

issue 80 | december 2010

# CRANAplus magazine

the voice of remote health



educate 24  
advocate 34  
support 44

# from the editor



This December edition is a bumper issue of the *CRANApplus* Magazine, filled with stories, photos and information for your holiday reading pleasure.

As the year draws to an end we reflect on the growth and accomplishments our association has achieved in 2010. Under the leadership of our CEO Carole Taylor and our Board of Management, we have reached significant milestones of which we can all be proud: record membership giving us a stronger voice when advocating for remote health; the development and delivery of new FLEC courses; record course participation rates and the success of the online eRemote program; the expansion of the Bush Support Services program that continues to gain momentum Australia-wide as an increasing percentage of the remote health workforce actively embrace telephone and internet-based counseling; self-care proactive projects and self-care competitions; and unique programs tailored to meet the needs of remote

health. Read all about these milestones in this edition.

The 2010 Annual Conference in Adelaide delivered on all our promises and has been hailed a run-away success. We have photos of the highlights in this magazine; for more visit our website. Delegate feedback this year has given us some great ideas to incorporate into the 2011 conference in Western Australia.

We invited you in our last magazine to share your stories about your day-to-day work, and in this edition we bring you insights from two members working on offshore oil platforms in the Indian Ocean.

The 2010 *CRANApplus* Scholarships are designed to assist students with the cost of a clinical placement in a remote or isolated setting. This year scholarships were awarded to six recipients from across Australia. In this edition four of the students recount their experiences, and share their photos with us. In keeping with our objective to support these remote health professionals of the future, we will dedicate a section of the *CRANApplus* Magazine each edition to their stories and accomplishments.

You will also find the much-anticipated FLEC Calendar for 2011. Additional courses are being offered in 2011 to meet demand and as always will fill quickly. We encourage you to consider your training needs for the coming year and book early to secure a place in these nationally acclaimed short courses.

Best wishes for a happy and safe holiday season and happy reading.

**Anne-Marie Borchers**  
Business Manager, *CRANApplus*



**Australian Government**  
**Department of Health and Ageing**

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**About the Cover:** Isabelle Ellis, 2010 *CRANApplus* Aurora Award winner. Interview featured on page 18.  
Photo: Rosey Boehm.

# from the ceo

Amazingly enough we are fast approaching the end of another very busy CRAN*plus* year. They say that the older you get the faster the years go – but 2010 has just disappeared. My theory is that the busier you are the faster time passes: after the age of 50, I prefer my theory.

Anyway, enough of my insecurities. There is no doubt that this year has certainly been hectic but rewarding. Our achievements have been many this year. The successes have been lauded as they have happened. And celebrations have been numerous.

But CRAN*plus* is much more than a list of achievements. What I do want to do in this the final article for the year is to stop and recognise the people who have made us grow and achieve as much as we have – and the most important group in this regard is you the members.



Whether you are new to the CRAN*plus* family or have been with us for some time, it is only with the support of our membership and your continued loyalty and drive, that we are encouraged to grow and to respond to the needs of members and their clients.

It is you the members who have helped us through two very complex constitutional changes that have changed the face and substance of the organisation, to become a more inclusive and dynamic player in the field of remote health.

It is you the members who have contacted us with your concerns, your encouragement and your ideas that have helped keep us grounded while surging forward to meet your needs in terms of training and support.

And it is you the members that prove to Government that we have sound representation and credible coverage of the vast areas that make up remote Australia.

I would also like to recognise the role played by the Board of Directors of CRAN*plus* in our achievements this year and the two years prior to that. Without a very brave, solid and resourceful Board, change would be impossible. Through the President, Christopher Cliffe, your Board has been a strong working unit which has had the dual task of ensuring that the continued viability, ethos and commitment of CRAN*plus* is maintained whilst also presiding over the very significant changes we have gone through in recent times. It is my opinion that the Board has done a remarkable job in keeping the balance right and ensuring that no change compromises the 'family' feel of the organisation or the beliefs it holds dear.

And lastly, I would like to acknowledge the work, the dedication, the commitment and just raw talent of the CRAN*plus* staff. By staff I also include those who work for us as psychologists, facilitators, academics and in other part-time or contractual arrangements. Those people simply add to the pool of permanent staff who make up the most inspiring, slightly eccentric and wonderful group of people I have ever had the privilege to work with.

This is the CRAN*plus* family.

I thank you all from the bottom of my heart for just being who you are and I would like to wish each and every one of you a happy and safe Christmas and another fulfilling year in 2011.

**Carole Taylor**  
CEO, CRAN*plus*

# engage

## from the president

Just a quick message to mark the end of 2010: a very memorable year for most people I've spoken to!!!

The changing landscape around health reform has occupied most of the Board's time over the past year. We keep hearing that this is an evolution, not a revolution. I'd have to suggest that it is an extremely fast evolution from our perspective! In our attempts to ensure that remote, isolated and Indigenous needs are not forgotten in the thrust and pulls of political lobbying from multiple competing parties, CRANApus is 'chicken-winging' (as our very own Libby would say) its way in to ensure that the interests of our members, and their communities are heard.

The most imminent large change is the announcement of the first of 15 Medicare locals to be formed, taken from the existing divisions of general practice.







CRANApus and our partners are lobbying hard to ensure that the governance of these new entities isn't just an extension of the current boards, whose primary purpose is to support GPs. For these new entities to actually take up the challenge of ensuring comprehensive primary health care to ALL people who live in their areas, they need to be functionally multi-disciplinary; be led and driven by the communities for which they serve; commit to a transition to community control; and foster true partnerships with other service providers in delivering the complex suite of programs needed to improve our healthcare.



**“The changing landscape around health reform has occupied most of the Board’s time over the past year.”**

As the land mass for these Medicare locals is likely to be huge and the voice of the remote, isolated and indigenous communities within them small, compared to the regional demands, it’s essential that CRANApus has an opportunity to advocate on behalf of our constituents. Your continued personal and corporate membership gives us the capacity and credibility to do just that. There are huge opportunities coming with all of this change, a wonderfully exciting time to be in health care in Australia.

On that note, I will wish you all a wonderful festive season, and hope that the New Year brings you much health and happiness.

**Christopher Cliffe**  
**President, CRANApus** ●



Photo: Steve Batten.

# board of directors



## christopher cliffe

**President**  
**Chair Education**  
**Subcommittee**

Christopher is the Manager for Primary Health Care for the Royal Flying Doctor Service in Queensland.

An experienced clinical leader in the field of remote comprehensive Primary Health Care, Christopher has worked as a Remote Area Nurse in a variety of remote and rural communities in South Australia and the Northern Territory.

Christopher has provided leadership to a variety of health care organisations during his career, specifically as Nursing Director for Remote Health in the NT, Leigh Creek Hospital in SA, and Lorne and Colac Hospitals in Victoria.

Most recently Christopher was executive director of the National Centre for Quality Improvement in Indigenous Primary Health Care, helping to establish the centre as a sustainable not-for-profit entity for the health industry.

Christopher has extensive international experience, working for the Red Cross in war and disaster zones, with missions to the South of Sudan, Abkhazia (Georgia), Afghanistan, PNG, Sri Lanka, the Bali Bombing, the Boxing Day Tsunami and most recently the earthquake in Haiti.

In addition to undergraduate nursing qualifications, he holds a Masters Degree in Public Health and is a Justice of the Peace.

Christopher has served as President for the last four years.



## sue kildea

**Vice President**

Sue is a Professor of Midwifery and holds the Clinical Chair in Midwifery as a joint appointment

between the Mater Health Services Brisbane and the Australian Catholic University. Sue has extensive clinical experience in primary health care models and women's health in rural and remote areas of Australia and is one of Australia's leading advocates for maternity service reform, promoting the return of birthing services to rural and remote areas.

Sue's interests are in safety, quality and professional collaboration in maternity care. She has a particular interest in increasing the capacity of the health workforce to maximise their effectiveness to make a difference to the lives of Aboriginal and Torres Strait Islander families.

Sue was the Perinatal Health Analyst who compiled the Maternal Deaths in Australia Report 2000–2002. In 2004 she was awarded the UTS Human Rights Award for her contribution to advancing reconciliation between Indigenous and non-Indigenous Australians during her PhD work. Sue has worked as a technical advisor in the development of guidelines, competencies and protocols for reproductive health and maternity services.

Her international experience includes working as a midwife in South Africa and midwifery consultancies in Indonesia and Mongolia. She is currently working on a World Health Organisation project in Viet Nam, which aims to make pregnancy safer and reduce the numbers of mothers who die in childbirth, particularly in the primary care setting.





Photo: George Fort.



## lyn hinspeter

### Secretary Chair Conference Subcommittee

Lyn has more than 45 years in nursing and still considers

having worked as a Remote Area Nurse in Queensland to be a highlight. Hospital trained, Lyn later graduated from CQU at 53 with a Bachelor Health Science in nursing.

Lyn has worked in such diverse places as off-shore islands, small remote towns, Aboriginal communities throughout Cape York and mining communities. She has been involved in PNG and the Philippines, still travelling to the Philippines for three weeks each year to teach at the International Christian College of Manila.

Lyn reckons being a member of the Board has been “an interesting and rewarding experience

and a steep learning curve.” She represents CRANaplus at both CoNNO (Coalition of National Nursing Organisations) where she has also been a council member for the past two years, and on DVA’s Community Nursing Industry Advisory Committee.



## john wright

John is a Remote Area Nurse working in the Northern Territory. He started work as a farmer, shearer, and grain handler before attending university and commencing a career in nursing.

After two years as a ward nurse and seven years as an emergency nurse, John moved to the bush in 2003. Since then he has attained a Masters Degree in Remote Health Practice, and a second Masters Degree in Remote Health Management.



## jo appoo

### Chair Indigenous Subcommittee

Jo is a highly regarded and very experienced Aboriginal Health Worker. Jo currently

works as a locum in a variety of remote community clinics.

Jo, a Bunjalung woman, was born in Murwillumbah NSW. She was employed in a number of fields but it was when she went to work in Aged Care in Docker River that, in her words, “an old fella told me I’d be a good Aboriginal Health Worker” that she decided to give that a go. Completing Certificate 3 and later, Certificate 4 in Aboriginal Health Work she worked at Alice Springs Hospital and later on Tiwi Island. Here she set up and managed their first aged-care program and over five years, built it into a successful and sustainable service. In conjunction with the Tiwi Health Board, Jo assisted in the development of alternative care options for the elderly and culturally appropriate models for the residents of four communities on the island and introduced a meals on wheels program.

Later Jo was appointed Clinic Manager, Central Australian Aboriginal Congress, the largest Medical Health Clinic in Central Australia. Jo’s role was to oversee changes in intervention outcomes, patient flow and client complaints.

Jo is the first Aboriginal appointee to the Board of Directors of CRANAPlus.

We want to hear your stories about remote health practice, and the best will be included in future editions. Editorial submissions, photos and questions about editorial content should be directed to [publications@crana.org.au](mailto:publications@crana.org.au)



## isabelle ellis

### Chair Credentialing Subcommittee

Isabelle Ellis is the Head of Department for Nursing and Midwifery in the new

La Trobe Rural Health School, Latrobe University in Bendigo. Prior to this Isabelle held positions with both the Combined Universities Centre for Rural Health in the Pilbara, Western Australia and Charles Darwin University.

Isabelle has been involved with CRANAPlus since 1993, when she was working as a Remote Area Nurse at One Arm Point in the North West of Western Australia. She has held various positions on the Board and is a Past President.



## john ryan

### Acting Treasurer

John is a lawyer living in Newcastle, focusing in recent years on medical negligence. As luck would have it, he says, his wife is a nurse.

As well as owning and operating successful practices, John has experience in a wide range of legal areas. He was the first president of the professional standards panel of the Newcastle Anglican Diocese; and is a past member of the Community Aid Program through Belmont Local Court.

He has been a tutor at Newcastle University; a supervisor at the Newcastle Legal Centre; and a lawyer representing patients at Mental Health tribunals.

John has worked with rural, remote and Indigenous clients and was drawn to CRANAPlus, with its vision and energy, as a way to contribute to improved outcomes. ●



# new board member

## janie dade smith

Dr Janie Smith is a rural woman who now lives on the beautiful northern rivers of New South Wales. She is a highly experienced health educationalist, evaluator and project manager who has extensive experience in remote and rural workforce issues across all of the health disciplines. In 2004 Janie established her own small dynamic national organisation, *RhED Consulting Pty Ltd*, and has since led over 40 consultancies that involved high level project management in developing accredited undergraduate and postgraduate curricula, policy development, Indigenous health, program review, research and innovative workforce development.

Janie lived in the Northern Territory for 11 years in the 1980s, where she undertook her midwifery training, was in charge of the medical ward at the Royal Darwin Hospital and worked on Bathurst Island (Nguiu) in 1985. She wrote the *Queensland Aboriginal and Torres Strait Islander Health Worker Program* in Cairns and later worked as the Executive Officer for CRANA in 1993–1994.

In the past five years she has undertaken numerous consultancies that involved remote work – the development of an education plan for the *Remote Vocational Training Scheme*, the *NT Review of Nursing and Midwifery Education and Training*, *NT Review of Medical Education and Training*, the *Organisational Review of CRANA*, an *Evaluation of the NT Chronic Disease Strategy*, strategic and educational development for *Royal Flying Doctor Service* and *The Public Health Research and Education Program* in Chronic Disease education with *Menzies School of Health Research*.

Janie previously wrote the *Bachelor of Pharmacy Program* at James Cook University in 2000 and has recently completed a large research consultancy for the *Pharmacy Guild of Australia*. She has also worked for four years for the *Royal Australian College of General Practitioners* as their *National Education Development Officer* and multiple other roles across the public, private, community controlled and not for profit sectors. Janie is well published, is the author of *Australia's rural and remote health: A social justice perspective* now in its second edition, she is adjunct Associate Professor at James Cook University and Southern Cross University and sits on the *Council of the National Rural Health Alliance* as chair of its *friends committee*. Janie is delighted to be voted onto the Board of CRANAplus and looks forward to contributing towards its future directions. ●



Photo: Steve Batten.

# a 'remote' passion

Associate Professor Trudy Yuginovich may not have personally worked in a remote area during her long nursing career – but that hasn't stopped her from making "remote" one of her areas of passion.

Her book, *Voices in the Dust*, published last year, focuses on the history of remote area nursing, specifically looking at why it has never been recognised as a specialist area of practice.

"Ultimately that is what we want," says Trudy. "But I don't know if it is going to happen for many years. It has generally been seen as no different to nursing in the metropolitan area."

She considers negative factors working against the change in status have been the silence of nurses in the past, and the lack of a concerted voice.

Trudy, who has just completed more than a decade on the CRANAPlus Board of Management, considers CRANAPlus is playing a crucial role in changing this situation.

**"CRANAPlus is now recognised as the authority in Australia in remote area nursing."**

"It has taken a long time. CRANA was established in 1983. But slowly the profile and importance of the organisation has risen," she says.

"CRANAPlus is now recognised as the authority in Australia in remote area nursing.

"And we are now in the position where our CEO is regularly approached to sit on committees and be involved in policy decision-making."

Trudy, who has been nursing since 1966, decided in 1985 to go back to studying in earnest and *Voices in the Dust* is a result of her PhD research completed in 2000. "I don't think I was supposed to have that much fun doing a PhD," she laughs.



She is now conducting community-based research in the area of keeping people over the age of 65 out of hospital. So far, she has completed research into the amount of aged care content currently being provided in under graduate nursing curricula throughout Australia.

Trudy reckons she will retire "when I grow up." That moment is probably about two and half years in the future. "Then I will have the grand adventure," she predicts.

In the meantime, Trudy is the Associate Director of the Faculty of Sciences at Fraser Coast and is the Nursing Program Coordinator.

Trudy is a Fellow of the Royal College of Nursing Australia. She has successfully supervised Honours, Masters and PhD students to completion both on campus in Queensland, New South Wales, Northern Territory, South Australia as well as off shore (Canada, Austria, Solomon Islands, Emirates). In 2009, Trudy was invited to present the inaugural Fraser Coast International Nurses day Oration. ●

# advertising rates

## Standard rates

		One issue	2 issues (- 10%)	3 Issues (- 15%)	4 Issues (- 20%)
Full page	Type: 128mm W x 183mm H Trim: 148mm W x 210mm H Bleed: 154mm W x 216mm H	1,600	2,880	4,080	5,120
Half page	Horizontal: 128mm W x 90mm H Vertical: 65mm W x 183mm H	880	1,584	2,244	2,816
Third page	Horizontal: 128mm W x 59mm H Vertical: 65mm W x 121mm H	600	1,080	1,530	1,920
Double page		3,040	5,472	7,752	9,728

## Colour rates

		One issue	2 issues (- 10%)	3 Issues (- 15%)	4 Issues (- 20%)
Full page	as above	2,240	4,032	5,712	7,168
Half page	as above	1,232	2,218	3,142	3,942
Third page	as above	840	1,512	2,142	2,688
Double page		4,256	7,661	10,853	13,619

## Magazine insert

			1000	2000
Full size	Trim: 148mm W x 210mm H Artwork must be supplied		450	900

Magazine is printed in A5 format. Other advertising sizes can be negotiated. Note: Back cover unavailable until December 2011.

**Publication Dates:** March, June, September, and December

**Submission Dates:** First day of February, May, August and November

Rates are in AUD\$ and are inclusive of GST. All artwork to be submitted by close of business on the published deadline date.

Full colour ads to be submitted in high resolution PDF format with all fonts embedded and all colours separated into CMYK. ●

# principal partner



**Australian Government**

**Department of Health and Ageing**

The vision of the **Department of Health and Ageing** is *Better health and active ageing for all Australians*. The department is responsible for achieving the Government's priorities for population health, aged care and population ageing as well as medical services, primary care, rural health, hearing services and Indigenous health. The department administers programs to meet the Government's objectives in health system capacity and quality, mental health, health workforce, acute care, biosecurity and emergency response. The department supports the Australian community's access to affordable private health services and is responsible for policy on Medicare and the Pharmaceutical Benefits Scheme. ●

# CRANAp<sup>plus</sup> corporate members



Finding the right balance  
Barkly Region Alcohol and Drug Advisory Group Inc.

**Barkly Region Alcohol and Drug Advisory Group (BRADAAG)** was established in 1982 as a community based group to address alcohol and other drug issues.



**Cairns Nursing Agency** is the employment gateway for Nurses and Healthcare professionals traveling to, around and through Northern Queensland and the Northern Territory



**CQ Nurse** is Australia's premier nursing agency, specialising in the placement of nursing and midwifery staff, in regional, rural and remote facilities.



**Northern Territory Dept of Health & Families Remote Health Branch** offer a career pathway in a variety of positions as part of a multi-disciplinary primary health care team.



**Department of Health WA Country Health Service**  
– working together for a healthier country WA.



**Indigenous Allied Health Australia's** vision is to achieve the same quality of health for Aboriginal and Torres Strait Islander peoples.



The **Indian Ocean Territories Health Service** manages the provision of health services on both the Cocos (Keeling) Islands and Christmas Island.



**Katherine West Health Board** provides a holistic clinical, preventative and public health service to clients in the Katherine West Region of the Northern Territory.



**NASANSB** The Best Place For Nurses. As South Australia's leading nursing agency we have the greatest choice of general, specialist and aged care shifts in all regions.





The cornerstone of the **NT Medic** workforce development strategy is the recruitment, retention and professional development of their NT workforce in support of the needs of the rural and remote regions.



**NAA NSW** provides a selection of staff for public and private hospitals, aged care and mental health facilities throughout metropolitan and regional New South Wales.



**NAA QLD** is located in the heart of Brisbane, and provides general, mental health and aged care staff to hospitals throughout metropolitan and regional Queensland.



**WANA** prides itself on offering the greatest choice of shifts and work opportunities – from the glitter of Perth, to rural towns and the red heart of the outback.



Since 1989 **Oxley Nursing Service** has based its service on what health clients and professionals would be seeking – ethical, professional, approachable and supportive.



The **Remote Area Health Corps (RAHC)** is a new and innovative approach to supporting workforce needs in remote health services, and provides the opportunity for health professionals to make a contribution to closing the gap.



**Randstad's** healthcare team has provided the best people, recruitment solutions and HR services to your industry for over 30 years.



**Silver Chain** provides primary health and emergency care to 11 remote communities throughout Western Australia where there is no resident doctor or hospital.

# CRANAplus 2010 conference



Top: President Christopher Cliffe and Chief Nurse and Midwifery Officer Rosemary Bryant. Above: Conference delegates.

# ighlights



Top left: Greg Cavanagh, NT Coroner. Top right: Lee Thomas, Federal Secretary ANF.  
Above: Delegate Claire Kappel at Welcome ceremony at Adelaide Zoo.

Photos: Rosey Boehm.



Top: Presentation of the Graduates ceremony is a highlight of the Annual Conference.  
 Above: Theo Allen (left) and Christopher Cliffe with NRSHN exhibitors Sandra Nelson and Jane Jamison.





Photos: Rosey Boehm.

Top: Noela Davies. Middle: CRANApplus Award trophies.  
Bottom: Conference delegates.

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Photos: Rosey Boehm.

Top: Excellence in Remote Health Management award recipient Emma Barritt with Christopher Cliffe.  
Above: Primary Health Care Champion award recipient Sharon Liversey with Wendy Mackay.

# the end of an era

After almost 27 years in Central Australia, Associate Professor Sabina Knight, a CRANA (now CRANAP<sub>plus</sub>) foundation member, is off to Mount Isa to take up the position of Director of the Mt Isa Centre for Rural and Remote Health (MICRRH).

Sabina, well-recognised as a leader in remote health, has focused her career on health inequalities – namely remote, isolated, vulnerable populations and rural health, and, in particular, Aboriginal and Torres Strait Islander health.

Sabina was a passionate driver in the establishment of CRANA and has served in many capacities including President, a long term Board member, and also as a member of staff. She has represented CRANAP<sub>plus</sub> on a plethora of committees, forums and research including the 'Back from the Edge' project.

## "Sabina was a passionate driver in the establishment of CRANA..."

Sabina has played pivotal roles in numerous achievements notched up in the world of remote nursing in Australia over the years including:

- the development and implementation of the Remote Emergency Care program;
- the Clinical Procedures Manual for Remote & Rural Practice;
- the initial concept of a telephone counselling and support service and the establishment of the Bush Crisis Line (now Bush Support Services);
- the development and delivery of a Post Graduate Remote Health Practice Program for remote health professionals; and
- involvement in the CRANA Model of Locum Relief Project in Cape York. As President of then CRANA she assisted with the Flinders University bid to establish the Centre – then known as the University Department of Rural Health.



After a long association, Sabina is leaving The Centre for Remote Health in Alice Springs where she has been coordinating the Remote Health Practice and Remote Health Management Programs.

The move also marks the end of an era for her house in Alice Springs (sometimes referred to as Sabina's guest house), where hundreds of remote health professionals, students, academics, Ministers and Departmental heads and various individuals have stayed over the years.

Sabina is a big-picture person, with the ability to see opportunity for RANs, practitioners and services to develop programs that make a difference and contribute to the delivery of safe high quality health care in remote areas.

Sabina is a Fellow of the Rural Leadership Australia, a Fellow of RCNA and has accepted an invitation to be a Fellow of CRANAP<sub>plus</sub>.

She has been appointed to Boards, foundations, panels and Councils over the years, notably as one of the ten Commissioners on the National Health and Hospitals Reform Commission, and continues to hold a range of positions – too numerous to mention.

There is no doubt that, from Mt Isa, Sabina will continue to make her mark in remote and rural health. ●

# red dust on her shoes

The die was cast the day Registered Nurse Isabelle Ellis began her career in Cloncurry in Queensland, the birthplace of the Royal Flying Doctor Service.

It was the mid-80s and Isabelle was, firstly, shocked by the inequalities in health provision and, secondly, stirred by what she witnessed – and went on to choose remote area nursing and remote health as her life's work. Three decades later, and the red dust has never left her shoes. "Even though I am not physically working in a remote area now, my work is still there," she says.

Now 'Professor' Ellis, with numerous letters after her name, Isabelle can list nurse, mentor, educator, researcher and manager among her many influential roles over the years.

A leading academic and currently Chair of Rural and Regional Nursing at La Trobe Rural Health School in Victoria, Isabelle is the 2010 CRAN*plus* Aurora Award winner, in recognition of her national leadership and outstanding contribution to remote area nursing and remote health across Australia.

Isabelle says she was stunned at the CRAN*plus* conference dinner in October when her name was called out as the winner of the Award. "They were talking about this person and their achievements and I thought it sounded like one of my colleagues," she said. "Then my name was called out. I nearly fell over."

Isabelle has an extensive history of active leadership in the improvement of health care to remote Australia; she is known for her innovation in education and clinical support; her research has vastly improved remote health care; she has used her involvement on the CRAN*plus* Board to further the interests of people who live and work, visit or pass through remote areas of Australia; she has become a specialist in multimedia and e-learning; and her commitment to social justice, Aboriginal and remote health is evident to all.

"I had no idea where my career was taking me when I started," Isabelle says. "I always liked teaching, and life has pushed me into spots where I have had the opportunity to do it. I still maintain a clinical role – as a midwife – but I do enjoy teaching, helping people to learn. Lifelong learning, after all, is an essential part of living."

Isabelle herself has completed a Masters of Public Health and Tropical Medicine, a Grad Dip Professional Communication (multimedia), a PhD in public health and a Masters of Business Administration (Executive). Her PhD examined the use of technology to improve remote health care.

**"We used to see young children suffering from severe dehydration due to diarrhoea and it wasn't unusual to be putting a drip into a small baby... We have come a long way – but we have a long way to go."**

Multimedia is now one of Isabelle's areas of specialty, having invented the online case-based learning environment for nursing students. She is now looking at the potential of interactive 3D avatar games as part of an interdisciplinary approach to assist patients through the whole health journey.

Over the years, Isabelle considers many developments have improved health in remote areas: such as developments in health infrastructure, housing and health literacy. "We used to see young children suffering from severe dehydration due to diarrhoea and it wasn't unusual to be putting a drip into a small baby," she said. "We have come a long way – but we have a long way to go."





Past and present Aurora recipients: Left to right: Libby Bowell, Sabina Knight, Isabelle Ellis, Robyn White and Vicki Gordon.

She considers the next big step is empowering Indigenous Health Workers to take their rightful place in the system. “We won’t be able to move forward until we do,” she suggests.

“Indigenous Health Workers do a course of study that provides very good public health training. But, when they come home to their communities to work, nurses and other practitioners don’t support the role they are trained to do. Their knowledge of public health is way more than that of nurses, but their ability to apply their knowledge is limited – when you have a health system that defaults so easily to acute health.

“My view is that we need to credential all remote area nurses in the area of public health, in skills such as teamwork. That will make a difference. Remote area nursing is a specialist area. It requires those basic skills outside the norm.”

It is natural, then, that one of Isabelle’s positions as a CRANAP<sup>plus</sup> Board member at the moment is on the credentialing committee. Isabelle has served CRANA and now CRANAP<sup>plus</sup> in a range of

committee and board roles since 1994, including serving as president in 2002.

With many highlights over the span of her career, Isabelle says the biggest was securing funding for the Centre for Remote Health, based in Alice Springs, 10 years ago. “Along with Sabina Knight and Paul Worley, we managed to convince the government to fund the centre. That is definitely the biggest highlight,” she said.

At that time, Isabelle was a nurse at One Arm Point in WA, Sabina was nursing in Central Australia and Paul was a GP in rural SA. Now Paul is Professor Paul Worley, Dean of Medicine at Flinders University in SA and Associate Professor Sabina Knight, also a former CRANA Aurora award winner, coordinates the Remote Health Practice and Remote Health Management Programs at the Centre for Remote Health in Alice Springs.

“I am now at La Trobe,” Isabelle says. “I work with a wonderful team and there are lots of exciting developments ahead of me.

“Watch this space!” ●

# between two cuppas

**The job of an Offshore Nurse (Medic) can often be described as “Ground Hog Day”. Then there are the days that can push you out over the edge: literally. Offshore Nurse Helen Sikkens has this tale to tell.**

It is just after 0600hrs and I am sitting in my office, drinking my first cup of coffee for the morning, when the radio crackles into life and I am asked to go to the platform’s radio room. A large tugboat in our area has a sick crew member on board and is in need of help.



Photo: Helen Sikkens.



Photo: Helen Sikkens.

Above: Preparing to go ‘over the side’. Top: Whalesharks are often seen from the rig. Opposite: Helen believes you can’t beat the view from her office window!

It’s hard talking over the radio because of the delay, but I can still hear the crewman in the background groaning. After a few more questions and with the amount of groaning going on, I know I’m dealing with an acute onset of renal calculi (a kidney stone) and, by the sounds of it, delivery is not far away.

We have two ways to help this guy: one is to get the boat to return to the beach in very rough seas, which will take about 12 hours; the other is to get him onto our platform, into a helicopter and off to hospital.

The wind speed, gusting up to 25 knots, is making our decision just that little bit harder. Going over the edge of our platform in the FROG to pick him up does present a few issues. But, after a few minutes of discussion, it’s clear this is our only solution.

The “FROG” is a Marine Personnel Transfer unit that is hooked onto a crane and winched back and forward between boats and platforms to transfer crew. They are mostly used in Australian waters for emergency transfer of crew. ►►





Photo: Helen Sikkens

Bringing the patient back on board the rig.

► They are not employed lightly because of the risk associated with their usage. In the three and half years of working offshore on platforms and rigs, this is the first time I have had the need to use one.

The tugboat, using its entire engines to line up with our crane, comes alongside the platform and under the hook. Meanwhile, I strap myself and my emergency equipment into the FROG and, along with a rigger for assistance, we are lifted up by the crane and swung out over the waves.

Our big worry is the danger of the FROG starting to spin around on itself in the high winds.

Successfully reaching the tugboat, we are met by the crew who grab the equipment and walk me to the sick crewman.

With the seas rocking and rolling, I do a quick assessment, administer Pethidine and Maxalon and, after providing the much-needed pain relief, I have only one thing left to do: to get back off this boat and into the air to our safe and solid non-rocking platform. Otherwise there would be two people vomiting.

We load the sick man onto the stretcher and strap it back into the FROG. I sit at his head so I can speak with him and the rigger from the platform is at the foot. We both have radios to speak with the crane driver and the operation team on the platform at all times.

Winched back on board the platform, which is even more fun as the winds have started to get stronger, we camp in a temporary medical centre set up for me and my client on the helideck. It is a long way down from the helideck to the medical centre and, with the helicopter and retrieval team already on its way, this is a better solution than carrying a 100 kilo guy down and up the stairs within one hour. Crouched out of the wind in our temporary cover, one of the guys in the makeshift medical centre puts it best; this is like working in MASH.

I get the IV lines going and O2 on to him and, once the helicopter and retrieval team arrive on deck, we carry our client to the helicopter, do the hand over and watch as they take off. Then out comes a baby kidney stone, which our client names after our Platform.

It's now 0830hrs – time for my second cup of coffee. ●



# brief gig on an oilrig

## Jacinta O'Connor outlines some of the more obscure but essential skills of working on an offshore oil platform.

A brief stint as a relieving medic on an offshore oil platform showed me some of the contrasts and a couple of similarities to remote community and hospital-based nursing.

The working day for me began with a 20-minute helicopter flight that dropped me off at work in the shallows of the Indian Ocean near Karratha, W.A, where you can still see land on a clear day with high visibility.

Clear days and high visibility are things you learn to take note of – along with temperature, humidity, wind direction and wind speed. As a medic in this environment, a large part of the role can be spent providing this information to the helicopter pilots who constantly ferry passengers and freight from the mainland.

The Maternity Emergency Care, Remote Emergency Care and the Advanced Remote Emergency Care CRANAP<sup>plus</sup> courses, have given me the skills and knowledge base to attend to a medical emergency in a remote location.



Photo: Jacinta O'Connor.

Bottlenose dolphins.

Other advantages of these courses include meeting other remote health workers who share their personal experiences and often pass on a few tips and tricks that the courses cannot cover and you won't read about in the induction books.

Other skills I learned and developed on this particular job included:

**Selective Hearing:** Sleeping quarters are bunk beds and your room mate or neighbour could start up the sinus chainsaw at any time. Earplugs are provided, specifically for outside use, but come in handy indoors as required.

**"I must say I enjoyed my time on the platform, with thanks to the help provided from Helen Sikkens, Dorothy Klundert, Steve Fuller and all the bigger digger riggers..."**

**Stamina for the Stairs:** With your toes safe and sound inside steel-cap boots, you'll need to tap them up and down the stairs a lot because whatever it is you need, it will be on another level.

**Resistance to the Catering:** Meals are provided and are mostly far too tempting to maintain portion control.

**Immunity to Cabin Fever:** Working and living in close quarters for extended periods requires a certain amount of antibodies to be circulating within your system. High doses of tolerance or humour can assist if symptoms develop.

I must say I enjoyed my time on the platform, with thanks to the help provided from Helen Sikkens, Dorothy Klundert, Steve Fuller and all the bigger digger riggers who kept themselves fit and healthy and resisted feeding me to the ever-present circling sharks below. ●



# educate

## CRANaplus investing in our future workforce



Photo: Libby Bowell

The first REC course conducted for undergraduates, held this year in Canberra, followed hugely effective campaigning, networking and lobbying from nursing students around Australia. In 2011, both a REC and a MEC course are planned for undergraduates... again due to overwhelming campaigning from students.

**Educational Manager Libby Bowell outlines the history of this development.**

The first REC course conducted for undergraduates had its beginnings at the CRANaplus conference in Alice Springs in 2009 where a small group of very enthusiastic students, passionate about pursuing remote area nursing as an option for their practical placement and with an eye on their future employment, presented a paper. As part of their very active networking at the conference they approached me as Educational Manager to pose the question: Why can't students do REC



Along with Geri Malone, Kath Ferry, Kath Bowman and Sue Orsmond, I travelled to a very cold, very frosty and very icy Canberra where the welcome couldn't have been warmer.

Twenty enthusiastic students from different campuses that have a National Rural Health Student's Network Health Club had gathered to attend the course. Participants had come from as far afield as Townsville and rumour had it that we could have filled the course several times over!

The course was run to the usual REC course program, with slight modifications to the course content and the assessment process. ►►



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courses? Suffice to say, in the end, as a result of many discussions, both personal, by phone and email, a deal was struck. The students would assist in finding/organising a venue, catering and accommodation for facilitators and participants, while CRANApplus would find/organise facilitators, equipment and readings.

**"Participants had come from as far afield as Townsville and rumour had it that we could have filled the course several times over!"**

True to their word, the students, ably led by Steph Jeremy, liaised with Evatt Primary School in Canberra to use this as the venue over the weekend and the date was settled for 2-4 July. Not sure who thought going to Canberra in July was a good idea, but...



Photo: Libby Bowell.

» Participants completed the multiple choice test as usual, with the scenario assessment used as a learning exercise to give the participants the opportunity to repeat the Primary Secondary survey process in a one-on-one situation with the facilitators.

The participants were very enthusiastic and interactive and were obviously very engaged in the course. The feedback was overwhelmingly positive with many students expressing their gratitude to CRANAp<sub>lus</sub> and the education team for agreeing to conduct the course.

*"Thank you for providing this course for students. It has been terrific! Thank you! 😊"*

*"Thank you very much. It was wonderful/ inspiring to have skills in various areas demystified and made real. Appreciate all your travel, time, effort, enthusiasm and belief in us students. Hope to see you all again!"*

The demystification theme was echoed by a number of participants.

*"This course has been a fantastic learning experience. There are so many things that have been explained that will be helpful in many situations. I will definitely recommend this course to others."*



Photo: Stephanie Jeremy.



Photo: Stephanie Jeremy.





Photo: Libby Bowell.



Photo: Libby Bowell.

Top left: "Now I get it!" Left: Left to right: REC course facilitators: Kathy Bowman, Sue Orsmond, Kath Ferry, Libby Bowell and Geri Malone. Top right: Students with Kath Bowman during a skill station presentation. Above: Intubation and airway management skill station.

It would seem that the consolidation of theory was also a recurrent theme for the students.

*"Lectures were great, nice short and informative. It was perfect timing with the content revising much that we have recently learned. The hands on approach and being able to practice the skills really helped demystify the skills. The content was perfectly pitched. Thank you so much CRANaplus. I am so extremely grateful."*

**"The participants were very enthusiastic and interactive and were obviously very engaged in the course."**

*"Thank you for taking the chance to impart your knowledge on a bunch of students! This course has consolidated much of the university teaching in a useful and practical manner, and has given me the confidence to perform a methodical and effective emergency patient assessment."*

So maybe July was the right time of year after all! It would appear that some students would like the CRANaplus formula to be adopted by their institution. ►►



Canberra students with facilitators.

► *"I hope that in the future universities may use the teaching techniques used by CRANApplus."*

*"Best course I've been to. Wish uni prac could be this informative and easy to break down. Presenters were excellent and approachable. Have learnt so much during the short weekend that I can use within my career. Don't want the weekend to be over!!! 😊"*

The future also featured in much of the other students' feedback. Many participants expressed an interest in working in rural and remote areas once they have graduated and felt the course provided them with some useful knowledge and skills for future practice.

*"I have had 3 days with CRANApplus facilitators and I now feel ready to help in a successful way a critically ill patient. The workshops were helpful to consolidate the theory we had learnt from the lectures. I have learnt a lot and I would, with no hesitation, suggest/encourage any undergraduate 3rd year nurse to undertake this 3 day course."*

There was also a solid recommendation for other students to attend the course.

*"I enjoyed the course very much and will be recommending it to other students."*

*"This course has been a fantastic learning experience. There are so many things that have been explained that will be helpful in many situations. I will definitely recommend this course to others."*

From a facilitator perspective the participants' enthusiasm was palpable and it was well worth our efforts to take them on board and hopefully make this an annual venture!

By providing this educational opportunity for students who are interested in this special career choice, we at CRANApplus are investing in the future remote/rural workforce.

An added bonus is that the organisation is also successfully forging relationships with our country's future workforce. ●



# FLEC courses for 2011

Location	Dates	Remote Emergency Care (REC)	Maternity Emergency Care (MEC)	MIDUS	Advanced REC	Aboriginal Health Workers
Scottsdale Tasmania	11-13 Feb		•			
Portland Victoria	25-27 Feb	•				
Mansfield Victoria	4-6 March		•			
Karratha WA	25-27 March	•				
Darwin NT	25-27 March			•		
Alice Springs NT	12-14 April					•
Orroroo SA	15-17 April	•				
Kununurra WA	29 Apr-1 May			•		
Mackay QLD	29 Apr-1 May				•	
Alice Springs NT	13-15 May				•	
Carnarvon WA	13-15 May		•			
Cairns QLD	20-22 May	•				
Cairns QLD	24-26 May					•
Darwin NT	27-29 May		•			
Darwin NT	31 May-2 June					•
Broken Hill NSW	17-19 June				•	
Rockhampton QLD	24-26 June			•		
Longreach QLD	8-10 July		•			
Cowra NSW	29-31 July		•			
Port Lincoln SA	2-4 August					•
Ceduna SA	12-14 August		•			
Darwin NT	19-21 August				•	
Alice Springs NT	19-21 August			•		
Cairns QLD	16-18 Sept		•			
Kalgoorlie WA	23-25 Sept				•	
Mt Isa QLD	23-25 Sept		•			
Perth Pre-conference	30 Sept-2 Oct	•				
Perth Conference	October	Conference				
Perth Post-conference	October		•			
Oatlands Tasmania	11-13 Nov	•				
Swansea Tasmania	25-27 Nov			•		

# eRemote program is a winner

The eRemote program, providing a comprehensive, innovative online education program to meet the needs of the remote, rural and isolated practitioner, has been a huge success.

Since it was launched in late June, the modules on offer have already been extended from the initial seven core mandatory modules to 12.

As of 22nd October, the eRemote program had 149 end users, with 48 completing the Advanced Life Support (ALS) program as part of the pilot Advanced Remote Emergency Care course. The ALS program has received excellent feedback from participants.

*“The beauty of this is that it keeps things simple...”*

Some testimonials on the program are below:

*“Module one – I found this very useful, it is quite a while since I looked at normal A&P of the heart, great opportunity to recap.”*

*“I really enjoyed this module (four); it really got me thinking about how to work out what the hell is going on with ECG. Always been my weak point, I found this a very logical way of breaking down the different aspects of the tracing.”*

*“The beauty of this is that it keeps things simple, logical explanation of the main drugs in an arrest.”*

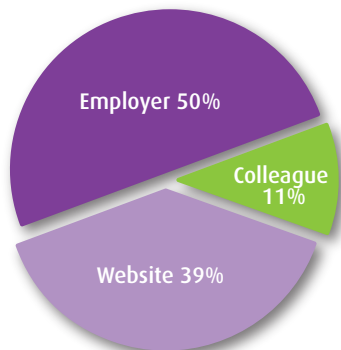
*“Excellent co-ordinator support. Easy to contact and helpful with course learning.”*

An evaluation has been conducted of the initial seven core mandatory modules:

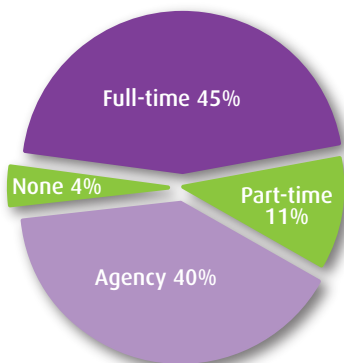
- Basic Life Support
- Fire Awareness
- Cultural Awareness
- Building a Respectful Workplace
- Medication Calculations
- Introduction to Infection Control
- Manual Handling with Ergonomics

Some demographics of the 32 respondents:

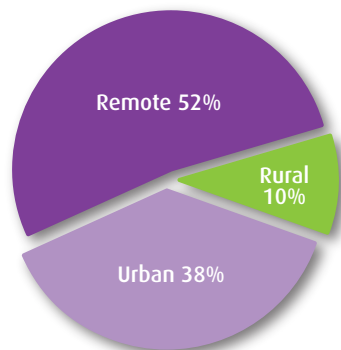
**How did you hear about the online program?**



**Current Employment Status**

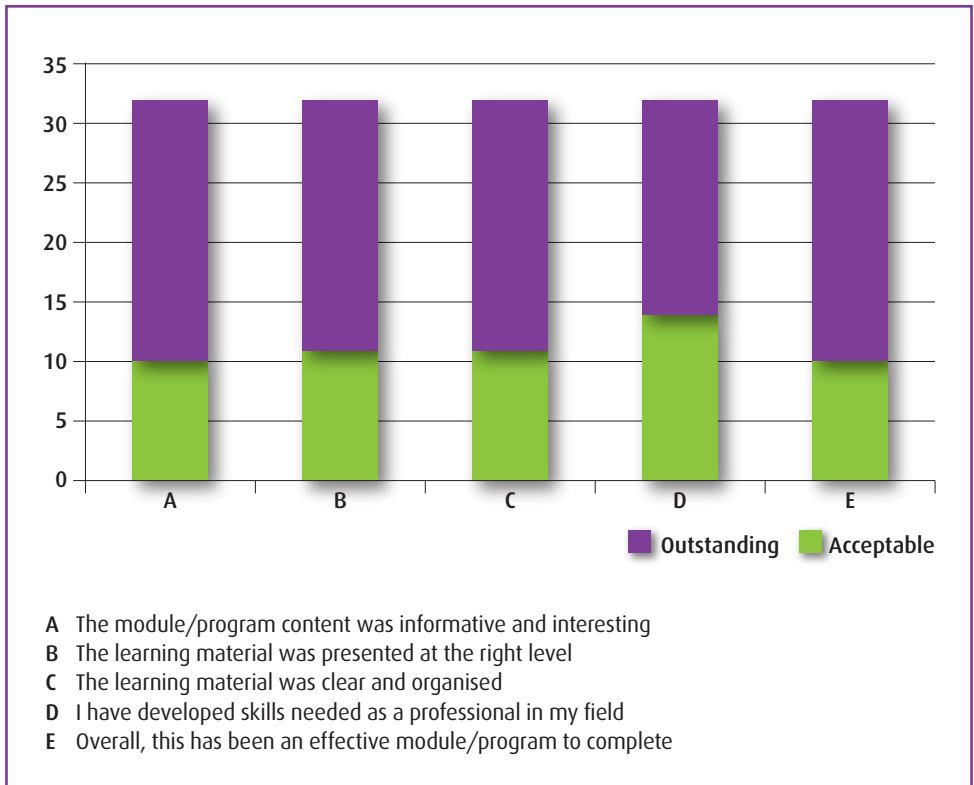


**Location**



Respondents were asked about their level of satisfaction of the modules. The outcomes are shown below:

### Levels of Satisfaction



### Some comments

- Great layout and presentation, easy to navigate and utilise functions offered. Great extra resource links and theoretical information included.
- This was fantastic, well done to Lenny for the wonderful voice over, it added so much to the presentation just in the way he spoke the words.
- Very good covered all aspects of infection control I thought.

- Not very computer savvy when it comes to Internet. Had fun learning.

The participants were also asked for feedback on additional aspects that need to be covered.

One suggestion to improve the information provided when a question is incorrectly answered is being addressed. At the moment, participants are given the correct answer. In the future they will also receive an explanation.

Another respondent suggested bullying as a topic to be covered. ►►

» All respondents reported that they would be taking a number of skills and ideas back to their workplace following the course, including:

- Hints and knowledge on fire and safety
- Heightened awareness of how to deal with difficult behaviours
- Understanding of cultural issues to assist in the management of Indigenous people
- Improvement procedures for effective manual handling, and
- Increased confidence in handling an arrest

The question asking if respondents would recommend the course to others received a resounding 100 per cent YES.

**Would you recommend this module/  
program to a colleague?**

**Yes 100%**

In summary, the eRemote programs are hitting the target in meeting the needs of clinicians by providing links to current remote best practice, while ensuring it has a positive outcome on the skills, knowledge and capacity of the remote, rural and isolated health workforce.

More eRemote programs are being developed to support the remote, rural and isolated practitioner so please visit the eRemote website at <http://courses.crana.org.au> ●



Photo: Steve Batten.



# CARPA standard treatment manual

## 5th edition: erratum

- Page 245: Medicines for chronic kidney disease  
Step 3; Dot point 1; Indented dot point 1  
**Perindopril-indapamine** should read **Perindopril-indapamide**
- Page 276: Syphilis and donovanosis  
Dot Point 1; Indented dot point 1  
**Benzathine penicillin** 1.8mg (2.4 million units) should read **Benzathine penicillin** 1.8g (2.4 million units)
- Page 358: Do – for infected testes

**For all men with discharge from penis AND any Indigenous man aged under 45 years or non-Indigenous man under 35 years with no discharge**

- Treat as STI – give
  - **Ceftriaxone** IM 250mg single dose
  - **AND Azithromycin** oral 1g single dose
  - **AND Doxycycline** (over 8 years) 200mg daily for 14 days

**For any Indigenous man 45 years or over or non-Indigenous man 35 years or over with no discharge from penis**

- Treat as UTI – give
  - **Cephalexin** 1g twice a day (bd) for 14 days
  - **OR Amoxicillin-clavulanate** 875/125mg twice a day (bd) for 14 days

Should read

**For all men with discharge from penis AND any man under 45 years with no discharge**

- Treat as sexually acquired – give
  - **Ceftriaxone** IM 500mg single dose
  - **AND Azithromycin** oral 1g single dose
  - **AND Doxycycline** (over 8 years) 200mg daily for 14 days

**For any man 45 years or over with no discharge from penis**

- Treat as UTI related – give
  - **Trimethoprim** daily for 14 days (*doses p404*)
  - **OR Nitrofurantoin** (not if chronic kidney disease stage 3, 4, 5) for 14 days (*doses p401*)
  - **OR Amoxicillin-clavulanate** for 14 days (*doses p394*)

- Page 404: Antibiotics Table  
Trimethoprin-sulphamethoxazole (co-trimoxazole); 12 years and over  
1600mg (1 tablet) should read 160mg (1 tablet)



# advocate

## health reform still on the agenda

As members are aware, health reform has been a major focus of the Government this year. Progress stalled during the election phase and health reform will change and be less bold as a result of the minority Government, but there are areas where the reform process will continue as planned.

**“There needs to be a balance between being large enough to attract a decent funding base and looking after localised needs.”**

The main push will be the progress towards the Medicare Local (ML) or Primary Health Care organisations and this is one area where we will need to be extremely vigilant. The Medicare Locals have the potential to be a very good,

localised planning and brokerage unit or to be divisions of general practice by another name.

There are many issues around the ML system that need to be addressed if they are to work properly and even more so in the remote context.

- The Governance needs to be genuinely inclusive with consumer input;
- There needs to be sufficient flexibility in the remote context to ensure that communities of interest are understood and large areas do not suck the life out of small and more remote regions;
- Planning must not be centralised and it is important that there is an understanding of the problems in remote areas when decisions are exclusively or largely based on population sizes.

There needs to be a balance between being large enough to attract a decent funding base and looking after localised needs. We must move away from the “one size fits all” approach.



This area and that of the Local Hospital networks, their interaction and the extent to which the remote non-medical model will fit in, will be heavily discussed. I am sure that we will need to work very closely with Government if this process is to have any positive benefit for our sector. This will certainly be the main focus of our advocacy efforts in the coming days and months.



Wish us well, as we really will have a hard time making people understand that remote health is social policy as well and not just based on health economics – working on generating that understanding is essential.

**Carole Taylor**  
CEO, CRANApplus ●



Photo: Barry Skipsey, Hermannsburg central Australia.

# new insights into nursing role

**Giles Barrington, a recipient of a CRANApus scholarship, describes his time on Flinders Island in Bass Strait, the largest of 52 islands in the Furneaux group and the location for a multipurpose medical centre serving a population totalling around 850.**

It was a few weeks after choosing Rural and Remote as my preference of region for a three-week clinical placement that I found myself in a six-seater Cessna with a fellow nursing student and a pilot called John, bumping around above the extremely rough waters of Bass Strait, on my way to Flinders Island.

My destination was the Flinders Island multipurpose medical centre.

**“My visit to Flinders Island was rewarding both professionally and personally, giving me the chance to explore this beautiful island and meet some lovely people.”**

The aim of the placement, as a component of one of my second-year subjects within the Bachelor of Nursing degree focusing on contemporary nursing practice, was to give me an appreciation of community and aged-care services and the opportunity to develop various skills essential to nursing practice.

Most of the people in the Furneaux group of islands inhabit Flinders Island with the remainder on the smaller Cape Barren Island to the south. The medical centre provides healthcare services to this community, has a wing for residential aged-care, acute care, accident and emergency and articulates with a GP and dental service, all under the one roof.

There is also a fortnightly flight to Cape Barren Island where the GP, dentist and rural nurses hold a clinic for the primarily Indigenous residents of this island.

My time on Flinders focused around the care of the residents and acute admissions to the centre. This allowed me to focus on the ‘grass roots’ nursing care involved in assisting people with their ADLs, regular medications, meals and hygiene, as well as the occasional dressing.

Now, to the seasoned nurse this may sound really basic, but until now in my nursing degree I have not had the opportunity to practice these skills regularly as my placements have been in settings where they are not regularly used. I took this opportunity to work with experienced RNs, ENs and carers to practice these skills.

The people on Flinders were genuinely nice and the community spirit strong. I found spending three weeks in such a small place, where everyone knows everyone, where drivers wave and the shopkeeper remembers you, was great.



Trousers Point, Flinders Island. Source: University of Tasmania Department of Rural Health website.



I had the opportunity to attend community events for both health promotion and recreation and gained new insight into the role of community health nurses in primary health promotion.

This placement also showed me how nurses work in collaboration with other health services, medical and dental, to provide holistic and comprehensive patient care. I enjoyed working with experienced and professional RNs; their teaching and knowledge allowed me to improve my own practice and develop essential nursing skills.

My visit to Flinders Island was rewarding both professionally and personally, giving me the chance to explore this beautiful island and meet some lovely people. I think one day I might like to go back to Flinders, for a bit longer than three weeks.

I would like to thank CRANaplus for providing me with my scholarship, as it will go towards the expense of undertaking this rural placement and spending the time away. Thank you, sincerely. ●

## community, culture – and camp dogs

**Kayne Jansen's experience spans cultural divides as well as physical distance when he heads off to Lajamanu at the top of the Tanami Desert in the Northern Territory.**

I'm a nursing student from Kiama – a wealthy coastal town of 12,000 people on the South Coast of NSW. I wanted to get an idea of what it was like to nurse in the Bush, gain an insight into life in remote areas, and have a holiday in the middle of session... How naïve was I, as I started to call a long list of remote health clinics in the NT, looking for a placement. Katherine West Health Board was one of the few who said that they'd be willing to have me.

Dusk fell as I drove into the remote Aboriginal community of Lajamanu, 3,900km from Kiama. I couldn't believe what I saw; I was afraid to get out of my car. I made a dash to the after-hours clinic phone to let the nurse manager know that I had arrived – and retreated to the elevated safety of my Land Cruiser out of reach from the gnawing jaws of the camp dogs (okay, my fears were obviously disproportionate with reality).

This is a bit embarrassing – but I was also a little scared of Indigenous people. I was worried

that, as a non-Aboriginal person, I would not be accepted by the community. After studying Australia's history of colonisation and genocide, this fear isn't completely baseless.

But it was more than that; I had a fear that I would somehow be held to account. This was definitely not the case. The people were so good to me; welcoming me into their community, homes, and culture.

**"A highlight was definitely being invited to go hunting by a group of young Warlpiri men..."**

The absolute best part of my experience was engaging with the community – especially outside work. I spent most of my afternoons just walking around and playing with the kids – quickly overcoming my fear of the verbose camp dogs.

A highlight was definitely being invited to go hunting by a group of young Warlpiri men, who drove me around in the back of their ute all day in the blistering heat of the desert, chasing bush turkeys and goannas. ►►

» I've found it really hard to respond to people when they ask me about my experience in Lajamanu. I think this is mainly because I don't really understand a lot of what I experienced there myself. And I've learnt to avoid making conclusions about issues that are more complex than I understand. It was an amazing place where my ideas of Australia – in terms of landscape, people, and politics – went through radical, contradictory changes. I'd highly recommend traveling to this area to everyone.

I'd like to thank CRANApus for their generous scholarship – which helped make this experience possible. Also a big thanks to Katherine West Health Board – who really did much, much more than was required of them. This includes Lajamanu Health Centre – who looked after me like I was another member of the team. Another thanks to the University of Wollongong's School of Nursing, Midwifery, and Indigenous Health – for helping to organise this placement.



Above: Elder Ronnie Jakamarra Lawson and Kayne Jansen.  
Below: Steph Jeremy.

And finally – thanks to my family for lending me money – among other things. ●



# go remote is steph's advice

**With a great deal of effort and enterprise, Stephanie Jeremy, Senior Nursing Representative on the National Rural Health Student Network, finally reaches Utopia.**

It was the 2009 CRANAP<sup>plus</sup> conference in Alice Springs that fuelled my desire to undertake a remote placement as part of my nursing degree. Being a member of the National Rural Health Student Network, I was able to receive funding to attend the conference where I met many enthusiastic people. Inspired by the event, I placed a message in the CRANAP<sup>plus</sup> Friday Flyer at the conference, stating that, if anyone was interested in having a student, to please contact me.

Two locations contacted me and I am so grateful that they did, as placement at both ultimately came to fruition.

**"I had the opportunity to learn and practice new skills as well as skills I had previously learnt such as those from the REC Course."**

Previously, my university was not open to rural or remote nursing placements, and in fact I was emphatically told "that remote was the wrong location"! I took exception to this comment but was fuelled even more to win the fight to undertake a remote placement.

I wrote proposals, had meetings, did research and presented the information to try to facilitate my placements – and to make it easier for other students to access rural or remote placements in the future. All of this was hard work but was eventually fruitful as I was able to gain credit for the placements to go toward my Nursing degree.

The placement I received through the CRANAP<sup>plus</sup> scholarship was undertaken at Utopia in the Northern Territory with the Urapuntja Health Service. I was there for two weeks and was grateful to have been able to experience such a fantastic model of primary health care.

Unlike some locations, the clinic is not situated in the middle of a town, but is decentralised, servicing approximately 14 outstations spread across the country. Population rates vary greatly, with the outstation populations ranging from 20-100 people, and an overall population of approximately 900 permanent residents.

Four out of five days a week are spent visiting the outstations to provide healthcare to the residents. Each day, vehicles are packed with the necessary equipment and medications, and then a nurse and/or doctor and an Aboriginal Health Worker (AHW) drive to set up a clinic – usually on a veranda.

Up to four outstations may be visited in one day, dependent on the distances to locations; specific care needs of patients; the potential number of people living at the location; staffing levels; the weather; and staff fatigue due to emergency out of hours call-outs.

I had the opportunity to learn and practice new skills as well as skills I had previously learnt, such as those from the REC Course. While I have heard criticisms of the provision of this model of care, my experience was that of seeing many empowered people taking more responsibility for their health than I had seen in other locations.

I am extremely grateful to have been in the company of such wonderful, knowledgeable, skilled and generous people such as Theo Allen (RN), the other nurses Netti and Jeanie, Dr Kam Saraswati, and the wonderful Aboriginal Health Workers – Andrew, Joyce and Rosabella (among other people).

I recommend other nursing students make the effort, no matter how hard it seems, to go remote – you will never experience anything like this in your whole degree! ●

# acute experience in kerang

**For Emma-Jane Lush, a second-year nursing student at Bendigo LaTrobe University, her rural experience proves to be an enriching recipe.**

As a second-year nursing student, I am required to undertake a two-week acute clinical placement. Due to the large number of students at my university, a placement in Bendigo proved difficult to get my hands on, and it was decided that I would undergo my placement at Kerang District Health. At first, I was disappointed that I would be based in a rural community for an acute placement, due to my belief that I would not have as rich an experience as students situated in Bendigo. How I was mistaken!

I arrived at the hospital on the Monday of my first week to find a small acute ward, and not much more. Despite the fact that I am a very optimistic person and attempt to make the best of everything, I was underwhelmed. But, as I was taken through orientation with a group of students, already my first impressions were beginning to adjust. It was explained to us that the support team at Kerang District Health would always strive to provide us with the best possible learning opportunities, and all the nurses are so multi-skilled that we would be participating in enormously varying levels of care.

After orientation, my opinions had slightly shifted, but I was yet to be convinced. But the convincing didn't take long at all.

We began our rounds on the Tuesday, and upon walking into handover we were immediately welcomed and treated with respect.

**"I left my acute placement in Kerang feeling extremely competent for a second-year nursing student."**

The whole day was incredible and I developed an amazing amount of new clinical skills while improving those gained from first year. For the remainder of the placement I found myself excited to start a new day; a credit to the staff, the patients, and the environment. By the end of the placement I felt an important and respected part of the nursing team; a rarity in student placements I'm sure.

The clinical support provided to us by the nursing staff was incredible and faultless, and I cannot thank them enough. They did indeed strive to provide me with all possible opportunities, and they found the perfect balance between assistance and allowing my independence. It was an honour to be guided by them in the clinical setting.

I left my acute placement in Kerang feeling extremely competent for a second-year nursing student. I would highly recommend any students with the option to undertake placement in Kerang to jump at the opportunity. Kerang District Health has such multi-dimensional and varying levels of care; combine this with the incredibly knowledgeable and supportive staff and you have a recipe for an enriching clinical experience. Thanks again to Kerang District Health and to CRANAP<sub>plus</sub> for an amazing opportunity. I will never forget the experience, and will be a better nurse because of it. ●



Photo: Steve Batten.

# invitation to the campfire



Photos: Rosey Boehm.

In September this year CRAN*plus* was invited to attend South Australia's multi-disciplinary rural health forum "Campfire 2010 – Rural Exposed!"

The event, held in the Adelaide Hills region at Monarto, 40 minutes from Adelaide, is a collaborative effort of the three South Australian multi-disciplinary rural health clubs: Adelaide University Rural Health Alliance (AURHA), University of South Australia's Rural Health Club (ROUSTAH) and Flinders University Rural Health Society (FURHS)

Run by students for students, the aim of the conference was to inform and educate health students at the three universities about the exciting career opportunities, placements, research and innovations currently being conducted in rural SA and around the country. ►►

Top: Campfire 2010 is launched by students with a bonfire to mark opening night. Left: Snake handling featured at the opening – student with Womma python.





» Approximately 100 students studying medicine, nursing, midwifery, dentistry, physiotherapy, occupational therapy, health science, pharmacy, podiatry, nutrition and food science and dietetics all gathered together around the campfire at Monarto Equestrian Centre to spend the weekend learning about each other's professions and experiences.

## "All Rural Health Clubs have a multi-disciplinary focus..."

There are 29 Rural Health Clubs (RHCs) nationally. All Rural Health Clubs have a multi-disciplinary focus and run a number of activities each year in order to promote rural and remote health careers to their members.

We took this opportunity to raise the CRANAplus profile with the various disciplines and alert them to the educational and support services available to them through CRANAplus.

CRANAplus offers support to RHC students in a number of ways:

- the Bush Support Services 24/7 toll-free telephone counselling service;
- the CRANAplus 'Undergraduate Remote Placement Scholarship' is designed to financially assist six students annually with the costs associated with a clinical placement in a remote setting;
- CRANAplus membership is offered at an affordable rate for students; and
- CRANAplus continues to support the annual National University Rural Health Conference. ●



Photos: Rosey Boehm.

# support

## being on the margins is about more than

by Mark Millard

Many people talk about *remoteness* as a kind of geographic state of being 'a long way away from many things that matter', and *isolation* as the subjective state of feeling cut off from, and a long way away from things. As such, the former is often measured 'objectively' and the latter 'subjectively.' It's often said that geographical remoteness creates challenges that are intractable and expensive to solve, and its only through new technologies of communication and transport that we may overcome these.

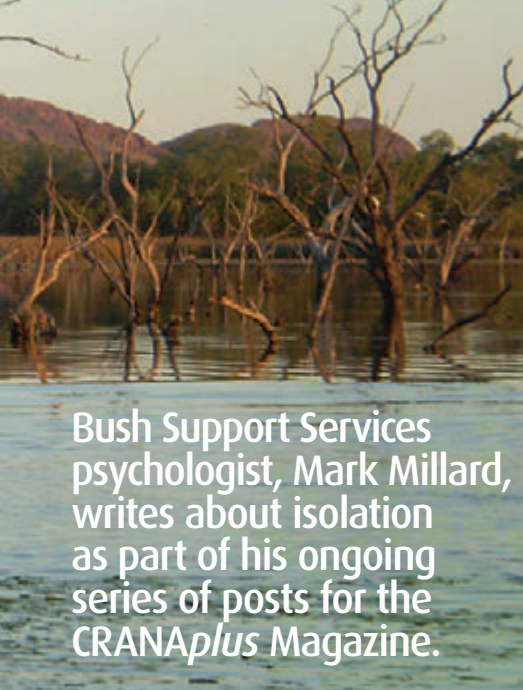
No doubt these ideas are time-tested and useful starting points, but some discussions I've had along the road with RANs make me wonder if there's a bit more to this picture, especially in terms of understanding how and why people sometimes come to feel a profound and disabling sense of isolation that makes it difficult to survive in the bush.

Other people, of course, find some aspects of geographical isolation stimulating and invigorating!

**"...people sometimes come to feel a profound and disabling sense of isolation that makes it difficult to survive in the bush."**

Frequently we notice that the places where people sometimes generally feel more isolated in negative ways are by no means the most geographically isolated. If these places have a feature in common, it is that the physical isolation they do experience is exceeded and magnified by serious issues with what I call *organisational systemic isolation*.





Bush Support Services psychologist, Mark Millard, writes about isolation as part of his ongoing series of posts for the CRAN*plus* Magazine.

distance!



Photo: Steve Batten.

Following this line, it's useful to think about isolation as more than just a subjective state: there can be social systemic isolation that is grounded in the architecture and layout of organisational systems and how they work, that can be and feel every bit as solid and intractable as geographic isolation. The disappointing thing is that geographically isolated places are often more vulnerable to this – the 'out of sight out of mind' phenomenon.



The good thing, though, is that this kind of systemic isolation is sometimes easier to fix than some of the problems created by being 600kms from the nearest hospital. The reason is because it is based in a malleable stretchable space, and if we make an effort this can be overcome within organisations.

**"...it's useful to think about isolation as more than just a subjective state..."**

One well-known remote area nurse gives a perfect illustration of the isolation caused by social systems with the story of her endless struggle to get her TV and home internet service fixed. Her problem was bedded, not in being geographically remote, but more in the process used by the maintenance section of the Health Department she was dealing with; a process that works perfectly well in urban locations but couldn't respond effectively to maintenance requests in far-flung places. The way the system kept failing made the isolation experienced far worse than it would have been because of geography itself. In terms of basic property repairs and maintenance she may as well have been in another hemisphere! ►►



► Interestingly, even though we can't change the number of kilometres away and the challenges of reaching a place, this situation cries out for a systemic solution.

Perhaps it was to be found in changing the way that requests for work had to be processed, so that they didn't need two visits – one for a quote before approval to carry out the work; or perhaps more communication and flexibility in the work ordering process needed to be achieved; financial responsibility for such small repairs could be delegated to on-the-ground clinical staff; or there may be local contractors who needed to be given prior *carte-blanche* approval to fix small things. The details don't matter, but you get the idea! Changing things in the system can change the degree of isolation that we experience in very material things (like these basic repairs), and this can change how isolated we feel.

**“Changing things in the system can change the degree of isolation that we experience in very material things...and this can change how isolated we feel.”**

The same goes for the ways that meetings are organised; the ways that in-services are scheduled; transport arranged; documents circulated; decisions and executive processes arranged; and consultations carried out. When Therese Forbes and I recently travelled to the Torres Straits, management there made a decision that it would be important to offer our workshops on some of the Outer Island centres. This seems to me a clear example of a decision that mitigates geographical isolation by scheduling in-services as close to people's places of work as possible.

Funnily enough, it's sometimes things not happening inclusively (that could be done differently) that leads to immense frustration

and irritation amongst remote staff. People seem willing to move heaven and earth if they feel heard and understood within the systems in which they work.

In a recent paper presented to the CRAN*plus* Conference, I listed the following as some of the features of systemic isolation:

- Can be very different in different settings with different practices.
- Exists within organisations, somewhat independent of geographical remoteness
- Is acutely felt at times of stress and crisis
- Magnifies and amplifies pathologies, both organisational and individual (sometimes leading to temporary relief from it!)
- CAN BE EASIER to do something about (in terms of resource constraints!)

And I listed these suggestions that are really basic and simple, to help relieve it: It's difficult but it can be resource neutral!

- Believable, genuine attempts to hear, recognise and acknowledge the circumstances of remote work
- Frequent, quality communication
- Investment in empathic, inclusive managerial and organisational relationships
- Honesty from managers about the challenges and barriers that often constrain remote work settings and managers themselves
- A believable, demonstrable base position that is supportive and empathic toward remote workers – even if nothing material can be immediately added, but changes can be made to the way things are done that reflect the realities on the ground.

The American version of the Macmillan English Dictionary gives food for thought when it describes isolation as: “The state of being separated from other people, or a situation in which you do not have the support of other people.”

It is possible, even without an extra dollar, to do something about this kind of isolation just by the way we relate, individually and as workplace systems. ●

# the BSS psychologist team



The BSS Psychologist Team at the 2010 Conference Welcome Ceremony: From left to right: Chris Martins, Jacky Lyons, Tracy Quinney, Cheryl Anderson, Annmaree Wilson, Therese Forbes, Mark Millard.

## bush support guide for worry warts

by Annmaree Wilson

So many people I know are worriers: me included! I remember worrying as a child. I remember feeling sick in the tummy about learning my letters and numbers ... oh the stresses and strains of kindy were enormous!

In those moments when I can stop myself from fretting, I realise that it is such an unhelpful thing to do. I mean, I would have learnt to read and write despite my angst. Even today, when I can think rationally about the things I have been worrying about, I realise they would be sorted without the added burden of the ruminations.

The question is: How to stop worrying? It seems that to answer that question, you first have to understand the purpose that worry serves. Worry is part of the fight or flight response and appears to be significantly related to the impact of uncertainty. It is a bodily response to a threat that does not actually require either fight or flight, so we get locked into the ruminations.

There is a great book that should be the bible of all worry warts called "Stop Worrying" by Professor Ad Kerkhoff. He points out that there is a big difference between worrying and thinking because thinking (usually) results in coming up with solutions to problems whereas worrying does not. As a result, he refers to worrying as a form of "self torture".

The answer seems to be to find a way of breaking the worry cycle. Kerkhoff advocates an interesting solution to compulsive worrying. He suggests that worrying should be an intentional activity.

He suggests planning two set times for worrying each day, ie coming up with a worry programme. Fifteen minutes of intense and focussed over-the-top worrying twice a day is the order of the day! When worrying thoughts come into your mind at other times, you need to remind yourself that there is a time and place for worry. And then you focus on the present. ►►



Photo: Stephanie Jeremy

►► Mindfulness exercises give us a great opportunity to break the worry cycle: and focus on the present. Mindfulness is about being aware of the full range of experiences that exists in the present moment. The important factor for worriers is that this awareness occurs without judgement. So you just don't employ those little grey cells that trigger worrying. This includes sensory impressions in all sensory modalities as well as emotions and thoughts including visual imagery.

You can achieve a state of mindfulness by focusing your attention on your breath or a repetitive phrase. When you notice your attention has wandered you bring it gently back. During mindfulness you notice the contents of consciousness without becoming distracted, or worrying about them.

So if you find yourself beside yourself with worry ...break the cycle! You will feel calmer and give your thoughts room to work out a solution! ●

# have a "real" and m

The message that we all hear repeatedly over the Christmas period is for peace and happiness and love. This message is on Christmas cards, carols and in the press.

But unfortunately for many people Christmas is a sad time. Those of us who are relatively well off with secure lives, employment and health tend to think that the "Christmas Blues" should only affect other less fortunate people. However, the seasonal sadness that occurs at Christmas can touch all of us.

Christmas is a time when feelings of loss and grief of a loved one or relationship can be magnified. It is a time when tricky current relationships can reach boiling point and it is a time when we all tend to overindulge in too much food and alcohol and definitely spend too much money. All of these things add real stress to our lives.

The first step in dealing with the Christmas Blues is to get real. We need to see Christmas for what it is.

Of course, for those with Christian beliefs it is a special spiritual time.

For all of us it can be a positive time to spend with loved ones, family or to take a break. But it is important to acknowledge the stresses, to acknowledge the mind games sentimental Christmas carol tunes can play on our emotions and to be aware of the ploys to make us spend money.

Having a real Christmas then means accepting that we may actually experience a variety of emotions at Christmas. We might be very relieved that we are having a few days off work. At the same time, we might be grieving the end of an important relationship and feel sad and lonely.

# mindful christmas from BSS

Trying to fight the negative emotions just does not work. Mindfulness teaches us to step back and “watch” the emotion. If you let them float in they will float out again.

This mindfulness technique stops you from wallowing in the more negative emotions that threaten to engulf you and help you stay in the present. Once you acknowledge that you may feel many emotions, some of which are negative, you can do something about them. Get active, breathe, go for a walk, stretch. Any activity will break the cycle of ruminative thought that projects you into the past or future rather than staying put in the here and now.

Getting real at Christmas also means connecting with other people. Isolating yourself prevents you from opening a door to more positive experiences. It is important that you reach out even if it is via telephone or computer.

Give and receive Christmas gifts with grace. There is real joy in both giving and receiving gifts. It is easy if we are feeling down to view this tradition from a cynical perspective. The important thing here is not to create more stress for yourself by getting into debt with the gifts that you buy for others. Some of the most valued gifts are home-made and definitely home-baked. And when you receive a gift just say “Thank you”!

There is comfort in having routine and ritual as part of our daily life. Christmas is no exception. The exciting thing about being an adult is that we can pick and choose our rituals and if we do not have anything in particular that we do at Christmas we can create our own traditions.

This could be anything from the Christmas tree and roast turkey tradition to a long walk and DVD in the afternoon. Whatever it is, think about it, plan it and look forward to it. It is in tradition that the loss of loved ones can be expressed. For some people this may be a visit to a cemetery, for others the planting of a tree or a toast to absent friends.

Finally, getting real for Christmas is about finding the balance between treating yourself to a little extra food or alcohol but not going overboard.

So all of us from Bush Support Services wish you a real and mindful Christmas. Don't forget we are available twenty four hours, seven days a week even over the Christmas and New Year period.

**Annmaree Wilson**  
**Bush Support Service ●**



Photo: George Fort.



# stress buster competition winners

Laughter and leadlight; music, makeup and massage: these are among the winning ways put forward by CRANAp<sup>plus</sup> members in this year's Stress Buster competition.

**Blackall Hospital** in Blackall, Queensland, with 22 employees combining to present an impressive array of stress-busting solutions, have won \$1000 as the group winner of the competition.

Their ideas include using the Wii Fit, doing jigsaw puzzles and having a massage chair available in their break room for all employees to de-stress. They also have a walking group and their knitting group has contributed to the BSS Cosy Blanket Project.





The individual winner is **Helen Dawe** from WA who receives \$500. Helen uses leadlighting to relax.

The \$50 winners are:

**Kelly-Anne Williams & Peter Granaway** from Darenton NSW who advocate "Make each other laugh, the harder the better, to decompress."

**Wendy Tempest** from Cocos Keeling Island WA whose winning suggestion is Photography and the Sea.

**Janet Scolyer** from Tullah TAS who bakes to classical music.

**Carina Mayers** from Longreach QLD who encourages her children to play "Beauty Salon" as a means of being pampered as they do her hair, apply makeup and provide her with coffee and cakes. ●

# BSS team celebrates national psychology week 2010

National Psychology Week was celebrated by the BSS Team with a display held at the CRANAP<sub>plus</sub> office in Alice Springs. Health organisations based in Alice Springs were encouraged to attend. The event was well received, with a steady attendance throughout the morning, no doubt in part to the offer of Colleen's legendary Devonshire morning tea.

On offer were tip sheets on the management of some common psychological issues, such as anxiety and depression, leaflets on the role of psychologists and BSS resource and promotional materials.

Encouraged by the good response to the information day, we anticipate it will be repeated next year, in both the Alice Springs and Adelaide offices. ●



Photo: Amy Blom.

Colleen's recipe to 'de-stress'.

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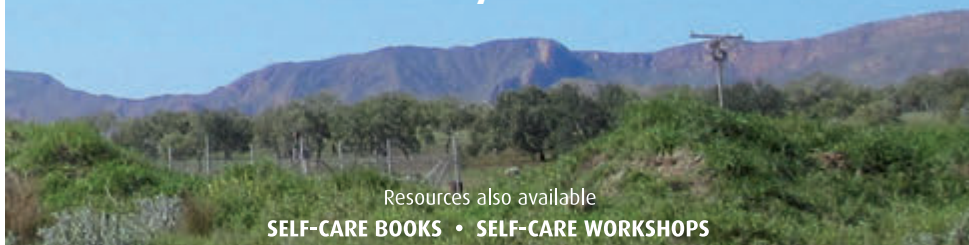
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# Season's Greetings and Best Wishes for the New Year



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for everyone*

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