

Rural Emergency Enhancement Workshops

Background Paper

Purpose

The Rural Health Branch, in collaboration with Regional Offices, will facilitate interactive workshops in every Region to engage the rural health sector in developing strategies for enhancing emergency care across rural Victoria.

The provision of core emergency care in rural Victoria is a real challenge. Government, health services and professionals are already investing significantly in the enhancement of rural emergency care. The rural workshops will provide an opportunity to showcase some of these achievements. However, there is still a lot to do and you are invited to attend a workshop to contribute to the development of strategies that can be implemented by government, health services and health professionals.

This paper is intended to:

1. provide background on the delivery of emergency care in rural Victoria
2. overview government policy and program supporting delivery of rural emergency care services
3. prepare workshop participants to engage in collaborative strategy development to further enhance rural emergency services across Victoria.

Those that should attend will be directly involved in the provision or receipt of emergency care in rural health services, multi-purpose services and bush nursing centres. Members of health service boards and bush nursing centres committee of management, health service executives, clinical managers, nurses, doctors and allied health professionals involved in the delivery of emergency care are invited. Other key stakeholder groups such as Ambulance Victoria and the Division of General Practice are also invited to contribute to these discussions.

Background

The rural emergency system

Rural Directions for a Better State of Health (DHS, 2005) outlined a three-tiered health system structure for rural Victoria, with health services are defined as:

1. Regional
2. Sub-regional (*previously District*)
3. Local
 - 3.1 Local – community
 - 3.2 Local – health service

Each of these health service types has a role to play in the provision of emergency health care.

The sixteen regional and sub-regional health services in rural Victoria have 24-hour emergency departments with doctors on site to provide a full range of clinical support. These health services provide care to their own communities and should also support smaller health services in their regional areas.

In local health services nurses and on call doctors provide emergency care.

Figure 1 shows the 55 health services that rely on GP-Visiting Medical Officers (VMOs). This reliance presents challenges for doctors in finding an acceptable work-life balance, and for health services in ensuring continuous, uninterrupted emergency service provision. To better manage emergency health services into the future, many health services are ensuring nurses are well trained and supported by appropriate guidelines so that, where appropriate, health care needs can be met without medical support and doctors are only called in when necessary.

Figure 1: Health services with visiting medical officers and bush nursing centres



Source: Boundaries – Local government Australian geographic classification 2004
Population – ABS estimated residential population 2005

Victorian rural emergency patient profile

People who present at the emergency area of health services are generally ‘triaged’ first by a nurse – this is a preliminary assessment to determine the urgency of a patient’s clinical need for treatment. The nurse initiates a plan of action. The Australasian Triage Scale (ATS) is used in most health services by nurses to determine the urgency of a patient’s needs relative to the needs of other patients and ensure that patients receive treatment in a timely manner. The ATS stipulates that assessment and treatment should be provided immediately if the patient is categorised as ATS category 1 or within 120 minutes if they are at the other end of the scale – ATS category 5 (Australasian College of Emergency Medicine, 2000).

In rural health services that rely on GPs for their medical services, there is likely to be a longer period of time between the patient presenting and attendance by the doctor. It has been estimated that this period could extend on average up to 30 minutes¹. This is because the doctor is generally not on the health service premises and has to return, often from their own private practice. In this context, a nurse can deliver effective and timely care for many less complex patients if they are competent to initiate treatments (including medications), give self-care advice, refer back to a GP within clinic hours or arrange for the patient to be transferred. In Victorian bush nursing centres (BNC) the registered nurse is usually the sole practitioner and is referred to as the remote area nurse (RAN).

It is argued that effective nurse triage and interventions may reduce the number of times doctors are called back to the health service. However, it is important to emphasise that the triage category of the patient cannot be the only determinant of whether the doctor should be called in; some category 5 and 4

¹ This estimate is based on preliminary, unpublished results of the *Rural Collaborative Practice Model Pilot*.

patients will need to be admitted and will need to be seen by a doctor (Australian College for Emergency Medicine, 2004).

Patient data from the health services and BNC engaged in the Rural Collaborative Practice Model Pilot (described below), indicated that:

- Between 70 and 80 per cent of all presentations do not require urgent treatment
- Most people presenting in emergency care do not require admission
- A doctor is involved either directly or via telephone for over 70 per cent of all presentations
- The RAN working in the BNC operated without direct medical support for almost all of the patients (estimated at 75 per cent of patients)
- Approximately 50 per cent of patients require medicine
- Many calls to doctors are for medication orders for non-urgent presentations (26 per cent for ATS category 5 and 43 per cent for ATS category 4)
- Up to 19 per cent of medicines administered to patients presenting at the emergency service are for pain; 9 per cent are antibiotics and antifungals; 3 per cent for nausea and vomiting; 3 per cent for inflammation and allergies and 3 per cent for tetanus and other vaccines.

Current and future workforce challenges

In Australia, the workforce is growing by approximately 170,000 people a year. According to current trends, this figure is expected to decline to 12,500 per year by 2020 (Department of Health and Aged Care (Aust), 2001 p.xvii). This is in the context of an ageing population that will lead to increasing demand for health care.

For Victoria, the prospects are worse with workforce growth expected to drop to zero by 2012 (Department of Health and Aged Care (Aust), 2001).

So unless this outlook changes, the next twenty to thirty years will see an increasing, and unprecedented, focus on obtaining (and keeping) the Australian workforce, including the health workforce... (Australian Health Ministers' Conference, 2004).

In 2005, the Productivity Commission released its report on Australia's health workforce. It brought about a reassessment in the way work is performed and the factors that restrict innovation. Referring particularly to the challenges of maintaining the health workforce in rural and remote areas, the commission stated that

[i]n such an environment, the adverse consequences of rigidities and inefficiencies in regard to competencies, scopes of practice, and education and training for health workers, can be very significant (Productivity Commission, 2005 p.xxvii).

The commission stressed the importance of using the skills of the existing workforce in the most efficient and effective way to meet the challenge of workforce shortages and distribution problems. Submissions to the commission identified 'impediments affecting allowable scopes of work, appropriate mixes of competencies and job redesign and substitution. Submission representing registered nurses, physiotherapists and pharmacists, for example, considered that their training and skills suited them for "higher level" tasks' (Productivity Commission, 2005 p.14).

What can rural communities expect?

The Victorian Government's commitment to ensuring a strong and sustainable rural health system, with a network of health services as close as possible to where people live, is outlined in *Rural Directions for a Better State of Health* (DHS, 2005). Traditional models of care and professional practice boundaries, and solutions that rely on these will be insufficient to respond to the workforce challenges. If rural health services are to deliver emergency care as close to where people live as possible, then responding to the workforce challenges will require new ways of working, new technology, innovation and a commitment and capacity to change at all levels of the system.

In 2006-2007, an Expert Advisory Group worked with the Rural Health Branch to develop an understanding of the various levels and responsibilities of emergency services across the rural health system, and also to determine what minimum emergency resuscitation and stabilisation capability should be expected of all rural health services. The Advisory Group agreed that public health services in rural Victoria can expect people to present in urgent need of care at any time. In view of this, all health services need to be able to provide a level of safe and appropriate time critical emergency health care to rural communities. This means all rural health services should ensure that available clinicians, working together, have the capacity to perform emergency resuscitation and stabilisation for both adults and children, defined as the minimum emergency service response.

Minimum emergency service response

Assessment

- triage
- comprehensive patient assessment

Airway management

- all airway management techniques up to and including laryngeal mask airway
- cervical spine immobilisation with rigid collar
- administration of oxygen

Breathing support

- bag valve mask
- decompress a tension pneumothorax using needle decompression or 'pneumocath'
- management of a sucking chest wound

Circulation support

- peripheral intravenous cannulation and therapy including intravenous fluid replacement
- provision of first line emergency medications including thrombolysis
- semi-automatic or automatic external defibrillation
- intraosseous needle insertion

Ongoing management

- management of mental health emergencies*
- initial management of patient while awaiting further assistance or transfer

Initiate transfer

- initiate the appropriate transfer protocol
- prepare patient and patient information for transfer

* with established links with area mental health services, and a directory of local community services and practitioners, including general practitioners, able to provide support to people with mental health or psychosocial problems

Consultation

The health service sector was invited to comment on the discussion paper containing these minimum service responses. The results of this consultation suggest that while there is broad support for this level of access, at this stage not every health service has the capability to deliver all of these service responses. In summary some of the issues raised in this consultation included:

- Workforce shortages impacting on the availability of GPs to support on-call, medical emergency specialists and radiologists
- Ensuring nurses have the range of clinical skills needed to deliver these requirements
- Support needed in developing and adopting evidence-based clinical guidelines, including standing orders
- Regional health services taking a greater role in supporting other health services, particularly with training, clinical networks and supervision, and referral arrangements
- Proximity and capacity of ambulance services
- Medico-legal issues and protection

Suggestions made for further action to enable the sector to deliver this minimum service response included:

- Better use by health services of the statewide Nurse on Call
- Develop a competency-based training program on the Australasian Triage Scale.
- Ensure signage is appropriate to the service by working with local government and developing minimum standards for signage
- Develop sub-regional emergency training plans to create economies of scale and improve communication and cooperation between services
- Make available evidence-based clinical guidelines for all health services to use
- Develop standardised referral and transfer forms
- Ensure the medical credentialling and defining clinical scope of practice policy supports the delivery of the minimum emergency service responses

Rural emergency enhancement workshops

These regional workshops aim to tease out the barriers that currently exist in achieving this minimum level of service in a sustained way, and develop strategies for overcoming these barriers and contingency plans for when the available clinical capacity cannot deliver these core services. The fundamental purpose of this exercise is to assure rural communities that they will receive the appropriate and timely care within a comprehensive and coordinated system.

It is expected that the rural emergency enhancement strategies developed from these Regional workshops will be multifaceted in recognition that there is no one right answer, any single strategy cannot work in isolation and the responsibility for implementing strategy and achieving changes are shared by Government, health services and health professionals.

Your input needed

The program for the Workshops will be made available shortly. In order to get the most out of the workshop, you are asked to come prepared to contribute to the development of strategies to strengthen your rural health services' capacity to deliver the minimum emergency responses described in this paper.

To this end, please consider three key issues we should focus on in the workshops when developing strategies that will make the most difference to your hospitals' capacity to deliver the emergency care responses.

Attachment: Summary of initiatives

Following is an overview of key government strategies that have been implemented or are currently underway to strengthen the capacity of rural health services to delivery a sustainable level of safe emergency care.

Rural Collaborative Practice Model Pilot

During 2007-08, the Rural Collaborative Practice Model was piloted at five rural hospitals, including one bush nursing centre. This Pilot engaged clinicians, health managers and government in a collaborative, action research approach to developing strategies that will ensure the sustainability of rural emergency services in Victoria.

This Pilot was driven by the needs expressed by nurses, doctors and health services managers to find alternative solutions to maintaining these critical services in the face of workforce shortages and population ageing. The Victorian Department of Human Services and the Health Services Management Innovation Council jointly fund the pilot.

The participants of the Pilot identified the following key barriers to achieving a more effective emergency care model where doctors were called in only for the urgent and complex presentations, and nurses were able and willing to manage more non-urgent presentations on their own:

- Variable clinical capacity and confidence of nursing staff
- Legislation relating to drug supply limits nurses' capacity to manage many non-urgent presentations without calling a doctor
- Fear of the 'unknown emergency patients'
- Lack of clarity and consistency regarding roles, responsibilities and doctor call-back decisions
- Lack of clinical guidelines
- Issues relating to working as a team, inter-professional communication, conflict and change
- Unrealistic community expectations (Sullivan *et al.*, 2008)

The strategies implemented by participating pilot sites included:

- Stakeholder engagement and communication strategy
- Advanced nursing education and inter-professional training
- Embedded evidence based guidelines
- Supportive operational policies
- Improved patient documentation and data (Sullivan *et al.*, 2008)

After 12 months, outcomes achieved included:

- Improved nurses competence and confidence
- Reduced number of times doctors attended
- Improved communication
- Heightened understanding – medico-legal position
- Improved nursing career structure (Sullivan *et al.*, 2008)

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Legislative change proposal

The Department of Human Services has consulted on the proposal to change the *Drugs, Poisons and Controlled Substances Act (1981)* and *Health Professions Registration Act (2005)* to authorise appropriately trained registered nurses (Division 1) working in rural Victoria to supply medicines for specific conditions, under certain circumstances and according to evidence-based protocols. This proposal is progressing and may be considered by Parliament early in 2009 (Department of Human Services, 2008).

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Nurses performing x-rays

Workforce shortages are affecting radiographers in the same way they affect other health professions. There is both the need and potential for an increased number of appropriately trained health professionals to undertake plain film radiography². Increasingly General Practitioners (GPs), registered nurses, allied health staff and paramedics may be involved, particularly in rural areas of Victoria where already there are limited or no radiographic services.

In Victoria the Department of Human Services has the authority to issue a 'use license' to nurses and general practitioners and currently 172 GPs and 5 nurses hold licenses, however the number of practising non radiographers is difficult to ascertain. In contrast, both Queensland and Western Australia have in excess of 400 licensed x-ray operators practicing in accordance with guidelines to ensure appropriate and safe patient imaging. In New South Wales and South Australia approximately 200 nurses and 50 GPs, and 122 nurses, hold licenses respectively.

The practice of non radiographers taking plain x-rays is not new; nurses, doctors and allied health staff in rural and remote areas have been performing this task for many years and World Health Organization data suggest 80-90% of plain radiography is performed by non radiographers (Smith & Jones, 2007).

In many Victorian rural health services GPs and radiographers are not onsite 24 hours per day. In practice Small Rural Health Services (SRHS) are supported by Visiting Medical Officers (VMOs) and the majority do not have access to on call radiographic services. The ability to provide care in the local setting is impeded by non medical staff being unable to undertake plain x-rays. In a recent survey of Small Rural Health Services (SRHS) Directors of Nursing, 93 per cent of respondents could foresee a role for nurses to undertake plain x-rays³.

An investigation into enabling more nurses to initiate plain x-rays in rural health services has commenced, and the Department will consider what incentives and service improvements are required to enable nurses to undertake plain x-rays where this is clinically and operationally appropriate and will improve patient outcomes.

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Nurse practitioner program

The Victorian Nurse Practitioner Project (VNPP) provides a focal point for the development of NP policy and legislation as well as providing funding to support public health services to implement models of care that include NPs. VNPP funding provides support to both health services and individual nurses for the educational and clinical preparation of nurses to become NPs.

The VNPP is currently in Phase 4 and has a focus on enhancing the delivery of health care in the Victorian public health system through the effective and strategic integration of sustainable models of NP practice.

The objectives of Phase 4 are to:

- Assist health services to develop service plans for nurse practitioner services that are strategic, sustainable and integrated with broader health service directions
- Ensuring plans for NP services and models are aligned with relevant existing organisational and/or workforce plans
- Facilitate collaboration between health services in the development and implementation of NP service plans and models, and
- Build engagement, collaboration and consultation with local stakeholders to support the NP role.

Building on the success achieved by targeting a number of funding rounds to support emergency models, the VNPP is now aiming to focus efforts to create a critical mass and progressively deliver cohorts of NPs in other key areas. In 2008, priority areas for VNPP funding are renal care, stroke care, mental health and drug services and palliative care.

The applicability of NP models in rural settings is apparent with over 60% of currently endorsed NPs working outside the metropolitan area. Six of the 17 endorsed emergency NPs are employed in rural

² Plain film radiography refers to an x-ray examination during the course of which the x-ray tube and film remain stationary and no contrast medium is introduced into the patient.

³ Email responses (2008) from 32 SRHS Directors of Nursing and Remote Area Nurses

/regional areas, two NP are endorsed as rural and remote NPs and a number are currently employed as NP candidates in emergency and/or rural and remote care.

In 2008, 15 rural health services are being supported to develop organisational service plans for the implementation of nurse practitioner services across their health service or in partnership with other health services or providers. In a number of cases the service planning has identified that primary care/urgent care are areas of service gaps that are being recommended as priority areas for the establishment of NP models.

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Emergency Care Improvement and Innovation Clinical Network

The *Emergency Care Improvement and Innovation Network* (clinical network) supports sustainable improvements and innovation for the delivery of accessible, appropriate, efficient and effective emergency care across the Victorian health system. The key objective of the clinical network is to lead innovation and ongoing improvements in the delivery of emergency care in Victoria's public hospitals.

The clinical network aims to:

- foster communication and collaboration between health services and the department
- provide leadership and transparency in the development and implementation of innovation
- provide analysis and advice to assist emergency departments (EDs) design and deliver innovation and system improvements
- inform health policy for the delivery of consistent, efficient and effective emergency care across the Victorian health system.

The clinical network is not an alternative to operational or local health service management structures or accountability, nor does it have accountability for direct service provision. Rather the mandate of the clinical network is to support organisations to collaborate on and participate in sustainable improvements and innovation within the scope of the network.

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Rural Enhancement Program

The Rural Enhancement Program (REP) grant is provided to approved health services to support Visiting Medical Officers (VMOs) who participate in a dedicated 24-hour on-call roster for emergency presentations. Where hospitals have made other contractual arrangements that include a 'return to the Emergency Department', the REP does not apply. Funding for this program was significantly increased in the 2007-08 budget.

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Ambulance policy initiatives implementation 2008/2011

The 2008 State Government budget boost of \$185.7 million provided the biggest single investment into the state's ambulance services in Victoria's history: two new medical helicopters, and 59 new and upgraded services.

After a consultation process across the State, Government decided that the three previous ambulance services – Rural Ambulance Victoria (RAV), the Metropolitan Ambulance Service (MAS) and the Alexandra and District Ambulance Service (ADAS) would merge to form Ambulance Victoria (AV) on 1 July 2008.

One of the new choppers – to transport ill and injured babies, children and adults as part of the statewide retrieval system – will be based at Essendon airport from March 2009. Responsibility for adult retrieval services has been transferred to the former Metropolitan Ambulance Service in November 2007 to further support improvements in retrieval services to health services and patients.

An additional helicopter in rural/regional Victoria, based at Warrnambool to provide additional coverage to south-west Victoria, is scheduled to commence July 2009.

In rural Victoria, nine ambulance stations will be refurbished or rebuilt – at Ballarat, Neerim South, Avoca, Timboon, Anglesea and Hamilton and services upgraded at Colac, Anglesea, Timboon, Alexandra, Apollo Bay and Mirboo North.

Extra crews will be added to stations on major country transport corridors – at Woodend, Kyneton, Kilmore and Gisborne, and new MICA single responder units will be established at Geelong, Bendigo, Ballarat and the Latrobe Valley.

An \$8.3 million component of the Budget will employ 20 dedicated off roster rural/regional paramedics across the state, over and above a recent regional campaign to recruit an additional 100 paramedics into country Victoria to release rural station officers from their operational roster to dedicate more time to manage staff.

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Pre ambulance basic life support (PABLS) strategy

There are a number of life-saving medical treatments that may be effectively administered by members in the community before an ambulance arrives. This is particularly important in cases of cardiac arrest and where a patient is unconscious or not breathing. The ambulance service program budget provides up to \$3M annually to fund initiatives within this strategy likely to obtain the best patient outcomes for people who experience cardiac arrest and other emergencies.

Since its inception in 2002/03, the PABLS strategy has funded programs and projects across four initiatives:

- Cardio-Pulmonary Resuscitation (CPR) aims to increase the participation of bystander CPR through a targeted CPR awareness program. This program is focusing on people aged 50 years and older.
- Community Emergency Response Teams (CERTs) are established in outer metropolitan and small rural communities that cannot sustain a locally placed professional ambulance service. CERTs comprise trained community volunteers who are simultaneously dispatched with a professional ambulance crew, from a larger neighbouring area, in response to cases of suspected cardiac arrest and other emergencies within their local community.
- Emergency Medical Response (EMR) involves fire fighters from the Metropolitan Fire Brigade, trained to administer CPR and defibrillation, simultaneously dispatched with paramedic crews in response to cases of suspected cardiac arrest in the inner city areas of Melbourne.
- Public Access Defibrillation (PAD) involves Automated External Defibrillators (AEDs) being placed in public locations with a high volume of daily visitors such as Sovereign Hill and Melbourne Airport, for use by locally trained personnel.

New models of care

Ambulance Victoria (AV) currently operates a traditional emergency ambulance based approach system in which requests for service prioritised in accordance with medically approved dispatch protocols and a stretcher ambulance dispatched. The attending ambulance crew provide assessment and treatment in accordance with approved Clinical Practice Guidelines and then transport the patient to an emergency department if required.

An increasing prevalence of preventable conditions, an aging population with chronic clinical conditions and changing dynamics and capacity of the health workforce, mean that approaches to service delivery need to become more flexible, particularly in rural and remote areas. Without innovation and flexibility in service delivery, the ability of the health system to meet the emerging needs of the community is becoming increasingly difficult.

AV has an established service delivery infrastructure across rural Victoria and is interested in developing innovative models of care in partnership with other health services to respond to these changing health needs and workforce dynamics in rural Victoria.

In the next few years, AV would be interested in:

- Exploring appropriate models of urgent care developed and implemented in other jurisdictions in Australia as well as internationally to determine their applicability to the Victorian environment
- Identifying priority communities within which to pilot new models of care
- Trialling and evaluating different models of care in communities with different needs

Ambulance Victoria Rural Service Delivery Plan

Public ambulance resources are limited and need to be used appropriately and efficiently to maximise availability for their primary purpose, which is responding to unplanned emergencies. Following the creation of the new organisation, Ambulance Victoria intends to review future service delivery requirements in rural Victoria.

The Ambulance Victoria rural service delivery planning process will provide an initial opportunity to consider alternative approaches to the role of the ambulance service and paramedics in rural communities (to feed into the larger 'New models of care' project mentioned above).

The development of alternative models of service provision would involve whole-of-health partnerships and examine how collaborative approaches might provide more clinically effective and efficient patient care.

The planning process will involve consultation with health sector stakeholders during 2009.

Attractive employer model

A healthy workplace environment is the right of every worker and goal of every good employer. Considering individual employee needs and encouraging life balance are important issues when focusing on the challenge of workforce recruitment and retention. The Service & Workforce Planning Branch understand that a well-supported workforce of sufficient size and distribution is critical to Victoria's ability to provide a quality public health service. Attrition, turnover, productivity, and employee health and wellbeing are all factors requiring attention and strategic direction.

Research evaluating various organisational change models in Australia and overseas has been undertaken to determine the most appropriate strategy for Victorian health and community services. It was found that a suitable statewide model would require, as a key element, a surety that organisations acknowledge and focus on equitable employee relations, having genuine concern for the safety and wellbeing of workers.

Adopting an attractive employer model approach has been recommended. This approach should concentrate on developing and supporting a select group of fundamental employee relations areas or issues. A set of secondary focus areas would then be addressed and developed to further support organisations with specific priorities and problem areas. The research summated this structural methodology as providing a solid foundation for building health and community services capability in recruitment and retention initiatives, allowing also for variation based on individual organisation contexts.

A state-wide focus group was formed to assist with determining the level of interest and support for the suggested attractive employer model approach within the Victorian health sector. This interactive forum, engaging community and health service stakeholders, discussed current and potential future barriers and issues relating to workforce recruitment and retention. Uncovering ways for the department to assist health and community services to address these barriers and better inform the attractive employer strategy is the focus.

The issues considered most critical in attracting and retaining a workforce in an environment of increasing demand were identified as management and leadership quality; cultural change; professional development; the rural Victorian workforce situation; and greater industry promotion overall. The knowledge that recruitment and retention issues are not restricted just to the health sector but pertain to all industry sectors, inclusive of public and private, was emphasised. Given this, brand competition is an important factor to incorporate as a wider consideration when building an attractive employer framework.

The next phase of the attractive employer model project will focus on establishing, by further consultation and trialling, a usable model for Victorian health and community services. The intention is to

develop a practical framework that will assist services in maximising their objective of being considered attractive employers. This will be achieved through addressing key issues and allowing all levels of the health sector to access the support available within Victoria.

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Training and Development

Remote Area Nurses Emergency Training

Remote Area Nurses (RANs) employed by bush nursing centres are required to undergo annual competency based training in emergency care and stabilisation skills in order to manage and administer drugs for first line emergencies.

Annual competency requires successful completion of distance learning modules followed by attendance at a two day workshop comprising of lectures, tutorials, skill stations and scenarios where the application of theory to practice is assessed. The training program has been allocated 25 CNE points by RCNA.

Since 2005, the Remote Area Nurses Emergency Guidelines (RANEG) have been developed each year in collaboration with Rural Ambulance Victoria (Ambulance Victoria from July 2008). The RANEG provide the clinical framework for RANs to respond to emergency incidents in circumstances where they are unable to contact a doctor.

Since 2005, up to 50 RANs from 14 bush nursing centres have undergone the training and been assessed as competent on an annual basis.

The strong relationship with Ambulance Victoria has led to the development of a Memorandum of Understanding in relation to RANs being available to respond to 000 at the request of the AV Operations Centre.

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North Grampians Emergency Care Upskilling Program

The North Grampians Emergency Care Upskilling Program was conducted in 2007 to evaluate the applicability and transferability of the RANEG training with Division 1 nurses working in five small rural health services. Twenty five nurses located across sixteen campuses were assessed as competent in the use of the RANEG (under the direction of a doctor).

The key findings of the program included:

- Confirmation of the applicability and transferability of the RANEG training for Division 1 nurses working in small rural health services
- Increased competence and confidence in managing emergency presentations and enhanced relationships with doctors and ambulance paramedics
- Acknowledgement that there will be limitations around skill levels and exposure to emergency patients in a rural environment

In August 2008, fifteen participants from the 2007 program undertook an Emergency Care Update and Reaccreditation Program. All participants were assessed by AV as competent and have requested that annual competencies be maintained.

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Emergency Triage Education Kit - Education Program for Rural Health Services

This training program was aimed at providing nurses working in small health services with the ability to fully utilise the Emergency Triage Education Kit, thereby facilitating consistent and accurate application of the ATS across all health services.

The objectives of the strategy were:

- To provide at least two training opportunities in each of the five rural DHS Regions
- To educate and support designated nurses (eg. educators, nurse managers and after hours co-ordinators) in each health service to act as 'train the trainers'.
- To provide an educational program that equips designated nurses to fully utilise the ETEK in their health service to provide optimal care for their communities.
- To enable the health services to have a sustainable educational strategy for all nurses (both presently and in the future) working in their emergency care areas by making optimal use the ETEK.

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Continuing Nurse Education

Access to continuing nurse education has been identified as a significant incentive to attract and retain nurses in Victoria's public health services and therefore strengthen the capability and capacity of Victorian public health services. The Continuing Nurse Education (CNE) grant is designed to assist public health services in the acute health sector to run professional development programs. The CNE Grant provides a contribution to the cost of the overall nurse education program offered by the health service.

Collaborative models of education provision between health services promote efficiencies in education provision. These are formalised through the establishment of consortia in regions.

The grant funds a wide range of activities determined by organisational education priorities as well as state and national priorities. The grant does not fund activities designed specifically for aged care, rehabilitation, palliative care or mental health services.

Nurse education programs comprise a series of planned professional development activities which meet the educational objectives of the health service/consortium and the professional needs of nurses. Activities may include accredited or non-accredited courses, workshops, study days, web based or self directed learning activities.

In the 2008-2011 funding period there is a focus on providing programs

- with clear educational objectives
- which support the strategic directions of the organisation
- which support Victorian Government policy objectives, including those stated in the Victoria – public hospitals and mental health services policy and funding guidelines. The Nurse Policy Branch may advise priority areas annually.
- based on a training needs analysis involving nurse executive and participants
- that are responsive to changing needs throughout the funding period.

In recognition of the costs associated with providing education in rural and remote areas, a baseline minimum amount is allocated each year to the rural sector (40% of the total funding available for the state). Distribution of funds is based on equally weighted Nursing EFT at 30 June 2007 and a measure of acute and sub-acute activity.

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Nursing E-Learning

Regional e-learning strategy grants in 2006-07 and 2007-08 were provided to rural health service consortia to complement the Continuing Nurse Education Program.

E-learning, or learning facilitated through web-based media, is an increasingly important tool used by health services to improve access to educational and training materials and to increase compliance with mandatory training. The benefits associated with e-learning for nurses and health services in rural areas include:

- Access to learning opportunities is maximised, particularly in rural/isolated areas.
- There is a range of e-learning materials commercially available.
- E-learning materials can be developed to address mandatory training requirements.
- E-learning can be linked to other forms of learning e.g. classroom, self directed learning, skills labs.
- E-learning materials can be developed to assist with interdisciplinary learning and to promote interprofessional teams.

Key conditions of the grants include that health services in the regions work in partnership on e-learning initiatives and that all nurses in the region should benefit from the initiative through access to improved programs targeting their professional training and development needs. Grant funds are directed to activities aimed at augmenting e-learning capacity and capability within the regions, and promote sustainable e-learning outcomes.

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Doctor training and placements

General Practitioners (GPs) with procedural skills and qualifications make a significant contribution to service delivery in rural and regional Victoria. The objective of the Advanced Procedural skills training for GPs program is to increase the number of procedural GPs by providing more opportunities for GPs to acquire and maintain the relevant skills in anaesthetics, surgery, obstetrics and emergency medicine. This initiative articulates with the national Australian General Practice Training Program by supporting the development and provision of skill training in priority areas, beyond the skills required for 'core' general practice, and helps to retain skilled doctors in regional Victoria.

In addition to Advanced Procedural training is an Extended Skills training program for GPs. This program enables health services to expand the number of training posts available at the advanced skill level and will provide additional opportunities for GPs to up skill in areas of workforce shortage. The range of disciplines is extensive and includes refugee health, aboriginal health, alpine sports medicine, palliative care, obstetrics and paediatrics.

To increase the number of specialists in rural and regional Victoria, the department has developed the *Strengthening Medical Specialist Training Program* which increases the number of clinical training places across the state, and maximises medical specialist training capacity without increasing pressure on the teaching capacity of public hospitals. Over 50 specialist training places are funded in rural and regional hospitals each year. Clinical placements for doctors in rural and regional areas are also being supported through rural clinical schools.

The government is also investing strongly in expanding training into non traditional settings for all medical trainees, from undergraduate medical students, to interns, registrars and specialists. These settings may be community health, general practices or private hospitals.

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Clinical Skills

The *Clinical Skills Centres in Hospitals* Project has focussed on three areas – training clinical educators to teach clinical skills; development of training modules for a variety of applications (life support, respiratory skills, intravenous therapy etc); and the literature review examined current research into the area of simulation-based training.

Train-the-Trainer

The Train-the-Trainer package focuses on providing training materials to train clinical educators to teach clinical skills to health professionals in Victoria, including through the use of simulation.

Clinical Training Packages

The Training Packages cover 11 inter-professional training programs for a set of core clinical skills.

The training packages currently being developed include:

- Adult basic life support
- Paediatric basic life support
- Adult advanced life support
- Paediatric advanced life support
- Respiratory management 1 and 2
- Intravenous therapy
- Nasogastric therapy
- Chest tube management
- Safe medication administration
- 12 lead electrocardiogram

Clinical Skills Strategy

The department recognises the need to develop a strategic direction for clinical skills and simulation in Victoria. This will be achieved through a specific project in this area in 2008-09.

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Reference list

- Australasian College of Emergency Medicine (2000) Guidelines for implementation of the Australasian Triage Scale in Emergency Departments. Australian College of Emergency Medicine.
- Australian College for Emergency Medicine (2004) The relationship between emergency department overcrowding and alternative after-hours GP services. College of Emergency Medicine, West Melbourne, pp. 6.
- Australian Health Ministers' Conference (2004) National Health Workforce Strategic Framework (Australian Health Ministers' Conference, ed). Australian Government.
- Department of Health and Aged Care (Aust) (2001) Population Ageing and the economy - Research by Access Economics P/L. Department of Health and Aged Care,.
- Department of Human Services (2007) Rural emergency health services minimum specifications - draft. DHS - Victoria.
- Department of Human Services (2008) Sustaining rural emergency services - Proposal for nurses to supply medicines: A discussion paper (Department of Human Services, ed). Victorian Government.
- Department of Human Services (2005) Rural directions for a better state of health (Department of Human Services, ed). Victorian Government
- Productivity Commission (2005) Australia's health workforce. Australian Government, Canberra, pp. 435.
- Smith T. & Jones P. (2007): Remote x-ray operator radiography: A case study in interprofessional rural clinical practice. *Journal of Interprofessional Care* **21**, 289-302.
- Sullivan E., Francis K. & Hegney D. (2008) Advancing a profession - a collaborative approach to public policy. In *Public Health and the Agricultural Rural Ecosystem*, Saskatoon, Canada.