Beyond the Nursing Domain

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In this presentation, I will address the dilemmas that arise for the nurse, in the absence of medical, pharmaceutical, radiological and allied health personnel. I will draw heavily on my experience as a rural and remote area nurse in the Kimberley and Eastern Goldfield regions of Western Australia.

It is well established that nursing practice in remote areas crosses the conventional boundaries of nursing. (Cramer 1989, Munoz and Mann 1982). This reality is not acknowledged or supported by current legislation regulating nursing practice. This opens up a myriad of dilemmas for the remote area nurse. Compelled by circumstances and isolated form other support services, the nurse is commonly required to operate in the grey area of the law. I hope this paper will help to initiate debate on the issues confronting the remote area nurse.

Working as a remote area nurse demands a resourcefulness unsurpassed in the city. For many nurses, including myself, commencing employment in a remote community is a confrontation with reality. Romantic notions of working in such an area are soon dispelled. Long gone are the protective walls of your teaching hospital, that nurtured you through three years of tender loving care and the latest in modern technology. You can feel the confidence, built up over years of practice, your efficiency and competence gained in hospital wards, slowly slipping from your grasp. One struggles to hold that internal control as the realisation of life in the bush sinks in. This lack of control leads to professionally accepted standards, being undermined.

Learning the hard way is presently an inevitable and unenviable part of the notice remote area nurse. Part of the apprehension lies in the carrying out of procedures that are traditionally the domain of medical and allied health personnel. These procedures become essential to nursing practice. Remote area nursing competencies need to be established and acknowledged. These competencies not only encompass a level of skill, but embrace knowledge and understanding. Conflict and frustration often arise for the remote area nurse when treatment given or needed, is beyond their scope of practice.

Trail and error learning often predominates, with little or no support from nursing or medical colleagues. (Munoz and Mann 1982) Role models or even clear guidelines on which to base remote area practice are scarce or inappropriate. (Kreger 1991) In this environment, the nurse endeavours to provide a health service based on a primary health care approach to best of their ability. This method of learning does not ensure a safe level of practice that equates to urban areas. The community could be considered at risk through poor preparation of the nurse to the demands of the health consumer. Often through precedents set by previous nurses, the expectations placed on the nurse far exceed experience. Community pressure leads the nurse to practice beyond the nursing domain. Unlike their urban counterparts, remote area nurses have a high primary care load. (Philp 1988) Primary care refers to the first
level of contact usually sought by the consumer because of a perception of an existing health problem. (AHMAC 1988).

The nurse is responsible for clinical management of both emergency situations, involving varying degrees of trauma, and routine, ongoing illness within the community. This may occur in a variety of settings outside the health centre with its limited resources, such as, the site of a car accident which may be at the road side or in the middle of the bush. Treating the victim or domestic violence within the home, while the family argument rages around you, is one of my more frightening experiences. Assisting a woman in labor in the back of a Toyota in the middle of the night, another.

Nurses are frequently having to manage paediatric and adult clients in the absence of medical practitioners. Remote area nurses are required to perform both physical and psycho-social assessment as part of primary care management. (Cramer 1989, Kreger 1991) The presentation of the client determines the nurses approach and urgency with which the examination must be performed. Kreger (1991) asserts that “The assumption that nurses are able to competently perform (these functions) ... is supported by Muirhead (1988) in the Interim Report of the Royal Commission into Aboriginal Deaths in Custody.” These assumptions are often ungrounded and yet the expectation of the community and medical colleagues exists. Once again, it is trial and error, that teaches you what information needs to be gained and how to get it, to intelligently collaborate with medical personnel.

Part of this assessment includes initiating and undertaking investigations such as x-rays and pathology. Tests need to be taken as part of specific management, infection control, screening or in response to a doctors instructions. Pap smears, various types os swabs and venipuncture are undertaken by the nurse. Knowledge of appropriate preparation, storage and transportation of all specimens for the laboratory is essential.

It is a legal requirement that the doctors signature is on the pathology form. Pre-signed forms enable remote area nurses to request pathology tests in the name of the doctor.

Specific skills and knowledge needed for taking specimens such as pap smears and venipuncture are often learnt “on-the-job” and sometimes at the expense of the client’s comfort. Correct interpretation of results and knowledge of abnormal pathology findings assists the nurse in initiating urgent treatments. (Kreger 1991) Educational institutions and teaching hospitals have created inconsistencies in nurse competencies in this area. This places the nurse and the community at risk.

Due to the nature of their work and uniqueness of their situations, remote area nurses, in reality, make medical diagnosis, as opposed to nursing diagnosis. Being the only available health professional, community expectations demand that the nurse assume elements of the doctors role.

Remote area nurses experience pressure from consumers and medical colleagues to extend their practice and conform to a precedence. Kreger (1991) maintains that in this situation, “little or no consideration is given to the nurse’s competence, the safety of the consumer, or legislative and professional issues relevant to nursing.”

Medical and surgical procedures are often undertaken by the remote area nurse. In a community where I was employed, it was not unusual to be responsible for suturing, involving infiltration with local anaesthetic, trauma victims after weekend fights. It is often essential prior to evacuating cases such as serious trauma, illness, antenatal complications, or obstetric emergencies, to stabilise the patient. This sometimes necessitates the insertion of
a cannula and commencement of intravenous therapy and medication by the nurse. This is supported by Kreger’s 1991 research into the educational needs of remote area nurses.

Initiation of medical treatment presents a dilemma to the remote area nurse. Generally, an experienced nurse knows what the problem is, and how to deal with it. In emergency and non-emergency situations, consideration of the legal position of what treatment you are about to commence, presents its own problems. Despite medical consultation and collaboration, it is the nurse who is ultimately responsible for the well being of the client.

Ongoing disease control programs such as trachoma and sexually transmissible diseases, or alcohol and substance abuse problems, demand a level of expertise of the remote area nurse not expected in urban areas. The nurse is often required to make decisions and initiate treatment to maintain control and prevent further spread of infection.

Remote communities also have their share of psychiatric problems that nurses are expected to deal with. Mental Health Services are yet to extend sufficiently to rural areas despite the increasing need. This makes consultation with appropriate personnel very difficult.

Prescribing medications in the absence of medical consultation is a necessity that sometimes cannot be avoided. Once again, the nurse is put into a compromised position. State and Federal governments, as well as Nurses Boards, have been slow in providing realistic support, recognition or guidance to nurses facing these dilemmas. (Cramer 1989, Kreger 1991) Kreger (1991) suggests that “Generally, the authorities response has been to deny ... existing inappropriate legislation and policy, thereby leaving remote area consumers and nurses inadequately protected.” Northern Territory is the only exception to this. Legislation has been in place addressing the issue of remote area nurses prescribing medication. I believe that only recent in Victoria and South Australia, initiatives in confronting this problem are under way. (personal communication)

Further to the dilemma facing remote area nurses, is the adoption of their role as pharmacist. Remote area nurses are responsible for the ordering, storage and control of the substances. This often contravenes the various Poisons Acts and regulations across Australia.

Domains of other allied health personnel, fall into the realm of the remote area nurse. Measuring of door handles shower recess and toilets for the installation of aids for the disabled client is a common occurrence. The high incidence of respiratory disorders in Aboriginal children, necessitates expertise in postural drainage and percussion. Dietary advice and education is a continuing responsibility of the remote area nurse in the absence of nutritionist. Generally, the cost of accessibility of allied health to service remote areas is unrealistic. Responsibility for these areas becomes part of the extended domain of the nurse.

In conclusion, remote area nurses, against all odds, are the sole providers of a twenty four hour health care service to isolated communities. Denying the dilemmas in providing this health care, only serves to thwart efforts in ensuring a standard of safety. Pressure from health consumers and medical colleagues to go beyond legal and professional limits to conform with the precedence, add to the nurse’s anxiety.

Professionally accepted standards of practice are often undermined by the sheer nature of isolation, poorly resourced health centres and unreliable accessibility to specialist medical and allied health personnel. Achieving and maintaining appropriate remote area nursing competencies will ensure safe, high quality health care. Trail and error learning does not instil confidence for the practicing nurse, as the boundaries of job demarcation are breached. Through appropriately educating and equipping nurses for an expanded practise in remote
areas, the present difficulties may be overcome in achieving safety for the health consumer and the nurse.

Relevant legislation to protect the community and the remote area nurse has been denied for too long. Despite efforts from some individual states, illegality of practice is of considerable concern. The relevant authorities are yet to face the realism of nurses working in remote areas, providing a cost effective health service, to some of the most disadvantaged people of Australia.

Remote area nurses are having to confront a number of issues, but of most concern is the establishment and maintenance of nursing competencies and the legality of practice. Remote area nurses need the unqualified support of this conference in achieving appropriate education and changes to legislation. It is through this conference, that these issues can be discussed and highlighted, in achieving a safe, high quality health care service to remote areas.

References


