Changing Models of Care using the QNC scope of practice

What are the nursing roles within outpatients departments?

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Acknowledgments

- The great nursing team at Redcliffe Outpatients
- NUM's - Colleen Willis; Denise Kolera –(previous)
- M. Nielson – QNU Organiser
- QNC Scope of Practice - S Ragua – Nurse educator Caboolture

Redcliffe SOPD & PPA = 50,000 OOS each year

Beds = 247

Population of = 80,000

Background

- In 2005, Redcliffe Hospital, obtained funding to redevelop the Specialist Outpatient department.
- As part of the redesign and planning, the models of care and service provision were reviewed and the team investigated opportunities to modify the models of care to improve patient journey and experience.

Historical development of SOPD service

- At Redcliffe Hospital – SOPD commenced as a specialist rooms model.
- No planning into opportunities for patients or staff it was about the specialist consult.
- Historically – not seen as an area for "skilled" staff.
- Often used to place, injured/disabled staff who can no longer work in the wards

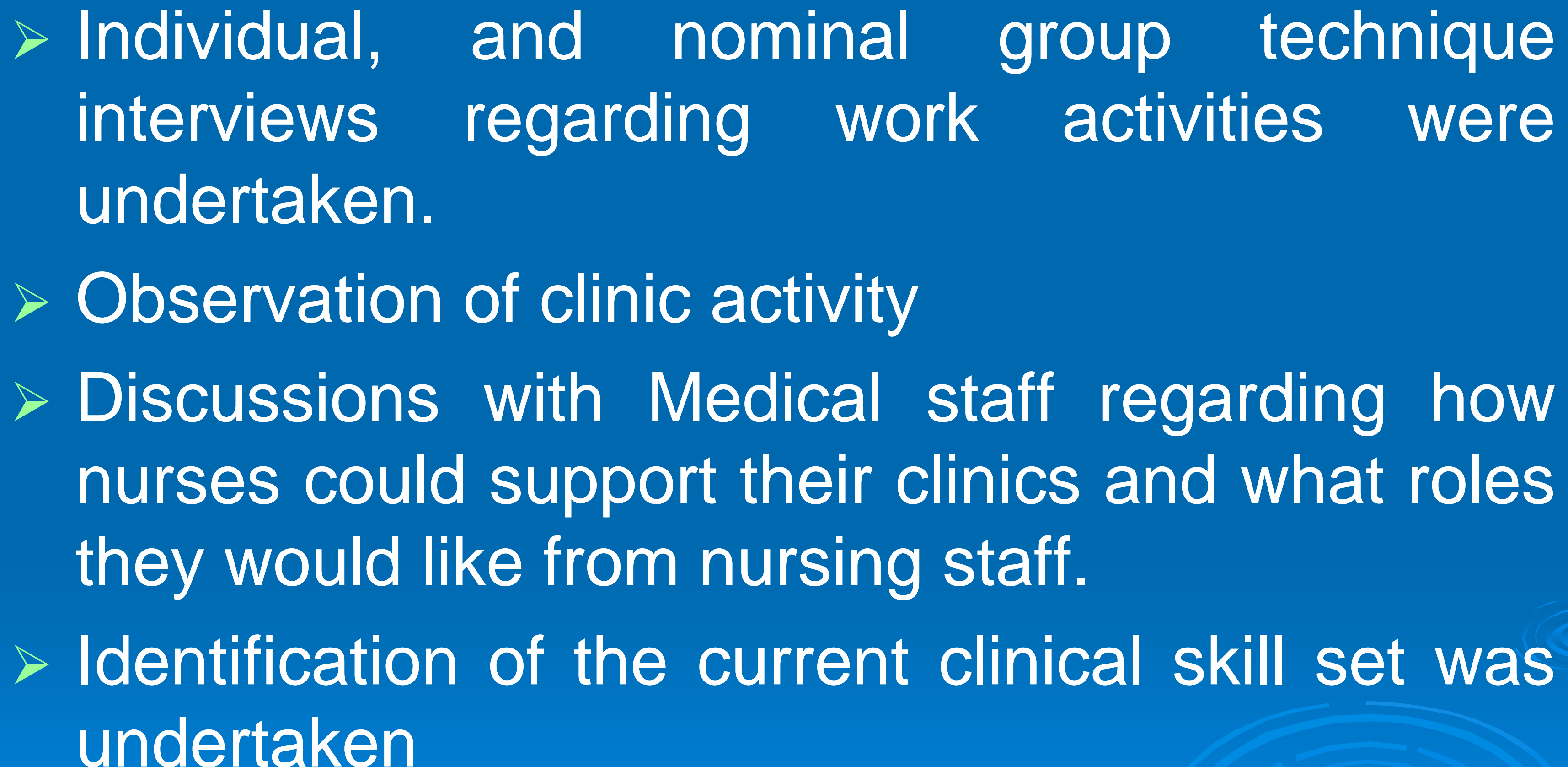
Developing the Model of Care

- Literature review
  - Few documented models of care for SOPDs/Ambulatory services within hospitals, were some great articles by Gold Coast University hospital.
  - Mainly described an integrated medical model, but with waiting lists on the increase was this the best model?

Review of the clinics/tasks

- A review of the roles of nursing, administrative and some medical team members was undertaken.
- It was evident at this time that the roles between nursing and administrative staff were blurred and there was significant capacity to improve the clinical services by increasing the roles of nursing staff within the SOPD
- It was also clear that many Drs were not aware of HOW nursing staff could support their clinics.

How could we progress?



How did we review the nursing roles?

The scope of nursing and midwifery practice is:

- that which nurses / midwives are educated, authorised and competent to perform *(? and confident)*

- influenced by
  - context in which they practice
  - their level of competence
  - clients' health needs
  - policies of service provider and legislation

The Queensland Nursing Council – Scope of practice framework for nurses and midwifes (2005)

Principles for advancing the SOP of RNs / ENs

- Primary motivation - meet health needs / improve health outcomes
- Processes exist for ensuring:
  - continuing education
  - competence assessment
  - appropriate clinically focused supervision
- Change in SOP is:
  - Lawful
  - Appropriate for the context
  - Consistent with nursing standards and service provider policies

Scope of nursing practice – different roles –at Redcliffe SOPD

AIN
non clinical, support roles

USINs
Not currently employed in the unit but under consideration

ENs (Med),

RNs, CNs, NUM, CNC & Nurse Educator (provides support to the unit)

Nurse Practitioner
(Candidate – Urology)

PODS

- "Clinical PODS" have been formed in specialties to review the roles of each level of nursing staff, there is now a clear framework to assist in the remodelling of services. In both Urology and Orthopaedics clinics, the roles of the AO, EN, RN, CN – Care Coordinator and CNC/Nurse Practitioner have been defined. This is an ongoing process and is assisting the team in developing new models of care to support the patient.
- The changes to roles of nursing and administrative staff have been an evolving process and we have worked closely with team members to provide them with the support and training required to undertake their expanded roles.

Advantages of Clinical POD Model

- Empowers staff to develop their specialty service
- Staff identify own learning requirement
- Skilled staff provide seamless patient care/support to Doctors
- Trust is developed between medical/nursing/administration staff
- Staff can see the "big picture" and suggest improvements

Possible disadvantages to the POD model.

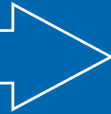
- Possible territorial behaviour of staff (medical and nursing) about their clinic and processes
- Can create leave replacement/rotation issues

What is the difference between RNs and ENs using a scope of practice framework?

- **RN** is responsible & accountable for:
  1. The comprehensive assessment of individuals / groups,
  2. Interpreting assessment data,
  3. Developing a nursing care plan,
  4. Gathering & interpreting evaluation data,
  5. Their own actions,
  6. Delegation.

- **EN** is responsible & accountable for:
  1. Gathering patient assessment & evaluation data,
  2. Their own actions,
  3. Implementing delegated interventions under supervision.

Drs Rooms



Referrals

Categorisation

- Analysed
- Categorised (Protocol) CN
- Grouped for Dr to categorise - APEN

Booking

- CN Role to consider overbook/rescheduling
- CN – Contact re history paediatrics

Arrival

Various Clinics

Medical

EN – ECG/Weight/Measure/Spirometer/BMI

Rheumatology

EN – Undertake patient questioning

RN – Review history – complete comprehensive history

Surgical

Limited/Nil

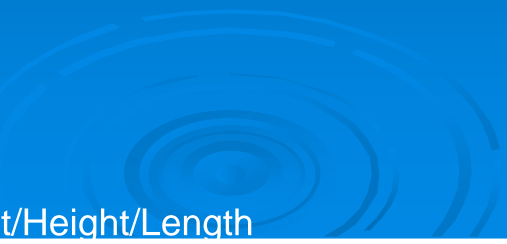
Paediatrics

EN – Weight/Height/Length

Care Provision

Protocol driven – Nurse Drive clinics

Coordinate the one-stop shop ie Orthopaedics – If patient is Cat 1 for OT they have their anaesthetic



Paediatrics

Topic	Consultant	Care Coordinator	Enrolled Nurse	Administration Officer
Leave management	Notifies team of leave / backfill minimum of 4/52 prior	Reviews appointments to be moved / cancelled – completes template form for NUM to approve		Closes / modifies HBCIS when – template change form is received
Template management	Reviews / recommends template changes with CC and NUM	Reviews clinic templates with consultant and NUM 6 monthly		(CRO) Updates HBCIS templates as per form
referrals	Categorises new referrals	Collects / reviews referrals weekly and hands to Categorising consultant		(CRO) – add referrals to HBCIS
		Provide support to patients on list with community contacts etc for speech therapy, hearing, allied health, CTS, Early intervention service		
External phone calls	Follow up call Advise if further SOPD action is required	Take phone calls from GP complete paediatric phone call form with advice given Advises AO if HBCIS appointment to made for phone advice	Refer calls to the Care Coordinator or the ESO Paediatric Director	(ESO) Take messages and record on paediatric phone call form. Forward forms to consultant for review

Paediatrics

Topic	Consultant	Care Coordinator	Enrolled Nurse	Administration Officer
Clinic flow	See patients within appointment times		If issues with late clinics or delays escalate these to the NUM SOPD &/or the Director Paediatrics	Contact all patients 1 day prior to the clinic to confirm appointments Update HBCIS to seen following appointment. If pts <30 minutes late contact the Dr in Clinic to advise whether to rebook or decrease appt. time.
FTA process	Review FTA charts and notes from Care Coordinator and make recommendations to AO re further appointments / discharge / FTA process	Contact all FTA new pts, rebook or remove and document in the chart as necessary	Notify Care Coordinator of all FTA new appointments. Contact parents during/after clinic for all FTA reviews. Document and notify clinic consultant at the end of the clinic.	Complete HBCIS – FTA / discharge process as directed
Behavioural Referrals	Allocate behaviour patients evenly amongst consultants	To commence behaviour screening template.		

Urology

Topic	CNC Urology	Care Coordinator	Enrolled Nurse	Administration Officer
Leave management		Reviews appointments to be moved / cancelled – completes template form for NUM to approve		Closes / modifies HBCIS when – template change form is received
Template management	Reviews OT wait list and recommends template changes with CC and NUM to manage OT demand	Reviews clinic templates with consultant, CNC and NUM 6 monthly		(CRO) Updates HBCIS templates as per form
Referrals		▪Collects / reviews referrals weekly and hands to Categorising consultant ▪Using protocols categorises Cat 1/ 3 as approved ▪Provides phone support to patients on the waiting list (as patients contact) ▪Referrals as deemed necessary, ie continence; other services		(CRO) – add referrals to HBCIS
Patient care/ clinic flow	**Manages own urology clinics, sees patients with medical supervision and guidance:** ▪LUTS Clinics· ▪Stone Clinics· ▪Follow up / Discharge Clinics· ▪Haematuria Clinics Continence Clinics / Complex Care Clinics	As for EN at this stage **PLUS**	**Supports Urology Clinics:** ▪Ensures patients have completed all assessment forms for their appointment (e.g. IPPS score) ▪Assists patients with completion of assessment forms ▪Initiates and evaluates Bladder Diaries with clinic CN/CNC ▪Takes observations if needed– e.g. B/P, Urinalysis ▪Undertakes Urine flow measures ***NEW*** ▪Catheterisation/R/O catheterization ***NEW*** as allocated by the RN.	

Urodynamics	▪ Management of Procedures and Occasions of Service ▪ Training of staff ▪ Mentor nursing staff	▪ Support CNC with clinics	▪ Assists with urodynamic procedures (competency based) ▪ Monitor and care of machinery and equipment ▪ Performs catheterisation and Urodynamic procedure	
		ESWL: ▪ Receives and processes ESWL applications ▪ Organises date for ESWL and post procedure follow up ▪ Contacts patients with date for treatments and provides education **Stent management** ▪ Maintains Stent Register &monitors patients with Ureteric Stents ▪ Identifies if stent's short or long term placement and organizes management options for these patients		
Preadmission		▪ Completes the Preadmission questionnaire for all cat 1 patients. ▪ Make anesthetist bookings if required.		
Education	▪ Complex procedures ie Cystectomy; Radical Prostatectomy ; Supra-pubic Catheterisation; Complex surgical procedures	▪ Education on a broad range of conditions preoperatively	▪ Catheter Care ▪ Continence management ▪ Home care of catheters, tubes and drainage appliances	
FTA process		Contact all FTA new pts, rebook or remove and document in the chart as necessary	Notify Care Coordinator of all FTA new appointments. Document and notify clinic consultant at the end of the clinic.	Complete HBCIS – FTA / discharge process as

EN Role in Urology SOPD Developed

- Urinalysis
- Bladder Scan
- Urine Flow Rate
- Insert and change IDC and SPC
- CISC – Education
- Patient Education –assess education technique
    - TURP
    - TURBT
    - PCNL
    - TRUS
    - Circumcision
    - Insertion of stent
    - Intravesical MMC and BCG
    - ESWL
    - TOV
- Assessment
    - I-PPS
    - Continence assessment form
    - Bladder Diary
- Urodynamics to be done:
    - Patient education
    - Set up equipment
    - Support RN
    - Maintain equipment and Consumables

Future considerations

- Questions to consider?
- What level of clinical practice is ACTUALLY required?
  - ie 1.0FTE NP

    = 1.0 CN + 0.5 EN

    = 2.0 FTE EN
  - What will support the patients while waiting or reduce the wait time?

Sharing of knowledge

- Need to consider the use of professional networks to share upskilling or competency packs ie through SOAC (QLD) or Urology networks etc
- Question the model of care within the unit at least annually with the team, to consider any opportunities to improve the patient experience or validate some of the nurse/doctor developed processes

Thank you