Nurse & Midwifery Navigator Service

Hello and welcome to the first of our quarterly newsletters. I would like to introduce the Nurse & Midwifery Navigator Service and their role to you and your team.

You may already liaise with the team or have heard your patients mention a Navigator supporting them through their health care journey. If you are not familiar this is a brief background.

The implementation of the NMNS is an election commitment from 2015. The NMNS is a nurse led model of care, supporting and advocating for our more complex and vulnerable patients, through their health care journey. Navigators are experienced nurses who have an in-depth understanding of our health care system. The service aims to improve our most complex and vulnerable patients’ journey through healthcare systems bridging any gaps and linking them to appropriate health services across the care continuum. The empowerment of patients and their families to self-manage their healthcare in conjunction with primary care services is a key component of the NMNS with the intention of reducing frequent presentations to the emergency department/hospital admissions as a means of managing chronic complex long-term conditions.

The Navigator does not focus on the patient’s disease process, rather adapts care to the patient’s changing needs throughout their health care journey. Navigators work across traditional boundaries working in partnership with multiple health specialists to ensure patients receive appropriate and timely care.

Our hospital and health service presently has 10 Navigators. They are experienced nurses from various specialties – surgical and trauma, cardiac, community, aged care and veterans’ health, palliative care, rural, remote and indigenous health. They pool and share their collective knowledge within the team to best support THHS patients. The team also includes a Nurse Practitioner, Midwifery Navigator and a Paediatric Navigator.

How can we help you?

Referrals to our service come from within our HHS. We encourage our patients to identify their primary health care provider or GP. As our patients have complex chronic conditions it is important we partner with their primary health care provider or GP to appropriately support their health care journey. We are well positioned to facilitate communications between the tertiary facility and the primary health care provider or GP.

A Nurse Practitioner is attached to the service managing clients with complex chronic disease (CHF, COPD). The role assists with action planning/early exacerbation management and promotes linkages with Primary Care.

How to contact us

We are available Monday to Friday
8am - 4.30pm on 4433 2690 or via email THHS-NurseNavigators@health.qld.gov.au