

The Role And Function Of The Rural Nurse In Australia

Desley Hegney

Alan Pearson

Alexandra McCarthy

Published by Royal College of Nursing, Australia

First published 1997

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Cataloguing-in-publication data

ISBN — 086396589 -X



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This study was supported by a Commonwealth Department of Health and Family Services, Rural Health Support, Education and Training Grant (Grant No 245 - The Role and Function of the Rural Nurse and Grant No.341 - A National Investigation and Support Project for Australian Rural Nurses).

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Acknowledgments

The authors wish to acknowledge the invaluable assistance of a number of organisations and people without whom this study would not have been completed:

- Participating Health Services and Registered Nurses
- The registered nurses and health services (both Government and non- Government) who supported and participated in Phases One and Two of the study. For ethical reasons, the names of the nurses and health services who participated in Stage Two of the study cannot be publicly acknowledged

The Management Committee of the Grant:

- Ms M Gendek - The Australian Nursing Council
- Mr Ian Blue - The Association for Australian Rural Nurses
- Ms Joanne Hope - Australian Nursing Federation (1994-1995)
- Ms Anne-Marie Scully - Australian Nursing Federation (1996-1997)

State Government Bodies

Particular thanks are due to Ms Melissa Vernon from the Western Australian Health Rural Policy Section for her assistance with national 'phone-in notification of the nurses in Phase One of the study.

Data Analysis

Dr Paul Bramston, Lecturer, University of Southern Queensland who provided assistance with the design of the SPSSX database and data analysis in Phase Two of the study.

Word Processing, Typesetting and Proofing

Ms Judy Simpson, University of New England, Clinical School of Nursing, Tamworth; Ms Jodi Loxton from the Joanna Briggs Institute for Evidence Based Nursing, Adelaide; Mr Brent Hodgkinson from the Joanna Briggs Institute For Evidence Based Nursing, Adelaide; and Ms Ysanne Chapman of the Department of Clinical Nursing, The University of Adelaide. The authors also wish to acknowledge the assistance of the staff of the University of Southern Queensland for their support.

Project Funding

This study was funded by the Rural Health Education, Support and Training (RHSET) project grants. Funding was provided to Grant No. 245. (The Role and Function of the Rural Nurse) and Grant No. 341 (A National Investigation and Support Project for Australian Rural Nurses). Particular thanks is given to the advice and support of Mr Des Murray, formally from RHSET, and the Association for Australian Rural Nurses.

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Executive Summary

This national study aimed to:

1. identify the role and function of the rural nurse in a hospital setting in Australia;
2. collect data to provide a base-line for the development of competencies for rural registered nurses in different size health service locations; and
3. identify areas of priority for continuing and award education and training for rural nurses in different practice settings.

In phase one of the study, 72 rural nurses were interviewed individually or in small focus groups and 29 were interviewed on the telephone, in response to a national, toll-free 'phone-in' organised over two days in December, 1994. Data from these interviews were analysed to elicit the views on rural nursing. In the second phase of the study, a stratified, random sample of 129 rural health care facilities which offered acute care surveys participated in a one-day census on July 31st, 1996. On this designated census day, a series of questionnaires were administered and the work of the nurses in each facility was observed. Facilities from all States were involved in the study, with the exception of the Northern Territory and the Australian Capital Territory.

The study generated extensive data on the nature and current characteristics of rural nursing in Australia. A range of variables which impact upon the job satisfaction of rural nurses and therefore retention of the rural nursing workforce were isolated and differences between nurses working in different size health care settings were identified. Overall, the job satisfaction of rural nurses was high, but the complexity of rural nursing and the variability in roles across facilities were both unexpected.

The results suggest that the rural nurse in Australia offers an extremely comprehensive range of health services to rural people. This pivotal role in health care is found to be undervalued by other health professionals and managers, and not well understood by rural people. Rural nurses express a need for better preparation to perform in these diverse roles.

An extensive literature review, and the findings of the study, highlight a high level of ambiguity surrounding the role and function of the rural nurse and a number of inconsistencies between the metropolitan-oriented, dominant perceptions of what constitutes everyday nursing practice and the realities of rural nursing. The findings of the study give rise to the following recommendations:

Recommendations

The Role Of The Rural Nurse In Australia

The role of the registered nurse in rural Australia is complex and requires expertise in a wide range of sophisticated health care activities. The majority of these nurses provide nursing care in the absence of on-site medical and allied health support staff. Rural nurses are central to the delivery of health care in rural areas but the centrality of their role is largely invisible. It is therefore recommended:

Recommendation One

That Federal, State and Territory Health Departments accept this report and implement the recommendations by establishing a national taskforce to advise governments on:

- *the preparation of nurses for rural practice*
- *the skill levels and mix of nurses required for rural practice (beginner, advanced, registered, enrolled)*
- *the type and content of education and training programs*

It is further recommended that this taskforce make recommendations to State and Territory governments on the implementation of changes to legislation and industrial awards to reflect contemporary rural nursing practice.

Membership of the taskforce will be drawn from professional and industrial nursing bodies (Australian Nursing Federation, Royal College of Nursing, Australia, The Association for Australian Rural Nurses Inc); nurse advisers employed by State Departments of Health; The Commonwealth Office of Rural Health; Rural Health Policy Units of State and Territory Departments of Health; and relevant medical organisations such as the Australian College of Rural and Remote Medicine (ACRRM). The RHSET program is the recommended funding source with the Commonwealth providing oversight of the progress of activities.

Recommendation Two

That the Australian Nursing Federation form a working party to review the career structure for rural nurses. The working party will comprise of representatives from rural nursing organisations (the AARN); other professional nursing organisations and Colleges; Nurse Advisers employed by State Departments of Health; and universities and other education and training providers (eg. RHTUs). The RHSET program is the recommended funding source with the Commonwealth Office of Rural Health providing oversight of the progress of activities.

Recommendation Three

That the Commonwealth Office of Rural Health establish a working party under the auspices of the National Rural Health Alliance to develop a CD-ROM or on-line resource, based on WWW technology, which rural nurses can access in emergency and non-emergency situations. Membership of this working party will comprise representatives from the Association for Australian Rural Nurses; education and training institutions (professional nursing colleges, Rural Health Training Units, universities, TAFE); the Rural Health Policy Forum; Nurse Advisers employed by the Department of Health; and the ANF. The development of this material will be funded by the RHSET program with the National Rural Health Alliance responsible for progress to the Commonwealth Office of Rural Health.

It is further recommended that State and Territory Health Departments accept responsibility for the placement of the material on-line and for on-going maintenance

Recruitment And Retention Of Rural Nurses

Rural health services are highly dependent on registered nurses to function effectively. Although strategies to recruit and retain medical practitioners have been developed, little attention is paid to recruiting and retaining well qualified and experienced rural registered nurses. It is therefore recommended:

Recommendation Four

That State and Territory Departments of Health implement strategies, as a priority, to recruit and retain university prepared nurses into rural health services with less than 50 acute beds and that strategies include the use of the funding currently allocated to Graduate Transition to Work programs.

Recommendation Five

That all nurses employed for locum relief in rural areas have undergone an accredited advanced nursing practice program to prepare them for rural nursing practice. Funding for such training is to be made available from State and Territory Health Departments Casemix budget allocations for education and training.

It is further recommended that State and Territory Health Departments contract the development and delivery of such programs to providers such as the Rural Health Training Units. The development of such programs could be funded by the Commonwealth's RHSET program.

Recommendation Six

That each State and Territory Department of Health establish rural nursing locum relief banks for use in Government and non-Government rural and remote health services from which services can purchase suitably educated nursing relievers. Locum relief banks, once established, will be self-funding.

Recommendation Seven

That Federal, State and Territory Departments of Health establish a working party under the auspices of the Royal College of Nursing, Australia for the development of a national marketing strategy which promotes rural nursing as a professional career with high job satisfaction. Membership of the working party will include professional and industrial nursing associations (ANF, RCNA, NSW College of Nursing, AARN, CRANA); representatives from the higher education sector (especially regional universities); representatives from the Rural Health Training Units; and representatives from the Federal, State and Territory Departments of Health. Funding for the working party would be allocated from the RHSET program, with the Commonwealth Office of Rural Health responsible for the progress of the working party.

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Recommendation Eight

That State and Territory Health Departments ensure that line managers, at the local level, have undergone management training which enables them to implement strategies to deal effectively with change. In particular, the implementation of the principles of primary health care will improve interdisciplinary and community involvement and cooperation.

Recommendation Nine

That Government and non-Government Health Authorities acknowledge the importance of relationships between nurses and other health professionals in rural areas and the impact of role conflict on recruitment and retention of nurses by formalising and legitimising existing roles of nurses. Local health managers must introduce strategies to overcome interdisciplinary tensions over role boundaries.

It is further recommended that the implementation of a Primary Health Care Model of service delivery be prioritised in small rural health services to improve interdisciplinary relationships.

Education, Training And Support For Rural Nurses

Rural registered nurses require advanced education and strong support if the health status of rural Australians is to be maintained. This education and training should begin at the undergraduate pre-registration level and continue throughout the nursing career.

It is therefore recommended:

Recommendation Ten - Undergraduate Education and Training

That the Commonwealth, through the Minister for Health and the Minister for Employment, Education, Training and Youth Affairs:

(a) have all higher education institutions involved in nursing education quarantine a minimum of ten percent of places in pre-registration nursing courses for students with a rural background; and

(b) direct regional universities to give priority of entry into undergraduate pre-registration courses to local students. This could be achieved by the quarantining of a specified number of places. The number of places will be based on the information provided by State and Territory Health Departments on projected workforce requirements.

Recommendation Eleven

That State and Territory Governments adjust Casemix formulae for education and training to reflect the increased costs of accessing education and training for rural nurses. Health services eligible for the adjusted funding rates will be a minimum of two hours drive from a provincial, regional or metropolitan university, Rural Health Training Unit or other education and training provider.

Recommendation Twelve

That all education and training providers of rural nursing programs respond to the identified barriers to education and training within this report and provide programs that are flexible and meet the needs of individual rural nurses rather than those of the education and training institutions.

Recommendation Thirteen

That all Government and non-Government Health Authorities make available, in consultation with rural nurses, adequate child minding facilities to allow nurses better access to education and training programs. These facilities can be available at the nurse's employment venue as well as at the education and training provider venue. As health is the responsibility of the community as well as the Government, local health services could consider a joint project with the community for the provision of these services.

Recommendation Fourteen

That all health authorities provide rural nurses with on-going access to advanced nursing practice courses. These courses will include education and training in advanced nursing skills. Funding for the development of these courses will be provided by the Commonwealth's RHSET Grants. In recognition of the identified existing barriers in accessing education and training programs, State and Territory Health Departments will endorse the recommendations made regarding access to overcome these barriers. The program, therefore will be provided using various methods of delivery (on and off-site) and include education and training in the following areas:

- *accident and emergency first-line emergency care, acute assessment skills and triage*
- *midwifery*
- *paediatrics*
- *coronary care*
- *intensive care*
- *general medical/surgical and perioperative knowledge and skills*

It is further recommended that the Advanced Nursing Working Party currently established by the Commonwealth Office of Rural Health, make recommendations on the structure and implementation of such courses for rural nurses.

Recommendation Fifteen

That all Government and non-Government health authorities include in Enterprise Agreements the right for all rural registered nurses to a set number of paid study days per year. The number of days will be negotiated between nursing industrial bodies (ANF, QNU, NSW Nurses' Association) and employers.

Recommendation Sixteen

That all Government and non-Government health authorities use as a measure of the outcomes of the health service the annual performance of managers in relation to the extent to which nurses have accessed education and training programs.

Recommendation Seventeen

That all education and training providers (professional nursing colleges, universities, TAFE, RHTUs) state clearly and publicise information concerning the availability of courses, entry requirements, selection criteria, cost of courses and the means of application. To increase rural nurses' awareness it is recommended that education and training providers utilise regional newspapers and newsletters such as the Queensland Nursing Council's Forum.

Recommendation Eighteen

That all registered nurses undergo an orientation program to rural practice prior to commencing work in rural health services. The orientation program will be of a duration sufficient for nurses to up-grade to the knowledge and skills necessary for the beginning advanced practice role. The program will include advanced nursing skills (cannulation, suturing, taking of X-Rays and so on; cultural orientation; and an understanding of the diversity of rural communities). The program, designed to be offered by a variety of education and training providers (RHTUs, universities, professional nursing colleges) will articulate into an accredited advanced nursing course.

It is further recommended that this orientation course be developed by a working party established under the auspices of the Commonwealth Office of Rural Health. Membership of the working party will include nurses representing universities; representatives of the nursing advisers from the State Department of Health; and the Rural Health Training Units.

Recommendation Nineteen

That the Commonwealth, through the Minister for Health and the Minister for Employment, Education, Training and Youth Affairs establish a working party under the auspices of the Commonwealth Office for Rural Health to develop an accredited preceptor program for registered nurses currently employed in practice. The program would incorporate adult learning principles; clinical teaching skills; and the role of the preceptor in student learning.

Membership of the working party will be drawn from professional nursing bodies (the Colleges, AARN, CRANA); nurse advisers from the State Departments of Health; the universities and TAFE; and Rural Health Training Units.

Recommendation Twenty
That education and training providers recognise the difference in training needs brought about by the impact of hospital size and rurality when developing and delivering programs to nurses in rural areas. It is further recommended that these programs be flexible to meet the individual needs of rural nurses.

1. Introduction

Introduction To The Study

In common with a number of other countries, the development of health care in rural Australia has relied heavily on the work of nurses. In the late nineteenth century, and the first half of this century, nurses have provided extensive health care services without any readily available access to medical or allied health personnel, other than via radio or other forms of telecommunication. For the most part, these services provided by nurses were highly regarded by rural people and the health status of these people, whilst still lower than those of people living in metropolitan areas of Australia, has steadily increased.

The exponential growth in medical science; the increasing sophistication of health service consumers' knowledge; and the proliferation of medical specialists in the latter half of this century have all contributed to the desire of rural people to have access to medical practitioners and health specialists, and to the increasing ambiguity surrounding the legitimate role of the rural nurse.

This study, funded by the Rural Health Support, Education and Training program of the Commonwealth Department of Health and Family Services, was designed to explore and examine the current state of nursing in rural Australia and to contribute to the contemporary debate of rural health through clarifying the role of the rural nurse in Australia in the 1990s.

Study Aims And Objectives

The broad aim of the study was to define the role and function of the rural registered nurse in the practice setting by examining the function of 'generalist' rural nurses in hospital and community settings.

Objectives

The objectives of the revised study were to:

- identify the role and function of the nursing practitioner in rural Australia
- identify both common elements of, and differences in, the role of the rural nurse
- identify, from the data collected on nursing practice, areas of priority for support, education and training for rural nurses in different practice settings

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- contribute to contemporary debate on maintaining health, and achieving health gain, for rural Australians

Study Design And Methods

The study used a wide range of approaches to generate both qualitative and quantitative data. Similarly, data analysis was both quantitative and qualitative in nature. The study design incorporated two phases:

Phase 1: An Exploratory Survey Of Rural Nurses

Phase 2: A National Census Of Rural Health Care Agencies

Phase 1: An Exploratory Survey Of Rural Nurses

In Phase One data were collected through face-to-face interviews and focus groups held in rural locations throughout Australia and from responses to a national 'phone-in for rural nurses. This survey approach was considered to be the most appropriate method of documenting the beliefs held by rural nurses about rural nursing practice, and was originally planned to serve as a precursor to the development of a survey instrument to be used in a major postal survey. This postal survey of a random sample of 4000 rural nurses was to have been Phase Two of the Study.

Selection Of The Respondents

Face-To-Face Interviews And Focus Groups

Thirty registered nurses who worked in rural settings in all Australian States were interviewed face-to-face. Additionally, a total of 42 registered nurses participated in the thirteen focus groups held either in their own health service or at the 3rd Annual Conference of the Association for Australian Rural Nurses at Roseworthy, South Australia, making a total of 72 participants in this phase of the study. None of the participants were from the Northern Territory as over 98% of its area is classified as remote. Additionally, none of the participants were from the Australian Capital Territory (ACT) as this area is largely urban. The classification of nurses who participated in the study is listed in Table 1.1. While it is recognised that nursing awards vary from State to State, for ease of analysis the Queensland Registered Nurse Award has been used in this study. A Level One Registered Nurse is a Registered Nurse; Level Two is a Clinical Nurse recognised for their specialist role and working in an advanced clinical position; Level Three is a Nurse In-Charge of a ward with an expert consultative role; and Level Four is an Assistant Director of Nursing either clinical, management, research or education. Level Five is a Director of Nursing or Hospital Manager.

**Table 1.1 Classification Of Nurses Participating In The Interview
And Focus Group Component Of The Study**

Employment	One To One Interviews	Focus Groups
Community health nurses / district nurses	10	5
Level one registered nurse	9	20
Level two registered nurse	0	4
Level three registered nurse	7	7
Level four registered nurse	2	1
Level five registered nurse	2	5
Total	30	42

The areas selected aimed to capture the diversity of rural nursing practice. The respondents worked in:

- nursing posts
- small rural hospitals where there was at least one medical officer in the town
- district hospitals where there was more than one medical officer in the town but no resident medical officer employed in the hospital
- base hospitals which employed resident medical officers as well as a number of specialists
- community nurses whose role was primarily health education and promotion
- district and community nursing centres which provided a treatment and preventative nursing service to both large and small rural communities

In recognition of the difference of rural communities, the towns were selected to reflect the cultural and economic diversity of rural Australia. Examples of the economic base of the rural locations in this component of the study were:

- agriculture
- fishing
- university
- tourism

In addition, two of the towns had a substantial indigenous population. With the exception of Western Australia and southern Victoria, all of the rural towns visited were experiencing a long and protracted drought. The towns participating in this component of the study are listed in Table 1.2.

Table 1.2 The Places Of Interview And Focus Groups (Phase One)

Town	RaRA Classification
Ararat, Victoria	Rural Other
Barraba, New South Wales	Rural Other
Bruny Island, Tasmania	Rural Other
Camperdown, Victoria	Rural Other
Dalby, Queensland	Rural Major
Forbes, New South Wales	Rural Other
Hamilton, Victoria	Rural Major
Kalbarri, Western Australia	Rural Other
Launceston, Tasmania	Capital City (but the nurse worked in rural areas around Launceston)
Lismore, New South Wales	Rural Major
Miles, Queensland	Rural Other
Moora, Western Australia	Rural Other
Moree, New South Wales	Rural Other
Port Pirie, South Australia	Rural Other
Quirindi, New South Wales	Rural Other
Taroom, Queensland	Rural Other
Tamworth, New South Wales	Rural Major
Warrnambool, Victoria	Rural Major
Warwick, Queensland	Rural Major

Selection Of Participants

In 1994, contact was made with the Directors of Nursing of four rural hospitals in South-Eastern Queensland (two Rural Other, two Rural Major); four rural hospitals in Western Victoria (two Rural Other, two Rural Major); staff employed in two base hospitals in New South Wales (both Rural Major); staff employed in one district hospital of New South Wales (Rural Other); the Director of Nursing in a rural hospital in New South Wales (Rural Other); and two nurses who worked in community health services

in New South Wales (one Rural Major, one Rural Other). A colleague in Western Australia approached one nurse who was employed in a nursing post and another who worked in a community health centre. In addition, three nurses at the 3rd Annual Conference of the Association for Australian Rural Nurses, who were from South Australia (Rural Major), New South Wales (Rural Other) and western Queensland (Rural Other) were asked to participate in the study.

Interviews Arranged By The Director Of Nursing At Hospitals

Health services selected for workplace interviews were contacted by phone to ascertain their willingness to participate. Only one hospital (in Victoria) declined. The majority of the Directors of Nursing stated they were pleased that 'someone was taking an interest in rural nursing' and were therefore willing to arrange the interviews. They were asked to provide for interviews with a range of nurses with varying levels of experience, length of service, qualifications and attitudes. In addition, a request was made that they include not only nurses who were considered to be 'good role models', but some who were not. Most of the Directors of Nursing did provide nurses with a range of experience - from a nurse who had re-entered the workforce in 1994, to others who had over 20 years nursing experience. It appears that all the nurses interviewed were those whom the Director of Nursing had chosen to speak on behalf of the hospital, that is, those with a good image.

While the majority of the hospitals endeavored to ensure that the nurse being interviewed was doing so in work time, the staffing restrictions (and in small rural hospitals the small number of staff) did not allow some nurses to participate in work time. The extended role of the nurse and the lack of specialist staff in rural areas was highlighted when, in two instances, the participant was required to deliver care to a patient during the interview. The interviews were completed after the crisis.

The participants were at first concerned and suspicious of why academic researchers would be interested in their practice. Issues of confidentiality were raised by the majority of the nurses and, in one case, the tape recorder had to be turned off several times at the participant's request.

While the nurses did vary in their experience, skills and knowledge, the health services varied as well. Some health services were growing (especially base hospitals) whilst others had been downgraded. In addition, the range of services available varied from specialist referral centres to a Nursing Post.

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Interviewees Chosen By The Researchers

While the respondents were chosen by the Directors of Nursing in 12 of the towns visited, four nurses from three towns in New South Wales were personally contacted. The selection of respondents (including those interviewed at the AARN conference) was influenced by the need to ensure that the workplace statements reflected the diversity of rural settlements and health services in Australia.

The respondents were asked questions (see Table 1.3.) which would provide information about their practice in a rural health service. The questions were asked in an order to suit each individual. The open-ended interview method was chosen as it was considered the best way of obtaining the meanings, understanding and interpretation of the subject under study (Denzin 1989).

Table 1.3 Questions Asked Of Respondents

1. What does the word 'rural nursing' mean to you?
2. How do you feel about working in a rural area?
3. What are the advantages and disadvantages of your role?
4. What are your relationships like with the medical officer/s? How many are in the town? Do you have specialist or visiting specialist services?
5. What strategies do you use when dealing with local medical officers?
6. What are your relationships like with allied health workers?
7. What strategies do you use when dealing with them?
8. What do you think are the legal aspects of your role? What areas concern you and why?
9. How do you maintain your skills? Who teaches you?
10. How do you access education (in service, continuing, award)? What are the barriers to this access?
11. How can education barriers be overcome?
12. How do you feel about your extended practice role? What areas could be improved and why?
13. Is anonymity an issue in your nursing practice? How does knowing people and being known impact on your practice?
14. Do you feel safe in this environment? If not, what areas concern you and why?
15. Are there any other points that you feel are important that we have not talked about as yet that you would like to discuss?

National 'Phone-In

In addition to the interviews and focus groups, a free call national telephone number was established for the 17th and 18th December, 1994. Twenty nine calls were made to the toll free number in response to announcements in the rural journals and a mail out to rural health agencies.

Data Analysis

Audio-tapes of the interviews, focus groups and nurses' comments from the national 'phone-in were transcribed verbatim and the transcripts were entered to facilitate data management using the software program 'NUD*IST'. The text was then categorised according to emerging themes. Due to data collection methods and the small number of respondents, quantitative data from the national 'phone-in were not analysed.

Ethical Considerations

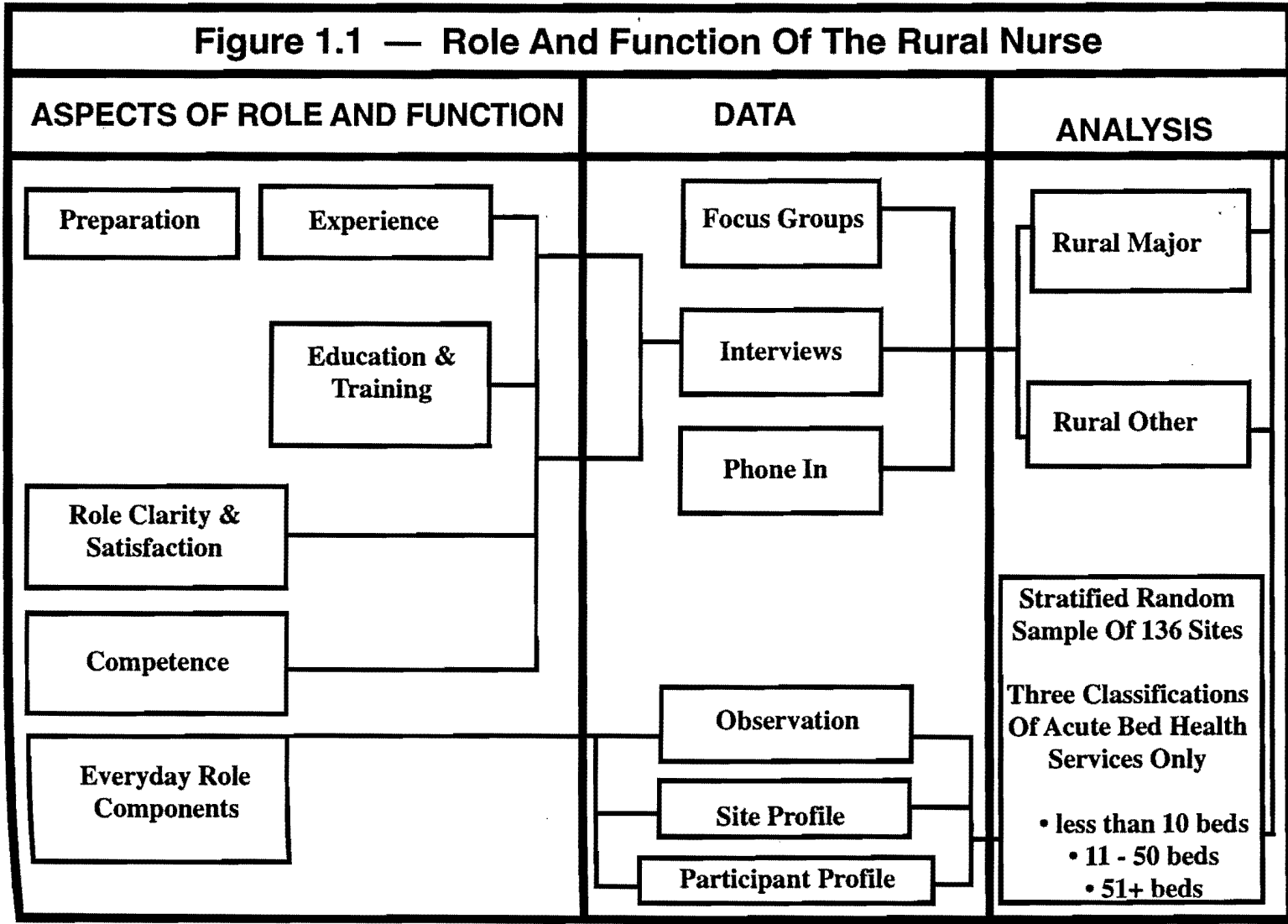
This phase of the study was approved by the University of New England's Pro Vice Chancellor's (Research) Advisory Committee on Ethics in Experimentation on Human Participants on the 29th May, 1994. All participants in the interviews and focus groups signed a plain language consent form, a copy of which was retained to allow participants to contact the researchers should they wish to withdraw from the study. Participants in the 'phone-in gave verbal consent to their participation after a full explanation of the study was given. The original consent forms are kept with the tapes, transcriptions of the tapes and 'phone-in forms in a locked filing cabinet. They will be retained for a five year period and then destroyed.

Achieving Authenticity

In all interpretive and critical research there is a need to strive for authenticity and validity. However, these approaches do not attempt to reach generalisable conclusions which can be applied to the total rural nursing population in Australia. Further, while care was taken to avoid leading questions in the interviews, the interview approach in itself is not intended to capture *all* of the views of rural nurses within the workforce. Every effort has been made to include conflicting viewpoints which arose within the interviews and focus groups.

On completion of this component of the study it was apparent that the planned Phase Two would not satisfactorily address the study question—What is the Contemporary Role and Function of the Rural Nurse? At a meeting of the Project Management Team, Phase Two of the study was redesigned and a request was lodged with the funding body (RHSET) seeking to modify the original research plan for a national census of nurses. The modifications made to Phase Two of the study are detailed in Figure 1.1.

Figure 1.1 — Role And Function Of The Rural Nurse



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The study design was modified further when it was apparent that a national census of all rural nurses in all settings was not possible. For example, it would not have been possible to document the practice of nurses in aged care, community health, district nursing and acute care. After consultation with the Management Team, the decision was made to only include health services with acute facilities in the study. Phase Two of the study, therefore, involved only health services which were classified as Rural Other and Rural Major and had acute facilities on-site.

Phase 2: A National Census Of Rural Health Care Agencies

Method And Sample Selection

All health facilities in the Hospital and Health Services Year Book (1995) which met the following criteria were selected for inclusion in the study:

- the services are government-funded
- not-for-profit
- they provide acute services to rural communities

It should be noted that stand alone aged care, community health, district nursing services and psychiatric only health services were not included.

Following the compilation of a list of health services which met the criteria (n=730), each service was classified as Rural Major or Rural Other according to the Department of Human Services and Health (1994) Rural and Remote Area (RaRA) criteria and the Australian Bureau of Statistics Database (1991) requirements for Statistical Local Areas. Whilst this classification is recognised by the Department as ambiguous by definition, involving judgements concerning the relative remoteness of an area, and how such remoteness should be defined (particularly where distance from a major centre or size of a community enters the question) it was considered to be the most appropriate classification for this study.

In addition to the Rural Other and Rural Major classification, the selected health services were sub-classified according to acute bed using the following criteria:

- Category One:** Bush Nursing Centre; Multipurpose Centre; Hospital with 10 or less acute beds
- Category Two:** Hospital 11 to 50 acute beds
- Category Three:** Hospital 51 to 100 plus acute beds

Because of the lack of detailed information available on such a large sample, complete accuracy concerning specific breakdown of bed numbers was not possible. However, as far as practicable aged care beds were not included when accounting for bed numbers.

Using a random numbers table, two hundred and ten facilities (n=210) were chosen from the population (n=730) in proportion to their total representation. For example, if there were 73 facilities in the category, therefore representing 10% of the total, 10% of 210 (21) were chosen from this category at random.

Participating Health Services And Nurses

Following selection, a letter was sent to the 210 health services, describing the study and asking for their participation. The response rate from the written requests for participation was 120 (57.14%). The rate of non-respondents was 90 (42.8%). Of the 120 replies, 90 agreed to participate (75%); 10 (8.3%) required further ethics approval (which was obtained in all cases); and 20 (16.6%) chose not to participate.

The second round entailed the ninety non-respondents being contacted by telephone, 42 of these facilities agreed to participate (46.67%). The total of participating health services following telephone follow-up was 142 (67.62%).

The non-participating facilities, while expressing great interest in the study, gave the following rationale for their non-participation:

- limited staff numbers did not allow for a study of this magnitude to be undertaken within their health service
- they were closing (or had just burnt) down
- they were in the midst of management or administrative changes that did not facilitate the introduction of such a comprehensive investigation of practice

Of the health services that had originally agreed to participate 8 were compelled to withdraw when it became apparent that staff numbers were not adequate to cover the observation period. A further 5 facilities provided unusable data, giving a total of 129 facilities (64.5%) participating in the study. The final number participating in each category were:

Category One: 14 (13 Rural Other and 1 Rural Major)
Category Two: 84 (75 Rural Other and 9 Rural Major)
Category Three: 31 (11 Rural Other and 20 Rural Major)

The enthusiasm expressed by the majority of the respondents was gratifying. Many had felt a need for such a study in order to legitimise their practice, and were eager to cooperate in any way possible.

Research Tools

A pilot study was undertaken in a Rural Other facility over a twenty-four hour period to eliminate any discrepancies in the tools. The participants in the pilot study suggested some additions to the skills to be observed and to the site booklet. All suggestions were incorporated to improve the layout of the booklets.

Site Booklet

Each health facility was required to complete a site booklet to provide a comprehensive profile of the service (n=129). This included the nature of the service offered; the number of acute beds; the major source of funding; details of the nursing, allied health and medical workforce, and the number of inpatients on the day of the census; the nature of the acute services offered on that day; details of community services offered; and methods of patient retrieval and transfer. Participants were also invited to share any other information about their health service they believed relevant (see Appendix I).

Staff Questionnaire

Each health service was asked to select one nurse to be observed for each of the shifts the health service was operating on the 31st July, 1996. As some health services worked only one shift in the 24 hour period (for example, nursing posts) the total number of nurses who completed the staff questionnaire was 364. Two of these questionnaires were not included in the study as they were completed by enrolled nurses. The total number of questionnaires analysed was 362.

These questionnaires provided a profile of selected personal details, their level of training, their type of appointment, the average number of hours they work per week, and the length of time spent in nursing. Participants were invited to comment freely on how their education and training had prepared them for the role of the rural nurse, the perceived barriers to appropriate training, and their satisfaction in general with their role (see Appendix II). Their comments provided rich qualitative data.

Observation Booklet

The observation booklet attempted to capture in detail the activities of the rural nurse in a specified 24 hour period. It listed 193 skills commonly performed in rural nursing practice, with space for additional ones performed that were not already included (see Appendix III). Each skill was observed nationwide at 32 specified times in a 24 hour

period. In addition to these activities, the nurses were asked to note the context of practice. These contexts of practice were essential to uncovering the nature of rural nursing practice, for example, whether nurses were initiating treatment without medical orders, whether they were working from documented protocols, and the exact staff mix on duty at any given time.

The total number of observation booklets returned were 364. Of these, 17 (4.67%) were excluded from the study because of inaccurate recording, resulting in a useable sample of 345.

Reducing Observer Bias

All observers were personally contacted via telephone prior to the study at least once to explain the exact nature of the study and their role. In addition, a detailed instruction paper was included with all booklets. Many observers contacted the research team for further clarification of details, mainly to do with recording of the context of practice. Despite the attention paid to instructing the observers, 17 shifts contained unusable data and were discarded. The most common errors included the observation of the practice of enrolled nurses, or excessive activity during the observation period (for example, 200 different activities by one nurse on one shift).

Sample Bias

The sample is a randomly selected representation of a stratified list of health services. While every attempt was made to ensure that the health services in the sample had at least one acute bed, one facility was withdrawn after the data collection phase when it became apparent that it was solely an aged-care service.

Whilst it is acknowledged that there are time differences between the States, the data collection did not specifically aim to identify the activities occurring at a particular time of day. It is recognised however, that observations in South Australia and Western Australia were recorded at different times to that of Victoria, Queensland, Tasmania and New South Wales. The industrial action suddenly planned for the day of the census in Victoria did affect the study and it was decided to move the observations one day forward in the one facility taking part in such action (n=1).

Ethical Considerations

Phase II of the study was approved by the research ethics committee of the University of Southern Queensland on the 29th May 1997. Each health service subsequently agreed to participate with the Director of Nursing signing and returning a plain language

statement and consent form that fully explained the scope and nature of the study. Ten facilities required further ethics approval by their own committees, all of which were granted.

All nurses completing the questionnaires and those being observed signed a consent form and were given a copy of the plain language statement explaining the nature and intent of the study, with the names and contact numbers of the investigators, and were advised they could withdraw at any time (see Appendices IV and VI).

All data is stored in a locked cupboard for five years and will then be destroyed. The booklets were numbered and only the chief investigator and the research assistant have access to the list which identifies the health services. It was agreed that health services would not be named in the report.

Data Analysis

After the trial and finalisation of the three tools, an SPSS database was established. Completed questionnaires were coded and entered onto this database. Quantitative statistical tests used included Chi-square and Correlations.

Qualitative data was transcribed verbatim and transcripts were entered to facilitate data management using the software program NUD*IST. The text was then categorised according to emergent themes.

Rural And Remote Area Classifications

Whilst acknowledging that there are many definitions of rural and remote areas in Australia, the authors chose to use the Commonwealth of Australia's Rural and Remote Area Classification to determine each Statistical Local Area's (SLA) rurality rating. The rural/remote area classifications are discussed in detail in the literature review.

The study included an extensive search of the literature and a comprehensive review precedes the results and discussion chapters of this report.

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