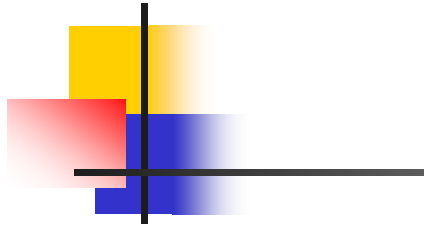


# Development of NZs first Old Age Psychiatry Nurse Practitioner



Liz Langer: Psycho-geriatric Nurse Practitioner  
Hazel Saville: Charge Nurse Manager









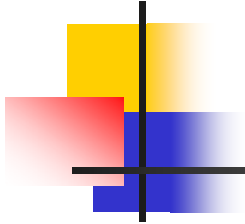
# By Day

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# View from Liza's place by Night!







# Evolution of the NP role in NZ

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- Internationally
- Recognition by the MoH of NP potential: Project (1998)
- Understanding by the MoH that NPs could play an integral part in delivering the Governments priorities for health
- Guiding Principles of NP development
  - NPs address and reduce inequalities and inequities in health.
  - The role is centred on patient and population needs and improving health outcomes.
    - Therefore population health status will drive the provision of NP services, including gaps in services created by doctor shortages



## Identified Needs/Problems requiring solutions: Mental Health Service for Older People

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Gap in service provision in Otago.

- Unfilled psycho-geriatrician position
- Overworked psychiatrist
  - Response times
  - Crisis admissions due to non-responsive service
- Unmet need in Residential Aged Care Facilities (RACF)
- On-going staffing vacancies and closed beds



# Clinical Role

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- All RACF referrals come directly to NP from GPS, RACFs, NASC, CPNs, MHSOP
- Assessment, ordering and interpreting laboratory tests/findings
- Medication management / prescribing
- Establishes/considers diagnosis / differential diagnoses
- Management
  - Autonomous case management , consult with/triage with the psychiatrist & GPs (other disciplines as necessary)
  - Consultancy to CPNs / Rapid response
- Consultancy
  - Provide coaching, teaching, mentoring to RACF / PHO staff to enhance their capacity and capability re early intervention and management.
  - Development and implementation of evidence-based protocols and guidelines



# Initial Referrals & Assessments

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## The First 12-months:

- New Assessments
  - 161
- Contacts
  - 1112
- Deaths

## ■ Eighteen months on:

- New Assessments
  - 247
- Contacts
  - 1936
- Deaths
  - 60

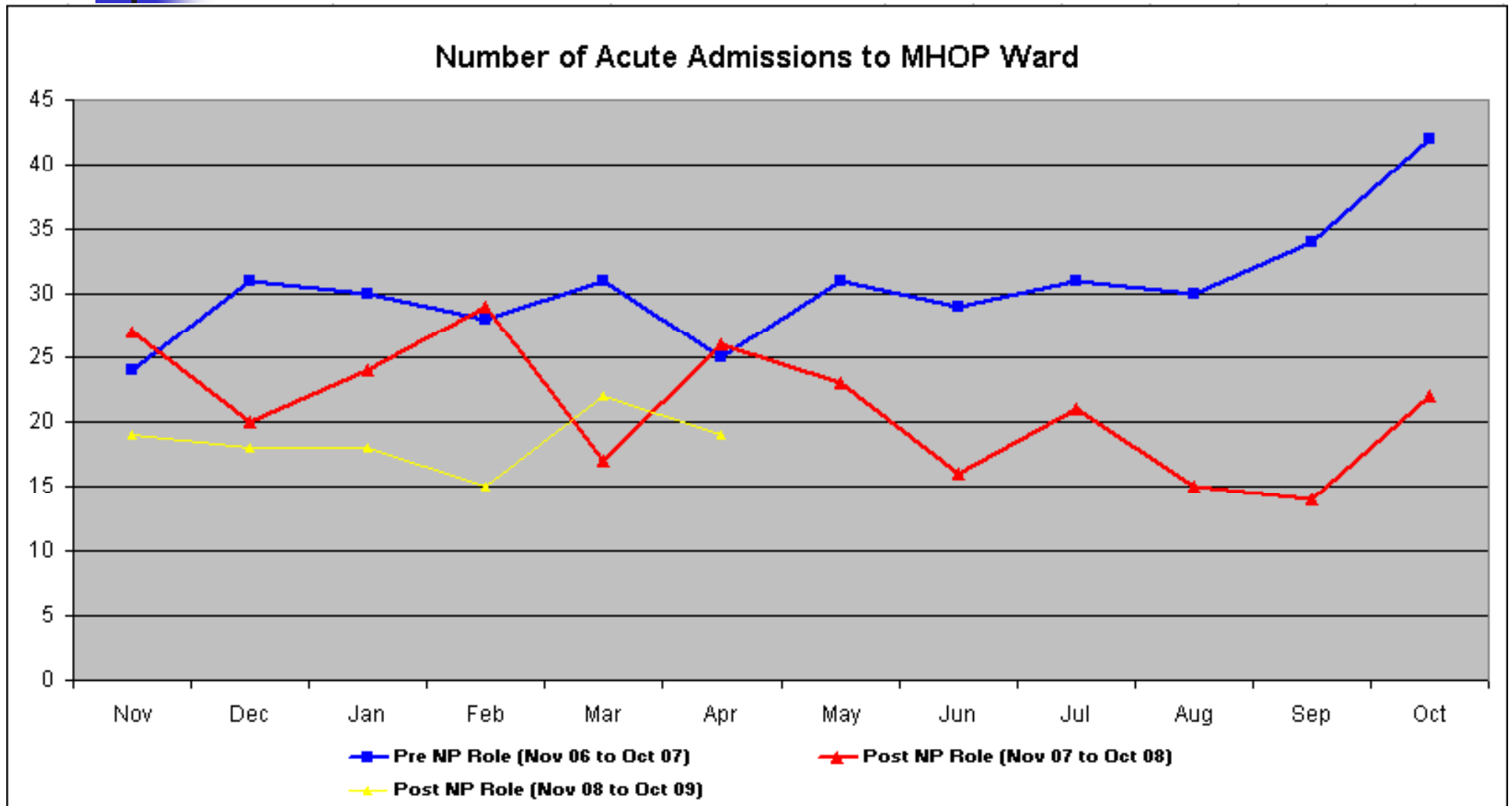


# Follow-up

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- Intensive – minimum 3-5 visits weekly
- Consult-liaison
- Short term
- Shared-care clinic with GP
- PRN
  - Preventing Admission
    - Managing delirium
    - Managing dehydration
    - End of life support
    - Acute behaviour management
  - Acute hospital discharge

# Avoiding Admissions





# Education

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- In services on restraint minimisation/challenging behaviours
- RACF in house staff education sessions
  - Re medications
  - Approaches
  - Progression of illness/End of life care
  - Complicating factors
    - Hydration
    - Constipation
    - Urinary retention/infection



# Clinical Scenarios

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- Mr. Mac
  - Staff meetings-behaviour management
  - Psychologist intervention
  - Medication adjustment
  - Facilitation of meeting re transfer to D6 facility



# Clinical scenario 2

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- Managing Delirium
  - Sr. Louise
  - Lab tests
  - MMSE



# Quality Outcomes

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- Older People
- RACF Providers
- GPs/Practice Nurses
- Ward/DHB – Bed Management/Financial
- Collaborative practice-no erosion of roles, additional resource on the team
- Job Satisfaction



# Where to from here

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- Ongoing monitoring
- Formal Evaluation – mix of qualitative and quantitative data
- Engage Planning and Funding
- Continue NP education across sector and nationally
- Plan for future roles and NPs