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MEDICAL INSTRUCTIONS REQUIRED TO BE GIVEN TO NURSING STAFF BY TELEPHONE BY MEDICAL STAFF – PROCEDURE (2.380)

Except in the case of emergency all treatment must be prescribed in writing by a medical officer. In the case of an emergency, treatment may be prescribed by telephone but the treatment so ordered must be confirmed and signed on the patient’s treatment sheet by the Doctor who prescribed it within **24 hours**.

On occasions when instructions are conveyed to the nursing staff by telephone, the nurse who receives the instructions must record in the patient’s permanent record details of the treatment prescribed, the name of the Doctor who ordered it, the time it was ordered and the time the treatment was given.

It is emphasised that only in the case of an emergency may treatment be prescribed by telephone.

CHECKING DRUGS BEFORE ADMINISTRATION

The Maternal and Perinatal Committee has recommended that babies be given Vitamin K1 routinely, as soon as practicable after birth, as a prophylaxis against haemorrhagic disease of the new born.

To avoid medication errors generally, it is emphasised that all drugs should be checked carefully by reading the label (as well as checking the physical appearance) before administration. Ampoules should be left in their original box until required for use. Drugs should not be transferred from one container to another in the ward.

The particular hazard of confusing ergometrine and Vitamin K1 may be avoided by keeping in the delivery room only those drugs that are likely to be used during labour or immediately thereafter. The Department suggests that Vitamin K1 should not be kept in the delivery room but in some other suitable place and given to the baby as soon after birth as practicable.

USE OF ELECTRIC BLANKETS

The Department feels that with the use of electric blankets, special problems arise which place some restrictions on their use in hospitals. These are:

- An electric blanket on a hospital bed is not only in use 24 hours a day, but is subject to excessive wear due to patient movement and is liable to creasing when a patient is in a semi-reclining position. These factors would not only reduce the life of the blanket, but would make it more subject to failure caused by element breakage or hot spots. Hot spots could cause fire, and all electric blankets used in hospitals should be fire resistant.

- It is considered likely that blankets may become wet due to water or urine, or medical cleansing agents. They are not designed to be washed regularly and regular washing will shorten their life, and may affect the element and insulation.

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• Electric blankets should never be used while the patient has any type of electro-medical equipment attached, as they could induce harmful currents in electrode leads of the electro-medical apparatus. Each bed on which an electric blanket is in use should be suitably identified to ensure that electro-medical equipment is not used on the patient whilst the blanket is connected to the supply. (NOTE: switching off the blanket only is insufficient; it must be disconnected from the supply.)

USE OF HOT WATER BOTTLES

To assist in reducing the number of accidents, hot water bottles should be used only in conformity with the following policy:

• Nurses should be instructed to exercise care in the filling and use of hot water bottles.
• If a hospital does not possess other suitable and adequate means of heating for the comfort or treatment of patients, hot water bottles may be used for the purpose where suitable.
• Under no circumstances may a hot water bottle be allowed to remain in the bed of a patient who is unconscious from any cause whatsoever, but there is no objection to its being used for preheating such a patient’s bed.
• Where a hot water bottle is requested by a patient, its use may be permitted only with the consent of a Medical Officer, the Director of Nursing or her deputy.
• The greatest care must be exercised at all times to ensure that the risk of a patient’s being burned through the use of a hot water bottle is eliminated; the bottle should be suitably covered and there should be no exposure of any metal portion.

APPLICATION OF HOT OR COLD PACKS (GL2005_015)

This circular should be read in conjunction with the Patient Matters Manual (use of hot water bottles).

The purpose of this circular is to draw to the attention of nursing, allied health and medical staff, the potential of injury occurring to patients, when hot or cold packs are applied to the skin.

This circular can be used as a resource for local health services to develop and implement local guidelines and policies and in conducting educational sessions on the safe use of hot or cold packs.

The greatest care must be exercised at all times to ensure that patients are not harmed as a result of the inappropriate use of hot or cold packs. Staff may wish to discuss with the medical officer, Director of Nursing, Nursing Unit Manager or the leader of the clinical team, whether hot or cold packs are an appropriate treatment, prior to use.

Clinical practice requires the assessment of the sensory status and condition of the patient’s skin prior to any hot or cold pack being applied. The sensory status of the treated area and the condition of the patient’s skin should be regularly monitored while the hot or cold pack is in use. Continuous application of hot or cold packs should not exceed 20 minutes and may need to be less, depending on individual circumstances. At the first indication of any adverse signs, treatment should be stopped.
At the commencement of treatment, the site and time should be recorded in the patient’s health care history. On completion of treatment and after the treated area has been examined, the duration of application and condition of the treated area should also be recorded.

Particular care should be taken with the following patients who are at higher risk of injury:

- infants;
- patients who are unconscious, including patients undergoing general anaesthesia;
- patients who have impaired sensation, including patients with neurological conditions or those undergoing spinal or epidural anaesthesia or local nerve blocks;
- patients where sensory status is unable to be assessed;
- older patients;
- patients who have language or communication difficulties.

Commercially available heating or cooling devices should comply with the relevant Australian Standard where this exists and be used in compliance with the manufacturer’s instructions and locally developed policies. The subject list of Australian Standards for the Health Care Industry (SL01) is available from:

Standards Australia  
PO Box 1055, Strathfield NSW 2135  
Telephone: 02 9746 4700  
Facsimile: 02 9746 3333

**CARE WITH HOT WATER**

The Department is concerned with the incidence of patients being scalded by uncontrolled hot water in hospital bathing areas. The Government Insurance Office has advised that several successful legal actions have been brought against hospitals arising from patients being “scalded”.

Although there is a current ongoing programme for converting existing hospital hot water systems to controlled temperature units the programme will take some time to complete. The attention of all hospital personnel should be drawn to the need for constant vigilance where the temperature of hot water is uncontrolled and being used by patients. Water should not be above 108°F (42.2°C) at the bath tap or nozzle. Only the hospital is to make any adjustments to any equipment which functions automatically.

**ADMINISTRATION OF DISPOSABLE ENEMAS - DANGER FROM EXCESSIVE PRESSURE (85/66)**

The attention of the Department of Health has been drawn to a potential hazard in the administration of disposable enemas. Instances of perforation of the bowel wall have been reported, and this is regarded as extremely serious. Only those staff who have been fully instructed and assessed in the administration of disposable enemas should be permitted to administer such treatment.

It has been found possible to generate pressures in the order of 300 mm Hg by hand administration of disposable enemas, and fluid delivered direct to mucous membranes at this pressure may cause severe mucosal damage. Further harm may result should fluids gain access to the vascular system, particularly when an enema fluid contains phosphate salts of sodium.
All medical and nursing staff should be reminded of the potential dangers associated with the administration of enemas, and the following guidelines should be observed.

(a) excessive manual pressure must be avoided. Disposable enema containers should be only gently squeezed until the fluid is dispelled;

(b) the treatment of constipation should rarely involve the use of enemas. Bowel preparation for labour can often be successfully achieved by using suppositories;

(c) disposable enemas containing phosphate salts of sodium should not be used routinely when enemas are required, and such enemas should only be administered when specifically ordered by a medical practitioner;

(d) disposable enema nozzles should be lubricated before insertion;

(e) particular care must be taken when administering disposable enemas to children, with only the very gentlest of pressure being applied;

(f) prolonged retention of the enema solution should be avoided, particularly by patients with colonic disease;

(g) administration of an enema should cease if a patient complains of severe pain;

(h) self administration of disposable enemas should be encouraged whenever possible;

(i) manufacturers’ instructions should be observed;

Hospitals would be well advised to establish a reporting system for recording details of adverse effects or incidents arising from the administration of disposable enemas.

**LEAVE OF ABSENCE OF PATIENTS FROM HOSPITAL (93/69)**

Prior to any leave of absence being granted hospitals should ensure that the permission of the patient’s attending medical practitioner has been obtained and is documented within the patient’s medical record file together with any advice given to the patient that such absence from the hospital could have a deleterious effect on the efficacy of their treatment and/or the state of their health.

Discharge and re-admission procedures must not be undertaken when the period of leave of absence of a patient from the hospital does not exceed 7 days.

Patients on leave of absence exceeding 7 days are to be officially discharged.

N.B. The period of 7 days is regarded as being inadequate for patients of psychiatric units and patients of units caring for the developmentally disabled. Longer periods are required in respect of these patients in order to assess whether the patient will be able to manage in alternate accommodation (e.g. at home).

Therefore, patients of these units may be granted leave of absence for periods of up to ten (10) days before they are regarded as having separated from the hospital.

Patients granted leave of absence for periods in excess of the approved units should be separated for statistical purposes although formal discharge procedures may not be carried out.
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Prior to any leave of absence being granted hospitals should ensure that the permission of the patient’s attending medical practitioner has been obtained and is documented within the patient’s medical record file together with any advice given to the patient that such absence from the hospital could have a deleterious effect on the efficacy of his/her treatment and/or the state of his/her health.

In respect of any day on which the patient is on leave from a recognised hospital for the whole 24 hours of the day, no fees are to be charged. For nursing homes and other non-recognised hospitals, patients are charged fees for the first four days of leave. After four days patients are not to be charged fees for any of the leave period. Nursing homes are to be aware that the Commonwealth will pay fees for periods of leave up to nominated absences and claims should still be lodged for the Nursing Home Benefits in accordance with the Commonwealth guidelines.

Patients whilst on leave of absence, who return to hospital for treatment for periods of less than 24 hours are to be charged as if not on leave for that day.

See also definition for leave on p.3.14 of the Fees Procedures Manual.

HOME NURSING

GENERAL

The Sydney Home Nursing Service is a public hospital under the auspices of the Health Department.

The aims of the Service are to provide competent nursing care to those who need nursing care at home; and to provide whatever support systems which may be needed to assist the family and/or patient to retain their maximum level of health and independence.

SERVICE ELIGIBILITY

The Nursing Service is available to anyone in the community requiring intermittent nursing care. This includes people who are on Workers’ Compensation, Third Party Insurance or War Veteran patients.

FEES

There is no charge for pensioners. However, those who are not on a pension are charged a small fee which will be discussed with the patient and family on the first visit.

HOURS OF SERVICE

Between 8.00 a.m. and 4.30 p.m. seven days a week.

It is important that the referrals are made before 4.00 p.m. especially on Fridays if visits are needed on the weekends.

When referring patients the following information is necessary:

- Name and address of patient, telephone number, date of birth, next of kin.
- Full details concerning diagnosis and treatment including written medical orders for drug administrations.
- Medical Officer.
- Date of discharge.
The referral should be made to the Centre Nursing Unit Manager. The Sydney Home Nursing Service Headquarters is located at 36 Boyce Street, Glebe. Telephone 9660 1166.

The Sydney Home Nursing Service Centres are located at:

- **Sydney Home Nursing Service**
  9 Northumberland Road  
  AUBURN NSW 2144  
  Phone: 9646 4170

- **Canterbury Centre**
  Canterbury Hospital  
  Canterbury Road  
  CAMPSIE NSW 2194  
  Phone: 9787 0599

- **Parramatta Centre**
  Marsden Street  
  PARRAMATTA NSW 2150  
  Phone: 9843 3182

- **Ryde Centre**
  Victoria Road (Ward 18, Gladesville Hospital)  
  RYDE NSW 2122  
  Phone: 9816 0550

- **Manly Centre**
  C/-Manly Hospital  
  Darley Road  
  MANLY NSW 2095  
  Phone: 02 9887 5444

- **Mona Vale Centre**
  C/- Mona Vale Hospital  
  Coronation Street  
  MONA VALE NSW 2103  
  Phone: 9998 0333

- **Northern Sydney Centre**
  C/- Cameron Building  
  Macquarie Hospital  
  Wicks Road  
  North Ryde NSW 2113  
  Phone: 9887 5444

- **Hornsby Centre**
  C/- Hornsby & Ku-ring-gai District Hospital  
  Pulbrook Parade  
  HORTNSBY 2077  
  Phone: 476 1292
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- Hillview Community Health Centre
  1334 Pacific Highway
  TURRAMURRA 2074
  Phone: 449 9144

- Glebe Community Care Centre
  184 Glebe Point Road
  GLEBE 2037
  Phone: 660 5455

- Surry Hills Community Health Centre
  594 Crown Street
  SURRY HILLS 2010
  Phone: 699 9900

- Kings Cross Community Health Centre
  Oswald Lane
  DARLINGHURST 2010
  Phone: 33 3011

- Newtown Community Care Centre
  79 Enmore Road
  ENMORE 2042
  Phone: 516 2066

- Eastern Suburbs Community Nursing Rehabilitation Service
  C/- War Memorial Hospital
  Birrell Street
  WAVERLEY 2024
  Phone: 389 9800

- Sylvania Community Health Centre
  29 Sylvania Road
  SYLVANIA 2224
  Phone: 522 5055

- Redfern House Annex Health Centre
  Albert Street
  REDFERN 2016
  Phone: 690 1222

- Maroubra Community Health Centre
  130 Garden Street
  MAROUBRA 2035
  Phone: 349-6000

- Rockdale Community Health Centre
  16 King Street
  ROCKDALE 2216
  Phone: 597-2644
NURSE PRACTITIONERS IN NSW (PD2012_026)


PURPOSE

This policy directive supersedes NSW Health PD2005_556 and should be read in conjunction with Nurse Practitioners in NSW Guideline for the implementation of Nurse Practitioner roles within NSW Health.

NSW Health supports the role of the Nurse Practitioner as an important component of healthcare provision in NSW. Nurse Practitioner positions aim to improve access to care and address gaps in existing health care services through flexible and innovative models of care delivery and may therefore enhance service delivery options.

This policy statement and the associated guideline are intended to ensure that:

a) NSW Nurse Practitioner (NP) positions are established and sustained in a consistent manner;

b) Local Health Districts (LHDs) are provided with guidance on the processes required to effectively establish, implement and sustain Nurse Practitioner roles in NSW;
c) Nurse Practitioner positions are supported by a robust governance framework, including support for Transitional Nurse Practitioners (TNPs) preparing for endorsement as a Nurse Practitioner.

This policy reflects changes in both state and federal legislation and changes made by the Nurses and Midwives Board of Australia (NMBA) to the Nurse Practitioner endorsement pathways.

MANDATORY REQUIREMENTS

The following conditions must exist within the LHD to support the Nurse Practitioner position:

1. Establishing Nurse Practitioner Positions

1.1 Positions are established in order to address identified clinical service needs or gaps in existing services for target populations. Nurse Practitioner roles may be implemented within new models of care or may enhance existing services (*Guideline section 4*).

1.2 Adequate recurrent funding must exist within the context of a service or department to support the position outside of existing nursing workforce requirements, including relevant equipment, resources and funds for ongoing development. Adequate funding must also to be identified to support regrading of current services to include a Nurse Practitioner role.

1.3 LHDs are not obliged to create Nurse Practitioner positions in order to regrade an individual who has been endorsed, commenced relevant study or expressed an interest in becoming endorsed as a Nurse Practitioner.

1.4 The process of establishing positions is guided by principles of collaborative planning, practice, evaluation and succession planning within a multidisciplinary environment (*Guideline section 4*).

1.5 Once the establishment of a position has been approved by the Local Health District (LHD) Director of Nursing and Midwifery (DNM) and as per local recruitment requirements, it is to be advertised in the usual manner.

1.6 Where a Nurse Practitioner is not available, an appropriately experienced Registered Nurse (RN) may be employed into the Nurse Practitioner position in a ‘transitional’ role (CNC 2 pay grade) for a conditional period of up to three (3) years while they work toward endorsement as a Nurse Practitioner (*Guideline section 5*).

1.7 The Nurse Practitioner or Transitional Nurse Practitioner is able to practice within a collaborative, clearly articulated model with the support of other health professionals, management personnel and identified executive support (*Guideline section 4*).

1.8 Nurse Practitioners/Transitional Nurse Practitioners report professionally to the facility DNM or Facility/Service manager. In the event a Nurse Practitioner service is located across facilities, the position will report to the LHD DNM. Nurse Practitioners/Transitional Nurse Practitioners may also report operationally to Nurse Managers of the relevant services. Nurse Practitioners/Transitional Nurse Practitioners have a collaborative professional relationship with Nursing Unit Managers and Nurse Managers.

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Organisational support is to exist which ensures the Nurse Practitioner service is able to develop and function as required including indirect clinical time, clinical supervision and mentorship arrangements, study leave and IT support (Guideline sections 4 & 8).

Indirect clinical time is to be included within Nurse Practitioners/Transitional Nurses rostered hours. For single full time positions, indirect clinical time available must not be less than eight hours per fortnight with pro rata equivalent for part time. Services involving more than three positions may consider a rotational arrangement (Guideline section 8).

Within each LHD nursing and midwifery directorate or equivalent, there is to be a Nurse Practitioner Co-ordinator portfolio. This portfolio is allocated to a suitably resourced Nurse Manager or Nurse Practitioner (Guideline section 4.2).

Endorsed Nurse Practitioners within the public health system must not utilise the authority and title of this endorsement including the legislated extensions to clinical practice unless employed in a Nurse Practitioner position.

Nurse Practitioners are to lead evaluation of the service delivery against the key indicators identified in the initial needs analysis and or business case (Guideline section 12).

Requirements for registered nurses enrolling in courses leading to endorsement as a nurse practitioner

NSW Health employees wishing to enrol in university courses leading to endorsement as a Nurse Practitioner must obtain approval from the DNM of the employing facility prior to enrolment in order to ensure indemnity arrangements apply. Evidence of approval is supplied by the DNM/Service/Facility manager of the employing facility or service directly to the education provider (Guideline section 6).

Supervision of clinical practice is provided by appropriately experienced, qualified and supportive supervisors and mentors (Guideline section 6.1).

These requirements apply to all RNs wishing to enrol in degree courses leading to endorsement as a Nurse Practitioner.

Scope of practice

A scope of practice (ScOP) document is developed by the Nurse Practitioner/Transitional Nurse Practitioner in collaboration with the Multidisciplinary Support Committee (MDSC) at the local level within six (6) months of the position being established or filled (Guideline section 7).

For a Nurse Practitioner/Transitional Nurse Practitioner in a designated position, the ScOP is developed and agreed at the local level by the MDSC, once signed by the chair of the MDSC it becomes the operational document and is forwarded to the LHD DNM and CE for acknowledgement.

The ScOP is to be consistent with the expertise and level of competence of the individual.
4. **Prescribing arrangements**

4.1 The Director-General, in accordance with s17a of the *Poisons and Therapeutic Goods Act 1966*, has approved a list of poisons, restricted substances and drugs of addiction as the NSW Nurse Practitioner formulary. This *list reflects the national formulary approved for Nurse Practitioner prescribing listed on the Pharmaceutical Benefits Schedule (PBS)* but does *not infer the ability to prescribe these as PBS subsidised items (Guideline 10.6).*

4.2 The **NSW Nurse Practitioner formulary** will be updated from time to time as required to include other poisons, restricted substances and drugs of addiction to reflect expanding scopes of practice (Guideline section 10.1).

4.3 Nurse Practitioners employed by NSW Health are *therefore authorised* to prescribe, use, possess or supply, in line with their scope of practice, those poisons, restricted substances and drugs of addiction included on the **NSW Nurse Practitioner formulary**.

4.4 A separate formulary for each Nurse Practitioner approved at the local level is *not required* if all items to be prescribed are included in the NSW Nurse Practitioner Formulary (Guideline section 10.1).

4.5 Poisons, restricted substances and drugs of addiction a Nurse Practitioner may wish to prescribe not included in the NSW NP formulary must be specified and approved separately. These are collated into an appended formulary to be forwarded by the LHD DNM for approval by the LHD CE (Guideline section 10.2).

4.6 Nurse Practitioners and Transitional Nurse Practitioners should develop a list of preferred medications (P Drugs) which is consistent with the ScOP. P Drugs do not require approval at a local level to be independently prescribed by Nurse Practitioners as long as they are consistent with the approved NSW Nurse Practitioner or an appended formulary (Guideline section 10.4).

4.7 **Nurse Practitioners practicing in a community setting may issue prescriptions for medications subsidised by the PBS.** Nurse Practitioners practicing in NSW public hospitals must *not* issue prescriptions for medications to be subsidised by the PBS for inpatients (or those to be discharged), emergency or outpatients (Guideline section 10.6).

4.8 Nurse Practitioners must adhere to LHD policy along with all State and Commonwealth law in relation to prescribing, including the requirements to have collaborative arrangements in place in order to prescribe PBS medications. Nurse Practitioners have a professional and legal obligation to ensure that they prescribe within their ScOP.

5. **Provision of MBS services**

5.1 Nurse Practitioners employed in localities granted an exemption as part of the Section 19(2) Exemptions Initiative may apply for a MBS provider number and therefore provide eligible services (Guideline section 11.1),

5.2 In order to provide MBS subsidised services Nurse Practitioners must ensure they have collaborative arrangements in place in accordance with the **National Health (Collaborative arrangements for nurse practitioners) Determination 2010** (Guideline section 9.6).
IMPLEMENTATION

Chief Executives, Health Service Executives, Managers
- Support the implementation of Nurse Practitioner services by including the role in service planning as appropriate;
- Lead the service needs analysis and formation of the business case as part of the Multidisciplinary Support Committee (MDSC) (Guideline 4.4);
- Assist in ensuring positions are fully operational by facilitating prompt endorsement of approved business cases and appended formularies as appropriate;
- Assign responsibility, personnel and resources to implement this policy;
- Ensure that funding sources for Nurse Practitioner roles are resolved prior to the recruitment process;
- Provide line managers with support to mandate this policy in their areas;
- Ensure that local protocols are in place in each facility to support implementation.

LHD Director of Nursing and Midwifery in addition to above
- Demonstrate leadership in identifying opportunities for implementation of the Nurse Practitioner role within service planning;
- Identify and support an appropriately resourced Nurse Manager or Nurse Practitioner to undertake the role of LHD NP Coordinator.

Facility DON
- Facilitate and process the application for organisational support required for entry into courses leading to endorsement as a Nurse Practitioner;
- Ensure that funding sources for Nurse Practitioner roles are resolved prior to recruitment process;
- Demonstrate leadership in identifying opportunities for implementation of the Nurse Practitioner role within service planning;
- Lead and participate in the service needs analysis, formation of the business case and position description as part of the MDSC;
- Demonstrate leadership in the implementation of Nurse Practitioner services by identifying opportunities to develop services, supporting Nurse Practitioners/Transitional Nurse Practitioners within senior nursing forums and engaging with key stakeholders to ensure role development and sustainability.

Hospital, facility, clinical stream, non clinical and unit managers, Heads of Departments, Nurse Managers, Nursing Unit Managers
- Work collaboratively with the Nurse Practitioner/Transitional Nurse Practitioner and MDSC in the implementation and evaluation of Nurse Practitioner services,
- Lead and participate in the service needs analysis, formation of the business case and position description as part of the MDSC as appropriate.

Nurse Practitioners/Transitional Nurse Practitioners
- Work collaboratively within the organisation to implement and evaluate Nurse Practitioner services;
- Participate in the service needs analysis, formation of the business case and position description as appropriate as part of the MDSC;
- Ensure ScOP is developed within specified timeframes;
- Ensure legal and professional obligations are met in relation to the provision of MBS and PBS services;
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- Ensure legal and professional obligations are met in relation to prescribing requirements;
- Identify learning needs and objectives in line with education requirements and the model of care and ensures supervised practice to achieve these;
- Ensure requirements for endorsement as a Nurse Practitioner are met within specified time frames;
- With executive support, lead evaluation of the service delivery against the key indicators identified in the initial needs analysis and or business case;
- Ensure practice remains appropriately supervised during transitional period and otherwise as required.

Registered Nurses seeking to enrol in courses leading to endorsement as a Nurse Practitioner
- Secure formal approval to undertake the clinical practicum requirements while employed by NSW Health from the DNM of employing facility prior to enrolment;
- Ensure adequate information is provided to stakeholders regarding the required commitment to supervision of clinical practice;
- Ensure practice remains appropriately supervised during clinical practicum;
- Ensure practice outside of clinical practicum does not extend beyond the boundaries of the ScOP for which employed.

For further information related to this policy or any other assistance, please contact the Principal Advisor, Nurse Practitioner Project in the Nursing and Midwifery Office on (02) 9391 9490.

NURSE PRACTITIONERS IN NSW – GUIDELINE FOR IMPLEMENTATION OF NURSE PRACTITIONER ROLES – NSW HEALTH (GL2012_004)

PURPOSE

This guideline has been developed to support implementation of PD2012_026 Nurse Practitioners in NSW.

KEY PRINCIPLES

- Nurse Practitioner positions are established to address gaps in service delivery for target populations by introducing new flexible and innovative models of care or by complementing existing services.
- The establishment and implementation of Nurse Practitioner services is guided by a consistent process within supportive and collaborative environments.
- Nurse Practitioners and Transitional Nurse Practitioners are supported by robust clinical governance frameworks.
- Nurse Practitioner services are evaluated within a multidisciplinary environment to ensure needs of target populations are met and opportunities to expand or improve services occur.

USE OF THE GUIDELINE

Whilst a summary of relevant legislation is provided, it is essential that this guideline is understood along with the standards, codes, regulations and any additional legislation relevant to Nurse Practitioners at both the State and Commonwealth level. These include but are not limited to the National Competency Standards for the Nurse Practitioner, Nursing and Midwifery Board of Australia (NMB&A) Safety and Quality Framework for Nurse Practitioners and the Registration Standard for endorsement of Nurse Practitioners.
This guideline has been prepared to assist stakeholders to establish, implement and evaluate Nurse Practitioner positions in a consistent manner across NSW by informing:

- Organisations considering implementation or expansion of Nurse Practitioner services.
- Nurse Practitioners.
- Registered Nurses (RNs) employed into Nurse Practitioner positions (Transitional Nurse Practitioners) while working toward Nurse Practitioner endorsement by the Nursing and Midwifery Board of Australia (NMBA).
- RNs employed by NSW Health wishing to enrol in courses leading to endorsement as a Nurse Practitioner.
- Education providers enrolling students employed by NSW Health into courses leading to endorsement as a Nurse Practitioner.

**Organisations should use this guideline to:**

- Identify and define gaps in the current service provision and ensure that Nurse Practitioner roles are established and equipped to address these *(Guideline section 4).*
- Enable and support a structured, collaborative process for establishing, implementing and evaluating the role or service effectively *(Guideline section 4).*
- Enable and support formal arrangements for supervision of clinical practice.
- Identify clear roles and responsibilities in establishing, implementing and supporting Nurse Practitioner roles.
- Ensure clinical governance frameworks are in place including robust clinical supervision arrangements, mentorship opportunities, evaluation processes and performance appraisal *(Guideline section 6.1).*
- Ensure decisions regarding model of care and scope of practice (ScOP) are able to be made collaboratively at a local level by the Multidisciplinary Support Committee (MDSC) to enable a flexible and responsive model of care *(Guideline section 4.3).*
- Ensure Nurse Practitioner roles are implemented in line with **PD2012_026** Nurse Practitioners in NSW.

**Nurse Practitioners should use this guideline to:**

- Work collaboratively within the organisation to develop, implement and evaluate flexible, innovative Nurse Practitioner models of care.
- Develop a ScOP reflective of individual expertise and competence that supports prescribing practice *(Guideline section 7).*
- Ensure ScOP is aligned with intended model of care delivery.
- Identify learning objectives in order to satisfy educational requirements, support ongoing continuing professional development (CPD), maintain competence, enable and expand ScOP as appropriate.
- Lead multidisciplinary evaluation of Nurse Practitioner role/service *(Guideline section 12).*

**Transitional Nurse Practitioners should use this guide to:**

- Collaborate to ensure organisational support, including clinical supervision requirements, are in place upon commencement and are sustained throughout the transitional period *(Guideline section 5).*
- Work collaboratively within the organisation to develop, implement and evaluate flexible, innovative Nurse Practitioner models of care.
- Develop a ScOP document reflective of individual expertise and competence that supports supervised advanced practice *(Guideline section 7).*
- Work collaboratively to identify and meet learning needs.
15. NURSING

- Ensure ScOP is aligned with intended model of care delivery.
- Ensure educational and endorsement requirements are met within agreed timeframes (Guideline section 3).
- Lead and or participate in multidisciplinary evaluation of Nurse Practitioner role/service (Guideline section 12).

Registered Nurses wishing to undertake courses of study leading to endorsement as a Nurse Practitioner are to:
- Ensure formal approval is obtained from the DNM of the employing facility prior to enrolling in any course leading to endorsement as a Nurse Practitioner (Guideline section 6).
- Ensure all clinical placement hours are adequately supervised and competencies assessed according to required university standards.
- Ensure practice outside clinical practicum is maintained within the ScOP appropriate to current employment and all advanced practice is appropriately supervised.

SECTION 1 – INTRODUCTION

The use of drugs and alcohol produces a significant health burden on the Australian community. Issues related to the use of alcohol and psychoactive drugs impact all areas of medicine and health care. The health and economic costs associated with the use of drugs and alcohol is high with the annual cost of drug use in Australia estimated to be $34.4 billion (Collins & Lapsley 2002). Currently, these costs are identified as:

- $21.1 billion – Tobacco
- $7.6 billion – Alcohol
- $6.1 billion – Illicit Drugs

In 1998, just over 23,313 deaths in Australia were attributable to drug use, representing around 18% of all deaths. Of these, the vast majority were owing to tobacco use (19,019), with 3,271 owing to hazardous or harmful alcohol consumption and 1,023 due to illicit drug use (Ridolfo & Stevenson, 2001). Almost 260,000 hospital episodes in 1996-97 were attributable to alcohol, tobacco and other drug use (National Drug Strategy Household Survey, 1999 Release).

Drug and alcohol use can also complicate the management of other health issues of people presenting to health services. Nurses and midwives have long been identified as primary caregivers. In this context they are well positioned to recognise hazardous use and early symptoms of complications from drug and alcohol use and to intervene appropriately (NH&MRC 2001, de Crespigny, 2001, 1996; Goodin, 1997, 1990, Novak and Petch, 1994).

Historically, health professionals have been reluctant to assess patients’ drug and alcohol use or to implement early or brief interventions. The evidence shows that nurses often do not have the requisite knowledge or skills to intervene (de Crespigny, 2001, 1996, Novak and Petch, 1994) even though many acknowledge that such intervention is a legitimate activity (Goodin, 1997). Lack of organisational support for nurses’ and midwives’ management of drug and alcohol issues has also been a traditional barrier to further work in this area (ALAC 2000, Connolly et al, 1998). High staff turnover and difficulty in recruiting staff, especially in rural areas, has also been a barrier to retaining drug and alcohol knowledge and skills.

This policy directive aims to ensure adherence to minimum standards of practice in all health care settings for the assessment and management of all patients, in relation to their drug and alcohol use.

SECTION 2 – TARGET

2.1 Who is this policy for?

This policy applies to the NSW Health Service System, which, for the purposes of this policy, refers to Area Health Services, Statutory Health Corporations (including Justice Health), Affiliated Health Organisations, and NSW Department of Health. It is directed to Directors of Nursing and Midwifery, however titled, Directors of Community Health Services, Directors of Mental Health Services, Nurse Managers, Nursing Unit Managers, Clinical Nurse Consultants, Nurse Educators, Registered Nurses, Midwives, and Enrolled Nurses.

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1 NSW Health now uses the term ‘drug and alcohol’ for issues related to substance use. Responsibility for policy development for drug and alcohol issues lies with the Mental Health and Drug & Alcohol Office, except for tobacco related harm. Responsibility for policy development for the latter lies with Tobacco and Health Branch.
2.2 Background

The NSW Strategic Plan – Nurse Education and Nursing Management of Alcohol and Other Drugs (here referred to as ‘the Strategic Plan’) was released in 1991 by the NSW Department of Health. This plan was reviewed and updated into ‘Framework for Progress 2000-2003’ and the ‘Clinical Guidelines for Nursing Practice 2000 -2003’. This initial Strategic Plan was effective in highlighting the need for clinical policy and nursing and midwifery education on drug and alcohol issues.

In 1996, the NSW Nursing Project – Alcohol and Other Drugs was established to review the Strategic Plan. As part of this review, the project group carried out a major survey of all NSW public hospitals and community health centres to determine the level of implementation achieved since the release of the Strategic Plan.

The 1995/96 Survey of Activities Related to the NSW Strategic Plan for Nurse Education and Nursing Management of Alcohol and Other Drugs results indicated that while many aspects of the Strategic Plan had been adopted in NSW hospitals and community health centres, there was room for improvement in its implementation.

The Survey also highlighted that local health service drug and alcohol policy varied between hospitals and was not well integrated. The continued variance of policy and education frameworks was problematic for nursing and midwifery staff across NSW.

This policy is accompanied by the ‘Clinical Guidelines for Nursing and Midwifery Practice in NSW: Identifying and Responding to Drug and Alcohol Issues’.

2.3 Aims of the policy

The aim of this policy is to ensure effective and comprehensive assessment and clinical management of patients who are affected by their use of drugs and alcohol. The focus of nursing and midwifery practice is to give equal regard to both the physical and psychological safety of the patient. All nursing and midwifery practice should aim to reduce harm and improve health outcomes for patients who are at risk due to their drug and alcohol use.

2.4 General Principles

Contact with patients who have been using drugs and alcohol may occur in a variety of health care settings such as community or hospital based services, general health or specialised health facilities. Regardless of the context, management of patients with drug and alcohol issues must be integrated into the care planning for each patient. All practices must be consistent with this directive.

At a minimum, each Health Service/facility must recognise and ensure that:

1. Access to comprehensive health care is an individual’s right. This right should not be impaired by any health professional’s value judgements about the use of alcohol or drugs.
2. All staff are encouraged to have a positive approach to working with patients with drug and alcohol issues.
3. There is a balanced range of interventions available for the management of patients with drug and alcohol issues.
4. Staff are aware of, and have easy access to, written policy and clinical guidelines for intervention and management of patients with drug and alcohol issues.

5. Staff are proficient in performing standardised procedures and implementing protocols for the assessment, management and referral of patients identified as using drugs and alcohol at hazardous or harmful level. The skills required to manage patients with drug and alcohol issues are core clinical skills and should be reviewed and updated on a regular basis.

6. Staff receive appropriate education on:
   - Varied presentations related to drug and alcohol use;
   - Assessment, management and referral of patients identified as using drugs and alcohol at hazardous and harmful levels;
   - Implementation of clinical guidelines to support appropriate management and care of patients with drug and alcohol issues.

7. The needs of children and adolescents, older people, Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, and gay, lesbian or transgender groups are addressed in a clinically and culturally appropriate manner by all staff.

8. Clear response procedures are in place for services and agencies that frequently require support or refer patients who are using drugs and alcohol at a hazardous or harmful level.

2.5 Policy Principles (Clinical)

1. Assessment of all drug and alcohol use is part of the overall nursing and midwifery assessment for each individual.

2. All episodes of care provide an opportunity for the patient to gain health information and insight into issues related to their drug and alcohol use, and for clinical staff to intervene appropriately.

3. Signs and symptoms of intoxication are accurately identified, recorded and are managed to reduce the risk of overdose and further complications from drug and alcohol use.

4. Nursing and midwifery care planning will incorporate effective strategies for the monitoring and management of all withdrawal syndromes.

5. NSW Department of Health and Health Services will endeavour to achieve a high level of knowledge and skill among nursing and midwifery staff. Knowledge and skill is to be developed and maintained in line with current clinical guidelines for best practice for managing drug and alcohol issues.

2.6 Key stakeholder responsibilities

Responsibility for implementing this policy directive rests at all levels of the health system - from statewide bodies to individual nurses and midwives in local health facilities. For nurses and midwives within NSW to achieve the aims and principles outlined in this document, it is essential to identify the roles and responsibilities of the key stakeholders.
Role of NSW Department of Health

NSW Department of Health provides leadership and organisational support for Health Services to implement the strategies contained in this document. This support will include:

1. Ensuring that this policy directive and the accompanying *Clinical Guidelines for Nursing and Midwifery Practice in NSW: Identifying and Responding to Drug and Alcohol Issues* are regularly reviewed and updated to reflect best practice;
2. Ensuring that performance agreements between NSW Department of Health and Health Services incorporate the principles and strategies contained in this document and the accompanying *Clinical Guidelines*;
3. Monitoring and evaluating nursing and midwifery management of drug and alcohol issues across NSW;
4. Monitoring and evaluating education on drug and alcohol issues across NSW;
5. Working with nurse and midwife education providers and the Nurses and Midwives Board NSW to enable accurate and consistent curricula on drug and alcohol issues;

Role of Health Services

Health Services must provide leadership and support for nursing and midwifery management of drug and alcohol issues at a local level. They must be largely responsible for implementation of the principles and strategies contained in this document and the accompanying *Clinical Guidelines*. Health Services responsibilities will include:

1. Adoption of nursing and midwifery management of drug and alcohol issues as a high priority across all Health Services facilities;
2. Implementation of consistent and appropriate protocols on nursing and midwifery management of drug and alcohol issues across all Health Services facilities;
3. Implementation of a consistent and appropriate nursing and midwifery education policy on drug and alcohol issues across all Health Services facilities;
4. Regular monitoring of the delivery and quality of nursing and midwifery management of drug and alcohol issues across all Health Services facilities;
5. Regular monitoring of the delivery and quality of nursing and midwifery education on drug and alcohol issues across all Health Services’ facilities; and
6. Adequate allocation of funding to support all the above.
Role of nurse managers and midwife managers

Nurse managers and midwife managers are key agents in the successful adoption and supervision of best practice in the delivery of all clinical care. It is therefore essential that these managers take a key role in the implementation of the Clinical Guidelines at a unit level, and to monitor and support nursing and midwifery education and training at this level. Nurse manager and midwife manager responsibilities will include:

1. Adopting a policy on nursing and midwifery management of drug and alcohol issues as a high priority within the unit;
2. Ensuring awareness and implementation of the Clinical Guidelines within the unit;
3. Ensuring adequate levels of education on drug and alcohol issues within the unit;
4. Regular monitoring of delivery and quality of nursing and midwifery management of drug and alcohol issues within the unit;
5. Regular monitoring of delivery and quality of nursing and midwifery education on drug and alcohol issues within the unit; and
6. Management of unit funding to support the above.

Role of registered nurses, midwives and enrolled nurses

All registered nurses, midwives and enrolled nurses in NSW are responsible for adhering to the principles outlined in this document and for clinical expertise according to the accompanying Clinical Guidelines.

Registered nurse and midwife responsibilities will include:

1. Understanding and appropriate implementation of policies and protocols governing the management of drug and alcohol issues;
2. Awareness of the Clinical Guidelines for Nursing and Midwifery Practice in NSW: Identifying and Responding to Drug and Alcohol Issues;
3. Inclusion of drug and alcohol history in routine patient assessment;
4. Knowledge of the pharmacological effects of drug and alcohol. Understanding of drug and alcohol dependence and its bio-psycho-social consequences;
5. Recognition of issues for care planning arising from assessment data;
6. Provision of interventions for patients identified as using drugs and alcohol at hazardous or harmful levels;
7. Provision of relevant patient education regarding drug and alcohol use supported by information resources and specialist/service referral as necessary;
8. Recognition of signs and symptoms of intoxication, overdose and withdrawal syndromes and implementation of nursing and midwifery strategies to respond to these states; and

Enrolled nurse responsibilities will include:

1. Understanding and appropriate implementation of policies and protocols governing management of drug and alcohol issues;
2. Awareness of the Clinical Guidelines for Nursing and Midwifery Practice in NSW: Identifying and Responding to Drug and Alcohol Issues;
3. Assistance with drug and alcohol history taking in routine patient assessment;
4. Knowledge of the pharmacological effects of drugs and alcohol. Awareness of drug and alcohol dependence and its bio-psycho-social consequences;
5. Recognition of issues for care planning arising from assessment data;
6. Facilitation of intervention for patients identified as using drugs and alcohol at hazardous or harmful levels;
7. Provision of relevant drug and alcohol information resources as necessary;
8. Recognition of signs and symptoms of intoxication, overdose and withdrawal syndromes and implementation of nursing and midwifery strategies to respond to these states; and

Participation in continuing professional development on drug and alcohol issues.
### ASSESSMENT

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<tr>
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<th>Outcomes</th>
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| Assessment of all drug and alcohol use is part of the overall nursing and midwifery assessment for each individual patient. | - Assessment includes a record of the quantity and frequency of drug and alcohol use.  
- Drug and alcohol use is recorded including prescribed medication, non-prescribed pharmaceuticals.  
- Assessment includes:  
  - type of drug  
  - dose, frequency and duration of use  
  - time and amount of last dose  
  - route of administration. | - Nursing and midwifery staff have an understanding of the clinical implications of drug and alcohol intake.  
- Nursing and midwifery care management strategies are clearly defined in relationship to overall clinical care.  
- Nursing and midwifery care is planned to address the physical and psychological needs of the patient.  
- Patients do not feel stigmatised for drug and alcohol use as this assessment is not done selectively. |

**Responsibility**

- Health Services  
- Directors of Nursing and Midwifery (however titled)  
- Directors of Community Health Services  
- Directors of Mental Health Services  
- Senior Nurse Managers and Midwifery Managers  
- Nursing Unit Managers and Midwifery Unit Managers  
- Clinical Nurse Consultants, Clinical Midwifery Consultants, Nurse Educators and Midwifery Educators  
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# OPPORTUNISTIC INTERVENTION

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<tr>
<td>Nurses and midwives realise opportunities to intervene with all patients regarding their drug and alcohol use</td>
<td>• Education of all nursing and midwifery staff in appropriate intervention strategies related to the use of drugs and alcohol.</td>
<td>• Nursing and midwifery staff develop clinical drug and alcohol skills that enhance patient outcomes.</td>
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<td>As part of regular, standard clinical practice, nurses and midwives intervene with any patient who is identified as using drugs and/or alcohol at a harmful or hazardous level.</td>
<td>• Provision of resources in the form of pamphlets and other written materials and relevant education material to assist nursing and midwifery staff with appropriate interventions. • Provision of information regarding specialist drug and alcohol services to all nursing and midwifery staff.</td>
<td>• Patients are informed of the health risks associated with drug and alcohol use. • Patients have increased access to information to help reduce or cease drug and alcohol use where appropriate, and about safe use and associated health effects; • Patients have increased access to information about treatment options, resources and referral networks.</td>
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**Responsibility**

- Health Services
- Directors of Nursing and Midwifery (however titled)
- Directors of Community Health Services
- Directors of Mental Health Services
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### INTOXICATION & OVERDOSE

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<tr>
<td>Signs and symptoms of intoxication are accurately identified and managed to reduce the risk of overdose and further complications from drug and alcohol intake.</td>
<td>• Comprehensive recording of recent drug and alcohol intake from individual or accompanying persons.</td>
<td>• Nursing and midwifery staff have a clear understanding and knowledge of the signs and symptoms of intoxication and overdose.</td>
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<td>• Assessment of physical signs, mental status and level of consciousness.</td>
<td>• Nursing and midwifery staff plan nursing or midwifery management according to signs and symptoms recorded.</td>
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<td>• Other reasons for presentation that may mimic intoxication (eg. Hypoglycaemia, head injury) are excluded.</td>
<td>• Nursing and midwifery staff provide early identification of complications related to intoxication.</td>
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<td>• Monitoring tools, (Glasgow Coma Scale), breathalyser units or BAL are used, where available.</td>
<td>• Risk of progression to overdose is reduced.</td>
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<td>• Vital signs are observed and recorded.</td>
<td>• Patient and staff safety is maintained.</td>
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<td>• Nursing and midwifery management is aligned to outcomes of observations.</td>
<td>• Morbidity and mortality is reduced.</td>
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<td>• Nursing and midwifery staff carry out appropriate referral for concurrent or conjoint treatment.</td>
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### Responsibility

- Health Services
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- Directors of Community Health Services
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## WITHDRAWAL MANAGEMENT

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<tr>
<td>Nursing and midwifery care planning will incorporate effective strategies for the monitoring and management of all withdrawal syndromes</td>
<td>- Assessment and identification of indicators of risk of withdrawal</td>
<td>- Nursing and midwifery staff develop knowledge and skill in the recognition of withdrawal symptoms and associated clinical management.</td>
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<td>- Observation for signs of withdrawal as clinically indicated.</td>
<td>- Nursing and midwifery staff effectively manage withdrawal states.</td>
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<td>- Detailed documentation including the use of appropriate withdrawal scales (Alcohol Withdrawal Scale, CIWA-AR Scale, Modified Finnegan’s Chart).</td>
<td>- Risk of patient progressing to a severe withdrawal syndrome is minimised with access to effective clinical care.</td>
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<td>- Early identification of changes in clinical condition and institution of appropriate nursing and midwifery management strategies.</td>
<td>- Opportunities for intervention and further treatment are enhanced, and complications are minimised.</td>
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<td>- Monitoring of fluid and nutritional intake.</td>
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<td>- Maintenance of patient and staff safety.</td>
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### Responsibility

- Health Services
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EDUCATION

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<tr>
<td>NSW Dept. of Health and Health Services will work with educational institutions and professional bodies to ensure a high level of knowledge and skill among nursing and midwifery staff.</td>
<td>- Core curricula within nurse and midwife education to include knowledge and clinical skills in the management of drug and alcohol issues.  &lt;br&gt; - Education frameworks within Health Services reflect knowledge and clinical skills in nursing and midwifery management of drug and alcohol issues.  &lt;br&gt; - Support for curriculum development for all speciality courses and training to include relevant education in clinical management of drug and alcohol issues.  &lt;br&gt; - All education and orientation programs to address attitudinal issues which may impair assessment and appropriate intervention.</td>
<td>- Nurses and midwives have an understanding of the key concepts and principles underpinning quality care for patients with drug and alcohol related illness and injury.  &lt;br&gt; - Nursing and midwifery staff have an awareness of the physical and psychological effects of drug and alcohol use.  &lt;br&gt; - Nursing and midwifery staff have knowledge and skills, commensurate with their roles, in the effective management of drug and alcohol presentations.  &lt;br&gt; - Nursing and midwifery staff intervene appropriately, regardless of their own attitudes and beliefs in relation to drug and alcohol use.</td>
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<tr>
<td>Access to comprehensive health care is an individual’s right. This right should not be impaired by any health professional’s value judgements about the use of alcohol or drugs.</td>
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NURSING AND MIDWIFERY CLINICAL GUIDELINES – IDENTIFYING & RESPONDING TO DRUG & ALCOHOL ISSUES (GL2008_001)