The number of Australians aged 80 years and over is expected to double over the next two decades and triple over the next 50 years, with the proportion of those living with profound disabilities expected to increase by 70% over the next 30 years. Australian Bureau of Statistics (ABS) projections estimate that the number of persons aged 80 years and over most likely to require nursing home or hostel accommodation will increase by 63%, from 520,000 people in 1998 to 1.4 million people by 2031. These trends highlight the need to examine health care management strategies for this growing patient population.

Discussion

The general practitioner has traditionally been the sole provider of primary care to older persons living in residential aged care, although a multidisciplinary approach is required to meet all needs. An integrated approach for primary care of the aged person in residential aged care is well described by The Royal Australian College of General Practitioners in which the GP is the primary care provider working with residents, families, residential aged care facility (RACF) staff (e.g., nurses, personal care attendants), pharmacists, allied health (e.g., physiotherapists, psychologists, podiatrists, occupational therapists, speech pathologists, social workers, radiographers, orthotists, optometrists, and dieticians) and other primary care and specialist care providers.

The nurse practitioner (NP) is proposed here as an extended nursing role that may further complement this management approach.

The nurse practitioner in aged care

The role of the NP was originally developed in the United States of America in 1965 and is well established in the United Kingdom, Canada, Europe, Australia, New Zealand, and the Pacific. Within Australia, the NP role was initiated in the early 1990s with subsequent role development, implementation and endorsement. Slow uptake of the NP role in Australia has been attributed, in part, to lack of access by NPs to the Pharmaceutical Benefits Scheme (PBS) and the Medicare Benefits Scheme (MBS).

In Australia, the NP has been defined as: ‘a registered nurse educated and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The NP role includes assessment and management of clients using nursing knowledge and skills and may include but is not limited to the direct referral of patients to other health care professionals, prescribing medications and ordering diagnostic investigations’.

Within primary care, the NP role has been shown to promote continuity of care, fewer acute care episodes, decreased hospitalisations, lower readmission rates, and enhanced patient satisfaction. Over the past decade, studies have demonstrated positive outcomes associated with the role of the NP in residential aged care. These findings include lower incidence of hospitalisations when compared to two sets of controls (2.43 NP group vs. 4.63 and 4.67 control, p<.001). Demonstrated hospital cost savings, on average, of US$103,000 per year per NP, improved resident personal health knowledge, enhanced working relations between medicine and nursing, and improved resident access to care. Activities of the NP
include providing routine, preventive care and acute care visits, as well as promoting ongoing communication and coordination of care. Such findings support consideration of the NP role within residential aged care as a strategy to enhance resident safety and family satisfaction, while potentially reducing organisational and provider risk. Workforce models within residential aged care include NPs employed externally by a managed care company to augment the provision of primary care services, shared care in which the NP and medical practitioner share joint responsibility, and NPs employed by the RACF to provide advanced clinical assessments, prescribe medications and treatments, and refer for pathology and radiology diagnostics. Key elements important to consider for implementation of the role are collaboration, communication, and barriers to practice.

**Collaboration**

Collaboration has been identified as critical for successful interdisciplinary health care. It relies on underlying understanding and perceptions, and effectiveness of working relationships.

Within the context of residential aged care, collaboration may take on a structured approach, in which the patient is referred to the NP by the GP. Formal collaboration may be used to establish a written agreement or ‘contract’, outlining general responsibilities, communication patterns, general regimens, and evaluation of patient care. Mutual agreement on approved evidence based protocols and supplemental algorithms may help provide a documented plan of care. Such protocols are required in multiple clinical settings throughout Australia for NPs to prescribe medications.

**Communication**

Communication between clinicians and managers has been identified as another critical component of interdisciplinary relationships. Transfer of information is vital for patient safety and continuity of care. Yet, effective communication may be hindered by the differing communication styles of nurses and GPs. Nurses have traditionally learned to share information with a ‘stylised script’, resulting in potentially redundant information that lacks depth and clinical meaning. Strategies to enhance communication between NPs and GPs include formal ‘clinical decision making worksheets’ in which the NP uses a standardised language recognised between disciplines, standardised guidelines for effective handover, detailed summaries after acute episodes, or simple communication logs in which patient referrals and care plans are detailed by the NP for the referring GP.

**Barriers to practice**

Concern among medical practitioners regarding the NP role and scope of practice has been identified as a barrier, stemming from some GPs’ uncertainty of the NP’s ability to meet clinical and competency demands. A study conducted by Wilson et al. examined GP perceptions of NPs. General practitioners expressed concerns about the NPs’ competency and training, especially in relation to medicolegal issues. Conversely, NPs have reported feeling continually scrutinised and having to defend their practice on a regular basis. The newness of the role and unfamiliarity with working at an advanced level of practice with medical practitioners may also be a barrier.

The Australian Medical Association has argued that, while nurses are an essential part of the primary care team, they are not a substitute for GPs. Indeed, the NP is an expanded nursing role based upon a foundation of advanced practice, education and training that works collaboratively with multiple disciplines. Appropriately trained NPs provide ‘enhanced use of both medical and nursing personnel’. Not a threat, but an asset and benefit to practice, the NP role may provide innovation and new ways of thinking. Educational activities, such as one-on-one or small group periodic sessions and formal preceptor relationships may assist to enhance working relationships between GPs and NPs as well as mutual appreciation of roles and responsibilities. Concerns should be acknowledged and strategies identified that may facilitate mutual understanding and trust.

Another barrier to practice is that of appropriate remuneration for NP services within the community. Currently, NPs lack access to the PBS and MBS creating an environment that does not allow fair and equitable access to NP services. In the community, patients must pay for medications prescribed and services provided by the NP. This creates a practice barrier that limits the extent to which GPs and NPs may work together in addressing patient care for individuals living in a RACF, making delivery of services unnecessarily cumbersome and difficult to manage.

**Conclusion**

An enhanced NP role in the provision of primary care to the older person living in residential aged care presents an opportunity for change within the Australian health care system. Working in collaboration with GPs, the NP provides a complementary and extended nursing role that will assist in addressing the growing and complex needs of older persons. It is with collaboration, coupled with effective communication, that this model of care may enhance access to and quality of health care services. By considering this model, stakeholders such as GPs, nurses, residential aged care managers and policy makers, may discuss and debate perceived benefits or concerns. Strategies to encourage dialogue between stakeholders may include the formation of working parties through general practice organisations and networking with professional organisations such as the Australian Nurse Practitioners Association. By acknowledging concerns that may exist, health care providers will be better equipped to deal with future health care demands and change.

Conflict of interest: none declared.

**References**