

# Crossing the boundaries: Embracing the potential

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Start with a great idea



And follow through!

# Model of care

Look at target population first and the needs and gaps – how will you fill the gap? Or can you?

Where do you want to be situated? And why?

What are your strengths and weaknesses that you bring to the table?

Who do you need?

Have a mentor who is your advocate but will challenge you.

# What I wanted

- Providing quick service
- Ease of contact
- No cost to community
- Utilising existing knowledge base and building upon this
- Working with current services and providing holistic care. Each service using its strength.

# Point of interest

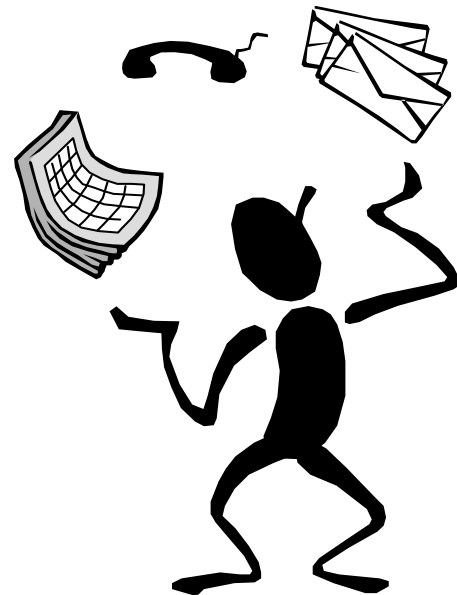
Role developed around the service not the individual.

Look at what you need to develop within your own practice to met this need.

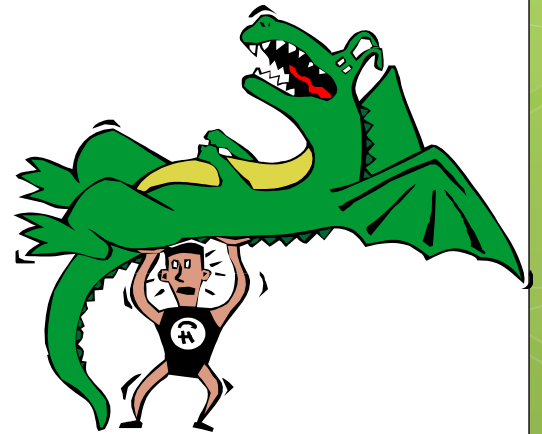


# Up skilling

Not just about skills based, but assessment and networking.



importance of  
competence and  
realising limitations



# Issues you may face

eg not being able to prescribe on RACF  
med charts and strategies put in place to  
deal with this







# Adaption

adapt expertise to suit target population eg  
for me younger people also

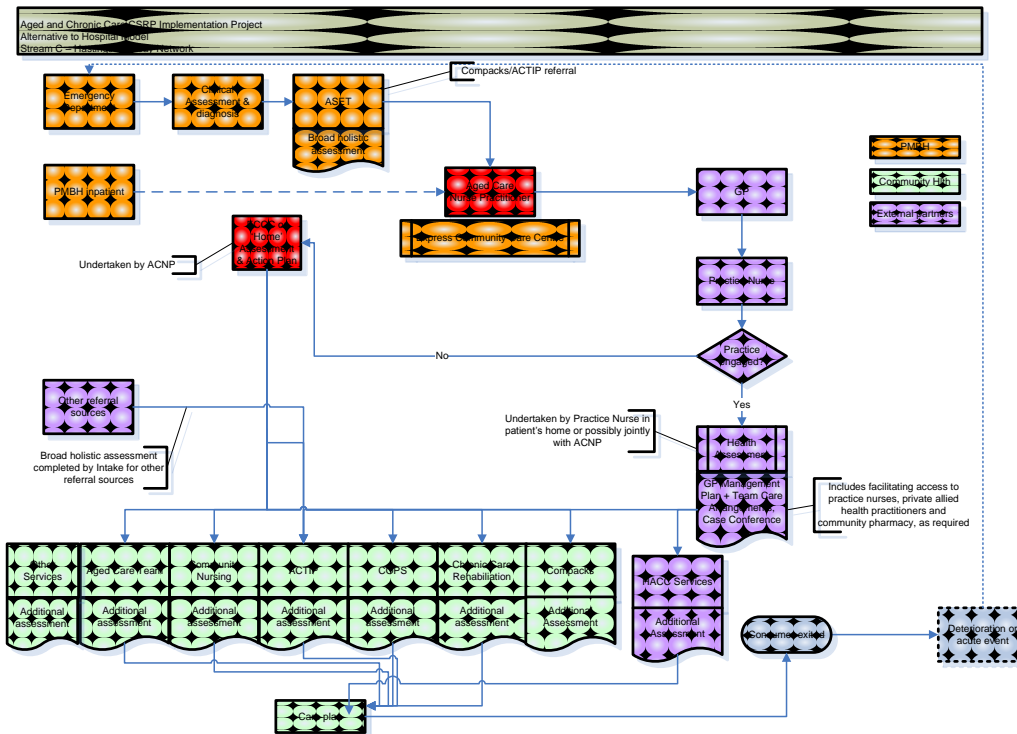
Try to make a difference to your population.

# Pitfalls

eg infrastructure,  
support systems  
managers understanding the rôle  
everyone wants a say  
self care boundaries



# Peoples input



- ACNP 'working day'
  - 8-9: pick-up cases, liaison
  - 9-12: ECCC assessments
  - Afternoon – flexibly deployed to home assessments, additional ECCC assessments, networking, support to RACFs/GPs
  
- Managing assessments
  - Booked via ACNP
  - Typically within 72 hours
  - Earlier intervention with admission-risk or anxious patients
  - Preference for in-centre assessment (time efficient)

# My Journey

## First day

Infrastructure

## Within 3 weeks

## First year

Asked to locum a GP while on holidays



## Five years on .....

- admission rates increased in over age 70 from approx 40% (2007) to approx 60% 2012. People who present need to be admitted – lower acuity – me
- PBS
- Outside funding – bladder scanner \$20, 000

# June 2012 Stats

93 new referrals seen

Occasions of service: 172

17 working days

Distances from Laurieton (South) to  
Telegraph Point (north), Comboyne  
(West).

## Calculation method for predicted bed days saving

[(No of pts seen by NP) x (admission rate for >70s as fraction) – (pts admitted within the month following NP review)] x average LOS for 2007.

Was for month but LOS increased each month and figures became inflated.

### 2007 figures for state:

LOS: 7.91 days

Admission rate: 52%



# June 2012

$93 \times 0.52 (48.36) - 0 (\text{nil pts admitted}) \times 7.91$

= 382 potential bed days “saved” for the month

Try new ideas all the time..

## “Partners in care”

To create a “virtual ward” of PMBH within an aged care facility as a trial for 6 months.

4 beds being trialled.



- Hospital will increase capacity of acute care beds.
- Pts are transferred to an ACF – pt type can include at risk but no longer requiring acute care (no placement pts).
- No ACAT assessment

# Issues to overcome

- Medical records
- Costing
- Consent
- Governance
- OMG!! factor



## Potential saving

1. Savings: ????

2. Indirect saving: 'saved' beds would be immediately refilled.

# What's next??

- Admission rights into an ACF – commonwealth and state funding
- Work with a University to assist student to build capacity and models



“The harder you work, the luckier you are”  
Mark Twain

**I Disagree**

the smarter you work, the luckier you are





## Debbie Deasey



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