

**AUSTRALIAN NURSING & MIDWIFERY FEDERATION
(TASMANIAN BRANCH)**



SUBMISSION

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**One State, One Health System, Better Outcomes
Delivering Safe & Sustainable Clinical Services
White Paper Exposure Draft**

Australian Nursing & Midwifery Federation (Tasmanian Branch)

Organisation Overview

The Australian Nursing and Midwifery Federation (ANMF) is both the largest nursing and midwifery union and the largest professional body for the nursing and midwifery teams in Tasmania. We operate as the State Branch of the federally registered Australian Nursing and Midwifery Federation. The Tasmanian Branch represents over 7,500 members and in total the ANMF across Australia represents over 240,000 nurses, midwives and care staff. ANMF members are employed in a wide range of workplaces (private and public, urban and remote) such as health and community services, aged care facilities, universities, the armed forces, statutory authorities, local government, offshore territories and more.

The core business of the ANMF is the industrial and professional representation of nurses, midwives and the broader nursing team, through the activities of a national office and branches in every state and territory. The role of the ANMF is to provide a high standard of leadership, industrial, educational and professional representation and service to members. This includes concentrating on topics such as education, policy and practice, industrial issues such as wages and professional matters and broader issues which affect health such as policy, funding and care delivery. ANMF also actively advocates for the community where decisions and policy is perceived to be detrimental to good, safe patient care.

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1. Executive Summary & Key Responses

The need for reform of the Tasmanian health system is unquestionable. The current system is facing major challenges including significantly reduced budgets; long waiting lists; capacity deficits; an ageing population and a significant growth in chronic disease. Reconfiguring health services is driven by wanting to deliver better quality clinical services for individuals and communities through reducing fragmentation and revision of the governance structures.

The ANMF (Tas Branch) supports these reforms on the basis of the modernisation of supporting processes; maximising the impact of public funding and the creation of a system that is accountable, effective, efficient and capable of responding to the emerging and ongoing needs of the Tasmanian community.

Key Responses:

1. The ANMF (Tas Branch) believe it is necessary to keep a High Dependency Unit available at the Mersey to support the capacity to escalate care if needed.
2. The ANMF (Tas Branch) advocates the registered nurse as the only generalist clinician within the health workforce and the scope of practice for nurses should be defined by the broad scope as applied through regulation and not narrowly defined by other professional groups.
3. Advanced and extended practice roles for nurses will enhance the efficacy of multi-disciplinary teams and will improve the quality of services to the Tasmanian population through the ability to provide:
 - a repertoire of therapeutic response;
 - insightful, sophisticated clinical judgements; and
 - clinical decision making justified by application of advanced knowledge and skills.
4. The ANMF (Tas Branch) expects nursing and health workforce reform and redesign must be planned, coordinated and evidence-based.
5. The ANMF (Tas Branch) expects the implementation and evaluation/monitoring of health workforce reform occurs in consultation with the health professions.
6. The ANMF (Tas Branch) expects Quality of Care considerations are at the forefront of decision making when considering changes to the way in which health services are delivered.
7. The ANMF (Tas Branch) does not agree with the closure of the John L Grove Centre.
8. The ANMF (Tas Branch) has an expectation that a “no disadvantage” threshold will be applied to all decisions related to the re-profiling of nursing services across the state. The “no disadvantage test” for industrial conditions must be upheld including a minimum of twelve months salary maintenance, if required.

9. The ANMF (Tas Branch) takes this opportunity to strongly advocate for nursing leadership positions within the proposed Tasmanian Health Service structure and the Chief Nursing Officer within the DHHS.
10. The ANMF (Tas Branch) fully supports the maintenance of nurse educator positions in both general and specialty areas to build and maintain capacity for the existing nurse/midwifery workforce and to ensure the safety and quality of nursing care through evidenced based practice.
11. The ANMF (Tas Branch) seeks reassurance that any failure to achieve the savings does not lead to further compromise of the proposed redesign.
12. The ANMF (Tas Branch) would argue that any pre-emptive changes to mental health services through either the RDF or clinical services redesign is premature in the extreme as any reforms must include information from the consultations associated with the *Rethink Mental Health Project*.
13. The ANMF (Tas Branch) fully supports the amalgamation of mental health services into the THS.
14. The ANMF (Tas Branch) strongly advocates the Tasmanian Ambulance Service is brought within the Tasmanian Health Service to integration of the service, remove barriers and ensure seamless organisation of transfers.
15. The ANMF (Tas Branch) strongly advocates the Family Child Health services and School Nurses are brought within the Tasmanian Health Service to ensure continuum of care for families and children. The maintenance of child protection in Human Services is appropriate.
16. The ANMF (Tas Branch) does not support Tasmanians incurring travel and accommodation costs as this may be inequitable and cause undue hardship. Reimbursement strategies are not practical.
17. The ANMF (Tas Branch) cautiously supports the introduction of Medi-hotels but with a rigorous framework for introduction related to; proximity to services, quality of accommodation, comprehensive screening, clear lines of accountability and responsibility.
18. The ANMF (Tas Branch) support significant investment to ensure integration of IT systems across the state.

2. Introduction

The ANMF (Tas Branch) welcomes the opportunity to contribute to the development of an integrated, effective, safe and sustainable health system for Tasmania into the future.

The ANMF (Tas Branch) has adopted consultative process for collecting and collating the viewpoints of ANMF (Tas Branch) staff, members, Council and Executive in response to the *White Paper - Exposure Draft (March 2015)*. The ANMF (Tas Branch) submission expands and elaborates on the feedback already provided to the Green Paper, *Delivering Safe and Sustainable Clinical Services*.

3. Communication, Transparency & Clarity

The 'Exposure Draft' (p4) states "*Importantly, redesign of the health system will ensure that we spend our existing health funds more efficiently, including by providing improved surgical services to deliver cost benefits.*" The ANMF (Tas Branch) seeks reassurance that any failure to achieve the savings does not lead to further compromise of the proposed redesign.

The reforms detailed in the "*exposure draft*" represent the most substantial change in the health system in Tasmania for a significant number of years and it is self-evident that to ensure success an effective communication strategy is required. Nurses and midwives in Tasmania represent 70% of the affected workforce and yet the evidence suggests the consultation process has been seriously flawed by the scant level of information and clarity provided to both middle management and frontline staff. The ANMF (Tas Branch) has serious concerns that this has resulted in a substantial disaffection and disengagement by those most able to bring success to the reforms and to harness community collaboration. It is difficult to believe that at this stage of the reforms there remains a lack of clarity about the projected profile of particularly the Mersey Community Hospital, and the subsequent implications for staff and the community. ANMF (Tas Branch) has an expectation that a "no disadvantage" threshold will be applied to all decisions related to the re profiling of staff services across the state. Additionally all staff will be respected industrially, and have a "no disadvantage test" for industrial conditions, maintaining at least 12 months salary maintenance where relevant.

The proposed closure of the John L Grove Rehabilitation Unit is also perplexing. The central tenet of the "*exposure draft*" advocates reform across the continuum of care yet the closure of this service is argued on the basis of discontinuation of funding from the Federal Government rather than on the expressed service need of the community. Communication, transparency and clarity create trust in an organisation and reduce the costs associated with change. The inference has been drawn that staff tenure is secure however their futures are uncertain. It would seem counterproductive to be failing on all counts at this stage of the reform. The ANMF (Tas Branch) does not agree with the closure of this service.

4. Role Delineation Framework (RDF) Considerations

ANMF (Tas Branch) has commented on both the intent and scope of the RDF in the written submission to the *Green Paper*. However problems (not limited to below examples) remain within the revisions to the RDF issued within the 'Exposure Draft'.

Cancer Services

Medical Oncology

The workforce requirement within the RDF includes a Clinical Haematologist without mention of an Oncologist.

Renal Services

An important service previously provided to patients in the north of the state with renal disease was a 'conservative care clinic' for dialysis patients. This was a multidisciplinary team of a Nephrologist, Chronic Kidney Disease Educator and Social Worker. This clinic supported many patients in the community with an opportunity to be supported in their journey with chronic disease and symptom management. This led to better community management and less risk of acute admission. However the funding for the educator was ceased and this service was stopped. There is a strongly held view by both the Nephrologist and nephrology nurses that this service be included in the revised plan. The substantial growth in renal services across Tasmania should be reflected in dedicated positions funded on an ongoing basis as a minimum of the RDF in all 3 regions are: dedicated vascular access nurses, CKD educators, transplant co-ordinators and home therapies training positions.

Intensive Care Services

Level 6: requires research focus in line with accreditation including Research Nurse and Clinical Liaison Nurse Specialist.

Orthopaedic Services

Level 6: should include dedicated Clinical Nurse Educator.

Neonatology

Require Clinical Nurse Educator and Clinical Nurse Consultant for Level 6 services.

Additionally, it is not agreed that neonates less than 28 weeks should be transferred interstate. On the consultation day, all eight admitted neonates in NPICU at RHH were less than 28 weeks.

Drugs and Alcohol

Specialist nurses should be employed in Level 2 and above services.

Mental Health

The 'Exposure Draft' (p4) identifies the *Rethinking Mental Health Project* as an activity which will provide significant direction to the future integration and design of mental health services

in Tasmania. However the DHHS own update (March 2015) reveals that any insights garnered through the consultations which occurred between October 2014 – March 2015 “...will be analysed and will help inform the identified priorities that will form the basis of a long term plan for mental health in Tasmania.” The ANMF (Tas Branch) would argue that any pre-emptive changes to mental health services through either the RDF or clinical services redesign is premature in the extreme as any reforms must include information from the consultations.

The wording within the RDF requires clarification and amendment to ensure both practitioners and consumers are clear of the meaning. “*Capacity for non-authorised treatment*” should read “*not authorised under the Mental Health Act*”. This presumably makes reference to voluntary patients. This is a very important matter for consumers.

Adult mental health services as outlined in the RDF remains the same category but with increases in alcohol and drug services at the MCH. This increase in service is welcome, however the ANMF (Tas Branch) is concerned this increase in service is aligned to the media announcement of 3 May 2015 indicating funding will be directed toward “ice” related treatment only.

Child and Adolescent Mental Health Services (CAMHS) remain a significant concern as an output service which is significantly understaffed. Discussions related to CAMHS do not appear to be informed by the coronial enquiry nor is there evidence of a timely response to the recommendations. It is revealed that CAMHS services will increase at the RHH and LGH, NWRH staying the same and MCH continues without this service. The distribution of these services is not the only concern the actual quantity of service is more important as timely access is the single most important therapeutic response. The redesign of the RHH will provide only two CAMHS beds aligned to the Paediatric Unit.

The RHH will provide the only Level 6 Adult Mental Health Unit. This will fill the role of the existing PICU. However the bed numbers will reduce from 8 down to 5/6 depending on the use of the de-escalation bed. This will have significant effects on the capacity for intrastate transfers as the current PICU will be downgraded to an HDU. As this unit will have a full occupancy (based on current experience at 8 beds) there will not be the capacity to take patients from either the North or North West leaving the patients, community and health service at risk.

The inference within the ‘Exposure Draft’ is that primary health services including GP’s and NGO’s will have to meet the needs of mental health clients where the system does not. It is also suggested that tele-health will provide opportunities for assessment of mental health clients. This demonstrates a lack of understanding of the foundational importance of the Mental State Exam which also includes a physical assessment. Within the RDF Level 6 services will be the only service providing ‘*mental health care 24hrs*’. This includes “*comprehensive mental health multidisciplinary teams available 24hrs per day 7 days per week on site*”. The contemporary understanding of these teams in mental health include: nursing, social work, psychology, diversional therapy, occupational therapy and medicine. Is there to be a MH MDT in the contemporary understanding or does this only mean capacity for medical referral to someone within the hospital?

The ANMF (Tas Branch) fully supports the amalgamation of mental health services into the THS. Additionally for continuum of care, family child health and school nurses should also be transferred back to health under THS.

Other

- No reference to Out Patient or Ambulatory Services
- Nurse Unit Manager for each unit to be included
- Liaison and Discharge Coordinators need to be included
- No reference to After Hours Management
- No reference to Nurse Practitioner roles
- Clinical Nurse Educators, Clinical Nurse Consultants and Clinical Coordinators have been excluded.

5. The Mersey Community Hospital

The ANMF (Tas Branch) is disappointed the 'Exposure Draft' is lacking in detail and specificity and demonstrates a lack of understanding of the current operations of the Mersey Community Hospital and the role it plays within the Tasmanian health system. This was also revealed during a post forum visit by a number of staff from the Office of the Minister for Health.

This is with particular reference to:

1. The HDU manages patients who require **close observation** for such things as cardiac conditions, respiratory disease, non-invasive ventilation, electrolyte imbalances, and complications from diabetes, renal failure, specialised drug infusions, and post-operative patients requiring short term monitoring. The HDU at the MCH supports people with single organ failure and receives step down patients from other ICUs. The HDU also monitors the telemetry service which allows patients to move around while being cardiac monitored and respond to Medical Emergencies within the hospital. These are the invaluable functions HDU currently offers the community. The changes to the service profile as detailed within the 'Exposure Draft' reports the HDU at the MCH will become a short stay unit able to stabilise and prepare patients for transfer. Is the semantics here that the level of skills knowledge and expertise required to stabilise patients remains the same however the timeframe is condensed?
2. The inference is drawn that the small number of approx. 6 ventilated patients per year is cause for concern when in fact this is a role **not expected** to be filled by an HDU. This small figure successfully illustrates the capacity and importance of the HDU at the Mersey to not only safely recognise the deteriorating patient and transfer them to more appropriate support services but also to operate within the scope of service as currently exists.
3. The proposed increase in high volume day surgery implies there is no need for an escalation of care option within the Mersey Community Hospital (MCH). The absence of a care escalation area would also severely restrict the type of patient who could access the MCH day procedure Centre of Excellence. There are a large number of Tasmanians with co-morbidities such as sleep apnoea requiring non-

invasive ventilation, cardiac conditions, and renal failure which all increase anaesthetic risk. These patients, along with patients who unexpectedly react to anaesthetic or do not recover well would all benefit from an on-going high observation area. The continuation of the HDU would also cater for the unstable cardiac patients who would continue to be brought to the MCH Emergency Department for stabilisation.

4. Failure to mention, within the 'Exposure Draft', the additional requirements at the North West Regional Hospital and the Launceston General Hospital to accommodate increased presentations and admissions which will not be accommodated at the MCH as well as the increase in ED presentations when the MCH reduces to 16hr operation. In the last year the activities of the MCH included:
 - 4500 emergency admissions via the Emergency Department
 - 856 admissions to the HDU
5. There is considerable concern from nursing staff at the MCH about the current inability to provide a timely and reliable ambulance patient transport system. There are significant delays in transferring patients due to a lack of available ambulances. This system is currently under stress and the potential for catastrophic outcomes is high. This would be further exacerbated by an increased volume of patients having to be transported to a higher acuity hospital and the increased activity and occupancy of receiving hospitals.
6. The Role Delineation Framework details there will be no general physicians on site. The MCH currently offer a safe and quality service in liaison with specialists in other areas, and provide for a growing community effectively, successfully recognising the limited scope of the service where necessary.
7. The lack of certainty about the ongoing maternity services at the MCH is creating significant concern to nurses and midwives for the well-being of pregnant women in the area, particularly considering the level of social disadvantage within the area and the lack of affordability to travel. If the MCH is to lose maternity services it will also lose gynaecology services as they are always delivered concurrently to maintain skill base, aid recruitment and manage gynaecological emergencies. There are two different employers for midwives, currently DHHS have additional conditions; the final decision will impact on the midwifery work force numbers; maintaining competence due to proposed changes; maintenance of entitlements; and privately employed midwives say they may feel undermined in the quality of care provided due to speculation.

6. Nursing Leadership & Governance

As the largest healthcare workforce, nurses and midwives have a significant influence on optimising health service productivity and effective patient health outcomes.¹ Nurse executives lead and provide stewardship to the nursing workforce through professional governance standards. Most importantly nurse executives are able to create a vision of professional practice for nurses and midwives through strategic thinking, workforce and organisational development. Executive nurses are also able to create and lead innovations in nursing practice and are foundational in creating work environments of team work and shared governance.²

Shared governance aligned with clinical governance is the key to promoting a culture of organisation revision. The nurse leader uses the principles of shared governance to work with others to create the framework for professional nursing practice and delivering key health service targets. This ‘*Ward to Board*’ role is vital in ensuring there is a professional nursing lead with visible authority and can act as an advocate for nurses and midwives at the executive level. The absence of this leadership results in a demoralised workforce and high staff turnover.³

Critically, as leaders with a clinical background as well as management knowledge and skills, nurse executives are able to combine an operational perspective with knowledge of how decisions related to staffing and clinical care delivery will impact on patients.⁴ They influence the strategic direction of the organisation through their input regarding service delivery, resource allocation, workforce planning and development, governance arrangements and clinical quality assurance.⁵ Leadership and Pilot champions of clinical services redesign may be auspiced through the nursing executive.

The ANMF (Tas Branch) takes this opportunity to strongly advocate for nursing leadership positions particularly of a Chief Nurse in the DHHS, external to the operational THS, and Executive Directors of Nursing within the proposed Tasmanian Health Service Structure.

¹ Buchan, J & Aiken, L 2008, Solving nursing shortages: a common priority, *Journal of Clinical Nursing*, 17(1), pp.3262-3268.

² Talbert, T 2012, The role of the nurse executive in fostering and empowering the advanced practice registered nurse, *The Nursing Clinics of North America*, 4(2), pp261-267.

³ Kirk, H 2008, Nurse executive director effectiveness: a systematic review of the literature. *Journal of Nursing Management*, 16(3), pp.374-381.

⁴ Kings Fund, 2009.

⁵ White, J 2011, ‘Reflections on strategic nurse leadership’, *Journal of Nursing Management*, Vol.15, no.5, pp. 508-521.

7. Care Team Optimisation

A significant opportunity exists within the reforms for the increased utilisation of nursing workforce through deliberately creating a practice culture capable of enhancing and sustaining a diversity of nursing team roles. The ANMF supports the many innovative programmes and strategies already in place that are designed to improve patient centred care and improve efficiency within a constrained budgetary environment. However all decisions need to consider how to make best use of the skills and expertise of the existing workforce and also be open to the possibility of different ways of working. We can learn from the experience of other states, territories and countries – but also must be mindful of the unique characteristics of our island state which may present challenges when attempting to ‘transplant’ models and programs developed elsewhere.

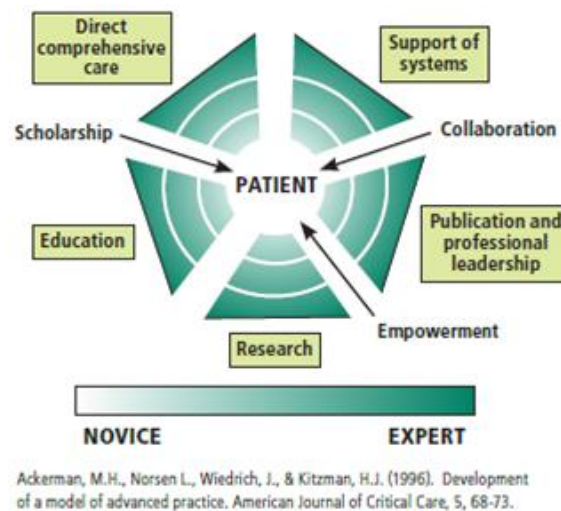
The demands of modern health care on the delivery of nursing services have increased radically, and will continue to do so. In virtually all contexts in which nurses provide care there has been increased patient acuity, complexity of the care required, volume of patients/clients, diversity of case mix, expectations that practice is based on evidence and demands for accountability. Concurrently there has been a decreased length of stay and time available for meaningful professional/patient interaction. This situation has increased enormously the need for highly developed critical problem solving and organisational skills on the part of all health professionals including nurses.

A scope of practice defines those activities that a practitioner is educated, competent and legally authorised to perform. The actual scope of practice for individual practitioners is influenced by the needs of patients/clients; by the individual’s education and competence; the settings in which they practice; and the requirements of the employer.

It is asserted that the scope of practice for nurses should be defined by the broad scope as applied through regulation and not narrowly defined by other professional groups.

The current Poisons legislation restricts practice and a complete review is required to enable nurses to practice to full scope of practice. This may include stranding orders and Nurse Practitioner formulary.

Nurses bridge the gap between coverage and access to health services through the ability to co-ordinate increasingly complex care for wider patient groups. Advanced practice nurses and Nurse Practitioners provide a way to address health service gaps or needs to improve health outcomes and also offer a way to attract, recruit and retain expert clinicians to work within the health system and create an extended career pathway.



Potential Innovations in Practice

1. Nurse-led triage services which provide high needs people with access to care and arrange lower cost access as part of their care plan.
2. Nurse-led rural after hours phone triage services to direct patients to the most appropriate referral centre.
3. Community observation units capable of accepting patients presenting at an acute hospital but who require treatment or monitoring beyond the initial hours of assessment.
4. Acute Demand Liaison Nurses – 10yr experience in Canterbury Health (New Zealand).
5. Nurse Endoscopists - Evaluations complete for Queensland Pilot (2014). This would be a significant advantage to the re-profiled MCH.
6. Rural Health Nurse Practitioners with sufficient specialist knowledge, skills and experience to practice in environments with limited or no collegial, medical and/or other support and are well suited to meet the demands of underserved areas.
7. Specialist advanced practice nurses able to work within specialist areas to provide clinical expertise, build capacity within the nursing workforce and provide education to ensure evidence based practice e.g. surgical advanced practice nurse working across surgical services.
8. Nurse Practitioners
 - a. Vascular Access
 - b. Hepatitis C
 - c. Rheumatology
 - d. Palliative Care
 - e. Renal Dialysis
9. Express Admission Nurses - Steward fast admissions through Emergency Departments.

10. Nurse/Midwifery-led '*Pop Up*' clinics in rural and remote areas using trusted community places as health information/screening hubs e.g. libraries.
11. *Buurtzorg* Model of neighbourhood nursing practice where self-directed nursing teams work with minimal administrative oversight in collaboration with patients, families, physicians and the community - <http://buurtzorgusa.org/about.html#model>
12. Establish acute medical assessment units which identify patients who could be 'pulled' from the hospital and supported more appropriately in the community with increased nursing support (Canterbury Health Service save an estimated 100 bed days per month).
13. Increase the number and scope of advanced practice nursing positions and Nurse Practitioners and **fund the necessary education and support for nurses to advance their roles.** Nurse Practitioner candidate positions should be funded and consistency in scope of practice within Emergency Departments across the state.
14. Extended role nurses able to perform X-Rays in rural and remote areas supported by tele-health to increase access to services (Lorne Community Hospital/Vic Health pilot Evaluations 2014).
15. Outreach midwifery services and Group Practice extension.
16. Nurses Liaison role in ICU to co-ordinate discharges and follow up after discharge.
17. Access to alcohol and drug detoxification and specialist services in rehabilitation facility to remove these clients requirement in AMU.
18. Discharge coordinators to ensure pathway planning and monitor referrals and discharges e.g. Ortho RHH has successful model and after hours discharge coordinators beneficial.
19. Pre admission nurse assessment.
20. Nurse Practitioners leading complex case management.
21. Note that some community health roles have been diluted and deskilled in a bid to save money and employ junior nurses.

8. Workforce Development & Education

The '*Exposure Draft*' states the revised clinical services profile provides an opportunity to address an incoherent workforce development plan. However the clinical services profile as detailed in the RDF has removed many nurse educator positions as an essential requirement of the workforce profile for each service. This is short sighted and ill considered. The successful revision of clinical services is dependent on a workforce capable of flexibility, adaptability and premised on evidence. The training priorities mentioned within the '*Exposure Draft*' are directed at the needs of medical practitioners. This emphasis would seem to be disproportionate to the need of the entire health workforce.

Nurse educators play a critical role in supporting novice practitioners, ensuring contemporary practice and enabling and facilitating the mobility of staff within a service. They also ensure

minimum standards of education are maintained as part of a sound clinical governance framework. The loss of this nurse education infrastructure will seriously compromise the initial and ongoing education of nurses and midwives. ANMF (Tas Branch) fully supports the maintenance of nurse educator positions in specialty areas to build and maintain capacity for the existing nurse/midwifery workforce and to ensure the safety and quality of nursing care through evidenced based practice. The ANMF (Tas Branch) welcomes the proposed partnership relationships with a range of education providers.

9. Nursing Performance Scorecard

Patient outcomes have been defined as the end result of treatment or care delivery and the ANMF (Tas Branch) argues the implementation of a Nursing Performance Scorecard embedded within the State-wide Clinical Governance Framework is an urgent action. The need for a clear and transparent relationship between the clinical governance activities and outcomes for consumers is vital in ensuring the right services are delivered in the right place at the right time by the right person. The failure of patients/consumers to be able to have access to their own health record which would enable them to share the information with health care providers is both absurd and risky. This is exacerbated by the current situation where and exposes all to a high level of unmitigated risk.

The identification and measurement of the outcomes that reflect nursing's unique contribution are required. Nurse sensitive indicators reflect the structure, process and outcomes of nursing care. The structure of nursing care is indicated by the supply of nursing staff, skill mix and education; process indicators measure aspects of nursing care related to assessment, care planning and turnover and outcome measures are indicators that improve if there is a greater quantity or quality of nursing care. ⁶Agreed standards, skill mix targets and performance scorecard indicators must be integrated across the regions and levels of disadvantage and inequity minimised. The introduction of a transparent scorecard available through dashboards will enable the review of a number of integrated measures and identify emergent issues and remediation by nursing workforce interventions. Increased qualified nurse skill mix has demonstrated a decrease in pneumonia and hospital mortality⁷ and higher numbers of qualified nurse skill mix has also demonstrated lower rates of "Failure to Rescue" and lower rates of mortality.⁸

The ANMF (Tas Branch) recommends the introduction of a distinctly Tasmanian taxonomy of indicators including but not limited to:

1. *Skill mix*: The balance between trained and untrained, qualified and unqualified and supervisory and operative staff who make up nursing teams. Specific metrics related to the nursing skill mix across the nursing grade continuum is essential.
2. *Sustainability*: This metric is vital to measure the regeneration of the nursing workforce. Graduate recruitment reflects the regeneration of the workforce into the

⁶ American Nurses Association, Nursing Sensitive Indicators. www.nursingworld.org

⁷ Aiken et al. 2014, Nurse Staffing and education and hospital mortality in nine European countries: a retrospective cohort study, *The Lancet*, Vol.383.,pp.1824

⁸ Needleman, et al. 20012, Nurse staffing levels and the quality of care in hospitals, *N.Eng.J. Med.*, 346, pp1715-22.

future whilst measuring the age of the existing workforce enables systematic planning when combined with data related to nursing turnover.

3. *Productivity and Efficiency.* The productive hours available and the percentage cost particularly related to overtime, casual and agency use. Leave liability, workers compensation and turnover are all critical indicators of the capacity for nursing to affect quality outcomes. This metric supports the measurement of critical information in the context of activity based funding and supports a nuanced understanding of trends. Nursing Hours per Patient Day must be included here.
4. *Quality.* Nurse Sensitive Outcomes consistent with the National Safety and Quality Health Service Standards will ensure the implementation of nursing systems which are safe, appropriate, efficient and reliable.
5. *Access:* This metric would identify risk populations where without a nursing service, no service would be available.

10. Information Technology

The ANMF (Tas Branch) asserts that significant reform as proposed through the '*Exposure Draft*' will be seriously compromised by the parlous state of information technology across the health system. The current system does not enable efficient, timely and safe transfer of information between regions, across services or with community providers. This not only limits continuity of care but poses serious risks to safety and quality. In the contemporary context of technically mediated care a synergy between systems should be a minimum performance expectation. Without this synergy rapid change and innovation in service scope, profile and flexibility are not possible. Tele-health has been defined as delivery of health services over a distance using telecommunications⁹Technological advances offer a nexus of opportunity for nurses and midwives to develop new and expanded scopes of practice.¹⁰

The '*Exposure Draft*' identifies the need for partnerships between private and public providers. This is commendable as patients and clinicians move between both. For example, patients may see the clinician in private rooms but be treated in public services. Yet there is no system which allows the latest information to be passed in a timely way between the services, clinicians, treating facility and the patient.

ANMF (Tas Branch) support significant investment to ensure integration of IT systems across the state.

Potential Nursing Practice Enablers Through Applications of Tele-Nursing Include:

- Home monitoring of physiologic parameters, video consultation, and enabling self-management of chronic illness.

⁹ General Practice Computing Group, 2004

¹⁰ Talamini MA, Hanly EJ 2005, Technology in the operating suite. *Journal of the American Medical Association.* ;293:863–866

- Clinical information can be shared with other professional colleagues remotely.
- Home tele-care is rapidly evolving as a means of providing care in home or community settings with the primary role of providing support for the patient rather than the health professional.¹¹
- Nursing clinics through tele-health - coaching for chronic disease management can be continuous and timely to prevent premature and frequent Emergency Department presentations.
- Electronic Standing Orders packages across the State which enables consistent protocol-led care that is flexible enough to be used across rural and urban primary care.
- *Flipped Healthcare*¹² the control of service access is in the hands of the patient and engages individuals and communities in promoting health.

11. Transport & Accommodation

The proposed changes within the RDF, clinical services redesign and the amalgamation of the THOs has revealed the lack of a well-resourced and integrated ambulance and retrieval service within Tasmania. There is currently reported a frequent circumstance where patients will be transferred to services for surgery but no mechanism available to transfer them home post-operatively if there is no alternative available. This also results in inappropriate admissions to local hospitals. This is of significant concern in regard to the proposals to increase the activity and movement of patients between services and regions. The failure of an effective pre-hospital service will pose unacceptable risks to the community particularly when other supporting services become more widely distributed. The use of expensive retrieval and pre-hospital services is not a cost effective utilisation of resources where alternative transport options may be better introduced. However the expectation for Tasmanians to incur substantial transport and accommodation costs is not supported by the ANMF (Tas Branch) as this may be inequitable and cause undue hardship.

A review needs to be undertaken on the skill mix and level of paramedic to meet the future needs with higher levels of ICU paramedics to relieve the requirement of a RN to travel with patient to monitor arterial line. Note current overtime rates for ambulance service and significant additional resources will be required.

The ANMF (Tas Branch) strongly advocates the Tasmanian Ambulance Service is brought within the Tasmanian Health Service to integration of the service, remove barriers and ensure seamless organisation of transfers.

Accommodation options for those required to travel and access services away from home at acute hospitals would be well served by medi-hotels. It is acknowledged that medi-hotels may form part of a whole health service improving access to hospital services. However the

¹¹ Celler, B.G., Lovell, N.H. and Basilakis, J. 2003. Using information technology to improve the management of chronic disease. *eMedical Journal of Australia*, 179(5):242-246

¹² Barry, MJ & Edgman-Levitan S Shared Decision Making-Pinnacle of patient-centered care, *N Engl J Med* 2012, Mar 1; 366(9))

screening must be limited to self-caring individuals making transitions between the community and acute care sector. The ANMF (Tas Branch) cautiously supports the introduction of medi-hotels but with a rigorous framework for introduction related to: proximity to services, quality of accommodation, comprehensive screening, clear lines of accountability and responsibility.

Currently, it is reported that North West residents have to “find their own way home” from the Royal and cover the costs. Equity across the state for all residents must be considered. There is a 6-24 hour wait for ambulance transport from the Mersey to transfer patients to the RHH or LGH. Bed management and transport should all be centralised.

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