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The Status of Rural Nursing: Twelve Years On

Title Page

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The Status of Rural Nursing in Australia: Twelve years on

Abstract

In 1996 Desley Hegney published a seminal review of the literature concerning the status of Australian rural nurses. This article updates and expands that original paper by reporting on an integrative review exploring the same topic area between the years 1996 until 2008. Findings show that definitions of rural nursing are now integrated with those of remote nursing on a continuum of distance and contextual difference. The role and function of rural nurses is examined, along with a discussion of the importance of a primary health care approach in meeting community needs. The influence of social determinants of health is explored in this context. The culture of rural health workplaces in relation to the role and function of rural nurses is also a feature of this review. Research into the rural nursing workforce and, in particular, the recruitment and retention of staff are examined, with the high attrition rate of new or novice rural nurses pinpointed as a common theme in these studies. Important legislative changes that have affected rural nursing practice are also identified. This article concludes with a discussion of the latest research into Australian rural nursing, focusing on education in rural universities and the potential to develop new or novice nurses through the development of supportive relationships.

Key Words: rural, remote, nurse, workforce, legislation

Introduction

In 1992 the Association for Australian Rural Nurses (now the Rural Nursing and Midwifery Faculty of the Royal College of Nursing, Australia) was established, providing an avenue through which academics, clinicians and policy makers could discuss and advocate for inquiry into what had previously been an invisible area of practice. Research studies about rural nursing and rural nurses in Australia followed, with a seminal article by Desley Hegney,

The Status of Rural Nursing in Australia: A review being published in 1996 (1996). This article defined rural nursing, identified the role and function of the rural nurse and discussed rural nurses' extended role. Issues of job satisfaction, lack of anonymity, recruitment and retention, preparation for practice, peer support, culture, legal aspects and relationships with medical officers were also discussed in this significant contribution to the literature.

Reviewing the literature from 1996 onwards, this paper will explore and discuss definitions of rural nursing and factors that impact on the role and function of nurses working in rural areas, including advanced practice in primary health care settings. Context and the implications of living and working in the same community will be explored in relation to culture, anonymity, and the problem of workforce. Changes to legislation that now impact on rural nursing practice will also be outlined. The article will conclude with an account of the progress that has been made in developing and supporting rural undergraduate nurses and developing a culture that is supportive of learning and professional development in rural health workplaces.

Search Methods

A systematic search of the literature was undertaken of the electronic databases CINAHL, Ovid MEDLINE, PubMed, Proquest, and Medline, as these are most relevant to nursing. The search terms used were a first level combination of *rural*, *nurse* and *Australia*, limited by the years 1996-2008 and to English publications. This process resulted in 178 articles that were then mined using the following terms: *advanced practice*, *education*, *recruitment*, *retention*, *culture*, *mentoring* and *legislation*. The search terms used to guide this search were derived from the findings of Hegney's (1996) review and were expanded based on the authors' knowledge and experience of developments in rural nursing practice in Australia over the last decade. Abstracts of these articles were examined and all articles that discussed the status of rural nursing were retrieved. Relevant policy documents were also obtained from the websites

of the Federal, State and Territory governments, Australian Rural Nurses and Midwives, National Rural Health Alliance, the Australian Institute of Health and Welfare, and the Australian Bureau of Statistics.

The following discussion present an integrative review of the literature retrieved. Through the use of an integrative review, we are able to present a detailed examination of current themes that exist in the literature relating to rural nursing in Australia.

Rural Nursing

Who is a rural nurse? Researchers exploring the field of rural nursing have answered this question in a manner appropriate for their study. Given the broad nature of this role, researchers will often rely on participant self-definition (Mills, Francis, & Bonner, 2007a; National Rural Health Alliance, 2005). Originally the identity of rural nurses was tied to population numbers and health service staffing mixes that included the presence or absence of a resident medical practitioner (Hegney, 1996; Thornton, 1992). In recent times the definition of rural nursing has been widened to include nurses working outside of major metropolitan areas where patients have reduced access to health services. These nurses may practice within teams that have resident or non-resident members such as medical practitioners, allied health practitioners and specialist nurses (Francis, Bowman, & Redgrave, 2002).

Within the literature, debate is ongoing in respect to the difference between rural and remote area nurses. The role of the nurse working in remote areas is more clearly defined by the context of their practice (Council of Remote Area Nurses of Australia, 2008; Currie, 2007; Yuginovich & Hinspeter, 2007). Research indicates that nurses working in rural areas (similar to those working in remote communities) use a lifespan approach to practice; these nurses are considered to be generalist-specialists whose role is influenced by the context in which they work (Hegney, 1997a, 1997b; Hegney, 2000; Hegney, Pearson, & McCarthy, 1997). On average both rural and remote nurses are older (43 – 42.8 yrs) than their

counterparts working in major cities (41.9 yrs) (Australian Institute of Health and Welfare, 2008c).

Context of practice in rural areas is much more divergent than context of practice in remote areas, and it is this this divergence, which creates the point of difference between the two. Kruske et al. (2008) argue the generalist role of rural nurses increases as the population declines. Thus, the more remotely nurses are located, the greater is the generalist nature of the work. Context of practice therefore is the most major influence on the role of the rural or remote area nurse. . Influences on context include: distance from a tertiary referral centre, the size and composition of the team in which nurses work; the prevailing working conditions; and the size and composition of the community for whom nurses care (including ethnicity). When these factors are taken into consideration it is apparent that rural and remote area nurses' generalist role is found along a continuum and that there are more similarities than differences in their roles (Kruske, et al., 2008).

The Australian Government have formulated several measures of rurality and remoteness that provide a framework for clarifying the context of nursing in rural, or remote areas (Australian Government Department of Health and Ageing, 2005). Of these, The Remoteness Area Structure within the Australian Standard Geographical Classification (ASGC), produced by the Australian Bureau of Statistics (ABS, 2002) is currently used to produce the Australian Institute of Health and Welfare 'Nursing and Midwifery Labour Force statistics' (Australian Institute of Health and Welfare, 2008c). This structure consists of five categories based on an accessibility/remoteness index (ARIA) score, which measures the remoteness of a point based on physical road distance to the nearest service facility in an urban centre (Australian Bureau of Statistics, 2001). Statistical research that uses the AGSC as a framework for analysis informs policy and funding decisions affecting rural and remote nurses. In order to compare like with like therefore, it can be argued that the ASGC is the most appropriate classification system by which a rural nurse can be designated.

The Australian Institute of Health and Welfare consider nurses working in the categories of outer regional, remote and very remote to be non-metropolitan (Australian Institute of Health and Welfare, 2008c). The following figure (1) illustrates the number of non-metropolitan, (rural, remote or very remote) nurses in Australia. Data from 2001 and 2005 indicate a steady increase in numbers, with the greatest increase occurring in outer regional areas. More recent data have not been published and the reliability of future published data is likely to be questionable given the poor returns currently experienced by the AIHW during the renewal of registration process.

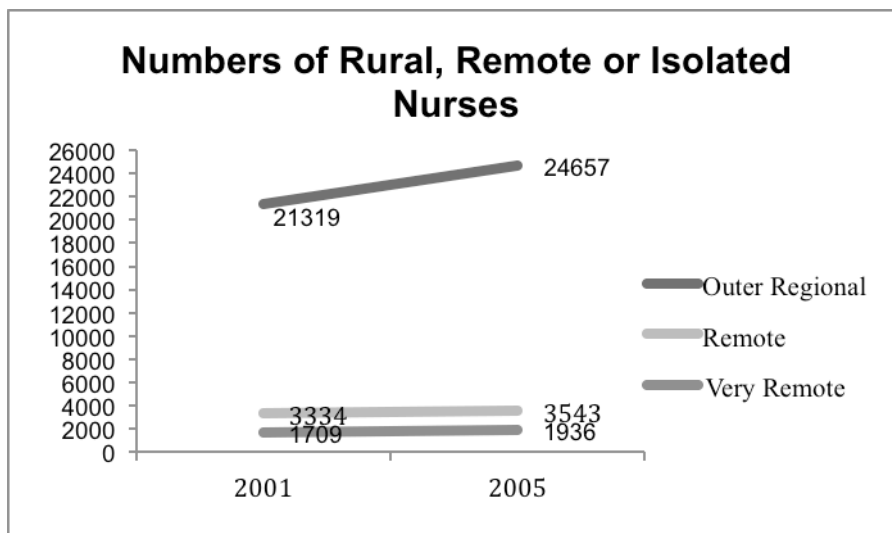


Figure 1: Rural Nursing Workforce Adapted From (Australian Institute of Health and Welfare, 2008c).

A key report produced by the Australian Productivity Commission (2005) (which also used the ASGC classification) found that the rural and remote nursing workforce was the most stable and sustainable of the health professions. Figure 2 illustrates differences between health care professionals and population ratios, relative to major city levels.

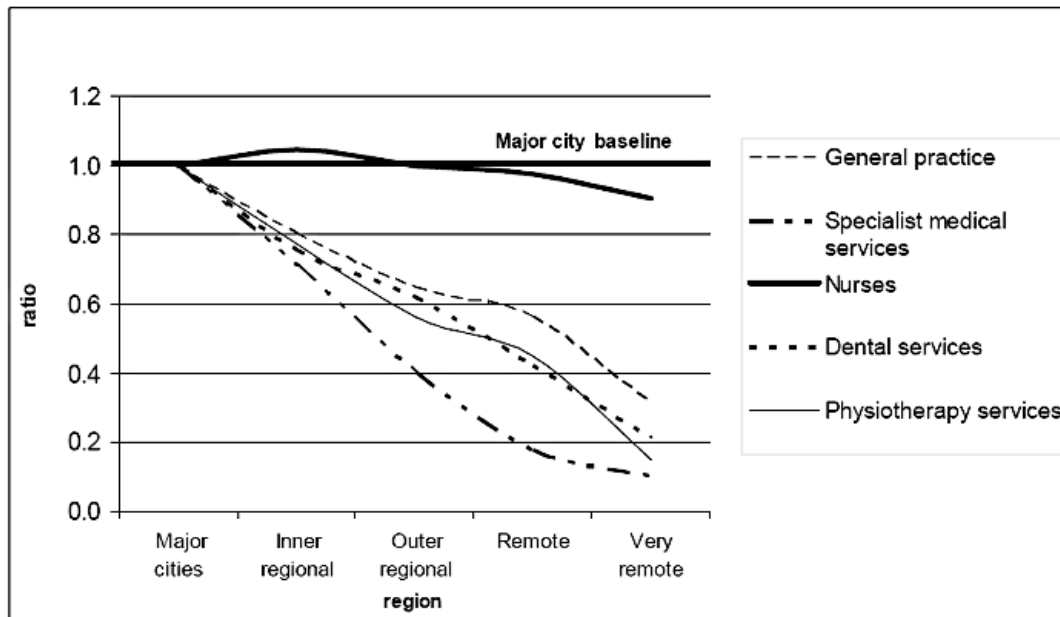


Figure 2: Health Care Professionals Relative to Location Adapted from (Productivity Commission, 2005, p. 205).

Role and Function of Rural Registered Nurses

While it is acknowledged that rural nurses work along a continuum from novice to expert (Benner 1994), the multifaceted and diverse role of the rural nurse (Kenny & Duckett, 2003), results in a particular emphasis in the literature on the importance of advanced nursing practice (Hegney, 1997b; Roberts, 1996). Advanced practice nurses demonstrate specialist skills and knowledge gained through further studies and/or extensive experience, and as such can be considered an authority in their field. Nurses endorsed by the Queensland Nursing Council who have successfully completed The Rural and Isolated Practice Nursing Endorsement (RIPRN) to work under the *Health (Drugs & Poisons) Regulation 1996* (Timings, 2006) are one example of rural nurses who work at an advanced level.

These advanced rural nurses ‘integrate education, research, management, leadership and consultation into their clinical role’ (National Rural Health Alliance, 2005, p.4) with some expert nurses achieving nurse practitioner status (Bagg, 2004). Despite the fact that the original legislation in Australia permitting a nurse practitioner role was limited to nurses working in rural and remote areas, earlier studies raised concerns that the attainment of nurse

practitioner status within the rural nursing workforce was limited by a high proportion of the population not holding an undergraduate nursing degree (Hegney & McCarthy, 2002; Kenny & Duckett, 2003). However, these concerns have been unfounded, with several States (e.g. New South Wales and Western Australia) initially providing alternative routes to nurse practitioner status (through demonstration of expert knowledge rather than a Master degree), thus overcoming the limitation of an academic qualification. However, despite these initiatives, and the relative isolation of their work, the number of actual rural nurse practitioners remains very small relative to the overall number of rural nurses. A recent national survey found that in 2007 there were only 11 rural/remote/generalist Australian nurse practitioners registered to practice (Gardner, 2007). The reasons for these low numbers could be related to the lack of academic qualifications, disinterest by rural nurses in a nurse practitioner role, the role confusion outlined by Turner, Keyzer and Rudge (2007); the lack of nurse practitioners to access the Medical Benefits Scheme (MBS) and the Pharmaceutical Benefits Scheme (PBS) or many other influences. Regardless, exploration of these influences is beyond the scope of this review.

Francis et al. (2002) argue that the context of rural nursing practice means that nurses will often work in isolation from a multidisciplinary team. Findings from a later study examining the practice of rural mental health nurses support this view (Gibb, 2003). Francis et al.'s (2002) extensive review of the literature identified a set of core areas that determined a rural nurse's ability to manage their practice well, these include: interpersonal skills, management ability, knowledge of legal and ethical concepts, advanced clinical practice, education, and research. Such a broad range of areas is indicative of the generalist role of rural nurses, a situation intensified by reduced levels of health professional support in delivering models of service delivery and care as compared to their metropolitan counterparts.

In addition to the professional isolation often experienced by rural nurses, there are other common characteristics of rurality that influence their role and function. The World Health

Organization (WHO) identifies a number of social determinants of health, such as poverty, stress, unemployment, social support, food and transport, that impact on health status (Simmons & Hsu-Hage, 2002). These factors are particularly significant in rural and remote areas in Australia. We know that people living in these areas have less access to health care services provided by multidisciplinary teams of professionals and adequate and affordable transport. The lack of primary, secondary and tertiary education services limits students' scholarly attainment and school attendance. There is also a greater degree of socio economic disadvantage, reduced access to affordable healthy foods in some rural or remote areas, and higher incidences of injury, infections and zoonoses related to industry and the environment (Australian Institute of Health and Welfare, 2008a, 2008b; Hugo, 2002; Larson, 2002; Simmons & Hsu-Hage, 2002).

For Aboriginal and Torres Strait Islander peoples¹ living in rural or remote areas of Australia, these same characteristics of rurality result in even poorer health outcomes as they are compounded by this population groups' higher incidence of chronic disease and a greater prevalence of risk factors such as smoking, alcohol and other drug use, hypertension and obesity. Even though the majority of Indigenous Australians live in major cities and inner regional areas, a much larger proportion of the total Indigenous population (25%) lives in remote or very remote Australia, as compared to the proportion of non-Indigenous population (2%) (National Rural Health Alliance, 2006; Pink & Allbon, 2008). For Indigenous Australians, culture also becomes a social determinant of health when the practices and beliefs of mainstream health care providers do not align with their own (Wilson & Grant, 2008).

¹ Throughout this paper we will use the term Indigenous Australians to include both Aboriginal and Torres Strait Islander people.

In order to address the influence of the social determinants of health , rural nurses need to be a 'jack of all trades and master of many' (Hegney 1995 cited in Hegney, 1996, p. 1) in order to meet community needs. Use of a primary health care approach that encompasses all people, belief systems and life circumstances is integral to the role and function of rural nurses (Francis & Chapman, 2008). Policy developments following on from the recently released WHO final report on the social determinants of health (2008) will demand a reorientation of rural nurses' role to a comprehensive primary health care model of service delivery and care. Given that the current workforce has been prepared for practice through predominantly hospital based training, such a shift will have to be underpinned by comprehensive education in the tenets of primary health care. This will support the development of a new role for rural nurses, compared to the traditional role which has been to operate within an illness orientated medical model (Mahnken, 2001).

Living and Working in the Same Community

Rural Culture

Culture may be defined as 'the ways in which people live their lives and the values and beliefs which lie behind what they do in everyday activities' (Gray & Phillips, 2001, p.53) . People who live in rural communities often share an ideology of difference compared to urban dwellers, underpinned by a need to protect and preserve local infrastructure such as hospitals, schools and services (Dade Smith, 2004). This sense of belief in the significance of rural communities by their members may lead to the exclusion of some groups, such as Indigenous people, immigrants, women, the young and the old, who are sometimes seen by more powerful sectors of local rural communities as non-productive community members (Gray & Phillips, 2001). Conversely groups that may be considered a minority in other towns have shaped the culture of some rural communities significantly. An example of this is the well-established migrant populations from countries such as Greece and Italy who have

greatly influenced local primary production to include activities such as viticulture (Hegney, et al., 2008)

It is of utmost importance, therefore, that rural nurses are culturally prepared to work in rural communities. One area which has seen significant improvement is the ability of rural nurses to work appropriately within Indigenous communities. This improvement can be seen to be a direct result of the formation of the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) in 1997. Outcomes from the program of advocacy that CATSIN has engaged with over time are evident in the cultural awareness training required of both urban and rural nurses by government and non-government organisations, and the inclusion of an Indigenous health subject in many undergraduate nursing programs (Indigenous Nursing Education Working Group, 2002).

The Culture of Rural Health Workplaces

Influencing the work of rural nurses are the implications of living and working in the same community, a phenomena that can be termed 'live my work'. 'Live my work' describes a phenomenon whereby rural nurses need to learn to manage their worlds from the perspectives of community member, nurse and health care consumer (Mills, et al., 2007a).

The concept of culture therefore impacts on rural nurses in a variety of ways. Not only do rural nurses have to understand the culture of the wider community, they also need to understand and be able to manage their local workplace culture. This includes understanding and communicating to others the idiosyncrasies and work patterns of general practitioners, and other allied health practitioners with whom they work (Mills, et al., 2007a). This translator role is one that rural nurses also must adopt within the community, frequently acting as a buffer between GPs and patients outside of normal work hours (Zeitz, Malone, Arbon, & Fleming, 2006).

Living their work includes a requirement for nurses to maintain relationships with other members of the health care team outside of work, which subsequently affects dynamics within the work environment. Findings from a study by Lea & Crickshank (2007) illustrate the social cliques in rural health care facilities that can arise from life outside of work. Such social cliques have the potential to lead to undercurrents in the workplace that foster a “pecking order”, placing new and novice rural nurses at the bottom. High workloads, an expectation that graduate nurses will “hit the ground running”, a lack of role models and the breadth of the nursing role are all identified in this study as key barriers in assimilating new staff into the culture of rural health care facilities (Lea & Cruickshank, 2007). The outcome from not being able to perform to an unrealistically high level as a student or new graduate working in a rural health care facility can result in experiences of marginalization, overt and covert criticism, and being ostracized as a consequence of not belonging to the social clique (Sedgwick & Yonge, 2008). Horizontal violence such as this, expressed in the form of gossiping, exclusion and allowing new or novice nurses to “sink or swim” forms the cultural underbelly of rural health workplaces (Mills, Francis, & Bonner, 2008a). Such findings strengthen support for Francis et al.’s (2002) suggestion that the list of core areas required for rural nursing practice incorporate interpersonal, communication, management and advanced clinical skills.

Anonymity

For rural nurses, their working day is not contained in working hours, rather wherever they are other community members will identify them as a nurse as well as a community member. For some rural nurses this results in them feeling as though they are ‘living in a fish bowl’ (Blue, 2002, p.200) always under surveillance; others feel that they are living and working in a supportive community environment, possibly closer to family and friends (Hegney, McCarthy, Rogers-Clark, & Gorman, 2002b). Rural nurse’s interconnectedness with the community usually results in informal and formal interactions with others that build social

capital through a sharing of knowledge and resources. Social capital in this sense is considered a positive outcome of increased trust between community members with reciprocity, or giving back, considered normal (Lauder, Reel, Farmer, & Griggs, 2005). A recent study discussed the dual relationships that many rural nurses have to account for when working with clients requiring palliative care (Kenny, Endacott, Botti, & Watts, 2007). Research about pharmacists and social workers working in rural towns found that they also struggle with high visibility that results in a lack of privacy and increased personal risk from disenfranchised members of the community (Allan, Ball, & Alston, 2008).

The Rural Nursing Workforce

The most prominent theme that arises in the literature that is the subject of this integrative review is the issue of recruitment and retention. Mills, Francis and Bonner (2006) argue that the literature regarding the “problem” of workforce for rural nurses is embroiled in the politics of signification. Academics see the clinical area as the problem, whereas industry sees the undergraduate preparation of nurses as the issue. The inadequacy of universities to sufficiently prepare undergraduates to enter rural nursing practice was also noted in the 2002 Australian Senate Inquiry into Nursing (Crowley & West, 2002; Kenny & Duckett, 2003). There is evidence of common ground, however, when both academics and advocates, such as professional bodies and unions, discuss the inequity between the level of support provided to undergraduate and graduate doctors to attract them into rural practice and that provided to rural and remote nurses (Hanna, 2001). There is also general agreement between academics, advocates and government that the international shortage of nurses (International Council of Nurses, 1999, 2006) continues to have a significant influence on the ability to recruit appropriately prepared nurses (Hegney & McCarthy, 2000; Iliffe, 2000; National Nursing Workforce Forum, 2000; Productivity Commission, 2005).

Research into factors that influence the recruitment and retention of rural and remote nurses in Queensland found that management practices in rural health facilities, emotional demands of work, poor workplace communication, family responsibilities, and a lack of management recognition for work well done, were the main reasons for nurses changing employers (Hegney, McCarthy, Rogers-Clark, & Gorman, 2002c). Of note are the findings from the study by Hegney, McCarthy, Rogers-Clark & Gorman (2002c) who found a high attrition rate for participants who were new graduates. The authors postulate that this could be attributed to limited opportunity for rural undergraduate clinical placements and a sense of “culture shock” resulting from moving to a rural area, which is congruent with later studies discussing the experience of new graduates in rural health care facilities (Lea & Cruickshank, 2007; Wallace & Boylan, 2007).

The same study also examined the factors that rural nurses considered important in retaining nurses in the workplace. Being part of a team, job satisfaction, a rural lifestyle, relationships with nursing colleagues in the health facility and a sense of belonging to the community were identified as the top five reasons to stay (Hegney, McCarthy, Rogers-Clark, & Gorman, 2002a). These findings were supported in later studies in Australia and overseas that also identified positive aspects of nursing in a rural community (Hegney, et al., 2002b; Mills, Francis, & Bonner, 2008b; Teasley, et al., 2007).

Legislation and Rural Nursing

Over the past twelve years, all States and Territories have undertaken a review of legislation that regulates nurses and midwives. The most significant change for nurses employed in rural and remote areas has been the implementation of registration, endorsement or authorization provisions for the nurse practitioner role in all States and Territories. These provisions recognize that communities in rural areas rely heavily on nurses with advance practice skills (National Rural Health Alliance, 2005). Associated Acts, such as drugs and

poisons legislation, have also been amended to accommodate the expanded role of Nurse Practitioners, however, at the time of writing this article, the Australian Government's Pharmaceutical Benefits Scheme remains unavailable to nurse practitioners.

The vast majority of nurses employed in rural areas are not nurse practitioners yet many are required through necessity and community expectation to perform in an advanced role. Endeavouring to meet the needs of clients and patients as and when these needs arise may result in nurses breaching legal boundaries enshrined in legislation such as nurses Acts and drugs and poisons legislation. Greater flexibility in the role of nurses in rural areas, along with a revision of associated legislation, is necessary to ensure that communities are provided with a least a minimal standard of health care (Sullivan, Francis, & Hegney, 2008). In Queensland such amendments occurred in 2001 with the introduction of the rural and isolated practice endorsement for registered nurses known as RIPRN (Timnings, 2006).

While these measures go some way to recognize and legitimise the unique role of nurses in rural locations, governments must accept the need to clarify the role of nurses in rural and remote areas and increase their legal status through appropriate changes to legislation, funding and policy (Sullivan, et al., 2008). Increased accessibility to educational programs that address the specific requirements of nurses employed in these locations will promote safe, effective practice (National Rural Health Alliance, 2005), ultimately decreasing the potential for nurses to be forced to perform below an acceptable standard of care. Such measures should address barriers that currently exist that reduce opportunities for experienced nurses to secure nurse practitioner status. These activities are necessities that will ensure high standards of care within legal boundaries regardless of geographical location of employment.

Developing and Supporting Rural nurses

More recent research and publication in the field of rural nursing focuses on developing alternative undergraduate programs that aim to prepare local people to become nurses in rural communities. One of the outstanding initiatives reported in the literature is the establishment of a satellite campus on Thursday Island in the Torres Strait, by the School of Nursing, Midwifery and Nutrition of James Cook University (2005). Such a strategy is reflective of the recommendations of the Indigenous Nurse Education Working Group whose report *getting em n keeping em* (2002) provided clear guidance to Australian schools of nursing and midwifery regarding the recruitment and retention of Indigenous people into undergraduate nursing programs (Usher, Miller, Turale, & Goold, 2005).

Research undertaken in other rural universities has found that while there were challenges in studying at a rural satellite campus (such as learning through the use of video or audio recordings of lectures), the advantages outweighed the disadvantages. Students at the Renmark Campus of Flinders University in South Australia reported greater levels of support from their family and friends than they would have experienced had they relocated to an urban university campus, the ability to form a close supportive network with other students because of the small size of the group, and opportunities to experience local clinical placements that fostered potential future employment as a registered nurse (Gum, 2007).

Developing a culture that supports learning in the workplace is an ongoing project for many rural nurses who demonstrate leadership attributes in their practice (Gibb, Anderson, & Forsyth, 2004). Mentoring as a strategy to improve the retention of rural undergraduates was introduced as part of the Australian Government Rural and Remote Nurse Scholarship Program in 2003 (Mills, Lennon, & Francis, 2006). Since then research has shown that experienced rural nurses often act as a translator of local culture, guides to the politics of rural nursing, and are clinical teachers for new or novice rural nurses, cultivating and growing staff through a variety of mentoring relationships (Gibb, Forsyth, & Anderson, 2006; Mills, 2008).

Furthermore, accidental mentoring also happens when an experienced rural nurse observes or senses a critical incident has occurred for a new or novice rural nurse and supports them for a short time to manage and understand the situation (Mills, Francis, & Bonner, 2007b). These supportive activities are particularly effective in reducing the effect of those negative factors described above that impact on recruitment and retention of nurses in rural or remote areas.

Conclusion

Twelve years following the publication of *The Status of Rural Nursing in Australia: A review* what progress has been made? The body of knowledge relating to Australian rural nursing is now well established and continues to grow. In this integrative review of the literature, rural, and remote nursing practice has been explored in depth, focusing on issues of significance to this unique area of practice. The role and function of rural nurses, the implications of living and working in the same community, workforce issues, legislation and preparation for practice and the importance of developing and supporting rural nurses are common themes in the published work. The increasing body of knowledge regarding nursing in rural areas has proved the impetus for changes in the role of the registered nurse, including accompanying legislation. While these are positive steps, it is apparent that some States have moved further in the recognition of the specialist, advanced role of rural nurses. It is apparent, therefore, that national equality in the legitimization of these nurses' role and adequate preparation and support for this important professional role is achieved. The future for rural nursing in Australia is nonetheless bright, with increasing acknowledgement of the significant of the nursing role in the delivery of health services in the rural and remote areas of our vast country.

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