Rural and Remote Health
MEDLINE listed
Impact factor 0.868
The International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy
ISSN 1445-6354

PERSONAL VIEW

The right staffing mix for inpatient care in rural multi-purpose service health facilities

LM Malone, JK Anderson

Charles Sturt University, Bathurst, New South Wales, Australia

Submitted: *21 October 2013;* ***Revised:*** *15 May 2014;* ***Accepted:*** *16 May 2014;* ***Published:*** *3 December 2014*

Malone LM, Anderson JK

The right staffing mix for inpatient care in rural multi-purpose service health facilities
Rural and Remote Health **14: 2881. (Online) 2014**

Available: http://www.rrh.org.au

ABSTRACT

Context: The Multipurpose Service (MPS) model has been in existence in rural and remote Australia for more than 20 years yet there is little guidance about developing an appropriate staffing structure.

Issues: Managers of these facilities face issues related to isolation, safety, funding models and the need to provide a variety of services with limited resources and staffing. Because MPS are designed to meet unique community needs, a single staffing structure is not suitable for every site. Managers need to consider these issues in order to determine the most effective staffing structure for their particular environment.

Lessons learned: Issues and concerns for managers are highlighted including discussion which may enhance the ability of managers to make appropriate decisions for their unique site.

Key words: Australia, career and education pathways, Multipurpose Service program, staffing model.

Context

The Multipurpose Service (MPS) program commenced in 1992 in rural and remote Australia to address the health needs of rural and remote communities in providing more efficient and effective healthcare services. Despite having been in existence for more than 20 years there is still little guidance in the literature regarding staffing of this unique model of care.

In view of current workforce recruitment and retention issues, Health Workforce Australia is looking to expand staff classifications to better meet staffing requirements[1]. For

managers and planners there is little clarity about the staffing model that best suits an MPS. This article examines some of the major issues – managerial, patient/resident care and human resource – to be considered when devising the right skill mix for an MPS. This will assist managers and planners to make decisions about future staffing configurations.

Issues

Management

The development of an MPS often takes into account existing buildings and sites, with not all MPSs using a greenfield 'one-stop shop' model. This is due to the existence of functional or recently constructed buildings, which makes it inefficient to rebuild or redevelop the entire service. Managerial issues for MPSs include functioning over more than one site, safety and security responsibilities and the effective cost management of staffing within this model[2].

Multiple sites

Many MPSs are developed by merging an existing aged care facility and a small rural hospital. To limit costs associated with this merger, some retain existing buildings, which results in one health service that spans more than one site or building[2]. This creates issues in relation to staffing. Although patient or resident numbers alone may not require large numbers of staff, the distance between sites and security issues may increase the number substantially. This can have a negative impact on the economies of scale in staffing these facilities.

The geographical isolation also inhibits the ability to form an effective team, as distance does not allow sharing of staff. In order to manage work, individual buildings require a division of work in order to make best available use of staff, creating further divisions within teams[3].

Work health and safety

Safety is a particularly significant issue in those small rural communities that do not have 24-hour police services or security services[4]. Some services provided by MPS programs such as emergency care, drug and alcohol services and mental health services may create safety issues for staff, patients and residents. Many MPS function with very limited staffing numbers, making it difficult to sustain staff who meet work health and safety education requirements (eg committee training, infection control, fire safety and security training)[5]. A health and security assistant in an MPS is not mandatory, but it is something that many managers consider[3].

Cost

The range of staffing classifications available for use in an MPS has cost implications for health service delivery. The MPS manager needs to consider the unique configuration of the MPS and staff accordingly, considering industrial requirements, possible staffing profiles, and non-nursing duties that can be performed by some staffing classifications as dual roles[2,6]. One of the objectives of an MPS is to achieve economies of scale; with small client numbers this can only be achieved with multi-skilled staff[3].

Meeting legislative requirements and remaining cost-effective are issues that many MPS managers face. The issues are difficult to change on a day to day basis which is contingent on how the initial model was implemented for their particular site.

Patient and resident care

Safe delivery of patient and/or resident care is another issue for MPS. Two major areas of concern are the provision of emergency care services often mixed with residential aged care. For managers and staff these two speciality areas are significantly different and require different expertise.

Emergency care

The MPS model is designed for rural and remote areas, which requires a particular skills mix to deal with a wide variety of emergency presentations. All emergency presentations need to be triaged by a registered nurse or doctor to determine the

level of care required[7,8]. Even though most MPSs have doctors available, not many have a doctor on site to provide immediate emergency care. In these instances, a registered nurse is required to assess the need for and initiate immediate emergency care interventions until medical assistance can be obtained from a doctor either in person or through a telehealth facility[8].

In New South Wales, emergency departments are allocated a designated level of care ranging from 1 to 5[9]. A level 1 emergency department only requires one registered nurse to be on staff at any one time, level 2 requires two registered nurses, and so on[10]. The level is dependent on the availability of radiography services[11]. Emergency department presentations can have significant staffing implications for MPS when a major trauma occurs (eg motor vehicle accident, industrial incident) or during tourist influxes at particular seasons or because of significant events. The possibility of these irregular events places additional stress on rural and remote nursing staff in their feelings of competence and the need to maintain their skills and deliver safe patient care in the specialty of emergency care. These staff spend the majority of their time working in aged care[3,12].

Aged care

The differences between residents deemed high care or low care are a determinant of the number of hours of care required and the level of staff qualification to provide care. A high-care facility requires a registered nurse to be on site at all times to coordinate care[13]. Many different staffing classifications for provision of basic personal care are available. The roles in the different classifications may not be directly related to inpatient care of residents but can have significant cost implications for the service manager to consider in developing their staffing model.

Staff members specific to aged care e.g. diversional therapists also need to be considered for inclusion in an MPS staffing profile. Allocating funds to this role eliminates the possibility of this funding being diverted and the needs of the aged care residents not being met. As MPS are designed for rural and remote environments the issues associated with finding well qualified staff in these situations are a challenge, especially people with such specific qualifications as diversional therapy. Similarly other skilled staff such as physiotherapists, podiatrists and other allied health staff are also difficult to recruit and retain[2].

The challenge for managers of MPS to adequately meet patient/resident care needs is compounded by the diversity of skills and resources available in meeting emergency and aged care needs simultaneously. This is difficult to do whilst maintaining a cost-effective and economically viable service for limited patient and resident numbers in small communities. In order to do this effectively human resource issues need to be considered.

Human resources

To maintain an economically viable health service the largest component to be considered is the availability of human resources. Managers need to consider the ability of staff to multi-skill across various service requirements, and they need to meet industrial award obligations. To recruit, retain and develop skilled and suitable staff, career opportunities and access to ongoing education are valuable.

Multi-skilling

Due to the variety of services that an MPS aims to deliver, multi-skilled staff members are the most valuable asset. The difficulty lies in the recruitment and retention of these staff[2,3,14-16]. Registered nurses need to be able to provide specialised acute emergency care as well as aged care, often without the support of an on-site medical officer, or recent experience. Staff specialising in aged care are also required to have skills and abilities within emergency and acute care[3,12]. Some lower classifications of staff may have to work in areas that are unfamiliar or for which they don't have the educational background.

Limited staffing numbers at any time within an MPS places strain on the delivery of inpatient care when a trauma

presents to the emergency department. In those situations in which a staffing profile does not take into account a worst-case scenario presenting to the emergency department, people holding lower level classifications can be placed in situations where they feel they have little choice but to operate outside their scope of practice[3]. This is one reason why there is an increased emphasis from industrial unions, which are advocating an increased number of registered nurses on a staffing profile as part of the next round of industrial negotiations[17].

The variety of staffing classifications in an MPS is extensive. Sometimes, inpatient care is provided by staff who also have responsibilities in cleaning, cooking and security[10,18]. This raises questions for managers who play a part in deciding which tasks are delegated to each person and can have industrial implications when attempting to combine tasks previously undertaken by several staff members. Financially, however, this may be beneficial, which may lead to greater workforce stability.

Other allied health professionals such as physiotherapists, podiatrists and occupational therapists are available to MPS residents but need not be considered part of the staffing profile; these services could be offered by private providers[4]. In order to meet the holistic requirements of small communities and provide excellent of services, these positions should be considered. This feature could engage community support for the model of care.

Industrial award obligations

All MPSs are bound by industrial award agreements. These are now increasingly specifying minimum levels of staffing and qualifications for managers[10]. These industrial awards vary from state to state, but have frequently been developed from specific perspectives (eg emergency care or aged care) and, due to the nature of an MPS combining these services, can be difficult to implement. Small populations and small numbers of staff limit the political influence of people working in MPSs to lobby for a separate classification within industrial awards. No state has taken the task of recommending staffing levels for an MPS due to the complexity and variety of care delivery required. There is an absence of recommended nursing hours per patient per day in industrial award agreements despite MPS being in existence for over 12 years.

Career and education pathways

Nurses working in an MPS are required to spend the majority of their time in aged care. As well as this requirement for aged care qualification and skills, emergency department presentations place an imperative on nurses to have specific emergency qualifications to allow them to deal with a variety of presentations (some which are life-threatening) without onsite medical or allied health support[3]. Staff are expected to be skilled in both the acute care and aged care areas yet access to opportunities for practical skill upgrades is a difficulty faced by both staff and managers. Access to ongoing education and professional development is a challenge for many nurses working in an MPS. Attending face-to-face training is limited by the availability of staff to backfill and the distances required to travel. When it does happen, it occurs at increased cost and length of time away from the service. Online e-learning packages are available to support nurses to maintain their skills; however, these address theoretical learning rather than practical skill development and do not provide networking and collegial support, which prevents professional isolation. Healthcare workers who would like to enter the nursing profession need to obtain university or other further education qualifications that may require them to physically attend institutions a substantial distance away[3,15,16,19].

Career pathways are limited for people working in MPSs. In small rural and remote facilities, often with only one or two management positions, staff progression is limited[3]. For registered nurses the clinical nurse specialist role is available as a step on the career pathway; however, it is contingent on professional development, and relevant skills and experience relative. Other classifications, such as clinical nurse consultant and nurse practitioner, are limited due to budget constraints and population demographics, including low

population numbers. The model of staffing for an MPS requires a minimum of two staff members, one of which needs to be a registered nurse[10]. Classifications higher than a registered nurse place pressure on the budget.

The imperative for health service managers is to create an environment that attracts well-qualified staff while providing support for their ongoing professional development. The financial responsibility in maintaining a cost-effective service is not always congruent with the professional needs of skilled staff working in an isolated community.

Lessons learned

The MPS model, with its focus on integrating services under one management structure, aims to address the needs of a wide variety of clients. How well this is achieved is debatable, due to the conflicting ideologies of acute and aged care. Managers and senior staff usually come from an acute care background and are challenged by the concepts of aged care, particularly when faced with the imperatives of emergency care. One of the major restrictions to providing a service that supports staff aspirations and optimal patient care is the financial constraint faced by health service managers on a daily basis.

References

1. Health Workforce Australia. *Health Workforce Australia – 2012–2013 workplan*. Adelaide: HWA, 2012.

2. Sach J, Associates. *Multi-purpose Services Program Evaluation (Victoria): final report*. Melbourne, VIC: Commonwealth Department of Health and Ageing & Victorian Department of Human Services, 2000.

3. Anderson J. *Developing a collaborative rural health identity: a grounded theory study of the development of multi-purpose services in rural New South Wales*. Canberra, ACT: Charles Sturt University, 2010.

4. Australasian Health Infrastructure Alliance. *Australasian health facility guidelines: health facility briefing and planning – Multipurpose Service Unit*. (Online) 2012. Available: http://healthfacility guidelines.com.au/AusHFG_Documents/Guidelines/[B-0350]% 20Multipurpose%20Service%20Unit.pdf (Accessed 4 November 2014).

5. Australian Government. *Work Health and Safety Act 2011, C2011A00137*. Canberra: Australian Government ComLaw, 2011.

6. Andrews G, Dunn J, Hagger C, Sharp C, Witham R. *Pilot Multi-Purpose Services Program: final report*. Adelaide, SA: Centre for Ageing Studies, Health Solutions and Consortium for Evaluation Research and Training, 1995.

7. Australasian College for Emergency Medicine. *Policy on the Australasian Triage Scale, P06*. Melbourne, VIC: Australasian College for Emergency Medicine, 2013.

8. NSW Department of Health. *Triage in NSW rural and remote emergency departments with no on-site doctors: review and recommendations of the NSW Rural Critical Care Committee*. North Sydney, NSW: Statewide Services Development Branch, 2004.

9. NSW Ministry of Health. *Role delineation levels of emergency medicine: consistent with the guide to the role delineation of health services*. 3rd edn. North Sydney: NSW Ministry of Health, 2013.

10. Industrial Relations Commission of NSW. *Public Health System Nurses' and Midwives' (State) Award, 2011*. Sydney, NSW: Industrial Relations Commission NSW, 2011.

11. NSW Health Department. *Guide to the role delineation of health services*. 3rd ed. Sydney, NSW: NSW Health Department, 2002.

12. Neumayer B, Chapman J, Whiteford G. Role of multi-purpose service programs providing residential aged care in rural Australia: a discussion paper. *Australian Journal of Rural Health* 2003; **11(6):** 287-291.

13. Australian Government. *Aged Care Act, No. 112*. Canberra: Commonwealth Government, 1997.

14. Gibb H, Forsyth K, Anderson J. Culture of rural nursing practice: a critical theoretical analysis of determinants of power in nursing. *Australian Journal of Advanced Nursing* 2005; **23(2):** 34-39.

15. Hegney D, McCarthy A, Rogers-Clark C, Gorman D. Retaining rural and remote area nurses: the Queensland, Australia experience. *Journal of Nursing Administration* 2002; **32(3):** 128.

16. Francis KL, Mills JE. Sustaining and growing the rural nursing and midwifery workforce: understanding the issues and isolating directions for the future. *Collegian* 2011; **18(2):** 55-60.

17. New South Wales Nurses Association. NSW Nurses 'See Red' over O'Farrell's failure to act on patient safety. (Online) 2013. Available: http://www.nswnma.asn.au/nsw-nurses-see-red-over-ofarrells-failure-to-act-on-patient-safety (Accessed 17 October 2013).

18. Industrial Relations Commission of NSW. *Health Employees' Conditions of Employment (State) Award*. Sydney, NSW: Industrial Relations Commission NSW, 2008.

19. Gibb H. Educating nurses for rural clinical practice: working and studying alone. In: D. Wilkinson, I. Blue (Eds). *The new rural health*. South Melbourne, VIC: Oxford University Press, 2002; 253-259.