's Mental Health Service (MHS) was quick to see the potential of the Nurse Practitioner role. In 2003 the Mental Health Service's *Nurse Practitioner Working Party* was developed to explore the potential of the role within the service. A *Strategic Planning* document was developed which identified service gaps within the mental health service and then identified opportunities for the service through the development of Nurse Practitioner roles. The gaps/areas of need were identified as being rural Mental Health Services, dual diagnosis of mental health and intellectual disability and consult/liaison services with the primary care teams. Whilst identifying potential Nurse Practitioner positions and the benefits they could provide within the MHS the development of roles has been limited to clinicians gaining the Nurse Practitioner registration. Whilst there were 6 clinicians identified who were someway towards gaining the Nurse Practitioner registration, to date we have not seen them gain the Nurse Practitioner registration. However, there are two nurses employed in trainee Nurse Practitioner positions in Primary Health Care who are close to gaining the Nurse Practitioner registration.

ODHB Current Nurse Practitioner Position

The current Nurse Practitioner role within the MHS is in the area of dual diagnosis (intellectual disability and mental health). The mental health service is contracted to provide a mental health service to people with an intellectual disability who present with conditions that meet the secondary services entry criteria. The Nurse Practitioner position was developed primarily due to a lack of experienced clinicians within this specialised area of mental health, in particular consultant psychiatrists. Consistent with the core principles discussed above, the role was developed as a direct result of a service gap/need, with the position requiring skills that would once have been possible only through the employment of a doctor. Appendix 2 shows the scope, responsibilities and skills of the current Dual Diagnosis Nurse Practitioner position.

The Dual Diagnosis Nurse Practitioner position operates within a collaborative model (demonstrated below) where the Nurse Practitioner and consultant psychiatrist work together. The Nurse Practitioner meets with the consultant psychiatrist 1 – 1.5 hours per week to manage the population of people / caseload. This time is used for supervision/mentoring and any patient contact required by the consultant.



The role was first piloted and then made permanent after it showed positive outcomes, some of which are shown below:

- Decrease in length of waiting time to access specialist assessment / consultation
- Significant decrease in number and length of consultations with psychiatrist (in excess of 85%).
- Decrease in relapse and admission rate due to more responsive service, timely interventions and increased capacity of non-governmental organisations (NGOs) to manage appropriate interventions within the community.
- Decrease in length of admission times due to comprehensive community follow-up by Nurse Practitioner.
- Decreased use of the Mental Health Act
- Increase in contact with Primary Health Care Clinicians (GPs/Practice Nurses) for dual diagnosis patients.
- Increase in education, mentoring and supervision provided to NGO staff.
- Increase in education provided to other DHB health professionals / services

Current Proposal

It is envisaged that there are many similarities between the already established Dual Diagnosis Nurse Practitioner role and the current proposed role of a Nurse Practitioner position in Mental Health of Older Person's services, as many of the needs will be similar, particularly in relation to the need to support the Consultant Psychiatrists role and to strengthen the skills within NGOs (ie Aged care Facilities) and GPs.

Current Situation Older Persons Health

International research shows us that Nurse Practitioners can enhance the care of older people in residential aged care. A randomised/controlled trial from the United States found that Nurse Practitioners reduced hospital admissions by approximately 50%, and it was estimated that each Nurse Practitioner saved $103,000 (Net USD) per year in health care costs (Kane, 2003). Data from a Canadian study of Nurse Practitioners working in residential aged care facilities in Ontario demonstrated that Nurse Practitioners played an important role in preventing unnecessary hospital admissions (Ontario Ministry of Health and Long Term Care, 2002). Results suggest that between 30% and 65% of cases would have been transferred to hospital without the Nurse Practitioners involvement.

An evaluation of Nurse Practitioners working in a U.S. Medicare Health Maintenance Organisation (HMO) serving exclusively nursing home residents found that by simply being present in the residential aged care facility on a regular basis, the Nurse Practitioner developed relationships with facility staff that improved identification of early changes in residents' status and monitoring of ongoing treatment (Kane et al., 2002). The study concluded that the Nurse Practitioner in residential aged care serves as an extension of primary health care services, providing both medical services and a coordinator/case manager role.

To date in New Zealand we have only one Gerontology Nurse Practitioner outreach service. This service operates within the Waitemata District Health Board (WDHB). The Nurse Practitioner outreach service was piloted because of the impact the Residential Aged Care population was having on acute services within the WDHB. A review of WDHB hospital admissions from residential aged care from October 2005 through September 2006, demonstrated the following (Boyd 2006):

- The average acute hospital length of stay for all people over 65 years is 3.5 days, compared to 4.9 days for those over 65 admitted from residential aged care. For those patients being admitted into residential aged care directly from a hospital stay, the length of stay is 8.6 days.
- On average, there are approximately 24 acute care beds utilised daily by all subsidised and non-subsidised RACF residents. This represents roughly three quarters of the beds of one acute care ward.
- There is 10% hospital mortality for older people admitted from residential aged care, compared with 1% hospital mortality of all people over 65 admitted to acute care services .
- Acute care utilisation by aged care residents converts to an approximate annual cost of $5,256,000.
- An audit completed by the Assessment, Treatment and Rehabilitation (AT&R) gerontology nurse specialist of WDHB admissions in August 2006 from residential aged care found the most common primary reason patients were admitted to hospital was shortness of breath and pneumonia (33%), followed by

dementia/delirium (25%), falls, and COPD.

Following the implementation of the pilot Nurse Practitioner Gerontology outreach service an evaluation was done with local Residential Aged Care Facilities (RACF's.) Admissions to hospital, emergency department contacts and hospital length of stay were compared for the three months in the previous year to the three months during the pilot of the local RACFs the Nurse Practitioner was working with. The results showed a decrease in all aspects of acute care utilisation - see table 1

Acute Care Utilisation Waitemata DHB

Period	ED	Admissions	Average LOS
1. Nov. 05 to Jan 06 Pre pilot	37	26	6.7
2. Nov 06 to Jan 07 Pilot Period	25	20	3.3

(Boyd 2006)

The implementation of the Gerontology Nurse Practitioner position in the WDHB showed positive outcomes. The position has now become permanent.

Current Situation in Otago

We know from the 2001 census that the percentages of elderly in NZ is increasing disproportionate to the younger population. This disproportion is greater in Otago then in the remainder of NZ and is expected to continue. At the 2001 Census:

- 14.0 percent of people in Otago Region were aged 65 years and over compared with 12.1 percent for all of New Zealand.
- In 2001 12% of New Zealand's total population was aged 65 years and over and this is expected to increase to 19% by 2021

It is likely that there are many similarities between the WDHB and our own DHB. In fact the Average Length of Stay (ALOS) in the ODHB for three months Jan-March 2007 is higher than the WDHB statistics:

ODHB Services for Elderly People's Health

ALOS January – March 2007

- General ALOS – 5.06 days
- ALOS Without 6C -4.74 days
- Care of Older People
  - 6A – 18.5
  - 6B – 17.76
  - 6C - 26.3

The following anecdotal evidence suggests there is a consensus among senior clinicians within the ODHBs Older Person's Mental Health Services about the benefits of a Nurse Practitioner role and the gaps in services for Older People's Mental Health within the region.

For its population the ODHB region should have at least two Psycho-Geriatric Consultant. One Consultant position has been a long term vacancy . The current consultant feels stretched and finds it necessary at times to practice in a less than preferred way, for example, consultations by telephone. The current Consultant is supportive of a collaborative Psycho-Geriatric Nurse Practitioner role being established and believes the role will contribute positively to filling gaps across the sector.

The Charge Nurse on Ward 6C and nurses in the community state they need clinical follow up for clients recently discharged from the hospital to evaluate drug response, behaviour changes related to the medications and

adaptation back to the community setting. The benefits of having a proactive service operating within the RACFs is also acknowledged. The following recent event demonstrates this need;

Case study

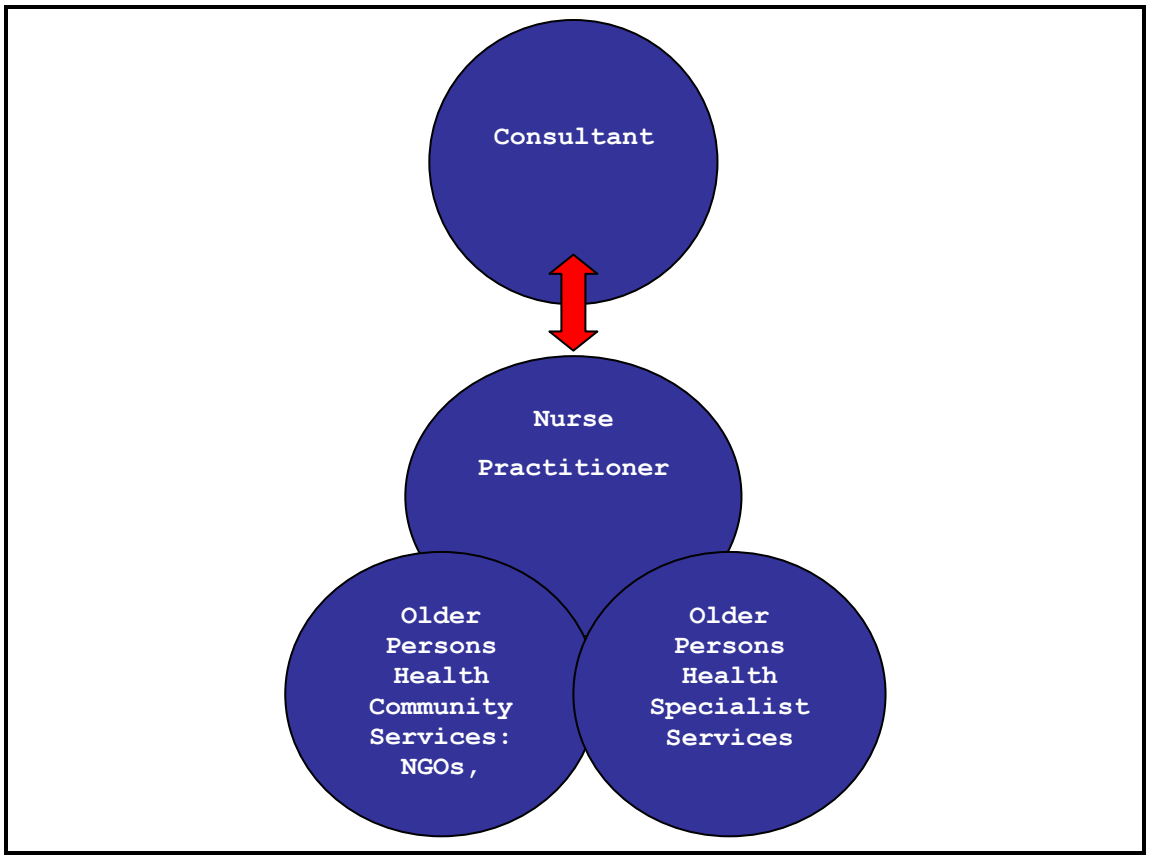
A nurse manager of a D-4 rest home caring for a person recently discharged from the public hospital repo the resident was exhibiting side effect from the psychotropic medications. The GP requested that th manager call the psychiatric registrar, who told the nurse manager that this was a low dose of medica could be prescribed at a much higher dose. A couple of days later the Consultant called and reduced because of the side effects. Fortunately the nurse manager and staff were able to convince the client to with the medication and narrowly avoided another hospitalisation. This client had a history of refusing me and then required re-hospitalisation. This personal account demonstrates the need for more service homes.

GPs in the community also state there is a desperate need for Psycho-geriatric support of the elderly in rest homes because of the lack of access to specialist consultants. The GPs prescribe to the best of their ability and the client frequently ends up in hospital. Rest home residents' GPs are required to review their condition and medication every 3 months. If the GP doesn't make weekly visits to the rest home, acute care needs are met by telephone consultations or by visits to A&E. Such practice causes increased heath care costs, when many of the problems could be addressed in the rest home by a Nurse Practitioner.

The current proposal is aimed at reducing current gaps between sectors in Mental Health Services for Older People, by improving access to care through a more responsive service with a high degree of continuity of care, while saving costs through reduced admission rates and length of stay. The purpose of the position is:

- To increase the integration of services for Older Person's Mental Health across the DHB Older Person Health Services and Residential Aged Care Facilities (RACF). Principally, this position seeks to incr capability of Residential Aged Care Facilities to proactively identify and intervene for common geriatri thereby reducing the incidence of preventable acute admissions.
- Prevent hospital admissions, emergency department consultations and decrease the length of sta hospital admissions are unavoidable.
- Increase early, proactive assessment and intervention of common geriatric issues in Residential Ag Facilities and build capacity to manage more complex interventions within the facility.
- Promote partnership and improved integration across primary/community and secondary services for Re Aged Care residents and those discharged from hospital to residential aged care.
- Promote an increased alliance with Residential Aged Care nurses and caregivers
- Develops and influences education, health policies and clinical standards/practice at a service and loca Older People's Health and Nurse Practitioner issues.
- The specific aims include:
    - Taking clinical responsibility for people with dementia, delirium, serious mental illness and those p with significant challenging behavior, through the development of a collaborative triaging model consultant psychiatrist.
    - Developing educational packages, protocols and guidelines for common geriatric issues (phys mental health related) that can contribute to mental health and functional decline for those in re aged care. This will include issues around medication and side-effects
    - Providing targeted gerontology education and clinical coaching/mentoring for residential aged care caregivers and Primary Health Organisation (PHO) staff.
    - Affirming life and regarding dying as a normal process and supporting patients, residential aged ca and families with end of life decisions.

This would be achieved through a model similar to the already established ODHB Nurse Practitioner role:



Alignment with Ministry of Health Strategies

The current proposal aligns with the Ministry of Health's strategies and priorities for Older Person's Health and Mental Health. The Older Person's Health strategy and the Positive Aging Strategy (Ministry of Health 2001) are aimed at developing an integrated approach to health and disability support services that is responsive to older people's varied and changing needs. This approach should mean that an older person is able to access needed services at the right time, in the right place and from the right provider. Providers work closely together, and, where appropriate, with families, whanau and carers. Services and programmes in the continuum may include health promotion, preventive care, specialist medical and psychiatric care, hospital care, rehabilitation, community support services, equipment, respite care and residential care.

The current Mental Health strategy/plan - *Te Tahuhu: Improving Mental Health 2005-2015* (2005) sets out several plans aimed at building mental health services (outside the provider-arm) by broadening the range of services and supports available for people affected by mental illness. Within this document there is a very strong emphasis on agencies working across boundaries. Of particular interest to this current proposal are the strategies within Te Tahuhu of "*Working Together*", "*Responsiveness*" and "*Primary Health Care*".

"Working Together" is aimed at "strengthening cross-agency working together" (pg. 18) – with immediate emphasis on strengthening the alignment between the delivery of provider-arm health services and the delivery of other government-funded services ie RACF. "Working together will mean that effective partnerships will need to be built between DHB providers, non-governmental organisations and PHOs/GPs".

The "Primary Health Care" strategy is aimed at building and strengthening the capability of the primary health care sector to promote mental health and wellbeing and to respond to the needs of people with mental illness. It outlines an immediate emphasis on, "building linkages between PHOs and other providers of mental health services to ensure integration occurs to meet the needs of all people with mental illness", and "strengthening the role of PHOs in communities to promote mental health and wellbeing and prevent mental ill health"

The "responsiveness" challenge reinforces the importance of services meeting the unique needs of specific population groups.

Rationale

We have strong evidence internationally and now from the WDHB to show that the role of a Nurse Practitioner can reduce hospitalisations and thus reduce costs. The data from Waitemata indicate 25% of hospital admissions for people over 65 are because of delirium. Prevention, diagnosis and treatment of delirium in the rest homes thus could significantly reduce hospital admissions and length of stay. The ALOS in ODHB care of the older person shows significantly longer stays than in the remainder of the hospital. After initiating a pilot project with Nurse Practitioners working in RACFs WDHB significantly reduced hospitalisation of residents from rest homes. The assessment of behaviour issues with concomitant care-planning has also been shown to reduce hospitalisations and transfers from one facility to another. WDHB data shows ALOS of patients who were admitted to rest homes after hospitalisation had twice the ALOS.

Providing educational resources and mentoring for RACF staff and families can also be instrumental in providing a higher quality of care and satisfaction and reducing hospital admissions.

Problem & Opportunity

The fundamental drive for change is the need to implement the Health of Older Peoples strategy and mental Health strategy, and the need to consider this in the context of the Ministerial directions also contained in the Primary Health Care strategy. By the very nature of the care they require, older people residing in the community, either in their own homes or in aged care facilities are at high risk for exacerbations of illness and health decline and therefore are at increased risk of admission to secondary services (Ministry of Health, 2002; Ashton, 2000). Keeping people well in a community setting by attention to what happens to them in the Primary Care setting, and other community settings such as residential care, decreases the pressure on acute services and allows these resources to be applied with increased efficiency. Currently attention focuses on managing the spend in acute services, without adequate attention to preventing people from getting there in the first place, and/or ensuring that their use of this resource is as limited as possible. Demand for secondary/specialist services will increase as the population ages – particularly within Older Peoples services. We currently have the opportunity to actively decrease unnecessary admissions and LOS within the ODHB, due to the availability of an experienced psycho-geriatric Nurse Practitioner, who is familiar with the provider arm and residential Mental Health of Older people sectors and who is familiar with working in a collaborative relationship with the current consultant.

Business & Operational Impacts

The introduction of a Nurse Practitioner role is envisaged to maximise the use of contracted beds and specialist clinician time by:

- Decreasing hospital admissions from residential aged care to acute care beds through early intervention and by improving capacity for complex nursing interventions in the Aged-care Residential Facilities
- Decreasing LOS for unpreventable admissions
- The comprehensive assessment and management of the physical and mental health of older people within the sector will be achieved by the Nurse Practitioner and consultant working collaboratively (rather than consultant having to see all clients)

Relationship development in both the primary care sector and residential care sector and the consequent ability to enhance services across settings for minimal investment is an anticipated impact of this proposal. There is also potential benefit to share resources, knowledge and expertise to enhance the capability of all settings to meet the

needs of this population. This is an opportunity to take a systems view of managing a specific population and to break down barriers to this at all levels.

Initiative Risk Assessment

There are very few risks associated with this proposal outside normal operational issues, with the most obvious risk being the cost of employing a Nurse Practitioner, however, the cost of maintaining more complex clinical interventions in the community are far less than the cost of maintaining a hospital bed.

Risk of Not Proceeding with Initiative

- Escalation in admissions and costs as aged care population increases.
- Potential increase in indirect costs due to increased prescribing.
- Nurse Practitioner leaves region and therefore skills and expertise lost to region
- Lost opportunity to promote partnership and improved integration across primary and secondary services.
- Lost opportunity to promote an increased alliance between mental health secondary services and residential aged care nurses and caregivers.
- Lost opportunity to promote workforce development for residential aged care nurses and caregivers los.

Cost Benefit analysis

Costs

These costs have been provided by the Business Analyst, based on the assumption that no cover is provided for leave, and a normal day shift is worked. A mid-range salary for Grade 8 Nurse Practitioner has been used, and no step or award increases have been factored in. Being a mobile position, the cost of leasing a car (1800CC Toyota Hatch) used for 70% of the time is included, this being more cost efficient than utilising a transport pool vehicle.

Salary of Nurse Practitioner	$ 87,081 (mid range)
Vehicle expenses	$ 6,194
Telephone expenses	$ 1,742
Information Technology	$ 1,620
Overheads	$ 18,264
TOTAL	$114,901

Savings/Benefits

Whilst the financial benefits of this proposal are perhaps not overtly robustly quantifiable, the relative cost of maintaining population wellness in the community is well established as being less, both in dollar terms and in quality of life terms, than admitting clients to an in-patient environment. It is clear that capacity in the system needs to be increased, and the data we have to date from Waitemata DHB and internationally on the efficiency of such a service demonstrates that building capacity within the community is much more cost effective than adding or maintaining beds.

Financial Benefits to ODHB Mental Health Service

- Potential decrease in bed numbers (25% in Waitemata)
- Preventing unnecessary admissions – potential savings in operational (direct and indirect costs)
- Increased capacity of Consultant Psychiatrist due to ability to spread clinical load
- Decreased use of the Mental Health Act

Patient Benefits:

- Improved health/mental health as a result of early intervention and by improving capacity for complex nursing interventions in this environment
- Decreased preventable geriatric mental health exacerbations

- Reduced disruption in care for clients and transfers between settings
- Reduced length of stay for unavoidable admission
- Improved multi-disciplinary care
- Decreased polypharmacy

Residential Aged Care Providers:
- Workforce development and empowerment
- Improved employee job satisfaction.
- Decreased after-hours transfers to hospital
- Decreased after-hours GP visits
- Improved protocol and guidelines for care/interventions
- Increased coordination/access to ODHB Mental Health of Older Person's Service

General Practice:
- Increased access to specialist psych-geriatric consultation
- Improved coordination with the multi-disciplinary team in primary and secondary care
- Enhanced assessment data reported by nurses and caregivers
- Improved systematic psycho-geriatric assessment data.

FTE availability:
It is acknowledged that as a new position, the FTE resource will initially be sourced from within existing services. Once established however, it is envisaged that the wide reaching benefits across the entire mental health in aged care sector will give rise to this position being resourced as new FTE as part of a Planning and Funding process.

A number of options have been considered for identifying initial FTE resources, including spreading the FTE across several cost centres where consistent high vacancies exist, however it seems more prudent to track the real resource usage where it occurs (Mental Health of Older People), being cognisant that while this may appear from a budgetary perspective to be outside available FTE, across the Specialist Portfolio it is expected to remain within limits.

While significant benefits are anticipated as detailed above, this will take time to be evidenced, and will not mean the physical presence /resource of the Nurse Practitioner within any one treatment setting. The cost of employing the expertise inherent in a Nurse Practitioner is greater than the cost of other nursing staff, necessitating greater than 1.0 FTE being utilised.

Current vacancies in Mental Health of Older People

Cost centre	Vacancies at 31 Aug 07		Budgeted cost per FTE	Total budgeted for vacanc
Ward 6c - 2507	RN	2.0	66,144	$132,208
	EN	0.4	54,329	$ 21,732
Day Hosp – 3655	RN	0.4	59,408	$ 23,763
Day Nursing - 4259	RN	0.6	65,109	$39,065
Total nursing resource avai	**3.4**			**$216,768**

- Average cost per FTE 63,755

As indicated in this table, sufficient resource currently exists within Mental Health of Older People to resource a Nurse Practitioner from existing FTE – on average cost, around 1.8 FTE would be needed.

It is currently difficult to attract nursing staff to Mental Health of Older People, and long term vacancies exist, particularly for Registered Nurses, resulting in a situation of staff shortage on ward 6c. Should recruitment efforts be successful, it will be important to retain the ability to employ to safe levels, and this needs to be acknowledged in approving this proposal.

Outcomes

It will be important to consider what data needs to be collected to evaluate the provision of the additional service

Conclusion.

The current proposal and service initiative is population focused, needs based and community oriented and is supported internationally by highly credible bodies such as the World Health Organisation under the principles of Primary Health Care. It also solidly supports our own national health system objectives contained in the Health of Older Peoples strategy, the Positive Aging strategy, the primary health Care strategy and Mental Health strategy. Whilst it has a primary aim of prevention of admission to hospital and emergency department visits, it is also based on the need for better integrated care across all care settings and improved residential care through nursing and caregiver education and training.

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Appendix

Appendix 1

New Zealand Nurse Practitioner Competencies

Competencies for the Nurse Practitioner[2]

1 Articulates scope of nursing practice and its advancement.

The nurse:

- defines the scope of independent/collaborative nursing practice in health promotion, maintenance and restoration of health, preventative care, rehabilitation and/or palliative care
- describes diagnostic enquiry processes responding to actual and potential health needs and characteristics of the particular population group
- explains the application/adaptation of advanced nursing knowledge, expertise and evidence based care to improve the health outcomes for clients across the care continuum within the scope of practice
- generates new approaches to the extension of nursing knowledge and delivery of expert care with the client groups in different settings.

2. Shows expert practice working collaboratively across settings and within interdisciplinary environments.

The nurse:

- demonstrates culturally safe practice
- uses advanced diagnostic enquiry skills
- develops a creative, innovative approach to client care and nursing practice
- manages complex situations
- rapidly anticipates situations
- models expert skills within the clinical practice area
- applies critical reasoning to nursing practice issues/decisions
- recognises limits to own practice and consults appropriately
- uses and interprets laboratory and diagnostic tests.

3. Shows effective nursing leadership and consultancy.

The nurse:

- takes a leadership role in complex situations across settings and disciplines
- demonstrates skilled mentoring/coaching and teaching
- leads case review and debriefing activities
- initiates change and responds proactively to changing systems
- is an effective nursing resource
- participates in professional supervision.

4. Develops and influences health/socio-economic policies and nursing practice at a local and national level.

The nurse:

- contributes and participates in national and local health/socioeconomic policy
- demonstrates commitment to quality, risk management and resource utilisation
- challenges and develops clinical standards
- plans and facilitates audit processes
- evaluates health outcomes and in response helps to shape policy.

5. Shows scholarly research inquiry into nursing practice.

The nurse:

- evaluates health outcomes, and in response helps to shape nursing practice
- determines evidence-based practice through scholarship and practice
- reflects and critiques the practice of self and others
- influences purchasing and allocation through utilising evidence-based research findings.

6. Prescribes interventions, appliances, treatments and authorised medicines within the scope of practice.

The nurse seeking prescribing rights:

- uses professional judgement to:

2.1 assess the client's health status

2.2 make a diagnosis

2.3 implement nursing interventions/treatments

2.4 prescribe

2.5 refer the client to other health professionals

- orders appropriate diagnostic tests, accurately interpreting the results and prescribing in accordance with these results
- collaborates and consults with, and provides accurate information to, the client, the client's family and other health professionals about prescribing relevant interventions, appliances, treatments or medications
- facilitates the client's access to appropriate interventions or therapies
- prescribes and administers interventions, appliances, treatments and medications (including vaccines) within legislation, codes, scope of practice and according to the established prescribing process and guidelines
- prescribes within a framework of current best practice, nursing knowledge and knowledge of pharmacology, physiology, chemistry, pathophysiology, pharmacokinetics and pharmacodynamics
- understands the use, implications, contra-indications, and interactions of prescription medications with each other and with alternative/traditional/ complementary medicine and over-the-counter medications/appliances
- understands the age-related implications of prescriptive practice on clients within the particular scope
- accurately documents assessments of the client's health status, diagnosis and decisions made about prescribed interventions, appliances, treatments, medications and referrals or follow-up
- evaluates the effectiveness of the client's response to the prescribed interventions, appliances, treatments and medications, and monitors decisions about prescribing, taking remedial action and/or referring accordingly
- demonstrates an ability to limit and manage adverse reactions/emergencies/crises
- recognises situations of drug misuse and acts appropriately
- understands the regulatory framework associated with prescribing, including the legislation, contractual environment, subsidies, professional ethics, and roles of key government agencies.

Appendix 2.

Scope of Practice: Dual Diagnosis Nurse Practitioner Position ODHB

SCOPE OF PRACTICE: DUAL DIAGNOSIS NURSE PRACTITIONER POSITION
BERNADETTE FORDE

Primary Patient group

- Adults (17 years and over) with a diagnosed intellectual disability and concurrent major mental illness (who meet the Adult Mental Health services entry criteria) and,
- Adults with an intellectual disability who have been prescribed psychotropic medication and require a medication review.
- Adults across the Mental Health service who have a significant physical health issue and who are not engaged with a Primary Health provider

Clinical Tasks and Responsibilities
Dual Diagnosis

- Has clinical responsibility for patients within the ODHBs mental health service with a dual diagnosis of major mental illness and intellectual disability
- Through case-management is responsible for each patient throughout their contact with the service from the initial contact/assessment through to recovery and discharge.
- Conducts comprehensive mental health assessments, orders and interprets laboratory findings; establishes differential diagnoses/diagnosis.
- Mental health assessments are comprehensive, including information from the client, their family/whanau and support providers
- Following assessment, plans and implements evidence-based interventions, which nay include the following:
  - Pharamcotheapy and medication management
  - Develops appropriate treatment / management plan (which includes Early Warning Signs, Crisis Management plans, Risk Management Plans) in conjunction with community service provider / NGO and/or family.
  - Counselling
  - Cognitive and/or Behaviour Intervention
  - Develops creative and innovative evidence-based approaches to clients with special needs or who present as complex cases
  - Health education, covering both mental health and physical health matters
- Admitting clients for in-patient treatment and working collaboratively with in-patient staff in shared care arrangement;
- Collaborates and consults with the client, family/significant others and other health professionals, providing accurate information and support about relevant interventions and treatments
- Establishes and documents the treatment plan, and throughout contact maintains records that are detailed, complete and in-line with organisational documentation standards.
- Operates within a framework of current best-practise
- Demonstrates culturally safe practice
  - Demonstrates respect within working relationships
  - Works in partnership with families, consumers and other clinicians
  - Invites, develops and maintains links with Te Oranga Tonu Tanga (Maori Mental Health Team)
- Works independently and interdependently:
  - Recognises limits to own practice and triages to the consultant psychiatrist appropriately
  - Refers to other disciplines as appropriate and works effectively in shared care arrangements with other clinicians – across both professional disciplines and services

- Evaluates the effectiveness of the client's response to interventions and treatments and makes changes and/or referrals accordingly.
- Determines when the patient has recovered/met goals
- Discharges the patient

General Mental Health

- Provides a consult-liaison service to other clinicians within the wider mental health service for patients with significant physical health problems who hare not enrolled with a PHO.

Consultation

- Works to bridge the gap between secondary and primary/ community-based care by providing consultation and co-ordination of care to:
  - Community staff /NGOs,
  - Families,
  - GPs / Practice Nurses

Other Relevant Health Professionals

- Works actively in the community to promote case reviews and medication reviews for people with intellectual disability.
- Supports community service providers to develop the necessary knowledge and skills to manage/support people with dual diagnosis to live well in the community

Health Promotion and Education

- Promotes the development of the Primary / Community Sector regarding Dual Diagnosis issues by providing education about mental wellness/illness, restoration of health, maintenance and preventative approaches to:
  - Community organisations/NGOs, families
  - GPs and Practice Nurses
- Provides specialist dual diagnosis education to clinicians within the mental health service

Leadership

- Provides clinical leadership within the Mental Health Service and the wider ODHB on:
  - Dual diagnosis issues
  - Aspergers
  - Intellectual disability
- Is an effective nursing resource
- Provides advise and education to clinicians about the Nurse Practitioner pathway
- Provides supervision and mentoring to expert nurses preparing for Nurse Practitioner registration
- Is actively involved in national groups for Mental health, dual diagnosis and Nurse Practitioner issues
- Participates in professional supervision
- Is actively involved in policy, quality and service development within the MHS. Initiates change within the MHS and responds proactively to change

Appendix Three

Example Nurse Practitioner: Mental Health Of Older Person's Service: Job Description

Otago District Health Board
Position Description

Position Title: **Nurse Practitioner: Mental Health of Older Person's Service**
Responsible to: **Service Manager**
Prepared/Reviewed: **Nurse Director and Nurse Practitioner, May 2007**

Organisation Structure

- The role of Nurse Practitioner reports to the Service Manager for all operational and line management issues.
- Functional relationships are between all providers of Older People's Mental Health and Older People's Health Services.
- The professional relationship is between the Nurse Director of Mental Health Services and the Executive Directors of Nursing of ODHB.
- Professional Accountability is to the Nursing Council of New Zealand.

Position Holder's Name: **Signature:** _____**Date:**_____

Manager's Name: **Signature:** _____**Date:**_____

Purpose of the Position

- To increase the integration of services for Older Person's Mental Health across the DHB Older Person's Mental Health Services and Residential Aged Care Facilities (RACF). Principally, this position seeks to increase the capability of Residential Aged Care Facilities to proactively identify and intervene for common geriatric issues, thereby reducing the incidence of preventable acute admissions.
- Prevent hospital admissions and decrease the length of stay where hospital admissions are unavoidable.
- Increase early, proactive assessment and intervention of common geriatric issues in residential aged Care Facilities
- Promote partnership and improved integration across primary and secondary services for Residential Aged Care residents and those discharged from hospital to residential aged care.
- Promote an increased alliance with Residential Aged Care nurses and caregivers
- Develops and Influences Education, Health Policies and clinical standards/practice at a Service and local level Older People's Health and Nurse Practitioner issues.

- The specific aims include:
  - Takes clinical responsibility for people with dementia, delirium, serious mental illness and those presenting with significant challenging behaviour, through the development of a collaborative triaging model with the consultant psychiatrist.
  - Develops protocols and guidelines for common geriatric issues (physical and mental health related) that can contribute to mental health and functional decline for those in residential aged care.
  - Provides targeted gerontology education and clinical coaching/mentoring/supervision for residential aged care nurses, caregivers and PHO staff

1. Articulates Scope of Nursing Practice and its Advancement, and 2. Shows Expert Older People's Mental Health Clinical Practice Working Collaboratively across Settings and within Interdisciplinary Environments	
Accountabilities	Performance Measures
Takes clinical responsible for older clients with dementia, significant behaviour issues, delirium, and/or major mental illness from initial contact through to recovery and discharge back to the community, through: • The provision of advanced gerontology assessment • the development of a collaborative triaging model with the consultant psychiatrist. 1. Clinical practice and performance will be consistent with Nurse Practitioner competency 2 2. Will have a caseload of around 40-60 clients 3. Will establish an outreach service to Residential Aged Care Facilities (RACF). 4. Consults appropriately, facilitating the client's access to appropriate services and interventions. 5. Where appropriate will have shared care arrangements with clinicians in the Older People's Health service. 6. Where appropriate will undertake role of Responsible Clinician under the MHA	• Scope of Practice document / Peer review attesting to advanced nursing practice • Number of clients on case load • Number of out-patient clinics held • Number of consultations with clients, family/support staff and other health professionals • Number of contacts with consultant and evidence of decrease in consultants waiting list • Decrease in waiting list for assessment and follow-up appointments • Decrease in hospital admissions • Evidence of referral to appropriate clinicians / services • Evidence of positive shared-care arrangements/relationships • Client and family/NGO satisfaction surveys • Evidence/record of ongoing supervision

2.A, Promotes the Development of Health Services for Older People's health within the Primary Sector	
Accountabilities	Performance Measures

Has a strong preventative and promotion perspective focusing on Older People's physical and mental health.
1. Provides targeted gerontogy education and clinical coaching / mentoring to Residential Aged Care Nursing staff, PHOs (GPs and Practice Nurses and NGOs, family/whanau.
2. Education and mentoring will have a focus on mental wellness, restoration of health, maintenance and preventative approaches and will be aimed at supporting Aged Care Nursing staff and PHO clinicians to develop the necessary knowledge and skills to manage/support people with experience of dementia and other mental illness back in the community.
3. Develops protocols and guidelines for common geriatric issues that can lead to health and functional decline for those in residential aged care.
4. Works actively in the community to promote case reviews and medication reviews for people who are prescribed anti-psychotic medications.
5. Co-ordinates and supports the transition back into the community clients who have required an in-patient assessment. This will include liasing and education with PHOs and, NGOs/family's, significant others.
	• Number of education sessions provided to the community.
	  • PHOs – GPs and Practice Nurses
	  • Residential Aged Care (RAC) staff
	  • Families
	  • Other Health Professionals
	• Evidence of clinical contact with PHO clinicians , RAC Staff and Families
	• Evidence of medication reviews completed – decreased polypharmacy
	• Evidence of coordination to transition clients post hospitalisation

3. Leadership	
Accountabilities	Performance Measures
1. Provides clinical leadership within the ODHB regarding; • Dementia, delirium and major mental health disorders • Nurse Practitioner issues 2. Contributes to and participates in service development and professional activities in the Older People's Mental Health Service 3. Is an effective nursing resource in specialised scope and advanced nursing 4. Participates in professional supervision 5. Initiates change and responds proactively to changing systems	• Evidence of clinical consultancy with clinicians and other services • Evidence of involvement in service development meetings/groups/projects • Evidence of involvement in Nurse Practitioner developments at both a local and national level. • Attendance at the Nurse Practitioner New Zealand (NP) Professional Development Days - bi-annually and Older People's Heath Service meetings • Evidence of mentoring/coaching and provision of supervision

4. Develops and influences health policies and practice at a service, local and national level	
Accountabilities	Performance Measures
1. Contributes to and participates in service development, clinical standards and policy in the Older People's Health services – both community and hospital based services. 2. Demonstrates commitment to quality improvement activities within the service 3. Actively participates in education and teaching within the mental health service aimed at providing quality service provision	• Evidence of involvement in service and policy development • Evidence of involvement in quality improvement initiatives within the organisation • Evidence of working to improve client, family, RAC satisfaction • Evidence of attendance and presentation at local, national and international conferenc • Number of Education sessions provided in the Older People's Mental Health Service • Attendee feedback • Attends the Older People's Health conference annually • Evidence of encouraging clinicians to demonstrate evidenced-based practice • Evidence of fostering a culture of inquiry and reflection.

5. Competency Five - Shows scholarly research inquiry into nursing practice	
Accountabilities	Performance Measures
1. Evaluates health outcomes, and in response, helps to shape nursing practice / service delivery 2. Determines evidence-based practice through scholarship and practice. 3. Reflects and critiques the practice of self and others 4. Increases interest and activity related to research and evidence-based practice in the mental health service. 5. Evidence of involvement in research related activities	• Evidence of shaping policy and service provision based on outcomes. • Evidence of ongoing evidence-based education • Evidence of reflection on practice • Evidence of encouraging colleagues to demonstrate evidenced-based practice

Generic Criterion	
Health & Safety	
Accountabilities	*Performance Measures*
To participate in and comply with the requirements of the Health & Safety in Employment Act 1992 and associated OD policies	Work practices ensure safety for self and others Advice or assistance is sought before commencing an unfamiliar work practice Hazards are identified, control plans documented, and hazards eliminated, minimised or isolated Comply with Otago DHB incident reporting policy and Health & Safety Policy Emergency management procedures and compulsory / compliance education and training completed. Demonstrates knowledge of the health and safety database
Risk Minimisation	
To actively contribute to Risk minimisation activities within the serv	• Contributes to the service's risk minimisation activities by: • Identifying risks • Notifying the manager of these • Participating in the service's risk minimisation activities • Complying with Otago DHB policies, procedures, protocols and guidelines • Participating in audits
Team Member	
Individual responsibilities actions and contributions enhance the success of the area/service/team and division	• Builds and maintains productive working relationships • Participates as a member of designated group(s) • Values individual effort, innovation and creativity
Treaty of Waitangi	• Works in a way that demonstrates: • Partnership and shared decision making with Māori • Participation and consultation with Māori • Protection of Māori needs, values and beliefs

Relationships

Internal:

- Clients / Family / Whanau / NGOs
- Nursing staff & Multidisciplinary team
- Service Manager
- Nurse Director

External:

- Primary Health Care Providers

Person Specifications

Credentials

Essential:

- New Zealand Nurse Practitioner Registration.
- Current practising certificate
- Current driver's licence