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nursing federation

Submission to consultation by the Australian
Commission on Safety and Quality in Healthcare on
Patient Safety in Primary Health Care

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1. Introduction

Established in 1924, the Australian Nursing Federation (ANF) is the national union for nurses and midwives, with Branches in each State and Territory of Australia.

As the largest professional and industrial organisation in Australia, the ANF has a membership of over 192,000 nurses, midwives and assistants in nursing. Members are employed in a wide range of settings in urban, rural and remote locations in both the public and private sectors.

The core business of the ANF is the industrial and professional representation of our members and of the professions of nursing and midwifery.

The ANF participates in the development of policy relating to nurses and midwives on issues such as: practice, professionalism, regulation, health and aged care, community services, veterans' affairs, education, training, workforce, socio-economic welfare, occupational health and safety, industrial relations, social justice, human rights, immigration and migration, foreign affairs and law reform.

The ANF welcomes the opportunity to respond to the invitation from the Australian Commission on Safety and Quality in Healthcare (ACSQHC) to provide comment on the discussion paper *Patient Safety in Primary Health Care*. As will be outlined below the ANF took a lead role in bringing together peak nursing and midwifery groups to develop a consensus statement on primary health care;¹ and also convened meetings of peak national interdisciplinary groups in 2008/09 to discuss positioning of primary health care as the centre of health care in this country. With this background work the ANF is particularly pleased that the ACSQHC is endeavouring to stimulate discussion about patient safety in primary health care in Australia.

2. Nursing and midwifery in primary health care

2.1 General comments

In its submission to the National Primary Health Care Strategy (February 2009) the ANF applauded the Australian Government for putting the spotlight on primary health care, and expressed strong support for the necessity of developing a national primary health care strategy. The suite of reforms commissioned by the Federal Labor Government enabled a sensible integration of the primary health care strategy into the broader context of health and aged care services. The ANF argued that positioning primary health care at the centre of health policy would lead to significant improvements in health for all Australians across their lifespan.

The ANF acknowledges the Commission's current efforts to position primary health care on the national agenda through the circulation of this discussion paper *Patient Safety in Primary Health Care*.

The notion of 'first level contact of individuals, the family and community' as espoused in the international Declaration of Alma Ata² dovetails with accessibility to nursing and midwifery care as nurses and midwives practice across all geographic and socio-economic spheres.

The ANF supports the view that there is a twofold benefit in embedding a well established primary health care sector within the country's approach to health care: reducing the demand on the acute sector while at the same time improving health outcomes and population health and well being.

2.2 Practice of nursing and midwifery in relation to primary health care

Primary health care is fundamental and inherent in the philosophical base of the disciplines of nursing and midwifery.

Nurses and midwives together form the largest health professional group in Australia, providing health care to people across their lifespan. Together they comprise over 55% of the entire health workforce.³ Nurses and midwives are the most geographically dispersed health professionals in Australia, working in homes, schools, communities, general practice, local councils, industry, offshore territories, aged care, retrieval services, rural and remote communities, Aboriginal and Torres Strait Islander health services, hospitals, the armed forces, universities, mental health facilities, statutory authorities, general businesses, and professional and industrial organisations.

The International Council of Nurses position statement *Nurses and Primary Health Care*⁴ states:

Nurses are the principal group of health personnel providing primary health care at all levels and maintaining links between individuals, families, communities and the rest of the health care system. Working with other sectors, other members of the health care team or on their own, nurses explore new and better ways of keeping well, or improving health and preventing disease and disability. Nurses improve equity and access to health care and add quality to the outcome of care.

The practice of midwives' is described as being woman centred; a primary health care discipline founded on a partnership relationship between women and their midwives.⁵ Midwifery care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.⁶

Nursing and midwifery are key professions to engage in achieving the aim of patient safety in primary health care.

2.3 Primary health care defined

The ANF maintains a position that there is a difference between primary health care and primary care. In 2009 the ANF, as part of a group of leading nursing and midwifery professional organisations, developed a consensus view on primary health care in Australia which argued that: a) primary care and primary health care “generally represent two different philosophical approaches to health care”, and b) primary care is a subset of primary health care.⁷

The peak nursing and midwifery organisations agreed that the Australian Government led health reform agenda in Australia “offers a unique opportunity to consider an enhanced model of primary health care that extends beyond the services of a general practitioner (primary care) to a multidisciplinary model to offer comprehensive, patient centred primary health care services”.⁸

The nursing and midwifery consensus view supports the notion of difference between primary health care and primary care, as espoused by Keleher (2001)⁹ who says that primary care is

Commonly considered to be a client's first point of entry into the health system if some sort of active assistance is sought. Drawn from the biomedical model, primary care is practiced widely in nursing and allied health, but general practice is the heart of the primary care sector. It involves a single service or intermittent management of a person's specific illness or disease condition in a service that is typically contained to a time limited appointment, with or without follow-up and monitoring or an expectation of provider-client interaction beyond that visit.

In its position statement *Primary Health Care*, the ANF¹⁰ maintains that “primary health care acknowledges a social view of health and promotes the concept of self reliance to individuals and communities in exercising control over conditions which determine their health”. Primary health care is seen by the ANF to be

*...both an approach to dealing with health issues and a level of service provision. As an approach it deals with the main health problems and issues experienced by the community. It may include care and treatment services, rehabilitation and support for individuals or families, health promotion and illness prevention and community development.*¹¹

The suite of health reforms initiated by the Australian Labor Government in 2008 provide an opportunity to broaden Australia's health policy and funding strategies from a narrow focus on hospital based care and the treatment and cure of already established conditions to health promotion and early intervention to prevent disease and injury within a primary health care milieu.

As the Australian nurses' and midwives' consensus view makes clear

The policy and provision of primary health care is shaped around the contribution of citizens identifying priorities for the promotion of healthy living, the prevention of disease, injury and disability. In addition, it must meet the health care, treatment, self management and rehabilitation needs of people, their families and communities; and their desire for humane, safe care across the period of their lives.

A variety of responsive forms of service delivery, provided by a range of providers, including nurses and midwives must be available to meet the needs of all people, including those with special needs such as intellectual disability and cultural or language barriers; and giving priority to those most in need.¹²

The ANF fully supports the Declaration of Alma Ata assertion that primary health care is:

.. essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process.¹³

A central message coming through the above citations is that patient safety in primary health care is increased when the community is actively engaged in identifying needs, planning for services and evaluation of care delivery. It is the view of the ANF that such policies and care delivery, driven by collaboration with the community, would ensure a greater degree of safe patient care in primary health care.

2.4 Characteristics of primary health care

The ANF considers the characteristics of primary health care to be those espoused in the vision statement which drives the nursing and midwifery consensus view on primary health care in Australia document previously referred to.¹⁴

The characteristics of primary health care included in the consensus view vision statement are:

- Care coordination and a team based approach to care
- Participation
- Partnerships for health

- Access and equity
- Education
- Innovative models of primary health care
- Governance and funding
- Safety and quality, and
- Sustainability

Essential elements of each of these characteristics which contribute to patient safety in primary health care include:

Care coordination and a team based approach to care

- Collaboration by all health professionals to co-ordinate care from health promotion, prevention of illness/injury through to illness and rehabilitation
- Continuity of care across health care settings (especially from tertiary to primary health care)
- Care co-ordination by the most appropriate health professional to meet the needs of the person and the local community

Participation

- Active involvement of individuals and communities in planning and implementation of their health care
- Health literacy to promote understanding to aid in self-management of health care
- Culturally appropriate and respectful care

Partnerships for health

- Working with individuals and communities to enable self-reliance or support where this is required
- Recognition of shared responsibility for health
- Partnerships between health professionals, health service providers and communities and other services which impact on the social determinants of health

Access and equity

- Understanding the diversity of the community
- Health care based on need and not the ability to pay
- Innovative care that reaches people where they are rather than necessarily coming to a 'centre'

Education

- Continuing professional development for all health professionals working in the primary health care arena
- Importance of pre-entry and ongoing integrated inter-professional development and education for effective transdisciplinary primary health care

Innovative models of primary health care

- Investment in research to provide a strong evidence base for models of primary health care
- Inter-disciplinary research into innovative models of care to promote collegiality and recognise imperatives for team based care in primary health care

Governance and funding

- Governance responsibility vested in local communities, which have insight into local health care needs
- Nurses and midwives, as regulated, qualified health professionals, will determine the extent and scope of their practice for safe care delivery. Funding models need to reflect this accountable practice, such as the removal of 'for and on behalf of' processes and not linking funding of employment of nurses to general practitioners.

Safety and quality

This is described as:

Effective systems of corporate and clinical governance are necessary at all levels of primary health care to monitor and improve the safety and quality of services. This includes:

- o open, transparent monitoring and reporting systems*
- o collection and use of data and information for driving change and improvement with performance indicators based upon the social determinants of health and other evidence based quality indicators of access, safety, effectiveness, appropriateness, efficiency and consumer participation*
- o investment in research for achieving continuous improvement*
- o effective organisational systems that promote safety and quality*
- o robust regulation of the conduct, health and performance in professional practice of health professionals*
- o strong consumer participation in all processes*
- o occupational health and safety.¹⁵*

Sustainability

- Adequate funding that will:
 - o Enable innovative clinical practice trials
 - o Ensure continuity of successful programs
 - o Support nurses, midwives and other health professionals undertaking outreach programs into community sub-groups who are marginalised from mainstream primary health care services
 - o Provide necessary resources for the primary health care workforce so that it can achieve its aims of health promotion, early intervention and illness/injury prevention.

2.5 Actions for improving patient safety in primary health care

There are two particular areas to which the ANF considers action needs to be directed in order to improve patient safety in primary health care. These are funding and qualification/competence of workforce as outlined below.

Funding models

The ANF maintains that the key to providing better access for the community to primary health care services, and therefore better assurance of patient safety, is the development of funding models in which the funding follows the person and not the provider (as in the current fee for service model).

MBS and PBS: The nursing and midwifery workforce is currently an under-utilised resource in the primary health care arena. This is due either to restrictions on scope of practice or lack of recognition of the role and function of nurses and midwives. The ANF considers that there needs to be a much better utilisation of the nursing and midwifery workforce in order to provide appropriate services for **all** geographical areas and population groups. Nurses are the largest health care professional group across geographical areas – and in fact may often be the only health care professionals in remote areas. The Australian Government's Productivity Commission Research Report *Australia's Health Workforce*²⁴ provides a stark revelation of the fact that, unlike all other health professionals, nursing and midwifery numbers remain fairly constant relative to population for communities located further away from the major cities. While nurses and midwives in all areas can and do provide primary health care, the health promotion and prevention component of that care must often be minimalised due to lack of funding support and recognition of its importance (thus providing potential for compromising patient safety).

To better meet the needs of the community in all geographical areas (metropolitan, regional, rural and remote) and across all population groups, (especially those currently marginalised from, and under-served by, mainstream health services such as the homeless or Indigenous people), legislative changes are required to enable nurses to extend their current scope of practice. In particular, current policies in relation to access to the Pharmaceutical Benefits Scheme (PBS) and the Medicare Benefits Scheme (MBS) by nurse practitioners, registered nurses (such as general practice nurses and community nurses), and midwives, mean that the practice of these nurses and midwives is restricted. Patients are grossly inconvenienced and inefficiencies and duplication of services occur. The enactment of the Health Legislation Amendment (Midwives and Nurse Practitioners) Bill 2009 and two related Bills on 1 November 2010 will improve this situation with nurse practitioners and eligible midwives being able to gain access to MBS rebates and PBS subsidies for their patients. But there remains some way to go to improve access to the services of these health professionals by the community.

Prescribing rights: Expanding prescribing rights more broadly for nurses, midwives and other regulated non-medical groups would greatly enhance access to more timely care for people in primary health care settings and improve patient safety in health care. As regulated health professionals due importance would be given to ensuring appropriate education and competence to safely prescribe within scope of practice.

Funding incentives: Action is needed to ensure that the incentives available to rural and remote health professionals are equitable across the professions, in order to recruit and retain these practitioners. In many rural and remote settings, small numbers of people from a range of health professions work together in teams. Any inequity in the range of incentives that is available to each of the professions undermines the collaborative nature of multidisciplinary team work and should be reduced or eliminated where possible.

At present, there are significant inequities in the incentives available to nurses and midwives in rural and remote areas compared to those available to medical professionals. For example, many incentives are available for medical students to encourage them to consider a career in rural and remote health but few are available for rural and remote nurses and midwives. Given that rural origin is an important predictor of rural practice, more effort should be made to encourage rural students to consider a nursing or midwifery career and for those interested in a rural health career to have the opportunity to undertake rural clinical placements.

Outreach services: Funding models for primary health care must encompass not only service centres - to which the community goes, but also itinerate/outreach services - where nurses, midwives and other health professionals take their services to people and attend to their health needs in their own environment.

The following case study taken from the document *Primary Health Care in Australia: a nursing and midwifery consensus view*¹⁶ epitomises provision of outreach primary health care services which place patient safety at the core of service delivery.

Coachstop Caravan Park Outreach Project

An initiative of the Maitland Local Government demonstrates that identification and action on detrimental aspects of a social environment can pay dividends on a community's health status.

The Coachstop Caravan Park is the prime provider of housing for 150-200 people classified as "at risk" families and individuals. Many of these people have been homeless, in prison and juvenile institutions, a number are from mental health facilities or refuges, and some are transient, moving from park to park in search of affordable housing.

In 2000 health professionals observed a high number of referrals from this park coming from a number of agencies including the Emergency and Obstetrics Departments of Maitland Hospital, Department of Community Services, Australian Childhood Immunisation Register and in one instance a funeral director. Follow up of residents of the park was complicated by factors such as their being unable to be contacted by phone, frequently not at home when health staff attempted to visit them, a general lack of trust of "government services", and the transient lifestyle of many.

It was apparent that to achieve contact an onsite presence in the park was required by health professionals. The Maitland/Dungog Community Health Service negotiated to run a pilot outreach Child and Family Health Clinic from an onsite van staffed by a Child and Family Health Nurse and a Generalist Community Nurse. A picture emerged of a very disadvantaged community sharing common characteristics: largely reliant on Centrelink benefits, poor functional literacy skills, frequent domestic violence, high level of substance use, high rate of Hepatitis C, social isolation with poor self esteem (particularly the women), poor school attendance, a high proportion of residents with a history of childhood sexual assault, abuse and/or neglect, failure to access mainstream health services (many individuals did not have a Medicare card), or General Practitioners.

With funding from the Primary Healthcare and Partnerships (Women's Health Outcomes) NSW Health, a two year project was initiated, with the outreach van being staffed by an Early Childhood Nurse, a Project Officer (Registered Nurse), and a Registered Psychiatric Nurse. The intervention was based on the Social Health Model addressing the WHO social determinants of health. Additionally the WHO Ottawa Charter for Health Promotion 1986 was referred to, which includes advocacy and enablement as a means to achieving equity in health.

The project design combined innovative outreach with community capacity building and partnerships with a range of other service providers including drug and alcohol services, dental and women's health services, immunisation services, Centrelink, a volunteer General Practitioner, education, and community businesses and charities such as the St Vincent de Paul food program.

The project's core values were:

- Residents providing the driving force for program reorientation and decision making
- Interactions based on mutual respect and trust to give positive outcomes
- Stakeholder decision sharing as a key feature of the delivery model
- Sustainable inroads gained as a fundamental objective

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With these values, the objectives of the project then included:

- Partnerships to address the social determinants of health
- Reorienting health services to meet the needs of park residents
- Strengthening working partnerships between the residents and mainstream health services
- Developing capacity building within the caravan park
- Increasing residents literacy and health literacy through education
- Strengthening community action. Helping residents set their health priorities and plan strategies to address them.

Six indicators of success of the project were identified as: reduced social isolation, improved housing options, an increase in personal skills, literacy and health literacy, improved sense of a supportive community, improved access to appropriate health services, and improved maternal and child health outcomes.

Based on data from the Emergency Department of The Maitland Hospital, primary health care interventions were established to address underlying social and health issues. For example, after a number of presentations with needle stick injuries disposal bins were placed in the toilets and a needle and syringe program established on the outreach van.

Another important intervention was advocacy for improved living conditions on the park. Children were frequently admitted to hospital for respiratory conditions exacerbated by damp musty vans. Improvements in nutrition necessarily began with negotiating for full size refrigerators in all the vans as opposed to bar fridges. Lack of transport, a barrier to accessing services, was solved by a partnership between a businessman, St Vincent De Paul and Centrelink.

Within six months there was a beginning of a sense of community in the park and a culture change. People were attending TAFE courses and antenatal care. Children were attending school. Further capacity building took place amongst other health services, schools and other government departments. These organisations reorientated their services to make them more accessible, many delivering from the outreach van. Outreach services were extended to Paediatric clinics and a public health physician volunteered as a general practitioner on his day off. Social entrepreneurial partnerships were established with private businessmen and fundraising was used to allow children to participate in sport, dance classes, school excursions and in some instances to supplement preschool fees. As park residents regained confidence in health and social services they were linked back into mainstream services.

The Coachstop Caravan Park outreach service continues to evolve and now has a permanent home (a demountable) in the park. It has been successful in engaging socially and economically disadvantaged families and individuals living in the caravan park and delivering a high quality health service on minimal funding. The intervention has been very successful in returning family members to housing, work, employment and health services. The women now attend antenatal care and the children have access to enriched childcare and preschool. Additionally the broader community is now aware of the residents' plight and there is a subsequent break down in social isolation. The holistic approach of the intervention allowed residents to make changes in many areas of their lives. The broad range of collaborative partnerships all delivering services onsite or through the outreach van made the services accessible. Ease of access is essential when people's lives are in chaos.

This highly successful nurse-led primary health care model could be replicated in many communities.

Qualifications and regulation

There is a growing number of unlicensed and/or unqualified workers providing aspects of care in community and primary health care settings. It seems incongruous in an age of increasing emphasis by governments on accountability and delivery of safe competent care and scrutiny by consumers of health and aged care, that we do not have national standards for educational preparation, codes of professional conduct or regulatory frameworks in place to govern the care provided by this significant cohort of community and primary health care workers.

The ANF is currently undertaking a major national campaign – *Because We Care* - which has included extensive lobbying of the Australian Government to invest funding in educational opportunities, and explore the feasibility of developing a licensing system, for aged care workers, regardless of the setting of providing care for older people in this country. This culminated in initiatives announced in the Federal Budget 2010/11 which addressed many of the ANF requests. Improvements in the care performance of this level of worker in community aged care has a flow on effect of reducing preventable hospitalisations and demand on the tertiary sector as well as a transfer to an unfamiliar environment for the older person; and of enabling older people to stay living in their own homes longer resulting in a decreased demand on residential aged care beds. Gains of a professional practice framework for these community aged care workers will also impact on currently unqualified and unlicensed workers in other primary health care settings, to achieve improved quality, safety, performance and accountability for the community.

Research

Nurses, midwives and other health professionals employed in primary health care settings need to have funding support which enables them to undertake clinical loads as well as health promotion/education and research loads. Health care managers must be respectful that time is built into the working life of primary health care professionals for them to be able to meet with population groups to discuss lifestyle modification options and to listen to concerns and barriers to achieving a healthier lifestyle. Investment in time to assist people become more self-reliant and better able to manage their own health care needs, will have positive sustainable outcomes for the health system as a whole and the community if hospitalisations can be avoided and/or chronic disease/disability better managed.

Funding models need to include time for clinicians of all disciplines to carry a clinical load and have allocated time for research activities – literature searching including systematic reviews; time for collecting and collating data, analysing data, funding for contracting out aspects of work if required, writing up results, publishing, speaking at conferences to disseminate research. There are two aspects to research application which need consideration – either implementing research findings of others for example, the work of the National Institute of Clinical Studies, or other primary health care centres; or implementing findings of own research.

Also, funding must be provided for research education and on-going continuing professional development of health care professionals. There must be acknowledgement of the equal value of both qualitative and quantitative research in supporting clinical practice.

In addition, funding models need to include the ability for primary health care health professionals to mentor novice researchers coming into the sector. Likewise, funding models should include the facility for consumers of primary health care to participate in research.

Data collection: Funding needs to be provided for software which will enable consistent data collection from primary health care services across jurisdictions for reporting at that level and also to be able to migrate into data systems at the national level. Ideally, then, the elements for data collection need to be agreed initially at a national level to facilitate a consistent approach.

e-Health

The primary health care sector would benefit from improved lines of communication between the different areas of the health and aged care system. However, while many people are able to utilise their informal networks to navigate their way around the complexities of our primary and tertiary systems, or have a significant other who can assist them with this, for some particular groups the whole process is incredibly daunting.

Improvements in information transfer between primary health care areas and different sectors of the health and aged care arena can be achieved through financial investment in integrated electronic systems. Ready access for all health professionals employed in primary health care settings to email, internet, records management systems, and patient history records systems, is essential for timely and safe health information management.

There is a critical role for eHealth – in this era of widespread use of electronic information systems, the use of eHealth is fundamental to primary health care. Health care professionals require access to information in a timely manner and consumers of care need to know that these professionals have access to this information, for example, most recent tests/procedures/consultation remarks so that visits can be conducted efficiently for both parties.

Ehealth means that health care professionals can keep up to date with the latest evidence and the whole gamut of issues presented by clients; consumers of primary health care services can remain informed if they so wish to or be encouraged to do so. Transfer of information is rapid and timely, with an increased chance of consistency in information when coming from the same/similar source for all parties. Web based information allows health care professionals to direct clients to particular sites for information, either through use of computers set up in the primary health care facilities or to refer to at home. Individual electronic health records (IEHR) mean that people don't have to rely on their memory each time they visit a health care professional regarding previous history, medicines or treatments. Access to the same information via the IEHR should lead to a significant reduction in gaps which frequently occur now in client treatment. Everyone is able to review the same information and consider what others have decided/prescribed thereby reducing duplication of tests/medicines ordered, reducing the dollars spent in the health care system, reducing time wastage and inconvenience to clients and their carers, and most importantly ensuring a greater degree of safety through consistent and shared patient information.

Models of care

There are many examples across the country of models of care which could be replicated on a broader scale to effect patient safety through efficiencies both by utilising the most appropriate health care professionals, and by engaging with the community to ascertain the most appropriate solution to health or aged care needs.

Two models which ANF support and want to highlight, are demonstrated exemplars of models of care that utilise the available workforce to provide comprehensive primary health care services in rural communities. The following examples fit well with the international Treaty of Alma Ata definition of primary health care which places health in the broader social context.

Port Macquarie Aged Care in NSW

The far north coast of New South Wales has one of the highest concentrations of older Australians, with a quarter of the population of Port Macquarie aged over 65 years.

It's here that Debbie Deasey works as a nurse practitioner treating the elderly in their homes and residential aged care facilities and keeping them away from the Emergency Department at Port Macquarie Base Hospital

Working from the hospital and with the help of her "very supportive" GP mentors, Debbie assesses and, where necessary, prescribes medicines.

"So if someone's aged over 70 and can't access their GP, I'll go out and help treat them for a variety of things, including pneumonia, infections, delirium or checking catheters."

A local girl who started as a hospital cleaner around 16 years ago, Debbie completed her registered nurse education before undertaking a Masters in Gerontology. She began work as an aged care nurse practitioner in October 2007, and loves the choice it gives the elderly.

"The patient is safe, the staff are happy and it prevents an ambulance trip and an emergency presentation." The other patient benefit is a next day review of the treatment and the extra time Debbie can take as a nurse practitioner. "They like that one-on-one service – they can ask questions and I'm not as rushed as a GP."

"I'm also looking at the patients from a nursing perspective, so I take into account the family, the environment, medications and the education I can provide," she says.

"It also empowers the residential facilities by enabling them to get a nurse practitioner in straight away to take care of something simple like dehydration." Debbie would love to see more nurse practitioners working in aged care within residential facilities and in the community. But she says easing up the restrictions on PBS and MBS benefits access is crucial to this expansion.¹⁷

* The NSW Department of Health has estimated Debbie's work has saved the hospital \$1.5 million in hospital *admissions for over 65s*.

Walwa Bush Nursing Centre in Victoria

Following the failure of their not-for-profit community Bush Nursing Hospital when funding ceased, the Walwa community rallied to establish a Bush Nursing Centre. It is built around a small health care workforce which includes a nurse practitioner, Sandi Grieve, and four nursing colleagues who together conduct a nurse-run emergency facility, and a General Practitioner, Dr Dave Hunt. The major features of the Centre are a community centre, used for training, meetings and functions; a gym for public use and nurse-run programs; a community vegetable garden; nursing and management offices that co-ordinate various allied health services, community services and health education programs; and nurses accommodation (a nurse stays overnight for on-call emergency work). Importantly the Centre is like a hub within the community in that the nurses go out into the community to visit elderly people, and the primary school children come into the Centre to learn healthy cooking and exercise, as well as using the facility for concerts. Initially the community raised funds towards the Centres establishment. Now, while funding is from state and federal government, the whole community works to ensure that existing programs and new initiatives are aimed at sustaining the Bush Nursing Centre, the medical practice and the community.¹⁸

Occupational health

Action is needed to take multidisciplinary teams of health professionals into workplaces to provide easy access for workers to a health assessment. This is particularly pertinent in a society which is exhibiting higher levels of diabetes mellitus type 2, cardiac conditions and obesity.

Occupational health nurses provide for and deliver health and safety programs and services to workers and community groups. This area of nursing practice focuses on promotion and restoration of health, prevention of illness and injury and protection from work related and environmental hazards. They have an integral role in facilitating and promoting an organisation's on site occupational health program. Their scope of practice includes disease management, environmental health, emergency preparedness and disaster planning in response to natural, technological and human hazards to work and community environments. Occupational health nurses provide specialist health and safety advice and administer Injury Management, First Aid and Emergency Preparedness Programs; as well as develop provide health education programs, such as exercise and fitness, nutrition and weight control, stress management, smoking cessation, breast and testicular self examination, management of chronic illnesses and effective use of health services. These nurses are only employed in some businesses and the ANF considers that their services need to be available across the whole spectrum of workplaces to really impact the health of the community.

2.6 Work currently being done to improve patient safety in primary health care

There are many examples of work being done to improve patient safety in primary health care given in the document *Primary Health Care in Australia: a nursing and midwifery consensus view*.¹⁹ Specific ones highlighted here are developing processes for nursing and midwifery practice in their communities based on evidence of safe care. All of the nurses and midwives involved collaborate with other health professionals as they deliver care in an environment of seeking to gain the trust of their clientele, improve patient identification and confidentiality issues in conveying vital information to the care of the individual or community, and involve patients in their own care.

Example 1: Deb Spurgeon, remote mental health nurse practitioner, is part of a team of health workers including remote mental health nurses in the Northern Territory providing specialist mental health services to Indigenous communities. This is having a positive impact on mental health outcomes at the local level. The nurses' services are provided according to community need. The basic premise is that mental health is one component of holistic health care and guidance and advanced level support is provided to local health care providers within a primary health care model.

Indigenous people are receiving reliable, long term treatment and gaining stability which enhances family and community life. As a result of this work people are gaining a greater understanding of mental illness and mental health problems. This in turn helps families and communities with awareness levels and makes it easier to intervene early and achieve better outcomes.

Example 2: Catherine Fisers, school nurse, provides a primary health care service in a suburban Melbourne primary school. With specific reference to patient safety activities this nurse has written submissions and received state government funding grants for: better hand washing equipment in the bathrooms for students and teachers; padding for schoolyard posts (basketball, netball and football) after gathering statistical data on the number of injuries caused by these hazards; provided H1N1 education and support to the whole of the school community; and written a weekly column in the school newsletter dealing with different topics from how to clean your asthma spacer, to cough and sneeze etiquette and healthy eating. There has been overwhelming support for this primary health care nursing role, a role that continues to evolve through consultation with the students, the teachers and the parents.

Example 3: Andrew Whale, Nurse Unit Manager for primary health care community nursing in NSW, has spent much of his time working from a caravan called MERV - Men's Educational Rural Van. MERV is a mobile men's health check-up and information service that travels to workplaces and community sites in the Mudgee district in NSW. Men have their blood pressure, blood glucose and cholesterol levels checked followed by a discussion with a community nurse about men's health issues. Men are provided with information about heart disease, alcohol consumption, smoking, prostate cancer, bowel cancer, sexual health, testicular self examination, healthy eating, exercise and mental health. In the first year of the service, 1,246 men accessed MERV and 51 visits were conducted to local worksites or community events. About half the men who visited MERV at this time were aged 41-60 and more than a third had not seen a GP for a full health check up within the past year. About 83% of men accessing MERV for a second time had followed most recommendations made on their first visit.

2.7 Work on patient safety in primary health care which would benefit from national coordination

While there are many exemplars across the country of work on patient safety in primary health care the ANF wishes to highlight two. The first is a nurse-led pilot project at Flinders Medical Centre in South Australia, which has improved health outcomes for Indigenous patients travelling from remote areas for cardiac surgery. This project is worthy of replication across the nation. Research by the nurse, Monica Lawrence, revealed that many Indigenous patients attending a tertiary facility in Adelaide for surgery were psychologically and clinically unprepared. In crude figures 21 out of 48 patients scheduled for surgery did not show up over a 6 month period in 2004-2005. The remote area nurse liaison pilot project reduced the no shows to zero. Many Indigenous patients were not properly informed and prepared for surgery due to language difficulties. Simple strategies to improve communication between the hospital and local communities made a great contribution to improving attendance rates and successful health outcomes.

The second is the nurse-led primary health care clinic established this year in Canberra. In the first two months of operation this government funded nurse-led clinic, staffed by nurse practitioners and advanced practice nurses, saw 2,400 patients. The community has clearly voted with their feet on this model of primary health care which could be replicated in all states and territories.^{20,21}

2.8 Clinical governance in primary health care

The ANF considers that the most appropriate health care professional at the time should take the leadership role. This will change depending on the circumstances – it could be the nurse, midwife, medical practitioner, an allied health professional, or an Aboriginal Health Worker. In a multidisciplinary team, members work together interdependently to develop goals and a common treatment plan, although they maintain distinct professional responsibility and individual assignments.²²

3. Conclusion

The ANF is firmly of the view that a well structured and well resourced primary health care sector should be central to this country's health care system. As highlighted in this paper essential elements of an effective primary health care system which will ensure a greater degree of patient safety are that it is: team based; accessible to all communities; culturally appropriate; involves community participation; is adequately funded to support the services needed to be delivered to meet the communities' health and aged care needs; supports the educational and on-going professional development requirements of the health care professional team; and is sustainable.

Success of patient safety strategies and sustainability of the primary health care sector will be measured in terms of engagement and capacity building of both staff and communities, evidence of ownership by communities, and ability to demonstrate that both health care professionals and the community have access to the education and information required to effect positive outcomes of health and aged care.

The ANF looks forward to learning of the outcome of the consultation process on patient safety in primary health care and to participating in ongoing work of the Commission.

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