Submission No 21

THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO THE DELIVERY OF SPECIFIC HEALTH SERVICES AND SPECIALIST CARE IN REMOTE, RURAL AND REGIONAL NSW

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Thank you for the opportunity to add my voice to that of others concerned about provision of health care in rural/remote regions. I am an RN (non-practicing) and a former paramedic who has worked predominately in rural NSW, although my early years in both professions were in major urban centres. I worked as an RN in an MPS for 10 years before moving to the tertiary sector where I worked for a further 10 years as a lecturer at a rural university. I have spent the past 3 years working as an independent researcher in the area of rural and remote health professional education and I am doing PhD research in rural health professional education. I have followed this enquiry closely and thank you for your attention to the health needs of rural and remote people.

I am noticing locally that we have more paramedics (I have yet to ascertain whether they remain in town or whether they are being used to backfill larger centres. They used to spend most of the day not in town even though the hospital was told that we didn't need an emergency capacity as this would be provided by ambulance.) There is an additional RN at the MPS to cover ED. This is excellent, particularly as the older, more experienced workforce retire. At least young RNs will have someone else to confer with. Affordable dental care is non-existent. I recently had to pay a 'gap' that was three times the amount 'contributed' by my health fund. As I no longer have paid work, I won't be able to attend regular check-ups.

'Fixing' rural health is far from being as simple as a single solution so I will caveat my comments by stating that I am offering personal experience of working in an MPS and an education/research perspective as a former lecturer and current researcher.

Working in an MPS

What Existing Scope of Practice Fits Best? - I loved working in our local MPS however, it was fraught with many non-clinical challenges. When no doctors were available, the RNs were told we were amazing and could handle anything. Then, when there was a move to close smaller emergency departments, suddenly, the RNs couldn't manage the ED without a doctor. Our capacity changed depending upon the existing narrative at the time. The constant changes in who you had to call at different times of day, out of hours, weekends etc. was hard for experienced staff to follow let alone newer staff. Although I came to the MPS with two relevant health qualifications, I needed to do much more education in order to feel confident and competent to work in the role; such as suturing, eye injuries, backslabs etc. I also worked to achieve licensing as a remote x-ray operator. I was asked if I would undertake a Masters degree as a nurse practitioner, which I did, however, with three subjects left to complete and having spent more than $7000 in subject fees – I was told I could not work in that capacity at the MPS, I would need to move to one of the larger nearby hospitals. In my mind, that defeated the purpose. Those of us from a rural background in the NP programme agreed that we were doing the course to credential, and in some instances, legalise the work we were already doing. The NP programme (run by a major metropolitan university) was good in that it promoted attitudes to leadership in provision of health care which I put to good use, BUT there was nothing else in the course that taught me anything useful for a rural scope of practice. Urban-based lecturers were confused by our topics in assignments as they had no understanding of rural/remote practice. Although I occasionally did shifts at the larger hospitals, the point of NP capacity in the MPS was to support the doctors by independently managing the triage 4 and 5 cases

that present to the ED that formed the majority of presentations. The remote x-ray qualification was rendered useless because I couldn't formally request/order an x-ray and who would be responsible for interpreting it? (Some of these challenges still persist.) I noted one suggestion within the review regarding sending rural nurses to urban locations for training. I completely disagree with this for two reasons. Firstly, in order to learn how to work rurally, you have to work rurally. Working in even major rural centres does not prepare you to work rurally. Secondly, it serves to reinforce negative stereotypes that the *real* work is in the city which must be so much better than rural work.

Dual/Blended Scopes of Practice - Having both RN and Paramedic qualifications, I was asked by one area administrator if I would be tempted to use my paramedic skills – going on to suggest that I should not; yet another manager who heard this said "but you would if you had to right?" This is a common dilemma for dual qualified professionals who must work under a single professional scope. (Highlighting the failure here of dual nursing and paramedic degrees that would be useful in rural areas. I know this from the number of post graduate nurses working rurally who flocked to paramedic programmes to support their competence and confidence to work independently in emergencies.) I note within the report on this investigation, suggestions that paramedics could work in emergency departments. While this might be useful in some locations, typically high acuity cases for which they would be perfect are low and they are not trained for low acuity cases that tend to be in the majority in small hospitals. It isn't necessarily a solution in emergencies either as I am aware of incidents where paramedics missed critical diagnoses such as STEMI that were subsequently picked up by the RNs. The pitting of one professional group up against another being better to work in certain environments is not productive and can be interpreted as demeaning for those with blended skill sets required by over-lapping rural roles. Such is the strength of professional silos, there were nurses who said that if paramedics were brought into the ED, they would either not help them, or they would leave. One administrator claimed it would happen "over my dead body". For me, having both skill sets was useful in a small hospital, particular for patients who present in the back of cars and seriously injured in the back of utility trucks and required extraction prior to treatment. (Although I admit that sometimes I forget which professional group I gained the skills from. It just became my rural scope of practice.) There are also opportunities presented here. If paramedics were trained to manage minor presentations, they could avert presentations to EDs in the first place. Blended skill sets should be viewed as desirable in rural practice, not a competition.

A different Type of Skill Rusting - All of these skills, all of the training I did became useless when we were reduced to about 5 band aid protocols for very minor cases. This was insulting. So I resigned, hoping that working in the tertiary sector would allow me to influence education for rural practice. The ten years working rurally left me wondering why it is that there is so little education that targets the knowledge and skills necessary to work in rural practice contexts. (I note here that recommendations and actions out of this inquiry are very welcome such as an additional RN in our local hospital to cover the ED, local nurses have told me that they now have access to additional training and financial support to achieve education that would mitigate some of the experiences I encountered.) There just seems to be so much emphasis on band aid solutions when training that meets the needs of small communities seems so obvious. I discovered that those with the power to influence

rural curricula in universities, largely didn't have rural backgrounds so didn't see or understand the need. Perhaps it was my failure to articulate my ideas adequately, but my ideas were met with responses ranging from horror to scepticism.

Duplication and Wasted Resources - I want to mention some other situations I encountered as I think they are opportunities for further useful change. As a spoke site in a hub and spoke model, I was frustrated by waste of time and resources. I would assess and treat a patient, organise transport to the hub site and speak with a registrar regarding transfer of the patient to their care. They would then go to the hub site ED where the bloods we took would be discarded, our IV cannula removed etc and the patient would be completely reassessed. (I know this from also working at the hub site where they would sometimes ask me how I knew certain relevant details. I would simply tell them that I had read the notes that came with the patient.) Surely hub and spoke sites could work together to reduce such duplication, waste, further time spend in already over-burdened EDs and repetition of invasive procedures that are uncomfortable and sometimes risky for patients. Additionally, there are state-wide procedures for many circumstances that just do not fit rural locations. The inquiry demonstrated multiple occasions when health care is assisted by hospitality staff. It was not uncommon that a cardiac arrest would have myself, an EN and a wards-person. When contrasted with vison of urban hospitals that have designated roles for multiple health staff in emergency situations – holding us to the same procedures is completely unrealistic. Again, my suggestions to have smaller hospitals practice two person cardiac arrest drills were quickly dismissed because "that is how all of NSW Health does it". When you can't comply with the procedure, this is then used against you to demonstrate that you can't cope with an emergency. It is the old judging a fish by its ability to climb a tree and confusing lack of capability with lack of resources.

I also recall paramedics bringing a critically injured patient into the ED for retrieval. The incident was on a dark section of highway in the early hours of a Winter's morning – sub zero in this area. They were told they would have to wait for the helicopter. They elected to wait at our nearby hospital that was warm, well-lit and offered nursing assistance and additional equipment. I agree with their decision, although it would have been quicker to continue via road transport. The health service did not agree. Apparently the hospital was left to wear the cost of the evacuation. We once hand-ventilated a patient for two hours because no helicopter was available. We could have had the patient at the hub site three times over by road in that time. These *systems* don't consider the cost to people in the community and fail to allow for judgement in particular circumstances.

Providing Emergency Services - When we had a doctor at the MPS, the RNs fielded constant questions from management regarding what procedures were carried out by the RN and what was done by the doctor. The fees attached to each individual procedure or action on top of a call-out fee should not be occurring when it is the RN who does most of this work. Usually by the time a doctor arrives, the ECG is done and interpreted, cannula inserted, bloods taken and some drugs/fluids given. Yet the doctors would charge for it. Doctors were refusing to come to the hospital in the middle of the night for illnesses such as a person with a toothache. I understand this as they have their normal work to go to in the morning with a surgery full of people. We tried to shield them from calls where they weren't really needed

because sometimes they were so tired. I'm not talking about minor dental pain though, but people with a lot of pain and a swollen face. Some (not all) of the doctors want the call out fee, but don't want to attend to do the work. Neither do they want the nurses to have a protocol to manage these cases. So what are the patients to do? They have usually already described an inability to access a dentist. They can't/shouldn't wait until morning, probably couldn't get a GP appointment and in some cases there is no public or private transport to allow them to go elsewhere.

It is unreasonable to expect that people will flock to the larger hospitals and services just because of closure of smaller services. We know that particularly older residents just won't do it. They will wait – even with chest pain. They then become sicker, have greater healthcare needs and ultimately it costs more. Primary Health Care and health literacies will take time to translate into improved health and reduced presentations, and that probably won't be realised until the high volume of older people (proportionately higher in rural areas) with high levels of chronic disease are gone.

Defined Scope of Practice - There is also no consistency with scope of practice and guidelines for RNs (although I am hoping the rural generalist programme will help). Should nurses follow FLECC guidelines, use the PCCM or other rural/remote guidelines? Have they been trained to use them? Do they have the skills and knowledge to act on the guidelines? One of the problems in rural and remote areas occurs when urban nurses take up a contract in a rural and remote location and don't even have the assessment skills to know which page of a set of guidelines to turn to. I have lost count of how many social media posts I have seen from young nurses who have just accepted a rural/remote contract and are asking what they need to know for when they get there. We were even sent a staff health nurse once that was almost catastrophic for one young patient because of a failure to recognise a sick patient. This also then becomes problematic when more urbanised administration looks at the incident and cite it as another example of small hospitals not having the knowledge to cope. (I have even theorised that this is a deliberate strategy to close small rural hospitals.) Centralised recruitment has compounded this issue by continuing to supply nurses without emergency experience because they don't deem there is a need for it in small hospitals – in spite of repeated requests for staff to have this capacity.

Cultural Attitudes - Finally, I want to point out some cultural issues that need to be attended to if anyone is to ever *want* to work rurally. I had been told while working in Sydney that 'the poor dears in rural areas don't know much'. This was common and confused lack of knowledge with lack of resources. Attitudes are powerful. We had a running 'joke' with the paramedics when we transferred a patient. They would return to tell us what criticisms had been levelled at us by staff at the hub site. (Such was the repeated derision from hub site nurses who would also refuse to work where there is no doctor.) Often it was regarding little things like the day I wrapped a gown around a pillow because we had no pillow cases. Apparently that was cause for much laughter. These attitudes can lead to poor professional identity and implicit messaging that you are an inferior species and really, who would *want* to work rurally? So often what is stated by others is either not true or out of context and I will expand on the reasons for this in the next section on tertiary education.

Scope of the Issue - MPS and small hospitals with fewer than 50 beds constitute approximately 70% of all public hospital services in Australia. So while the handful of staff in one small hospital may seem insignificant, more broadly they constitute a large portion of the health care workforce. Nurses outnumber doctors 10:1 in rural/remote areas and have been previously reported as a stable workforce that were a fixed-cost, 24/7 presence. Rural health professionals care for people who have multiple comorbid conditions and are therefore more complex to manage, tend to present later in the course of an illness and are therefore sicker by the time they present and take longer to assess. And yet, they don't figure in state nurse/patient ratio arrangements.

The rural and remote health workforce is not limited to public or private health care providers. There are many health care professionals who work in relative or actual isolation in industrial, tourism, justice, defence, shipping and other roles. (this was my Masters research project). The workers in these contexts experience the same broad scopes of practice, professional isolation and need for education specific to that type of practice. Often, because they sit outside of health systems, their lack access to on-going education that meets their needs is magnified. Together, the sum of these rural and remote practice contexts points to a perhaps larger than anticipated need for a specific, recognised qualification and specific education for this scope of practice.

Tertiary Sector

What is 'Rural Education'? - I recently conducted a scoping review of rural health professional education literature (published in an international peer reviewed journal). I wanted to see exactly how and what is being taught about rural health. The literature in isolation painted an appalling picture. It appeared that largely, what is referred to as 'rural' education is standardised health professional education conducted in a rural area, or, relates to recruitment and retention strategies or rural background, and not to education strategies per se. (Medicine does seem to be ahead of the curve in relation to teaching rural content.) I suspect that in practice, some rural content and maybe specific teaching strategies exist, they just aren't being documented in research. There is a big difference between standardised education delivered IN a rural setting and education FOR rural practice. Much of the literature *appeared* to 'dump' students in rural locations on a 'rural placement' and hope they absorbed rural concepts by osmosis. In some cases (particularly with short placements) it actually reinforces preconceived negative ideas about rural practice.

'Preparation' to Work Rurally - While not meaning to 'bash' UDRH, as there are other issues that limit their influence, their mission to increase rural recruitment and retention over the past 30 years is not working. Neither are we seeing improvement in population health outcomes as a result of their operation. I'm also not intending to claim that their focus on students with rural background (therefore having an existing rural identity) and rurally located education is not important. However, I don't understand why (with the possible exception of medicine) 'education' does not seem relate to what students are being *taught*. I am not so naïve as to believe that education is a stand-alone solution either, but there is

some evidence that graduates won't go to rural locations because they don't feel capable to manage a broad scope of practice, particularly in isolation. I recently spoke to a new graduate nurse who told me that her degree did not prepare her in any way for working rurally. I asked what part she felt least prepared for and she told me it was emergency work, explaining that she had been told not to worry about it, just turn the camera on. (She had no idea at the time what that even meant.) I follow a social media site that constantly supports the lack of preparation for rural practice. Nurses seeking/undertaking rural contracts post questions that highlight just how little they know about rural practice. Fundamental skills such as being able to assess a patient and formulate a diagnosis so you know what page of the treatment guidelines to turn to that I referred to earlier. This, in turn, highlights the lack of value placed on requiring a particular standard and, that any bum-on-a-seat will just have to be good enough in hard to staff rural communities. This has quality and safety implications for staff and most certainly for rural residents and affects continuity of care.

The university where I worked had an operational health centre that had some telehealth capacity – what an opportunity to use that for rural consultations AND to teach students; also conveying information about remotely delivering care and how to use the equipment at the same time. (At the time I left it was not being used in a teaching capacity.) Again, I caveat this by saying that telehealth is a useful tool, not a single solution. Provided there is connectivity, there are incredible options available for telehealth that can allow practitioners to remotely listen to breath and heart sounds and examine an ear etc. I am not aware of this technology being used or taught in Australia, although JCU used to have two subjects related to remote communication and using technology. Specific topics and teaching methods can be used to accelerate learning which would be useful for health professionals who need to take on early responsibility for care at an expert level. As far as I can ascertain, such teaching strategies are not being used in Australia. It is also not as simple as dumping subject content online and saying you are providing rural education.

Hidden Curriculum - Part of the problem with the lack of rural curricula is that many urban educators don't have rural experience so they don't know what content to write into their subjects and what assessment tasks to set students. Although inadvertent, attitudes are transferred to students that indicate that rural/remote health is not important. On several occasions I walked into teaching sessions where smaller hospitals and rural health professionals were being scoffed at claiming that rural practitioners do not know very much because they never get to see or do much. This is so far from the truth, yet contributes to implicit bias being conveyed to students.

Implications of Non-Rural Background –

I witnessed non-rural lecturers claiming to have conducted rural research when their projects could have been set in an urban location. There was no engagement with rural concepts. Their claim to rural research was simply because they conducted a project in a rural setting. One lecturer explained that they were offering students on placement half-price movie tickets to get them to stay in smaller locations over the week end… I recently came across an article related to rural health education that listed one of the themes as 'preparation for practice'. Excited to finally find a concrete teaching practice, I was again

disappointed to learn that this theme related to helping students to book their accommodation. This demonstrates my point though about the lack of rural curricula content and assessment, or at least a lack of documenting it. I even encountered a lecturer with their name on a text book about rural health who had no idea what actually happened in rural/remote practice.

One of the reasons why there is so little published research is that health professionals often have to teach along side their own practice and patient load, so who has time to also publish particular teaching methodologies?

Content V Competencies - In my time in the tertiary sector, I witnessed the effects of stripping content from courses in favour of competency/skills-based approaches. Particularly for more complex skills, students often couldn't remember a skill a month later that they had been assessed as competent to perform. Students need subject content to give context to the work they will need to do. This is what will help define their role as health professionals where they will need to make decisions in situations they have not been prepared for, and it is what separates them from being technicians. Even information as fundamental as the social determinants of health was being removed. Preparation for rural practice requires more education, not less. It is good to see though, that there is some requirement to teach students about Indigenous health and I would agree with assertions made within the review cautioning against blanket initiatives that just 'tick the box' on inclusion of Indigenous content. There are teaching strategies (published) that can maximise the effectiveness of placement experiences for students.

A New Direction - I have recently had accepted for publication an article imploring health professional educators to consider what rural content is in their subjects and to consider the implications of hidden curriculum on attitudes to rural health (health education journal). I am currently working on research that explores the level of rural content in health professional curricula – so far it seems that disciplines such as law are doing this better than many health education providers which is more than a little disappointing. As part of my PhD, I am trying to address fundamental rural information that needs to be included in rural curricula and to define how it should be taught and assessed.

Having worked and studied rural concepts in such depth, my thought is that rural health needs a dedicated health practitioner – not a quick-fix two year course that won't be valued, not a nurse practitioner, not a paramedic practitioner but a rural practitioner with a specific identity. It requires a post-graduate programme that will have pathways from a number of health professional backgrounds and give them a dedicated, recognised, unifying skill-set that health professionals will *want* to do as part of a career path. The programme has to teach an extended scope of practice that is admired and desired by health professionals. It needs to be a robust course that health professionals aspire to do because it comes with the kudos of being 'top of the heap', not a role that is currently viewed as being least desirable. Working in rural health is amazing from the point of view that you do get to see and do everything! It is a great career but it can never be promoted as such while such insidious attitudes are promulgated from within the professions and within the very professional nurseries (even rural ones) that are supposed to be preparing health professionals for rural practice contexts. I think that an entirely new, contemporary role

would mitigate the deeply entrenched professional silos and associated attitudes, allow for a rural-specific identity to be developed, provide a role that is recognised and is applicable across multiple rural/remote contexts of practice. Such a course will require sound educational design grounded in rural knowledge. Whatever strategies are put in place, I hope I have at least highlighted the importance of the need for a concurrent cultural shift in attitudes towards rural practice.

I hope my insight is useful.