Advanced Nursing Practice: Experiences of Clients and Multi-Discipline Health Workers in Bush Nursing Centres in Rural Victoria

Mollie Burley

Lesley Siegloff, Mollie Burley, Elaine Duffy

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Lesley Siegloff, **Mollie Burley**, **Elaine Duffy**, Monash University Centre for Rural Health

AIMS

This paper describes the development, implementation and work in progress of a study of advanced nursing practice in the "bush nursing" context in rural Victoria. Specifically, data are presented about the experiences of clients attending five nominated bush nursing centres in Eastern Victoria and the experiences of "other" health care workers involved in client care with "bush nurses". Data collection is still in progress as this paper is being written therefore we will present only the interim findings from clients at this time. We will include data collected from health care workers and an update of information from the clients in time for the conference.

The specific aims of the Victorian Rural Nurse Project Part 2: Advanced Rural Nursing Practice Model: Bush Nursing (VRNP2) are to:

- describe and validate the advanced rural nursing practice (Registered Nurse Division 1) role and service delivery model [This is not part of this paper];
- describe the characteristics of the advanced rural nursing practice role of the "bush nurse" in Victoria [This is not part of this paper];
- explore the views and experiences of clients and other health care workers with regard to the "bush nurses" role[1]; and
- document health outcomes and consumer satisfaction with the services.

METHODS

The study utilises an Action Research methodology that focuses on participatory research and action for change which incorporates both a quantitative and qualitative approach. Through the Action Research framework we will seek understanding and learning from experience at every stage of the process. The action research process will provide practitioners the opportunity to integrate theory and practice and is described as particularly useful in community settings[2,3]. There will be an ongoing cyclic collaborative process involving questioning, field research, analysis and reflection, conclusions, recommendations for action and action itself throughout the life of the project that will lead to improved rigour[4,5,6]. In addition, the use of varied informants and several different methods and comparisons will facilitate triangulation[7]. The NHMRC argue that qualitative research methods are appropriate for better

understanding experience and, to influence the economic, political, social and cultural factors in health and disease. This style of research also facilitates improved interactions between various participants and the effect of health outcomes on decisions about health care[8].

A reference group was established to guide the project and to provide advice to the project team[9]. An expert panel, with specific skills in the areas of emergency care and rural and remote nursing, will provide clinical advice to the project team and participants, and will assist in the identification of health outcomes appropriate for Victorian bush nursing centre clients in small rural communities[10].

A series of teleconferences were utilised to refine and modify the questionnaires developed for clients and other health care workers. A preliminary workshop provided more details about the project via a "sample pack" of client documents related to the study. The workshop specifically explored the bush nurses perceptions of "advanced nursing practice" competencies, identified specific clinical practice categories and explored a range of possible health outcomes for clients that are to be trialled and implemented in each centre during the study. The action research model facilitated input from the bush nurses, management and community representatives in developing questionnaires, data collection strategies and reporting arrangements.

Project posters, newspaper articles and a radio interview accompanied the launch of the project in August 2000. At each centre all clients were invited to participate in the project by the bush nurse. Clients agreeing to participate were provided with a "client package" which included:

- contents sheet — this explained what each item was, it's purpose and who was to take the action required;
- client contact details — requested the name, telephone number and preferred day and time for contact by the research team. The nurses faxed this document to the researchers;
- explanatory statement — provided details about the project and the contact details for the Project Officer and the Monash Ethics Committee;
- consent form — the consent form could be completed either by the clients themselves or the Parent/Guardian, if this was relevant. Clients were asked to sign the form and place it into the envelope provided. The nurses sent the envelopes (reply paid) to the researchers with their normal mail service; and
- client questionnaire — each client received a copy of the questionnaire so they knew exactly the questions the researchers would ask on the telephone.

As client contact details were received they were entered on to an Access database. Once the consent form was received the Project Officer then rang the client as close as possible to their preferred time to arrange an interview time, or, to complete the questionnaire during the initial call. Questionnaire response data were recorded in the Access database with the Statistical Package for Social Sciences (SPSS) utilised for

analysis of the quantitative data. Qualitative data will be analysed in detail at a later date using the NVivo software package.

Individual "bush nurses" provided a list of health care workers they collaborated with in the scope of their work. The list is broad and diverse and includes general practitioners, medical specialists, allied health workers, mental health workers, Maternal and Child Health nurses, Pharmacists, Diabetes Educators, Ambulance services, Psychologist, Community development workers, Adult Day and Support Services (ADASS), alcohol and drug workers, masseur, naturopath, chiropractor and service co-ordinators. Questionnaires have been mailed and are due for return in December. A second questionnaire and reminder with a final return date in early January 2001 will be forwarded to participants who do not meet the December deadline

The action research technique enabled the research team to: have increased flexibility and responsiveness; involve participants and local communities being "researched"; and provided the opportunity to "emphasise discovering novel or unanticipated findings with the possibility of altering the research plan as the need arises" [11,12,13].

RESULTS

As the project is still in progress, interim findings will be presented from the "client" questionnaire data. Comparative analysis will be undertaken at a later time. Responses from health care workers involved in shared care with the "bush nurses" will be provided closer to the conference, and actions taken as a result of this information will be described.

Four of the five bush nursing centres commenced the project on the target date with one centre starting approximately three weeks later following official agreement to participate by the Committee of Management. To date we have received and recorded 145 contact and consent forms and have successfully obtained information from 74 clients, a response rate of 51%. We have been unable to reach every client in the desired two-week period, following their visit to the bush nursing centre due to delays in receiving their consent form or non availability at the time of contact.

Of the 74 clients who participated in the survey all except 2 agreed to complete the questionnaire immediately. Of these approximately 50% had completed the questionnaire at home prior to our call. Interviews where the clients had completed their questionnaires lasted approximately 2 minutes compared to 8–10 minutes for clients who had not completed the questionnaire.

62.2% of all participants were female. The numbers attending each centre were 36.5% at Cann River, 35.1% at Buchan, 17.6% at Dargo, 9.5 at Swift's Creek and 1.4% at Gelantipy.

93.2% had used a bush nursing centre before and used the bush nursing centres every 10 months or so. Of all clients 39.2% attended on the day for an appointment, 29.7% because of illness, 17.6% seeking advice and 6.8% due to an accident. On average participants had travelled about 7.5 Kilometres to the service and had lived in the area for 31 years. 32% of the respondents had lived in their community for 40 or more years,

21% for between 26–39 years and 34% for between 9–25 years. 77% of the respondents were aged 45 or older with 50% of these being over 65 years old.

People knew about the centre because they were locals (63.5%), from other sources (32.4%) or from the local paper and the project notices (2.8%). The majority of participants (81.1%) described themselves as living in a remote town with the remainder stating they lived in a rural town with a population of less than 2000.

In exploring the question of access 54.1% stated they had access to a small regional hospital, with the remainder describing access to a large regional hospital. 9.5% of clients did not respond to this question with the majority of responses being received as completed questionnaires directly to the researchers, without any telephone contact. 27% stated they had access to a Community Health Centre, the nearest of which is approximately 1.5 hours from the closest bush nursing centre. 2.7% usually had no access to a bush nursing centre but indicated they would like this service in the Metropolitan area. 79.7% indicated they had access to a pharmacist, but that they obtained some medication from the bush nurses.

89.2% had access to a GP with two of the five centres providing general practitioner services in a limited capacity each week. The remaining respondents indicated they went to the next larger town. 85.1% indicated that they had no access to medical specialists.

In terms of their health, respondents rated their health status as Good (37.8%), Fair (25.7%), Very Good (24.3%), Excellent (6.8%) or Poor (5.4%). 73% indicated that their health was about the same as a year ago, 12.2% feeling much better now, and 9.5% feeling somewhat worse, 4.1% feeling somewhat better and 1.4% feeling much worse. The majority of participants (90.5%) were aged 35 years or older with the greatest number ranging between 55–74 (43.2%) years of age. 89.2% were still driving their own car with 8.1% utilising other forms of transport (8.1%), usually with someone else driving.

Of greatest interest were responses about how important specific items were to clients and how satisfied they were with these items. The researchers were specifically interested in items of high importance (I) and low satisfaction (S) as these would identify areas where improvements could be prioritised. All respondents rated satisfaction higher than importance and there was no more than two scores difference between any items in approximately 98% of the responses.

The scores for importance (I) were subtracted from the scores for satisfaction (S) and the difference (D) indicated the respondent's priorities as follows:

Highest importance

1.	Access	=	0.02
2.	Communication	=	0.11
3.	Facilities	=	0.13
4.	Discuss care	=	0.25
=5.	Quality of service, and Opportunity to feedback	=	0.26
6.	Knowledge of services	=	0.31
7.	Input into services needed	=	0.55

Lowest importance

Respondent's individual scores for satisfaction and importance from high to low.

Satisfaction — high to low	Importance — high to low
Communication skills of staff	Communication skills of staff
Quality of service	Access to service
Access to service	Quality of service
Discuss care	Facilities available
Knowledge of services available	Discuss care
Facilities available	Knowledge of services available
Opportunity to provide feedback	Opportunity to provide feedback
Input into type of service needed	Input into type of service needed

Respondents were asked to indicate what they liked, didn't like or that could be improved with regard to the centre, services and staff. An overview of preliminary data to date follows.

The centres

Clients **liked** the convenient, modern, clean, tidy and comfortable facilities that were easy to access, in good locations and also described as excellent. Other comments included:

> The centre is wonderful and equipment is first class.
>
> The atmosphere is friendly and warm and the centre is compact.
>
> Well run, attractive focal point for the town.
>
> Everything is there at the centre. We are one hour away from a city.

In some facilities clients **didn't like** the lack of space, a step into the waiting room, the close proximity of the waiting room to the treatment room (lack of privacy) or the location in the main street. The latter point referring to confidentiality which one client commented about:

> … so everyone knows who is at the centre

Suggested **improvements** included to: have a permanent doctor or at least one more frequently, have more types of medication available, add space or a room, be more child friendly, provide more money and to play the music louder in the waiting room to provide more privacy.

The service

Clients **liked** the services repeatedly describing them as excellent, available, very good, many voluntary services, efficient, and minimal waiting time.

> constantly changing to meet the needs of the individual or the community
>
> It's there if needed providing security particularly if you are older
>
> Excellent, the bush nurse goes to see people if they can't get to the centre
>
> Enables people to remain at home. Great confidence in the care they receive.

Clients indicated they **didn't like** the reduction in services that is, not having a 7-day a week 24-hour service that was available when needed. Consequently, some respondents stated they now felt insecure:

> It's scary not having 24hr access. We feel guilty asking for service after hours because the nurses do this out of the goodness of their heart.
>
> Reduced services. After hours we have to ring the ambulance. It takes 1¾ to 2 hours to get here so you have to decide if you are sick enough to call the ambulance out.

The majority of respondents could not identify any areas for **improvement**. Of those that offered areas for improvement respondents identified that services could be improved if: the Centre was open 7 days each week, anti-venom was kept on site, psychiatric nurses were available and foot care provided at a low cost. One respondent suggested more publicity of "human interest" stories whilst another proposed a telephone answering service not affected by power blackouts. The main theme that arose was summarised by one respondent's comment on the need for:

> An increase in hours to provide better cover for after hours emergencies.
>
> Longer daytime hours and the return of after hours service.
>
> 24 hrs a day as it used to be. It's a shame because the facility is there and not being used.

One respondent suggested that the Bush Nursing Committee members should have more medical knowledge::

> People with more "medical knowledge" need to be on the committee, not locals they're on every committee. Should be through the Bush Nursing Committee.

The staff

Clients **liked** the nursing staff and described them as very nice, easy to talk to, very understanding, providing a good service, helpful assistance, obliging, and efficient. The extensive knowledge of bush nurses was acknowledged and valued, as was their professionalism.

> Very open staff, can talk freely with the bush nurses. Good physiotherapist, naturopath and doctor.
>
> Approachability and availability of staff.

> They try to find alternative, well considered, thoughtful solutions
>
> Do their best — they are wonderful. Respond quickly to your call. Extremely competent.
>
> A good mob to go and see.
>
> Very professional, caring, thorough and prompt. After hours back-up is excellent and they are confidential.

One respondent summarised their view in four words:

> Friendly, professional, local, informed.

Areas **disliked** with regard to nursing staff were very few in number and included comments such as the limited availability of relief staff, the lack of privacy in a small town and what they perceived to be personality differences. Two specific areas identified by clients were:

> Sole nurse can be a bit abrupt. Some community members do not attend for that reason.
>
> Lack of communication between staff and management committee.

The majority of respondents were unable to suggest any areas for **improvement** in relation to staff and offered positive comments such as extremely efficient, no complaints, happy with them. One respondent suggested the bush nurses should be trained in and allowed to insert "stitches", another proposed that they should have more authority to dispense stronger medicines, whilst another suggested there should be an assessment of scheduled hours against those actually worked. There was a suggestion that two nurses job sharing provided the clients with a choice of practitioner and that there needed to be recognition of and responsibility for maintaining confidentiality. General comments about the bush nurses included:

> Very nice and very important to us.
>
> The nurses are really good, they talk to you and tell you things.
>
> They are all the best. Thank goodness we have such wonders around us.

Two specific comments relate to improvement in the types of services provided, access to services, and 24 hour service:

> Increased backup from more social-welfare agencies. More time and money for increased local access to these services. Increased liaison with the school.
>
> 24 hr staff in attendance is preferable. One time I had no money for the phone and didn't have the address of the nurse to seek help.

Respondents were invited to make additional comments about their experience with the bush nursing centre. The diversity of the comments reflects positive experiences and acknowledgement of the role of nursing staff at the centres. Many expressed their gratitude and appreciation for the help received and recognised they "were lucky" to have access to the centres. Some clients made brief reference to losing the service, which may reflect their awareness and anxiety about the reduction of health services in

other small rural communities. The comments that best summarise the general views of clients include:

> I have lived here for 12 years. All the nurses provide excellent, professional, wonderful service with great back-up. We would hate to lose them.
>
> I have seen the effects of the bush nursing centre on the community. The elderly and sick are cared for with maximum care and attention. It's a holistic service where staff are part of the community.
>
> We're on a major highway so the centre is vital if there is an accident — we will have nothing if the centre is reduced. They provide a service to travellers and holiday makers also.
>
> Our bush nurses are our lifeline. We would hate to be without them, wouldn't want to be without them. They answer the questions we ask. They're the tops, all you do is just ring if you need help.
>
> The service is a lifeline of our small community.

One respondent expressed the view that though the bush nursing centre committee had no medical knowledge, they controlled the work practices of the nurse:

> The committee have no medical knowledge and they are "in control" of the nurse.

CONCLUSIONS

Bush nurses practice at an advanced level and provide a unique style of care for rural and remote communities in Victoria. Clients and other health care workers clearly value and support the bush nursing role and have had the opportunity to influence strategies for improved service delivery at the bush nursing centres. The Action Research Model proved to be an effective method of involving participants in the study design, implementation and recommended action for continual improvement in service delivery. More specifically multi-disciplinary teams and collaborative action have been of significant benefit to the overall project. Bush nurses are regarded as a "lifeline" by their communities with the role requiring a diverse range of generalist knowledge and skills to meet the needs of the community.

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AUTHORS

Lesley Siegloff is Director of Nursing and Community Services, Inglewood and Districts Health Service, Inglewood Victoria, and Honorary Senior Lecturer, Monash University, Faculty of Medicine, School of Rural Health and School of Nursing.

Lesley is a Registered Nurse, and has a Diploma of Teaching Nurse Education, Bachelor of Education Nursing Studies, Master of Nursing Administration, Fellow of the Australian College of Nurse Management, Fellow of the College of Nursing Australia.

Lesley is currently the convenor of the of the Association for Australian Rural Nurses Victorian Branch Steering Committee.

Lesley has been a registered nurse for 35 years working in clinical practice, education and management in Victoria, New South Wales, South Australia and Indonesia. She is committed to the health of the people in rural communities and to ensuring rural nurses have the skills and knowledge, support and recognition to fulfill their role in the community.

This paper represents the outcomes of collaborative research with colleagues from Monash University Faculty of Medicine, School of Rural Health — Associate Professor Elaine Duffy and Ms Mollie Burley.

Mollie Burley has a professional background in nursing, research, education and quality systems, which has been well honed in the public health system and the higher education arena. She is employed at the Monash University School of Rural Health as a Research Fellow. Her research activities include the current Victorian Rural Nurse Project: Advanced Nursing Practice and involvement in the Urgent Care in Victorian Rural towns project.

Mollie is also a unit advisor in the Master of Rural Health and is involved in the Monash University undergraduate nursing program in the area of rural health practice. Mollie joined Monash Rural Health following a number of years working in the community health and quality areas in senior management positions at the Maffra District Hospital Community Health Service and Central Gippsland Health Service. During these appointments she implemented a "Social Model of Health" approach for clients utilising a multi-disciplinary team that included nursing, allied health, community development, health promotion and exercise components in each program. Mollie is also involved in the development of the new Monash Double Degree in Nursing and Rural Health. Mollie is currently the secretary for AARN and for the newly formed Victorian Branch Steering Committee.