Practice Nurse Networking Night

Tuesday 13 August 2024

phn GOLD COAST

An Australian Government Initiative

Acknowledgement to Country

Artist: NARELLE URQUHART, WIRADJURI WOMAN]

Gold Coast Primary Health Network would like to acknowledge and pay respect to the land and the traditional practices of the families of the Yugambeh Language Region of South East Queensland and their Elders past, present and emerging.

Housekeeping

- Please switch mobile phones to silent during presentations
- Rest Rooms
- Evacuation procedure

GCPHN Update

Kellie Trigger

Director Health Intelligence Planning and Engagement

2024 - 2026

STRATEGIC PLAN

Our Operating Environment*

857 General Practitioners

210 General Practices

80.5% of adults saw a GP in the last 12 months

39 is the median age of residents

83 is the average life expectancy

640,778 residents live in our region

Males	311,152
Females	329,627
Aged 0-14	112,672
Aged 15-24	77,240
Aged 25-44	174,546
Aged 45-64	161,960
Aged 65+	114,349

12,724 residents identify as Aboriginal and Torres Strait Islander people

86,196 residents use a language other than English at home

89.3% of people over 45 assessed their health as excellent, very good or good

39.6% of adults who reported having at least one long-term health condition

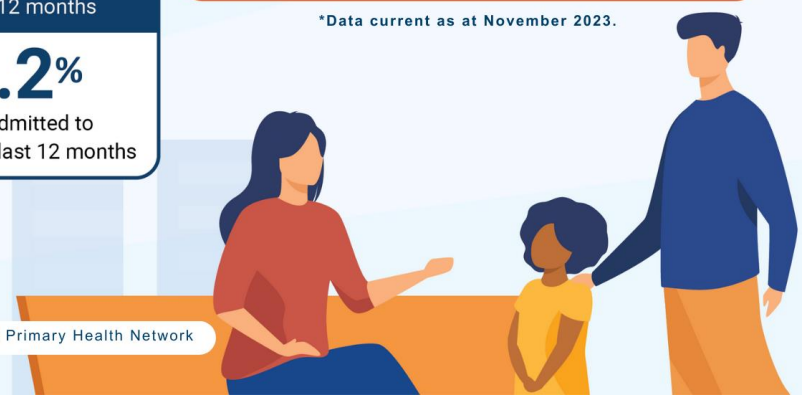
33.1% of adults saw a specialist in the last 12 months

13.2% of adults admitted to hospital in the last 12 months

3,042,220 number of GPs services provided face-to-face

675,725 number of GPs services provided via telehealth

*Data current as at November 2023.



STRATEGIC PLAN 2024-2026

Plan on a Page

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GOALS	STRATEGIES	SIGNPOSTS OF SUCCESS
Improve coordination of care to ensure people receive the right care in the right place at the right time by the right person	• Enhance the coordination of care for people so they experience improved health outcomes. • Continually evolve needs assessments and planning to inform health service development and investment. • Commission health programs which meet priority community health needs and build capacity in our service sector. • Collaborate with the community, health services and government to co-create innovative solutions to health system challenges. • Engage the community in health promotion and targeted preventive care initiatives.	• **Systems that support coordinated care for patients.** • **Working with partners to design and commission services.** • **Commissioned services support prioritised health needs.** • **Improved relationships with health and government partners.** • **Health promotion activities support increased access to services.**
Increase efficiency and effectiveness of primary care services, particularly for those at risk of poor health outcomes	• Improve access to digital health programs that enhance the accessibility of care. • Advocate and enable access to primary care services, especially in areas of high need and high population growth. • Measure how our activities impact health outcomes, service accessibility, and the experiences of consumers and providers.	• **Supporting the primary care sector to deliver quality services.** • **Improved patient outcomes.** • **Improved consumer experience.**
Actively engage and advocate for the primary care sector to facilitate improvement in our local health system	• Contribute to building a capable, progressive, skilled, and culturally safe workforce that can respond to evolving needs. • Build the capacity of providers to inform, implement and raise awareness of our commissioning activities. • Develop, deliver, and coordinate communications to ensure stakeholders receive practical and timely information to inform their operations. • Support primary care services to plan, prepare for, and respond to, evolving health needs and crisis.	• **Growing, training, and supporting the local health workforce.** • **Services are culturally safe.**
Operate as a high performing, efficient and accountable organisation	• Maintain best practice governance systems that demonstrate efficiency, accountability, and transparency. • Continuously improve our capability as commissioners to ensure meaningful outcomes for our community. • Retain an organisational workforce that fosters a culture of continuous learning and quality improvement.	• **A well-governed and financially sustainable organisation.** • **Retaining a skilled workforce.** • **Satisfaction of our employees and partners with our performance.**

Our Vision And Values

Building one world class health system for the Gold Coast.

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SUSTAINABLE
Efficient, Effective, Viable

EVIDENCE-BASED
Research, Documenting, Transparent

ACCOUNTABLE
Respect, Responsible, Outcomes

INNOVATIVE
Flexible, Pioneering, Evolutionary

COLLABORATIVE
Partnerships, Integrated, Engaged

INFLUENTIAL
Visible, Valued, Courageous

Quintuple Aim

How we measure success of all our activities are underpinned by the Quintuple Aim, which allows us to measure our strategic objectives through what we aim to achieve.

Join the Clinical Council

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The Clinical Council ensures that influential recommendations and advice from a clinical perspective is presented to the GCPHN Board, informing the best possible decisions on health and primary/community-based care to improve health outcomes in accordance with the strategic intent of the PHN.

The Clinical Council currently has vacancies for:

- First Nations Health Worker
- Nurse – General Practice, Aged Care and / or community
- General Practitioner – Practice Owner
- General Practitioner – Contract / Employed
- Pharmacist
- Specialist and / or hospital-based clinician

Clinical Council Nominations: First Nations Health, Nurse, Clinician, Pharmacist, & General Practitioner (Multiple vacancies) - GCPHN (applynow.net.au)

Nominations close:
Friday 30th August at 9am

Transition to Practice Program

Join our September intake today

APNA's Transition to Practice Program is our evidence-based support program for nurses new to primary health care, who feel they would like a helping hand getting to know this exciting sector.

Gold Coast PHN are co-sponsoring places on the program for nurses based in their region.

You'll be paired with an experienced mentor, have access to exclusive education tools and resources, and meet other nurses just like you through small-group learning activities. And it's completely free!

If you are an experienced primary care nurse, we're also looking for mentors. You'll have the full support of our team to help nurses reach their full potential and you'll be paid for your time.

To find out more, scan the QR code!

Or email us at
transitiontopractice@apna.asn.au

Event – Annual Immunisation Update

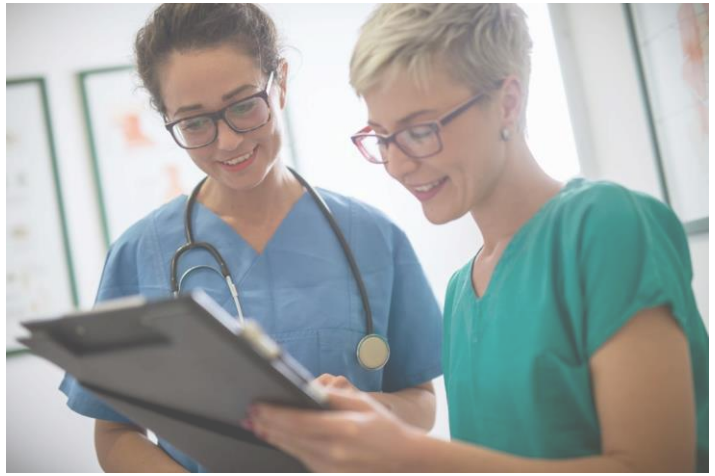
Tuesday 22nd October – 6pm

- **Gold Coast Primary Health Network (GCPHN) invite Gold Coast general practice nurses to an educational and networking session for the annual GCPHN Immunisation Update.**

- **This educational update will explore:**
  - Updates from the Gold Coast Public Health Unit (GCPHU)
  - Gold Coast Primary Health Network initiatives
  - Opportunity for nurses to express an interest in nurse shadowing for GCPHU clinics.

- **Learning Outcomes:**
  - Discuss local immunisation updates and initiatives.
  - This event will offer an opportunity to network with fellow general practice nurses.

- **Dinner will be provided.**



SAVE THE DATE – To come through GP&P News, Practice Manager and Nurse email network.

Useful Links

Short-Term Restorative Care Program:

- 8-week program available to older Australians
- Program delivered by a team of health professionals
- Aim is to help individuals return to earlier levels of independence and can delay the need for long -term care and support services
- https://www.myagedcare.gov.au/short-term-care/short-term-restorative-care

Department of Veteran Affairs (DVA) – Care for a Veteran:

- DVA offers a range of care services that can help veterans to remain living independently in their own home or support their return home after a hospital stay
- Services are also available to help support and guide a move into residential aged care
- https://www.dva.gov.au/get-support/health-support/care-home-or-aged-care

Active and Healthy Program

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The City of Gold Coast's Active and Healthy Program offers over 300 free and low-cost activities per week across the Gold Coast.

Activities are facilitated by qualified, experienced and community minded professionals that are trained in First Aid, CPR and Mental Health First Aid.

The Active and Health Program includes Wellness programs such as Walk and Talk for wellness, Water Therapy, Sit and Stretch, Active memory and Balance, Men's Health and Lower Back Health. Activities are modified to suit various levels of ability, delivered by allied health professionals and can support chronic disease and mobility concerns.

Together we can BE ACTIVE & HEALTHY

Active&Healthy

HEAD TO HEALTH kids
QUEENSLAND

- Targeting **mild to moderate** mental health presentations in children under 12
- Children presenting with social, emotional and developmental **needs that cannot be met by the primary sector.**
- **Do not meet threshold/criteria for tertiary** intervention
- For children and families with multiple challenges that **are not currently having their needs met by a service.**
- Works from **multiple locations in the region** and aims to see families at a location that is convenient to them.
- Referrals through **Head to Health** phone line on 1800 595 212
- www.goldcoast.health.qld.gov.au/h2hk

Bowel Cancer Screening Project (Research and QI opportunity)

Michelle Everington
Clinical Trial Coordinator

phn GOLD COAST
An Australian Government Initiative

The Daffodil Centre
A partnership between Cancer Council | The University of Sydney

Background – Bowel Cancer

- 4th most commonly diagnosed cancer in Australia
- 3rd most common cancer worldwide
- 2nd most deadly cancer in Australia
- Develops without early signs or symptoms

- **9 out of 10** bowel cancers can be **successfully treated** through early detection
- Screening is an effective method to detect bowel cancer early

AIHW Cancer Data in Australia 2023

Background – National Bowel Cancer Screening Program

- Aim: reduce deaths from bowel cancer due to early detection
- One of the most life-saving public health programs in Australia
- Eligibility: 45 – 74 years
- Immunochemical faecal occult blood test (iFOBT) detects blood in stool
- National Cancer Screening Register (NCSR) tracks and monitors patients

Participation – National Bowel Cancer Screening Program

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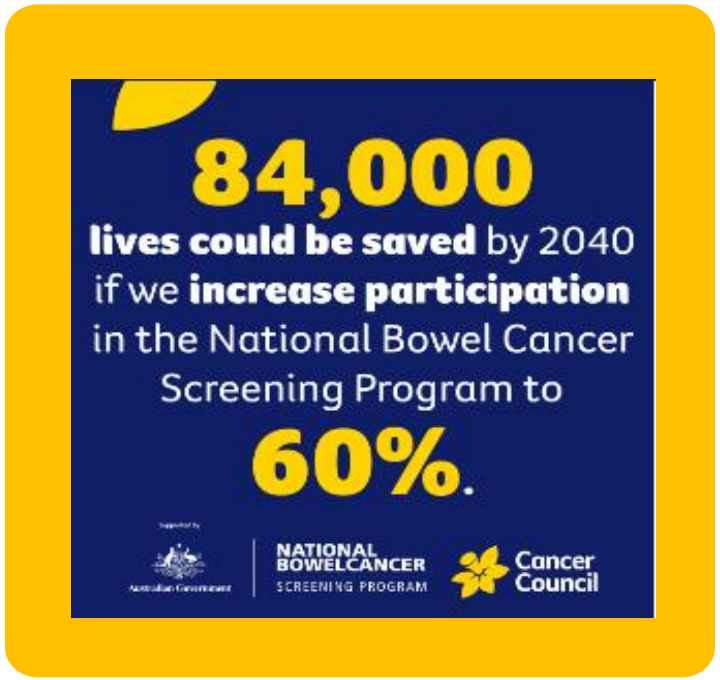
40% Participated in the NBCSP.

60% DID NOT participate in the NBCSP.

Modelling estimates that...



AIHW NBCSP Monitoring Report 2024

Lew JB et al. Lancet Public Health. 2017 Jul 1;2

How do we get to 60%?

Bowel Cancer Screening Project (MAIL, GP & SCALE trial)

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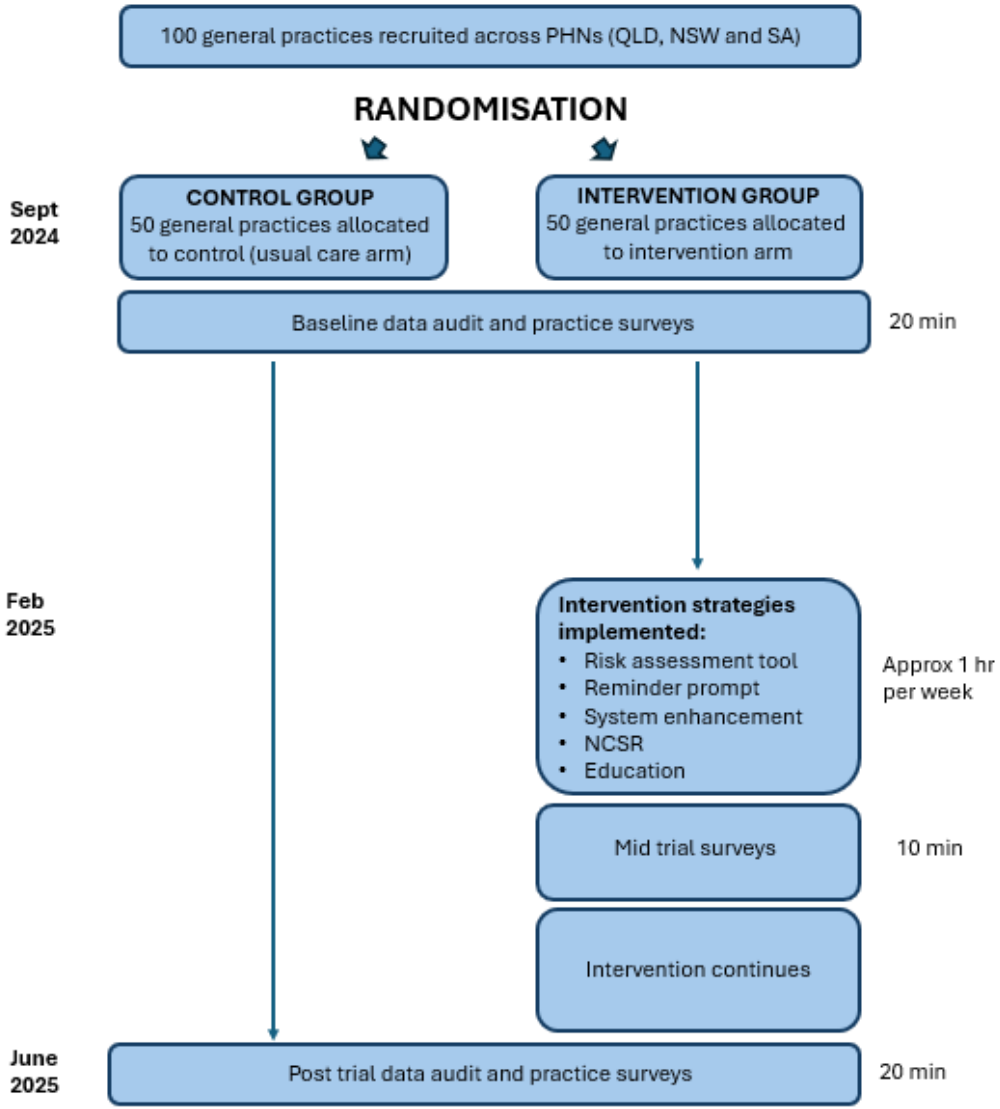
Pilot intervention aimed to:

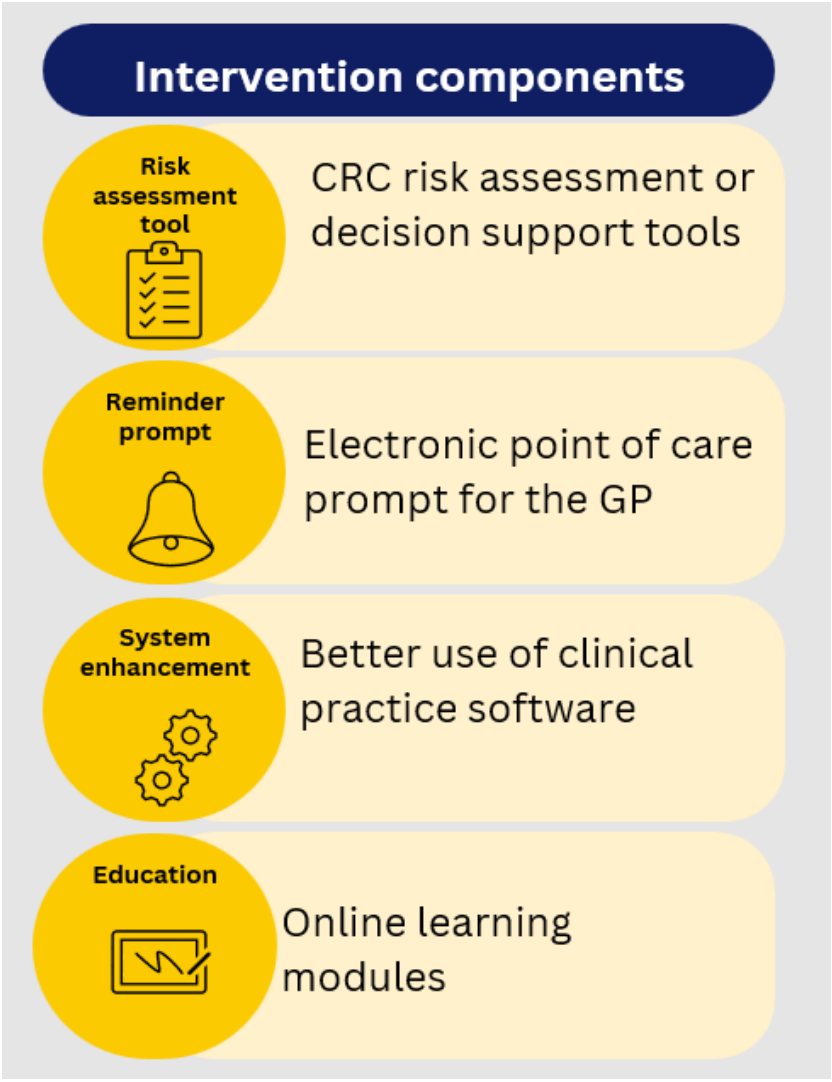
- Increase involvement of general practice in promoting the National Bowel Cancer Screening Program.
- To ensure patients undergo bowel cancer screening in line with clinical guidelines.

The Daffodil Centre
A partnership between Cancer Council | The University of Sydney

Understanding what works best to support bowel cancer screening

What's involved?





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Benefits

- $2000 incentive practice payment
- Improving patient health outcomes - reduce deaths from bowel cancer due to early detection!
- CPD hours
- Dedicated support
- Enhance practice capabilities whilst also meeting PIPQI and accreditation requirements

Requirements

Inclusion criteria:

- ✓Commit to the trial period of September 2024 – May 2025.
- ✓Interest in bowel cancer screening.
- ✓At least two GPs (2 FTE) willing to participate.
- ✓Nominated Practice Champion who is willing and able to liaise with the Clinical Trial Coordinator (CTC).
- ✓Use of Best Practice or MedicalDirector as the Clinical Information System (CIS).
- ✓Primary Sense (population management and clinical audit tool) installed and shares de-identified data with GCPHN.
- ✓Practice **cannot** share a server with another practice.
- ✓Windows 10 or higher, i5/i7 16GB processing or willing to upgrade.
- ✓1000 or more active patients and sees minimum of 35 adult patients per day.

What’s next

Let me know if you are interested or need further information.

Phone or email Michelle on 5612 5478 or via michellee@gcphn.com.au.

I’ll you send consent to participate forms

Express your interest here

Questions

Optimizing vulnerable patients care in an increasingly Complex Healthcare System

Zena Marks

Nurse Navigator – Complex Care

Jingeri.
We acknowledge the Traditional Custodians of the land in which we work, live and grow, the Kombumerri, Wangerriburra, Bullongin, Minjungbal and Birinburra peoples, of the Yugambeh Language speaking nation. We also pay our respects to Elders past, present and emerging. We also acknowledge other Aboriginal and Torres Strait Islander people present today.

Content

- What's Complex Care?
- IMPACCT Service
- GCHHS Community Services Complexity
- Patients journey
- Examples of how we Nurse Navigate patients to promote health, equity and access to care.

What's Complex Care?

Definition of patient complexity in adults: A narrative review

Conclusion: A consensus concerning the definition of patient complexity was lacking. Most definitions incorporated nonmedical factors in the definition, underlining the importance of accounting not only for medical but also for non-medical aspects, as well as for their interrelationship.

Nicolaus S, Crelier B, Donzé JD, Aubert CE. Definition of patient complexity in adults: A narrative review. J Multimorb Comorb. 2022 Feb 25;12:26335565221081288. doi: 10.1177/26335565221081288. PMID: 35586038; PMCID: PMC9106317.

Hospital Avoidance

Discharge Support

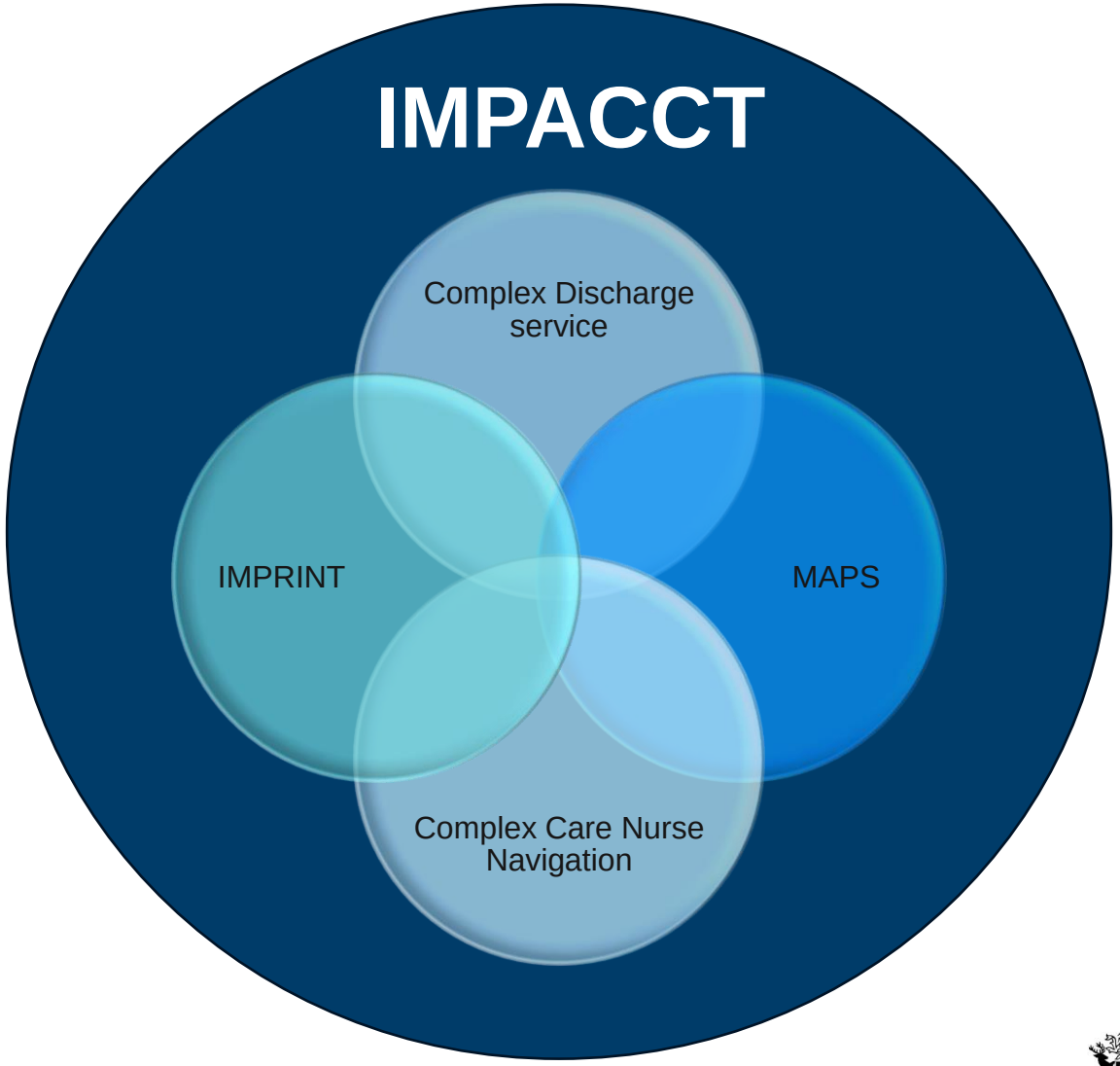
IMPACCT Services

Vision:

A community strengthened through care & connection

Mission:

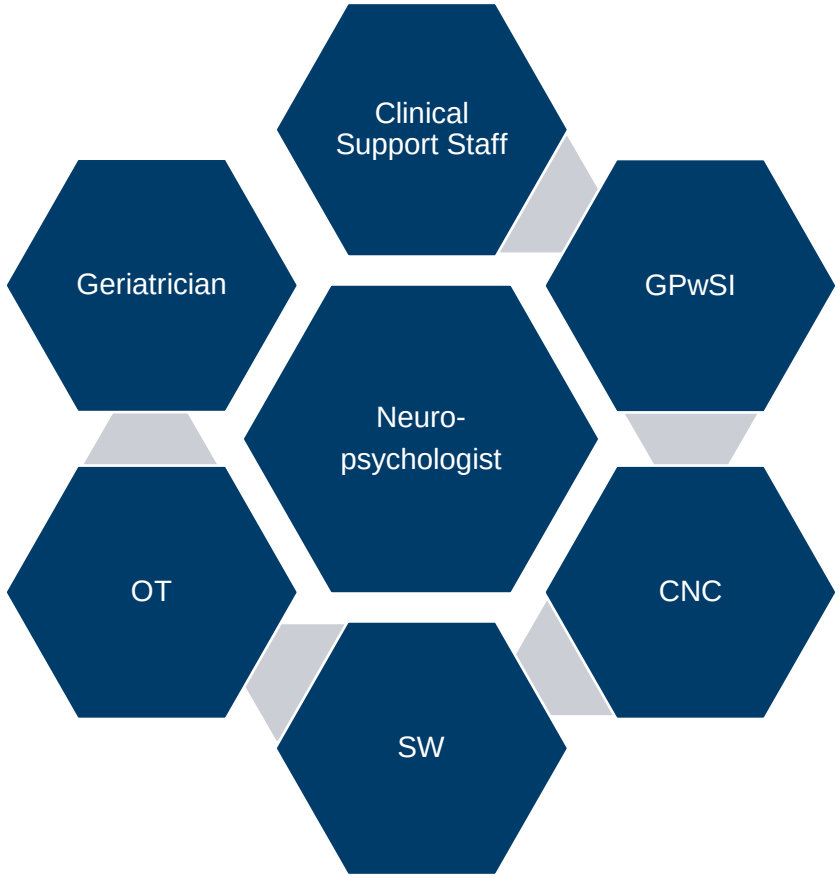
To promote health, equity and access to Gold Coast community members with complex needs through support, empowerment, interagency collaboration and advocacy.



Gold Coast Health
always care

Queensland Government

IMPRINT



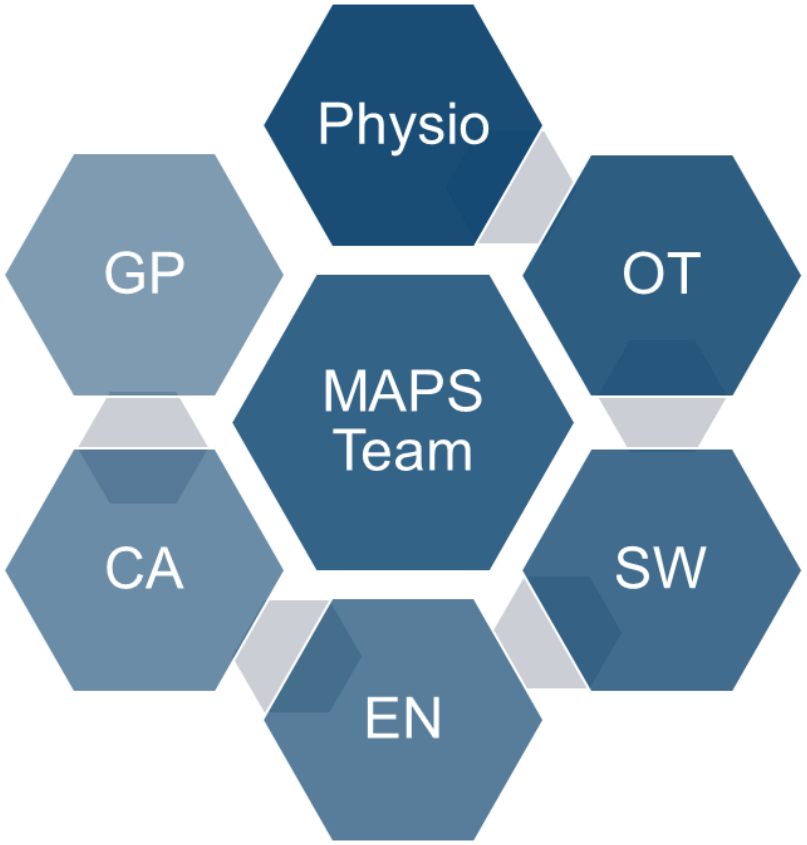
Suitability

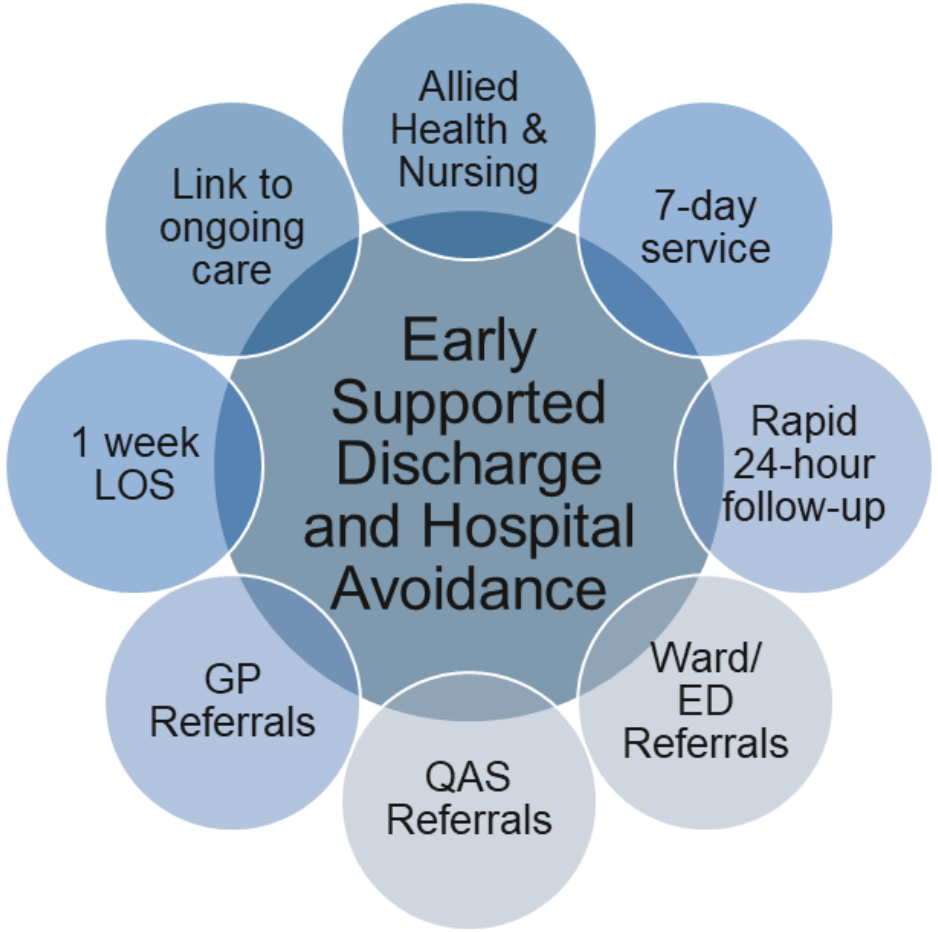
- Resident of the Gold Coast
- Eligible for a level 3 or level 4 home care package
- Consenting to engage with IMPRINT
- Require an in-home review with a multidisciplinary team

Service

- specialised and targeted assessment and intervention
- Provide education on what services are available and how to link with them
- Support Advanced Care Planning

MAPS


Physio
GP
OT
MAPS Team
CA
SW
EN


Allied Health & Nursing
Link to ongoing care
7-day service
Early Supported Discharge and Hospital Avoidance
1 week LOS
Rapid 24-hour follow-up
GP Referrals
Ward/ ED Referrals
QAS Referrals

Complex Discharge Services

Service

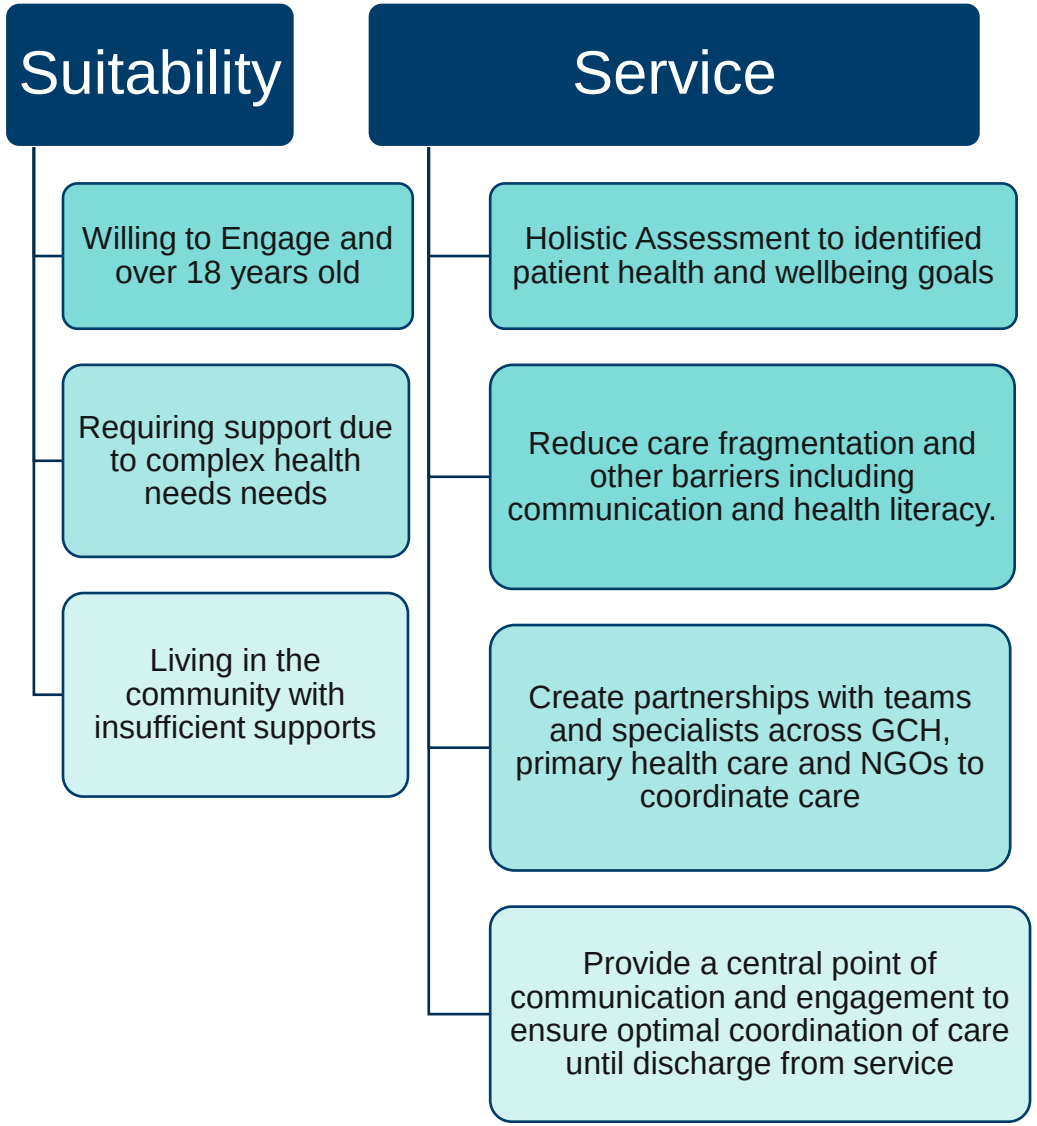
- specialist allied health psychosocial or functional assessments to engage community services
- Avoidable hospitalisation imminent without additional supports
- Shared management of vulnerable clients, Age16+
- Pt Dsc on LOS funding to support and confirm arrangements post
- Gaps/Access difficulties to existing services

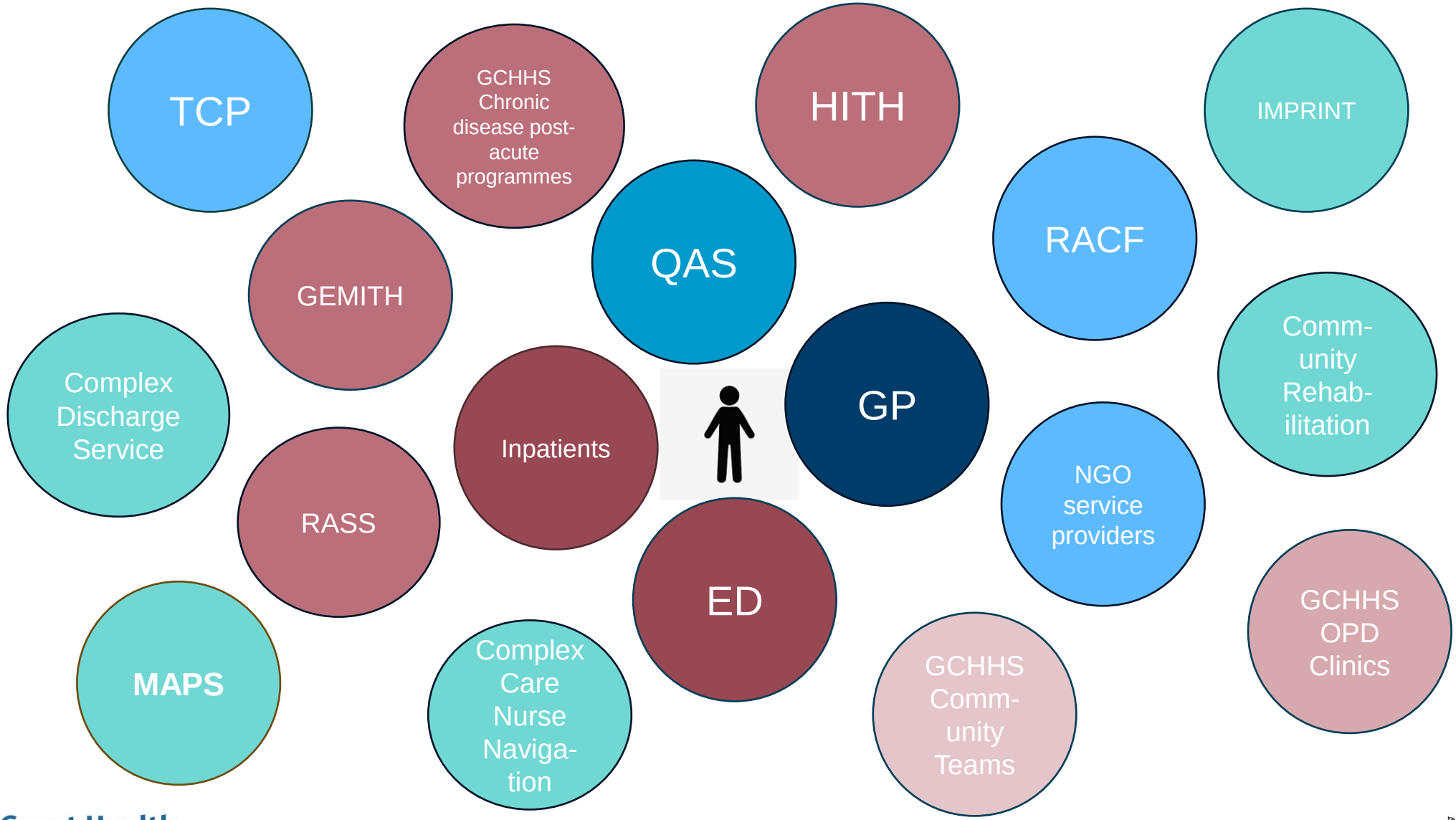
Suitability

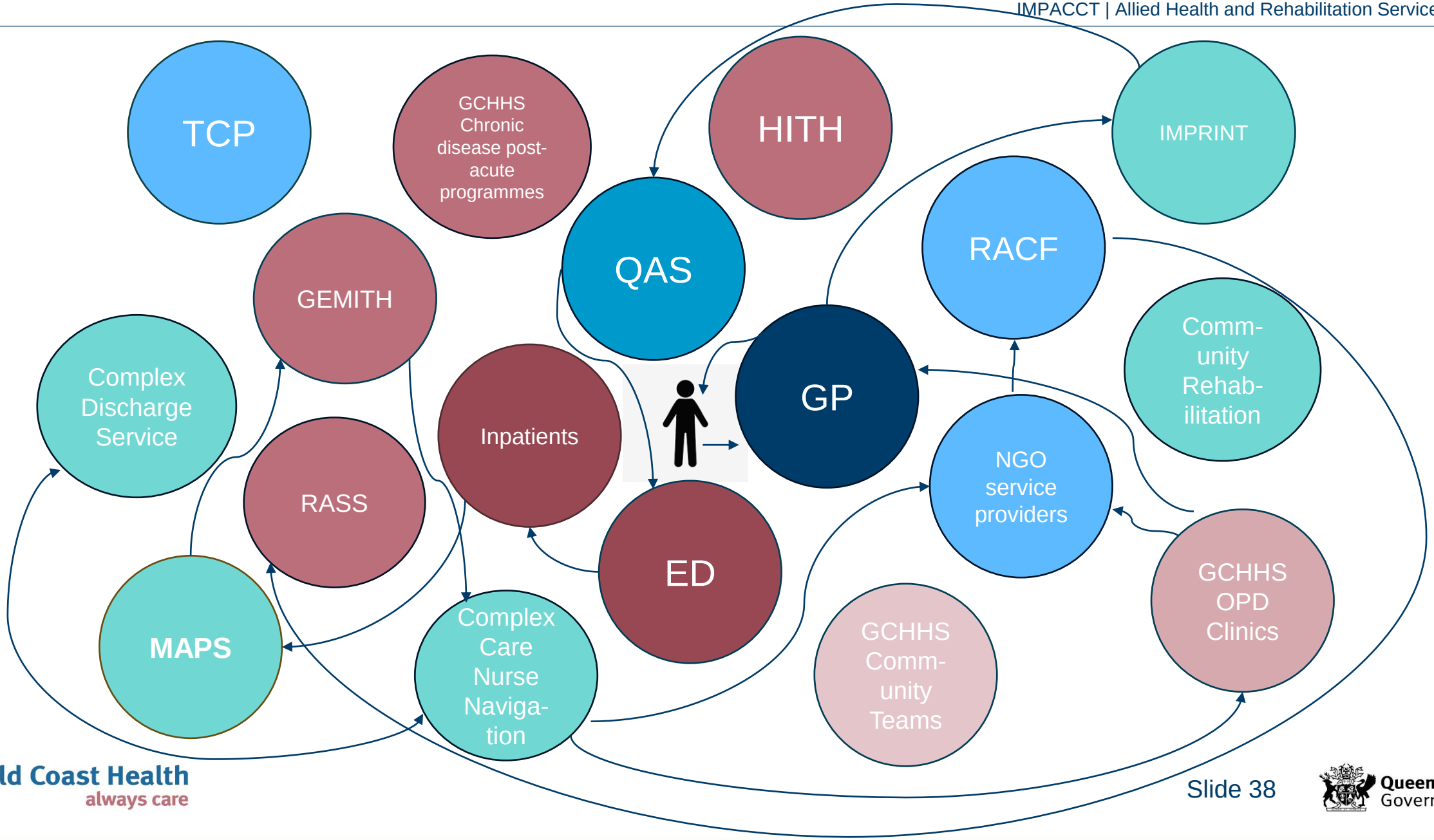
- Those at risk of avoidable hospital presentations
- Supporting early safe discharge
- Supporting alternative care environments to sustain safety of patients in transition between hospital and community

Nurse Navigation- Complex Care

8 Nurse Navigators




TCP
GCHHS Chronic disease post-acute programmes
HITH
IMPRINT
GEMITH
QAS
RACF
Complex Discharge Service
Inpatients
GP
Comm-unity Rehab-ilitation
RASS
NGO service providers
ED
MAPS
Complex Care Nurse Naviga-tion
GCHHS Comm-unity Teams
GCHHS OPD Clinics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GEMITH
Comm-unity Rehab-ilitation
Complex Discharge Service
GP
Inpatients
NGO service providers
RASS
ED
GCHHS OPD Clinics
MAPS
Complex Care Nurse Naviga-tion
GCHHS Comm-unity Teams

Scenario 1

- 28yr old, Female with a recent history of recurrent ED presentations.
- intellectual impairment, Rett syndrome, seizures and communicated using basic sign language
- a living in 24/7 supported accommodation
- mother was legal guardian
- help facilitate the care of her daughter for a booked laparoscopic hysterectomy and gastrostomy procedures booked for later in the month.

Assessment

- Mirja conducted a comprehensive assessment with the patient, her mother, carer and, NDIS Co-ordinator providing information and input. Some clear goals for care were agreed upon, with priority placed upon planning and support for upcoming surgery, and future contacts with the hospital for care, including:
- Advanced Care Planning support
- ED Acute Management Plan
- Inpatient Behaviour Support Plan

Multi-disciplinary meeting Arranged

Held a multidisciplinary team meeting attended by:

- Medical Director, Gynaecology,
- Clinical Director InSPIRD,
- Consultant Anaesthetist,
- NUM Operating Theatres,
- Clinical Care Coordinator – Gynaecology

Plan of Care

- A tailored plan was developed and communicated with the attendees, bed managers and anaesthetic and recovery staff, and NUM of Gynaecology to share with clinical team. The plan agreed upon included:

- Direct admission to Gynaecology ward with Anaesthetic review to be undertaken on admission.
- Confirmed to be first on theatre list for day of surgery.
- Planned nil by mouth time to minimise discomfort and distress.
- Family member/carer would be present 24/7 during admission.
- Organised for Gastroenterology to perform planned gastroscopy in theatre rather than in Endoscopy suite.
- Developed post-operative management planning for pain management and de-escalation and sedation requirements if challenging behaviours emerge.
- Planned with bed managers for bed to be available as soon as patient ready to leave recovery to ensure smooth transition.
- Development of an inpatient management plan which was agreed upon by the NUM of Gynaecology and shared with the nursing team.

Communication

- emailed the patients' mother details of the inpatient management plan
- shared with all parties for her inpatient stay

Co-ordination

- shared a copy of postoperative care in simple language with her carers
- mother and Nurse Navigator communicated closely in the following days with the patient's mother and specialist teams
- Aided facilitate changes to Gastroenterology and Neurology outpatient appointments to prevent multiple attendances.

Prevention

- Endorsement was gained for the ED Acute Management Plan (ED AMP)
  - developed in consultation with:
  - Neurologist,
  - GP,
  - patients' mother
  - endorsed by ED Consultant.

The ED AMP aims to prepare both the patient, her family, primary care providers, and hospital staff for future ED presentations so that known reasons for presentation can be managed promptly and appropriately to her needs.

(Visible in the viewer)

Discharged with a letter:

- to GP summarising care
- offer to re connect in the future if case management scenario arise again.

Scenario 2

51 yr old, Male with intellectual impairment:

- living in supported accommodation with 24/7 carers under the NDIS.
- Under care of OPG and Public Trust
- **PMHX**
  - T1DM – Charcots arthropathy and multiple toe amputations.
  - CML
  - HT
  - CKD
  - Epilepsy

Assessment

- Previous ED use:
- 2024- 29 as at 21/4/24 (11 in previous year)
- FTA – 12 in 2024 (nil in the previous year)
- Extensive wounds to right greater toe (was close to palliation)

- NDIS provider over utilising ED as unable to manage behaviours. Supports workers showed disengagement whilst at appts with pt and ignored requests for assistance.
- NDIS relinquishment of cares as finding it too hard to manage,
- pt showed nil behaviours whilst at Podiatry appts and engaged well with all staff. Supports workers showed disengagement whilst at appts with pt and ignored requests for assistance.

Plan of Care

- Care Co-ordination:
  - Liaised extensively with stakeholder: senior podiatrist, QAS, behaviour practitioner and support coordinator to develop plan of care for pt to be managed either at home or in podiatry clinic to reduce utilisation of ED.
  - Hospital community pathway NDIS Co-Ordinator new provider found
- Health literacy to support workers re his wound care and interactions impacting on patient outcomes
- Behaviour regulation: flagged pt case with hospital NDIS coordinator, when admitted for forefoot amputation due to risk of further amputation required, if pt discharged with current NDIS provider due to ongoing and increasing behavioural dysregulation.

Communication

- Multiple stakeholder meeting with:
  - Support co-ordinator
  - Behaviour practitioner
  - Support worker manager
  - OPG
  - Hospital NDIS co-ordinator
  - Managing director of NDIS provider
  - Social work

Developed:

Wound care plans with podiatry

Wound care bay in his home (patient focused care)

Developed a QAS Management plan

Developed ED management plan

Health literacy to support worker of new NDIS provider on behaviour impacting wound care

Co-ordination

Nurse Navigator ensured:

- smooth transition to new NDIS provider via ‘Hospital to Community’ pathway by acting as the link between hospital and community through stake-holders engagement.
- OPG,
- Support Coordinator,
- behaviour practitioners,
- diabetes NP,
- Podiatry,
- diabetes dietitian.
- GP
- QAS
- ED

Prevention

- NN followed up in the home multiple times to ensure all stakeholders were comfortable in providing patients care – educating as required / service manager liaison
- He had a new NDIS provider who understood and managed his needs.
- He stopped presenting to ED and attended all his OPD appointments
- ED and QAS management plans in place.
- Provided videos and photos of wound care so NDIS provider could educate new staff to maintain standards

Wound is now healing!

Examples of patients types we manage

- Older person at home
- Disengaged and over engaged patients
- Health deterioration and poor self-management
- Transition to Adult services
- NDIS provider break down with high healthcare needs
- Psychosocial vulnerabilities

Any Questions

?

Essential Health Summit

Adelaide, 25 - 27 July 2024

apna

Australasian Society of Lifestyle Medicine

Bianca Radford – Practice Nurse
Myhealth Ashmore Plaza

Perform Peripheral Intravenous Cannulation

Clinical Placement Supervisor workshop: supporting students in PHC placements

Importance of the first 2000 days of life: how the primary care nurse can shape the future of health

Nurse led models of care

Assessing Frailty in 40–70-year-olds

Immunisation- Sharpen your knowledge

sanofi

Australian Government
Department of Veterans' Affairs

- Sanofi – immunisation update for RSV, Influenza and Menquadfi
- Empowering health transformation – shared medical appointments in the Northern Territory
- Coordinated veteran's care
- HPV self-collection update
- Vision for Primary Health Care reform and how do we get there

Take home information

- The Essential Health Summit will be in Brisbane in 2025.
- Provides opportunities to improve your practice and patient care within your clinic.
- Gained a larger understanding of how APNA is working to improve Primary Health Care.
- Ability to network and liaise with other nurses and personnel in PHC.
- Speak with Monika from PHN if interested in taking nursing students within your clinic.

phn
GOLD COAST

An Australian Government Initiative

'Building one world class health service for the Gold Coast

Level 1, 14 Edgewater Court Robina QLD 4226

www.gcphn.org.au

ABN: 47 152 953 092