

Getting it right in Queensland rural and remote areas

Sue Crocker, North Queensland Workforce Unit

FACILITATOR: I'd like to start this afternoon by introducing Sue Crocker, and the topic of Sue's theme this afternoon is Getting it Right in Queensland Rural and remote areas. Thanks, Sue.

SUE CROCKER: Hello. Firstly, thank you for that welcome. And what a pleasure it is to present at the conference. A bit cheeky, "Queensland Getting it Right in Rural and Remote Areas". We kind of think we're on the way. I don't think we've got it completely right, but we're certainly moving in the right direction, so we went for the positive approach that we are getting it right. Just some quick demographics. Queensland is covered by 1.7 million square kilometres, and most of the population of Queensland actually live outside the capital city.

And as a lot of you know, that's where a lot of health dollars get spent, in capital cities, so we're pretty happy up in the north to actually have this model and to be able to present it on a stage. I'm going to talk about the collaborative practice model that registered nurse, Indigenous health workers, and the medical officer work under in Queensland's rural and remote areas. I'm going to differentiate between isolated practice areas and rural hospitals, because we implemented the model initially in the isolated practice areas a lot earlier than what we did in rural hospitals.

When we started the isolated practice model back in 1998 we looked at what was happening in isolated practice areas. Predominantly the isolated practice areas in Queensland are Aboriginal and Torres Strait Islander communities. What we found was that the care delivered by registered nurses was often ad hoc, there were no standard clinical protocols or guidelines to guide practice, documentation was poor, and follow-up was almost non-existent. There was good support for the nurses out there, medical officer support by telephone with RFDS, but that collaborative model wasn't as good as what we thought it could be.

So we looked at how to develop that model and how to integrate collaboration and get some standardised clinical protocols and guidelines. In 2001 it was raised, that the same issues as those in isolated practice areas existed in rural hospitals. We undertook consultations with rural hospitals and we visited all the rural facilities in Queensland. What we found from that, was that a lot of the rural hospitals didn't have any access, or limited access, to pharmacists, and this is what this graph is showing you here. Queensland is broken up into three zones: northern zone, central zone and southern zone.

And as you can see, the southern zone example there, there's over 40 rural facilities with probably only about 10 or 11 pharmacists to service those areas. So the quality use of medicines is also an issue for us. When we visited the rural facilities we also looked at standing orders. There are a lot of standing orders out there written by medical officers for registered nurses to be able to administer and supply medication, but what we've found with those standing orders were they were quite ad hoc, they were different from facility to facility, there was no standardisation, and they varied in the content in regards to management and assessment.

Some had no assessment criteria, the drug dosages including duration and requirement for follow up were missing, they were just not quality standing orders. So we already had what we call the Isolated Practice Course, and I'm just going to talk a little bit about how that was

developed and then it progressed on to be a Rural and Isolated Practice Course. We had a Nursing Act that enabled us to be able to deliver courses and to have nurses endorsed by the Queensland Nursing Council to practise in an expanded role. So we needed to develop a course curriculum and have it approved by the Queensland Nursing Council.

The Queensland Nursing Council put some guidelines around that, and what we wanted to do was develop a role profile, what we wanted advanced practice nurse look like in rural and isolated practice areas. So we developed a role profile and had a look at standards of practice expected of the registered nurses working out there. We had our course developed, we got it accredited through the Queensland Nursing Council, and we called it initially, the Isolated Practice Course, for isolated practice areas and in 2001 changed it to the Rural and Isolated Practice Course when rural hospitals were included. There was also some legislation that we had to look at, in Queensland it is called the Health (Drugs and Poisons) Regulation 1996.

Under the Health (Drugs and Poisons) Regulation 1996 in Queensland, nurses were unable to supply or administer medications without a doctor's instruction, so we were able to, with the support of the Queensland Nursing Council, Queensland Health Nurse leaders and RFDS medical officers, have that changed to expand that scope to enable nurses to be able to administer and supply. To be able to do that, we didn't want ad hoc administering and supplying as well, so we developed what we called a drug therapy protocol. That drug therapy protocol listed all of the drugs that nurses could administer or supply while working in isolated practice areas and rural hospitals. They also too provided restrictions and conditions around how those drugs could be used by the registered nurse.

To make the drug therapy protocol work we had to have health management protocols. We had a very successful partnership with the Royal Flying Doctor Service, Queensland section, and we developed what is known as the Primary Clinical Care Manual. The Primary Clinical Care Manual contains clinical guidelines and clinical protocols for all health professionals working in rural and remote areas of Queensland. I guess it's pertinent to point out at this point in time, we always thought that this was a multi-disciplinary approach, that the Primary Clinical Care Manual was never going to be a nursing practice manual or Indigenous health worker practice manual or a medical officer practice manual, but one to be used by all staff working in isolated practice areas and rural hospitals.

We wanted to use that notion of collaboration and multi-disciplinary approach to health, and I'll talk a little bit about that. Once these protocols and guidelines were developed they then needed to be approved by the health facility. There are different mechanisms in place for approval of those clinical guidelines and clinical protocols, and they do vary a little bit from the isolated practice areas in the rural hospitals. And the reason for that is a lot of the rural hospitals have got medical superintendents, so we didn't want to just go in there and say, "These are now your protocols and guidelines, we want you to follow them". Instead we asked them to "have a look at them with the Director of Nursing and decide what it is that you want your nurses what it is you want your nurses to be able to do".

We did the same with the Indigenous health workers. There was no scope for Indigenous health workers to be able to supply and administer medications under Queensland legislation. So we changed that, and we developed a course, we called it the Isolated Practice Course for Health Workers, and the health workers who were enrolled in that course were at diploma level and they had to be working in designated isolated practice areas.

And most of those isolated practice areas in Queensland are in the Torres Strait, Cape York and Cairns District Health Service. We had some difficulties with that. Our first cohort, we didn't have a high percentage of completion rate of that course, so we sat back and we had a look and we evaluated and asked the students why they dropped out. They identified the workload was

too much and what we were asking of them was too much, and we, I guess assumed that there was a higher level of knowledge than what there actually was. So we've gone back now and we're currently in the process of reviewing the curriculum, and we're going to break it down into modules, which we think will be a little bit more bite-sized for them to be able to take on.

We did a lot of numeracy and literacy at the beginning of the course, drug calculations, but there was a lot of the basic anatomy and physiology missing, and what was going to be a six month course turned out to be a two year course, and the health workers really struggled with it. Those that completed it are doing fantastically. Some of the feedback from them now is that they still don't quite feel comfortable in some of their clinical skills, so we're going back now and just updating them with their clinical skills. And what they can do is, they're initiating medication, which is something that they haven't felt comfortable doing before.

Some of the communities that we're talking about only have Indigenous health workers as service providers. When we developed the Primary Clinical Care Manual it had to be evidence based. So we went to a great deal of trouble, I guess, making sure that this manual was evidence based and continues to be evidence based. The clinical protocols and guidelines are put together by specialists in the different areas, and the Director of Medical Service for the Royal Flying Doctor Service, Queensland section is the editor of the Primary Clinical Care Manual, so we work closely every two years to review that manual, which we're currently in the process of doing now.

The underpinning element of all of this was collaborative practice. We felt that there was a lot of talk about collaborative practice, but nowhere was it actually defined. So as part of the Primary Clinical Care Manual and all the courses that we developed, we felt that we had to come up with a definition of what collaborative practice was. And this is the definition that we came up with. It's a term used to describe the practice relationship between registered nurses, medical practitioners, Indigenous health workers and other health professionals, who will use the Primary Clinical Care Manual as a guide to their practice and professional relationship.

The collaborative practice relationship incorporates the dual notions of collaboration and accountability. The defining characteristics of the collaborative practice relationship are mutual respect and acknowledgment of each profession's role, scope of practice and unique contributions to health outcome, clearly stated protocols and guidelines, clinical decision making, which comply with relevant legislation and are supported by the health facility and the health organisation. There are clearly defined levels of accountability, with an acceptance that joint clinical decision making is an integral component of collaborative practice, and a belief that the best health outcomes are achieved when well prepared health professionals work in collaboration and partnership in both a practice and educational setting.

So initially to do this, we had a lot of support from the medical officers throughout Northern Queensland. They marked case studies for the registered nurses who were completing the course to gain their endorsement. The feedback from the medical officers was very positive in that they were starting to realise what expertise that they had in their nursing staff working in their areas. So the report back from them was that it was a really positive experience. When we rolled the course out to the rural areas, we also had that feedback from medical superintendents and medical officers who were marking case studies.

So I think it supported that relationship between those two health professionals. So why did we actually want to implement this model across rural hospitals, seeing we already had it in isolated practice areas? Well, they're typically small, resources are limited, you need to get the best out of what you've got there and to use human resources to their maximum. Usually large distances separate them from regional or base hospitals, rural and remote health professionals

work collaboratively in expanded generalists roles, so they're often doing tasks that they're actually not prepared for when registered nurses go to work in these facilities.

They don't undergo a lot of the training that's expected and required of them to be able to deliver the services that they do. They need to adopt a practice to meet the needs of the community. So when we do our training, it's actually quite different when we go there and work out in these rural and isolated practice areas, as you all know. So what can a rural and isolated practice endorsed nurse do? They can only practice under their endorsement while they're working in a designated rural hospital or an isolated practice areas, and that's all designated by the Health (Drugs and Poisons) Regulation 1996, so it doesn't cover provincial hospitals just because you have this endorsement with the Queensland Nursing Council.

They can initiate and/or supply controlled and restricted drugs listed in their drug therapy protocol and a health management protocols. In Queensland we can administer S2s and 3s without a doctor's instruction, which means give a single dose, but we can't send people home with S2s and 3s. But a rural and isolated practice endorsed nurse can make that decision to send somebody home with S2 and 3 without consulting a medical officer.

Some of the drugs that are listed in the drug therapy protocol include commonly used antibiotics, diuretics, analgesics, vaccines, both oral and injectable contraceptives, and topical and ear and eye preparations. So it's quite comprehensive. There's a lot of restrictions and conditions around the controlled drugs, in that it gives a mirror of opportunity for the nurse to be able to administer a drug without a doctor's instructions if circumstances don't allow contact with the medical officer. So ideally, we want contact with the medical officer, but if it can't happen for some reason then that nurse can proceed, and they must contact the medical officer as soon as possible afterwards.

So what can an authorised Indigenous health worker do? They can only practice again while they're working in the Aboriginal or Torres Strait Islander community, and again that's designated by the Health (Drugs and Poisons) Regulation 1996. They can administer or supply a controlled or restricted drug, an S2 or 3, under a drug therapy protocol and a doctor's instruction. So the difference between the health workers and the registered nurses is that on each occasion the health worker must be in consultation with the medical officer at some point. Over the telephone they need to relay what their assessment is and what their management is.

We've just, in the last few years, had the chronic disease strategy come to Northern Queensland and with that had an enormous impact on the Indigenous health workers, particularly in the Torres Strait, as they couldn't supply people with their ordinary everyday oral hypoglycaemics and their anti-hypertensive medications. So what we did was we put the chronic diseases into the Primary Clinical Care Manual, which then allowed the health worker to be able to supply, on a doctor's instruction, the medications for patients to manage their chronic diseases. So again, I was talking about that burden of knowledge with the Isolated Practice Course for the health workers.

We then gave them a whole heap of drugs that they hadn't even learnt anything about, to be able to supply, it was quite overwhelming for them. So what have we got to do? With the health workers we're in the process of redesigning the curriculum, we're going to go for a modular approach, we're going to look at the immunisation module first, so we needed to have changes to the legislation to be able to do that again, and we got in principle support to do that about two weeks ago. So we're writing the module now for immunisation, and then we'll hopefully do the same with sexual and reproductive health, isolated practice, which will incorporate some of those acute presentations, plus a chronic disease module.

Given the large number of chronic disease medications we're thinking along the lines that maybe we do need to have a separate chronic disease module, and certainly utilising the work that Janie Smith has done in this area promotes the need to develop chronic disease modules. That's probably about all I need to say, other than without the partnership of the medical officers, the RFDS, this certainly wouldn't have been able to happen in Queensland. It's had a big impact on the quality of health service delivery by registered nurses in rural hospitals and isolated practice areas in particular. Documentation has improved significantly, follow up is conducted and treatment and management is standardised. Where we're up to now is that we need to go back and we need to have a look at how is it working in the rural hospitals in particular.

We need to do some research in the isolated practice areas and see what sort of impact it's had on Indigenous health outcomes. There's a lot more follow-up now than what there has been in the past. Nurses now have minimum practice expectations and standards, they need to answer to a registering body the Queensland Nursing Council if they are practice outside their scope of practice. The Indigenous health workers, as I said, we need to develop the new curriculums for them. There's no governing body for the health workers, which has created some problems for us in the fact that who's going to monitor practice and practice standards and that sort of thing.

So what we're doing and endeavouring to do is to set up boards in each of our health service districts, where senior Indigenous health workers can monitor the practice of their authorised Indigenous health workers and keep that monitoring process, like the Queensland Nursing Council does with the registered nurses. So thank you for your time, thank you for coming, thank you for listening, and happy to take any questions.

PRESENTER

Sue Crocker is currently employed as a Nurse Educator educating rural and remote workforce, co-ordinating Primary Clinical Care Manual review. She also represents the North Queensland Workforce Unit on the Health (Drugs and Poisons) Regulation 1996 committee. Sue's education qualifications are a Masters in Nursing Degree in Health Science Graduate Certificate Child and Family Health Rural and Isolated Practice and Immunisation Endorsed. Sue's previous positions include rural and remote nurse educator, remote area nurse, community health nurse and intensive care nurse.