Strategies to Remote Area Nursing

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This paper outlines the role of remote area nurses and demonstrates that they play a pivotal role in remote area health service delivery. It discusses some of the problems and frustrations of their role and suggests some tried and tested strategies to improve their morale, retention rate and service delivery.

Nurses have played a unique role in the provision of health services to remote areas of this country. They were the first health professionals to venture out and settle in remote communities and unlike many services their line of service in a great number of places has remained unbroken ever since. Frontier Services and its successor’s nurses alone can claim a proud record of care in 38 nursing outposts established since 1912. Jenny Cramer has identified 8 remote communities in Tasmania, 15 in South Australia, 16 in New South Wales, 17 in Victoria, and no less than 47 in West Australia and 64 in Queensland where nurses alone provide professional community based health care. Other health service providers come and go, fly in and fly out but the nurses have remained 24 hours, 7 days a week, 365 days of the year.

The earliest nurses endured long arduous journeys by car, mail truck, camel, boat or train to reach their outposts. Once there they lived with extremes of heat and cold, dust, flies, poor housing, irregular supplies and frequently almost nonexistent communications networks and services not to mention loneliness, professional isolation and long hours of work. It is surely a tribute to their endurance, persistence, commitment and professionalism that they remained while others continued to shun leaving the comforts of the coastal fringe. But can we honestly say that the situation has improved much to this day? Granted, radios, road and air-services have all brought big improvements in communications, better electricity services have helped mitigate against the effects of the climate, supply lines are more frequent and predictable and some professional support is available through such organisations as the Royal Flying Doctor Service. Nurses circumstances in relation to 80 years ago have improved immeasurably but when looked at in relation to their present day city contemporaries the picture is much less positive. The Council of Remote Area Nurses of Australia have identified numbers of places where nurses are living in sub-standard accommodation, with unreliable radio or telephone services, unsafe vehicles, unreliable power supplies, substandard or inappropriate equipment to mention but a few problems. In addition where their city contemporaries enjoy carefully restricted work hours, work loads and professional boundaries the lone service deliverer in a remote community is invariably expected to do a full days work.
in a clinic then be on call at all other times (and frequently for days if not weeks on end) and to provide a full range of care from acute emergency and first response care to general outpatients, home and community nursing, counselling, health promotion education and screening not to mention pharmaceutical dispensing, emergency dental care, basic pathology, veterinary and radiography, general administration, ordering, building maintenance etc. In many respects the role is boundless and limited only by the number of hours in the day.

And where old problems are being improved upon by advances in technology etc. new ones are taking their place. Professional isolation has undoubtedly improved. There would be few places now where a doctor cannot be contacted for consultation over a radio or telephone for an acute case relatively quickly. But what of the non-acute? The situation where you are not sure whether a lump should be taken seriously, or a headache, or vague symptoms. Do you bother a busy and thinly spread medical service? How do you unwind after seeing 40 patients in a clinic each of whose condition is different and cannot be discussed outside professional circles? Worse still who do you turn to when the medical opinion goes against your better judgement and you are the person with the patient in the remote community who you know to be at risk? Where do you stand legally, ethically and morally? Who can assist you in deciding? There is no supervisor on the scene, no colleague to hand over to on the next shift, no medical hierarchy to appeal through. What city contemporary can claim the same breadth of problems? It could be argued that these problems have always been there. The difference these days lies in community expectations. With the advent of improved communications and radio and television in particular peoples expectations of their health service have been raised. Nowadays people know what is available in the city and expect to have access to similar services. Equally, the nursing profession as a whole has altered its expectations of its members. It is no longer good enough for a nurse to blindly follow a doctor’s order against their better judgement. A nurse is now considered legally as well as ethically responsible for their own actions.

So, even if physical isolation from other professionals has improved professional expectations and responsibilities have, if anything, become much more marked greatly increasing the potential for stress. But my intention is not so much to harp on about the professional, personal and other difficulties confronting remote area nurses, although they are undoubtedly real, diverse and iniquitous and in urgent need of attention. It is rather to point out that there is a large professional body who are well aware of the health problems of remote communities, who have a great bank of knowledge and expertise. Who have proved themselves capable of delivering a highly professional standard of care. Who have shown themselves committed to the welfare and well-being of people in remote areas and who are interested and willing to continue their involvement but are being hamstrung, frustrated, disillusioned and burned out by bureaucratic mismanagement, poor working conditions, lack of a say in determining priorities, modes of delivery, etc. The human resources are there but they will only continue to be there if the iniquities are addressed. It is obviously uneconomic not to mention impractical to suggest that every small community needs its full compliment of doctors and paramedics. Even if you could attract them what interest is there in the long term for a doctor in communities where most of the health problems stem from the characteristically poor public health facilities, chronic social disorders or, alternatively, in fiercely independent communities such as opal mining towns where people stay healthy because they can’t afford to get sick?

In contrast the interest is there for a nurse whose training equips them to assess a patient’s condition, deliver basic emergency care, undertake non-medical outpatient care, screen children for deviations from the normal, teach and promote good health practices, advise mothers with new babies, care for the elderly as well as collecting statistics, maintaining records, ordering supplies etc.
Provide support for them in this role: provide courses and in-service material to prepare them for the specifics of the role; give them an administrative framework in which they are supported but not dominated, encouraged rather than dictated to, consulted rather than questioned and free rather than tied and I do not doubt that remote area nursing as a discipline of choice will continue to attract recruits, that morale and commitment will lift, and that the service they provide, and the outcome for the people in their care, will also. In case the sceptics among you would doubt the effect of such changes let me quote you a proud example from the history of Australian Inland Mission, Frontier Services and now of the Health Department of West Australia, of what can be achieved where nurses are listened to and supported in their work. In Fitzroy Crossing in the late 60s the Sisters in the 2 sister nursing outpost were becoming increasingly frustrated by their inability to make any impression on the health status of the community. They complained that by the time Aboriginal children in particular reached them they were in such a state that even if they lived the chances of them returning to optimum health were minimal. They managed to convince the Australian Inland Mission Board that nothing would change until they could get out into the camps themselves and start teaching good health practices and identifying people with early signs of illness. The Board provided Sister Pat McPherson with a 4 WD vehicle and from those simple origins has grown the great community health network in Western Australia of today.

Frontier Services and its predecessors has, since 1912, run over 35 different nursing outposts and conducted numbers of different health or health related programmes in remote areas. While not claiming to have discovered a foolproof system or not having made any mistakes we believe that a number of our practices have stood up to the tests of time and trial and are worthy of consideration by this conference as a helpful model for nursing outpost services. I will talk about them in no particular order because each is a part of a total package. Firstly: With rare exceptions we always appoint 2 registered nurses to an outpost regardless of the workload. Thus Birdsville which sees an average of about 120 patients per month has the same staffing level as Coen which sees 350 and really needs 2 staff. The rationale behind this is that fewer patients probably implies an even greater degree of isolation and fewer back-up services. The other aspect that needs to be considered is that, in the smallest communities in particular the nursing outpost frequently becomes the focus of community activities and a drop-in centre for the locals. In these circumstances the psychosocial and counselling role of the nurse can be paramount and this can place an added burden on staff who have no-one to share it with. There are also the obvious advantages that two can take turns to do the clinic, be on call and get away for a break. It removes the all too frequent complaint about uncertainty of whether a reliever will actually arrive to allow you to have days off.

Secondly: Staff are appointed for one year in the first instance with the option for staying a second year if they so choose. Reasons for this are also numerous: We believe that it usually takes most people at least six months to adjust to the lifestyle and the work pattern and to get to know the community sufficiently well to start to be of any value to them. We believe that setting a timeframe, and a not unrealistic one at that, gives people something to work towards without feeling overwhelmed. The goal cannot just be realistic it has also to be reasonable. There is no doubt that remote area nursing with its environment of extreme temperatures, physical, social and professional deprivations, unpredictable work hours etc. is demanding
and extremely tiring. A year gives them a time frame in which to pace themselves. In the second year they have a chance to reap their rewards but at the end of this time very few feel they are not ready to take an extended break. In our experience we have found that very few leave without completing their year and increasingly more are asking to do a second. The other point to note is that Frontier Services takes responsibility for finding their replacements at the specified time. We believe it is important for staff to know that they will be replaced and will have someone to hand over their work to. Staff can of course come back to work for us. Some request transfer to other outposts but most are encouraged to return to city hospitals to refresh their confidence, have regular work hours and a private ‘private’ life.

Thirdly: High priority is given to recruitment of suitable staff. Knowing when staff are due to finish their contracts is an enormous help in planning and gives time to select suitable people. No-one can really predict how anyone is going to adjust to a remote area but some indicators are helpful. In selecting staff we look obviously first and foremost for a general nursing certificate preferably with a midwifery certificate and/or increasingly a psych one. A useful combination with all the psychosocial and substance abuse problems in remote communities, has been one nurse with midwifery and the other with psychiatry. They should be 25 or older not merely so they have had time to gain some nursing experience but also some experience of life. Staff under 25 usually require a much greater level of supervision and support and there is a much greater risk of them becoming totally demoralised if they are unable to cope. They need to have worked in more than one hospital and preferably to have travelled extensively. Such people are usually much more adaptable, are used to a variety of living and working conditions and to settling down quickly. They also need of course to be in good health. Having established these criteria we then believe it is important to give an applicant as clear a picture of their role and function as possible. Conditions are explained in detail and people are encouraged to go away and think about things before indicating whether they are interested or not. We believe it is better to lose them at this point than once they have been through an expensive orientation and establishment process. If they then show an interest the challenge is then to appoint them to a suitable setting with a compatible partner. The latter can be the least predictable part of the whole process and can often boil down to very domestic criteria such as whether they smoke very heavily or not, are an animal lover or not etc. The emphasis of the whole exercise cannot just be on the filling of a slot. The slot will not stay filled for long if the individual arrives to find a totally unexpected role and community or incompatible partner. Nor will it stay filled if the person becomes totally unnerved and demoralised by being given a task which they are ill equipped to fulfil.

Fourthly: Frontier Services tries very deliberately not to dictate a modus operandi to staff. Staff are obviously given a job description and their function determines much of what they do: an obvious example is that they are expected to run clinics at certain times collect statistics, maintain supplies etc. but within these unavoidable constraints they are left pretty much to their own devices and it is a rare member of staff who lets us down. The understanding is that they are professionals and as such they have the right to determine, and are quite capable of determining, their own priorities. They are therefore left to decide who will work when, who will take particular responsibility for an aspect of their work, what they will do and when etc. The Nursing Co-ordinator is available to act as a mediator if there is a dispute but generally I see my role as keeping a watching brief to ensure the division remains equitable rather than dictating to them what they should do and how they should do it. Generally speaking problems are few and far between. The vast majority of the staff flourish and if anything act more responsibly knowing the trust that has been placed in them. They also know we will give them as much support as possible and try and assist them to find solutions to problems. Our stock answer if a member of staff rings with a problem is “how
can we assist you to overcome it?” “What would you like us to do, say etc?” Not, this is the solution which you must adopt however inappropriate it may be in the circumstances.

Fifthly: We place a high value on visiting staff. It can be a very tall order to continually leave a desk piled high with paper and spend up to 2 or 3 days just getting to a centre but the importance of doing this should never be underestimated. Staff need to know and respect their employers. They need to have confidence that the person understands their circumstances, knows what they are going through and will give them a sympathetic ear: They need in short to trust them. Equally staff in head office need to know them; their weaknesses and their points of vulnerability as well as their strengths. At interviews you only discover so much about a person. You discover much more about them and they about you when you stay with them and spend time with them in their own environment. Again, experience has shown that the first visit should be a minimum of 3 nights. The first night they are usually sizing you up and you have to adjust to their pace (you are probably still running on city time while they will be running on bush), the second they might start to open up and by the third you should really be getting down to important matters. It is a rare remote area nurse who doesn’t have lots to tell you, lots to unload and lots of questions and they need to be given time to do this. If they aren’t given time you will leave them feeling disgruntled and unheard and the visit may well create more problems than it solves. Subsequent visits don’t need to be so long but its important not to forget bush time and to make sure each of them has time to have their say even if it may seem trivial. Such visits can help to stabilise the team, open up new lines of communication and give people the confidence and enthusiasm to continue their work. Without them we believe the staff turnover and the administrative headaches would be immeasurably higher and the standard of service significantly lower. Time prevents me going on at greater length and others will talk about aspects such as educational needs and medical backup. I should like to conclude be reiterating that there are a number of simple cost effective measures which could be taken to improve the lot of remote area nurses and that these can be shown to result in a workforce which is more stable, more committed, more confident and ultimately more competent and well able to provide a high level of professional and appropriate care to people in remote areas.