Health Workforce Australia
Expanded Scopes of Practice Program
Evaluation Progress Report 2

Centre for Health Service Development

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# Table of Contents

1 **KEY MESSAGES** ................................................................................................................................ 1

2 **EXECUTIVE SUMMARY** ..................................................................................................................... 2

  2.1 Program delivery – What did you do? .......................................................................................... 2

  2.2 Program impact – How did it go? ............................................................................................... 3

  2.3 Program sustainability – Can you keep it going? ...................................................................... 3

  2.4 Program capacity – What has been learnt? ................................................................................. 4

  2.5 Program generalisability – Are your lessons useful for someone else? ..................................... 4

  2.6 Program dissemination – Who did you tell? ............................................................................... 5

3 **INTRODUCTION AND BACKGROUND TO THE HWA-ESOP PROGRAM** ...................................... 6

  3.1 Overview ....................................................................................................................................... 6

  3.2 Project implementation sites ....................................................................................................... 6

  3.3 Aim of this report ........................................................................................................................... 6

4 **EVALUATION TEAM ACTIVITIES AND PROJECT SUPPORT** ........................................................ 7

  4.1 Compendium of Data Requirements and Evaluation Tools ......................................................... 7

  4.2 Coordination of tool use and data collection ............................................................................... 7

  4.3 Evaluation support ....................................................................................................................... 7

  4.4 Reflections and lessons learned ................................................................................................. 9

5 **TRAINING AND IMPLEMENTATION: ADVANCED PRACTICE IN ENDOSCOPY NURSING (APEN)** ............................................................................................................................................... 11

  5.1 Overview ....................................................................................................................................... 11

  5.2 Description of the training pathway ............................................................................................ 11

  5.3 Training entry requirements ....................................................................................................... 13

  5.4 Training progress and outcomes ............................................................................................... 13

  5.5 Implementation of the model of care .......................................................................................... 16

  5.6 Stakeholder engagement strategies in training and implementation ........................................ 17

  5.7 Barriers and enablers .................................................................................................................. 17

  5.8 Reflections and lessons learned ................................................................................................. 19

6 **TRAINING AND IMPLEMENTATION: PHYSIOTHERAPISTS IN THE EMERGENCY DEPARTMENT (PED)** ....................................................................................................................... 21

  6.1 Overview ....................................................................................................................................... 21

  6.2 Description of the training pathway ............................................................................................ 21

  6.3 Training entry requirements ....................................................................................................... 26

  6.4 Training progress and outcomes ............................................................................................... 27

  6.5 Implementation of the model of care .......................................................................................... 29

  6.6 Stakeholder engagement strategies in training and implementation ........................................ 32

  6.7 Barriers and enablers .................................................................................................................. 33

  6.8 Reflections and lessons learned ................................................................................................. 35

7 **TRAINING AND IMPLEMENTATION: NURSES IN THE EMERGENCY DEPARTMENT (NED)....** 37

  7.1 Overview ....................................................................................................................................... 37

  7.2 Royal Prince Alfred Hospital ...................................................................................................... 37
List of Figures

Figure 1  Nurse Endoscopist Skills Training Program Overview ................................................................. 12
Figure 2  The ACT Expanded Scope of Practice training pathway ............................................................. 22
Figure 3  The advanced musculoskeletal physiotherapy clinical education framework ............................ 24
Figure 4  The Alfred Hospital education and training pathway ................................................................. 25
Figure 5  SAAS Country ECP Training Pathway ....................................................................................... 57
Figure 6  SJANT/Edith Cowan University ECP Training Pathway ............................................................ 61

List of Appendices

Appendix 1  Lead and implementation sites by sub-project ................................................................. 80
Appendix 2  HWA funding allocation and execution date by project ...................................................... 81
Appendix 3  Ethics approval status ........................................................................................................... 84
## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTAS</td>
<td>ACT Ambulance Service</td>
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<tr>
<td>APEN</td>
<td>Expanded Scope of Practice – Advanced Practice in Endoscopy Nursing (referred to as APEN projects)</td>
</tr>
<tr>
<td>CHSD</td>
<td>Centre for Health Service Development, University of Wollongong</td>
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<tr>
<td>ATAS</td>
<td>Ambulance Tasmania</td>
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<tr>
<td>CNC</td>
<td>Clinical Nurse Consultant</td>
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<tr>
<td>CNS</td>
<td>Clinical Nurse Specialist</td>
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<tr>
<td>ECP</td>
<td>Extended Care Paramedic</td>
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<td>ED</td>
<td>Emergency Department</td>
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<tr>
<td>ERP</td>
<td>Expanded Scope of Practice – Extending the Role of Paramedics (referred to as ERP projects)</td>
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<td>ESOP</td>
<td>Expanded Scopes of Practice Program also referred to as the Program</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<td>HWA</td>
<td>Health Workforce Australia</td>
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<td>ICP</td>
<td>Intensive Care Paramedic</td>
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<tr>
<td>NED</td>
<td>Expanded Scope of Practice – Nurses in the ED (referred to as NED projects)</td>
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<td>NP</td>
<td>Nurse Practitioner</td>
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<tr>
<td>PED</td>
<td>Expanded Scope of Practice – Physiotherapists in the ED (referred to as PED projects)</td>
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<tr>
<td>PCP</td>
<td>Primary Contact Physiotherapist</td>
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<tr>
<td>Program</td>
<td>Used to refer to the Expanded Scopes of Practice Program in its entirety</td>
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<tr>
<td>SAAS</td>
<td>South Australian Ambulance Service</td>
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<tr>
<td>SJANT</td>
<td>St John Ambulance Northern Territory</td>
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1 Key messages

The Centre for Health Service Development (CHSD), University of Wollongong, was appointed in June 2012 to undertake the program evaluation of the Health Workforce Australia - Expanded Scopes of Practice (HWA-ESOP) program. Health Workforce Australia (HWA) currently funds 26 organisational projects across Australia. Several organisations have more than one implementation site.

The focus of this second evaluation progress report is the training and implementation phase; it is consequently formative – providing a view of the ongoing progress of the four sub-projects:

- Advanced Practice in Endoscopy Nursing (APEN)
- Physiotherapists in the Emergency Department (PED)
- Nurses in the Emergency Department (NED)
- Extending the Role of Paramedics (ERP)

In summary:
- All project teams are implementing their ESOP initiative in accordance with their project/implementation plans however the majority of projects are still at the partial implementation stage (meaning that they have not implemented all elements of their expanded scope of practice model of care), mainly because training is still in progress, or there are delays in securing approval for some of the proposed changes.
- The project teams are engaged and enthusiastic and working hard to achieve their project objectives.
- The majority of stakeholders are supporting implementation with limited resistance to the new workforce models identified amongst patients, service providers and organisations. In each sub-project there are pockets of resistance and project teams are working to address issues that are within their control.
- The training programs implemented to date appear to be ‘fit for purpose’ and providing the necessary knowledge, skills and competencies.
- Most projects have underestimated the time and resources involved in training. This was particularly so when competencies had to be developed or clinical placements needed to be arranged as part of the training pathway.
- Learning pathways that articulate to a nationally recognised qualification may be more sustainable. In addition processes for endorsement of new roles may facilitate sustainability if they permit practice outside the training organisation.
- The medical mentoring and supervision role is critical to all ESOP projects, without strong medical engagement it is unlikely that expanded scope of practice roles can be effectively implemented.
- As practitioners apply the expanded scope of practice model of care, additional training needs are emerging. There should be a structured approach to continuing professional development for these ESOP roles.
- The implementation of some elements of the ESOP models of care, for example prescribing, are bigger than the individual project and projects are unlikely to achieve this without the support of State and Territory health departments.
- Implementation of ESOP initiatives needs to be continuously monitored to ensure the emerging risks and issues are communicated and addressed.

The final evaluation progress report will focus on evaluation and sustainability issues.
2 Executive summary

The HWA-ESOP program is part of a work plan implementing the National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015. It was instigated to address known areas of workforce shortage in the Australian health system by expanding the scopes of practice of nurses and allied health professionals. There is a need to implement and evaluate these models systematically and to assess whether they are suitable for wider (national) roll-out and the conditions under which they are most likely to succeed.

In total, 26 organisations have received funding under the HWA-ESOP program with projects under way in excess of 30 sites. As national evaluator of the program, CHSD’s role is to assist sites with planning and carrying out their evaluation activities, to monitor evaluation outcomes and to collect, organise and synthesise evaluation data from the program as a whole, to inform future policy and practice. In this report, we describe the progress of project teams in the training and implementation phase of the Program.

Our review of each of the four HWA-ESOP sub-projects has generated a range of findings, many that are common across the program. The syntheses of major lessons learned at the program level that pertain to this current operational phase are provided in relation to the six key elements of the program evaluation framework.

2.1 Program delivery – What did you do?

- The APEN and PED projects are progressing as planned with their training and on track for completion by the end of this year. The training progress for NED projects is more variable, whilst the major training requirements have been completed by the ERP projects.
- A range of high quality training materials have been produced across the sub-projects and are being applied appropriately.
- All project teams are implementing their ESOP initiative in accordance with their project/implementation plans recognising that several have negotiated amendments in response to changing circumstances.
- The majority of projects are still at the partial implementation stage (meaning that they have not implemented all elements of their expanded scope of practice model of care), mainly because training is still in progress, or there are delays in securing approval for some of the proposed changes.
- The project teams are engaged and enthusiastic and working hard to achieve their project objectives.
- Several NED projects opted to recruit personnel already trained and with the requisite experience and this negated the need for training pathways and accelerated implementation.
- Several project teams have identified the need for budget variations as implementation has progressed, frequently training costs; leave cover and contingency costs were underestimated.
- Project teams require diverse skill sets to effectively manage all aspects of training and implementation. Several project teams based in larger organisations benefitted from access to existing training and education support staff and/or clinical redesign teams. Project teams in smaller organisations have not had this resource and this has impacted their ability to develop training packages according to the planned schedule. Some organisations have chosen to outsource their training.
- The APEN and PED sub-projects have lead sites, their respective implementation sites have found the support of lead site has streamlined implementation, reduced duplication and provided an ongoing source of support and expertise.
2.2 Program impact – How did it go?

- According to project reports the majority of stakeholders are supporting implementation with limited resistance to the new workforce models identified amongst patients, service providers and organisations. In each sub-project there are pockets of resistance and project teams are working to address issues that are within their control.

- In most instances training programs were not fully developed and documented prior to commencing implementation. This created stress for those developing the training program and a lag for several implementation sites. In future, training programs should be fully developed prior to implementation.

- The training programs implemented to date appear to be ‘fit for purpose’ and providing the necessary knowledge, skills and competencies.

- Most projects have indicated that they underestimated the time and resources involved in training. This was particularly so when competencies had to be developed or clinical placements needed to be arranged as part of the training pathway.

- As implementation is progressing, several sites are finding they are not seeing the numbers of certain clinical presentations that were anticipated and this has negatively impacted upon training and competency acquisition. A more comprehensive needs analysis at project commencement may reduce this risk in the future and/or a review of project scope once the training program is completed and implementation is underway to ensure project objectives can be met.

- Projects with an active executive sponsor and/or senior leadership within the project team are better equipped to address barriers to training and implementation.

- Projects have generally been responsive and adapted implementation on the basis of internal monitoring and review; for example, several projects have revised their hours of operation in response to patient throughput data.

- Effective implementation of a new model of care frequently requires redesign of a range of supporting processes, often these issues are difficult to identify in the planning stages. Virtually all projects encountered this issue, for example, ERP project teams needed to establish new referral pathways for patients that were not being transported.

- For many projects existing information systems could not be easily modified to enable recording and extraction of data items specific to the ESOP model of care. Consequently additional data collection methods have been implemented which has created extra work for project teams. There is also a lack of consistency in the availability of data across systems and implementation sites.

2.3 Program sustainability – Can you keep it going?

- Most projects believe that the selection criteria they established for the ESOP roles and training entry criteria generated the ‘right’ candidates however these criteria may require review to ensure an ongoing pool of appropriate candidates.

- Learning pathways that articulate to a nationally recognised qualification may be more sustainable, noting that Universities require minimum numbers of students for a course to be viable. In addition processes for endorsement of new roles may facilitate sustainability if they permit practice outside the training organisation.

- Training pathways that include on-line delivery components are more accessible for clinicians in rural and remote locations.

- Training pathways designed for qualified and experienced clinicians should include capacity for recognition of prior learning.

- Training for ESOP roles may need to include broader learning areas relating to leadership and communication to enable championing of the new role and conflict resolution.
As there is a relatively short implementation period for the ESOP projects, staff changes have a significant impact, especially where mandatory training is a positional requirement. Few projects built in redundancy to cover leave entitlements.

A range of projects are dependent on access to medical officers and/or specialty staff for the assessment of competencies. Whilst experience with the ESOP projects to date has been positive, some sites are reporting that the workload created for medical officers may not be sustainable in all organisations.

Rarely have projects considered exit points for their training pathways, for example, when ESOP clinicians were unable or chose not to complete components of the training the decision was made for them to withdraw from the training program. In most cases this was probably appropriate however if projects are replicated nationally there will need to be consideration of this issue to ensure value for money from future training investments.

2.4 Program capacity – What has been learnt?

Training programs need to accommodate different learning styles and include appropriate and relevant learning outcomes, strategies and student resources.

Feedback from ESOP clinicians has emphasised the importance of competency based training for experienced health professionals where they get to apply the new skills in a real-world clinical setting.

For several sub-projects the training is intensive and has to be completed whilst ESOP clinicians implement the new model of care. This has highlighted the importance of factoring in ‘non-clinical time’ for self-directed learning.

The medical mentoring and supervision role is critical to all ESOP projects, without strong medical engagement it is unlikely that expanded scope of practice roles can be effectively implemented.

As practitioners apply the expanded scope of practice model of care, additional training needs are emerging. There should be a structured approach to continuing professional development for these ESOP roles.

Some projects did not adequately consider the alignment between their proposed model of care and the industrial classifications of the available workforce; this has necessitated modification of practices to ensure that ESOP practitioners are working within their delegated scope of practice.

Where two lead sites have been established more structured communication processes are needed to bring them together to develop a more collaborative approach.

2.5 Program generalisability – Are your lessons useful for someone else?

Those projects with clearly documented models of care and related clinical guidelines are more easily adopted by other organisations as they explicitly state the scope of practice. Inevitably clinical guidelines will need to be adapted to fit the local service delivery context.

Several project teams have identified concerns that the provision of the ESOP training may generate expectations amongst personnel of higher remuneration and this may prove a barrier to extending the project for both organisations and clinicians.

Projects using a modular approach that is linked to competency based assessment appear to have greater flexibility for training and implementation.

The implementation of some elements of the ESOP models of care, for example prescribing, are bigger than the individual project and projects are unlikely to achieve this without the support of State and Territory health departments.

At this stage it appears that national scalability might be enhanced through developing a national framework or approach to training that can be adapted at a jurisdictional level to accommodate differences in the State and Territory context, generate buy-in and address legislative differences.
- National implementation is likely to be enhanced with access to high speed internet services as face-to-face education strategies may reduce the capacity for regional, rural and remote communities to participate.

2.6 Program dissemination – Who did you tell?

- Project teams have employed multiple strategies to engage stakeholders, particularly in overcoming training and implementation barriers. An ongoing stakeholder management plan is required as the need to communicate and engage stakeholders doesn’t lessen as implementation proceeds.
- Implementation of ESOP initiatives needs to be continuously monitored to ensure the emerging risks and issues are communicated and addressed.
3 Introduction and background to the HWA-ESOP program

3.1 Overview

The Centre for Health Service Development (CHSD), University of Wollongong, was appointed by HWA in June 2012 to undertake the evaluation of the Health Workforce Australia - Expanded Scopes of Practice (HWA-ESOP) program. This is the second of three evaluation progress reports. The reporting period extends from the end of February to mid June 2013. The focus of this report is on the training of ESOP staff and the implementation of new models of care. This complements and builds on the first report, which focused on the set-up phase.

3.2 Project implementation sites

Four sub-projects have been funded under the HWA-ESOP program:
- Advanced Practice in Endoscopy Nursing (APEN)
- Physiotherapists in the Emergency Department (PED)
- Nurses in the Emergency Department (NED)
- Extending the Role of Paramedics (ERP)

Within each sub-project there are a number of implementation sites, and two sub-projects (APEN and PED) also have lead sites providing guidance and support to implementation sites. In total, 26 organisations have received funding under the HWA-ESOP program. A list of the project sites is provided in Appendix 1.

3.3 Aim of this report

Training ESOP staff to undertake their new roles confidently and safely is a key activity of the HWA-ESOP program. During the set-up phase, the national evaluation team collected formative data including details of the proposed training and descriptions of the new models of care. Site visits, national workshops, and consultations with advisory groups were rich sources of information. In addition, the APEN, PED and NED implementation sites have now submitted three progress reports to HWA up until the end of March 2013. The ERP projects have provided one progress report and their interim report which covers the period until the end of May 2013.

This current report brings together information from all these sources to create a comprehensive overview. Specifically, this report describes:
- training models and approaches used within sub-projects, including entry requirements and where relevant, assessment methods
- progress and outcomes of training to date
- lead and implementation site activities pertaining to the implementation of the new models of care
- stakeholder engagement strategies related to training and implementation
- factors that promote or hinder training and implementation activities.

The national evaluation team's reflections are also provided on the emerging risks and lessons learned regarding training and implementation, both at the sub-project and the program levels.
4 Evaluation team activities and project support

4.1 Compendium of Data Requirements and Evaluation Tools

The current version of the Compendium (Version 1.0) was updated in March 2013 with the final data specifications for sub-projects (including ‘Frequently Asked Questions’ attachments), as well as minor amendments to a number of evaluation tools (see Thompson et al., 2013).

Stakeholder consultation is ongoing and any revisions are made on the basis of feedback and the experience of implementation. Several project teams have requested customisation of specific evaluation tools, for example, the project team at Royal Children’s Hospital Melbourne had developed their own evaluation tool to capture patient experience. This project team has worked collaboratively with the national evaluation team to review this tool to address both local and national evaluation requirements.

4.2 Coordination of tool use and data collection

A major focus for the national evaluation team during the reporting period has been working with projects to coordinate data collection and the use of evaluation tools. Since the commencement of the evaluation, the national evaluation team has placed an emphasis on discussing with projects their roles and responsibilities in relation to evaluation activities. More recently, a session at the second round of workshops for the APEN, PED and NED sub-projects was given by the national evaluation team to further explain expectations around data collection and administration of evaluation tools and clarify related issues.

Ongoing communication, in the form of telephone discussions and email correspondence, has been required to ensure projects are on track and administer evaluation tools, and comply with requirements for the national evaluation data collection. Concerted effort with this aspect of project support will be maintained during the next reporting period to ensure projects, mainly some of the NED projects, incorporate all required tools into their local evaluation design.

4.3 Evaluation support

4.3.1 Contact with HWA

Close contact continues to be maintained between HWA and the national evaluation team. Monthly program management teleconferences are held, email communication remains regular, and telephone discussions have taken place as issues arise. As opportunities have emerged face-to-face meetings have also occurred. The national evaluation team values the professional relationship that has developed with HWA, which is perceived as open and transparent. Evaluation issues arising with projects have been dealt with effectively and efficiently to this point, due in no small part to this partnership approach.

4.3.2 Telephone and email contact

The national evaluation team has continued to provide ongoing support and guidance to ESOP staff at lead and implementation sites in the conduct of their own evaluation activities. National evaluation team members have been available as a point of contact for project teams, maintaining regular telephone and email communication, responding promptly to queries, and participating in mutually agreed teleconferences.

Since the last reporting period, the national evaluation team made telephone and email contact with all projects in relation to baseline data collection. The first data extraction was due on 31 March 2013. The national evaluation team statistician has continued to work with projects to assist with the extraction process, troubleshoot any problems and ensure that a complete and accurate as possible data extract has been submitted. There are two PED sites that have not
submitted their baseline data at the time of this report. Significant rationalisation of administrative positions in these organisations has resulted in limited access to the data and performance personnel that supply this data. Both project teams are working to address these delays. The national evaluation team statistician is currently reviewing the status of baseline data received from all project teams to identify any data quality issues that may impact on the availability of key data items for the evaluation.

During May – June 2013 the national evaluation team has conducted a round of teleconferences with each of the 26 funded organisations. The purpose of these teleconferences was to obtain information on progress related to implementation and training, as well as to discuss progress with projects’ evaluation data collection. During these teleconferences projects were also advised of planned future site visits later this year (for all PED and NED sites) and/or early in 2014 (for all APEN and ERP project teams). Any queries about evaluation (such as processes for administering tools and timeframes for data submission) were addressed. Further information on the use of evaluation tools will be provided during the next series of sub-project workshops in July/August this year. All telephone and email activities are being recorded in a communications log, where they are coded for type of contact, duration, content and other information.

4.3.3 Workshops

HWA has organised a series of workshops throughout the life of the HWA-ESOP program. During this reporting period, the APEN sub-project second workshop was conducted (April 2013). The principal objectives of this workshop were to identify lessons learned so far, support sites to plan for financial sustainability through development of a business case, clarify project evaluation requirements and final deliverables, and facilitate interaction and information sharing between project sites. As with previous workshops, this workshop was well attended and project teams valued the opportunity it provided for networking with other participants and interacting with members of the Project Advisory Group.

The second workshop for the ERP sub-project is scheduled in mid-July with the third series of workshops planned throughout August for each of the APEN, PED and NED sub-projects. The focus for these workshops will include training, sustainability and lessons relevant for future national implementation.

4.3.4 Site visits

During the reporting period a small number of site visits were conducted, either opportunistically or at the specific request of project teams. For example, a visit was made to ACT Ambulance in March 2013 to work through a range of queries about the baseline data submission and other evaluation issues. A series of meetings were conducted with Ambulance Tasmania in May 2013, which included in-depth semi-structured interviews with the project’s two ECPs focusing on training and implementation issues, as well as discussions with the project manager about evaluation issues. In addition, the project lead from the Wollongong Hospital NED project met with a member of the national evaluation team to discuss and review the evaluation tools.

The second round of site visits is currently being organised. The proposed period for site visits is November and December 2013 for PED and NED projects, and February and March 2014 for APEN and ERP projects. These are planned as two-day visits, which will provide an opportunity to meet face-to-face and have comprehensive discussions with project teams leading up to the conclusion of projects, and also conduct interviews with ESOP clinicians and other key stakeholders from each project. Any final data collection issues will also be addressed during these site visits.
4.3.5 Progress reports

HWA has established a routine progress reporting process for all project teams. The APEN, PED and NED project teams have each provided project plans and three progress reports whilst the ERP project teams have lodged an implementation plan and one progress report with an interim report due from each ERP project team in May/June 2013. The reports provided to date have been reviewed by both the national evaluation team and HWA. Whilst progress reports continue to vary in their comprehensiveness they do provide critical information and quality seems to be generally improving.

4.3.6 Project Advisory / Reference Groups

The external Project Advisory or Reference Group for each sub-project has continued to contribute to the HWA-ESOP program, through the provision of professional expertise, guidance and clinical advice to HWA, project teams and the national evaluation team. During the current reporting period, the key interaction between the national evaluation team and Project Advisory / Reference Groups occurred during the second APEN workshop on 10 April 2013 with the APEN Project Advisory Group. The most recent Paramedic Reference Group teleconference was held on at the 15 April 2013. Discussions at these meetings focused on the sub-project’s progress and issues of implementation.

4.3.7 Clinical advisors

The national evaluation team has continued to interact with the clinical advisors engaged by HWA to assist with professional and implementation issues. The workshops provide an important opportunity for this interaction. During this reporting period the clinical advisors for each sub-project reviewed Evaluation Progress Report 1, providing valuable comments and feedback.

4.3.8 Victorian Department of Health

The Victorian Department of Health’s involvement in the HWA-ESOP program has been ongoing. The Steering Committee continues to meet monthly with the Victorian based APEN and PED project teams. There has been some difficulty in securing the minutes from these meetings on a regular basis. To keep abreast of developments the national evaluation team has maintained direct contact with the Steering Committee Chair, for example meeting face-to-face following the recent APEN workshop in Brisbane.

Evaluation Progress Report 1 identified issues for the evaluation that are generated by the additional project management resources and the extra layer of governance provided by the Victorian Department of Health. These issues are still being considered and addressed by the national evaluation team.

4.4 Reflections and lessons learned

A range of reflections and lessons learned about the evaluation team activities and project support were documented in Evaluation Progress Report 1 and will not be repeated here. The major additional insights since the last reporting period are summarised below.

- Final report and toolkit development: A key reflection emerging from evaluation support activities provided to date is the need for assistance that a number of projects will require in producing their final reports. HWA are considering making these reports available to the public, and as such they will need to be structured in a consistent manner, with a high degree of readability and professionalism. Strategies will need to be implemented to ensure this is achieved and HWA is currently exploring options for project support to improve the consistency and quality of these final reports.
As ERP project teams have recently produced an interim report this template may prove useful for other sub-projects. The interim report structure used follows the 1:3:25 format developed by the Canadian Health Services Research Foundation. It is anticipated that project teams will be able to use this interim report as the foundation for their final report.

HWA is currently finalising its requirements in relation to project toolkits. The Funding Agreements for APEN, PED and NED sub-projects require participants to develop toolkits and guidelines to support national implementation of their implemented model of expanded scope of practice. Where a lead site is responsible for development, related implementation sites will be expected to contribute to the toolkit and guidelines.

- **Maintaining consistent messages**: Due to unforeseen circumstances HWA has experienced several staffing changes that have reduced resources for project support for the APEN, PED and NED sub-projects throughout January – May this year. Further staffing changes will occur within the ERP sub-project post July. These staffing changes are unavoidable but highlight the importance of both HWA and the national evaluation team maintaining contact and ensuring consistent messages are communicated to project teams.

- **Reinforcing evaluation requirements**: Despite the multiple communication strategies used with project teams to clarify national evaluation requirements, several sites recently claimed to be ‘unaware’ of their responsibilities and role in relation to several of the evaluation tools provided in the ‘Compendium of Data Requirements and Evaluation Tools’, (first issued in November 2012). In some cases this may be more about issues using the tools than actual ‘unawareness’, however the lesson learned is that constant reinforcement is needed through email, telephone, progress reports and sub-project workshops about evaluation requirements.

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1 Available at: [http://www.cfhi-fcass.ca/publicationsandresources/resourcesandtools/communicationnotes/10-06-01/d497a465-5398-4ec8-addf-d7c8b6be1e43.aspx](http://www.cfhi-fcass.ca/publicationsandresources/resourcesandtools/communicationnotes/10-06-01/d497a465-5398-4ec8-addf-d7c8b6be1e43.aspx) accessed 12 June 2013.
5 Training and implementation: Advanced Practice in Endoscopy Nursing (APEN)

5.1 Overview

This section provides an overview of training and implementation activities and discusses key issues that have arisen during the current reporting period. Data from various sources have been synthesised in preparing this section of our report (refer to Section 4). A comprehensive description of the rationale for the APEN sub-project, the model of care and scope of each project was provided in Evaluation Progress Report 1.

The APEN sub-project responds to a national trend of increasing demand for endoscopy services, in part due to the implementation of the national bowel cancer-screening program. Traditionally medical officers have performed endoscopies. The APEN sub-project aims to implement an innovative model of expanded scope of practice for nurse endoscopists. There are well-established nurse endoscopist models and training programs in the UK (Williams et al, 2009)².

Five services have been funded by HWA to implement APEN projects. Logan Hospital in Brisbane has been funded as a lead and implementation site. The Austin Hospital in Melbourne (Austin Health) has also been funded as a lead and implementation site and is supporting three other services (Alfred Health, Western Health and Southern Health) which have been funded as implementation sites.

5.2 Description of the training pathway

A description of the APEN sub-project training pathway (as envisaged at the commencement of the project) and trainee entry requirements was provided in Evaluation Progress Report 1 as part of a formative evaluation of the project’s establishment phase activities. A summary is provided below to serve as a reference point for discussion in the following sections of the key issues that have emerged during the reporting period.

The training program being implemented for the APEN sub-project can be characterised broadly as comprising two components: the first is a theoretical learning module in which trainees complete a self-directed learning package offered by the University of Hull, UK; the second is a skills and training development program in which trainees undertake extensive supervised clinical practice that includes formative and summative clinical assessments. The training program is structured so that the two components are implemented concurrently over a 12 – 18 month period with the objective of graduate trainees being able to perform competent diagnostic colonoscopy within a defined practice scope. Successful completion of the theoretical learning module results in a Graduate Certificate qualification from the University of Hull.

A schema of the training program (produced by Logan Hospital) is provided in Figure 1. It is intended for the training program to be common to both models of care employed by each lead site and to be completed by 31 December 2013 with the APEN project ending on 31 March 2014. The training model was developed so that each implementation site manages the orientation and introduction of the nurse endoscopist to their local organisation. The skills training component of the program was adapted from recent research conducted by an interdisciplinary group of scientists from the University of Queensland and the Queensland Health Clinical Skills Development Service.

The first phase of face-to-face training occurred in December 2012 and was attended by five trainees (two from Logan Hospital, one from Alfred Health, one from Western Health and one from Southern Health). Each of the trainees has since completed the colonoscopy e-learning package and passed the related assessment. An orientation workshop was provided for nurse endoscopist trainers / medical leads in January 2013 at Logan Hospital. The next face-to-face training occurred in January 2013 and the theoretical component then commenced in late January 2013.
5.3 Training entry requirements

The lead sites collaboratively developed the position descriptions and recommended entry criteria and key attributes of the trainee nurse candidates. Logan Hospital was successful in recruiting two nurse endoscopist trainees to fill 1.4 Full Time Equivalent (FTE) positions, one already an endorsed nurse practitioner and the other a nurse practitioner candidate. These positions were established at the Queensland classification of a nurse grade seven, nurse practitioner candidate.

Austin Hospital coordinated the recruitment process for all Victorian sites. Nurse endoscopists were appointed to Alfred Health and Western Health with positions readvertised for Austin Health and Southern Health. All positions were appointed at the Victorian classification of a level five clinical nurse consultant. After a second round of advertising all nurse endoscopist positions were filled.

The selection criteria for the positions reflect the training entry requirements. These include a Bachelor of Nursing Science (or equivalent) with at least five years of experience post their graduate nurse year and a minimum of two years in endoscopy (ideally candidates had at least three years full time experience in the gastroenterology specialty with at least two of these in endoscopy). The desirable criteria included a post-graduate course in gastroenterology. The lead sites agreed to be flexible about this requirement to broaden the pool of applicants. If a candidate did not have this post-graduate qualification they could supplement their experience by completing a foundation module in gastroenterology (under-graduate level) prior to commencing the training pathway. It was originally agreed that these criteria would be mandatory following completion of the HWA project, however there is a need to find a balance between appropriate pre-requisite knowledge and experience and ensuring a large enough pool of potential applicants.

In addition to their clinical competencies, trainees required a range of additional attributes. For example, the lead sites felt that candidates would need particular qualities to manage the challenging conversations that may arise with their peers, have the confidence and ability to promote the role and the experience and knowledge to ensure the role is embedded in safe practice.

5.4 Training progress and outcomes

The APEN training program has been developed in the context of HWAs broad strategic objective to address known areas of workforce shortage in the Australian health system by expanding the scopes of practice of nurses. As such, a key objective has been to ensure that the training program and related processes are both sustainable and suitable to be implemented by other hospitals at a later date. The national evaluation team has been mindful to ensure that this core principle, which has underpinned the development and implementation of the training pathway, is considered in evaluating its progress and outcomes to date.

Two trainees from Logan Hospital (1 x 1.0 FTE and 1 x 0.4 FTE) and one trainee from each of the other four implementation sites (3 x 0.8 FTE and 1 x 0.4 FTE) are participating in the training program. Five of the trainees commenced the training program in late 2012 with the trainee at Western Health commencing in February 2013. Western Health indicated that their later start date has not had a negative impact on their trainee’s progress or overall experience of the program.

As at the end of May 2013, there has been good progress with the training program being implemented largely as planned across the five APEN project sites. As expected, a range of issues and concerns have emerged during the reporting period and there have been some variations in the way that the training model has been implemented across sites. Possibly the most critical issue involves frustration in relation to the lack of clarity around the roles of each lead site. This has been an obstacle in establishing a consistent approach to the APEN sub-project and is of particular concern as one of the key project deliverables is the development of a national training program. The contrasting perspective provided is that training may in reality need to be...
State based to ensure it meets State specific requirements, optimises access and attracts State Department of Health funding. This issue has clear implications for future APEN training initiatives.

5.4.1 Theoretical learning module

Each of the APEN trainees is progressing satisfactorily with the theoretical learning modules being completed through the University of Hull, UK. At the time of writing, each of the trainees is enjoying a brief study recess having completed Semester 1 of the course. Feedback from several of the Victorian trainees has indicated that the volume of work from the University of Hull is far greater than had been anticipated. One trainee indicated that between 15 and 20 hours per week is required to complete her study commitments including having to complete a 3,000 word essay on a weekly basis. Logan Hospital’s response to this issue has been that the tasks allocated by the University of Hull are self-directed and intended to be relevant to and support the trainee’s current level of clinical experience. In this context, the trainees can spend as much or as little time on their set tasks as they feel necessary. Logan Hospital also reiterated its willingness to discuss or clarify any issues regarding any aspect of the training requirements.

Some confusion arose during the reporting period regarding whether a Graduate Certificate would be awarded by the University of Hull on successful completion of the theoretical learning module after some issues were raised by the university about the depth of theoretical training being offered. A related issue arose regarding whether recognition for prior learning is likely to be offered for modules completed by the APEN trainees that subsequently enrol in Masters level degrees at Australian universities. It has recently been confirmed that University of Hull will definitely award a Graduate Certificate on successful completion of the theoretical learning modules. In addition, Logan Hospital is currently holding discussions with the University of Queensland regarding options for recognising prior learning for subjects completed through the University of Hull to provide a learning pathway that articulates to a Masters degree.

One of the Victorian sites highlighted the need for candidates to develop additional skills to those being taught through the University of Hull learning modules. For example, it was suggested that there is a gap in key subject areas such as ‘leadership’ that will be important for the trainees in the future.

In an effort to address this issue, Southern Health hosted a training day, facilitated by their lead site, on 14 May 2013 that was attended by all of the trainees (except one Logan Hospital trainee who was on leave). The training day included a presentation from the executive sponsor at Southern Health and a consultant gastroenterologist on the subject of ‘how to deliver bad news’. Feedback from this training day highlighted that the trainees found it to a valuable way of addressing some of the non-clinical training issues and it provided an important opportunity to spend some time with their fellow trainees.

Finally, we note two other minor concerns raised by the Victorian hospitals. Firstly, some concern was expressed about the relevance of some of the training materials in the Australian clinical setting. Secondly, concern was expressed about minor delays (usually about three to four days) that have occurred on occasions when trainees have been waiting for feedback from the course coordinator at the University of Hull.

Notwithstanding the issues identified above, there is widespread agreement by APEN sites and the sector more broadly that utilising training materials from the University of Hull represented the best approach for this sub-project. At the same time, there is broad consensus that it would be preferable for future APEN training programs to be offered by an Australian university. Options for training programs are discussed in Section 5.8.1.
5.4.2 Skills development and supervised clinical practice

Each APEN site has implemented a model of skills development and supervised clinical practice that aligns with the agreed training model (as shown in Figure 1). At this stage, there are no differences in the roll out of the training program arising from the different models of care being implemented in Queensland and Victoria. As at May 2013, each trainee has satisfactorily completed the required elements of the training program and is on target to complete the required number of colonoscopies by the end of 2013. The number of colonoscopies completed by each trainee at the time of writing was as follows:

- Logan Hospital trainee 1: 43
- Logan Hospital trainee 2: 84
- Austin Hospital trainee: 41
- Alfred Hospital trainee: 105
- Western Hospital trainee: 96
- Southern Hospital trainee: 60

Importantly, the number of colonoscopies completed is only one metric to be considered. A range of related issues, as discussed below, have emerged during the reporting period that will require careful consideration for the current and future APEN initiatives.

As noted above, the first phase of face-to-face training occurred in Brisbane in December 2012 and January 2013. Feedback from all sites indicates that this training was of a very high standard and was an ideal way for the trainees to commence their training program. This finding is consistent with the evaluation of these sessions completed by the training facilitators. The Victorian trainees particularly noted that the tip control training provided an excellent opportunity to develop skills in the movement of the colonoscope shaft and that being able to treat patients (during the January training) provided a valuable training opportunity.

A key unresolved issue, that may require intervention by HWA relates to the proposed quarterly tip control assessment. The training program requires each APEN trainee to complete progressive quarterly assessments of colonoscope tip control and insertion competence. The assessment process requires trainees to complete three of four trials of the tip control assessment task in less than 90 seconds. This assessment has been included in the training program because it has been previously validated\(^4\) and is intended to feed into the trainee’s overall assessment in conjunction with information recorded in their log book.

Under the current arrangements, trainees are required to travel to Queensland to complete this assessment each quarter. An alternative arrangement has been offered where the tip control equipment (and training staff) could be transported to Victoria to allow each Victorian trainee to undertake their assessment at the Austin Hospital. However, the Victorian sites feel that both of these options are unnecessarily expensive and therefore not practical. There is also an emerging view that tip control assessment is not necessary at this stage of the training program given that the trainees are now routinely performing colonoscopies on patients. One site suggested that additional formative assessments on patients could be undertaken as an alternative to further tip control assessment. This issue requires further discussion both in relation to current trainees and in developing future training programs. The tip control assessment process has been included because of the developmental nature of the nurse endoscopist training program and for evaluative purposes; it is not intended to maintain this quarterly assessment on an ongoing basis.

A further issue that will require consideration concerns the selection of patients for the trainee’s summative Direct Observation of Procedure (DOPs) assessment at the end of the training program. One site has noted the importance of ensuring that patients are selected for this assessment process consistently across all of the APEN sites.

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\(^4\) This evidence was not published at the time of this report but has been presented at conferences.
In relation to supervised clinical practice arrangements, each APEN site has implemented a model that is consistent with the training program guidelines. This includes each trainee being allocated at least two dedicated training lists per week. There are some variations in the number of patients allocated to each list, particular supervision arrangements and the protocol for allocating patients to the training lists. The national evaluation team has documented these variations below and will continue to monitor their impact and include a detailed analysis in the final report:

- Most sites have established two dedicated training list per week for each trainee. Logan Hospital ran four lists per week prior to one of its trainees going on maternity leave and is sometimes running three lists per week for its second trainee. The Austin Hospital is running three lists per week for its trainee. Southern Health operated only one list per week initially due to a delay in the availability of its third procedure room, but is now running two lists per week.

- The number of patients allocated to each training list varies between three and five. It has been suggested that allocating a larger number of patients (more than four) may decrease the proportion of procedures that the trainee is able to completed unassisted.

- The supervision arrangements during the trainee lists vary between APEN sites. For example, at one site, all trainee lists are being supervised by one clinical mentor. At another site, the supervision is being shared between two gastroenterologists and two colorectal surgeons. In both cases, the respective trainee has indicated that they are very satisfied with the arrangement.

- Three of the five sites are allocating patients to the APEN training list basically using the same approach applied in allocating patients to a physician endoscopy list. The rationale for this approach is for trainees to be exposed to a wide range of clinical presentations. Within this model, one site excludes patients that have previously undergone colectomy surgery as well as patients referred through the national bowel cancer screening program.

- One site is developing lists for the APEN trainee specifically to ensure a range of clinical presentations and includes one weekly list being supervised by the head of surgery. This site is excluding private patients from the trainee’s list.

- The final site has taken a different approach to allocating patients to its training lists. At this site, only category three waiting list patients have been assigned to the training lists. The rationale for this approach is for the APEN training program to serve as a mechanism to address very long category three waiting lists by providing services to patients that would not otherwise receive services for at least two years.

- Most of the trainees are spending some time (typically about five minutes) with each patient prior to their procedure being undertaken whilst only some of the trainees have been seeing patients following their procedure.

5.5 Implementation of the model of care

Logan Hospital is implementing a model of care that is based on a nurse practitioner (candidate) model, with wider scope for autonomous practice. The nurse practitioners will work collaboratively and function autonomously within the gastroenterology-endoscopy service in a fully integrated role. They will perform endoscopy and related health care functions within a broad scope of practice including: advanced patient assessment; interpretation of diagnostic interventions and pathology, differentiating diagnoses; establishing management plans, including selection and prescription of appropriate medication and direct referrals to other health care professionals.

The Austin Health model of care is being implemented by all Victorian APEN project sites and is based on an advanced practice nurse model with the nurse endoscopist undertaking protocol driven activities within a defined practice scope in a delegated role (i.e. under the direct supervision and delegated authority of a senior medical officer).
Organisational drivers have informed which model these project sites have adopted. In this context, throughout the implementation period it has been important to capture the full spectrum of activity undertaken by the nurse endoscopist including participation in multidisciplinary meetings, research and clinical consultations.

As evidenced by the information provided in section 5.4.2 implementation is progressing well, with a high level of organisational support amongst implementation sites.

5.6 **Stakeholder engagement strategies in training and implementation**

Project teams agreed at the outset of the project on the need for an on-site clinical champion to assist with managing the complex and influential stakeholders involved in endoscopy. A range of internal stakeholder engagement strategies have continued to be employed during this reporting period. Many are the same strategies identified in Evaluation Progress Report 1 and are not replicated here other than to note that project teams continue to rely on mechanisms such as meetings, workshops and technologies such as email and teleconferences to update stakeholders.

A key issue previously identified was the level of engagement from registrars and consultants. It was reported previously that whilst there is a high level of support from the medical officers involved in the project and most consultants within the endoscopy units of implementation sites, more generally there is antipathy towards the project from specialists who see no value in the process of training nurse endoscopists. As the training and implementation process has continued, it is pleasing to report that all APEN sites have consistently reported a high level of acceptance from medical officers exposed to the project. It should be noted, however, that this has mainly involved medical officers working within the endoscopy units. There has been only one instance reported where an individual physician has not been willing to work with an APEN trainee.

In relation to external stakeholder engagement, the broad representation of the APEN Project Advisory Group (PAG) probably means that it will function as a key external stakeholder engagement mechanism for this sub-project. By way of example, the sense of uncertainty about the position of the Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy (CCRTGE) continues to be a major issue for Victorian trainees (refer to Section 5.8.2). It is hoped that HWA, through the APEN PAG will provide some clear communication in relation to this issue. Similarly, the APEN PAG has been the primary mechanism for obtaining feedback on the views of bodies such as the College of Physicians and the College of Surgeons in relation to this sub-project.

5.7 **Barriers and enablers**

Some of the barriers and enablers that have emerged during this reporting period have been discussed in previous sections as they relate directly to the APEN training program. This section presents a brief discussion of other barriers and enablers relevant to implementation that have emerged during this reporting period.

5.7.1 **Role clarification**

Evaluation Progress Report 1 identified an issue related to the patient’s understanding that the nurse endoscopist is in a training role and the potential for patients to refuse treatment if they are informed that the practitioner performing the procedure is in a training role. It was noted that there needs to be clear communication with patients that the nurse endoscopist is already a qualified and experienced registered nurse who has undertaken specific training in endoscopy.

In the current period, this issue has arisen only at Southern Health, where category three wait list patients have been contacted and offered to have a colonoscopy undertaken by an APEN trainee. Amongst this group, there has been a 20% refusal rate by patients. This site has expressed the
view that this is likely to be because patients are being given the opportunity to decline much earlier in the clinical process than is occurring at other sites.

5.7.2 Recruitment and training

In relation to the concerns expressed around the University of Hull modules, Logan Hospital has indicated that differences in the position descriptions between the States meant Queensland applicants had to demonstrate that they possessed the key attributes of the position to a greater extent than Victorian applicants. This may have led to some applicants in Victoria not fully appreciating the level of work that would be required.

It has also been noted that two of the Victorian trainees had not previously completed previous post-graduate studies. In contrast, the lead site in Victoria has noted that despite some initial concerns about workload levels, all of the Victorian trainees are now progressing well through the training program.

It has also been suggested that future applicants should be required to have endoscopy experience rather than only gastroenterology experience and that consideration may need to be given to ensuring that the next cohort of applicants have appropriate post-graduate qualifications. It has also been previously noted that there is a need to balance the attributes of future applicants with the risks of narrowing the potential pool of eligible applicants for the position.

5.7.3 Resourcing issues

A number of resourcing issues have emerged in this reporting period. Most notably, Logan Hospital continues to be unsure about whether it will receive funding from Queensland Health to cover costs (for items such as consumables and additional clinical staff) associated with its training lists that are not met through HWA project funding. It is possible that when the 2013/14 budget is released, that their training lists may need to be reduced.

The Austin Hospital also indicated that the project officer role at a lead site definitely requires a full-time position to effectively support the implementation sites. Similarly, Logan Hospital identified the considerable in kind investment of resources that has been required for it to fulfil its responsibilities as a lead site.

Southern Health noted that their decision to operate a separate process for contacting category three wait list patients has been particularly resource intensive. At the same time, this site has emphasised the considerable benefits that have emerged from this process. All category three wait list patients have now been contacted and those suitable for the APEN trainee and who gave consent have been treated. This service is now in the process of contacting category two waiting list patients who will be treated by the APEN trainee.

5.7.4 Legislative and policy issues

The principal legislative and policy barriers that have arisen in this reporting period relate to the uncertainty around the conjoint committee endorsement of the APEN nurses. On a related matter, some of the APEN sites have commenced the process of developing scope of practice guidelines for the nurse endoscopist role that will be submitted to their respective scope of practice committees in the near future. This will be critical to ensuring that the nurse endoscopy positions are endorsed prior to the completion of the APEN training program.

In was noted in Evaluation Progress Report 1 that the Project Advisory Group had also identified the need for the training pathway to have an exit point in the event of trainees not completing the full program of study (this is an issue that is important for national scalability). We have since discussed this issue with each of the APEN sites and have struggled to identify any sensible exit
strategy that could be implemented in the event of non-completion of the training program. This issue may require further consideration.

5.7.5 Project management and support issues

Each of the APEN sites has continued to report a high level of executive level project support which is viewed as critical to its ongoing success. Both of the lead sites have commented on the level of resources required for a lead site and most sites have noted the considerable level of project reporting that is required.

The recent introduction of fortnightly teleconferences between the lead sites and HWA has been viewed as a good opportunity to keep updated on developments of other sites and to share lessons and experiences. More generally, there is a sense amongst the APEN sites that the level of communication with HWA has decreased in recent months. By way of example, several sites indicated that a commitment was made to provide feedback that did not subsequently occur.

5.8 Reflections and lessons learned

A broad range of training and implementation issues have been undertaken during the current reporting period. The APEN sites have progressed from the set-up phase and are now well entrenched in the implementation of the training program. Feedback from the projects’ progress reports, the national workshop and through the national evaluation team’s ongoing dialogue with sites indicates that a high level of enthusiasm has been maintained with staff committed to ensuring the project achieves a successful outcome.

5.8.1 Options for future national training initiatives

There is an emerging view that the University of Queensland will be best placed to offer future APEN training modules given its recent work in this area with the Queensland Health Clinical Skills Development Service. Issues and options in relation to future training programs are emerging and various views have been expressed by APEN sites. These will continue to be monitored and discussed in future evaluation reports. At this stage, the national evaluation team note the following developments that have emerged during this reporting period:

- Logan Hospital is holding discussions with the University of Queensland to develop endoscopy specific clinical knowledge learning modules. It is expected that these elective modules could be available as part of a Masters level degree from 2015.
- There are differing views across the APEN sites regarding whether the proposed training should be part of a nurse practitioner program or a clinical Masters program. This issue is part of the wider debate regarding the different models of care being implemented in Queensland and Victoria.
- The University of Queensland will require a minimum number of students for any courses to be viable and this has the potential to prohibit the delivery of theoretical modules locally.
- The proposed learning modules could be delivered through a distance education model.
- The University of Queensland has indicated that it may support recognition of prior learning for modules completed through the University of Hull. This will require retrospective approval of supervised clinical practice undertaken by APEN trainees.
- It has been suggested that future trainees be required to complete the Graduate Diploma in gastroenterology offered by the University of Queensland prior to undertaking future APEN training programs. This requirement will need to be balanced against the need to recruit staff and the impact this requirement will have in restricting the pool of potential applicants who could be successful in the nurse endoscopy program.
5.8.2 Post training endorsement

The issue of post training endorsement has been discussed extensively throughout this sub-project and is included here because it has been has been raised by several of the Victorian sites during this reporting period. At the commencement of this sub-project, it was hoped that successful completion of the training program would lead to the APEN nurses being credentialled as nurse endoscopists by the Conjoint Committee for Recognition of Training in Gastrointestinal Endoscopy (CCRTGE). The program was designed accordingly to ensure that the trainees would meet all of the requirements of the CCRTGE including completing the required number of procedures during their training.

At this stage, it is not known (although it is now considered unlikely) whether the CCRTGE will credential the APEN nurses. The view has been clearly expressed by the trainees that they are hoping to receive endorsement from the CCRTGE and be provided with relevant guidelines for ongoing training and credentialing requirements. The trainees have expressed a strong desire for the Project Advisory Group to provide some clear guidance on this issue.

Each of the APEN sites is aware that even if CCRTGE credentialing does not occur, the APEN trainees will be qualified and entitled to practice as nurse endoscopists provided they meet the requirements of their employing organisation. This will involve each organisation developing scope of practice guidelines and working within local requirements to get approval at the hospital and local health network level for the endorsement of advanced practice nurse endoscopist positions. If this occurs, individual nurse endoscopists will be protected and recognised in their employment.

At the outset of the sub-project, the APEN sites agreed that they would ensure that all of the CCRTGE requirements are met through the training program regardless of whether endorsement subsequently occurs. More recently, several Victorian sites have indicated they are unclear about the number of procedures that they are required to complete. In response, Logan Hospital have advised that each trainee will be required to complete 200 unassisted colonoscopies and be signed off by their supervisor to meet the requirements of the CCRTGE.

5.8.3 Summary

The key learnings that have emerged during this reporting period can be summarised as follows:

- The training program has been implemented largely as planned by all APEN sites
- Logan Hospital has invested a significant level of resources in developing and coordinating the training program
- The APEN trainees have not been completely satisfied with the structure and relevance of the learning modules being delivered through the University of Hull
- APEN trainees require highly developed interpersonal skills in addition to clinical training to work effectively as nurse endoscopists because of the challenges associated with working in a newly established clinical role
- There are varying views across APEN sites around the best approach for certain elements of the training program, most notably in relation to the need for quarterly tip control assessment
- There are some variations in approaches to the supervised clinical practice across APEN sites that will lend themselves to being evaluated at a later point in the project
- There has been a high level of stakeholder engagement for the APEN project amongst internal stakeholders, notwithstanding some resistance from a small number of physicians
- The issue of whether the CCRTGE will provide endorsement of APEN trainees remains unresolved and is of particular concern to the current trainees.
6 Training and implementation: Physiotherapists in the Emergency Department (PED)

6.1 Overview

There are two lead sites for this sub-project – the Alfred Hospital and the Canberra Hospital / ACT Health – each with their own model of care. Both lead sites are also implementing the PED model of care in their own organisations. The Alfred Hospital is lead to four implementation sites which encompass seven hospitals: within Alfred Health (at both the Alfred and Sandringham Hospitals); Southern Health (Casey and Dandenong Hospitals); St Vincent’s Hospital Melbourne, which is in a partnership arrangement with Ballarat Base Hospital; and Alice Springs Hospital. The Canberra Hospital / ACT Health is lead to three implementation sites covering three hospitals in addition to their own: Cairns Base Hospital, Robina Hospital and Flinders Medical Centre.

6.2 Description of the training pathway

The two lead sites for this sub-project have each developed an expanded scope of practice training pathway. These pathways have been adapted for the HWA-ESOP project and are described in the sections below.

6.2.1 The Canberra Hospital / ACT Health

The ACT Health Directorate in partnership with the International Centre for Allied Health Evidence (iCAHE) at the University of South Australia has been developing an expanded scope physiotherapy model since 2007. Scoping projects, pilot studies, and extensive consultation and literature reviews have culminated in a model which allows the ESOP physiotherapist to assess, treat and diagnose musculoskeletal presentations to the ED, as well as provide limited prescribing services, manage simple fractures and interpret x-rays.

There is a four staged approach to this training pathway that begins with recruitment of suitably qualified and experienced physiotherapists, and is followed by training, credentialing and implementation of the ESOP role. These training steps are outlined in Figure 2.

The training and credentialing are two key components of the ACT training pathway. The training component consists of a tertiary level program, delivered by the University of Canberra. This program commenced in February 2012 and offers the following modules:

- Injection therapy (8881 - Extended Scope Physiotherapy 1 PG);
- Pharmacology (8882 - Extended Scope Physiotherapy 2 PG);
- Radiology (8883 - Extended Scope Physiotherapy 3 PG);
- Leadership (8884 - Physiotherapy Advanced Problem Based Clinical Practice 1 PG);
- Evidence based practice (8885 - Physiotherapy Advanced Problem Based Clinical Practice 2 PG);
- Clinical practice (8886 - Physiotherapy Advanced Problem Based Clinical Practice 3 PG).

The Canberra Hospital / ACT Health program requires completion of a Postgraduate Diploma in Extended Scope Physiotherapy,( a Graduate Certificate or a Doctor of Philosophy - Clinical Physiotherapy) are also available from the University. The Graduate Diploma course consists of the six modules listed above which are generally completed over two semesters. The course includes four weeks of face-to-face classes completed over the two semesters. The University requires that applicants have a degree in physiotherapy with a postgraduate qualification (in the proposed area of extended scope of practice) and three years clinical practice experience or equivalent. The fee for the course is $18,000. Recognition of prior learning is available on application to the University.
The credentialing component of the Canberra Hospital / ACT Health training model involves supervised practice of the expanded scope skills and completion of a competency log book. During this component, the physiotherapist is supported by an identified clinical team, which may include members from the orthopaedic, radiology, physiotherapy and pharmacology departments.

Figure 2 The ACT Expanded Scope of Practice training pathway

Further information regarding this program is available from the University of Canberra website.\footnote{Available at: http://www.canberra.edu.au/courses/index.cfm?action=detail&courseid=198JA&year=2012. Accessed 30 May 2013.}
This team provides supervision, guidance and feedback while the physiotherapist gains practical, first-hand experience through a variety of clinical interactions and presentations.

The purpose of the log book is to formalise the acquisition of skills and competency required of the ESOP physiotherapist. The log book includes assessment of clinical skills in the following areas:

- Interpretation of imaging;
- Relocation of small joints, including administration of local anaesthetic;
- Simple fracture management;
- Prescription of limited medications.

On completion, the log book demonstrates that the physiotherapist is able to perform the outlined skills with confidence, expertise and minimal risk of adversely affecting the patient. Competencies are assessed by ED consultants or other ESOP physiotherapists working in a primary contact role in Canberra Hospital.

As part of the training and implementation process for the HWA-ESOP Program, the Canberra Hospital / ACT Health lead site also conducted on-site one day workshops at all three implementation sites to provide them with the background and resources to introduce the new role/model of care. The workshops presented information in five modules:

- Workforce redesign (including change management strategies to support role redesign and extension for expanded scope physiotherapists, and provision of template human resource documents)
- Planning and governance (presenting pre-planning strategies to avoid potential barriers, and information regarding medication guidelines, core competencies and applications for medicines, poisons and therapeutic goods licences)
- Education and training pathways (including formal supervision of expanded scope physiotherapists, the university course outline and information, credentialing criteria and clinical skills logbook)
- Evaluation strategies (including the role of evaluation in ESOP, and the planning, designing and reporting of such projects)
- Data collection, which included an outline of different means of collecting information.6

### 6.2.2 Alfred Health

The training model developed by Alfred Health is one where the emphasis is on a competency based framework, supported by external learning modules. It has been developed to provide a consistent and co-ordinated program to meet the learning and competency assessment requirements of ESOP physiotherapy roles. The program has grown through the use and adaptation of previously developed resources, and input and feedback from expert clinicians throughout the Victorian public health sector. The result is a flexible and adaptable training model that can be tailored to meet the needs of individuals and organisations.

The core values underpinning the Alfred model are to:

- utilise the expertise of musculoskeletal physiotherapists in the ED
- provide a team approach to service delivery, aiming for a minimum of three to four physiotherapists offering a 7 day service
- site the Emergency Department musculoskeletal team within the broader hospital Physiotherapy Musculoskeletal Team to promote work across advanced practice musculoskeletal roles and avoid ‘siloing’; and

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provide education and training predominantly in the workplace with work-based competency assessment of expanded scope skills.

The Alfred model fits within a broader conceptual framework (illustrated in Figure 3), consisting of operational, evaluation, governance and resource supports.

**Figure 3** The advanced musculoskeletal physiotherapy clinical education framework

The clinical education framework consists of the following components:

- **Pathway to competency in the workplace.** This involves meeting the predetermined criteria of relevant experience required by the organisation.

- **Advanced musculoskeletal physiotherapy competency-based learning and assessment resource,** consisting of a:
  - Pathway to competence in the workplace, measured across the elements of professional behaviours, lifelong learning, communication, provision and coordination of care, and in an area specific to practice context
  - Competency standard, a self-assessment tool to help clinicians reflect and identify strengths, their own learning needs, and allow tailoring of the training and assessment program to meet these needs
  - Learning needs analysis, a self-assessment tool that assists with identification of gaps in knowledge and direct learning
  - Learning and assessment plan which describes the learning activities to be undertaken and the methods by which assessment of these will occur
  - Work-place learning program – these comprise the education and training modules, outlined in Figure 4 and described in further detail below
  - Assessment and related tools – a variety of tools and methods of assessment are provided to allow each organisation to evaluate the competency of the ESOP physiotherapists

- **Mentoring program** – this is separate to the clinical supervision the ESOP receives and is provided by a suitably qualified and involved staff member.
Curriculum overview – an orientation program whereby the ESOP physiotherapist “shadows” either an experienced physiotherapist already working in the role or an ED consultant or senior registrar for a minimum of 40 hours prior to seeing patients in the ED.

- Ongoing competency, whereby a plan for ongoing learning and competency is developed together with the mentor and/or clinical supervisor.

Figure 4   The Alfred Hospital education and training pathway

The education and training pathway is illustrated in Figure 4 and consists of:

- internal and external education modules;
- a professional portfolio;
- supervision in the expanded practice role; and
- work-based competency assessment.

The internal modules address fracture management, musculoskeletal presentations, differential diagnoses, wound management, paediatrics and pathology. These modules were developed in conjunction with the implementation sites so their feedback could be incorporated. They have been delivered sequentially to the implementation sites.

The externally provided modules are:

- Radiology, provided by the University of Melbourne and consisting of 36 hours of lectures/workshops presented in block mode over a period of one week. Students are additionally expected to undertake approximately 72 hours of self-directed learning.
- Pharmacology; also provided by the University of Melbourne (The University of Melbourne Pharmacology subject is conducted in first semester by the School of Pharmacy – Organisations may stipulate this as a requirement for particular scope of practice such as
physiotherapist initiated analgesia. Whilst optional, for some specific practice contexts it is recommended that trainees engage in formal education in this area.

- Diabetes module, provided by the Australian Physiotherapy Association. This module is completed on-line and takes an estimated eight hours of study.

There is an expectation that non-clinical time is allocated to allow the physiotherapist to complete these learning modules. Ideally up to four hours per week should be made available however several sites reported that they could allocate no more than one hour per week because of clinical demands. The time required to complete the training program will vary depending on the experience of the physiotherapist and the number of hours of work in the ESOP role, but is expected to take between 3-6 months. It is an intensive training program with a significant investment of the participants’ own time required to cover the required material and assessment tasks.

The Alfred model is flexible in delivery of the education and training, and there is scope for recognition of prior learning. A physiotherapist new to advanced musculoskeletal physiotherapy roles would generally complete the entire competency-based program of both the learning and assessment pathways. However a physiotherapist already experienced in particular areas of expanded practice may not need to undertake all the education modules and may only require the assessment pathway, whereby they provide evidence they have met the requirements of the standard and competency assessment.

Students who successfully complete the training pathway receive a certificate of attainment, but no academically recognised qualification.

### 6.3 Training entry requirements

The entry requirements applied by the two lead sites are described below. It is important to note that these requirements are not necessarily the same as the selection criteria for a primary contact physiotherapist, which could differ from organisation to organisation.

#### 6.3.1 Canberra Hospital / ACT Health model

The requirements for entry into the ESOP program are:

- A tertiary degree in Physiotherapy and Australian Health Practitioner Regulation Agency (AHPRA) Registration;
- Five years of relevant clinical experience; and
- A Masters qualification in a clinically relevant field.

#### 6.3.2 Alfred Health model

The requirements for entry into the Alfred Health ESOP program are:

- A tertiary degree in Physiotherapy and AHPRA Registration;
- 5-7 years of musculoskeletal experience; and
- Completion (or enrolment in) a Masters of musculoskeletal practice.

Additionally however, in the Alfred model, entry via the Australian Physiotherapist Association’s (APA) experiential pathway is possible, whereby a physiotherapist may be awarded a musculoskeletal physiotherapist title without completing the Masters course if the following criteria are demonstrated:

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7 Australian Physiotherapy Association Diabetes module is available at: [http://www.learningseat.com/servlet/ShopLearning?learningId=38954&categoryName=Diabetes+For+Physiotherapists+-+8+CPD+Hours](http://www.learningseat.com/servlet/ShopLearning?learningId=38954&categoryName=Diabetes+For+Physiotherapists+-+8+CPD+Hours) accessed 30 May 2013.
• At least five years clinical / practical experience, with evidence of a period of at least three full
time equivalent years in the relevant discipline area;
• Current APA membership of the relevant National Group;
• Evidence of having engaged in a variety of programs of education to advance knowledge in
the relevant field of physiotherapy. Applicants need to have accrued 20 Continuing
Professional Development hours in the relevant disciplinary area in the last year; and
• Successful completion of an examination and assessment of skills.

During recent telephone interviews with each lead and implementation site, relevant staff members
were asked to comment on these entry requirements and whether they led to the most appropriate
physiotherapists being trained for these roles. Responses to these queries varied and there was
an association between the views of project teams and their location. For example, project teams
in regional and remote locations identified challenges in attracting physiotherapists with the
qualifications and experience necessary for the ESOP role. Personnel from Cairns Base Hospital
and Alice Springs Hospital frequently attract recent graduates with less experience. The Cairns
team expressed interest in different training models, for example an in-house training pathway that
would assist a physiotherapist at the level of HP4 with some musculoskeletal experience to
progress to the level of HP5. (The primary contact physiotherapy role requires advanced
physiotherapy skills and is remunerated at the level of HP5).

6.4 Training progress and outcomes

Training via the Alfred model is relatively flexible in delivery, and current students are at different
stages of completion. The project manager from Alfred Health estimates however that most
students have completed 70-80% of the learning modules and all modules should be finished by
June/July 2013. The students will then focus on the work-based competency assessments. There
have been no changes made to the training pathway to date. All physiotherapists undertaking this
training pathway are expected to successfully complete the course. Progress at each of the sites
training under the Alfred model is described below.

6.4.1 Alfred Hospital

The Alfred Hospital currently has five physiotherapists in the emergency department undergoing
ESOP training, three of whom started in the role recently (since February 2013). All are at
different points along the training pathway. Some staff are working in full time roles and others
part time, therefore they are at varying levels of completion of the training pathway. The numbers
of patients seen has likely been affected by the training and supervision requirements of the
physiotherapists new to the role. Numbers may also be affected in the near future by a new triage
model (Split Flow) which has commenced at the hospital. This involves allocation of patients to
the next available doctor, rather than by presentation category. This is likely to affect the number
of patients seen by the ESOP physiotherapists, at least in the early days of the implementation of
this new model.

6.4.2 Sandringham Hospital

Earlier in the year, some of the experienced ESOP physiotherapists were moved from the Alfred
Hospital to Sandringham Hospital. As a result, the physiotherapists at this site are working almost
at full scope, with the paediatric module still to be completed. Throughput of patients at
Sandringham is high and the feedback from patients and other members of the hospital staff is
very positive and supportive of the expanded role.

6.4.3 Southern Health (Casey Hospital and Dandenong Hospital)

Training at these sites is progressing well, despite the resignation of a fulltime Grade 3
physiotherapist earlier in the year. A new Grade 3 physiotherapist commenced in March however,
and is progressing through the competency package with approximately 40% completed.
Quarterly workshops are being held with all the ESOP physiotherapists to monitor their progress.
Casey Hospital has 1.4 Full Time Equivalent (FTE) Primary Contact Physiotherapists (PCPs) and
a project manager 0.6 FTE (which includes 0.1 FTE for the clinical lead role as well). Dandenong
Hospital is maintaining its existing PCP model with 1.0 FTE PCP, this position is permanently
funded.

6.4.4 St Vincent’s Hospital Melbourne

All four physiotherapists at St Vincent’s are currently undertaking the ESOP training and are at
different stages of completion. All are expected to complete the course. The project team is
currently doing some work on wound assessment and preparing materials for their next Steering
Committee meeting to formalise a process and competencies for assessment of minor wounds.
The physiotherapists are successfully treating a wide range of conditions and receiving very
positive feedback.

6.4.5 Ballarat Base Hospital

Ballarat Base Hospital has three physiotherapists undergoing the ESOP training. It is anticipated
that one of this team will complete all training requirements by the end of the year, with one PCP
aiming to be 80% complete and the third PCP 50% complete (due to other pre-existing study
commitments). The project team have followed the training pathway developed by the Alfred
Hospital lead site, however are considering not completing the wound management module as
they are unlikely to pick up any patients with lacerations as these would be directed elsewhere in
the ED by the triage nurse.

6.4.6 Alice Springs Hospital

Alice Springs Hospital has 2.0 FTE PCP positions and these hours are shared amongst four
physiotherapists (this is to allow cover on week-ends). All four physiotherapists are participating in
the training pathway, where resources permit (for example funds were only available for three staff
to attend the University of Melbourne Radiology module). They are progressively working through
the learning modules as a group; two staff members anticipate completing the pathway by the end
of the year. They are working with their lead site to streamline credentialing and assessment
processes as this was proving too onerous for the ED consultants.

6.4.7 The Canberra Hospital / ACT Health

The Canberra Hospital has one HWA-funded physiotherapist and another expanded scope
physiotherapist in the ED. The HWA-funded physiotherapist is currently undergoing the training
program and is due to complete the program by the end of 2013.

The Canberra Hospital / ACT Health project team are supporting implementation sites at Cairns
Base Hospital, Robina Hospital and Flinders Medical Centre. The primary training via the ACT
model is through completion of a Graduate Diploma in Extended Scope Physiotherapy through the
University of Canberra. Training of the physiotherapists via the ACT model is progressing, and
students are due to finish the coursework (clinical topics) in the second semester of 2013 and
competencies (as evidenced by their log book) by December 2013. All of the ESOP
physiotherapists are expected to complete their training by the end of this year.

The model and training program as previously developed was rolled out to the physiotherapists for
the HWA-ESOP program. However feedback on the course from physiotherapists at the
implementation sites has led to modification of the original training program. This feedback largely
concerned the applicability of the information in the modules to emergency departments outside
the ACT. For example, nitrous oxide is used for pain relief in Queensland but not in the ACT. The
development of competencies regarding its use was therefore required for physiotherapists in this
jurisdiction, and use of nitrous oxide was added to the pharmacology module and the clinical skills logbook. Other feedback related to the radiology module - this was delivered completely online and students felt the on-line delivery needed to be supported with face-to-face training for the interpretation of imaging. Consequently the ACT has arranged for the Clinical Director of Orthopaedics to attend the current clinical block (occurring the week of 27 May 2013) to provide teaching on x-ray interpretation.

Progress at each of the sites training under the Canberra Hospital / ACT Health model is described below.

6.4.8 Cairns Base Hospital

The ESOP physiotherapist at this site is progressing through the training program and due to complete all elements by the end of 2013. A range of concerns were identified about the training, particularly in relation to different clinical practices within the EDs of participants, however these appear to have been addressed. Overall, the course content has been received positively and for those elements for which feedback was provided, the University of Canberra and Canberra Hospital / ACT Health have made prompt amendments.

6.4.9 Robina Hospital within the GCH&HS

The training of the expanded scope physiotherapist at Robina Hospital should be complete in July 2013 due to recognition of prior learning. Several positive elements of the training program were identified for example, the pharmacology unit, and the log book and competency framework and the way in which these were formalised. Difficulties were seen in the timing of the training, which started quite late in terms of when the physiotherapist started in this role, and it has been suggested that the radiology unit is reviewed as it was not entirely applicable to the PCP role.

6.4.10 Flinders Medical Centre

The team at Flinders Medical Centre has established a staff pool of three to provide a seven day a week service. Due to funding restrictions only one physiotherapist has been able to participate in the Graduate Diploma program. All personnel are working through the competency based assessment process. The team at Flinders have found the logbook and framework to develop the medical mentoring relationship that was supplied by their lead site, has been very helpful. They found the radiology module only partially relevant as the content on CT and MRI scans was not applicable to the role of the PCP in the ED environment. In addition there was no component on radiation safety, this has subsequently been addressed. Under their own initiative, the team at Flinders Medical Centre supported the PCPs to attend a Lightbox Radiology Education course and found this both relevant and useful.  

6.5 Implementation of the model of care

Implementation is progressing well at all PED sites, with significant organisational support for the ESOP program and a high level of interest in the efficiency and effectiveness of the primary contact physiotherapy role in the ED setting.

6.5.1 Alfred Hospital

As noted previously, three new physiotherapists started in February 2013 at the Alfred Hospital, and training of these staff has impacted on the number of patients they have been able to treat. (These three new physiotherapists are part of a team of five physiotherapists). Anecdotal feedback from patients treated by the ESOP physiotherapists is very positive and the staff are well integrated into the team, (the PCP role is well established in the ED and has been in operation for several years). Whilst the established physiotherapists are providing the expanded scope role, the

newer physiotherapists that are still completing the training, are partially implementing the model of care, as they progressively achieve the required competencies their scope of practice is expanding.

6.5.2 Sandringham Hospital

The model is almost fully implemented at the Sandringham Hospital, with only the paediatric module still to be completed. The ESOP physiotherapists are very busy, particularly on Saturdays with musculoskeletal sporting injuries. The Alfred team decided to move some of their more experienced PCPs to establish the Sandringham service, which commenced in February 2013. To date, feedback on the ESOP role from within the hospital has been very supportive and the physiotherapists have become well integrated into the team. Patient feedback has also been very encouraging and complimentary of the service provided.

6.5.3 Southern Health (Casey Hospital and Dandenong Hospital)

Implementation of the model of care at Casey Hospital was interrupted with the resignation of an experienced physiotherapist in January. A new physiotherapist was recruited, and has commenced the training pathway. The number of patients seen at this site is high and there are a high proportion of paediatric cases. Preliminary evidence suggests that the expanded role is leading to reduced lengths of stay and shorter ED waiting times. Anecdotal accounts indicate that the physiotherapists are filling an important role and that they are missed in the ED when there is no coverage for a shift. Patients are providing positive feedback as are the hospital staff. The project team has lodged a business case and are optimistic that future recurrent funding may be identified. Implementation is considered to be partial however, as the physiotherapists have not completed their training, and guidelines regarding the ability to administer simple analgesia (such as Panadol and Nurofen) are still pending. Dandenong Hospital had a well-established PCP service and this is continuing with the inclusion of a soft tissue review clinic.

6.5.4 St Vincent’s Hospital Melbourne

Implementation of the model at St Vincent’s is proceeding well with a stable staff roster, high patient numbers and all PCPs working through the training pathway. This model of care is not new to the St Vincent’s Hospital ED and consequently there is a high level of acceptance from other members of the health care team. The PCPs have not yet completed the Alfred training pathway and will shortly complete the radiology and pharmacology modules, they also still require formal assessment of certain competencies. They are seen to be providing an important service and are able to identify a large cohort of patients suitable for PCP care. There is a high level of support around the organisation, and a business case has been submitted for recurrent funding. Patient feedback is also very positive, with patients pleased to be seen quickly and provided with appropriate care.

6.5.5 Ballarat Base Hospital

The team at Ballarat Base Hospital is experiencing increased acceptance by other members of the ED team. From April to June they have been trialling a week-end PCP service (Saturday, Sunday, and Monday) and this has been very well received by both patients and ED personnel. The PCPs cannot administer medication and they are still ensuring that radiological examinations are reviewed in conjunction with the ED consultant. They have observed a high level of patient acceptance of the role and believe that staff acceptance has increased since the week-end trial commenced.

6.5.6 Alice Springs Hospital

The new ED at Alice Springs Hospital opened officially on 11 June 2013. This development has had a significant impact on the ESOP project team as it has necessitated the development of a
range of documentation, including operational guidelines, for the PCP role. There is a varying level of support for the model of care amongst ED consultants however the junior medical officers and nursing staff have valued the role and their improved access to musculoskeletal physiotherapy advice. Patient numbers are slowly increasing however there is a view emerging that the ED role may be complemented by the establishment of a soft tissue review clinic run by the PCP. The project team are implementing all aspects of the model of care except for the administration of medication.

6.5.7 The Canberra Hospital /ACT Health

At this lead site, implementation of the model progressed smoothly, primarily because the model, training and credentialing was already in place. Locally there have been no changes to the model, however as noted previously, some changes have been needed to address practices at the implementation sites.

The HWA funded physiotherapist is still undergoing training, therefore the project cannot be considered to be fully implemented. This physiotherapist commenced in December 2012 and training started in February 2013. The physiotherapist is currently working in this position on a full-time basis. Another physiotherapist is employed at 0.6FTE, and there are plans to recruit an additional physiotherapist to a part-time role.

The current load for each physiotherapist is high and expected to increase once an administrative position has been filled, reducing the non-clinical workload of the physiotherapists. The ESOP physiotherapists cover the period from 8am to 9pm. This has been received very positively by staff and patients, with many of the relevant cases presenting in the afternoon and evening. The patients have provided positive feedback – they report that they are being seen quickly and receiving very good information from the ESOP physiotherapist.

6.5.8 Cairns Base Hospital

The ESOP physiotherapist is currently working at full scope of practice as they have many years of experience in this role, however they are not yet permitted to independently order and interpret plain film x-ray, this occurs in tandem with the ED consultant. The project team are working with their Director of Radiology and Radiation Safety Committee to address this issue. Due to legislative restrictions in Queensland, physiotherapists are only able to prescribe through a research trial. They can administer what are termed ‘Schedule 2’ medications which include over-the-counter analgesia such as Panadol and Nurofen. The physiotherapist sees both primary and secondary contact patients.

6.5.9 Robina Hospital within the GCH&HS

The ACT model has been successfully implemented at the Robina Hospital with only the pharmacology module to be completed and the scope limited by final approval to administer local anaesthetics and nitrous oxide. The expanded practice physiotherapist has a high throughput and in one month, saw amongst the highest total number of patients treated by any staff member that month. The expanded scope physiotherapist is conducting independent x-ray review. The PCP still has not secured authorisation for limited prescribing rights but this is being progressed within the organisation. As a result, hospital staff and senior management are very supportive of this role and are applying for permanent funding of the position. There are also plans for other expanded scope roles, with the nurse practitioners investigating an off-site clinic incorporating the expanded scope physiotherapist.

6.5.10 Flinders Medical Centre

Implementation is progressing well at Flinders Medical Centre with the winter months generating a high volume of paediatric sporting injuries that are a natural fit with the ESOP physiotherapy model.
of care. The role is well embedded in the ED and there is a high degree of support from other members of the health care team for the PCP. The PCPs are not providing any medication and are not injecting patients, for example for ring blocks. The project manager has met with the State Allied Health Advisor and is working to progress this; however, this matter may not be resolved before the project concludes. Whilst the PCPs are providing some plastering they have not yet signed off on competencies for all types of plasters. They are finding that the PCP is frequently called on to provide some secondary contact support, even though a secondary contact physiotherapist is based in the ED.

6.6 Stakeholder engagement strategies in training and implementation

All sites report a continuing process of stakeholder engagement regarding the ESOP physiotherapy roles within the hospital. With regards to the training and implementation, these engagement strategies include communication both internal and external to the organisation. Internal engagement strategies include:

- meetings and consultation with directors from within the hospital including radiology, pharmacy, orthopaedic and neurosurgical directors regarding provision and development of training resources and clinical governance documents;
- regular meetings with and presentations to steering committees and working groups to update and inform stakeholders regarding training and implementation progress;
- meetings with relevant staff regarding the development of the work-based competency standards;
- formal and semi-formal consultations with the ED consultants during the ESOP physiotherapists shift to provide updates on the project;
- training sessions for new medical staff to update and inform them regarding the role of the ESOP physiotherapist within the emergency department; and
- monthly email updates to key staff within the organisation regarding progress and implementation.

External engagement strategies have included:

- regular lead-implementation site teleconferences to discuss emerging issues and progress;
- using events where ESOP physiotherapists from all sites are together (such as residential training modules) to discuss issues and concerns;
- participation in a Work Based Competency Standard working party to collaboratively develop the framework and standards;
- consultation with groups such as the Medicines and Technology Policy and Programs and the Allied Health Professions’ Office Queensland to assist legislative change with regard to prescribing and radiology requesting rights for physiotherapists;
- external presentations to groups regarding the training models; and
- meetings held with the Flinders University Course Advisory Committee to advocate for ESOP models of care to be introduced into the curriculum.

Lead sites have played a key role in engagement of key stakeholders, through communication both at their own and the implementation sites. This has involved conducting onsite workshops, which not only involved presentation and provision of information regarding the training pathway and resources, but also allowed engagement with the implementation teams and their wider stakeholders. Regular and ongoing communication with the project officers, managers and ESOP physiotherapists at each site has ensured that training progress and implementation is monitored and assessed and that potential barriers are addressed where possible. There is generally positive support from implementation sites for the contribution the lead sites have made to their respective projects.
A number of sites (both lead and implementation) pointed out that within their organisation there were particular key stakeholders who required additional time and effort to ensure the smooth progression of the training and implementation of the program. At one site for example, the program manager regularly set aside time to talk through the issues with a “difficult” stakeholder in order to obtain support for the project.

Many sites identified that early and broad stakeholder engagement was crucial to the successful implementation of the ESOP role, and the wide range of engagement strategies in place during this later stage suggests that these strategies continue to be necessary and important throughout the life of the project.

6.7 Barriers and enablers

The sites identified a number of factors that hindered and others that enabled training and implementation activities. The barriers predominantly raised are about training, supervision and workload and legislative restrictions. The key enabling factors include the assistance and support of lead sites, progress with training and role recognition and stakeholder engagement and support.

6.7.1 Training, supervision and workload

A number of sites commented on the cost of undertaking the University of Canberra training program, and suggested this may be a barrier to the uptake of the ESOP physiotherapy model. The timing of the modules and relative inflexibility of these was also seen as a barrier – as these modules are only offered at fixed times, the ESOP physiotherapists are unable to provide the expanded scope services until formal completion of these units is achieved. The inflexibility of the training also means that all ESOP clinicians are attending the training (and are therefore absent from the ED) at the same time, causing difficulties in staffing levels and rosters.

The requirement to liaise with the ED Consultant for all cases during the competency assessment or credentialing phase was also identified as problematic. The consultants are often very busy and there can be a long wait to discuss the case presentation with them and have them check x-rays thus increasing the patient’s time within the ED.

Staff noted that there was limited non-clinical time set aside for the ESOP physiotherapist for self-study, which led to delays in the completion of modules and the other non-clinical requirements of the ESOP project. The workload associated with completion of the training pathways is reported to be considerable, particularly when the service did not incorporate allocated time for study and completion of the training elements.

6.7.2 Legislation

Within a number of the implementation site jurisdictions, legislative restrictions have limited the full implementation of the ESOP physiotherapy model of care. These restrictions include limitations on administering and prescribing medications, requesting and interpreting x-rays, and completion of Workers Compensation forms.

In the Northern Territory and Queensland prescribing is currently outside the physiotherapists’ scope of practice. While discussions to address these issues have commenced it is unlikely that they will be resolved in these jurisdictions in time to trial prescribing as an expanded scope task for the current project.

The Queensland Radiation Safety Act currently prohibits physiotherapists requesting x-rays. Queensland Health has processes to allow physiotherapists to undertake this task however medical officers are still required to countersign these requests. The sites are working with the Australian Physiotherapy Association to lobby Queensland Health for legislative change.
A related barrier involved Cairns Hospital not permitting the ESOP physiotherapists to request x-rays due to concern from the steering committee regarding the physiotherapist’s knowledge of radiation health risks. This was an early barrier to providing the expanded scope service at Cairns Base Hospital. However, in response to this issue, the University of Canberra has now included radiation safety in the graduate training program. Completion of this module is likely to satisfy the steering committee and allow the physiotherapists to order x-rays.

Examination of the provisions in the Workplace Safety / Worker’s Compensation Acts indicates that only South Australian clinicians are legally able to complete Worker’s Compensation forms. This restricts the autonomy of the ESOP physiotherapists as they are unable to provide a complete service to work-injured patients in the current environment. In an attempt to address this, the Canberra Hospital / ACT Health Directorate team are liaising with their legal department regarding steps required to allow worker’s compensation certificates to be completed by physiotherapists for ACT employees and will assist Queensland sites to undertake similar steps if appropriate.

6.7.3 Assistance and support from the lead site

Implementation sites commented that the workshops conducted onsite and the provision and sharing of material by lead sites greatly assisted with the training and implementation of the ESOP physiotherapist role. This support provided the implementation sites with the benefit of previous experience, confidence that the project would succeed and removed the need to develop their own framework for training and implementation. The implementation sites appreciated the initial on-site visit and the subsequent support via email, telephone and teleconferencing.

6.7.4 Progression with training and role recognition

Progression of the ESOP physiotherapists through the training pathways has allowed implementation of the expanded scope practices. For example, completion of the credentialing for Pharmacology, Radiology and Injection Therapies under the University of Canberra post graduate program allows the physiotherapists, under supervision, to begin medication administration / prescription and appropriate injections (selected joints and digital blocks), and interpretation of medical imaging. In jurisdictions where there are limitations to the provision of particular expanded scope activities, the completion of these modules is seen as important in progressing discussions and reaching agreement with the relevant stakeholders.

The identification of a clinical mentor has also been noted as an enabling factor, facilitating the supervised undertaking of expanded scope tasks and the completion of the clinical skills log book.

The ability to begin to provide expanded scope services has led to an improvement in morale and job satisfaction, and increased confidence in the skills of the physiotherapist by other staff within the emergency department.

6.7.5 Stakeholder engagement and support

Lead and implementation sites identified the support they received from key stakeholders as a factor facilitating the training and implementation of the physiotherapy expanded roles. For the Alfred Hospital lead site, this was evidenced by the commitment and enthusiasm of clinical personnel from implementation sites to contribute to the development of the competency standards. This has resulted in a collaborative framework representing multiple health organisations and resulting in a strong, representative and broadly acceptable framework. Strong support from staff within the ED was also identified by all lead and implementation sites, from the triage nursing staff becoming more aware of appropriate cases for the ESOP physiotherapist to treat, to the senior consultants providing expertise for clinical supervision.
6.8 Reflections and lessons learned

In their progress reports, sites were asked to provide their reflections on the project’s progress – specifically, the lessons they had learnt and changes that should be made. These responses were analysed for common themes and integrated with findings identified by HWA and the national evaluation team through site visits, additional project documentation and ongoing contact with the project teams. The results are described below.

6.8.1 Training program entry requirements

At this stage project teams predominantly feel that the requirements for the primary contact role and associated training pathways are appropriate. There is an emerging view however that these could possibly be more flexible. For example the requirement for a Masters degree may limit the number of otherwise suitable physiotherapists able to take on the primary contact role. This was particularly an issue for project teams in smaller geographical locations, where there was concern that as the service expanded to seven days a week the current entry requirements would limit the number of physiotherapists able to enrol in the program and thereby limit the potential pool of candidates for the ESOP role.

Several clinicians felt that having experience working in the ED was more important than having a post graduate qualification. Personal qualities of adaptability and previous experience in a secondary contact role were also considered valuable attributes and possibly more important than particular skills in musculoskeletal practice. The entry requirements may need to be reviewed in light of the experience of the HWA ESOP program and it has been suggested that they could be altered to allow inclusion of ‘sports physios.’ The ACT model may be able to incorporate the APA experiential pathway option in its entry requirements as per the Alfred model.

6.8.2 Workload

The workload involved in completing both training programs is high and many project teams underestimated the time this would take. Where participants did not have time allocated for study and completion of the modules, it was suggested that this may impact on the capacity for some students to complete the course.

Project teams also appear to have underestimated the work required for other members of the ED staff involved in the project. For example, data managers were required to assist with the data extraction for reporting, generating additional work for staff not funded under the HWA project. Others also noted the time required to manage implementation of the ESOP project, and that for future implementation it would be important to ensure appropriate project management time is secured. The role of ED consultants in providing medical mentoring and competency assessment is critical to the successful implementation of the ESOP physiotherapy program.

6.8.3 Lead-Implementation site issues

Lead sites raised a number of issues that confronted them in the implementation of the project, largely relating to the importance of good communication. One site noted that it is difficult to gauge whether the lead site is meeting the needs of the implementation sites despite regular teleconferences and other forms of communication. Both lead sites noted that there is little communication between them, but that this would be beneficial and action should be taken to address this.

Implementation sites generally found the lead sites to be very helpful, approachable and provided good resources. Leadership from the lead site in terms of the actual implementation of the project was considered crucial, and having someone onsite for a couple of days in the very early stages would facilitate project establishment. Lead sites should also be fully operational in terms of staffing and availability prior to leading the implementation at another site. In particular, training
pathways and resources should be more fully developed prior to extending these to implementation sites.

Current individual fortnightly teleconferences between lead and implementation sites are considered useful; however both the lead and implementation sites indicated that these might be better as monthly conferences that include all sites to facilitate sharing and problem solving across the broader group.

6.8.4 Applicability of training model

The lessons learnt in regards to the development of the training model were that the training needs to be applicable to other EDs in other jurisdictions. Canberra Hospital / ACT Health recognised that the training model was developed in the ACT for the ACT environment and that the issues that have arisen were due to material that was not applicable or insufficient for other sites. Adaptation of the model was therefore important to ensure that the ESOP physiotherapists are fit for the role as it will operate in their own ED.

The Alfred Hospital staff also noted that developing the model took a lot longer than first thought, particularly in terms of making the program applicable outside their ED and hospital. In doing this it was considered important to use the accepted language for each section of the course to enable the content to be understood and adopted by the relevant stakeholders. It was also noted that while it is easy to determine a standard of competency, it is more challenging to determine how and who is to assess that competency.

There has also been discussion regarding whether it is appropriate to consider an exit strategy for students who do not complete the training pathways. It was generally thought that all elements should be completed, however some sites considered that it may be possible that modules could be done independently and to obtain certification in one component only. If a physiotherapist did not complete all elements of the training, it could still be possible for them to work in the expanded scope role in certain circumstances, providing particular services.

As the ESOP role is still in its infancy, the leadership module was considered to be important to fulfil the ‘ground-breaking’ and stakeholder engagement functions of this role. In time however as the role becomes more widely accepted, this may not be necessary for all physiotherapists to complete, and perhaps only one or two ESOP physiotherapists in a hospital would require this. There was general agreement amongst course participants that training pathways should include the facility for recognition of prior learning.
7 Training and implementation: Nurses in the Emergency Department (NED)

7.1 Overview

This sub-project also responds to the increasing number of presentations to Emergency Departments and the pressures resulting from the national four-hour rule. The aim of this initiative is to introduce expanded scope of practice to nursing roles to support other members of the health care team to focus on consumers with more complex presentations. The implementation sites have taken diverse approaches and the objective of HWA is to assess the ‘best bets’ for future development. The projects focus on one of the priority areas of mental health, paediatrics or rural and regional implementation.

The multiple implementation sites selected, (thirteen project sites across eight organisations), are listed in Appendix 1. As each project has its own training pathway, this section of the report is structured slightly differently to the sections describing the APEN, PED and ERP sub-projects. Each NED implementation site is discussed in turn, and as stakeholder engagement strategies related to training and implementation are quite specific to each site these are reviewed on a site by site basis. The section concludes with a brief synthesis of barriers and enablers to project training and implementation and general reflections and lessons learned for the NED sub-project.

7.2 Royal Prince Alfred Hospital

7.2.1 Description of the training pathway

Four Mental Health Liaison Nurses (MHLNs) have been recruited at the level of Clinical Nurse Specialist (CNS). They are supervised by a Mental Health Nurse Practitioner (an existing appointment to the ED, who also runs an ED based outpatient clinic). To date there are no documented training pathways or competency requirements. HWA has requested more formal documentation as a required outcome of the project, and at a recent teleconference the project team reported that these materials were under development. Identifying training requirements will form part of the evaluation.

Clinical assessment skills have been discussed as a potential progression for this role. It may aid continuity of care and ensure that the CNSs can identify physical ailments as part of their MH assessment. There is the potential for this project to liaise with Eastern Health in relation to the integration of physical and mental health assessments.

7.2.2 Training entry requirements

Formal criteria for appointing CNSs to the role will be developed as part of the evaluation, in order to facilitate transferability of the model. Requirements are expected to include at least three years’ clinical experience and having begun or completed a post-graduate qualification. Some of the MHLNs were recruited from the community mental health team, which has been beneficial as many of the patients are known to the MHLN.

7.2.3 Training progress and outcomes

The training has been largely informal. One-to-one training and clinical supervision was provided by the Nurse Practitioner (NP) to recruits during their first month in the MHLN role. They were also provided with written materials. The team is supported by ongoing mentorship rather than structured training. For example, monthly MHLN team meetings provide an opportunity to discuss practice-related issues, clinical cases and aspects of the MHLN role. These are seen as a vital part of team development and valuable in helping standardise the service provided by the MHLN team. Training in specific subjects has also been provided by clinicians with expert knowledge in those areas. All members of the team have accessed a clinical supervisor outside of Royal Prince
Alfred Hospital ED. In addition, clinical supervision and training is available via the daily ED multi-disciplinary team meetings.

7.2.4 Implementation of model of care

Four MHLN covering 3.0 Full Time Equivalent positions have started work and the model of care has been fully implemented since around March 2013. The team is led by a MHNP. The roles cover 7.30am – 10.00pm, seven days per week.

The model involves working as a team to assist with information gathering and rapid assessment, managing difficult patients, and providing timely intervention to mental health patients as soon as possible after triage. MHLNs coordinate patient care, liaise with carers and work with Drug & Alcohol and Psychiatric teams. The nurses use medication standing orders, supported by the hospital’s pharmacy department.

All mental health patients treated by the MHLN team are assessed by a medical officer who devises a care plan in collaboration with the team. The medical officer continues to hold responsibility of care for the patient and is consulted in decisions regarding referral, transfer of care, treatment and discharge. When the NP is not on duty, the MHLNs report to the Nursing Unit Manager / ED staff specialist and are integrated into the ED team. Protocols and clinical practice guidelines have been developed to maintain the scope of the practice of MHLNs, ensure adequate clinical governance and enable transferability of the model.

One staff member resigned in April / May 2013 and a new nurse has been appointed into this vacant full time position. The former MHLN has agreed to take part in interviews regarding the role as part of the project’s local evaluation. The team is considering recruiting an additional person to make rostering easier and ensure coverage during leave.

MHLN team members have been providing in-service education to other ED nursing staff. In the period leading up to the third progress report, three education sessions were provided. The content of the education sessions will be included in the tool kit created at the end of the project.

7.2.5 Stakeholder engagement strategies in training and implementation

Two problems were identified for the project. Assessment processes and documents are often duplicated between the MHLN team and the psychiatry service, with patients having to answer the same questions for several different people. In addition, standardised assessment documents required for the mental health service do not always apply well to the patients and clinical situations seen by MHLN team members. In response to these issues, discussions have taken place within the MHLN team and with the psychiatry team and there is now greater consensus on responsibility for documentation.

7.3 Wollongong Hospital

7.3.1 Description of the training pathway

The project involves expanding the scope of practice of Mental Health Clinical Nurse Consultants (MH CNCs) who are working within the hospital’s ED. Historically, the CNC’s role has been to complete the Mental Health –Outcomes Assessment Tools (MH-OAT) for every person presenting to the ED with a mental health issue. Their scope will be expanded to include: brief therapeutic interventions for patients with self-harm, suicidal thoughts or diagnosed personality disorder; ordering medications under standing orders; and ordering pathology tests under standing orders. Training involves a one-day course in Brief Intervention Therapy, based on the Project Air Strategy for Personality Disorders. Training and assessment of competence in using the medication standing orders will be provided by the hospital’s chief pharmacist and nurse educator. In order to
use the pathology standing orders, CNCs must receive education on each of the tests ordered, clinical decision making and reviewing results.

7.3.2 Training entry requirements

It appears from the available documentation that no new nurses were employed for the project. Instead, the training and expanded scope was aimed at existing CNCs working in mental health in the ED.

A position description has been written for the MH CNC role. It specifies a minimum of five years’ Full Time Equivalent post-registration experience in mental health nursing along with the following criteria:

- Proven knowledge or experience in acute mental health care, with demonstrated commitment to recovery-oriented mental health service provision;
- Proven knowledge and ability to provide innovative therapeutic interventions for people presenting to ED with self-harm, suicidal thoughts or personality disorder;
- Evidence of ability to deliver mental health education programs for consumers, carers, nurses and other health professionals;
- Demonstrated experience in identifying, reviewing, implementing and evaluating clinical pathways, guidelines or flowcharts for complex client groups;
- Commitment to continuous quality improvement and ability to conduct research and evaluation.

The MH CNCs are expected to have expertise in clinical leadership, planning and management; mental health consultations, liaison and networking; development, review and evaluation of policies and procedures; education and training; and quality improvement, research and evaluation.

7.3.3 Training progress and outcomes

The project team reported in their third progress report to HWA that training packages were at “varying stages of development”. An ED triage package had been written and was awaiting a glossary. Orientation training for CNCs new to the ED was under development, as was training for use of medication standing orders. Nurse educators and MH CNCs were providing assistance with the development of the training packages.

The MH CNCs completed a one day training program in Brief Intervention Therapy for self-harm, suicidal thoughts or diagnosed personality disorder. This was based on the Project Air Strategy for Personality Disorders and was carried out on 13 February 2013.

On 13 and 14 March 2013, the CNCs and the project officer completed a Coaching for Performance workshop with Illawarra Shoalhaven Local Health District staff who use this framework for clinical supervision.

A competency map for ED MH CNCs will be developed after the project has been implemented (anticipated around September 2013).

7.3.4 Implementation of model of care

The model of care includes the use of standing orders for medications and pathology tests, nurse-initiated admissions to mental health units, and brief interventions for people presenting with personality disorder, suicidal thoughts or self-harm.

Both standing orders have been approved and policies written for clinical governance. The medication standing orders authorise CNCs to administer anti-psychotic and benzodiazepine
medications to adults (18 to 65 years) with mild to moderate behavioural disturbance, mood disturbance, psychosis or substance intoxication or withdrawal. The pathology standing orders enable the CNCs to initiate pathology orders ensuring comprehensive assessment. The MH CNCs will also be authorised to review the patient before the ED doctor sees them. The following tests are authorised under the standing orders: full blood count; electrolytes, urea, creatinine; liver function; calcium, magnesium and phosphate; thyroid function; urine drug screen; and blood glucose. The tests may highlight physical disorders which can present as psychiatric symptoms, and contribute to timely, holistic physical care for the patient.

A care plan module has been provided as a framework for the brief interventions for personality disorders (estimated to be a quarter of all ED MH presentations). This module helps consumers set short- and longer-term goals to assist them on discharge.

The CNCs have each been employed for some years with the current model of care and have struggled to see the benefit of this clinical redesign initiative. One ED MH CNC resigned and the position was readvertised with a new job description.

7.3.5 Stakeholder engagement strategies in training and implementation

The key stakeholders in this project are the ED MH staff members who have been using the existing model of care for many years. In the project officer’s words, the project “challenges cultural norms” in the ED including long-standing practices that are assumed – sometimes wrongly – to be based on policy and evidence. The CNCs have raised industrial issues in relation to the project. The project officer attended the two-day Coaching for Performance workshop with CNCs to foster a closer working relationship and has been regularly emailing ED MH CNCs asking for their input into the project. This has had a variable response. In addition, a training day was held on 5 April to address these issues.

Senior managers and members of the ED health care team are actively involved in the project, as demonstrated by their attendance at committees, education to MH CNCs and promotion of the project in district-wide meetings. They have provided practical assistance to the project officer. The ED team have also invited the CNCs to attend ED meetings. Mental health CNCs continue to deliver in-service education to general ED staff. The project officer has presented to stakeholders including psychiatric registrars and consultants, the mental health leadership group, and Inpatient Unit / Psychiatric Emergency Care Centre staff, in an effort to improve knowledge of the project throughout the service. This strategy has also served to invite input from a larger group of stakeholders than initially engaged.

7.4 Eastern Health

7.4.1 Description of the training pathway

Two specialist mental health nurses have been introduced into the ED environment. They work within the Psychiatric Triage and Emergency Response Service across two EDs in the Eastern Health area (at Box Hill Hospital and Maroondah Hospital), covering peak clinical demand times across seven days. One is an endorsed Mental Health Nurse Practitioner, the other a Nurse Practitioner candidate with an existing postgraduate diploma in a relevant area. Both are highly experienced in advanced psychiatric or mental health nursing roles. Consequently, little additional training has been needed to prepare these new staff for their ESOP roles, apart from orientation to the ED environment, the mental health service, and Eastern Health. Basic organisational training has included clinical risk assessment, safe aggression free environment, dual diagnosis training, family sensitive training and other mandatory and non-mandatory training that is not specific to the NP role.

Support needs are met through weekly supervision by the ED consultant psychiatrists as well as monthly group supervision for the two project NPs with one other NP and two NP candidates. In
addition to the mandatory 20 hours of continuing professional development, the NP will need to complete 10 hours relevant to the mental health and ED context, covering areas such as prescribing and administration of medicines, diagnostic investigations, consultation and referral. It is anticipated that the NP’s time will be divided 80/20 between clinical work and research / education / practice development, while the NP candidate will receive additional leave as needed to meet academic, supervision and professional development requirements.

7.4.2 Training entry requirements

Candidates for the ESOP role were registered nurses with current, unconditional Nursing and Midwifery Board of Australia (NMBA) registration. To be eligible, they must have completed or be working towards Masters-level qualifications (Master of Nursing Practice) or equivalent in Nurse Practitioner Studies as approved by the NMBA via the Australian Health Practitioner Regulation Agency (AHPRA). If completed, they must be endorsed by NMBA via AHPRA as a Nurse Practitioner (Mental Health). If working towards this qualification, they must have some existing postgraduate training such as a Postgraduate Diploma of Psychiatric / Mental Health Nursing, or equivalent, and have completed or be working towards the Therapeutic Medicines Management and Health Diagnostics modules of a Masters-level course. In addition, experience of at least three years’ full-time (or six years’ part-time) advanced practice nursing over the past six years was required.

7.4.3 Training progress and outcomes

The two new staff commenced work in early December 2012. The NP candidate has since become endorsed as a Nurse Practitioner.

7.4.4 Implementation of model of care

The model has been fully implemented since January 2013. Networks and support systems have been established in the EDs and Mental Health Triage.

An initial data review of assessment outcomes for the ESOP staff indicated that only 50% of assessments had been completed within the four-hour National Emergency Access Target (NEAT) requirement. In response, a meeting was arranged with the service manager, ESOP staff and project manager to discuss. In the recent teleconference, the project team noted that there were differences between the two NPs in whether NEAT targets were met, although procedures had been standardised across the two EDs. This was being investigated further.

In response to consultations with ED managers, the two NPs are developing a training package on challenging behaviours, which they will deliver to ED staff along with protocols for staff to deal with these behaviours. This was identified as a training need for ED staff. The NPs have reviewed an existing package and compared it with one produced by the Austin Hospital. The new package will be aimed at medical and senior nursing staff.

7.4.5 Stakeholder engagement strategies in training and implementation

The model relies on a support network within Eastern Health and with the Nurse Practitioner Collective. This network has been established, and a supervision and support framework developed.

Challenges for the project include engaging the triage manager and also an acting triage manager who covered the role during the manager’s absence on leave. There were some issues involving rostering, and one of the ESOP staff did not understand their role in reporting via the triage manager for daily operational requirements. To address these difficulties, meetings were held and role and reporting lines clarified. The project manager reiterated the position description reporting lines, plus project requirements of the role.
There has been resistance from the Medication Management Committee to the proposed formulary for prescribing. This is not specific to the project NPs but is affecting their work. The doctors on the committee had concerns about allowing NPs to prescribe some of the medications in the formulary, and the project team made a case that these were being prescribed within their scope of practice. Currently the issue has been addressed by providing after-hours support to the NPs (they are able to ring a doctor for advice on prescribing). The issue is affecting other MH NPs in the hospital as well, and the project team is working on a resolution.

7.5 Prince of Wales Hospital

7.5.1 Description of the training pathway

Project documentation refers to credentialing of nurses to run the Fourth Door Safety Net Program model of care. According to the project’s third progress report, a framework for education and implementation has been developed, along with a competence / examination framework for the nurses involved in the ESOP roles. However, no specific details are provided and it is unclear what the education, competency assessment and credentialing involves in practice.

7.5.2 Training entry requirements

The ESOP roles were filled by three Clinical Nurse Consultants (CNCs) - Grade 2: one is employed full-time, and two at 0.3FTE. Candidates were to have at least five years’ post-registration experience, including at least three years in the ED, and relevant post-graduate qualifications. The CNCs are studying and working towards NP endorsement and are receiving medical mentoring from a Fellow of the Australasian College of Emergency Medicine, with additional support from a CNC.

The project’s model of care document notes that the role should be filled by “a senior emergency nurse, an accountable practitioner, who is progressing towards autonomous practice and demonstrates clinical leadership in nursing and is a role model for an advanced level of practice in nursing. Frameworks for ethical and responsible practice will be based on the Australian Nursing and Midwifery Council (ANMC) National Competency Standards for the Nurse Practitioner”.

7.5.3 Training progress and outcomes

The full-time ESOP nurse has become endorsed as an NP but is now moving to another hospital. Due to budget restrictions, the role will not be replaced. Instead, the other two ESOP nurses will pick up extra shifts, and the project manager (who has advised he is a qualified NP) will cover leave.

Succession planning has been built into the project. Four ED nurses are undertaking advanced clinical nurse training (which is one step below the Expanded Practice Nurses) and it is anticipated they will be available to replace ESOP staff that leave.

A training pathway is being documented, for use in preparing future staff for ESOP roles, as well as informing other potential sites. The project team reports that it has drafted a curriculum, lectures and other materials reflecting the care and expertise required for patients sent to the review clinic. The training materials have not been used as the ESOP staff members were employed at CNC (moving to NP) level. It is designed to be used as a manual, and “topped up” as required with new cases and information.

7.5.4 Implementation of model of care

The model of care has been fully implemented for sub-acute and fast-track patients. For at least the past two months, the ESOP nurses have been using the model with sub-acute (and some fast-
track) patients suitable for discharge and later review. They see on average 18 to 20 people per day or about 310 patients per month through the clinic. They cover the hours 9.30am to 6.00pm Monday to Sunday, including public holidays (except Christmas). According to the project manager, 95% of patients were discharged within four hours and of those 60% were discharged in 30 minutes.

The model originally included ambulance patients, referred to as P3 patients, i.e. non-emergency transports. There were concerns about the time required to manually link records relating to patients presenting by ambulance as booked cases (or non-emergency transports to the ED). This meant it would be difficult to get data accurately capturing the patient journey through the ED. In addition, considerable time and resources would have been required in the set-up phase to resolve data quality issues and develop automated reports to allow monitoring of outcomes. These difficulties contributed to the team’s decision to exclude these patients from their target group. The mental health aspect of the model has not been implemented due to stakeholder issues (see below).

7.5.5 Stakeholder engagement strategies in training and implementation

Prince of Wales Hospital reported difficulties in getting stakeholder buy-in for the inclusion of mental health patients needing low-medical risk clearance. After ongoing negotiations a decision was made to exclude this patient group from the project scope.

Three focus groups have been conducted with nurses in the ED and feedback was overwhelmingly positive. These discussions also provided an opportunity for the project manager to explain and clarify the role of the ESOP nurse and the model of booking appointments at the EPN led ED review clinic. This has led to more nurses making bookings on behalf of patients they want reviewed or suspect will not be seen by a GP within 48 hours. Nurses also appear to be prompting doctors to book appointments for suitable patients. Feedback from doctors has also been positive and they see the service as an extra safety mechanism for patients discharged from the ED.

7.6 Murrumbidgee Local Health District

7.6.1 Description of the training pathway

Originally, 23 nurses were expected to be trained at five sites: Batlow, Tumbarumba, Tumut, West Wyalong and Wagga Wagga. This has now been revised down to 21 trainees, with between two and eight nurses per site. Because participants will enter the ESOP program with different levels of prior skills and experience, training and education is being individually tailored to address their specific needs.

The competency-based ESOP education and training program has three parts: online education modules, face to face skills education and competency assessment in the use of the clinical pathways to manage patients.

Five education modules have been developed by the project team, based on national resources and evidence-based practice, and approved by the Project Steering and Governance Committee. These are being delivered online via Knowledge Presenter software and each takes approximately 20 minutes to complete. The five topics are: ear problems, eye problems, minor limb injuries, minor lacerations and vomiting and diarrhoea. Each module covers clinical knowledge such as pathophysiology, patient assessment, medication, discharge, and patient education, and includes scenarios in which the trainee must apply his / her knowledge. Additional topics in a module may be added as required. Assessment is built into the modules in the form of quizzes, which trainees must complete with 80% accuracy in order to progress. Knowledge of the clinical pathways to be used in the ESOP model of care are be assessed.
The clinical knowledge modules must be completed successfully before trainees can commence clinical skills training. There are four hours of face-to-face clinical training per module. Suitably qualified clinicians – including registrars, NPs and GPs / Visiting Medical Officers – will provide skills training days to present evidence-based, best-practice approaches to the skills required for implementing the clinical pathways. Training may involve simulation. All trainers are approved by the Project Steering and Governance Committee to ensure they have the appropriate level of knowledge and experience. Competency-based assessments take place at the end of each training day to ensure trainees can demonstrate the skills required. Finally, each trainee is required to complete a clinical competency assessment for each module. Assessment takes place in the ED environment, ensuring he / she can demonstrate the following abilities:

- recognise a patient suitable for the ESOP care pathway;
- take a complete patient history according to the pathway;
- complete the required documentation;
- troubleshoot patient care utilising the pathway including escalation;
- follow the discharge process required for each patient.

Certificates for completion of the online and face-to-face training and the final competency assessment are then submitted to the Executive Director of Nursing and Midwifery Services for review and authorisation.

At each site a clinical “coach” has been appointed to provide support and guidance (not training or assessment). The coach is a suitably experienced person who undergoes the same training and assessment as the trainees.

### 7.6.2 Training entry requirements

All senior ED nurses with triage qualifications working in the Murrumbidgee Local Health District can request to be part of the education and training program. Entry is limited to registered nurses who have high levels of competence and experience in specific core emergency nursing skills including patient assessment and triage. They must possess knowledge of key emergency nursing concepts and be able to demonstrate this advanced knowledge and skill before commencing ESOP training. Eligible nurses will have recently attended an applicable short course that includes competency assessment; previously attended such a course and recently completed reaccreditation requirements; or undertaken a Recognition of Prior Learning (RPL) assessment that complies with the RPL guide and is approved by the program coordinator. Applicable courses can include, but are not limited to:

- Graduate Certificate in Nursing (or higher) (Emergency or critical care);
- First Line Emergency Care Course (FLECC) or equivalent;
- Trauma Nursing Care Course or equivalent;
- Emergency Nursing Paediatric Course or equivalent;
- Australasian Triage Scale Education Course based on Emergency Triage Education Kit.

In addition all ESOP candidates must show evidence of completion of a course which addresses the needs of the deteriorating patient, such as the NSW Health “DETECT” course (Detecting deterioration, Evaluation, Treatment, Escalation and Communicating in Teams). They are expected to be able to demonstrate an enhanced ability to recognise and manage a deteriorating patient.

### 7.6.3 Training progress and outcomes

A process for recognition of prior learning was developed for the project. This enabled nurses to provide evidence indicating that they had achieved certain competencies required for ESOP work. Criteria for recognition of prior learning were established and the acceptable forms of evidence
specified. The process involves completing a self-assessment and collating evidence, meeting the assessor to discuss qualifications and competency level, making a plan for assessment and/or collection of further evidence if required, and then gaining formal recognition and acceptance to undertake ESOP and the associated training.

Because the project has limited access to IT support, an external contractor was engaged to design the online education. The contractor was placed on a trial until the first education module could be checked for quality. The IT department was then asked to upload the module onto the Area’s staffnet. In the interim, a link was sent to participants so they could access and start the education.

At the time of the most recent project progress report, two of the five online modules had been developed and approved, and a third was under development. A face to face education and training day was scheduled for late January/early February 2013. The project had negotiated access to YouTube which enabled use of training videos, making training more interactive and enhancing the motivation of participants.

At the teleconference on 22 May 2013, the project team reported that all five online modules had been completed by 21 nurse trainees. Four nurses had withdrawn from the project. Skills training is expected to be finished by the middle of June 2013, after which participants will travel to Wagga Wagga for rotation in the ED, working with NPs for two days in order to consolidate their skills and knowledge. It is anticipated that it will take about six weeks for all nurses to have completed their two days’ rotation and competency assessments. This is limited by the fact that only two NPs are available to provide the necessary supervision and assessment, and by rostering issues (i.e. the need to ensure adequate staffing at sites while trainees are away in Wagga Wagga). It is expected to be finished by the end of July 2013.

Nurse trainees can also practice skills in their own facilities under the supervision of doctors, while waiting for their two days’ NP rotation in Wagga Wagga. There are different opportunities available at different sites; for example, the two West Wyalong participants have arranged to practice suturing at a lesion removal day run by a local GP.

7.6.4 Implementation of model of care

The project was endorsed in Murrumbidgee Local Health District policy in February 2013. The policy sets out expectations regarding information and procedures governing the implementation of the project and the use of clinical pathways by the ESOP nurse. It describes the ESOP model of education, clinical training and support, the procedures for assessment of competence, the role of coaches, and the governance processes.

Full implementation has not started as nurses are still in the training phase. There have been some legal issues to resolve regarding the question of whether nurses can be authorised to perform this role, or whether it is outside their scope of practice and therefore not covered by the organisation or NSW Health if there is an adverse outcome. The project team has been checking with the medico-legal team at NSW Health and also researching relevant literature to clarify this issue. HWA has arranged a site visit in June with the Clinical Advisor to review progress on this matter. Implementation was expected to start at the end of May 2013 with the first tranche of trained nurses and be completely rolled out across all sites by the end of July 2013.

All ten planned clinical pathways, covering five topics, have been created, providing a step-by-step guide to management of patients who meet the appropriate criteria. They are waiting “sign off”. They include identification of suitable patients; red flags and prompts to escalate care; assessment processes specific to each presenting problem; treatment guidelines based on assessment findings; discharge guidelines and “safe for home” criteria. The ESOP nurse is prompted to remove the patient from the pathway when assessment findings fall outside specific criteria and then advises them to contact a Medical Officer. Before using a pathway, the ESOP nurse is
required to have completed the relevant training and assessment. Pathways are teamed with Medication Standing Orders specifying appropriate medication to facilitate treatment. The standing orders were developed with the Murrumbidgee Local Health District Chief Pharmacist and approved by the Murrumbidgee Local Health District Area Drug and Therapeutics Committee.

7.6.5 Stakeholder engagement strategies in training and implementation

The ESOP Clinical Advisory Group (CAG) has designed the clinical pathways used in the ESOP project, based on evidence-based practice. The CAG is made up of experts in the Nursing, Medical, Radiology and Pharmacology fields. Other health professionals were consulted on the pathways, which were then ratified by the Project Steering and Governance Committee and forwarded to Murrumbidgee Local Health District’s Executive Director of Medical Service, Executive Director of Nursing and Midwifery and the Director of Critical Care Service for the final sign off.

In order to engage sites in the project, reimbursement was provided for participants’ study days. Site managers were also invited to the study days to get a better understanding of the skills and education the nurses are receiving. This has resulted in better engagement, and site managers are now helping build momentum for the project. The project team has noted that early engagement of stakeholders, especially GPs, managers and nursing staff, is essential and a longer lead-in time would have facilitated better engagement.

7.7 Kilmore and District Hospital

7.7.1 Description of the training pathway

This project aims to expand the scope of practice of registered nurses in the Kilmore and District Hospital Urgent Care Centre (UCC). The training program has been designed with a view to national replication, so that it will be effective and transferable. The program is modular and focuses on four areas of practice: suturing; application of plaster for simple, stable fractures; provision of limited diagnostic radiology procedures; and management of presentations for ear, nose and throat conditions. It includes online components as well as practical training, competency assessment and ongoing mentoring and supervision. Trainees are also required to undertake the Certificate IV in Training and Assessment (TAE 40110). This additional requirement builds sustainability into the model of care by ensuring that trained nurses can provide ongoing education and support to other emergency nursing staff.

The program involves two days of training in wound closure and suturing, followed by clinical competency assessment provided at the UCC and in theatre by Visiting Medical Officers. One-day training in clinical casting and immobilisation is provided to enable nurses to apply plaster for simple, stable fractures. A total of four days’ clinical competency assessment takes place at the UCC, Royal Children’s Hospital (RCH) and The Northern Hospital (TNH). An ear exam simulator was purchased to assist with training to manage presentations for Ear Nose and Throat (ENT) symptoms. Visiting Medical Officers provide clinical training using the simulator, after trainees have completed a one-day course in aural health. All three of these courses are available nationally and provided by the Benchmarque Group, a registered training operator. Nurses also complete the Remote and Rural X-ray Operators course provided by University of South Australia. This 10-week online course, which includes two days of practical assessment, leads to licensing in Victoria and enables the nurses to take patient x-rays in accordance with specific guidelines. Nurses will be expected to work in accordance with a Good Practice Guide for remote operator x-ray services currently being developed by the Victorian Department of Health. Completion of the Certificate IV in Training and Assessment (TAE 40110) involves an online course delivered over six months by Registered Training Organisation Southern Cross Training.

Once training and competency assessment is completed, nurses will be supervised and mentored by local experts including GPs. This ensures the local GPs have an opportunity to observe the
enhanced practice by the candidates and be assured of the long term competency of each ESOP registered nurse. A set of ongoing competency assessments will be developed. These will be completed at agreed intervals (annually) to ensure maintenance of skills. These can be completed by local experts or in conjunction with nurses who hold a Certificate IV in Training and Assessment.

7.7.2 Training entry requirements

Essential eligibility criteria were as follows:

- Current AHPRA nursing registration
- Tertiary qualification in Nursing
- Minimum of five years post-registration nursing experiences
- Police check and clearance prior to commencement
- Demonstrated effective interpersonal and communication skills.

In addition, the following were desirable:

- Post graduate studies in Emergency nursing
- First Line Emergency Care accreditation
- Advanced Life Support accreditation
- Certificate IV in Training and Assessment (TAA or TAE).

7.7.3 Training progress and outcomes

Positions were advertised internally in July 2012 and there were 11 applicants. Six registered nurses were appointed on 16 August 2012, each with three to ten years’ experience at Kilmore and 22-33 years’ nursing experience in total. Originally the project plan included four nurses, but permission was received from HWA to appoint the extra two candidates.

The plaster casting course was completed on 5 October 2012 and the wound closure course on 15-16 November 2012. Aural health training was completed on 15 March 2013. Four candidates commenced the Remote and Rural X-ray Operators course at University of South Australia in February 2013 for completion in April 2013. All six candidates attended four clinical support days at RCH and TNH in October to December 2012.

The online course for Certificate IV Training and Assessment began on 1 October 2012. Two candidates refused to undertake the Certificate IV and subsequently withdrew from the project in February 2013. The remaining four ESOP staff began the course, which was to have been completed by 1 April 2013; however, an extension was granted until 30 June 2013.

A medical model was purchased for ongoing training and assessment in ENT presentations and a Visiting Medical Officer agreed to provide education sessions to ESOP staff in early 2013. Staff members have also been using the model for self-directed learning.

All training and education is expected to be completed by June 2013. A Professional Practice Portfolio was commenced by all ESOP candidates and they continue to gather evidence of their own learning and competence. Competency guidelines have been developed and implemented.

7.7.4 Implementation of model of care

The implementation stage commenced on 1 October 2012 with six RNs ready to undertake ESOP training. When two candidates refused to complete the Certificate IV program, the project manager sought advice from HWA. Although various support strategies were offered, the candidates continued to refuse to undertake the course. Following consultation with HWA, the project sponsor (Director of Nursing) and project lead (Nursing Unit Manager) the decision was
made that all components of the project need to be completed or the candidates would need to withdraw, which is what they chose to do. Two candidates withdrew from the project in February 2013, leaving a total of four candidates as set out in the original project plan.

One of the nurses works full-time night duty, while the other three work days, for periods of five, six and nine days per fortnight respectively. This means days are fully covered and nights partially covered by ESOP staff. Currently no medical officers are on call at nights, although some are willing to do so. The hospital has few presentations at night (average of around five) and when necessary, nurses call GPs at night to authorise suturing, application of plaster, and other ESOP activities.

All four ESOP nurses have completed training and competencies in plastering. Four have completed training in suturing. In order to gain competency in this area, nurses must treat five patients in consultation with a doctor or medical officer. Due to a low number of suitable patients, only two of the four nurses have been able to complete this competency to date. To address this situation, the nurses have been attending a GP “lumps and bumps” clinic. ENT competency assessment is being done in consultation with a medical officer, and progressing well.

Although training in imaging has been completed, this aspect of the project has not been fully implemented due to industrial issues and discussions with the Victorian Department of Health. The Certificate IV training was extended by two months, which has required investment of more funds into the training budget. This online course was not included in the original project budget but was added to enhance sustainability. The trainees have struggled with the online format, and the project manager has reflected that face-to-face learning may have been preferable. In summary, some aspects of the model have been fully implemented while others are still in progress.

7.7.5 Stakeholder engagement strategies in training and implementation

The difficulties in implementing ESOP for nurses in the area of imaging and x-rays have highlighted the importance of early and ongoing strategies for stakeholder engagement. There have been a number of successes in this area, however, notably the development of a set of policies, procedures and guidelines in consultation with key stakeholders to support the nurses in practice. In addition, the project has secured access to advanced training opportunities at tertiary hospitals in Melbourne, in the form of on-site clinical support at The Northern Hospital and The Royal Children’s Hospital. ESOP candidates have attended four clinical support days at these hospitals.

Other key stakeholders include the organisations identified as suitable providers for the ESOP training. It was deemed essential to identify nationally accessible training opportunities to ensure quality and sustainability. These organisations are: the Benchmarque Group (a Registered Training Organisation) for wound closure, casting and aural health; and Capital Health Radiology (a private provider of radiology services) for imaging and x-ray training and assistance. Three local medical centres are providing support for the suturing, plastering and ENT aspects of the model. They are: Wallan Family Medical Practice, the Wallan Medical Centre, and the Kilmore Medical Centre. The project continues to foster positive relationships with key stakeholders through active engagement communication and reciprocal respect.

One challenge that has faced the project is the lack of doctors available on-call overnight (that is, from 10.00pm to 8.00am). This presents a significant barrier as the ESOP RNs cannot assess, treat and discharge patients independently within their current scope of practice. After discussions with the HWA Clinical Advisor, the project team approached local GPs to see if they would agree to receive calls from ESOP RNs overnight if relevant patients present. Another strategy to overcome this barrier that is still being explored is working with the Northern Hospital to develop a Memorandum of Understanding around out-of-hours medical support.
7.8 **Sunshine Hospital**

### 7.8.1 Description of the training pathway

The project aims to improve care and reduce waiting times for paediatric patients in Triage 4 and 5 categories by providing additional training to nurses and clinical pathways to guide management. Nurses will refer to medical staff for diagnosis, guidance on appropriate treatments, and discharge. The project focuses on seven minor illness and four minor injury presentations: bronchiolitis, croup, asthma, wound care, earache, burns, limb injuries, head injury (no loss of consciousness), urinary tract infection, diarrhoea and vomiting, abdominal pain.

Nurse trainees attend a four-day Paediatric Foundations Program at Royal Children’s Hospital and an in-house, one-day course run by a Nurse Practitioner. This covers gluing and wound management, x-ray ordering and nurse-initiated medications. ESOP nurses are observed by doctors and supported by senior nurses who have done a six-month discovery program. An online tutorial and assessment will be provided for medication training.

The need for more formal competency assessment was discussed with the project team at the recent teleconference with evaluation team members.

### 7.8.2 Training entry requirements

Registered Nurses (Division 1) who were currently employed in the Sunshine ED were eligible to apply for ESOP training. Four candidates were selected from the 12 applicants. Three of the four had post-graduate qualifications and all were very experienced in ED. They were appointed, on secondment from the ED until November 2013, to cover a total of 2.5 Equivalent Full Time (EFT) positions (later reduced to 2.2 EFT). At a recent teleconference, the project team said they felt the recruitment had been pitched at the right level. Although some nurses may not have formal qualifications, their experience and drive can compensate for this more than adequately. They also noted that taking the most experienced staff from the pool of ED nurses can mean the department is depleted.

### 7.8.3 Training progress and outcomes

The one-day in-house training session was conducted on 21 September 2012. It covered all aspects of patient care provided by ESOP nurses. All ESOP nurses have completed the four-day Paediatric Foundations Program at RCH.

An online quiz has been developed to assess competency with medications but it has not been used yet due to issues with Standing Orders review and approval (see below).

Since the training, there has been a noticeable enhancement of skills in the ESOP nurses. For example, Sunshine has always provided nurse-initiated X-ray training for senior nurses, but the additional training has enhanced their proficiency in examining patients before sending them off for X-ray. Nurses have initiated their own clinical supervision. For example, they discuss patients with the Nurse Practitioner or consultant paediatrician to confirm whether their assessments were accurate.

### 7.8.4 Implementation of model of care

Nurses commenced in their ESOP roles on 8 October 2012, although the role was modified until the training package and clinical practice guidelines were approved. The Standing Orders are still awaiting approval. This is a wider issue affecting all of Western Health, not just the Sunshine ESOP project.
A work station, stock, equipment and information technology support were provided. Clinical guidelines and pathways were developed with input from all key stakeholders including the Pharmacy Utilisation Committee and Scope of Practice Committee.

Initial data analysis showed that the original shift times were not productive, particularly in the mornings. These have been changed to cover peak demand times better and allow a longer period of overlap when two ESOP nurses are rostered on together. This allows one to work in the assessment room while the other monitors patients who have been returned to the waiting room for medical review, and means patients experience more continuous nursing care. The morning shift is 9.30am to 10.00pm and the afternoon shift is from 1.00pm to 11.30pm with ten-hour shifts instead of the original eight-hour shifts and a later finishing time. The combination of longer shifts and fewer days provides better work-life balance for the nurses.

7.8.5 Stakeholder engagement strategies in training and implementation

There were some initial difficulties with staffing which were resolved with more education. For example, a senior nurse pulled an ESOP nurse from the role to assist with patients in another area. Six education sessions were run to inform all ED staff about the project, and the ED email distribution list has been used to communicate updates to all staff. The project has benefitted from a flexible attitude among ED nursing staff (there are around 130 nurses employed in the ED at Sunshine) and supportive leadership from medical staff including one staff member who is well-respected and taking an active role in developing the skills of nursing staff. The project has been well accepted by medical staff in the ED and there have been compliments from patients’ families on the quality of care received from the ESOP nurses.

In addition, the project team has been providing monthly updates on project status to ED senior divisional staff meetings and regular reports directly to the Director of Nursing, Operations Manager, Divisional Director of Emergency Medicine, ED nursing and medical management and educators.

There have also been some difficulties in establishing consistent protocols for medication use, with mixed messages from different directors regarding what nurses are authorised to administer. Internal policies and procedures have been barriers to change in this area.

7.9 Royal Children’s Hospital

7.9.1 Description of the training pathway

The project aims to extend the hospital’s existing Criteria-Led Discharge (CLD) initiatives to include three respiratory conditions (asthma, croup and bronchiolitis) and gastroenteritis. Patients suitable for treatment on the CLD pathway will be identified at triage and then assessed by a doctor or Nurse Practitioner, who will mark the CLD paperwork with any additional criteria for discharge, medication instructions and so on. Trained nurses will then take over treatment of the patient in accordance with the CLD pathway and guidelines, consulting with medical staff as needed. When the patient has met the criteria for discharge, this will be implemented by the nurse with no further involvement by medical staff, potentially improving the efficiency and flow of the ED.

To be eligible to implement the CLD pathways, ED nurses must first attend an in-service training session on the project or meet with the project team to learn about the CLD pathways and the required training. They are given a kit containing the training materials, including competency requirements and assessment paperwork. They complete a pre-training questionnaire, followed by the training packages. All nursing staff are completing the training and new staff will also be required to soon after they are appointed. The training uses a combination of paper based and on-line resources and takes about two hours to complete. The topics covered are: Criteria-Led
Discharge; paediatric hydration assessment; and paediatric respiratory assessment. A list of required readings is specified, including clinical practice guidelines and parent information leaflets.

7.9.2 Training entry requirements

All permanent nursing staff (approximately 100) are eligible and encouraged to complete the training and implement the CLD pathways and paperwork.

7.9.3 Training progress and outcomes

An education package was developed by a working party in the ED. Answer sheets for the competency assessments were distributed to assessors to ensure standardisation.

Nurses undertook the education and competency assessments in January 2013. Completion of the education took longer than expected due to annual leave, staff resistance to undertaking assessments, and availability of project team and education team to conduct assessments. However, a high level of completion was achieved due to the continued support from the ED nursing education team and senior nursing staff. As a result, all in-service education has been completed. New staff and those who are returning from leave continue to receive training as needed.

7.9.4 Implementation of model of care

CLD pathways were implemented from February 2013. The ED patient information system has been adapted to allow eligible patients to be flagged, and additional “procedures” have been included to capture CLD patients. Further adjustments may be required.

The availability of appropriate patients for CLD has been affected by the concurrent implementation of four observational beds within the Short Stay Unit, aimed at patients who are to be observed for less than 12 hours. There is overlap between the target patient groups for this initiative and the ESOP project, which will reduce the number of these presentations seen by ED nurses and therefore may impact on data collection for the project.

7.9.5 Stakeholder engagement strategies in training and implementation

As noted above, a working party in the ED devised the training package for nursing staff, including CLD, respiratory and hydration assessment competencies. Other stakeholder engagement strategies included:

- a project information display for the ED tearoom, which is regularly updated;
- in-service education of the CLD project to nursing and medical staff;
- regular impromptu (one-to-one) education and support for staff regarding the CLD project.

The project team has had multiple meetings with the ED director regarding changes to the patient information system, and has liaised with clerical staff regarding paperwork requirements for the project and ongoing support for project-related issues. ED administration support staff have also provided assistance with baseline data collection on presentation rates for the project’s target diagnoses, and the decision support unit has been consulted regarding the availability of additional data and reports.

Outside the ED, the project team has also liaised with the Short Stay Unit (Dolphin Unit) staff regarding paperwork and project requirements for CLD patients admitted to the ED observation beds. Feedback to date has been encouraging.
7.10  **Barriers and enablers**

The project sites identified a number of factors that hindered and others that enabled training and implementation activities. In most instances these factors have also been captured in the section below on reflections and lessons learned. The barriers predominantly raised are about role clarity in relation to the model of care, recruitment and retention and competency assessments. The major enabling factors in relation to training and implementation include collaborative development and improved access to resources. These are discussed briefly below.

7.10.1  **Role clarity/model of care**

The projects for implementation in rural regions (Murrumbidgee Local Health District and Kilmore Hospital) were developed in part to address the problem of limited medical cover in these geographic areas. However both of these project teams have needed to review their model of care to ensure that the expanded scope role as it relates to assessing and discharging patients remains within the accepted parameters of professional practice for the industrial classification of the nursing positions working within the EDs. This has generated some frustration for project teams but currently in Australia only Nurse Practitioners are authorised to practice independently and within their defined scope of practice, without medical review and nurses working outside their scope of practice may not have appropriate medical indemnity cover. The HWA Nurse Clinical Advisor has provided a range of suggestions to overcome this barrier including the use of telehealth, negotiating with medical staff to take calls overnight and/or negotiating to access medical staff after hours at other hospitals.

Most projects have been required to gain approval for certain elements of the model of care, such as the use of standing orders relating to providing medication or ordering pathology. For some project teams this approval process has taken considerable time to navigate. For Kilmore Hospital, the delay in implementing nurse x-ray has occurred in part because further consultation was needed with the lead radiology service provider and because of broader policy changes being negotiated by the Victorian Department of Health (Guidelines for Best Practice for Remote Operator X-Ray). The project manager is now a member of the Department’s expert reference group whilst at a local level the project team is working with their executive staff to develop a Memorandum of Understanding with the local radiology provider.

7.10.2  **Recruitment and retention**

Some projects have experienced changes in the ESOP staff and whilst this has the potential to impact on implementation, all project teams appear to have managed this situation. Prince of Wales Hospital has had a key ESOP nurse transfer to another hospital to take up a Nurse Practitioner appointment. Due to restrictions on recruiting new personnel, the other ESOP nurses working part-time are increasing their hours to cover this vacancy. At Royal Prince Alfred Hospital a departing Mental Health Clinical Nurse Specialist has been replaced with a newly recruited staff member.

Two project teams have had staff members withdrawn from the ESOP initiative during the training phase. For example, Kilmore Hospital had two of their six trainees withdraw from the project in February 2013 as they did not wish to complete all components of the training program; four candidates continue to be engaged. Murrumbidgee Local Health District has had four candidates withdraw from the project in the initial stages of the training program.

7.10.3  **Competency assessments**

Several projects have reported challenges in developing and implementing appropriate competency assessments. This includes a range of methodological issues including developing appropriate indicators of competency, ensuring consistent assessment and identifying strategies for staff who do not achieve competency.
For some the issue has been an inadequate volume of presentations to allow the trained personnel to demonstrate competency. Projects have implemented alternative strategies to address this, such as arranging placements in GP clinics to allow the nurses to meet their assessment requirements.

One project does not have the support of all GPs and Visiting Medical Officers reducing the available learning opportunities for ESOP nurses to consolidate and implement the knowledge and skills they have obtained. The project team is increasing communication with these medical officers in an attempt to address this issue.

7.10.4 Collaborative development

A positive enabling factor identified by many teams relates to the opportunity that the ESOP project has provided to work with other members of the health care team and collaboratively develop training, policies and processes and clinical guidelines. The Wollongong Hospital has engaged both nurse educators and the Mental Health Clinical Nurse Consultants working in the ED in the development of training packages. At Kilmore Hospital key stakeholders have contributed information that has assisted with the development of relevant policies and guidelines to support the expanded scope of practice. At Royal Prince Alfred Hospital, effective collaboration and consultation with ED medical and nursing staff, as well as the psychiatry team, has enabled useful feedback on the development and refinement of mental health liaison nursing team processes. Whilst at Sunshine Hospital, the Scope of Practice Committee and Pharmacy Utilisation Committee have assisted with the development of clinical guidelines to ensure safe practice by the nurses working in the ESOP role.

7.10.5 Improved access to resources

The funding provided by HWA has enabled some project teams to purchase training resources to facilitate skills development for the ESOP nurses and improve patient management. In one case it also allowed the project team to secure internet access so that nurses could utilise interactive training modules only available via YouTube.

7.11 Reflections and lessons learned

During the current reporting period the projects have been completing their training programs, and / or implementing their models of care. The training programs conducted are mainly internal programs consisting of education modules; some of these delivered by external providers and with competency based assessments. Those projects conducting training programs as part of their project are at varying stages of completion, from fully completed to finalising clinical competencies. In most projects, implementation has occurred ranging from initial implementation to full implementation.

These reflections and lessons learned draw upon feedback from the projects’ progress reports, the national workshop, through teleconferences, additional project documentation and ongoing contact with the project teams.

The key learnings that have emerged during this reporting period can be summarised as follows:

- The project scope / model of care needs to be clearly defined to ensure that the training and implementation planned is realistic and achievable. This may be enhanced by projects undertaking needs analysis for the change in practice of the expanded nursing roles.
- The project scope needs to be reviewed once the training program is completed and the implementation has started to ensure the project is still able to achieve their objectives.
The scope of practice for nursing positions needs to align with accepted industrial classifications specifically in relation to diagnosis and discharge needs as lack of clarity about these limits has delayed training and / or implementation in some projects.

A few projects had found that gaining approval for medication standing orders / nurse initiated medications has been slowed down by resistance from medical staff and internal organisational committees.

The development of training programs – especially the development of competencies and documentation of specific guidelines and pathways – requires expertise and support, and the time allocated to this phase was underestimated by several projects.

The attainment of clinical competencies is contingent upon adequate numbers of clinical cases. This has not always been possible with the current presentations, and projects have implemented other strategies to address this. However, this has impacted on the time frames initially proposed for training / competency completion.

Most of the training programs have been developed internally or access local resources such as the RCH four-day course. Though appropriate and cost effective for these projects, these training programs may not be easily transferrable to other sites.

Projects need to have a training strategy in place for newly recruited staff.

Those projects electing to recruit staff already trained and with the required competencies to deliver the ESOP model of care have been able to achieve full implementation within weeks / months of recruitment.

Implementation needs to be flexible as some projects have found once implementation has been underway that rosters, leave cover, and / or hours of service delivery needed to be changed from what was originally implemented.

Projects in the implementation stage, with either access to data and data analysis expertise, and / or quality improvement processes, are able to investigate and make improvements to issues affecting the implementation such as changes to the start and finish times, or the medication review protocols to reduce representations.

The range of stakeholder engagement strategies implemented have been effective in developing, supporting, implementing and reviewing the project activities.
8 Training and implementation: Extending the Role of Paramedics (ERP)

8.1 Overview

This project aims to support the national transfer and further implementation of critical elements of an existing Extended Care Paramedic (ECP) model that has been developed and implemented within metropolitan Adelaide by the South Australian Ambulance Service (SAAS). There are five project implementation sites: ACT Ambulance (Canberra), Ambulance Tasmania (Launceston), St John Ambulance Northern Territory (Darwin), SAAS (Mt Gambier / Limestone Coast) and SAAS (Port Lincoln / Eyre Peninsula). The SAAS model has provided a starting point for all project teams however every implementation site has had to adapt and make changes to aspects of the model to suit their available workforce, organisational needs and local health service infrastructure and context.

There is no lead site for the ERP sub-project; however SAAS opened access to its metropolitan ECP training program to other project teams. ECPs from ACT Ambulance, Ambulance Tasmania, SAAS Mt Gambier and SAAS Port Lincoln all attended the training program provided in Adelaide in October 2012. SJANT, because of their existing training arrangements with Edith Cowan University (ECU) had their ECPs attend the ECP training program developed by ECU.

As all project teams are implementing essentially the same model of care (allowing for local contextual adaptations), there is a high degree of similarity in the training pathways. These pathways are described in the sections below.

8.2 Description of the training pathway

8.2.1 South Australian Ambulance Service (Mt Gambier and Port Lincoln)

ECPs are intensive care paramedics who have completed further specialised intensive training, skills enhancement and placements. ECPs are highly skilled clinicians who work collaboratively with other health care professionals to manage and treat certain patients in their homes or own environments without requiring transport to hospital. SAAS operates the ECP program for all members of the community. ECPs operate within the scope of practice outlined in the SAAS Clinical Practice Guidelines for Intensive Care Paramedics and Extended Care Paramedics.

The SAAS ECP course is structured across eight weeks (refer to Figure 5). It was planned that the ECPs would spend week 1 - 4 focused on classroom teaching; week 5 and 6 experiencing clinical placements in the regional area and week 7 and 8 occupied with clinical placements in Adelaide and course assessments. This is followed by a four week internship, which usually includes sessions about the Emergency Operations Centre and South Australian Computer Aided Dispatch (SACAD) system. A key feature of the SAAS model is there is always a 24 hour ECP presence in the EOC. The EOC based in Adelaide tasks cases to ambulance crews across the State.

The didactic teaching phase is supported through the use of the ECP Internship Portfolio which recognises that ECPs throughout their clinical internship will progress through stages of development to reach proficiency. It aims to consolidate the ECPs knowledge with clinical practice. This process occurs through a combination of:

- Adult learning processes
- Supportive on-road direct supervision
- Supportive EOC supervision
- Clinical experiences according to clinical competence
It relies on access to competent and experienced ECPs to provide support and mentorship. The ECP – Clinical Internship is conducted over a five rotation period and includes on-road operation deployment and EOC deployment. The ECP completes ‘Intern Clinical Evaluation Reports’. Recognising that the ECP is an adult learner, the emphasis rests with the ECP to ensure they get the most out of the clinical internship and enhance their extended care paramedic skills. The internship also provides an opportunity for the ECPs to engage with GPs and community service providers.

The training course (originally designed for the metropolitan ECP program), includes a diverse range of presenters from within SAAS as well as a range of clinical experts from outside the organisation. The ECP course timetable for the classroom teaching component consists of a wide range of teaching sessions relevant to the role of the ECP and includes both theoretical and practical components. A substantial part of the clinical content was delivered by Professor Hugh Grantham (former Executive Director Clinical Services, SAAS).

The clinical placements arranged within Adelaide for ECPs were offered with various health professionals (medical specialists, nurse practitioners and allied health personnel). They included a range of facilities for example, Royal Adelaide Hospital, The Queen Elizabeth Hospital, Royal District Nursing Service, Lyell McEwin Health Service, Modbury Palliative Care Service etc. The intent of the placements is to provide ECPs with practical experience in a range of clinical skills such as wound care, suturing, catheter insertion, management of percutaneous endoscopic gastrostomy (PEG) feeding tubes and assisting palliative care patients with pain management in the community.

The major change in training from the usual metropolitan ECP training pathway related to the inclusion of regional clinical placements. In Mt Gambier these occurred with GPs, Mt Gambier A&E, Palliative Care, Community Nursing, Residential Aged Care Facilities (RACFs) and the local Better Care Coordinator. In Port Lincoln the placements occurred with GPs, Port Lincoln ED, Port Lincoln Aboriginal Health Service, Palliative Care, Community Nursing, and the Better Care Coordinator.

The four week internship commences after the clinical placements are completed. For the SAAS Mt Gambier project team the internship was predominantly spent in the Limestone Coast with the two country ECPs working with each other to form a crew under the mentorship of Dr Trevor Burchall (Director of Emergency Medicine, Mt Gambier ED). During this internship they also planned a one week rotation with an ECP in metropolitan Adelaide. This approach was taken to reduce the time the ECPs spent away from home for training purposes.

The ECPs from SAAS Port Lincoln participated in the same training pathway however returned to Port Lincoln for their regional clinical placements and internship. The nature of the clinical placements differed slightly to those planned for the SAAS Mt Gambier ECPs reflecting the availability of local primary care service providers. The SAAS Port Lincoln ECPs work as both first and second responders so their opportunity to gain experience in the ECP role has been influenced by the volume of emergency cases during the training and implementation period. The SAAS Mt Gambier and SAAS Port Lincoln ECPs did not complete the EOC training sessions as they will not work in the EOC, as this is only possible when ECPs are based in the metropolitan region.

SAAS has the ability to utilise teleconference / video conferencing facilities for training, coaching and ongoing supervision of the ECP staff. E-learning and online delivery to supplement the course content is also available in SAAS. The local clinical coordination committee in each SAAS project implementation site is responsible for reviewing the clinical needs of the ECPs and identifying ongoing training requirements.
The objectives of the SAAS ECP course are detailed and comprehensive. A summarised version is provided below.

The course aims to:

- Provide an overview of the equipment used by an ECP (ensuring the ECP becomes familiar with all aspects of the ECP vehicle), administrative processes specific to the ECP and SAAS media management principles.
- Provide an overview of the clinical audit process (including the purpose of clinical audit and relevance to ECPs) and the ECP ED avoidance audit.
- Provide a basic understanding of microbiology, immunology and inflammatory response.
- Enhance the ability of the ECP to evaluate the cardiovascular system, respiratory system and central nervous system.
- Provide the ECP with an understanding of the processes and role of pathology, specifics of sample collection, ability to interpret pathology results, signs and symptoms seen clinically that may be explained by abnormal pathology, presentation of a range of infections and their clinical management in the community, including the ability to carry out and interpret the results of point of care testing using the i-STAT machine.
- Illustrate the role of General Practitioners in primary health care to the ECP.
- Enhance the ability of the ECP to evaluate and manage simple ear, nose and throat problems, diabetes and its management in the community, evaluate minor injuries including musculoskeletal injuries of the upper and lower body.
- Provide the ECP with comprehensive knowledge concerning the pharmacology of medications both carried by an ECP and commonly encountered in the community (with a particular focus on pain management).
- Enhance the knowledge of the ECP of the various options available for definitive care and improve clinical judgement in this area including addressing problems with the elderly, legal and ethical issues presented through their role.
- Provide the ECP with the ability to evaluate and formulate management plans for management of cases in the community with a focus on the ECP clinical practice pathways including.
suturing and wound care, insertion of catheters, insertion of PEG tubes, support for palliative care patients

- Provide the ECP with the knowledge to use the SA Health Open Architecture Clinical Information System (OACIS) and workplace procedures relevant to their role with a particular focus on the Emergency Operations Centre.

Assessment requirements are customarily outlined at the commencement of the ECP program. It appears there was some confusion amongst participants about the country specific assessment requirements for ECPs. At the end of the four week didactic period students participated in an assessment process that was conducted by Professor Grantham and included an ‘On site Clinical Examination’ and an oral viva. During the clinical internship each ECP is required to complete a minimum of eight clinical case audits. The ECP Internship Portfolio notes that ‘Recognition of a gradient of advancement in Extended Care Paramedic clinical practice will be paramount developing to proficient’. The SAAS Mt Gambier ECPs are able to access the existing monthly clinical auditing process afforded to metropolitan ECPs. This is a well-established peer / medical officer case review system and provides an avenue for education and clinical quality control. The SAAS Mt Gambier project team found the inclusion of their local medical mentor in the assessment process to be beneficial for ECPs.

8.2.2 ACT Ambulance Service (ACTAS)

ACTAS outsourced their ECP training to SAAS and all ECPs attended the four week lecture block in Adelaide in October 2012. SAAS was seen to have a well-established and proven training program for ECPs and because of the small number of ECPs proposed for the ACT, this method was considered to be the most cost efficient and effective way of delivering this training. The ECPs returned to the ACT to undertake site specific training for another four weeks followed by a period of internship. It was intended that the ACT Ambulance Service Education Unit would develop the ACT specific training required to provide context to the ACT setting and also coordinate the clinical placements. This was to involve input from stakeholders to provide an understanding of the services they provide and how they will interact with the ECP. It is unclear to what extent this occurred in practice.

The clinical placements for the ECPs in the ACT were coordinated consistent with the process for other clinical placements. The project team was responsible for negotiating these placements which proved challenging within the available timeframe. ACT Ambulance is not managed by the ACT Health Directorate and is one of four operational arms of the ACT Emergency Services Agency, which form part of the Directorate of Justice and Community Safety. The public health facilities most suitable for clinical placements are under the jurisdiction of the ACT Health Directorate. Initially the ACT Health Directorate had concerns about medical liability for the ECPs and wanted ACTAS to enter into a specific deed of agreement, eventually this was resolved as there is a Territory wide medical liability agreement and this covers paramedics working in hospitals.

Clinical placements ended up being more limited than originally planned. Clinical placements have been identified as a critical element of expanding the clinical role of paramedics particularly in the areas of geriatric medicine, community nursing and palliative care. Local clinical placements were identified as an area that could be improved particularly in identifying specific areas for placements and better coordination. Additionally, the outcomes and objectives required of the clinical placements could have been communicated better. The ECPs mentored each other for a period of time to assist with the implementation of the extended role, however during this period there was a relatively small number of cases, so in retrospect this period of time should have been extended.

The ACTAS Clinical governance committees required documentation about the model of care, expanded scope of practice, clinical guidelines and training requirements which had to be developed. The ECP Scope of Practice and Clinical Practice Pathways were discussed by the
ACTAS Clinical Advisory Committee with the ECP Clinical Practice Pathways complementing existing ACTAS Clinical Management Guidelines.

ACTAS negotiated an arrangement with the Capital Region Retrieval Service for medical mentoring for their ECPs; in the event that the medical personnel are unavailable then ECPs can contact the Emergency Department consultants at Canberra Hospital. ACTAS had no ECPs to mentor the new trainees on the road and this has been a disadvantage. Arrangements have also been put in place to provide the ECPs with access to the ED for skills maintenance.

ACTAS identified a range of issues with the didactic training component provided by SAAS. For example, they identified that there is a need to contextualise the training and adapt sessions to meet local needs and practices. Comments were received that more comprehensive learning objectives and lecture notes, which could act as a future resource, were needed for ECPs returning to other States and Territories, particularly considering the absence of other ECPs or medical experts with extensive experience in mentoring ECPs.

ACTAS ECPs underwent the same assessment processes as the SAAS ECPs. Professor Grantham travelled to Canberra to complete the ‘On site Clinical Examination’ and an oral viva.

8.2.3 Ambulance Tasmania (ATAS)

The chosen candidates for the Ambulance Tasmania ECP program were provided training based against a curriculum using the SAAS ECP program as the basis or standard. Ambulance Tasmania also decided to send their ECPs to the four week didactic component of the SAAS training program. The small number of ECPs proposed for Ambulance Tasmania meant that outsourcing to SAAS was the most cost efficient and effective way of delivering this training.

Ambulance Tasmania has had to customise the model as it was originally designed for a metropolitan setting and Launceston requires a more regional or rural model. A gap analysis was completed against current clinical competencies of the Ambulance Tasmania Intensive Care Paramedic and the clinical competencies specified in the SAAS ECP program. This resulted in a bridging program of eight weeks duration, inclusive of clinical placements. During this period three in-house training days occurred. The clinical placements occurred in various locations across the northern region of Tasmania. These placements have been reported as very valuable and encompassed a range of communities surrounding Launceston including Beaconsfield, Longford, Westbury / Deloraine, and George Town. Several facilities were included such as Ashleigh Detention Centre, Launceston General Hospital and the Diabetes Centre (Northern Integrated Health Centre). A four day placement with Launceston General Hospital provided diverse clinical experiences in for example, general medicine, allied health, pathology, plastics, burns and emergency medicine. There were also placements with community nursing, palliative care and the Diabetes Centre at Northern Integrated Health Centre.

Ambulance Tasmania invested significant effort into developing Clinical Practice Protocols with a well-defined scope of practice for ECPs and these were released in April 2013. Whilst the SAAS model had ECP Clinical Practice Pathways these were specific to the South Australian context. The Ambulance Tasmania ECP protocols have been developed in consideration of local context and have been recommended by the Tasmanian Ambulance Clinical Council (TACC) and approved by the Chief Executive Officer for use by ECPs when working for Ambulance Tasmania. The protocols represent a multi-disciplinary consensus based on evidence and expert opinion regarding common extended care problems encountered in the pre-hospital setting. The main differences between standard practice within Ambulance Tasmania and the ECP protocols is the extensive range of medications available including the use of antibiotics and a wider range of analgesia. ECPs are also authorised to perform urinary catheterisation and have a greater focus on wound care including suturing and applying wound care glue. To ensure clinical relevance and competency is maintained, the ECP program has been enveloped into the Ambulance Tasmania clinical governance framework in entirety.
The Tasmanian Medical Director, General Practice and Primary Care, agreed to participate as a project member, and provide medical mentoring for the ECPs. The ECPs are also working to develop their own network of medical contacts as a further source of advice and assistance. For example, Launceston based Palliative Care Specialists have provided the ECPs with their mobile telephone numbers in the event they need support in caring for palliative care patients. The ECPs perceive that this was a direct result of their clinical placement with the palliative care service.

Since the initial training was completed in late 2012, the Ambulance Tasmania ECPs have not undergone any further training and/or evaluations (it is to be noted that the Ambulance Tasmania ECP staff have attended all internal training as required by Ambulance Tasmania). Ambulance Tasmania is unsure of the expected requirements of further training in relation to the ECP program. As an organisation Ambulance Tasmania is supportive of training elements being reviewed on a broader scale and in recognition of this issue the position of Project Manager has been revised to include 0.2 FTE for education and training. Ongoing education and training requirements are not specified in the SAAS model and no budget allowance has been allocated through the HWA project funds to ensure competency of staff is maintained.

Ambulance Tasmania has a structured training system based upon Regional Training Units (RTU), the Regional Education Coordinators (REC) are tasked with providing training, which may include Clinical Practice Guideline familiarisation, identification of audit specific parameters, in-field audit training and other areas as required, to Clinical Support Officers (CSO) and other members of the RTU. CSOs oversee and/or conduct the majority of clinical reviews for their region with the view that outcomes from clinical audits may lead to opportunities for further training and education. The training needs of the ECPs will need to be incorporated into this existing system.

The Ambulance Tasmania ECPs saw value in participating in the training as part of a group and being able to interact with the SAAS and ACTAS ECPs. These networks were maintained after the completion of the face-to-face training with ECPs using this peer network for information and support. Ambulance Tasmania personnel commented that more clearly articulated learning outcomes and supporting notes would provide a useful reference.

The Ambulance Tasmania ECPs did not participate in any form of assessment after completion of the SAAS four week didactic training component. Consequently Ambulance Tasmania has expressed concern that they have received no official evaluation or learning outcome documentation.

8.2.4 St John Ambulance Northern Territory / Edith Cowan University

St John Ambulance Australia NT (SJANT) pursued a different training approach as they had a pre-existing contract with Edith Cowan University (ECU) which included provision for ECP training. The training was provided through a combination of distance education, in class teaching (including simulation) conducted in Darwin by ECU educators and clinical placements in West Australia before returning to Darwin for further placements. The program has been facilitated by ECU’s Paramedical Science program in partnership with SJANT. On completion of the unit assessments students are eligible to claim up to four units within the Master of Science (Paramedical Science) or to elect to be awarded a Graduate Certificate.

Students began this training pathway, phase 1, in October 2012 which focused on preparing participants for the ‘in-class’ sessions through the use of e-learning modules which extended over approximately eight weeks.

Phase 2 commenced with a two week intensive ‘in-class’ program completed on 21 December 2012 encompassing the majority of the new physical skill and applied knowledge requirements of the ECP. The students continued to work through the six online learning modules:
Module 1: The expanded role and introduction to the expanded examination (The Role, Taking a Complete History, The Expanded Physical Assessment, The Paediatric Assessment)

Module 2: Physical examination (Examination of the Head and Neck, Examination of the Back and Extremities, Examination of the Chest and Lungs, Cardiovascular Examination, Abdominal Assessment, Examination of the Eye, Neurological Examination)

Module 3: Chronic disease management 1 (Introduction to Chronic Disease Management, Chronic Heart Failure, Chronic Obstructive Pulmonary Disease, Heart Disease, Hypertension, Respiratory Infections)

Module 4: Chronic disease management 2 (Diabetes Mellitus, Gastrointestinal disorders, Genital / Urinary tract problems, Fever, Dehydration)

Module 5: Chronic disease management 3 (Dermatologic problem management, HEENT, or Head, Eye, Ear, Nose and Throat problem management – ear / nose / throat unit, HEENT problem management – ophthalmology unit, HEENT problem management – oral / dental unit)

Module 6: Common syndromes in aged care (Constipation, Delirium and Dementia, Falls, Depression and Urinary incontinence).

Each module includes learning materials, assessment criteria and learning outcomes. Modules covering cultural competence, ethics and law in health practice were delivered to ensure the new scope of practice was contextualised to include application of these areas of scholarship. Visiting lecturers from ECU and other appropriate teaching facilities and programs were employed to deliver the program.

Phase 3 of the training pathway aimed to supplement the in-class learning with 120 – 160 hours of clinical placement which included two weeks at Fremantle Hospital and where possible a further one to two weeks in a large GP clinic in Darwin and / or an Aboriginal health clinic where possible. Practicums and placements were scheduled in both West Australia and the Northern Territory (NT) during January and February 2013. ECU facilitated clinical placement agreements with the Department of Health NT for the NT public hospitals including Royal Darwin Hospital. Other clinical placement agreements with stakeholder providers are progressively being formalised through individual ECU / community clinic agreements (refer to Figure 6).

Figure 6 SJANT/Edith Cowan University ECP Training Pathway
The course learning outcomes are provided below, at the completion of the program the student will be able to:

- Describe, the anatomical and physiological processes associated with maintaining and / or restoring homeostasis;
- Apply pathophysiological concepts to the clinical management of individuals or groups experiencing altered homeostasis;
- Examine the range of therapeutic and rehabilitative approaches that may be applied to individuals or groups experiencing altered homeostasis within primary health care setting;
- Apply research findings within area of primary health;
- Apply advanced theoretical knowledge in their area of clinical practice;
- Evidence significant progress towards achieving clinical competence within an area of primary health care;
- Integrate the findings of research into clinical practice within an area of primary health care;
- Apply knowledge of psychosocial support to patients and significant others with complex needs including those from diverse cultures;
- Discuss the implications of pertinent legislation and ethical frameworks in the delivery of primary health care;
- Apply a theoretical knowledge of anatomical and physiological processes to interventions and therapy that maintain and / or restore homeostasis within this area of paramedical specialisation;
- Evaluate the range of therapeutic and rehabilitative approaches that may be applied to individuals / groups within this area of paramedical specialisation;
- Evaluate the effect of cultural, psychological, ethical and legal issues on complex clinical decisions and management policies regarding patient care;
- Demonstrate skills sets appropriate for advanced physical examination on a patient;
- Analyse signs and symptoms associated with common medical presentations and prioritise care for those patients;
- Apply effective communication skills in order to perform as part of a health care team;
- Demonstrate an understanding of issues unique to the primary health care role such as triage, patient referral and treatment under direction of authorised clinical practice guidelines.

Assessment was conducted by ECU personnel and consisted of the compilation of a portfolio that included an assignment, two reflective case studies and the use of a clinical log to demonstrate competencies in several clinical domains. In addition ECU developed Clinical Practice Guidelines and medication guidelines specifically for the program.

### 8.3 Training entry requirements

The recruitment and selection process undertaken by each project site has been documented in Evaluation Progress Report 1 (Thompson et al, 2013). All ERP project sites used similar selection criteria to that used by SAAS. Whilst position descriptions were developed in accordance with local conventions, the SAAS ECP position description provided a useful reference point. All project teams followed their established organisational processes for recruitment and selection. This varied from an Expression of Interest process through to internal advertisement of the ECP positions.

For the SAAS Mt Gambier and SAAS Port Lincoln projects, the selection process was conducted in accordance with SAAS protocols and by a panel of four to five personnel, including experienced ECPs and Professor Hugh Grantham (Professor of Paramedics at Flinders University and former

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Executive Director of Clinical Services, SAAS). In addition to responding to a series of interview questions, candidates participate in a role play (they are given 30 minutes preparation time and a collection of case notes for a fictitious patient and asked questions about their management of the patient based on the information provided). The only modification to the selection criteria was to restrict applications to Intensive Care Paramedics (ICPs) in the SAAS Mt Gambier region (there were eight ICPs eligible at the time of recruitment). In addition, the process included an emphasis on applicants’ understanding of research, rural workforce issues, and rural health issues. The successful applicants also needed to be willing, and have the capability, to be involved in the future development of the local and national extended scope of practice research, including stakeholder engagement and data collection. SAAS Port Lincoln restricted applications to ICPs from Port Lincoln. There were six ICPs that were eligible to apply from within the region. In the instance that the available selection pool did not produce any successful applicants, the application process was to be opened up to eligible ICPs across the organisation.

The SAAS model does not specify training entry requirements; it is assumed that participants have already met the essential minimum criteria for the ECP role which are outlined below.

- **Educational/Vocational Qualifications:**
  - Two years post qualification authority to practice as an Intensive Care Paramedic (ICP) within SAAS

- **Experience in the following:**
  - Demonstrate advanced level of pre hospital clinical practice.
  - Providing leadership in the out-of-hospital environment.

- **Knowledge of the following:**
  - SAAS’ strategic planning process, including how it links to the development of annual plans, goals, objectives and individual performance plans
  - Legislation, regulations, codes of practice, policies, standard operating procedures relevant to the role
  - Operational reaccreditation processes
  - Human resource and performance management principles and practices

- **Personal Abilities/Aptitudes/Skills in the following:**
  - Demonstrated ability to work as an autonomous practitioner.
  - Effective leadership skills including highly developed skills in communication, problem solving, conflict resolution and negotiation.
  - Demonstrated ability in the facilitation of change management.
  - Demonstrated flexibility, innovation and creativity which can be applied to the Health setting.
  - Demonstrated advanced clinical skills.
  - Demonstrated ability to participate in high quality research.
  - Use of Microsoft desktop products, such as Word, Outlook and Excel

Desirable criteria include a tertiary qualification in a health discipline and commitment to workplace values.10

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10 SAAS Metropolitan Patient Services – Job and Person Specification Extended Care Paramedic, Classification ECP5.1, dated 27 April 2012.
ACTAS adopted selection criteria from an existing expression of interest process for a clinician working group due to parallel requirements. In addition they used the selection framework from SAAS to support identification of most appropriate staff. For example, the interview questions used by ACTAS were developed and based on the interview process from South Australia.

Ambulance Tasmania had only 72 hours to select candidates prior to the commencement of the SAAS training so used an Expression of Interest process that was open to all ICPs in the State. Ambulance Tasmania through an interview process looked at candidates who possessed positive characteristics in problem solving, interpersonal skills, communication, clinical knowledge and capacity for extended practice.

Consequently for the project teams at SAAS Mt Gambier, SAAS Port Lincoln, ACTAS and Ambulance Tasmania, selection as an ECP was the key criteria for entry into the training program.

SJANT recruited from within their organisation and in response to operational needs and ECP program requirements, candidates were recruited as ECP / Station Officers (ECSO). The training developed in conjunction with ECU includes a defined entry pathway into further studies. The selection criteria for the ECP role are outlined below:

**Essential criteria**
- Paramedic with current authority to practice with minimum of 2 years on road experience in this capacity.
- Demonstrated ability to lead a team of Paramedics.
- Exceptional ability in clinical auditing and providing performance feedback to team members.
- Excellent communication skills (written and oral) in a multicultural environment.
- Synthesise appropriate, patient centred individualised management strategies.
- Demonstrate advanced communication and negotiation ability in order to achieve the optimum patient centred outcome.
- Demonstrate an advanced awareness of the wider medical / political environment and the interactions with other members of the health professional team.
- Demonstrate appropriate decision making ability in selecting treatment options for a range of clinical presentations up to and including complex patients with multiple co morbidities, drug interactions and logistical constraints.
- Demonstrate understanding of the implications of abnormal pathology and microbiology results.
- Formulate and initiate ongoing patient care plans that are patient centred and involve the whole multidisciplinary care team.
- Achieve minimum service requirement in a service theory and protocol test.

**Desirable criteria**
- Intensive Care Paramedic with current authority to practice.
- Demonstrate maturity and appropriate soft skills such as resilience and flexibility for an advanced clinician representing the organisation.
- Be a current approved workplace assessor / on-road tutor or have the ability to obtain this.

**8.4 Training progress and outcomes**

The majority of ECPs in the implementation sites have completed their training, including:
- SAAS Mt Gambier – three ECPs
- SAAS Port Lincoln – two ECPs
- ACT Ambulance Service – four ECPs
- Ambulance Tasmania – two ECPs
- St John Ambulance NT – four ECPs

SAAS Mt Gambier has trained three ECPs and all three have completed the didactic component, clinical placements, regional clinical placements, exam and assessments. One ECP had to complete some additional rotations to provide some further training and support. The ECPs were ready for deployment by the 31 December 2012. Two ECPs work to a flexible rostering model (7.00am – 6.30pm) seven days a week with an additional ECP trained to provide back up and holiday relief. The local medical mentor was also involved in the assessment process for the ECPs.

SAAS Port Lincoln has selected three ECPs with two attending the October 2012 training and the third participating in the March 2013 training program. These ECPs are working in a dual role providing both emergency and ECP response as part of a two person crew. This crew is given preferential assignment to ECP call outs but remains part of the normal emergency operations in Port Lincoln. Two staff members have successfully completed their assessment processes and internship. In recognition of ongoing mentoring requirements SAAS has allocated funds for additional mentoring in the 2013/2014 financial year.

The four ECPs from ACTAS have completed their assessment requirements (as noted previously the ECPs were assessed by Professor Grantham on site in Canberra).

Ambulance Tasmania decided not to utilise the SAAS assessment methods and the two ECPs have not completed any assessment tasks.

For SJANT, all ECPs have completed the two week theoretical and practical placement and related assessment tasks. Several are still working through their academic log books and portfolios and training is expected to be ongoing. Some of the ECPs have indicated that after spending time ‘on-road’ they have identified additional training needs. For example, several ECPs have indicated interest in obtaining more suturing experience. There have been delays in finalising clinical placements for one SJANT ECP, due to competing work demands in the first six months of this year.

As the ECPs gain confidence in their role they will inevitably identify other patient groups suitable for their skill set and this may necessitate further training. Most project teams are relying on existing organisational processes for ongoing professional development to identify and address these emergent training needs. As SJANT did not have access to experienced ECPs they have provided additional support and mentoring through a new Paramedic Training Officer. The project team has also instituted weekly meetings with the ECPs to review cases and promptly address any issues arising during the previous week.

Interviews with ECPs are still underway at the time of preparing this report, however feedback from ECPs, project managers and team members to date shows that the training provided (irrespective of the provider) has generated ECPs who are ‘fit for purpose’ and demonstrating safe and appropriate clinical practice. The training appears to have been ‘manageable’ and ECPs were accepting of the need to be away from home for several weeks to complete different training components.

Since the start of this initiative all project teams have reported that they have been approached by other staff interested in participating in the ECP training pathway.
8.5 Implementation of the model of care

8.5.1 SAAS Mt Gambier

SAAS Mt Gambier ECPs became operational on 31 December 2012 and consider they have achieved full implementation status. As SAAS already had ECPs as part of their service delivery model all the necessary procedures and work instructions were already in place. The main change that has had to be addressed is ensuring the personnel in EOC and existing ECPs working in metropolitan Adelaide, understand the reality of working in a regional and rural environment. The roles that the Country ECPs (a term used by the Mt Gambier and Port Lincoln project teams), will perform will be slightly different to those of their metropolitan counterparts; this is a reflection of their location. Ongoing education of staff to improve understanding of the different aspect of the ECP role is occurring in conjunction with the country ECPs and existing staff. Due to an increasing workload in Mt Gambier there were some concerns that the ECPs may be seen as a resource that can be used as a backup crew for emergency work. This has resulted in a need for clear communication with EOC staff that if there is an alternative that can be used as a solo responder (i.e. Operations Manager, Clinical Team Leader or Regional Team Leader) that they should be dispatched prior to the ECP being dispatched for any emergency work.

8.5.2 SAAS Port Lincoln

SAAS Port Lincoln ECPs also became operational from 31 December 2012. The hours of ECP cover have been affected by the ability to initially recruit only two ECPs (originally it was intended that six ECPs would be appointed). As noted previously a third ECP is currently undergoing training but this person will not be operational until the end of August 2013. Two of the three major GP Clinics in Port Lincoln are very supportive of the program and have accommodated the ECPs for clinical placement days, which were of extreme benefit to the ECPs and helped establish relationships with clinic staff. The third GP clinic is showing interest in working with the ECP, however not all GPs based within this service are fully supportive of the role. The ECPs are reportedly engaged in the role and whilst the ECP case numbers are not large they are slowly increasing. The project team report that appropriate cases are being identified for the ECPs.

8.5.3 ACT Ambulance (ACTAS)

ACT Ambulance has trained four ECPs who are working to a seven day peak demand roster. The ECPs are additional to the current frontline resources. ECPs currently work as single officers seven days a week, twelve hours per day from 10.00am – 10.00pm. The ECPs do not have a dual function as an emergency ambulance resource with the exception of critical emergency cases (such as cardiac arrest) where they are the closest available resource. The ECP roster commenced on 14 January 2013 and has a focus on mentoring and building ECP confidence and capacity in the role. The scope of practice and clinical practice pathways were not signed off until 20 February 2013 after endorsement from the ACTAS Clinical Advisory Committee. The ECP roster was suspended for a period of two weeks from 8 – 23 February 2013 until the clinical practice pathways and scope of practice were signed. The implementation phase has proved difficult mainly due to time constraints. The requirement of establishing clinical structures, protocols, and frameworks along with the development of policies, procedures and reporting lines has been very challenging in the period of time allocated. The implementation process would be improved if clinical governance arrangements and related policies and procedures were formalised prior to the commencement of a project of this magnitude.

There has been an increase in caseload of the ECPs especially over the past 3 months. This is explained by the evolution of the capability including approval of the expanded scope of practice and increasing familiarisation with the capability by both internal and external stakeholders. Anecdotally, it would appear that the majority of cases relate to pain management, tube replacement / maintenance and wound management. These areas were a focus in both the initial didactic training and clinical placements. Following development and implementation the ECP
The capability is being managed within the existing ACTAS management structure. The ECPs report through an Operations Manager to the General Manager (Operations).

8.5.4 Ambulance Tasmania (ATAS)

The two full-time Ambulance Tasmania ECPs are supernumerary to the Launceston operational roster and commenced in mid-January. They work four shifts on and four shifts off (12 hours per day) from 10.00am to 10.00pm. The ECPs commenced on-road in mid-January however they could not work to the full scope of practice until their Clinical Practice Guidelines were signed off by their organisation. The ECPs caseload is determined by the current dispatch grid and ECPs respond to cases deemed relevant to the program. They also respond to cases of all categories and types in order to maintain clinical skill and competency as per normal dispatch methods. Some referrals also arise from front-line Ambulance Tasmania crews and local health providers. A transfer of delegation of operational matters occurred in March 2013 to Northern Region – with the aim of streamlining these processes for the ECPs as they were previously dealing with the Project Manager based in Hobart for all issues. The ECPs are working effectively and have applied themselves well. Due to restrictions generated by the Tasmanian Poisons Act the ECPs are still unable to utilise the full spectrum of pharmacology. Ambulance Tasmania has also decided to defer implementation of the i-STAT machine and patient point of care testing, until it can ensure that reporting and follow-up processes are established within an the Ambulance Tasmania clinical governance framework.

Ambulance Tasmania has made a significant investment in developing Clinical Practice Protocols for the ECPs. Each protocol clearly outlines the practice levels for Extended Care Paramedics. Staff are responsible for ensuring they only operate within their approved scope of practice and should contact the Clinical Services Division for clarification regarding practice approvals if required. Ambulance Tasmania does not currently support the model of an ECP being situated in the Communication Centre. This is providing a barrier in being able to “hand-pick” or select appropriate ECP based jobs. In order to counter this, the ECPs have been set-up with access to the northern region caseload enabling them to self-select jobs that they feel may be relevant to their scope of practice. The implementation phase of the project has been aided by the high level of acceptance by the northern region General Practitioners and the wider allied health community. There were some delays that arose because of the limited time allocated within the project framework to implement a safe and workable scope of practice and accompanying guidelines. This resulted in the ECPs being not as effective in the first six weeks of implementation.

8.5.5 St John Ambulance Northern Territory

SJANT has trained four Extended Care Station Officers through ECU with hospital based clinical placements occurring in West Australia. The ECP training was aligned to the SAAS curricula. The ECPs commenced operations on the 20 March 2013. The SJANT Medical Director is providing medical mentoring however most direct clinical supervision is occurring through the Paramedic Training Officer. The SJANT ECP Clinical Practice Guidelines were developed to define the clinical care that would be within the scope of the ECP and the agreed process for the performance of specific clinical skills for all operational staff. These guidelines have resulted from collaboration between the SJANT Director of Operations and the Medical Director. The Medical Director of SJANT is an emergency physician with extensive experience in emergency care, pre-hospital, disaster and retrieval medicine. This combination of medical expertise in general practice and emergency / critical-care, is perceived to provide an ideal medical support base for the ECPs.

8.6 Stakeholder engagement strategies in training and implementation

The major focus of stakeholder engagement during this reporting period has been two-fold. Firstly, formal and informal communication activities have been implemented to engage stakeholders in both the primary care and emergency sector about the role of the ECP and build support for the role. Whilst most of this engagement occurred during the project set-up phase,
project teams report there is an ongoing need for communication about the role of the ECP both within and outside their organisations. This has been particularly important in relation to clinical governance processes and gaining support for ECP specific clinical guidelines and pathways. Project teams that have established ECP Steering Committees / Clinical Coordination Committees with multi-disciplinary representation have found this a useful means of stakeholder engagement.

The second focus has been on arranging clinical placements for ECPs to ensure they create the professional and referral networks essential to their role. **SAAS Mt Gambier** has experienced good engagement with the majority of service providers and is strengthening relationships with Country Health SA. The project team has also investigated opportunities for joint research and evaluation activities with the Flinders University Rural Clinical School which has personnel based in Mt Gambier.

**SAAS Port Lincoln** has used their Clinical Coordination Committee as a way of engaging other clinicians particularly through the case audit process.

**ACTAS** has reported that stakeholder management has been one of the biggest challenges for this project. There appears to be a poor understanding of the role of ambulance in the primary health care setting by a range of external stakeholders. This poor understanding can result in a lack of acceptance of the ECP concept and has been hampered by the short lead time for the project which did not provide enough time for stakeholder engagement.

**Ambulance Tasmania** has advised that consultation is ongoing in areas such as pathology and the part that these service providers may play in the ECP project, along with continued dialogue with the Launceston General Hospital ED.

**SJANT** has found that ongoing engagement is needed with the Indigenous community particularly with other health care providers and agencies to establish effective referral pathways. They have also identified the need for a dedicated resource for GP liaison. Whilst responses from the GP community have been positive, there is further work to be done to strengthen these relationships. The establishment of a clinical placement agreement between Edith Cowan University and the Department of Health NT for NT public Hospitals including Royal Darwin Hospital has been one of the most significant gains during this reporting period. This will enable SJANT ECPs to complete clinical placements locally. ECU played an important role in facilitating this arrangement.

### 8.7 Barriers and enablers

Through project progress reports and telephone interviews, project teams have identified a range of barriers to progress and factors that have supported or enabled their implementation of the ECP initiative. Barriers and enablers related to a range of issues have previously been detailed in Evaluation Progress Report 1 (Thompson et al. 2013)\(^{11}\). For the sake of brevity only summarised issues pertinent to training and implementation are included in this section of the report. Barriers are addressed first and include: clinical placements, case identification, prescribing, and balancing training and implementation phases. The key enabling factors relevant to training and implementation include: support from external parties and network development.

#### 8.7.1 Clinical placements

The clinical placements have been identified by project teams as an integral component of the ECP training program. For most project teams these were something new that had not occurred previously for paramedics in their locality, this meant that considerable time and effort was needed to arrange these placements. This was compounded by the short set-up phase and also by a lack

of clarity as to which placements might be most beneficial for the ECPs. The SJANT team benefitted enormously from its relationship with Edith Cowan University as they provided a Clinical Placement Coordinator who not only arranged placements in West Australia for the ECPs but has gone on to negotiate local arrangements with Royal Darwin Hospital and other service providers for clinical placements within Darwin.

8.7.2 Case identification

Each project team is using existing call dispatch systems with ECPs allocated cases through the State or Territory based Emergency Operations Centre or equivalent. In SAAS project sites an ECP is based in this centre to facilitate appropriate case identification. The SJANT team has a clinical resource within the Joint Emergency Services Call Centre. All project teams have acknowledged that non ECP personnel working within these centres have established ways of working and change management is needed to help them adapt to the ECP role. An efficient way of identifying ECP cases and tasking crews is critical to success. This can be difficult when there are varying levels of ECP cover in certain sites that have to be understood by call centre staff operating on a State wide basis, and usually from a capital city.

8.7.3 Prescribing

Project teams from ACTAS and Ambulance Tasmania have commented on the inability for their ECPs to ‘supply’ / prescribe medicines, particularly antibiotics as this limits the management of specific cohorts of patients in their own residence. The issue of prescribing for health professionals goes beyond the boundaries of this ECP initiative and should be referred to HWA’s Health Professional Prescribing Pathways project.

8.7.4 Balancing training and implementation phases

The focus throughout this project has been on the implementation of the ECP role. Most project teams have expressed the view that it may have been more efficient to develop the model of care and supporting clinical guidelines and resources separately from implementation, as trying to do both of these things at the same time has proved difficult. This was exemplified by the lack of a defined scope of practice which project teams new to the ECP model needed to improve understanding and acceptance of the ECP role, skills and procedures. The development of this resource took some project teams close to three months and involved extensive consultation with internal and external health care providers. This in turn, has impacted upon the capacity for the ECP to implement all aspects of their role.

Lack of flexibility in Departmental policy for travel for a four week period – necessary for ECPs attending the SAAS didactic training component – was an issue for one project team.

8.7.5 Support from external parties

SAAS Mt Gambier has been particularly encouraged by the support provided by the Director of the ED at Mt Gambier Hospital and SAAS Port Lincoln by the support of local GPs. A range of clinicians have offered to support ECPs across all project sites, without any expectation of remuneration and a genuine desire to assist with the implementation of the project.

The project teams from ACT Ambulance Service and Ambulance Tasmania were extremely appreciative of the support provided by SAAS through opening access to their training program to their ECPs. Without this support it is unlikely that these jurisdictions would have been able to achieve the required implementation timeframes. The ECPs who participated also found it extremely useful to be part of a broader group of trainees and they have maintained contact with each other and shared information and resources via email and file share applications.
SJANT were highly satisfied with the training and support provided by Edith Cowan University for their ECPs. The assistance with arranging suitable clinical placements and monitoring assessment tasks was invaluable.

8.7.6 Network development

Another enabling factor has been the networks that have developed throughout the ESOP project. Paramedic services have a reputation for collegiality and co-operation and there is evidence of a high level of sharing of resources and information between project teams.

The implementation of the ECP role has also encouraged project teams to develop a range of new networks within their communities. This has occurred through various means, such as consulting with Medicare Locals about GP access, working with Aboriginal health organisations to establish referral pathways and arranging clinical placements with specialty services including palliative care and diabetes management.

8.8 Reflections and lessons learned

A broad range of training and implementation issues have been addressed during the current reporting period. The ERP sites have progressed from the set-up phase and have mostly completed the training pathway and are now well entrenched in the implementation of the program. Feedback from the projects’ progress reports, the national workshop and through the national evaluation team’s ongoing dialogue with sites indicates that a high level of energy has been maintained with staff committed to ensuring the project achieves a successful outcome.

In their progress reports, sites were asked to provide their reflections on the project’s progress – specifically, the lessons they had learnt and changes that should be made. These responses were analysed for common themes and integrated with findings identified by HWA and the national evaluation team through additional project documentation and ongoing contact with the project teams. The key learnings that have emerged during this reporting period can be summarised as follows:

- Whilst a core curriculum for ECP training can be developed by one jurisdiction it will inevitably need to be customised to fit the local operational context.
- Further consideration should be given to how project sites can be supported when they have no prior experience of implementing a new model of care, for example, the lack of experienced ECPs in the ACT, Tasmania and Northern Territory reduced access to mentoring and support for the new ECPs.
- Negotiating appropriate clinical placements takes time and requires particular expertise and contacts. There may be scope for providing guidelines to assist project teams with this requirement. Clinical placements provide ECPs with practical opportunities to demonstrate new skills in a supportive environment and are a key element of the training pathway; they also facilitate the development of referral networks.
- It will take time for jurisdictions to build a ‘critical mass’ of ECPs to ensure the initiative is sustainable, already it appears that ‘one size does not fit all’ and different staffing models will be needed to facilitate implementation. For example, regional and rural areas may not have enough work to justify an ECP unless the ECP also works as a first responder. The logistics of combining the emergency responder and ECP role may be challenging, however ECPs need a mechanism for maintaining their ICP skills.
- Documented clinical guidelines assist other key stakeholders to understand the scope of practice and provide a framework for ECPs to operate within.
- Regular feedback on the progress of implementation within the project’s organisation is an effective way of building support for the ECP role and addressing any misconceptions or concerns.
- The range of stakeholder engagement strategies implemented has been effective in developing, supporting, implementing and reviewing the project activities.
- Ongoing training will be needed for ECPs and this is best managed by using existing organisational processes for skill review and professional development.
- Implementation of the ECP initiative needs to be continuously monitored to ensure that emerging risks and issues are addressed.
9 Emerging risks

This section discusses risks that have emerged during the current reporting period, with a particular focus on risks related to training and implementation.

Risks previously identified in Evaluation Progress Report 1 are not included in this report, unless especially pertinent to the areas of training and implementation, or if the risk has persisted and remains a significant concern that necessitates consideration. No new evaluation risks emerged during the period.

9.1.1 National replication issues

The issue of national replication of successful ESOP models of care and where appropriate, associated training programs, is an important issue for all sub-projects. For example, difficulties in adapting training programs for the local context have been observed in both PED and ERP project sites. This has occurred because of variations in clinical practice, for example the use of nitrous oxide in the EDs of Queensland hospitals for pain relief for specific musculoskeletal conditions necessitated a modification to the PED training program provided to ESOP personnel from Queensland project sites. For ERP project teams, ensuring that clinical guidelines for ECPs align with the organisation’s internal clinical governance processes is of high importance. It is important that factors that influence the successful adaptation of these programs to a local level are identified and documented.

In addition, one APEN project has advocated for a unified national approach to training i.e. one training program provided nationally, through a training provider such as the National Endoscopy Training Initiative (NETI). NETI, established by The Gastroenterological Society of Australia (GESA) and the Australian Gastrointestinal Endoscopy Association (AGEA), provides “a comprehensive series of national, formalised and standardised colonoscopy workshops conducted by high quality trained supervisors.”12 Other APEN sub-project stakeholders have argued that the extended time to secure national consensus on a training pathway may delay further implementation of the nurse endoscopist role and propose State based approaches to training. Within this environment, both project sites agree on the training outcomes and competencies and are keen to work together to ensure that the skill level of nurse endoscopists is nationally consistent.

The NED projects were funded on the basis of providing an opportunity for promising models of care to be implemented and more thoroughly assessed in varying localities and contexts. There is variability in training arrangements and models within the NED sub-project and consequently not all models of care are likely to be suitable for national implementation.

Finally, and as was noted in Evaluation Progress Report 1, considerable resources need to be invested in documenting the training pathway, resources and assessment methods for national replication.

9.1.2 Assessment

Ensuring objective and consistent assessment methods for training pathways that are competency based has emerged as a challenge for several projects. Issues exist around the assessment process, including collecting evidence and making judgements about whether competency has been achieved by trainees. Smaller organisations and / or those in rural and remote locations may have inadequate volumes of particular cases to allow staff to achieve and maintain competencies. In addition, smaller sites generally have less access to educational resources and advice than those based in large teaching hospitals which has resulted in an increased workload for project staff when developing training packages. This can be compounded by the limited availability of

senior staff with the appropriate experience, skills and time to assess competencies and / or provide supervision.

Projects have developed diverse approaches to address this issue. For instance, SAAS primarily uses one assessor, and whilst this may not be sustainable in the longer term, should result in consistent assessment judgements.

9.1.3 Learning styles

Adult pedagogical principles recognise that differences in learning styles exist, with adult learners having different preferences for different styles. Most sub-projects have addressed this by using a combination of teaching methods, although inevitably the format of training programs is not always suitable for all trainees. For instance, some participants may have difficulty completing an online training component that is theoretical, whereas perform well when learning in a practical environment such as a clinical placement. Catering for the varied learning styles of participants and achieving the right balance between educational formats is a challenge, particularly where national implementation is a goal. This extends to ensuring that course materials and resources are appropriate and that the pace of the training program fits with project implementation timeframes and clinician workloads.

9.1.4 Barriers to training entry

This issue is two-fold and includes ensuring that appropriate health professionals can gain entry to the training program as well as recognising that participants will bring with them a variety of previous skills and qualifications.

The selection criteria for the ESOP clinicians will require review as the implementation and evaluation proceeds. Training programs that mandate that all participants complete every training module, regardless of prior learning or previous skills and qualifications have been problematic for some sub-projects. This lack of recognition of prior learning and experience has been reported to have discouraged some ESOP clinicians, who may have felt that they had adequate experience in certain clinical areas to be exempt. It is also likely to have made some potential recruits reconsider applying for a position within projects.

For example, Flinders Medical Centre (PED) has noted that physiotherapists working in the primary contact role may already possess skills and qualifications that the University of Canberra Graduate Diploma in Extended Scope Physiotherapy is designed to impart to trainees. These skills may have been gained through several means such as lead clinician initiatives, completion of Masters Degrees or other formal training. It is also possible that ESOP clinicians already possess skills learnt through extensive practical experience, even if not formally qualified. The capacity to recognise prior learning is a necessary element of any intensive training program, particularly if the intention is to provide this training in varying States and Territories.

9.1.5 Exit pathways

Experienced educators attending the recent APEN Project Advisory Group meeting raised the risk of not having ‘exit pathways’ for the nurse endoscopy training program. This training pathway extends over a year and is intensive. In all sub-projects there are examples of training pathways that are competency based. In these instances participants customarily continue until they are competent, repeating the learning and assessment process until competency is achieved. University based programs are structured differently and assessment is often less flexible. Consequently more formal training pathways that include tertiary components may require exit points; this may be in the form of a Graduate Certificate for students enrolled in Graduate Diploma programs.
9.1.6 Certification and accreditation / credentialing issues

Several projects have identified concerns about the end result for ESOP clinicians who are making significant investments in training. For example, an organisation’s credentialing committee may reject a candidate’s credentialing application despite them completing the ESOP training pathway. Project teams are working to reduce this risk by maintaining regular communication with their respective credentialing committees and ensuring that projects operate within a robust clinical governance framework. This is also an issue of concern for the nurse endoscopists in all APEN project sites as credentialing is usually a decision of the hospital employing the health practitioner.

9.1.7 Funding issues

The availability of funds to meet the full costs of training is a risk that has been identified by several HWA-ESOP projects.

In a number of cases the funding problems affecting training have largely been out of the control of projects, including budget constraints in health services and approvals for non-patient contact staff travel. As such, close liaison with the Executive team and Project Sponsor is essential.

The costs of the training programs have also caused problems for some project teams, who may not have adequately budgeted for this component of their project. ACT Health (PED) has noted that all of their implementation sites identified that that they were unaware of the costs relating to the post-graduate education program deemed essential to the ESOP role, and minor reorganisation of the implementation sites’ budgets was required. A site could not provide paid study leave to a number of participants to attend the face-to-face education days, due to budget limitations. To overcome this risk the project negotiated with individual participants to attend the education sessions in their own time.

Alternatively, not all projects have seen the value of training programs, which can require high resourcing levels (including both the costs of attendance and costs of replacing front line clinical staff) to be completed. This is especially the case when certain modules are perceived to be of little relevance to the role of the ESOP clinician.

9.1.8 Implementation risks

The key implementation risk for projects relates to the stage of implementation achieved by projects at this point, with several projects only having obtained partial implementation. While there are valid reasons for why these projects are not yet fully implementing their model of care, there is a need to closely monitor the individual progress of these projects to ensure full implementation is achieved. In addition, inadequate implementation by projects will result in sub-standard data collection, which has a negative flow on effect for the evaluation, impeding the ability to evaluate the impact of the projects.

The most significant implementation risk that has hindered projects in fully implementing their model of care, or poses a risk to those projects that have already achieved full implementation, relates to human resources and workload issues. Staff turnover is a reality within the healthcare environments in which projects operate. Resignations of project staff, including project managers and ESOP clinicians, have affected implementation progress at some sites, and are an ongoing risk for all projects. Recruitment and training of staff to replace these positions can be time-consuming and resource intensive. Similarly, staff leave can be problematic when it results in the extended absence of a key individual from a project team, coupled with this the majority of projects have no funding to back-fill absences when ESOP staff use their leave entitlements.

Another risk impacting on implementation relates to legislative and policy issues. These issues were raised in Evaluation Progress Report 1, and during the current reporting period some of these persisted for projects and further issues arose related to the themes previously established.
For example, ACT Health (PED) has continued to report impediments to physiotherapists prescribing, foreseeing the possibility that non-medical prescribing in each State may not be completed within the HWA-ESOP program timeframes. They report that it remains highly unlikely that some sites can participate in the model of non-medical prescribing utilised within the ACT. In addition, some sites have also experienced a lack of support for elements of their model of care due to medico-legal implications.
10 Reflections and lesson learned at the program level: training and implementation

The preceding review of each of the HWA-ESOP sub-projects has generated a range of findings, many that are common across the program. This section aims to synthesise the reflections and major lessons learned at the program level that pertain to the training and implementation phase. They are presented in relation to the six key elements of the program evaluation framework. At this stage of the ESOP program as can be expected, projects’ implementation status is a ‘moveable feast’ as activities are completed and/or issues arise.

10.1 Program delivery – What did you do?

- The APEN and PED projects are progressing as planned with their training and on track for completion by the end of this year. The training progress for NED projects is more variable, whilst the major training requirements have been completed by the ERP projects.
- A range of high quality training materials have been produced across the sub-projects and are being applied appropriately.
- All project teams are implementing their ESOP initiative in accordance with their project/implementation plans recognising that several have negotiated amendments in response to changing circumstances.
- The majority of projects are still at the partial implementation stage (meaning that they have not implemented all elements of their expanded scope of practice model of care), mainly because training is still in progress, or there are delays in securing approval for some of the proposed changes.
- The project teams are engaged and enthusiastic and working hard to achieve their project objectives.
- Several NED projects opted to recruit personnel already trained and with the requisite experience and this negated the need for training pathways and accelerated implementation.
- Several project teams have identified the need for budget variations as implementation has progressed, frequently training costs; leave cover and contingency costs were underestimated.
- Project teams require diverse skill sets to effectively manage all aspects of training and implementation. Several project teams based in larger organisations benefitted from access to existing training and education support staff and/or clinical redesign teams. Project teams in smaller organisations have not had this resource and this has impacted their ability to develop training packages according to the planned schedule. Some organisations have chosen to outsource their training.
- The APEN and PED sub-projects have lead sites, their respective implementation sites have found the support of lead sites has streamlined implementation, reduced duplication and provided an ongoing source of support and expertise.

10.2 Program impact – How did it go?

- According to project reports the majority of stakeholders are supporting implementation with limited resistance to the new workforce models identified amongst patients, service providers and organisations. In each sub-project there are pockets of resistance and project teams are working to address issues that are within their control.
- In most instances training programs were not fully developed and documented prior to commencing implementation. This created stress for those developing the training program and a lag for several implementation sites. In future, training programs should be fully developed prior to implementation.
- The training programs implemented to date appear to be ‘fit for purpose’ and providing the necessary knowledge, skills and competencies.
Most projects have indicated that they underestimated the time and resources involved in training. This was particularly so when competencies had to be developed or clinical placements needed to be arranged as part of the training pathway.

As implementation is progressing, several sites are finding they are not seeing the numbers of certain clinical presentations that were anticipated and this has negatively impacted upon training and competency acquisition. A more comprehensive needs analysis at project commencement may reduce this risk in the future and/or a review of project scope once the training program is completed and implementation is underway to ensure project objectives can be met.

Projects with an active executive sponsor and/or senior leadership within the project team are better equipped to address barriers to training and implementation.

Projects have generally been responsive and adapted implementation on the basis of internal monitoring and review; for example, several projects have revised their hours of operation in response to patient throughput data.

Effective implementation of a new model of care frequently requires redesign of a range of supporting processes, often these issues are difficult to identify in the planning stages. Virtually all projects encountered this issue, for example, ERP project teams needed to establish new referral pathways for patients that were not being transported.

For many projects existing information systems could not be easily modified to enable recording and extraction of data items specific to the ESOP model of care. Consequently additional data collection methods have been implemented which has created extra work for project teams. There is also a lack of consistency in the availability of data across systems and implementation sites.

10.3 Program sustainability – Can you keep it going?

Most projects believe that the selection criteria they established for the ESOP roles and training entry criteria generated the ‘right’ candidates however these criteria may require review to ensure an ongoing pool of appropriate candidates.

Learning pathways that articulate to a nationally recognised qualification may be more sustainable, noting that Universities require minimum numbers of students for a course to be viable. In addition processes for endorsement of new roles may facilitate sustainability if they permit practice outside the training organisation.

Training pathways that include on-line delivery components are more accessible for clinicians in rural and remote locations.

Training pathways designed for qualified and experienced clinicians should include capacity for recognition of prior learning.

Training for ESOP roles may need to include broader learning areas relating to leadership and communication to enable championing of the new role and conflict resolution.

As there is a relatively short implementation period for the ESOP projects, staff changes have a significant impact, especially where mandatory training is a positional requirement. Few projects built in redundancy to cover leave entitlements.

A range of projects are dependent on access to medical officers and/or specialty staff for the assessment of competencies. Whilst experience with the ESOP projects to date has been positive, some sites are reporting that the workload created for medical officers may not be sustainable in all organisations.

Rarely have projects considered exit points for their training pathways, for example, when ESOP clinicians were unable or chose not to complete components of the training the decision was made for them to withdraw from the training program. In most cases this was probably appropriate however if projects are replicated nationally there will need to be consideration of this issue to ensure value for money from future training investments.
10.4 Program capacity – What has been learnt?

- Training programs need to accommodate different learning styles and include appropriate and relevant learning outcomes, strategies and student resources.
- Feedback from ESOP clinicians has emphasised the importance of competency based training for experienced health professionals where they get to apply the new skills in a real-world clinical setting.
- For several sub-projects the training is intensive and has to be completed whilst ESOP clinicians implement the new model of care. This has highlighted the importance of factoring in ‘non-clinical time’ for self-directed learning.
- The medical mentoring and supervision role is critical to all ESOP projects, without strong medical engagement it is unlikely that expanded scope of practice roles can be effectively implemented.
- As practitioners apply the expanded scope of practice model of care, additional training needs are emerging. There should be a structured approach to continuing professional development for these ESOP roles.
- Some projects did not adequately consider the alignment between their proposed model of care and the industrial classifications of the available workforce; this has necessitated modification of practices to ensure that ESOP practitioners are working within their delegated scope of practice.
- Where two lead sites have been established more structured communication processes are needed to bring them together to develop a more collaborative approach.

10.5 Program generalisability – Are your lessons useful for someone else?

- Those projects with clearly documented models of care and related clinical guidelines are more easily adopted by other organisations as they explicitly state the scope of practice. Inevitably clinical guidelines will need to be adapted to fit the local service delivery context.
- Several project teams have identified concerns that the provision of the ESOP training may generate expectations amongst personnel of higher remuneration and this may prove a barrier to extending the project for both organisations and clinicians.
- Projects using a modular approach that is linked to competency based assessment appear to have greater flexibility for training and implementation.
- The implementation of some elements of the ESOP models of care, for example prescribing, are bigger than the individual project and projects are unlikely to achieve this without the support of State and Territory health departments.
- At this stage it appears that national scalability might be enhanced through developing a national framework or approach to training that can be adapted at a jurisdictional level to accommodate differences in the State and Territory context, generate buy-in and address legislative differences.
- National implementation is likely to be enhanced with access to high speed internet services as face-to-face education strategies may reduce the capacity for regional, rural and remote communities to participate.

10.6 Program dissemination – Who did you tell?

- Project teams have employed multiple strategies to engage stakeholders, particularly in overcoming training and implementation barriers. An ongoing stakeholder management plan is required as the need to communicate and engage stakeholders doesn’t lessen as implementation proceeds.
- Implementation of ESOP initiatives needs to be continuously monitored to ensure the emerging risks and issues are communicated and addressed.
10.7  Next steps

The final evaluation progress report will focus on evaluation and sustainability issues. It is due in mid-December with project’s final reports expected from all PED and NED project teams in late December 2013.
### Appendix 1  Lead and implementation sites by sub-project

<table>
<thead>
<tr>
<th>Sub-project</th>
<th>Organisation</th>
<th>Project Site</th>
<th>Lead</th>
<th>Implementation</th>
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* Formerly Southern Health.
## Appendix 2  HWA funding allocation and execution date by project

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<th>Execution Date</th>
<th>Total Funding (GST Incl.)</th>
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<td>23/05/2012</td>
<td>$255,380</td>
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<tr>
<td>South Eastern Sydney Local Health District (Prince of Wales Hospital) - Implementation Site</td>
<td>N/A</td>
<td>23/05/2012</td>
<td>$325,000</td>
</tr>
<tr>
<td>Sydney Local Health District, The Royal Prince Alfred Hospital - Implementation Site</td>
<td>N/A</td>
<td>12/06/2012</td>
<td>$343,455</td>
</tr>
<tr>
<td>The Royal Children’s Hospital - Implementation Site</td>
<td>No</td>
<td>6/06/2012</td>
<td>$119,000</td>
</tr>
<tr>
<td>Western Health (Sunshine Hospital) - Implementation Site</td>
<td>No</td>
<td>23/05/2012</td>
<td>$350,000</td>
</tr>
</tbody>
</table>

**Expanded Scope of Practice: Extending the Role of Paramedics**
<table>
<thead>
<tr>
<th>Recipient</th>
<th>Victorian Department of Health Funding Allocation</th>
<th>Execution Date</th>
<th>Total Funding (GST Incl.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SA Ambulance Service Inc (Limestone Coast) - Implementation Site</td>
<td>N/A</td>
<td>26/06/2012</td>
<td>$680,446</td>
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<tr>
<td>SA Ambulance Service Inc (Port Lincoln) - Implementation Site</td>
<td>N/A</td>
<td>26/06/2012</td>
<td>$690,727</td>
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<tr>
<td>St John Ambulance Australia Northern Territory Inc - Implementation Site</td>
<td>N/A</td>
<td>21/06/2012</td>
<td>$712,903</td>
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<tr>
<td>State of Tasmania through the Department of Health and Human Services, trading as Tasmanian Ambulance - Implementation Site</td>
<td>N/A</td>
<td>12/06/2012</td>
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<tr>
<td>The Australian Capital Territory through the ACT Emergency Services Department, trading as ACT Ambulance - Implementation Site</td>
<td>N/A</td>
<td>29/06/2012</td>
<td>$962,000</td>
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</tbody>
</table>

* The Austin Consortium holds funding for all Victorian implementation sites; HWA has not entered into individual contracts with each Victorian implementation site.
## Appendix 3  Ethics approval status

<table>
<thead>
<tr>
<th>Project implementation site</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expanded Scope of Practice: Advance Practice in Endoscopy Nursing</td>
<td></td>
</tr>
<tr>
<td>Austin Hospital</td>
<td>In progress</td>
</tr>
<tr>
<td>Heidelberg Hospital</td>
<td>In progress</td>
</tr>
<tr>
<td>Southern Health (Monash Medical Centre)</td>
<td>In progress</td>
</tr>
<tr>
<td>Alfred Health (The Alfred Hospital)</td>
<td>In progress</td>
</tr>
<tr>
<td>Western Health (Western Hospital)</td>
<td>In progress</td>
</tr>
<tr>
<td>Logan Hospital</td>
<td>Approved</td>
</tr>
<tr>
<td>Expanded Scope of Practice: Physiotherapists in the Emergency Department</td>
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</tr>
<tr>
<td>The Alfred Hospital inc. Sandringham Hospital</td>
<td>Approved</td>
</tr>
<tr>
<td>Alice Springs Hospital</td>
<td>Approved</td>
</tr>
<tr>
<td>Southern Health (Casey Hospital)</td>
<td>Approved</td>
</tr>
<tr>
<td>Southern Health (Dandenong Hospital)</td>
<td>Approved</td>
</tr>
<tr>
<td>St Vincent’s Melbourne</td>
<td>Approved</td>
</tr>
<tr>
<td>Ballarat Hospital (Ballarat Health Service)</td>
<td>Approved</td>
</tr>
<tr>
<td>ACT Health (The Canberra Hospital)</td>
<td>Approved</td>
</tr>
<tr>
<td>Cairns Base Hospital</td>
<td>Approved</td>
</tr>
<tr>
<td>Flinders Medical Centre</td>
<td>Approved</td>
</tr>
<tr>
<td>Gold Coast Health District (Robina Hospital)</td>
<td>Approved</td>
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<tr>
<td>Expanded Scope of Practice: Nurses in the Emergency Department</td>
<td></td>
</tr>
<tr>
<td>Kilmore and District Hospital</td>
<td>Application not lodged</td>
</tr>
<tr>
<td>Eastern Health (Box Hill and Maroondah Hospitals)</td>
<td>Approved</td>
</tr>
<tr>
<td>Sunshine Hospital</td>
<td>Approved</td>
</tr>
<tr>
<td>Royal Children’s Hospital Melbourne</td>
<td>Approved</td>
</tr>
<tr>
<td>Wollongong Hospital</td>
<td>Approved</td>
</tr>
<tr>
<td>Murrumbidgee Local Health District</td>
<td>In progress</td>
</tr>
<tr>
<td>Prince of Wales Hospital</td>
<td>Approved</td>
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<tr>
<td>Royal Prince Alfred Hospital</td>
<td>Approved</td>
</tr>
<tr>
<td>Expanded Scope of Practice: Extending the Role of Paramedics</td>
<td></td>
</tr>
<tr>
<td>South Australian Ambulance Service - Limestone Coast</td>
<td>In progress</td>
</tr>
<tr>
<td>South Australian Ambulance Service - Eyre Peninsula</td>
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</tr>
<tr>
<td>Ambulance Tasmania</td>
<td>Application not lodged</td>
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<tr>
<td>ACT Ambulance Service</td>
<td>Application not lodged</td>
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<tr>
<td>St John’s Ambulance Service</td>
<td>Application not lodged</td>
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</table>