Australian Nursing & Midwifery Federation
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Travis Review

ANMF (Vic Branch) submission to the Travis Review statewide census of hospital and theatre capacity.

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Introduction

The Australian Nursing and Midwifery Federation (ANMF) was established in 1924. The ANMF is the largest industrial and professional organisation in Australia for nurses and midwives, with Branches in each state and territory of Australia.

The ANMF (Victorian Branch) represents in excess of 72,000 nurses, midwives and personal care workers (the latter predominantly in the private residential aged care sector). Our members are employed in a wide range of enterprises in urban, rural and community care locations and the public and private health and aged care sectors.

The core business for the ANMF is the representation of the professional, industrial and educational interests of our members and the professions of nursing and midwifery.

The ANMF participates in the development of policy relating to nursing and midwifery practice, professionalism, regulation, education, training, workforce, and socio-economic welfare, health and aged care, community services, veterans' affairs, occupational health and safety, industrial relations, social justice, human rights, immigration, foreign affairs and law reform.

The ANMF (Vic Branch) was delighted to be invited to make a submission to the second phase of the Travis Review. Our submission specifically addresses innovative models of care, with a focus on nurse-led innovations in healthcare that expedite and enhance patient care in public hospitals. We have identified several current innovations in care to improve and optimise existing and currently funded capacity across Victorian public hospitals.

Opportunities for system-wide capacity building

Each of the Branch's proposals improves the health processes surrounding patient care, reduces non-value adding activity and increases the efficiency and quality of care.

The approaches we recommend within Victoria to support hospitals drive innovation and systems improvement include expanding nurses' scope of practice (SoP) in emergency departments (EDs) and mental health services to reduce waiting times and increase bed capacity.

We recommend the introduction of criteria led discharge (CLD) from nurses. A CLD model has been introduced at the Royal Children's Hospital and has seen a dramatic reduction in discharge wait times for patients ready to go home and not needing medical review.

Increasing the utilisation of Nurse Practitioners (NPs) in emergency and outpatient departments, as well as in the role of liaisons between outpatient/inpatient, community and aged care services, has proven to reduce emergency department admissions and goes some way to addressing issues with acute and chronic aged care patients that may not necessarily require hospital admission.

Midwife-led pregnancy assessment areas in public hospitals are another successful nurse-led innovation, such as the model of care introduced at Monash Health's maternity services. We would also encourage consideration of expanding postnatal care in the home for well women.

The after-hours triage phone service operating out of Caritas Christi Hospice has reduced patient presentations at EDs and is a system that could be used statewide.

Nurse-led clinics, such as the bladder cancer service at the Royal Melbourne Hospital, have also cut waiting list times for essential medical services.

All of the above suggestions are currently in practice and all could be expanded statewide.

Specific opportunities to enhance existing and currently funded capacity

As above, the following programs and improvement directly extract maximum value from expensive infrastructure and reduce patient delays for treatment:

- Expanded scopes of practice programs for nurses in emergency departments and mental health areas
- Criteria led discharge
- Midwife led pregnancy assessment areas in public hospitals
- Increasing Nurse Practitioner practice in emergency and outpatient departments
- Nurse Practitioner liaison roles for inpatient/outpatient, community and aged care
- Enhanced postnatal care in the home
- After-hours telephone triage services
- Nurse led bladder cancer surveillance clinics
- Nurse led retinal screening programs

1. Expanded Scope of Practice Programs

Emergency Departments

Expanding the SoP of registered nurses and fully utilising nurse roles in Victorian EDs optimises the capacity of hospitals to better treat the community.

There has been some widening of nursing roles through expanding SoPs, with Health Workforce Australia conducting a number of projects that looked at the feasibility of expanded SoP for nurses.

The aim of the expanded SoP in EDs was to prepare the nursing workforce to respond to increasing acute presentations, as well as the predicted increase in acute presentations in ED for people with chronic health conditions.

These projects in innovation included the broadening of ED nursing duties to allow nurses to undertake clinical care such as:

- Suturing
- Wound management for minor wounds
- Fracture setting and plastering
- Pain management initiatives

Expanded SoP projects had the following outcomes in EDs:

- Increase in the capability and productivity
- Increased patient throughput
- Improved performance targets
- Reduced triage times

- Increase in the number of patients meeting the four hour waiting time standard

Expanding SoP provides an immediate system improvement by using the current registered nursing workforce to treat patients that would ordinarily be a lower triage level and thus have to wait longer for medical intervention. The model increases hospital capacity and boosts the ability to provide timely and early intervention.

Mental Health

Eastern Health's mental health model was developed to build upon the skills of the nurse practitioner (NP) role and was later expanded to include registered nurses' SoP.

The model included expanding the nurses' roles to include:

- Comprehensive physical assessment
- Initiation of pathology requests
- Prescribing selected medication in accordance with hospital policy/guidelines and standing orders
- Referring patients to specialist health practitioners and/or services

The innovations in this model included providing a holistic care framework in a single point of care delivery to the patient and reduced the likelihood of multiple practitioners providing elements of care, developing the NPs skill base and increasing the mental health workforce's capability.

2. Criteria Led Discharge

The Royal Children's Hospital introduced the criteria led discharge (CLD) 'Good to Go' program in its Medical Short Stay Unit (MSSU) at its emergency department in June 2012. The MSSU cares for children who present to ED and require up to 48 hours of care.

CLD is dependent on a set of clinical criteria for each of the six diagnoses groups led by the condition of the patient. These criteria are set upon patient admission by the treating doctor. This is done in close collaboration with nursing staff and involvement with the parents.

Nurses decide when these criteria are met and communicate with parents to organise and facilitate patient discharge. Provided these criteria are assessed as being met by a registered nurse – and the patient has been seen by their treating doctor within 24 hours of discharge – the patient can be discharged without the need for further medical review.

The CLD model in the MSSU has:

- Reduced times between patients being ready for discharge and their actual discharge time;
- Avoided unnecessary delays in patient discharge
- Improved bed access
- Increased family satisfaction due to improved communication and more timely discharge
- Nurses more empowered in the workplace
- Improved collaboration between nursing staff and consultants

CLD would have an immediate positive impact if introduced as a statewide public hospital standard policy.

3. Midwife-led pregnancy assessment areas

Midwife-led pregnancy assessment areas address capacity issues and innovation. Both antenatal non-labour assessment areas, which minimise the requirement for antenatal admission to hospital, and early labour assessment areas, providing pre birthing care to free up birth suite facilities and staff, are viable programs that could be expanded as a statewide model of care.

These areas operate to differing degrees at various hospitals and not at all at others. With support via appropriate policies, procedures, staffing and infrastructure, these areas provide an improved service to women and flexibility to health services when responding to peaks in demand.

Increasing the number of midwife-led antenatal clinics has freed up medical staff to perform other work and decreased waiting times for women. The most extensive example of this innovation is Monash Health, which introduced a new clinic template across three sites which cater for approximately 9,000 births per annum.

Continuity models of midwifery care, including caseload and homebirth, have also been introduced in some hospitals. These models provide particular benefits in larger facilities where bed numbers are under pressure and, with careful regulation, can be expanded or introduced in additional health services.

4. Enhanced postnatal care in the home

- Further reduction in postnatal length of stay for uncomplicated births can be achieved if enhanced services, especially breast feeding support, are provided to assist women at home.

- In order to ensure no detriment to clinical outcomes, models should be developed where women and infants can be visited by a midwife twice in a day if required.

5. Increasing Nurse Practitioner practice in emergency and outpatient departments

The NP's SoP includes the care of the patient with complex and chronic conditions, both within the ED and the outpatient setting.

These conditions include but are not limited to:

- acute low back pain management
- minor head injury
- acute foot complaints
- knee and shoulder injuries
- mental health
- pharmacology
- infectious diseases
- palliative care (including patients with complex needs)
- Type 2 Diabetes Mellitus
- Ongoing management of heart failure and renal disease

The 9th conference of the Australian College of Nurse Practitioners in 2014 included a presentation which demonstrated an initiative to increase the skills and knowledge of the NP by undertaking

radiology interpretation of fractures, and ultrasound in the ED, musculoskeletal assessment in pain management, and renal colic. These innovations in practice by NPs are well suited to applications in other Victorian health services and warrants consideration by policy makers.

6. Nurse practitioner, hospital admission risk program (HARP) and community health centre nurses' care of the patient across the inpatient/outpatient sectors, community and residential aged care

NPs, HARP and community health centre nurses have established essential healthcare links between the community and the public health system. In addition to acting as liaisons between EDs and aged care facilities, NPs, HARP and community health centre nurses provide care for chronic and complex patients in the community who reside in their own homes. These roles lead to a reduction in the number of admissions to acute EDs and hospital admissions and/or readmissions.

Applicability

Within the clinical setting, the emergency department NP visits the nursing home to assess the health status of an acutely ill resident for the purpose of providing a diagnosis and, where required, prescribing treatment for the condition without having to transfer the resident to the ED. This process of care frees up valuable ED capacity to admit more urgent and criteria related admission to the ED via Ambulance Victoria or walk-in emergency presentation.

In addition, the NP with the notation of aged care is well placed to review all the residents in an aged care facility that affords itself to a collaborative arrangement with the individual resident's general practitioner. Within this model, the NP diagnoses, prescribes and authorises treatment for residents with signs and symptoms of, but not limited to, urinary tract infection, pneumonia, simple infections, wound care, and urinary incontinence.

Nurses employed in HARP services, as well as medical officers, also undertake a liaison role between the ED and the residential aged care home to individually diagnose and treat the residential care recipient in their home, which is the aged care facility, and avoid unnecessary presentation to the ED and any subsequent acute hospital admission.

HARP and community health centre nurses act as a health liaison between the hospital and chronic and complex patients residing in their own homes. In this capacity, the nursing care targets chronic and complex patients and assists them in the management of their condition and reduces the need for hospital admissions.

NPs with a notation of palliative care have established an increased access to palliative care expertise by providing end of life care across both the community and the inpatient settings.

7. After-Hours Telephone Triage Service

As a way to access an after-hours telephone triage service model, we recommend the model operated out of the Caritas Christi Hospice (St Vincent's Health). The service provides after-hours medical and nursing support and has many facets that improved both the patient's care and the efficiency of the healthcare provided.

These improvements in care include:

- Improved patient accessibility to support and a continuum of care
- Reduced presentations at EDs or the need to visit after hours health services
- Provided after-hours medical and nursing support
- Enabled the health service to capture date and monitor the service for quality assurance;
- Enabled best practice initiatives such as:
    - improved access to afterhours medication services in emergency situations;
    - development of policy to manage AH care issues;
    - Support of families when a patient dies out of hours and verification of patient death is needed.

8. Nurse-led bladder cancer surveillance clinic

The Royal Melbourne Hospital was successful in obtaining funding from the Department of Human Services (DHS) to set up a nurse-led flexible cystoscopy bladder cancer surveillance clinic. In July 2009, the clinic commenced after the development and institution of a nurse training program.

Within this model, patients with low-grade bladder cancer require regular and ongoing cystoscopies to detect any recurrences and to enable early intervention and follow up treatment. Conventionally, it had been the role of medial registrars and fellows to perform the cystoscopies with Victorian health services. These busy clinicians spend 12 months at this institution with their primary focus being the acquisition of surgical skills and knowledge to treat patients effectively.

Due to the high volume of cystoscopies required, it had not been possible to keep up with the demand. Patients were on the waiting list for unacceptable lengths of time. Bladder cancer research did not occur due to the lack of a known or tracked cohort of patients.

With the establishment of the nurse led clinic, this has significantly reduced patient time [waiting list] and ensures more timely screening and surveillance of patients. This, in turn, enables earlier intervention and treatment which significantly reduces morbidity and cost to government of treating otherwise advanced cancers.

9. Nurse-led infant Retinopathy of Prematurity screening clinic

The nurse-led Retinopathy of Prematurity (ROP) screening project began at the Royal Women's Hospital (The Women's) as part of an initiative to ensure premature infants at risk of developing ROP were screened and, if necessary, provided the capacity for the initiation of treatment to prevent blindness. With a shortage of neonatal ophthalmologists and a growing number of infants requiring screening, an alternate pathway to achieve this was required.

The Women's commenced this project in 2012 with two registered nurses trained by the neonatal ophthalmologist to take images of the retina as part of the screening process for ROP. These images are then downloaded to a database for the ophthalmologist to view either on site or offsite, with treatment plans determined at that point.

This project has been very successful with another registered nurse now educationally prepared for the role. It is anticipated that an outreach program could be established; where nurses could screen infants outside the confines of the walls of the health service and even extend to remote areas, with the ophthalmologists viewing these images centrally.

The benefits of screening infants this way reduces the length of hospital stay, with the flow on effects including cost efficiencies and allowing highly skilled nurses to advance their scope of practice. With the advent of tele-health this model could be expanded to other health services in the Victorian context.

Measurement

We understand that the above programs have been measured by their individual services and have produced a range of successes. However, on the information provided and where relevant, the innovations presented reduced emergency department waiting times, reduced delay in treatment, increased bed capacity, reduced waiting lists for critical medical treatment and filled an essential gap between the community and the system, particularly in the crowded aged care sector and emergency departments.

Potential for statewide expansion

We recommend that each of the services presented are contacted directly for further information on facilitation resources. Nevertheless, most, if not all, of the above innovations are transferable within the Victorian health care context and have applicability for statewide application.

Victoria's public health system requires a centralised system where successful innovation can be reported, understood and implemented. We are currently reliant on facilities learning about others' work and/or mostly reinventing the wheel rather than sharing the learned experience of others and seamlessly implementing.