A Nurse Practitioner (NP) is a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The NP role includes the assessment and management of patients using nursing knowledge and skills and may include but is not limited to initiation of diagnostic investigations, prescribing of medications and direct referral of patients to other health care professionals. The NP role is grounded in the nursing profession’s values, knowledge, theories and practice and provides innovative and flexible health care delivery that complements other health care providers (ANMC 2006). NPs practice collaboratively as an interdependent member of the multidisciplinary health care team and provide autonomous, patient centred care.

The scope of practice (ScOP) of the NP is determined by the context of practice, the education and level of competence of the individual, policy and service requirements and forms part of the Nursing and Midwifery Board of Australia Safety & Quality Framework.

Each NP must develop an individual ScOP that reflects their expertise and competence. While the ScOP may be similar for NP’s working in certain clinical specialties, it must reflect the capabilities, expertise and competence of the individual. Establishing and ensuring competence to practice within a ScOP is the responsibility of both the NP and employer. The employer and NP are to ensure the defined ScOP is evidence based and in accordance with the LHD policy requirements and NMBA S&QF

Clinical judgement regarding a particular clinical procedure or treatment plan is made by the NP in light of the clinical data presented by the patient and the diagnostic and treatment options available. In making clinical decisions the NP remains conscious of their level of expertise and utilise available resources and expertise of the multidisciplinary health care team.

The authorising legislation for the use, possession, supply and prescription of medications by NPs in NSW is the Poisons & Therapeutic Goods Act 1966 and the Poisons and Therapeutic Goods Regulation 2008.

Regulation of NPs is in accordance with the Health Practitioner Regulation National Law (NSW) No 86a
Demographics and supporting services
Sydney Adventist Hospital (SAH) is a private not for profit hospital that sits across many Local Health Districts and extends from the Hornsby Local Government Area (LGA) in the North, to Ryde LGA in the south and The Hills LGA in the west. The SAH’s service provision is not limited by Local Health Districts and covers approximately 6 LGA’s, with most patients attending from suburbs within a 10 – 15 Km radius from SAH, an estimated area of 707 square kilometres. This area includes many Residential Aged Care Facilities (RACF).

Population in this area is estimated at approximately 784635. With an aging population an increase in demand of palliative care services is expected.

Services within the SAH include but are not limited to:
- Emergency Care Department
- General Surgery
- Orthopaedics and Vascular Surgery
- General Medicine
- Cardiology
- Intensive Care and Coronary Care
- Occupational Therapy and Physiotherapy Services
- Acute Pain Service
- Social Worker and Spiritual Care Services
- Pathology and Radiology Services
- Paediatric and Special Care Nursery
- Oncology and Radiotherapy Services
- Palliative care
- Chronic and Complex care

Model of care
Aim
- to provide advanced nursing care, management and evaluation and timely access to clinical expertise for patients and their carers during all phases of their illness.
- to navigate the patient and their family across boundaries and service providers.
- to foster collaborative relationships with other service providers
- to be an extension of the existing Palliative Care services
- to be part of a multidisciplinary team
- to provide an innovative and flexible nursing service that improve patient outcomes
- to provide care that is holistic and encompasses the physical, psychological and spiritual
- inpatient hospital visits
outpatient visits following discharge to home or residential aged care facilities (RACF)
outpatient clinic consultations.
to work within the Scope of Practice according to principles of best practice;
iliaise with community providers and carers to allow patients to remain in their homes for end of life care
facilitate admission to SAH either via Emergency Care (EC) or as a direct admission to the Palliative Care Ward (POON), in collaboration with their AMO.

### Service Description

#### Target Population of service
The age range of patients will be eighteen years and over.

#### Health Service Setting
Adventist Healthcare Limited currently provides inpatient palliative care services. These services are not defined by LGA or NSW Local Health Districts. Patients are seen within the hospital with a small proportion of acute palliative care patients attending outpatient clinics. Patients are managed at home in collaboration with the local community services and their General Practitioner within an area of approximately 15km.

#### Facilities/Facility where the Nurse Practitioner Role or Service Operates
The PCNP covers the geographical area of the upper north shore and northwest of Sydney. The primary practice environment for the PCNP is Sydney Adventist Hospital. Patients will also be seen in their own homes and local aged care facilities within a ten kilometre radius of SAH.

#### Operational Aspects
The PCNP is employed by Adventist Healthcare Limited

### Parameters of practice

#### Elements of care
Palliative Care refers to the care of any patients with a life limiting illness. Often these patients may be referred early in their illness trajectory for symptom control, education/information or psychosocial issues and support. Once immediate issues are resolved the patient is followed up with telephone contact until they require further face to face intervention.

This includes but is not restricted to end stage:
Malignancy; neurodegenerative disorders; dementia; renal disease; cardiovascular disease; chronic respiratory disease and AIDS related diseases. These disease processes can manifest a multitude of complex symptoms for patients.

**Exclusion from care**
- The PCNP will not see patients with chronic pain only.
- Persons under the age of eighteen
- Persons with chronic and complex care that is potentially reversible and not life limiting

**Process of care**
The assessment and management of individuals by the PCNP is aimed at managing symptoms, determining where the patient is in their illness trajectory and determining reversible and irreversible conditions. The process is guided by evidenced based practice.

This process includes a comprehensive holistic assessment of the patient and their family / carer(s) and an advanced physical examination as appropriate. SAH is currently investigating the implementation of the Palliative Care Outcomes Collaboration (PCOC)

**Referral pathway / initiation of contact with service**
Generally patients are referred to the PCNP for the following reasons:
- Management of patients with complex symptoms who have needs exceeding the scope of the general practitioner or staff of RACF;
- Exacerbation of symptoms, sudden change or deterioration in condition;
- End of life care in the terminal phase of the illness
- Information regarding palliative care, service provision and care options

**Criteria for Referral**
Life limiting illness includes but is not restricted to end stage:

malignancy; neurodegenerative disorders; dementia; renal disease; cardiovascular disease; chronic respiratory disease and AIDS related diseases.

Patients may be referred early in their illness trajectory for management of symptoms and then followed up with telephone calls when symptoms have resolved. Ongoing contact is maintained and services increased as their care requirements change

**Source of Referral**
Attending Medical Officer, (AMO) Registrar’s or their proxy
Health Care Professionals SAH
Residential Aged Care Facilities (patients to be known to SAH)
SAH Emergency Care Department
SAH Case Managers
NUM – any level SAH
Cancer Support Centre
Carers, families, patients
General Practitioners
Other health care providers

**Referral Pathway**
All in patient referrals are made using Sancare.
Outpatient referrals use form (MR1ABC) faxed to Cancer Support (02 9487 9065)
Referrals are then triaged and prioritised according to urgency.

Referrals will be accepted by telephone – providing follow-up documentation is provided.

**Prescribing and dispensing arrangements**

- The PCNP formulary lists the poisons and restricted substances that may be processed, used, supplied or prescribed by the nurse practitioner under Section 17a of the Poisons and Therapeutic Goods Act 1966 (2) & Part 1 section 4 & 4A of the Poisons Therapeutic Goods Regulation 2008 (3).
- The PCNP is allocated a Prescriber Number and may prescribe items included on the PBS schedule as NP items and private prescriptions for patients in the community.
- The PCNP can prescribe medications on an inpatient medication chart.
- The PCNP has the authority to initiate, cease and titrate those medications listed in the PCNP Formulary.
- Medications will only be prescribed following assessment of the individual patient.
- The principles of the Quality Use of Medicines are observed
- The PCNP will use the most recent Australian Medicines Handbook; MIMS or MIMS ‘online’; and Therapeutic Guidelines: Palliative Care.
- The PCNP will document, maintain and update medical records for all medication changes made by the PCNP. The PCNP will observe, record, report patient’s condition, efficacy and reaction to drugs and treatment to the relevant health professionals.
- The PCNP will consult with the GP / Medical Specialist / Palliative Care Specialist, when appropriate, to discuss management plans for complex patients and for those patients not responding as expected to recommendations.
- Many medications used in Palliative Care are used ‘off label’, for indications, and routes of administration outside of the TGA approval. These indications and routes of administration are evidenced based in the Palliative Care literature.
- The PCNP can cease drugs no longer required after discussion with the patient and family and at the request of the General Practitioner or Medical Specialist.
- Patients in the terminal phase of their illness will have reduced ability or inability to swallow medications. The PCNP will reduce or cease oral medications and change to an alternate route, as appropriate. This process is
undertaken in an informative collaborative manner with the patient, family and carers as well as their attending medical practitioner.

**Diagnostic investigation arrangements**
Investigations are required to assist diagnosis or provide a baseline of health. The PCNP may order appropriate medical imaging and pathology investigations if there will be a clear benefit to symptom management and patient outcome. Appropriate investigations may include but are not limited to:

- Urine culture and sensitivity
- Sputum culture and sensitivity
- Wound swabs culture and sensitivity
- Pathology: including FBC; Group & hold cross match; LFT; Calcium (corrected); UEC; INR; APPT.
- Medical Imaging: Plain X-rays – including chest, abdomen, skeletal
- Other diagnostic investigations may be ordered following discussion with the referring team.

It is the responsibility of the PCNP to ensure that these results are followed up, interpreted and documented in a timely manner and to consult appropriately with the referring team to discuss management or follow up with the AMO, if required.

If the PCNP is away on leave arrangements will be made for the follow up of any investigations ordered.

The PCNP has a commitment to prevent duplication of services and unnecessary diagnostic investigations and consultation with pathology and medical imaging staff should occur as appropriate.

**Appended Formulary**

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**Exclusions:** A nurse practitioner must not prescribe, give a written or oral instruction or supply or administer medicines (1) that have not been approved by the Therapeutic Goods Administration outside the terms of the manufacturer’s product information (off-label) unless sufficient evidence to demonstrate safety.

**Specific procedural activities**
Including but not limited to:

- Management of Peritoneal implantable ports. This includes accessing, drainage of acities fluid as prescribed by Specialist team and heparin locking as per SAH policy and procedure manual.
- Management of venous implantable port. This includes accessing and heparin locking as per SAH policy and procedure manual.
- Monitoring of Blood Glucose Levels (BGL)
Collaborative arrangements

Collaborative arrangements are required to enable Nurse Practitioners to provide access for patients to MBS and PBS subsidy. Arrangements are in line with s5(1a) of the National Health (collaborative arrangements for nurse practitioners) Determination 2010. The PCNP complies with these requirements by:

- Where a patient is referred in writing to an eligible nurse practitioner by a specified medical practitioner; or,
- An oral arrangement exists between the nurse practitioner and a specified medical practitioner and the nurse practitioner documents a series of prescriptive notes in the clinical record.

The PCNP will consult appropriately according to the patient’s Palliative Care Outcomes Collaborative (PCOC) phase, where the patient is in their illness trajectory and the agreed management plan for the patient:

- Persistent signs or symptoms beyond the expected time of resolution despite treatment;
- Sign(s) of recurrent or persistent infection;
- Any atypical presentation of a common illness or unusual response to treatment;
- Any sign(s) or symptom(s) of behavioural changes that cannot be attributed to a specific organic cause;
- Palliative Care emergencies such as cord compression, hypocalcaemia, superior vena cava obstruction;
- Symptomatic or laboratory evidence of previously unidentified change in condition or unexpected deteriorating function of any vital organ or system;
- When a patient’s condition destabilises unexpectedly;
- When it is determined by the PCNP after assessment, be it ongoing or emergency, that the treatment or diagnostic test needs fall outside the approved Scope of Practice;
- When a patient requires admission;
- Any other conditions or patients who are outside the approved Scope of Practice.

A therapeutic management plan will be formulated by the PCNP in line with best practice. Consent will be obtained from patients prior to consultation and Scope of Practice and Drug Formulary will be made available to other health professionals within multidisciplinary team.
Clinical Governance Arrangements

Study, clinical supervision and mentorship arrangements
The PCNP is responsible for the maintenance of their clinical knowledge and skills through ongoing professional development. This includes but is not limited to:

- Attending professional development days, to include both Nurse Practitioner and Palliative Care domains
- Maintaining Continuing Professional Development (CPD) points
- Completing mandatory competencies as required by SAH
- Presenting at conferences both within Australia and overseas
- Regular contact with the Palliative Care Nurse Practitioner Network
- Regular meetings with Director Medical/ Surgical Nursing
- Monthly Clinical Supervision with nominated member of Spiritual Care Team
- Regular meetings with the Palliative Care Specialist
- Monthly Journal club peer review meetings

Describe how the NP role / service articulates into organisational governance arrangements

- The PCNP is responsible operationally to the Director Medical/ Surgical Nursing.
- Clinically responsible to the Palliative Care Specialist
- Professionally responsible to the Nursing Executive Officer, Adventist Healthcare Limited

The PCNP is accountable for their clinical practice decisions and actions, together with their conduct as a health professional. The Safety & Quality Framework that maps the PCNP’s domain of responsibility and accountability includes the following:

- The PCNP Scope of Practice;
- The Australian Nursing and Midwifery Council (ANMC) National Competency Standards for the Nurse Practitioner;
- Mandatory Reporting;
- The ANMC Code of Ethics and Professional Conduct for Nurses in Australia);
- The NSW Health Code of Conduct (PD2005_626);
- Annual Declaration;
- Co-regulatory requirements of Medicare and NMBA;
- NMBA Audit Process;
- Prescribing Authority legislation and collaborative arrangements;
- Notification of performance, conduct or health matters.

In addition, the PCNP will comply with all applicable SAH and NSW Health policies, procedures and guidelines.
In an emergency situation the PCNP will be expected to do no harm, and to act in the best interests of the patient.

The PCNP will participate in the continuing evaluation of the Palliative Care service.

**Clinical Resources**

The PCNP will have access to but is not limited to:

- Consultation room/ office
- Allied Health services
- Pathology services
- Radiology services
- Mobile Phone
- Assessment tools (Sphygmomanometer, BGL machine, Thermometer, Oximeter, Stethoscope)
- Medical library/ Online resources
- Access to electronic database
- Remote access to hospital database
- Vehicle to allow consultations away from base
- Secretarial support

**Professional role activities**

**Clinical leadership, education and research**

Is demonstrated by:

- The provision of advice and guidance for nurses on matters of clinical practice and professional development;
- The provision of expert advice, education and support to nursing staff and other health professionals in a variety of settings including Residential Aged Care, Hospital, Community and Tertiary environments;
- Participation in the review and evaluation of policies, procedures and guidelines to improve standards of patient care in relation to Palliative Care;
- Participation in formal processes for the strategic and operational planning for the Palliative Care service;
- Demonstrated leadership with regard to the ANMC Professional Code of Conduct and Code of Ethics for Nurses.
- Ensuring that all standards, policies and procedural recommendations of the organisation, the nursing professional bodies and national and state professional palliative care bodies are maintained;
- Working to advance the understanding and integration of the Nurse Practitioner role in the Health Service and community.
- Involvement in research activities and initiation of research activities.
Evaluation

Strategy for evaluation of model and ScOP review
Patient and health professional surveys will be used to evaluate the PCNP services. Information gathered by these surveys will help direct goal setting and improve service provision.

The PCNP and Nursing Services /committee shall update, evaluate and amend the scope of practice whenever the PCNP’s duties have substantively changed or every twelve months when the service requirements are reviewed, incorporating the annual performance appraisal.

Any alterations must be submitted to the Chief Executive of Adventist Healthcare Limited. This document is invalid if any alterations or amendments are made without the approval from the Chief Executive of Adventist Healthcare Limited.

Performance review
Regular meetings with the Nursing Unit Manager POON ward will be undertaken to ensure compliance, give support and mentor the PCNP.

- Annual performance Appraisal as per SAH policy and procedure.
- Regular meetings with the Palliative Care Specialist
The Multidisciplinary Support agree that this scope of practice and model has been developed collaboratively and is supported practice for the named nurse practitioner.

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<td>Nursing Services Committee Chairperson</td>
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<td>Pharmacy and Drug Committee Chairperson</td>
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<td>Name: Dr Jeanette Conley</td>
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<td>Name: Dr Gillian Rothwell</td>
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<td>Executive Committee Chairperson</td>
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<td>Name: Dr Leon Clark</td>
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