Overview of the Kangaroo Island Community Outreach Nurse Practitioner role

Who will the Nurse Practitioner see?	What will they do?	What will they achieve?	When will they be available?	How will the service be offered?	Where will the service be offered?
Kangaroo Island Community Outreach Nurse Practitioner will assess and/or manage: • Consumers unable to get timely access to a GPs and who are likely to present to the Emergency Department • Consumers with complex chronic health conditions requiring further assessment and follow-up • Consumers in the community who do not currently access services, for example, Aboriginal consumers • Consumers with barriers to accessing health services, for example, transport or mobility barriers	Kangaroo Island Community Outreach Nurse Practitioner can provide: **Assessment** • Advanced clinical assessment **Radiology** • Order x- ray and/or ultrasound **Pathology** • Can order blood tests **Referral - can refer on to** • GPs • Other Nurse Practitioners • Emergency Department • Other specialists **Pharmacy** • Can prescribe certain medications **Discuss and promote** • Diet and weight management • Immunisation • Exercise and lifestyle modifications • Smoking cessation **Link in with other services to improve coordination of care** • Community health services • Junction SA • Mental health services • Hospital • Ambulance • Off Island health services • Schools **Note:** What the Nurse Practitioner will do will be further defined once recruitment is complete	Kangaroo Island Community Outreach Nurse Practitioner role aims to: • Improve access to health assessment and treatment • Reduce presentations at the Kangaroo Island Health Service Emergency Department • Reduce workload pressures for GPs • Provide cost-effective care • Target at-risk populations • Increase access to culturally safe health services • Provide outreach services in rural and remote communities • Provide mentorship and clinical expertise to other health professionals	The role will be advertised in June 2022 and commence in August 2022 Part of the role will be to further define the Model of Care	The Kangaroo Island Community Outreach Nurse Practitioner (KICONP) is **employed by SA Health**, Community Health KI (The Cooke Centre) BHFLHN **KI Medical Clinic** The KICONP will have shared-care arrangements with GPs at KI Medical Clinic and will see current GP patients with unmet chronic and/or complex health needs **Supports KI Aboriginal people** to access culturally safe health and wellbeing services alongside the BHFLHN Aboriginal Health team **Community** members who are referred from partner agency and/or community groups with defined health education needs	• **Parndana** outreach clinic x1 day week • **Penneshaw** outreach clinic x1 day week • **Kingscote** at KI Medical Clinic x1 day week • **Home visiting/partner agency visits** as needed x2 days per week across the Island • **Coordination of care and health promotional activities** in collaboration with community as needs are identified — may include activities provided in group setting **Note:** Where the service will be offered will be refined based on needs and capacity

Case Studies

Examples of the types of consumers the Nurse Practitioner will work with and what they will do

Case Study 1 — Chronic disease (asthma with other co-morbidity)

- Greg is a 50-year-old male, working as a farmer, who lives in the western districts of Kangaroo Island.
- He has been diagnosed with asthma, which sometimes gets worse in winter.
- Greg does not regularly see a GP due to the distance and time it takes to go for an appointment and needing to take most of the day off from farm work.
- Greg has presented to the Kingscote Emergency Department several times with an acute asthma attack, resulting in loss of work due to the unmanaged asthma.

What the Nurse Practitioner can do:

- Can regularly see Greg at the Parndana outreach clinic near his farm to ensure that his chronic disease plan is followed up and his asthma is better managed.
- Will assess Greg, provide relevant health education regarding his asthma management, review his asthma medications, and adjust them as required.
- Greg will have his primary health care needs met closer to home reducing his lost work time and need to present at the Emergency Department.
- Where a consultation with the GP is required the Nurse Practitioner can assist to coordinate this via a telehealth appointment with the GP.

What this means for the Greg:

- Greg will have improved work life balance by reducing the time required to access health care.
- Greg will have improved health status as his asthma will be better managed.

Case Study 2 — Aboriginal consumer who is currently not accessing health service on Kangaroo Island

- Jill lives with her three grandchildren at Parndana. She has diabetes but finds it difficult to regularly see a GP as she is busy caring for her grandchildren.
- Jill finds it difficult to get to appointments as she does not drive and has limited money, given she provides food for herself and her grandchildren.

What the Nurse Practitioner can do:

- Can provide Jill with a home visiting service to ensure her diabetes is better managed.
- Would collaborate with the diabetes educator at Community Heath to develop a diabetes management plan that best controls Jill's illness — may include ordering blood tests to better understand her diabetes and adjusting her medication and diet as required.
- When the Nurse Practitioner visits, other matters relating to the health and wellbeing of the children may be discussed and the Nurse Practitioner can work with Jill and link her with the GP clinic as required.
- The Nurse Practitioner can also, with Jill's permission, liaise with the school to ensure it is aware of the health and wellbeing needs of the children.

What this will mean for Jill:

- Jill will be able to access support for her own health and wellbeing needs which means she is better able to attend to the needs of the children in her care.
- The children in her care will also have their health and wellbeing needs identified and will have better coordination of care and services to meet their needs.