New Zealand Nurse Practitioner in Residential Aged Care

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Nurse Practitioner

- Started in Colorado, USA 1965
  - Loretta Ford and Henry Silverman
- Began in Australia 2000 and New Zealand 2001
- Australia 1,248 roughly 1 NP/20,000 population
- New Zealand 246
  - NZ - 10% older adult focus
  - NZ – 50% primary healthcare focus
Can, May and Pay

**New Zealand NP**
- 2014 authorised Prescriber, full access to the medicines formulary
  - Previously NPs were designated prescribers – limited formulary
- Death certificates soon
- Tests and imaging regional variation

**Australian NP**
- Australia some access limitation to medicine formulary
- 2010 Australian NP access PBS/MBS
  - Previously NPs could prescribe, but with no medicines subsidy
  - MBS reimbursement for tests and imaging
Number of Nurse Practitioners Registered per year in New Zealand

NZ Nurse Practitioner Registrations
Oldest Old Increasing Proportion of Deaths

Data source: Statistics New Zealand. Historic estimates and National population projections, 2014(base)-2068, slide by Prof. Heather McLeod
### International Comparison of Place of Death for those >65

**JB Broad, et al. 2012**

<table>
<thead>
<tr>
<th>Country/Region</th>
<th>Residential aged care</th>
<th>Hospital</th>
<th>Other# incl. own home</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealand 2003-07</td>
<td>38</td>
<td>34</td>
<td>28</td>
</tr>
<tr>
<td>Australia 2005</td>
<td>32</td>
<td>54</td>
<td>14</td>
</tr>
<tr>
<td>Canada (Manitoba) 2006</td>
<td>32</td>
<td>51</td>
<td>17</td>
</tr>
<tr>
<td>USA 2005</td>
<td>29</td>
<td>43</td>
<td>29</td>
</tr>
<tr>
<td>Belgium 2001</td>
<td>24</td>
<td>54</td>
<td>23</td>
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<tr>
<td>England and Wales 2008</td>
<td>21</td>
<td>57</td>
<td>23</td>
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<tr>
<td>Austria 2009-10</td>
<td>18</td>
<td>52</td>
<td>31</td>
</tr>
<tr>
<td>Czech Republic 2009</td>
<td>17</td>
<td>61</td>
<td>22</td>
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<tr>
<td>Ireland 2000-10</td>
<td>14</td>
<td>58</td>
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<tr>
<td>France 2005</td>
<td>13</td>
<td>58</td>
<td>30</td>
</tr>
<tr>
<td>Japan (Kyushu) 2000-04</td>
<td>12</td>
<td>69</td>
<td>19</td>
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<tr>
<td>Singapore 2006</td>
<td>7</td>
<td>57</td>
<td>35</td>
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<tr>
<td>Korea 2009</td>
<td>3</td>
<td>67</td>
<td>31</td>
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</tbody>
</table>
Life Course Approach to Healthy Ageing

High and stable
Significant loss

Declining

Functional ability

Intrinsic Capacity

Health services
Prevent chronic conditions or ensure early detection and control

Reverse or slow declines in capacity

Manage advanced chronic conditions

Long-term care
Support capacity-enhancing behaviours

Ensure a dignified late life

Environments
Promote capacity-enhancing behaviours

Remove barriers to participation, compensate for loss of capacity

Source: WHO 2015
Clinical Frailty Score
Rockwood et al.

7. **Severely Frail** – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8. **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** – Approaching the end of life. This category applies to people with a life expectancy < 6 months, who are not otherwise evidently frail.

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**Where dementia is present, the degree of frailty usually corresponds to the degree of dementia:**

- **Mild dementia** – includes forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

- **Moderate dementia** – recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

- **Severe dementia** – they cannot do personal care without help.
ELDER 2016:
Distressing Symptoms 1 month before death

- Depression
- Fear
- Anxiety
- Agitation
- Resistance to care
- Pain
- SOB
- Skin breakdown

Total, Cancer, Dementia, Chronic Illness
A day in the life of aged care NP

• 2 sessions per week per facility of 60-80 residents
• 10-12 visits a.m. session (3-4 hours)
• Some recent examples:
  – Vomiting and haematuria
  – BPSD, Depression, delirium
  – Seizure disorder management
  – UTI, Pneumonia, Anaemia, falls
  – family meetings about ACP and goals of care (e.g. resident admitted for palliative care – but did not die)
  – Admission assessments
  – Monthly/Quarterly reviews
  – End of life care
  – Monthly MDT and GP supervision round
A systematic review of the effectiveness of advanced practice nurses in long-term care

• 4 Studies, 15 papers – 2 CNS and 2 NP models
• All quasi-experimental
• Reductions in:
  – depression,
  – urinary incontinence
  – pressure ulcers
  – restraint use, and aggressive behaviours
  – improved family satisfaction with medical care
NP Models in Residential Aged Care

- **Secondary Outreach**
  - Employed by district health board
  - Aligned with geriatricians

- **Primary Care Provider**
  - Paid by aged care providers
  - Aligned with primary care provider
Residential aged care Integration Programme


INTEGRATION

SUPPORT
- Resident comprehensive gerontology assessment
- Wound assessment
- Practice Development
- Quality initiatives
- Advanced care planning for high need residents

EDUCATION
- Clinical coaching:
  - Specific gerontology care education
  - Palliative care approach
  - Wound care

INTEGRATED CARE COORDINATION
- Liaison & care coordination:
  - Residents & families
  - GP & PHO
  - Geriatricians
  - Specialist doctors & services
  - Acute hospital admissions
  - DHB Multidisciplinary team
  - Hospice & Palliative Care providers
Staff are less stressed and more supported by having access to a nurse practitioner

• “And then you’d sit and stress should I, should I hold on, should I wait another day before I fax him, and ...... Now I don’t have that – I couldn’t imagine having that right now “. (RN)

• “You know that you have (NP) coming in on this day. Having a sick resident you used to have to monitor him until the GP comes next week or whenever. Now you know that someone is coming”. (CNM)
GP and NP Collaboration

- Collaboration and trust are key

- “We’ve both got the abilities to do those things (diagnostic investigations, treatment plans etc.) but we have different strengths and weaknesses in different areas really. So I see someone like (NP) with her whole extended role is just incredibly useful for me in that she’s got a lot more experience at working in rest homes”. (GP)
Thank You.

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