Nurse Navigators

Information for general practitioners

A new nursing service model has been introduced into the Sunshine Coast Hospital and Health Service (SCHHS) as part of a statewide Department of Health initiative.

The nurse navigator service aims to assist patients with complex health care needs in navigating to and from their referring primary care provider or general practitioner, through to hospital, community health and back home again, the service is part of the Community Integrated and Sub Acute Service (CISAS).

This service model puts patients and their family at the centre of care and supports the patient's journey through an increasingly complex healthcare system.

How will the nurse navigator service benefit patients?

Patients with complex health care needs who require services from numerous care providers, or those who have presented multiple times to a health service stand to benefit from the nurse navigator service.

As experienced nurses with a high level of clinical knowledge and a comprehensive understanding of the health system, nurse navigators will work closely with the patient and their G.P., being the patient's key point of contact and coordinating care for the patient across a range of service providers.

Nurse navigators will provide patients with an end-to-end service that is focused on safe and quality patient care, linking them with services, including Aboriginal and Torres Strait Islander patients to ensure the patient receives the right care at the right time and in the right place.

The service provided by nurse navigators will complement other care coordination services through the development of partnerships across sectors and providers, ensuring a system-wide, integrated approach to health service delivery.

This will help patients with high and complex needs to move seamlessly through the health system, linking them with the health professionals, and ensuring they receive care and services tailored to their needs.

Standard 2
Partnering with consumers

Standard 11
Service delivery

Standard 12
Provision of care

More efficient use of resources in service delivery also results in lower system-wide costs, particularly for those populations with multiple health and social needs and significant productivity gains for all health professionals and the broader health system.

The nurse navigator will also be able to support patients to inform and educate them regarding their health needs so to empower patients to make informed decisions regarding their own health care and be better prepared for their journey through the healthcare system.

Nurse navigators in action

Scenario 1

Mary is 76 years of age. She lives alone in a small rural community and does not receive any formal community support. She has hypertension, macular degeneration, type 2 diabetes, mobility issues due to osteoarthritis and requires bilateral knee replacements.

Mary's nurse navigator supports Mary navigating My Aged Care to gain access to community support and plays a key role for Mary as her advocate in aligning and coordinating her appointments with her general practitioner, orthopaedic surgeon, ophthalmologist, endocrinologist and allied health professionals.

Mary's nurse navigator works across the network of health service providers ensuring quality care is provided throughout her health care journey. Utilising a person centred approach to care, Mary's nurse navigator works closely with Mary and her general practitioner, to develop a care plan focused on meeting Mary's needs, educating her on her care options to make informed decisions about her health and supporting her during her interactions with the various services and professionals who will care for Mary on her journey through the health care system.

Scenario 2

John is 59 years of age and lives in the Sunshine Coast Hinterland. He has a background of chronic heart disease and chronic obstructive pulmonary disease.

Over the last week John has been getting increasingly short of breath and visits his local health centre before being admitted to hospital for treatment for pneumonia. The hospital recognises that John's care needs are complex and assigns him a nurse navigator. The navigator helps identify and coordinate access to the services that John requires so that he isn't left to do this on his own when he is at his sickest and most confused, and helps ensure that John will receive the care he needs, when and where he needs it.

The navigator also helps John liaise with his G.P., hospital admission, develops a care plan and will be his key point of contact in negotiating the health system.

John's nurse navigator works across organisational and sectoral boundaries to coordinate and manage his complex health care needs, taking into account his medical history and rural location. The nurse navigator acts as a central point for communication and engagement with all stakeholders who have a role in John's health care, ranging from his local health service, to his cardiology and respiratory specialist nurses and doctors, as well as his family members.

The nurse navigator spends time with John to educate him about his conditions and will support him to self-manage his health and wellbeing. Having identified John as a high risk patient, the nurse navigator maintains regular contact with him to ensure he is safe and his health needs are being met. This end-to-end approach helps John overcome any potential barriers to receiving the care he needs, and helps him avoid unplanned readmissions to hospital.

Location of the Nurse Navigator Service:

The nurse navigator service within the Sunshine Coast Hospital and Health Service is currently based at: Gympie Community Health Centre 5489 8690, Nambour Community Health Centre 5470 5703 and Caloundra Community Health Centre 5436 8552.

Hours of operation:

Monday to Friday 8.30am to 4.30pm excluding public holidays
Referrals are to be directed to the following contact:
Referral fax: 5479 9673.
Email SC-CCCSIntake@health.qld.gov.au or through Health Pathways.