**NDEC Site Nomination Form**

**Facility name:**   **LHD:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Demographic questionnaire:** | | **Responses** |
| 1. How many GPs are in town? | |  |
| 1. How many GP VMOs service the facility? | |  |
| 1. How many other Medical Officers (MOs) work at the facility? | |  |
| 1. Do all GPs/MOs support the implementation of the model? | | **Yes / No** |
| 1. How many presentations do you receive in your ED per year? | |  |
| 1. What percentage of your presentations would be ATS 4/5? | |  |
| 1. What is the approximate time to treatment from triage (for patients after hours) if the GP is called-back? | |  |
| 1. In what situations would the NDEC model be implemented? 2. 24/7 3. after hours only 4. only when GP is unavailable 5. combination of the above | |  |
| 1. How many registered nurses at the facility would be eligible to be trained in the model? | |  |
| 1. What is the average number of GP call backs the facility makes per month? | |  |
| 1. How do you plan to educate the local community? Please select all that apply below: | |  |
| * Brochure and/or poster for the ED * Local newspaper / media release * Local Health Advisory Council * Other . | * Information forum * LHD and ECI website * Local Council |

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| **Other comments (including any potential barriers to implementation):** |

**Roles and responsibilities of participating facilities:**

Please circle **yes** or **no** in response to the following statements.

|  |  |
| --- | --- |
| * I agree to promote and support protected **training** time for nursing staff to attend the mandatory education and accreditation program. This is a requirement to use the model. | **Yes / No** |
| * I will promote and support the completion of regular **audits** to ensure accredited nursing staff are applying the model appropriately. | **Yes / No** |
| * I will promote and support the model and the **nursing management guidelines** as developed and endorsed by the ECI. This will be released and groups will be provided and an opportunity to withdraw their support prior to implementation. | **Yes / No** |
| * I will promote and support all **planning and** **evaluation** activities including participation in meetings, information sharing, providing data as requested by the ECI and encouraging the completion of a pre and post staff and patient satisfaction survey. | **Yes / No** |

**ECI team contacts / enquiries:**

Christen Stubbs [Christen.Stubbs@health.nsw.gov.au](mailto:Christen.Stubbs@health.nsw.gov.au)

**Please provide name and contact details for:**

**Site Project / Nursing lead: the ECI will be in regular contact with this person to plan implementation**

Print name Email Phone

**GP / MO lead: the ECI will be in regular contact with this person to plan implementation**

Print name Email Phone

**LHD Executive Sponsor: the ECI will be in regular contact with this person to plan implementation**

Print name Email Phone

**Agreement**

**I have read and understand my roles and responsibilities as an endorsing party to this project. I agree to work with the NSW Emergency Care Institute to facilitate the implementation of this model in my local facility.**

**Medical lead**

Signature Date

Print name Position and Organisation

**Nursing / HSM lead**

Signature Date

Print name Position and Organisation

**Local Health District**

Signature Date

Print name Chief Executive / delegate