CRANApplus

Remote National Standards and Credentialing Project – CRANApplus

Literature Review

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Introduction

Background

CRANAPlus is the peak professional body for remote and isolated health, and is dedicated to the development and delivery of safe, high quality primary health care to remote and isolated areas of Australia. In December 2012, CRANAPlus contracted Freestone Associates to review and prepare a report on the national and international literature that identifies best practice standards for the provision of health care for remote and isolated area health services. This project was funded by the Commonwealth Department of Health and Ageing and was commissioned to inform the development of a Remote National Standards Framework.

Approach and methodology of literature review

This review of evidence was a desktop exercise that focused on best practice standards for health care in remote and isolated areas. Peer-reviewed literature, published reports, or best practice standards published between 2000 and 2013 were used where possible. A systematic data search identified relevant literature using Medline, PubMed, CNAHL, EMBASE, Health and Society, Rural and Remote and Indigenous databases, university libraries, professional libraries, journals, books, articles, anecdotal (interviews), and other grey literature (policies, reports, evaluation documents). Key words for internet searches included: health service standards, clinical governance, remote and isolated practice.

Introduction

In undertaking a national and international literature review on best practice standards for the provision of health care for remote and isolated area health services, it was firstly important to clarify some terminology. This review seeks to define what standards are, identifies what the literature says about remote and isolated communities, defines best practice, and examines quality and safety in the context of standards development. Importantly, clinical governance and its intrinsic relationship to workforce are also reviewed, to clarify the strong connections they have with standards, and quality and safety.

Following an extensive examination of the literature specific to development and particular experiences in developing, publishing, and measuring performance against standards for remote and isolated contexts, it became clear that there is little represented in the published literature on standards that are exclusively used for remote and isolated health services. To address what appears to be a significant gap in reported knowledge and practice in this area, standards applicable to other health jurisdictions have also been examined for possible relevance and applicability.
Remote and isolated communities

Remote and Isolated Communities defined

Within Australia there have been several ways in which remoteness and rurality have been defined. Overall these use parameters such as the relative size of a community, its proximity to a larger population setting, and the range of and accessibility to key services. The three systems most commonly used include:

- **Rural Remote and Metropolitan Areas classification (RRMA).** The RRMA uses population size and direct distance from the nearest service centre to determine seven categories: capital cities, other metropolitan centres, large rural centres, small rural centres, other rural areas, remote centres, and other remote areas.

- **Accessibility/Remoteness Index of Australia (ARIA).** ARIA uses a geographical information system (GIS) to define road distance to service centres to produce a sliding scale of remoteness. ARIA includes five categories: highly accessible, accessible, moderately accessible, remote, and very remote.

- **Australian Standard Geographical Classification (ASGC).** The ASGC defines remoteness by Census Collection Districts on the basis on the average ARIA score within the district. The remoteness of local areas is then assessed and classified by the ARIA categories: major cities, inner regional, outer regional, remote, and very remote. (SARRAH, 2013)

The Accessibility/Remoteness Index of Australia (ARIA) was reviewed in 2001, and within that review the determination of what constitutes remote and very remote (isolated) was articulated following the weighting of scores. (Commonwealth of Australia Department of Health and Aged Care, 2001, p. 19)

- **Remote** (ARIA score >5.80 – 9.08) – very restricted accessibility of goods, services and opportunities for social interaction.

- **Very Remote or isolated** (ARIA score >9.08 – 12) – very little accessibility of goods, services and opportunities for social interaction to 0.2 Major Cities of Australia (Commonwealth of Australia Department of Health and Aged Care, 2001, p. 19)
In determining the ARIA ranking, the following have been categorised using the Remoteness Structure. (Australian Bureau of Statistics, 2011)

<table>
<thead>
<tr>
<th>ARIA Value Range</th>
<th>Area Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater than 0.2 and less than or equal to 2.4</td>
<td>Inner Regional Australia</td>
</tr>
<tr>
<td>Greater than 2.4 and less than or equal to 5.92</td>
<td>Outer Regional Australia</td>
</tr>
<tr>
<td>Greater than 5.92 and less than or equal to 10.53</td>
<td>Remote Australia</td>
</tr>
<tr>
<td>Greater than 10.53</td>
<td>Very Remote Australia</td>
</tr>
<tr>
<td>Off-shore, migratory and shipping CCDs</td>
<td>Migratory</td>
</tr>
</tbody>
</table>
Remote and Isolated Practice defined

In their article, ‘Defining Remote Rural Practice’, Smith, Margolis et al. (Smith, et al., 2008) describe remoteness in the geographical context as characterised by “…geographic isolation, cultural diversity, socioeconomic inequality, and Indigenous health inequity, amid poor resourcing and extreme climatic conditions”.

The authors go on to describe eight key features of remote practice:

- Remote doctors are generally employed in either government health centres or in non-government organisations rather than in private practice.
- Medical practice is isolated and is tremendously testing, particularly due to being geographically, climatically, professionally, personally, environmentally, politically, and
culturally isolated. Also, resources are much scarcer and often irregular in their accessibility.

- Telemedicine is frequently utilised for assessing and treating patients.
- There is a greater expectation of clinical expertise on doctors working in remote and isolated locations to diagnose and manage illness. Support services to assist in clinical diagnosis are not always available, such as laboratories, x-ray facilities or other specialist services.
- Treatment protocols in remote area practice require a knowledge across primary, secondary and tertiary care. Some examples of what may need to be covered: renal medicine, complex conditions, palliative care, obstetrics, surgery, anaesthetics, pathology, dentistry, and working with other health care workers such as nurses, Aboriginal health workers, paramedics, veterinarians, and humanitarian aid workers.
- Given that remote area practice will inevitably require practitioners to work in Aboriginal communities it should be recognised that these peoples are often marginalised and have poorer health status, different worldviews and cultural interpretations of health and illness.
- Remote medicine requires a sound and respectful multidisciplinary approach with an emphasis on teamwork.
- Remote communities often demonstrate poorer security and thus public safety risks are higher. In order to live and work effectively it is important to develop a good understanding of the environment and utilise public and population health approaches to improve the overall health status of the community. There is a need to work closely with community and be cognisant that there is a high staff turnover, often resulting in depleted corporate memory of health services. (Smith, et al., 2008, pp. 159-160)

In his article, ‘Defining Remote Health’, John Wakeman concluded that a definition for remote health could best be described as:

“...an emerging discipline with distinct sociological, historical and practice characteristics. Its practice in Australia is characterised by geographical, professional and, often, social isolation of practitioners; a strong multidisciplinary approach; overlapping and changing roles of team members; a relatively high degree of GP substitution; and practitioners requiring public health, emergency and extended clinical skills. These skills and remote health systems need to be suited to working in a cross-cultural context; serving small, dispersed and often highly mobile populations; serving populations with relatively high health needs; and a physical environment of climatic extremes”. (Wakeman, 2004, p. 214)

The definitions previously described support the definition adopted by CRANAplus of remoteness as:
“having characteristics which include:

- 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” (Malone & Cliffe, 2012).

However, CRANAplus go on to caution that no one definition of remoteness may adequately cover all circumstances or conditions.

The Canadian experience of defining what is rural and remote contributes to the dilemma of attempting to describe a universally applicable definition. In a 2005 discussion paper prepared for the Canadian Nurses Association, the author Rural Nursing in Canada quotes MacLeod, Browne, and Leipert, who identified that the nursing and medical literature define rural and remote practice: “based on the skills and expertise needed by practitioners who work in areas where distance, weather, limited resources and little backup shape the character of their lives and professional practice”. (Hanvey, 2005)

The recently published National Strategic Framework for Rural and Remote Health acknowledges: “It is particularly important to note that, as the distance from major cities and regional centres increases, disease risk factors and levels of illness increase. The cost of providing health services also increases with remoteness, while the availability of existing infrastructure and workforce become more limited. In addition to changes in the geography, population demographics change with increasing remoteness”. (Standing Council on Health, 2012)

As identified by Malone and Cliffe in 2012, remote health professionals can be employed in a wide range of settings, including government health services, community controlled health services, Aboriginal medical services, primary health care clinics, multi-purpose centres, private general practices, mining and other industries, mobile and fly-in/fly-out services, as well as private and NGO health services. (Malone & Cliffe, 2012)
How the delivery of best practice health care is defined and contextually constructed for remote and isolated areas

Best Practice Health Care and Health Service Standards – What does this mean?

Best practice is a term used frequently across all sectors of business, industry, government, non-government organisations, and services generally, to describe the standards or benchmarks that have been developed to assist in improving policies and practices.

Health service standards provide the remote and isolated health service with a measure against which they can assess themselves and demonstrate improvement. They also:

- Help service users and carers to understand the quality of service to which they are entitled.
- Help to ensure implementation of the duty the health service has with respect to human rights and equality of opportunity for the people living in remote and isolated areas.
- Enable formal assessment of the quality and safety of health and social care services.

In delivering health services, wherever the location might be, it is expected that best practice will be underpinned by an evidence base. According to the Cochrane Collaboration:

“… evidence-based health care is the conscientious use of current best evidence in making decisions about the care of individual patients or the delivery of health services.” (Cochrane Collaboration, 2012)

In remote and isolated communities, healthcare delivery is generally based on a primary health approach. (Wakerman, Humphries, Wells, Kuipers, Entwhistle, & Jones, 2008); (Humphries & Wakerman, Primary Health Care in Rural and Remote Australia: Achieving equity of access and outcomes through national reform, 2010); (National Rural Health Alliance, 2009); (Malone & Cliffe, 2012); (Royal Flying Doctor Service, 2013)

Elements of best practice in primary health care include:

- “Characteristics and social determinants of health of local population should be analysed to inform planning and quality improvement.
- Services should be able to demonstrate effectiveness of treatment using outcome measures.
- Services should be able to demonstrate appropriate coordinated care.
- Services should support a collaborative approach to service delivery.
- Clients should receive a complete assessment.
• Care plans and care coordinators should be in place for clients with multiple or complex needs.
• Clients and carers should be supported to participate in improving the patient experience and health outcomes.
• Referral processes, clinical handover, and transfer of information should support effective continuity of care”. (Hanley, 2012)

National Health Standards

In 2010, the Australian Government, through the Health Ministers of all States and Territories, endorsed the Australian Commission on Safety and Quality in Health Care (ACSQHC) 10 Standards, to be implemented from January 2013 into all government hospitals and day procedure centres.

The 10 Standards address the following areas:

• “Governance for Safety and Quality in Health Service Organisations
• Partnering with Consumers
• Preventing and Controlling Healthcare Associated Infections
• Medication Safety
• Patient Identification and Procedure Matching
• Clinical Handover
• Blood and Blood Products
• Preventing and Managing Pressure Injuries
• Recognising and Responding to Clinical Deterioration in Acute Health Care
• Preventing Falls and Harm from Falls”. (Australian Commission on Safety and Quality in Health Care, 2011)

In tasking health facilities with the directive to ensure that they meet the 10 Standards, it has been recognised that healthcare facilities constitute a range of sizes, structures, and complexity of services and that some flexibility should be considered in the application of the standards. This should be especially noted when applying the standards to the remote and isolated health services that exist across the vastness of Australia’s outback and northern communities. (Australian Commission on Safety and Quality in Health Care, 2011, p. 4)

To better understand the needs of small rural and remote health facilities, the ACSQHC commissioned a report (Anderson, Balding, & Leggatt, 2012) to determine the challenges faced by these facilities in implementing the standards. The report included consultation with a wide range of key stakeholders, and provides substance for the premise that, while there is commitment to the implementation of standards that represent evidence-based best practice,
there will be difficulties in meeting the standards to the level required of larger health services. Some of the issues identified included lack of resources and training, and the need for strong leadership. (Anderson, Balding, & Leggatt, 2012, p. 31)

The Australasian College of Health Service Management (ACHSM) has recognised the importance of leadership in managing quality improvement and state: “Effective clinical leadership is an important driver of healthcare quality and safety improvement.” (Australasian College of Health Service Management, 2013) A recent literature review from Health Workforce Australia supports this assertion and goes further in claiming evidence that: “The development of effective clinical leadership is considered vital in the current Australian context of health care reform and change. There is a specific need for frontline clinical leaders, who will be well placed to influence best practice at the service level …” (Health Workforce Australia, 2012, p. 20) A significant barrier to achieving a culture of strong and transparent clinical leadership in remote health practice is related to workforce issues. These issues are explored further in this paper.

Clinical governance

To understand why clinical governance is so important in the delivery of safe, high quality, and effective health care it is necessary to understand what the term means.

The Australian Council on Healthcare Standards defines clinical governance as:

"... the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks, and fostering an environment of excellence in care for consumers ..."

(Australian Council on Health Care Standards, 2004)

Other definitions include:

“Clinical governance is a process – indeed, more than a process. It's an organising principle, a state of mind, the day-by-day, flesh-and-blood embodiment of how we practise – acting together across the traditional boundaries of our different roles and responsibilities; concentrating our will to care, the skills we have acquired, and the resources at our disposal – in order to give our patients – all of them, whatever their means, wherever they are – the best and safest care that a good health service can deliver.” From a speech delivered by Sir Liam Donaldson, Chief Medical Officer of the NHS, UK. (Donaldson, 2003)

“The responsibility of governing bodies to demonstrate sound strategic and policy leadership in clinical safety and quality, to ensure appropriate safety and quality
systems are in place, and to ensure organisational accountability for safety and quality.” Dr Heather Wellington (Victorian Healthcare Association, 2005, p. 7)

“The framework through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in healthcare will flourish.” (Harding, 2011, p. 1)

From the United Kingdom, Benning et al. in their major study, ‘Large scale organisational intervention to improve patient safety in four UK hospitals: mixed method evaluation’, state that the general aim of good clinical governance and patient safety is: “to avoid unnecessary harm, pain or suffering as a result of error in medical interventions”. (Benning, et al., 2011, p. 3)

They contend that strategies which aim to diminish the incidence of adverse events should include:

- “Building a culture of safety and good leadership
- Training to enable organisations to identify problems and develop and evaluate methods to reduce risk
- Foster an understanding of the principles of safe practice”. (Benning, et al., 2011, p. 3)

This is supported by Reid (Reid, 2002, p. 1), also from the United Kingdom, who contends that: “…Clinical governance integrates various well-known quality initiatives into one framework, based on the philosophy of continuous quality improvement. Inherently this quality strategy acknowledges the fundamental role of culture and leadership, in addition to emphasising the role of staff learning, development and empowerment as aspects of developing quality services”.

In a recent review by Philips et al. (Philips, et al., 2010), which posed the question ‘Can clinical governance deliver quality improvement in Australian general practice and primary care?’, the literature revealed that, when identifying outcomes for clinical governance, the strategies employed focused mainly on audit performance against indicators and peer-led reflection on evidence or performance, but competence was only infrequently identified.

The researchers concluded that their evidence found: “…clinical governance is fragmented, and focuses mainly on process rather than outcomes. Few publications address models that enhance safety, efficiency, sustainability and the economics of primary health care. Locally relevant clinical indicators, the use of computerised medical record systems, regional primary health care organisations that have the capacity to support the uptake of clinical governance at the practice level, and learning from the Aboriginal community-controlled sector will help integrate clinical governance into primary care”. (Philips, et al., 2010, p. 602)
In their review of evidence underpinning clinical governance, Philips et al. (Ibid.) defined quality using the nine dimensions of quality from the 2001 National Health Performance Framework (National Health Performance Committee, 2001). These nine dimensions are:

- **Efficiency**: An individual or service can achieve desired results with the most cost-effective use of resources.
- **Effectiveness**: An individual or service can achieve desired health outcomes.
- **Capability**: An individual or service has the skills and knowledge to provide a health service.
- **Accessibility**: A service allows people to obtain health care irrespective of income, geography or cultural background.
- **Safety**: An individual or service avoids or reduces to acceptable limits the actual or potential harm from health care management.
- ** Appropriateness**: An individual or service provides care, intervention or action that is relevant to the client’s needs and based on established standards.
- **Continuity**: An individual or service can provide uninterrupted, coordinated care or service over time.
- **Responsiveness**: An individual or service provides respect for persons and is client orientated.
- **Sustainability**: A service can provide infrastructure such as workforce, facilities and equipment to respond to current and emerging needs.

**Workforce**

If sound clinical governance is to support safety and quality improvement, and enable all stakeholders to effectively contribute to a safe and high quality of care and service, then it is imperative that the health workforce is equipped and supported to meet the health needs of remote and isolated communities through that central focus of quality and safety. The recruitment and retention of a sufficient and appropriately skilled and experienced health workforce for remote and isolated health services is fundamental to achieving good clinical governance, along with strong clinical leadership.

In 2009, the Australian Audit Office undertook an audit of the rural and remote health workforce. The report found that:

“... over the last decade, Australia has experienced workforce shortages in a number of health professions, particularly in rural and remote regions. The ongoing shortage of doctors and nurses in these areas of the country has many characteristics in common with difficult social policy issues – it is multi-causal with many interdependencies, has
no clear or definitive solution, is not the responsibility of any one jurisdiction and, ultimately, requires health professionals to move to, or work for a longer period in, a rural and remote area”. (Australian Audit Office, 2009)

Wilson et al., in their review of inequitable workforce distribution in rural and remote areas globally, recognise that:

“The shortage of healthcare professionals in rural communities is a global problem that poses a serious challenge to equitable healthcare delivery. Both developed and developing countries report geographically skewed distributions of healthcare professionals, favouring urban and wealthy areas, despite the fact that people in rural communities experience more health related problems”. (Wilson, Couper, De Vries, Reid, Fish, & Marais, 2009, p. 1)

The recently published National Strategic Framework for Rural and Remote Health (NSFRRH) recognises the perplexing issues around appropriate workforce for rural and remote areas. This includes appropriate numbers, skills and qualifications, and also recruitment and retention strategies.

With regard to recruiting skilled health professionals, the NSFRRH describes the importance of recognising the preconceptions (health practitioners) have about working in rural and remote communities. These generally relate to:

- Professional and social isolation (for the health professional and their spouse and family).
- Poorer local amenities and infrastructure.
- Limited training and professional development opportunities.
- Difficulties of delivering services in geographically isolated areas.
- Long-distance travel, extended working hours, and lack of locum support. (Standing Council on Health, 2012, p. 40)

The NSFRRH identifies that governments and communities can also actively challenge the common perceptions of working in rural and remote settings by:

- Promoting the advantages of rural and remote practice, including opportunities to develop a broader range of skills and experience.
- Increasing local capacity to ‘grow your own’ workforce, as students originating from rural and remote communities are more likely to return to work in these communities, and availability of quality and safe housing.
- Ensuring health professionals have access to peer and locum support, and opportunities for training and continuing professional development.
The World Health Organization recognises that even developed countries experience difficulties in recruitment and retention of a skilled workforce in remote and rural areas, leaving many vulnerable and disadvantaged communities bereft of appropriate levels of health care, and compromised by access and affordability. In a 2010 global policy paper a range of recommendations were made which, it is believed, would improve the attractiveness of remote and rural practice to qualified and skilled health personnel. These included:

1. **Education recommendations**

   Use targeted admission policies to target prospective students with a rural background and develop education programs with a rural and remote context for various health disciplines, as this is likely to lead to graduates choosing to practise in rural areas.

   Establish higher education centres catering to students from rural and remote areas outside of city and regional areas, as it is more likely that they will stay and practise closer to their own communities.

   Ensure that students have as much exposure as possible to life and work in rural and remote communities, as this is likely to influence their decision making with respect to their future practice location of choice.

   Examine and adjust undergraduate and postgraduate curricula, so that rural and remote health topics are included and their competencies in these areas would be enhanced, leading to greater satisfaction in their workplace, and contributing to higher levels of retention.

   To increase retention, design accessible and innovative continuing education and professional development programs that meet the needs of rural and remote health practitioners.

2. **Regulatory recommendations**

   Increase the potential for job satisfaction, by introducing and regulating enhanced scopes of practice in rural and remote areas, thereby assisting recruitment and retention.

   To increase the numbers of healthcare workers in rural and remote areas, provide targeted but appropriate education and training to a variety of healthcare workers (such as Aboriginal Health Workers or ancillary health staff).

   Provide support and assistance to healthcare workers to ensure that their compulsory discipline-specific professional requirements are met.

   Provide scholarships, bursaries, and other similar types of educational support, accompanied by formal service agreements, to serve in remote areas for a specified time post-graduation.
3. **Financial incentives recommendation**

Provide financial incentives that can be sustained, such as hardship allowances, assistance with housing, free transportation, paid study leave and vacations, and family allowances, which are adequate enough to outweigh what is perceived by many as the opportunity costs associated with working in rural and remote areas.

4. **Personal and professional support recommendations**

Improve living conditions for health workers and their families, and make investments in infrastructure and other services such as sanitation, electricity, telecommunications, and schools, to improve and enhance the living conditions of health workers, as these issues can have a major impact on decisions to locate to and remain in rural areas.

In order to make these posts professionally appealing, ensure safety and security in the working and environment, including appropriate equipment and regular supplies, supportive supervision, and mentoring.

Identify and implement outreach activities which appropriately facilitate cooperation and support between health workers from better served areas and those in underserved areas, and, if possible, use telehealth and other electronic technology to provide additional support to health workers.

Develop a career path and support career development programs in remote areas through experiential learning, education, and training, which can be conducted on site.

Support the development of professional networks and professional associations, and provide access to relevant health journals and other publications, to assist in improving the morale and status of the healthcare workers and reduce the sense of professional isolation.

Conduct public recognition measures, such as health days celebrating the work of rural and remote healthcare workers, participate in or develop awards and recognition locally, nationally, and even internationally, which would lift the profile of working in rural and remote areas. These often generate the conditions to improve fundamental motivation and thus contribute to retention. (World Health Organization, 2010)

Humphries et al. also argue that, while it is critical to the delivery of good primary health care in remote areas that there be sufficient workforce numbers and expertise, the central issues of recruitment and retention of the health workforce: “... becomes much less of an issue when adequate infrastructure, good management, professional development opportunities, clear role delineation and a supportive critical mass of practitioners are developed”. (Humphries, Wakeman, Wells, Kuipers, Jones, & Entwistle, 2008, p. 78)
There are several examples of countries around the world where, to meet the health needs of sparsely distributed and remote populations, it is recognised as essential to have a skilled and experienced workforce to meet health demands. Australia is not alone in this dilemma. For example, Scotland struggles with providing a workforce able to deliver high quality care to its remote areas and islands to a standard comparable to that provided in urban areas. The greatest challenge is ensuring that the workforce has access to continuing education and training opportunities to equip them with the specific skill-set required for the work they undertake, and this goes beyond just being a broad generalist practitioner (Cantrell, Nicoll, & Sabin, 2010). The Scottish government (Scottish Government Health and Social Care Directorate, 2008) recognises the issues of ensuring an appropriate continuum of care for people living in remote and isolated areas of Scotland and has made commitments to the specific training and education needs of remotely-based health professionals through a ‘Remote Community Resource Hub Staffing Model’. This model has: “…a generalist team covering a wide range of competencies, based on the needs of the local populations. Teams should comprise of medical, nursing, AHP, social and voluntary care backgrounds, incorporating informal carers from the community as appropriate”. (Ibid.) In a publication from the nursing organisation, ‘Nursing in Rural and Remote Canada’, it has been suggested that, to attract and keep qualified staff in remote and isolated First Nations and Inuit Community Managed Primary Health Services, nurses preparing for employment be advised to:

- “Understand and appreciate issues in First Nations and Inuit governance of health care;
- Establish supportive networks with other nurses who work in community services;
- Identify personal learning objectives in nursing skills and social-cultural health issues;
- Negotiate with the community for financial and infrastructure resources (e.g. time off) to support professional practice.” (Kulig, McCloud, & Lavoie, 2007, p. 2)

Within the Australian context of living and working in remote and isolated Aboriginal communities, the same advice seems equally relevant.

The relationship between workforce and quality and safety in patient care is an important element in overall health outcomes. Informed, educated, and skilled staff form the backbone of quality and safety initiatives. Therefore, the issues of recruitment and retention require that there is a full understanding of good incentive programs to attract a skilled workforce to remote and isolated health care settings. This should be underpinned by sound evidence on what motivates healthcare providers and health professionals. The recent Health Workforce Australia literature review found that: “In practice, health care providers are motivated by a
Leadership in a best practice workforce can be challenged by the tyranny of distance. A thesis study by Weymouth et al. examined these issues through an extensive consultation process with remote area nurses who, in the main, concurred that it is possible to achieve leadership through distance management by those who had a sound understanding, were empathetic of the full range of difficulties experienced by remote and isolated practitioners, and who had the skills and capacity to use technology as a means of clinical, organisational and social (including personal safety) supervision. (Weymouth, n.d.) They go on to emphasise the critical importance of appropriate recruitment and orientation.

**Safety and quality – What this means for health care standards**

In a recent article, Obeidat et al., who conducted an extensive study in Saudi Arabia on the ‘Impact of healthcare quality on patient safety in Saudi Arabian hospitals’, found that “Quality consists of the degree to which health services for individuals and populations increase the likelihood of desired health outcomes (quality principles), are consistent with current professional knowledge (professional practitioner skill), and meet the expectations of healthcare users (the marketplace)”. (Obeidat, Alzaidi, Shannuk, Al Jarrah, & Al Zu’bi, 2012, p. 97)

This can be summarised by viewing quality health care as the overarching umbrella under which patient safety is protected. Patient safety has also been defined by the Institute of Medicine (IOM) as: “the prevention of harm to patients”. (Mitchell, 2008)

To realistically evaluate quality of care it is important that five key factors be examined, including the: “person receiving care; the professional providing care; the context; the type of care provided; and the timing of outcomes expected from the care provided”. (Burley & Greene, 2007, p. 3)

Burley and Greene go further, and identify the core drivers of quality of care are: the (health care) system, the organisation, the community and the individual, all of which must be considered when assessing the extent to which quality can, and is demonstrated in remote area contexts. (Burley & Greene, 2007)

Safety and quality have also been described as follows:

“Effective systems of corporate and clinical governance are necessary at all levels of primary health care to monitor and improve the safety and quality of services. This includes:

- open, transparent monitoring and reporting systems
• collection and use of data and information for driving change and improvement with performance indicators based upon the social determinants of health and other evidence based quality indicators of access, safety, effectiveness, appropriateness, efficiency and consumer participation
• investment in research for achieving continuous improvement
• effective organisational systems that promote safety and quality
• robust regulation of the conduct, health and performance in professional practice of health professionals
• strong consumer participation in all processes
• occupational health and safety”.

(Australian Nursing Federation, 2010)

In 2012, Queensland Health prepared and published a Clinical Safety and Quality Governance Framework (Queensland Health, 2012), which provides insight into the high priority areas of quality and safety approaches that need to be considered and put in place (some of which are required by that state’s Standards). These include:

• “Risk registers
• Incident management
• Consumer feedback management
• Credentialing and scope of practice
• Management of concerns about clinician performance’ (Queensland Health, 2012, p. 16)

These approaches are supported by the core areas of the Clinical Governance Standards Operational Plan (Queensland Office of Rural and Remote Health, 2012), and also reflect the range of statutory obligations placed on health services in Queensland under the Health and Hospitals Network Act 2011.

Processes used to develop best practice standards from the national and international literature

There are several key bodies in Australia that develop standards used in the healthcare industry, including the: Australian Council on Health Care Standards (ACHS) and Standards Australia. Quality Improvement Council (QIC) – providing continuous quality improvement and accreditation in health and community services (this organisation was preceded by the Community Health Accreditation and Standards Program (CASP). Australian General Practice Accreditation Ltd (AGPAL), part of the Australian College of General Practitioners (ACGP).
Standards Australia have clarified that while Standards are not enshrined in statutory regulation, they are required in any industry that strives for best practice. The process must be transparent and has been articulated as follows:

The Standards Australia standards development process is clear and scrupulously defined using the three basic international tenets of:

- Openness and transparency of process
- Consensus
- Balance of representation (Standards Australia, 2012)

The following is an overview of the rationale for the above tenants:

**“Openness and transparency of process:** Transparency is a significant element of standards development and intends that every act must follow a well-established procedure which is equitable to everyone and that each phase is open to external examination.

**Consensus:** Consensus in standardisation is the process through which a Technical Committee, a committee comprising varied and disparate interests come to an agreement on what the standards should represent against the requirements articulated. This results in standards that best meet the needs and produces a Standard which best matches the needs and principles by which the organisation and the community as a whole expect.

**Balance:** Membership of a Standards Australia Committee is constructed to ensure there is a recognised and legitimate balance of people who are equipped to represent the very needs of stakeholders as broadly as possible”. (Standards Australia, 2012)

Standards Australia is a member of the International Organization for Standardization (known as ISO), which is a network of the national standards institutes of some 161 countries, and which coordinates the system and publishes the finished standards. ISO is at the basis of all systems using the ISO 9001 management systems.


The ACHS is an organisation that is both independent and not-for-profit. Its aim is to improve the quality of health care in Australia. This is accomplished through continual review of
performance, assessment, and accreditation. ACHS is recognised globally, being the third healthcare accreditation agency to be established worldwide (after the Joint Commission on Accreditation for Healthcare Organizations, USA, and the Canadian Council on Health Services Accreditation). The Joint Commission and the Canadian Council are independent of government and other stakeholders, as is the ACHS. The ACHS develops standards and provides accreditation services to those standards. (Australian Council on Healthcare Standards, 2012)

The experience in Canada, with respect to the processes for developing standards for healthcare in remote contexts is very similar to Australia, as indicated above. A First Nations and Inuit Home and Community Care Program Standards and Policies Working Group is established to develop the standards with support and assistance, input, and direction of a national working group for Standards, Scope of Practice, Liability, and Training. The Working Group, having developed draft standards recommends to a National Steering Committee for their review and approval. In addition, input is sought from First Nations and Inuit communities, specifically to identify pertinent feedback from those who would be operationalising the manual in the field. It is intended that the standards, as documented in the Standards Manual be seen as a living document, which would be flexible to changing practice and environmental contexts. (Lefebre, 2000)

There are other bodies that develop standards for specific areas of health care, which may be provided to remote and isolated communities, including the College of General Practitioners for general practices. Their standards are developed by the RACGP in consultation with general practitioners across Australia. The Australian government offers a Practice Incentive Payment (PIP) for accredited practices. Quality in Practice (QIP) is a subsidiary of Australian General Practitioners Accreditation Limited (AGPAL), and provides quality accreditation for a range of primary health care providers, such as diagnostic imaging practices, optometry, and physiotherapy practices. (Mental Health Coordinating Council, 2010)

The Community Care Common Standards (CCCS) replaced the HACC National Service Standards across Australia in March 2011. These standards represent a component of the ongoing process of reform by the Australian Government and State and Territory Governments that began in 2005, and they were developed to streamline provisions in community care. There are three key standards:

- Effective Management
- Appropriate Access and Service Delivery
- Service User Rights and Responsibilities (Department of Health and Ageing, 2010)
The Quality Improvement Council (QIC) is a non-profit, independent Australasian (its standards are used in both Australia and New Zealand) accreditation body, which has existed for over 20 years.

Its purpose is: “To promote continuous quality improvement in health and community services through the provision of standards, accreditation programs and developmental resources for the benefit of health services users, staff and the wider community”. (QIC, 2004)

QIC worked closely with the Australian Commission on Safety and Quality in Healthcare to refine the new national standards, assessment tools and the accreditation system. It is believed the new system will be complementary to the QIC Standards and Accreditation Program. (Ibid.)

What are best practice standards?

Best practice can be described as: “…a technique or methodology that, through experience and research, has proven to reliably lead to a desired result. A commitment to using the best practices in any field is a commitment to using all the knowledge and technology at one's disposal to ensure success”. (Rouse, 2007)

Standards can be described as: “…published documents setting out specifications and procedures designed to ensure products, services and systems are safe, reliable and consistently perform the way they were intended to. They establish a common language which defines quality and safety criteria” (Standards Australia, 2013).

Best practice standards are underpinned by guidelines that ensure consistency in the development and implementation of best practice in the healthcare setting. Guidelines are often constructed as strategies or principles that have been agreed to by discrete practice groups, and are developed to assist health professionals, as well as their clients/patients, to make informed, based on evidence, decisions with respect to the health intervention or care to be provided. Best practice guidelines are based on available evidence and are relevant for the specific clinical issue.

- Best practice guidelines are used to support decision-making.
- Best practice guidelines can be used to support the development of policies, procedures, protocols and programs.
- Best practice guidelines should be used as a resource tool. (Ibid.)
The components of best practice used for the delivery of care in remote and isolated communities

A framework for rural and remote health as a means of assuring effective health services in rural and remote areas, which meets the goal of achieving improvements not only in health status for remote and isolated populations but in the environment as well, was recommended in an action plan that came out of a 2002 project ‘Action on Nursing in Rural and Remote Areas, 2002–2003’ (National Rural Health Alliance Project Team, 2002). The report agreed the following:

- “Health is positive, multidimensional, and participatory;
- Services must be aimed at the population in their own environment, embracing the whole network of health and community issues; and
- Models of care must adopt diverse, but complementary strategies, based on enabling, facilitating and rewarding.” (Ibid.)

In Queensland, a study was undertaken to determine a best practice approach to the delivery of health care to remote and isolated Aboriginal communities. The study found that there was a mix of primary, secondary, and tertiary services provided by a range of health professionals, either living in the community or flying-in/flying-out. The study concluded that there should be support for: “… the development of a new model of health service delivery in remote or isolated areas of Queensland with a greater emphasis on primary health care. Implicit in planning for such a change is consideration of the contextual elements impacting on individual communities that need to be assessed and incorporated into a population based primary health care framework”. (Birks, Mills, Frances, Coyle, Davis, & Jones, 2010). This may have implications for the development of healthcare standards, as standards would need to reflect PHC practice, rather than higher level health care delivery as seen in rural and regional settings.

In an example from Canada (Canadian Homecare Association, 2006), the Canadian Homecare Association undertook a project to identify service gaps and the key drivers for best practice in the remote areas of that country. As a result, the four key drivers for best practice were revealed as:

- Use of teleconferencing and videoconferencing technologies (Telehospice, Telehomecare, Telehealth).
- Partnerships with hospitals and practitioners.
- Activities to increase public awareness and implement educational initiatives.
As a result of the study, the major recommendations (which have clear resonance for the Australian context) included:

- Leveraging partnerships to optimise local resources and build required capacity.
- Utilising case management as a strategy for systems integration to maximise community resources and access resources outside the community.
- Empowering the client and family caregivers to promote independence and provide guidance and the appropriate use of scarce resources.
- Using technology to train, provide service, support family caregivers, decrease isolation, and build healthcare teams. (Canadian Homecare Association, 2006, p. 21)

According to another study, this by Taylor et al. (Taylor, 2001, p. 3): “There must be an environment that supports and maintains best practice. This environment may be developed through credible opinion leaders practicing and promoting evidence-based practice in rural and remote areas”.

Standards for remote and isolated health care

The Aboriginal and Torres Strait Islander Health Sector Accreditation and Quality Standards Project

The Aboriginal and Torres Strait Islander Health Sector Accreditation and Quality Standards Project was a joint research initiative, conducted in Australia between the Cooperative Research Centre for Aboriginal Health (CRCAH) in Darwin, and the Office for Aboriginal and Torres Strait Islander Health (OATSIH), over the period 2006 to 2008. (Cooperative Research Centre for Aboriginal Health, 2008)

The project was conceived at a roundtable meeting convened by OATSIH in October 2006, where the issue of a sector-wide accreditation system was discussed. At that roundtable there was unanimous support for a model of accreditation that would ensure Aboriginal and Torres Strait Islander people received the best possible care available, no matter where they lived.

The main aim of this project was to provide guidance to OATSIH in the Commonwealth Department of Health and Ageing on:

1) “Accreditation standards that could be applied to the Indigenous community controlled health sector (the Sector);

2) The most feasible approach to implement accreditation against those standards;

3) The support needed throughout the Sector in order to achieve such accreditation”. (Cooperative Research Centre for Aboriginal Health, 2008, p. 3)
As identified in this project, the specific health needs of Aboriginal and Torres Strait islander peoples in relation to quality or safety of care are not addressed in mainstream quality improvement standards and accreditation processes. They also highlighted that current standards and quality review processes do not consider the capacity of services to provide culturally specific skills and knowledge to address the health and related social needs of Aboriginal and Torres Strait Islander peoples (Cooperative Research Centre for Aboriginal Health, 2008, p. 14)

**Remote Health Standards and Accreditation Program**

Building on from the Aboriginal and Torres Strait Islander Health Sector Accreditation and Quality Standards Project and the findings that, while standards existed there was a lack of relevance to the remote context, the Northern Territory Government concluded there was a need to develop a set of standards specific to the needs of the remote health context. Additionally this would also support a framework for accreditation that could be used to accredit remote health centres in the Northern Territory against the standards developed. To this end, a pilot program was developed, through extensive key stakeholder consultations, known as the Remote Health Standards and Accreditation Program. (Loudon & Frendin, 2012)

The process undertaken included establishing a partnership between the NT Government, ACHS, RACGP and AGPAL. The EQuIP and RACGP existing standards were mapped and reviewed and, in consultation with working groups, other key stakeholders, and health workers, the existing standards were then adapted or modified to meet a remote healthcare context. A gap analysis was undertaken and new standards were developed where gaps were identified.

The standards were piloted in four sites and a survey conducted to assess recommendations and make further changes as a desktop exercise. The standards were developed around the three core principles of the Australian Quality and Safety Standards (see page 7). Subsequently there were 13 Standards, 42 Criteria and 126 Measures developed. It is intended that the standards, having already being piloted in the NT, will be launched and then applied during 2013 in the Northern Territory health services (Frendin, 2013). While, a copy of the draft standards can be found at appendix 1, the full document including indicators is not available until final publication. The standards will be used in the accreditation process to be undertaken by ACHS and AGPAL.

According to Loudon and Frendin (Loudon & Frendin, 2012) the rationale behind developing the standards was that remote health is unique and therefore standards for healthcare practice need to be demonstrate recognition of the following issues:

- A population health and preventative health approach
• The role of Indigenous leaders
• Lack of infrastructure in remote communities
• Telemedicine and eHealth initiatives
• Emphasis on remote teams and leadership needs
• Expanded scope of practice (non-referral oriented care)
• Different legal, ethical and professional contexts
• The role of community development
• Self determination
• Role of traditional owners in the process
• Health services delivery related to community events and incidents
• Retrieval and evacuation processes
• Overnight care of retrieval patients when there are no in-patient facilities. (Ibid.)

Given the dearth of literature that specifically identifies healthcare standards for remote and isolated healthcare centres and providers, the above project, while initially built on work focusing on Aboriginal health services, could be seen as a sentinel body of work that could be extended across all remote and isolated healthcare services in Australia.

Accreditation of Aboriginal Controlled Community Health Services (ACCHS)

In 2007, OATSIH tasked the Quality Improvement Council (QIC) to develop an Indigenous Accreditation Framework to assist in streamlining the multiple accreditation approaches Aboriginal Medical Services were grappling with. The Framework project constructed a set of goals, as well as a plan that recognised the various standards overlap. A set of congruent procedures were developed that focused on the three main accreditation problem areas, which were identified in the research findings.

• “Goal 1: Streamline standards and accreditation procedures to ensure that workload was manageable and duplication was avoided.
• Goal 2: Ensure that the accreditation process was more responsive, especially recognising the cultural requirements of the organisations undergoing accreditation.
• Goal 3: Encourage the integration of quality improvement processes, particularly targeting the fragmented quality improvement activities between medical clinics and other parts of the ACCHS”. (Einfeld, 2009, p. 4)

The mapping process carried out by QIC included a comparative analysis of QIC standards and the standards of the Royal Australian College of General Practitioners, against a set of ACCHS functions that identified the significant overlap between standards concerned with human
resource management, health information, and physical resources. As a result, through negotiation it is possible to articulate some exemptions during the assessment process. (Einfeld, 2009)

**First Nations and Inuit Home and Community Care Standards Template Manual**

A practical example of both an approach and development of standards for remote health services comes from the First Nations and Inuit Home and Community Care Program Standards and Policies Template Manual (Lefebre, 2000). It provides suggestions for how local health services and their communities can build their own standards and policy manuals. The manuals developed are intended to be used as tools to support the development of customised standards and policies to address the specific needs of each community and its First Nations and Inuit Home and Community Care Program.

This approach is similar to that recommended in the final report of the Australian Commission on Safety and Quality in Healthcare, on Small Rural and Remote Hospital Issues with Implementing the National Safety and Quality Health Service Standards Project (Anderson, Balding, & Leggatt, 2012), in that the manuals do not reflect mandatory practice. It is intended that they be used as building blocks, or a starting point, for health services and their communities to assist them in developing tools that meet the needs of their unique situations.

The process used in this example of standards development requires congruence with professional, regulatory, legislative, and liability imperatives. Keys to the development of best practice standards were identified as leadership, partnership, consultation, appropriate resourcing, and the promotion of research. (Ibid.)

**Community Care Common Standards Guide**

The Home and Community Care (HACC) Community Care Common Standards consists of three Standards and 18 expected outcomes relating to those Standards. Each of the Standards includes a principle that encapsulates the purpose of that Standard.

**Standard 1: Effective Management:** The service provider demonstrates effective management processes based on a continuous improvement approach to service management, planning and delivery principles that summarises the intent of that Standard.

**Standard 2: Appropriate Access and Service Delivery:** Each service user (and prospective service user) has access to services and service users receive appropriate services that are planned, delivered and evaluated in partnership with themselves and/or their representative.

**Standard 3: Service User Rights and Responsibilities:** Each service user (and/or their representative) is provided with information to assist them to make service choices and has
the right (and responsibility) to be consulted and respected. Service users (and/or their representative) have access to complaints and advocacy information and processes and their privacy and confidentiality and right to independence is respected (Department of Health and Ageing, 2010, p. 2).

While the HACC Program does not cover acute care settings and only limited primary health care settings, it does provide support to a variety of circumstances likely to be seen in remote and isolated communities. Many of the services provided in these settings will be funded through the HACC program. The currently funded services include:

- Nursing care
- Allied health care
- Meals and other food services
- Domestic assistance
- Personal care
- Home modification and maintenance
- Transport
- Respite care
- Counselling, support, information and advocacy
- Assessment of service users and coordination of services.

It is reasonable to conclude that the standards used in accrediting HACC services are likely to be useful references for standards development in remote and isolated community healthcare settings.
Conclusion

Following an extensive review of the literature, in an attempt to identify health service standards for remote and isolated health services applicable to the Australian remote and isolated context, it became clear that, even globally, very little is available.

The literature search identified one project currently being undertaken that appears to be the most relevant to the project’s aim. The Remote Health Standards and Accreditation Program pilot, from the Northern Territory, is an important activity that has potential to provide a user-friendly, affordable, and relevant set of standards for the rest of the Australian remote and isolated health jurisdictions. Similarly, the existing standards for primary and community health services, which have been published and used for accreditation across other Australian geographical contexts, could be integrated into these standards to provide a national dimension to the standards that have been developed.

While it currently seems there are no formally adopted national standards for Australian remote and isolated health services, there is a body of existing work from nationally recognised accreditation programs that could legitimately and appropriately be used to develop a set of specific health service standards. This would require leadership and advocacy from the remote and isolated health sector, and the establishment and/or strengthening of meaningful partnerships with the key agencies and professional bodies already working successfully in the health sector.

There has been extensive work undertaken in many jurisdictions to define the differences between urban/regional/rural areas; however, a focus on remote and isolated communities has been more difficult to determine. The literature, in the main, continues to link rural and remote in one description, and this is the case both in Australia and overseas. It would be reasonable to assume that not recognising the important differences between rural and remote healthcare settings has resulted in the absence of an articulated set of health service standards, specifically applicable to the remote and isolated healthcare setting. Australia may well be taking the lead in this with the work previously described in this paper, which is currently being undertaken by the Northern Territory Department of Health.

The literature identified a strong focus on workforce issues in remote and isolated areas of Australia and in other similar contexts, such as in Canada and Scotland, and it is important to recognise that there is a correlation between the skills, qualifications, experiences, and professional development opportunities of those health professionals working in remote and isolated communities, and the quality of care provided. It also seems that applying best practice of clinical governance through strong leadership is an important element in the measurement of performance in the absence of specifically defined standards; however, this
leadership must extend to the advocacy for a discrete set of standards for the remote and isolated context.

It would appear from the literature that there is sufficient evidence to support what best practice in remote and isolated health services should look like – especially in the area of clinical governance. This literature review emphasises the key role that the remote and isolated workforce must play in ensuring the highest possible quality of care is delivered to the peoples of remote and isolated Australia, and that this role must be recognised and supported.

The literature supports the conclusion that the development of a set of appropriate and consistent standards is within reach and, with cooperation and effective partnership, can be realised in a timely and effective manner.
References


Australian Nursing Federation. (2010). *Submission to consultation by the Australian Commission on Safety and Quality in Healthcare on patient safety in PHC*. Canberra: ANF.


Cooperative Research Centre for Aboriginal Health. (2008). *Aboriginal and Torres Strait Islander Health Sector Quality Accreditation and Standards Project*. Darwin: Cooperative Research Centre for Aboriginal Health.


Frendin, P. (2013, January 22). General Manager Central Australian Remote Health Services Department of Health NT. (L. Livingstone, Interviewer)


