Nurse Practitioners in NSW - Guideline for Implementation of Nurse Practitioner Roles - NSW Health

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Functional Sub group:
- Clinical/ Patient Services - Imaging - diagnostic and interventional
- Clinical/ Patient Services - Nursing and Midwifery
- Clinical/ Patient Services - Pharmaceutical
- Clinical/ Patient Services - Pathology
- Personnel/Workforce - Workforce planning

Summary:
This guideline supports the implementation of NSW Health Policy Directive PD2012_026 Nurse Practitioners in NSW. The document outlines changes to Nurse Practitioner scope of practice, formulary arrangements and endorsement pathways and includes guidance on establishing and implementing Nurse Practitioner models of care.

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Applies to:
- Local Health Districts
- Speciality Network Governed Statutory Health Corporations
- Board Governed Statutory Health Corporations
- Chief Executive Governed Statutory Health Corporations
- Affiliated Health Organisations
- Public Health System Support Division
- Community Health Centres
- NSW Ambulance Service
- Ministry of Health
- Public Health Units
- Public Hospitals

Audience: All staff

Distributed to:
- Public Health System
- Divisions of General Practice
- Health Associations
- Unions
- NSW Ambulance Service
- Ministry of Health
- Private Hospitals
- and Day Procedure Centres
- Tertiary Education Institutes

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NURSE PRACTITIONERS IN NSW GUIDELINE

PURPOSE

This guideline has been developed to support implementation of PD2012_026 Nurse Practitioners in NSW.

KEY PRINCIPLES

- Nurse Practitioner positions are established to address gaps in service delivery for target populations by introducing new flexible and innovative models of care or by complementing existing services,
- The establishment and implementation of Nurse Practitioner services is guided by a consistent process within supportive and collaborative environments,
- Nurse Practitioners and Transitional Nurse Practitioners are supported by robust clinical governance frameworks,
- Nurse Practitioner services are evaluated within a multidisciplinary environment to ensure needs of target populations are met and opportunities to expand or improve services occur.

USE OF THE GUIDELINE

Whilst a summary of relevant legislation is provided, it is essential that this guideline is understood along with the standards, codes, regulations and any additional legislation relevant to Nurse Practitioners at both the State and Commonwealth level. These include but are not limited to the National Competency Standards for the Nurse Practitioner, Nursing and Midwifery Board of Australia (NMBA) Safety and Quality Framework for Nurse Practitioners and the Registration Standard for endorsement of Nurse Practitioners.

This guideline has been prepared to assist stakeholders to establish, implement and evaluate Nurse Practitioner positions in a consistent manner across NSW by informing:

- Organisations considering implementation or expansion of Nurse Practitioner services.
- Nurse Practitioners.
- Registered Nurses (RNs) employed into Nurse Practitioner positions (Transitional Nurse Practitioners) while working toward Nurse Practitioner endorsement by the Nursing and Midwifery Board of Australia (NMBA).
- RNs employed by NSW Health wishing to enrol in courses leading to endorsement as a Nurse Practitioner.
- Education providers enrolling students employed by NSW Health into courses leading to endorsement as a Nurse Practitioner.
Organisations should use this guideline to:

- Identify and define gaps in the current service provision and ensure that Nurse Practitioner roles are established and equipped to address these *(Guideline section 4)*.

- Enable and support a structured, collaborative process for establishing, implementing and evaluating the role or service effectively *(Guideline section 4)*.

- Enable and support formal arrangements for supervision of clinical practice.

- Identify clear roles and responsibilities in establishing, implementing and supporting Nurse Practitioner roles.

- Ensure clinical governance frameworks are in place including robust clinical supervision arrangements, mentorship opportunities, evaluation processes and performance appraisal *(Guideline section 6.1)*.

- Ensure decisions regarding model of care and scope of practice (ScOP) are able to be made collaboratively at a local level by the Multidisciplinary Support Committee (MDSC) to enable a flexible and responsive model of care *(Guideline section 4.3)*.

- Ensure Nurse Practitioner roles are implemented in line with PD2012_026 Nurse Practitioners in NSW.

Nurse Practitioners should use this guideline to:

- Work collaboratively within the organisation to develop, implement and evaluate flexible, innovative Nurse Practitioner models of care.

- Develop a ScOP reflective of individual expertise and competence that supports prescribing practice *(Guideline section 7)*.

- Ensure ScOP is aligned with intended model of care delivery.

- Identify learning objectives in order to satisfy educational requirements, support ongoing continuing professional development (CPD), maintain competence, enable and expand ScOP as appropriate.

- Lead multidisciplinary evaluation of Nurse Practitioner role/service *(Guideline section 12)*.

Transitional Nurse Practitioners should use this guide to:

- Collaborate to ensure organisational support, including clinical supervision requirements, are in place upon commencement and are sustained throughout the transitional period *(Guideline section 5)*.

- Work collaboratively within the organisation to develop, implement and evaluate flexible, innovative Nurse Practitioner models of care.

- Develop a ScOP document reflective of individual expertise and competence that supports supervised advanced practice *(Guideline section 7)*.
• Work collaboratively to identify and meet learning needs.
• Ensure ScOP is aligned with intended model of care delivery.
• Ensure educational and endorsement requirements are met within agreed timeframes (Guideline section 3).
• Lead and or participate in multidisciplinary evaluation of Nurse Practitioner role/service (Guideline section 12).

Registered Nurses wishing to undertake courses of study leading to endorsement as a Nurse Practitioner are to:

• Ensure formal approval is obtained from the DNM of the employing facility prior to enrolling in any course leading to endorsement as a Nurse Practitioner (Guideline section 6).
• Ensure all clinical placement hours are adequately supervised and competencies assessed according to required university standards.
• Ensure practice outside clinical practicum is maintained within the ScOP appropriate to current employment and all advanced practice is appropriately supervised.

REVISION HISTORY

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ATTACHMENTS

1. Nurse Practitioner Scope of Practice template
2. Appended drug formulary including approval template
3. Nurse Practitioner student enrolment – approved
4. Nurse Practitioner student enrolment – not approved
5. Notification of newly established Nurse Practitioner role template
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1 DEFINITIONS

**Australian Health Practitioner Regulation Agency (AHPRA):** AHPRA supports the 10 National Health Practitioner Boards in implementing the National Registration and Accreditation Scheme in their primary roles of protecting the public and managing the registration processes for health practitioners and students around Australia.

**Collaborative arrangements:** A collaborative arrangement is an arrangement between a Nurse Practitioner and a Medical Practitioner required to be in place in accordance with *The National Health (Collaborative arrangements for nurse practitioners) Determination 2010*. Collaborative arrangements are only required to be in place for Nurse Practitioners to prescribe Pharmaceutical Benefits Scheme (PBS) subsidised medications and provide services subsidised by the Medicare Benefits Scheme (MBS).

**Continuing therapy only prescribing model (CTO):** A prescribing model that may be utilised by Nurse Practitioners to enhance continuity of care where the prescribing of a medicine for a patient has been initiated by a medical practitioner, but prescribing is continued by a Nurse Practitioner where appropriate. (This is similar to existing arrangements between specialists and medical practitioners for prescribing certain medicines.) As an example, a Nurse Practitioner may continue the prescription of an antihypertensive medication which was initially prescribed by the patient’s GP.

**Eligible Nurse Practitioner:** Nurse Practitioner who meets the criteria to apply for a Medicare provider number or PBS prescriber number allowing provision of MBS subsidised services or prescription of PBS subsidised medications.

**Endorsement:** The process by which a RN is authorised by the NMBA in accordance with s95 of the *Health Practitioner Regulation National Law (NSW)* No 86a to use the protected title of ‘Nurse Practitioner’ and therefore utilise the extensions to clinical practice including prescribing, referral, diagnosis, initiation of diagnostics and discharge from care.

**Indirect clinical time:** Refers to time allocated within rostered hours for Nurse Practitioners/Transitional Nurse Practitioners which is dedicated to aspects of the role such as model of care and scope of practice (ScOP) development, continuing professional development, research and quality projects, teaching, mentoring, administration and evaluation.

**Medicare Benefits Scheme (MBS):** The National health care funding system which gives eligible Australian residents, access to health care at an affordable, or no cost, by subsidising payments for private medical services.

**Multidisciplinary Support Committee (MDSC):** Committee established at a local level as part of a clinical governance framework to support the establishment, implementation and sustainability of a Nurse Practitioner position and assist in developing governance structures, model of practice and in progressing the development of a ScOP. It is expected that the committee contains the relevant expertise to support role development.
Nursing and Midwifery Board Australia (NMBA): The NMBA is responsible for registering nursing and midwifery practitioners (and students), developing standards, codes and guidelines for the nursing and midwifery profession, handling notifications, complaints, investigations and disciplinary hearings, assessing overseas trained practitioners who wish to practise in Australia and approving accreditation standards and accredited courses of study. Functions of the NMBA are supported by Australian Health Practitioner Regulation Agency (AHPRA).

Nurse Practitioner (NP): A RN who is educated and endorsed to function autonomously and collaboratively in an advanced and extended clinical role. The NP role includes assessment and management using nursing knowledge and skills. The role may include, but is not limited to, the direct referral of patients to other health care professionals, prescribing medications and initiating and interpreting diagnostic investigations¹.

The title of ‘Nurse Practitioner’ is protected and may only be used by RNs endorsed by the NMBA to do so.

NSW Health: means, for the purposes of this guideline, all public health organisations, the Ministry of Health, the Ambulance Service of NSW and all other bodies and organisations under the control and direction of the Minister for Health or the Director-General of Health.

Participating Nurse Practitioner: A participating Nurse Practitioner is an eligible Nurse Practitioner who renders a Medicare rebateable service in a collaborative arrangement or collaborative arrangements of a kind or kinds specified in the regulations.

PBS prescriber
A practitioner who is approved to prescribe PBS medicines under the National Health Act 1953, practices within a collaborative arrangement or collaborative arrangements of a kind or kinds specified in the regulations and has been issued with a PBS prescriber number.

Pharmaceutical Benefits Scheme (PBS): Part of the Australian Healthcare funding system designed to ensure Australian residents and eligible overseas visitors have access to necessary medicine at a subsidised cost.

Preferred Drugs (P Drugs): A list of drugs compiled by a Nurse Practitioner/Transitional Nurse Practitioner chosen as part of preferred treatments for common conditions. This list is an important prescribing aid to assist the prescriber in becoming familiar with commonly prescribed medications. This list does not require approval at a local level.

Safety & Quality Framework (S&QF): NMBA regulatory framework for Nurse Practitioners.² The S&QF outlines those standards, codes and legislative requirements within which Nurse Practitioners must practise, ensuring ongoing competence and safe practice.

¹ National Competency Standards for the Nurse Practitioner, Australian Nursing and Midwifery Council (ANMC), 2006, NMBA, 2010
² Guidelines on endorsement as a Nurse Practitioner, NMBA 2011
Scope of Practice (ScOP): A document developed by the Nurse Practitioner/Transitional Nurse Practitioner in collaboration with the MDSC outlining the model of care delivery and the nursing and healthcare activities inherent to the care delivery model. Each ScOP will reflect the competence of the individual employed in the role.

Shared care prescribing model (SCM): Prescribing model that may be utilised by Nurse Practitioners in situations where the care of a patient is shared between the Nurse Practitioner and a medical officer (for example an admitting officer of a specialty unit to which the patient is being admitted in a formalised arrangement) with an agreed plan to manage the patient. The details surrounding shared care arrangements will depend on the practitioners involved, the patients’ needs and the healthcare context.

Supervised clinical practice: A formal process of professional support and learning that enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice and enhance consumer protection and safety of care in complex situations. This process should be based on a framework of reflection and review.

Transitional Nurse Practitioner (TNP): A RN employed into an established Nurse Practitioner position, who is supported by the employing organisation and whose clinical practice is supervised while practicing at an advanced level (Guideline section 3) in order to fulfill requirements for endorsement as a Nurse Practitioner by the NMBA.

2 LEGISLATION AND REGULATION

Prescription, possession, supply and use of poisons, restricted substances and drugs of addiction.

The authorising legislation for a Nurse Practitioner to prescribe, possesses, supply and use poisons, restricted substances and drugs of addiction in NSW is the Poisons and Therapeutic Goods Act 1966 and the Poisons and Therapeutic Goods Regulation 2008.

Approval to prescribe poisons, restricted substances and drugs of addiction.

Poisons, restricted substances and drugs of addiction available for Nurse Practitioners to prescribe, possesses, supply and use must be approved by the Director-General (or delegate) according to s17A of the Poisons and Therapeutic Goods Act 1966. This approval is a function that has also been delegated by the Director-General to the Chief Nursing and Midwifery Officer (CNMO) NSW and the Chief Executive (CE) of the relevant LHD accordance with S21 of the Health Administration Act 1982. The approval of poisons, restricted substances and drugs of addiction for Nurse Practitioners in private practice to prescribe, possesses, supply and use is the delegated responsibility of the CNMO. CEs may be required to utilise this delegation to approve appended formularies.

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3 NHS Management Executive 1993
Title protection, endorsement and regulation
Relevant legislation regarding title protection, endorsement and regulation of Nurse Practitioners is according to the Health Practitioner Regulation National Law (NSW) No 86a.

The registration of a Nurse Practitioner is endorsed by the NMBA as being qualified to administer, obtain, supply, prescribe and use a scheduled medicine or class of scheduled medicines in accordance with s94 the Health Practitioner Regulation National Law (NSW) No 86a.

Collaborative arrangements
Legislation regarding collaborative arrangements includes:

- The National Health (Collaborative arrangements for nurse practitioners) Determination 2010
- The Health Insurance Amendment Regulations 2010 (No. 1)

Safety & Quality Framework (S&QF)
The primary purpose of the S&QF is to ensure the protection of the public. The S&QF does this by outlining those standards, codes and legislative requirements within which Nurse Practitioners must practise, ensuring ongoing competence and safe practice. Nurse Practitioners are required to practise in accordance with the S&QF. Failure to comply with the S&QF will incur disciplinary action by the Board that, if proven, carries considerable disciplinary consequences for Nurse Practitioners.

The elements of the S&QF are:
- scope of practice
- codes of professional conduct and ethics
- national Nurse Practitioner competency standards
- annual declaration
- NMBA audit process
- mandatory reporting
- notification and management of performance, conduct or health matters
- co-regulatory requirements of Medicare and the Board
- prescribing authority and compliance with state and territory legislation
- collaborative arrangements.

Practice will be in accordance with evidence based practice and all relevant NSW Health and LHD policies, procedures and guidelines.

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4 Collaborative Arrangements for Participating Midwives and Nurse Practitioners FACT SHEET Medicare Financing and Analysis Branch, 2010
3 ENDORSEMENT AS A NURSE PRACTITIONER

The National Registration and Accreditation Scheme for health professionals in Australia commenced on 1 July 2010 under the Health Practitioner Regulation National Law Act (the National Law)⁵. The Nursing and Midwifery Board of Australia has established State and Territory Boards to support the work of the National Board within the scheme. The National Board will set policy and professional standards, and the State and Territory Boards will continue to make individual notification and registration decisions affecting individual nurses and midwives including decisions regarding Nurse Practitioner endorsements.

Endorsement of RNs as Nurse Practitioners is according to the NMBA Endorsement as a nurse practitioner registration Standard⁶, developed under section 38 of the National Law. This registration standard describes the requisite qualification and experience required for endorsement as a Nurse Practitioner. RNs may apply for endorsement through the NMBA and once endorsed, will be entitled to use the protected title of ‘Nurse Practitioner’. It is an offence for a nurse, midwife or any other person to hold themselves out as a Nurse Practitioner unless they hold a current endorsement from the NMBA.

Nurse Practitioner endorsement no longer carries a notation limiting practice to a particular specialty. In accordance with the NMBA Position Statement - The Scope of Practice of Nurse Practitioners⁷, applicants will be expected to demonstrate 3 years full time equivalent advanced practice within the intended area of practice within the previous 6 years, and any change to this ScOP is to be evidenced by appropriate education and skill development.

The NMBA have also published Guidelines for endorsement as a nurse practitioner⁸ including the S&QF which exists to support safety and quality in practice.

The endorsement process is separate to that of employment and does not necessarily ensure the NP is competent in all skills and tasks within a particular specialty context. Specifically, the endorsement process does not:

- Ensure the Nurse Practitioner has the skills and experience required for a particular position within a specific health service
- Define the clinical skills, services, procedures or patient populations the Nurse Practitioner may be competent to provide or undertake autonomously
- Verify the quality of the services provided by the Nurse Practitioner⁹.

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⁵ The Health Practitioner Regulation National Law Act as in force in each state and territory.
⁶ NMBA Endorsement as a nurse practitioner registration standard (2011)
⁷ NMBA Position statement Scope of practice of nurse practitioners
⁸ Guidelines on endorsement as a Nurse Practitioner, NMBA 2011
⁹ Clinical Governance for Nurse Practitioners, Queensland Health (2010)
As with any position, the responsibility for ensuring the appropriateness and competence of an individual for a particular position within any health service rests with the employer and the Nurse Practitioner.

To be eligible for endorsement as a Nurse Practitioner, the RN must be able to provide evidence to demonstrate all of the following:

1. current general registration as a registered nurse with no conditions on registration relating to unsatisfactory professional performance or unprofessional conduct

2. the equivalent of three (3) years’ full-time experience in an advanced practice nursing role within the area of intended practice, within the past six (6) years from the date when the complete application seeking endorsement as a Nurse Practitioner is received by the Board

3. successful completion of a Board-approved Nurse Practitioner qualification at Master’s level or education equivalence as determined by the Board

4. compliance with the Board’s National Competency Standards for the Nurse Practitioner and

5. compliance with the Board’s registration standard on continuing professional development.

The National Competency Standards for the Nurse Practitioner can be accessed from the Board’s website at www.nursingmidwiferyboard.gov.au under Codes and guidelines.

Two pathways have been established for endorsement as a Nurse Practitioner.

3.1 Pathway 1

Applicants must demonstrate evidence of successful completion of an Australian Nursing & Midwifery Accreditation Council (ANMAC) accredited and NMBA approved Nurse Practitioner program of study at Masters’ level.

Board-approved programs of study are listed on the NMBA’s website.

3.2 Pathway 2

Applicants must demonstrate evidence of the successful completion of:

1. a program of study at Master’s level that is clinically relevant to the applicant’s context of advanced practice nursing for which they are seeking endorsement as a Nurse Practitioner

2. supplementary education that will demonstrate equivalence and meet the National Competency Standards for the Nurse Practitioner.
Supplementary education for pathway 2 applicants may include ANMAC approved subjects related to health assessment, diagnostics, pharmacology and prescribing if this education is not evident within the applicant’s application.

A **portfolio of evidence** is required to support applications for endorsement via either pathway (including supplementary education demonstrating equivalence). Portfolio requirements are available on the NMBA website.

### 3.3 Advanced practice

Defining exactly what reflects advanced practice leading to endorsement as a Nurse Practitioner is not always straightforward or uniform. Whilst there may be elements of advanced practice demonstrated within a variety of nursing roles, it is necessary that RNs applying for endorsement demonstrate competence in those essential to the Nurse Practitioner role which is focussed on the provision of direct clinical care to patients or target populations. These elements also include education and professional development, research, clinical leadership and collaborative practice, practice development and quality improvement.

In demonstrating the required level of practice of a Nurse Practitioner, it is expected that the RN competently demonstrates the ability to:

- undertake comprehensive health assessments of patients within target populations in order to collect relevant clinical data to inform clinical and diagnostic decision making processes
- articulate sound reasoning behind clinical, diagnostic and prescribing decisions that are informed by evidence based practice and made within a nursing context
- utilise critical and reflective thinking, complex reasoning and analysis to guide assessments, clinical judgements and decisions whilst managing complete episodes of patient care
- practice with a high degree of autonomy and accountability and apply extended practice competencies within a nursing model of practice
- perform in a clinical leadership role evidenced by participation in practice development activities including mentoring, education, active participation in communities of practice, policy development, research and quality improvement
- exhibit sound, high level knowledge and skills applied to a broad range of challenging, complex and changing situations.

All requirements are outlined by the [ANMAC National Competency Standards for the Nurse Practitioner](https://www.nmba.org.au) which have been adopted by the NMBA and define the minimum expectations for Nurse Practitioner Practice in Australia. The standards, which build on the core competency standards for RNs and those defined for advanced nursing practice, are those by which RNs performance is assessed to obtain and retain endorsement as a Nurse Practitioner. It is these competencies that should form the basis for peer review and performance appraisal.
3.4 Nurse Practitioner Competencies

Standard 1

**Dynamic practice that incorporates application of high level knowledge and skills in extended practice across stable, unpredictable and complex situations.**

**Competency 1.1**
Conducts advanced, comprehensive and holistic health assessments relevant to a specialist field of nursing practice

**Performance indicators**
- Demonstrates advanced knowledge of human sciences and extended skills in diagnostic reasoning
- Differentiates between normal, variation of normal and abnormal findings in clinical assessment
- Rapidly assesses a patient’s stable and complex health care problem through synthesis and prioritisation of historical and available data
- Makes decisions about use of investigative options that are judicious, patient focussed and informed by clinical findings
- Demonstrates confidence in own ability to synthesise and interpret assessment information including client/patient history, physical findings and diagnostic data to identify normal and abnormal states of health and differential diagnoses

**Competency 1.2**
Demonstrates a high level of confidence and clinical proficiency in carrying out a range of procedures, treatments and interventions that are evidence based and informed by specialist knowledge

**Performance indicators**
- Consistently demonstrates a thoughtful and innovative approach to effective clinical management planning in collaboration with the patient/client
- Exhibits a comprehensive knowledge of pharmacology and pharmacokinetics related to a specialist field of clinical practice
- Selects/prescribes appropriate medication, including dosage, routes and frequency pattern, based upon accurate knowledge of patient characteristics and concurrent therapies
- Is knowledgeable and creative in selection and integration of both pharmacological and non-pharmacological treatment interventions into the management plan in consultation with the patient/client
- Rapidly and continuously evaluates the patient/client’s condition and response to therapy and modifies the management plan when necessary to achieve desired patient/client outcomes
- Is an expert clinician in the use of therapeutic interventions specific to, and based on, their expert knowledge of specialty practice
- Collaborates effectively with other health care professionals and agencies and makes and accepts referrals as appropriate to a specific model of practice
• Evaluates treatment/intervention regimes on completion of the episode of care, in accordance with patient/client determined outcomes

Competency 1.3

Has the capacity to use the knowledge and skills of extended practice competencies in complex and unfamiliar environments

Performance indicators
• Actively engages community/public health assessment information to inform interventions, referrals and coordination of care
• Demonstrates confidence and self-efficacy in accommodating uncertainty and managing risk in complex patient care situations
• Demonstrates professional integrity, probity and ethical conduct in response to industry marketing strategies when prescribing drugs and other product
• Uses critical judgement to vary practice according to contextual and cultural influences
• Confidently integrates scientific knowledge and expert judgement to assess and intervene to assist the person in complex and unpredictable situations

Competency 1.4

Demonstrates the skills in accessing established and evolving knowledge in clinical and social sciences, and the application of this knowledge to patient care and the education of others

Performance indicators
• Critically appraises and integrates relevant research findings in decision making about health care management and patient interventions
• Demonstrates the capacity to conduct research/quality audits as deemed necessary in the practice environment
• Demonstrates an open-minded and analytical approach to acquiring new knowledge
• Demonstrates the skills and values of lifelong learning and relates this to the demands of extended clinical practice

Standard 2

Professional efficacy whereby practice is structured in a nursing model and enhanced by autonomy and accountability

Competency 2.1

Applies extended practice competencies within a nursing model of practice

Performance indicators
• Readily identifies the values intrinsic to nursing that inform nurse practitioner practice and an holistic approach to patient/client/community care
• Communicates a calm, confident and knowing approach to patient care that brings comfort and emotional support to the patient/client and their family
• Demonstrates the ability and confidence to apply extended practice competencies within a scope of practice that is autonomous and collaborative
• Creates a climate that supports mutual engagement and establishes partnerships with patients/client/carer/family
• Readily articulates a coherent and clearly defined nurse practitioner scope of practice that is characterised by extensions and parameters

Competency 2.2

Establishes therapeutic links with the patient/client/community that recognise and respect cultural identity and lifestyle choices

Performance indicators
  • Demonstrates respect for the rights of people to determine their own journey through a health/illness episode while ensuring access to accurate and appropriately interpreted information on which to base decisions
  • Demonstrates cultural competence by incorporating cultural beliefs and practice into all interactions and plans for direct and referred care
  • Demonstrates respect for differences in cultural and social responses to health and illness and incorporates health beliefs of the individual/community into treatment and management modalities

Competency 2.3

Is proactive in conducting clinical services that are enhanced and extended by autonomous and accountable practice

Performance indicators
  • Establishes effective, collegial relationships with other health care professionals that reflect confidence in the contribution nursing makes to client outcomes
  • Readily uses creative solutions and processes to meet patient/client/community defined health care outcomes within a frame of autonomous practice
  • Demonstrates accountability in considering access, clinical efficacy and quality when making patient-care decisions
  • Incorporates the impact of the nurse practitioner service within local and national jurisdictions into the scope of practice
  • Advocates for expansion of the nurse practitioner model of service that will improve access to quality, cost effective health care for specific populations

Standard 3

Clinical leadership that influences and progresses clinical care, policy and collaboration through all levels of the health care service

Competency 3.1

Engages in and leads clinical collaboration that optimise outcomes for patients/clients/communities
Performance indicators

- Actively participates as a senior member and/or leader of relevant multidisciplinary teams
- Establishes effective communication strategies that promote positive multidisciplinary clinical partnerships
- Articulates and promotes the nurse practitioner role in clinical, political and professional contexts
- Monitors their own practice as well as participating in intra-disciplinary peer supervision and review

Competency 3.2
Engages in and leads informed critique and influence at the systems level of health care

Performance indicators

- Critiques the implication of emerging health policy on the nurse practitioner role and the patient/client population
- Evaluates the impact of social factors (such as literacy, poverty, domestic violence and racial attitudes) on the health of individuals and communities and acts to moderate the influence of these factors on the specific population/individual
- Maintains current knowledge of financing of the health care system as it affects delivery of care
- Influences health care policy and practice through leadership and active participation in workplace and professional organisations and at state and national government levels
- Actively contributes to and advocates for the development of specialist, local and national, health service policy that enhances nurse practitioner practice and the health of the community

The UK Department of Health has published Advanced Level Nursing: A Position Statement based on international definitions and competencies related to advanced practice, including the National Competency Standards for the Nurse Practitioner. The statement outlines fundamental requirements in defining advanced practice which can also be applied to clinical practice accepted as advanced in Australia. The document seeks to provide indicators of advanced practice within each practice element relevant to the Nurse Practitioner role.

3.5 Ongoing endorsement

Ongoing endorsement as a Nurse Practitioner is contingent upon the Nurse Practitioner meeting the Board’s requirements for renewal of registration annually. Nurse Practitioners are required to make an annual statutory declaration that they have met requirements under section 109 of the National Law, including completion of the required continuing professional development and meeting the recency of practice requirements.

Requirements for ongoing endorsement as a Nurse Practitioner
4 ESTABLISHING NURSE PRACTITIONER POSITIONS

Nurse Practitioner positions are to be established within a multidisciplinary environment based on a culture of collaboration, respect and acceptance. Implementation is guided by the principles of collaborative planning and practice, patient centred care and evaluation. Positions are developed to implement a new or expanded model of care to address identified needs or gaps in current service provision and are integrated through robust health service planning. Definition of the role is essential to successful role integration including clear a job description, ScOP, reporting lines, description of the model of care and service delivery.

Whilst the role is centred primarily around the provision of direct clinical care, organisations establishing a Nurse Practitioner position acknowledge and support the inherent aspects of the role including research, education, mentoring, management, administration and the extensions to clinical practice (independent prescribing, referral, initiation of diagnostic investigations and the ability to diagnose and discharge patients from care).

4.1 Preparing the case for a Nurse Practitioner position

Prior to the implementation of a Nurse Practitioner role or service, it is essential organisations undertake both a detailed research and planning phase to review current service provision and identify gaps, reconcile the Nurse Practitioner role as appropriate to address these and prepare both the service and organisation for role implementation. The process can be divided into separate steps including service analysis, business case and implementation and evaluation. The following diagram provides an outline of the process and resources organisations may find useful.
Service needs analysis

A needs analysis is the process of identifying, describing and evaluating the problems experienced by a defined population and identifying possible solutions.

A clear service needs analysis will provide a foundation for the preparation of a strong, evidence based business case to support implementation of the role.

The NHS Education for Scotland (NES) and the Scottish Government have developed an Advanced Nursing Practice Service Needs Analysis Tool\(^9\) which organisations may find useful in undertaking a needs analysis. The tool aims to support health service teams to identify, collect and interpret relevant data that will assist in clarifying the problems for patients accessing current services including:

- **Patient needs** – priority problems and goals, epidemiology, population health/demographics, health data, relevant health policy documents & regional health strategies and geographic context

- **Service needs** - current model of care, the need for a new model of care, drivers for change, stakeholder communication, workforce planning

The tool also includes sections relevant to advanced practice roles and outlines issues for organisations to consider prior to moving on to implementation phase:

- **Advanced practice role** - defining a new model of care and the advanced practice role, parameters of accountability, governance arrangements, education & training requirements

- **Infrastructure** - implementation strategies, resources & sustainability

- **Evaluation** - evaluating the advanced practice role & model of care

Once a service analysis has been undertaken and the gaps or needs identified, this information is presented to the organisation as part of a business case.

**Business case**

A well developed business case outlines the reasons current service provision may need revision in order to better address the needs of the target population.

The rationale underpinning the development of a business case is to ensure that resources and funding are focused in support of a specific consumer need. As an example, the intent of introducing a Nurse Practitioner service might be to improve system performance but the business case is that better service provision would improve access to high quality health care for patients. The business case should capture both the quantifiable and unquantifiable characteristics of the advanced practice role including the potential benefits of aspects such as health promotion, participation in research, leadership activities, chronic disease prevention and or management, symptom control and patient education and counselling.

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The background for a business case should highlight current issues or gaps in service provision identified in the service needs analysis, and the manner in which implementation of Nurse Practitioner service may address these issues (model of care delivery). It should include:

- the expected benefits
- other options considered (with reasons for accepting or rejecting each option)
- cost benefit analysis
- a gap analysis comparing actual and potential outcomes
- a risk benefit analysis
- consideration should also be given to the risks of leaving service provision unchanged, including the impact on the service and target population.

This information will form the justification for service change. Forming a business case is the responsibility of stakeholders and sponsors and should not be left to an individual. A template to assist in the development of a business case is included in A toolkit for the implementation of the Nurse Practitioner role developed by the Government of South Australia (SA Health).\(^{10}\)

**Implementation and evaluation**

The decision to implement or expand Nurse Practitioner services should be guided by a defined process. Whilst the Needs Analysis Toolkit encourages organisations to consider many important factors, to ensure the process is systematic and comprehensive, an established tool such as the PEPPA Framework\(^{11}\) should be used. The framework has been developed to provide a systematic approach to the introduction, implementation and evaluation of advanced nursing practice roles and includes several tools to assist in each phase. The SA Health role implementation toolkit is based on the PEPPA framework.

The aims of the framework are to:

- Utilise relevant and appropriate data to support the need and identify the goals in implementing a clearly defined role
- Support the development of an advanced practice nursing role characterised by patient-centred, health focused and holistic care
- Promote the full integration and utilisation of advanced nursing knowledge, skills and expertise from all role dimensions including direct clinical care, education, research, leadership and professional practice

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\(^{10}\) Nurse Practitioners in South Australia A toolkit for the Implementation of the Role.

\(^{11}\) Participatory, Evidence-Based, Patient-Focused Process for Advanced Practice Nursing (APN) Role Development, Implementation, and Evaluation.
• Create practice environments that support Nurse Practitioner role development by engaging key stakeholders from the health care team, practice setting and health care system in the role planning, implementation and evaluation process.

• Promote ongoing Nurse Practitioner role development and model of care enhancement through continuous and rigorous evaluation of progress in achieving pre-determined outcome-based goals.

The framework aims to assist organisations in overcoming common challenges and barriers encountered when implementing roles by undertaking careful planning, implementing collaborative strategies and improving stakeholder understanding.

4.2 Organisational Support

Clear organisational support is essential for both successful implementation of the role and its ongoing development and functional sustainability. Important components of this support include:

- identifying the need for change to service delivery
- identifying the goals change aims to achieve
- understanding and acceptance of the Nurse Practitioner role
- clear nursing leadership
- support from ‘role champions’ throughout the organisation
- clear, consistent communication pathways between key stakeholders.

To promote and support the implementation process LHDs are encouraged to develop Multidisciplinary Support Committee/s (MDSC) and nominate an LHD Nurse Practitioner Coordinator.

4.3 LHD Nurse Practitioner Coordinator

The LHD Coordinator is to have a well informed understanding of the Nurse Practitioner role and related policy in order to support functional Nurse Practitioner roles, promote networking opportunities for Nurse Practitioners/Transitional Nurse Practitioners, assist position description and ScOP development (as required), liaise with the Nursing & Midwifery Office (also includes maintaining the Nurse Practitioner Information System (NPIS) database), provide advice and ensure consistency in role development and policy implementation. LHD DNMs nominate an appropriately resourced Nurse Manager or Nurse Practitioner to this portfolio.

4.4 Multidisciplinary Support Committee

The MDSC has both a supportive and functional role in driving the development and implementation of the role. It is therefore imperative that the MDSC is able to make decisions relevant to the development and implementation of the Nurse Practitioner role or service at a local level.
4.4.1 Role of the MDSC

While the MDSC is not responsible for service planning, it is essential the committee interacts with health service planners across the multidisciplinary environment in order to identify service needs or gaps in current service provision and understand how these may be best addressed. Gaps may include a lack of service or a need to augment existing services. This analysis should also resolve whether the Nurse Practitioner model is best suited to address the service needs and complement existing services. Consideration may also be given to whether an established position within the current model of care may enhance service delivery if it were to be developed into a Nurse Practitioner role.

The committee also supports the development, implementation and evaluation of the model of care and the clinical governance framework through collaboration with the Nurse Practitioner/Transitional Nurse Practitioner in developing a ScOP consistent with the model of care/service delivery.

The MDSC chair is responsible for approving the finalised ScOP, at which time the document becomes operational, prior to acknowledgement by the LHD Director of Nursing and Midwifery (DNM) and Chief Executive (CE).

4.4.2 Structure of the MDSC

LHDs may decide to establish one committee if needing to support positions across a small area or number of facilities or several committees throughout organisations to accommodate a larger number of roles. A single MDSC may substitute members to ensure each role is fully supported.

The MDSC is to include key members of the healthcare team who are familiar with the Nurse Practitioner role and are directly involved with the provision of care to the target population. It is essential that members of the MDSC have a clear understanding of the Nurse Practitioner role, including the extensions to practice and support the integration of the role into the health service.

The MDSC is to be limited to a core group of members that seeks advice from external sources for assistance and clarification as required. Suggested membership may include some of the following:

- NP/TNP (where employed)
- Clinical supervisor and Mentor
- Facility/Service DNM
- Operations manager* /Nursing Unit Manager *
- Director of medical service/Department Head
- Ward, community or clinical service pharmacist
- NP Coordinator LHD
- GP*
4.5 Organisational readiness

A risk assessment and management strategy for implementing the service or expanding the Nurse Practitioner service or ScOP are essential as part of the pre implementation plan. An assessment of the organisational readiness should also be made to ensure adequate systems exist to support the role. A clear understanding and acceptance of all aspects should include:

- The legal principle of vicarious liability in the designated area of practice and the necessary arrangements for supervision of clinical practice and mentorship for students, Transitional Nurse Practitioners and Nurse Practitioners
- The extensions to clinical practice (independent prescribing, diagnosis, initiation of diagnostics, referral and discharge from care)
- Relevant legislation and regulation
- Committed recurrent funding arrangements
- Succession planning
- Incorporation of the NP service into the organisation’s safety and quality processes
- Organisational support required including clinical governance
- Educational requirements
- Clear and consistent communication strategies to include all relevant stakeholders
- Requirements for endorsement
- Potential implications of the role on existing services.

Identifying mechanisms that will enable Nurse Practitioners to work in partnership with other health care professionals including medical practitioners, nurses and midwives and allied health professionals, as well as ensuring consumer participation in ongoing planning, development and evaluation of the role is essential.

Once the decision to establish a Nurse Practitioner position has been made, approval must be given by the LHD DNM and supported by the LHD CE.
The LHD is required to notify the Chief Nursing and Midwifery Officer (CNMO), NSW Ministry of Health of the position being established. A template to assist in making this notification can be found at Appendix C. Notification assists the Nursing and Midwifery Office (NaMO) in facilitating support networks and workforce surveillance.

4.6 Recruitment into Nurse Practitioner Positions

Once a position has been approved it is to be advertised by the LHD in the usual manner. Nurse Practitioners who meet the criteria may apply for the position. In the event a suitable Nurse Practitioner is not available to fill the position, the organisation may decide to employ an RN working toward endorsement as a Nurse Practitioner into a ‘transitional’ role (Transitional Nurse Practitioner). Transitional roles also assist in succession planning, sustainability and expansion within Nurse Practitioner services. The decision to employ an RN into a transitional role will require the organisation to support necessary learning opportunities, supervision of clinical practice and mentorship arrangements.

Organisations must also accept that employing a RN in a transitional capacity will extend the time before the role can become fully operational. Organisational support is required throughout the transitional period to ensure necessary competencies are reached and the requirements endorsement as a Nurse Practitioner are met.

5 TRANSITIONAL NURSE PRACTITIONERS

Prior to employment, RNs who are considered for transitional roles must demonstrate the relevant clinical expertise, a high degree of knowledge and the ability and the necessary skills to develop practice at an advanced level. It is expected that applicants suitable for transitional roles have completed or are undertaking a relevant NMBA approved Nurse Practitioner Masters’ degree or equivalent (a clinically relevant Master’s degree) or meet course entry requirements at time of employment. Successful applicants who are not enrolled are expected to enrol at the next available opportunity.

Whilst Transitional Nurse Practitioners are expected to define a relevant ScOP and a list of P Drugs, Transitional Nurse Practitioners are to ensure practice remains within ScOP boundaries and appropriately supervised.

Transitional Nurse Practitioners do not have the same legislated clinical privileges as Nurse Practitioners and their practice is to remain supervised until endorsement. TNPs are therefore not able to diagnose, treat, prescribe or discharge patients independently.

5.1 Transitional period

Nurse Practitioners are required to demonstrate complex clinical decision making skills in the assessment and management of patients including diagnostic and prescribing decisions. Therefore, it is essential that throughout the transitional period Transitional Nurse Practitioners are provided with the appropriate clinical supervision, mentorship
and learning opportunities to develop skills in diagnostic reasoning, advanced physical assessment and the prescribing process together with the opportunity to be supervised facilitating entire episodes of care including development and evaluation of management plans.

Ensuring appropriate learning opportunities may necessitate periods of supervised practice within other facilities to enable Transitional Nurse Practitioners to achieve learning outcomes and develop required competencies. Transitional roles should also support professional development through observational contact with established Nurse Practitioner models of care where possible. This will assist in reducing professional isolation, increasing understanding and identifying skills and knowledge required to optimise the role. Such opportunities may consist of organised placements within other facilities, attending workshops or study days in other facilities or LHDs or observational visits.

Transitional Nurse Practitioners will align their learning needs and objectives with regard to skill acquisition and development of appropriate knowledge base to the needs of the target population and model of care delivery identified for the Nurse Practitioner service.

Organisations supporting Transitional Nurse Practitioners toward advanced practice may wish to develop a framework to guide development within the clinical setting. Based on the Nurse Practitioner competencies, frameworks may outline core skill sets, learning goals and objectives and include a clinical education program including supervised clinical practice designed to facilitate development and compliment tertiary education programs. Skill acquisition and competency assessment should also align with the relevant components of Nurse Practitioner Masters’ program.

Transitional Nurse Practitioners may facilitate care using advanced standing orders where appropriate. Standing medication orders may be developed in line with NSW Health PD2007 _077 Medication Handling in NSW Public Hospitals to allow the initiation medications by RNs in certain circumstances, although all other prescriptions must be written and signed by a Nurse Practitioner or medical officer. Local protocols may also be developed to allow initiation of diagnostic investigations.

Transitional Nurse Practitioners are expected to commence the planning and preparation for their role by:

- assisting in defining the model of care (as required)
- developing the body of scientific knowledge required for advanced practice
- developing ScOP and identifying P Drugs and treatments for common diagnostic groups
• identifying and developing core skill sets
• collaborating with the facility to establish appropriate clinical supervision and mentorship arrangements in collaboration with their chosen education provider and multidisciplinary support group
• developing professional networks
• identifying and participating in leadership, research, audit and evaluation opportunities in line with professional role requirements outlined in the National Competencies for Nurse Practitioners. Meeting these requirements will be assessed as part of the endorsement process.

5.2 Position descriptions

Position descriptions for RNs in transitional roles must incorporate descriptors supporting the RN in undertaking supervised practice relevant to the specialty at an advanced level acceptable for endorsement by the NMBA. These will include mentored and supervised clinical practice performing advanced health assessments, developing skills in clinical decision making, diagnostic reasoning, the prescribing process, initiation and interpretation of diagnostics, extended skills acquisition, development of therapeutic management plans, referral and the decision to discharge from care. This is essential in ensuring the RN is adequately indemnified and will be required as evidence of advanced practice for the endorsement process.

It is essential that position descriptions are developed in line with the competencies required for endorsement and the model of service delivery (guideline section 3 – see advanced practice). This is to ensure role definition is clear and practice is supported and enabled at advanced practice level.

5.3 Non progression

The length of time a RN may remain transitional in a Nurse Practitioner role is not to exceed three (3) years without acceptable reason otherwise the position may be readvertised. In the event an RN fails to successfully progress through the course or endorsement requirements within expected timeframes, the organisation and Transitional Nurse Practitioner are to reflect on the experience to date. As appropriate, performance management and a review of the model of care and existing organisational support is to occur and adjustments made accordingly.

Where the RN has been employed into a permanent position, and is unable to complete the endorsement process within the required timeframes, the RN is to be offered an existing vacant position within the LHD for which they are suitably qualified.

6 REQUIREMENTS FOR RNs ENROLLING IN COURSES LEADING TO ENDORSEMENT AS A NURSE PRACTITIONER

There are numerous university degrees leading to an ‘advanced practice’ qualification, although only limited courses lead to endorsement as a Nurse Practitioner. These courses include clinical practicum subjects during which students are expected to
develop and demonstrate the advanced clinical skills required to practice as a Nurse Practitioner. A list of approved courses is available on the NMBA website.

6.1 Approval

Applicants wishing to enrol in a degree course leading to endorsement as a Nurse Practitioner must submit a formal application for approval to the DNM of the employing facility to undertake the clinical component of this program whilst employed by NSW Health. It is essential that approval is given prior to enrolment as it is the agreement by which the student is indemnified while undertaking the clinical practicum component of study. Students who enrol without formal approval will not be covered by NSW Health indemnity insurance for any patient care undertaken in an advanced capacity or that is outside the scope of practice for which they are employed. These students will require separate clinical placements to be arranged and supervised by the university.

In deciding if the organisation or facility is able to adequately support the required learning, an assessment is made by relevant stakeholders (RN, Nursing Unit Manager (NUM), clinical service managers, medical directors, DNM) to confirm the current level of practice, the potential within the current position to develop the advanced practice skills required and to successfully complete course requirements. An assessment is also made as to whether resources such as supervision of clinical practice and mentorship would be available within the current employment arrangements. Approval is given only if the DNM is satisfied, after consultation with key stakeholders, the above criteria are met and the facility is willing to accept responsibility for supervision of clinical practice. The DNM and key stakeholders must be informed as to whom the nominated primary clinical supervisor and mentor/s responsible for assessing competence will be and be satisfied the nominees will provide appropriate supervision.

In approving the application, the employing facility agrees that the role and the RN will be appropriately supported and supervised in developing toward entry level advanced practice. This includes the skills to be developed and patient interactions to be undertaken during clinical practicum such as performing advanced health assessments, developing skills in clinical decision making, diagnostic reasoning, the prescribing process, initiation and interpretation of diagnostics, development of therapeutic management plans, referral and the decision to discharge from care.

This requirement applies to RNs who wish to enrol in an accredited, NMBA approved course leading to endorsement as a Nurse Practitioner. This agreement is made within the RN’s existing employment context and is not automatically transferrable should the RN move to another position, service or LHD.

Templates for granting or not granting approval are found at Appendix D and E.
6.2 Supervision of clinical practice and mentoring

In order to ensure the student is able to safely develop toward advanced practice, appropriate organisational support and supervision must be in place to ensure the RN is supported in expanding and extending their ScOP. Further guidance is provided by NSW Health guidelines for *Extend the Practice of Health Professionals (Guidelines for Hospitals Seeking to)*.  

Whilst arrangements regarding supervision of clinical practice at the place of employment of the student are *facilitated* by the education provider, it is the responsibility of the RN to ensure a formal approval is sought for clinical practicum to occur within employment and the responsibility of the employing facility to ensure supervision of clinical practice is provided by appropriately experienced, qualified and supportive supervisors/mentors.

The Clinical Education & Training Institute (CETI), now the Health Education and Training Institute (HETI), have published *The Superguide - a handbook for supervising allied health professionals* and *The Superguide - a handbook for supervising junior doctors* both of which provide useful information for supervisors, mentors, Transitional Nurse Practitioners and students on developing a framework for supervision of clinical practice including:

- Functions and methods of supervision
- Setting learning expectations
- Developing learning goals and contracts
- Governance and evaluation of supervision
- Supervision in rural and remote settings
- Role of supervisors
- Facilitating supervision
- Managing a clinician in difficulty.

Organisations are encouraged to develop a supportive framework which will ensure both learners and supervisors receive maximum benefit from the experience.

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12 *PD2005_042 Extend the Practice of Health Professionals (Guidelines for Hospitals Seeking to)*
Prior to agreeing to provide supervision of clinical practice, supervisors/mentors must ensure they are aware of the course and university requirements, agree they have the appropriate skills and are able to commit sufficiently to support the required learning.

7 SCOPE OF PRACTICE AND MODEL OF CARE DELIVERY

All healthcare professionals are required to practice within their professional and individual ScOP. The ScOP of a Nurse Practitioner is that for which the individual is educated, competent and authorised to perform and is shaped not only by the education, competence and experience of an individual, but also the standards of the profession, requirements of the health service, needs of the target population and the practice setting. It is an expectation of the NMBA that Nurse Practitioners are competent in the specific area of practice required to meet the needs of their target population. Further information on the ScOP is provided on the NMBA website within the Position statement - Scope of practice of nurse practitioners.

7.1 Changes to scope of practice (ScOP) requirements

Prior to July 2010, legislation (Nurses and Midwives Act NSW) required Nurse Practitioners in NSW to practice according to ‘approved clinical practice guidelines’. The Nurses and Midwives Act NSW has since been repealed, and new legislation pertaining to health practitioners (Health Practitioner Regulation National Law Act (NSW) No 86a) came into effect in July 2010. This legislation no longer requires Nurse Practitioners to have ‘approved clinical practice guidelines’ in order to practice autonomously, although the need for a clearly defined ScOP remains an important part of a local clinical governance framework, the National Competencies for the Nurse Practitioners and the S&QF (NMBA). Revised policy in NSW recognises the need to ensure this process is efficient and managed locally in order to progress operational Nurse Practitioner roles.

7.2 ScOP for Nurse Practitioners

Nurse Practitioners are required to develop their ScOP in order to define their area of expertise and competence and to describe to the health care community the populations and range of health conditions that a Nurse Practitioner treats regularly within the context of his or her practice. The ScOP also defines the practice of nursing for which Nurse Practitioners are authorised to prescribe in NSW.

7.3 ScOP for Transitional Nurse Practitioners

Transitional Nurse Practitioners are also required to develop their ScOP. This process provides a framework that enables clinical and professional development to occur that is appropriate for the model of care and service delivery and also the opportunity for learning needs to be identified as a priority and integrated into the learning goals for supervised practice.

Developing a ScOP ensures the Transitional Nurse Practitioner becomes familiar with the responsibilities and requirements of advanced and autonomous practice while in a
supervised capacity and provides ongoing opportunity to identify and develop the necessary knowledge base, skills, competence to enhance preparation for practice throughout the transitional period. The ScOP remains a ‘work in progress’ and is reviewed periodically in line with expanding capabilities. Once endorsed, the ScOP should be sufficiently developed to support full functionality of the role at the close of the transitional period.

7.4 Developing a ScOP

To simplify development of the ScOP document and ensure the aims of the document are met, it is important that it is developed around two distinct themes: the model of care delivery and the scope of practice of the Nurse Practitioners/Transitional Nurse Practitioners practice within that model of care.

An important driver in the development of the ScOP is identification of the needs of target populations around which the role of the Nurse Practitioner continues to develop. A ScOP is also influenced by the wider environment including the context of practice, relevant legislation, existing policy, quality, risk management frameworks and organisational culture.

A ScOP document cannot and should not attempt to include every healthcare activity that will be undertaken or diagnostic intervention requested, as to become restrictive or limit reasonable therapeutic initiatives. The document outlines the broad populations, presentations and diagnostic groups for whom care will be provided. Management and therapeutic interventions undertaken will be guided by evidence based practice and by the competence and experience of the Nurse Practitioner or Transitional Nurse Practitioner.

The ScOP and model of care are developed by the Nurse Practitioner/Transitional Nurse Practitioner in collaboration with the MDSC. The ScOP will align with the model of care and service delivery against which the position has been developed. This ensures the ScOP complements the intended model, is in line with LHD policy and procedure and is consistent with the competence and expertise of the individual in order to protect the patient and Nurse Practitioner/Transitional Nurse Practitioner.

Consistent with principles of best practice, Nurse Practitioners/Transitional Nurses should refer to relevant current evidence based clinical practice guidelines in order to define preferred treatments and prescribing practice.

As is the case with any employee, it is the responsibility of both the NP and the employer to be satisfied that an individual is competent to perform all aspects of the role as outlined within a ScOP.

7.5 Purpose of defining the ScOP and model of care

The purpose of defining the ScOP and model of care for a Nurse Practitioner service is to inform the health care and wider community, including patients, about the Nurse Practitioner role and its delineations including:
• the context in which care is delivered in order to meet the identified need/s or gaps in current service provision (describes the model of care such as circumstances, situations, environment and framework within which care is delivered including available clinical and supporting resources)

• determining the individual’s ScOP as an essential component of an effective governance framework and defines the practice of nursing for which a Nurse Practitioner is legislated to prescribe in NSW

• an outline of the extensions to clinical practice, parameters of practice and associated responsibilities (arrangements to facilitate prescribing, referral and dispensing mechanisms, boundaries of care)

• the manner in which the service articulates with existing services and the wider healthcare community including the professional and functional relationship to other services and healthcare professionals

• evaluation strategies around delivery of the model of care and ScOP ensuring outcomes and needs of the target populations are met

• accountability, responsibility, quality and safety mechanisms (including arrangements for patients falling outside ScOP).

7.6 Principles of developing a ScOP and model of care

• the ScOP reflects the education, competence, expertise and experience of the individual Nurse Practitioner/Transitional Nurse Practitioner thereby protecting both the patient and the individual

• an ethical decision making framework guides the Nurse Practitioner/Transitional Nurse Practitioner in the development of their ScOP and their ability to accept and manage the consequences of treatment responsibility for patients

• the ScOP should not limit appropriate therapeutic and or professional initiatives such as diagnostic investigations initiated and medications prescribed (or dosages)

• clinical competence is essential in treating the target population according to current best evidence, relevant policy and procedure

• Nurse Practitioners are accountable and responsible for all aspects of their clinical decision making and as senior, skilled clinicians refer and consult as necessary, and refer if a patient’s condition or severity of symptoms falls outside their ScOP

• the model of care and ScOP may change and develop over time in line with the expertise and competence of the Nurse Practitioner and needs of the target population ensuring a responsive and flexible model of service delivery

• ScOP is reviewed yearly as part of performance appraisal to ensure the service is meeting the identified service needs and to ensure the model/ScOP
incorporates the professional growth of the Nurse Practitioner/Transitional Nurse Practitioner. This will also ensure the service develops in response to changing needs of the target population and the Nurse Practitioner/Transitional Nurse Practitioner maintains the required competencies to practice within the defined ScOP.

Decisions about the ScOP of an individual may be guided by the use of decision making tools. The NMBA has provided specific guidance on developing a ScOP for nursing and midwifery professionals in the Professional Practice Framework. This includes advice on accepting and making delegations, and recognising practice limitations through the National Framework for Decision Making by Nurses and Midwives of Scope of Practice (ANMC 2010; approved NMBA 2010)\(^\text{13}\) including a summary tool to guide nursing decisions in developing a ScOP. This framework outlines the responsibilities of the Nurse Practitioner/Transitional Nurse Practitioner and the organisation in making ScOP decisions within a collaborative context of planning, risk management and collaboration.

The principles of the National Decision Making Framework allow employers, regulators, governments, consumers, professional groups and workforce planners to be confident that Nurse Practitioners are supported to make decisions about their ScOP and that care is provided in the public interest around a framework for decision making that is based on competence.\(^\text{14}\)

### 7.7 Outlining the model of care

A well defined model of care maintains the focus of the role in order to avoid ‘drift’ into other responsibilities or roles and to ensure the needs of the target populations and service gaps to be addressed are clear. The model of care may draw on and also guide the skill development, competence, experience and knowledge base of the Nurse Practitioner/Transitional Nurse Practitioner to prioritise patient safety and effective care provided. The model of care may expand and develop over time in line with the expertise and competence of the Nurse Practitioner/Transitional Nurse Practitioner ensuring a responsive and flexible service delivery.

In developing a model of care, the organisation together with the Nurse Practitioner/ Transitional Nurse Practitioner, must consider the level of expertise and the degree of extended support or intervention patients may potentially require and who may be best placed to provide such care in order to help define articulation points with other health care services. It is expected that the organisation and the Nurse Practitioner/ Transitional Nurse Practitioner will consider all responsibilities to patients in the event of an emergency or that a patient falls outside the ScOP. Elements included in the model of care describe:

- the gaps in service provision the model aims to address
- the target population including any exclusions from care

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\(^{13}\) Guidelines on endorsement as a Nurse Practitioner, Safety and Quality Framework, NMBA 2010

\(^{14}\) National Framework for Decision Making by Nurses and Midwives of Scope of Practice (ANMAC 2010; approved NMBA 2010)
• operational aspects such as operating times, practice environment including physical resources, clinical and infrastructure support, (including indirect clinical time)

• practice environment including supporting and collaborating services (including in emergency situations), eg. acute inpatient/community/emergency services

• broad categories of the conditions, symptoms or presentations the Nurse Practitioner may treat (not exhaustive)

• focus of care including assessment, diagnosis, care planning, initiation of therapeutic management plans and diagnostic investigations, health promotion, prevention management/detection of chronic disease, screening, complication prevention, evaluation of care and referral outside service as appropriate

• arrangements for the initiation of diagnostic investigations, prescription and supply of medications, collaborative arrangements

• clinical governance, mentorship and clinical supervision arrangements

• professional role - activities in which the Nurse Practitioner/Transitional Nurse may engage in order to meet the role domains (education, mentoring, research, evaluation)

• evaluation criteria including key performance indicators

• resources to be made available such as phones, work spaces, equipment, pagers, car, computer.

In order to ensure consistency across NSW a ScOP template is found at Appendix A. The template is also consistent with the requirements of the S&QF. Nurse Practitioners and Transitional Nurse Practitioners should use the template when reviewing the ScOP but are not expected to do so until the usual review period has expired or it is felt earlier review is required.

8 INDIRECT CLINICAL TIME

Indirect clinical time is dedicated to aspects of the Nurse Practitioner role not involving direct patient care. Activities may include but are not limited to role, model and ScOP development and or review, leadership activities, evaluation of the model of care, mentoring, research, professional development of self or others or administrative obligations such as participation in committees, consultancy or role promotion. Participation in such activities is in line with the National Competency Standards for the Nurse Practitioner. It is recommended that Transitional Nurse Practitioners also utilise indirect clinical time together with clinical supervisors to ensure appropriate skill development, review of progress through learning objectives and course requirements, and to ensure required competencies are achieved.
The allocation of indirect clinical time assists in developing and maintaining a model of care that recognises and utilises all aspects of the role to gain maximum benefit for the health care service and the target population.

9 DIAGNOSTIC INVESTIGATIONS

Nurse Practitioners, together with all clinicians who are initiating diagnostic investigations, are required to follow NSW Health Policy and the principles of evidence based practice.

As part of the extended rights and privileges, Nurse Practitioners may initiate diagnostic investigations relevant to their scope of practice. Diagnostic investigations may include the initiation of pathology and medical imaging and while these are expected to be relevant to the ScOP, are no longer tied to lists of approved investigations or clinical practice guidelines.

Consideration needs to be given as to which test is the most suitable to assist in planning treatment. As well, decisions regarding these diagnostic investigations should take into account whether they are evidence-based, age-appropriate and cost-effective.

The Royal College of Pathologists of Australasia has issued Guidelines for Pathology Requesters and Pathology Providers which outline the responsibilities for clinicians initiating requests for pathology. The guidelines define the Requester’s responsibilities beginning with the decision to initiate a request and continuing until the clinician has taken appropriate action in response to the report generated by the request. In line with this responsibility, the guidelines also state the Requester (or employing organisation) must have appropriate systems in place to ensure that:

- the informed cooperation and consent of the patient is obtained by informing the patient about the tests required, what the tests involve, the foreseeable risks and benefits of the tests and the implications of declining treatment. The information should be tailored to meet the requirements of the patient
- where requesting tests or investigations for notifiable diseases, Requesters should ensure that the patient is aware of the Requester’s reporting obligations
- requests are properly initiated by fully and accurately completing a request form with the relevant patient, clinical and test information
- requested tests and investigations are identified using generally accepted names or acronyms
- overdue reports are identified and followed up with minimum delay
- pathology reports are acted on appropriately and in a timely manner
- in the absence of the original Requester, a suitable delegate has been nominated to act on the result

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• support staff are provided with clear and sufficient documented policies and procedures to be followed for the management of pathology requests and reports. This should include policies covering confidentiality and privacy.

Nurse Practitioners are also able to initiate requests for diagnostic imaging and have similar responsibilities in relation to initiating these requests including:

• ensuring the likelihood of test results actually influencing management (although the importance of excluding certain diseases or conditions is acknowledged in some cases)
• providing adequate clinical details with the request in order to provide appropriate information on which the imaging specialist can base the report
• ensuring the request for diagnostic imaging is not a substitute for examining the patient
• ensuring consultation with imaging and other specialists in complex clinical situations in order to determine the most appropriate test
• being aware of the risks a test may involve in order to determine the potential benefits will outweigh those risks
• ensuring, particularly in younger patients, if possible and clinically appropriate, imaging options that do not utilise ionizing radiation are selected (eg MRI, ultrasound)
• avoiding duplication of tests, assisted by
  ▪ awareness of previous tests performed or requested by other healthcare professionals
  ▪ ensuring patients are aware of the importance of reviewing previous tests or results (and have them available when possible).

10 PRESCRIBING AND FORMULARY ARRANGEMENTS IN NSW

Nurse Practitioners are authorised by law to prescribe independently. This authority is based on educational preparation that develops an in-depth knowledge of pharmacology and pharmacokinetics related to the relevant practice specialty. As independent prescribers, Nurse Practitioners are responsible and accountable for the assessment of patients with both undiagnosed and diagnosed conditions and for decisions regarding appropriate clinical management including prescribing.

Prescribing decisions for Nurse Practitioners in NSW are no longer required by law to be tied to ‘approved clinical practice guidelines’. The ScOP defines the ‘practice of nursing’ for which a Nurse Practitioner is authorised to possess, use, supply or prescribe a poison, restricted substance or drug of addiction under the Poisons and Therapeutics Goods Act 1966.
10.1 NSW Nurse Practitioner Formulary

Nurse Practitioners are endorsed as qualified to administer, obtain, possess, prescribe, supply or use a schedule or class of scheduled medications by the NMBA under s94 of the National Law and authorised to do so under the Poisons and Therapeutics Goods Act 1966.

In accordance with s17A of the Poisons and Therapeutics Goods Act 1966, authorisation of possession, use, supply or prescription of substances by nurses and midwives;

(1) A nurse is authorised to possess, use, supply or prescribe a poison, restricted substance or drug of addiction for the purposes of the practice of nursing, if:

(b) the nurse is a nurse practitioner who is authorised in writing by the Director-General to possess, use, supply or prescribe that poison, restricted substance or drug of addiction.

Removing the need for each medication prescribed by Nurse Practitioners to be approved at a local level and in accordance with s17A of the Poisons and Therapeutic Goods Act 1966, the Director-General has authorised the items within the Pharmaceutical Benefits Schedule (PBS) available for prescription by Nurse Practitioners as the NSW Nurse Practitioner formulary.

This formulary provides for the poisons, restricted substances and drugs of addiction that may be possessed, used, supplied or prescribed by Nurse Practitioners within their ScOP while employed by NSW Health.

While the formulary resembles the list of items available on the PBS for prescribing by Nurse Practitioners (Nurse Practitioner items) it does not infer the ability to prescribe PBS subsidised medications. The formulary will be updated from time to time to reflect the expanding scopes of practice and the introduction of new models of care.

Therefore there is no longer a need for a separate formulary to be approved at the local level unless additional drugs not listed on the NSW Nurse Practitioner formulary are to be prescribed (see section 10.2 below).

Over the counter (OTC) preparations do not require a prescription; however any Nurse Practitioner who recommends an OTC drug is accountable for her/his actions. The same applies to complementary therapies. Nurse Practitioners are required to develop a process for receiving timely communication of drug alerts and other updates of changes in therapeutics.
10.2 Appended drug formulary

Under s21 of the *Health Administration Act*, the responsibility for authorising a Nurse Practitioner to prescribe, possess, use and supply a poison, restricted substance or drug of addiction is also delegated by the Director-General to the Chief Nursing and Midwifery Officer (CNMO) NSW. These Nurse Practitioners are required to submit a separate formulary appropriate to their scope of practice to the Chief Nursing and Midwifery Officer NSW (CNMO) for approval. Requirements for submitting a formulary for approval can be found on the Nurse Practitioners in NSW website.

10.3 Quality use of medicines

All prescribers, including Nurse Practitioners are required to comply with the *National Strategy for the Quality Use of Medicines* as part of the overarching *National Medicines Policy* and ensure prescribing practice is evidence based and in line with professional standards, relevant legislation and local policy.

Quality Use of Medicines includes:

*Selecting management options wisely by:*
- considering the place of medicines in treating illness and maintaining health
- recognising that there may be better ways than medicine to manage many disorders.

*Choosing suitable medicines if a medicine is considered necessary so that the best available option is selected by taking into account:*
- the individual
- the clinical condition
- risks and benefits
- dosage and length of treatment
- any co-existing conditions
- other therapies
• monitoring considerations
• costs for the individual, the community and the health system as a whole.

**Using medicines safely and effectively to get the best possible results by:**

- monitoring outcomes
- minimising misuse, over-use and under-use
- improving people’s ability to solve problems related to medication, such as negative effects or managing multiple medications.

### 10.4 Best practice prescribing principles

As with all prescribers, Nurse Practitioners should adhere to best practice prescribing in relation to prescribing including:

- prescribing only for a patient whom the nurse practitioner has assessed as having a genuine clinical need for pharmacological treatment
- taking into account the patient’s medication and medical history before prescribing
- communicating and document prescribing decisions and the reasons for them
- being clear to patients about the reasons for prescribing or not prescribing
- taking into account the patient’s situation, concerns and expectations
- writing unambiguous prescriptions using correct documentation
- minimising misuse, over-use and under-use
- prescribing within the limitations of knowledge, skills and experience
- taking into account other factors that might alter the benefits and risks of treatment
- utilising relevant evidence-based guidelines to support decision making
- understanding the pharmacokinetics and pharmacodynamics when prescribing for high-risk patient groups such as:
  - the elderly
  - indigenous populations
  - neonates
  - infants
  - children
  - pregnant and breastfeeding women
  - patients with renal or hepatic impairment
  - treatment of persons for drug dependency.
Prescribers are also expected to comply with existing hospital policy, restrictions and approval mechanisms such as:

- antibiotic restriction policies/antibiotic stewardship
- medication reconciliation
- formulary items that are restricted and require Drug and Therapeutic Committee approval
- high risk drug policies
- Drug and Therapeutic Committee policies where only one item is kept, for example, many hospitals choose to keep only one 5HT3 blocker. Should a prescriber have a particular reason for a different drug to be stocked, local approval mechanisms would need to be followed
- NSW Health policy regarding medication and medication handling.

10.5 Supply of medication

In accordance with legislation, Nurse Practitioners are able to supply (dispense) medication they prescribe. This may be necessary if Nurse Practitioners practice out of hours or in community settings without access to local pharmacy services. Nurse Practitioners in collaboration with facilities have a legal responsibility to ensure access to appropriately labelled and packaged medicines. This may require appropriately prepared starter packs to be made available.

10.6 P Drugs

P Drugs are defined as the preferred choice of a prescriber for particular indications. Nurse Practitioners/Transitional Nurse Practitioners are encouraged to develop a list of medications used regularly in practice that is consistent with medications commonly prescribed in the treatment of conditions, symptoms and diagnosis treated within target populations.

Prescribers commonly prescribe between 40 and 60 drugs routinely\(^\text{16}\). It may be that some Nurse practitioners may prescribe as few as five depending on their ScOP. These drugs will differ between prescribers for reasons such as varying availability, cost, facility formularies and individual interpretation of information. The P Drug concept encourages prescribers to become familiar with treatment and dosing schedules. P Drugs help prescribers avoid repeated searches for the appropriate drug in daily practice and repeated use of P Drugs will help prescribers become familiar with the effects and side effects of medications. This concept will be particularly beneficial to new prescribers and will assist in consolidating practice. A guide to selecting and using P Drugs is available in the *World Health Organisation Guide to Good Prescribing*.

P Drugs should be consistent with local LHD and or facility formularies, policy and procedure. Where this is not the case, the Nurse Practitioner should form a case through local processes and apply to have the medication/s added to the formulary to ensure availability.

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10.7 Prescribing under Continuing Treatment Only and Shared Care Models

While these prescribing models are a compulsory requirement for Nurse Practitioners prescribing some PBS subsidised medications, they may also be considered for use by Nurse Practitioners in NSW Health voluntarily in order to encourage continuity of care for patients and supported prescribing practice.

Nurse Practitioners may choose to prescribe certain medications from within the NSW Nurse Practitioner formulary as **Continuing Therapy Only (CTO)** or as part of a **Shared Care Model (SCM)** between the Nurse Practitioner and a collaborating medical officer unless the Nurse Practitioner is competent to initiate and prescribe these drugs independently.

**Continuing therapy only**
Where the patient treatment and prescription of a medicine has been initiated by a medical practitioner, but prescribing is continued by a Nurse Practitioner. (This is similar to existing arrangements between specialists and medical practitioners for prescribing certain medicines.) This model may be relevant for Nurse Practitioners caring for a patient being admitted who may require routine medications to be continued as appropriate while an inpatient. Medications must be listed on the NSW Nurse Practitioner or an appended formulary.

**Shared Care Model**
Where care is shared between a Nurse Practitioner and a medical practitioner in a formalised arrangement with an agreed treatment plan, in a patient centred model of care. An example of this may be where a Nurse Practitioner refers a patient to an admitting medical officer who agrees to assume the care of a patient on admission and requires a medication to be commenced that the Nurse Practitioner may not wish to initiate independently. In order to commence treatment, medication is prescribed on the advice and in collaboration with the medical officer only if it is listed within either the NSW NP or an appended formulary.

The details surrounding shared care arrangements will depend on the practitioners involved, the patient needs and the health care context. Nurse Practitioners are responsible for ensuring situations under these models of care are used are within their ScOP and in collaboration with appropriate health care professionals.

10.8 Nurse Practitioner prescribing in NSW public hospitals

Nurse Practitioners employed in public hospitals may prescribe from the NSW Nurse Practitioner formulary for patients within their ScOP, although the prescription of medications for non admitted patients such as discharged patients, outpatients and patients seen in emergency departments is complicated by the inability for those medications to be prescribed as part of the PBS and dispensed in the community. This is due to separate **non PBS** funding arrangements in NSW public hospitals (see Pharmaceutical Reform in Public Hospitals section below) therefore prescriptions issued to non admitted or discharge patients cannot currently be issued under the PBS for patients in NSW public hospitals. These prescriptions must be issued as private prescriptions (see 10.9 ‘Private Prescriptions’ below). If a private prescription is issued
Nurse Practitioners must ensure patients are aware they may be charged a higher unsubsidised cost for these medications when they are dispensed.

Prescribing for inpatients is not affected.

**10.8.1 Pharmaceutical Reform in public hospitals**

The Pharmaceutical Reforms provide eligible patients in participating public hospitals with access to subsidised medicines under the Pharmaceutical Benefits Scheme (PBS) and a range of chemotherapy medicine through the Chemotherapy Pharmaceuticals Access Program (CPAP).

The key objectives of the Pharmaceutical Reforms are to provide public hospital patients with:

- access to the PBS as occurs in the community and private hospitals
- appropriate supply of medicine upon discharge or as a non admitted patient of a hospital
- access to a range of chemotherapy medicine as a non admitted or a day admitted patient
- a smooth transition between the hospital and community health settings.

**NSW does not** currently participate in agreements accommodating pharmaceutical reform. This means the responsibility for providing medications including those required as an inpatient and on discharge remains that of the hospital. PBS/RPBS prescriptions cannot be issued in public hospitals in NSW; this includes emergency, discharge and outpatients.

**10.8.2 PBS/RPBS Arrangements for Nurse Practitioners in NSW**

Nurse Practitioners in NSW who care for patients in a **community setting** are eligible to apply to participate in the PBS/RPBS regardless of public sector employment. The community setting for this purpose is defined as outside the inpatient, emergency or outpatients setting.

**Examples**

**Inpatients, discharged inpatients, emergency and outpatients patients**

Nurse Practitioners employed within a hospital setting and whose patient population includes inpatients (or those being discharged from an inpatient setting), patients in the emergency department or outpatient clinics **may not** issue prescriptions for PBS subsidised medications.
Community patients

A Nurse Practitioner employed by NSW Health to practice within in a community setting i.e. patients at home, where the episode of care occurs outside of the inpatient setting, may issue PBS subsidised prescriptions. These patients are neither inpatients, emergency nor attending outpatient clinics,

A Nurse Practitioner who practices in a service located near or on hospital grounds may issue PBS prescriptions as long as patients are not classed as inpatients, outpatients or emergency patients.

Transboundary models

If a Nurse Practitioner model is trans-boundary, for example across both the hospital and community settings, the Nurse Practitioner may issue PBS subsidised medications within the community only and NOT within the inpatient setting.

PBS benefits can only apply to medications prescribed by doctors, dentists, optometrists, midwives and who are approved to prescribe PBS medicines under the National Health Act 1953. Eligibility to prescribe under the PBS also allows Nurse Practitioners to supply pharmaceutical benefits under the Repatriation Pharmaceutical Benefits Scheme (RPBS).

For a prescription to be eligible for subsidy, Nurse Practitioners must ensure that they prescribe only medicines listed as ‘Nurse Practitioner items’ and prescribe them in accordance with the restrictions listed on the PBS for the ‘NP’ prescriber type (SCM or CTO) and that the prescription of any medicine is within the Nurse Practitioners ScOP and formulary.

Listing details for the same product may differ between sections of the PBS and different PBS item codes apply for each prescriber type. Nurse Practitioner items available for PBS prescription and explanatory notes may be found on the PBS website under browse Nurse Practitioner items.

Medications not listed on the PBS as a Nurse Practitioner item may still be prescribed if within the NSW NP or an appended formulary approved by the LHD CE as a private prescription (Guideline section 10.9).

Together with collaborative arrangements, certain PBS medicines also have additional conditions for prescribing by Nurse Practitioners.

PBS has five categories under which Nurse Practitioners may prescribe and with which they must comply for medications to be subsidised by the PBS:
• **Unrestricted** – NPs may initiate prescribing and manage ongoing client care
• **Shared care model (SCM)** – care is shared between a nurse practitioner and medical practitioner through an agreed plan (as described in Guideline section 10.5)
• **Restricted** – PBS listing specifies prescribing restrictions
• **Continuing therapy only (CTO)** – medication commenced by medical practitioner, but prescribing may be continued by a nurse practitioner (as described in Guideline section 10.5)
• **Authority listing (section 100)** – authority required from Medicare Australia prior to prescription.

A Nurse Practitioner who applies for a PBS number enters an agreement with the Commonwealth Government, stating they are eligible to participate in accordance with existing Commonwealth and State funding agreements relevant to their practice. PBS arrangements are not managed or administered by the LHD or health care facility.

To be **eligible** for a PBS prescriber number a Nurse Practitioner must:

• be registered under the National Registration Accreditation Scheme
• be endorsed as a Nurse Practitioner by the Nursing and Midwifery Board of Australia

Whilst a Nurse Practitioner may be eligible to apply for a PBS prescriber number, he or she is responsible for ensuring that participation in the PBS i.e. use of that prescriber number is in line with existing State and Commonwealth funding arrangements. Use of PBS prescriber numbers is monitored by Medicare audit processes which form part of the NMBA S&QF.

In order to prescribe PBS subsidised medications Nurse Practitioners must also ensure they have collaborative arrangements in place in accordance with the National Health (Collaborative arrangements for nurse practitioners) Determination 2010.

### 10.8.3 Collaborative arrangements

The arrangement between an eligible nurse practitioner with a medical practitioner must provide for:

• consultation with a specified medical practitioner
• referral of a patient to a specified medical practitioner
• transfer of the patient’s care to a specified medical practitioner.

Collaborative arrangements can be demonstrated by:

• being employed or engaged by a medical practitioner or an entity that provides medical services **OR**
• receiving patients on written referral from a medical practitioner **OR**
• a signed written agreement with a specified medical practitioner/s OR
• an arrangement in the Nurse Practitioner’s written records.

For Nurse Practitioners employed by NSW Health, collaborative arrangements are demonstrated by being employed or engaged by an entity that provides medical services that enable the required consultation, referral and transfer of care between the Nurse Practitioner and medical officers as required.


All medications prescribed by Nurse Practitioners in NSW must be in accordance with state prescribing law, that is approved by the Director-General (or delegate) under s17A Poisons and Therapeutic Goods Act 1966.

10.9 Private prescriptions

Nurse Practitioners may still prescribe medicines from within the NSW Nurse Practitioner (or appended) formulary if the medication is not listed on the PBS or if they do not have a PBS prescriber number.

These are non PBS prescriptions or ‘private prescriptions’.

Non PBS medications must be written if:

• the patient is a non admitted, emergency or discharge patient within a public hospital in NSW
• the medicine is not listed on the PBS Schedule
• the medicine is not listed on the PBS Schedule for prescription by Nurse Practitioners
• the patient’s clinical condition does not match the restriction listed in the Schedule
• the patient will use the medication for a different purpose than listed in the Schedule
• the patient is not eligible for PBS/RPBS medicine (for example, a visitor from a country without a Reciprocal Health Care Agreement with Australia).
All prescribers are legally obliged to ensure non PBS prescriptions are written in accordance with relevant legislation.

11 MBS ARRANGEMENTS

Medicare was introduced in 1984 to provide eligible Australian residents with affordable, accessible and high quality health care. Medicare program provides access to:

- free treatment as a public patient in a public hospital
- free or subsidised treatment by health professional such as medical practitioners, allied health professionals, participating optometrists, dentists (specified services only), or Nurse Practitioners and midwives (from 1 November 2010).

From 1 November 2010, Medicare benefits will be payable as items 82200 - 82215 for services provided by eligible, **privately practising** Nurse Practitioners working in collaboration with a medical practitioner. Participating Nurse Practitioners will also be able to request certain **pathology and diagnostic imaging items** for their patients and refer patients to specialists and consultant physicians.

To be eligible for a Medicare provider number a Nurse Practitioner must:

- be registered under the National Registration Accreditation Scheme
- be endorsed as a Nurse Practitioner by the Nursing and Midwifery Board of Australia
- be in private practice to access MBS services, refer to specific specialists and request some pathology and diagnostic items
- be employed in a locality within NSW that has been granted an exemption under the COAG Improving Access to Primary Care in Rural and Remote Areas (s19(2) exemptions) Initiative or within Aboriginal Community Controlled Health Services.

11.1 COAG Improving Access to Primary Care in Rural and Remote Areas (s19(2) exemptions) Initiative

Under this initiative, small rural and remote towns, with populations of less than 7000 and with an identified general practitioner (GP) shortage are eligible for an exemption of 19(2) of the Commonwealth Insurance Act 1973.

This clause, specifically 19(2) states that:

2. *Unless the Minister otherwise directs, a Medicare benefit is not payable in respect of a professional services that has been rendered by, or on behalf of, or under an arrangements with:*
a. *The Commonwealth*
b. *A State*
c. *A local governing body or*
d. *An authority established by law of the Commonwealth, a law of a State or a law of an internal Territory.*

3. *An exemption to section 19(2) of the Act allows Medicare benefits to be claimed for eligible non admitted, non referred professional services that have traditionally been provided by state governments in small rural health facilities.*

NSW participation in this initiative presents an opportunity to improve the provision of primary health care services to local communities through reinvestment of MBS revenue raised.

Nurse Practitioners are eligible to apply for a location specific provider number if they are employed within a locality granted an exemption under this initiative and therefore provide eligible services.

Sites wishing to apply for an exemption will engage in an approval process coordinated by NSW Ministry of Health. Nurse Practitioners are not able to apply individually.

Medicare billing cannot commence until a location specific provider number has been provided by Medicare, this process should be commenced as soon as exemption status is conformed.

11.2 *Eligible services within COAG Improving Access to Primary Care in Rural and Remote Areas (s19(2) exemptions) Initiative*

- Non admitted, non referred professional services provided by Nurse Practitioners are eligible where a Nurse Practitioner obtains a provider number under the s19(2) Exemption Initiative.

- Non admitted patients are those attending emergency departments/emergency services, outpatient clinics and those treated offsite by hospital staff through outreach arrangements or community based clinics.

Patients receiving eligible services under the initiative will remain public patients of the NSW Health system.

If practicing in more than one location, Nurse Practitioners must have a provider number for each location. If a Nurse Practitioner changes practice location, application must be made for a new provider number specific to that location.
11.3 MBS Arrangements for Nurse Practitioners Employed by Aboriginal Community Controlled Health Services

Directions issued under section 19(2) of the *Health Insurance Act (1973)* allow participating Nurse Practitioners employed by Aboriginal Community Controlled Health Services (ACCHSs) to access Medicare benefits for the services they provide.\(^{17}\)

In accordance with the Direction, participating Nurse Practitioners employed by an ACCHS listed on the Direction should:

- Use a provider number specific to each location at which he or she provides services
- Accept the assignment of the Medicare benefit in accordance with section 20A of *The Health Insurance Act (1973)*
- Have a formal agreement with the ACCHS in relation to Medicare benefits such as electronic funds transfer link to transfer the Medicare benefits to the ACCHS.

Further information is available from the Office for Aboriginal and Torres Strait Islander Health at: oatsih19.2enquiries@health.gov.au.

12 EVALUATION

Evaluation of the Nurse Practitioner role and model of care is critical to the development and sustainability of the role. Nurse Practitioners are ideally placed to lead and/or participate in evaluation of the service in terms of quality, safety, effectiveness, appropriateness, consumer participation, access and efficiency. Nurse Practitioners may need to seek additional organisational support and/or assistance in order to undertake such evaluation. It is recommended that this process occurs annually and includes review of the model of service delivery and ScOP to ensure it remains relevant and appropriate. This will assist in building a relevant database of information surrounding the efficacy and efficiency of the service and contribute to resources relevant to growth and development of the role. An example of an evaluation framework is found below.
The example highlights areas the service may wish to include as part of the evaluation. Some areas may be more relevant to certain models of care than others.

The evaluation process should be identified early in the implementation phase and provide clear definition around the aims and outcomes to be achieved and how these are to be evaluated. Evaluation should reflect not only the key performance indicators for implementation of the role as identified by the organisation in the needs analysis, but should also aim to capture the nursing expectations of the role.

The evaluation process may include tools such as clinical audit, patient and staff surveys and case audit, presentation and review. Evaluation aims to improve the quality or delivery of care by reviewing and examining care and outcomes and
comparing these with the predicted or predetermined outcomes measures to drive practice change or improvements. As Nurse Practitioner roles are developed to address service gaps or needs, it is therefore important that the role is evaluated against the main performance indicators it was introduced to address in order to ensure needs are being met. It is also important to identify any opportunities to expand or improve the service. Any evaluation process should be collaborative and aim to inform best practice. The AUSPRAC The Nurse Practitioner Research Toolkit 18 includes audit tools Nurse Practitioners may utilise in the evaluation process.

Performance review should occur routinely as per local LHD policy and is the responsibility of both the employee and employer. Nurse Practitioners and Transitional Nurse Practitioners may wish to keep an activity log to record professional activities throughout the review period. A an example may be found on the Nursing & Midwifery, Nurse Practitioners in NSW website.

For further information regarding this guideline contact the Principal Adviser, Nurse Practitioner Project, Nursing & Midwifery Office on (02) 9391 9490.

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18 2009 Australian Nurse Practitioner Study (AUSPRAC)
A Scope of practice template

Nurse Practitioner/Transitional Nurse Practitioner

Scope of Practice example

<table>
<thead>
<tr>
<th>Name of NP/TNP</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty</td>
<td></td>
</tr>
<tr>
<td>Local Health District</td>
<td></td>
</tr>
</tbody>
</table>

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 NPs 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 the NMBA S&QF.

Clinical judgment 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 and 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.

Practice will be in accordance with current best evidence and both relevant NSW Health and local LHD policies, procedures and guidelines.
Practice context/setting

Demographics and supporting services

Example:
The Local Health District covers an area of 34 square kilometres extending from Balmoral in the south to Calgary in the north and comprises 3 local government areas (LGAs) and divided into 2 planning networks with St Elsewhere General located in the --- network. Health services within this network also include the following services.....

Population in the ---- network is estimated at 85 600, and the --- network at 34 000 making a combined total of 119 600. The LHD is the third fastest growing rural LHD in NSW with expansion predominately occurring in coastal regions. The area serviced is expected to experience the highest rates of growth. Significantly, in 2006, the LHD reported a proportion of people over 65 years at 23.4% of the total population compared to the NSW average of 19.4%. This figure is expected to increase considerably in coming years.

The LHD has an estimated indigenous population of 5.1% and 21% of households are reported as low income.

Model of care

Aim

List the identified service gaps or needs the NP role/service aims to address – these will form the basis of evaluation

Example:
Recent audits of ED presentations at St Elsewhere General demonstrated that representations account for 34% of all ED presentations with 43% of these patients aged 65 and over, with a further 21% within the 45-64 age group, a group known to include a significant number of chronically ill patients.

Service analysis identified a diagnostic profile of patients who were at risk of preventable admission, presentation or representation to Emergency Department. Reflecting the findings of the NSW Health Avoidable Admission Strategy, this profile demonstrated six of the eight NSW Health-designated DRGs for hospital avoidance were frequently represented in ED presentations and admissions at St Elsewhere General.

Research conducted with local services currently providing care to patients within these cohorts reported increasing numbers of patients within these cohorts requiring urgent assessment and management, often resulting in patients requiring assessment and management of sub acute conditions being referred to EDs for timely care. These services included community nursing services and General Practitioners. Patients self referring to EDs were also surveyed and frequently reported difficulty in accessing community health care services.

The NP role has therefore been implemented to provide autonomous care for patients at risk of avoidable admission to hospital and presentation or representation to EDs in an effort to:

• complement existing services by extending the ambulatory care model from St Elsewhere General to ensure patients have access to high quality health care in the community for both acute and sub acute conditions
• reduce avoidable admissions, ED presentations and representations
• assist in reducing ED workload in preparation for incoming KPI related to 4 hour targets
• provide nursing assessment, health care management and clinical support at an advanced level to patients and carers, including a reassessment service as required to further assist in hospital avoidance.
Service description

Target Population for Service

Example:
The Nurse Practitioner will provide autonomous health care for at risk patients over 65 years (45 years for Aboriginal and Torres Strait Island cohorts) residing within both the community and Residential Aged Care Facilities.

Referrals for patients falling outside these cohorts will be considered on an individual basis if their health care needs fall within the NP’s ScOP.

Health Service Setting

Example
The NP service is trans-boundary and includes community, inpatient and Residential Aged Care settings. The service provides a flexible, integrated nursing service facilitating both improved access to health care and patient outcomes. The NP practices autonomous and in collaboration with other health care professional across health care settings.

Facilities/Facility Where Nurse Practitioner Role or Service Operates

Example:
The NP service is based at St Elsewhere General and although the service will include inpatient and Emergency Department attendances, will primarily operate in the community and Residential Aged Care Facilities within the --- network.

Operational aspects

Examples:
operating times to meet peak demands
physical resources (car, computer, work spaces, phone, equipment etc)
collaborating services (key stakeholders)

services available to support NP service such as

St Elsewhere General Hospital including;
- Level 5 Emergency 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 Pastoral Care Support
- Pathology and Radiology Services
- Paediatric and Special Care Nursery
- Oncology and Radiotherapy Services

Smallington District Hospital including;
- Level 3 Emergency 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 Pastoral Care Support
• Pathology and Radiology Services
• Paediatric and Special Care Nursery
• Oncology and Radiotherapy Services
• Rehabilitation
• Palliative care
• Chronic and Complex care
• Drug and alcohol
• Aged Care Assessment Teams and Aged Care Services
• Community nursing services

Parameters of practice

Elements of care

Example:
Elements of care include
• comprehensive health assessments
• initiation and interpretation of diagnostic interventions
• differential diagnosis
• initiation and evaluation of therapeutic management plans
• health promotion and education
• care delivery and co-ordination
• patient advocacy
• non pharmacological approaches such as pressure area management, diversional therapy, bladder retraining
• medication titration
• symptom management/control
• complication prevention

Common presenting conditions and disease states managed by the NP (not exhaustive)

Example:
Priority conditions and DRG categories for the first phase of service implementation (year 1) are as follows;
• Cellulitis (DRG:J64B)
• Feeding tube and indwelling catheter complications (including uncomplicated reinsertion)
• Minor injury and illness
• Community acquired pneumonia (DRG:E62C)
• Upper respiratory tract infections
• COPD (DRG: E65B)
• Bronchitis and asthma (DRG: E69C)
• DVT (DRG: F63B)
• Post fall management
• Delirium
• Depression
• Medication review/reconciliation
• Geriatric syndromes
• Wounds
Urinary tract infections (DRG: L67C)
Acute non-surgical pain (musculotendinous disorders) (DRG: I71C)

Phase 1 DRGs have been included based on current evidence supporting the treatment of low complexity, acute medical conditions in alternative care settings other than acute inpatient hospital beds by providing early assessment, intervention and risk identification within aged care and chronically ill patient cohorts. These conditions are also within the NPs current area of expertise and competence.

Phase 2 of implementation (year 2) include strategies to include the following:
- Chest pain (DRG: F74Z)
- Seizure (DRG: B76B)
- Headache (DRG: B77Z)
- Gastroenteritis (DRG: G67B)
- Acute angina
- Hypertension
- Epididymitis
- Orchiditis
- Prostatitis
- Renal colic (inpt or ED only)
- Electrolyte imbalances
- Fractures (Complex inpt or ED only)
- Seizures (inpt or ED only)

The NP will support expanding the scope of practice by incorporating the required education and competency assessment into an ongoing professional development plan.

**Exclusions from care**

**Example:**

Patients falling outside the NP scope of practice will be referred to appropriate health services.

Patients demonstrating haemodynamic instability and or evidence of life threatening conditions will receive initial treatment as appropriate within the NPs ScOP (including emergency measures) and subsequently referred and transferred to the ED, the NP may continue to collaborate in the care of these patients.

Currently excluded from autonomous NP care include are patients presenting with (not exhaustive):
- Anaphylaxis
- Hypovolemic
- Poisoning
- Acute myocardial infarction
- Pancreatitis
- Haemorrhage
- Perforated bowel
- Pulmonary oedema
- Diabetic ketoacidosis
- Hypoglycaemia

**Process of care**

**Example:**

**Criteria for referral**
- Patients who are unable to be assessed by their usual care provider and are likely to present to the ED for assessment and or management,
- Patients who have an identified health care concern that is not able to be managed by usual service, for
Referral pathway/initiation of contact with service

- Referrals are initiated by Health care professionals, RACFs, carers, families, patients, ED to the NP service via mobile phone.

Referrals will be received and triaged by the NP according to clinical urgency. The NP will arrange to assess the patient or advise transfer to hospital as deemed appropriate.

Diagnostic investigations

Initiation of all diagnostic investigations by the NP service is in line with the ScOP. As the NP is not able to initiate MBS subsidised services, investigations are requested from the outpatient diagnostic imaging and pathology services at St Elsewhere General or Smallington District Hospital.

Request forms are completed by the NP, an appointment made for either the patient to attend the outpatient service, or for the pathology sample to be taken by the visiting pathology service. Request forms are left with the patient or delivered to the imaging/pathology service by the NP. The NP may also collect the pathology sample and arrange delivery along with request form to the pathology service. Copies of all results are sent to the patient’s attending GP and the Director of Emergency Services for timely follow up in the event the NP is not available.

Prescribing

The NP has an allocated prescriber number in order to issue PBS subsidised prescription within the community setting.

Prescribing is according to the NSW NP formulary according to her ScOP and has an appended formulary as attached approved by the LHD CE.

Medication orders within RACFs are facilitated by the use of a hospital medication chart for a period of 5 days or until the order can be transferred to the RACF medication chart by the patient’s attending GP. PBS prescriptions may also be issued as required to ensure ongoing supply.

Dispensing Arrangements

The NP carries a supply of commonly prescribed medications to ensure timely access to medications as required. A supply of medications will be dispensed according to local policy to ensure adequate supply is available to the patient until ongoing supply is available. The NP has adequate arrangements in place to ensure all obligations are met in relation to labelling and storage.

The NP may liaise with local pharmacists to ensure medications are dispensed to RACFs in similar circumstances to a patient’s usual medications eg Webster Pack.

Specific procedural activities

Examples:
- Uncomplicated reinsertion/change of gastrostomy tubes
- Digital anaesthetic blocks
- Local anaesthesia
- Wound repair
- Removal of foreign body – ear/eye/subcutaneous
- Incision and drainage of simple abscess
- Dementia and delirium screen

Collaborative arrangements (as required to facilitate access to MBS & PBS)

Example:
- Collaborative arrangements are demonstrated through employment by an organisation employing one or medical officers in an arrangement that allows consultation, referral and transfer of care as required and through direct collaboration with and referral by a patient’s attending GP.
Clinical Governance Arrangements

Part A: Study, clinical supervision and mentorship arrangements

Example:
The TNP is enrolled in year 1 of the Masters of Nursing (Nurse Practitioner) at Calgary University in a full time capacity. It is estimated completion will be over three years. Approval to enrol given by DNM. Study leave arranged.

Supervision of clinical practice is to be provided by --------- (NP Primary Care), Dr ----- (Geriatrician) and Dr------ (ED Physician). TNP has requested mentorship from both ----- (NP Primary Care) and ------ (NP Aged Care).

A clinical education framework has been developed, identifying core skill sets and specific knowledge to be developed throughout each semester to support tertiary study and ensure skills are appropriate to the model of care delivery. Acquisition of these skills and knowledge base will be supported by learning contracts. Formal education is undertaken within indirect clinical time and four cases are presented throughout each semester to the MDSC.

Example
Mentorship for the NP is provided by ---- (NP Aged Care). Supervision of clinical practice and education in order to expand the current ScOP to include reinsertion of gastrostomy tubes is provided by ----- (Gastroenterologist) and will also include periods of supervised practice in clinic in order to demonstrate competence.

Part B: Describe who the NP role / service articulates into organisational governance arrangements

Include factors such as ensuring clinical effectiveness, ongoing education & training, complaints handling, clinical risk management, consumer involvement, performance appraisal, ensuring evidence based practice, clinical information management, reporting & consultation etc

Clinical resources

Evidence based practice is guided by resources including; enter those appropriate to NP/TNP practice

Example:
The clinical practice of the NP will be guided by acknowledged sources of evidence based practice:

Professional role activities

Clinical leadership, education and research

The NP role encompasses clinical leadership, education, quality improvement and research activities as part of an advanced practice role.

Indirect clinical activities to support these aspects of the role include:

- Provision of advice and guidance for nurses on matters of clinical practice and professional development
- Provision of expert advice, education and support to nursing staff and other health care professionals in a variety of settings including residential aged care, hospital, community and tertiary education environments
- Participation in quality improvement projects
- Participation in the senior nurse leadership group at St Elsewhere General
- Active participation in professional organisations including the Australian College of Nurse Practitioners and the Royal College of Nursing Australia
- Leading evaluation of NP service on an annual basis.

Include aims to publish papers, present at conferences etc.

Evaluation

Strategy for model of ScOP review

The model of care and ScOP will be reviewed each year post evaluation. The evaluation will assist in identifying issues which may require changes to be made within the model of care or expansion within the NP ScOP. Review will be conducted through the MDSC, include internal and external stakeholders and will also consider the need and opportunities to expand the service as required.

Evaluation Strategy

Key performance indicators

- Clearly define the issues the NP role/service was implemented to address
- Outline the indicators the service has defined that will demonstrate effectiveness e.g. preventing avoidable admissions, reduced ED workload in relation to identified target populations
- Outline key role components to be evaluated such as prescribing decisions, documentation, differential diagnosis, complex decision making, advanced health assessments, referral decisions, consultation (ensure key areas are addressed, these may vary between NP models)
- Outline strategies to evaluate each area.
Performance Review

NP performance review will occur annually, ideally after the evaluation of the service and review of the model and ScOP has occurred. This will allow opportunity to develop an ongoing professional development plan at performance review.

The review will be a 360° appraisal including individuals working alongside the NP/TNP in all aspects of the role and will include areas such as communication, team work, technical competence, clinical leadership.

The NP/TNP will present a summary of the review and a role activity report as part of the review.

The Multidisciplinary Support Committee agree that this scope of practice and model has been developed collaboratively and is supported practice for the named nurse practitioner.

<table>
<thead>
<tr>
<th>Multidisciplinary Support Committee Chair</th>
<th>Signature</th>
<th>Date agreed</th>
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<td>Position</td>
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Nursing Executive acknowledgement

| Local Health District Director of Nursing and Midwifery Services | Signature | Date |
|                                                               |           |      |
| Name                                                           |           |      |

| Facility Director of Nursing and Midwifery Services | Signature | Date |
|                                                    |           |      |
| Name                                               |           |      |

Local Health District Chief Executive acknowledgement

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Appended Drug Formulary

If an appended formulary is required, the template is to be completed and the formulary approved by the LHD CE.

**Prescribing Reference:** Nurse Practitioner/Transitional Nurse Practitioner to insert preferred prescribing resources/references

**Dosages are not transcribed into formulary in order to avoid transcription error**

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<tr>
<th>Class</th>
<th>Drug name (generic)</th>
<th>Clinical presentation</th>
<th>Notes</th>
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*Eg. CTO, SCM etc as appropriate*
Approval of Appended Nurse Practitioner Formulary

POISONS AND THERAPEUTICS GOODS ACT 1966

Section 17A

Nurse Practitioner Authority to Possess, Use, Prescribe or Supply Substances

I, (insert name of officer) Chief Executive of (insert name of Local Health District) being the duly appointed delegate of the Director-General of the Ministry of Health in accordance with section 21 of the Health Administration Act 1982 and subject to this authority:

Do hereby approve the attached formulary in accordance with NSW Ministry of Health Policy Directive relating to the practice of (insert name of Nurse Practitioner) while employed by the (insert name of Facility/LHD) and,

Pursuant to the provisions of section 17A (1b) of the Poisons and Therapeutics Goods Act 1966, I authorise (insert name of Nurse Practitioner) while employed by the (insert name of Facility/LHD) as a Nurse Practitioner to possess, use, supply or prescribe poisons and restricted substances and drugs of addiction within the attached formulary for the purposes of the practice of their profession as Nurse Practitioner.

Dated this _____________________ day of ______________________ 20

______________________________  (signature)

______________________________  (name)
B  Appended drug formulary and approval template

Appended drug formulary

Prescribing Reference: Nurse Practitioner to insert preferred prescribing resources/references

Dosages are as per prescribing references and are not transcribed into formulary. This is in order to avoid transcription error and the need for constant review to ensure information remains current. As with all prescribers, it is expected Nurse Practitioners prescribe according to the principles of best practice.

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Possession, use, supply or prescription of poisons, restricted substances or drugs of addiction that are not included within a formulary approved for use by the relevant Nurse Practitioner contravenes state prescribing law.
Approval of Nurse Practitioner Formulary relating to the functions of Nurse Practitioners

POISONS AND THERAPEUTICS GOODS ACT 1966

Section 17A

Nurse Practitioner Authority to Possess, Use, Prescribe or Supply Poisons, Restricted Substances and Drugs of Addiction for the purposes of the practice of nursing.

I, <insert name>, Chief Executive <insert LHD>, being the duly appointed delegate of the Director-General of the Ministry of Health in accordance with section 21 of the Health Administration Act 1982;

Do hereby approve the attached formulary pursuant to the provisions of section 17A (1B) of the Poisons and Therapeutics Goods Act 1966, I authorise <insert name of NP here> while employed by the <insert employing facility here> as a Nurse Practitioner to possess, use, supply or prescribe this list of poisons, restricted substances and drugs of addiction for the purposes of the practice of their profession as Nurse Practitioner.

Dated this _____________________ day of _____________________________ 20

______________________________  (signature)

______________________________  (name)
C Notification of newly established role template

I am writing to inform you of a newly established Nurse Practitioner position within the <insert LHD>.

The position is located at <insert facility> and aims to address service gaps across the <insert specialty> within the <insert setting>.

The position is <delete as appropriate – currently vacant/to be advertised/currently filled by a Nurse Practitioner/Transitional Nurse Practitioner>. Further details are provided below.

Name of Nurse Practitioner/Transitional Nurse Practitioner:

Email:

Date of endorsement:

Date commenced in Nurse Practitioner position:

Date commenced/completed NP course of study (if not endorsed):

Position type: Rural/remote/metro
D Notification Nurse Practitioner student – not approved

Issue on LHD letterhead

Course Coordinator
<insert name of course>
<insert name of university>
<insert address>

To whom it may concern

Facility:
Name of applicant:

As the <insert position> at <facility>, I must advise, that following consultation with all relevant stakeholders, approval has not been granted to <insert name of potential student> to undertake the clinical practicum1 required to complete the <insert name of course> at <insert name of university>.

As a current employee of NSW Health, the following criteria have not been met to allow the clinical practicum to be supported by the facility:

Delete as appropriate

- Current position does not provide necessary opportunities to develop the advanced practice skills required,
- The clinical environment is not able to provide adequate or appropriate supervision of clinical practice,
- The applicant’s current level of practice is not currently developed to a level that will enable transition to advanced practice,
- <insert other reasons as appropriate>.

While NSW Health supports the professional development of staff, it is essential that when this development is undertaken within the context of an applicant’s employment, conditions exist to both support and ensure the employee and the facility are indemnified in the event of an adverse incident occurring. In this instance I am not satisfied that the extension and expansion of <insert name of potential student’s> scope of practice can be undertaken within an appropriate environment. On this basis, approval cannot be provided for <insert name of potential student’s> participation in the clinical practicum.

Should the situation change in the future, I would be pleased to review a subsequent application for approval from <insert name of potential student>.

Yours sincerely

<insert name, title & facility>
<insert date>

---

1 Clinical practicum for the purpose of this policy refers to activities undertaken within the clinical setting in order to advance and or extend the Registered Nurse scope of practice for the purpose of completing the requirements of courses leading to endorsement as a Nurse Practitioner.
E  Nurse Practitioner student enrolment – approved

Issue on LHD letterhead and send directly to education provider

Course Coordinator
<insert name of course>
<insert name of university>
<insert address>

To whom it may concern

Facility
Applicant

As the <insert position> at <insert facility>, I must advise, that following consultation with all relevant stakeholders, approval has been granted to <insert name of potential student> to undertake the clinical practicum required to complete the <insert name of course> at <insert name of university>. The application is approved on the following basis:

- Current position provides the necessary opportunities to develop the advanced practice skills required,
- The clinical environment is able to provide adequate and appropriate supervision of clinical practice,
- The applicant’s current level of practice is developed to a level that will enable transition to advanced practice,
- Circumstances allow <insert name of potential student> to complete all or a component of the clinical practicum in a supernumerary capacity, by prior arrangement, within other clinical areas or facilities if required in order to ensure learning objectives are met.
- <insert other reasons as appropriate>

I understand and am satisfied that by approving <insert name of potential student> to undertake this professional development within the context of <his/her> current employment that NSW Health indemnity arrangements apply throughout the clinical practicum. Additionally, this approval includes, where required, <insert name of potential student> to be supernumerary for all or a component of the practicum hours in order to meet course requirements.

Yours sincerely

<insert name, title & facility>
<insert date>

---

1 Clinical practicum for the purpose of this policy refers to activities undertaken within the clinical setting in order to advance and/or extend the Registered Nurse scope of practice for the purpose of completing the requirements of courses leading to endorsement as a Nurse Practitioner.