Nurse Navigators

Nurse Navigator role principles

Purpose

The purpose of this document is to provide an outline of the key principles for the Nurse Navigator category of roles and to clarify the model of care they fulfil. This document is intended to be a high level over-arching model of care that is flexible and adaptable so that it can be operationalised in a manner that meets the needs of the service it is supporting.

Key role principles

The nurse navigator function is a fundamental part of the nursing role. It aims to facilitate the patient journey in what has become an increasingly complex health system. This facilitation will be achieved by reducing fragmentation, mitigating barriers, educating, empowering and coordinating patient care. These roles are intended to transcend across multiple specialities, support nurse led service models and augment existing models of care within a facility or clinical area. The key principles related to the nurse navigator role are outlined below:

1. Coordination of patient-centred care

- Provide care coordination across the patient journey for a selected cohort of patients using a multi-disciplinary, holistic approach that is not simply about treating symptoms or a disease, but rather the whole patient.
- Facilitate the application of patient centred integrated care pathways that are personalised and may use tools such as pathways.nice.org.uk/ or other models as determined by the clinician.
- Facilitate the delivery of care to a cohort of patients including:
  - Patients requiring complex ongoing management, including those with multiple co-morbidities. For example: mental health patients requiring complex holistic care and Aboriginal and Torres Strait Islander patients
  - High frequency presenters for unscheduled care.
- Facilitate effective patient centred care by enhancing systems integration and reducing fragmentation and barriers when establishing a personalised care pathway. For example: using telehealth or other technology to facilitate care coordination.
- Enhance patient quality of life.
  - Use and support the application of clear escalation and de-escalation pathways

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- Integrating evidence-based models of care as a foundation for the provision of care
- Coordinate timely access to appropriate health and social services when necessary.

2. Creating partnerships

- Provide a central point of communication, engagement and coordination for all stakeholders involved in patient care.
- Ensure that all stakeholders, (most importantly the patient and their carer(s), are equal contributing partners in the patient care journey.
- Establish consistent and effective lines of communication across primary and tertiary care providers using innovative communication pathways where needed.
- Facilitate clinical care review meetings, particularly those focusing on discharge planning and continuing management.
- Supervise support and mentor students, graduates and other clinical staff.

3. Improving patient outcomes

- Deliver care that is based on predetermined key performance indicators which is focussed on patient outcomes throughout the patient journey across the health care system.
- Foster and encourage active patient engagement in the development of health care goals which promote self-management and seek to improve patient health literacy.
- Enhance health literacy to support patients and their families to make informed decisions about their health care options including advanced care planning (Advance Health Directive).
- Facilitate access to specific services and practitioners required to maximise positive patient health outcomes and health literacy.

4. Facilitates systems improvement

- Provide a leadership role within the organisation and act as an agent for change, with the role reflected within the organisational structure.
- Possess high level systems literacy that allows the NN to promote cohesion across the health continuum to reduce fragmentation, duplication, time delays, inappropriate treatment and other barriers to effective patient centred care.
- Assess at a functional and systems level the barriers to effective communication with respect to referral pathways and the flow of information to support patient centred care.
- Lead quality improvement activities and participates in research activities relevant to the assessment and development of the NN role on an ongoing basis. This may take the form of collating outcome measures, Key Performance Indicators (KPIs), staff and patient satisfaction surveys, or any health service improvement activity.

Service Model

Implementation of the NN role needs to be considered in the broader context of health service planning to maximise the contribution and efficiency of the nursing workforce. Establishing the model is part of a strategic agenda that focuses on improving patient outcomes through sustainable nurse led service models.

The service model will meet the needs of the patient and is intended to flexible and responsive to the health service needs. The role is intended to work across multiple specialties remaining focussed on the patient and their journey. The role scope is not to be limited by a disease process. Functionally, this means that the Nurse Navigator care of a patient will grow and adapt with the changing needs of the patient irrespective of the traditional medical or nursing specialities that would define care in other contexts.

There is an opportunity to redefine existing and develop new innovative roles within the Nurse Navigator model of care. Individual health services should seek to identify how best to apply the Nurse Navigator role to their patients' and organisational requirements.

At Sunshine Coast Hospital and Health Service, the Nurse navigator service is part of the Community Integrated and Sub Acute Service (CISAS).

Potential outcome measures for Nurse Navigator positions

- Reduced length of stay in prescribed cohort of patients
- Reduced avoidable hospital admissions
- Reduced readmission rates
- Reduced unscheduled care presentations
- Increased patient and clinician satisfaction
- Quality of life indicators
- Reduced standardised mortality ratio
- Reduction in number not ready for care
- Increased evidence of advanced care planning (Advance Health Directives)
- Reduced outpatient/procedural/surgical wait times

For further information please contact:

Gympie Community Health Centre: 5489 8690
Nambour Community Health Centre: 5470 5703
Caloundra Community Health Centre: 5436 8552

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