



# *A Framework for Remote and Isolated Professional Practice*

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## INTRODUCTION

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

**CRANApus** believes it is imperative to have nationally consistent standards of practice for remote health service delivery to improve health outcomes for those living and working in remote areas, and such as, has developed A Framework for Remote and isolated Practice, underpinned by safe and quality care principles.

## FRAMEWORK FOR REMOTE AND ISOLATED PROFESSIONAL PRACTICE

The framework consists of five elements which are aimed at all health professionals providing care in the community, based upon 'fly-in fly-out' (ffo), 'drive-in, drive out' (dido) mining and all other settings.

### FRAMEWORK FOR REMOTE and ISOLATED PROFESSIONAL PRACTICE

- Definition of remote and isolated areas
- Describing remote practice
- Characteristics of remote health services
- Pathway for Remote Practice for Nurses/Midwives
- Validating remote professional practice

## DEFINITION OF REMOTE AND ISOLATED AREAS

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

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

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

### Discussion

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

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

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

Areas are classified as:

- RA1 - Major Cities of Australia
- RA2 - Inner Regional Australia
- RA3 - Outer Regional Australia
- RA4 - Remote Australia
- RA5 - Very Remote Australia<sup>1</sup>

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

The use of geographical classifications in reference to remote and isolated health care is of limited value. This relatively singular interpretation of 'remoteness' fails to take into consideration other factors that impact on the access to and availability of quality health services in any given community.

**CRANAplus** believes the following factors need to be considered:

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

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<sup>1</sup> Department of Health: Doctor Connect: *Australian Standard Geographical Classification: Remoteness Area (ASGC- RA)*: Australian Government website: <http://www.doctorconnect.gov.au/internet/otd/publishing.nsf/Content/ra-intro>

## DESCRIBING REMOTE PRACTICE

### The Setting

Remote health professionals work in a variety of setting as described in **CRANApplus'** definition of Remoteness.

Remote health professionals are an integral part of the health care system in Australia. Remoteness, in and of itself, is a social determinant of health.

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

- dispersed population,
- poor health status,
- diverse cultures
- social erosion
- geographic isolation,
- problematic transport,
- poor infrastructure,
- small economic base, poverty, high unemployment
- limited political influence,
- harsh extremes of climate and
- high turnover of workforce across all disciplines
- limited opportunities for private models of health care

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

- State and Territory Government health services
- Community controlled health services
- Aboriginal Medical Services
- Primary Health Care Services / Clinics
- Multi-purpose centres
- Private general practices
- Mining and other industries
- Mobile and fly-in fly-out (fiffo) services
- Private and Non Government Organisation (NGO) health providers

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

### The Workforce

There is limited data currently available around the remote and isolated health workforce in Australia that accurately reflects the numbers, vacancy rates, characteristics and settings/facilities in which they work. In a series of papers by Lenthall, et al (2011)<sup>2</sup> the characteristics of the nursing workforce in remote has been described. The data available reflects that remote Australia has a disproportionately lower number of health professionals per head of population, in comparison to urban and rural Australia.

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<sup>2</sup> Lenthall S, Wakerman J, Opie T, Dunn S, MacLeod M, Dollard M, Rickard G, Knight S: (2011). Nursing workforce in very remote Australia: characteristics and key issues: *Australian Journal of Rural Health* 19(1): 32-37.

This mal-distribution is across all health professional groups and whilst nurses are the most evenly distributed across all geographical areas and comprises 50 % of total workforce; their numbers and those of midwives are decreasing in remote areas. Remote health workforce, work longer hours, and are older comparative to the urban workforce. The remote communities are becoming increasingly reliant on overseas trained professionals, short-term placements and fly in fly out services.<sup>3</sup>

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

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

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

## Scope of Practice

### **CRANApus** supports the following definition of Scope of Practice:

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

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

*The actual scope of an individual's practice is influenced by the*

- *context in which they practice*
- *consumers' health needs*
- *level of competence,*
- *education, qualifications and experience of the individual*
- *service provider's policy, quality and risk management framework, and*
- *organisational culture.*<sup>4</sup>

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<sup>3</sup> AIHW (2010c) *More doctors and nurses, but supply varies across regional and rural areas*. Media release October 2010. Website accessed June 2012 URL: <http://www.aihw.gov.au/media-release-detail/?id=6442464894> .

<sup>4</sup> Australian Nursing and Midwifery Council: National framework for the development of decision-making tools for nursing and midwifery practice, September 2007.

## CHARACTERISTICS OF REMOTE HEALTH SERVICES

**CRANaPlus** identifies two key principles, which are essential for a robust, safe and sustainable remote and isolated health service:

- Comprehensive primary health care model of care
- Robust remote clinical governance framework.

**CRANaPlus** supports the following definition of Primary Health Care:

*Primary health care is socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximizes community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health. Comprehensive primary health care includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation<sup>5</sup>.*

**CRANaPlus** supports the following definition of Clinical Governance:

*The systems by which the governing body, managers and clinicians share responsibility and are held accountable for patient or client care, minimizing risks to consumers, and for continuously monitoring and improving the quality of clinical care<sup>6</sup>.*

## Staffing

**CRANaPlus** supports the concept of minimum ratios of staffing in remote PHC services, taking in to consideration the population, size of the community, remoteness from other significant health services and the ill-health burden experienced by its population.

**Standard of Health Service Staff<sup>7</sup> to Population Ratios by Community Size.**

Pop range	AHW's	Nurses	Doctors
>3,000	1:350 (9)	1:500 (6)	1:1,000 (3)
1,300 – 2,999	1:250 (5 – 9)	1:450 (3-6)	1:1,000 (1.5 – 3)
800 – 1,299	1:200 (4- 6)	1:300 (2.5 – 4.5)	1:800 (1 – 1.5)
400 -799	1:100 (4- 8)	1:200 (2- 4)	1:600 (1)
250-399	1:75 (3.5 – 5.5)	1:200 (1.5 – 2)	1:400 (1)
75 - 249	1:75 (1 – 3.5)	1:150 (1 – 2)	1:400 (0.5)
<75	1:50 (1.25)	1:150 (1)	1:400 (0.5)

(Numbers in brackets estimated number)

Table 1

<sup>5</sup> Australian Primary Health Care Research Institute (APHCRI)

<sup>6</sup> Australian Council on Healthcare Standards, (2004) ACHS News Vol. 12 1-2 Sydney.

<sup>7</sup> Bartlett B.,Duncan P : Top End Aboriginal Health Planning Study: *Report to the Top End Regional Indigenous Health Planning Committee of the Northern Territory Aboriginal Health Forum.* April 2000, PLANHEALTH Pty Ltd, NSW.

Table 1: Standard of Health Service Staff to Population Ratios by Community Size (p7), uses the basic staff to population ratios of AHW 1:50, Nurses 1:200 & Doctors 1:400 and modifies according to size of communities, whereby in larger communities, economies of scale and access to other human services (health & otherwise) means that fewer numbers can be effective as opposed to the smaller communities with smaller population numbers

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

### Remoteness and Isolated Practice within a Health Context<sup>8</sup>

The definition below provides a succinct summary of the characteristics, different settings and models of care, differentiating remote workforce practice from rural and urban workforce practices.

Remote Health practice in Australia is characterised by geographical, professional, and often social **isolation** of practitioners through:

- geography and terrain, limiting access and egress
- cultural and social isolation
- environmental and weather conditions resulting in isolation
- isolation due to long distances
- professional isolation from colleagues, peers, and supports
- isolation as a result of infrastructure, communications and resources.

Remote Health is carried out in **contextually different settings**, including but not limited to: government health services; community controlled health services; aboriginal medical services; primary health care centres; multi-purpose centres; private general practices; mining; and other industries like tourism; mobile and fly-in/fly-out services; as well as private, and non-government organisation health services.

Remote Health practice is **delivered through**:

- health service models catering for highly mobile populations
- predominantly Nurse-led models of care
- collaborative multidisciplinary approaches, in partnership with community and stakeholders
- an understanding of the community within its cultural context
- overlapping, and evolving advanced and extended roles of team members
- integrated comprehensive primary health care approach, inclusive of acute and emergency care, chronic disease and public health across the life span
- scopes of practice that are informed by the identified needs of, and engagement with the community.

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<sup>8</sup> CRANaplus 2013: Adapted from Wakerman J: Defining Remote Health: Australian Journal of Rural Health, 210–214: (2004) and Malone G, Cliffe C: Framework for Remote Practice: CRANaplus (2012, Jan 4) This definition is the work undertaken by the National Standards Advisory Group (2013).



## PATHWAY TO REMOTE PRACTICE FOR NURSES/MIDWIVES

**CRANApus** believes that Nurses and Midwives who work in remote and isolated practice need a generalist approach using a broad scope of practice, to address the diverse needs of their entire community.

A Remote Area Nurse/Midwife is defined as *a registered nurse whose day-to-day scope of practice encompasses broad aspects of Primary Health Care and requires a generalist approach. This practice most often occurs in an isolated or geographically remote location. The RAN/M is responsible, in collaboration with others, for the continuous, coordinated and comprehensive health care for individuals and their community*<sup>9</sup>.

Remote area Nurses and Midwives have varying career backgrounds. There are some professional pathways that will prepare individuals for working in remote, isolated and resource poor environments, such as:

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

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

Each remote health role will differ, depending on the unique needs of each community. Specific roles and extended scope of practice may require preparation in:

- Maternal and Child Health
- Mental Health
- Women's and Men's health
- Community Capacity Building / Health promotion
- Chronic disease management
- Emergency care
- Workplace Health & Safety

To maintain competence in the workplace requires nurses/midwives to embrace the concept of 'life long learning' to gain the necessary knowledge, skills, attitudes and behaviors to meet their obligation to provide ethical, effective, safe and competent practice.<sup>10</sup>

*Continuing professional development (CPD) is the means by which members of the profession maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives.*<sup>11</sup>

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<sup>9</sup> CRANApus 2013: Adapted from Sabina Knights definition of Remote Area Nurse (1993). This definition was the work undertaken by the CRANApus Credentialing Pilot Project Advisory Group (2012-13).

<sup>10</sup> Nursing and Midwifery Board of Australia: Frequently Asked Questions: *Continuing professional development for nurses and midwives*: Updated May 2014: accessed 4 July 2014

website: <http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ/CPD-FAQ-for-nurses-and-midwives.aspx>

<sup>11</sup> Nursing and Midwifery Board: Continuing Professional Development: Registration Standard (2010) (p1): Accessed 8 July 2014

website: <http://www.nursingmidwiferyboard.gov.au/Registration-Standards.aspx>

CPD activities may be informal and formal, broad and varied to maintain competence in the workplace. Possible examples may include, but not limited to:

- Post graduate Education
- Short courses
- Conferences
- Webinars
- Forums
- journal club
- mandatory workplace activities – cardio pulmonary resuscitation, fire training

Continuing professional development activities must have relevance to the individual' scope of practice with clear aims and objectives that meet the individual's self assessed requirements. <sup>12</sup>

Minimum CPD required for annual renew of registration by NMBA<sup>13</sup>

Type of Registration	Minimum Hours	Total Hours
Registered nurse or Enrolled nurse	20 hours	20 hours
Midwife	20 hours	20 hours
Registration as a registered nurse and midwife	Registered nurse – 20 hours Midwife – 20 hours	40 hours
Registration as an enrolled nurse and midwife	Enrolled nurse – 20 hours Midwife – 20 hours	40 hours
Nurse practitioner (Registered nurse with endorsement)	Registered nurse – 20 hours Nurse practitioner endorsement – 10 hours relating to prescribing and administration of medicines, diagnostics investigations, consultation and referral	30 hours
Midwife practitioner (Midwife with endorsement)	Midwife – 20 hours Endorsement – 10 hours relating to prescribing and administration of medicines, diagnostics investigations, consultation and referral	30 hours
Registered nurse with scheduled medicines endorsement (rural and remote)	Registered nurse – 20 hours Scheduled medicines -10 hours	30 hours
Eligible midwife (Midwife with notation)	Midwife – 20 hours Notation – 20 hours relevant to the context of practice and across the continuum of midwifery care	40 hours
Endorsed eligible midwife (scheduled medicines) (Eligible midwife with endorsement)	Midwife - 20 hours Endorsement –20 hours (e.g.10 hours relating to continuum of midwifery care and 10 hours relating to prescribing and administration of medicines, diagnostics investigations, consultation and referral).	40 hours
Registration as a nurse and endorsed eligible midwife	Registered nurse – 20 hours/Enrolled nurse – 20 hours Midwife – 20 hours Eligible midwife with a scheduled medicines endorsement – an additional 20 hours (e.g.10 hours relating to continuum of midwifery care and 10 hours relating to prescribing and administration of medicines, diagnostics investigations, consultation and referral).	40 hours

<sup>12</sup> Nursing and Midwifery Board of Australia: Frequently Asked Questions: *Continuing professional development for nurses and midwives*: Updated May 2014: accessed 4 July 2014

website: <http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/FAQ/CPD-FAQ-for-nurses-and-midwives.aspx>

<sup>13</sup> Ibid p3.

## Topics relevant to remote and isolated practice

The Topics relevant to remote practice may include, but not limited to:

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

Postgraduate education or qualifications are beneficial for remote and isolated practice. Courses, which are more relevant to the remote context include:

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

**CRANApus** recommends all nurses and midwives working in remote and isolated health services, be provided the opportunity to undertake a comprehensive introductory and orientation program(s).

**\*\*Recommended courses that can be undertaken pre- employment or within the first year:**

- Remote Emergency Care (REC) or equivalent\*\*
- Advanced Life Support (ALS) \*\*
- Pharmacotherapeutics for RAN/M's\*\*
- Non Midwives: Maternal emergency care (MEC) or equivalent\*\*
- Midwives: Midwifery up skilling (MIDUS) or equivalent\*\*
- Immunisation\*\*
- Driver education courses 4x4\*\*
- Cultural education\*\*
- Annual Core Mandatory competencies – through eRemote or equivalent
  - Fire & Evacuation
  - Manual Handling
  - Drug Calculation
  - Basic Life support

The frequency of re-certification will be dependent upon health service requirements, personal CPD needs and professional recommendations.

It is important to note:

- ALS generally needs to be updated / re-certified every year, this is dependent upon the provider's recommendations.
- Emergency courses i.e. REC and MEC to be undertaken with a maximum interval of 2 years, to maintain competence.
- Jurisdictional or employer specific requirements, such as:
  - Queensland Health, Remote and Isolated Practice Registered Nurse (RIPRN) Course
  - Northern Territory, Department of Health, prerequisites for Remote Health nursing/midwifery employment.

## VALIDATING REMOTE PROFESSIONAL PRACTICE

**CRANApus** undertook a Credentialing Pilot Project for Nurses/Midwives (2012-2013) with the intent of informing the implementation of a sustainable CRANApus Credentialing program. Whilst the project was relatively small in numbers and did not eventuate in the adoption of a formal credentialing program, there were several positive outcomes arising from this project. Specifically, the development of the Professional Standards of Remote Practice: Nursing and Midwifery.

The purpose of credentialing is to assure professionals and the public that the individual nurse has achieved agreed levels of practice and experience, has recency of practice in the specialty/area of nursing practice, and has met agreed levels of education and continuing professional development requirements<sup>14</sup>.

### Overall Outcomes of the Credentialing Pilot Program (2012-2013)

- The development of a professional initiative that will become CRANApus policy on remote area workforce development and quality health care for the remote community.
- Confirmation of the professional standards for remote practice.
- The development of tools to support a future program
- A central and consistent source of communication about the credentialing program, as well as support for participants.
- The development of policy and processes associated with the program.

### Move from Credentialing to Validating Program

Whilst not pursuing a 'formal credentialing program', we believe it is important to pursue a process for recognition of individual registered nurse/midwife who meets the Professionals Standards of Remote Practice that **validates** their status as an Advanced Practice RAN/Ms.

**CRANApus** believes the benefits of validating include:

- **The setting of clear nationally consistent standards for remote health practice, to promote safety and quality in practice.**
- **The provision of a workforce benchmark for Governments, employers, and education providers**
- **Clarity around the career pathway for RAN/M's**
- **Recognition by the profession and health industry as specialist area of nursing**
- **Recognition of Advanced Practice RAN/Ms by their colleagues and the profession as clinical leaders of remote and isolated nursing/midwifery practice**

A peer review process, coordinated by CRANApus, will be undertaken for the assessment of a registered nurse/midwife professional portfolio, inclusive of the nine 'Professional Standards of Remote Practice'. The nine Professional Standards each with set criteria necessitates the individual to show demonstrated evidence as to how they have met the criteria requirements.

This process is voluntary for the individual. An individual registered nurse/midwife may choose or be nominated to undertake the assessment against the Professional Standards. For the recognition and acknowledgement of their practice and validation of their status of Advance Practice Remote Area Nurse. CRANApus will invite the individual to be a Fellow of CRANApus.

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<sup>14</sup> Coalition of National Nursing Organizations, Project to Develop a National Nurse Credentialing Framework, (May 2011): Accessed 7 July 2014: website:

[http://www.conno.org.au/images/stories/PDF/Meetings/Aug11/conno\\_credentiaing\\_framework\\_final.pdf](http://www.conno.org.au/images/stories/PDF/Meetings/Aug11/conno_credentiaing_framework_final.pdf)

CRANApus has an Application Package, which sets out the requirements to meet the criteria of the Professional Standards. A volunteer peer review panel consists of remote nursing/midwifery professional experts will assess the evidence provided.

### Professional Standards of Remote Practice

In 2013 the 'Professional Standards of Remote Practice: Nursing and Midwifery' was endorsed by **CRANApus** as a National Standard. The Professional Standards were then, revised by the Pathway to Remote Practice Advisory Group (June 2014) to reflect contemporaneous remote and isolated nursing/ midwifery practices.

#### **Standard 1**

Has appropriate registration and endorsements for practice and works in accordance with the Professional Standards for the Nurse/Midwife (NMBA).

#### **Standard 2**

Maintains own health, wellbeing and resilience within a professional, safe working environment.

#### **Standard 3**

Practices within a culturally respectful framework

#### **Standard 4**

Practices within a Comprehensive Primary Health Care model of service delivery

#### **Standard 5**

Works within care pathways, and develops networks of collaborative practice.

#### **Standard 6**

Has a level of clinical knowledge and skills to safely undertake the role.

#### **Standard 7**

Has a period of recent clinical practice in a remote and isolated location within the past 5 years.

#### **Standard 8**

Has an ongoing commitment to education relevant to practice in the remote environment.

#### **Standard 9**

Practices within a Safety and Quality Framework.

The professional standards are available on CRANApus website:

<https://crana.org.au/advocacy/professional-issues/professional-standards-of-remote-practice-nursing-and-midwifery/>

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Revised V4	August 2014	Whole document