



Te Whare Whakakotahitanga Mo Te Hauora Taiwhenua

A HANDBOOK for *new and locum rural nurses*

What you need to know when you

- ❑ *need to assess your readiness as a nurse for a rural role and responsibilities*
- ❑ *are a nurse taking up a permanent or locum role involving first on call responsibilities*
- ❑ *need to manage risk and keep safe in a new rural nursing role*
- ❑ *are a rural practice/employer setting up for a locum or new nurse*

Linda Brown, Marg Eckhoff, Gayle Lindley and Shelley Jones
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Centre for Rural Health
Department of Public Health and General Practice
Christchurch School of Medicine and Health Sciences
University of Otago
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ABOUT THE CENTRE

The Centre for Rural Health was established late 1994. It was funded (initially by the Southern Regional Health Authority, then the Health Funding Authority and finally by the Ministry of Health) for a series of projects to support rural health services and community involvement. The Centre was under the directorship of Martin London and Jean Ross from, respectively, rural general practitioner and rural nurse backgrounds. It was also known as the National Centre for Rural Health. The Centre closed in late 2002, with final publications being completed in 2003. The resources and reports created under the auspices of the Centre were uploaded mid 2003 to be available indefinitely.

AUTHORS

Linda Brown RGON, PGDipHSc(Primary Rural Health Care), FCNA
Rural Nurse Facilitator, Centre for Rural Health
Clinical Lecturer, Primary Rural Health Care, Department of Public Health and General Practice, Christchurch School of Medicine and Health Sciences, University of Otago
Rural Practice Nurse, Te Anau Health Centre

Marg Eckhoff RGON TNCC PGDipHSc(Primary Rural Health Care)
Rural Nurse Manager, Roxburgh Medical Services Trust Board

Gayle Lindley RGON, ENPC, TNCC, PGDipHSc(Primary Rural Health Care)
Rural Nurse Specialist (Harihari), West Coast District Health Board

Shelley Jones RCpN BA MPhil
Consultant to Centre for Rural Health

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what we mean by 'new nurse' and 'locum'

This handbook is designed to be useful when nurses are taking up a rural role – particularly one that involves 'first on call' cover (or acting as a locum in such a role) – whether experienced in rural nursing or not.

In other words, the nurse may be

- new to rural nursing
- an experienced rural nurse, taking up a new job
- taking up a newly established rural nurse position
- acting as a locum for a rural nurse.

In particular, nurses in *locum roles* may be

- otherwise employed in a secondary/tertiary care setting but fill in for a rural nurse or general practitioner (GP) for a weekend or just a few days on an irregular basis or as part of a roster
- a resident of the rural community and in other employment there -- for example, employed primarily as a practice nurse or in the rural hospital and providing on-call relief for the resident GP at weekends or for evenings
- a full-time rural nurse locum, booked to cover rural nurse absences on a more or less continuous basis
- taking a full-time extended locum to cover maternity leave or an unfilled position.

INTRODUCTION

Welcome to this handbook for new and locum rural nurses in New Zealand

We developed this handbook *primarily for the nurse* undertaking a locum for a rural nurse who provides 'first on call' services (either providing on-call relief for the General Practitioner (GP) or working in an area without a GP). As we believed it could be useful beyond the locum situation, we piloted it across a range of situations (locums, new appointments and setting up new positions). The feedback we received from these nurses and managers was that it did have a wider application, and so the final version has been modified to apply to 'new rural nurses' – broadly interpreted, *as discussed on the previous page*.

However, we have kept the locum scenario as an emphasis in the handbook, as the brevity and impermanence of the rural nurse locum role means that these nurses are most in need of guidance at a time they are least likely to be able to refer to supports usually otherwise available.

Moreover, rural communities are heavily dependent on the commitment and availability of rural health practitioners, but practitioners need time out for the well being of both themselves and their families, and for their professional development. 'Time away' will usually not happen unless a locum can be called upon. Therefore, the nurse who acts as a rural nurse locum is a valuable member of the rural health team, enabling it to provide cover, continuity and a high standard of care. The locum role is vital to the sustainability of health care in many rural communities.

The better prepared nurses are to undertake the clinical and professional responsibilities in a rural nursing role, and the better prepared they are for the experience of working in a rural community, the more likely they are to enjoy their work and life. In particular, the 'fit' between what is involved in working as a rural locum and personal and family life patterns is important when individuals decide whether being a locum is for them. In time, nurses who undertake locum roles establish their own ways of adjusting to rural life and locum practice. What follows is not a definitive 'how to' of taking up a new rural nursing job (whether locum or permanent), but advice that we trust will be helpful.

We also intend the handbook to be *a useful tool for those responsible for arranging locums, orientating new nurses or establishing new positions*. The handbook is not only something you offer the nurse, but can be part of your own reference and preparation. We recommend that you review the templates available at the back of the ORIENTATION PACK FOR NEW RURAL PRACTITIONERS AND THEIR FAMILIES IN NEW ZEALAND (Brown, Maw & London 2001) as you develop your own package. This handbook complements any orientation package you may have developed for newcomers.

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Linda Brown
Marg Eckhoff
Gayle Lindley

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HOW TO USE THE HANDBOOK

It is intended for both the new nurse and those setting up the locum arrangement or orientation

If you are a nurse contemplating taking on a rural locum contract or a rural nursing role, this handbook will

- help you assess your readiness for the role and responsibilities
- introduce you to work as a Rural Nurse or Rural Nurse Locum (RNL)
- help you manage risk and keep safe in your nursing practice in a rural area.

It is also a resource for practices, employers and nurses when orientating a new nurse, or setting up a locum or permanent position.

Different sections are written from different perspectives

Since it is the nurse who will make a deliberate decision to take up a rural nurse role, the **first section is written primarily as a guide to the nurse** in making that decision. However, it is useful to the host/employer in making their own assessment as to whether the nurse has a suitable background, experience and the skills required.

The **second section is written primarily from the perspective of the employer or host practice as a guide to setting up for the new nurse**. The nurse taking up a new job or locum will find it useful as her/his own checklist for what to expect.

The **third and fourth sections are written primarily for the new nurse as guides to practice and risk management** once in the rural role. The employer or host practice will want to review these sections in order to make sure that these expectations square with their own.

What it can do

This package can guide the new nurse and host/employer through setting up a locum engagement and orientation to the rural nurse role. Beyond that, a new rural nurse will find it an ongoing reference and useful resource day-to-day.

What it cannot do

Obviously, this handbook cannot substitute for the orientation period required for a new nurse to become familiar with the characteristics and modus operandi of a particular situation. Especially in the case of the locum, a few days of familiarisation are essential for clinical and professional safety, to ensure that the locum nurse is able to connect with the team with which she/he will be working.

What makes for a 'good' locum experience

Your experience of locum work will depend on your prior experience; specific preparation for the job; effectiveness of your orientation; availability and use of your personal and professional support networks; and the support given by the communities you work in.

We recommend, above all, an appropriate preparation for rural nursing, whether in a locum or permanent role

Reference is made throughout this handbook to the Diploma and Certificate in Primary Rural Health Care, offered by the University of Otago (see www.chmeds.ac.nz/departments/ruralhealth/dip.htm for further details).

We recommend these postgraduate courses to all nurses undertaking rural nursing roles, in particular to those with positions where they will be 'first on call'. The courses were specifically designed in conjunction with rural nurses and their managers to enable nurses to become 'rurally competent', and prepared for primary response in medical emergencies through the PRIME module. The PRIME module (or similar) is essential preparation for a nurse with first on call responsibilities.

Section 1 what's involved

Since it is the nurse who will make a deliberate decision to take up a rural nurse role, the first section is written *primarily as a guide to the nurse* in making that decision. However, it is *useful to the employer making an assessment* as to whether the nurse has a suitable background, experience and the skills required.

Section 1 includes an overview of rural nursing; some questions to help nurses assess their preparedness and readiness for a rural nurse role, whether permanent or locum; and pointers on finding rural nurse positions or locums and making the role work for oneself.

WHAT DOES IT MEAN TO BE A NURSE IN A RURAL AREA?

What's 'different' about rural nursing?

In smaller rural communities, health care needs are met by only a few health professionals. The rural nurse must therefore be a generalist with a wide knowledge and range of skills. Work is likely to be unpredictable.

Taking on a rural nursing role may mean moving from a hi-tech environment with a team of specialist doctors and nurses to working with a team of community volunteers in a "do it yourself" environment. This may be challenging enough, and combining it with an unfamiliar lifestyle may be unsettling. However, nurses usually enjoy the experience, finding autonomy and independence in the rural nurse role, and that they are respected and valued by the team and community. The opportunity to use your experience and skills in a different setting is a motivation for taking on a rural role.

What education and experience do you need to work in a rural area?

Ideally, nurses taking up locum or permanent rural nursing roles are already experienced rural nurses. However, the reality is that contracts to cover weekends and study and annual leave are sometimes taken by nurses without rural experience. Equally, rural nursing jobs will also be taken by nurses new to the rural setting. This handbook is intended for all new nurses in rural areas but will be particularly useful to those without rural experience.

Rural nursing is seen as a specialty area of practice in that a set of 'distinctively rural' competencies is required in addition to clinical and professional role competencies. Specific preparation for rural nursing roles is offered in the postgraduate Diploma and Certificate in Primary Rural Health Care currently available through the University of Otago at the Christchurch campus.

However, as a rural nurse's clinical work is mostly generalist in nature, a locum or new nurse should have a wide range of nursing experience and skills. A clinical background encompassing a range of secondary and tertiary care specialities means that you have a breadth and depth of clinical understanding. Rural nurses find clinical experience in emergency departments and general practice invaluable, and that primary health care nursing has enabled them to develop an understanding of caring for people in a community (Jones & Ross 2002).

Nurses taking permanent or locum positions in rural health services will differ in their career paths. Clinical practice, continuing professional development, postgraduate education and life experience all contribute to confidence and competence in any nursing role.

What support will I need as a new rural nurse or locum?

The nurse in any new position – whether as a locum, in a new job or in a newly established position – may feel personally and professionally isolated, so guidance and support is essential.

Clinical supervision is provided for nurses studying the applied rural health paper of the Diploma in Primary Rural Health Care. Confidential mentoring is available from rural nurse colleagues through the Rural Nurse National Network. Because it is a good idea to discuss practice issues with others working in similar situations, a peer support/review group, perhaps with other rural nurses or RNs is recommended. Meetings and discussions can take place via teleconferencing if necessary.

What will it mean for my personal and family life?

This question needs to be thought through very carefully in relation to your own situation.

Unless they also have work in the rural community, partners of rural nurses may at first feel isolated and find it difficult to find their niche. Any difficulties would be compounded if the partner had previously closely aligned their identity with their career, especially as there are limited opportunities for career development in rural communities. Equally, children may experience culture shock in a new environment and miss their friends and familiar surroundings. However, positives such as recreational opportunities, clean air and natural environment may help to minimise any negative aspects.

If you are moving to a locum role, your children's and partner's commitments to schooling and work respectively may mean that your family may not be able to accompany you. Family worries may seem worse if you cannot be there, and you may feel guilty that you can't be there.

Be aware that if your role is that of a sole practitioner, free time to spend with family may be limited and your plans easily disrupted.

SELF-ASSESSMENT FOR A RURAL NURSING ROLE

Rural reality check

On the assumption that when you are new to something, "you don't know what you don't know", this section gives you a picture of the realities of working in a rural setting so that you are in a better position to assess whether it will suit you, and whether you have appropriate experience and skills.

Understanding rural communities

If you are not a local you will need to learn about each community's history and culture (both ethnic and social), and also high-risk activities in the area, for example, logging, deep sea diving or gang activity.

Rural people usually equate health with the ability to work. They may be more likely to access health services for a physical problem preventing them from working than other health matters, e.g. a fractured ankle may be seen as more serious than hypertension. Bear in mind this work ethic and rural 'philosophy of health' when planning treatment.

Rural people are often fiercely independent, preferring to rely on their own social networks than on outsiders, but as a health professional you will most likely be welcomed warmly. However, as a newcomer your practice may be compared with the host practitioner or predecessor, which can be disconcerting.

Rural communities can be wary of changes to services as their experience is that change has meant a loss of services, and it is possible that your appointment could cause some insecurity. It should help if your host practice or predecessor explains the reasons for the change to the community through a local or practice newsletter or paper. For instance, in the case of a locum appointment, an announcement might say that you are being employed as a support to the existing service.

Part of your orientation briefing should include 'insider' knowledge about the community's social structure and unwritten rules. If you are unfortunate enough to break the unwritten rules, it could impact on how well you are accepted.

Joining a rural health team

As a rural nurse you will be part of a number of teams- most important is that you are clear about who is called on for what, and how they work together. This should be covered in your orientation.

Three types of rural health teams have been identified (Ross 2001:35):

A **rural community team** may comprise local community members, police, fire brigade and ambulance officers, school personnel, healthcare volunteers and health professionals. These people are often long-term residents who understand and use the informal networks within the community. Members may include the mailman who kindly delivers medication to house bound patients or the farmers and fishermen who provide transport in an emergency and who can advise on any special features of the local terrain and unpredictabilities in the weather, for instance, "If there's heavy rain, best not to use the bottom Wainui Stream bridge, there's another bridge a mile up the road".

A **rural health professional team** whose members either work together in shared premises or within the same rural community. However a lack of shared goals between health professionals themselves and the community as well as the personalities of individual health professionals may restrict effective teamwork.

An **expanded or secondary rural health team** has some members based out of the area but who contribute to the health care of the community. Especially if your locum role is more than just a brief period, arrange to meet the person who will be the 'voice' on the phone when you call for advice or help.

Your scope of practice as a rural nurse

Rural nursing roles vary according to the need of the particular community and the availability of other health professionals. As a locum, the scope of your practice will be guided by the rural nurse role you fill in for and the skills and preparation you bring to it - for instance, if you are not an independent vaccinator, vaccinations will not be part of your practice unless a doctor is on site.

Rural nursing, by its very nature, at times complements the practice of other health professionals, and at times substitutes for them (for instance, in emergency situations the PRIME trained nurse is able to undertake responsibilities normally considered medical). Particularly as nurses' roles expand and advance, the boundaries between nursing and medicine shift depending on circumstances and relationships.

In emergency situations you may feel a responsibility to do whatever you can to maintain life as to do otherwise may constitute neglect (Scharff 1998:30). However, no nurse should be pressured to work beyond what is legal or the level of his/her education or support.

**Self assessment:
Do I have the range of
clinical skills required?**

This handbook specifically addresses the new nurse who will be available for first call. It therefore includes sole practitioners, and locums covering nurses providing first call services. Therefore you need to be well prepared for the responsibility and unpredictable nature of rural work. You will need good problem-solving skills with the ability to anticipate and manage complex situations. In an emergency you will need the ability to think on your feet.

Which of these *advanced clinical skills* do you have?

- Advanced health assessment
- Advanced cardiac life support

- Triage (on site and by telephone)
- Intravenous cannulation, fluid replacement and venipuncture
- Recording, monitoring and basic interpretation of electrocardiographs
- Wound care, including basic suturing
- Fracture management including splinting and basic plastering
- Management of acute trauma and illnesses with medical back up at a distance
- Disease state management, for example asthma and diabetes.

All of these skills are likely to be required if you have first on call responsibilities. The skills needed and what you can bring is part of the discussion to set up any rural nurse position. Obviously, if you do not have the clinical skills required for the role, you cannot present yourself as competent to do it.

Although rural nurses providing first call services feel most anxious about managing medical emergencies and major trauma, in reality, they are only a small part of rural practice. It is more common to be dressing wounds, treating minor injuries and giving advice for fevers and colds or vomiting and diarrhoea.

***Self assessment:
Will I be able to function
competently in a rural
community?***

A recent project (Jones & Ross 2000) to establish what competencies are required in rural nurse roles found that rural nursing roles vary in the mix of clinical skills and specialties required, but there were 'distinctively rural' competencies common to all, see TABLE 1 *overleaf*. These rural competencies overlay rather than replace basic competencies (such as those required for registration (NZNC 2002) and enable the nurse to bring her/his generic and specialist competencies to the distinctive character of rural communities and rural practice, and to be effective in the rural context.

Since 'rural' is the critical factor, your care will be effective when it is based on an understanding of

- rural communities and rural nursing practice
- how to care for people in a rural community
- rural people's philosophy of health provision.

Obviously, if you are not an experienced rural nurse, a willingness to learn about rural people and practice is a good place to start.

***What your host/employer
will want from you***

The contract with your employer will cover the basics as for any Registered Nurse position, as well as expectations for the specific role to be undertaken. Expectations for a locum or 'first on call' position are likely to include:

- current Annual Practising Certificate as a New Zealand Registered Comprehensive or General Nurse
- commitment to development and maintenance of skills and education at an advanced level
- PRIME qualification updated every two years (if working within a PRIME contract) *or* equivalent pre-hospital emergency training updated every two years
- experience or training in advanced health assessment

- experience or training in triage
- independent vaccinator status if vaccinating without a doctor on site.
- experience in community nursing.

Preparation for a 'first on call' or locum role

Courses that will equip you with the clinical skills required for a locum or 'first on call' role include:

- PRIME
- Certificate/Diploma Primary Rural Health Care (includes PRIME)
- Triage for Nurses (College of Emergency Nurses, NZNO)
- Trauma Nurse Core Course (College of Emergency Nurses, NZNO)
- Advanced Cardiac Life Support
- Advanced Paediatric Life Support
- Paediatric Emergency Core Course (College of Emergency Nurses, NZNO)
- a number of other Clinical Training Agency funded postgraduate nursing programmes may have relevance to your role (e.g. public health, mental health, child and family, emergency).

FINDING A RURAL NURSE POSITION AND MAKING IT WORK FOR YOU

If you want to do rural nursing – how do you find a position?

District Health Boards (DHBs), Independent Practitioner Associations (IPAs) and soon the Primary Health Organisations (PHOs), particularly those covering isolated and sparsely populated communities, would be good places to make enquiries. Positions may be also advertised in general and professional newspapers. Networking with rural nurses and rural support organisations will be helpful, as many positions are filled through word of mouth. You could join the Rural Nurse National Network and advertise your interest through their newsletter.

If you are looking for a new rural nurse or locum, how do you find him/her?

Advertise in the newspapers, on websites and make enquiries through the Rural Nurse National Network. You may be able to make contact with students and graduates of the Diploma in Primary Rural Health Care who may be looking for placements. Word of mouth through other locums and rural nurses could be helpful, or a note in the RNNN Newsletter (see section on support for contact details). The Rural GP Network (Inc) holds a contract for arranging rural GP locums but does not at present cover nursing locums.

Family issues for locums

The 'fit' between what is involved in working as a rural locum and your personal and family life pattern is important in how well it works out for you. Of course, your partner, children and significant others need to be involved in deciding how long, how often, how many and when your locum contracts should be. If you are providing multiple locum services, careful forward planning is needed so that you can fulfil the employer's requirements as well as your own personal and family needs. Family and personal commitments need to be understood by those employing nurses in locum roles, and the overall employment package is flexible enough to accommodate the 'not negotiable' needs of children and partners.

Table 1: 'DISTINCTIVELY RURAL' COMPETENCIES

Related to isolation and distance, availability of back up

- ▶ assessment and triage as **first-response** to trauma and other life-threatening or serious emergency
- ▶ **mobilizing and coordinating** local and distant resources in emergencies and non-emergencies
- ▶ **planning care** (self, family, nursing and other) that is appropriate to the patient's situation and resources (care anticipates, supplements, involves those resources)
- ▶ **telephone consultation** including advising, counselling and triage

Related to managing the professional and personal self in a smaller community

- ▶ gaining **entrée** and **trust**, and establishing **credibility** in a community
- ▶ establishing both **boundaries** for self and with others as a professional and community member; negotiating a changing role; dealing with breaches and breakdowns
- ▶ establishing and utilizing appropriate/safe/discreet sources of **personal and professional support**
- ▶ selecting **community involvements** and roles to align/amplify professional responsibilities

Related to nurse/patient relationships

- ▶ moving into and out of (establishing/negotiating/disengaging from) **effective nurse/patient relationships** with fellow community members/persons known to oneself
- ▶ establishing an effective relationship with the visitor/tourist/stranger/foreigner
- ▶ engaging with or entering parts of the community where one is not of the dominant **culture** in ways that are safe, appropriate and effective

Related to independence and interdependence with other health professionals and anticipating resolution of unsatisfactory legal provisions:

- ▶ practising within current legal provisions and/or **managing cover or accountability** for breaches and difficulties
- ▶ building respectful and productive **collegial relationships** with doctors, other health personnel and other 'officers of the community'
- ▶ managing **timely and appropriate responses and treatment orders** from other health professionals

from Discussion Document: Competency Framework for Developing Rural Nursing, Jones and Ross (2000), opposite page 10.

Please note that the Competency Framework will be updated (incorporating the feedback received) and posted on the Centre for Rural Health's website (www.moh.govt.nz/crh) in 2003, so we advise you to download that document for the most recent and complete expression of these competencies.

Social support for locums and new nurses

You will need support from your usual circle of friends and family and also in your new environment.

For locums, planning beforehand how to keep in touch with family and friends while you are away can help those you leave at home. It would be reasonable to expect that if your position is for any length of time that your leave entitlement would be similar to that of the practitioner you are relieving, which means that you could plan visits home or for family or friends to visit and explore the area with you. Planning ahead means that you'll be able to look forward to your breaks, and meeting up with others is more likely to happen if everyone has diaried it.

Any new nurse – whether in a permanent or locum position – will find it helpful to identify a key member of the community who can be called on for trustworthy and discreet insight about 'how things work around here'. Each practice and community should have arrangements in place to make you feel welcome and help you to develop your early support systems – discuss this at your handover. Having a key identity take responsibility for introducing you could help smooth your entrée into the community.

Managing role expectations and boundaries

Being accepted in a community usually requires community involvement in some way, so it is difficult to completely separate your professional and personal lives. However, you will need to try to set clear boundaries between your personal and professional relationships. Ways of establishing boundaries include wherever possible having your consultations in a clinical setting, and as friendships develop, raising issues that might arise and establishing joint boundaries. Patients, friends, families and communities will then come to know that whatever your role with them they can feel 'safe' with any privileged information you might have.

Even in a locum role, if you are in the area long enough, it is likely that the friends you make will become your patients. A counsellor, mentor or clinical supervisor can help you steer a safe course through personal/professional boundaries and ethical issues.

Nurses without partners may find rural practice lonely as establishing intimate relationships within a small community is fraught especially when in a sole charge role. Sexual relationships should be avoided.

As you become known as 'the nurse', people may stop you in the local shop to discuss their health. For confidentiality and practical reasons it is best to advise them to see you in the work situation. From a self-management perspective, unless it is an emergency, you are entitled to go about your personal business without unnecessary interruption.

As rural practitioners have high expectations of themselves and a well-developed work ethic it is easy to become over-committed to the role. While you may be able to sustain a high level of service for a short period as you enter a new job or as a locum, remember that this may create expectations too demanding and sometimes inappropriate for permanent staff to be able to fulfil.

If you find that rural practice is for you...

Locum work can be a way to discover that rural nursing is for you. We recommend the CAREER DEVELOPMENT FRAMEWORK FOR RURAL NURSES (Jones & Ross 2002) recently published by the Centre for Rural Health as a good resource if you are thinking about rural nursing. It describes the preparation, learning and clinical experience rural nurses have found useful in their development.

Section 2 getting ready

The second section is written primarily from the perspective of *the employer or host practice as a guide to setting up for the locum or new nurse*, as it is the employer's responsibility to ensure that equipment, work premises and transport (if provided) are of a suitable standard. It is also useful as an indication to the *nurse of what to expect*.

Section 2 includes notes and checklists on business and contractual arrangements; orientation and handover; and highlights the preparation that the employer/host is responsible for.

Checklist A: THINGS TO GET READY FOR THE NEW NURSE/LOCUM

Accommodation – let the nurse know prior to arrival:

- postal and street address (and directions to find)
- phone number
- bedrooms and beds (as there may be family or friends to stay)
- what linen and household appliances are supplied
- especially what cooking facilities
- if not part of the employment package, what rental arrangements
- distance from work
- what shops and recreational facilities are nearby
- arrangements for handover of keys
- whether self-contained or not

Work Vehicle – will the nurse be required to use his or her own car or is one supplied? Either way it should be well maintained, serviced and suitable for the many miles travelled on rural roads. The following information should be supplied on a brief fact sheet:

whether the nurse's or provided car

when a car is provided

- | | |
|---|---|
| <input type="checkbox"/> garaging | <input type="checkbox"/> make and registration |
| <input type="checkbox"/> fuelling | <input type="checkbox"/> keys (where kept, and where spares are kept) |
| <input type="checkbox"/> requirements for keeping a log | <input type="checkbox"/> permission to use for other than work |
| <input type="checkbox"/> servicing if problems | <input type="checkbox"/> call number for car radio to ambulance control |
| <input type="checkbox"/> local road safety problems e.g. loose gravel, flooding | |

Communication system details which may include

- work place phones - internal extensions/codes/quick dial/outside line
- answer phone – how to set and retrieve messages.
- cell phone – are there any areas where it doesn't work?
- access to fax machine (useful for prescriptions and sending ECG reports to the base hospital for reading and advice)
- pagers - how to use and how to access the message centre – any blank spots where the pager doesn't work – if so how to advise backup phone numbers
- radio telephones (used in some areas with isolated or unreliable communication) and instructions
- alternatives – any backup communications for use during failure in adverse conditions
- location of spare batteries and chargers for any of the above

Community profile – refer to ORIENTATION PACK (Brown, Maw & London 2001); also see QUICK SKETCH on page 14. Note that the community profile should also be supplied to the backup GP.

Practice Profile which covers the points below (refer to ORIENTATION PACK)

- the team
- computer system
- administration
- map or layout of work place
- equipment lists and instructions for use
- emergency protocol
- appointment hours and after hours arrangements and rosters
- security issues
- protocols/clinical guidelines/standing orders¹

¹ A **protocol** is a code of behaviour or agreement. **Guidelines** are principles put forward to set standards or determine a course of action. A **standing order** is an agreed method of treatment in a prescribed set of circumstances. We recommend that these be reviewed annually. See also discussion on page 30.

SETTING UP A RURAL NURSE LOCUM

Both the employer and the nurse will find this a useful reference section

This section is written from the employer or host practice's perspective as it is their responsibility to set up arrangements for the locum.

This section contains a number of useful checklists and tools which are ideally prepared by the permanent or departing nurse, who is most familiar with what is involved in the role. The employer or host practice will want to get these materials prepared long before the locum nurses arrives – for example, *see previous page* for CHECKLIST A: THINGS TO GET READY.

Contractual and business arrangements should be agreed before the nurse starts work

As in any contract for professional services, rural nurses are entitled to be well remunerated, to have mutually agreed and clear expectations of their practice scope and standards, and to have a safe and well-supported working environment.

Most organisations will have their own or collective contracts but we have suggested some additional things for a contract in CHECKLIST C *overleaf*.

As the locum or new nurse may have some clear ideas about what he/she wishes to see in the contract it is best to approach it as a two way communication process. The nurse may also wish to have an adviser (such as a nurse adviser or union adviser) look over the contract before accepting it.

Checklist B: KEY AREAS TO COVER IN YOUR NEGOTIATIONS

Remuneration

The nurse may have some parameters in mind. You will need to agree on a rate for normal working hours, and any variation for on call hours, whether on an hourly rate or fixed amount (e.g. a payment to cover weekend on call). A locum may receive the full PRIME payment, or a different arrangement negotiated. Payments for ACC work should be covered, and any other contracts such as venipuncture for blood alcohol or DNA specimens.

Scope of Practice

The locum or new nurse should have been informed of what the position requires so that they have been able to assess the fit with their knowledge, experience and skills. Equally, the nurse should have advised the employer of the suitability of his/her scope of practice for the position offered and whether he/she has any additional skills or services to offer. The nurse must be credentialed as an independent vaccinator if he/she is to vaccinate without a doctor on the premises.

Responsibility

Both parties need to know lines of communication and accountability, which will include providing your annually reviewed guidelines and standing orders to the nurse. Both parties have a responsibility to ensure that the nurse's postgraduate education and professional development commitments can be met, as continuing education enables the nurse (whether a permanent or locum appointment) to meet the health needs of the community. The nurse is responsible for keeping his/her indemnity insurance up to date, and the employer will want to check that it is current.

Checklist C: POINTS TO COVER IN THE CONTRACT***Hours of work, including on call commitment and rosters:***

- geographical area and scope of responsibility e.g. *You are responsible for first contact 24 hour health care for area A and 24 hour PRIME call for areas A & B*
- practice/clinic/appointment times
- time off entitlement

Remuneration

- hourly rate or weekly salary
- weekend rate
- weeknight rate
- public holiday rate
- for separate contracts such as PRIME, or collection blood alcohol specimens for Police

What is supplied/funded by the employer:

- accommodation
- vehicle
- travel expenses
- cell phone
- call minder/call waiting service
- equipment
- protective/reflective clothing

Arrangements for back up and support:

- orientation (with whom and when)
- general practitioner contact
- hospital contact
- personal/professional support
- standing orders/guidelines
- continuing education/professional development
- nurse's indemnity insurance up to date

Other...

CHECKLIST D: FOR HANDOVER

- password for the computer
- cellphone or pager
- call number for car radio to ambulance control
- keys to the car, work premises and your accommodation
- PRIME or emergency bag/back pack
- oxygen cylinder and connections
- drug bag stocked with emergency drugs
- multi-use stiff neck collar or range of sizes
- basic bag for dressings, bandages etc
- hard hat
- headlamp
- torch
- emergency plans/protocol
- laminated list of all essential phone numbers
- street map and a district rapid number map
- topographical map (gives huts, tracks, rivers etc)
- practice profile and community profile (or QUICK SKETCH *see below*)
- ACC provider number
- list of back-up personnel
-

QUICK SKETCH (if there's no community profile available)

- what is the size of the area that you are responsible for?
- what is the population?
- where is the nearest hospital and how far away is it by road/by air?
- are the roads adversely affected by weather conditions?
- how many towns are there?
- what is the terrain?
- what industries are there?
- is the traffic flow heavy?
- are there any special needs areas for example health camp, high risk activities?
- are there influxes of visitors for example fruit pickers, tourists, shearers ?
- who is who in the community and extended health team?

Personal arrangements

Making sure that the nurse has accommodation appropriate to their personal situation is obviously important. For the well being of a locum and safety of equipment, backpacker or camping ground accommodation is not suitable.

It is worth identifying someone in the community who might 'befriend' the new nurse (this will, of course, be done with great care!) – perhaps someone of a similar age and situation who can be relied on to 'be there' for the nurse as a fellow community member in an appropriate way e.g. another parent with school age children.

ORIENTATION AND HANDOVER

An orientation package complements the on-site orientation and practical handover

Orientation of the locum or new nurse is ideally done by the nurse normally in the permanent position, which means that there needs to be some overlap time for handover. The orientation should include a package which is sent to the nurse prior to arrival as reviewing it beforehand means that she/he will be able to ask pertinent questions.

We recommend that the orientation package be developed from (or checked against) the template in the ORIENTATION PACKAGE FOR NEW RURAL PRACTITIONERS AND THEIR FAMILIES IN NEW ZEALAND (Brown, Maw & London 2001). *The orientation package should include:*

- a profile of the area of work and of the community including relevant maps, street directory, farm or batch/crib location maps
- contract for the position
- job description.

The handover should include:

- a tour of the facilities
- a tour of local area which includes local landmarks (e.g. the War Memorial or cemetery) helpful to a new person and key locations (e.g. the junction between Main and South Roads) will be useful reference points for community members when giving directions
- meeting the team
- meeting some of the key or long-term residents of the community who will assist the locum or new nurse to settle in.

Most of the details handed over verbally should also be in writing although this is also an opportunity to pass on confidential and insightful information that you would not want put to paper.

Handover should be structured and well-organised

The face-to-face handover must ensure that nothing is forgotten -- see *previous page* for CHECKLIST D: FOR HANDOVER. While many of the things listed in the checklist seem obvious, they are not obvious to the new person, who needs to be briefed about them before the nurse handing over disappears. Being organised and able to give an orderly well-prepared orientation sends a message that the new nurse is valued and you are interested in the community receiving a high standard of care. *Overleaf* is an outline of areas to cover in CHECKLIST E: HANDOVER BRIEFING.

CHECKLIST E: HANDOVER BRIEFING - AREAS TO BE DISCUSSED

<i>Current patient or community problems</i>	<p>Now is the time to handover on current issues, problems and cases. You have a good idea of which ongoing areas will continue to be ongoing and the handover is an ideal time to give a good background and outline the plan of care.</p>
<i>Protocols/Clinical Guidelines/Standing Orders</i>	<p>Standing orders or clinical guidelines currently in use should be up-to-date and ready to hand. These should, of course, be compatible with and referenced to any national guidelines and best practice (<i>see also</i> discussion on page 30).</p> <p>Discuss what is usual practice between team members, and which particular protocols and procedures the nurse has had appropriate preparation for. For instance: Giving drugs following a standing order, or after a telephone instruction from a GP or doctor at the base hospital? All parties should remember that the locum or new nurse is under no obligation to undertake any standing order or protocol outside a nursing scope of practice.</p> <p>If there are any limitations to the locum or new nurse's practice, especially in emergency situations, other team members should already have been alerted to this so that ways to work with and around any limitations can be explored in the handover period (rather than in an emergency on the roadside on a dark and stormy night with poor reception).</p> <p>If a nurse has brought his/her own guidelines then this would be a good time to review them together.</p>
<i>Equipment</i>	<p>Make sure that the nurse is familiar with the operation of the equipment (e.g. ECG machine, autoclave, nebuliser, computer) and also have clear written instructions available (e.g. how to log-in).</p> <p>Instructions for the use of equipment should include a contact name and number for repairs or problems.</p>
<i>Medical back up and support</i>	<p><input type="checkbox"/> Identify medical support people and the process for communication, including:</p> <ul style="list-style-type: none"> • a GP available for treatment advice and prescriptive authority (ideally someone who knows your community, maybe the neighbouring GP, or it could be a rostered arrangement). • specialist advice. <p><input type="checkbox"/> Let the nurse know the best times and methods for non-urgent communication with the support people, and where possible arrange face-to-face meetings between the support people and the locum or new nurse</p> <p><input type="checkbox"/> Communicate the written protocol for the authorization and signing of prescriptions, and identify whether standing orders and/or clinical guidelines are to be used.</p> <p><input type="checkbox"/> Ensure that the doctors providing back-up have mapping and profiling of the community they are providing support to.</p> <p>Establish the back-up for the back-up – for example if the doctor is called away on an emergency, the locum or new nurse must know who else to call on urgently, perhaps a doctor at the local or base hospital.</p>

Checklist E continued next page

HANDOVER BRIEFING: AREAS TO BE DISCUSSED continued**Team support**

- Other sources of back-up and support should be identified in a written record and may include:
 - hospital nurse specialists
 - other primary health care nurses
 - relieving nurses
 - secondary services
 - social and government agencies
 - community volunteers.
- You may also have a pool of registered nurses who are available to help in emergencies or for the escorting of seriously ill or unstable patients. Contact details should be supplied.

Essential contacts

- A list of all essential numbers must be handed over, and should include:
 - Emergency
 - Ambulance control
 - Civil Defence
 - Police/Search and Rescue Personnel
 - interpreters available
 - Poisons Centre
 - team members
 - laboratory
 - pharmacy
 - chaplains
 - local rural hospital and base hospital
 - local and regional contacts
- Handover should also include a briefing as to the levels of proficiency held by the ambulance officers in the locality.

Medications

- List in writing:
 - what MPSO drugs are held in the practice/office, including controlled drugs (and the maximum stock), and where to find them
 - any local standing orders for giving these to patients
 - the backup GP to ring for help and advice
 - pharmacist contact details, how to place the order, and take delivery of it
 - if there is no local pharmacist find out the alternatives used by your host practice, and how to make contact.

Charging

- List in writing:
- what services patients need to pay for
 - whether casualls are given credit
 - ACC provider number whilst RNL works in this practice
 - what is to be claimed from ACC (e.g. consultation fee and schedule payment) to be claimed
 - whether there is a part charge to the patient.

Other...

- record-keeping for cold chain monitoring of vaccines
- despatching of specimens
- ordering of supplies

Section 3 **on the job...**

The **third section is written primarily for the locum or new nurse as a guide to practice** once in the role. The employer or host practice will want to review these sections in order to make sure that these expectations square with their own.

This section covers responding to emergencies, and how and when to transfer and refer patients. It also covers dealing with deaths and other sensitive areas.

Table 2: AMBULANCE EDUCATION COUNCIL TRAINING LEVELS

*Please note that the Ambulance Education Council's training levels correspond with ambulance officer titles in use **only** in DHB provided ambulance services in Wairarapa, Taranaki and Nelson-Marlborough. Please refer to Appendix 3 for information on the titles/competencies which apply within St John Ambulance and Wellington Free Ambulance services.*

Pre Hospital Emergency Care (PHEC) Officers or Primary Care Officers

PHEC Officers have been trained in advanced first aid and are authorised to administer Entonox and undertake advisory defibrillation (via Automatic External Defibrillator) and monitoring. In addition to the PHEC standards, Primary Care Officers have completed some Core Health unit standards.

National Certificate Officers

Have undertaken the National Certificate in Ambulance (Patient Care and Transport), which is at Level 4 on the New Zealand Qualifications Authority (NZQA) framework – “Ambulance officers awarded this qualification are functioning pre-hospital emergency care providers with knowledge in anatomy, physiology and pathophysiology, and skills to manage a wide range of trauma and medical conditions, including crisis intervention and application of clinical problem solving techniques to patient care” (NZQA 1999a:2).

The compulsory unit standards include

- maintain the ambulance vehicle for operational readiness
- manage the scene of an incident in ambulance services
- provide pre-hospital patient care in ambulance services
- provide further pre-hospital patient care in ambulance services
- provide integrated clinical practice in ambulance service
- care for patients during transportation in ambulance service
- drive ambulance vehicles in operational situations
- provide enhanced basic life support
- provide extended first aid
- carry out shock advisory defibrillation
- move and position patients in preparation for transportation (NZQA 1999a:3-4).

Authorised competencies at this level include: administration of Aspirin, Entonox and Salbutamol; blood glucose measurement and advisory defibrillation and monitoring (Clinical Advisory Group New Zealand Ambulance Board (CAG NZAB) 1999:10).

Intermediate Care Officers (ICOs)

Have attained the Certificate and two units of the Diploma (known informally as the ‘IV’ and ‘cardiac’).

Authorised competencies at this level include: cardiac monitoring; manual defibrillation; GTN spray; IM Glucagon; IV Dextrose; IV cannulation and IV fluid administration (CAG NZAB 1999:10).

Paramedics

Have undertaken the National Diploma in Ambulance (Paramedic) at Level 6 on the NZQA framework, which enables them to “demonstrate advanced patient care skills particularly in the following areas:

- initiation of intravenous therapy in cases of severe hypovolaemia or medical emergency
- cardiac monitoring, basic arrhythmia recognition and defibrillation
- assessment of patients and initiation of care
- administration of selected drugs (Adrenaline, Atropine, Frusemide, Lignocaine, Midazolam, Morphine, Metoclopramide, Naloxone, Stesolid (CAG NZAB 1999:10))
- advanced arrhythmia recognition and subsequent drug therapy
- advanced airway management by endotracheal intubation, emergency cricothyrotomy, and the use of chest drains for thoracic traumatic emergencies” (NZQA 1999b:2).

EMERGENCIES

Be prepared

Review your handover and orientation checklist to make sure you know how to access and/or use everything you might need. We've marked useful tips like this:

Communications

- be familiar with the communication equipment and procedures before working on your own
- know where spare batteries are kept
- where available, make sure radio telephones are charged up
- check local procedure for nurse safety for after hours calls (see Section 6).

Driving

- always keep the petrol tank full, as you never know when or how far you will travel
- if a newcomer to rural driving please take care, particularly on gravel roads
- drive with regard to the conditions and your experience
- remember that the New Zealand Police have stated that a PRIME responder cannot exceed the speed limit.

Map

- make sure your map of the local area is in the car or emergency bag
- your map should include farm locations and streets if appropriate, and rapid numbers where available.

Emergency Bags

- replace anything you use out of the bags as soon as possible after a call, you never know when you might need them again
- collect all your rubbish from a call-out in a bag so it is easy to know what to replace (but of course, dispose of sharps in a sharps receptacle).

Responding to an emergency page

When you receive an emergency page, ring the Ambulance Control Centre. Identify yourself fully and where you are responding from. Listen carefully to the details. If you are unsure where to go, say that you need to follow the ambulance. This is preferable to travelling in the ambulance as they may have to transport the patient in the opposite direction, or you may receive another call.

- if you are not sure where to go, follow the ambulance.

Working with the ambulance crew

The majority of ambulance officers are volunteers, and while it is possible that you may work alongside people trained to any of the levels outlined in TABLE 2 on the *previous page*, in rural areas most are usually trained to PHEC or NCO. Some Rural Nurses also provide the ambulance service.

Ambulance staff are key members of the rural health team and 'teamwork' is the key word. While working with volunteer staff increases your obligation to remain with sick patients, volunteers are a dedicated and vital addition to your service. They know and understand the useful key people, networks and services available on their area.

There are a few ICOs (known as 'Paramedic' in St John's service) on rural ambulances and occasionally they may have a paid position 8.00am – 5.00pm Monday to Friday. However you will usually encounter Paramedics (known as 'Advanced Paramedics' in St John's service) and ICOs when ambulances or helicopters come from the regional centres to participate in recovery and transfer. (See Appendix 3 for St John ambulance officer titles and competencies).

The Paramedics and ICOs are using their skills frequently and are a very welcome source of practical support and advice when they arrive. You will probably also meet fire service personnel who will be first-aid trained and have expertise in the use of cutting gear.

Ambulance staff may see a locum or new nurse as an outsider on their patch. It will help to accept their observation and recordings of a situation without obviously repeating everything straight away. Respect their skills and knowledge of the area and include them in your assessment, planning and treatment of patients. Ultimately, however you are accountable for your own practice and they will understand your need to re-examine a patient in order to plan for on-going care and to relay accurate information when referring elsewhere.

In some areas the ambulance staff and rural practitioners work together through PRIME but in some localities there has been rivalry. It may be a good learning experience and useful to help you integrate with the team to join with the local ambulance people on their training nights. This way you can assess each other's skills and abilities and perhaps learn from each other.

Take care of your own gear

You are responsible for making sure nothing gets lost!

- when you are out with the ambulance be careful not to get equipment mixed up.

Emergency transport

Ambulance Control will co-ordinate the use of transport in an emergency. In rural areas this may be by boat, helicopter, fixed wing aeroplane, ambulance or private vehicle. You will need to advise ambulance control the level of care required by the patient during transport and may be required to accompany a seriously ill or unstable patient if there is no one else suitably qualified. This can be a difficult call to make as it may leave the community without any assistance if no one is available to take over. Arrange back-up to cover your absence if you can, otherwise let ambulance control know that you have had to leave your area. You may be able to arrange to be met part of the way by another ambulance team and in some remote localities this process may need to be repeated, with the journey taking upwards of six hours. Alternatively it may be possible or necessary to arrange an emergency retrieval team from the regional hospital.

Medical evacuations

Medi-vacs are commonly carried out by helicopter and occasionally by fixed wing or float plane in isolated rural areas when time is critical or road travel unsuitable or not available. Helicopters are also used to carry health and emergency personnel and equipment to emergency situations.

Helicopters

Check when commencing each job where the nearest helicopter for medi-vacs is based and what is the usual response time and local protocol for activation. The request will go through Ambulance Control which has authority for medi-vacs.

Response time will vary in each location and can be dependent on

weather and visibility. The pilot has the final say on suitability of flight conditions.

- when expecting a helicopter ensure a suitable landing site and clear away any debris within 50 metres to prevent it being lifted up into the blades of the helicopter by the downdraft (this includes linen, blankets and loose equipment)
- protect the patient by sheltering inside the ambulance or away from the landing site
- close the emergency bags to prevent dust being blown into the equipment
- make sure that someone from the police or fire brigade takes charge of guiding the helicopter for landing and for subsequent safety around the machine
- ensure that the pilot has acknowledged your presence before approaching
- helicopters should always be approached from the front of the machine i.e. keeping well clear of the tail rotor (whereas the approach to a fixed wing aeroplane is from behind i.e. clear of the propellers).

If you work in an area that makes frequent use of helicopters you might consider a course on working with helicopters (contact St John's Ambulance for further information).

“Better to load and go than stay and play”

It is worthwhile initiating emergency interventions as necessary and usually under medical guidance if you have the necessary knowledge, experience, skill, time and equipment. Otherwise, if outside your scope of practice, or time is more critical than the care you can give, you might consider it *“better to load and go than stay and play”*.

Poisoning

If a patient has swallowed poisonous plant material or excess medication ring the National Poisons and Hazardous Chemicals Information Service at Dunedin Hospital -- phone 03 474 7000.

- before you call, note:
 - the name of the substance
 - how much was consumed
 - how long ago
 - weight/age of patient
- ask Poisons Centre to fax relevant information
- only use charcoal as advised by the Poisons Centre
- paper cups with lids and straws are useful for hiding the charcoal's colour when children are concerned.

TRANSFERS AND REFERRALS

Patient transfers/referrals

During your orientation to a practice you should find out where to refer patients to consult a GP or for hospital admission. You'll need to know the answers to these questions ahead of time:

- will you need to ring a GP first or can you access the appropriate hospital doctor direct? (the latter approach is quicker for emergency situations)

- is there a rural hospital and what level of care does it provide?
- where is the nearest base hospital?
- if necessary, you can request a helicopter evacuation (but Ambulance Control approve and arrange)
- some areas may send a paramedic or specialist doctor to the scene.

Admissions/medical referrals

Medical referrals will be to your backup GP, unless the patient has another choice e.g. their regular GP may be from outside the area.

- admissions are usually arranged through the hospital registrar – find out at your orientation whether this can be arranged direct with the hospital or must go through your backup GP
- don't be put off by house staff who may not understand your circumstances or capabilities -- the consultants are usually supportive if you need to ring them for advice.

SENSITIVE SITUATIONS

Sudden death

In the case of a sudden death, and/or when the patient hasn't been seen by a doctor in the last three months or there is doubt over the cause of death, advise the Police who will determine if a Coroner's case applies. They will contact the GP to verify that she/he will sign the Death Certificate.

- the deceased must not be moved if to be viewed by the Police
- you may need to complete a 'sudden death' form, and if the Police require a copy, make sure you keep one for your records
- you need to be aware of local protocols, including where post mortems are undertaken and local arrangements for funeral director services.

Expected death

If a death has been expected e.g. a terminally ill patient, then the police don't need to be involved.

You have an opportunity to make the experience as easy as possible for the family by assisting with any necessary processes in a caring manner. There should be no reason to rush things. Find out from the family exactly what they want to do and which funeral director they wish to use. Although it will be useful to have contact details for the local funeral director, families may also choose someone from further afield.

The family may want the deceased to remain in their home for a while. Alternatively, if there is a delay before the funeral director's arrival you may need to make other arrangements. It is helpful to know in advance what is usually done in that community. Sometimes a room at the clinic or health centre is used for viewing the deceased, but you will need to make sure that it is secure from unintentional visitors.

- there is no need to do anything with the body except lay them straight, false teeth in place with the head in a normal position, mouth and eyes shut.

Cultural considerations in death

As you may be unfamiliar with specific cultural needs, it is important to ask the family for guidance, so that your care is sensitive and appropriate. Since for Maori "...the dead are to be cared for, cherished, mourned, spoke to, honoured... to [be accompanied] until that ultimate

committal to the earth" (Dansey 1992:108) examinations or procedures which delay release of the body to the care of whanau can be distressing for the family (*see resources* for further reading).

Mental health problems

If you have a mental health enquiry, assess the situation and if necessary suggest that the person gets help or is referred on. The nearest hospital will be able to tell you who is on call for any mental health emergencies. If for any reason there is no one available (e.g. at a rural hospital), then you need to ring the emergency psychiatric services at the base hospital.

- if there is any resistance to what you are suggesting you should still seek advice and document carefully
- if the patient is in danger of hurting him/herself or anyone else, then ring for the police
- admission to a psychiatric hospital requires the Duly Authorised Officer (DAO)
- any sedative intervention you use prior to transport must be authorised by the DAO
- if having contact with the patient or the family puts you in danger, leave immediately and ring for the police.

Sexual abuse

You should follow any protocols of the host practice.

Acknowledge the trauma of the victim and help him/her to feel safe. If a complaint is to be made, the history taking, examination and investigations of alleged or suspected sexual abuse must be meticulous as well as sensitive.

- the patient should not shower or wash clothing and if possible should not eat, drink or urinate until examined
- seek their permission to contact the police and a suitable doctor for the examination
- the police in the nearest main centre can put you in touch with a 'Doctors for Sexual Abuse Care' (DSAC) doctor for guidance (many doctors decline to do sexual abuse examinations, preferring them to be done by someone who does them regularly and is more competent)
- while a locum is not the appropriate person to undertake a sexual examination, you may still need to give immediate attention to physical, non-genital injuries
- if the patient wishes, the police can also put you in touch with an appropriate support person for the patient from Victim Support, or try Rape Crisis
- victims of sexual abuse may be eligible for ACC funded counselling
- details are not required on the ACC form – it is marked "sensitive claim" and is sent in a separate envelope to a screened department of ACC.

Other treatment issues for consideration include emergency contraception, management and prophylaxis for possible sexually transmitted diseases. Follow up care should be offered to check on any injuries and consequences of the assault.

- Child abuse**
- if you suspect that a child or young person you see may have been abused, deal with the presenting problem only
 - document the injuries carefully, and consider diagramming them
 - do not make promises about keeping a confidence that you may not be able to keep, as you may need to involve the police, Children, Young Persons and Families (CYFS) or another health professional
 - you can use the presenting problem as the reason for referral when explaining to parents
 - if you have grave concerns for the safety of the child you should ring the police.

This child should be seen by a GP as soon as possible, or if no GP is available you may wish to discuss the injury and your concerns with a paediatrician, or if sexual abuse is suspected, a DSAC doctor.

- Documentation required by police**
- a medical record of examination is to be completed in cases of assault or abuse on a set of forms used nationally (POL 387 a, b, c)

MANAGING YOUR CONSULTATIONS

Telephone consultations The distances involved in providing rural care necessitates a great use of the telephone consultation – both to ensure travel is not wasted, and also to provide advice in the interim.

Some points for the safety of you and your caller:

- note the name, number, address and D.O.B. of the caller (you may need to return the call)
- where practical speak to the patient
- take a full history and note the anxiety of the caller
- if you are happy to deal with the situation over the phone ensure that the caller is also comfortable with that arrangement
- always check that the caller knows that they can call again if concerned and that you are still happy to see the patient if wished
- if you are not completely happy, sight your patient
- record your telephone consultations in the patient's notes, as you would any other consultation
- for casual enquiries, keep a record of the consultation in a notebook kept for this purpose.

Documentation as evidence of the consultation must be available, as it could be required should there be a problem at a later date, for instance, a query about advice given.

Otago Practice Nurses Section has produced a useful tool for telephone triage (refer to Appendix 1: RESOURCE LIST for availability).

Factor in the distance when planning care When planning patient care bear in mind that in rural areas public transport is usually non-existent and access to health care may be subject to weather and road conditions. Your patients may have many miles to travel to access primary or secondary health care.

Home visits

Wherever possible arrange to see patients at your work premises but don't forget to ask how long it will take them to drive there. It may be that you will already be in the neighbourhood on another call.

- take detailed instructions, as it can be difficult to find a house or bach especially at night
- always take the telephone number of the caller so you can ring back if you get lost
- if necessary ask for help, people are usually happy to help out.

Don't forget your own safety (*see also 'When making a home visit' and 'Ask for help if you have any concerns' on page 31*). As a locum or new nurse it will take time to know whether or not to have concerns for your own safety, so err on the side of caution.

- let someone know where you are going or arrange for Ambulance Control to call you at a predetermined time to check that all is well.

Tourists

Caring for overseas tourists requires an awareness of their special needs including the language and cultural differences and the circumstances they are experiencing. Translation cards with commonly used phrases can be useful. Some communities have interpreters and/or Victim Support personnel who can assist. Where available, Victim Support is contactable through the police.

- be sensitive and open to their body language
- be aware that extra thought may be required in planning care.

Your responsibilities in relation to ACC

The Accident Compensation Corporation was formed in 1974 and provides medical and income related compensation as well as replacement of protective clothing damaged in an accident.

In order for a patient to be eligible for ACC assistance, an external force at a particular time leading to an injury or lesion must be identified. A foreign body must cause a lesion to qualify e.g. a piece of chalk up a child's nose must cause inflammation or a scratch to qualify for funding.

- your description of events needs to be clear otherwise it can lead to costly and time consuming interactions and maybe loss of fees or patient entitlements
- remember to do the appropriate paper work for ACC or PRIME using the ACC provider number (to be used only while working in that practice)
- use the correct form for each ACC contact – the patient takes one copy – check that both you and the patient have signed the form
- there may be a consultation fee and a schedule payment to be claimed from ACC as well as a part charge to the patient
- check the tetanus status of ACC patients (*see below*).

Charging

Ensure you know any charging arrangements, what services patients need to pay for and whether casuals are given credit.

There may be a consultation fee and a schedule payment to be claimed from ACC as well as a part charge to the patient. Employers may have arranged an ACC provider number for a locum to use only while working in that practice.

Tetanus status

The Immunisation schedule changed in February 2002 and tetanus vaccine booster is now given routinely at ages 11, 45 and 65 years. A tetanus/diphtheria vaccine is advisable and should be offered in the following cases:

- the patient is presenting with a wound and hasn't had a vaccination in the last ten years
- the wound is dirty and patient hasn't had a vaccination in the last five years.

If the patient has never had a primary course of Td (tetanus diphtheria vaccine) then one should be offered. If you classify the wound as dirty and the patient has never had a primary course then TIG (tetanus immunoglobulin) plus a course of Td should be offered (Ministry of Health 2002a:94). *Please refer* to the current immunisation handbook distributed by the Ministry of Health for further information (Ministry of Health 2002a).

Remember to check the tetanus status of ACC patients presenting with a wound. *See also below* the notes on vaccinations.

Vaccinations

Administer and document vaccines according to the vaccinator handbook, recommended schedule and vaccination procedures and the procedure of your host practice/employer.

- when appropriate give vaccines at the beginning or the end of the consultation, as the patient must wait for 20 minutes after administration of the vaccine
- because of the risk of anaphylaxis or other reaction, when administering vaccines you should have another person on site
- unless you are an independent vaccinator, a doctor should also be on the premises
- if the vaccine is to be administered IM, change to a new needle, as the one you've used for drawing up will deposit vaccine subcutaneously, which could cause a local reaction.

Medications

NEW ETHICALS lists drugs available on 'Medical Practitioners Supply Orders' (MPSO) for administration to patients in an emergency or to initiate treatment. The MPSO requisition needs to be signed by a doctor before it goes to the pharmacy.

Some sole practicing Rural Nurses have a special license (renewable each year) for the storage and administration of dangerous drugs. However, these nurses seek advice from the backup GP when administering these drugs.

- in a hospital or clinic you have colleagues to check drugs with -- if working alone you might consider using a family member or patient to verify the drug, dosage and expiry date
- another strategy is to keep the ampoule for later verification with a colleague if possible
- it is a good idea to make a list of all drugs used and replace them, where possible, as soon as you are able
- be sure to know how to access further supplies, especially of narcotics

- when administering parenteral medication, give according to your standing orders or doctor's advice and prescription but also verify administration instructions and the diluent to use with the packet insert or *refer to* NOTES ON INJECTABLE DRUGS (supplied by New Zealand Hospital Pharmacist's Association Inc)

Sign for all drugs given, and document carefully:

- information given to the patient
- site of administration
- the needle size
- details of the batch number including expiry date

For example:

R/deltoid 25g 1" IM etc.

R/lateral thigh (or vastus lateralis) 25g 1" IM etc.

Section 4 **managing risk**

The **fourth section** is written primarily for the locum or new nurse as a **guide to professional self-management and risk management** once in the role. The employer or host practice will want to review this section in order to make sure that these expectations square with their own.

This section covers: safety and risk management in your practice; managing yourself in the professional role; your personal safety and professional support.

SAFETY IN PRACTICE AND RISK MANAGEMENT

Safety in practice means knowing your limits

Work with the skills you have and do your best. You would run the risk of being unsafe in your practice if you attempt to go beyond your capability and training. Obviously, you do not want to put your patients at risk, nor your own registration.

Indemnity

You must have indemnity insurance. You can arrange this privately, but most nurses have indemnity insurance through their membership of a professional organisation such as NZNO or College of Nurses Aotearoa.

Documentation

Document and sign all details of what you have done with a patient, including phone consultations. In a court of law if you haven't written it then you haven't done it! In most practices patient records are computerised, although there may be a different method for casual patients.

Your careful documentation of treatment or medication administered under standing orders or verbal/faxed orders is critical (*see below*).

Document patient debits/credits according to each practice's system.

Drug orders

It is imperative that orders are followed exactly and documented carefully. However you also have a responsibility to assess your patient and the appropriateness of the order, so if you consider the use or dose of a prescribed drug inappropriate, you must discuss your concerns with the prescriber or back up GP.

Standing and verbal orders

New regulations for standing orders became available in late 2002 (see Media Release, 'New Standing Order Regulations will provide greater consistency', 26 November 2002, www.moh.govt.nz/media.html). You are advised to familiarise yourself with "Guidelines for the Development and Operation of Standing Orders" available from the publications link on the Ministry of Health's website (www.moh.govt.nz). Note particularly these two points:

- professional judgement and policies determine how and whether standing orders are followed: "a standing order *permits* or *empowers* people to supply or administer medicines; it cannot *require* them to" (Guideline 5, MOH 2002b:3)
- staff expected to work under a standing order should be identified and consulted in its development (Guideline 6, MOH 2002b:3).

Each practice will have its own clinical guidelines and standing orders for treatments and the prescribing of drugs. When following verbal or standing orders be sure you understand and agree with the instructions given by the doctor, ensure that the doctor's signature is obtained (according to the protocols of your practice). Your documentation should include the circumstances, communication and name of prescriber in addition to details of the medication order (drug, dose, route, time, date, any parameters). The nurse should not feel pressured to do anything that he/she is not comfortable with or competent and educated to do.

Dangerous drugs

Dangerous drugs, which should be locked away securely in a safe and recorded in a register, are at times held in the locked boot of a car and may be the responsibility of a sole nurse. When on call these drugs should be securely locked in the boot of your work vehicle. You are strongly advised against keeping dangerous drugs in the house as you then risk intruders seeking drugs. However, if your area is subject to hard frosts, drugs in the boot of an ungaraged car may freeze, so think about garaging or insulating the drugs (e.g. in a chilly bin).

YOUR PERSONAL SAFETY AND SECURITY

At the practice or clinic

If there is an alarm system, know how it works, the code number and what to do if it is activated. Do not enter the premises alone if the alarm is ringing, or if there are signs that security has been breached – call the Police.

When making a home visit

Your safety is paramount. Be sure to take a good telephone history when you get a call, as any inconsistencies in the information you obtain may alert you to a potentially hazardous situation. When you are going on a call out, especially after hours, let someone know where you are going, or write the address and phone number down in the unlikely event that you fail to return.

Ask for help if you have any concerns

If you are concerned about a call requesting a home visit, ring the Police. It may be prudent for them to accompany you. If you live alone and no one is going to notice that you haven't returned from a call, give Ambulance Control your address and phone number and ask them to give you a ring at a pre-arranged time to check that all is well. Ambulance or fire-brigade officers are others who may be in a position to help.

During your orientation check what arrangements are currently in place for these situations.

MANAGING YOURSELF IN THE PROFESSIONAL ROLE

Coping with different values

Rural communities are often conservative with high expectations for the behaviour of key people. You may have difficulty accepting traditional rural values, which may be at odds with your experience of urban life. There is a balance needed here between fitting in and being true to your own values and beliefs.

If you are resident long enough in the community to become fully integrated, you may have the opportunity to be an agent of change, but in a short term placement it will be more prudent to make a personal compromise. Without the level of trust as earned by an incumbent practitioner, it is possible that the community could actively resist change from a newcomer, and may even extend that to resisting nursing care.

Whether it is individual patient care, or community development, all your nursing interventions must be based in a comprehensive understanding of rural communities and their philosophy of health care provision.

Personal issues, role boundaries and self-management

Newcomers are highly visible in small communities so you will have less anonymity than you may be used to. Many will relish the meeting of new people, visiting different communities and health practices and the learning experiences encountered but others may find it lonely and find the lack of privacy disconcerting.

Closeness to the community can be very rewarding in rural practice. Unless you are a permanent or long-term reliever it will be more difficult to develop friendships. However the caring nature of your role will mean that you may become very close to some in the community and find it difficult when you need to break those ties to move on.

In a rural community, involvement in the intimate and confidential concerns of individuals is complicated by your involvement with the individual in community life, or with their family and friends. For instance, you may be dealing with someone's partner's STD... Your mentor or clinical supervisor will be an excellent sounding board and adviser in such situations.

Confidentiality

In rural areas you cannot talk of any health situation or event, even in abstract terms, without someone rightly or wrongly putting names and places to it. Small communities have a pretty good grapevine. You will also soon find that blood or business relates most people. Total discretion and absolute confidentiality is required.

Debriefing

Be sure to attend any debriefings. They should always be organised after a major incident or accident, and will usually involve the police, fire brigade, ambulance and the health professionals involved. If the situation has been particularly traumatic for everyone, the base hospital may feel it appropriate to send someone to the area for a meeting.

The debriefing is not a witch-hunt, but an opportunity to discuss events and bring closure to any uncomfortable feelings, learn from the experience, make any changes needed and move on.

If debriefings are not already part of what that community does, maybe you could initiate one if a situation warrants it.

Finding the professional support you need

You may think you are professionally isolated but many rural nurses actually feel part of a much wider/expanded team than in urban practice. There are the community volunteers, rural nursing colleagues your GP backup and various medical teams at the base hospital you can contact for on-going support, in emergencies or when your back-up GP is unavailable. Discuss the most appropriate ways for communication with your host practitioner.

Nursing colleagues can be a great source of support, especially specialist nurses at the local hospital who can be very helpful with clinical and procedural matters, and nurses in the support network available through the Rural Nurse National Network, National Centre for Rural Health.

Where possible take part in meetings and continuing professional education (such as trauma sessions or PRIME updates) with the support people you will be working with. Learning together will help you develop trust and an appreciation of each person's skills.

Clinical supervision, peer review and mentorship are all recommended for your personal and professional support and development. These activities in a safe and confidential environment help you identify and resolve problems, as well as evaluate your competence and accountability in practice.

Tips for taking care of yourself

Useful tactics for self care suggested by the writers of the ORIENTATION PACK FOR NEW RURAL PRACTITIONERS AND THEIR FAMILIES IN NEW ZEALAND include

- plan well ahead for adequate days off and annual leave
- make the most of your time off you may find that a complete break by leaving the area is restorative.
- know and accept what is realistic for you
- learn to say no
- have your own General [or Nurse] Practitioner (*from Brown, Maw & London 2001*).

Reflection on practice

Keeping a journal in which you write about critical events and your nursing practice is a useful way to debrief with yourself. It can be used to prompt discussion with your mentor or clinical supervisor later.

Be sure not to identify any patients or colleagues by name or any indicative details. Remember too, that any documentation of an incident could be required in a hearing, and it is therefore advisable that your personal reflection could not be interpreted as an admission of liability (see Brown 2000:24).

At the time of writing, NZNO's Professional Nurse Advisers are working with Shelley Jones, an independent nurse adviser, to develop guidelines to assist nurses with issues of safety around the journaling of reflective practice (see Trim 2002:28).

Handing back at the end of the locum

A handover with the host practitioner to discuss your work and events in the practice will contribute to continuity of care and help you feel you have completed the job and leave with a sense of closure as a locum. Any feedback should be helpful, encouraging and constructive so that you can reflect on your work, learn from the experience and make changes where necessary. It is important that you leave the job feeling happy about your contribution – because locums play a vital role in the sustainability of health services to rural communities.

SUPPORT PEOPLE AND NETWORKS

Resource people at the Centre for Rural Health

The Centre for Rural Health is incorporated with the Canterbury Chair of General Practice Trust and is based within the Department of Public Health and General Practice, Christchurch School of Medicine and Health Sciences, Christchurch. Since its inception in 1994, it has actively supported rural health care and has completed a number of national rural projects. It is located on the 6th floor of St Elmo Courts, 47 Hereford Street.

The Rural Nurse National Network is coordinated from the Centre.

Centre for Rural Health
St Elmo Courts
PO Box 4345
CHRISTCHURCH

ph 03 364 3611
fax 03 364 3632
www.moh.govt.nz/crh

	role	contact
<i>Jean Ross</i>	Co-Director (Nursing) and Coordinator, Rural Nurse National Network	dd 03 364 3610 jean.ross@chmeds.ac.nz
<i>Linda Brown</i>	Facilitator, Rural Nurse National Network (<i>Mondays and Tuesdays</i>)	ph 03 249 7318 fax 03 249 7318 engserv@xtra.co.nz
<i>Martin London</i>	Co-Director (Medical)	ph 03 364 3634 martin.london@chmeds.ac.nz

Rural Nurse National Network

The RNNN is coordinated from the Centre for Rural Health, as above. Please see Appendix 2 for details.

Resource people at the Institute of Rural Health

The Institute is a charitable trust affiliated with the Department of General Practice and Primary Health Care at the University of Auckland, and the Waikato District Health Board. It is based in Hamilton.

Institute of Rural Health
Bryant Education Centre
Waikato Hospital
Private Bag 3200
HAMILTON

ph 07 858 0986
fax 07 858 0970
www.instituteofruralhealth.org.nz

	role	contact
<i>Robin Steed</i>	CEO	dd 07 858 0986 robin@instituteofruralhealth.org.nz
<i>Iain Hague</i>	Professional Development Facilitator for North Island (a role supporting general practices)	025 290 7933 iain@instituteofruralhealth.org.nz
<i>Kamiria Gosman</i>	Director of Rural Health (Nursing)	025 847 7433 kim@instituteofruralhealth.org.nz
<i>George Tripe</i>	Director of Rural Health (Medical)	025 247 7454 george@instituteofruralhealth.org.nz
<i>Ron Janes</i>	Associate Professor, involved in research through Goodfellow Unit, Auckland University	027 272 3790 ron@instituteofruralhealth.org.nz
<hr/>		
<i>Directors of Rural Health</i>	The Directors of Rural Health are based in the North and South Islands of New Zealand. They work with rural communities, the rural workforce and the Ministry of Health in the support of rural health and development of rural health policy.	
	<i>based at</i>	<i>contact</i>
<i>Pat Farry</i>	Te Waipounamu Rural Health Unit, Dunedin	ph 03 479 7430 fax 03 479 7431
<i>Kamiria Gosman</i>	The Institute of Rural Health, Hamilton	ph 07 858 0986 fax 07 858 0970
<i>George Tripe</i>	The Institute of Rural Health, Hamilton	ph 07 858 0986 fax 07 858 0970
<i>Martin London</i>	Centre for Rural Health, Christchurch	dd 03 364 3634 martin.london@chmeds.ac.nz
<i>Jean Ross</i>	Centre for Rural Health, Christchurch	dd 03 364 3610 jean.ross@chmeds.ac.nz

REFERENCES

BROWN Eileen (2000) Taking Risks with Professional Practice **Kai Tiaki Nursing New Zealand** 6(9):24

BROWN Linda, MAW Heather & LONDON Martin (2001) **Orientation Pack for New Rural Practitioners and Their Families in New Zealand** Centre for Rural Health : Christchurch

Clinical Advisory Group New Zealand Ambulance Board (1999) **Authorized Patient Care Procedures** New Zealand Ambulance Board : Wellington

DANSEY Harry (1992) A View of Death **Te Ao Hurihuri: Aspects of Maoritanga** edited by Michael KING, Octopus : Auckland

JONES Shelley & ROSS Jean (2000) **Discussion Document: Competency Framework for Developing Rural Nursing** Centre for Rural Health : Christchurch

JONES Shelley & ROSS Jean (2002) **Draft Discussion Document: Career Development Framework for Rural Nurses** Centre for Rural Health : Christchurch

MINISTRY OF HEALTH (2002a) **The Immunisation Handbook 2002** Ministry of Health : Wellington

MINISTRY OF HEALTH (2002b) **Guidelines for the Development and Operation of Standing Orders** Ministry of Health : Wellington

NEW ZEALAND QUALIFICATIONS AUTHORITY (1999a) **National Certificate in Ambulance (Patient Care and Transport)** from www.nzqa.govt.nz

NEW ZEALAND QUALIFICATIONS AUTHORITY (1999b) **National Diploma in Ambulance (Paramedic)** from www.nzqa.govt.nz

NURSING COUNCIL OF NEW ZEALAND (April 2002) **Competencies for Entry to the Register of Comprehensive Nurses**, Wellington : Nursing Council of New Zealand

ROSS Jean (2001) **Dimensions of Team Effectiveness in Rural Health Services** Centre for Rural Health : Christchurch

SCHARFF J E (1998) The Distinctive Nature and Scope of Rural Nursing Practice: Philosophical Bases, Chapter 2 in **Conceptual Basis for Rural Nursing**, Helen J. Lee (Ed), Springer Publishing Company, New York

TRIM Susanne (2002) Exemplars Require Caution **Kai Tiaki Nursing New Zealand** 8(2):28

Appendix 1 **resource list**

Resources related to rural practice

Brown, Maw & London (2001)	Orientation Pack for New Rural Practitioners and their Families in New Zealand	Centre for Rural Health
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Gives an overview of rural practice and provides a template for the description of each practice

JONES Shelley & ROSS Jean (2000)	Discussion Document: Competency Framework for Developing Rural Nursing	Centre for Rural Health
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Outlines a set of 'distinctively rural competencies' nurses must add to clinical and nursing role competencies

JONES Shelley & ROSS Jean (2002)	Draft Discussion Document: Career Development Framework for Rural Nurses	Centre for Rural Health
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Describes the preparation, learning and clinical experience rural nurses have found useful in their development

ROSS Jean (2001)	Dimensions of Team Effectiveness in Rural Health Services	Centre for Rural Health
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Resources related to emergency nursing

Advanced Life Support Group	Advanced Paediatric Life Support the Practical Approach 2nd ed	BMJ Books
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BICKLEY Lynn S, HOEKELMAN Robert A	Bates Guide to Physical Examination and History Taking 7th ed	Lippincott
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BRUCKNER Peter & KHAN Karim	Clinical Sports Medicine 2nd ed	McGraw-Hill
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ENA (Emergency Nurses Association)	CEN (Certified Emergency Nurse) Review Manual	Kendall Hunt
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KITT Stephanie, SELFRIDGE-THOMAS Judy, PROEHL Jean A, KAISER June	Emergency Nursing: A Physical and Clinical Perspective 2nd ed	W B Saunders
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McRAE Ronald (1994)	Practical Fracture Treatment	Churchill Livingstone
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Joan CHAPPLE (1991)	Soft Tissue Injuries	Allen & Hanbury
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Resources related to Maori health

TAPSELL Rees	Chapter 3 'Maori Health' in Cole's Medical Practice in New Zealand	Medical Council of New Zealand
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DURIE Mason (1994)	Whaiora. Maori Health Development	Oxford University Press
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Other resources

ALLEN Peter (1985)	Understanding Ear Infections	Smith Kline Beecham
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OTAGO PRACTICE NURSE SECTION (1998)	Practice Nurse Telephone Triage Guidelines 2nd ed	Otago Practice Nurse Section, NZNO
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Protocols for telephone triaging

MURTAGH John (1991)	Practice Tips	McGraw-Hill
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Appendix 2 **information on RNNN**

*Please photocopy reverse side
if you wish to join the
Rural Nurse National Network*

RURAL NURSE NATIONAL NETWORK

Free Membership Enrolment

Name

Address

.....

Phone (h) Fax (h).....

Phone (w) Fax (w).....

E-mail

Area of Nursing
(e.g. Public Health, District, Midwifery)

Post or fax to:

Jean Ross
Coordinator, Rural Nurse National Network
Centre for Rural Health
St Elmo Courts
P O Box 4345
CHRISTCHURCH

Phone: 03 364 3610 Fax: 03 364 3632

Appendix 3 **Ambulance officer titles for St John and Wellington Free**

Where ambulance services are provided by Wairarapa, Taranaki and Nelson-Marlborough DHBs, ambulance officer titles correspond to the Ambulance Education Council's training levels.

This appendix includes information about St John's and Wellington Free ambulance officer titles

ST JOHN AMBULANCE OFFICER TITLES

ST JOHN MEMORANDUM re Ambulance Officer Skills

**To: Medical and Accident Clinics
Emergency Departments
General Practitioner Surgeries**

Recently St John changed their qualification names for ambulance officers. The following is an indicator for medical and nursing staff to advise what ambulance crews are capable of delivering at the various qualification levels.

The following is a list of ambulance officer skills that are delivered by St John ambulance officers. All St John personnel wear a qualification patch on their uniform that indicates their qualification level and therefore the skill set they are trained to deliver. Training up to Paramedic is completed by the St John Private Training Establishment. Advanced Paramedic is completed at a University level under the current system. All ambulance officers deliver the skills below their qualification level. Therefore an Advanced Paramedic can deliver all the skills and competencies up to and including those lists for Advanced Paramedic, Paramedic up to the level of Paramedic and so forth.

All St John ambulance officers operate within authorised patient care procedures that are endorsed and reviewed each two years by the St John Clinical Advisory Group. The St John Clinical Advisory Group consists of managers and medical advisors from around New Zealand. Patient care procedures are based on empirical evidence and best practice. Effective 1 January 2003 each St John member will be issued with a set of updated authorised patient care procedures and these will also be web based on the St John web site. As a result of a review changes will occur to the following qualification level competencies.

Ambulance Officers at all levels will conduct and initial scene assessment, patient assessment and manage any life threatening medical or trauma emergency as well as the scene, The emphasis will be on triage, treatment and transport of an appropriately packaged patient. Splinting, positioning, management of the airway, breathing and circulation are basic competencies conducted by all ambulance personnel.

What follows are additional competencies provided by each qualification level as at 23 September 2002.

Certificate in Primary Care – known as ‘Primary care 1 or 2’

Oxygen therapy
Advisory External Defibrillation
Entonox

National Certificate in Ambulance (Patient Care and Transport) known as ‘Ambulance Officer’

Cardiac Monitoring
Manual Defibrillation
GTN Spray
IM Glucagon
IV Dextrose
Intravenous cannulation
Intravenous fluid administration

National Diploma (Paramedic) known as 'Advanced Paramedic'

Endotracheal intubation
Nasopharyngeal airways
Cricothyroid puncture
Chest Decompression
Adrenalin
Atropine
Frusemide
Lignocaine
Midazolam
Morphine
Metoclopramide
Naloxone
Stesolid

Ambulance Officers work is retrospectively audited in a medical audit and their skills assessed annually in a Clinical Skill Revalidation process.

Steve Yanko
Clinical Manager
Southern Region

stevey@stjohnsouth.org.nz

Ph 03 474 3212 Mob 027 4976623 Fax 03 4777994

St John, 17 York Place, Dunedin, New Zealand

St John, P O Box 5055, Dunedin, New Zealand

www.stjohn.org.nz

WELLINGTON FREE AMBULANCE OFFICER TITLES

Information provided by Sarah Hoyle, PTE Manager, Wellington Free

Wellington Free Ambulance covers the bottom of the North Island from Pekapeka on the West through to the top of the Rimutakas on the East. Wellington Free Ambulance Officers wear patches but aren't called Paramedics until they have achieved the National Certificate in Ambulance. Those holding the full National Diploma are titled Intensive Care Paramedics. Note that Wellington Free also provides paramedics to the Life Flight rescue helicopter service operating out of Wellington and covering the northeast corner of the South Island down to Kaikoura.