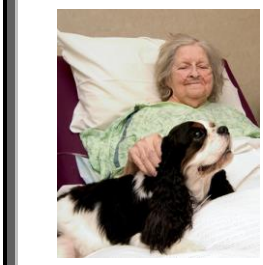
EVALUATION REPORT

Nurse Practitioner Role in Mental Health Services for Older Person's



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Nurse Practitioner Position in Mental Health of Older Person's Service: Evaluation Twelve-months on.

The Nurse Practitioner (NP) role in Mental Health of Older Person's service has been established for 12-months and therefore it is timely to evaluate the development of the position.

Introduction

After understanding the potential of the NP role, the Mental Health Service developed the first NP position in 2004 to manage the group of patients who have both a developmental disability and a major mental health issue. After seeing the benefits of this dual diagnosis NP role it was recognised that there could be significant benefits for NP positions in other areas of mental health, particularly those areas where there were gaps in service provision, for example, gaps caused by a shortage of medical staff. Fitting this bill was the Mental Health of Older Person's Service (MHOPS) which was struggling to implement the Ministerial directions in the Health of Older Peoples strategy and Primary Health Care Strategy in relation to early intervention and prevention aimed at keeping people well in the community setting. 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). The Ministry of Health (MoH) identified that in order to decrease pressure on acute services in the future and therefore allow resources to be applied with increased efficiency it would be crucial to keep people well in the community setting by attention to what happens to them in the Primary Care and residential care settings. When developing and promoting the NP role the MoH recognised the valuable role that NPs could play in this area.

At the point of the proposal/business plan for an NP position in MHSOP, attention was focused on managing the spend in acute services, without adequate attention to preventing people from getting there in the first place. It was envisaged that an NP role could support a changing direction and move some of the focus to preventative care in the community thereby keeping people well in their community setting and preventing acute hospital admissions

The following combination of factors saw the development of a second NP role (the subject of this report) in 2007 in the MHOPS:

1. **Demographics and statistics for the elderly population in NZ** which showed percentages of elderly increasing disproportionate to the younger population and this disproportion being greater in Otago than in the remainder of NZ. Without a change in service provision and a shifting of focus to preventative work in the community setting the projection was for a substantial increase on acute mental health for older people's services in the future.
2. **A gap in the ODHB Older Persons Mental Health Service**. A position for a Psycho-geriatric consultant had been vacant for several years with the current consultant "feeling stretched and finding it necessary at times to practice in a less than preferred way, for example, consultations by telephone (Business Plan 2007)". Due to a lack of community focus and suitably skilled staff there was no linkages between the provider-arm MHOPS and the Residential Age Care Facilities (RACFs) i.e. Rest-homes. Therefore no alignment

with Te Kokiri and Te Tahuhu's strategies of "Working Together"; "Primary Health Care" and Responsivenss:

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

3. **The availability of an experience NP** who had immigrated from America with thirty years experience in the area of psycho-geriatrics and who was familiar with both the provider-arm Mental Health of Older Person's service and RACFs.

Business Plan

A Business Plan for an NP position was presented which was ultimately about acknowledging the need for additional capacity in the system for this population. The proposal was aimed at reducing current gaps in MHOPS, by improving access to care through a more responsive community-based service with a high degree of continuity of care, while saving costs through reduced admission rates and length of stay. The purpose of the proposal was:

- *"To increase the integration of services for older person's mental health across the DHBs Older Person's Mental Health Services and Residential Aged Care Facilities (RACFs). Principally, this position seeks to increase the capability of RACFs to proactively identify and intervene for common geriatric issues, thereby reducing the incidence of preventable acute admissions.*
- *Prevent hospital admissions, emergency department consultations and decrease the length of stay where hospital admissions are unavoidable.*
- *Increase early, proactive assessment and intervention of common geriatric issues in RACFs and build the capacity of RACFs to manage more complex interventions within the facility.*
- *Promote partnership and improved integration across primary/community and secondary services for RACF residents and those discharged from hospital to residential aged care.*
- *Promote an increased alliance with RACF nurses and caregivers*
- *Develops and influences education, health policies and clinical standards/practice at a service and local level for 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 presenting with significant challenging behavior, through the development of a collaborative triaging model with the consultant psychiatrist.*
  - *Developing educational packages, protocols and guidelines for common geriatric issues (physical and mental health related) that can contribute to mental health and functional decline for those in RACFs. This will include issues around medication and side-effects.*
  - *Providing targeted gerontology education and clinical coaching/mentoring for RACF nurses, caregivers and Primary Health Organisation (PHO) staff.*
  - *Affirming life and regarding dying as a normal process and supporting patients, RACF staff a families with end of life decisions (Business Plan 2006)*

Evaluation and Outcomes

This evaluation will be based on the "Potential Benefits" that were outlined in the Business Plan and on "Performance Measures" from the NP Job Description developed for the role. Because of some repetition amongst categories this report has clustered the perceived benefits for the purpose of evaluation.

Problem Identification based on the Business Plan/Proposal

Gap in psycho-geriatric service provision

1. No effective alliance/relationships between provider-arm Mental Health for Older Person's Service and Residential Aged Care Facilities.
2. Lack of nurse mentoring and opportunities for clinical supervision in RACFs from advanced clinical practitioners.
3. Long-term unfilled psycho geriatrician position leading to:
    - Overworked psychiatrist
    - Long response time for New Assessments and Follow-up visits
4. Acute admissions for potentially preventable geriatric mental health exacerbations due to non-responsive service

Functioning of the NP Role

The primary function of the NP role is through case-management and consultancy as follows:

- **Clinical Case-management and Consultancy**: All RACF referrals into MHSOP go directly to NP who then takes clinical responsibility for this group
    - Assessment, including ordering and interpreting laboratory tests/findings
    - Establishes/considers diagnosis / differential diagnoses
    - Management
        - Autonomous case management, consulting with/triaging to the psychiatrist (other disciplines) as necessary
- **Teaching & Mentoring**
    - Provide coaching, teaching, mentoring to RACF / PHO staff to develop their capacity and capability re early intervention and management of this population group.
    - Development and implementation of evidence-based protocols and guidelines

Promoting partnership and improving integration between secondary and community/primary services:

1. Partnerships with Residential Age Care Facilities:

- Dunedin City: There are 26 RACFs in Dunedin.
    - To date Liz has developed links with all 26 RACFs in the Dunedin and has regular contact with them. Some of these links are well developed and some are more recent.
- North Otago: Palmerston (1), Kurow (1); Ranfurly (1) & Oamaru (5) Total: 8 RACFs.
    - Liz has had one of contacts with the one RACF in Palmerston and two RACFs in Oamaru but has no capacity to follow-up.
- Central Otago – Roxburgh (1); Lawrence (2), Cromwell (1); Alexandra (2); Wanaka (1); Total 7
    - Liz had had contact with one RACF in Alexandra, but as above nil capacity for regular follow-up.
- South Dunedin Milton (1); Balclutha (2) Total 3

- Liz has had one contact with the RACF in Milton and one of the RACFs in Balclutha. Consistent with above no capacity to expand regular follow-up into the rural setting

- **Southland**: There appears to be significant gaps in Southland in mental health provision for older persons. There is no consultant psycho-geriatrician. Otago's consultant psycho-geriatrician is now running monthly clinics in Southland (with freed up capacity from the current NP position), however, this is not fulfilling the need and there is no ability within this role to stretch the service to the RACFs. There appears to be fragmentation between two departments who have some community nursing input into this area. It appears that there is no integration and limited collaboration between these services. Liz has made contact with the Southland service but has no further capacity within her role to provide any extension of service in Southland. There is significant scope for the development of partnerships or regionalisation between Southland and Otago in this area with the development of a further NP position.

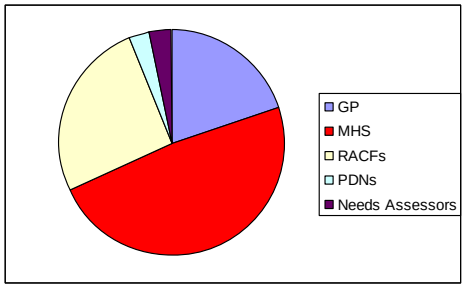
2. Partnerships with GPS and Practice Nurses

- Liz has had contact with 32 GPs this varies from regular to occasional contact, but this is increasing as time goes on with several GPs starting to make regular contact with her and also the development of a joint clinic with Dr Bulow at Ross Home once a fortnight.

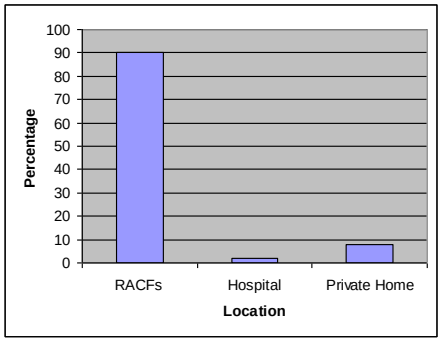
Referral & Assessments for first 12-month Period

- **Number of Assessment and Contacts**
  - New Assessments 162
  - Contacts – 1112

- **Referral Sources**



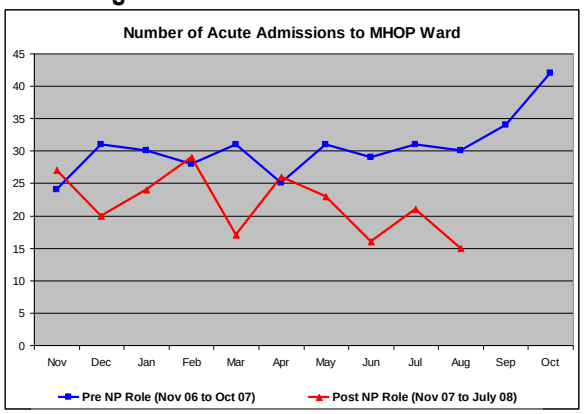
- **Location of Assessments**



Type of Contacts

- **Clinics in RACFs:** Are set at regular scheduled times mostly weekly or fortnightly
- **Frequency and Type of Contacts**
  - Intensive 3-5 visits per week,
  - Short-term,
  - Consult-liaison,
  - PRN

Preventing Admission



There has been a definite and significant decrease in hospital admissions since the commencement of the NP role. It has continued to show a downward trend, other than the month when the NP was on annual leave when there was a peak in admissions.
There have been several patients where it is fairly certain that there has been an avoided admission. The interventions that have prevented admission are:

- Managing delirium
- Managing dehydration
- End of life support
- Acute behaviour management

Length Of Stay

The relationship that has developed between the NP and the RACFs and the assurance of regular scheduled follow-up appears to be resulting in earlier discharge

Increased capacity of consultant psychiatrist

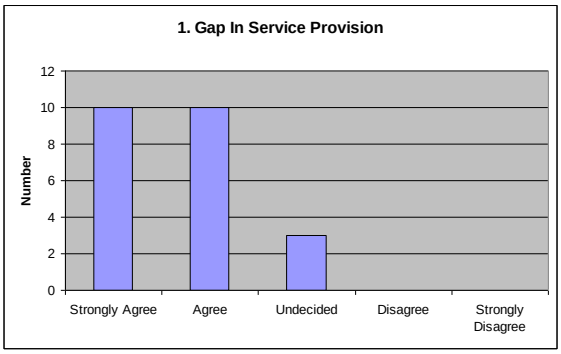
Feedback from the consultant psychiatrist (Dr Seifert) is that the NP position "has greatly relieved the demands on the frontline consultant psychiatrists with a notable decrease in admissions of pts. Patients now benefit from direct expert nurse practitioner care/contact - assessment and the development of management plans to assist the RACFs to maintain pts longer within their familiar territory. Many situations are resolved after single, care interventions, for example basic bladder & bowel care, or medication adjustments".

As outlined above the implementation of the NP role has allowed for some expansion of the consultant psychiatrists role into Southland.

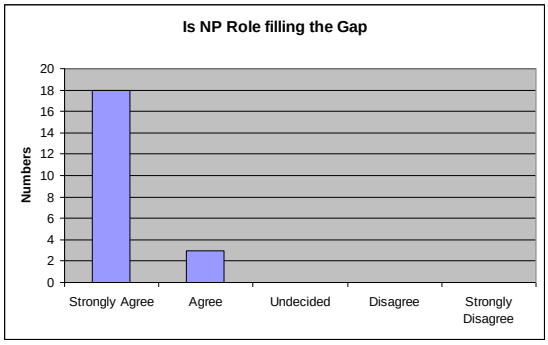
Survey from Residentail Aged Care Facilities

Of the 26 RACFs given questionnaires 21 responded representing a high response rate of 81.7%

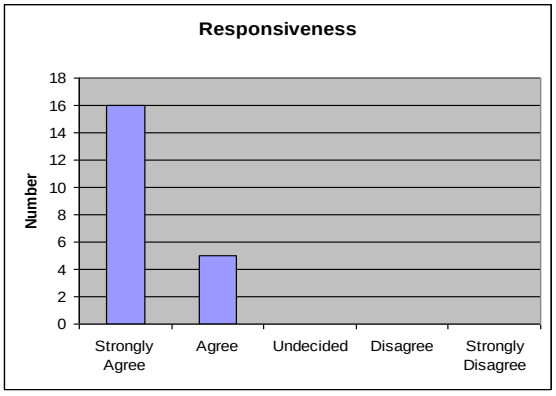
1. **Gaps in Service Provision**: Did you think there was a gap in specialist psycho-geriatric input into Residential Aged Care Facilities prior to Liz's role?



2. **NP Role filling the Gap**: If so do you think Liz's role is filling this gap?

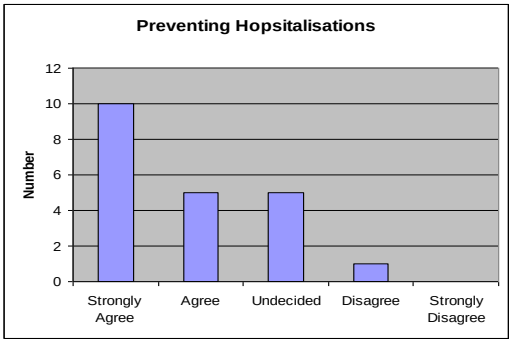


3. **Responsiveness**: Do you find the consult-liaison/follow-up service provided by Liz is effectively responsive?

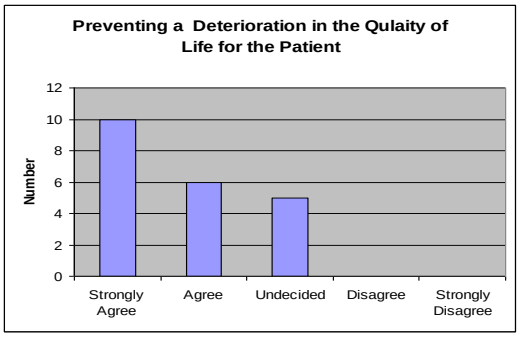


4. Prevention: Do you believe Liz's role has resulted in preventative interventions that have prevented a deterioration in a patients health/mental health that could have resulted in:

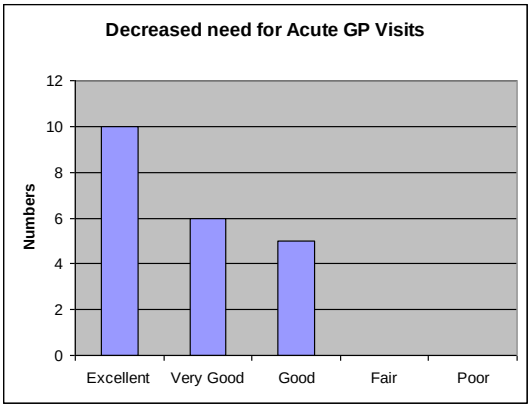
- An acute **hospital admission**?



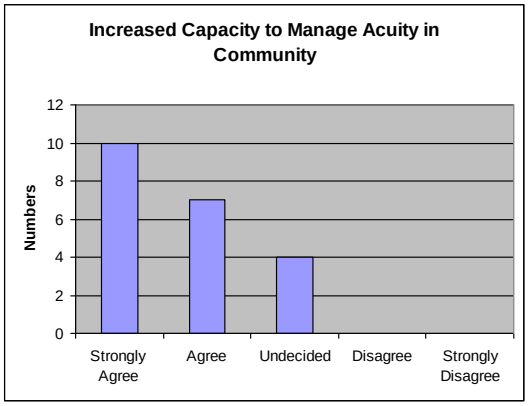
- A deterioration in **quality of life for a patient**?



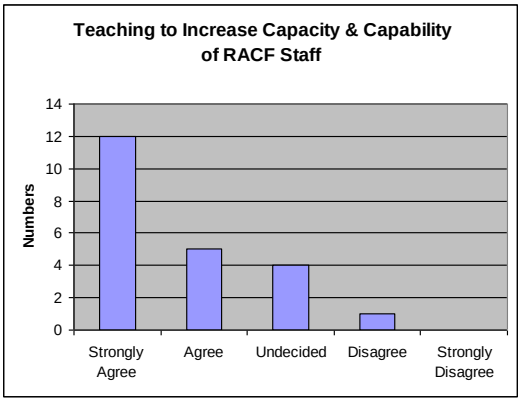
- **Decreased need for GP** visits?



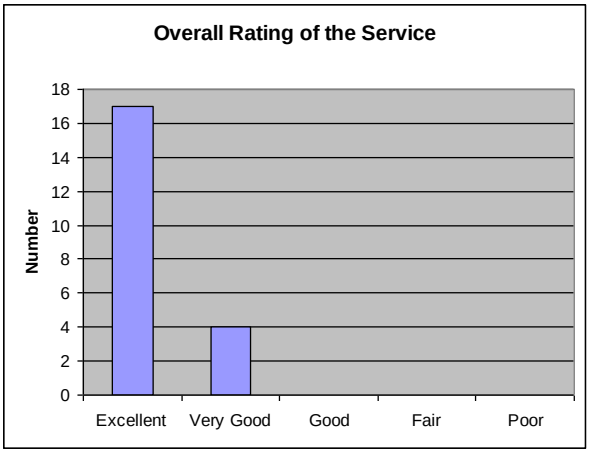
5. **Increasing the capacity and capability of RACF staff**: Do you believe that with Liz's support you are able to manage patients with more complex health issues which would have in the past required an acute hospital admission?



6. **Teaching & Mentoring**: Has Liz's role had a helpful in terms of informal teaching i.e. the teaching that is generated from individual patients and their treatment, in terms of increasing staffs knowledge and skills in your service organisation



7. Overall Rating of the Service



8. **Qualitative Responses**

- *Is there anything you would like Liz or the Service to do differently?*
  - Many comments about the definite need for the service with some comments stating that they believe there are more NPs needed in this sort of role
  - Ability to expand teaching time to increase the knowledge and skills of caregivers
- *Any other comments or feedback?*
  - There was numerous positive feedback on the service, in particular:
    - The responsiveness (promptness) and the availability of the service. RACF staff commented that they are able to page Liz and get an immediate response and any urgent issues are mostly able to be dealt with on the same day without the need for crisis intervention.
    - Mentoring role to RACF registered nurses is considered very valuable
    - Explanations are clear, understandable and able to be implemented without difficulty.
    - Teaching, especially in relation to behaviour problems and medication

Conclusion

The objectives of creating the NP position in MHSOP, as described earlier were to develop and promote effective alliances/relationships between provider-arm Mental Health for Older Person's Service and Residential Aged Care Facilities and the Primary Health Care teams. Through the formation of such relationships it was anticipated that nurses in the RACFs would receive mentoring and education aimed at increasing their capacity and capability to manage more complex clinical presentations With this increased capability and capacity it was envisaged that there would be significant benefits, firstly a better quality of life for the residents by prevention of acute exacerbations in their health through a prompt service. Secondly, by reducing admission rates into secondary services as a result of a responsive early intervention service. Another perceived benefit from the role was restoration of a reasonable work load for the consultant psychiatrist who had been stretched for many years.

In the first 12-months of the service commencing, the results of this evaluation have shown:

1. Admission rates have decreased
2. The development of an alliance and effective partnership between the provider-arm MHSOPs and RACFs
3. Development of a responsive early intervention service between provider arm- MHSOPs and RACFs
4. Provision of effective mentoring and coaching to RACFs registered nurses and nurse managers
5. Provision of some teaching to caregivers
6. The building of partnerships with the Primary Health Care clinicians

The Nurse Practitioner role has been successful at filling a gap in service provision in this area, however, there is no capacity for further expansion of the service within the current 1FTE NP position. Liz is currently working to maximum capacity. The following gaps/limitations remain:

1. Unable to provide a service to the rural areas
2. Education sessions to caregivers in the RACFs is limited and with additional time could become an integral part of the service.
3. Mentoring and coaching to RACF registered nurses only occurs within the context of the clinical visit – there is no time for formalised sessions.
4. It has been identified that there are major gaps in services in Southland that could significantly benefit from a nurse practitioner. There is no capacity to expand in this area in the future with only 1 FTE
5. Potential to develop the role more for people living in their own home. It may worthwhile exploring the current District Nursing function and role to explore whether there may be benefits for an NP in this area

Recommendation

The implementation of the NP role has been a great success; however there remains some gaps/limitations within the service and role. These gaps and limitations could be successfully filled by the development of a second NP role. Future planning should be given a priority as Liz will be retiring within the next five years (maybe less). There is a lot of sense in utilising her skills and knowledge by developing a Nurse Practitioner Trainee position. Such positions appoint a nurse who is well along the pathway in terms of his/her educational qualification. Whilst working under the supervision of the NP, the nurse is supported to complete their education and the Nursing Council assessment process. It is also worth exploring the possibility of Liz mentoring someone into an NP role in the Southland area, or considering a regional position under the Southern-alliance.