framework for remote practice

Authors: Malone, G and Cliffe, C

introduction/background

CRANAPlus is the peak professional body for remote and isolated health, providing advice to Government, service providers, clinicians, and consumers on equitable access to safe high quality health services.

CRANAPlus believes it is imperative to have nationally consistent standards of practice for remote health service delivery to improve health outcomes for those living and working in remote areas, and has developed a framework for remote practice, underpinned by quality and safety.

This framework is aimed at all health professionals including community based, FIFO, Mining, and all other remote and isolated settings.

This framework encompasses:

• Definition of remote
• Defining/describing remote practice
• Characteristics of remote health services
• Preparation for remote practice
• Credentialing Nurses and Midwives for remote practice.

1. definition of remote

CRANAPlus defines remoteness as a complex subjective state, the causal factors of which are:

• geography and terrain limiting access and egress
• being socially and culturally isolated
• environmental and weather conditions resulting in isolation
• isolation due to distances
• being isolated from professional peers and supports
• isolation as a result of infrastructure, communications and resources.

We believe no one remoteness classification system can adequately cover the complexity in which our members practice.
Discussion:

Defining remote areas has traditionally been based on Commonwealth Government categories of remoteness, using a range of classifications:

- RRMA (Rural, Remote and Metropolitan Areas) classification
- ARIA (Accessibility/Remoteness Index of Australia) classification (based on ARIA index values)
- ASGC (Australian Standard Geographical Classification) Remoteness Areas (based on ARIA+ index values – an enhanced version of the ARIA index values).

The current classification system used by Department of Health & Ageing is the ASGC-RA system: based on road distance from a locality to the closest service centre in each of five classes of population size.

Areas are classified as:

- major cities
- inner regional
- outer regional
- remote and
- very remote.

In general, when inner regional and outer regional are taken together we use the term regional. When remote and very remote areas are taken together we use the term remote.

The use of geographical classifications in isolation is of limited value. This relatively singular interpretation of ‘remoteness’ fails to take into consideration the other factors that impact on the access to and availability of quality health services in any given community or part there of.

CRANAplus believes the following factors need to be considered:

- Geography and terrain: mountainous terrains and islands can result in isolation from resources and limit access but still be within an area designated through the classification system as non remote e.g. Bruny Island (TAS)
- Being socially and culturally isolated: where living and working in a cultural different to your own/or where social networks are limited or different to your usual supports and networks.
- Environmental and weather conditions: resulting in isolation: natural disasters such as flooding or inclement weather like snow and storms, result of other natural disasters
- Isolation due to vast distances as per the remoteness classifications, distance and the time to access services can vary due to the mode of transport or the quality of the roads.
- Setting for practice: such as operating in the aeromedical environment where altitude is the isolation factor along with limited resources, or where security procedures is an isolating factor e.g. prisons
- Being isolated from professional peers and supports, this includes health professionals working in non health organisations e.g. detention centre’s, tourism, mining, industry
- Isolation as a result of infrastructure, communications, security processes that limit access e.g. Defense forces, International development (AID workers). Unreliability of communication systems and referral pathways.
2. defining/describing remote practice

The setting:

Remote health professionals work in a variety of settings, both remote and isolated areas, as per the CRANAplus definition of Remoteness.

Remote health professionals are an integral part of the health care system in Australia.

Remoteness, in and of itself is a social determinant of health.

Remote and isolated practice areas present particular challenges to the delivery of quality services, including:

- dispersed population,
- poor health status,
- diverse cultures
- social erosion (Stolen generations)
- geographic isolation,
- problematic transport,
- poor infrastructure,
- small economic base, poverty, high unemployment
- limited political influence,
- harsh extremes of climate and
- high turnover of workforce across all disciplines.

Remote health professionals are employed in a range of settings, including but not limited to:

- Government health services
- Community controlled health services
- Aboriginal Medical Services
- Primary Health Care Services/Clinics
- Multi-purpose centres
- Private general practices
- Mining and other industries
- Mobile and fly-in fly-out services
- Private and NGO health providers.

It is widely acknowledged that the remote and Indigenous populations of Australia have a higher burden of diseases and subsequent reduced life expectancy, yet poorer access to equitable health services compared to the rest of the Australian population.
The workforce:

There is limited data currently available around the remote and isolated health workforce in Australia that accurately reflects the numbers, vacancy rates, characteristics and settings/facilities in which they work.

In a series of papers by Lenthal, et al (2011) the characteristics of the nursing workforce in remote has been described. The data available reflects that remote Australia has a disproportionately lower number of health professionals per head of population, in comparison to urban and rural Australia. This maldistribution is across all health professional groups and whilst nurses are the most evenly distributed across all geographical areas and comprises 50 % of total workforce; their numbers and those of midwives are decreasing in remote areas. Remote health workforce work longer hours, and are older comparative to urban workforce. Remote communities are becoming increasingly reliant on overseas trained professionals, short-term placements and fly in fly out visits. (AIHW, 2010).

Remote health professionals are typically hard-working, flexible, adaptable, resourceful and passionate about their work. Their practice encompasses all of the challenges, and the considerable rewards, of this unique and specialised field of healthcare.

Remote health professionals are guided by ‘health’ as a whole-of-life concept, encompassing physical, spiritual and emotional well-being of individuals, family, community and the environment.

Remote health professionals in accordance with their scope of practice, are specialist practitioners who provide and/or coordinate a diverse range of health care services for a diversity of population groups.

CRANApuls supports the following definition of scope of practice:

“A profession’s scope of practice is the full spectrum of roles, functions, responsibilities, activities and decision-making capacity which individuals within the profession are educated, competent and authorised to perform.

The scope of professional practice is set by legislation — professional standards such as competency standards, codes of ethics, conduct and practice and public need, demand and expectation. It may therefore be broader than that of any individual within the profession.

The actual scope of an individual’s practice is influenced by the:

- context in which they practice
- consumers’ health needs
- level of competence, education,
- qualifications and experience of the individual
- service provider’s policy, quality and risk management framework and
- organisational culture.”

3. characteristics of remote health services

CRANAPlus identifies two key principles, that are essential for a robust, safe and sustainable remote and isolated health service:

• Comprehensive primary health care model
• Robust remote clinical governance framework.

CRANAPlus supports the following definitions of Primary Health Care and Clinical Governance;

Primary Health Care:

“Primary health care is socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health. Comprehensive primary health care includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation.”

Australian Primary Health Care Research Institute (APHCRI).

Clinical Governance:

“The systems by which the governing body, managers and clinicians share responsibility and are held accountable for patient or client care, minimising risks to consumers, and for continuously monitoring and improving the quality of clinical care.”


Staffing:

CRANAPlus supports the concept of minimum ratios of staffing in remote PHC services, taking in to consideration the population, size of the community, remoteness from other significant health services and the ill-health burden experienced by its population.
Table 1  Standard of health Service Staff to population ratios scaled by community size.

<table>
<thead>
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<th>Pop range</th>
<th>AHWs</th>
<th>Nurses</th>
<th>Doctors</th>
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<tr>
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<td>1:500 (6)</td>
<td>1:1,000 (3)</td>
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<td>1:450 (3 – 6)</td>
<td>1:1,000 (1.5 – 3)</td>
</tr>
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<td>1:300 (2.5 – 4.5)</td>
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<td>1:200 (2 – 4)</td>
<td>1:600 (1)</td>
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<td>1:150 (1 – 2)</td>
<td>1:400 (0.5)</td>
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<tr>
<td>&lt;75</td>
<td>1:50 (1,25)</td>
<td>1:150 (1)</td>
<td>1:400 (0.5)</td>
</tr>
</tbody>
</table>

(Numbers in brackets are estimated) Top End Aboriginal Health Planning Study, Bartlett & Duncan, (2000).

The table above uses the basic staff to population ratios of AHW 1:50, Nurses 1:200 and Doctors 1:400 and modifies according to size of communities, whereby in larger communities, economies of scale and access to other human services (health and otherwise) means that fewer numbers can be effective as opposed to the smaller communities with smaller population numbers.

In addition to this narrow mix of health care providers, CRANApuls highlights the need for inclusion of a system to ensure access to Midwives, Oral Health Professionals, Nurse Practitioners, Allied Health Professionals, mental health workers and Specialists medical services in any model.
4. pathway to remote practice for nurses and midwives

CRANAPlus believes that Nurses and Midwives who work in remote and isolated practice need a generalist approach, utilising a broad scope of practice to address the diverse needs of their entire community. RAN’s (Remote Area Nurses) provide essential care across the life span commencing from before the cradle to beyond the grave.

Remote area Nurses and Midwives come from a variety of career backgrounds. There are some professional pathways that will prepare individuals for working in remote, isolated and resource poor environments. e.g.:

- Emergency care, pre-hospital care and/or in a critical care area.
- Rural and regional health settings
- Community nursing roles or Practice nursing

New graduates may enter the remote health workforce through a dedicated graduate program that has a specific focus on preparing for a rural and remote context.

Each remote health role will differ, depending on the unique needs of each community.

Specific roles and extended scope of practice may require preparation in:

- Maternal and Child Health
- Mental Health
- Women’s and Men’s health
- Community Capacity Building/Health promotion
- Chronic disease management
- Emergency care.

The knowledge and skills can be acquired at various levels.

Short course or continuing professional development activities, examples include:

- Cultural Safety
- Emergency Care
- Primary Health Care
- Immunisation
- Pharmacology (Endorsement for scheduled medicines)
- Chronic disease courses i.e. Diabetes, Asthma, Renal
- Workplace Health and safety.
Tertiary postgraduate qualifications:

Any postgraduate education will be of benefit to remote practice, some more specific to the remote context may include:

- Remote/rural health practice
- Public health
- Primary health care
- Health promotion
- Critical care (Emergency care).

**CRANAPlus recommend the following** for all nurses and midwives working in remote and isolated health, a comprehensive initial orientation program followed by these essential educational requirements:

- Remote Emergency Care (REC) or equivalent
- Advanced Life Support
- Pharmacotherapeutics for RAN’s,
- Non Midwives: Maternal emergency care (MEC) or equivalent
- Midwives: Midwifery up skillling – MIDUS or equivalent
- Immunisation
- Driver education courses 4x4
- Cultural education
- Annual Core Mandatory competencies – through eRemote or equivalent
  - Fire and Evacuation
  - Manual Handling
  - Drug Calculation
  - Basic Life support.

**“These are recommended courses that can be undertaken pre-employment or within the first year. The frequency of re-certification will be dependent upon clinical exposure and operational requirements, with a maximum interval of every 4 yrs.”**

**Consideration** also needs to be given to jurisdictional or employer specific requirements, such as:

- QLD Remote and Isolated Practice Registered Nurse Course (RIPRN)
- NT Department of Health prerequisites for Remote Health Nursing employment.
5. credentialing for remote practice

The purpose of credentialing is to assure professionals and the public that the individual nurse has achieved agreed levels of practice and experience, has recency of practice in the specialty/area of nursing practice, and has met agreed levels of education and continuing professional development requirements.

**CRANAplus** is an active member of the Council of National Nursing Organisations, (CoNNO) and participated actively in the Project undertaken to develop the national nurse-credentialing framework, see [http://www.conno.org.au](http://www.conno.org.au)

The process for becoming a credentialed remote area nurse is assessed against the Professional Standards of Practice within the specialty area as determined by CRANAplus.

This is a voluntary process for remote area nurses.

CRANAplus believes the benefits of credentialing include:

- The setting of clear nationally consistent standards for remote health practice, to promote safety and quality in practice
- The provision of a workforce benchmark for Governments, employers, and education providers
- Clarity around the career pathway for RANs
- Recognition of this specialist area of nursing

### 5.1 Professional Standards of Remote Practice: Nursing and Midwifery

The individual RAN must be able to demonstrate that they comply with the following Standards:

- **5.1.1** Has appropriate registration and endorsements for practice
- **5.1.2** Works in accordance with the professional standards of a Nurse/Midwife as defined by the regulatory authority
- **5.1.3** Works in accordance with the competency standards of a Remote Area Nurse/Midwife as defined by the CRANAplus National RAN Competencies
- **5.1.4** Practices within a culturally respectful framework
- **5.1.5** Practices within a Comprehensive Primary Health Care model of service delivery
- **5.1.6** Works within care pathways and develop networks of collaborative practice
- **5.1.7** Has a level of clinical knowledge and skill to safely undertake the role
- **5.1.8** Has a period of recent health practice in a remote/isolated location
- **5.1.9** Has an ongoing commitment to education to practice in the remote environment
- **5.1.10** Practices within a Safety and Quality framework

These Professional Standards are endorsed by CRANAplus as a National Standard
References:


Australian Primary Health Care Research Institute (APHCRI).


Bartlett B., Duncan, P. Top End Aboriginal Health Planning Study: Report to the Top End Regional Indigenous Health Planning Committee of the Northern Territory Aboriginal Health Forum. April 2000, PLANHEALTH Pty Ltd, NSW.
