CRANAplus
improving remote health

CRANAplus framework for remote and isolated practice

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Framework for Remote and Isolated Practice, CRANAplus, 2012

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introduction

CRANAplus is the peak professional body for remote and isolated health, providing advice to Government, service providers, clinicians, and consumers on equitable access to safe, high quality health care.

CRANAplus believes it is essential to have nationally consistent standards of practice for the remote health workforce to improve the health outcomes for those living and working in remote areas. As a result, this 'Framework for Remote and Isolated Practice' has been developed.

framework for remote and isolated practice

The framework consists of five elements which are aimed at all health professionals providing care in the community, regardless of the model of service delivery.

Framework for Remote and Isolated Practice

- Definition of remoteness
- Remote and isolated workplace settings
- Characteristics of health services
- Pathway to Remote Practice for Nurses/Midwives
- RAN Certification

definition of remoteness

CRANAplus defines remoteness as a complex subjective state, the causal factors are:

- geography and terrain limiting access and egress
- being socially and culturally isolated
- environmental and weather conditions resulting in isolation
- isolation due to distances
- being isolated from professional peers and supports
- isolation as a result of infrastructure, communications and resources

Defining remote areas is often based on Commonwealth Government categories of remoteness, using a range of classifications including:

- RRMA (Rural, Remote and Metropolitan Areas) classification
- ARIA (Accessibility/Remoteness Index of Australia) classification (based on ARIA index values)
- ASGC (Australian Standard Geographical Classification) Remoteness Areas (based on ARIA+ index values – an enhanced version of the ARIA index values)
- MMM (Modified Monash Model)

CRANAplus believes the following factors need to be considered:

- **Geography and terrain limiting access and egress**
  Mountainous terrains and islands can result in isolation from resources and limit access but still be within an area designated through the classification system as non-remote e.g. Bruny Island (TAS).
- **Being socially and culturally isolated**
  Living and working in a culturally different community different to your own culture, and social networks
  are limited or different to your usual supports and networks.
- **Environmental and weather conditions resulting in isolation**
  Natural disasters such as flooding or inclement weather like snow and storms, result of other natural disasters.
- **Isolation**
  The vast distances, distance and the time to access services can vary due to the mode of transport or the quality of the roads.
- **Setting for practice**
  Operating in the aeromedical environment where altitude is the isolation factor along with limited resources, or where security procedures is an isolating factor e.g. prisons.
- **Being isolated from professional peers and supports**
  Inclusive of health professionals working in non-health organisations e.g. detention centres, tourism, mining, industry.
- **Isolation as a result of infrastructure, communications, security processes that limit access**
  For example Defense Forces, international development (AID workers). Unreliability of communication systems and referral pathways.

remote and isolated workplace settings

Remote health professionals work in a variety of settings as described in CRANAplus' definition of Remote and isolated areas. Remote health professionals are an integral part of the health care system in Australia. Remoteness, in and of itself, is a determinant of health.

Remote and isolated practice areas present particular challenges to the delivery of quality services, including:

- Small and/or dispersed populations
- Poorer health status
- Diverse cultures
- Social erosion
- Geographical isolation
- Challenging access and egress
- Limited and aging infrastructure
- Smaller economic potential, poverty, higher unemployment
- Limited political influence
- Harsh extremes of climate
- High workforce turnover across all disciplines
- Limited opportunities for private models of health care

Remote health professionals are employed in a range of settings including, but not limited to:

- State and Territory Government run health services
- Community controlled health services/Aboriginal Medical Services
- Primary Health Care Services/Clinics
- Country Hospitals/Multi-purpose Hospitals
- General practices
- Mining and other industries
- Mobile and fly-in fly-out (FIFO) services
- Non-Government and Not-For-profit Organisations

It is widely acknowledged that the remote and Indigenous populations of Australia have a higher burden of diseases and subsequent reduced life expectancy, yet poorer access to equitable health services compared to the rest of the Australian population.

The Workforce

There is limited data currently available around the remote and isolated health workforce in Australia that accurately reflects the numbers, vacancy rates, characteristics and settings/facilities in which they work. In a series of papers by Lenthall et. al (2011)[1] the characteristics of the nursing workforce in remote has been described. The data available reflects that remote Australia has a disproportionately lower number of health professionals per head of population, in comparison to urban and rural Australia.

This mal-distribution is across all health professional groups and whilst nurses are the most evenly distributed across all geographical areas and comprises 50 % of total workforce their numbers and those of midwives are decreasing in remote areas. Remote health workforce work longer hours and are older comparative to the urban workforce. The remote communities are becoming increasingly reliant on overseas trained professionals, short-term placements and fly in fly out service[2].

Remote health professionals are typically 'hard-working', flexible, adaptable, resourceful and passionate about their work. Their practice encompasses all of the challenges, and the considerable rewards, of this unique and specialised field of health care.

Remote health professionals are guided by 'health' as being a whole-of-life concept, encompassing physical, spiritual and emotional well-being of individuals, family, community and the environment.

Remote health professionals in accordance with their scope of practice, are specialist practitioners who provide and/or coordinate a diverse range of health care services for the entire population.

Scope of Practice

CRANAplus supports the following definition of Scope of Practice:

> A profession's scope of practice is the full spectrum of roles, functions, responsibilities, activities and decision-making capacity which individuals within the profession are educated, competent and authorised to perform.
>
> The scope of professional practice is set by legislation – professional standards such as competency standards, codes of ethics, conduct and practice and public need, demand and expectation. It may therefore be broader than that of any individual within the profession.
>
> **The actual scope of an individual's practice is influenced by the:**
>
> - context in which they practice
> - consumers' health needs
> - level of competence
> - education, qualifications and experience of the individual
> - service provider's policy, quality and risk management framework
> - organisational culture[3]

characteristics of remote health services

CRANAplus identifies two key principles, which are essential for a robust, safe and sustainable remote and isolated health service:

- Comprehensive primary health care model of care
- Robust clinical governance framework.

CRANAplus supports the following definition of Primary Health Care:

> Primary health care is socially appropriate, universally accessible, scientifically sound first level care provided by health services and systems with a suitably trained workforce comprised of multi-disciplinary teams supported by integrated referral systems in a way that: gives priority to those most in need and addresses health inequalities; maximises community and individual self-reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health. Comprehensive primary health care includes health promotion, illness prevention, treatment and care of the sick, community development, and advocacy and rehabilitation[4].

CRANAplus supports the following definition of Clinical Governance:

The definition of clinical governance that underpins the Clinical Governance Framework is as follows:

> Clinical governance is the set of relationships and responsibilities established by a health service organisation between its state or territory department of health (for the public sector), governing body, executive, clinicians, patients, consumers and other stakeholders to ensure good clinical outcomes. It ensures that the community and health service organisations can be confident that systems are in place to deliver safe and high-quality health care, and continuously improve services.
>
> Clinical governance is an integrated component of corporate governance of health service organisations. It ensures that everyone – from frontline clinicians to managers and members of governing bodies, such as boards – is accountable to patients and the community for assuring the delivery of health services that are safe, effective, integrated, high quality and continuously improving[5].

Staffing

CRANAplus supports the concept of minimum ratios of staffing in remote PHC services, taking in to consideration the population, size of the community, remoteness from other significant health services and the ill-health burden experienced by its population.

Table 1: Standard of Health Service Staff to Population Ratios by Community Size

Pop range	AHWs	Nurses	Doctors
>3,000	1:350 (9)	1:500 (6)	1:1,000 (3)
1,300–2,999	1:250 (5–9)	1:450 (3–6)	1:1,000 (1.5–3)
800–1,299	1:200 (4–6)	1:300 (2.5 – 4.5)	1:800 (1–1.5)
400–799	1:100 (4–8)	1:200 (2–4)	1:600 (1)
250–399	1:75 (3.5–5.5)	1:200 (1.5–2)	1:400 (1)

(Numbers in brackets estimated number)

The table above uses the basic staff to population ratios of AHW 1:50, Nurses 1:200 and Doctors 1:400 and modifies according to size of communities, whereby in larger communities, economies of scale and access to other human services (health and otherwise) means that fewer numbers can be effective as opposed to the smaller communities with smaller population numbers[6].

In addition to this narrow mix of health care providers, CRANAplus highlights the need for inclusion of a system to ensure access to Midwives, Oral Health Professionals, Nurse Practitioners, Allied Health Professionals, mental health workers and Specialists medical services in any model.

Remote and Isolated Practice within a Health Context

The definition below provides a succinct summary of the characteristics, different settings and models of care, differentiating remote workforce practice from rural and urban workforce practices.

Remote Health is carried out in contextually different settings, including but not limited to: government health services; community-controlled health services; aboriginal medical services; primary health care centres; multi-purpose centres; private general practices; mining; and other industries like tourism; mobile and fly-in/fly-out services; as well as private, and non-government organisation health services.

Remote Health practice is delivered through:

- health service models catering for highly mobile populations
- predominantly nurse-led models of care
- collaborative multidisciplinary approaches, in partnership with community and stakeholders
- an understanding of the community within its cultural context
- overlapping, and evolving advanced and extended roles of team members
- integrated comprehensive primary health care approach, inclusive of acute and emergency care, chronic disease and public health across the life span
- scopes of practice that are informed by the identified needs of, and engagement with the community.

pathway to remote practice for nurses/midwives

CRANAplus believes that Nurses and Midwives who work in remote and isolated practice need a generalist approach using a broad scope of practice, to address the diverse needs of their entire community.

A Remote Area Nurse/Midwife is defined as:

> A registered nurse/midwife whose scope of practice encompasses broad aspects of Primary Health Care and requires a generalist approach. This practice most often occurs in an isolated or geographically remote location. The RAN/M is responsible, in collaboration with others, for the continuous, coordinated and comprehensive health care for individuals and their community[7].

Experience gained in following areas of practice may help prepare for the generalist skill set required to deliver Comprehensive Primary health Care in a remote context:

- Rural and regional health settings
- Community nursing or practice nursing roles
- Emergency care
- International development

Newly qualified registered nurses may enter the remote health workforce through a dedicated transition to practice program with a specific focus on preparing for a rural and remote context.

Each remote professional health role will differ, depending on the unique needs of each community.

Specific roles and scope of practice may require preparation in:

- Maternal and Child Health
- Mental Health
- Women's and Men's Health
- Community Capacity Building/Health promotion
- Chronic disease management
- Emergency care
- Workplace Health and Safety

To maintain competency in the workplace, nurses and midwives must embrace the concept of 'lifelong learning' to ensure they have the necessary knowledge, skills, attitudes and behaviors to meet their obligation to provide ethical, effective, safe and competent care.

> Continuing professional development (CPD), is the means by which members of the profession maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities needed throughout their professional lives[8].

CPD activities may be informal and formal, broad and varied to maintain competence in the workplace. Possible examples may include, but not limited to:

- Post graduate education
- Short courses
- Conferences
- Webinars
- Forums
- Journal club
- Mandatory workplace activities – basic life support, fire training

Continuing professional development activities must have relevance to the individual's scope of practice with clear aims and objectives that meet the individual's self-assessed requirements.

Minimum CPD required for annual renew of registration by NMBA[8]

Type of Registration	Minimum Hours	Total Hours
Registered nurse or Enrolled nurse	20 hours	20 hours
Midwife	20 hours	20 hours
Registered nurse and midwife	Registered nurse – 20 hours/Midwife – 20 hours	40 hours
Nurse practitioner	Registered nurse – 20 hours Nurse practioner endorsement – 10 additional hours relating to prescribing and administration of medicines, diagnostics investigations, consultation and referral	30 hours
Midwife practitioner	Midwife – 20 hours Midwife practioner endorsement – 10 additional hours relating to context of practice, prescribing and administration of medicines, diagnostics investigations, consultation and referral	30 hours
Registered nurse with scheduled medicines endorsement (Rural and remote)	Registered nurse – 20 hours Scheduled medicines endorsement – 10 additional hours relating to obtaining, supplying and administration of scheduled medicines	30 hours
Midwife with scheduled medicines endorsement	Midwife – 20 hours Scheduled medicines endorsement – 10 additional hours relating to context of practice, prescribing and administration of medicines, diagnostics investigations, consultation and referral	30 hours
Registered nurse and midwife with scheduled medicines endorsement	Registered nurse – 20 hours/Midwife – 20 hours Scheduled medicines endorsement – 10 additional hours relating to context of practice, prescribing and administration of medicines, diagnostics investigations, consultation and referral	50 hours

Topics relevant to remote and isolated practice

The Topics relevant to remote practice may include, but not limited to:

- Cultural Safety
- Emergency Care
- Primary Health Care
- Immunisation
- Pharmacology
- Chronic disease courses i.e. Diabetes, Asthma, Renal
- Workplace Health and Safety

Postgraduate education or qualifications are beneficial for remote and isolated practice.

Courses, which are more relevant to the remote context include:

- Remote/rural health practice
- Public health
- Primary health care
- Health promotion
- Critical care (Emergency care)

CRANAplus recommends all nurses and midwives working in remote and isolated health services, be provided the opportunity to undertake a comprehensive introductory and orientation program(s) inclusive of personal and professional safety and security.

*** Recommended courses that can be undertaken pre-employment or within the first year:**

- Stay Safe and Secure*
- Remote Emergency Care (REC) or equivalent*
- Advanced Life Support (ALS) *
- Pharmacotherapeutics for RAN/M's*
- Maternal emergency care (MEC)for non-midwives or equivalent*
- Midwifery up skilling (MIDUS) or equivalent**
- Immunisation*
- Driver education courses 4x4*
- Cultural Safety**
- Annual Core Mandatory competencies – through eRemote or equivalent
    - Fire and Evacuation
    - Manual Handling
    - Drug Calculation
    - Basic Life support

The frequency of re-certification will be dependent upon health service requirements, personal CPD needs and professional recommendations.

It is important to note:

- Advanced Life Support course to be undertaken with a maximum interval of 2 years, to maintain competence.
- Emergency course to be undertaken with a maximum interval of 2 years, to maintain competence.
- Jurisdictional or employer specific requirements, such as:
    - Queensland Health and Victoria Health, Remote and Isolated Practice Registered Nurse (RIPRN) Course
    - Northern Territory, Department of Health, prerequisites for Remote Health nursing/midwifery employment.

positive safety practices

The delivery of quality health care is intrinsically linked to the health, safety and wellbeing of all people involved including workers, visitors, family and clients. Remote and Isolated practitioners may be vulnerable to psychological or psychological harm if exposed to unfamiliar and uncertain situations or events including but not limited to a lack of secure food, people experiencing extreme poverty, inter-generational trauma, aggression and violence, roaming dogs, extreme temperatures, conflicting expectations and extreme driving conditions.

When working in remote and isolation, how do you incorporate safety, security and wellbeing practices into your everyday work that are culturally appropriate and effective?

CRANAplus has identified seven domains to guide your safety practices in every-day work for remote and isolated health. These are reflected in further detail in the CRANAplus Safety and Security Guidelines[9] and include:

1. **Accompanied** – never alone if attending call-outs after hours or during business hours if there is an unknown event concerns for safety.
2. **Prepared** – necessary education to be both professionally and personally prepared for a role in remote and isolated practice
3. **Resilient and prevent fatigue** – ability to respond to the challenges of remote practice including minimising fatigue though workload management and prioritising self-care.
4. **Workforce and career** – plan and balance work with life
5. **Communication and connectivity** – ensure reliable and effective communication and transport
6. **Prevention and De-escalate** – prevention and de-escalation skills
7. **Identify Hazards and manage risks** – identify, report and contribute to the management of hazards and risks

CRANAplus believes that it is critically important for those working in remote and isolated practice to gain additional skills and knowledge to manage safety in complex and culturally diverse environments. This includes be prepared for known events that may threaten safety including being proficient in maintaining optimal safety by applying a risk management approach and safety tools such as those located within the Working Safe in Remote and Isolated Practice Handbook[10].

A key measure to build your capability and confidence in the prevent and control work related violence is education[11]. Typically, training is based on an assessment of risk in your work area. In the remote and isolated health, it should be aligned with working within a comprehensive Primary Health Care model of service delivery. This covers theory, to understand work-related aggression and violence, prevention (how to assess and take precautions), Interaction (deal with an aggression or violent person) and response/recovery (post incident actions).

RAN certification program

Certification Program

CRANAplus believes it is important to pursue a process for recognition of individual registered nurses who meet the Professionals Standards of Remote Practice that validates their status as a Remote Area Nurse (RAN).

A CRANAplus Certified RAN will be a nurse with the requisite skills, knowledge and experience to be responsive to the fundamental health needs to their remote, rural and/or isolated community, employer and patients. The Professional Standards of Remote Practices for nurses is the foundation that guides the minimum standards for high quality and safe nursing care in isolated areas[12].

Benefits of undertaking a Certification process will be:

Nurse

- Professional recognition
- Driven by our profession
- Aspirational career development opportunity
- Ability to move between employers/jurisdiction without having to 're-do'
- Defines a minimum standard for the provision of competent, safe, quality care
- Clarity and confidence in scope of practice
- Clarity on educational preparation and study requirements

Patient

- Clear expectations of the standard of care
- Comprehensive Primary health care approach
- Caring for individuals, families and entire community
- Access to safe, quality nursing care regardless of location

Health Service

- Nationally recognised
- Minimum Standard of knowledge and skill for the provision of competent, safe, quality care
- Improved Clinical Governance
- Retention (improved)

Professional Standards of Remote Practice

The 'Professional Standards of Remote Practice: Nursing and Midwifery' is endorsed by CRANAplus as a National Standard[13].

Standard 1

Has appropriate registration and endorsement for practice and works in accordance with the professional Standards for Registered Nurse/Midwife (NMBA).

Standard 2

Maintains own health, wellbeing and resilience within a professional, safe working environment.

Standard 3

Practices within a culturally respectful framework

Standard 4

Practices within a Comprehensive Primary Health Care model of service delivery

Standard 5

Works within care pathways and develops networks of collaborative practice.

Standard 6

Has a level of clinical knowledge and skills to safely undertake the role.

Standard 7

Has a period of recent clinical practice in a remote and isolated location within the past five years.

Standard 8

Has an ongoing commitment to education relevant to practice in the remote environment.

Standard 9

Practices within a Safety and Quality Framework.

references

1. Lenthall S, Wakerman J, Opie T, Dunn S, MacLeod M, Dollard M, Rickard G, Knight S: Nursing workforce in very remote Australia: characteristics and key issues: *Australian Journal of Rural Health* 19(1): 32-37(2011).

2. AIHW Media Release: *More doctors and nurses, but supply varies across regional and rural areas.* (Ocober 2010): https://www.aihw.gov.au/news-media/media-releases/2010/2010-oct/more-doctors-and-nurses-but-supply-varies-across

3. Nursing and Midwifery Board of Australia: *National Framework for the development of decision-making tools for nursing and midwifery practice*, September 2007 – rebranded: http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Frameworks.aspx

4. Australian Primary Health Care Research Institute (APHCRI) presentation given by Ms Caroline Nicholson: *Development of a framework for integrated primary/secondary health care governance in Australia* (17 July 2012): http://files.aphcri.anu.edu.au/resources/lectures-presentations/conversations-aphcri/c_nicholson_presentation.pdf

5. Australian Commission on Health Care Standards: *National Model Clinical Governance Framework* (2017): https://www.safetyandquality.gov.au/wp-content/uploads/2017/12/National-Model-Clinical-Governance-Framework.pdf

6. Bartlettt b., Duncan P,: Top End Aboriginal Health Planning Study: *Report to the Top End Regional Indigenous Health Planning Committee of the Northern Territory Aboriginal Health Forum*. April 2000. PLANNED HEALTH Pty. Ltd. NSW.

7. CRANAplus: *Definition of Remote Area Nurse/Midwife*: Credentialing Pilot Project Advisory Group (2013)

8. Nurses and Midwifery Board of Australia: Fact sheet: Registration Standard: *Continuing professional development* (November 2016) website: https://www.nursingmidwiferyboard.gov.au/Registration-Standards/Continuing-professional-development.aspx

9. CRANAplus Safety and Security Guidelines 2017: crana.org.au/uploads/pdfs/CRANAplus-Safety-Security-Guidelines.pdf

10. CRANAplus Work Safe in Remote and Isolated Handbook 2017: https://crana.org.au/uploads/pdfs/CRA_Safety_Booklet_online.pdf

11. WHO, Guidelines on Workplace Violence in the Health Sector 2003: http://www.who.int/violence_injury_prevention/violence/interpersonal/en/WV_ComparisonGuidelines.pdf

12. CRANAplus: RAN Certification: Nursing in remote and isolated practice: brochure: p2, 2017: https://crana.org.au/certification/ran-certification/

13. CRANAplus: Professional Standards of Remote Practice: Nuses/Midwives (2014): https://crana.org.au/resources/practice/standards/

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