

Clinical Practice Guidelines
for
Nurse Practitioners
in NSW

February 2005

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Nurse Practitioner Clinical Guideline Critical Appraisal Tool

This information should be read in conjunction with NSW Health Policy Directive 2005_556 Policy for Nurse/Midwife Practitioners in New South Wales.

Nurse Practitioners in NSW

- Nurse Practitioners are registered nurses who practise at an advanced level. This “advanced level practice incorporates the ability to provide care to a range of clients at a level, which demands:
 - A repertoire of therapeutic responses;
 - Insightful sophisticated clinical judgements;
 - Clinical decision-making justified by application of advanced knowledge.” [NSW Nurses Registration Board, 2002, Nurse Practitioners in New South Wales: Information Brochure.]

Advanced Nursing Practice

"Advanced Nursing Practice is the application of an expanded range of practical, theoretical, and researched-based therapeutics to phenomena experienced by patients within a specialised clinical area of the larger discipline of nursing" (Hameric, 2000 p.47).

Advanced nursing practice (ANP) is an umbrella term. It describes an advanced level of nursing practice that maximizes the use of in-depth nursing knowledge and skill in meeting the health needs of clients (individuals, families, groups, populations, or entire communities). In this way, ANP extends the boundaries of nursing’s scope of practice and contributes to nursing knowledge and the development and advancement of the profession. [Canadian Nurses Association 2002, *Advanced Nursing Practice: a National Framework*]

Being an expert-by-experience in a specialty is not on its own sufficient for advanced nursing practice. Nor is accepting more delegated medical tasks or technical procedures. Advanced practice differs from expert practice or extended roles in its scope and sphere of influence and its application of advanced nursing knowledge.

The scope of advanced nursing practice is distinguished by autonomy to practice at the edges of the expanding boundaries of nursing. It is firmly grounded in the unique body of knowledge that is nursing. In advanced nursing practice, the nurse makes use of scientific theories drawn from nursing and other disciplines, as well as current research which enables articulation of sound rationale for the selection of nursing actions.

One hallmark of advanced practice is the use of self-initiated treatment regimes, and collaborative working relationships, as opposed to dependent functions. Discriminative judgement is used in solving complex nursing problems.

The area of patient management, as a hallmarks of the NP's role, should therefore identify specifically the areas of prescribing, the initiation of diagnostic investigations and patient referral.

What is a scope of practice?

A scope of practice is how a nurse practitioner describes his or her practice. It includes reference to the population service group (e.g. mental health, primary health care) in which the nurse practitioner is authorised to practice.

A scope of practice is required for each Nurse/Midwife Practitioner.

The scope of practice is that which Nurse/Midwife Practitioners are educated, authorised and competent to perform. The actual scope of practice of individual Nurse/Midwife Practitioners is influenced by the settings in which they practise, the health needs of people, the level of competence and experience of the Nurse Practitioner and the policy requirements of the service provider. The scope of nursing practice encompasses clinical, educational, administrative and scholarly dimensions of nursing practice and for a Nurse/Midwife Practitioner should incorporate specialist practice of the registered nurse and be at an advanced level.

Advanced practice is characterised by greater and increasing complexity and exists beyond beginning practice on the continuum of nursing practice. Education, experience and competence development mark advancing practice. As practice becomes more advanced nurses demonstrate more effective integration of theory, practice and experiences along with increasing degrees of autonomy in judgements and interventions. [Adapted from Queensland Nursing Council, 2002, Scope of Nursing Practice Decision Making Framework, pages 5-6].

The Nurse/Midwife Practitioner's scope of practice should also include the context in which practice is delivered. The context of practice is usually indicated by defining the following:

- Age range of patients/clients
- Presenting symptoms or complaints
- Actual disease state or diagnosis
- Severity of the symptoms
- Geographical location of the patient or client⁵

This scope of practice statement/description is to be based on the guiding principles in the Queensland Nursing Council's *Decision Making Framework* (2002). This document can be accessed at

www.qnc.qld.gov.au/upload/pdfs/practice_standards/Scope_of_Nursing_Practice_Decision_Making_Framework.pdf

Where do NPs practice?

The scopes of practice and patient focus will determine the choice of work settings. Nurse practitioners could work between provider groups in both rural and urban settings, including:

- community health centres
- public health services
- hospitals and hospital clinics
- workplaces (occupational health)
- general practices or any specialist clinics
- nurse practitioner centres/offices
- nursing homes and hospices
- home health care agencies.

Within this scope, the nurse practitioner provides services targeted at a specific population or patient group – such as children, youth, adults, older persons or an immigrant community.

Broad scopes of NP practice in NSW

In 1992 the International Council of Nurses proposed a nomenclature for nursing specialties including seven broad categories and 61 sub-specialties.

[International Council of Nurses (1992) *Guidelines on Specialisation in Nursing*. Geneva: ICN]. These categories were then recommended for use in Australia by the National [Review of Specialist Nursing Education 1997, Evaluations and Investigations Program Higher Education Division, Department of Employment, Education, Training and Youth Affairs]

The seven broad scopes of practice have been adopted by the NMB:

- mental health nursing
- maternal & child health nursing/midwifery
- rehabilitation & habilitation nursing
- medical/surgical nursing
- community health nursing/primary health care nursing
- high dependency nursing

Within these broad scopes, candidates will identify their area of practice by delineating their specialty, or their sub-specialty, population or client group.

Nurse practitioners are qualified to make independent and/or collaborative decisions in partnership with individuals, families or communities. They may act as the regular health care provider for their client group. Their practice will emphasise health promotion and maintenance and disease prevention as core activities.

Other nurse practitioners may be qualified in acute care (e.g. intensive care, anaesthetics, neonatal). Their care, professional practice and critical thinking will emphasise advanced assessment, treatment skills and clinical management skills consistent with best practice for patients in specialised tertiary-level services.

Nurse practitioners are competent to:

- obtain health histories and perform physical examinations
- diagnose and treat acute health problems such as infections and injuries
- case manage clients with highly complex chronic conditions, assisting them to access services to keep them in their homes and family environment

- diagnose, treat and monitor chronic diseases such as diabetes and hypertension
- undertake clinical management and monitoring of treatment regimes
- order, perform and interpret diagnostic studies such as laboratory test results and X-rays
- prescribe medications and other treatments within their scope of practice
- collaborate with other health professionals as needed
- refer to other health professionals as necessary
- accept referrals from other health professionals.

See Notes re the NP extended rights & responsibilities Appendix 1.

Clinical Guidelines

Clinical Guidelines for NSW Nurse Practitioners

Under Section 78A of the amended Nurses and Midwives Act 1991, NSW Nurse/Midwife Practitioners are required to work under guidelines which relate to their functions as well as making provision for the possession, use, supply or prescription of poisons or restricted substances under Section 17A of the Poisons and Therapeutic Goods Act 1966 [Nurse/Midwife Practitioners Amendment, Nurses and Midwives Act 1991, s. 78A].

As part of these guidelines the Nurse/Midwife Practitioner will be required to identify their

- a. scope of practice i.e. context and level of practice (as defined in section 6.1)
- b. diagnostic tests that will be used and a list of medications (formulary) that will be prescribed including the related clinical condition;
- c. existing clinical practice guidelines that are relevant to their practice.

The AHS is to ensure that each Nurse/Midwife Practitioner has defined their guideline/scope of practice and that this is evidence based and in accordance with the AHS policy requirements (e.g. Codes of Conduct and Ethics, etc.).

“A contravention by a Nurse/Midwife Practitioner of the approved guidelines does not give rise to an offence but may constitute professional misconduct or unsatisfactory professional conduct.” [Nurse/Midwife Practitioners Amendment, Nurses and Midwives Act 1991, s. 78A (5)]. In addition, all Nurse/Midwife Practitioners are expected to adhere to the policies and procedures of their employing institution, inclusive of the Nurse/Midwife Practitioner’s guidelines/scope of practice that describe their functions and role.

The approval of these NP guidelines (including the scopes of practice) has been delegated by the Director-General, NSW Department of Health to the Chief Executives of each AHS. In order to ensure consistency across NSW a guidelines and formulary approval proforma is appended to the N/MP policy NSW Health Policy Directive 2005_556.

Additionally, prior to final Chief Executive signoff, the Area or hospital Drug Committee needs to approve the drugs that are identified for use by the Nurse/Midwife Practitioner in the formulary to ensure clinical appropriateness and consistency with local policy. The signed agreement must include the Area Director of Clinical Operations and the Area Director of Nursing and Midwifery Services.

AHS approved guidelines

It is requested that when a NP guideline is approved by an AHS a copy of the guideline, local signatories and the formulary is to be sent to the Chief Nursing Officer, NSW Health

A Definition of Clinical Guidelines:

'systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances'.

[Lohr, KN and Field.MJ (1992) A provisional instrument for assessing clinical practice guidelines. In: Field MJ & Lohr KN (eds). *Guidelines for clinical practice: from development to use*. Washington D.C. National Academy Press, 1992.]

They are designed to help practitioners assimilate, evaluate and implement the increasing amount of evidence and opinion on current best practice.

Another definition:

A clinical guideline “is a document that contains procedures related to delivering a particular aspect of [clinical] care. It is based on current research and [best] clinical practice, which includes care practices for all members of the health care team.” [Vance, J (2002) Implementing Clinical Guidelines: Yes You Can! <http://www.amda.com/caring/april2002/cpginaction.htm>]

Clinical practice guidelines are intended as neither cookbook nor textbook, but where there is evidence of variation in practice that affects patient outcomes and a strong research base providing evidence of effective practice, guidelines can assist health care professionals in making decisions about appropriate and effective care for their patients.

Distinction between clinical guidelines & protocols:

| Guidelines | Protocols |
|---|--|
| <ul style="list-style-type: none"> ◆Composed of elements describing different aspects of the patient’s condition and the care given ◆Evidence-based | <ul style="list-style-type: none"> ◆Can vary in specificity and quantity of operational information the elements contain ◆Variation in the degree to which they are optional ◆Not always evidence-based |

What do Clinical Guidelines look like?

The structure can be deterministic or branching.

Deterministic ones are made up of fixed lists of elements describing aspects of care that should be followed, irrespective of the information available to the practitioner. They may be used to define minimum levels of care but are less useful as they do not allow for appropriate decision making.

Branching guidelines are usually represented as algorithms. The recommended course of action at each stage depends on critically assessing and evaluating the clinical information gathered from the patient and then deciding on a course of action outlined in the guideline.

The format of the clinical guidelines will often be determined by the particular aspect of care they address and by the target patient population. Sometimes the guidelines may give a broad objective for care and criteria sets for its achievement. At other times guidelines may provide greater detail and specificity including more information about the patient's condition and treatment options.

Clinical Flexibility

Clinical guidelines should identify exceptions to their recommendations and indicate best clinical judgement or patient preference.

Professional judgement should not be replaced by reliance on a guideline.

What a CG IS NOT:

- a recipe nor step-by-step approach to assessment and treatment
- a nursing practice or procedure that most nurses in the specialty already perform
- a standing order
- simple descriptions of aetiology, prevalence and assessment

How can Guidelines be accessed?

Guidelines are not usually identified as being only for the use of one particular profession, and the importance of multi-professional development of guidelines cannot be overstated.

Listings (electronic clearinghouses) for guidelines often are listed under "Hospitals" or "professional organisations". The CIAP – Clinical Practice Guideline database is a collection of guidelines or policies that have been collated and placed within a database for ease of searching by either body system or individual topic. The CIAP web-site can be accessed through the DoH page. <http://internal.health.nsw.gov.au:2001/guidelines/index.html>

How do Nurses know if the guideline is a good one?

Guidelines are appraised on whether they have been developed using high levels of evidence of best practice; are valid; reliable and meet multi-professional consensus. As well, they should use unambiguous language, precise definitions and a user friendly format.

How are the best practice guidelines chosen?

- There is a growing number of best practice guidelines being developed by both Nursing and Medical professional bodies for most medical and surgical presentations in Australia as well as international ones (e.g. Scottish Intercollegiate Guidelines Network (SIGN); National Institute for Clinical Excellence U.K. (NICE); New Zealand Guideline Group; etc.).
- For example, the *Medical Journal of Australia* list 59 clinical guidelines on their web site www.mja.com.au/public/guides/guides.html and state “Clinical guidelines published by the *MJA* represent the consensus opinion of experts based on review of the scientific literature.”
- In addition to this there are also professional Colleges and other consortia that have developed clinical guidelines to assist with specific areas of practice such as Paediatric guidelines for General Practitioners. An example of this is the Greater Eastern and Southern NSW Child Health Network that have 12 guidelines at www.sch.edu.au/geschn/index
- The choice of guideline is based on the following:
 - The clinical condition of the patient
 - The scope of practice of the Nurse Practitioner
 - Consultation with the multidisciplinary team that the NP will be working with
- Nurse Practitioners have been advised to identify existing clinical guidelines that provide best practice information about a particular clinical presentation that the NP will be treating, to identify which parts of the guideline are relevant to the NP’s practice and to add a formulary section to identify the drugs the NP will be prescribing.
- N.B. Many papers on the development of clinical guidelines give much information about the development of them from scratch including a multidisciplinary development group, levels of evidence, clinical questions posed re intervention and prognosis. Much of this information is not relevant when you are adapting existing guidelines. The advice on levels of evidence can be largely summarised by stating that the highest level of evidence should be used.

How do they know that these are the most appropriate best practice guidelines?

For the individual NP accessing Clinical Guidelines:

There are now a number of guides and standards available that many of these published guidelines have already been evaluated against. These include the NH & MRC (1998) *Guide to Development, Implementation and Evaluation of Clinical Practice Guidelines* which uses the AGREE (Appraisal of Guidelines Research and Evaluation) tool that looks at the level of evidence used.

- In addition to this there are a myriad of other tools available, for example:

- Canadian Family Physician Critical Appraisal (which assess the strength of the study & clinical importance for Family Practice)
- Critical Appraisal Skills Program (CASP) Appraisal Checklists (evaluating rigor, credibility and relevance)
- Critical Appraisal Worksheets e.g. *JAMA (Journal of American Medical Assocn.)* User Guides (these evaluate causation & harm, diagnostic tests, therapy, economics, etc.)
- *Cochrane Collaboration Handbook*

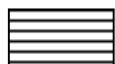
With this in mind the task of the NP is to take an existing CG and define, in some detail, the following:

- which parts of the CG apply to the NP especially clinical exclusion criteria
- the patient population covered by the NPs use of CG – that is, what is their scope of practice?
- details of management of the patient's condition including investigations and therapies including a formulary of drugs and follow up(if required)
- when to consult or to refer a patient to another member of the healthcare team
- expected outcomes of the NP interventions

Scoping Clinical Guidelines for Nurse Practitioners

For example, the *British Guideline on the Management of Asthma*

| Diagnosis & Natural History | | Outcomes | | | | |
|-----------------------------|--|---|----------------------------------|---|---|--------------------|
| Diagnosis | Non pharmacological management | Pharmacological Management | Inhaler Devices | Management of acute asthma | Asthma in Pregnancy | Outcomes and Audit |
| Asthma in Adults | Primary Prophylaxis | Mild intermittent asthma | Technique & training | Lessons from the studies of asthma deaths & near fatal asthma | Natural history | |
| Childhood Asthma | Environmental factors | Introdn of regular preventative therapy | Beta 2 agonist delivery | Acute asthma in adults | Management of acute asthma in pregnancy | |
| Asthma in Pregnancy | Complementary & alternative medicine Dietary manipulation | Add-on therapy | Inhaled steroids | Tmt of acute asthma in adults | Drug therapy in pregnancy | |
| | | Poor control on moderate doses of inhaled steroid – addition of fourth drug | CFC propellant vs HFA propellant | Further investigation & monitoring | Management during labour | |
| | Gastro-oesophageal reflux | Continuous or frequent use of oral steroids | Prescribing devices | Asthma management protocols & proformas | Drug therapy in breastfeeding mothers | |
| | immunotherapy | Stepping down | Use & care of spacers | Hospital Discharge & follow up | | |
| | | Novel therapies | | Acute asthma in children aged over 2 years | | |



The hatched areas represent the NPs scope of practice & therefore the relevant sections of the guideline for their treatment of Asthma.

When adapting existing CGs the NP should consider the following:

- The CG should show some detail of expert decision making by the NP
- The CG should show evidence of clinical judgment in individual cases and therefore words like “should” and “must” are inappropriate however NPs need to document variations in practice including their rationale for doing so [Appraisal of Guidelines for Research & Evaluation, 2001, St George’s Hospital Medical School London]
- The description of patient management presumes advanced practice and expert decision making and therefore it is not necessary to have an exhaustive list of possible options for treatment but just to describe the usual ones.

The area of patient management is one of the hallmarks of the NP’s role and should therefore identify specifically the areas of limited prescribing. the initiation of diagnostic investigations and patient referral.

Formatting/Presentation – To make the parts of the guideline used by the Nurse Practitioner clearer

- ❖ Flowcharts/decision trees may be a useful way of demonstrating a clear decision for inclusion/exclusion or treatment modality for the target population
- ❖ Use “Footers” to identify which version of draft document is being submitted and the date of writing (see attached direction on how to insert a Footer into a document)
- ❖ Use the “Track Changes” Word® document tool to make changes to a draft version so that any changes can be readily identified (see attached direction on how to use the “track changes” tool)

Consider the use of “flags” for alerting problem Signs & Symptoms, when to urgently refer or to highlight other possible pitfalls in clinical decision making

For Example:  or ➔ or ⇒ or ►

- ❖ An example of a pitfall might be failure to rule out mastoiditis in ear infections; or peritonsillar abscess in tonsillitis
- ❖ Consider identifying clinical differences for specific populations e.g. geriatric or paediatric
- ❖ Consider the use of severity scores which may assist in identifying the group to be referred
- ❖ Consider listing “pearls” of practice e.g. rebound tenderness is less likely in geriatric patients with appendicitis; the use of antiemetics for penetrating eye injuries to reduce the possibility of extrusion of eye contents; or documentation of neurovascular status after splinting

Clinical Guideline Language

- ❖ The language should be specific, clear and unambiguous and where possible written in plain English, however a degree of medical terminology will still be necessary. Lay descriptors should be avoided unless used as patient discharge advice.

Standard of writing

The guidelines should be of a written standard expected for professional papers and therefore the following criteria need to be met:

Format

The guideline should contain the following:

- Description of the target population and scope of practice;
- Patient assessment including diagnostic investigations such as pathology and medical imaging;
- Treatment and other patient management including prescribing medications;
- Medication treatments should include dose (or dose ranges), indications, contraindications, cautions, main adverse effects;
- Expected outcomes including time frames need to be specified;
- Follow up and referral to medical, allied health and other relevant resources.

Language

- The language should be specific, clear and unambiguous and where possible written in plain English. However a degree of medical terminology will still be necessary. Lay descriptors should be avoided unless used as patient discharge advice.
- Where abbreviations are used, the full description should be included for the first time with its abbreviation or acronym and for subsequent times the shortened form can be used. Where many specialty-specific abbreviations need to be used a list of abbreviations attached to the guideline may be helpful.

Clarity

- The guideline should be concrete and precise in regard to its patient population, care priorities, assessment and management.
“An example of a specific recommendation [for management] is:
Antibiotics have to be prescribed in children of two years or older with acute otitis media if the complaints lasts longer than three days or if the complaints increase after the consultation despite adequate treatment with painkillers; in these cases amoxicillin should be given for 7 days (supplied with a dosage scheme).
An example of a vague recommendation is: Antibiotics are indicated for cases with an abnormal or complicated course.”
[St George’s Hospital Medical School, London, 2000, *Appraisal of Guidelines for Research & Evaluation (AGREE) Instrument.*]
- Flowcharts/decision trees may be a useful way of demonstrating a clear decision for inclusion/exclusion or treatment modality for the target population.
- Tables are helpful to identify signs & symptoms that differentiate between mild, moderate or severe.

Referencing

- The use of other clinical guidelines, flow charts, tables, etc. need to be fully referenced using a recognised referencing system that includes
 - Author or organisation;
 - Year of publication or authorship;
 - Title;
 - Journal or website if applicable;
 - Relevant page numbers, table numbers, etc.
- Recommended pathology parameters including biochemistry, haematology and microbiology levels or ranges need to be fully referenced. For example, ranges of a drug serum level that is considered to be within a therapeutic range.
- Suggested therapeutic dosages for medications need to be referenced. This is particularly important for specific populations such as paediatric, neonatal, geriatric and renal or hepatic impaired patients.
- These references may include:
 - developed or adapted clinical guidelines;
 - journal articles;
 - hospital protocol;
 - hospital handbook;

and these should be referenced appropriately. In the absence of empirical evidence, clinical treatment recommendations should be a consensus of opinion of the local multidisciplinary stakeholders. The clinical recommendation should therefore contain a note identifying that it is a consensus opinion and list the names of those giving that opinion.

Possible Subheadings for Clinical Guidelines

- ❖ There are many possible subheadings but the only useful ones are those that are relevant to and best describe your practice.
- ❖ There is no one authoritative or exhaustive list and so they can be mixed and matched or deleted if not relevant

Although there is NO SET FORMAT for NP Clinical Guidelines

There are *some common headings you might expect to find in most guidelines*

e.g.

- I. **Introduction** – needs to be brief & describe:
 - Disease state/presenting issues
 - Where on the continuum the NP is practising (i.e. their **scope of practice**) (e.g. mild hypertension <140/90; minor wounds excluding face; mild dehydration i.e. < 8 –10%)
 - Age, range, gender, etc.

The Clinical Guideline should delineate the Patient Population to be seen by the Nurse Practitioner

- ❖ Age range, gender, clinical severity, clinical description and comorbidity should be clearly described.

Hint: Tables maybe helpful to identify signs & symptoms which differentiate between mild, moderate or severe

Hint: Flow charts and decision trees may also be useful

Identification of obvious **PITFALLS** (potential traps or unusual presentations) in diagnosis may be useful

Consider the use of “flags” for alerting potential problem Signs & Symptoms or when to urgently refer any Obvious & Immediate Exclusions (e.g. suspected ischaemia, suspected or impending airway compromise e.g. epiglottitis; haemodynamically unstable; significant drug reactions)

NB: depending on the location the NP may be expected to follow other protocols/guidelines in these instances such as the Rural Emergency Clinical Guidelines – Adults. This is a local decision and the NP and the AHS need to have a clear agreement about this and similar issues.

- II. **Assessment** – physical assessment and history especially what specifically identifies the disease state and its severity

This may be a point of referral if outside the NPs patient population in terms of severity or disease state

- III. **Investigation** (may be a separate section or a sub-section of assessment)
What investigations are required that will assist a definitive diagnosis:
 - pathology
 - medical imaging

Content - as part of the pre-existing guideline:

- ❖ Ensure there is list of:
 - Diagnostic investigations
 - Pathology investigations
 - Formulary of Drugs (including generic name, indications, dose/route/frequency, therapeutic class, schedule & contraindications/cautions/side effects) & don't forget to include IV fluids if these are required

associated with and outlined in the clinical guideline

This may be a point of referral if outside the NPs patient population in terms of severity or disease state

- IV. **Management** – Describes the actual care or treatment/procedure e.g. dressings, removal of foreign body; splinting/plastering; bed rest; patient education; counselling; etc.
Includes Prescription of medications or other treatments
- List contraindications/cautions/interactions as applicable

This may be a point of referral for additional services or if outside the NPs scope of treatment

- V. **Outcomes** –
- expected response described in some detail especially timeframe
 - actions that will be taken if outcome(s) not achieved

This may be a point of referral for additional services or if outside the NPs scope of treatment

- VI. **References** of current best practice

Ensure that the Clinical Guideline used

Has current references to justify the investigations, interventions and outline expected outcomes.

Should be based on best available evidence. The evidence should be from current literature.

Where empirical evidence is unavailable medical officer recommendations using a consensus approach should be sought whereby the outcome is focused on the maximum benefit and minimum harm for the patient

Where 2 or more CGs are merged ensure that each area of your practice has been covered and that repetition has been avoided

- VII. **Evaluation** expected time when Clinical Guideline should be reviewed within a 1 year period (or earlier if there is a population or practice change)

Statement of Intent of Clinical Guidelines

It would be advisable for each guideline to contain a qualifying statement outlining the following:

- intent and scope of the guideline
- need for individual judgement

In relation to this the NH & MRC advises the following process be followed:

Guidelines developers need to demonstrate that they have taken reasonable steps to ensure that the guidelines were properly prepared and that they are based on the best information available at the time of publication. The guidelines should clearly state that they are not a definitive statement of the correct procedure; rather, they constitute a general guide to be followed, subject to the medical practitioner's judgment in each case. They should also state the date the guidelines have been issued and make it clear that the information is correct only

to that date. [Chapter 6.2, NH & MRC, 1999, *A guide to the development, implementation and evaluation of clinical practice guidelines*, Canberra: Commonwealth of Australia]

Disclaimer

With this advice in mind each clinical practice guideline must contain a disclaimer outlining the intention and limitations of the guideline. Suggested wording for the disclaimer might be:

This document reflects what is currently regarded as safe practice, however, as in any clinical situation there may be factors which cannot be covered by a single set of guidelines. This document does not replace the need for the application of clinical judgment to each individual presentation.

Local implementation of guidelines & proposed Nurse Practitioner role

It may provide clarity for the Nurse Practitioner role if some short description is included regarding the setting the Nurse Practitioner will be working in and how these guidelines might be utilised in relation to the local conditions.

Local Review of Guidelines

It is most important for each NP's ability to practice effectively that they have the support of local stakeholders for their guidelines and formulary. The local stakeholders are usually relevant medical clinicians, pharmacists, radiographers, pathologists and other key nursing personnel who will be involved with the work of the NP. However, the difficulty in getting all stakeholders together is acknowledged and, if pre-existing best practice guidelines are adapted, it may only be necessary to meet with each stakeholder individually to explain the extent of the NP's role and formulary, rather than trying to get all stakeholders together to write a new set of guidelines. The adapted guidelines and formulary could then be sent out to each stakeholder for comment with a required response date. Majority consent is required, but it is also important that the stakeholders understand how the NP will practise, which is why individual briefings may assist if there is any uncertainty. When the guidelines are sent in to [now the Chief Executive] (or Director-General) for final sign off, the signed agreement of the each individual stakeholder is required.

[Memo from Mary Chiarella, CNO, 16 October 2003]

Local Review/Endorsement Group – list of names, signatures, dates and roles

To ensure the clinical guidelines remain at the level of best practice these need to be reviewed within a 1 year period or earlier if there is practice or population change.

Clinical Guidelines should contain a title page which includes the AHS or hospital logo

Multidisciplinary Team Sign Off Process

- ❖ Include Approval/Authorisation from the multidisciplinary group you are (will) be working with:
 - Medical Officer(s)
 - Pharmacist/Drug Committee
 - Radiographer
 - Pathologist
 - Nursing Manageras appropriate

The National Health & Medical Research Council provides the following recommendation:

Guidelines developers need to demonstrate that they have taken reasonable steps to ensure that the guidelines were properly prepared and that they are based on the best information available at the time of publication. The guidelines should clearly state that they are not a definitive statement of the correct procedure; rather, they constitute a general guide to be followed, subject to the medical practitioner's judgment in each case. They should also state the date the guidelines have been issued and make it clear that the information is correct only to that date. [NH & MRC, 1999, *A guide to the development, implementation and evaluation of clinical practice guidelines*, Canberra: Commonwealth of Australia]

Process for Authorisation of Clinical Guidelines

- ❖ *Because it is often difficult to detect errors or ambiguities in your own work it is important that you get it carefully proofed by a colleague with strong English language skills*
- ❖ The submission of an **electronic copy** would be greatly appreciated and speed up the authorising process. Sign off sheets with signatures of local reviewers can be faxed
- ❖ If hard copies are submitted please do not spiral bind *draft* versions being sent for external review
- ❖ Once multidisciplinary agreement/approval has been obtained the draft CG(s) should be sent to your AHS office.

Role of Clinical Expert Reviewer

- AHSs may decide to have CGs externally reviewed prior to final CE signoff. (the decision to do this rests with the AHS).
- The role of the clinical expert in reviewing the Nurse Practitioner guidelines is crucial to ensure best practice is encapsulated in each guideline.
- The reviewer should keep in mind that clinical practice guidelines are “designed to improve the quality of health care, to reduce the use of unnecessary, ineffective or harmful interventions, and to facilitate the treatment of patients with maximum chance of benefit [and] with minimum risk of harm” [NH&MRC, 1998, *A guide to the development, implementation and evaluation of clinical practice guidelines*.]
- Each guideline should be based on best available evidence.
- The choice of the patient population in terms of acuity and severity should be within the expected level of a NP's practice.

- The guideline should provide a concrete and precise description of the appropriate management in each specified situation and patient group as permitted by the body of evidence and the scope of NP practice.
- It would be expected that each guideline clearly identifies those patients or conditions that need referral (urgent or otherwise) to medical practitioners.

It is imperative that the expert clinical reviewer accurately critique the NP clinical guideline against their knowledge and experience of best practice in order to assist in the safety and quality of care delivered by the NP. The professional integrity of the NP role is largely dependent upon its ability to withstand scrutiny from the clinical experts in the related specialty.

Information for Reviewers

Scope of Practice & Local Implementation

Each Clinical Guideline needs to clearly define the nurse practitioner's scope of practice and in particular the boundaries. The points of urgent or other referral need to be clearly defined and it should be emphasised that these referral points can occur anywhere along their continuum of practice.

When making these delineations in care boundaries, the nurse practitioner needs to consider not only the responsibilities of their role but also their level of expertise; and what extended support/intervention the patient requires, when they require it and who can provide it.

In addition to this, each nurse practitioner & their Area Health Service need to have a clear understanding of the obligations/responsibilities of the nurse practitioner in relation to medical emergencies. For example, the rural regions have developed the Rural Emergency Clinical Guidelines (Adult) and the responsibility of the nurse practitioner in regard to emergencies will be delineated by their level of expertise and the guideline. It may be useful for metropolitan areas to also identify the role of the nurse practitioner in regard to medical emergencies taking into account available local resources and the nurse practitioner's area and level of expertise.

The following perspective may be of assistance:

Practitioners are not expected to be aware of all the national clinical guidelines, only those relating to their own area of practice. In an emergency situation outside of the practitioner's usual area of practice, he or she is expected to do no harm, to act in the best interests of the patient and use the most up-to-date knowledge available to him or her at the time. [United Kingdom Central Council for Nursing, Midwifery and Health Visiting, 1996, *Guidelines for Professional Practice*, London].

NOTE:

NPs need to develop a process for receiving timely communication of drug alerts and other updates or changes in therapeutics.

The advanced practice and theoretical education of the nurse practitioner will enable independent or collaborative models of care to be developed in hospitals and the community, and between both environments. Nurse practitioners will provide a wide range of assessment, treatment interventions, health promotion and disease management including differential diagnoses, ordering, conducting and interpreting diagnostic and laboratory tests, and administering therapies in response to the actual and potential needs of the individual, group or family.

Ownership of Clinical Guidelines

Authorised clinical guidelines are the property of the Area Health Service which employs the nurse practitioner. The clinical guidelines are specific to the nurse practitioner's expertise and scope of practice. Should a nurse practitioner leave their position, the AHS will either need to employ another nurse practitioner that has the appropriate expertise to work with the authorised clinical guidelines; or employ a nurse practitioner with different expertise and develop new clinical guidelines.

A nurse practitioner may transfer to a nurse practitioner position in another AHS. In that case the nurse practitioner may be able to use their original authorised clinical guidelines providing the AHS agrees that there is a need for that particular scope of practice and the scope of practice is congruent with the authorised clinical guidelines. Otherwise new or modified clinical guidelines would need to be authorised.

Local Sign Off: In addition to consultation with and review by a local multidisciplinary team, these guidelines are presented to the Hospital or AHS Drug Committee. It is also expected that the NP, as an expert in their field, will be conversant with current literature and best practice through attendances at specialty conferences and other clinical discussion such as hospital based grands rounds, etc.

- It also needs to be borne in mind that guidelines do not replace the need for the application of clinical judgment to each individual presentation.
- NEW Review Process: The approval of NP clinical guidelines has now been delegated from the Director-General to the Area Health Service Chief Executives. Prior to this sign off:
 - The guidelines are to be approved by the Area Director of Clinical Operations and the Area Director of Nursing and Midwifery
 - The AHS Drug Committee
 - An *external* expert reviewer

The old process for guideline approval

The NP guidelines were originally sent to the Nursing & Midwifery Office and then sent out to Nursing & Medical expert reviewers to comment on their quality and safety. If required, any changes were made to the guidelines prior to Director-General approval.

- [Nurse Practitioner Guidelines Appraisal Tool](#)
A suggested appraisal tool is attached (Appendix 1)
This tool has been used for the review in excess of 70 NP Guidelines and has found to be useful for reviewers.
- [Ongoing Review](#): It is expected that the guidelines will be reviewed at least every 2 years or earlier if there is a population or practice change. (NSW Nurse/Midwife Practitioner Policy – PD 2005_556).

Appendix 1.

Notes re the NP extended rights & responsibilities

This following notes have relied heavily on:

Nurse Practitioners Association of Ontario, *Standards of Practice for Registered Nurses in the Extended Class*, accessed at www.npao.org/npstandards.html on 15 March 2004;

and has adapted it to reflect the requirements of NSW Nurse Practitioners according to NSW legislation.

1. Level of nurse/midwife practitioner practice

Practice at an advanced level assumes a level of competence in the following areas:

1. Health assessment and diagnosis
2. Therapeutics
3. Health promotion and disease prevention

1.1 Health Assessment & Diagnosis

The nurse/midwife practitioner,

- performs a comprehensive health assessment, including an appropriate health history and physical examination;
- demonstrates sound clinical judgment and diagnostic reasoning abilities in synthesizing health information in order to identify a health problem or medical diagnosis within their scope of practice;
- modifies assessment technique according to the patient's condition, culture and stage of development;
- applies the principles of pathophysiology, including aetiology, developmental considerations, pathogenesis and clinical manifestations of commonly encountered acute and chronic illnesses and injuries, in order to diagnose a disease or disorder within their scope of practice;
- determines the need and appropriately orders and accurately interprets the results of relevant medical imaging and laboratory tests to either diagnose a disease or disorder; or monitor a previously diagnosed disease or disorder;
- effectively communicates health findings and/or diagnosis of a disease or disorder to the patient and discusses the prognosis and options for treatment for those conditions within their scope of practice;
- ensures all patients that fall outside of the nurse/midwife practitioner's scope of practice are appropriately referred to medical officers or other allied healthcare team members. Also ensuring this process occurs in an appropriate and timely fashion.

1.2 Therapeutics

- The nurse/midwife practitioner initiates and manages the care of patients with diseases or disorders within their scope of practice and/or

monitors the ongoing therapy of patients with chronic illness by providing effective pharmacological or counselling interventions.

- The nurse/midwife practitioner critically appraises and applies current, relevant research into clinical practice.
- The nurse/midwife practitioner applies knowledge of pharmacology, including pharmacokinetics and pharmacodynamics when selecting/prescribing drugs included in their formulary to treat diseases or disorders within their scope of practice.
- Where appropriate, the nurse/midwife practitioner provides effective counselling to individuals, families or groups.
- The nurse/midwife practitioner manages the treatment of patients with diseases or disorders within their scope of practice by:
 - Assisting/supporting/facilitating patients to design, follow and evaluate recommended therapeutic regimes;
 - Monitoring the effect of the chosen therapy, making necessary adjustments within their scope of practice;
 - Evaluating the effect of selected treatments and interventions using sound diagnostic reasoning.

1.3 Health promotion and disease prevention

The nurse/midwife practitioner implements strategies to promote health and prevent illness with individuals, families and groups.

1.4 Signing or Writing Sick Certificates

Approval has been sought from the Director-General NSW Health for nurse/midwife practitioners to be given the authority to sign written certificates in support of sick leave applications within public health facilities. Currently nurse/midwife practitioners are precluded from doing this.

Nurse/midwife practitioners cannot approve sick or other leave when it relates to a Workcover claim as it is specified in Commonwealth legislation that a medical practitioner needs to authorize Workcover claims.

2. Referrals

Consultation with other health professionals is the foundation of multidisciplinary care. It is expected that nurse/midwife practitioners will consult appropriately with other members of health professions to ensure that the overall health needs of their patients are met.

The expectations for consultation focus on the situations that extend beyond the nurse/midwife practitioner's scope of practice.

The nurse/midwife practitioner should consider referral to a medical officer or specialist medical officer in the following situations:

- Persistent signs or symptoms despite treatment;
- Symptomatic or laboratory evidence of previously unidentified, decreased or decreasing function of any vital organ or system;
- Sign(s) of recurrent or persistent infection;

- Any atypical presentation of a common illness or unusual response to treatment;
- For a non Mental Health-Nurse Practitioners: any sign(s) or symptom(s) of behavioural changes that cannot be attributed to a specific organic cause;
- A deviation from normal growth and development in an infant or child.
- In *potentially life-threatening situations*, this list includes, but is not limited to:
 - Any sign(s) and symptom(s) of an acute event that is potentially threatening to life, limb, or eyes;
 - Sign(s) and symptom(s) of obstruction of any system;
 - Signs of severe or widespread infection;
 - A fever $>39^{\circ}\text{C}$ in a child 3-36 months with no identifiable focus of infection;
 - Any sign(s) or symptom(s) of illness in a child < 3 months;
 - Any blunt, penetrating, or other wound that may involve damage below the fascia or functional impairment.
- When a patient's chronic condition destabilises especially an unexpected deterioration in the condition being managed;
- Or any other conditions/clinical presentations that the nurse/midwife practitioner and the medical officers have agreed to; or any other conditions that the nurse/midwife practitioner believes are outside their scope of practice.

2.1 Referral Process

- Clearly present the reason for and the level of urgency for consultation;
- Describe the level of consultation requested: an opinion, a recommendation, or both, a concurrent intervention, or a transfer of care;
- Ensure the physician has appropriate access to the patient's health information;
- Document the request for and the outcome of the consultation.

2.2 Implications of Referrals by NPs without MBS numbers

A lack of MBS provider number means that NPs *either* cannot refer patients to specialists as they do not fit the Medical Benefits Scheme referral criteria *or* require a special arrangement with each specialist MO. A referral without a MBS provider number affects what can be claimed by the patient if they were to see a specialist MO without a valid referral. It would also affect the MOs payment i.e. s/he could claim for that consultation. So the patient could agree to full fee pay with no reimbursement - but this type of patient is rare.

However, if there is an in-house agreement and if patients attending outpatients are not billed under Medicare (many Public Hospital OPDs are now registered as specialist clinics as a cost-shifting & revenue raising exercise) then NPs may be able to refer them. Agreement from the MO would be required. The hospital's finance section should know the details of the billing arrangements currently in place for RPAH.

If a hospital had Medicare billing and agreed to waive it in order to treat the NP referred patient as a totally public outpatient (i.e. no charge and no Medicare consultation signed) then the NP would be free to refer that patient if the MO accepted the referral.

3. Medical Imaging

The nurse/midwife practitioner may order medical imaging in the following situations:

- Confirm the diagnosis of a short term, episodic illness or injury as suggested by the patient's history and/or physical findings;
- Rule out a potential diagnosis that, if present would require consultation with an appropriate medical officer for treatment;
- Assess/monitor ongoing conditions of clients with stable chronic illnesses;
- Screen for disease.

3.1 Scope of Responsibility

The nurse/midwife practitioner is expected to:

- Complete a medical imaging request by indicating the type of imaging (X-ray, ultrasound, CT scan, MRI, etc.), the required views and the clinical details including relevant history, etc. (in making the request the nurse/midwife practitioner is expected to know the contraindications to ionising radiation exposure, and the associated risks and benefits of ordering these diagnostic tests).
- Interpret the image or seek Radiologist interpretation
- Document the imaging request and result as part of the patient's treatment plan.

4. Ordering Laboratory Tests

The nurse/midwife practitioner may order medical imaging in the following situations:

- Monitor the ongoing condition of a patient with a previously diagnosed illness or disorder;
- Confirm symptoms of decreasing/increasing function of a vital organ or system;
- Confirm a diagnosis of a short term, episodic illness or injury as suggested by the patient's history and/or physical findings;
- Rule out a potential diagnosis that, if present, would result in consultation with an appropriate medical officer for treatment;
- Perform screening activities.

4.1 Scope of Responsibility

The nurse/midwife practitioner is expected to consider the following factors when ordering laboratory tests:

That the test is required in order to determine the most appropriate treatment plan, and that screening activities are done in an age-appropriate, evidence-based and cost effective manner. This may mean that the nurse/midwife

practitioner regularly reviews the laboratory tests available to ensure that their requests are based upon current best-practice principles.

The nurse/midwife practitioner is expected to:

- Complete a request by indicating the type of laboratory tests required and the clinical details including relevant history, etc.
- Interpret the result or seek medical officer interpretation
- Document the laboratory request and result as part of the patient's treatment plan.

Where the nurse/midwife practitioner is responsible for collecting the pathology sample transport guidelines from the laboratory need to be adhered.

5. Standards for Prescribing Drugs

Nurse/midwife practitioners are expected to provide their patients with the following information for prescription and Over-the-counter (OTC) drugs:

- The expected action of the drug;
- The importance of compliance with prescribed frequency and duration of the drug therapy;
- The potential side-effects;
- The signs and symptoms of potential adverse effects (e.g. allergic reactions, etc) and actions to take should they occur;
- Potential interactions between the drug and certain foods, other drugs or substances;
- Specific precautions to take or instructions to follow;
- Recommended follow-up.

5.1 Scope of Responsibility

Monitoring and documenting the patient's response to drug therapy is integral to the authority to prescribe drugs. Based on the patient's response, the nurse/midwife practitioner may decide to continue, adjust, or withdraw the drug or to consult a medical officer or pharmacist.

OTC drugs need not be included in the formulary, as they do not require a prescription. However, any nurse/midwife practitioner who recommends an OTC drug is accountable for her/his actions. The same is true for complementary therapies.

Nurse/midwife practitioners are required to develop a process for receiving timely communication of drug alerts and other updates of changes in therapeutics.

5.2 Nurse/midwife practitioners and limited prescribing rights

Under Section 78A of the Nurses and Midwives Act 1991, NSW nurse/midwife practitioners are required to work under guidelines which relate to their

functions as well as making provision for the possession, use, supply or prescription of poisons or restricted substances under Section 17A of the Poisons and Therapeutic Goods Act 1966.¹

All the local stakeholders must agree the list of medications that a nurse/midwife practitioner may prescribe. This formulary provides for the poisons and restricted substances that may be possessed, used, supplied or prescribed by NP's under Section 17A of the Poisons and Therapeutic Goods Act 1966 and forms part of approved nurse/midwife practitioner guidelines, in accordance with section 78A(2) (a) of the Nurses and Midwives Act 1991.

The template for the drug formulary is given below.

| Drug (generic name) | Route | Dosage | Therapeutic Class | Clinical Presentation | Poisons Schedule |
|--------------------------------|--------------|---------------|------------------------------|----------------------------------|-----------------------------|
| | | | | | |
| | | | | | |

The following statement also needs to be included with the list of medications:

Any alteration must be submitted to the Chief Executive of the AHS for approval. This document is invalid if any alterations or amendments are made without the approval from the Chief Executive of the AHS.

The Area or Hospital Drug Committee needs to approve the drugs that are identified for use by the nurse/midwife practitioner in the formulary to ensure clinical appropriateness and consistency with local policy.

Before approving the guidelines or issuing an authority under section 17A, the authorised officer (including the CE) must be satisfied that they provide a clear and relevant structure for nurse/midwife practitioner services and that the list of drugs to be authorised under section 17A are appropriate having regard to the range of functions the nurse/midwife practitioner will be undertaking.

5.3 Prescribing Outside a Public Hospital

Although the nurse/midwife practitioner can prescribe medications approved as part of their scope of practice/clinical practice guidelines they will be largely limited to hospital-based prescriptions. This is because nurse/midwife practitioners do not have Pharmaceutical Benefit Scheme (PBS) Prescriber numbers. This means that if a nurse/midwife practitioner prescribes on an outside prescription the patient cannot claim a PBS (Commonwealth Government funded) price and would have to pay the full price. Frequently the full price for many drugs is quite prohibitive for most patients. Inside prescriptions (either for inpatients or outpatients) are provided through hospital pharmacies and therefore have minimal or no fees for patients. A way around this could be for the nurse/midwife practitioners in isolated regions to obtain a supply of regularly used drugs that they can dispense if required.

Each container holding a drug must be labelled according to the standards set out in the Poisons and Therapeutic Goods Regulations, 2002; NSW Health Policy Directive 2005_105 Handling Medication Community-Based Health Services/Residential Facilities in NSW – Guidelines; and NSW Health Policy Directive 2005_206 Handling of Medication in NSW Public Hospitals - Policy. In addition these medications also need to be stored appropriately. This process would need to be agreed to by local stakeholders.

Nurse Practitioner Clinical Guideline Critical Appraisal Tool

Guideline title: _____

Area Health Service: _____

| Criteria | Yes | No | Comments |
|---|------------|-----------|-----------------|
| 1. Is the guideline relevant to the practice of the Nurse Practitioner? That is, does it identify specifically the areas of clinical management including medications to be prescribed, the initiation of diagnostic investigations and patient referral? | | | |
| 2. Is the patient population specifically described? i.e. age range, gender, clinical description including severity and co-morbidity | | | |
| 3. Is the guideline specific and unambiguous? i.e. is the scope of practice clearly defined? Is the decision to consult and/or refer unambiguous? Have the patient care priorities (urgent or otherwise) been clearly delineated? | | | |
| 4. Are the number and type of investigations appropriate for the patient population and acuity? | | | |
| 5. Are the details of diagnostic investigations that the Nurse Practitioner is authorised to initiate, defined and clearly described? | | | |

| Criteria | Yes | No | Comments |
|--|-----|----|----------|
| 6. Is the decision making for the interventions clear and unambiguous? Does each drug have listed Contraindications/Cautions/Adverse Effects? | | | |
| 7. a) Is the drug formulary appropriate? | | | |
| b) Has it been provided to the Local Drug Advisory Committee? | | | |
| 8. Are the expected results of the treatments/interventions clearly stated? Including possible actions if expected result is not achieved e.g. review period; referral; additional/alternative intervention? | | | |
| 9. Is there stakeholder (multidisciplinary team) sign off? | | | |
| 10. Is the guideline appropriate for the local environment? i.e. Does it take into account available local resources and scope the NP's interventions appropriately? | | | |
| 11. Is the guideline based on current best practice? Does the guideline show evidence of this by citing current references for selection of patient population, investigations and interventions? | | | |

| Criteria | Yes | No | Comments |
|---|-----|----|----------|
| 12. Is the guideline written in plain English? (including accuracy and consistency in spelling and grammar) | | | |
| 13. Does the guideline have: ~ Area or hospital logo? | | | |
| Contain a Disclaimer including a Statement of Intent? | | | |
| ~ List of team members? | | | |
| ~ Date and version number? | | | |
| ~ Review date? | | | |
| 14. Does the guideline include the need to consult with other health practitioners as appropriate? | | | |

ⁱ Nurse/Midwife Practitioners Amendment, Nurses and Midwives Act 1991, s. 78A