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# The delivery of Primary Health Care in remote Australian communities: A Grounded Theory study of the perspective of nurses

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# The delivery of Primary Health Care in remote Australian communities: A Grounded Theory study of the perspective of nurses

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**Doctor of Philosophy**

**Kylie Maree McCullough**

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School of Nursing and Midwifery

2018

# The Delivery of Primary Health Care in Remote Australian Communities: A Grounded Theory Study of the Perspective of Nurses

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# Abstract

Around 85% of Australia's landmass is remote and sparsely populated. Across these vast areas of desert, wilderness and tropical islands, nurses provide the majority of health care services. The residents of Australia's remote communities have poorer health status than their metropolitan counterparts. The proportion of Indigenous people is high and health and social disadvantage is widespread. The characteristics of each remote community are unique and often reflect challenges associated with distance to tertiary health services and limited health resources. As a result, nursing practice within this context is very different to other nursing contexts. Despite recognition of Primary Health Care (PHC) as a comprehensive model of acute and preventative care well suited to areas of high health and social need, there is little known about how nurses use the PHC model in practice and research pertaining to this nursing context is limited.

This study was conducted from a Constructivist Grounded Theory perspective to generate a substantive theory. Data were collected through 23 telephone interviews and an expert reference group.

This study adds previously unknown information to the body of work about remote area nursing. The context of *providing PHC in a remote setting* was described as social with a focus on illness prevention and equality of care. Participants described personal satisfaction as a feeling of making a difference to the health and wellbeing of the community. However, the core issue participants faced was the *inability to provide PHC*. Four conditions that impacted on the core issue, were described as: understanding of the social world of the remote community, availability of resources, clinical knowledge and skill and, shared understanding and support. The process labelled *doing the best you can with what you have* emerged as the way participants dealt with the inability to provide PHC. The process involved four primary activities: facilitating access to health care, continually learning, seeking understanding, and home-making in a work environment. The outcome of this process was considered to be *making compromises to provide PHC*.

This study proposes a substantive theory to understand and explain Australian remote nursing practice. Recommendations include further exploration, testing and refinement of the substantive theory. The implications for practice include development of education and support programs and the findings promote the case for providing additional resources to health services in remote areas in order to support nurses in providing PHC.

# Declaration

I certify that this thesis does not, to the best of my knowledge and belief:

- incorporate without acknowledgment any material previously submitted for a degree or diploma in any institution of higher education;
- contain any material previously published or written by another person except where due reference is made in the text of this thesis; or
- contain any defamatory material;

Signed: [redacted]

Date:17/12/2018

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The journey of this PhD commenced many years ago when I was fortunate to find myself living and working in Kakadu National Park, a World Heritage Area listed for both its cultural significance and biodiversity values. As an inexperienced Remote Area Nurse, I was mentored by nurses and doctors with a depth of clinical knowledge that was second to none. Special thanks must be awarded to Patricia, Jenny, Angie, Kim, Monica, Julie and Peter who shared their knowledge and continue to support my research today.

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## List of abbreviations

| | |
|---|---|
| AHW | Aboriginal Health Worker/ Aboriginal Health Practitioner (title recently changed. AHW has been kept where this title was used by participants or in the literature) |
| ABS | Australian Bureau of Statistics |
| ATSI | Aboriginal and Torres Strait Islander peoples |
| ASCG | Australian Standard Geographical Classification |
| CALD | Culturally and Linguistically Diverse |
| CARPA | Central Australian Rural Practitioners Association |
| CRANAplus | Council of Remote Area Nurses Australia |
| GP | General Practitioner |
| GT | Grounded Theory |
| NACCHO | National Aboriginal Community Controlled Health Organisation |
| NP | Nurse Practitioner |
| PHC | Primary Health care |
| RAN | Remote Area Nurse |
| RN | Registered Nurse |
| SDoH | Social Determinants of Health |
| SEIFA | Socio Economic Indexes for Areas |
| SI | Symbolic Interactionism |
| WHO | World Health Organisation |

## Operational definitions

**Aboriginal, Torres Strait Islander, and Indigenous:** Terms used by participants have been kept as used by them. Within this thesis, ‘Aboriginal and Torres Strait Islander peoples’ is used to describe the First Nations people of Australia in accordance with the Australian Code for the Responsible Conduct of Research (National Health and Medical Research Council, 2018). ‘Indigenous people’ is used as an adjective where it is appropriate to include the Cocos-Malay people from the Cocos Islands.

# 1 Background

Almost 90 per cent of Australia’s population live in urban areas and the rest reside in small communities, scattered across vast tracts of wilderness or on small islands. These remote areas equate to approximately 85% of the Australian continent (Commonwealth of Australia, 2012). Remote communities share some common characteristics, such as limited resources and distance from goods and services. However, each community is unique in both its social capital and its needs. Some communities serve tourist populations, some are hubs for farming communities, others provide fundamental services for mining operations, and many function as focal points for Aboriginal and Torres Strait Islander peoples living on traditional lands (Coyle, Al-Motlaq, Mills, Francis, & Birks, 2010).

The Australian Bureau of Statistics define geographical areas as ‘remote’ or ‘very remote’ by the Australian Standard Geographical Classification (ASCG) (Australian Bureau of Statistics, 2003) which is based on road distance to essential services. The populations of remote communities range from about 150 to approximately 5000 residents. There are at least 1212 communities across remote areas of Australia (Smith, 2016) (Figure 1).

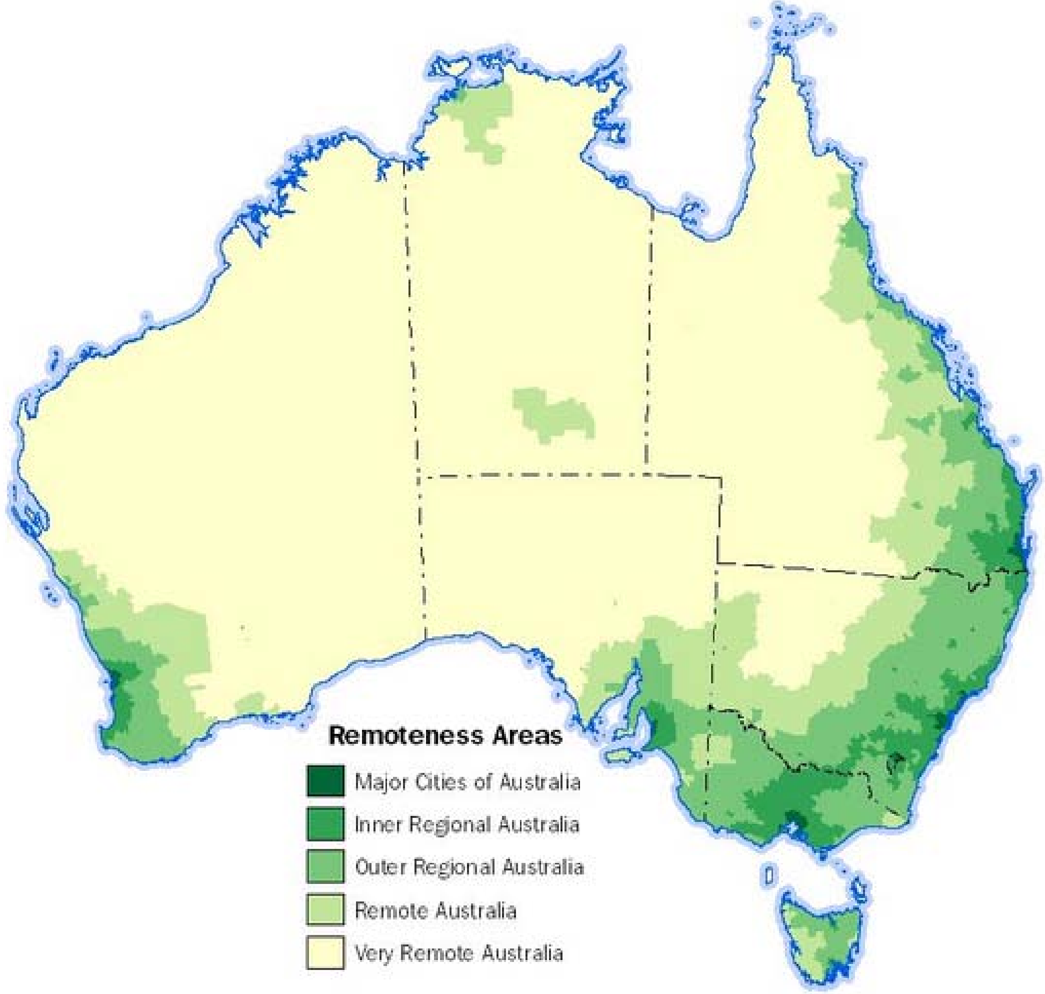


**Figure 1: Map of the 2016 Remoteness areas for Australia (Australian Bureau of Statistics, 2016).**

Whilst the majority of Aboriginal and Torres Strait Islander peoples live in metropolitan areas, the proportion of Aboriginal and Torres Strait Islander peoples living in rural and remote communities is high (Public Health Information Development Unit, 2013). Indigenous people comprise 45% of the population in remote areas and there are 1187 discrete Aboriginal and Torres Strait Islander communities in Australian remote areas (Smith, 2016)

Generally speaking, Aboriginal and Torres Strait Islander peoples have poorer health and lower life expectancy than non-Indigenous Australians (Australian Institute of Health and Welfare, 2012). Further, the more geographically remote a community is in Australia, the greater the likelihood of ill health (Australian Institute of Health and Welfare, 2012). These two factors point to a desperate need to prioritise the health and welfare of remote populations and to examine health care services in this setting.

## Social determinants of health

The Social Determinants of Health (SDoH) are a well-established construct for examining the causes of ill health. The SDoH recognise that people's lifestyles, social world and environments strongly influence their health. In order to examine the problem of inequality in key health indicators between remote and urban communities in Australia, the SDoH as described by the World Health Organisation (WHO) (R. Wilkinson & Marmot, 2003) are used as a framework for the following discussion.

### *Social gradient*

The social gradient or disparity in Socio-Economic Status (SES) of communities has been shown to contribute to poor health. SES is not a measure of social status or class but rather a combined measure of education, income, and employment; or rather access to social and economic resources and participation in society (Australian Bureau of Statistics, 2009; Urquhart, 2009). In lay terms, the gradient refers to the differences between the 'haves' and the 'have nots' within a society, and results in health inequalities between groups based on social and economic disadvantage. SES is seen as cyclical with those experiencing disadvantage likely to pass on this disadvantage to future generations. The Socio-Economic Indexes for Areas (SEIFA) (Australian Bureau of Statistics, 2006) measures relative socio-economic disadvantage. When this index is applied to the ASCG remoteness classification, using 2001 data, it can be seen that over 60% of very remote regions fall in the lowest quartile of socio-economic disadvantage, compared to around 15% of regions in Major Cities. Such income inequality between people who live in major cities and those who do not has increased over the last decade (National Rural Health Alliance Inc, 2017).

### *Stress*

People living in remote areas often experience economic stressors such as low incomes, poor housing and psychological stressors evidenced by indicators of poor mental health (McMurray & Clendon, 2010). The incidence of psychological distress among Aboriginal and Torres Strait Islander adults is twice that of non-Indigenous adults (Thomson et al., 2012).

### *Employment*

Furthermore, approximately 70 000 Aboriginal and Torres Strait Islander people live in remote areas and are welfare dependant, and an estimated 10 000 of these people live on remote outstations (Hughes & Huges, 2010). Whilst being unemployed is recognised as contributing to poor health, employment can also contribute to ill health. The key to this apparent anomaly is the nature and organisation of the workplace. Poor educational attainment often predisposes people to jobs that are repetitive, dangerous or provide minimal opportunity for control, all of which contribute to stress (R. Wilkinson & Marmot, 2003). Employment opportunities in remote areas are often provided by farming or mining industries. Workers in these industries are prone to injuries and accidents (Australian Institute of Health and Welfare, 2018) and poor mental health (Mclean, 2012).

### *Early life*

A good start in life is recognised as vital for ongoing good health (Barker, 2004). Maternal and child morbidity and mortality data suggest that that those living in remote areas are likely to suffer greater disadvantage than other Australians (Bar-Zeev et al., 2012). The rates of very low birth weight babies were higher in remote areas than metropolitan areas (Australian Institute of Health and Welfare, 2008). Maternal and infant morbidity and mortality rates are significantly worse for Aboriginal and Torres Strait Islander peoples than for non-Indigenous Australians (Australian Indigenous HealthInfoNet, 2018). These inequalities are increased for those living in remote areas (Bar-Zeev et al., 2012).

### *Social exclusion*

According to the WHO, social exclusion results from poverty as well as, ". . . racism, discrimination, stigmatisation, hostility and unemployment"(R. Wilkinson & Marmot, 2003 p. 16). Social exclusion increases the likelihood of poor mental and physical health and contributes to the cycle of poverty. The ongoing detrimental effects of colonisation, institutional racism and inter-generational trauma for Aboriginal and Torres Strait Islander peoples, are also well documented (Eckermann et al., 2010; Smith, 2007, 2016; Trudgeon, 2000). Being Indigenous and living in a geographically and socially isolated context may be the most significant contributors to the poorer health status of remote communities. Non-Indigenous people in remote areas also experience social isolation, as many reside there due to their employment rather than family connections. Social and professional isolation are often cited as significant stressors for this group (Garnett et al., 2008; Lenthall, Wakerman, Opie, et al., 2009).

### *Social support*

Social support is strongly associated with improved health outcomes. Social support is not just about individual relationships and social circles but includes the level of social cohesion which is often reflected in the social gradient or the levels of inequality within a society (Germov, 2018). Lack of social support may result in poor mental health and also a decreased ability to care for the sick or dying, or to encourage and support healthy lifestyle changes (McMurray & Clendon, 2010). Family and kinship are very important to many Indigenous groups (Eckermann et al., 2010). At the individual level, social support may be high. However, social support may be diminished in populations with high levels of social dysfunction. The ongoing consequences of colonisation and government policies that have seen Aboriginal peoples forcibly removed from their families and country, as well as high rates of incarceration and premature death among this community, have had a significant impact on social roles and function of kinship systems (Eckermann et al., 2010). In contrast, non-Indigenous people living in remote areas are often there simply for employment opportunities, only staying for the short to medium-term and do not live with this legacy. They often cite family reasons for leaving and rarely stay long enough to develop social support and relationships within communities (Garnett et al., 2008).

### *Addiction*

Environmental factors such as lifestyle behaviours and healthy eating have a significant impact on health. Overall the incidence of hazardous alcohol consumption is greater in remote areas than major cities but illicit drug use less than major cities (Australian Institute of Health and Welfare, 2005, 2017b). Rates of tobacco smoking are also much higher in Aboriginal and Torres Strait Islander peoples and of particular concern is the incidence of smoking in pregnancy (Thomson et al., 2012).

### *Food*

Furthermore, a good diet that includes plenty of fresh fruit and vegetables, small amounts of lean meat and a variety of whole grains and pulses is recognised as contributing to good health (National Health and Medical Research Council, 2013). Aboriginal and Torres Strait Islander peoples living in remote areas are more likely to eat bush foods than those living in metropolitan areas (Australian Indigenous HealthInfoNet, 2018). However, the reality for those living in remote areas is that bought food is very expensive due to high transport costs and lack of retailer competition with food prices 14-19% higher than in major cities (Australian Institute of Health and Welfare, 2005). Fresh fruit and vegetables are also rarely ‘fresh’ after several days of transportation in hot conditions and the cost is prohibitive (Smith, 2016). In addition, poor living conditions where people often do not have access to cooking, food preparation or storage facilities (refrigerators) mean people are less likely to eat fresh foods such as meat and dairy.

### *Physical activity*

Regular physical activity is recognised as improving health outcomes. In remote areas, time spent on physical activity was shown to decrease as people aged (Australian Bureau of Statistics, 2014). A lack of physical activity has been shown to increase the burden of disease in the Australian population and those in the lowest socio-economic groups have 1.7 times higher rate of physical inactivity burden than the highest socioeconomic group (Australian Institute of Health and Welfare, 2017a). Accompanied by decreased physical activity, poor quality food leads to obesity, diabetes, cardiovascular disease and a multitude of other health problems (Smith, 2016). The incidence of chronic diseases such as these is extremely high in Aboriginal and Torres Strait Islander populations and remote areas (Thomson et al., 2012).

*Transport*

The WHO policy focus regarding transport discourages driving and encourages the use of bicycles and public transport within urban areas. In the remote context, however, public transport is often non-existent and distances between places are too far on poorly maintained roads to travel by foot or bicycle. Moreover, transport in remote areas can contribute to poor health outcomes as high rates of motor vehicle accidents (Henley & Harrison, 2013). Transport is also a significant issue when it comes to accessing health services. Some people do not have access to vehicles, meaning people may delay or not attend the health service for treatment. Accessing tertiary services in major centres often necessitates lengthy and expensive journeys by plane, bus or private vehicle (McMurray & Clendon, 2010).

Although residents of remote communities comprise a small percentage of the Australian population, they have high health needs and demonstrate significant inequality in health status when compared to other Australians. This is especially true for Aboriginal and Torres Strait Islander peoples.

## 1.1 Primary Health Care

The Australian Government's 'Closing the Gap' program aims to eliminate inequalities in life expectancy between Aboriginal and Torres Strait Islander peoples and non-Indigenous Australians by 2031 (Council of Australian Governments, 2008). There are many arms to this strategy, but health care is a major focus. An important element in addressing health inequalities is access to health care services that recognise and work toward addressing the SDoH. This requires a re-orientation of the health system away from the 'medical' model of treating the disease or infirmity at an individual level to a Primary Health Care (PHC) approach that consistently includes the social and psychological aspects of a health problem as well as the medical diagnosis and treatment. PHC incorporates Primary Care (traditionally General Practitioner and first level services) with Health Promotion and Population Health in a way that emphasises community participation and empowerment, social justice and equity, cultural safety, trust and accountability and results in self-reliance and more effective health care (Talbot & Verrinder, 2018). The difference between Primary Care and PHC is more about *how* the care is provided rather than *what* services are provided (Australian Nursing Federation, 2009; Department of Health Western Australia, 2011; Heslop, 2002; McMurray & Clendon, 2010; Wakerman et al., 2008; WHO, 1986).

PHC first gained recognition as an approach to health care at the International Conference on Primary Health Care in Alma Ata, Russia, in 1979. Representatives from many of the member nations of the WHO and other global health bodies came together in an attempt to address global health inequalities and urge Governments to re-orient their health services to a social justice model of health (International Conference on Primary Health Care, 1978). The declaration reaffirmed the WHO definition of health as not just being the absence of disease but a state of physical, mental and social wellbeing that is a basic human right and aimed to reach a state of 'Health for All' by the year 2000 (Talbot & Verrinder, 2018).

The Declaration also provided a definition of the PHC approach. It includes the following;

> Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process (International Conference on Primary Health Care, 1978 p.1,2).

Barriers to the adoption of the Declaration have been reported as including: resistance to change (particularly where additional funding is needed); a lack of research with community as a focus rather than a specific disease or process; lack of well-prepared workforce to put PHC into action; and competing political and professional interests which maintain the flow of health funding to tertiary level care (Gillam, 2008). In an effort to progress the aims of the Declaration, conference delegates in Ottawa created the Ottawa charter to guide health promotion policies and programs. The Ottawa charter described Health Promotion as actions that develop personal skills and strengthen community action to enhance self- reliance, create supportive environments, build healthy public policy and reorientate health services to a collaborative and holistic approach to health service provision (WHO, 1986). The Declaration of Alma Ata and the Ottawa charter form the foundation of modern PHC philosophy.

### 1.1.1 PHC in Australia

In 2009, The Australian Nursing Federation (ANF) released a report outlining the consensus between Nurses and Midwives in supporting the philosophy and implementation of PHC in Australia (Australian Nursing Federation, 2009). The report outlines several areas where nurses and midwives can make a significant contribution to PHC objectives such as in health promotion, management of chronic disease, aged care, child and family care and mental health. Explicitly mentioned is the generalist role of nurses in underserved areas, such as with Indigenous and Culturally and Linguistically Diverse (CALD) communities and in rural and remote areas. Barriers to the adoption of PHC in Australia have included obstacles such as the current focus on hospital and medical based models of care and a lack of investment in the prevention of illness and injury(Australian Nursing Federation, 2009). This situation is likened to consistently supporting the ambulance at the bottom of the cliff rather than investing in a fence at the top (Jones, Jones, Perry, Barclay, & Jones, 2009). The ANF report calls for increased funding for PHC services, improved education and collaboration between members of multidisciplinary teams and communities and an increased focus on safety and quality of PHC with funding based on the demonstration of cost–effective positive health outcomes (Australian Nursing Federation, 2009).

The importance of a PHC approach to health service delivery is also evident in the Australian codes of conduct for Nurses; where principle seven states, "Nurses promote health and wellbeing for people and their families, colleagues, the broader community and themselves and in a way that addresses health inequality"(Nursing and Midwifery Board of Australia, 2018p.14). Lapum, Chen, Peterson, Leung, and Andrews (2009) provide a thought provoking insight into the similarities between the foundations of nursing practice and the philosophy of PHC. They claim that the theoretical underpinnings of PHC originate in principles such as: an emphasis on relationships between health providers and clients, client participation in care and an approach to health that goes ". . . beyond biological status to incorporate the client's psychological, social and environmental dimensions of health" (p.138). PHC is a model of health service delivery that is expected to curb the spiralling costs of chronic disease and with its focus on preventative care, bring about significant health improvements in communities by reducing health inequalities (Talbot & Verrinder, 2018). In this way there are strong parallels between nursing practice and PHC.

### 1.1.2 PHC for Aboriginal and Torres Strait Islander peoples

Aboriginal community-controlled health services first emerged in Australia in the 1970's. They are PHC services which are ". . . initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it, through a locally elected Board of Management"(National Community Controlled Health Organisation, n.d.para. 3).The emergence of community-controlled health services in Australia aligns with a shift towards implementing PHC philosophy. Furthermore, the National Aboriginal Community Controlled Health Organisation (NACCHO) has adapted the PHC definition provided by the Declaration of Alma Ata to better reflect their cultural viewpoint on health as follows:

> PHC is a holistic approach which incorporates body, mind, spirit, land, environment, custom and socio-economic status. PHC is an Aboriginal construct that includes essential, integrated care based upon practical, scientifically sound and socially acceptable procedures and technology made accessible to Communities as close as possible to where they live through their full participation in the spirit of self-reliance and self-determination. The provision of this calibre of health care requires an intimate knowledge of the community and its health problems, with the community itself providing the most effective and appropriate ways to

> address its main health problems, including promotive, preventative, curative and rehabilitative services (National Aboriginal Community Controlled Health Organisation, 2009 p. 6).

PHC services in remote areas (particularly in discrete Aboriginal and Torres Strait Islander communities) are often provided by community-controlled services, commonly referred to as Aboriginal Medical Services (AMS), which are governed by a board of directors and who independently manage health resources to meet the health needs of the community. PHC services or health clinics in other remote communities are provided by local State Governments or private organisations such as Silver Chain (Silver Chain Group Limited, n.d.).

### 1.1.3 Health care delivery in remote areas

Health care services in remote communities revolve around ‘the clinic’. Clinic opening hours are usually Monday to Friday, 8.30am until 4pm, with an on-call service for emergencies outside of these hours. Visiting specialists run sessions at variable frequency and often clinic staff such as nurses and Aboriginal Health Practitioners, will travel to smaller outstation communities or cattle stations within the region to provide mobile health services. For example; the health clinic situated in the remote town of Jabiru, NT (population 1000, 300 km distance from nearest tertiary hospital) currently services the town community and eight smaller outstations spread over a distance of 20 000 km$^2$. Clinic staff respond to all acute and chronic health needs within that catchment and transfer patients to the nearest capital city when the clinical need is greater than could be provided for within the clinic’s resources.

Although the ABS differentiates ‘rural’, ‘remote’ and ‘very remote’, many authors acknowledge similarities between classifications and combine the terms ‘rural’ and ‘remote’. There is debate about the appropriateness of the classification developed by the Australian Bureau of Statistics that is based on road distance to services, as it does not take into account available services; seasonal access or quality of road; social or cultural isolation; or isolation from professional peers or support (CRANAplus, 2013a). However, it is the most commonly adopted classification and is used to generate national statistics. Nevertheless, it is important to recognise that in contrast to many rural areas, remote and very remote communities rarely have access to resident medical practitioners (Health Workforce Australia, 2013). The absence of medical practitioners leads to systematic inequalities as funding is often allocated to medical practitioners exclusively (Humphreys & Wakerman, 2008). In addition, rural communities often have access to a small hospital and ambulance services, which remote and very remote communities largely do not. The increased resources and infrastructure accompanying these additional services may ameliorate some of the challenges experienced by remote health services. In addition, the absence of medical practitioners and other allied health and support services broadens the scope of practice of the remote health workforce. Workers are required to take on additional responsibility and tasks that may be outside of their professional domain and experience out of necessity as they are simply the only ones there (Cramer, 2006).

Remote communities do not have ready access to tertiary or specialist health services due to geographical distance; this means that local health services need to provide a comprehensive range of services to meet the needs of the local population. Such complex health services, such as local community clinics in remote areas, that meet the needs of populations with significant health disadvantage, require the most highly trained, knowledgeable and skilled health practitioners available (Tarlier & Browne, 2011). The National Strategic framework for Rural and Remote Health advocates for PHC service models (Health Workforce Australia, 2013). The objectives of the framework include: integration across traditional ‘borders’ between PHC, acute care, specialist care, Indigenous health and aged care service providers; new innovations supported by research and flexible funding, local community involvement in order to design services that meet consumer need and an increased capacity to provide preventative health services. Central to meeting these objectives is an appropriately trained and supported health workforce.

A quality PHC workforce is key to improving health outcomes for all, but especially those who are most socially disadvantaged (Australian Nursing Federation, 2009; WHO, 2010). The complexity of health needs in Indigenous communities demands that as well as advanced diagnostic and treatment skills, healthcare workers are also equipped to work with communities to address the social determinants of poor health (Tarlier & Browne, 2011). Therefore, of critical importance to efforts to improve the health outcomes of Australia’s remote residents, and subsequently to ‘close the gap’ in health inequality, is access to healthcare workers such as Registered Nurses (RN), Nurse Practitioners (NP), Aboriginal Health Workers (AHW) and General Practitioners (GP) (Buykx, Humphreys, Wakerman, & Pashen, 2010; A. Muecke, Lenthall, & Lindeman, 2011; WHO, 2010). Communities in remote areas have limited access to services, particularly tertiary services such as specialists, pathology, radiology and hospital services, however, they do often have a comprehensive PHC service that is either Government or community controlled; integrated care, such as a shared care maternity services, outreach service and access to telehealth services (Wakerman et al., 2008).

Although lack of access to health services is a considerable barrier to good health, Bar-Zeev et al. (2012) documented high utilisation of PHC services by infants under 12 months, in two large Aboriginal communities. Through a chart audit, the authors found that infants were seen frequently in the health clinic (fortnightly on average) and yet the hospitalisation rate was still high with 59% of infants hospitalised at least once in their first year of life. The majority of consultations were for acute illnesses such as gastroenteritis, respiratory illness and skin infections with only a third of consultations for routine health check-ups and other non-acute interventions. This study showed that acute health care services were available in these communities for these infants, however, it raises questions about the appropriate use of PHC services, the provision of preventative care and whether these PHC services' interventions were aimed at reducing social inequality or addressing the Social Determinants of Health. It's not known if the PHC services provided in the study by Bar-Zeev et al. (2012) were evaluated, however, Wakerman and Humphreys (2011) claim there is a lack of evaluation and monitoring of PHC services in rural and remote areas. They claim that innovative, contextualised models of care are effective but admit that there is a paucity of data from which to evaluate these models (Wakerman, 2009). In addition, as nurses provide the majority of health care services in remote areas; it is important to understand how nurses provide PHC in the remote setting. However, very little is known about how nurses integrate PHC principles into their practice in remote areas or what impact the PHC approach has on health outcomes for remote communities. This is the focus of the current study.

## 1.2 Chapter summary

In this chapter, the background and context of the study has been outlined with a particular emphasis on understanding the meaning of PHC. In addition to recognising the global origins of the PHC philosophy and the need to change the focus of health care from a biomedical to a social perspective. PHC models of care have been described in relation to Australia. Within the Australian context, the link between Aboriginal and Torres Strait Islander peoples and remote health was demonstrated and the importance of nursing in the delivery of health care within the remote setting was made. The aim of this study to describe the nature of PHC nursing practice within the remote setting was declared and the significance to nurses and health care delivery outlined.

In the next chapter, the current discourse on nurses working in remote PHC settings is reviewed with the aim of establishing a gap in current knowledge and justify the need for this study. In chapter three, Constructivist Grounded Theory is described and justified as the philosophical perspective for this study and a detailed account of the methods used is provided. Ethical considerations are also discussed.

In chapters four and five, the research findings are presented. In chapter four, the context of practice and the core issue as described by the nurses in this study are reported in detail. Chapter five presents the process that nurses used to manage the core issue of the inability to provide PHC and proposes the process outcome of *making compromises*.

Chapter six is concerned with the contribution to substantive theory made by this study and positions the theory within the context of existing knowledge. The thesis is concluded and limitations are described. Recommendations for additional research and practice are also provided.

# 2 Literature Review

In order to establish a need for the current study, a review of the literature relative to the phenomenon of interest was conducted. The methodological approach of Grounded Theory was selected after this review was conducted and will be discussed in detail in chapter three. Whilst an initial literature review is avoided in some Grounded Theory approaches, the choice of approach taken in this study recognises that an initial review of the literature is often necessary in order to refine the focus of the study, gain approval from relevant Research Ethics committees and meet the requirements for candidature in PhD programs (Charmaz, 2014).

Literature was sourced from leading databases including CINAHLplus, Proquest, Medline and Google Scholar. Keywords used included rural/remote are nursing, outback/bush nursing, and PHC nursing. This literature review was a scoping review that aimed to provide an overview of the key studies and topics in the field. The remote setting in Australia is most similar to that in Canada and New Zealand in terms of geography, nursing practice, socio-economic status and inequality between indigenous and non-indigenous peoples. Consequently, studies from these countries were also included in the search strategy.

This review commences with a description of nursing practice in remote areas, with a focus on the Australian remote setting. Key nursing workforce issues including retention, education and skill needs of nurses in remote areas will then be described. The scope of practice limitations of the Registered Nurse (RN) role within this setting will be discussed. The review then describes the role of Nurse Practitioners (NP) as experts in remote area nursing practice who, along with RNs were key informants for this study. Finally, this review identifies a gap in knowledge and nursing theory regarding how nurses practice PHC in the remote Australian setting.

## 2.1 Nursing practice in remote areas

Nurses have served the Australian 'Outback' for over 150 years (Yuginovich, 2009). In the early years, nurses had basic training, often lived among the people for many years and perhaps felt drawn to the outback by a sense of adventure or a religious calling (Brayley, 2013; Yuginovich, 2000). Nowadays, RNs working in remote areas, often referred to as RANs (Remote Area Nurses) are specialist- generalists who require a wide range of clinical skills to deal with emergency and acute presentations, issues relating to childbearing, palliative care, health promotion, screening and chronic disease management skills (Mills, Birks, & Hegney, 2010). Often coined 'nursing from womb to tomb', there is a high degree of General Practitioner (GP) substitution, cross-cultural communication and personal and professional isolation all within a resource-poor environment (Cramer, 2006; Dowd & Johnson, 1995; Smith, 2007). The complexity of health needs in Indigenous communities requires healthcare workers with advanced diagnostic and treatment skills as well as the ability to work with communities to address the SDoH (Tarlier & Browne, 2011). RANs are described by the Council of Remote Area Nurses Australia (CRANAplus), in the following way:

> Remote Area Nurses in Australia provide and coordinate a diverse range of health care services for remote, disadvantaged or isolated populations. Their practice is guided by Primary Health Care principles and includes emergency services, clinical care, health promotion and public health services. Remote Area Nurses work in a variety of settings including outback and isolated towns, islands, tourism settings, railway, mining, pastoral and indigenous communities. (Council Remote Area Nurses Australia, 2003p.107).

Of particular interest to this study is the specific reference to nursing practice that is guided by PHC principles and yet no studies could be found in the extant literature that specifically examined how nurses adopt these principles into their practice or what PHC means to nurses working in remote areas.

A small number of studies on nursing practice within the remote setting were found. For example, in her seminal study on remote area nursing in Australia, Cramer (2005, 2006) described nursing practice in remote areas of Australia as *amorphous* or constantly changing from ". . . nurse to nurse and from situation to situation"(2006 p.191), with underlying themes of detachment, diffusion, and beyond the nursing domain. This ethnographic work, undertaken over a year living in a remote Aboriginal community in Western Australia; is a comprehensive field account of nursing practice in remote Australian Indigenous communities. Nursing practice in remote areas is exposed by Cramer as being ". . . completely different from nursing as it is generally practiced in other settings"(Cramer, 2006 p.201) largely due to: the lack of boundaries to practice, a medical rather than nursing focus (which includes a doctor substitute role), social and professional isolation and unrealistic expectations of communities and employers.

An integrative literature review conducted by Coyle et al. (2010) examined how the burden of disease affected nursing practice in remote areas. These researchers discovered that nursing practice was complex, diverse and context specific and that primary care was prioritised over PHC. Primary care is sometimes referred to as selective PHC and has a more medical or illness focus rather than a comprehensive approach that aims to reduce social inequalities (Talbot & Verrinder, 2018).

Coyle et al. (2010) also described nursing practice as going beyond the necessary acute care clinical skills to incorporate health education and community health programs as well as a high level of non-nursing activities such as administration, patient transport, animal health, cleaning, and vehicle/equipment maintenance. The review outlined the differences between States and Territories in relation to preparation for practice and the varying roles of nurses in remote areas. The authors recommended further consideration be given to describing and defining the remote context of practice.

Al-Motlaq, Mills, Birks, and Francis (2010) focused on the importance of teamwork in remote health services in a multiple case study of five geographically diverse communities in Queensland. Informed by 23 interviews and four focus groups, this study described varying practice contexts where RANs functioned in inter-professional teams that included Aboriginal health practitioners, ambulance officers, aero-medical retrieval specialists such as the Royal Flying Doctor Service, and also non-health professionals such as teachers and police officers. They concluded that nurses have "... an actual or perceived inability to implement health promotion and disease prevention activities ... [and that] nurses' ability to address and reduce the increased burden of disease is limited by how they conceptualise and operationalise their role" (Al-Motlaq et al., 2010 p.476). Additional findings from this study showed that remote inter-professional teams were characterised by collaborative decision-making, communication and working in partnerships (Mills, Francis, et al., 2010). Role clarity was seen as essential to the success of these teams. Collegial support was sometimes available locally but was often accessed via the telephone or internet. Another paper from the same study, described the models of care delivered in Queensland by nurses. This study recognised that nursing practice was placed within a PHC philosophy where nursing practice was proactive in response to the needs of the community and reactive to the needs of individuals. They studied three models of care provided in Queensland; PHC clinics in Indigenous communities, with or without overnight bed capacity and outpatients clinics/small acute services in non-Indigenous communities. In this study, nurses considered the provision of PHC to be a burden and "... someone else's responsibility"(Birks et al., 2010 p.29). The authors noted that nursing practice was viewed as task-oriented rather than philosophically driven and that the primary focus was on "... addressing specific clinical issues rather than a wider view of prevention and the social and emotional wellbeing of their clients"(Birks et al., 2010 p.32).

Furthermore, Banner, MacLeod, and Johnston (2010) reviewed the literature to find examples of the process of role transition to a PHC model for nurses in remote areas. They found that PHC innovation required changes to the roles and work practices of nurses facilitated by intimate connections with the community that are characteristic of models of care that respond to community need (Banner et al., 2010). They recommended further research regarding innovative PHC practice models and the transition process.

These studies described remote area practice as ever-changing, context-specific and different to other types of nursing practice. Despite the aim of having a PHC focus, nursing practice was described as prioritising acute care over preventative health measures. Teamwork and relationships with communities were important aspects of nursing practice in the remote setting. Research that explicitly describes how nurses practice PHC within the Australian remote setting was not found.

### 2.1.1 Workforce studies

Despite the lack of research pertaining to PHC practice, several studies were reported in the literature that focussed on the nursing workforce. These studies examined issues such as retention and turnover of staff, workplace safety, employment conditions and stress and are discussed below. Although not directly exploring nursing practice in relation to a PHC philosophy, these issues are highly relevant as successful PHC services are reliant on a foundation of trust and respect between the community and the health service which develops over time (Coyle et al., 2010). Increased retention of healthcare workers is associated with advanced clinical skills and better continuity of care (Buykx et al., 2010). Likewise, high turnover of healthcare workers results in a loss of resources (or 'corporate knowledge') particularly in small communities (Humphreys et al., 2007). Unfortunately, turnover rates for remote health professionals; especially nurses, are extremely high (Buykx et al., 2010; Cramer, 2006) with the shortage expected to worsen over the next 10 years in line with the expected Australia-wide nursing shortage (Lenthall, Wakerman, Opie, Dunn, et al., 2011).

The outcomes of high staff turnover, inadequately prepared or supervised staff are likely factors that contribute to poor patient health outcomes due to inconsistencies in treatment and advice given, lack of follow-up and a high rate of expensive patient transfers to regional hospitals (S. Muecke, 2010). The solution was suggested as relating to the retention of nurses rather than a focus on increasing the supply (Humphreys, Wakerman, Pashen, & Buykx, 2009; Wakerman et al., 2008). Short-term contractors and rapid staff turnover were considered likely to compromise quality and safety of care (Hanna, 2001) (although this has not been empirically tested) be financially unsustainable; and negatively impact on continuity of care which affects health outcomes (Russell, Wakerman, & Humphreys, 2013). New models of practice that encourage retention and capitalise on the clinical knowledge and social relationships that arise over time, but also provide increased opportunity for career development, autonomy, clinical variety and challenge, should be described (Commonwealth of Australia, 2012) .

### 2.1.2 Stress and turnover

The difficulty in recruiting and retaining nursing staff in remote areas has been described in the literature where there existed a dichotomy between nurses finding enjoyment in the challenges associated with the remote setting but also experiencing significant stressors which eventually lead them to leave. For example, a study on mobility of nurses in the Northern Territory (NT), a state which employs a large number of RANS (Garnett et al., 2008), found that autonomy and clinical variety and challenge were the two main reasons for staying in the NT to work. This autonomy has been cited by others as an attractive aspect of RAN practice (Hegney, McCarthy, Rogers-Clark, & Gorman, 2002b). However, despite rural and remote area nurses reporting high levels of job satisfaction (Hegney, McCarthy, Rogers-Clark, & Gorman, 2002a), excessive workloads and unmanageable job demands expose staff to high levels of stress which increases turnover (Lenthall, Wakerman, Opie, Dollard, et al., 2011; Opie, Dollard, et al., 2010; Schmidt, 2004; Trinkoff et al., 2011). Staff turnover increases the job demands of existing staff as they are required to orientate and supervise in addition to their normal duties (Lenthall, Wakerman, Opie, Dollard, et al., 2011). The primary reason for leaving the NT was family and/or social relationships (Garnett et al., 2008).

In the remote setting, culture shock, violence and poor leadership were cited as significant factors that increased levels of stress for nurses in remote areas (Opie, Lenthall, & Dollard, 2011). Approximately 80% of RANs work in a cross-cultural environment (CRANAplus, 2013b). A. Muecke et al. (2011) discussed the experience and effects of culture shock for nurses new to the remote health context who need to adapt to different languages, social structures and traditions as well as differences in the burden and presentation of disease. The risk of violence towards RANs has been identified as a significant stressor that was related to the availability and skill mix of staff, relationships with the community and education and support (Fisher et al., 1996; Fisher et al., 1995; McCullough, Lenthall, Williams, & Andrew, 2012; McCullough, Williams, & Lenthall, 2012). Leadership models within RAN practice have been described as varied (Birks et al., 2010). Most remote PHC teams are led by RANs, others are led by Aboriginal health practitioners or administrators. In small teams or single nurse posts, leadership may come from a regional hub with only sporadic visits with most communication being via phone or email. This distance management model can be problematic, due to poor communication and a perceived lack of understanding by leaders of the demands of RAN practice (Weymouth et al., 2007).

Another factor described as contributing to high staff turnover is the need for nurses to reside within small remote communities. Practitioners new to remote areas sometimes find themselves living in a dysfunctional community that has drug and alcohol abuse that leads to violence (McCullough, Williams, et al., 2012). Others find the demands of ‘living where you work’, anxiety regarding working outside of normal professional practice boundaries, culture shock and long hours leads to stress and early termination of employment (Cramer, 2005; Dowd & Johnson, 1995; Fisher et al., 1996; Lenthall, Wakerman, Opie, et al., 2009).

The data shows that there is a chronic shortage and inequitable distribution of all health workers (Russell et al., 2013), that the turnover is high, the hours are long and the workforce is aging (Australian Institute of Health and Welfare, 2005; Lenthall, Wakerman, Opie, Dunn, et al., 2011). In addition, inadequate preparation of remote health staff in both clinical and cultural knowledge and skill has been criticised as encouraging lower expectations of service delivery or quick fixes to the most pressing problems without a long-term vision of a sustainable service (Simpson & McDonald, 2011).

It was evident that Remote area nursing is most commonly described in the literature in terms of workforce problems such as recruitment and retention and the impact of stress on nurses. There is a theme within this literature which suggests that high staff turnover impacts on the health of remote communities because nurses do not stay long enough to gain the necessary clinical and community knowledge to undertake the PHC role. It is essential then, that the role of nurses in the remote PHC setting is further examined.

## 2.2 Remote Area Nursing as a specialist nursing role

Most nurses working in remote areas are Registered Nurses, which means that they have completed an approved undergraduate program, are registered with the Nursing and Midwifery Board of Australia (NMBA) and are required to adhere to professional practice standards and conduct. Whilst most Australian Registered Midwives (RM) are also RNs, the number of RNs in remote areas with midwifery qualifications has decreased dramatically in the last few years (Lenthall, Wakerman, Opie, Dunn, et al., 2011). Although women are transported to regional or metropolitan areas to give birth, in some cases, births occur in communities that may not have midwives or with midwives who require up-skilling (Kildea, Kruske, & Bowell, 2006). In addition, ante and post-natal care is largely conducted in the woman’s community and monitoring and education during this stage is often the responsibility of nurses with little or no midwifery experience (Kildea, Kruske, Barclay, & Tracy, 2010).

Some RNs continue their studies and become Nurse Practitioners (NP) who have a broader scope of practice than RNs. The term Remote Area Nurse (RAN) is commonly used to describe all nurses working in a remote setting. As there are different meanings to the title ‘nurse’ within the remote setting, this section describes the differences between the roles of RNs and NPs and considers an alternative designation of RAN.

### 2.2.1 Registered Nurse in a remote area or Remote Area Nurse?

The generalist nature of remote health practice requires a wide range of clinical skills and knowledge applied in an environment of geographical and professional isolation (Wakerman, 2004). In addition to advanced clinical knowledge, understanding the unique context of nursing practice is vital. The differences between the metropolitan and remote contexts are vast, and even differences between remote communities can be marked. RN practice in the remote setting involves a component of GP substitution, and at times extends beyond the normal scope of nursing practice (Coyle et al., 2010; Hegney et al., 2002b). Pre-registration nursing curricula do not prepare nurses for practice in remote areas (Lenthall, Wakerman, & Knight, 2009) and mostly focus on preparing graduates for acute rather than PHC positions (Mackey, Hatcher, Happell, & Cleary, 2013). A comprehensive orientation program, post-registration education opportunities and guidance from clinical practice manuals in particular the CARPA manual (Central Australian Rural Practitioners Association, 2009) can assist the new RAN in their role (Coyle et al., 2010).

It is not known when the term “Remote Area Nurse” was first used; however, describing an RN working in a remote area as a RAN is common practice. The term denotes specialty knowledge and skill, but is applied to all RNs within the remote setting irrespective of amount of experience or formal qualification. Despite recognition of clinical knowledge that goes beyond the normal scope of practice of a RN, those in the remote setting are not formally recognised as RANs by the NMBA. It is this anomaly that prompted the development of the credentialing program and recognition of RANs as specialty practice nurses mentioned earlier (CRANAplus, 2012a, 2012b, 2016). This voluntary process articulates the required competencies or practice standards that are expected in order for nurses to work safely and effectively in remote areas, as endorsed by their professional body (CRANAplus, 2013b). Credentialed nurses are able to use the designation RAN to demonstrate that they have completed a process of training and recognition of experience within the remote context as evaluated by the professional body. Whilst this process of credentialing goes some way to establishing standards of practice, it is entirely voluntary and employers are not obliged to support staff in attaining these standards; it is not a formal endorsement by the NMBA, thus there is no regulation of the use of the term. Consequently, RNs working in remote areas are usually referred to as RANs regardless of whether they have attained RAN credentials or not.

In contrast, NPs are nurses who have undergone postgraduate education within a specialty area of practice, have undergone a process of endorsement and have the legal right to prescribe medications, order diagnostic tests and provide assessment and treatment services within their scope of practice (Australian Nursing and Midwifery Council, 2013). Only those RNs who meet the stringent requirements of the NMBA can be endorsed as NPs because the title ‘Nurse Practitioner’ is defined by legislation. The NP role is consistent with nursing values which often means moving the focus from illness, to care designed to promote heath and quality of life (Bryant-Lukosius & DiCenso, 2004). NPs consider additional clinical skills and responsibilities such as prescribing medications and ordering diagnostic tests as tools to facilitate holistic nursing assessment and the promotion of health and wellness, rather than the skills that delineate them from other nurses. The focus of NP practice in the community is client and family centred care, integrated teamwork, creating a link between doctors the community and hospital care; and innovative practice with an underlying evidence base (Martin-Misener, Reilly, & Vollman, 2010; Shiu, Lee, & Chau, 2012)

The advanced and extended practice of RANs was an argument for the introduction of NPs (Browne & Tarlier, 2008; Chiarella, 1998; Coyle et al., 2010; DiCenso et al., 2007; Harvey, 2011; Mitchell, 2000; Tarlier, Johnson, & Whyte, 2003).This was because RANs were often working outside of the usual scope of practice and legal requirements of RNs, particularly in relation to the use of medicines. The aim of establishing an NP designation to legitimise RAN practice is most clearly seen in Western Australia where the designation "Remote Area Nurse Practitioner"(RANP) was formalised and changes made to seven State Acts, Regulations and Rules that govern nursing practice (Western Australia Remote Area Nurse Practitioner Project Steering Committee, 2000). RANPs could only work in designated positions, had prescribing rights that were limited to standing orders (a specified list of medications to be used in a limited range of situations) and were required to work in partnership with a GP. RANPs could apply to the Nurses Board of Western Australia for recognition of competence based on prior learning and skills at an expected level of an accredited post-graduate diploma. Initially, RANs could apply for immediate endorsement as a RANP for a period of six months after the start of the program through a 'Grandfather' clause arrangement.

The argument for RANs to be NPs is supported by Tarlier and Browne (2011) who discussed the implementation of certified (credentialed) nurses in remote British Columbia after an earlier study where they found that the domains and competencies of NP practice were shared by outpost nurses in a remote Canadian Indigenous community and yet outpost nurses did not have to complete the postgraduate study and demonstration of advanced practice that NPs did (Tarlier et al., 2003). They argued that remote area nursing practice is an advanced and expanded practice role and as such, nurses working in this context should be NPs. They considered the introduction of a new designation of nurse as both unnecessary and contributing to the ongoing inequalities in service provision between remote and urban health services because credentialed nurses were second –best to NPs. Banner et al. (2010) also note a 'double-standard' that allowed Registered Nurses to function in an advanced and extended role in rural, remote and Indigenous communities when they would not be permitted to do so in an urban setting. This anomaly in nursing practice is criticised as encroaching on the rights of people living in remote areas and adding to the inequality in health status, particularly in Indigenous communities (Browne & Tarlier, 2008; Tarlier & Browne, 2011).

Despite the introduction of NPs as a response to the situation in remote areas where RNs were working in an unregulated advanced practice role, the reality of where NPs practice is surprising. A survey of 293 NPs (approximately 76% of potential respondents) in 2009, found that the greatest number (30%) of NPs worked in Emergency Departments and only 5.8% worked in community and primary care and 5.3% (*n*=11) working as generalists in remote areas. At the time of that report, 64% of all NPs worked in metropolitan areas (Middleton, Gardner, Gardner, & Della, 2011). Their study also identified many barriers to NP practice with the result being the under-utilisation of this resource within the health system.

## 2.3 Literature review summary

This review has revealed a paucity of research regarding the practice of nurses within the Australian remote PHC setting. Studies have largely focused on workforce issues such as recruitment, retention, stress and violence. There is a gap in the understanding of what nurses do in this setting and why they do it. Despite the acknowledgement that nurses ". . . play a major role in helping to shift the health system away from a predominant focus on illness and cure, toward increased attention to health promotion and disease prevention"(Besner, 2004 p.351); no comprehensive studies that describe an appropriate framework for PHC nursing practice were located.

In addition, this review detailed different types of nursing roles within the remote setting. RNs and NPs are the formal roles. However, the term RAN is commonly used in the literature to indicate a RN working in a remote setting irrespective of whether they have an endorsement from a professional body.

## 2.4 Aims and objectives

As a result of the literature review, the aim of this study was to describe and explain, from the perspective of nurses working in remote Australian communities, the delivery of PHC. The objectives of this study were;

1. To describe and explain from the perspective of nurses, the actions and interaction used to deliver PHC in remote communities.
2. To identify contexts and conditions where PHC principles are applied.
3. To uncover the factors which enhance or inhibit PHC nursing practice in remote areas
4. To develop a substantive theory which explains the nature and process used by nurses to deliver PHC in remote Australian contexts.

## 2.5 Significance

The National Primary Health Care Strategic Framework, endorsed by the Australian Government at state and federal level, presents an approach for a stronger PHC system in Australia and highlights the importance of PHC services (Standing Council on Health, 2013). The framework outlines the vision and strategic outcomes for health care reform and was developed in response to evidence that showed that ". . . health systems with strong primary health care are more efficient, have lower rates of hospitalisation, fewer health inequalities and better health outcomes including lower mortality" (Standing Council on Health, 2013p.v).

However, in order to articulate and evaluate the impact of health services reform towards a PHC model, it is necessary to understand how PHC principles affect the practice of those delivering the care. It is not known how reorientation of health systems towards a PHC model has affected nursing practice or what impact a PHC focussed nursing workforce has on health outcomes. Bourke, Taylor, Humphreys, and Wakerman (2013), discuss a lack of understanding of how concepts such as PHC and the SDoH are ". . . theorised, applied and operationalised in rural and remote health policy, practice and research" (p.66) while Besner (2004), suggests that further research investigating nurses' conceptualisations of PHC and how it shapes their practice is needed. Considering the experiences implementation of PHC into nursing practice may also lead to refinement and improvements in PHC objectives, service models and workload measures.

This chapter has provided an overview of the literature on nursing practice in the remote Australian setting and has identified the absence of a theoretical framework from which to understand and explain nursing practice in the remote setting. The next chapter outlines the methodological perspective and methods of the study along with addressing ethical issues associated with this research.

# 3 Methodology

In chapter two, the literature review established that there was a need for greater understanding of nursing practice within the remote setting in Australia. This chapter outlines the methodology and procedures used to understand the delivery of Primary Health Care (PHC) in remote Australian communities from the perspective of remote area nurses.

Qualitative methodologies are particularly useful when investigating areas that are poorly understood as they focus on the qualities, processes and meanings of the social world (Liamputtong, 2017). The lack of published research that seeks to understand the social phenomena of nursing in an Australian remote setting led to the consideration of qualitative methodologies as an appropriate approach for this study.

Ethnography focuses on the study of culture and shared meaning within groups of people (Liamputtong, 2017). Case study methods provide a framework for studying complex social phenomena on a case-by-case basis (Yin, 2009). Both case study and ethnography were explored as methods to understand nursing practice in this setting. However, these approaches proved difficult to undertake because of the challenges associated with the requirement of a period of time to be spent immersed in the setting and a lack of logistical support such as accommodation, living and travel costs, and family responsibilities prevented me from using these methods. Other qualitative methodologies, including phenomenology and narrative inquiry were also considered (Bourgeault, Dingwall, & De Vries, 2010; Polit & Beck, 2014) and could have led to important insights into the experiences of nursing practice in remote areas. Phenomenological inquiry aims to provide an in-depth description of the essence of a phenomena so that it can be communicated to others in an unbiased manner (Liamputtong, 2017). Narrative inquiry methods vary but they all focus on the importance of storytelling as technique for individuals to convey the meaning and experience of a phenomena in a sequential way (Liamputtong, 2017). Whilst narrative and phenomenological inquiry could have been an appropriate way to contribute to understanding the phenomena of remote nursing practice, Grounded Theory (GT) emerged as a methodology that supported my interest in the exploration of human behaviour from a sociological perspective and methodological expertise in GT was readily available to me.

Bourgeault et al. (2010), illustrate the difference between GT and other qualitative methodologies by comparing the reader's impression of having "having walked through someone else's world" (p.140) to GT where they feel ". . . that they carry someone else's social rulebook" (p.140). The metaphor of a social rulebook describes the reasons behind people's behaviour and suggests that behaviour is somewhat predictable based on the social context of people's lives. In addition, Grounded Theory (GT) was selected as an appropriate methodology for this study because theory has explanatory and not just descriptive power (Birks & Mills, 2015); and as such forms a framework of understanding that can predict and measure the impact of changing conditions (variables) on behaviour and outcomes. In addition theory informs practice by understanding a phenomenon (Birks & Mills, 2015). If a phenomenon can be more fully understood, then it can be more accurately measured and changes evaluated. Developing theory is primarily a journey of discovery best used in situations where there is a paucity of research and understanding about a socially – based phenomenon (Corbin & Strauss, 2008). Social groups share meanings and communicate those meanings through a process of socialisation (Grove, Burns, & Gray, 2013). The exploration of social process is particularly well suited to this study as the underlying philosophy of PHC is grounded in health as a social construct (International Conference on Primary Health Care, 1978).

This chapter describes GT methodology and the philosophical perspectives underlying this study. The methods used in this study will also be described. Ethical considerations are addressed in the final section of this chapter.

## 3.1 Grounded Theory

A theory can be defined as, “An integrated set of defined concepts and statements that present a view of a phenomenon and can be used to describe, explain, predict and/or control that phenomenon”(Burns & Grove, 1995p.160) . Corbin and Strauss (2015), elaborate by describing theory as explaining:

> . . . why events, happened and how persons give meaning to those events, then; based on that meaning and the resources they have to work with and what they think, do, and say. . . to respond; live with, change or shape their worlds to deal with that event. Theory shows process or the adaptations persons make . . . to align or match their actions and interactions to changes that are occurring in conditions. . . (p.190).

The development and application of theory to nursing is instrumental in the continued advancement of the nursing profession (Alligood & Tomey, 2010). Meleis (2012) describes nursing theory as, “a conceptualisation of some aspect of nursing reality communicated for the purpose of describing phenomena, predicting consequences, or prescribing nursing care” (p.29). Theory forms the basis of nursing practice by identifying outcomes and increasing efficiency and effectiveness (Meleis, 2012). Theory is also a communication tool. By identifying and articulating concepts the evidence needed to guide practice can be applied and shared (Meleis, 2012). The current lack of understanding of the ‘what? how? and why?’ of nursing practice within the remote setting limits future development of nursing practice or measurement of impact of nursing care in remote areas.

Well established nursing theories include philosophies of caring, models of care and substantive theories of specific practice environments or illness experiences (Alligood & Tomey, 2010). GT contributes to the nursing body of knowledge due to the generation of theory that can be empirically tested and applied to the clinical practice environment (Streubert & Carpenter, 2011).

There are different types of theories. Grand or Formal theories are well established and are generalisable across situations as they use abstract principles (Streubert & Carpenter, 2011). GT aims to produce substantive (sometimes called middle-range) theory (Grove et al., 2013). Substantive theories are only applicable to one area, but as they explore basic psycho-social processes they produce a theory with potentially broad applicability as the theory is not dependant on time or place (Streubert & Carpenter, 2011).

### 3.1.1 Philosophical underpinnings

Researchers who use qualitative methods acknowledge that there is no single reality or worldview and that perception and meaning is related to the situation or context (Grove et al., 2013). Therefore, a grasp of basic philosophy is an important skill for qualitative researchers, as research is an interactive process where the knowledge gained is constructed from the perspective of the participants viewed through the researcher's 'lens' (Grove et al., 2013; Markey, Tilki, & Taylor, 2014). Unlike several other research approaches, GT studies are inductive, that is they do not commence with a known theory that can be used as a framework for the study but rather the theory emerges from the data. The philosophical perspective guides all stages of the research project from data collection, analysis and reporting and aids in establishing rigor (Markey et al., 2014). Interpretation of data is said to follow post-modern thought which claims that all knowledge is limited by the situational limitations of the 'knower'. There is no actual 'truth' or 'right' way but rather multiple truths (Denzin & Lincoln, 2005).

There are two primary schools of thought that underpin GT methodology: *Pragmatism* and *Symbolic Interactionism* (Chamberlain-Salaun, Mills, & Usher, 2013; Jirojwong, Johnson, & Welch, 2011). Pragmatic philosophy explains experience as the continual interaction between people and their environment and that knowledge is generated ". . . through action and experimentation in context, and participative democracy as both a method and a goal" (Denzin & Lincoln, 2005 p.53). The influence of pragmatism in GT is evident when the core concern of the participants is understood from their perspective and the outcomes or consequences can be explained by the substantive theory (Strauss & Corbin, 1990). Charmaz (2014) contrasts pragmatism with positivism by observing that constructivist GT includes elements of positivist theories, which aim to ". . . explain empirical phenomena" (p. 232) and interpretive theories which ". . . depend on the researcher's constructions” (p.232) in adopting a pragmatic approach by studying “. . . people’s actions to solve emergent problems” (p.232). The pragmatist view sees reality as indeterminate and dynamic with multiple perspectives, whereas, the positivist view stems from the scientific method, where the researcher is unbiased and there is an assumption of an external reality (Charmaz, 2014).

Symbolic interactionism is a theoretical framework which guides an in-depth understanding of the social processes that occur in nursing practice (Benoliel, 1996). Symbolic Interactionism has its roots in Sociology and works on the assumption that “. . . perceptions and interactions with others shape one’s view of self and subsequent interactions”(Grove et al., 2013 p. 63). This means that people create reality by attaching meaning to situations and that these meanings and interactions explain social behaviour and individual actions. Grounded Theorists aim to understand peoples’ patterns of behaviour and understanding of their reality (Markey et al., 2014). The social process of interaction, “. . .  may lead to redefinition of experiences, new meanings and possibly a redefinition of self”(Grove et al., 2013 p.63). G.H. Mead is credited as the founder of Symbolic Interactionism, although he did not publish this theory; his students undertook this task after his death. Mead’s ideas were first published as ‘Mind, Self and Society’ in 1934 (1934, as cited by Strauss, 1969), where he first described reality as being developed through social interaction with others. The key concepts included: the importance of language as it reflects the minds ability to use symbols to create meaning, recognition that ‘self’ is the individual’s ability to reflect on the way they are perceived by others and that society is the context or place where these interactions take place.

GT was developed in the 1960’s through collaboration between Barney Glaser and Anselm Strauss. Glaser trained at Columbia University in quantitative methods whilst Strauss trained at the University of Chicago where he was influenced by interactionism and pragmatism (Liamputtong, 2017). Glaser’s and Strauss’ original text (1967) aimed to show that “. . . systematic qualitative analysis had its own logic and could generate theory . . . [by going] beyond descriptive studies into the realm of explanatory theoretical frameworks thereby providing abstract, conceptual understandings of the studied phenomena”(Charmaz, 2015, p.7). Over time, both researchers diverged in their thinking and different techniques for conducting a GT study emerged (Chamberlain-Salaun et al., 2013). Glaser’s techniques are often referred to as *Glaserian* GT and Strauss’ collaboration with Corbin (and Corbin’s continued development of the technique after Strauss’ death in 1996), is usually called *Straussian* GT (Streubert & Carpenter, 2011). Recently, Charmaz (2006) has challenged both methods and advocates for a constructivist version of GT which has become known as the Charmazian variant.

## Glaserian Grounded Theory

In Glaserian GT the researcher comes from a position of naiveté. This position reflects a positivist foundation where there is an emphasis on logic, analytic procedures, conceptual development and assumptions and the researcher as an unbiased observer (Denzin & Lincoln, 2005; Liamputtong, 2017). This is in contrast to Charmaz's view that the researcher's prior knowledge and experience are included in the interpretive process of developing theory (Charmaz, 2014). In Glaserian GT, literature reviews and preconceived ideas are deemed to distract the researcher away from the data and a specific research question is not required as the areas of greatest concern will be revealed by the participants. Interview guides are not used and interviews are not transcribed. Data analysis is focussed around memos written by the researcher during data collection (Streubert & Carpenter, 2011). Unlike Constructivist GT, Glaser's objectivist perspective does not account for the interaction between the researcher and participant, or the researcher's influence on theory construction (Liamputtong, 2017).

### Straussian Grounded Theory

Differently to Glaser, Strauss' own development of GT methodology emphasised meaning, action and process from an underlying pragmatic and SI view. Verification is an explicit goal, again reflecting GT's positivist foundations (Denzin & Lincoln, 2005). Prior knowledge of literature and/or relevant theories is used to gain insights into the data. A research question is stated and interviews are transcribed. Unstructured interviews and observations are primary methods of data collection and interpretation of the data is clarified with the participants. Themes, concepts and theories emerge from the data (Streubert & Carpenter, 2011). Strauss partnered with Juliet Corbin to develop and describe techniques used to generate theory and these methods have been criticised as being too prescriptive. However, more contemporary methods presented by Corbin are more flexible and based on social constructivist ideas (Liamputtong, 2017).

### Constructivist Grounded Theory

Constructivist GT may be considered an evolution of the methodology with its roots in the work of Strauss and Corbin (Mills, Bonner, & Francis, 2006). Charmaz developed the constructivist variant of GT by challenging assumptions about ". . . objectivity, the world as an external reality, relations between the viewer and viewed, the nature of data and authors representations of research participants"(Denzin & Lincoln, 2005 p.509). Unlike the Glasarian and Straussian traditions which claim theory is 'discovered', Charmaz understands theory as an interpretation of the phenomena and not an exact representation of it, in other words, theories aim to explain rather than describe a phenomena (Charmaz, 2006). Furthermore, the constructivist approach to GT promotes interaction between the researcher and participant whilst collecting data and in this way the ". . . knowledge is constructed through the lens of the researcher's interpretation of the data"(Markey et al., 2014, p. 19). Charmaz asserts that strict methods are not necessary and that techniques can be flexible so that the end result is a theory that is a construction of a reality as it was perceived by the participants and the researcher through their interactions (Liamputtong, 2017). This is in stark contrast to Glaser's objectivist viewpoint which aims to produce a theory that ". . . aim[s] for context-free generalisations and abstractions that do not include the historical, social or situated circumstances that frame the study" (Liamputtong, 2017p.153).

### 3.1.2 Philosophical orientation of this study

Markey et al. (2014) described the importance of grounded theorists' exploring their philosophical positions and assumptions before undertaking a GT study. This exploration necessitates an understanding of ontology (what is reality?) and epistemology (what is knowledge?) and guides the choices the researcher makes in terms of data collection, analysis, and interpretation. The following memo was written during a phase in the research process when I was grappling with determining my own philosophical ideas and approaches to the study of sociological phenomena.

> ***Memo:***
>
> *Awoken from my half-asleep musings on Symbolic Interactionism, post-modernism and Grounded theory methodology, sometime in late November; I realised that I had had yet to bake a Christmas cake. A Google search revealed a plethora of Christmas cake recipes. Scanning recipes, I immersed myself in the nature of Christmas cakes. Line-by-line investigation revealed common themes. Christmas cakes all required: dried fruit, a sweetener, a complex carbohydrate, a rising agent, binding agent and heat; in order to produce a pleasing and edible product. Each of these common categories could be described and understanding the properties of each category allowed me to substitute similar ingredients I had on hand. Understanding the properties of each category also allowed me to understand the relationships between each property which in turn affected the proportions of each ingredient. Some recipes were found to have additional ingredients like nuts or Brandy which would add to the flavour but not affect the actions or proportions of the other ingredients.*
>
> *When considering substitutions and whether I could avoid a trip to the shops, I asked myself "What is the core ingredient in a Christmas Cake? Which ingredients delineate this cake from other types of cakes? "The obvious answer was 'Dried Fruit'. The proportions and properties of all the other ingredients were dependent on their relationship with the core ingredient, dried fruit.*
>
> *Returning to Google, I uncovered many other cake recipes that included dried fruit, but they were not called Christmas cakes. I wondered, "Do Christmas cakes have meaning other than 'cake containing dried fruit'?" It was at this point that I realised that although I could describe the properties of a Christmas cake in rich detail, I would not be able to uncover the meaning of a Christmas cake without interpreting the actions or processes required to make*

> *that cake. As I reflected on past experiences of making and eating Christmas cakes, I remembered my Grandmother making the annual cake last almost a year; and that to have a slice, was a sign of great importance usually afforded only to the parish priest or some long lost relative.*
>
> *I quietly considered the application of this deeper understanding. In order to convey the true meaning of a Christmas cake to my own young family, I must include the children in the process; as the most defining features of a Christmas cake are that it's only made once a year, shared with special guests and is a socially constructed symbol of love and hope.*

This process of reflection revealed my preference for considering the world in terms of the meaning applied by the people who are experiencing it; rather than adopting a positivist view that may consider the action of making a Christmas cake to be based on established socially-defined roles or simply the need to provide nutrition. Reflecting on the memo above as the study draws to its end, I realised that the meaning I had applied to the action of baking a Christmas cake may not have been the meaning my Grandmother held. Living through the depression caused my Grandmother to be extremely frugal and offering a slice of special cake to the local priest may have been more about respect or status than love and hope. This realisation seems symbolic to me as a researcher because I think it shows the growth I have experienced in learning to 'dig deeper' and to think more abstractly and philosophically. This memo also allowed me to consider my ontological assumptions and with the guidance of Markey et al. (2014), I was able to identify as coming from a relativist perspective where 'truth' is a subjective construction of the social world. This perspective differs from that of a realist position where there is only one reality, which is independent of the researcher.

Nursing as a profession is both an art and a science (Crisp, Taylor, Douglas, & Rebeiro, 2013), and this study aimed for a balance between the rigor of scientific inquiry, and the art of interpretation and realistic construction of the participants world. In addition to the seminal works of Strauss, Corbin and Charmaz, this study was heavily guided by the text 'Grounded theory – A practical guide' by Birks and Mills, (2011,2015). This text was particularly useful due to its Australian perspective and practical examples of real GT studies. Of particular relevance to the philosophical orientation of this study, is the assertion by the authors that selecting one particular approach to GT is not necessary, so long as the methods used are clearly articulated. Engaging with the work of several authors was helpful in grasping the process of moving from qualitative description to abstract thought that remained true to the data.

After reviewing a range of approaches to GT, a constructivist approach was considered to be the most appropriate approach for this study because of my personal experience with the phenomenon of interest and my philosophical perspective. Constructivist GT can be considered consistent with the relativist perspective (Markey et al., 2014). My influence on data interpretation is described in the section regarding data analysis, but it is relevant to state at this point that I had spent several years working as a RAN and had maintained an active interest in the field prior to commencement of the study. This fact alone largely discounts a Glaserian approach to this study as it would be impossible to claim that I had come from a position of naiveté. Instead, I made explicit the source of thoughts, feelings and ideas as they were experienced throughout the study and I do not claim to have exercised objectivity in a positivist sense. This does not mean the study has not conformed to expectations of rigour and trustworthiness, or that the participants' reality is not respected but rather that the knowledge created during this study was a collaboration between myself, the supervisory panel and the participants. In this sense the theory and knowledge are 'constructed' and consistent with Charmaz's (2015, p. xiv) assertion that: "The endpoint of your journey emerges from where you start, where you go and with whom you interact; what you see and hear and how you learn and think. In short, the finished work is a construction – yours".

As a consequence, this study takes a constructivist perspective and was guided by a variety of GT methods. De Chesnay (2014) claims that is not essential to align oneself with one specific approach and strictly adhere to that approach, therefore the remainder of this chapter will focus on the specific GT methods used in this study. An overview of techniques used to ensure that the ethical integrity of this study was maintained throughout the research process will also be provided.

## 3.2 Setting and Sample

The setting for this study was Australian community health centres or Aboriginal Medical Services; colloquially referred to as 'nursing posts' or 'community clinics' located in the areas classified as 'remote' or 'very remote' as defined by the Australian Bureau of Statistics (see figure 1) (Australian Bureau of Statistics, 2003). Health services which included access to inpatient hospital services with resident Medical Practitioners were excluded from this study as these services were considered to have significantly more resources and clinical support than a community health centre.

The population from which participants were sought was nurses working in remote areas. The total number of potential participants was based on a 2009 study of RANs (Lenthall, Wakerman, Opie, Dunn, et al., 2011), which identified 1076 nursing positions at 301 sites in remote Australia. Three hundred and ninety three (43%) RN positions were located at 190 very remote PHC clinics without inpatient facilities. This study commenced with gaining the perspectives of NPs (as expert nurses) working in remote areas. Anecdotally, there are known to be at least 15 NPs with at least 5 years (and often many more) years of experience in remote areas either as a RN or an NP.

Purposive sampling, which is the deliberate selection of participants by the researcher (Burns & Grove, 1995), was used initially. Purposive sampling was a useful way of locating participants with the necessary experience and knowledge to enlighten the topic in the early stages of the study (Streubert & Carpenter, 2011). True to the principles of theoretical sampling, which is an essential aspect of GT methodology, participants in later stages of the study were chosen in relation to their knowledge or experience related to a particular concept identified in the analysis (Corbin & Strauss, 2008). It is important to understand that theoretical sampling is about '. . . fill[ing] out the properties of your categories" (Charmaz 2015, p.198) and not about representing a population to increase generalisability of the findings.

According to Charmaz (2015), theoretical sampling is a methodological step that delineates GT from other types of qualitative studies, by using abductive reasoning as well as inductive reasoning. Inductive reasoning is where a generalisation is made based on individual cases and is the rationale for constant-comparisons in data analysis which either validates or contradicts their interpretations (Corbin & Strauss, 2015). Grounded theorists use a form of 'abductive reasoning' in order to determine who to interview and for what purpose (Charmaz, 2015). This means that they use their interpretation to suggest a relationship between the categories and questions raised and who may be able to answer them. Abductive reasoning describes the process of inquiry whereby a researcher makes a ". . . mental leap" (Charmaz, 2014 p201) by hypothesising connections or logical links between concepts. The researcher then re-examines data or collects additional data in order to confirm or challenge the interpretation.

Theoretical sampling in GT is about selecting participants based on their anticipated ability to enlighten the emerging categories and theoretical construct. The researcher must purposely look for a wide variance within the participants in order to define the properties of the categories (Corbin & Strauss, 2015) and reach theoretical saturation. In GT, 'outliers' are as important as identifying 'common' themes as they describe the outer edges and provide depth to a study (Charmaz, 2014). An example of theoretical sampling in the current study was the recruitment of a Royal Flying Doctor Service flight nurse known to the researcher to be included in the participant sample. This particular nurse had worked as a RAN and continued to be connected to the remote context in the role of retrieval nurse. The researcher was prompted to explore the perspective as nurse participants were discussing working in a team environment with visiting health services.

The initial call for participants was sent to the Australian NP Remote Interest Group (NPRIG). At the time; the NPRIG consisted of 37 members nationally, approximately one third of whom were endorsed NPs, one third were NP students/candidates or academics and the remaining third were involved in the management or employment of NPs in remote areas. An example recruitment email is provided in appendix A.

A snowballing technique was used for recruitment of interview participants after the initial request for participants was made (Streubert & Carpenter, 2011). Snowball technique is considered a method of purposive sampling where participants are used to find other participants. This method is particularly useful when participants are hard to find (Streubert & Carpenter, 2011) and is appropriate for this study due to the small numbers and remoteness that characterises their practice.

## 3.3 Data collection techniques

### 3.3.1 Interviews

Semi-structured interviews involving in-depth coverage of a number of open ended questions was the primary data collection method for this study. The interview intent was to uncover each participant's interpretation or meaning of their experience as nurses in remote areas. The interviewer's role was to listen, observe and encourage the participant to talk with the participant as the expert in the subject (Charmaz, 2006).

Interviews took place via telephone or were conducted in person at a private location that suited the participants. Interviews were audio-recorded and transcribed by the researcher. The duration of each interview was between one and two hours. Notes were recorded during or immediately after each interview as memos or ideas that could be further developed.

Participants were given the choice of whether the interview was to face-to-face or via telephone. Either method is considered valid in GT, however non-verbal cues may be missed if interviews are not conducted face-to-face (Birks & Mills, 2015). I found the lack of visual interaction enabled me to focus on listening to the participant and writing notes without the pressure of demonstrating active-listening techniques such as maintaining eye contact and an open body posture (Stein-Parbury, 2014).

For most of the participants, the logistics of meeting in person were unfeasible due to their remote location. Therefore telephone interviews were a pragmatic choice. Two of the participants resided in a metro area close to the researcher when not working in remote areas and despite the opportunity to conduct the interview in person, both participants chose telephone interviews. It is unclear whether this was purely for convenience or whether the telephone method was somehow more comfortable for these participants.

My previous experience as a RAN and ongoing professional involvement in CRANAplus was a likely contributor to a trusting relationship and a perception of my credibility as a researcher. Therefore rapport between the participants and myself occurred easily as evidenced by the participant's willingness to talk about their experiences and elaborate when asked. According to Charmaz (2014, p.57), interviews aim to provide an ". . . interactional space where the participant can relate his or her experience". Creating this space is achieved when the researcher shows interest and encouragement by murmuring 'ums' and 'ahs' and by paraphrasing the participants experiences into statements in question form; this encourages further detail to be provided (Charmaz 2014). Another technique effective in this study, was to ask the participant if they were able to provide examples of situations or interactions that illustrated their point. This meant that the data went from broad statements like: 'people are so demanding' to 'there was this one time when . . . '

During interviews, the researcher must pay attention to the participant's emotional responses in order to interpret the meaning of what is being said (Chamberlain-Salaun et al., 2013). As the interviews were conducted over the phone it was impossible for me to observe body language, but instead I listened carefully to the tone and volume of the participant's voices. For GT researchers, transcribing interview data provides an opportunity to slowly and systematically consider the data and the verbal cues and use of language. This was particularly important in this study where the bulk of the interviews were conducted over the telephone. At all times during the transcription process, I kept a notebook close by and recorded thoughts and ideas that came to mind during the transcription process. These thoughts and ideas often evolved into memos which were used during data analysis. Charmaz (2014) concurs that GT methods are most effective when the researcher conducts both the data collection and analysis, as subtle nuances may otherwise be missed.

Initially, I explained that I would ask broad open-ended questions, starting with a recount of the nurse's journey towards remote area nursing and some description of the communities where they worked and their work activities. In the first interviews of this study (see appendix B); the following broad questions were asked in order to orient the participant towards the study topic.

1. "What does it mean to you to be a nurse in a remote area?"
2. "What are the most important things that nurses do in remote areas?"
3. "How do you contribute to the health of people living in remote areas?"
4. "What does Primary Health Care mean to you?"
5. "Why have you continued to live and work in remote areas?"

The interview questions changed as the data analysis process progressed, memos and questions that arose were collated and sorted into broad topics and held as a prompt for future interviews. In this way the questioning became increasingly more specific. The evolutionary nature of interview style in GT is supported by Charmaz when she states that interviews change from participant-centred to a ". . . mutual conversation about theoretical categories" (2014, p.19).

### 3.3.2 The literature as data

Whether or not to review the literature prior to generating the research aim and data collection, continues to be debated by GT experts (Birks & Mills, 2011). Glaserian researchers are advised to be as naive as possible about the topic under investigation in order to ensure that the resultant theory came from the data only with minimal outside influence on theory development (Denzin & Lincoln, 2005). Straussian GT takes a different view and claims that insight into the data does not spontaneously occur but emerges from ". . . prepared minds" (Corbin & Strauss, 2008 p.32). In order to analyse data, Straussian methods assert that a researcher must draw upon existing knowledge and experience in order to respond to the data. In this sense, the findings of a GT study are a product of the data and the researcher's knowledge and experience (Corbin & Strauss, 2008). Birks and Mills (2011) encourage researchers to consider using the literature as data within a GT study in order to enhance theoretical sensitivity and as an adjunct to theoretical sampling.

Charmaz (2014) acknowledges that many researchers engage in research areas with which they already have an in-depth knowledge and interest and that the requirements of ethics committees, funders and academic institutions mean that researchers must identify a gap in the literature and evidence as to the significance of the study, before they can commence. Literature may also be thought of as ". . . another voice"(Mills et al., 2006, p. 29) and analysed in light of the participant's perspectives, so long as the researcher maintains a critical stance when analysing the data. Charmaz, recommends that constructivist researchers withdraw from the literature for a period of time in order to focus on the participants data and then return to the literature at a later stage in order to bring further depth to the categories (Charmaz, 2014). This was the approach taken in this study.

#### Preliminary literature review

For the reasons outlined above, a literature review was conducted prior to the collection of data for this study in order to identify the salient concepts and gaps in the relevant body of knowledge and has been presented in chapter two. This process enhanced the researcher's theoretical sensitivity by identifying key concepts regarding the phenomenon of nurses delivering PHC in remote areas. The process of identifying key concepts is similar to the notion of Hubert Blumer's (1967, cited in Charmaz 2014) 'sensitising concepts'. Charmaz (2014) explains that sensitising concepts provide a starting point for GT researchers (in particular for developing initial interview questions) who must then remain open to exploring these concepts and using them as tools that are subject to change.

### Second literature review

Relevant literature was considered a source of data and an exploration of literature was conducted in relation to the emergent theory. Avoiding literature until after analysing the participant's data ensures 'groundedness', and a critical and reflexive attitude to the literature was maintained (Yarwood-Ross & Jack, 2015). Further exploration of the theory was conducted by reviewing the literature around specific key concepts and this data is presented in chapter six. In this manner, the substantive theory may incorporate elements of other theories or may add to other theories (Strauss & Corbin, 1990). It is also an important step in showing how the theory contributes to the body of knowledge (Dunne, 2011).

I avoided engaging with the academic or popular literature that related to remote area health from the time of the first interview until the categories and theory had emerged. At times I felt a strong pull to find answers in the literature and on reflection this was often during periods when the sheer number of codes and amount of data was overwhelming. It was during these times when the GT literature became critical as reviewing the methodological literature helped me to regain control of the data and understand the next step though the 'swamp'. Resisting the desire to seek answers in the literature also led me to find the answers within the data already collected or by locating another participant and asking them about an essential element for theoretical coding. Further detail about data analysis is provided below.

In summary, although there is debate about the role of literature in GT, this study was conducted in accordance with constructivist GT methods; that is, a preliminary literature review that showed the state of knowledge at the commencement of the study and identified both a need for the study and gaps in existing knowledge. Subsequently, there followed a period of abstinence from the literature, of about 18 months, to aid in focussing and 'grounding' the study in the perspective of the participants. The literature then became an additional source of data and was used to better understand each category and also to position the substantive theory within the broader body of nursing knowledge.

## 3.4 Data analysis

The following section details how GT methods have been applied in this study. The essential methods used were:

- data coding with increasing theoretical sensitivity;

- concurrent data collection and constant comparative analysis
- theoretical sampling and memo writing
- identification of a core category; and
- theoretical saturation and theoretical integration.

### 3.4.1 Theoretical sensitivity

GT recognises that a researcher's prior knowledge and experience of the research topic influences the interpretation of the data. Despite this, the theory that is generated must come from the data in order for it to be considered 'grounded' (Corbin & Strauss, 2008). Theoretical sensitivity describes the influence of the researcher in positive terms, stating that with sensitivity the researcher has ". . . the ability to pick up on subtle nuances and cues in the data that infer or point to meaning"(Corbin & Strauss, 2008 p.19). Sensitivity is developed through reviewing previous literature on the subject, personal experience and immersion in the data. The researcher must also demonstrate sensitivity for the topic and a willingness to be open to new ideas and creative thought (Corbin & Strauss, 2008).

Procedures for ensuring quality in GT include reflexivity which refers to a process of self - reflection undertaken by the researcher in order to identify bias and articulate the effect the researcher has on data collection and analysis (Streubert & Carpenter, 2011). A reflective journal can be used to document the researcher's thoughts and feelings as it provides a means to continually scrutinise the researcher's internal dialogue in order to achieve detachment and increased objectivity (Jootun, McGhee, & Marland, 2009). In this study a journal was used to articulate and make transparent my preconceptions and emotional reactions to the interview data. This was helpful in drawing my focus back to the experiences of the participants and ensuring that the findings were grounded in the participants' perspective whilst also recognising my influence. Another method used in this study, to draw out my feelings about each category and to articulate my interpretation based on each category, was to write creative short stories about memories that were triggered by some categories. The opportunity to write creatively instead of in academic style and to drill down to the feelings and most salient points of the story was an effective way for me to articulate my feelings and experiences of remote nursing.

#### *3.4.1.1 Personal experience of the researcher*

Charmaz (2014) states "From a constructivist perspective, theories reflect what their authors bring to their research as well as what they do with it" (p.259). Being explicit about how this knowledge has influenced both the data collection process and the data analysis process is vital so that an independent evaluation of the research process can be made (Corbin & Strauss, 2008). Charmaz

(2006), explained the interplay between prior knowledge and development of theory that is grounded in the data by stating that ". . . sensitising concepts and disciplinary perspectives provide a place to *start*, not to *end*" (p.17). She goes on to say that researchers must maintain an open mind and be prepared to discard preconceived ideas about the subject area in favour of concepts and explanations that come directly from the data.

Therefore, it is important that my previous experience and interest in the phenomenon of interest is stated. I worked as a nurse in a remote community for almost four years between 2000 and 2004. I have also previously researched the area of violence towards nurses in remote areas of Australia (McCullough, Lenthall, et al., 2012; McCullough, Williams, et al., 2012). In addition, I am an active member of CRANAplus which is the Australian professional organisation which represents nurses in remote areas.

My professional experience and continued involvement with remote health professionals meant that I brought practical and contextual knowledge to this study, thus heightening my theoretical sensitivity. I extensively used memos and journaling combined with regular input and guidance from my supervisors to ensure that the theory remained true to the data. In addition, returning to participants for further input and clarification, rather than relying on my personal perspective, helped enormously in 'testing' the meaning of key concepts and relationships.

#### *3.4.1.2 Keeping the analysis grounded in the data*

The researcher must be immersed in the data in order for the substantive theory to be truly grounded. As researchers become increasingly in-tune with the perspectives of their participants, the ability to understand meaning and connections between concepts develops (Charmaz, 2014). I read the interview transcripts several times prior to applying analytic procedures so that I could better understand the meaning of the data as a whole before applying conceptual labels. The following brief descriptions highlight the main techniques in data analysis.

### 3.4.2 Constant comparative analysis

Constant comparison is a fundamental technique in GT research. In order to ensure that the analysis and emerging theory is grounded in the data, GT researchers return to the data many times constantly comparing newly developed categories and concepts with previous data and analysis (Corbin & Strauss, 2008). Constant comparative analysis occurs simultaneously with data collection and develops theoretical sensitivity. Hoare, Mills, and Francis (2012), described this process as "dancing with data" (p.240) to illustrate the iterative nature of data analysis. The analysis of each new incident directs the collection of the next data which is then compared to previous incidents and identifies new avenues for data collection (Charmaz, 2006; Corbin & Strauss, 2008).

The aim of the constant comparative technique is to highlight similarities and differences between codes and categories and to add detail regarding properties and dimensions to each category or theme. Theoretical comparisons are of particular assistance when the researcher considers data which is difficult to analyse. Comparing an incident to its theoretical opposite, or placing the incident within another context in which a metaphor or simile is created can aid in understanding the incident at an analytical level (Corbin & Strauss, 2008). This was achieved in the current study when comparing differences in community and participant characteristics, for example whilst most participants were experienced NPs, I also interviewed a novice RN and an NP who had only spent three months working in remote areas for a different perspective.

#### *3.4.2.1 Memos and diagrams*

Reflexivity is an important step in establishing the quality of research and transparency of the researcher's decision-making and analysis and in this way ". . . identifies and acknowledges the limitations of the research"(Engward & Davis, 2015p.1532). Engward and Davis (2015) provided an insightful description of how they applied Alvesson and Skoldberg (2009) model of reflexivity to their GT study informed the process of reflexivity in this study. Of particular note was their understanding of the difference between reflexivity and reflection, whereby reflection simply relies on the researcher's recollection of events and feelings, as opposed to reflexivity which is a process of self-awareness that considers the impact on the research process itself by the researcher. Reflexivity requires input from an 'other' or rather needs to be made explicit so that an outsider can understand the decisions and judge the potential for bias and the logic behind the interpretation.

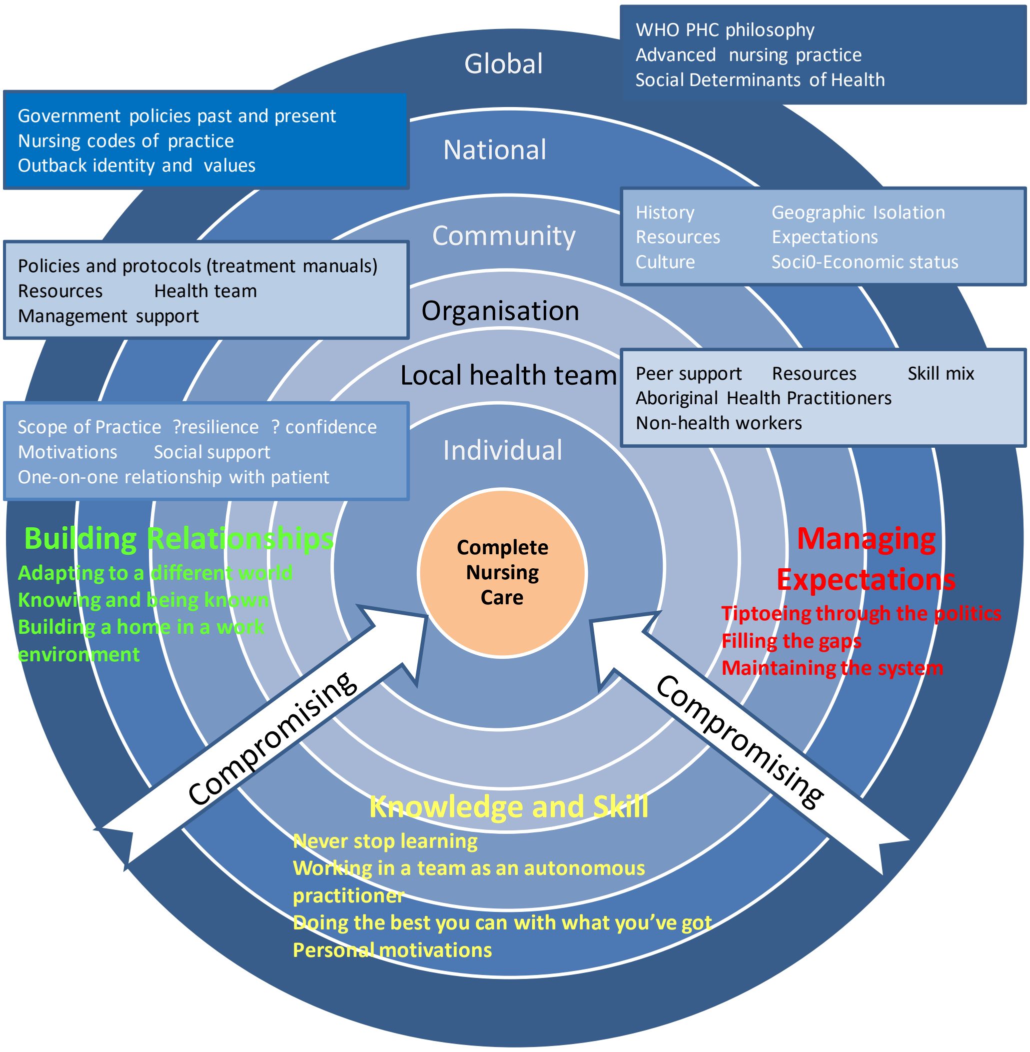
Writing memos and creating diagrams are an essential process in reflexivity during data analysis (Birks, Chapman, & Francis, 2008). Memos and diagrams are not descriptive in nature but document the 'thinking' of the analyst (Corbin & Strauss, 2008). Careful and timely documentation of emerging concepts, relationships and questions serve both to increase the reliability of the interpretive process, but also enable the researcher to trace the evolution of ideas (Birks et al., 2008). Memos have no defined format or length, although Corbin and Strauss (2008) highly recommend recording the date and a title for each memo to maintain order. Likewise, diagrams are a visual representation of the emerging relationships and should focus on analytical concepts or categories rather than raw data.

A conditional matrix is a tool proposed by Corbin and Strauss (2015) to help organise and link concepts and bring depth to the analysis. The tool aids researchers in identifying the 'players' that influence the meaning people give to actions and events. It also helps researchers in considering the range of possible conditions and outcomes and brings complexity into the analysis (Corbin & Strauss, 2015). Conditions and consequences and the relationships between them are dynamic can change. This is where the explanatory power of the theory comes from (Corbin & Strauss, 2015).Using a conditional matrix also guards against over simplification of the phenomena (Corbin & Strauss, 2008). The conditional matrix assists analysis by alerting the researcher to alternative micro and macro influences on the context of the phenomena; for example, organisational, governmental or international policies (Chamberlain-Salaun et al., 2013). The matrix leads to analysis and description of the *process(s)* of interaction between concepts. It recognises that concepts are related in non-liner ways and links between concepts create change in a dynamic way (Corbin & Strauss, 2008).

The conditional matrix is similar to situational analysis maps and diagrams (Clarke, 2005; Clarke, Friese, & Washburn, 2015). I used rudimentary forms to help illustrate the complexity of the phenomena I was studying. Charmaz (2014) endorses these techniques but cautions that they may force the ". . .data and analysis in a pre-established direction" (p.221).

Constructivist grounded theorists are particularly interested in the social worlds of participants and how those social worlds influence their behaviour and interpretation of meaning of events in their lives (Clarke et al., 2015; Mills, 2007). The use of situational and social world maps as described by Mills et al. (2007) was useful in making sense and connections between categories and codes during analysis. Figure 2 below shows a diagram that I created when considering the social worlds and influences on my participants.

Conditional matrix: the process of compromising practice: June 2015



Other possible external factors as proposed by Corbin and Strauss (2015)
Culture, values, beliefs, environment, gender, History, Health, Disease, Alliances, Economy, Politics, Regulations, Laws, issues, problems, Trades and agreements.

**Figure 2: Example of conditional matrix diagram (June 2015)**

Birks, Mills, Francis, and Chapman (2009), describe story-lining as a technique that can be used as a means to construct, integrate and ". . . bring to life" (p.407) a theory by showing relationships between abstract concepts. The authors suggest a framework for constructing the theory and ensuring that the story fits the data, rather than the data being forced to fit the story. The fundamental tenets include: theory takes precedence; allows for variation; limits gaps; evidence is grounded and style is appropriate (Birks et al., 2009). The researcher is encouraged to be creative in writing their storyline in order to explain the theory in an easily understood way; so long as the storyline closely reflects the analysis. Figure 3 below shows my diagramming of a story of remote practice as it changed over time. Developing a diagram that told a story was particularly helpful to me for discussing the data in an abstract way.

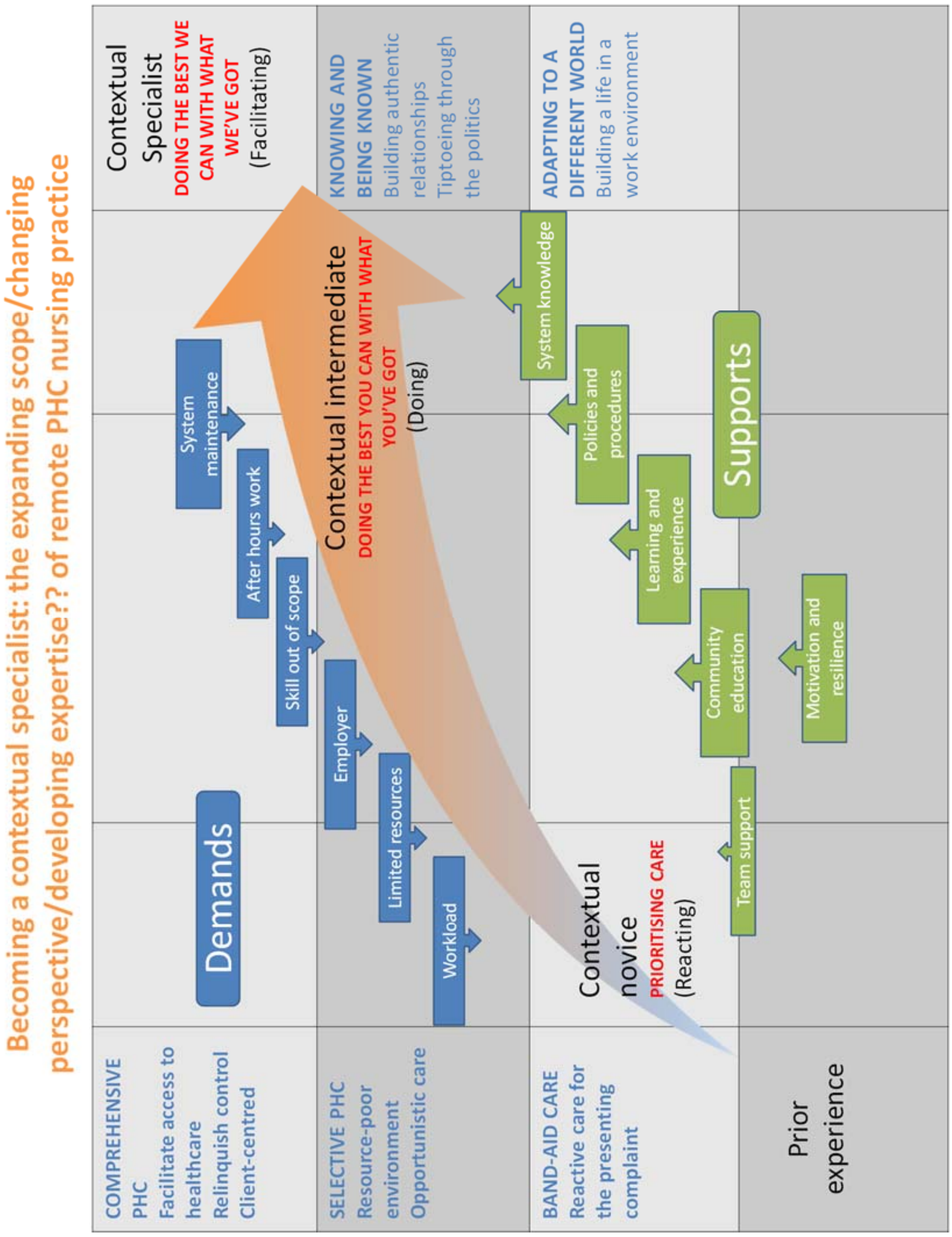


**Figure 3: 'Becoming a RAN': changing practice over time (October 2016)**

All three tools outlined above were used as guides and were incorporated into my practice of memo writing and diagramming. I used a variety of styles of memos as guided by the work of Birks et al. (2008). A notebook and blank paper was available at all times and many diagrams, questions and notes were recorded using them. Memos were incorporated with the data in a large Microsoft

Word™ document which was periodically saved and then copied into a new file so a record of changes and evolving ideas could be kept. The ‘review comment’ function within Microsoft Word™ was also used effectively as a way of recording my questions as they related to the data during the process of analysis. These ‘working’ documents with memos, questions and comments integrated with data in italics were frequently reviewed with feedback provided by the supervisory team throughout the analysis process.

Of greatest assistance in articulating the evolving theory, was the opportunity to discuss, consider and confirm concepts and relationships with the research supervision panel and then to represent these in diagrammatic form. The process of distilling ideas into a picture which shows movement and flow between concepts was an important record of the studies progress and helped when explaining ideas to others. Birks and Mills (2015), also support the use of diagrams as analytical tools as opposed to models to present GT findings. As an example, Figure 4 below shows my evolving thoughts about the role of making compromises. At this stage of analysis I considered the conditions identified in the conditional matrix as factors that impacted on providing PHC and I was starting to consider what processes my participants were using to deal with this key issue. The image of a nurse ‘balancing’ the health needs of patients with the availability of resources resonated for some time and eventually led to the identification of ‘making compromises’ as an outcome of the process nurses used to deal with their core issue.

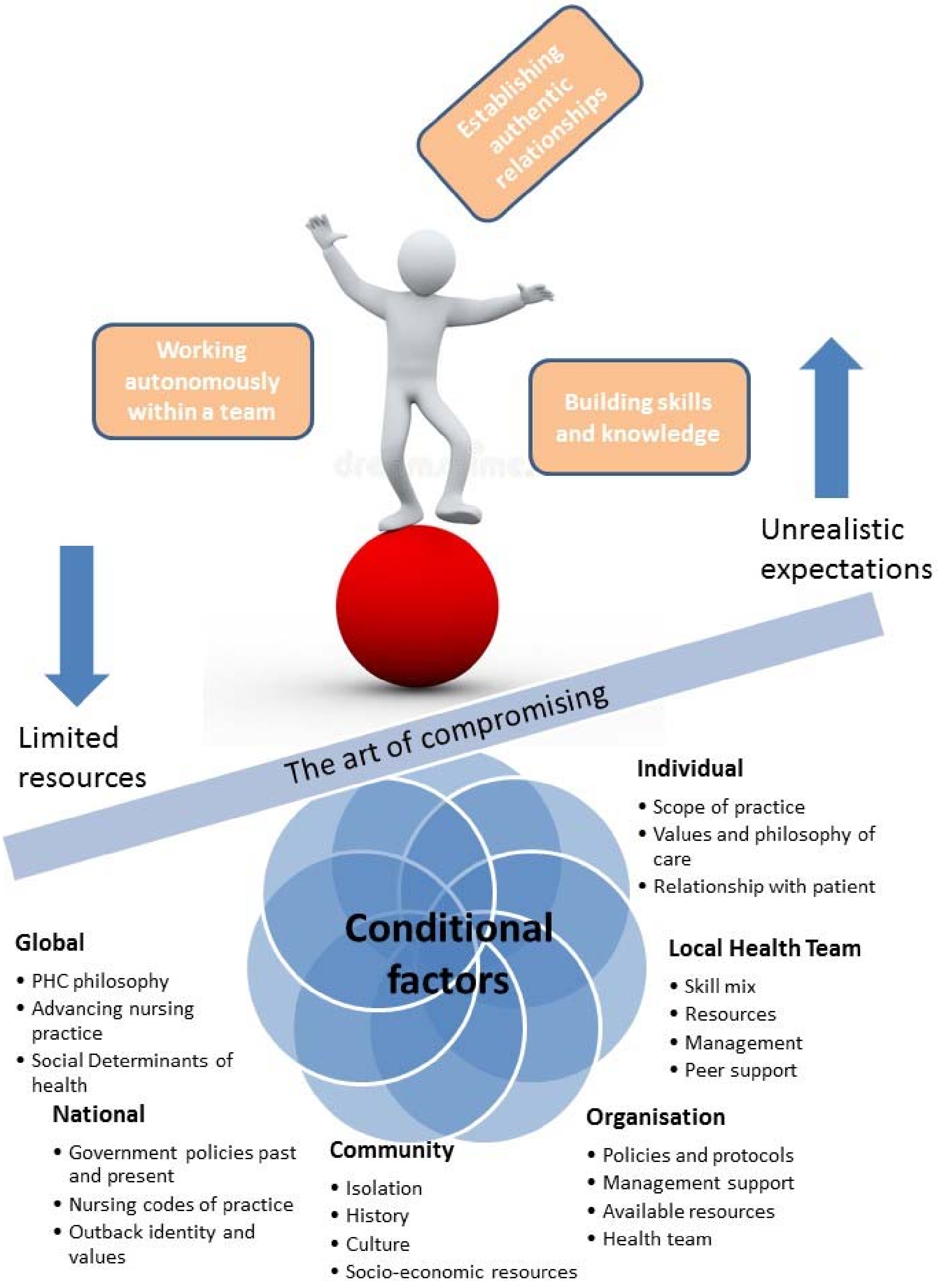


**Figure 4: A Balancing Act: conceptualising 'compromise' (September 2015)**

#### *3.4.2.2 Coding*

Coding is the process of identifying concepts and categories within the data. Coding is way of fracturing the raw data apart, combining multiple data sources and sorting the fractured data so that it can be put back together in a logical and ordered manner (Strauss & Corbin, 1990). GT differentiates between different types of coding which will be discussed below. Whilst coding is described in terms of a process that moves from open to axial and then selective coding, in practice, the process is much more fluid and often happens simultaneously (Strauss & Corbin, 1990). Computer programs can aid in the coding process by providing an audit trail and filing system. NVivo™ version 10 was used in the early stages of this project. After open coding the first 12 interviews in NVivo™, the researcher experimented with analysis using Microsoft Word™. The ability to use different levels of headings and control their arrangement as 'Major' and 'Minor' categories in the Document Map tool (and the automatically generated Table of Contents), provided by Microsoft Word™, accommodated the frequent rearrangement of categories and their relationships with other categories in a way not provided by NVivo™.

### Open Coding

Open coding refers to labelling concepts identified in the data then grouping similar concepts together and describing the properties and dimensions of these concepts. The process of assigning labels to data is one of construction, where the researcher chooses words that they believe reflects the reality of the participants and in this way interprets meaning in the data (Charmaz, 2014). In-vivo codes are code names that come directly from the words of the participants that may serve as 'symbolic markers'(Charmaz, 2014). Examples of in-vivo codes in this study include: "tiptoe through the politics" and "what's nursing? what's friendship?"

Strauss and Corbin (1990), encouraged researchers to ask questions about each concept such as "What is this? What does it represent?"(p.63). Identifying the characteristics of each concept and then exploring the dimensions of each characteristic, aids in finding patterns and connections between concepts within a category. For example; the concept of 'remoteness' has a number of different characteristics such as; distance to services, availability of services, climactic extremes and small populations. Each of these characteristics exist somewhere on a continuum which represents the dimensions of that characteristic.

Charmaz (2014) has advised researchers to ". . . code with words that reflect action" (p.116) which helps avoid imposing extant theories or ideas to the data and shifts the focus from description to process. Action words are fundamental in the application of Symbolic Interactionism and social justice, which collectively are concerned with concepts such as ". . . action, meaning, process, agency, situation, identity and self . . . ideology, power, privilege, equity and oppression . . ." (p.117). Coding for action can also be achieved with the use of 'Gerunds' where a noun is turned into a verb in order to convey process or action. Charmaz (2014) provides some useful examples ". . . describing versus description, stating versus statement, and leading versus leader". Coding for process or action is what differentiates coding in GT from coding for content analysis which is a technique used in other qualitative methodologies (Charmaz 2014).

The Open coding process ‘prepares’ the raw data for the analytic process of axial coding. The first three interviews were coded line-by-line in their entirety and generated hundreds of codes. Open coding was used at different stages throughout the analysis process. Line-by-line coding was frequently applied to sections of all interviews where the data was particularly dense, such as when participants told stories about their practice. It was a vital tool in keeping the analysis grounded in the data. Some codes were collapsed together into categories with an abstract title that broadly described a particular concept. This process is known as focused coding.

### Focused coding

Charmaz (2014) uses the term ‘focused coding’ to describe the next step in coding for theory, which involves sifting, sorting and synthesizing large amounts of data. Analytic thinking starts to move from the data to a more abstract or conceptual level. During this process, categories start to form and gaps in the properties and dimensions of categories become apparent. This stage of data analysis was very challenging. I grappled with defining and labelling the categories and many changes were made. Diagramming was useful in attempting to identify relationships between codes, which in turn helped to identify categories and relationships between categories. Reading widely through the GT literature and considering examples provided by other researchers, aided me in the progression of analysis. Corbin’s and Strauss’ (1990, 1998, 2015) descriptions of axial and selective coding describe a similar process of analysis to focused coding. Axial coding; as described by Corbin and Strauss; is the exploration of relationships between concepts and the formation of more abstract labels for categories of concepts (Strauss & Corbin, 1990). Concepts are drawn together by considering the *context* within which the categories are found, the *strategies* or actions used to handle the phenomenon and the *consequences* of those strategies (Strauss & Corbin, 1990). Figure 5 below shows a process of ordering and grouping the codes from the current study and finding relationships between them.

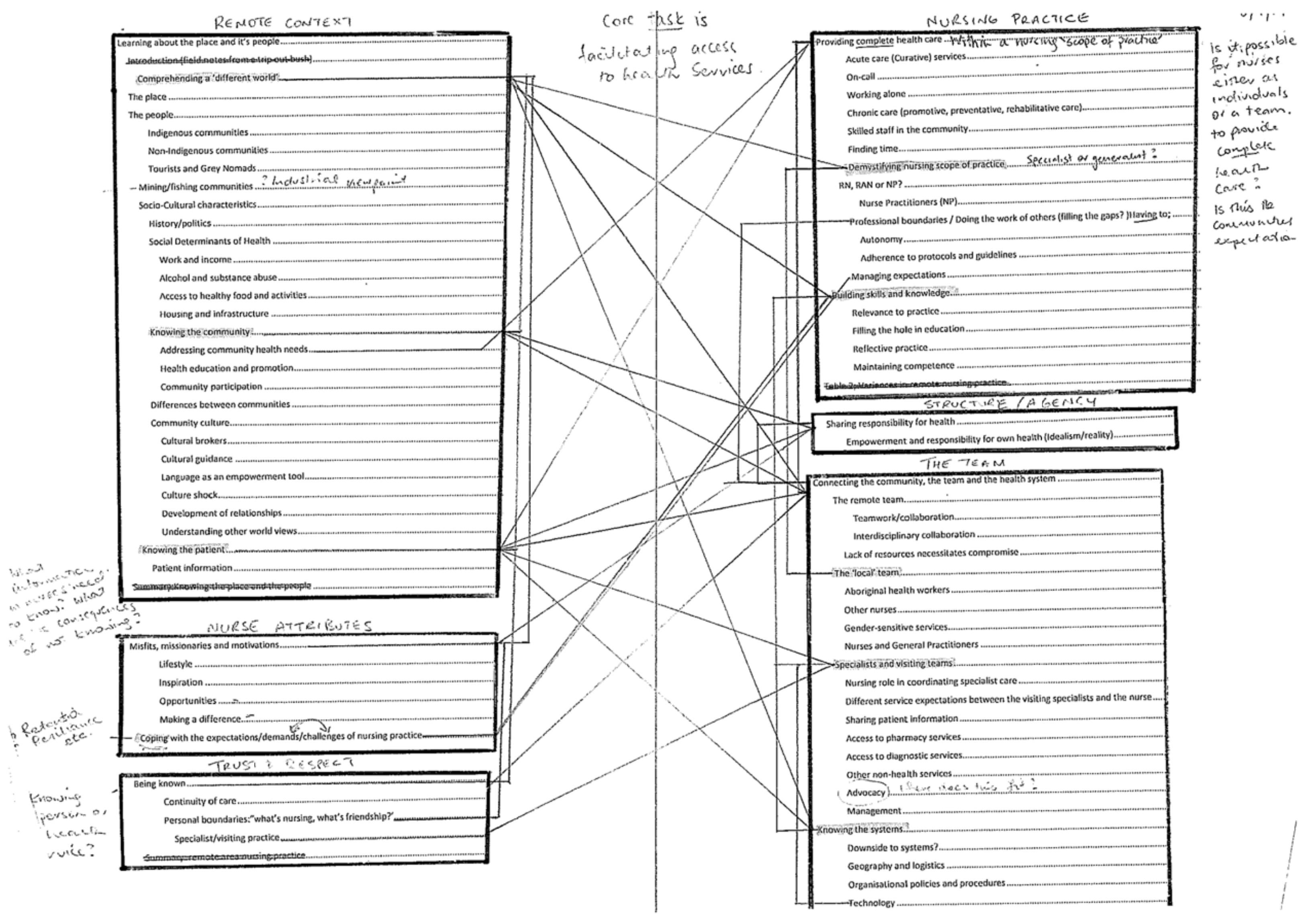


**Figure 5: Example of focused coding with lines indicating relationships between categories (November 2014)**

### Theoretical coding

Theoretical coding is the term used by Charmaz (2014) to describe how the categories and codes are related to each other to form the substantive theory. Theoretical coding is similar to Corbin's and Strauss' process called Selective Coding which describes the process of integrating the identified concepts and categories to develop a theory. This is the most abstract stage of analysis whereby a core category is chosen and then the relationships between that category and the other concepts that have been identified are pulled together in a logical way. The theoretical relationships between categories are then validated by the data (Strauss & Corbin, 1990). Theoretical coding describes the integration of categories into context, conditions, action – interactions and outcomes. An example of theoretical coding is shown in the diagram below (Figure 6) which depicts my process of finding and explaining relationships between codes at an abstract level.

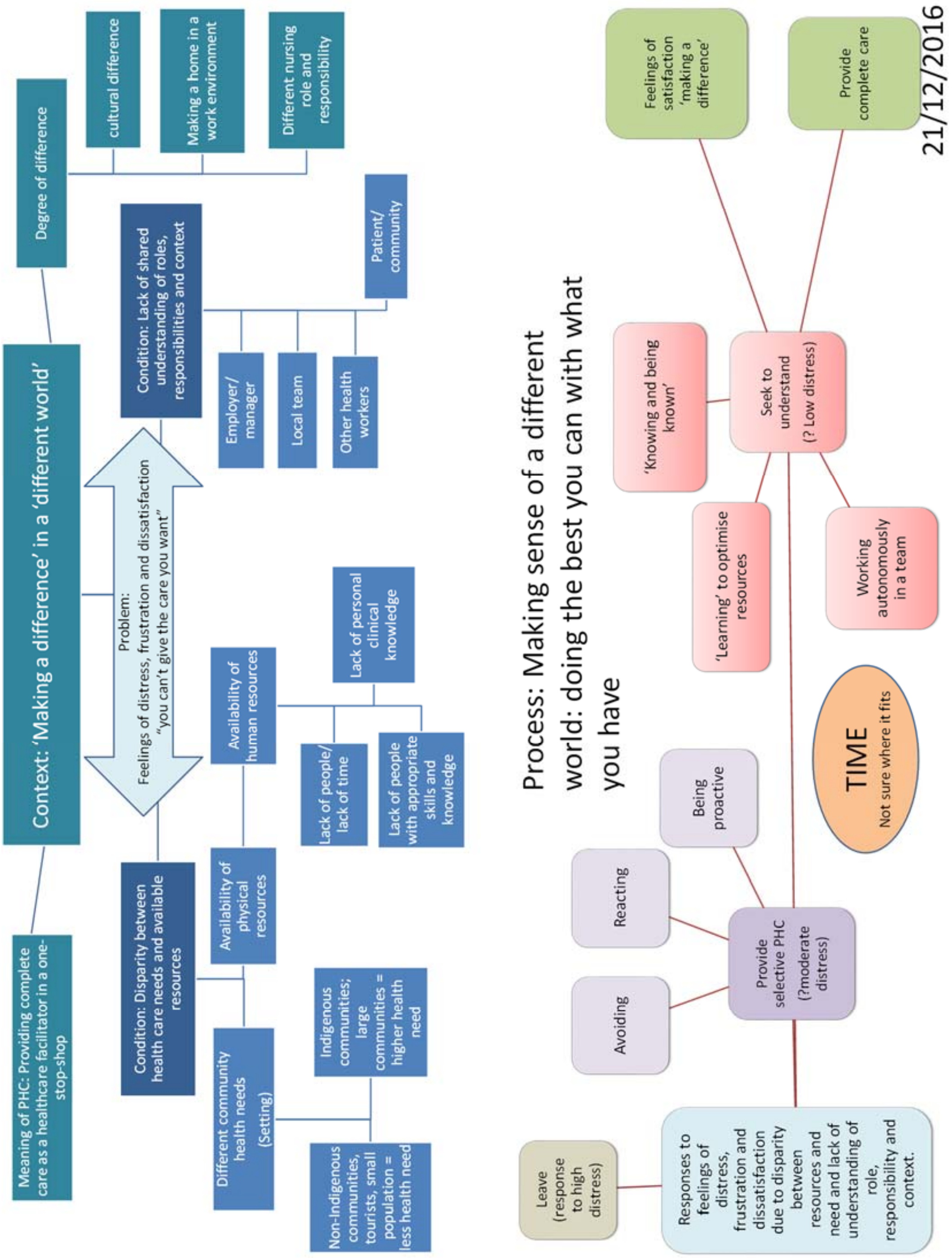


**Figure 6: Example of theoretical coding (December 2016)**

### *3.4.2.3 Conditions*

GT researchers analyse the data for examples of events or situations and explore how the participant gives meaning to these events. These events or situations are called conditions. Conditions may be problems, demands or challenges and are often identified when participants give explanations for their actions in these circumstances (Corbin & Strauss, 2015). The identification of conditions allows a theory to show that “. . . under these conditions, and given this meaning, one can expect that this action or that action will be taken, and this will be the result . . .” (Corbin & Strauss, 2015 p.154). The properties and dimensions of the conditions must be described in sufficient detail to explain differences between similar situations or events and differences in the responses made. Corbin & Strauss explain this point by saying, “Each participant in a situation comes with his or her own set of reasons for action-interaction, and rarely does each person have a grasp of the whole situation. It takes listening to many voices to gain understanding of the whole” (2015, p.162). The importance of constant-comparison and theoretical sampling becomes evident when describing the properties and dimensions of conditions as well as the variety of responses, known as action-interactions.

#### *3.4.2.4 Process*

In order to generate theory, GT researchers aim to identify a process which explains the response to the phenomena or core issue. In GT, ‘process’ describes the interplay between the context, conditions, action-interaction and consequences. Charmaz (2014) describes a process in terms of the links which bring single events together to form a whole. Whilst GT researchers generally look for a single basic process or central problem that participants try to resolve, some studies produce multiple processes or problems (Charmaz,2014). Charmaz (2014) cautions about oversimplification of complex phenomena and advocates exploration of multiple processes if they arise.

GT researchers then look for examples of how people respond and deal with the identified conditions and these are referred to as actions and interactions (Corbin & Strauss, 2015). People’s responses to events or situations reveal the meanings and feelings they have about that event or situation (Corbin & Strauss, 2015). For example, whether someone perceives an event to be challenging (difficult but satisfying) or demanding (difficult and unsatisfying) will be shown in their actions and the meaning they ascribe to the event. In this way, actions and interactions lead to consequences.

The process explains how the participants adjust and respond to changing conditions. A process is variable and routine, and can be reduced to smaller sub processes (Corbin &Strauss, 2015). Processes are not always linear or developmental (such as novice to expert) but they describe the continuous changes that affect the actions- interactions as described by the participants (Corbin & Strauss, 2015). Understanding the process is about finding patterns in behaviour and conditions that can predict outcomes and makes the theory dynamic and responsive to different situations.

The process is described by a core issue which is highly abstract and explains a central phenomenon or basic sociological process (Birks & Mills, 2015). Identification of the core issue is necessary in developing theory as all of the categories must link to the core issue which in turn explains the actions and interactions of the participants (Corbin & Strauss, 2015). Birks and Mills (2015) refer to the core issue as the 'hub' around which the other categories revolve. It is the relationships between the categories and the hub and between each other which elevates analysis from description of a phenomenon to explanation of the phenomenon. The nature of the relationships between these factors can change as a result of actions taken to manage the problems or challenges encountered by the participants.

Charmaz (2014), also talks about relationships between categories and describes GT as being ". . .a conceptual analysis of patterned relationships" (p.322). Charmaz does not though focus on the idea of a single core issue as an essential element of theory development. Other authors have also suggested that a theory may have multiple social processes (Clarke, 2005; Clarke et al., 2015). However, naming and describing the core issue can assist in establishing theoretical saturation and development of the properties and dimensions of the related categories (Birks & Mills, 2015). In this study, a core issue was identified and will be described in chapter four as *the inability to provide PHC*. The core issue tied all other categories together, similar to the way fabric connects the spokes of an umbrella together to form a whole (Corbin & Strauss, 2015). The core issue occurred frequently in the data, linked and explained variation in the data, had implications for a formal theory and in this way progressed the development of knowledge (Corbin & Strauss, 2015; Streubert & Carpenter, 2011).

An important aspect of describing process is identifying outcomes and what meaning the participants take from these outcomes. Consequences, either actual or predicted, affect the action-interactions that people take (Corbin & Strauss, 2015). Outcomes or consequences are the results of participant's responses to the conditions and context after taking into account the effects of actions-interactions (Corbin & Strauss, 2015). Physical, psychological or social consequences can be felt by the individual or other people and can result in emotional responses such as distress or satisfaction. Often these emotional responses can stimulate or change further action – interactions (Corbin & Strauss, 2015).

### 3.4.3 Theoretical saturation

Often confused with 'data saturation' which is identified when no new data emerges from new interviews, theoretical saturation is when ". . . gathering more data about a theoretical category reveals no new properties nor yields any further theoretical insights" (Charmaz, 2014 p.345). This is vital to the theory withstanding evaluation and tests of 'fit'. Theoretical saturation refers to the point of completion of the theory and is reached when "the main concern of the participants is clear and the theory explains how that concern is continually resolved" (Streubert & Carpenter, 2011, p. 136); categories are 'saturated' and new data does not provide any new theoretical insights, properties or dimensions of categories (Charmaz, 2006). Charmaz (2014) describes the defining features of a GT study are constant comparative analysis; that categories describe actions and processes rather than themes; that categories are abstract and varied and that data is collected via theoretical sampling method.

#### *3.4.3.1 Evaluation*

The major authors of GT methodology texts all describe methods for evaluating the substantive theory. However, consensus about criteria is complicated by the philosophical underpinnings of qualitative research. For example, if truth or accuracy in reporting the participants' experiences were desirable criteria then it would be difficult to assess 'truth' in constructivist GT. This is because the methodology acknowledges that the interpretation of meaning in the data is a construction between the participant and the researcher who unashamedly brings their own experiences and perceptions to the analysis (Charmaz, 2014). Similarly, Corbin and Strauss (2008) believe that qualitative research should be evaluated as a scientific, but also creative and artistic endeavour. They recommend substantive theories are evaluated for their 'credibility' meaning that the findings are, ". . .trustworthy and believable in that they reflect participants', researchers', and readers' experiences with a phenomenon but at the same time the explanation is only one of many possible 'plausible' interpretations. . ." (p.302). Credibility was enhanced in this study through discussions with RANs that were in addition to the formal interviews. It was decided to arrange a small reference group at the Centre for Remote Health in Alice Springs in October 2016, to discuss the emerging categories. The aim of the expert reference group was to evaluate the emerging categories for: evidence of fit with the participant's experience, applicability of the findings, the properties, dimensions and contextualisation of concepts, the logical flow of ideas, the depth and variation of the findings, and the creativity and sensitivity of the researcher's interpretations (Corbin & Strauss, 2008).

Five nurse academics who all worked in the field of remote health education and research, and had experience of working as a nurse in remote areas, agreed to attend and include their feedback as data to the study. One of the reference group participants (a NP) had previously participated in a telephone interview for this study some months earlier. The group discussion lasted approximately one hour and was audio-recorded. During the reference group, each person drew a concept map of their understanding of PHC and then explained it to the group. These diagrams and explanations were very helpful in raising the emergent codes from description to abstraction and were included in the data analysis. Two Examples can be found in chapter 4 of this thesis (figures 8 and 9). In addition, regular supervisory meetings were conducted to discuss the analysis of data.

Denzin and Lincoln (2005) also suggest that when a reader considers the quality of a study they should ask themselves; “Are these findings sufficiently authentic . . . that I may trust myself in acting on their implications?” (p. 205). They recommend assessment of both the rigorous application of the selected method and the process of interpretation. The interpretation should be based on defensible reasoning and be plausible (Denzin & Lincoln, 2005). Charmaz (2014) refers to *resonance* as the theory’s ability to reflect the meaning and experience of the participants. When I reached the point of theoretical saturation from my interview data, I was fortunate to be able to present the emergent theory, in draft form, at a conference for RANs. Over three days, using a large poster which displayed the theory and a brief explanation of each category, I had many opportunities to explain my interpretation of the data and seek feedback from RANs. Throughout this process, I remained open to suggestions and actively looked for gaps in the emergent theory that could be further investigated. No new categories arose from this process. Appendix C lists the presentations that have been made to CRANAplus conference delegates throughout the duration of this study. Each presentation and attendance at the conference was a form of member-checking where feedback from delegates (mostly currently practicing RANs) was sought.

The substantive theory presented in this thesis is *original* (Charmaz, 2014) and subsequently seminal in its description of PHC nursing in the remote setting. This substantive theory is considered *useful* (Charmaz,2014) in that it provides insight into a unique and poorly understood aspect of nursing practice and goes some way to filling a gap in the academic understanding of PHC as practiced by nurses in the remote setting. Charmaz (2014) refers to rigor in the conduct of a study as *credibility.* Birks and Mills (2011) elaborate on criteria for evaluation and include the importance of assessing how GT methods have been applied throughout the research process and whether the study has been peer-reviewed, is well written and shows attention to detail. Ultimately they claim that a quality GT study shows researcher expertise; methodological congruence and procedural precision. As this study was conducted under the umbrella of a University Higher Degree by Research; rigor was ensured by the supervision panel and overseen by the University’s Human Research Ethics committee. Details regarding the ethical considerations in the conduct of this study will now be described.

## 3.5 Ethical considerations

Data collection and recruitment of participants did not commence until approval was given by Edith Cowan University Human Research Ethics Committee on 08/04/2014 (approval number 10810). Approval was based on the principles of the National Statement on Ethical Conduct in Conducting Human Research (National Health and Medical Research Council, 2007).

### 3.5.1 Informed consent

Participation in this research project was voluntary and participants were advised that they may have withdrawn at any time. All participants returned a signed consent form (appendix D) based on the National Health and Medical Research Council's recommendations (National Health and Medical Research Council, 2012) prior to data collection or provided verbal consent which was recorded on their interview transcript. Participants were provided with an information letter which detailed the risks and benefits of participation (appendix E). Data collected was de-identified to maintain anonymity of both the participant and any community or persons they may have referred to in the interview.

### 3.5.2 Risks to participants and researcher

There was no indication that the participants suffered any harm as a result of this research. However, the participants were advised to contact the Bush Support Services phone counselling service if they felt any emotional distress as a result of participating in this research permission was granted for participants of this project to access this free and confidential 24 hour service.

The researcher ensured that the Occupational Health and Safety requirements of Edith Cowan University (ECU) were addressed at all times. Risks related to office ergonomics and risks associated with meeting participants outside of the university environment. These risks were managed according to the Guidelines for the Safe and Ethical Conduct of Research in the School of Nursing and Midwifery (Edith Cowan University, 2012).

### 3.5.3 Data Storage

Storage and management of both electronic and paper records pertaining to this project were stored according to the Guidelines for the Safe and Ethical Conduct of Research in the School of Nursing and Midwifery (Edith Cowan University, 2012; National Health and Medical Research Council, 2007). Specifically, all electronic data were kept on a password protected computer or other password protected hardware such as USB drive. All other data were stored in a locked room at ECU, School of Nursing and Midwifery.

At the completion of this study, all de-identified correspondence, transcripts and memos; along with audio-recordings will be stored in accordance with ECU data management policy and retained for at least five years. All identifying data has been deleted from the researcher's computer.

## 3.6 Chapter summary

GT was chosen as the methodology to guide and inform the conduct of PHC nursing in Australian remote areas, from the perspectives of nurses. In GT the aim is to identify concepts that explain the underlying social processes at play in a particular context that is grounded in the data and to create a theory that explains a process. Within that process a GT aims to describe the properties of the categories within the theory, show the range of conditions within which that process emerges and outline the consequences of that process. The substantive theory identifies relationships between concepts and allows the development of potentially testable hypotheses. This study has utilised the GT methods described in the literature and by the methodological originators and developers in order to produce a quality theory which is original in its presentation of the primary concern of the participants, reflects the experiences of those participants and faithfully adheres to the principles and methods of constructivist GT.

In outlining the methods used in this study, this chapter has presented evidence that the findings can be considered trustworthy due to methodological rigor, researcher reflexivity, adherence to ethical principles and member-checking of findings.

The following chapters present the findings from this study. Chapter four begins with a description of the context of nursing in remote areas of Australia and then explores the core issue and associated conditions as revealed in this study. The second part of the findings are presented in chapter five. This chapter describes the process that nurses in this study adopt in response to the contextual conditions.

# 4 Findings: Context and core issue

## 4.1 The context: Providing PHC in a remote setting

This study described the experience of PHC nursing in the Australian remote area setting. Context can be defined as "The situation within which something exists or happens and that can help explain it" (Cambridge dictionary, n.d.-b). However, in GT the use of the word context is different to common meanings of context such as environment or setting. In GT, context describes the background meanings that influence a person's actions and interactions in response to various situations or events (Corbin & Strauss, 2015). Therefore, it was imperative to first explore the context of PHC for the nurses in this study as this underlies their actions and interactions. Furthermore, in GT, researchers identify a core problem, challenge or goal which the participants seek to resolve (Corbin & Strauss, 2015). When constructivists explore how people construct meaning they learn ". . . how, when and to what extent the studied experience is embedded in larger, and often, hidden structures, networks, situations and relationships" (Charmaz, 2014, p240). In this sense, the factors which influence the person's experience of the core issue are called contextual conditions. Contextual conditions describe variation in the experience; that is, what influences the experience of the issue.

This chapter presents the context as: *providing Primary Health Care (PHC).* Providing PHC will be described as quality, effective care within a social model of health with an emphasis on illness prevention and making a difference in people's lives. Whilst exploring the context of providing PHC, however, it was apparent that nurses encountered difficulty in providing PHC in their daily practice. In this study, the core issue: *inability to provide PHC* was described by participants as *you can't give the care you want*. The core issue was experienced by the participants to different degrees in different situations and they responded to the issue in different ways; this is captured in the process labelled: *doing the best you can with what you have,* which will be described in chapter five.

Detailed presentations of the participants' collective perception of the PHC context and of the core issue they faced in practice (inability to provide PHC) will be presented followed by four contextual conditions that influenced the actions and interactions of the participants when they attempted to provide PHC will then be described. These four conditions were categorised as: *clinical knowledge and skill; availability of resources; understanding the social world and, shared understanding and support.* Figure 7 below shows that collectively; the context of providing PHC, the core issue as being the inability to provide PHC and the conditions which make the core issue more or less significant, describe and explain the contextual conditions of nursing practice in remote areas.

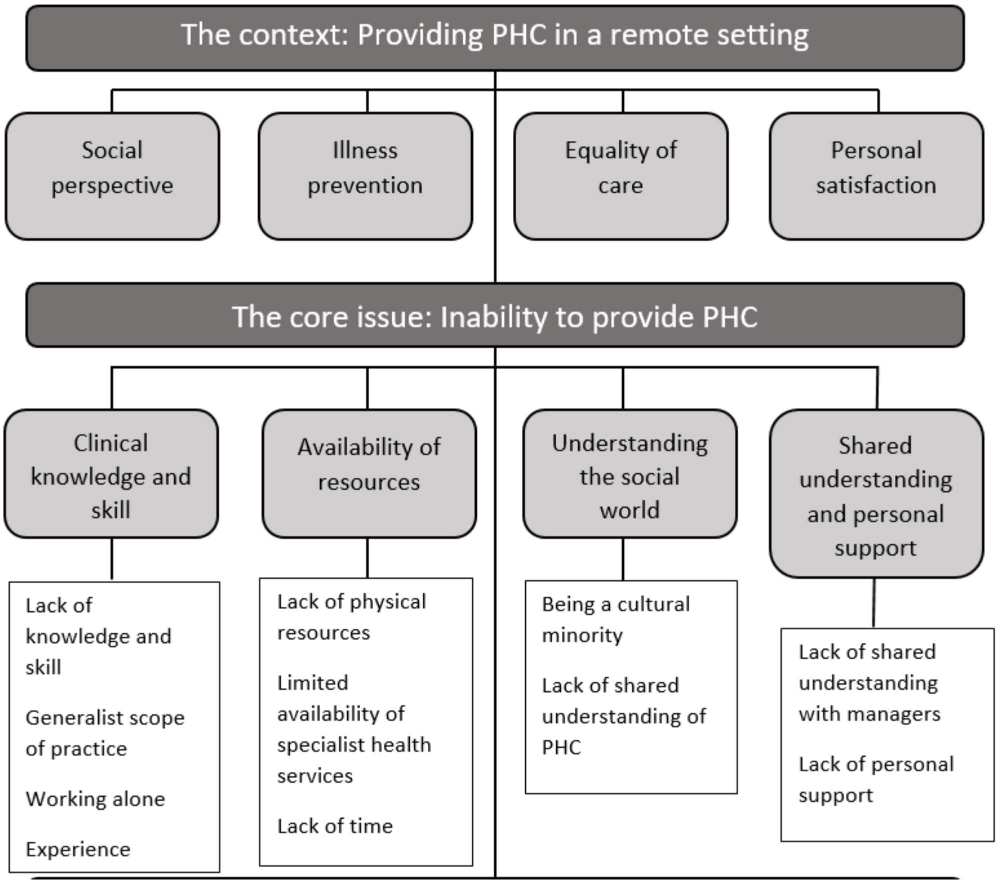


**Figure 7: The context and conditions of providing PHC in remote areas from the perspective of nurses**

### 4.1.1 The participants

The total number of participants in this study was 24. This total comprised of 13 NPs, seven RNs and four nursing academics from the Centre for Remote Health in Alice Springs who attended the expert reference group. Twenty participants were female and four were male. The ages of participants ranged from 25-67 years with an average age of 49 years. One participant identified as Aboriginal.

All interview participants were employed in roles relating to the remote context at the time of interview. Participants (including reference group) primary location of remote experience was: Northern Territory (*n*=14), Western Australia (*n*=6), Queensland (*n*=2), and Indian Ocean Territories (*n*=2). Participants had worked or were working, in a variety of communities, both Indigenous and non-Indigenous and reflected on their experiences in remote as a whole, rather than in relation to one particular community. One participant had been employed in a permanent full-time relieving position for many years, across a large number of communities within the same region.

Participants had varying degrees of experience from three months in a relief position to over 15 years' experience working as a nurse in remote areas. The total number of years of nursing experience in any setting ranged from 2–50 years with an average of 25 years' experience. Years of experience of being an NP ranged from 1–10, with half of the NP participants having worked as NPs for less than three years. Eleven of the 24 nurses held midwifery qualifications.

Participants also had a wide range of post-graduate qualifications and areas of expertise. Many had Masters level qualifications (*n*=16) as their highest level, two of the expert reference group held PhD qualifications and several had specifically studied Remote Health Practice (*n*=10). Participants were found who currently held 'specialist' remote area positions such as Chronic disease, Mental health, Women's and Children's health to include the perspective of preventative health care and education. The nurses in specialist positions were rarely required to respond to after-hours call outs although they were often available to assist with acute care when the clinic staff were under-resourced. Many of the NP positions fell into this category. However, most of these participants had worked in generalist remote positions prior to becoming specialised. Other participants were employed in 'generalist' positions whereby they were required to attend to acute, chronic and preventative health care. These nurses were also required to participate in regular on-call duties after business hours and over the weekend.

Finally, a note on presentation of data in this chapter. Quotations from participants are indicated in italics and participants are identified by a number prefixed by either: NP (Nurse Practitioner), RAN (Remote Area Nurse) or RG (Expert Reference Group member who were all Registered Nurses or NPs with experience in remote areas but may not have currently been practicing in this capacity).

### 4.1.2 Providing Primary Health Care in a remote setting

Participants in this study were asked to describe what PHC meant to them and how they applied their understanding of this philosophy of care into their nursing practice. PHC was described by the participants as including: a social perspective on health, an emphasis on illness prevention, providing equality of care, and feelings of personal satisfaction that came from the opportunity to make a difference. An overarching synthesis: *providing PHC in a remote setting* (hereafter referred to as: providing PHC) was generated and represented both the aim of nursing care; and subsequently the care they wanted to provide within the remote setting. Each element is explored below.

#### *4.1.2.1 Social perspective*

Participants described PHC as being a social philosophy of healthcare. This perspective encompassed understanding a person's social environment and their psycho-social needs rather than just their physical needs. Nurses referred to providing care from a social perspective as; '*Holistic care'* (NP3) '*complete care'* (NP3) and looking at '*the whole picture'* (NP1).

PHC provided opportunities to connect with the social world of patients. RAN4, as an example, described PHC as going to the community:

> *When I go out there and I'm working with a community worker and I'm getting out into the community and we're doing screening in the community or you're sitting under a tree you know with a family group and having a talk. . . about something that's worthwhile and you're engaged with the person – it's the best job in the world (RAN4).*

A social view of health was highly valued and described as an element of PHC. NP3 took the view that, *"**. . .** I very much look at the patient and how they fit within the social determinants of health and what . . . their complete health needs are, not just what their medical health needs are".* Similarly, RAN4 emphasised the importance of understanding a person's social environment and support network:

> *. . . I think you need to know what's happening for them outside the clinic in their lives, you know, are they working? Are they caring for anybody? . . . What level of support and support networks have they got out there? . . . Where they see themselves and where they fit in the community and sense of pride and all that sort of stuff . . . I think that's important (RAN4).*

Further elaboration of PHC was suggested to include the patient's social and psychological needs in addition to their physical needs. NP3 went on to reflect that,*" **. . .** we're looking at the psycho-social needs of the patient,* [as well as] *the physical needs of the patient".* PHC was also said to include interest in the bigger picture by looking outside of the immediate health concern. For NP2, it included:

> *. . .  saying: "What about their social stuff?" People didn't automatically think of that. Have they got money? Have they got transport? Where are they living? It's no good just sending them back to a remote community which is overcrowded . . . have they got someone to live with? Is their Centrelink* [welfare payments] *sorted out?*

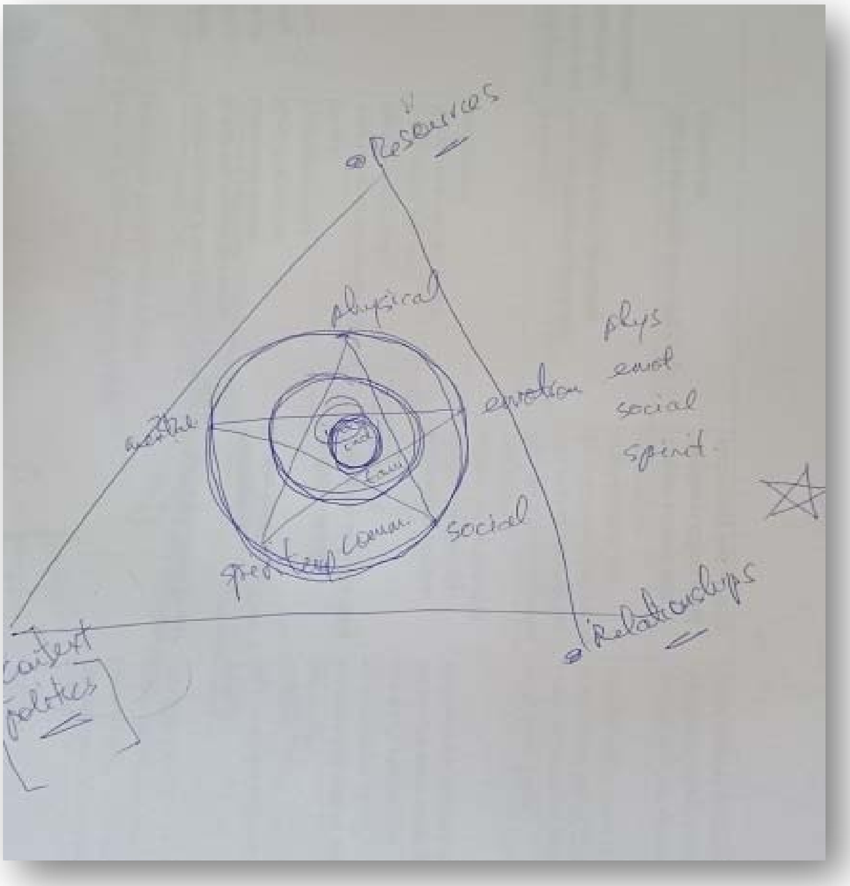
A social perspective meant that nurses considered the whole community as their patients and not just the individual who presented to the clinic, for example, NP3 sees, *". . . PHC as a population approach to care as well as an individual".* PHC also included understanding the person within the context of their family and community and building trust between nurses and families:

> *Treating it might not be just as simple as giving a tablet and yet you won't get to treat somebody unless you engage with them in the context of their family. You have to find out who's responsible for them* [where], *they sit with a family; so the family as a whole has to have trust in the medicine you are giving (NP4).*

Figure 8, drawn by a member of the expert reference group, which was convened early in the study to assist with concept development, represented PHC as a five-pronged star where the patient is cared for with the resources available within the context of their life and community:

**Figure 8: Reference group graphic: PHC as a five-pronged star**

> *. . . The individual, the family and the community are the areas of need when you are thinking about PHC. And then the five points of holistic care so; physical, emotional, social, spiritual and . . . mental . . . that extend all the way through the individual to the community to the family and that is what you are trying to do. And then you have a triangle of where you are working . . . resources, relationships and . . . the context and that includes the political context . . . these are components of what they are doing; of what they are providing (RG1).*



The figure above reflected a similar meaning of PHC to the interviewees in terms of viewing the patient within the context of their social needs. However, the description of PHC also included a wider community and political view. Outside factors and agendas impacted on the nurse's practice and this will be discussed as a contextual condition.

Encouraging community participation in health services was considered part of the PHC role, for example, "*. . . trying to get the community more interested and more involved in the health service" (NP7).* Participation was considered to be an indicator of credibility, *". . . we want to involve the* *patients in their care and offer a service to them so that . . . it is an authentic and credible service" (NP3).* Participation may also indicate nurses' personal values of empowerment to self-care:

> *. . . I've always been a little bit more in touch with natural therapies and eating well and not smoking and those things and being able to cure yourself. . . So for me this* [remote work] *. . . enabled me to help people to manage their own health better (NP3).*

This nurse seemed to view the remote setting as an opportunity to share this value in her work. The following quotes also indicate that community participation and patient involvement in care was valued, *". . . rather than doing everything for them and* [also] *encouragement for them to participate at some level" (NP13).* The importance of participation by family and friends in PHC was also highlighted in the expert reference group:

> *. . . the individual in the centre . . . supported by family friends and community on a foundation of things like housing, water supply and Social Determinants of Health with…. health services so like health promotion, medication, basic health care, nurses and that sort of stuff. But also that the family and friends they are part of the PHC, not just a recipient of it (RG2).*

Another member of the expert reference group described the health service (clinic) as being the centre of the universe (Figure 9) connecting other services and the community together:

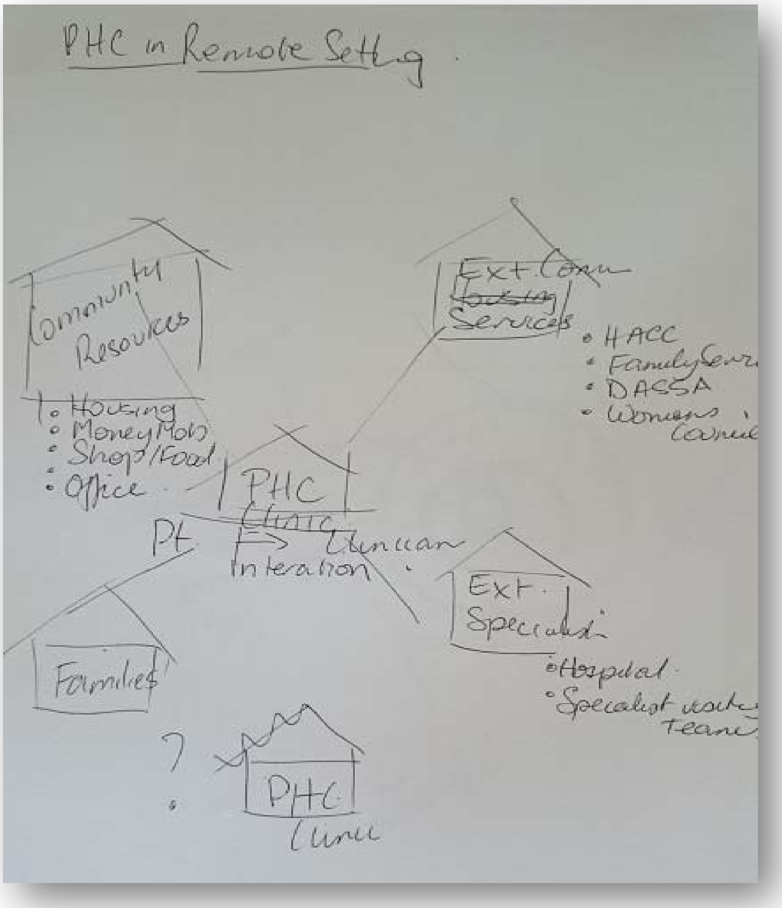


**Figure 9: Reference group graphic: the clinic is the centre of the universe**

> *. . . the clinic is the centre of the universe in a remote setting . . . And I've questioned that. Really the patient should be in the centre . . . taking control, but we live in an environment in the remote setting where the patient is disadvantaged and they can't take control . . . The patient comes there if they are ill, if they are in danger, if they have got no money, if they are getting beaten; they come to the clinic and I see that as a safe place. But I see PHC as an expert that I need to know all about the community resources, the housing, the money mob, the shop; . . . I can talk to the client then about those needs, I can talk to the family, I need to know where they live I need to know all those connections and who's important . . . for helping the patients, I need external things like the hospital specialist teams; I see PHC as how do I bring them in to the care of the patient? (RG3).*

The description above highlighed the importance of understanding the social world of community members in order to offer care that was holistic in nature. In addition, being patient- centred and empowerment of the individual and community was valued. Empowerment as an element of PHC also included providing education and support, "*. . . because it's such a paternalistic environment sometimes they don't feel empowered to do that. So it's about providing them with some* *information and support so that they can do something about it" (NP3).* Furthermore, the following participant in the expert reference group also described providing information and access to other services:

> *This is my community of people, . . . and this is me providing whatever support it is that that community needs. So I might use different things in a toolkit which might be clinical focus, or it might be relationship or it might be my brain or it might be my knowledge of systems or relationships with other people in the system to help this community to get to whatever their needs may be. Maybe it's housing, food, money. . . (RG4).*

She suggested that nurses required a range of knowledge and skills in order to provide that support. She elaborated by explaining that an aspect of support was handing power to the people by listening to them as symbolised by a microphone, ". . . *I have a microphone here to give them power and control" (RG4).*

Nurses described PHC as a philosophy of care where patients were viewed holistically within a social context of their family and community. Nurses appeared to value participation by patients and communities in health services, and some saw empowerment as an important goal of care.

#### *4.1.2.2 Illness prevention*

Providing PHC was also described as having a focus on wellness rather than illness, "*Because . . . everything is about wellness' (NP13).* PHC was also described as emphasising the prevention of ill health, often in terms of managing chronic disease and health promotion, "[PHC is] . . . *providing care prior to somebody being sick. It's about opportunistic healthcare and screening and to educate . . . before the problem turns into a chronic problem" (NP1).* As such, activities aimed at prevention of ill health were valued as, ". . . *providing a primary prevention approach" (NP3).*

A focus on illness prevention was an attribute of providing PHC that was different to a focus on acute care, "*. . . changing your focus of health care instead of just looking at the acute presentation and putting the band aid on to fix that and it's about taking a step back and trying to prevent stuff from happening" (NP1).* The use of the term "band-aid" was a colloquialism that indicated a temporary or basic solution to a more complex problem.

Health promotion and prevention were described as being 'proactive', "*I think that we need to have a proactive approach towards our care rather than react" (NP3).* The reference to 'reactive care' was interpreted to mean responding or focusing on acute care presentations. The following quote indicated that attending to acute care needs was considered an element of PHC, but was not as satisfying as health promotion and management of chronic disease:

> *. . . coming from ED . . . I used to love . . . the adrenalin; the drama of it all I suppose and I never saw myself as a person who would like diabetes or chronic conditions management. . . I think even now, emergency stuff . . . I do what I need to but it's not something that really excites me anymore (RAN6).*

Similarly, health promotion and management of chronic disease was considered to reflect the value of PHC, *". . . I like the variety which chronic conditions can give you because it's everything; every aspect of a person's life" (RAN4).* Health promotion and management of chronic disease were considered a core element of doing PHC well from the nurses' perspective, *". . . when a clinic is run right, the majority of our work is chronic disease related . . . out in Aboriginal communities "(RAN2)* and "*Look, why are you here? It's PHC, it's not an emergency department "(RAN4).* NP9 agreed, "*it was probably 80% chronic disease management and 20% acute" (NP9).*

These opportunities to work with people to prevent illness was considered satisfying and worthwhile:

> *I'd rather sit down with a diabetic patient and really sit there and talk and set some plans and help people work through those challenges of a diagnosis like diabetes or heart disease . . . It's that sort of helping people through . . . the emotional side of it as well, you know dealing with a diagnosis and then the second plan is to improve health (RAN6).*

However, some nurses were described as preferring the provision of acute care over health promotion as it was perceived to be more exciting:

> *I get really cranky when nurses themselves play 'mini-doctor', which might be the exciting stuff but they don't want to do the bread and butter stuff, which is the* [illness prevention] *programme stuff (RAN4).*

RAN2 elaborated with, " . . . *I think a lot of people when they come out here, all they want to do is the ambulance service they don't want to do the chronic condition checks*, [or] *. . . the annual health checks,* [or] *. . . the child health checks and they just want to do acute stuff" (RAN2).*

Health promotion and management of chronic disease was described as taking a preventative approach to care which was valued because they saw health as being about wellness rather than illness. It was evident in their descriptions that a focus on health promotion and prevention resulted in feelings of satisfaction and as such was interpreted as the care they wanted to provide within the remote setting.

#### *4.1.2.3 Equality of care*

Providing PHC was suggested by the participants to be providing quality care and also equality in access to care commensurate with what was available in urban settings. Quality care was also reflected in access to skilled and knowledgeable health practitioners as well as access to health promotion programs.

Nurses described wanting to provide quality care. This was sometimes framed in the context of valuing equality in access to health care, "*. . . these people deserve just a good quality care as the person presenting in a big city like Melbourne" (NP1).* Quality care was also described as relating to nurses' skill and knowledge, *". . . I think that* [physical and cultural safety] *is the beginning and then from there they* [nurses] *need to have the skill and the knowledge to provide safe and quality care" (NP1).* Of interest was that this comment was related to providing culturally appropriate and safe care as well as meeting physical health needs. This was interpreted as a link to quality care.

Quality care was also evidenced by the level of qualification of the health provider. In the following comment the participant describes herself as an NP and an 'Eligible Midwife' which is a midwife endorsed by the NMBA to prescribe medications associated with midwifery practice (Nursing and Midwifery Board of Australia, 2010).

> *I guess it was just a personal goal to be both a NP and an Eligible midwife, it's as far as you can go I guess and to be able to combine the two in a remote setting has huge advantages for the women in remote areas to be able to receive that general women's health and maternity type care (NP1).*

The reference to the advantages in the remote setting reflects the lack of availability of specialist women's health services such as Obstetricians and Gynaecologist. By being an NP and an Eligible midwife she was able to provide specialised care and prescribe medications, make referrals to specialist services and order pathology and radiology services. These additional skills and knowledge reduced the gap between what was available in her community and what was available in an urban setting. The previous quote also suggested that greater value was placed on generalist knowledge over clinical specialisation and seen as, advantageous to patient care.

The need for a broad range of nursing skills and knowledge was described as being 'a generalist' as opposed to 'a specialist'. The participant's use of the terms specialist and generalist appeared to align with the definitions described in the literature review. Even nurses with specialist roles including the management of chronic disease saw themselves as having generalist knowledge, "*I see myself as a generalist . . . but my specialised knowledge is around the chronic disease . . . but still very much the whole body approach and what are the things they actually need?" (RAN6).* Having a broad range of skills and knowledge was interpreted as necessary in order to provide PHC.

Having staff who were knowledgeable about PHC was implied as leading to improved health outcomes and quality care*, “He* [the cardiologist] *has a very PHC focus too. . . I think it improves the outcomes in the long term” (NP3)* because a PHC focus prioritises collaboration between health services and preventative health care:

> *. . . unless you’ve got really good PHC focussed people who know what this means who know exactly what lifestyle health or lifestyle medicine is all about and are engaged in it in a collaborative* [way], *then you’ve got very little chance of making much difference (NP8).*

Furthermore, quality care was judged in terms of avoidance of hospitalisation and medical evacuations, “*. . . we say the way to prevent* [medical evacuations] *is to do really good primary health. And that’s what we do. We have some kick-arse programmes . . .” (NP7).* Similarly, knowledge of the community lead to quality care and management of chronic disease which lead to less hospitalisations:

> *But as I got control of the chronic disease patterns and the more I knew about community and the more we worked together to actually get the right medication to the right patient, and they were actually doing what they could for their health there was less and less of that transfer stuff (NP8).*

It was apparent that equality of care was measured in terms of the care provided in urban areas, the frequency of patient transfers away from the community and the perceived competence of the health professionals in providing PHC.

### 4.1.3 Personal satisfaction: Making a difference

The participants in this study had all chosen to work in remote settings and most had done so for several years. Their motivation to pursue a career nursing in remote areas was explored. As such; feelings of personal satisfaction were examined in order to understand the nurse’s perspective on why they chose this context of practice. Exploring the reasons nurses gave for staying within this context shed light on the type of care they wanted to give and as such the meaning of the context.

Nurses described feelings of satisfaction as being associated with meeting the challenge of the remote setting, “*. . . when I first started I definitely wanted the challenge and I was excited by it you know, I wanted to prove myself in a way” (NP5).* Similarly, the following nurse reflects on the difficulties of PHC in a remote setting with a sense of achievement that she survived:

> *. . . they say that you hit the ground running and you sink or swim and I think that that was a good way to start my career because it . . . pushed me to be way outside the comfort zone and I enjoyed it, eventually, I looked back and thought, “Wow, that was pretty cool” (RAN1).*

Being able to provide care despite the challenges of a resource -poor setting, seemed to contribute to feelings of satisfaction as challenges were overcome:

> *I probably had a bit of that 'missionary thing' in the back of my head. And I wanted to go somewhere where if I didn't have machinery I would have to use my eyes and my hands and my ears to actually assess someone and I still have that mentality. If I don't have a saturation machine and a BP monitor and a defibrillator and that can I still look after this person? (NP2).*

Providing PHC within the remote setting appeared to be a desirable challenge and an opportunity for feelings of satisfaction when PHC was achieved.

The remote health setting is one of social disadvantage and many communities have a large proportion of Indigenous residents who also suffer health disadvantage. Having a personal connection to the context of Indigenous health was a strong motivation for the following nurse, even if the outcomes were not immediately evident:

> *I'm Indigenous and I came from a poor kind of upbringing . . . when I went through college, that's when I started learning about the social determinants of health . . . I come from Indigenous blood, low socio-economic background . . . That kind of made me a little bit more determined . . . So Indigenous health interests me from that respect, . . . I empathise with the situation (NP5)*

A social justice perspective was also evident when nurses talked about why they chose to work in PHC within the remote setting:

> *. . . I'm not a smarmy do-goodery type person . . . but I like that . . . as an organisation we have a social conscience and we are doing something to help marginalised people . . . I come from a very disadvantaged family and . . . I feel lucky that it's something that I can do that's a little bit benevolent . . . I'm doing a good job and I'm helping people (NP3).*

This participant valued the opportunity to care for people who were disadvantaged, and this value may be reflected in the perception of PHC as including empowerment of patients and communities. This nurse also identified an element of satisfaction as quality care (doing a good job) and making a difference (helping people).

When nurses described providing PHC, they described wanting to make a difference in the lives of people in their community. Making a difference was interpreted as a way of describing the care they wanted to give. For example, the following quote describes a situation where the nurse felt she had made a difference to the health and wellbeing of a patient:

> *. . . I've also got a fellow with end-stage cancer . . . that didn't have great pain control and he was only supposed to live six months and he's now into his eighth month so I've been teleconferencing with him and the [regional] palliative care team and then ordering him his*

> *Durodesic patches and I've got him on a pain chart and then getting extra supports for the family etcetera and that's been working really well . . . you can just make such a difference. This palliative care man is just so happy, you know, he says, "*[nurse]*, I feel the best I've felt since I left hospital" he's out tinkering with his car because he's got no pain and he's off to bingo on a Friday (NP9).*

This example suggested that the nurse judged her effectiveness based on the patient's measureable health outcomes (living for two months longer than predicted); and also the patient's perspective of feeling "the best" since leaving hospital. The nurse also described having knowledge of the patient's social situation and valuing his quality of life and independence (wellness) as well as relief from physical symptoms (health promotion and prevention). The nurse appeared to be satisfied with the quality of patient care provided and that things were "working really well", and "you can make such a difference".

Making a difference was described by nurses as being able to see changes in people's behaviours:

> *. . . you see the changes that people make. I think it's just those connections with people . . . you see what happens in the long journey that they are experiencing. Hopefully you can be part of some positive effects that come out of it (RAN6).*

Trust and building relationships were described as taking time to develop and a sense of achievement and satisfaction when the results led to increased engagement with the health service:

> *. . . at first . . . the adolescent and young adult boys would only ever see the health workers about whatever their problem was and about five years in . . . I'd be standing there and somebody would say, "I look you* [name]*" and I'd say, "you wanna see me?" . . . and that's when I knew I'd made it in terms of trust and confidentiality and respect for them and they having respect for me and I think that was one of the markers when I knew I was actually getting somewhere (NP8).*

The following nurse also expressed feelings of satisfaction as measured by past patients' efforts to maintain a connection with him after he had provided care:

> *. . . I got a phone call from some people. . . and her daughter had got very sick and nearly died one night . . . and so she phoned me up and she said "we would really like to come and visit you" . . . so . . . all these people came into the house and it was the . . . family of this girl that I had worked with back in 1991 . . . it was quite amazing (NP6).*

A sense of satisfaction through making a difference and the affirmation from the community and the employer that the nurse was making a difference was described as important. Without that affirmation, the context could seem too difficult and distress occurred, (in this case described as being in a 'state'):

> *. . . if you don't get affirmation from your community and you don't feel satisfaction in a job well done because the burden of disease is so high and you can see that you are not going to make a very big difference and if you don't get it from middle management then you do end up in a different sort of 'state' altogether (NP14).*

Similarly, RAN4 discussed her feelings of job satisfaction by stating that providing PHC in a remote setting was interesting, "*Why am I still here? . . . well, I suppose it is interesting work. . ." (RAN4).* With the qualifier, ". . . *when it goes well." (RAN4).* Ultimately, providing PHC was described as leading to satisfaction for nurses, *"I loved being able to give holistic care . . . that you got to know the patient well and the disease from their view" (NP3)*; and was described as the care they wanted to give.

### *Section summary*

This section described the meaning of PHC and identified the context of *providing PHC in a remote setting*. Providing PHC was described as the care nurses wanted to provide. This was defined as quality care from a social perspective with an emphasis on health promotion and prevention of ill health. Feelings of personal satisfaction were linked to feelings of achievement at overcoming the difficulties associated with the remote context, valuing social justice and measuring achievement based on observed improvements in health and feelings of appreciation for the work they do. However, the final quote in this section made reference to the core issue for these nurses; that they cannot always give the care they wanted to provide. This core issue is now presented in detail.

## 4.2 The core issue: Inability to provide PHC

Nurses in this study defined the care they wanted to give as providing PHC which encompassed a social model of health, health promotion, quality care in line with care in urban areas and the ability to make a difference. Delivery that reflected these terms within the remote setting was associated with feelings of personal satisfaction. However, it was evident that nurses were not always able to give the care they wanted to and this led to feelings of frustration and distress.

Feelings of dissatisfaction were expressed when nurses did not feel that they were making positive impact on health outcomes, "*. . . I don't think I'm making any difference" (RAN4)* or could not see improvements in health, *". . . I'm not sure I'll see any changes in my lifespan unfortunately" (NP5).* Another nurse described feeling unmotivated, *"It's very difficult at the moment to find motivation, 'cause . . . I don't know if we are making any headway in regards to improving health outcomes" (RAN2).* These comments revealed feelings of frustration and dissatisfaction because nurses did not consider that their work was effective.

The inability to provide PHC was described as, *". . . once primary health stops happening you become an ambulance service" (RAN2).* This was interpreted as meaning that acute care was prioritised over health promotion and management of chronic disease. Dissatisfaction was related to an inability to provide PHC by the following nurse, "*we say we are doing PHC but we're not" (RAN4).* This quote clearly showed that this nurse had experienced compromise in her perspective of what PHC nursing should be and what she experienced it to be in practice. A similar sentiment was expressed in terms of compromising on the care nurses wanted to provide, *". . . I think it's foundational; it's all a compromise! . . . you can't do what you would like to do" (NP14).* The use of the word foundational was further explained by this participant to mean that compromises were widespread and frequently encountered by nurses within this context. Not being able to do what the nurse wanted to do was also interpreted to be a reflection of compromises in quality of care, "*. . . and that's where I do think the care falls down the cracks"* (NP14).

It was evident that the inability to provide PHC was the core issue for the nurses in this study. The degree to which nurses were unable to provide the level of care they wanted to was explained by four contextual conditions. These conditions were categorised as: clinical knowledge and skill, availability of resources; understanding the social world and, shared understanding and support. The impact of the conditions varied by nurse and across practice settings, however, collectively the following four conditions describe the core issue of the inability to provide PHC in the remote nursing setting.

## 4.3 Condition one: Clinical knowledge and skill

Nurses in this study identified that a lack of appropriate knowledge and skill impacted on their ability to provide PHC. As discussed in the literature review in chapter 2, nursing knowledge in this setting reflected a broad scope of practice, known as 'generalist' rather than the 'specialist' knowledge that was associated with urban acute care settings. The extended scope of practice was associated with increased responsibility that was linked to autonomous practice. Whilst clinical knowledge was important, so too was knowledge about PHC and the socio-cultural context of the remote setting. This condition represented the participants' musings on the remote nurse's scope of practice and responsibility and their collective view that the degree of experience one had gained in the remote setting impacted on the ability to provide PHC because it took time to build the knowledge and skill appropriate to the remote setting.

### 4.3.1 Lack of skill and knowledge: 'My skills in remote were nothing'

Providing PHC in a remote setting required different knowledge and skill to urban nursing settings. In this study, nurses described their experiences when they first arrived in the remote setting and these descriptions revealed a common phenomenon where they discovered that PHC required a different set of skills and knowledge than they had previously needed. Most of the nurses interviewed were very experienced in the remote setting and the comments that follow were reflections on their early experiences as RANs.

When entering the remote setting nurses said that they felt as though their knowledge and skills were irrelevant because the context was so different from what they had previously experienced, "*All the traditional boundaries and knowledge base; everything that I had gone with before I had to throw that out the window and start again" (NP12).* The reference to previous nursing knowledge and roles as 'traditional' illustrated that they considered it to be different to what was needed in providing PHC. Furthermore, nurses evaluated their knowledge and skill in light of the new context, *"I thought I was pretty bloody good and I get there and all of a sudden I thought 'I know nothing, I know nothing!'" (NP3).* Objectively, NP3 cannot literally mean she had no relevant knowledge, as nurses were selected for employment based on demonstrated nursing experience, however, the emotion and repetition in this statement suggested strong feelings associated with entering a new and unfamiliar environment.

The perception of a lack of knowledge was described as being in part because the nurses did not have prior experience of the health needs of people in the remote setting, "*You will see things here that you will never see anywhere else" (NP12).* The knowledge deficit appeared to be particularly relevant for nurses who primarily worked with Aboriginal or Torres Strait Islander people:

> *. . . had I known I was going to end up here I would have wanted something extra* [in my nursing studies] *about the health issues and the co-morbidities of Aboriginal people and the issues in treating from that point of view, . . . because it is different, there's no doubt that it is different (NP12).*

The remote setting was compared to an urban acute setting by the following participant and described as different by, *"The way that I would have done things in my* [previous] *job is certainly not the way things were done there" (NP10).* NP3 also described clinical procedures and presentations as being vastly different from what she had experienced in a metropolitan hospital, as the following example shows:

> *I look in someone's ears and there's pus pouring out of their ear and I've never in my life seen that. And then she tells me to clean it with a Betadine syringe. Well, I thought 'you can't do that, that's ridiculous, we don't do that in ED!' And then the first time someone came in with a blood sugar of 30 I just about fainted on the ground I was ready to put up an insulin infusion! . . .  straight away I realised that even though I had a reasonable theoretical knowledge, my skills in remote were nothing (NP3).*

PHC was also considered to be a different way of working when compared to other nursing settings*" . . . our role, a big part of that is PHC . . . rather than when you're in the hospital ward"* (RAN1). Changing their own practice to become more PHC focussed was described as developing over time: *"I had to change the way I did everything . . . a whole pile of things gradually changed my practice completely" (NP8).* Changing nursing practice was described by participants as 'starting again', ". . . *you take away all your usual parameters and start again" (NP12).* Similarly, previous knowledge was challenged within this different world, *". . . you think you know something and then you realise you don't know anything about it at all" (NP7).*

Described as 'being PHC focussed', nursing practice changed from competence with episodic care to the perception that nurses needed to understand how the 'communities worked' and the impact of social determinants on health outcomes:

> *. . . I had always worked in a service where you got them in and you treated them, you did the best you could and then they were out of your department, never to be seen again . . . That was my modus operandi really and having to turn all that around to being PHC focussed and understanding how communities work and what the social determinants of heath were, was an amazing eye-opener for me (NP8).*

A lack of training and experience in PHC within the metropolitan acute care setting was described as underpinning the need to change practice once a nurse enters the remote setting, "*. . . because we recruit from emergency departments; there's lack of training around* [PHC]" *(RAN4).* Likewise, the need to adapt to a new model of care was considered to be less if the nurse had some experience in PHC, "*. . . I hadn't done any other remote or primary type nursing so maybe for someone who had done that there would be less of a challenge" (NP10).* A particularly confronting element of PHC was providing healthcare in a non-clinical environment, "*. . . if you are 'brought-up' in a hospital or an emergency department, getting out into the community and sitting under a tree and doing healthcare could be a bit confronting for some people" (RAN4).*

Time and practical experience was considered to be important factors in changing the way nurses practiced. This was evident in the following quote where the nurse describes becoming more 'comfortable' with incorporating the principles of PHC into nursing practice:

> *I didn't understand PHC . . . we didn't do it very thoroughly* [at university] *so it wasn't something I really felt familiar or comfortable with until coming remote . . . it's a completely different thing here, you are getting that continuity and the different age groups and so I think the reason I'm more comfortable with it 'cause you are practicing it a lot more (RAN1).*

It was evident that nurses recognised that PHC in the remote PHC context was a different way of providing nursing care to that of nurses in urban hospital settings. The degree to which PHC could be provided related to the scope of practice of the nurse. Within the remote PHC setting nurses were required to have a broad range of skills in order to care for communities across the lifespan.

### 4.3.2 Generalist scope of practice

Nurses described needing to have a generalist scope of practice and recognised that this was different to the specialised roles nurses undertake in urban settings, *". . . the varied nature of the role; so it was a lot broader than I guess what I'd experienced before . . . coming from a much more specific, targeted health service that was a bit of a challenge" (NP10).* It was apparent that nurses needed *". . . to know a little bit about a lot, so yes you can provide holistic care" (NP14)*, in order to attend to such a variety of health needs. RAN4 agreed when he said, ". . . *you need to have some information about a broad range of subjects; and if you don't know you have to know where to go to get it" (RAN4).*

The generalist approach to health services was considered to be very different to the specialised knowledge that nurses had before they come to remote areas. For example, the following participant had many years of experience in adult nursing, but was now required to assess and manage the health needs of the whole population, including children:

> *I will never forget the first time, . . . that I had to examine, was a child of two years old that had a cold. And I was used to doing adult nursing . . . and here I was confronted by this mother who was looking at me with . . . all the faith in heaven . . . and I didn't have a bloody clue what I was doing really! (RAN5).*

Nurses who were new to remote areas started from a place of limited understanding of health promotion, screening and management of chronic disease:

> . . . [I learned] *by osmosis, and . . . I started that study . . . I knew that there was a hole in my education that was never going to be filled by what I knew before . . . and the chronic disease management, it was a whole new thing . . . and doing child health checks to assess against milestones and have a look at what might be happening for those who might not be meeting their milestones, that sort of stuff, I just didn't know anything about it (NP8).*

Expertise in the remote context included a level of clinical assessment, reasoning and treatment knowledge not often required of nurses in other contexts. The lack of skills was interpreted as impacting negatively on the quality of care provided, *"I do think the care of the patients is impacted a lot by the lack of skills" (NP14).* Skills in assessment, diagnosis and pharmacology were considered to be vitally important to providing quality care but something that many nurses had very little education in:

> *. . . you need a certain level of expertise and you probably need to be able to make that call, like, to be able to ask the right questions and if people don't know how . . . they'll find it difficult and hard and challenging (RAN2).*

The notion that nurses were expected to go beyond what was commonly expected of nurses was described by several participants. One nurse described the RAN role as, *"You are so much more than a nurse" (RAN7).* This comment was interpreted as a perception based on comparative nursing roles rather than prescribed nursing scope of practice, as expansion of nursing scope of practice can occur if nurses are educated, deemed competent and are working within organisational policy. Further evidence of this perception was elucidated in the statement below:

> *. . . things that we expect from our RANs here are not. . . expected of them anywhere else; . . . they are expected to suture, they are expected to make decisions about drugs, they are expected to cannulate and not a lot of them do* [when they arrive] *(NP12).*

The lack of doctors at a local level created situations where nurses were required to undertake activities that were usually in the medical domain (although established protocols offered guidance):

> *. . . you have to, say if you are working out bush you don't have a doctor there to write out a path form for example so you write it out and order your pathology. Don't get me wrong you are following protocols and not just doing things willy-nilly (NP1).*

Likewise, the need to extend practice beyond the 'normal' scope of nurses was evident in the comparison with GP practice, "*It is really like being a GP, a RAN really has to have a fairly solid grounding in a lot of the things that GPs do*" *(NP12)*. Increased responsibility and decision-making was also described when comparing the role of nurses in remote areas with nurses in acute hospital settings:

> *. . . when you are working in ED, the final decisions aren't really lying with you. The assessment skills . . . only go to a certain point and then the doctor takes over with any treatment. . . as a RAN, you take on a wider scope, you are certainly doing a greater number of assessments; . . . greater responsibility and decisions – even though you are using clinical protocols you have to interpret those for how you are using them (RAN6).*

The generalist scope of practice was described as influencing the degree of decision-making and responsibility of nurses, "*. . . nurses, they need to keep the wheel turning . . . they work a lot harder nurses than GPs. And out here the decision-making level is not that far removed from each other. It's a bit of a worry" (RAN2).* Similarly, NP1 described the increased responsibility and decision making in terms of having to change her mindset of the nursing role; "*. . . to find out, to investigate and diagnose . . . it's changing that mindset*" (NP1). Confidence was also an important factor in the ability to move from assessment to diagnosis which has traditionally been a doctor's role:

> *. . . some people can be great at assessing but they can't put the bits together or they're not confident because it's always been seen as the doctor's province. They're not confident in saying well they've probably got this or they've probably got that (NP14).*

Nurses suggested that insufficient education about medications and pathology lead to errors and impacted on patient safety:

> *. . . I feel like our training in medication prescribing and side effects and interactions and all of that stuff is very limited in our nursing background. . . there are sort of alerts* [on computer systems] *and you've got your MIMS and all that sort of thing but it's still pretty easy to miss stuff and make errors (RAN1).*

Limitations in the use of these guidelines were identified by participants as nurses need to have the assessment skills and understanding of context in order to apply them properly:

> *And protocol books and things like that won't do it, . . . they don't know how to assess and they can't pick the appropriate diagnosis because once you pick the diagnosis you have a pathway to follow. If you can't assess properly and understand the person in context, then you can't pick the appropriate diagnosis which means you are floundering and you are lost and wondering how to care for that person (NP14).*

It was suggested that in addition to poorly developed assessment skills, nurses also had very little understanding of the holistic aims of providing PHC:

> *What I've observed more is that the nurses who are coming out now . . . they are not even very good at assessing and they don't necessarily understand that when I'm thinking about holistic care I'm looking at the person and looking at their needs at their time of life and for their illness or non-illness for whatever reason they presented, . . . like, is it a mother with a young child who has brought the child in for her immunisation but as a unit, do they need other things? . . . Does she need something for herself? (NP3).*

Even nurses with many years' experience may not have the necessary skills and knowledge needed in this context, "*. . . older, hospital-trained people they've never learned how to reason and they sometimes struggle. Clinical reasoning is definitely an important part of the job I would say" (RAN2).* Clinical reasoning was described as not being about doing a nursing task (in this case monitoring a diabetic's blood sugar level) but rather about moving to a higher level of critique where nurses thought about the 'why' and not just the 'what', "*. . . nobody would question it. They are so used to seeing high blood sugars that . . . they don't even look and say, 'hey this guy's got diabetes, why is his blood sugar so high?' They just write it down "(RAN2).*

Nurses in remote areas were required to complete health assessments that included aspects of health promotion and education around lifestyle health issues. These assessments were often electronic and integrated with the patient medical record. However, the use of technology was described as discouraging meaningful conversations with patients. The following nurse described the use of computerised care plans that were intended to be a prompt to start a conversation, but rather were used to generate a simple answer:

> *. . . the difficulty with the computer too is . . . it tends to be a 'tick and flick' process so; are you engaging with your client? . . . it's meant to be ideas to guide people around having a conversation about smoking or exercise or diet but . . . you are not getting that meaningful dialogue and the clients know what they are supposed to be saying. They will tell you what they think you want to hear (RAN4).*

It was apparent that the expected scope of practice of nurses working in remote settings was much broader and differed significantly to the practice of nurses working in urban areas. Nurses described needing a generalist knowledge that included information about health issues across the lifespan and specialised knowledge of health issues that affected Aboriginal and Torres Strait Islander peoples. In addition to a different range of clinical skills, it was apparent that the model of care; that is; PHC, was a different model of healthcare to the urban environment. In addition to the generalist skills and knowledge needed; it was found that nurses faced the additional challenge of practicing on their own.

### 4.3.3 Working alone

Remote health clinics were required to provide a 24 hour service to cover for emergencies. In practice, this meant that nurses needed to deal with any potential emergency on site or do whatever was necessary in preparation for referral to another service at another time. Working alone necessitated the need for a generalist scope of practice and was an aspect of the remote setting that differed from most urban nursing practice. Working alone exacerbated the condition of lack of skill and knowledge because when nurses were on their own, they had to rely on their own skill and knowledge as the primary resource.

The reality that nurses would work alone in remote settings justified the need for a broad generalist scope of practice for nurses in remote areas because they lacked access to other health professionals*, ". . . RANs have a very diverse skill range because they have to be independent working away from resources*" (NP4). RAN5 provided the following example that showed that in the absence of paramedics or access to the resources of a tertiary hospital, nurses working in remote areas were required to attend roadside retrievals as well as provide the clinical care required to stabilise and treat the patient until discharge:

> *. . . it's different to the ambulance bearers in town . . . In remote, you pick them up off the road, . . . they're in a shocked state, sometimes you've got to drive,* [a long way] *. . . trying*

> *hard to keep them alive, you've got no-one to hand over to, you then have to continue on when you get back to the clinic.*

Similarly, the use of 'all of a sudden' implies that this participant did not have the preparation or confidence in dealing with a roadside emergency, despite having the competence in the skill that was required:

> *. . . all of a sudden you weren't just being a nurse you were being a paramedic . . . police officer and whatever else comes with all that road side stuff and so that was crazy and I had hardly cannulated anyone and all of a sudden we were cannulating people who were dying . . . it was huge (RAN1).*

The generalist scope of practice was related to the degree of autonomy required and the need to use protocols and guidelines such as the CARPA manual:

> *. . . we didn't know what to expect, . . . I think we underestimated . . . dealing with people autonomously and working on our own and to use CARPA, . . . having that responsibility was a big learning curve (RAN6).*

Working autonomously led to greater responsibility, *". . .* [every day is a] *massive jump in responsibility and scope of practice" (RAN1)*. The experience was described as overwhelming at first as nurses entered a resource-poor environment where there was an expectation of autonomous practice, *". . . clinically it was pretty overwhelming as all of a sudden I was going from the Grad*[uate] *on the trauma ward* [where] *. . . I'll push the emergency buzzer . . . and the MET* [Medical Emergency Team] *call team will come running *laughs*; to, you're 'it' "(RAN1).* Again, being 'it' and not having anyone to hand over to, is a unique difference between the remote setting and metropolitan context of practice, this is seen as a challenge; difficult but rewarding:

> *. . . I don't think I could get this kind of experience anywhere else other than working remote . . . the acuity and the mix, you don't have anyone to hand over to, there's no one to come in and say 'ok, we'll manage this patient from here on in' . . . it's a huge challenge, it's a much wider scope of practice than you would normally get anywhere else . . . and the experience and the variety and I love it (NP12).*

Health services also respond to emergencies which was considered a challenging aspect of their role *". . . going out on the roadside to MVAs and being the first on the scene. I think that is extremely demanding on an individual" (RAN5)*. The variety and severity of acute health conditions encountered was indicated by the following participant, "*. . . you can have suicides, gunshots, roll-overs, people landing in fires, you know they are usually significant injuries, . . ." (NP9).* Or*, ". . .* [after-hours] *it's a lot of drunken stupor, people fighting, violence, car accidents . . . your heart attacks and sick children" (RAN2).*

Working alone was a different experience to working in other nursing settings, "*When you are on your own and there's nobody else around . . .we could talk to the DMO* [District Medical Officer] *but it was kind of like being left to look after this person on your own when previously in the ED it is very much a team approach" (RAN6).* Being the only person able to provide care was also described as being "the only set of eyes", "[What is most] . . . *challenging is the scope of practice that you have and that you are often the only set of eyes that will look at that person for the day and making sure that you haven't missed anything" (RAN1).* Nurses talked about losing sleep from worry about clinical situations (RAN4) and being:

> *. . . constantly alert . . . knowing where the trouble might come from and knowing what you might have to deal with; . . . You were always vigilant, . . . or half-awake about those types of things because there was nobody else and there was no control* (NP8).

Nurses in this study described feeling*; scared (RAN5), nervous (RAN4) and frightened (NP1)* at times when their skills, and experience did not prepare them for the situation at hand. Nurses described experiencing distress when they found themselves in situations where they did not have the requisite skill or knowledge to competently and confidently deal with the situation:

> *. . . I'd be very, very, nervous doing something like that myself and we've all been in that situation where the doctor on the other end of the phone says, "yep do this" and you think "oh gees, I don't know, this is out of my scope of practice" (RAN4).*

RAN6 explains feeling as though he underestimated the difficulty of working on his own, *"I think we underestimated . . . dealing with people autonomously and working on our own" (RAN6);* particularly in terms of patient assessment and clinical decision-making, "*So you are kind of like 'oh, is that normal? What do I need to do?' I think working after hours and not really having anyone around you and having to make big decisions about people's care" (RAN6)*. There were often times when nurses were the only ones available with health knowledge and access to resources within the community and so needed to do things they had never experienced before:

> *. . . the scope of practice remote area nurses are expected to have is huge and . . . it's scary sometimes . . . you're faced with something that you have little or no training in basically, but . . . if you don't do it or give it a go, is anyone else going to be able to? or do we try and evac this person at the cost of many thousands of dollars and inconvenience to them? . . . the questions are pretty big sometimes (RAN1).*

The 'big questions' referred to in the previous quote demonstrated the complicated decision-making process required by nurses and the vast array of other factors that needed to be considered when decision-making such as, cost to the health system (resource utilisation) and impact on the patient.

When faced with new situations, nurses described their actions as being outside of their scope of practice, *". . . faced with something that you have never seen before . . . clearly you are working outside your scope of practice" (RAN4).* However, the lack of alternative resources meant that nurses faced a dilemma of a lack of knowledge resources appropriate to the health need. In these situations, nurses were often required to 'have a go' which lead to feelings of distress for the nurses:

> *Like male catheterisation, you don't get taught that as a nurse and we had a fella out bush who had . . . urinary retention and . . . I was thinking we'd evacuate him and then the doctor says "no, no – well there's no plane; you'll have to do that" (NP14).*

Similarly, the following situation was described where the nurse identified how little preparation she had for supporting a woman in childbirth and yet she was the only one available to assist:

> *. . . I was the only one there (laughs) . . . I didn't do that well because I didn't instil a lot of confidence in this young girl. . . I didn't have any knowledge at all except for what is in the CARPA manual but in hindsight, knowing that I could come across that sort of thing, I probably should have (RAN7).*

In contrast, one nurse spoke of enjoying pushing the boundaries of her scope of practice; implying that she at times did things that were not normally expected of nurses:

> *I love the fact that it's not so regulated and you can practice beyond your scope a wee bit in these areas . . . In some respects, it can be unsafe – that lack of regulation but I'd like to think I don't practice unsafely (NP1).*

Another nurse considered working autonomously to be a positive aspect of the role, "*I think the autonomy is good as well you know you wouldn't get that autonomy working in a hospital" (RAN6)*.

It was evident that working alone could be distressing or rewarding and this variation was interpreted as being related to the degree of knowledge and skill available to the nurse in that particular situation. The ability to provide PHC appeared to be related to the nurse's degree of knowledge and skill relevant to the situation and the level of knowledge and skill seemed to be related to the length of time a nurse had spent working in a remote setting.

### 4.3.4 Lack of experience: 'it takes time to know this stuff'

In this study, time spent in the remote setting was described as 'experience'. Opportunities to learn and increase knowledge and skill occurred over time and exposure to a variety of clinical situations and through interactions with the social world. As such, a lack of experience was described as impacting on the ability to provide PHC because nurses did not stay long enough to develop their clinical skill or knowledge of the community and available resources. Conversely, nurses who spent extended time working with a particular community or region considered that they were better able to provide PHC.

As discussed earlier, nurses commonly entered the remote setting without the requisite skill and knowledge; as a result, they were required to, *"learn on the job" (NP1).* Experience was related to feelings of confidence in the nurse's decision-making, *". . .* [making the right decisions] *it's not easy, it comes with experience I think and education" (RAN2).* Conversely, a lack of experience appeared to lead to stress and worry:

> *I can remember myself in the beginning you second-guess yourself and you seem to not be able to sleep at night because you lay awake worrying if you have made the right decision. Is this person going to come back dead tomorrow? *laugh* (RAN2).*

Variation in the level of experience was also apparent in regards to nurses' responses and assessments of whether to attend an after-hours call out or just to triage on the phone:

> *. . . in the beginning, before you know the people, the population, before you know the um 'rules' you probably go out to things unnecessary and then as you get more experienced you become more selective and you are able to decide what's an emergency (RAN2).*

Nurses described a link between resources and experience where more experienced nurses could be considered to have greater resources and capacity than less experienced nurses:

> *we don't move psychiatric patients at night but if they were in a clinic and that person doesn't have any support, well that person might be very experienced and know that community and they could manage that patient through the night whereas if it was a new nurse without much experience and not confident then you'd want to get that patient out of there (RAN7).*

On the other hand, locum or transient nurses were considered to not have the knowledge needed to provide PHC, *". . . and then there will be quite a lot of transient nurses . . . that they feel out of their depth when they do hit remote clinics but they don't always look at the context" (NP14).* An example of a lack of understanding of context, which includes an assessment of the resources available was provided by RAN4:

> *. . . this poor nurse . . . she said, "oh I went out to a hanging and I just didn't know what I was doing and the guy had run off" and she didn't call the second nurse on-call, she didn't have her emergency equipment, she came rushing to the clinic, grabbed the ambulance and took off. So she had no emergency equipment in the back as that was sitting back at the clinic . . . and for a hanging you would always call your second on-call (RAN4).*

The difficulty recruiting nurses, who already have the required level of skill and experience to work in remote contexts, was discussed in chapter two. Nurses in this study, perceived that there had been a change over time to a younger, more transient workforce, “*. . . we’ve got a much more transient workforce with nurses and you are seeing a lot of younger nurses . . . coming through to try it out and I think and for the money (NP3).* According to the following participant rate of staff turnover appeared to be increasing:

> *I think* [the rate of staff turnover] *has changed in my time. Like when I first started in remote it wouldn’t be unusual to go to a clinic and the majority of staff have been there for two years or four years but now, . . . it’s not common . . . like it used to be (RAN4).*

The perceived impact of high staff turnover included a loss of continuity of care and impacts on team cohesion and development of clinical skills and contextual knowledge:

> *. . . in* [community] *they’ve got six nurses and they probably turn over every two weeks, three weeks, four weeks they turn over. You know you get that cycle going for four years and you see a lot of nurses coming and going, the same with doctors and stuff like that and there’s very little continuity of care (RAN2).*

Lack of continuity was also thought to impact on the health promotion efforts of nurses:

> *. . . there’s all these new staff and they* [the communities] *are supposed to be enthusiastic about every new idea that comes out there. . . and then people say “oh they’re non-compliant” and you know, shift the blame for their chronic disease or mismanagement back on them when really, they may get different stories from people because they are seeing different people all the time. . . depending on who you speak to and their level of knowledge and experience they are going to get told different things (RAN4).*

In addition, high staff turnover was considered to negatively affect the relationships communities had with health services:

> *. . . white people in remote communities are seen as disposable, this Aboriginal lady said to me once “you are like a washing machine; you just go around and around” they know that none of us are there for the rest of our lives. . .* [in community] *Nurses were abusive to patients and patients were abusive to nurses and the community didn’t care because somebody would always come and they would always be replaced. . . . you don’t get that sense of value (NP14).*

Transient staff were described as avoiding health promotion activities due to a lack of knowledge about PHC programmes, “*Relieving staff don’t have a* [health promotion] *programme normally so they don’t know what to do so they don’t do it at all. It doesn’t matter; I’m only here for two weeks or a month or whatever” (RAN4).* Management of chronic disease seems to be particularly adversely affected by high staff turnover, “*. . . chronic disease is becoming more and more complex and then when you’ve got a high turnover of staff,. . . well, you know it just doesn’t get done properly” (RAN4).*

It was suggested that it would take even more time to build trust for visiting nurses than for nurses who were resident in the community, *“. . . It takes time to find people, it takes time to engage people if you are only FIFO* [fly-in, fly-out] *and you’re not always there, then it takes time for people to trust you “(NP4).* A high rate of staff turnover also impacted on patient care because patients did not have relationships with the nurses and constantly changing nurses resulted in inconsistencies in care, “*Even in my role, visiting a clinic once a month, I can go in there and there’s new faces . . . and I think “oh god, I’ve got to start again”; well that’s how the clients are feeling; and it’s been happening to them for years” (RAN4).*

Learning on the job was interpreted as being more than learning clinical skills and knowledge but also learning about the community context. This learning appeared to develop over time:

> *There are some great resources available up here and people don’t end up getting referred or knowing about them because the staff themselves don’t know and there is such a high turnover of staff in an environment like this. You can’t learn all that stuff in 6-8 weeks. It takes* [time] *to know all this stuff (NP1).*

Similarly, expertise was considered to improve the quality of patient care, “*If somebody came to see a locum midwife the reality is they are not going to get the information or the care that they would if they see me” (NP1).*

A member of the expert reference group described expertise in terms of resources and knowledge capital when she talked about strengthening relationships and having a wide repertoire, or generalist knowledge:

> *. . as you have more experience in the area you have strengthening resources, strengthening relationships, . . . and that’s where your difference between your expert and your novice is in these areas . . . that’s what Benner* [nursing theorist] *had to say (RG1).*

This study has shown that in order to provide PHC, nurses need context-specific knowledge and skills. However, nurses new to remote areas and an increase in transient staff led to the perception that patient care was compromised and a lack of experience in the remote setting was interpreted as a lack of expertise to practice remotely.

### 4.3.5 Condition summary: Clinical knowledge and skill

The presence or absence of appropriate knowledge and skill was described as impacting on the nurse’s ability to provide PHC. Nurses commonly described themselves as entering the remote setting without the necessary generalist skills or understanding of providing PHC in the remote setting. In this sense, they started at a novice level that affected their ability to provide PHC and resulted in feelings of distress when they worked alone and were required to work beyond their scope of practice. Expertise developed over time and resulted in greater clinical knowledge as well as increased knowledge of the social world and resources available in the remote setting. It was concluded that nurses' ability to provide PHC was related to expertise gained through time spent in remote communities.

## 4.4 Condition two: Availability of resources

It was apparent that in the remote nursing setting, the level of resource available was not comparable to urban areas. A lack of resources included the availability of physical resources and nursing staff. Lack of resources also included the nurses' access to specialist practitioners. Nurses described experiencing distress and fatigue in situations where they did not have the time or resources to provide PHC.

### 4.4.1 Lack of physical resources: 'managing on the smell of an oily rag'

As presented in chapter two, the remote setting is commonly considered to be resource-poor. Geographical distance from tertiary facilities such as hospitals, impacts on patient health outcomes; especially in emergency or time-critical situations because of financial cost and time delays. However, even non-urgent screening, elective surgery and specialist services may be inaccessible to remote populations due to limited transport options and lack of financial assistance to travel to the tertiary service. Nurses in this study recognised that being resource-poor was characteristic of the setting and impacted on their ability to provide PHC. Resources varied between communities; particularly in relation to distance from tertiary facilities; for example; some communities were less than 300km from a hospital with an all-weather sealed road and 24-hour accessible airstrip whilst other communities were 800km or more by unsealed road, with only seasonal access, isolated islands or daylight-only access for air evacuation.

The absence of paramedics in remote communities, and the vast distance from tertiary services meant that nurses had to transport patients. Dealing with these situations was particularly demanding, especially without other people to assist and if the community was unfamiliar:

> *. . . you know when you've got an emergency situation and they won't listen to you . . . when you are trying to sort out the situation but it's just screaming and yelling and that can be very, very stressful and also very demanding . . . it's in the middle of the wet, . . . you can't see the numbers of the house . . . everybody is in the houses so there's no one you can ask (RAN5).*

Patient care was also impacted by the availability of retrieval services, meaning that nurses had to monitor and provide care for extended periods (sometimes overnight), *"At night there's only one aeroplane so there isn't a lot of resources to get people out" (NP14)*. Patient transport was found to be the nurse's responsibility, *" . . . I think it can be demanding on you when you haven't got a driver"*

*(RAN5).* Ambulance services in remote areas were often provided solely by volunteers; without even basic first aid skills. Relying on volunteers to drive the ambulance added to the demands on the nurse:

> *. . . ambulance transfer is a huge issue for us all, we all wait a long time . . .* [the volunteers] *are busy people, well they are out on properties and the mobile phone network only works immediately in town . . .* [when] *the call comes from St John's* [ambulance service] *they are not necessarily going to pick up (NP13).*

In the case of an unwell patient who required a nurse escort, or a situation where a nurse was required to leave town to attend to a motor vehicle accident, two nurses described that the town may then be left without any health providers at all (NP5, NP13).

However, some nurses had access to additional resources such as police and firefighters as part of the health team, particularly in regards to patient transport and emergency response, "*. . . it's generally through emergency stuff that we have interactions with the police so they're very good . . . we really do try to have a good relationship. And Parks* [National Parks Service] *the same as well . . . If you go to an MVA* [motor vehicle accident] *the firies* [fire fighters] *are just superb" (RAN6).*

In addition to the tyranny of distance, some clinics appeared to only have access to basic equipment, *". . . what's available for you there on the ground? Even if you wanted to deliver the best possible care . . . but you are in a situation where you don't have access to that sort of machinery then you may feel that you can't give the best care" (NP14).* One participant described working in a remote clinic as, *". . . you managed on the smell of an oily rag (NP8)".* This statement was interpreted as a colloquialism for managing on the smallest amount of resources (often in terms of money or equipment) possible. She then clarified this point by describing how when she first arrived at the clinic she:

> *. . . had to cobble together four Blood Pressure cuffs to get one that would actually work, there was no monitoring whatsoever, there was no ECG machine there was no, nothing really, there was no way of monitoring a patient. I didn't have the most simple things like dressings . . . I had come from state of the art . . . and I thought, "Jesus, are we still in Australia? What happened here?!" (NP8).*

The lack of resources appeared to be related to cost and logistics inherent with the resource-poor setting:

> *. . . why you may or may not have these best practice drugs or equipment . . . because it's just too expensive. Some of those drugs are very expensive and they go out of date so quick and then you can't get them out there* [as] *there is no regular travel* [delivery] *mechanism . . . it*

> *could be eight weeks until you got them. So there could be logistical reasons about why you haven't got all that equipment . . . (NP14).*

A lack of information technology infrastructure in some areas - such as electronic patient records- were thought to inhibit the provision of quality care, *". . . they didn't have a shared clinical . . . record so . . . it was so unsafe in terms of really looking after the patient well, because you never knew where bits and pieces of information about that patient might be*" (NP8). The lack of electronic record keeping systems meant that information was not transferred to RANs in the communities and this affected patient care*, ". . . people will go to hospital, . . . and you won't know if they have been sent home on anything, . . . or what Warfarin dose they are having. . . there shouldn't be these errors . . . it has a long way to go*" *(RAN1).*

Another comparison with health resources in urban areas was provided in regards to mental health services in communities, "*. . . the resources even in urban settings are not enough for the people who present and that's even worse in the remote context" (NP4).* NP4 then continued by describing how she would provide care differently if she had more resources:

> *. . . if you had the resources you would actually start to provide seminars . . . or western care and actually try to take care of people before they became unwell from an Indigenous perspective but to my knowledge I don't think any of that really happens . . . You are very much reactive rather than proactive, it was a huge frustration for myself (NP4).*

The lack of resources was attributed by NP4 as the cause of her frustration at not being able to give preventative care, meaning that she had to compromise on the care she was able to give. Being "reactive" was interpreted as responding to the immediate acute health care needs of an individual or community rather than being able to engage in health promotion, education or prevention measures.

Furthermore, NP14 described compromises in practice because of resource limitations. The limitations in resources were a combination of physical and human resources:

> *. . . we used to learn how to do intubation and everyone used to get very excited about it and I would say that ' you do realise that intubation is just the start of a process and if you intubate someone . . . you have to keep someone oxygenated and all that until help comes . . . if you can't maintain . . . airway, breathing and circulation, and if you can't support and maintain those with what you've got which is going to be basic, then they are probably going to die, and if you have more advanced equipment out there then that's fantastic but you have to have the people to actually use it (NP14).*

Similarly, a lack of access to diagnostic resources impacted on patient care as nurses had limited information about their patient's condition, *". . . if they walked into . . . ED* [after an MVA] *we would* *put them through the* [CT] *scanner and then decide everything else. Well it doesn't quite happen like that down here. So that took a bit of adapting" (NP13).* This comment showed that nurses compared the care they were able to provide with what was available in an urban environment. NP13 then elaborated, *". . . But initially you used to think about litigation . . .this is the protocol . . . and this is what was routine in Perth. But I'm not going to be able to do that down here! . . . That I find hard" (NP13).*

It was apparent that nurses judged the remote setting as resource-poor based on their comparisons with the level of resources available in urban settings. The lack of resources was perceived to impact on the nurse's ability to provide the care they wanted as evidenced in their comments linking lack of resources to an inability to provide best practice care and care and health promotion.

### 4.4.2 Limited availability of specialist health services

Distance from tertiary services also meant difficulty accessing specialist health services. To improve the lack of resident health resources, many specialist services visited communities on a periodic basis. Larger communities also employed nurses in specialist roles for example as child and maternal health or chronic disease management specialists. Sometimes these nurses were resident in the community and sometimes they worked in a hub-and-spoke model where they were based at a regional centre and travelled between several communities within a region. In addition, some communities employed Indigenous health workers who provided 'cultural liaison' roles as well as clinical duties.

Nurses identified that as individuals, they were not able to provide specialist care in addition to their generalist role, *"I personally think it's unrealistic for nurses to be specialists in everything*" (NP4). NP14 agreed, "*Nobody can do everything*". As nurses were the primary caregivers in remote health services; there was a need for specialist health services to supplement the nursing service. It was apparent that the composition of the health team at a local level differed between communities from single nurse posts to teams of several nurses, Aboriginal Health Practitioners and sometimes resident doctors. The following quote described one large resident health service:

> *. . . it's a big team, the manager, child health, we've got public health, chronic disease nurse, there's three to four nurses on the floor and we've got a triage nurse that alternates and a couple of the ladies are midwives, . . . there's probably about nine of us, . . . There's a lot of good resources in the clinic as well, like my manager has been nursing out here for 15 years and so she's pretty good to go to if I ever need a bit more information about anything (RAN1).*

This is in contrast to the following participant who worked at a single nurse post and so relied on visiting specialists:

> *. . . child health comes here roughly once a fortnight . . . we get a continence nurse, the dietician they all run clinics now, . . . a lot of the people who don't want to travel we can get those services in to them. I will do immunisations outside of times . . . there is quite a good palliative care network . . . And we sort of work in together . . . they also have the social worker. . . , so they can organise things like transport and respite if they need to go up to* [main centre] *for radiotherapy and organise accommodation there or if they are running into problems . . . with say, benefits and that they can get the social worker involved. . . I have a video conference facility here (NP13).*

These two contrasting examples demonstrate the variation in human resources in different remote communities.

However, sometimes certain specialist services simply weren't available. In the following example, the nurse recognised that the patient needed psychiatric services that were only available in the city:

> *. . . we tried to refer out to the sexual assault referral centre at* [regional hospital]*, if someone in the city gets sexually abused then that's where they go. . . We tried to refer them down there and they said no we can't take him unless he's suicidal. And I said: "well, he's not suicidal yet but how long do you want to wait!" (NP6).*

The lack of mental health services was commonly described, "*. . . there's no permanent mental health worker aside from the AHW so the services are less than the need is . . . so you are already behind the 8-ball"(NP4).* Access to specialist health services such as general pharmacy services also impacted on the quality of care provided in other communities where residents were seen to 'miss out', "*Why should our community miss out on access to pharmacy advice? You know when you get any medication you should be getting some kind of advice, not everyone can read" (NP5).*

However, even when specialists were available, it was apparent that providing PHC was sometimes impeded by specialist practitioners:

> *. . . a lot of patients have complex health needs . . . so they may come in with one problem but they've got a lot of co-morbidities so I find that even your specialists can be very isolating in what they look at and no one's really looking at the whole person (NP9).*

Furthermore, when talking about visiting specialist teams, in this case mental health, NP2 described feeling frustrated that the team did not share the same understanding of the need to provide PHC, "*. . . They were so busy honing in on the illness and I found that quite frustrating" (NP2).*

A shared understanding of the context and the nurse's perspective incorporated a mutual understanding of PHC. In the following quote, shared understanding is demonstrated as having a 'shared vision', "*. . . having that shared vision of population health priorities and understanding how* *you get from A to B and what's worth pursuing and what is just rubbish like your endless screening is just, is tricky to achieve" (NP8).*

Similarly, poor communication about patient care plans implied a lack of shared understanding and led to frustration, *". . .* [visiting health services] *certainly didn't review any sort of clear plan" (NP2).* In addition, the services that NP2 expected to be helping her to provide PHC, were seen to be 'taking' from the nurse and not 'giving back':

> *I was frustrated . . . about the multitude of visiting teams that would come out . . . for one to two days and they are all there to support you but . . . you end up giving so much to those teams as they want to know all your information about the patient and I didn't feel like I was getting much back (NP2).*

Frustration occurred when members of the health team did not have the skills and knowledge that was needed, *". . . that was luck of the draw as to who was in those teams." (NP8)*. This meant that the resource was potentially wasted and care and support were not provided to enable the nurse to facilitate access to the team for the community:

> *. . . with specialist visiting services is you often get people in those jobs because it's bums on seats and not necessarily specialist people working in those areas . . . And you got people coming out and they didn't know what to do and they couldn't focus themselves (NP2)*

Sometimes it was not the lack of availability of a particular specialist, but the lack of continuity that caused problems:

> *. . . you have a parade of doctors of all different sorts and doctors basically run their clinics without any input from the nurses . . . nobody has looked up the history to see why do they want to see the doctor? Do they need to? Is there something that needs to be followed up? (NP14).*

Some visiting services were not integrated with the work of the clinic, which caused problems for nurses, including perceived 'competition' for patients. The following example shows this conflict in the case of a visiting GP and an NP, *"I have no access to* [patient information] *because . . . they are literally using a room in the clinic for their business, it's a private business operated from this site" (NP13).* Similarly, doing the doctors work impacted on the availability of time to do the nurse's work:

> *The paperwork is demanding and it compromises your capacity I think . . . it's very difficult to go back and do the doctors work* [that was left incomplete] *you know, very unrewarding and demanding and fatiguing and um, professional satisfaction really decreases (NP5).*

The flow of information between specialist services and nurses seemed to be problematic at times:

> *. . . previously I found I would send very complicated women off with a referral to an obstetrician in Darwin and I'd never hear another thing and the sad fact of life is that Indigenous women, they come back from these clinics and I say 'what did the doctor say?' and they don't know or really understand and If I hadn't heard anything back; it might be three months before I get a summary of what went on and then the pregnancy's over! *laughs* so I'm working in the dark a lot of the time (NP12).*

Lack of information impacted on patient care because the nurse was not able to incorporate the specialist's assessment or treatment into the patient's care.

It was apparent that visiting services or specialised nursing roles only ameliorated the lack of access to specialist services to a limited degree. Some services simply were not available when needed and other services experienced challenges related to role clarity and communication. This lack of access to specialist knowledge extended beyond clinical knowledge to cultural knowledge.

###### 4.4.2.1.1 Availability of Indigenous health workers

Participants who worked in communities with a large proportion of indigenous peoples spoke of working with community health workers in various capacities. A recent title change from Aboriginal Health Worker (AHW) to Aboriginal Health Practitioner (AHP) recognises a specific, regulated professional role in Australia for Aboriginal and Torres Strait Island people. However, nurses also worked with other types of indigenous health and community workers as well. In the case of the Cocos – Keeling Islands, the health workers are not registered AHWs as they are not considered as Aboriginal Australians. This created a unique situation where they do not have access to the same education and support as AHWs and yet some of the health workers have spent more than 40 years providing care on the islands. One participant noted that they have seen many nurses and doctors come and go, they've seen many changes in health practice and policy over the years and yet they remain the constant 'face' of health care for their people.

Some nurses described having ready access to Indigenous health workers:

> *We've got a terrific team, we've got . . . AHWs who are . . . often on the floor and we've got two Alcohol and Other Drug* [workers] *and we have one guy who kind of swaps between being a driver and he kind of floats in and out. . . we all work really well together. Some people play a bigger part than others but the two main health workers, they're amazing . . . so everyone comes through triage . . . if they* [AHW] *want to take clients . . .* [or] *some days they just prefer to go out and bring people in or . . . if we need someone to translate or if we have something that's a little bit culturally difficult . . . they are always there . . ., I speak to the AHWs as much as I would any other nurse . . . they are great source of information (RAN1*).

Another participant described a similar working partnership with AHWs, where role clarity and communication was central to their collaboration:

> *. . . mostly it was dual consulting. They had basic training as health workers . . . they would do the initial observations, and get the story and then they would come and get me and we would talk through what we were going to do and often they would start the treatment unless it was medications and I would do that type of thing. So there were clear roles. . . so if we were doing screening bloods for a diabetic clinic or something like that, we work together to get all those done and all the vaccination campaigns . . . we did all those together (NP8).*

However, in many Indigenous communities, there was perceived to be a gap in culturally appropriate services, usually provided by AHWs, ". . . *Yeah, unfortunately they* [AHWs] *are rare and we could definitely do with an AHW here. Especially a female AHW" (NP1).* The lack of AHWs was considered to impact on the quality of care because of their role in communication and cultural understanding, "*Indigenous counsellors or health workers are usually better skilled at providing counselling . . . within culture. That's my observation" (NP4).* However, the lack of AHWs was linked back to a lack of resources for those positions:

> *. . . Indigenous people aren't necessarily going to open up about their thoughts and feelings to a western person and Indigenous health workers are there but there aren't enough of them and then I don't think they can't talk to everybody either because of the different skin systems or, it's just very complicated, not done very well and not enough resources . . . (NP4).*

The AHW role was recognised as potentially difficult and there seemed to be difficulties related to recruitment and retention of health workers in some areas, "*I've had people talk about wanting to come out but no-one's actually put their hand up as yet which is a shame" (NP6).* A lack of AHW's also led to an increase in workload because:

> *. . . the Aboriginal Health Practitioner positions, they're counted in the numbers but a lot of the positions haven't been filled and because they haven't been filled they've actually got rid of them and that's happened in the last 12 months . . . some of that has caused a decrease in actual staff on the ground (RAN4)*

The workload was also affected by the number of AHWs due to different expectations of the service. It was not clear if productivity could be directly compared between a nurse and AHW, " *. . . in some communities you may have an AHP* [AHW] *there but do they come to work? If they come to work; how long do they stay? How many clients do they see compared to a RAN?" (RAN4).*

Indigenous health workers were considered to be valued resources that assisted the nurses in providing PHC. However, it was evident that the availability and roles of these specialist practitioners varied between communities; with some communities having greater access than others.

### 4.4.3 Lack of time: "everyone feels so stretched"

Many of the nurses in this study described not having enough time to give the care they want. A lack of time was a result of a lack of human resources in relation to the health care need. The lack of time related to the busyness of the clinic and simply not having enough staff to complete the work.

High workloads were considered part of the experience of working in a resource-poor environment, "*When you are physically there, there is such a high workload, the hours are long, there was frustration but it is also a way of life"(NP4).* There was also a perception that staff shortage was getting worse over time," . . . *there is less and less staff on the ground to do the work these days" (RAN4).* The lack of replacement for staff on leave also meant that nurses were regularly short-staffed and struggling with unreasonable workloads, "*. . . the number they say they have on the ground is not necessarily a true reflection . . . you've got people who are on leave, sick leave, annual leave, study leave; they never have their full quota of staff on any given day" (RAN4).*

Inadequate staffing to reasonably manage the workload was found to be a common occurrence, "*. . . because everyone feels so stretched" (RAN4).* The paucity of human resources available in remote communities seemed to have a very significant impact on the nurse's ability to provide health promotion and PHC, ". . . [there's a] *lack of time to do it* [PHC] *effectively "(RAN4)* and also, *"We often feel like we're not delivering PHC at the clinic because you don't have time to . . . through the busyness and the amount of illness" (RAN1).* One nurse agreed that the inability to provide PHC was a result of a lack of time, "*I think we are demanding more and more from clinic staff . . . they struggle to keep on top of what's already on there – you know; a lot of things aren't done" (RAN4).* Work not being done during normal business hours appeared to result in an increase in after-hours call outs, " *. . . it was so busy during the day that people would think 'oh I've had enough, I'll just come after hours where I am seen pretty much straight away and I don't have to wait around" (RAN6).*

Not enough time to do PHC included screening measures such as adult health checks, "*. . . I have staff saying, '. . . it gets too busy here, we can't do a chronic disease check properly'" (RAN4).* Likewise, one participant reflected on the time available for proactive or preventative care:

> *. . . should be focussed on the Primary Health Care and Mental Health first aid . . .* [however] *All the time I was out there, minimal time did I spend doing anything proactive . . . I never got the opportunity to provide education or to work with the arts centre or the men's centre (NP4).*

Nurses perceived that a lack of nursing staff meant that nurses were unable to provide care to the whole community at all times, "*. . . once we leave then there is no provision of service in the community at all" (NP5).* Even when nurses were able to take time to sleep after a long night, the care of other members of the community was compromised due to the inability of the remaining staff to attend to the increased workload. The following quote described a situation where acute care took priority and illness prevention and chronic disease elements were likely to be compromised:

> *. . . if you were up all night, say you had monitored somebody all night in the clinic and they get evaced in the morning but you've had no sleep. You go back to bed and you may have a colleague who is there and that but if somebody staggers in with a chest pain in the morning and your colleague is stuck with them all day that means nobody else in the community, it doesn't matter if they need their tablets filled up or their depo injection (NP14).*

A lack of time and staffing resources dictated a prioritisation of care that lead to a focus on clinic-based acute care:

> *They don't always have time to get around to doing adult health checks and looking after the 'well' because they are snowed under with the emergency scabies that come every day and the chronic conditions stuff (RAN4).*

Similarly, providing care in the patient's home or outside of the clinic environment was seen to be desirable but unachievable because of time constraints, *". . . we don't have the capacity to really do home visits" (NP5).* When nurses did not have the time to attend to health promotion activities because the staffing resources were needed for urgent care they were considered to be unable to provide the care they wanted. For example, there are some formal health promotion activities such as 'chronic disease care plans' or screening programs. However, the following participant was concerned that the lack of knowledge around how to use the tools properly, and the lack of time needed to perform the health promotion activities, "*. . . managers need to allow staff the time to sit with somebody like me to get the education around it and there is a lot of staff resistance because all they see is more work for them" (RAN4).* Similarly, opportunities for education may be considered to be an additional demand on the RAN:

> *. . . for quite a long time we had specialists coming out to support us but then their idea of support wasn't to see patients it was to educate us more so that we could do more specialist care and there was no thought put around that you don't have the time or capacity to do that (NP14).*

However, specialist practitioners seemed to have more time to provide PHC and to have a greater ability to implement programs and recommendations:

> *. . . it's my area of expertise so I feel more comfortable wading through it and trying to find alternative solutions that if you're only going to try to implement stuff that is recommended, if it's not easy and it takes time, it's time that RANs don't necessarily have (NP4).*

Access to education opportunities for nurses to increase their skills and subsequently increase their own resources were perceived as limited and time consuming:

> *. . . staff are very restricted in how much study time they can get . . . in theory it shouldn't cost the clinics anything . . . to send for a NARHLS* [relief staff agency] *staff member but they really restrict staff coming in for training; they encourage it to be online now and that can be quite difficult because where do they get the time to do that? (RAN4)*

However, some nurses were provided support and encouragement by their managers to participate in education, *". . . the manager is pretty supportive in giving me study leave to do certain parts of my course and everything. Even the clinical practice here he's willing to backfill" (RAN6).*

Lack of time for education also extended to the nurse's role as an educator. The education role took time and added to the workload further increasing the demands on resources and inhibiting the nurse from providing PHC:

> *the expectation that you are also educating the community and that you will educate your co-workers and you will be the one to teach the administration people how to do the administration work and teach the health workers and that all takes away from the care for a lot of RANs (NP14).*

A lack of time was a direct reflection of the perception that nurses did not have enough staff to provide PHC. The lack of time meant that nurses prioritised their care activities and attended to presenting complaints rather than health promotion or education activities. The time demands on nurses were not just for clinical reasons but also contained an element of non-clinical tasks.

#### *4.4.3.1 Non-clinical workload*

Nurses described clinical care as the most important aspect of their work in providing PHC. In contrast non-clinical tasks such as paperwork, ordering, administration and clerical tasks as well as vehicle and equipment maintenance were unsatisfying and time-consuming.

The following participant described a range of non-clinical activities including: management of property, data systems, documentation and education; which she sees as barriers to providing PHC, *". . . some of the most obvious barriers* [to providing PHC] *is the huge administrative burden . . .* [which] *takes away from the time and capacity to do the clinical care" (NP14).* Again, the lack of resources for attending to the system was particularly demanding in single nurse posts:

> *. . . administration it's out of control and it's so demanding. . .. I'm talking about doing the stores order, data entry, clinical audits and things . . . they are trying to regulate and improve it but . . . for us as a single nurse it's very demanding . . . and we also have to check the Resus trolley, the Parry Packs, the Glucometer all that quality control with things it's very time consuming (NP5)*

This was further evidenced by their frustration at undertaking non-clinical tasks:

> *. . . you can't provide the care you want because of the care the system needs . . . the basic logistical stuff like you order your stores and your vehicles are operating and that sort of stuff and you've got to do that as well as filling out things for KPI's and quality improvement checks (NP14)*

The additional point of using resources inappropriately, for example, paying a nurse to do administration tasks that do not require nursing skills led to feelings of frustration, *". . . they are paying me way too much money to do administration" (NP5).* According to NP14, the time demands for maintaining systems were increasing:

> *I went back to doing the full-time remote area nursing and I was quite surprised at how much increased pressure and how much more maintenance the system needed than 4 years or so before when I had left it, . . . I still had to work at least one full weekend – at least 20 hrs per month- and long days just to keep the system administration requirements up (NP14).*

Another participant agreed that non-clinical demands take resources away from the nurse's clinical time:

> *. . . my job is here to provide healthcare needs and as a NP it was assumed that you know that would be in direct clinical care but anything else that comes along, I also do; . . . answering the phone; you are answering the front door, you are sorting out issues of the place and I have to do all my own ordering . . . if the bins and all that need emptying . . . you add up all these little tasks (NP13).*

Completing administration and other non-clinical tasks was also part of providing quality care *". . . you could 'not care' but you try to maintain a standard" (NP5).* However, the burden of non-clinical work was considered to contribute to burnout, *". . . I can see why people would burn out and why they wouldn't want to come back" (NP14).*

Nurses described a lack of human resources as leading to feelings of distress for nurses. Not having enough staff to meet the workload demands resulted in work being incomplete, fatigue and frustration. A lack of time to provide PHC and a lack of time to rest were compounded when relief staff were unavailable. When care was prioritised, acute care needs were more likely to be met and health promotion activities were more likely to be left unattended.

### 4.4.4 Condition summary: Availability of resources

Nurses were unable to provide PHC because the resources (both physical and human) were insufficient and this disparity lead to feelings of frustration and distress. The properties of this condition include physical resources such as medications and equipment, diagnostic resources such as CT scans, as well as a lack of human resources in terms of specialist staff, indigenous health workers and nurses. The availability of resources was found to vary in that some nurses had access to more resources than others and this was interpreted as influencing the ability for nurses to provide PHC.

## 4.5 Condition three: Understanding the social world

When nurses discussed the meaning of PHC, they talked about it being a social model of care where nurses strived to care for the individual's psychosocial needs in addition to the physical needs. They also stressed the importance of caring for an individual within the context of their family and community. In order to be able to provide this level of care, nurses needed to understand the social world of their patients. However, nurses described the remote setting as 'a different world' where they were the cultural minority and where their patients had different worldviews, different languages and a different understanding of roles and responsibilities within a PHC model. The degree of difference between the nurse and the community with whom they were living and working, was shown to impact on the nurse's ability to provide PHC because of a lack of understanding of a different social world.

In this study, nurses often used the word 'different' when they described the remote setting. The degree of difference appeared to be most significant on arrival in a remote community, ". . . *I often think back to the first week and it was so, how can I put it . . . in your face; um different" (NP12).* Other participants also described remote communities as different, ". . . [remote is] *so different from anywhere else*" (NP12), and "*There's nowhere else in nursing like working out remote and I think it's one of those most unique places*" (RAN6). Socio-economic status was perceived to be a significant difference, *"I had never come across anything like it, you know middle-class white girl. Never understood what actually was happening . . . in poor communities" (NP8).*

Nurses used colloquial terms to describe their feelings on arrival at a remote community, *"I was sort of like a 'stunned mullet' for about six months*" (NP8). A stunned mullet is defined as:

> Dazed, stupefied; uncomprehending; unconscious. The phrase alludes to the goggle-eyed stare (and sometimes gaping mouth) of a fish that has been recently caught and made unconscious. A person typically looks like a stunned mullet as the result of a sudden shock or surprise. (Australian National University, n.d.)

Similarly, another participant related her experience to feeling like, "*. . . I felt a bit like a deer in the headlights *laughs* that's the only way I can describe it"* (NP12). This colloquialism is also an indicator of shock as a response to an unexpected situation and is defined as, "To be so frightened or surprised that you cannot move or think" (Cambridge dictionary, n.d.-a). It was apparent that on arrival, nurses felt unprepared for what they would experience, "*. . . there's this world that I've been* *exposed to that I wasn't prepared for"(RAN1).* Similarly, another nurse described their experience out bush as survival due primarily to a lack of preparation and support. The emotive use of the word 'survive', points to the stress associated with the experience, ". . . *there was just two of us that had only been out remote for two weeks left to look after this community. . .. you survive through it" (RAN6).*

The following story of one nurse's arrival at her new home in a remote island community, illustrated the experience of being unprepared for such a different place. She was to be the only nurse in the community and had less than 24 hours to learn how things were done before the previous nurse left:

> *I got there . . . at two o'clock in the afternoon, I flew in and the girl* [previous nurse] *met me there and she said: "I'll be out of here on the plane at 11 o'clock in the morning so we are going to have to hand-over right?" I said: "Ok" and she talked, talked, talked about how things went and how immunisation went and how this program went and that program went. . . (NP8).*

The nurse then described:

> *. . . and at six o'clock at night we went up to the house and because she was leaving there was no food in the house and the island store which was the only store on the island had shut. . . so she* [the nurse] *said, 'oh, don't worry, we'll go down to the beach'. So we go down the beach and she has her uniform on and she takes this little red fishing line and she throws it in and starts catching sardines and sticking them in the pocket of her uniform. . . and I thought 'I think I've come to the wrong place!' *laughs*(NP8).*

Clearly, this participant considered the practice of catching her dinner and putting this in her uniform pocket to be a very different and unexpected experience as evidenced by her description that is was the 'wrong place'. Later on, she encountered further differences in terms of available resources and living conditions:

> *. . . and that night, there was no bed, I slept . . . on a mattress on the floor between two coverlets. . . there was nothing in the house, there were no frypans, no towels and no nothing and I thought 'oh . . . I don't know what I've done here!' (NP8).*

NP8's description of her feelings of discomfort were evident in her comments, however those feelings appeared to be temporal as seen in the following explanation that obtaining resources provided feelings of familiarity and comfort, which made the context less different:

> *. . . so I got . . . this girl to go shopping with me over the phone and ordered these big boxes of things and got them on the barge and got them sent up. Once I'd done that I thought 'oh, ok, I can stay, you know, I can sort of live here because I've got 'stuff' around me.' Um, and I started work. It was amazing (NP8).*

Therefore, feelings of distress appeared to ease as the environment became more normalised and nurses felt an increased sense of control. However, it was evident that entering a different community also invoked feelings of entering a different social world, even if the nurse had worked in other remote communities:

> *I feel confident and comfortable with what I know now and with my scope of practice. Up here, I know the place . . . so I feel really comfortable practicing autonomously. If you plonked me on Thursday Island or something where I didn't know anybody or how things worked I wouldn't be feeling as* [comfortable]*, I probably wouldn't want to work too autonomously (NP1).*

The degree of difference between the remote world and the nurse's urban world impacted on nurse's ability to provide PHC because providing PHC required nurses to understand the social worlds of their patients. In the remote setting, some communities have high proportions of indigenous peoples and some are situated on traditional indigenous lands. In this setting, nurses experienced a greater degree of cultural difference from their urban worlds than in communities of non-Indigenous populations.

### 4.5.1 Being a cultural minority

Many of the communities described by the participants were discrete Indigenous communities. These communities included Aboriginal, both desert and salt-water peoples, Torres Strait Islander communities and the Cocos – Malay people of the Cocos – Keeling Islands (which is an Australian territory in the Indian Ocean). Nurses entering these settings identified being in the cultural minority, "*. . . being the cultural minority in a lot of cases and that is what you are here. Here you are the cultural minority" (NP7).* Being in the cultural minority was associated with feelings of vulnerability, *". . . and in a way you are more vulnerable, because you are in a minority and you want people to like you in a way because you feel safer. . . no-body is liked by everybody all of the time that's just being realistic" (NP14).* For example, NP8 described being the 'only white person' for several months of the year:

> *. . . there were no police, there was a couple of builders and there were some FIFO guys . . . and then there was the teachers. . ., once the teachers and the builders left at the end of the November, you could be the only white person on the island until February (NP8).*

Nurses who had worked in indigenous communities stated that they experienced culture shock when entering this different world, "*. . . every day is massive culture shock. . ." (RAN1).* Some nurses had very little prior knowledge or experience with Aboriginal culture or history, "*I hadn't really thought much about Indigenous stuff or cultural stuff . . . in our training I don't remember anything about Aboriginal health" (NP1).* Neither had RAN6:

> *. . . I don't think I ever thought that people lived out in remote areas; I thought that everyone was integrated in together and I probably didn't actually think that there was an issue of colonial history or anything or the loss of land or anything. I didn't have any awareness of that at all (RAN6).*

One nurse talked about things not making 'sense' to her because she did not understand the community and culture. This lack of understanding prompted her to re-think the way she practiced nursing, *". . . it was about learning what was happening in the community, because, what I saw . . . was going around and around in my brain but wasn't making any sense for a while . . . and I knew I was doing things wrong" (NP8).* She then elaborated on this point by providing an example:

> *. . . an example; one day this lady came along and she had a skin infection and I was standing up by the bench and she was sitting down and I was talking to her about the skin infection . . . and anyway I gave her the Flucloxacillin [antibiotic] and when I walked out of the clinic that night there was an open bin that was just past the door and there was the Flucloxacillin . . . I caught up with her in the next couple of days and I said, 'how are you, how's your legs'? and she said they are the same but they are getting better now because I've been using sunlight soap on them and I said:" Ok, . . . you didn't take the antibiotics, I saw them in the bin" and she said "no, you frightened me" . . . I was really taken aback by that and when I sort of did some reflection on that I thought, you know what, I was treating her like a white woman in an ED where I was the person with the power and I was standing over her and telling her what was best for her . . . (NP8).*

This example showed how the nurse identified issues related to power and cultural difference when comparing this remote community to her previous experience working in a metropolitan hospital. Further evidence of cultural difference was recognised by the following participant when she spoke about differences in gender relationships within this different social world:

> *. . . the other difference was; men won't talk to you . . .* [I was] *sitting at the side of the river where it had gone over the road . . . waiting for it to go down and there were two or three vehicles that were all waiting you know with local men in them and I was chatting away and it took me a while to realise that '. . . this is a woman and I don't want to talk to her' . . . so there was a big change there and that was something else I had to get used to and accept (NP12).*

Again, there is the suggestion of changing perspectives that come with experience when she talked about it taking 'a while to realise' and that the cultural differences were something she had to 'get used to'. The following quote describes Indigenous worldview as different to the worldview of the nurse:

> *Indigenous people have really different ways of explaining what depression is or what psychosis is . . .* [mental health workers have] *to very much accept and try and talk the*

> *language that Indigenous people talk about how they perceive what's going on, we might be sharing the same thing but they think of it in a different way (NP4).*

Shared understanding appeared to be facilitated through experience and reflection, ". . . *every day I'm learning new things about the culture and I'll be like perhaps next time I could do it that way or whatever . . ." (RAN1).* The importance of experience in the degree of shared understanding was found in the observations of a nurse new to the remote setting, "*. . . there was almost an assumption that you somehow passively inherited that understanding* [knowledge of the patient and community]*, whereas, you didn't, you had to start from scratch with them. So that was a challenge" (NP10).*

Developing trust and respect occurred over time. There seemed to be a blending of 'worlds' where the nurse and the patients developed mutual understanding:

> *. . . they needed my service so they engaged with me . . . on the surface, but the actual trust and respect was much further down the track . . . and what was superficial in the first part I suppose became a much deeper relationship, without, you know, without me changing my culture I suppose, which was something that I was wary of um it became two cultures walking together (NP8).*

In describing her experience as 'two cultures walking together'; the previous participant considered the potential loss of her own cultural identity as a risk when adapting to a different context. The image of two cultures walking together highlights the importance of two-way or shared understanding. A lack of shared cultural understanding was thought to affect nurses' feelings of being accepted and valued in a community, "*You don't get the same affirmation back from a different culture, especially if you don't understand that culture. So you want to be liked . . ." (NP14).* Furthermore, a lack of cross-cultural understanding challenged the nurses' ability to provide complete care, "I *would question the appropriateness of a white person being able to provide real social and emotional wellbeing to Indigenous people because they often don't connect and they only share a certain level of stuff with you" (NP4).*

It was apparent that differences in understanding of health and health systems also contributed to an inability to provide PHC because, "*. . . has a different understanding of health altogether or comes from a different paradigm altogether and you are immersed in a western aspect of health" (NP14).* Cultural differences were said to lead to legal and ethical dilemmas for nurses; as an example, the following participant mentioned difficulty with determining if a person had declined treatment, "*. . . one of the big issues that I do have is finding out when someone has; if you like declined treatment. I find that a difficult one because certainly here they would never say to you outright 'no'" (NP12)*. NP12 recognised that culturally, patients may have a different approach to 'saying no' but this caused distress for her because of a lack of shared understanding of legal obligations of consent. This lack of shared understanding of the responsibilities of the nurse to ensure consent and the patient's responsibility to clearly indicate their agreement evidently led to feelings of frustration:

> *. . . but they would use every excuse in the book either not to come to clinic or not comply with medications or whatever, which for me is a very frustrating thing legally because legally they haven't said "no" and they haven't declined treatment so where do I go with this one? (NP12).*

It was apparent that nurses who worked in Indigenous communities viewed the setting from a non-Indigenous worldview. A different cultural perspective affected the nurse's ability to provide PHC when they did not have the necessary degree of understanding of the patient and communities' social worlds to be able to provide social and emotional care. However, it was apparent that nurses' perspectives changed over time as they developed greater understanding of the cultural context of their community. The degree of mutual understanding was influenced by the nurse's ability to effectively communicate with patients and communities.

#### *4.5.1.1 Communicating in a different way*

Communication was considered to be a property of a different social world in that there was variation in the ease or difficulty that nurses had when communicating with patients and communities. Working in Indigenous communities presented challenges due to language and cultural differences between the nurse and patients, *". . . there is a huge language difference and some of those things* [health concepts] *are quite complicated to understand"* (NP2). Communication seemed to present the greatest challenge identified by some participants, *"It was hard, you know, language with some people was a challenge and culture certainly was*" (NP10). Nurses considered the language differences to impact on their ability to build relationships that were considered an important tool in enhancing communication:

> *. . . the most challenging thing, and I find it every day is the cultural barriers . . . trying to develop a relationship with somebody and having them give you an accurate story so that you can try to help them. I find that . . . it's a lot more challenging here because you've got this huge language barriers (RAN1).*

Communication was described as being very different for nurses who had limited contact with Aboriginal people, even if they were both speaking in English, *"But with people who haven't* [worked with Aboriginal people] *and have come up from down south . . . they have sometimes a difficult time in understanding what* [they are saying]; *especially what the oldies are saying" (RAN5).* Sometimes the communication differences were dramatic such as in the following example:

> *There was one person who rang up a nurse on-call and said "oh my father's not breathing properly can you come to the house?" and she asked a few more questions and her instincts say, "oh I'll go". Well he's not breathing properly because he was dead (RAN4).*

Nurses entering this different world described practicing with a limited grasp of cultural differences in communication styles and social rules, *"I didn't know how to talk to people . . . I'd go up . . . to ladies that were pregnant and touch their bellies and go 'ahh, oh you're having a baby'. Oh well, I just about got shot down* [verbally put down] *about that!" (NP3).* NP12 agreed, "*I think one of the biggest things* [differences] *is the method of communication with the local Indigenous people" (NP12).* The method of communication alluded to differences in body language and communication styles, not just language differences. The data revealed that communication differences lead to feelings of distress for the nurse and appeared to motivate nurse to change the way they practiced:

> *. . . if I was to try and question them the way that I would in a town or a city they would just go quiet, look down and not say anything. I was at a complete loss, just a complete loss, where do I go from here? If you won't tell me what's wrong, then I can't help you. And it took me a long, long time really to settle into this roundabout way of discussing what was going on (NP12).*

Similarly, cultural differences in communication meant that people only shared information in particular situations, "*. . . they will talk to you if they happen to be in a consulting room for a consult but outside of that they are not likely to say very much" (NP12).*

The issue of communication was often referred to as a factor in shared understanding, " *. . . you can also be seen as hard or non-caring; it is very easy for people to put that burden on you, because they say you don't talk in the right way" (NP14).* Care was compromised for nurses who worked in communities where English was not the dominant language, "*You compromise in so many areas . . . so if you are working . . . with a population that is not literate in English" (NP14).* The lack of understanding leads to communication concerns, "*. . . when you don't even speak the same language and you are trying to talk in English, you can't be sure that you are explaining it- a complex thing" (NP14).* However, communication difficulties seemed to diminish with experience and time spent with Aboriginal people, "*. . . it was alright for me because I'd nursed Aboriginal people for many years . . . and being able to communicate with them was really reasonably easy" (RAN5).* In contrast, in situations of shared understanding, the nurse is able to provide guidance with competence and confidence:

> *. . . but if you work in a non-indigenous place you both speak the same language and you both come from the same cultural background generally and you both understand the same sort of etiquette so you might get people being unreasonable and ringing up at seven o'clock*

> *at night because they've run out of Panadol or whatever but you can generally talk it through with them (NP14).*

Likewise, NP12 discussed the uncertainty associated with a lack of cultural understanding:

> *After I've spent a month of trying and I realise that it's not coming together and can I legally say they have declined treatment? Or do I need to find a different way? Is it because culturally I've crossed a line here and it's not acceptable? So it can be quite difficult and quite frustrating but it can also be very, very, good when you finally figure out a way of doing it. So that can be one of the real challenges but one of the real ups when it works.*

This example showed how feelings of frustration and distress occurred when nurses did not have a shared understanding with their patients. Presumably, the nurse was describing patients who were not accessing the available health services despite her perspective that they should, when she refers to "declining treatment".

It was evident that lack of understanding was a factor in nurses' ability to provide complete care because they needed to understand the social world and perspective of their community in order to communicate effectively. Nurses who worked with communities or individuals where there was a high degree of mutual understanding were more likely to feel as though they were able to provide PHC. Shared understanding was a concept that extended beyond culture and communication to a shared understanding of the meaning of PHC.

### 4.5.2 Lack of shared understanding of PHC: 'Isn't the patient meant to be the coordinator of their care?'

Earlier, the nurses understanding of PHC was described in order to define the context of their practice. Nurses discussed wanting to empower people to take control of their own health needs. However, this study revealed a dilemma for nurses where their efforts to relinquish control of others' health seemed not to correspond with the wishes of the people they were caring for. This section describes a lack of shared understanding of PHC between nurses and patients.

#### *4.5.2.1 Non-compliance or free will?*

The expectation that patients take responsibility for their health, as an indicator of empowerment, was articulated as part of providing PHC for these remote nurses, "*. . . people have to take responsibility for their own health care" (RAN5).* However, history appeared to be linked to community expectations of care by the community:

> . . . [in the past, the community] *got all of their needs met and when you speak to the older ones, they said they loved it that way and they actually didn't like the new way of living where they had to manage their own finances, had to deal with preparing food and all that sort of stuff and they preferred the old way of living. . . I think a lot of that culture transferred through when the health service was set up there, they would look to the health service to*

> *provide their needs and it has been a struggle to get them to develop any independence as far as managing themselves (NP10).*

Similarly, NP8 described a situation where the expectation of the health staff was that the patient and their family would be the decision-makers but the family did not appear to have the knowledge and skill to make that decision so they relied on the nurse. However, the nurse showed feelings of discomfort over the 'onerous' responsibility:

> *. . . sometimes that* [relationship] *was an onerous responsibility . . . the doctor would say to the patient 'I think that this is actually what you should do" and the patient would turn to you and say "what do you think* [name]? *you tell me what to do". And so you know like, I'd be saying "no, no, this is your decision and your family's decision" . . . they were so helpless in that situation because their understanding because of their isolation was so limited that they saw me as the 'middle – man' who they trusted to make good decisions for them (NP8).*

The following quote showed the dilemma for nurses where patients taking responsibility for attendance at health appointments aligned with their PHC expectations and yet the people's expectations seemed to be that the nurses and health staff would take that responsibility, *". . . isn't the patient meant to be sort of the coordinator of their care?"* (NP14).

It was apparent that when patients did not seem to want to take on that responsibility for their own health care, nurses were left feeling guilty. The following participant, proposed a short-term loss for long-term gain type approach to encouraging empowerment, where the services were still available but no longer forced on people:

> *. . . and I think one should stop living in the past and empower people to make their own decisions and live their own lives, you know, and if the statistics look bad for a few years then let it look bad and stop feeling guilty, you know, have the services available but stop trying to force people to comply, you know? (RAN2).*

The issue of who took responsibility for health was shown to be a significant concern for other nurses as well. The link between empowerment as a goal and the nurse's role was described as a paternalistic approach. The following quote suggests nurses use their judgement about what aspects to take responsibility for and what aspects of health can be left to the responsibility of the patient:

> *I have a constant battle in my own head about this and I don't want to run . . . a paternalistic type of practice where I take on board complete responsibility for everything I don't see that as being my job at all and in fact I see my job as an education and encouragement to take that responsibility for themselves and that is a very, very difficult line to tread well and I think most RANs are very wary of this line, when do you lift that responsibility, and take that on yourself and when do you say "no, you have to take this responsibility?"(NP12).*

The link between experience and nursing judgement was made in the following statement which contrasts experienced RANs with those new to this context:

> *. . . of course it depends on the experience of the nurse as well, we've had a lot of younger ones coming up and 'having a go' and of course they were still in the hospital mode so they would take more on board of responsibility of the individual's health than the more experienced people (RAN5).*

Taking responsibility on behalf of people was referred to as 'nannying' in the quote below. The act of nannying was seen to drain the personal resources of the nurse and lead to a lack of satisfaction and a desire to leave the remote nursing context:

> *That's what we do out here, we nanny people. I personally have had enough of it. It doesn't satisfy me anymore. So that's why I'm probably thinking of moving more to a rural farming community or something like that (RAN2).*

Taking responsibility for health was only one aspect of the dilemma for nurses. The data revealed that nurses experienced frustration when people did not adhere to their recommended treatment regimens such as attendance at the clinic for treatments or taking medications. Evidence of confusion about the responsibility of health staff and patients in a PHC model was evident in the 'struggle' that the following participant described:

> [When talking with clinic staff] *. . . they would say they struggle as a clinic . . . about whether they should be providing outreach for people with Mental Health . . . people won't always come in to get their needle for various reasons, they might have gone fishing or they might actually have no insight that they need the needle or they didn't feel like walking down in the middle of the day as it is too hot (NP4).*

However, this nurse identified a wide variety of reasons why people do not access health care or are non-compliant with treatment. Patient participation in screening and other health promotion activities were identified as nursing performance indicators:

> *. . . to meet all your KPIs* [Key Performance Indicators] *and to do the right thing you are to take blood from* [diabetics] *every three months to see whether it's improving or not. And I vigorously resisted that because there are a bunch of people who certainly have diabetes, they are not really educated about it, they don't fully understand what we are talking about, they certainly are not taking their tablets and so all you are doing is saying, "it's getting worse" (NP14)*

However, the previous quote highlights the differences in perspectives of the nurse and some patients. The nurse was required to complete certain actions in order to fulfil her role and yet she challenged whether the action was actually in the patient's best interest.

It was outside the scope of this study to describe the patient's expectations of the nurse's role or what PHC means to them. However, it was suggested that people could be exercising their free will by choosing not to attend appointments or engage in health activities. NP13 questioned the role of nurses in facilitating access to appointments by implying that facilitation is akin to 'forcing' which would go against the idea of empowerment, "*. . . ultimately if people don't want to go* [for appointments], *then they don't go, do we force it?" (NP13).* It was also implied that some nurses consider non-compliance as a result of laziness, "*. . . it's easy to say "why aren't these people taking their pills? - they're lazy and they don't come to the clinic" (NP3).* However, other nurses suggested that people's life situations were complicated and explain their current lack of engagement with treatment as a choice:

> *. . . it might be that they don't understand what's going on, they are scared, . . . It might be as simple as they are in denial and they don't want to talk about their illness at the moment and that's their choice, . . . And if the way they self-manage is by not doing anything then we need to accept that as long as we've given them all the information (NP3).*

In studying the nurse's perspective, it was evident that the lack of shared responsibility resulted in conflict and frustration. It was also apparent that underutilised resources, such as the visiting dentist, lead to feelings of frustration because the nurse was left to deal with the consequences, such as an after-hours call out for an abscess, which the cause of the problem was not dealt with by the specialist:

> *You know there's enough Panadol around the town for them to be able to look after their own teeth and a lot of times they ring up with toothache when the dentist has been there for five days and they haven't been bothered to come and see him (RAN5).*

Similarly, the following nurse spoke of feeling frustrated that people did not seem to want the services that were offered and as a result, the nurse needed to take greater responsibility in advocating for the patient and presumably communicating the outcomes of consultations with specialists:

> *. . . we've got a senior GP and a diabetes educator and a chronic disease NP, dietician and stuff like that and we have* [tele] *conferences . . . the offer* [for patients to come] *is there . . . but nobody ever turns up . . . You know it's one of those things that in other countries and in other parts of the world people will come and ask you to do things like that but out here we ask our clients to do it but it doesn't always happen (RAN2).*

Likewise, non-compliance was described as causing frustration because people's health was not improving despite the efforts of the health services. The statement of 'all you can do is give drugs' provided an indication of the lack of engagement in health promotion and lifestyle advice by communities:

> *. . . the chronic disease people are often at a loss because all you can do is give people more drugs and people aren't taking very well the drugs that you do give them and so yeah, it goes round and round (NP14).*

However, the level of compliance was considered to vary between communities with some communities more compliant with others, *". . . I found in* [community], *people there took more responsibility for their health in taking their tablets than in any other community" (RAN5).* Engagement with the health service was seen as an indicator of the degree of responsibility that people took for their own health, however, it was noted that the degree of engagement varied within the community and that in some cases only a small group of people actually engaged with the health service:

> . . . [in] *any community you'll have a very small cluster of people who are going to engage with outside services . . . it was usually the most literate ones and the same 10-12 people that everyone, the Education Department, Health Department, Justice Department everyone wanted to engage . . . so those people get burnt out with all the good programs and policies and things that everyone is saying 'you should do this for your community; you should do this and that' and I'm not sure that that is a useful use of resources either (NP2).*

The reference to the use of resources was interpreted as meaning that there was inequality in the use of resources that were available. The issue of resources was also interpreted as an element of the frustration that was experienced when people did not access care when it was made available. In addition, it was evident that there was a lack of shared understanding about the roles of the nurse and the patient in a PHC model which lead to frustration and a lack of job satisfaction by the nurses.

### 4.5.3 Condition summary: Understanding the social world

Shared understanding of the context and role of the nurse were identified as conditions that influenced the nurse's ability to provide PHC. The condition of a different social world described the situation where nurses were the cultural minority and experienced situations where there was a lack of shared understanding of the social world. Nurses were unable to provide PHC because of differences in cultural understanding and communication. Similarly, nurses and communities appeared to have different understandings of who was responsible for an individual's health. This was evidenced in the nurses' feelings of frustration when patients were non-compliant with treatment and appeared not to want to take control of their health. This situation was in conflict with the nurses meaning of PHC being care that tackled social inequality by encouraging empowerment. Variation in level of shared understanding was evident and related to the degree of cultural and language difference between the nurse and the community. As such, it is likely that the greater the degree of shared understanding between the nurse and the patient or community then the more likely they are able to provide PHC.

## 4.6 Condition four: Shared understanding and personal support

A lack of shared understanding with others impacted on nurses' feelings of wellbeing, and they described feeling frustrated when others did not understand the context and setting they were working within. The perception that the context was not understood by others was congruent with the nurses own descriptions of entering a different social world and experiencing a context that is vastly different to other nursing settings. Nurses experienced frequent feelings of frustration with a lack of shared understanding with their managers (particularly in regards to the demands of after-hours call outs) and at times with their patients. Nurses also described feeling unsupported in dealing with their feelings of fatigue and distress that were exacerbated by the characteristic of living where they worked.

### 4.6.1 Lack of shared understanding from managers

In this study, nurses described feeling misunderstood and undervalued by those in management positions. A lack of understanding was evidenced by statements about unrealistic expectations and different ideas about the aims of PHC and realities of the demands of the context. In contrast, aspects of shared understanding were revealed in nurses' comments about good managers. The impact of shared understanding as a condition on the ability to provide PHC was shown by nurse's frustrations when seeking understanding about their role and the resources required. Differences in perspectives between nurses and their managers was most acute when nurses discussed the demands of after-hours call outs. A lack of understanding of the context and responsibilities of after-hours call outs between nurses and their managers, was found to contribute to feelings of distress and meant that nurses were not able to give the care they wanted to because they feared the response of their manager. A lack of shared understanding was also evident between the nurse and the patients who were considered to use the service inappropriately.

The culture and priorities of the local health team, and the ability to work in a PHC manner, were said to be greatly influenced by the local clinic manager:

> *. . . the way a clinic is managed and relationships with staff and whether or not program works and PHC is seen as a priority is very much clinic-manager driven . . . If the clinic manager doesn't deem it important or if she struggles with the community or the staff that whole 'trickle – down' effect happens and people just feel like they're lost and . . . you might get a bit of narkiness* [conflict] *between staff (RAN4).*

Nurses experienced frustration when they tried to provide complete care in alignment with their philosophy of PHC, but that this aim was not supported by management:

> *I think it's all good on paper . . . they* [the employer] *have a PHC plan and you read it and you think, 'oh I'm meant to be doing this, this and this, ok boss I want to do this and this' and* [they reply] *'No, no, you're acute'. So that's the continual thing . . . it's all on paper and* [the employer] *have the documents but actually transferring it to practice* [is not supported] *(NP5).*

Many of the participants in this study discussed experiencing a lack of support from their managers, either locally at the clinic or their manager in town. Nurses discussed feeling unvalued by their managers and that those feelings came from a lack of understanding of their experience:

> *. . . you don't get that sense of value . . . from our middle – management . . . there is very much this thing that you are a RAN you should be managing all these things and you shouldn't be over-stressed by it and if you are stressed ring up Bush Support Line* [telephone counselling service] *(NP14).*

The use of the words 'should be' indicate a disparity between the expectations of an outsider and the reality of what was achievable by the nurse. Feeling valued was also interpreted as being understood, "*It's the politics behind it all and I get really upset when RANs on the ground aren't treated well . . .* [by] *management. They are not really looked after and valued as they should be" (RAN4).* To the following participant, 'valued', means being recognised as an expert in matters relating to what is best for her community:

> *. . . that's what I mean, a top down approach, not bottom up. They don't want to ask us about 'what do you think? How would you do this?' sometimes I feel as if, it's as if my management don't like me and don't value my opinion (NP5).*

The level of support and understanding was expressed in terms of expectations and varied between managers and staff, "*They'll come and do a site visit and I think they have unrealistic expectations of what we can actually achieve" (NP5)*. The following participant claimed that a lack of understanding of the context and demands of remote health are largely to blame:

> *. . . our remote health service managers need to step up a little bit in terms of giving support to RANs that are exhausted. Even if it is just a phone call . . . I'm sure it's probably good in some areas but my direct line manager she's got a lot of RAN experience . . . but still lacks in my opinion what a RAN needs in a manager . . . if she had studied remote health she might understand . . . they probably have mainstream health management degrees or . . . lacked management skills all together, so you are just like "oh why bother?" (NP5).*

Nurses indicated a lack of shared understanding in terms of a lack of connection between managers (particularly those who are off-site) and the perspective of nurses in the community. Nurses seemed to feel as though there was a lack of understanding from management about their needs and contributions to the organisation:

> *. . . the people I work with locally at a managerial level are great; but the disconnect, particularly in our organisation when you get to the higher levels, . . . is incredible; they just either don't see or don't want to know what you are talking about (NP13).*

Criticism was interpreted as further evidence of a lack of understanding of the nurse's roles and responsibilities, *". . . they might even give us . . . criticism like, 'you're not even using the right paperwork' . . . it's very, very frustrating. And the criticism shows a lack of inter-professional understanding" (NP5).* In an attempt to address the issue of unrealistic expectations from the community in relation to inappropriate use of after-hours services, NP14 describes conflict between herself and her manager because of a lack of understanding of the situation:

> *I've had this argument with my direct line manager who really couldn't understand it. I really do think that there is a responsibility on the health department as a whole to actually educate these populations about the needs of their staff. And he was saying "but shouldn't the staff in the communities be doing that because they're the ones with the links?" (NP14).*

In contrast, some managers were perceived to have a greater degree of understanding of the nurse's perspective. Some managers were 'really good' and this was considered to be because they understood the demands of the remote context and minimised the impact of administration and non-clinical issues on the nurse:

> *. . . our district DON* [Director of Nursing] *is actually a NP . . . so . . . she completely 'gets it' and she's really good. She does the job and you don't really hear from her, . . . you don't have the rubbish impacting on you, that's all dealt with at a higher level, you've just got your work to do (NP9).*

Relationships between nurses and their managers seemed to be an important element in building shared understanding:

> *I think what I would do* [differently] *is talk things through with my manager a bit more . . . because . . . you were working much closer together but there wasn't room to give each other space so I think I would try to develop the relationship with her a bit stronger so that we were on the same sort of understanding (RAN1).*

It was apparent that the level of understanding of the context of a different world by managers was a significant factor in nurse's feelings of being valued. Frustration occurred when there was a low level of understanding and in contrast, a good manager understood the role and context of practice for nurses. It was evident that nurses also desired a shared understanding of PHC with their managers and other health professionals.

#### *4.6.1.1 Shared understanding of the demands of after-hours calls*

Nurses in this study who had participated in call outs after-hours frequently expressed distress and frustration with this aspect of their work. After-hours or on-call referred to the need to provide emergency assistance over a 24-hour period and over weekends. A particular issue that seemed to stem from a lack of shared understanding of the demands of on-call was evident in the many references to conflict with managers over whether nurses should have attended a call-out (and subsequently claimed payment for it) or whether the call was unjustified as not being an emergency. There was conflict between a nurses own values and experience in determining what 'deserves' after-hours attention and the employers need to manage financial resources, "*. . . and you get told that if you go out and it's not an emergency then you won't get paid because they want to save money on overtime and that's unreasonable" (NP14)*. However, a fear of professional consequences impacted on a nurse's decision-making;

> *. . . when nurses are too terrified* [of the managerial response] *to go out for anything you know then that's just leaving the door wide open to losing your registration because you are going to be deemed incompetent for not seeing someone (RAN4).*

In an attempt to reduce the cost associated with after-hours call outs, some employers created guidelines for what should not be attended, *". . . the 'company' has a list of things that they deem an emergency and so if somebody calls you with the flu or something like that you have to say 'sorry, that's not an* emergency'" *(RAN2).* The 'lists' were perceived as vague and the burden of responsibility remained with the nurse to determine the severity of the situation. In another example, the following situation was described where a nurse was called to an attempted suicide and she had not called for assistance from another nurse who was available in the community. The nurse justified responding on her own because she was concerned about being reprimanded by her manager. When asked why she attended on her own, she replied, *"oh but we get told off for the call . . ." (RAN4).* Clearly, the issues relating to expectations after-hours were complex. The following quote described the change in practice from patients arriving at the nurse's house in an emergency to the safer option of telephone triage:

> *. . . at the moment there's all this big stink about on-call, like nurses are getting rapped over the knuckles about going out for seemingly nothing and it's very, very difficult because they don't come to the house anymore like they used to and so you can't eyeball anyone and send them away, . . . you're working for nothing if you are going to do an extensive triage . . . They're expecting you to do a thorough triage over the phone and it's difficult if English is a second language . . . So it's very dangerous (RAN4).*

However, telephone triage also had problems such as communication difficulties, legal consequences of not attending in person and a lack of financial remuneration for the sleep disturbance and clinical assessment that occurs over the phone. It was apparent that if they did not attend call outs, and made their decisions over the phone then, the skills and responsibilities with triaging over the phone were not valued by the employer:

> *My problem is that you could spend 10 minutes on the phone triaging to cover your butt legally you are still better off going out if something happens. But also who's paying for that nurse to be triaging at two o'clock in the morning? Are you expected to do that for nothing? Which the answer is: 'yes'(RAN4).*

The following participant expressed concern about a lack of support if things went 'wrong' and concerns about transparency of Government processes and possibly less accountability to Aboriginal patients, "*. . . usually the coroner gets involved after they're dead and nurses have been taken to task. . . .and I say to nurses, 'you are going to be on your own'" (RAN4).*

On call was considered particularly demanding, many of the participants spoke of attending after-hours call outs in negative terms, and lack of sleep (NP5) or ". . .*downtime*" (NP10) to recharge, *"On-call, I found it probably was the most draining of all" (NP10); I think the demands of on-call can be extremely tiring" (RAN5).* In addition, nurses also had to consider tiredness of their colleagues when planning patient care; for example; *". . . it was two in the morning . . . do I disturb her* [the midwife]*?"(RAN4)*. The lack of staff to cover the next day's workload led to situations such as, "*. . . you might have had 18 hours up with a sick patient and got them out in a helicopter and an hour later another sick patient would turn up and you'd be up for another 2-12 hours or whatever so there wasn't any fatigue risk management"(NP8)*.

It was evident that after-hours responsibilities were a cause of frustration for nurses when their managers did not seem to understand the demands of the remote setting. Fatigue was a common experience of being called out at night and there was a lack of adequate resources the following day to enable the nurse to receive adequate rest.

#### *4.6.1.2 Patient expectations: when is the doctor going to be here?*

The expectation of remote communities that nurses will provide all of the health care was deep-rooted, "*It was the old idea from 1932 it had a matron and they did everything including treat the dog" (NP13).* The perception that nurses could do everything despite the contextual limitations was also suggested in the following statement:

> *. . . in Central Australia the first nurses . . . they were the only nurse… out here and they lived in these silver bullet caravans with no electricity . . . and they were everything, the emergency and the midwife and the lot (NP2).*

Similarly, misrepresentations of the availability of services in remote areas in media contributed to unrealistic expectations of the availability of health services. The following participant described feeling frustrated when she was unable to meet the expectations of clients in this setting:

> *I get frustrated by these people who travel around and are on some obscure tablet and they think you're going to have it sitting in a little remote clinic. And I don't like those* [advertisements] *. . . it gave the impression that if you have a heart attack . . . in the middle of nowhere that the medical service would 'appear'. By the time someone took off, an hour and a half to two-hour flight . . . half an hour on the ground and then two hours back. So you're not at an acute centre in 10 minutes. . .* [Also] *they come with this obscure rash that they've been to all these dermatologists and specialists and things and they think this poor nurse in the middle of nowhere would know how to fix it (NP2).*

Furthermore, sometimes nurses encountered patients who did not understand the role of RANs or that this was a resource-poor environment where specialist practitioners were unavailable. For example; a comparison was made between the expectations of tourists who expected to be treated by a doctor as compared to the expectations of Indigenous Australians who understood that they would be attended by nurses:

> *. . . one tourist came in with a fish barb in his foot . . .* [I] *introduced myself and he said; "I just want to stop you there; can you just tell me when the doctor is going to be here?" . . . and it made me realise about what people's expectations are and the difference between Indigenous and non-indigenous who from their history are usually seen by doctors where Aboriginal people in remote centres are very used to nurses providing their treatment (RAN6).*

The nurse then explained that, "*. . . sometimes, because you are a nurse, people don't always believe you all the time" (RAN6).* This interpretation was shared by NP2:

> *. . . the Aboriginal people haven't got much choice, they come and see a nurse as that was what the original health service was and they are used to a nurse and a doctor is a bonus whereas, white people . . .* [think] *if I'm sick I go to my GP I don't go to a nurse. So I think that was really what the frustration was . . . I want to see a doctor and the nurse was second rate (NP2).*

In addition, NP14 suggested that consumers were not aware of differences in health professional roles in the remote setting. It was apparent that the generalist nature of remote practice lead to expectations that nurses could help with any situation:

> *. . . as far as the different roles and what an Aboriginal Health Practitioner does compared to what a nurse does compared to what the Diabetes Educator does compared to what the doctor does; it's all health and people say that "well you are health, you should be able to help us" (NP14).*

Despite one participant commenting in positive terms about the services provided in their community, *"I think that most people that we interact with are very happy with what nurses provide" (RAN6);* several participants spoke of difficulty dealing with a lack of understanding of the role and responsibility of nurses by patients:

> *. . . they'll come and they won't have any repeat scripts and they don't think to get a summary of their medical history and they expect you to dish out all these narcotics for them when you don't even know the patient (NP9).*

A lack of shared understanding of the purpose of the after-hours service was a significant issue for nurses as it affected their levels of fatigue. For example, nurses expect to be called out for emergencies but some patients see after-hours as simply an extension of the usual service, ". . . *one of our communities' people like to sleep in the day and at night they want to have health services" (RAN2).* Another participant spoke of feeling frustrated that people did not attend to health problems at an earlier time, such as during normal clinic opening hours; interestingly the nurse indicated that he 'got his head around' the expectation that nurses would respond in the night for non-emergency consultations:

> *. . . I didn't mind being called if there was actually a problem at three in the morning; what really started to wear me down was being rung at three in the morning because someone's child had an earache and then you'd say, "how long have they had the earache for?" and they'd say, "three days." "What have you done for it?" "Nothing". That kind of stuff would really start to frustrate me but when you talked to the other nurses they would say, "well that's pretty normal, they would expect you to do that" . . . I don't think that's sustainable or fair. There's a service there for non-urgent things but just because at whatever time they decided it was convenient that is just paternalism, and it took me a while to get my head around how that worked (NP10).*

Refusing to attend a call-out for a non-emergency had the potential for conflict, depending on the patient's expectations:

> *. . . sometimes; it depends on the person, they'll throw a bit of a hissy fit . . . and sometimes they just say, "Ok, I'll come in tomorrow". I think that they just take a chance, if they get somebody who's willing to go then they've won (RAN2).*

An example of the result of a lack of shared understanding was given and it was revealed that when patients did not understand the role of the after-hours services, the nurse was exposed to verbal abuse and threats:

> *. . .people ringing up* [after hours] *for a toothache and the policy is that you don't get out of bed at two o'clock in the morning for toothache…But it would be nothing for you to be called a 'White, effing, C.' Over the phone with these people because they've got this toothache . . .*

> *the TO's* [traditional owners] *of* [community] *think that they have a right not to listen to any of the rules and regulations that everybody else has to follow and they will call you out at 12 midnight because they've got a boil and if you don't come it's a matter of "what's your name?" blah de blah. . . (RAN5).*

Similarly, a lack of shared understanding of the purpose or understanding of what constitutes an 'emergency':

> *. . . so they've still got used to the fact that they've got a RAN on site . . . and it was nothing to knock on the door at two in the morning and get the nurse up because they didn't have time to come in from the cows in the middle of the day (NP 13).*

Inconsistencies in care provision brought about by a frequent change of staff was also said to impact on the permanent staff in the community and contributed to feelings of distress and dissatisfaction. The following statement points to inconsistent practice as influencing the community's expectations of the nurse's role:

> *. . . these agency nurses only want money . . . they'll go out for anything because they want the call-out rate, . . . And it burns out permanent staff and then the community get cross because that other nurse went out; why won't you? (RAN4).*

In contrast, the following comment acknowledged the patient's viewpoint that they are seeking advice, treatment or reassurance because they do not have the resources to deal with that situation themselves at that time:

> *. . . I think everyone that phones generally has a reason to call. Whether I think it's an emergency or not I think it's important to them at that time and I think we need to respond . . . they are obviously anxious about something and we do need to respond (RAN6).*

It was apparent that nurses encountered different levels of understanding of their role and context when interacting with patients. Some had expectations that nurses could attend to any health issues and others were perceived to see nurses as inferior to other health professionals and as such may experience frustration when a nurse is the only health professional available. In addition, there seemed to be a lack of shared understanding of the purpose and limitations of after-hours services with patients seemingly calling for non-urgent matters.

### 4.6.2 Lack of personal support

To this point, the data has shown that nurses encountered a range of contextual conditions that impacted on a nurses' wellbeing due to fatigue, frustration and feelings of distress. In that sense the level of personal support available to the nurse related to their ability to cope with all of the other conditions impacting on their ability to provide PHC. Fundamental to their ability to cope with the demands of the remote setting was nurses' feelings of being supported. Being unable to talk about their experiences with others who really understood their situation contributed to feelings of not being supported.

In this study, nurses indicated that they had difficulty explaining and describing their role because the context of a different world was so different to that of other nurses:

> *we struggled to explain what we did . . . because of that remote context . . . there was a bit of glamour associated with remote . . . and it sounds a bit exotic if you like, . . . they couldn't explain it to their colleagues and they said "you just have to do it to know" (NP2).*

NP5 agreed by stating, "*. . . people don't understand what a RAN does" (NP5).* There was also a perception of misunderstanding of RAN practice by other people, "*We need to get some kind of frame of reference that can bridge a gap to say what it is and what people in more mainstream things can understand" (NP14).* The inability to talk about the demands of the setting impacted on nurses' feelings of being unsupported. Lack of support was also be seen in the inability of others to understand the experience of working as a RAN:

> *. . . they can't understand the setting that these nurses work in and the limitations these nurses work in . . . but you don't have somebody to talk* [to] *about . . . I think it's a really big issue and part of the retention and recruitment sort of staff. I think the Bush Support Line tries to do some of that from a realistic perspective but it is a big thing you compartmentalise your life and maybe that's a strategy, a survival strategy? (NP14).*

Nurses talked about the difficulties in accessing support from existing support networks 'down south' because people in that 'world' have no understanding of the remote 'world', "*. . . down south nobody has a reference for what you are talking about. You can't talk about it with people, you stop actually talking about a hugely complex and important part of your life" (NP14).* One nurse described not feeling as though the community really understood how life was for her, *". . . there's a lack of support. No one in this community understands really how it is for me. Because there's no one else on call and they don't have the level of responsibility" (NP5).*

In contrast, the following participant, who currently works in aeromedical retrieval explained how she incorporated the RAN perspective into their interactions with RANs:

> ***. . .*** *and because I've been there* [worked as a RAN] *I try to be really supportive but I know some of my colleagues can be so rude and so dismissive but working on the other side I know that they do so much for us to make our life easier and we need to appreciate them (RAN7).*

A lack of available relief staff was found to negatively impact on the individual nurse as they did not have the time needed to rest and recuperate. One nurse described feelings of being 'burnt out' after working for a long time continuously without a break from the community, "*. . . One time I did seven* *months and I asked for to go out a few times, . . . the nurse manager . . . kept saying 'we can't get relief, we can't get relief' . . . at the end of seven months I was pretty burnt out" (NP6).*

In addition, the need for permanent staff to frequently orientate and support new staff was interpreted as an additional drain on personal resources. For nurses who were already stressed because they did not have enough time to do the work or had not had enough time to rest, this added burden was considered to further contribute to nurse feelings of distress:

> *. . . the staff are just sick and tired . . . they are forever orientating people and they get tired of it; just sick of it, it's not necessarily a fault of the individual because of their personality it's the fact that they are doing the same shit over and over and then where's their reward for doing it? (RAN4).*

Compounding distress was identified by one nurse who described counselling staff who were distressed and crying because they had been in a place or dealing with the contextual demands for too long. However, self-identification of chronic stress was sometimes difficult, "*. . . if you've got staff there who have been there too long and they are starting to get burnt out and they don't recognise it or deny* [it]" *(RAN4).* Furthermore, it was suggested that not everyone had the same desire to maintain best practice and that this may be an outcome of being in a remote context for 'too long', "*. . . most of the remote nurses are interested in keeping up the best practice but there is bound to be a core group of people who have been there too long and don't care" (NP14).*

Similarly, the full impact of fatigue and distress may not be obvious to the nurse whilst they are experiencing it, with participants stating that they didn't realise how exhausted they were until they stopped working (NP8,) or indeed how distressed, *". . . I was crying nearly every day and not really realising, . . . I'm really not a sad person and I hadn't realised that I was sad, until I left" (RAN1).* Chronic stress and burnout was found to affect the resources available to the whole team as it weakens the support structures available at a local level, "*. . . they can't be a support person for somebody because they don't have the capacity; they may have when they first started but they can't do it anymore" (RAN4).*

Moreover, the lack of available staff led to fatigue and workload management concerns. The following nurse described her life as unbalanced when she was unable to take a break from her nursing responsibilities:

> *. . . you did have 18 and 19 day stretches and so I found that I was very tired. To me it's too (pause), all those jobs it's got a limited lifespan because I just found that my health is just so much better now . . . and I've just got more of a balanced life (NP9).*

Having an “unbalanced life” was interpreted as meaning that the workload expectations were too great because of the lack of nurses and other health staff to share the load. The result of this unbalanced life was an inability for nurses to sustain long periods in this setting. Likewise, the need to provide health care over a 24-hour period as “part of the job” with very few nursing staff, was found to have personal consequences for the nurses who are responding to the after-hours calls:

> *I think the on-call is always a downer really for working out here; especially having a young family. You can miss out being around in the evening if you have been called out and there’s things happen at the weekends and you end up being called out and missing special events. I said to my wife that sometime I get a bit down looking after other peoples’ families when you miss out on looking after your own family. But it’s part of the job and it comes with the territory and it is what it is and if I had to give up anything it would be the on-call (RAN6).*

However, there was also an example of services that had a much lower staff turnover and subsequently supported staff in staying longer in the community because they looked after the needs of their staff:

> *. . . the pay is better than most other places, the conditions are good and they’re looked after well. So if you want your leave, you get your leave straight away. There’s no sweat about it. If you are sick you get put off sick there’s no problem . . . they get good study leave . . . on top of that they get their immunisation stuff, their ALS all that stuff . . . so I think people are looked after well . . . the work is good fun, the clinics are nice, they’re clean and easy to work in, we’ve got good processes, . . . people can push themselves a little bit to be better nurses you know? And provide better care and we promote that . . . (NP3).*

The perspective of nurses that others do not understand the context that they are working in was supported by consideration of the setting as a different social world. Furthermore, nurses in the remote setting experience an additional challenge of living in the community where they work.

#### *4.6.2.1 Living in a work environment*

Living in remote communities meant that nurses had different social expectations and roles compared to when they worked in urban areas. They experienced a sense of immersion in the community, which was described as, “*We are right in the middle of the community and life in all of its glory goes on around you” (NP12).* The experience of being in the cultural minority meant that opportunities for social support and recreation were limited, “*You can’t choose your friends. There’s only x amount of people to be friends with. I think that’s probably the things that I find the hardest” (RAN2)*. Opportunities for social connection were limited by language and culture or to a small number of work colleagues:

> *. . . the only reason you’ve got to be in those remote communities is your work, you haven’t got any, if you like ‘outlet’ for leisure . . . you are going to be enmeshed with a group of*

> *people whose language and etiquette you don't understand and they are all your patients or else your co-workers (NP14).*

Situations where nurses did not get on well with their colleagues provided even fewer opportunities for personal support:

> *. . . I spend a lot of time counselling in this role as well;* [I come across staff] *who just end up crying and they are beside themselves and they don't know where to go, they feel unsupported and they don't feel as though they get on well with other colleagues (RAN4).*

*S*imply not having access to social activities in a remote community was describes as living with a, "*. . . lack of support, lack of normal things *laughs* . . . you can't go out for a coffee, you can't go out to a movie . . ." (RAN2)*. However, different communities had different resources and opportunities for social interaction. In the following description, NP7 outlined the differences between two nearby communities and how those differences affected feelings of isolation for nurses. In community 'A' the large number of 'expats' or other non-indigenous people alleviated some of the perceived social isolation:

> *I think the isolation of it gets to a lot of people. . . especially the nurses here who are by themselves;* [community A] *isn't so bad* [as community B] *because there's a huge expat population and it's like living on a cruise, every day there's tennis and golf . . . and people fill their days with activities . . . on* [community A], *people are here for two years and then gone, and so they behave like they are on vacation here . . . So living over here on* [community A] *is probably not so isolating for single people as there is always activities and there is a lot of other people in the same boat as you (NP7).*

In contrast, community 'B' which is only a short boat ride away was considered to be very isolating because of the absence of non-Indigenous people and social activities. However, feelings of social isolation were said to be reduced when family were present and when the nurse had their own activities to occupy their leisure time, "*I think that unless you have brought your entertainment with you, that is, your family or whatever it would be very socially isolating" (NP7).*

In remote communities, the nursing role extended beyond the clinic walls and outside of normal business hours:

> *When we were in* [community]*. . . one thing that we really noticed was that that's who you are in that community. You are the nurse; and it's really hard to separate that you are someone else outside of work that enjoys other things as well (RAN6).*

This lead to nurses feeling as though they had no privacy, "*. . . there's no anonymity" (RAN2).* The lack of anonymity impacted on nurse's sense of freedom*, "you can't just . . . 'be yourself'. You are always in the public eye, everybody knows you and everybody knows where you live" (RAN2).* The lack of anonymity in a small community also impacted on nurses' ability to rest and switch off from work, *". . . if you are at the shop or whatever, people will stop you and ask questions and I think being remote you just accept . . . that it's going to happen . . . it's just that recognition that you are who you are" (NP12).* Similarly, being known in the community, resulted in people seeking advice and healthcare outside of the expected working hours and setting:

> *. . . there is a lack of anonymity …* [I]*get text messages and phone calls, see people in the street constantly and I probably don't think a day goes by when someone doesn't just mention a little bit of something to do with work. It might be just 'oh I've got to see you about my immunisations next week' and I'm like 'oh yeah no worries' or questions and people at the door, that's very common (NP5).*

Furthermore, nurses described locals as having a lack of shared understanding of personal and professional boundaries:

> *I think that people on their own* [without a partner] *there in that role would be very lonely because when you go out. . . they want to talk work with you. They don't recognise that this is your time off and I found that very, very irritating. Because they just have very poor boundaries about that (NP9).*

The lack of anonymity impacted on nurses' ability to feel supported as they did not have the same opportunity to rest and 'be themselves'. There was a sense that they were always at work having to perform a social role even when seeking personal support in the form of friendship.

In addition to being known by the community, the nursing role meant that nurses had knowledge about patient's family situations and health histories. The experience of "everybody knew everyone" was considered to be a different environment in which to work:

> *. . . the other thing that was really unusual was that everybody knew everyone . . . It was strange to work in that environment . . . in my workplace* [in the city] *they're generally strangers, whereas everybody . . . knew every patient that came through they* [the staff] *. . . knew all of their extended family, all their health history (NP10).*

The following participant also contrasted urban as 'mainstream' to remote in regards to conflict resolution. Getting to know people and developing understanding took time and was of greater importance in settings where there was a small number of staff because people were known to each other. Situations of conflict needed to be resolved because of the on-going relationship that occurred in the remote setting:

> *. . . in mainstream . . . we don't take enough time to actually get to know people as well as we do in remote communities . . . we don't have to seek to understand because there's lots of nurses coming in and looking after patients in hospitals so that if I'm rude to a patient one*

> *day, then chances are I'm not going to see the patient again, but if I'm rude to a patient in remote or a staff member, I have to deal with that person all the time (NP3).*

At times this knowledge extended beyond health to other aspects of patients' lives, "*There was a few sort of court cases going on and obviously you learn things about people that you don't necessarily learn when you are friends with someone. So that was difficult as well" (RAN1).*

The following practice narrative described a difficult situation where the nurse had to determine the boundaries between the different social roles of being a nurse and being a friend. Unusually, the nurse had a long connection to the community prior to taking up a nursing position. She had obligations towards her friends but also a nursing duty of care to the patient:

> *One incident was with a young boy who was the son of one of my very good friends and he was very physically violent with his girlfriend, and so obviously being nurses our first port of call was to the girl who was getting bashed up and the family who, . . . were my very good friends, were really sort of favourable to the young boy because they were unhappy about how the young girl had been behaving . . . so that was a really difficult situation because they were giving me their opinions and saying she's done this, she's done that, and how can you be looking after her and whatever and so very much torn between trying not to ruin any relationships . . . but also* [acting] *appropriately as a nurse . . . So that was a difficult one (RAN1).*

The situation of nurses knowing intimate details about patients, a lack of anonymity and privacy for the nurse and the potential for relationships to be personal and professional created difficulties for nurses which were not often experienced in the urban setting. Living in the remote community where the nurse worked appeared to limit the availability of social support and reduced the nurses' opportunities for rest and relaxation. It was interpreted that inadequate personal support was likely to impact on the nurses' ability to provide PHC due to fatigue and distress.

### 4.6.3 Condition summary: Shared understanding and support

In this study, lack of shared understanding and support was identified as a contextual condition that contributed to the nurses' inability to provide PHC. A lack of support from managers as to the demands of the remote setting and a lack of shared understanding of the aim of PHC; lead to feelings of frustration and a perception that they were unsupported in their role. In addition, a lack of shared understanding of the limited resources and different scope of practice of the nurse by patients compounded feelings of frustration for nurses. Furthermore, a lack of personal support for feelings of fatigue and frustration, compounded with a lack of anonymity and opportunity for social support within the community lead to a reduction in the nurses' ability to cope with the demands of providing PHC.

## 4.7 Chapter summary

This chapter has described the context of nursing practice as providing PHC. Providing PHC was defined by the participants as being health care that was holistic in nature, including psycho-social and physical care for individuals and the community. Providing PHC was focussed on illness prevention and aimed for equality of care with that provided in urban areas. Nurses derived satisfaction in their work by feeling as though they had made a difference in people’s lives. However, this chapter has also revealed that nurses in the remote setting have to constantly deal with a core issue of the inability to provide PHC due to four contextual condition: lack of clinical knowledge and skill, lack of resources, lack of understanding of the social world and a lack of shared understanding and support.

A lack of clinical and contextual knowledge; in particular, the generalist scope of practice, working alone and a lack of experience were identified as properties of this condition. It was concluded that the ability to provide PHC was enhanced when nurses had increased skill and knowledge, were not working alone and had spent time within the remote setting in order to gain experience.

A lack of physical and human resources were found to contribute to feelings of frustration that the nurse could not provide PHC. In this study, nurses described feelings of distress, frustration and resultant compromises to patient care because there was not enough time or people to carry out the work. The lack of health workers with the appropriate knowledge and skill needed in this setting was also a significant determinant in the level of resources available to address the community need. A lack of resources was found to be a variable between communities that contributed to the inability to provide PHC. It was suggested that greater resources, particularly in regards to human resources and access to specialist knowledge, increased the ability for nurses to provide PHC.

A lack of understanding of being in a different social world was identified as another contextual condition. The properties of this condition included the experience of being a cultural minority with language and cultural differences and a lack of shared understanding of PHC. It was apparent that nurses needed to understand the social world of their community in order to provide PHC. Shared understanding was inhibited in situations where language and culture differed from the nurse and was particularly evident on entry to a remote community from an urban setting. Nurses experienced frustration and dissatisfaction when they perceived patient’s behaviour as being non-compliant or unwilling to take responsibility for their health. In contrast, nurses with similar language and culture to their patients or nurses with experience in the remote setting had a greater shared understanding and were subsequently better able to provide PHC.

Finally, situations where interactions between the nurse and manager generated feelings of distress and frustration were linked to a lack of understanding of the setting, the personal needs of the nurse or had different interpretations of the meaning of PHC. At times nurses also had to deal with a lack of understanding by patients of the impact of limited resources or the nurse's generalist role. In addition, nurses experienced a lack of personal support for fatigue and distress, which was exacerbated, by a lack of anonymity and opportunity for social interaction. A lack of shared understanding and support affected nurses' ability to provide PHC because they were tired and dissatisfied. However, it is likely that nurses with managers and patients who understand the setting and the goal of PHC would feel more supported in dealing with the challenges of the remote setting. Similarly, nurses with greater levels of personal support are better able to provide PHC within the limitations of the setting.

This chapter has outlined the remote nursing context and concluded that nurses want to provide PHC. However, nurses were unable to provide PHC because of the four conditions as described above. Despite their inability to provide PHC; nurses were still able to overcome the conditions and provide care for residents of remote communities. The following chapter describes the process that remote area nurses employ to deal with the core issue they face: Doing the best you can with what you have.

# 5 Findings: The process

The previous chapter described four contextual conditions that impacted on the nurses' ability to provide PHC. Variation in the availability of resources, clinical knowledge and skill; as well as the degree of understanding of the social world and support for the nurse underpinned the core issue for nurses that they were unable to provide PHC in the remote setting.

In order to develop a substantive theory that is inductively generated; grounded theorists focus on actions, interactions and processes that people use to deal with the situation of interest. This is because, "Meanings emerge through practical actions to solve problems" (Charmaz, 2014 p.263). It is through analysing people's actions that symbolic interactionism is revealed (Charmaz, 2014). Whilst many grounded theories are based on a single basic process that resolves a particular problem or goal; Charmaz (2014), claims that analysis may reveal many processes or problems within a particular setting. This chapter describes a process that RANs employ to deal with their inability to provide PHC, which is labelled: *doing the best you can with what you have*. The process outlines the strategies used by the nurses to ameliorate the contextual conditions and move toward providing primary health care.

Gerunds are verbs which function as nouns. Charmaz (2014), recommends using gerunds to describe processes as they help researchers see ". . . sequences and connections" (p.245). As such; each category within the process described in this thesis is a verb or a gerund. Where possible, in vivo codes have been used as they are the words of the participant. This chapter describes each category and the relationships between each category as follows: *continually learning*, *facilitating access to care, seeking understanding and making a home making in a work environment*. The consequence of the process: *making compromises*; will then be described. Finally, the substantive theory: *making compromises to provide PHC* will be described. Figure 11 at the end of this chapter, presents the substantive theory as a whole.

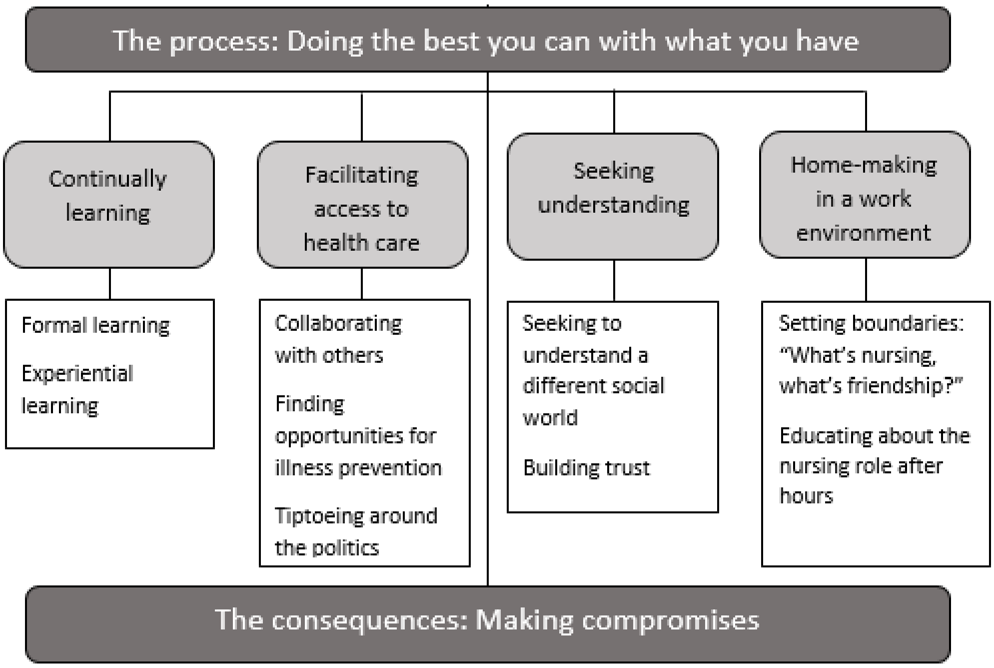


**Figure 10: The process: Doing the best you can with what you have**

## 5.1 Continually learning

Previous chapters have shown that generalist knowledge, specific to the remote setting was important in order to provide PHC. Increasing knowledge and skill was considered a strategy that assisted nurses in overcoming the lack of available resources by increasing the resources available to that community. In this study, nurses described identifying knowledge deficits in order to direct their learning. They then acted on this insight by engaging in formal and experiential learning opportunities. This section describes a strategy of continually learning as a response to the contextual conditions; lack of clinical and contextual knowledge, and lack of resources.

The need for extensive clinical and contextual knowledge was the, "*. . .* [the]*greatest demand on nurses there is, . . . number one is your knowledge" (RAN2).* In response to that demand nurses described a strategy of continued learning, "*. . . you've got to keep learning" (NP1)* and *"I'm still learning" (NP4).* This strategy facilitated the expansion of knowledge, "*. . . I think it's really about trying to find all the opportunities you can to extend your knowledge" (RAN6)* as well as the maintenance of existing knowledge and skill, *"you have to keep up your knowledge" (RAN2).* It was apparent that the process of continual learning was motivated by job satisfaction, *". . . but mostly it's commitment and interest in your job that will prevent you from losing your skills" (RAN5).* For example, due to difficulty leaving the community to access learning opportunities, one nurse chose to up skill whilst on recreational leave, demonstrating commitment and interest, "[while I'm on leave] . . . *I'm actually going down to* [tertiary facility]*. . . to refresh as I've looked after COPD before but not for a few years" (NP6).*

Application of learning to the clinical environment was revealed as a strong motivator in engaging with a continual learning process:

> *. . . the work actually fascinated me . . . and I would read stuff and I would think, "oh gee that's why that happens" . . . this is the background to that and I can see now why that marries up with that and so I was sort of fascinated the whole time which kept me engaged in it (NP8).*

The importance of relevance to practice was also noted by NP2 when talking about the knowledge deficit of RANs in regards to Mental Health:

> *We did do a survey . . . about what remote nurses wanted for their educational needs in as far as Mental Health and they kept saying. . . when you talk about this patient and talk about the drug they're on; that's education and that's the sort of thing they want to know. Things that are relevant to what they are dealing with. They don't want a presentation about self-harming if they don't have anyone who's self-harming or anything (NP2).*

Being interested, fascinated and committed to the nursing role in the remote context was interpreted as motivating factors for nurses to engage in the learning process. In this sense, the act of continually learning is related to nurse's feelings of job satisfaction and as such a contributor to their ability to provide PHC. In addition, nurses described that recognition of a knowledge deficit was a powerful motivation for knowledge acquisition.

Self-assessment of knowledge deficit reflected the nurse's perception of their own competence in a given situation and as such, was a fundamental aspect in determining scope of practice. Self-assessment was described as, "*I'm certainly aware of my limitations and areas that I'm not as proficient in, or need more information in"* (NP1). The importance of self-awareness was suggested by NP4, "*I don't think anyone can formally teach you, you have to have enough nous to think that you need to know this stuff, you learn it and watch it and you find out yourself" (NP4).* In addition to an assessment of knowledge, was an assessment of confidence which assisted in building trust and respect with clients and colleagues, "*. . . if you can provide the justification for why you are doing stuff, and feel confident in doing it; it kind of shows through" (RAN6).* Furthermore, evidence of a desire to continue learning appeared to motivate further investigation and learning, "*. . .I don't just accept what is handed to me, I am always looking a lot deeper" (NP1).*

Self-awareness of deficit in knowledge was an element of a generalist scope of practice as it determined a nurse's response to a situation, "*. . . So as a specialist-generalist . . . You need to be* *able to recognise that something is wrong and you need to be able to change it yourself if you have the skills and know if you've got the skill or not" (RAN4).* The impact on scope of practice was shown in the following quote where the nurse defined the boundary of their practice as being the identification of a problem and not necessarily the treatment, "*I can recognise that something needs to happen here but I may not know by what dose or what it needs to be" (RAN4).* This recognition was interpreted as the prompt for referral to another health professional.

Recognition of a deficit in knowledge was often described as the motivation for seeking further learning opportunities. Examples provided in this study included, "*last year I just did my Grad Cert in remote health management because I needed some management background" (NP7);* and, *"now I'm doing Mental Health and focussing on . . . ways to heal kids who've had trauma . . . once I found out it was an issue I just started studying it and reading about it and putting it into day to day practice and talking to the kids" (NP6);* as well as, *". . . I decided then to do my midwifery, because . . . that was the only thing that really frightened me out bush was anything obstetric related" (NP1);* and:

> *One morning this young girl came in, in labour and I took her to the clinic and I wasn't a midwife or anything and anyhow we delivered the baby and all went well . . . but I could have handled it a bit better so I thought well, I'd better go and do my midwifery (RAN7).*

The lack of available specialist staff was also a motivating factor in extending knowledge and skill in certain areas of need. For example:

> *We had no medical staff on the ground . . . so they used me – not like a doctor- but they trusted my clinical decision-making and my clinical examination skills . . . And that pushed me as I thought "oh shit, I'd better make sure I know everything I need to know about TB* [Tuberculosis]*", you know? (NP3).*

Likewise, expansion of scope of practice through a process of knowledge attainment was a worthwhile goal because it facilitated the aims of PHC practice in terms of providing complete care:

> *. . . I am fairly happy to step in and do other bits and pieces as well* [as Women's health]. *And in fact at the minute that is probably one of my goals to extend my practice a bit over the years and so that it can become much more PHC based than just purely women's health (NP12).*

Finding opportunities to participate in learning was seen as a response to a deficit in knowledge that came from an internal motivation that only some nurses had, *"I'm constantly looking things up on various websites etcetera and I know that my colleagues next to me – nobody does that sort of extra work" (NP1)* and*, ". . .* [I] *made myself any opportunity to try to master some of those skills that you need are quite crucial" (RAN7).* The internal motivation was interpreted as wanting to provide the best care, ". . . [I'm becoming an NP because] . . . *I wanted to know more. I wanted to be able to do* *what I am doing but better . . . it's more that I wanted to feel that people trusted what I said" (RAN6).*

Opportunities for learning occurred in formal settings such as courses and post-graduate study as well as the development of knowledge and skill in the setting through exposure to a variety of situations and interactions with others.

### 5.1.1 Formal learning

Nurses in this study discussed different ways of gaining knowledge. Formal learning and assessment by way of attaining a formal qualification was an important step to independent, safe practice. NP3 worked as an educator and explained why formal education was so important within this setting, *". . . I push students/ nurses to do* [study] *because if they haven't learnt the skills and theory . . . then they're never ever going to be as good as they can be . . . that's how I learned to be a better RAN" (NP3).*

Professional development and learning opportunities were not always freely available and the process of learning in the remote setting was difficult, *". . . I do a lot of online stuff and I tried to do some professional development every year . . . but I try to get involved in anything that CRANA's throwing out and . . . but yeah it's hard, really hard" (NP7).* Similarly, the following participant referred to the effort involved in undertaking learning activities, *". . . I know the* [other] *nurses always say 'you're just crazy with all the extra study you do and all the courses you go to' and I invest a lot; so it's hard work" (NP5).* Further evidence of the personal investment required by RANs and their supportive colleagues, to complete formal learning activities was provided in the following description:

> *. . . there was a nurse at* [community] *. . . she was very supportive of anyone doing midwifery . . . I used to commute, two weeks at* [community] *and I would be on call all that two weeks and then I'd catch the mail plane into Alice Springs and stay in the nurses' quarters for two weeks and just work in Midwifery and when I wasn't rostered on shift, I would work super-numery so that I could get my hours and my births and things up and* [the other nurse] *would be on-call . . . for the two weeks that I was gone. I couldn't have done it without her agreeing to do that as . . . It was basically a single nurse post for most of that year while we did turn and turn-about and I don't think* [the organisation] *actually realised what we were doing (NP2).*

Several post-graduate courses were discussed including a transition program supported by government employers in the NT. The Tran to RAN course covered, "*What PHC is and what the role of the remote nurse is" (RAN1)* as well as modules covering clinical emergencies, four-wheel drive skills (RAN1) and *". . . community health nursing, primary health, it was culture, context framework* *and it was remote advanced nursing practice" (NP3).* A learning pathway was evident with one qualification leading to another:

> *I came with no remote experience so for me I started off . . . by doing the Grad*[uate] *Cert*[ificate] *and then I went on and did the Masters in Remote Health which lead to NP so from there I kind of fell into it a little bit but to me it was a natural way it evolved as I was already working in extended practice (NP3).*

Engagement in formal learning in order to build knowledge resources was described as one effective way of reducing the lack of knowledge and skill. It was evident, however, that experiential learning was highly valued in the remote setting.

### 5.1.2 Experiential learning

Extended time in a community developed knowledge of the setting which allowed nurses to find ways to provide PHC, *". . . having been somewhere for this length of time is huge benefit and just knowing the regional area and how you go about things and how you get things done" (NP1).* Getting things done was an element of PHC because it invoked feelings of achievement and satisfaction. Likewise, the ability to get things done was linked to PHC because it required knowledge of the patient's social world in order to be effective:

> *To work remote, you need your clinical skills but you also need a lot of other skills that aren't clinically based for sure . . . so who do you go to in the community? It has nothing to do with being a nurse but rather how to operate in those remote communities; you need to know the logistics of the place (NP1).*

Practical or on-the-job learning was vital in developing understanding of the context of practice, *". . . I think the* [graduate] *program is very good, it is steeped in practical knowledge . . . you need it like that to understand how to work in the area" (NP3).* Similarly, NP1 described a combination of theoretical knowledge and practical learning:

> . . . [I] *learned a lot on the job . . . All the health promotion and PHC terms were new to me when I started . . . the Masters is where I learnt all that stuff about health promotion and community development . . . I learnt all of that while doing my Masters while I was working in a remote context (NP1).*

Learning on the job was a challenging process described as being, ". . . *thrown in the deep end*" (NP4). Although stressful, these situations were valuable learning opportunities when people were available to teach and support;

> *. . . I probably got into all sorts of strife looking back on it and people corrected me and educated me and I learnt and then as my career has progressed . . . there are formal courses that you can attend . . . otherwise a lot of it is role modelling and reading and watching (NP4).*

The following example shows how the nurse was encouraged by her peers 'to have a go'. She described studying the clinical guidelines in order to know 'the basics' but acknowledged the stress associated with putting theoretical knowledge into practice. In this situation, the nurse is interpreted as being competent but lacking confidence in the task which could only be gained through experience:

> . . . [the nurse manager] *said, "oh, come in and start examining" . . .and I'd been reading the CARPA . . . at lunchtime I was there reading it, at tea time I had it and after I had finished eating I would be reading until about 10 or 11 at night. So I knew the basics what to do but you know I have difficulty in 'fudging' anything so the sweat was just pouring off me . . . (RAN5).*

On the job learning happened during the application of clinical guidelines to practice:

> *. . . but going on the CARPA manual you become so good at following that and that was so well set up and user-friendly and very step-by-step and so it made things a lot easier . . . I guess I just picked that up as I went along (RAN7).*

Learning on the job occurred when nurses listened and watched what was going on and asked questions:

> [My advice is] . . . *don't be overbearing and just keep your mouth* [shut] *and listen and watch what people do and you know just sit back and watch other people. You quickly learn, you learn by asking questions (RAN2).*

However, on the job learning required resources in terms of staff who are willing and able to teach. The following participant described her need to ask questions as a 'burden' on the time resources of the other team members:

> *. . .because I don't think I know anything unless I can just rattle it off if someone asks me a question . . . but if I have to hesitate and go and get a book well . . . as far as I'm concerned, . . . I'm not up to the mark. . .. I'm very strict on myself not to be a burden to a team, to try to learn something as quick as you can so that you know you're not all the time asking questions and holding people up from getting on with their job (RAN5).*

Learning through interaction with others was another valuable method of learning. For example, in addition to gaining a graduate certificate, RAN6 said that it was, "*. . . the most beneficial course ever to interact with other people who are working out remote and share ideas".* Attendance at face-to-face learning programs were an opportunity for interaction and a break from the demands of the community:

> *. . . and they're tired and they might have other studies they are doing, so it's quite difficult to get staff into training or say staff in to the chronic disease conference or things like that*

> *where they could network with other people and have a bit of reprieve from the community. . . and meet other people and become rejuvenated and enthused and all that sort of stuff (RAN4).*

Learning through interaction with others was also evident in this program with the use of formal mentoring and learning support, "*we also get an entry coordinator . . . coming out . . . to spend some time with me and help me with my consults, check documentation or any kind of learning areas" (RAN1).* Interaction with other nurses was also a learning opportunity, "*I still am involved in the NP group . . . as a group share an awful lot and we have one clinical development day a month where the four or five of us get together and share stuff" (NP7)*. Support and teaching by experienced colleagues was considered a valuable asset in applying theoretical knowledge to practical situations, "*All these specialists can give great clinical advice, . . . I learnt off the doctors*" (NP14). However, access to this resource was not universal as indicated by the participant's use of 'lucky' and 'having the experience around' in the following comment:

> *I was absolutely out of my depth, but saying that I had the knowledge in theory but I was just marrying the theory and the practice up. I was very lucky to work with very good people . . . I just came in saying "look, I don't know anything, teach me what you know" . . . if you've got the right attitude people are keen to help you and I think that was my main survival mechanism was you know, using information and using your colleagues as a sounding board and having that experience around (RAN2).*

Sharing knowledge occurred in some mentoring situations where the mentee was able to share their knowledge with the mentor. The following description hints at the importance of time and relationships in the learning process:

> *. . . I had this critical care and recent hospital experience that I took to the community clinic there whereas* [the mentor] *had 20 years of remote nursing experience so she was all PHC and I learnt so much from her and having that mentor to work beside for two years, while I was studying as well all those concepts, I guess that's how I learnt it (NP1).*

Having a mentor who encouraged the mentee to observe their practice and then observed the mentee and provided feedback was particularly helpful:

> *Early on in the year I spent a couple of weeks sitting in and watching his consults and then in the later part of the year we have had an hour or two every couple of weeks for him to watch me do some consults and then he provides feedback. I get to sit in with* [the medical registrars] *when they do their consults which is great just to see how another person works, how they approach that whole body, whole person approach. It's just really good (RAN6).*

Asking questions was a commonly stated method of learning from others. Some nurses were able to access time to spend with other team members in order to learn about PHC and 'in-service' education was a regular time for group learning and sharing clinical knowledge:

> *. . . time with the child health nurse, time with the chronic disease and with public health . . . I am doing program time with each specific person and . . . every Thursday we have a different in-service and we come and learn about lots of different relevant things and it's great and an opportunity for you to ask questions or something you might not be so familiar with (RAN1).*

Asking questions was a way of understanding the thinking and behaviour of others as well as being a vehicle for feedback on the nurse's own practice:

> *. . . I've had some really good teachers and other nurses and psychiatrists and I've watched them interact and then I've asked questions afterwards and I've also had people tell me when I've got it wrong *laughs* so that I can learn (NP4).*

Similarly, asking questions was a method of maintaining currency of knowledge and skill, *". . . you can always maintain your skills and you can always improve on your skills if you are interested and you listen and you ask questions" (RAN5).*

It was clear that experiential learning was a valuable strategy for building knowledge; however, it required interactions with other staff and specialists who were willing to share their knowledge and support the nurse's ongoing learning. Experiential learning provided opportunities for nurses to prepare themselves for the demands of practice.

### 5.1.3 Section summary: Continually learning

The data revealed that nurses described a strategy of ongoing learning as a response to the conditions: lack of clinical and contextual knowledge and lack of resources to provide PHC. The strategy was guided by a self-assessment of deficit in knowledge that related to the issues they encountered in practice. Self-assessment and subsequent self-directed efforts at identifying and participating in learning opportunities were influenced by the nurse's interest in the topic and commitment to the job. Two main methods of learning were identified: formal and experiential learning. Continued engagement in learning activities was interpreted as increasing the knowledge resources of the individual nurse which in turn increased the resources available to provide PHC.

## 5.2 Facilitating access to health care

Facilitating access to care was a strategy used by nurses to increase the availability of health resources that occurred because of a lack of knowledge and lack of resources. Facilitating access was also an element of generalist nursing practice in that nurses needed a broad knowledge of the available health services, their roles and referral processes in order to facilitate the patient's access to care. *Collaborating with others* assisted nurses in providing PHC by enabling access to specialist care. Initiating contact with patients and *finding opportunities to provide preventative care*; were techniques nurses used to provide PHC with the resources that were available. Furthermore, political agendas impacted on nursing practice and *tiptoeing round the politics* was identified as a strategy that aided the facilitation role.

The health system was described as incredibly complex and knowledge of that system was considered part of the nursing role*, ". . .* [the health system] *it's a jungle out there. We find it that way and we are in it, let alone if you have no knowledge of it" (*NP9). Access to health care was facilitated when the health care providers knew the patients because "*. . . they're sick of telling their potentially intimate details to strangers over and over again" (NP9).*

Attending to a person's complete health needs was achieved by identifying, "*. . . how we can we can link them in* [to services]" (NP3). The ability to facilitate access to care was also influenced by the nurse's scope of practice), "*. . . know your own scope of practice within the organisation so you can almost be a go-between between the patient the nurse and the doctor to improve more holistic care" (NP3).* Knowledge of the various health systems that impacted on the lives and health of the community gave nurses a vital tool in providing PHC:

> *. . . not only do I know the community, but I know the health industry up here, all the resources that are available, who do you speak to about this? and who can I refer to for that? and all the processes, knowing all the databases. . . (NP1).*

The nursing role of providing PHC was described as being a healthcare facilitator in a one-stop-shop:

> . . . [PHC it's] *that we can be the entry point into any health care. . . that we are . . . accessible for everybody, . . . we can be a one-stop-shop for pretty much everything and that's particularly from a NP point-of-view . . . so if you come in with a sore toe, I can also look at your cholesterol, I can look at this, I can look at that, and let people know that we can be the facilitator or the coordinator of their health care (NP11).*

Facilitating access could involve referral to other health professionals and services:

> *. . . you can't micromanage everything you have to have a global perspective and then refer off . . . well say you were a diabetic nurse or something . . . you know all the tiny little bits of information because of your specialty, while as a rural and remote nurse, I'd be saying well she's on Diabetic medication, her HBA1C is 9.6 it's not meeting the target of less than 7, therefore I am going to refer them to the physician (NP9).*

Understanding what non-health services were available and how issues like income affected health was an aspect of providing PHC:

> *. . . like one of the questions I ask in the adult health check is do you eat well? Do you have enough money for food? . . . we want to know that . . . I might not be able to solve that problem for them but I'll say "you need to go down to that office and get another card, or you need to be getting more money than that, or you need to discuss with somebody down there the "money mob" about trying to budget better" . . . that all impacts on their health (NP3).*

Recognising the limitations of a generalist scope of practice, one nurse explained how she would provide care to the limits of her knowledge and then refer the patient to a specialist. In this way she was facilitating access to health services for her patients. Likewise; the following participant notes the importance of recognising a problem and referring to specialised services:

> *. . . I think it's appropriate that a RAN can provide some immediate emotional support and . . . understand the skills of open and closed questions and what to expect as a range of emotions after a death or . . . very basic mental state . . .* [they can] *put it in a 'box' and then send it somewhere (NP4).*

Participants in this study discussed their roles as facilitators of care by saying that they, ". . . *assist them to link in to other services"* (NP3); and they see 'value' in undertaking that role: "*. . .that's my value. . . I'm not an expert in cardiac care or diabetes or anything like that but it doesn't really matter because I can get hold of somebody who can tell me what to do . . . I can pull together those people*" *(NP14).* Having links to other health services were seen as improving patient care, ". . . *it gives us a link into the main cities. . . I liaise with all the cardiologists down there and what that has meant is that we are able to improve our patient care . . . because we've got a visiting team now*"(NP3).

Advocacy was an important aspect of facilitation, *"I think, nurses as a whole I see as being an advocate or a conduit. Nurses are really good at identifying things and being able to channel people in the right direction" (NP4).* In the following example, the nurse recognised that the patient needed psychiatric services that were only available in the city; unfortunately, the 'system' could not accommodate the patient so the nurse took on an advocacy role and was able to access that service on behalf of the patient, *" . . .*[psychiatry specialist] *refused to see him until I jumped up and down so bad and made such a noise that he said "ok". . . all I wanted* [was] *to get him seen by a Psychiatrist . . . so that we could get support for him in the school" (NP6).* One participant spoke of the need to 'make time' for non-clinical activities such as advocating for community services as these activities were an essential aspect of PHC:

> *. . . I will write to the children's commissioner if I am concerned about a situation with a child in it or I will write to . . . the royal Breast care nurse thing about issues of equity and things like that. I want their feedback and I want them to know about this stuff. I think that*

> *advocacy isn't always about direct clinical care, sometimes it's about quality improvement or education and things like that, leadership (NP2).*

Coordinating services (and transport) not only met the community health need by facilitating access, but was also cost effective. The following example showed the lengths the nurse went to in order to facilitate access to specialist care for the patients that needed it:

> *I actually got the speech* [therapist] *out twice on the plane. . . . we then got ENT* [Ear Nose and Throat] *coming out as well . . . we saw 32 people this year . . . Normally I would have to get those people into town, . . .* [to] *see the audiologist and the ENT specialist and then they'd make a decision as to whether they've got to have theatre . . . and then they'd come back out to* [community] *and then they'd have to go back down to* [regional centre]*to have their theatre and then they'd have to come back out to* [community]. *So this one plane flight saved 32 people x 2000km =64000km just by two people coming on a plane, we saved 64000kms of travel . . . we got the theatre list organised and in the same week I drove all those people into town and the ENT surgeon did all the theatre and I drove everybody back and we actually got a really good outcome (NP6).*

It was suggested that, " . . . *understanding the geography, culture and what resources are available" (NP1)* was an extremely important element of care in this different world. In terms of geography, differences in the meaning of remote were not defined by distance alone. Some of the participants lived several hundred (even thousands in the case of the Cocos Islands) kilometres from the nearest tertiary hospital, but even those who were a drivable distance experienced periodic seasonal limitations like flooding:

> *. . . if there's rain* [the] *access tends to flood a lot; then we've got a lot of stock life so it's not great to be travelling at night time, so those are just the environmental conditions that compromise and make it that bit more geographically isolated (NP5).*

Understanding the geographical limitations of the location was considered to be important in nursing care because nurses often had to plan how to access the patient or how to transfer the patient so that they could access specialist acute care:

> *. . .so the specialist-generalist who does understand . . . that the roads might be flooded and all that needs to be able to tell them about that so that they can work out a practical care . . . I think that's all crucial (NP14).*

Facilitating access to health care was an important strategy to increase the available resources to remote communities. Fundamental to facilitating access was working collaboratively with other health professionals.

### 5.2.1 Collaborating with others

Collaboration was a key activity in facilitating access to care. The remote setting provided many opportunities for collaboration, *". . . we've done* [training] *incidents where we all work together and it's just been great. And you don't get that anywhere else. You don't get that close relationship or that number of people to help out" (RAN6).* The need for collaboration with other health practitioners was vital and different to other nursing settings, *"I think that I collaborate more as a RAN I think that you absolutely need to collaborate more than you do in any other practice"* (NP14). Facilitating access to health services recognised that nurses in this context were working as part of a broader health team even though they may be working in isolation:

> *Often people say to me RANs work in isolation and autonomously but I've never felt more part of the team as a RAN, even though the team might have been in Alice Springs or on the end of the phone you had to be all the time within that team so I liked being a part of the team (NP3).*

Nurses in this study recognised that they could not provide PHC on their own and that they facilitated access to other health practitioners and services, as well as provided direct care:

> *I think as a RAN or NP for that matter . . . a lot has been made about the fact that you can work autonomously . . . I actually think it's an area that you have to . . . build the networks and relationships and you actually need to collaborate more rather than less because of the nature of the work and the fact that you can't be the be-all and everything and you can't know all about everything (NP14).*

Role clarity was considered to be an important aspect of collaboration, *". . . embedding specialists and generalists together and how they complement each other. . . it's also about being a lot more clear about what you do"* (NP14). Commitment was also identified as an important factor in the success of collaboration, "*If you had really good, committed people in those teams . . . you just had fabulous days with these people and you could get so much done and so much trust built" (NP8).* Working collaboratively required trust and provided opportunity for professional development:

> *. . . we had no medical staff* [to] *assist* [the doctor] *in doing clinical examinations of the patients and write it up . . . they trusted my clinical decision-making and my clinical examination skills to do that with the patients. And that pushed me . . . (NP3).*

Trust was enhanced by knowing the other members of the team and understanding the setting within which they work, *". . . I know the midwife out there who's referring and so the context makes a huge difference" (NP1).* Using telehealth technology facilitated the development of trust:

> *. . . it's all very well emailing people and sending referrals through, but I don't think that you build up any sense of . . . camaraderie or people trust you necessarily until they've seen you face-to-face . . . I think the Telehealth is just making such an enormous difference (NP12).*

Similarly, building and maintaining relationships was an aspect of collaboration and team work, "*. . .I spent most of my time building relationships and cobbling relationships together and things like that to keep the actual team functioning"* (NP14). An interesting example of the importance of trust in collaboration was provided:

> *. . . I said "that's interesting, but we don't usually let outsiders touch it" . . . what we do is say to him, "we want you to suggest what to do and we will look at it as a team and take it on board and we often run with your suggestion" . . . we are inviting him –that Cardiologist- into our team to work with us and to use his expertise to work with us we aren't asking him to come in and just do stuff and then walk out the door and not share all that stuff with us (NP3).*

The team clearly felt a sense of ownership over the decision-making process and it was apparent that it was necessary for visiting specialist to build trust with the resident health team and to have a shared understanding of their respective roles in order for collaboration to occur. Similarly, visiting health providers were expected to be introduced to patients as a way of communicating trust to the patients, "*. . . nobody goes to see one of these doctors without us introducing the patient to the doctor*" (NP3). Collegial relationships seemed to engender trust with patients and subsequently improved access to health services:

> *. . . I've been doing this for three years with* [a respiratory physician] *he comes out six times a year. Patients know him, and I'll say to patients "you know, I'm coming next week with that chest doctor. You know Doctor* [name]*?" . . . and we have a whole conversation around* [their health problem] *and then he* [respiratory physician] *pushes it (NP3).*

In addition, collaborative relationships with specialists improved access to care for patients,

> *. . . over the last 18 months to two years I've really built a good relationship with some of the specialists . . .they will refer clients back to me or I can refer to them or I can ring them so I have built up a good relationship with some of the specialists as well (NP11).*

Collaborative relationships extended beyond health to include outside services:

> *I've got to make sure I've got Department of Child Protection or somebody there and so they are really alert to the fact that this is what I'm doing and they jump in the car and come down and together we sit down and we talk to kids and we get them sorted (NP6).*

Collaboration was seen as a way to maximise the use of the available resources*, ". . .it's too much work for one person and that's why when we work in remote health so functionally well as a team is because the work is so overwhelming for one doctor to do" (NP3);* In a similar way, nurses actions optimised the time of visiting specialists and teams. The visiting teams relied on the nurse to identify the patients that needed to be seen and to have conducted a preliminary assessment or organised tests prior to their arrival:

> *. . . and I'd have an idea and already triaged patients out who should be seeing the doctor and others that I can manage and others that I just want to talk to him about who don't need to see him and there are always a little group of patients that just want to see the doctor themselves and they don't want to see me and that's fine (NP14).*
>
> *The doctor would come once a month . . . be there for two days . . . So when they came . . . I would run two rooms and run between them seeing as many patients as we could in that period of time and I'd sort it out, I'd go, this one needs this, this and this and the Doctor would be going "yes, yes, yes" *laughs* (NP8).*

Sharing information within the team was another aspect of collaborative professional relationships. This sometimes occurred after a visit by specialist teams:

> *. . . what's really important is that at the end of each visit we involve the clinic staff too and we have a meeting with the clinic staff and we go through all the patients that the specialist saw and tell the clinic staff about what's going on with their patients so that they can look at their patients more holistically and know what's going on with them (NP3).*

It was evident that nurses coordinated the sharing of patient information as way of facilitating collaboration:

> *. . . we don't get a consistent visiting medical officer fortnightly so it's a different one every week . . . there is a lack of continuity in their care . . . but I try my best to oversee it and make sure their scripts and things are up to date and I think if I was managing them as the primary clinician (NP5).*

The following nurse describes her actions in facilitating the flow of information between the patient and doctor:

> *I come up with a report of the patients we need to see and I go the week before to the community and talk to all the patients that need to come in . . . and then I also do a big follow-up at the end and I share all that information with the doctor and as well this is what we did, this is the suggestions that come up in regards to medications changes or further investigation. . . it means these teams are not coming in and doing stuff to our patients, they are coming in as part of the team and assisting us to care for the patients (NP3).*

This example shows how nurses used the relationships they had as the regular health provider to facilitate access to the specialist service because patients knew her and understood which doctor was coming and why. In addition, these actions are likely to increase efficient use of available resources as any issues are identified prior to the doctor visiting. In this sense, working collaboratively was based on trust and was likely to lead to more efficient use of specialist services.

Virtual methods of communication were tools used by nurses to facilitate access to specialist care in the remote setting.

### *5.2.1.1 Virtual communication*

Facilitating the sharing of information between health providers and patients, was commonly described as involving both phone and internet communication. Information technology was a vital tool for collaboration and facilitating access to health services, *". . . you need the ICT* [Information Communication Technology] *platform that is going to allow you to do integrated practice" (NP8).* Information technology and videoconferencing enabled efficient use of resources and created a platform that enhanced access to services:

> *. . . we've got a midwife who you can contact virtually. . . if it's a complex antenatal* [patient] *then I would say to her, ". . . we will do all your 'stuff' but how about we make an appointment to talk with the midwife as well and that way you can ask whatever questions" and then I'll just 'T' it up with the* [midwife] *and either do it via video conference or telephone where I'll do all the physical stuff and she can have a chat with the mum as well (NP11).*

Videoconferencing and Telehealth were tools that connected patients and specialists without the cost and inconvenience of travel:

> *. . . it is basically a mobile Telehealth unit so it's on a big trolley, it has a big TV screen, it's got a really high definition TV camera so you know for things like burns or lesions. . .. but it's like anything new though, it's about educating the community about how good it can be* [also] *trying to educate the specialists that they can't just have clients 'pop' back and see them for a five-minute review* [in the city] *(NP11).*

However, it was clear that some education on the benefits of virtual communications was also part of using these technologies to facilitate access and work collaboratively. Nurses described using technology to collaborate with other practitioners:

> *I go with them when they videoconference because some of them are older . . . and they might be deaf and . . . they cannot understand their* [doctor's]*accent. . . you've obtained a really good history from them so, if they don't answer it fully, then you can . . . say "you've told me this . . . is that right John?" so that therefore the specialist can . . . have a really clear picture and make really good decisions, that they are actually going to do (NP9).*

This example revealed that nurses took an active role in facilitating access to technology by assisting communication between the patient and specialists. In another example, a women's health NP described a pregnant patient with complex needs and the importance of a nurse-led collaborative approach:

> *. . . she's had a past cerebral thrombosis, also got kidney disease . . . She's now pregnant and she's much further on than anybody realised so there's lots of issues around . . . treatment*

> *for her kidney disease while she's pregnant and how we are going to manage this as a team, so . . . we did a Telehealth consultation with the Obstetricians . . . they were then able to talk directly to both Haematological and Renal consultants and we have . . . planned her care as a team, without her having to leave the community . . . she was there at the teleconference as was her daughter who wanted to be her support during the pregnancy. So everyone's in the loop, we all know what's happening (NP12).*

Another example from a visiting specialist nurse showed how she coordinated the care between the nurses, community and visiting service:

> *So I then rang the clinic . . . to say, " I've got a patient here, I've spoken to the family and . . ." then you'd explain that what you'd like to do is discharge him back into the care of his family and that if somebody from the clinic could have regular contact with them until the Mental Health nurse next flies out . . .* [I do] *a lot of phone working and a lot of networking . . . and the database that clinic used, I copied my notes from one database to their data base so that they had a copy of the discharge summary (NP4).*

It was clear that collaboration required methods of sharing information between the RANs, specialists and patients. Nurses were often the facilitators of these collaborations and used virtual methods such as video-conferencing, patient information databases and phone calls as strategies to overcome the lack of resources. Nurses also identified working with Indigenous health workers as a way of creating a culturally safe environment to facilitate access to care.

#### *5.2.1.2 Providing culturally safe care: working with Indigenous health workers*

Collaborative professional relationships with Indigenous health workers increased the nurses' ability to provide PHC because the collaboration helped overcome the contextual condition of working in a different social world. This is because creating a culturally safe environment was seen as the responsibility of the nurse as a core element of facilitating access to care, " *. . . the important role* [for nurses] *is that they create an environment in that community. . .* [and] *within the clinic . . . where people feel safe, culturally and physically safe to seek healthcare" (NP1).* For example; the following nurse recognised a situation that may have led to embarrassment for a patient, ". . . *I had an incident where I was close to a particular family and then a young boy . . . needed a men's health check and I got another staff member to do it because I wasn't sure of those boundaries" (RAN4).*

Culturally safe care was an integral part of seeking to understand and providing access to health services, *". . . often I would co-consult* [with Indigenous health workers] *which was a good thing really not necessarily because of the language it actually brought more people into the service for their care" (NP8).* Collaborative working with Indigenous health workers was considered a strategy used by nurses working with Indigenous people, "*In my first year when I was the nurse out at* [community], *I had an AHW out there for the whole time and we became pretty close actually"*

*(NP1).* Working with Indigenous health workers facilitated communication *". . . it was very difficult at first if they spoke* [language] *fast, then I wouldn't have a clue what they were talking about"(NP8).* Similarly, working with AHWs facilitated shared understanding and access to health services:

> *. . . I work almost hand in hand with* [name] *because culturally there are difficult things with sexual health and STIs then she's the one that I would go to for both advice and often if I think this is a family that won't want to see me or can't deal with seeing me, then I will get [name] to go and do the treatment. So yeah, I do work very, very closely with her (NP12).*

Shared understanding was facilitated by two-way communication with the AHW acting as interpreter:

> *. . . Sometimes . . . I couldn't get exactly what the problem was so* [health worker] *would interpret for me and then she would do it the other way around as well to interpret back about what we thought we were going to do about it and then both of us knew exactly where we were . . .* [the health worker] *was around the community and she knew exactly what was going on . . . so if something was not going right with the treatment she would know and come . . . tell me (NP8).*

Working collaboratively with an Indigenous health worker also provided feedback and information about patient and community health issues and nurses provided other examples of collaborative working, "*I go with the AHWs on a Tuesday and we might go to the school and do a school clinic or whatever it is the Indigenous health workers have got on for that morning" (NP9).*

Nurses described engaging in activities with the aim of facilitating access to care. The facilitation role included a role as the go-between for information sharing between the patient/community and specialist services. Facilitating information transfer improved the degree of shared understanding between the patient and nurse and nurse and other health team members. Nurses used technology to facilitate collaboration and worked with Indigenous health workers to overcome some of the challenges of working in a different social world. Ultimately, facilitating access increased the availability of health resources to communities.

### 5.2.2 Finding opportunities for illness prevention

Finding opportunities for preventative care was identified as a strategy for optimising the use of available resources by facilitating access to health promotion services at the time of an acute presentation. This method of working was efficient because nursing resources were not required in finding people and encouraging them to come to the clinic. Furthermore, opportunistic care was perceived to be beneficial to patients as it saved them time and was evidence of a holistic model of care that looked beyond the immediate physical health needs of the patient.

Nurses made more 'time' by combining health promotion activities with acute visits to the clinic, *". . . making the most of when you see a client that you attend to their acute presentation and you take the opportunity to do a full health assessment and offer some sort of health promotion" (NP1).* Acute presentations were an opportunity to provide health education:

> *. . . well I don't only do primary care because the bulk of my patients all come with some kind of acute illness . . . Someone comes in, they are overweight and they are smoking we will all, well most of us, will have a chat to them about smoking and making some lifestyle changes . . . it's not quite the same as doing asthma plans, care plans, which to me is what . . . preventative care* [is] *(NP13).*

Clearly, it would be quicker to do all the health checks or other assessments that are due for the patient while they are present in the clinic without having to make another time or locate and encourage the patient to attend:

> *. . . a young bloke might come in and he might say "oh, I've got a cut on my toe". . . a novice nurse would give him a band-aid on his toe and he'd go home; and maybe a more advanced nurse, I would want her to . . . have a bit of a conversation with him about their Mum and Dad maybe and say ". . . one of the things we can offer you is a full PHC check-up and what we do then is we talk to you about 'funny' things, like we talk about drugs and alcohol, we talk about diet, we talk about exercise, we talk about your friends, whether you work, so we could do that". Often this is the first time that young men and women have ever had the chance to talk with us and engage with us. . .* [and if they're] *needing any investigations then we'd do that as well (NP3).*

Health promotion was opportunistic and constantly integrated with other nursing activities. The following example showed how a simple nursing task such as dispensing medications could also include health promotion and education:

> *. . . it's about health promotion and sending out healthy messages all the time . . . for example, when people come to pick up their medication once a week, we want you to have a conversation with the patient, "How are you going with these tablets?"; "Do any of them give you a tummy ache?" and put them out in your hand and show them the tablets . . . or "how are you going with that smoking?" "Have you thought about giving it up yet?" you know just gentle things like that (NP3).*

Similarly, boundaries between nursing roles are less clear in this context. For example; specialist care workers (e.g. chronic disease specialist) still provided acute care because they were 'still a RAN' which was also an indication of the expected generalist scope of practice needed, ". . .*if I'm seeing someone and there's something acute that needs doing then I'll do it because I'm a RAN" (RAN4).*

Whilst it was clear that nurses used acute presentations as opportunities for health promotion and prevention of ill health. Nurses also initiated contact with patients and sought them out to remind them of treatment regimens or invite them to the clinic for a screening or assessment.

#### *5.2.2.1 Initiating contact*

Initiating contact with patients and communities was an element of facilitating access to care. Nurses reminded patients about appointments and treatments and attempted to engage them in health care. These actions were grounded in a desire to optimise resources and because they valued health care that prevented ill health. The degree to which nurses would initiate care was somewhat grounded in their beliefs about empowerment and linked to the condition of a lack of shared responsibility for health care.

Despite nurses considering PHC to be about people taking responsibility for their own health needs (empowerment); nurses actions when providing PHC included initiating contact to those that did not come to the clinic, *“. . . PHC isn’t just caring for patients that seek you out, it’s also about caring for those that don’t seek you out” (NP3).* Furthermore, initiating contact with people who did not access the service was considered to be an important nursing action, “*So that’s sort of what I want to focus on next year because there is that core group of people that you just never, ever see. And they are the ones that I want to chase after” (RAN4).* The term ‘spoon-feeding’ was used to describe the nurses’ actions when initiating care*, “We always busy spoon – feeding . . . you are chasing people because they won’t come and in other parts of the world you know people will come to you” (RAN2).*

At times, nurses worked with other health workers in order to initiate contact with patients who were not readily accessing the health service, “*. . . There are ‘challenging’ clients shall we say who we have difficulty accessing” (RAN6)*. This comment was made in reference to the cultural liaison role of AHWs. In addition to initiating contact with individuals, nurses also contacted other community organisations and encouraged their involvement in health services, “*. . . we used to do lots of sex-ed but it was more us pushing it on the school . . .”(NP11)*.

Initiating health care was seen to be an efficient use of resources for people with chronic illness that required regular medications, “*. . . some nurses thought it was cheaper and more effective to . . . keep peoples needles up* [for Antipsychotics and Rheumatic Heart Disease]”(NP4). In the following example, the nurse’s ‘watch people like hawks’ because the health staff had the knowledge and control and were able to prioritise health promotion and chronic disease. This way of working was justified as being cost effective:

> . . . [Evacuation] *it is stupidly expensive, so luckily, because they don’t know anything about health and they have to listen to us . . . and we watch people like hawks and we stay on top*

> *of them and we intervene way before they get to a crisis, it is very rare that we evac* [evacuate] *a local out for anything (NP7).*

Interestingly, initiating PHC was described as 'really good primary health' as measured by the use of resources as an indicator of good health. This nurse identified poor health literacy as a factor in facilitating nurses taking responsibility for people's health as part of their role. She also described watching and intervening as actions indicative of initiating care. Likewise initiating care kept people well and avoided costly air evacuations, "*. . . and although it was a paternalistic model of care it was actually keeping people well and more cost effective in the long term as they didn't get sick and need to be* [airlifted] *out" (NP4).* Of interest was the use of the term 'paternalistic' as this would be in contrast to values of empowerment. Indeed, some nurses considered activities that initiate care were not in line with providing PHC because the patient was not taking responsibility for their own health:

> *. . . the flip side, some staff felt that it didn't actually empower people . . . or they didn't learn anything about being responsible for their health so obviously this applies to both general and mental health (NP4).*

However, some participants identified situations where additional input or responsibility was justified, such as if the person was incapacitated, either physically or mentally; was a child; elderly or with certain conditions such as Tuberculosis or Rheumatic Heart Disease (RAN5):

> *It's a bit different if it's someone who's perhaps showing dementia or feeble and in that case I might do something, but I will ring people . . . the patients like it too and it gives me some feedback . . . part of my routine is I check* [the pathology], *I ring up the patients . . . and at the same time I will say, "did it all get sorted out and how's it going? ". . . people will appreciate that (NP13).*

Some health services had a reminder system that gave some reminders but then the expectation of the clinic staff was that the responsibility was then up to the patient;

> *. . . you would have your list and you would have to go and remind them . . . they would have one reminder to come and get their medication but if they didn't come . . . you reminded them again but then you didn't remind them after that and basically they then had to take responsibility and if they got sick that was their problem (RAN5).*

However, if the patient got sick they would need to come back to the health service for access to further treatment where they were told this illness was their responsibility, "*We looked after them of course but they were told they were sick because of this" (RAN5).* Being told that you are sick because you haven't taken your meds or adhered to the monitoring requirements or recommended public health schedules was unlikely to meet the aims of PHC because: *". . .you haven't done the groundwork . . . to explain to them why you are worried and find out if it is a worry for them" (NP14).*

Initiating contact aimed to engage people in preventative health care treatments such as appointments with specialists and adherence to treatment regimes. Whilst some nurses considered that resources spent making contact with people and facilitating their access to services was a cost-effective use of resources; others questioned the appropriateness of these actions when considering empowerment as an aspect of PHC.

### 5.2.3 Tiptoeing around the politics

Nurses in this study also talked about the influence of politics on their practice. Politics in this setting described organisational interests including policies and budgetary measures; community hierarchy and historical influences and even broad government political policy influences. Interestingly, nurses felt that they often had to work around these competing interests in order to facilitate access to care. The strategy of tiptoeing around the politics facilitated access to health services by positioning the health staff in a neutral position thus ensuring access for all.

History and politics within the community, sometimes referred to as, *". . . vested interests" (NP5)* were seen as an important aspect of the context of that particular community, *". . . it's not extremely busy but it is extremely political and it's extremely mobile and transient and so it's very hard to sort of get to know the full population that travels through* [the community]" (NP6). Community politics impacted on nurse's employment within certain communities, *". . . you also still get told all this stuff in Central Australia about being thrown out of the community . . . and the health department perpetuates that a bit by just shifting nurses around and around" (NP14).* This statement was interpreted as an example of powerbrokers in communities determining if a nurse is 'right' for that community and the employer's response was to move nurses between communities. Community politics also influenced the way health services operated and nurses practiced:

> *. . . you have all these little factions underneath the delivery of health in populations and if you are dealing with an area that has a strong* [cattle] *station thing, you have to tippee-toe much more carefully around the politics if you are delivering care to station people and Aboriginal people (NP2).*

It was apparent that nurses valued community consultation and involvement in health service provision as an element of PHC. However, it seemed that they were unable to facilitate this aspect of PHC because of the influence of outside parties. The feelings of frustration and lack of satisfaction at the lack of shared understanding and communication in Aboriginal health were evident when the following participant stated that she 'comes unstuck in this job':

> *. . . we don’t listen to the really experienced elders . . . the whole politics behind Aboriginal Health . . . nobody really wants to step up to the plate and say ‘hey are we doing this right?’ because to do it right we need to rethink everything we are doing. It’s too hard . . .and there’s no simple solution; but gosh we are spending a lot of time and money and effort . . . That’s where I come unstuck in this job, . . . we are just missing the point (RAN4).*

One nurse discussed the need for nurses to try to engage community members in health service activities, *“. . . a lot of members of the community don’t attend all of that stuff because of the dynamics within the community. So we still need to ferret out and talk to the other people” (NP7).*

Similarly, the following nurse referred to politics in terms of looking at the ‘bigger picture’, *“. . . sometimes you have to go along with something you don’t really want because that actually in the bigger picture helps and then other times people you can actually present a convincing argument that people will agree and they won’t go changing things around”(NP14).* She also suggested that over time, nurses accept the context, even if they don’t really understand it by ‘not worrying’ about it, *“. . . in the Aboriginal communities you either hang around and accept the way of life without understanding most of it and you go along with stuff and you don’t worry too much about it”* (NP14). Reduced political and economic resources; alongside the community characteristics were found to increase the challenge of remote work:

> . . . [what] *keeps me here are the challenges . . . looking at the political and economic challenges . . . We don’t have a sustainable agriculture, mining or tourism industry here, there’s not enough for an income. . . So just looking at that and the population dynamics . . . so it is more challenging to work here and I like a challenge (NP2).*

Understanding the politics was described as seeing the ‘bigger picture’ and in order to understand the politics nurses needed to be involved in many aspects of the community, *“Now I like . . . to be able to see that bigger picture and to have a finger in a lot of pies”* (NP2).

Understanding the local community politics was an important factor in nursing practice. This understanding developed over time and as such, was related to knowledge resources. Understanding the political influences on the community extended beyond the immediate community to national policy and political agendas. The aims and expectations of the nurses were not shared by those in positions of power, in particular the nurse’s perspective on the importance of empowerment and self-determination:

> *. . . too many of these things are people sitting in Canberra who have no idea what’s going on out here and they decide that this is how things will work and they assume that they are very culturally safe but at the end of the day it is still things being forced on to people from other places it’s not the people making their own decisions . . . it’s not going to be good for another couple of generations I don’t think (RAN2).*

Similarly, programs need to show they are being effective in order to obtain on-going funding. These programs also reflect the political values of the time, *". . . the sort of thing that I know the nurses working with the Aboriginal communities do because they are out there chasing, of course politically it is also expedient to do so" (NP13).*The influence of politics is highlighted by the following quote from an expert reference group member:

> *What is the circle of influence, and the politics behind this? and even extraordinary nurses working opportunistically as experts can only work within the political environment and the political environment at the moment in Australia is that we believe in comprehensive PHC but we actually deliver selective PHC so there is no such thing as comprehensive PHC (RG3).*

The influence of political agendas was also raised in relation to asylum seekers and the use of interpreters. The following nurse claimed not to be interested in politics but also acknowledged the influence politics can have on health care:

> *we use . . . the telephone interpreter service and there is generally one or two people on the boat who speak English but you have to be very careful about using them as interpreters for anything because a lot of the time those are actually the people who were smuggling them into the country . . . I'm only interested in the health stuff, I'm not interested in any kind of political agenda and so using those people for interpreting you have to be very careful about what the ulterior motives are and what information they are giving you (NP7).*

The following nurse elaborated on the issue of power and control in the politics of remote health by explaining that the ability and action of self-determination of Aboriginal and Torres Strait Islander peoples was impacted on from birth and influenced by wider societal pressures of disempowerment and lack of control. References to 'we' and 'they' point to actions that are aimed at early prevention of ill health which could be considered 'initiating' care. Poignantly, she states that even though non-Indigenous people were also subjected to systems of control, they are systems that fit with the predominant worldview:

> *. . . everything for Aboriginal people is controlled from the minute they are born. . . we're doing things to you and the minute you're born you are enrolled in Centrelink and you are immediately in the system and they want to monitor you at the health clinic every so often when you are little and tell your mum whether they are looking after you properly or not and then we want you to be in the education department. It's not much different for white people but white people, it's our systems, we've set them up (NP2).*

In a similar way 'tiptoeing' described situations where nurses defied the managerial rules in order to provide PHC, *". . . there were too many paediatric assessments going on after hours; well I would always go out for a child" (RAN5)* or demonstrated assertiveness with examples such as, *". . . the* *managers get pressure from higher up and I said, 'I can tell you now that no-one's telling me who I can and can't go out for, save your breath because I'll make the decision at the time'" (RAN4).*

Tiptoeing through the politics described the nurse's role in understanding the agendas and influences on health care within a community setting. The politics that affect a community impact on the nurses' ability to provide the care they want because sometimes they had to go along with things they didn't want to because it met the needs of others agendas. Nurses experienced frustration that communities were not involved in decision making and this reflected their inability to work towards PHC aims of empowerment. The data showed politics at a macro level, nationally and at a community level, but a lack of shared understanding was also evident between nurses and their managers or employers. It was apparent that nurses incorporated their understanding of the social world into their practice in order to provide PHC by facilitating access to care.

### 5.2.4 Section summary: Facilitating access to care

The strategy, facilitating access to care, described nursing actions in response to an environment of limited resources. Nurses perceived their role as a facilitator and in doing so, increased patient access to health services. Facilitation was dependant on collaborative professional relationships. Finding opportunities for preventative care was a method in which to optimise resources. Facilitation also encompassed nursing activities that initiated contact with patients in order to engage patients in the health service. Initiating contact was a controversial action in that some nurses considered 'chasing' people to undermine their efforts at empowerment whilst others thought that resources spent in these activities were justified as being cost-effective. Nurses also described working around the influences of external politics and agendas in order to provide PHC by facilitating access to care.

## 5.3 Seeking understanding

Understanding the social world of patients was an important element in providing PHC. However, significant differences in culture, communication, community understanding of PHC and a lack of shared contextual understanding as well as other politics and agendas; have been shown to limit the nurse's ability to provide PHC. It was apparent that nurses in this study valued authentic relationships as tools to overcoming the lack of shared understanding of the remote world. Knowing and being known was achieved using strategies that included: *seeking to understand a different world and building trust.*

### 5.3.1 Seeking to understand a different social world

The experience of being in a different social world lead to the condition of a lack of shared understanding. Seeking to understand describes the actions that nurses took to actively learn and engage with the different social world. Knowing the patients and the community and also being known by the community were found to be the key concepts in building mutual understanding, *"You got to know the community and they got to know you" (RAN5)*. Interacting with people over time was a vital aspect of building relationships:

> *. . . . but since I've been working remote you get to know people; you work with people and their whole family and it's that interactions with people . . . that you get this consistent approach where you see them time and again and . . . you build those relationships (RAN6).*

Seeking understanding was also an aspect of facilitating access to health services, ". . . *I'm listening to them, . . . I'm looking at their history, getting a good history, prioritising, working out what they want or don't want, giving options and then assisting them with their journey, and their health" (NP9).* There was also an apparent connection between providing PHC and knowledge of the patient, "*It's also about being more holistic in your mindset, so I'm really seeking out how to solve a problem for somebody. . . How I could say that best? . . . knowing everything about the patient" (NP3).* Understanding people's lives was an important function of understanding the whole person, "*. . . I think that a huge part of what we do is about developing relationships and seeing where people are living and working. . . more stuff outside of the clinic rather than just you know, dealing with acute presentations" (RAN1).* The following example of the impact on patient care of 'knowing' was provided:

> *. . . if you have a high turnover of staff and they don't know the communities then there might be someone in the community who has decided they don't want further treatment – they might have chronic renal failure on peritoneal dialysis but if you are a nurse who has just come on then you might not know that so . . . that can make a big difference (RAN7).*

Likewise, encouraging new staff to learn about the community from the community members themselves was an important strategy for developing understanding:

> *. . . when we get new staff in . . . I will tell them . . . from my perspective this is what my culture is and this is how I practice here but I always let the health workers and the admin staff and the local people guide them and they must be guided by those people, they are the power holders in this institution because they are going to be here long after we're gone and it's their community (NP7).*

It was clear that nurses actively sought to learn about their patients' social lives as a way of providing PHC. Understanding developed over time and through the establishment of relationships between the nurses and the community. Seeking understanding required an attitude of acceptance and non-judgement.

#### *5.3.1.1 Accepting others worldviews*

Although nurses were experiencing a different social world that they described as not understanding completely, they identified ways of communicating understanding and learning from others. Conveying a message of mutual understanding, equality and respect was described as:

> *. . . you have to be open to accept and acknowledge and appreciate the Aboriginal persons' view of life and that's not to say that I understand it, I have to give the message across that I accept it, I'm not judging it (NP6).*

Similarly, accepting without necessarily understanding was identified by another nurse, "*. . . in the Aboriginal communities you . . . hang around and accept the way of life without understanding most of it and you go along with stuff and you don't worry too much about it"* (NP14). It was suggested that equality and being non-judgemental was grounded in understanding each other's life experiences:

> *. . . if I'd experienced, what they'd experienced, then I would be in exactly the same place as they are, . . . they have got to where they are . . . and I've got to where I am and now we are looking at each other and it doesn't matter about culture or. . . whether it is a physical problem or a mental problem or a spiritual problem, we've got a problem and we come to face each other with that knowledge . . . We start our communication on that level of equality and it's non-judgemental (NP6).*

Being non-judgemental was also seen as being accepting, "*It's very different, . . . you have to be able to get on with people no matter who they are or no matter what their road in life is" (NP12).* Similarly, nurses also perceived that there would always be a lack of shared understanding because the context was culturally a different world:

> *I don't know that a white fella like me could ever understand the worldview of* [an Aboriginal person] *. . . if you think you know it then maybe you're in the wrong job because you never know it and it's about trying to find a way to not be judgemental about it . . . it goes back to that listening and hearing I guess what people will tell you (NP3).*

The previous quote identifies 'listening and hearing' as an important communication strategy in getting to know people. Listening and hearing was interpreted as understanding what people are saying at a deeper level and not just the superficial words. The idea of communities having issues other than what is immediately noticeable by an outsider was also suggested in the comment, "*. . . you think you know something and you scratch below the surface and find you don't know anything"* (NP7). An example of developing understanding of another person's worldview was provided below:

> *. . . recently I had a young guy . . . and he had left without his medical certificate and the next girl I brought in was a young mum like with a baby and the young guy popped back and was waiting at the door and I'm like "it's fine, just grab it, it's just on the printer" and he wouldn't*

> *grab it and he wouldn't come in and . . . anyway I ended up getting up begrudgingly . . . to get the paper for him and he walked off and the mum said to me "that was my poison cousin". . . and so he wasn't allowed and he was already being a little bit culturally inappropriate even just standing near the door . . . That was a good learning curve and I guess I'm just learning every day that the body language is massive there's so many things that go on that you don't even realise through hand signals . . .as there is more to it than what we see (RAN1).*

Accepting others worldviews and attempting to convey a message of non-judgement was interpreted as a link to the nurses' desire to provide PHC. Recognising cultural differences in communication and developing mutual understanding were actions that contributed to creating a safe environment for people to access health services.

#### *5.3.1.2 Learning language*

For nurses frequently faced with language difference; learning language was an important strategy for developing mutual understanding, "*Learning a language is learning a culture and so you are just that much closer and so learning a couple of words and it gives you a better understanding of how they interpret the world" (NP7).* However, not sharing language was also interpreted as a way of empowering indigenous peoples:

> *. . . when we first went out there and were being culturally appropriate and all that we thought we'd better learn some language . . . we learnt a bit, but not much. . .. One of the reasons I found it was better not to, was that it was the only privacy and control the people at* [community] *had. They could talk about a situation in their language I couldn't understand a word of it and I would have to trust that they were working out a reasonable solution and someone would tell me the solution. That was the only power that they actually had over us (NP2).*

Language was connected to social rules and concepts like 'shame'. In the following example, the nurse described her perspective on the importance of using correct anatomical terms in order to communicate clearly:

> *. . . I don't want people to make mistakes about what I'm talking about. So I'm very straight-forward about the language I use and I will call a vagina a vagina etcetera and it took me a little while to realise that to them that was a 'shame-job'. . . they couldn't deal with that, so now. . . I talk around things and I will still use the language when I think it's important to do so but I won't do it at the beginning of our relationship or the beginning of our consultation if you like so that we can build some kind of trust and then they can laugh when I do it (NP12).*

However, she acknowledged that she had to change the way she communicated in order to avoid embarrassment and build a trusting relationship. In this sense, communication was not just about language, but also about encouraging patients to share information about themselves in a culturally safe way:

> *I've always been honest with the clients I've looked after and I say "I'm a white lady; I know I can't ask or you won't tell me certain things". Most of the people I saw are acutely unwell so I'm like "you're going to have to share a little bit with me" and then I try to always have a health worker with me so that if I'm asking the wrong questions and they'd give me a look and I'd shut up and we'd move sideways *laughs* I think you have to be very adept and respectful about what you're doing and where you are going in order to achieve the questions you are asking (NP4).*

This quote highlights the importance of working collaboratively with Indigenous health workers in order to improve the quality of communication. Similarly, nurses developed insight into different ways of communicating that were sometimes very subtle:

> *. . . often you would be sitting there and they'd be talking about something else but they would be sitting shoulder to shoulder and . . . they'd be talking into the air between us and then after some time the message that they wanted you to have would be put out into that air . . . it might be something like they wanted you to come to a celebration or something like that . . .* [and] *they were sort of trying to protect you so that you didn't turn up in your bikini pants with a bottle of champagne . . . you needed to wear this and do that and be there and they'd tell you what your role was (NP8).*

Understanding cultural norms changed the way nurses communicated and practiced. In the following example, the nurse is male in a single nurse post. He was aware of the cultural rules around gender and intimate examinations so works around these sensitivities in order to create a culturally safe environment:

> *. . . I've dealt with women with sexually transmitted infections . . . and they can describe it to me and then make a diagnosis and then do a drawing and then say does it look like this? And does it feel like that? Does it have edges? . . . and then what we are going to do is treat you with this and if it doesn't work then you will have to go . . . and see a GP in* [regional centre] *. . . it's all done with sort of modesty and the least amount of embarrassment to them and . . . I'll make my mind up from what you say and what you tell me and I'll ask you questions and it might take a little bit longer but we get there (NP6).*

It was apparent that if nurses were aware of cultural difference and receptive to different ways of communicating then they could get to know individuals and their communities in a meaningful way that helped overcome the condition of a lack of understanding of the different social world. This in turn aided nurses in providing PHC.

#### *5.3.1.3 Getting to know the community*

Nurses described actions they would take to get to know people. Some of these actions were oriented towards clinical knowledge of the patient but other actions were aimed at understanding who someone was and where they fitted within their community.

Knowing the clinical history of patients; particularly those with complex health issues was an important strategy for nurses in providing PHC. For example; the following nurse described the process of gathering important information when being orientated to a new community:

> *. . . initially finding your feet and working out the clinic. . . I used to ask the bosses of each place, . . . the names of the psyche patients, straight away and I needed to know the names of the precarious chronic disease patients. . .Once I found out the names of the people, I used to get the person in charge to put the house numbers and about where they were because, . . . finding where they live in the middle of the night was a bit tricky . . . once you've been in there once you've got a handle on what is there (RAN5).*

Having been there once, she described accumulating knowledge of the community as 'having a handle on what's there'. Interestingly the following comment asserts that knowing the patient puts the clinician 'ahead' but there is also an indication that there may be a downside to knowing the patient. It's possible that prior knowledge may lead to assumptions or prejudices when providing care ('go the other way'):

> *I know my people . . . they will give me a history and as usual we will go through the medications and inevitably I will sit there and say "aren't you on your such and such anymore?" and they'll be "oh I forgot to tell you" . . . in some ways I'm ahead than when you meet them . . .That can be beneficial; it can also go the other way . . . (NP13).*

However, the potential for prejudice can also be seen in the following description by a relief nurse who felt as though he had attended after hours call outs unnecessarily because he didn't know the patients:

> *I found it disappointing that in my orientation there was probably four or five older people in the community who you would have been quite reasonable; not to prejudice me; but to inform me about their history and their behaviour . . . I'm dealing with this person and I'm trying to traipse through their history trying to find out how much of this is you know an emotional/social problem and how much was likely to be a physical problem as there was always components of shortness of breath or chest pain as their presenting complaint as part of their anxiety and then you'd speak to the other staff members and they'd go, "oh yeah that's so and so he rings up every second night with stuff like this" and you think, "well, it's a bit unfair" . . . I think there was a lot of an assumption that because they knew how, what patient x's history is that you somehow by diffusion knew that (NP10).*

Getting to know the people involved making social connections. Making connections started with introductions; and identifying other people that they may mutually know:

> *. . . relationship building is hugely important . . .* [some] *of these communities I haven't actually worked in before I took on this position, I say straight away, I'm* [name]. *I worked out at* [community] *and when I was out there, I know this one or that one so you could straight away make some kind of . . .* [connection] *(NP3).*

Similarly, knowing who the important people are in the community was considered to be a vital aspect of knowing the community, *"I think you should know the traditional elders of any given community. If you are going to be out there permanently or for any given time and living out there, then maybe find out who they are and introduce yourself"* (RAN4). The introductions to important people were apparently not facilitated by other staff (RAN4) so nurses needed to be *". . . confident enough to say, 'look, I might just duck out and see who the traditional owners are and introduce myself'" (RAN4).* RAN4 elaborated by saying, *"I made a point of doing that; of going and finding out who the traditional owners were are introducing myself to family groups who I saw around the community . . .  I told them who I was and what I was doing there" (RAN4).*

Another nurse also described getting to know community members by making a connection with mutual acquaintances in other communities:

> *. . . I used to employ tricks like trying to remember surnames from different communities and if they married up I'll say things like "oh, are you related to such-and-such in another community?" to try to establish that rapport in my next community (RAN4).*

One participant described a couple of situations where he was contacted a considerable time after he left the community by way of social connections that originated in his nursing role:

> *I got a phone call from the Shell service centre who said there's some Aboriginal people here that want to talk to you . . . and they said "you're* [name] . . . *you used to work at* [community]*"and I said, "yeah that was 10 years ago or longer" and they said, "we know people who know you . . . and we've run out of fuel and we really don't want to stay here" . . . and I said, "look I can give you some money to get to* [town]. *Maybe if I give you my post office box you can send it back" . . . about two weeks later I got an envelope with no message or anything just scrawled my name on the front with my post office box and 40 bucks in it. I knew exactly where it came from. So . . . you don't know how much you are known until stuff like that happens *laughs* (NP6).*

Nurses described getting to know people and forming social connections. This was described as being involved in the community. Being involved helped nurses to understand what resources were available and what the issues were for that community. As such, nurses were involved in community committees such as, *". . . I'm on the local emergency committee, I'm on the alcohol accord* *committee . . . road wise,* [and I] *was on the P&C* [parents and citizens school committee]*" (NP11)* and this participation was seen as an element of nursing practice, *". . . because it gives you a perspective of what's going on, and it's a good opportunity to do some education as well and health promotion stuff" (NP11).* Once trustworthiness was established, some nurses were asked to take on other roles within the community, ". . . *I sat on the justice committee and those types of things on the island. So like the naughty boys who were being given some sort of discipline, I was a part of that"* (NP8).

Nurses described actively seeking to make connections with people in the community in order to help them to understand the people they were caring for. Getting to know people was facilitated by making introductions and getting involved in the community.

### 5.3.2 Building trust

Building relationships was a way of developing shared understanding with members of the community. Fundamental to these relationships was trust, *". . . there was the trust there that made big difference as well* "(RAN1). Trust was related to communication and acceptance of others worldviews, *". . . building relationships and being tolerant and communicating is just the biggest thing that you can do for yourself to give yourself credibility and authenticity" (NP3).* This quote highlighted the link between relationships and trust. Trust was also about credibility which came from respect for knowledge, "*How do you get credibility? Well I guess it's because you do a good job because you know your stuff . . . so that patients believe you and* [you have an] *authentic relationship with them" (NP3).* Continuity of care played an important role in building trusting relationships which in turn facilitated meaningful communication. Trusting relationships were perceived by nurses as leading to improved health outcomes because people were more likely to access the service:

> *. . . you build such a better rapport with these woman . . . being the sole provider of everybody's antenatal care for a good period of time you definitely get to know the women and they start to feel a lot safer with you and come to you. I can't speak highly enough of continuity of care (NP1).*

Trust facilitated access to health services:

> *. . . when I got there there'd been a history of people jumping off boats and jabbing everybody with needles for their vaccinations and this had gone on for years and so all the parents were terrified of needles and they instilled that terror in the children and so when the children saw a white person, or a white nurse, they would all start screeching . . . and leaping out of prams . . . so I settled into a campaign of gathering the trust of the children to the point where they would just come in, lift up their shirt sleeves and say, "you pinin me now* [nurse]*".And then there was none of that crying and screaming and scraping them off the*

> *roof. But it took me almost a year to get the trust of the children so that when I was walking down the street that they would actually run up and give me a hug (NP8).*

The previous example showed how the nurse had become known and trusted in order to effectively provide access to immunisations and clearly showed the importance of authentic relationships. Time was also identified as a factor in building relationships. In the previous example the nurse suggested a time frame of a year and in the following comment the nurse suggests that it took more than a year to develop a sense of trust with the community:

> *. . . it did take me a little while to build up any relationships with the local people, they are quite shy and they are quite used to the clinic staff coming and going on a regular basis and there is a bit of disbelief that you are actually going to stay and so after 15 months I have finally got over that and so there is a sense of acceptance . . . (NP12).*

Furthermore, the significance of time in building trust was described in terms of frequency of interactions rather than chronological time:

> *. . . I can build up the trust over three to four meetings with women . . . until eventually they are happy to come in and they start talking about the fact they want to have babies . . . they just don't get embarrassed anymore and I think when I was a young man it was different. But now I'm an old man. . . maybe I'm just better at it than I used to be (NP6).*

The previous example also suggested that trust may overcome some cultural issues and subsequently facilitate access to health services, even in a resource-poor environment where a range of health professionals were not available. In addition, the nurse contrasted his ability to build trusting relationships in terms of his age, however, this comment was interpreted in light of this participant having spent many years working with Aboriginal and Torres Strait Islander peoples in remote areas. This may be a more significant factor than this age.

Having a reputation of being honest and trustworthy was considered important in order to encourage people to use the service, *"They see right through untruth. They see through you if you are not real and if you don't really care they'll see through that" (NP3).* Similarly, nurses perceived that patients were more likely to be engaged in health services if they knew the nurse and had an ongoing relationship with them:

> *I actually have an awful lot of corporate knowledge and a lot of buy-in from people. People know . . . my skill set and who I am and that I am always consistent and I'm here . . . so I'm a resource that's not just a resource because I have a piece of paper but if you've been here long enough . . .* [people]*out there will say "yeah, I know who you are and where you sit, I know that I've had contact with you before and your consistent and when you do things you say you will" so there's that trust that you have established and an identity with people . . . (NP4).*

Nurses who had established relationships described creating an identity and a reputation as someone who was a knowledge resource, was trustworthy and that this identity had developed over time:

> [I am seen by patients] *. . . as the expert person that they can go to and use as a resource and to ask information . . . and that gives credibility. . . If you don't have that credibility people aren't going to want to come and see you, . . . they will just think, "well you're a silly one, you don't follow-up, you don't care", so I think it's really important and it comes with a lot of responsibility (NP3).*

Moreover, nurses described that trust could be established by proxy in that, *"For you to be sort of 'endorsed' and for you to be introduced by people they trust so that they trust you by proxy" (NP4).* Trust or knowledge by proxy also appeared to extend to other members of the health team, *". . . he's* [the specialist] *seen as part of the* [health] *team, . . . they're not shy about seeing him and they want to listen to him" (NP3).*

It was apparent that seeking to understand the different social world of the remote community required an attitude of respect for different worldviews, a willingness to learn and understand language in order to facilitate communication, and activities that build trusting relationships. The strategy of seeking to understand was used in order to provide PHC.

### 5.3.3 Section summary: seeking understanding

Although nurses perceived that they may never truly understand the perspectives of those living in this different social world, they aimed to communicate empathy and non-judgement in order to build trusting relationships and facilitate access to health services. Nurses considered communication, trust and getting to know people as the actions needed to develop understanding of their communities.

## 5.4 Home-making in a work environment

Nurses in remote areas faced a particular challenge of living in small communities which were an extension of their work environment. In the remote setting, nurses held a specific social role as 'the nurse' and this influenced their access to social relationships and limited their ability to switch off from work and rest. Nurses in this study managed this situation by: *setting boundaries* and *educating the community about the nurse's role after hours.*

Nurses sometimes referred to their communities as 'home', ". . . *I've been working here six years. . . this is my community; my home . . . this community has become my loved ones and I do care what happens to them to a degree"* (NP5). A change over time was also implied in the following statement, *". . . so you became much more a person who was a part of the community than I had* *ever been before"* (NP8). A sense of belonging to a community was described as instigating a change in nursing practice, "*I wasn't shutting the door at 6 o'clock at night and going on home and never thinking about anyone again" (NP8).* It was clear that nurses felt an emotional connection to the community that was not severed at the end of the working day.

### 5.4.1 Setting boundaries: What's nursing, what's friendship?

Earlier in this thesis, nurses described having limited opportunities for friendship and personal support within the community, particularly in communities where they were the cultural minority. Nurses in this study also spoke of blurred boundaries between nursing and friendship because they had access to knowledge about people that they would not have had if they were in a purely nursing or friendship relationship. An example of this situation was provided by RAN1:

> *. . . you see the other side of the community and it was really difficult I think a lot more so knowing the people in many ways than if I didn't know them. Obviously that had a huge positive because the connection was so strong, the language and all that stuff was all there but you are seeing another side of your friends and people that we call family and having to deal with them in a very personal and very difficult way . . . and having to work out the boundaries between what's nursing, what's friendship? . . . was a huge challenge as well. (RAN1).*

Living and working in a remote community also meant that nurses interacted with their patients outside of the clinic environment.

> *I knew that I had to change the way I did everything because I could see the absolute . . . I really didn't know if this had been happening to me all my life because you never caught up with anybody but* [in the community] *you saw them . . . and saw their children the next day on the street (NP8).*

Another nurse described how she was able to provide healthcare while 'socialising' with the community and how this was connected to trust:

> *. . . I was socialising with the community all the time and so, you know I was with the young mums and we were fishing and hunting together and it was like "hey, you shouldn't give tea to that little baby" because you are out there with them, helping to make the food and whatever with them and so you . . . got the opportunity to be amongst everybody a lot more (RAN1).*

However, it was apparent that personal boundaries differed between nurses:

> [A colleague had] *been there for a long time . . . and she didn't approve of nurses doing anything with the community outside of the clinic . . . she was quite concerned for me and being able to draw . . . those boundary lines you know, living, breathing, eating, sleeping in a community I guess and getting burnt out; . . . she really had huge borders, . . . like she went*

> *from the clinic to her house and didn't go fishing or hunting or anything with people in the community (RAN1).*

The previous quote suggested that time spent in a community was related to a nurse's personal boundaries. There was also a connection with the resource-poor environment and the nurse's capacity to engage in this level of personal interaction by suggesting that this behaviour may lead to feeling burnt out. Another nurse who had spent considerable time in remote communities also described how his boundaries had changed over time and even 'shrunk':

> *I've become a little bit more insular I suppose . . . I haven't been as open* [here] *as I have with some other places I've worked. Like at* [community], *every weekend when my boys were little I we used to take some of the old men out to their country and we would wander around their country and we would do things with them . . . I don't know why I've chosen to be this way *pause* I haven't taken people out bush, . . . I've spent my time studying, I've had my boys with me . . . and I wanted to spend some time with them without being harassed by the people I was working with and for some reason the* [community] *people have acknowledged this and they've just sort of said 'unless it's really bad, we won't come and disturb you' and that's how we live . . . But . . . my life now is very different to how I interacted with people in other communities . . . I had boundaries . . . but people knew that if they wanted to go bush and I had the time and I wasn't on call that I enjoyed the experience . . . but I've taken on more of a scholarly approach to this job (NP6).*

He goes on to describe how his methods on engagement had changed and were different to the nurse that had recently arrived to relieve him:

> *. . . I just engage in a totally different way and it's been interesting just watching and reflecting on how . . . my replacement . . . engages with everyone and has people round for tea and I haven't done any of that. Basically I go to work, I go home, I have tea and I sit down and read books and that's it . . . (NP6).*

On reflection, another nurse described how her boundaries had changed now that she was living in another community, however, she also stated how this could be seen as 'negative':

> *. . . I learnt a few things about small communities and small towns and so I guess I was a little more cautious to you know be absolutely friendly with everybody and whatever and so I've approached the community lifestyle a little more cautiously which may be seen as a negative thing (RAN1).*

In the following example, the nurse was motivated by a desire to learn the local language and was also aware that spending too much time with one family or group might be perceived negatively by other groups in the community. She tried to establish 'balance' or 'share herself around' and even used her husband's role within the community as a way of not siding with one particular group:

> *Friendships; I was a bit tricky really. . . I would go to church on Sunday and I'd go to the club on Friday nights so that one group wouldn't get upset with the other group *laughs* because I was trying to learn the language and the skin groups and the church, the whole service is said in language. It was a good way of learning that and then it just kept people guessing "well is she a pub person or a church person?" *laughs* . . . so that was ok and then my husband, when he was there he'd play pool or whatever with some of the guys (RAN4).*

There was a sense of caution in establishing friendships, *". . . I wouldn't get too familiar in the sense of inviting too many people back to my home. I think I knew where the boundaries were" (RAN4).* A strategy to combat loneliness and social isolation was to have a significant other with you, *". . .* [what] *worked for me was actually having my husband out bush most of the time and then I'd do a lot of study" (NP14).* Loneliness, gossip and confidentiality were important considerations for nurses living in small communities. Also of interest was the suggestion by one participant that it was the community that had poor boundaries rather than the nurse and she highlighted the issue of confidentiality in small communities:

> *I was very grateful that I had my husband, so that I wasn't lonely. . . I had a few close friends in the community that I would mix with but I . . . didn't go to the pub at all . . . There's a lot of gossip in small towns . . . So you had to be very careful, because say if someone was* [talking about someone] *doing inappropriate behaviour, they might think that came from the clinic. You had to be very, very careful with your confidentiality and really pick your people as to who you were going to have as an ambulance driver with that confidentiality (NP9).*

As maintaining social support was considered important, some nurses talked about finding ways to get the support they needed without relying on the local community. On reflection, another nurse, said that if she had her time again she ". . . *would try and get myself out of there* [away from the community] *a bit more often . . . you still need to have a little bit of . . . contact with people who are on the same page as you" (RAN1)* and as a result was considering shorter stints out bush so that she was not away from family and friends for such a long time.

It was evident that nurses sought to create a boundary between their personal and professional lives as a way of meeting their needs for personal support. It seemed that the separation between what was nursing and what was personal life was set by the individual nurse and may change over time or in different situations. One way to establish a personal boundary was described as educating the community about the nurses' role out of normal business hours.

### 5.4.2 Educating the community about the nurse's role after-hours

Several strategies were employed by nurses to help manage separation between home and work. After-hours call outs were a common cause for fatigue and frustration and nurses attempted to educate their communities about the appropriate use of after-hours services:

> *. . . there was some training involved . . . they would call you out for anything . . . Well I said, "look I'm sorry, but the hours of operation are 8-4.30 Mon – Fri and it's triple 0 emergencies only." . . . I also got the sign up the street changed from 'hospital' to 'Primary Health Care centre' . . . I did live next to the clinic and it was fenced and I planted a lot of trees to make it look like a home . . . I would always come in for children – no matter what . . . then for other things I would say, "have you given some Panadol? Have you done this? Have you done that?" So by the end, by the time I had finished my 4.5 years, when they came up they would be like, "well, I've given Panadol and I've done this and I've done that" so they were a lot more informed as to the appropriateness of what they should do and also they were, the community in the end, really wanted to look after me to make sure I was ok. . . unless it was urgent they would say, "look I didn't come in on Saturday because I didn't want to disturb you and it wasn't urgent" and so they had really changed their mindset (NP9).*

It was apparent that nurses relied on community members understanding that nurses needed time to rest and privacy. An additional benefit of educating the community was an apparent increase in health literacy and empowerment. Other nurses also described educating their communities about appropriate use of the after-hours service:

> *. . . over the years we have been trying to offer a really consistent approach . . . and also we have a monthly newspaper . . . the end of every article I will write a little blurb about after-hours stuff. And we've got signs around town everywhere which gives examples of what would be classed an emergency so they would be things like, "chest pain, any deep cut that can't be controlled with normal first aid, severe abdominal pain, severely unwell child" and it's just a point form so it's quite clear to understand . . . if someone does come in . . . and they turn up here and it's nothing, I tend to . . . say, "well look you know, I've left my family at home having no dinner and I'm here seeing this" . . . explain to the community that there is only two nurses and we do need to be back at work the next morning (NP11).*

Furthermore, having patients arrive at your doorstep was considered an invasion of privacy that required firm and consistent action from the nurses:

> *I have a big sign on my door on my door that says, "if you need a nurse, call (. . .)" . . . Every month in the* [community newsletter] *I write "do not approach the nurse at home or call on private mobiles." I explain that it is an invasion of privacy and it's wasting valuable time in an emergency (NP11).*

Boundaries with the purpose of separating work and home life included advising community members not to come to the nurse's house:

> *. . . we try not to have people coming to the house. And I think probably when you first come, maybe at the beginning they try and come over a couple of times and you have to be quite firm in directing them to someone on-call all the time. I usually direct them there and say "you can't talk about this you need to go to the clinic" (NP12).*

Another nurse described establishing a consistent approach to this situation:

> *If I’m at the supermarket and wanting to buy my bread and someone’s wanting to show me a spot or something; I’m quite firm and I say, “show me tomorrow or ring me tomorrow” . . . .the final straw was one day my son had opened the door and there was a guy standing there with blood spurting out of his foot where he’s accidentally stabbed it and he’s left this great pool of blood on my doorstep . . . my son does not need to be seeing that sort of stuff so I am very firm and I try and encourage our relief staff to be exactly the same so that we do have that really consistent approach (NP11).*

Some communities appeared to understand the impact of call-outs and tried to manage the situation, “. . . [the health worker] *would put a note on the door, ‘*[the nurse] *is tired! . . . she is not on-call!’ *laughs* ‘unless you have chest pain or a broken arm, don’t wake her up!’” (NP8).* The following nurse also identified engaging with community leaders as a potential strategy for managing the workload after hours:

> *. . . engaging with community leaders and . . . setting up some simple guidelines . . . there could have been some education around examples of what those sort of things look like. . . if you were given a green-light to say at the end of the consultation, now this is something that really wasn’t urgent and could have waited until the morning . . . and in a respectful way suggesting that in the future that that doesn’t happen again (NP10).*

In regards to the use of the after-hours service, there appeared to be disagreement between nurses and managers over who was responsible for educating the community about appropriate behaviour and reasons for after-hours calls:

> *. . .what we actually thought was that the health department has a broader responsibility to educate communities about what is appropriate behaviour . . . Our line manager just couldn’t understand that and they said it was up to the nurses on the ground to educate the community. . . it is actually up to the departments to let them know that nurses are not machines and yes we do 24/7 call but there has to be a reason for that call (NP14).*

Nurses’ safety and privacy when living and working in remote communities was also an element to home-making. For example, NP8 described a situation where her property was damaged:

> *. . . they’d taken stuff out of the house while I was down in the clinic, and I was very upset about that . . . they actually flew me out of the island . . . And I said “oh I want to go back and sort this stuff out”. So we went back and I said . . . “I want you to call a community meeting for me.” So she called a community meeting and I remembered sitting there with the health workers and nobody came, nobody came, and then people started to drift in . . . and so they were very, very, apologetic and they said, “. . . Why don’t you put a big fence around your place?” . . . and I said, “I don’t want physical barriers, I want you to sort it out so that everybody knows that my house is my house;” and it never happened again (NP8).*

In this situation, the nurse contacted the community leaders and put the responsibility back on them to educate the community about the nurses need for privacy and security. Of interest was the apparent lack of involvement of the police or the employer. In this situation the nurse appeared confident in dealing directly with the community. Despite the issue of safety for nurses in remote areas being identified as an important issue in the literature and popular media, participants in this study did not discuss violence in any detail.

Community education and responding in a consistent manner were described as strategies that increased the communities understanding of the nursing role and reduced the amount of after-hours call-outs. This strategy was also interpreted as contributing to the nurses' overall approach to optimising resources by limiting non-emergency consultations after-hours and as such conserved the nurse's personal resources. An added benefit of community education was that it worked towards PHC goals of increasing health literacy and empowerment. In line with the condition of shared understanding, the data revealed a need for nurses to establish personal boundaries between their nursing role and personal relationships.

### 5.4.3 Section summary: home-making in a work environment

Nurses' actions to establish boundaries between personal and professional lives were strategies used in response to the condition lack of understanding and support. Community members were described as not understanding the need for nurses to have privacy and time to rest and that this was most obvious in their interactions outside of business hours. Nurses described education as a strategy for reducing non-emergency intrusion into their personal lives. Nurses were found to establish individual boundaries based on their experiences in the remote setting and the situation that they were in at the time.

## 5.5 The consequence: Making compromises

This thesis has described the context of providing PHC in the remote setting. Providing PHC involved having a social view of health which emphasised health promotion and equality of care and achieving personal satisfaction by feeling as though the work was making a difference. However, it was also evident that nurses experienced difficulty in providing PHC due to conditions such as: a lack of knowledge, a lack of resources, a lack of understanding of the social world and a lack of shared understanding and support. Nurses managed these conditions by employing strategies to build their knowledge, facilitate access to care, seek mutual understanding and make a home in a work environment. These strategies described a process of *doing the best you can with what you have*. This section presents the nurses statements about the process of doing the best they could and suggests that the consequence of doing the best they could with what they had was that they were frequently *making compromises.* The compromises they made were described as: *making compromises in relation to expectations of providing PHC*, and *accepting compromises in patient* *care.* In this way; *doing the best they can*, represents a compromise in their perception of providing PHC in the remote setting and *with what they have*; acknowledges the resource-poor nature of the remote setting and the apparent compromises to care that occur due to distance from tertiary services and lack of resources.

### 5.5.1 Making compromises in relation to expectations of providing PHC

When describing the context of practice, nurses in this study described PHC as being holistic and coming from a social perspective where they valued equality, prevention of ill health and sought to make a difference in the lives of the people they worked with. They described their role as 'generalists' who were able to provide care to the whole community over the individuals' lifespan. However, the data revealed that nurses were unable to provide this level of care and this lead to feelings of dissatisfaction and frustration. It was evident that a result of doing the best they could with what they had, was a compromise in their expectations of providing PHC.

Making compromises to expectations of being able to provide PHC was described as *providing some care*:

> *. . . but if you are looking at care from life to death across the lifespan in all aspects you can generally provide some care . . . you may provide better care in an aspect of the lifespan and what you do in other aspects is you provide some care (NP14).*

Similarly, recognition that outside influences impacted on the ability to provide PHC, led the following nurse to describe care as *selective PHC*:

> *We are a medical model-based care. Selective PHC at best. . . . and a lot of stuff we do is for a whole gamut of reasons and it may or may not be because we want this person to be really well and happy . . . there's environmental; there's food security . . . there's issues around employment . . . there's a lot of things we need to address . . . 'we' as in the health department (RAN4).*

Making compromises was a consequence of limited resources. As a result, nurse's actions could be explained as conserving their personal resources. Providing 'some' care was an outcome of nurses' actions to conserve their personal resources. Conservation of resources was seen in reference to coping with the workload, "*. . . sometimes when it gets too overwhelming, it's a coping mechanism to just deal with 'I'm just going to do an ECG and that's all I'm going to worry about'. . . It can just be too big and people become overwhelmed by it" (RAN4).* Limiting their activities to a smaller scope was also considered an aspect of providing some care, *". . . so I think they just wanted to work within what they were comfortable managing, which I guess is safe" (NP10).* The reference to being comfortable was a reflection of the knowledge and skill of the individual nurse. Feeling comfortable was also given as an explanation for why nurses did not engage in activities within the community but preferred to stay within the clinic environment, "*. . . you feel in control in the clinic, that's your world . . . and so you retreat to the clinic"* (NP14).

Furthermore, PHC activities required more time and resources than attending to acute care only. Therefore, nurses compromised on the extent to which they provided PHC based on their capacity:

> *But you also have to be sensible about your capacity . . . if you took PHC, you could get involved in housing if you like, but you can't write hundreds of letters to the housing department unless you've got capacity to do that sort of stuff. So you have to be mindful of your capacity (NP2).*

Capacity was a term that described personal resources and reflected an understanding of the reality of providing PHC within a context of limited resources. Making compromises to their expectations of making a difference in the community was revealed in the following comment where the nurse has adapted their expectations to better reflect their personal capacity:

> *. . .[to] work with Aboriginal people and that's now all I really want to do and . . . it's all I can do but it's all I want to do with the last couple of years of* [working] *life. To try and make a difference even if it's just for a few kids (NP6).*

In the previous quote, the nurse appeared to have re-evaluated his expectations and limited them to a more achievable goal. Similarly, nurses adapted to the need to compromise and limited how often they attended after hours call outs; they apparently compromised on a full face-to-face assessment of every patient who called after hours in order to conserve their personal resources:

> *. . . more experienced people triage a bit harder I think and they just won't go out to things; . . . I think as you get along a little bit you think more about getting a proper night's sleep than making that extra amount of money I think or you learn to look after yourself better and learn to manage burnout better (RAN2).*

When nurses put a lot of effort into providing education and programs that aim for client participation and encourage individual responsibility for health and then people do not engage; nurses compromised on their expectations of others and took a position of acceptance:

> *. . . the people who had been there for a long period of time um I guess had a more; approach of "you can only do what you can do" and you can only offer services or education but if they don't choose to engage in that then they don't . . . (NP10).*

Changes to personal beliefs and values were described as changing over time:

> *. . .  as a RAN you are physically living there every day . . . I think two things happen, either it's like a lobster in cold water and if you stay there long enough you actually get used to it. . . . I don't know whether you become complacent and you just accept, I think the other flip side is that people get so frustrated then burnt out and then have to leave (NP4).*

Evident in the previous comment was the idea that if nurses did not adapt to the remote setting that they experienced frustration and left the setting. Similarly, NP14 described compromising her ideas and beliefs in order to adapt to the context and provide PHC:

> *. . . that's your expertise . . . if you are going to get anywhere you are going to have to compromise, . . . Do you compromise in your own values about what you think should be the best health and shouldn't be the best health? How do you do it? . . . is really about what you've been taught . . . what your cultural beliefs, your philosophical beliefs and things are about care and how much you have to compromise on that to actually engage with the population to offer them anything of what you know (NP14).*

Making compromises to expectations of providing PHC was described as a consequence of being unable to provide PHC. Nurses who did not adapt their aim of providing PHC to the realities of the remote setting were likely to experience frustration and may leave the remote setting. When nurses made compromises to their expectations of providing PHC, they described their work as providing 'some' care. Nurses limited the care they gave as an attempt to conserve their personal resources. Providing 'some' care was clearly a compromise to the aim of providing holistic care across the lifespan but also a reflection of the reality of attempting to provide PHC within a setting of limited resources.

### 5.5.2 Accepting compromises in patient care

Nurses in this study talked about equality of care in comparison to the availability of health services (in particular tertiary and specialist care) with those in urban settings. Compromises in patient care were evident in nurses' comments about the impact of limited resources on their ability to provide the level of care they wanted to.

In the following statement, the nurse acknowledged that a limitation of the setting was the inability to transfer patients to a tertiary setting after dark:

> *. . . there were no night flying choppers so if something went belly up at 11 o'clock at night or even 5 in the afternoon . . . it didn't come. So whatever you had, was whatever you had; and you did the best you could (NP8).*

She justified an apparent compromise in patient care by explaining that she did her best in that given situation. Likewise, the following nurse also justified the potential negative outcome of patient care in terms of doing "all you could do":

> *. . . we had to evacuate people at night* [and drive] *for . . . an hour and a half before you could get to an airstrip . . .* [the other nurse] *found that really quite distressing . . . I gave her the saturation monitor because she felt so out of her depth without machinery and the saturation monitor was going to make absolutely no difference, the person was on oxygen and all you could do was drive as fast and safely as you could to get to help and if their*

> *saturations drop; well you had no more oxygen as there was only that one bottle that could be taken safely in the car and if it dropped and they stopped breathing then they were going to die; the machinery was absolutely irrelevant, but she needed that (NP14).*

This example also showed that nurses experienced distress when the necessary resources were unavailable and their ability to ‘do their best’ was restricted by a lack of resources. In addition, doing your ‘best’ in a particular situation, may not be the same as ‘best’ practice. The following example revealed a nurse’s explanation for not following the recommended guidelines for antibiotic administration:

> *. . . in terms of delivering evidenced-based care as you would in the city; it’s all well and good to say . . .” don’t give antibiotics here and hold off as long as you can” . . . [but] GP services, they are all Mon-Fri there is nothing that operates on a Saturday so it is only going to be the hospital* [30 minutes’ drive away] *so you do things* [that are not ‘best practice’] *. . . (NP13).*

Similarly, nurses justified their actions as doing their best; despite a perception that patient care was compromised because of a lack of alternative options, “*Sometimes you don’t have any option; you just have to give it your best go” (RAN 6).* Another nurse explained dealing with a complication of pregnancy in terms of having “to try” because there was no-one else available:

> *. . . so I put in a drip and rang the DMO and he said, “look she’s probably got tissue stuck in the Os, so you can just pull it out” and I said, “no, no I can’t do that I’m not a midwife”, he said “no, you can”. So I said “right, you’re going on speaker phone while I’m doing it because I need you there while I am doing it so that I can say if anything goes wrong” and have him yell out over the phone what to do next. . . . it’s that sort of stuff that makes me nervous but sometimes you are in a situation where you’ve got to try something (RAN4).*

Furthermore, doing your best with limited resources was described as ‘managing’, “*. . . we’ve managed with or without ED nurses when something goes wrong and you still manage” (RAN2).*

A further example highlights the potential compromises to patient care as a result of limited resources:

> *. . . the plane became . . . unserviceable- it broke. But this woman was really sick and so we got in the ambulance and drove . . . and as we were driving she was deteriorating, she was losing more and more blood into her abdomen and becoming more tachycardic . . . we gave her two units of blood that we had and that’s all we had and that’s all we could do and the whole time I was just holding my breath until we got her to Exmouth . . . she could have died, very easily died. Just through unfortunate circumstances (RAN7).*

In the previous example; the nurse alluded to the increased risk to the patient of having to transfer the patient by road and the delay in access to tertiary care that resulted. Another element was the increased risk to other community members when the nurse had to leave the community. In these situations, doing the best in the situation included an evaluation of risk:

> *. . . we take into account if it is needing a patient transfer by road . . . the risk of having such a full community and something else popping up, well we just try our best to you know, a lot of risk management and kind of those decisions (NP5).*

Nurses assessed risk based on the availability of resources and in doing so, justified compromises to best practice:

> *. . . like your compromises in best practice – is it really best practice to be ventilating somebody or giving streptokinase or something like that in a remote clinic setting with the sort of resources you've got around you?. . . (NP14).*

Nurses talked about accepting an increased risk of compromised patient care because of the setting, *". . . I accept that I work with a level of risk, . . . if I am waiting . . . two hours for the ambulance to arrive is that really good in a place where I can't really provide a lot of care?" (NP13).* As a further example; the following narrative described the process of risk assessment that was involved for a patient that required transportation from a remote area to a tertiary hospital for further investigation of a potentially life-threatening medical condition:

> *. . . the quickest way for me to send her is via a private car with her husband and I said: "her husband is quite sensible and he's willing to do that, but I said If you* [the consultant] *tell me I need to call an ambulance then . . . we can add 1-4 hours to the time it will take her to get there" . . . the other thing is, even if you have a volunteer ambulance and she does have an intra-cerebral bleed, what can they do in the back of a van? (NP13).*

It was apparent that the availability of nursing staff as resources impacted on patient care:

> *. . . you really have to think about . . . what staff is available and the sort of context you are in and the likelihood that somebody else might appear . . . I had a man with chest pain in the clinic . . . and they had a little aged-care centre and the aged care people rang up and said 'I think this person is having a hypo, she's not making sense and she's nearly unconscious' and I was on my own, I had no-one and I said 'I can't leave this man he's got chest pain' (NP14).*

Acceptance of the limitations of the setting was evident in nurses with experience in this context, *". . . there is a lot of pragmatism and certainly that describes me very well" (NP14)* and this pragmatism was evident in her explanation of her thinking about a life-threatening situation:

> *. . . If it was a life-threatening situation; like out bush that's basically A,B,C, Airway, Breathing, Circulation and you know what you've got to do there and you get on with it and if they die when you've done that then it wouldn't matter who you had consulted with they would probably have died anyway and if they don't die and those things are stabilised and fluids are up and running then you can consult with somebody or other . . . (*NP14)

It was apparent that nurses rationalised their inability to provide PHC by assuring themselves that they were doing the best they could with what they had. Making compromises was considered to be the result of doing the best they could with limited resources and was described as: doing all they could, trying their best, managing despite the lack of resources and evaluating risk. Although the examples provided by the participants above had an acute care focus, the descriptions of the inability to provide PHC included limitations to providing health promotion and holistic care activities.

## 5.6 The substantive theory: making compromises to provide PHC

The purpose of undertaking a GT study is to produce a theory. A substantive theory is one that relates to a specific problem or area (Charmaz, 2014). A GT:

> . . . explains the studied process in new theoretical terms, explicates the properties of the theoretical categories, and often demonstrates the causes and conditions under which the process emerges and varies, and delineates its consequences (Charmaz, 2014 p.10)

As such; the findings presented in chapters four and five meet the stated aim of the study, which was, to develop a substantive theory which explains the nature and process used by nurses in the delivery of PHC in remote Australian contexts. The theory is outlined below.

The substantive theory, *making compromises to provide PHC in a remote setting*, describes the context of remote nursing practice as *providing PHC,* from the perspective of nurses, as one where nurses wanted to provide holistic care for a community as well as individuals, where the focus was on preventing ill health and aiming for equality in access to health services despite the resource-poor remote setting. Nurses were motivated by a desire to make a difference in the lives of community members. The theory also describes the process that nurses working in remote settings use to manage the core issue: *inability to provide PHC*.

The inability to provide this level of care is dependent on four conditions: the nurses *understanding of the social world*, *the availability of physical and human resources*; the *nurse's knowledge and skill* and the level of *shared understanding* of the phenomenon of providing PHC in the remote setting and the degree of *support* by managers. This theory suggests that feelings of distress and frustration were related to the inability to provide PHC and that the conditions impacted directly on the nurse's ability or inability to provide PHC.

The theory proposes that nurse's actions and interactions can be explained as a process they use when seeking to manage the issue of an inability to provide PHC. The basic psychological process: *doing the best you can with what you have* is characterised by activities which enabled nurses to increase the resources available and as such increase their ability to provide PHC. *Continually learning, facilitating access to health care, seeking understanding and home-making in a work environment* were strategies which nurse’s used in seeking to alleviate their feelings of distress and frustration and increase their ability to provide PHC.

The consequence of the process; doing the best you can with what you have, was shown to be *making compromises.* In essence, the theory proposes that nurses adapt the context of providing PHC by making compromises to their expectations of providing PHC and accepting compromises to patient care. Changing expectations and accepting compromises are suggested to be coping mechanisms and positive outcomes that support nurses to conserve their personal resources and acceptance of the limitations of the remote setting is a protective mechanism in protecting nurses from distress and frustration. Figure 11 graphically presents the substantive theory.

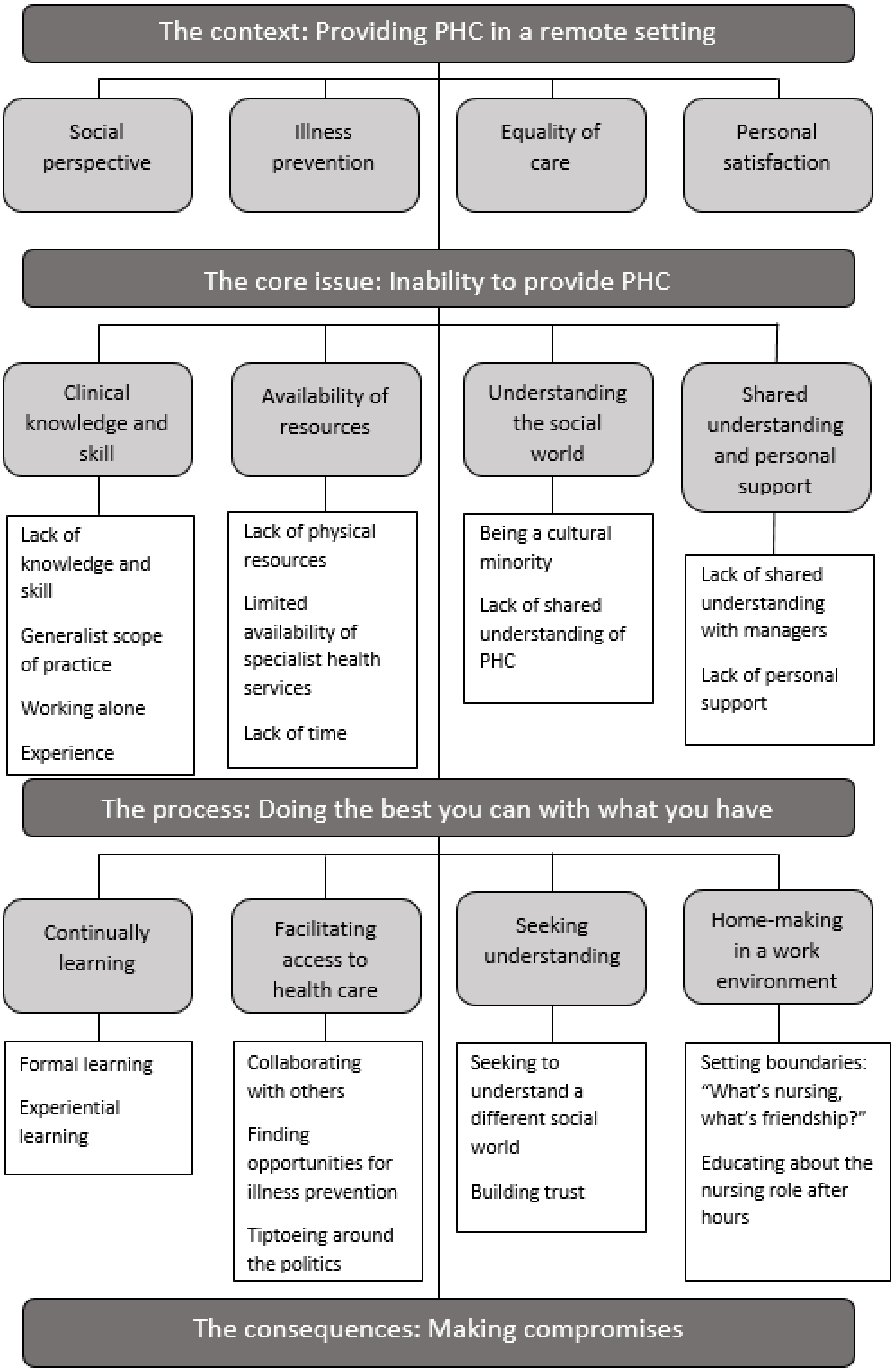


**Figure 11: The substantive theory: making compromises to provide PHC**

## 5.7 Chapter summary

This chapter described the process; doing the best you can with what you have; as a set of strategies used by nurses in the remote setting in an attempt to resolve the core issue of the inability to provide PHC. The strategies included continually learning, which was described as engaging in formal learning activities, and experiential or ‘on the job’ learning experiences. The second strategy was described as facilitating access to health care. Nurses did this by collaborating with others, finding opportunities for illness prevention and tiptoeing around the politics. The third strategy was seeking understanding, where nurses’ activities enabled them to gain a better understanding of the social world of the community. Building trust was the primary action nurses used to build relationships and gain a deeper understanding of the community. Finally, nurses worked towards making a home in a work environment; these activities entailed setting personal and professional boundaries and educating the community about the role of the nurse after-hours.

The process outcomes; making compromises, were also described in this chapter. The data revealed that in undertaking the process of doing the best you can with what you have, nurses were making compromises to their expectations of providing PHC and accepting compromises to patient care which were a result of the resource-poor remote setting. Making compromises, enabled nurses to provide some care even if it was not the holistic care they were striving to provide.

Collectively, the findings presented in chapter four and five of this thesis describe the substantive theory: making compromises to provide PHC. Chapter six will position this theory within the broader body of knowledge and provide recommendations for practice and further research.

# 6 Discussion

The aim of this study was to generate a substantive theory of PHC nursing in the remote Australian setting. The objectives of the study were to describe and explain the actions and interactions that nurses used to deliver PHC in remote communities from the perspective of nurses. These were derived from the need for theoretical frameworks specific to rural and remote health as necessary tools to create, ". . . comprehensive and context-specific approaches for rural and remote health" (Bourke, Humphreys, Wakerman, & Taylor, 2010p.55). Bourke and colleagues (2010) assert that the development of theories such as the one presented in this thesis, helps to articulate the assumptions inherent in the field of study and enhance the general understanding of the phenomenon. This deeper understanding then has the capacity to translate into policy and inform intervention where, "theory provides a basis to interpret data and direct analysis to ensure it will become knowledge" (p.55). This chapter is concerned with making meaning of the theory developed for this study, and with identifying how the findings may inform policy, practice, further research, and health professional education.

In the previous two chapters, findings were presented that described the context of *providing PHC* and identified the core issue for participants to be the *inability to provide PHC*. Four conditions were described that influenced nurses' ability to provide PHC. These conditions were: *understanding the social world*, *availability of resources*, *clinical knowledge and skill* and *shared understanding and support*. The findings also revealed a process of: *doing the best you can with what you have,* which represents a range of strategies used by nurses to manage the feelings of frustration and distress that were associated with the inability to provide PHC. The strategies were described as: *facilitating access to health care, continually learning, seeking understanding and home-making in a work environment.* The outcome of this process was described as: *making compromises to provide PHC*. Collectively, the context, core issue, process and consequences form a substantive theory of PHC nursing practice in the remote Australian setting. In this chapter the current study is positioned in the context of existing PHC and nursing research, with four key findings highlighted.

The first key finding relates to understanding the social world and shared understanding and support, that the remote setting was a different social world, particularly in regards to cultural differences and social roles. Participants described a lack of appreciation from others of the impact that working in a different social world had on their ability to provide PHC.

The second key finding describes nursing practice in the remote PHC setting as an advanced practice area where nurses with knowledge and skill relevant to the context are a significant health resource for the community. As nurses' expertise grew, and through collaborating with others, they optimised the resources that were available and increased access to health care. This finding suggests that nurses need encouragement and support to access opportunities for learning, both formal and experiential.

Closely related to key finding two, the third key finding questions the ability of nurses to meet their own, and others, expectations of providing PHC. Nurses questioned the concepts of patient involvement and responsibility in health care alongside the issues of a lack of resources, stress among nurses and quality of care provided. These doubts about the ability to provide PHC were expressed in the nurses' descriptions of the compromises they made to their expectations of providing PHC.

The fourth key finding develops the concept of making compromises to providing PHC as an outcome of doing the best you can with what you have. This study proposes a continuum of compromise whereby making compromises can positively or negatively impacts on the ability to provide PHC in a manner that provides job satisfaction and makes a difference to the health of individuals and communities. This chapter explores the key findings and concludes with an outline of the limitations of this study and implications for further research.

## 6.1 Key finding 1: The remote setting is a different social world

The differences between remote health care practice settings (and in particular remote indigenous communities) and those in urban areas, from where most nurses originate, are so extensive that participants in this study described the experience as entering a different social world with cultural, language and communication differences and different social roles. The RANs who participated in this study mostly lived and worked within the remote community setting. This meant that they created their home within the physical and social boundaries of the community. The degree to which nurses understood the social world of the remote community was described as impacting on their ability to provide PHC because understanding the patient within the context of their family and community was described as a crucial element of providing PHC. The nurses' descriptions of this aspect of their role and broader life are synonymous with literature around culture shock and social role adoption and adaption.

### 6.1.1 Cultural differences

Nurses in this study provided examples of cultural and communication differences that arose in the remote setting because there was a much higher proportion of Aboriginal, Torres Strait Islander and Cocos-Malay residents than metropolitan areas. For the nurses in this study, cross-cultural encounters were constant when working in discrete indigenous communities. Some communities had a high tourist population and nurses also described cross-cultural encounters with non-English speaking clients. Their examples described differences in gender roles and interactions, behavioural and body-language differences and differences in language and meanings.

From a nursing perspective, the experience and impact of entering the different social world of a remote community has only been described in an ethnographic study (Cramer, 2005) and in accounts of the lived experience of RANs in non-academic literature (Brayley, 2013; Cameron, 2017; Currie, 2013). The wider issues of  cultural differences and social issues facing RANs has also been identified as significant occupational stressors in a further study (Opie, Lenthall, & Dollard, 2011). Beyond the remote setting, several texts describe cultural differences and provide guidance for nurses in managing cross-cultural interactions (Eckermann et al., 2010; Kowal, 2015; Smith, 2016; Trudgeon, 2000). The current study confirms the significance of differences between remote and metropolitan settings and suggests that these differences impact on the nurses' ability to provide PHC.

The need for education and orientation to social and cultural differences, was identified by nurses in this study who also described experiencing culture shock when they arrived at a remote community for the first time, and to a lesser degree when they moved between communities. This finding is consistent with the expectations of other authors. For example a direct link between the experience of culture shock and adaptation of nurses in remote areas has been described in a literature review (A. Muecke et al., 2011) and recommendations for education on culture shock, social issues and intercultural factors are described by Lenthall et al. (2018).

The concept of culture shock does feature within the nursing literature, however it is largely focused on the experience of new graduates entering the nursing work environment. That said, the characteristics of culture shock that have been described in this context resonated closely with the experience of the participants in this study. In general terms, culture shock is characterised by feelings of discomfort and distress when placed in an unfamiliar cultural environment with different social meanings communication and behaviours (A. Muecke et al., 2011). Five stages are proposed, these are:

1. honeymoon (characterised by euphoria and excitement),
2. disenchantment (characterised by frustration and anxiety),
3. beginning resolution (characterised by crisis resolution and beginning understanding),
4. effective functioning (characterised by feeling comfortable and 'at home'), and
5. reverse culture shock (where nurses experience culture shock on returning to their home culture to find that they and it has changed over time) (Eckermann et al., 2010).

Culture shock has been correlated with high staff turnover and poor quality health care this is most likely to occur when nurse are in the disenchantment phase and have not begun to resolve the differences in cultural experience (A. Muecke et al., 2011). The participants in this study were experienced nurses and their descriptions of their experiences of culture shock were based on personal reflections of the first time of 'going bush'. Their reflections described a key strategy for coping with a lack of understanding of the different social world, which was labelled, seeking understanding. Seeking understanding implies the active pursuit of knowledge rather than passive learning, although it is likely that nurses will learn about the social world of the remote setting simply through immersion in the context. Seeking understanding best aligns with the beginning resolution stage where nurses develop strategies to learn about the social world and to function relatively effectively. Whilst some participants expressed frustration with their current roles and diminishing job satisfaction associated with the inability to provide PHC; most of the participants indicated that they enjoyed living and working in the remote setting. This satisfaction, combined with their longevity in remaining in remote areas may indicate that the participants had resolved their culture shock and were in the effective functioning stage.

This study frames examples of cultural difference as conditions that impede the nurse's ability to provide PHC because nurses needed to understand the social world of the community in order to provide a holistic, social justice approach to care. People who enter a different cultural context and expect eventually to return to their original social setting are referred to in the literature as 'sojourners' (Bochner, 2003). The work performance of sojourners has been described as relative to the degree of cultural difference with the host society; although the experience is not always negative as some people thrive on the challenge of cultural adjustment (Bochner, 2003). The suggestion that sojourners are less effective in their work is supported by Cramer (2005), who explains finding in her study in an Aboriginal community, that there was a strict segregation between Aboriginal residents and others and that this segregation ". . . governed most social relationships" (p.19). This segregation inhibited the nurse's ability to communicate and relate to community members which in turn reduced the ability to provide PHC. However, Cramer (2005).also claims that nurses who were trusted and respectful were given special privileged information, both personal and cultural by the community so that nurses could understand what the illness meant to them.

Cramer's (2005) findings resonate closely with the findings of this study in that nurses in this study also described having to interact with people in a completely different way compared to other nursing practice environments. For example, nurses described challenges associated with communication in this new world where people often spoke in languages other than English and communicated in an indirect style that was different to the direct question-answer style commonly used in mainstream health services. Communication with Aboriginal and Torres Strait Islander peoples has been described as a “consultation spiral” by Smith (2016) (p.145), who suggests that consultations start with broad topics such as family connections and hobbies in order to build trust and communication, then moves to more specific topics, often over more than one interaction. This reflects the experience of nurses in this study who described relationships with their patients that extended beyond a single consultation and they valued having continuity of care with patients and their families. Establishing trusting relationships in order to provide PHC was frequently stated as important to the nurses in this study, and this is also supported by Smith (2016), who described establishing trust and rapport as “. . . critical” (p.144). However, establishing relationships with Aboriginal and Torres Strait Islander peoples may be challenging for non-Indigenous nurses due to differences in language and culture and the history of colonisation and prejudice evident in Australian society (Kowal, 2015; Smith, 2016).

Furthermore, cultural differences in this social world were evident when nurses in this study described themselves as being in a cultural minority, which for most was a new experience. These cultural differences meant that they had to find ways of adapting to this complex new world and its social expectations of the nurses role. Nurses described the process of adaptation as “getting used to it”. As experienced nurses, the participants in this study recognised that their understanding of this different social world occurred over time and through interactions with community members. They claimed that as their understanding of the social world deepened they were better able to provide PHC that met their expectations of treating the patient holistically within the context of their family and community. Therefore, seeking understanding was a two way interaction where wanting to understand another person’s social world required a trusting relationship where information and experience could be safely shared. Nurses described introducing themselves to significant people in the community, participating in community activities and making connections with people, as methods of knowing and being known by the community. Understanding power relationships within a community and within the delivery of health services as well as understanding historical influences on the community have previously been described as important strategies for effective remote practice (Smith, 2016). Participants in this study also valued their personal relationships with patients and the wider community as resources that facilitated access to health care. However, participants also stated that they would never be able to fully understand the worldview or social world of indigenous peoples (specifically Aboriginal and Torres Strait Islander and Cocos-Malay peoples). In this regard, seeking understanding is also an element of continually learning. This finding is supported by a very recent study that examined the intrinsic and extrinsic work motivations of health practitioners who stayed for extended periods in remote areas  (Tyrrell, Carey, & Wakerman, 2018).Tyrell and team identified intercultural interests such as those discussed by participants in this study as a significant motivational variable that best predicted more than three years duration of employment in very remote areas.

### 6.1.2 Social roles

When entering the remote community social world, nurses described inheriting a social role of ‘the nurse’. Understanding social roles is grounded in Symbolic Interactionism, which is defined as the “Theory of how the self emerges from human interaction that involves people trading symbols (through language and gesture) that are usually consensual and represent abstract properties rather that concrete objects” (Vaughan & Hogg, 2014p.608). In this study, social roles within a community and shared understanding through interactions with other people influenced the nurses’ sense of self and identity. Nurses were often seen as a representation of a social object, in other words as a collective ‘we’ rather than an individual ‘I’ for example, “*that’s who you are in that community. You are the nurse;*” (RAN6). This notion is supported by Parson’s (1939) theories on professional and lay relationships and social roles, and especially by sociological concepts like “dual relationships”. Dual or multiple relationships refers to different social relationships with the same person (Germov, 2018). These concepts resonated with the participant’s descriptions of the importance of social relationships and their need to hold multiple roles within the community such as ‘nurse’ and ‘friend’.

Dual relationships were also evident when nurses described their colleagues as the only people to socialise with. Nurses living in remote communities were unlikely to have existing personal support networks or family within close proximity and due to being the cultural minority, they often looked to their colleagues for support and opportunities for recreation and socialising. A lack of social support within the occupational setting has also been identified as a significant contributor to stress amongst RANs (Dollard et al., 2012). This behaviour can be explained by the similarity-attraction hypothesis, which states that people seek out others with similar values, appearance, language and culture (also called in-group bias) which is known to be reassuring in a cross-cultural environment (Bochner, 2003). It is also known that sojourners with host-culture friends are more likely to have a positive experience of their new environment as their host-culture friends function as cultural mentors (Bochner, 2003). These concepts were evident in the current study when nurses talked about making a home in a work environment. Comments referring to limited options for social interaction and needing to spend time away from the remote community are examples that support the similarity-attraction hypothesis.

In contrast to urban areas where nurses can separate their professional and personal roles, the category labelled, *Home-making in a work environment* that emerged from the data collected for this study, described activities that nurses undertook to separate their personal and professional lives. Separation of personal and professional roles is described by Germov (2018) as two types of social relationships within communities: ‘Gemeinschaft’, which are social relationships that are based on personal bonds of friendship or kin; and ‘Gesellschaft’, which are social bonds that are based on personal and specialised relationships. It was evident that the degree of separation between personal and professional social relationships differed between nurses and between different communities. Nurses’ experiences ranged from full immersion in community life (including being considered family and speaking the local language which is evidence of gemeinschaft) to choosing to remain isolated from the community by maintaining strict separation between personal and professional identities (relationships that could be described as gelleschaft. Nurses in this study inferred that the purpose of these boundaries was to conserve the nurses’ personal resources by providing adequate time to rest and maintain their personal identity.

Nurses in this study described frequently being asked for medical advice outside of the professional setting and during personal time, including having people come to their homes for medical assistance. Some participants were annoyed or distressed at this intrusion into their private time, while others considered it to be part of the job. Preventing patients from seeking assistance at the nurses personal residence has been recommended as a policy aimed at reducing the risk of violence (McCullough, Lenthall, et al., 2012). However, it is not known whether this policy impacts on community expectations of the nurses’ role. Learning about the communities expectations (often set by previous nurses) and establishing boundaries that met their own personal needs, were stated by participants as important tasks for nurses new to this social world. Establishing professional boundaries and maintaining personal relationships has been identified as a job demand specific to nursing in the remote setting (Lenthall et al., 2018), the findings from this study, provide some description of the actions of nurses to determine and maintain personal and professional boundaries such as activities that aimed to educate community members about their different social roles and personal needs for rest and privacy with some effect.

Furthermore, knowledge of social roles of others within the community was identified as important to nurses within the remote setting. This degree of knowledge is not often needed when working within a metropolitan inpatient setting where care is oriented towards the individual rather than the community. The category labelled, *Tiptoeing around the politics* describes the nurses’ understanding of the power plays and vested interests within a community and nurses described community politics as influencing the way people accessed health care and the way health care was provided. Bourke, Humphreys, Wakerman, and Taylor (2012) proposed six key concepts that facilitate understanding of the rural and remote healthcare setting. They drew on Giddens' theory of structuration, which posits that overarching structures are created by and influence the actions of individuals, the six concepts included: geographic isolation, the rural locale, local health responses, broader health systems, social structures and power. Whilst, Bourke et al. (2012)'s framework goes some way to helping understand the complex nature of the remote setting and PHC context, the current study adds a nursing perspective that the remote setting is a complex social world and providing PHC relied on a good understanding of the social world of the local community by nurses. This study also found that participants were involved in community activities outside of the health arena in order to gain a deeper understanding of what was happening within the community.

### 6.1.3 Summary

This study revealed the significance of the social world to nurses providing PHC in the remote setting. Participants reflected on their own experiences of entering this different social world and described experiencing culture shock due to cultural differences. Social roles and identity were factors unique to the remote setting and nurses described forming boundaries between their personal and professional lives in order to manage their different social roles. The unique social world and social roles in remote communities was found to impact on nurses' ability to provide PHC, with increased contextual knowledge correlating with an increased ability to provide PHC. In addition to knowledge of the social world, the current study identified nursing knowledge and skill as fundamental to the provision of PHC in the remote setting.

## 6.2 Key finding 2: Developing nursing knowledge and skills increases health resources

In addition to nurses describing the remote setting as a different social world, nurses in this study also described nursing practice as totally different from other nursing specialty areas. They described their role as 'generalist' where nurses needed to know a little about a large range of topics and know how to get more help and information when needed. In describing their clinical practice they talked about needing clinical and assessment skills as well as specific knowledge about how to provide PHC. Discussion of the key finding that developing nursing knowledge and skill increases health resources is prefaced with a discussion about nursing scope of practice, the development and meaning of expertise, and the contribution of nursing knowledge to community resources. Finally, collaborating with others is discussed as a strategy to enhance access to health services and optimise the resources available.

### 6.2.1 Nursing scope of practice

A fundamental requirement of nurses is that one works within the scope of one's skills and experiences and it is recognised that skills and experience are engendered through observation and practice. Given this, nurses in the current study understandably described feelings of anxiety when they were required to deal with a clinical situation or perform a skill they had not encountered before. Although nurses were able to consult with a doctor via phone and use clinical guidelines to aid decision-making they frequently made independent clinical decisions. Autonomous practice and the need to do things because there was no-one else to do them, caused anxiety and concern that their practice was sometimes outside of their designated scope of practice and potentially unsupported by legislation.

A perceived lack of clinical knowledge and skill, particularly when working alone, has been described by several authors (Becker, 2016; Cramer, 2005; Lenthall, 2015). Notably, in her thesis on the experience of locum nurses, Becker (2016) described nurses entering the remote setting as ". . . urban-based professionals with urban-based education" (p.167). Her findings described confusion about scope of practice and concern about the level of decision-making that was required. In the current study participants described other nurses with little or no experience in this setting as having a narrow acute care focus that reflected their specialist urban knowledge and skill. A further study by Ashley, Halcomb, Brown, and Peters (2018), described the experiences of RNs who transitioned from acute care to PHC, describing them as commonly reporting difficulties with adjusting to the new practice setting. Almost half of their respondents reported feeling isolated, unsupported or overwhelmed with the transition process. This finding was similar to the findings of the current study. However, the impact on the nurses who were supervising, educating and supporting nurses who were transitioning were not reported by Ashley et al. (2018) whereas nurses in the current study described the high level of staff turnover as draining the resources of the permanent staff because of the need to provide additional supervision and support to transitioning nurses.

Ethical principles and legislation are an integral part of a definition of 'scope of practice' and 'duty of care'. Nursing standards and codes of conduct (Nursing and Midwifery Board of Australia, 2014, 2018) do not specifically define what tasks nurses can and cannot do. Furthermore, myriad of other legislation impacts on nursing practice such as: Poisons and Dangerous substances Acts; Privacy and confidentiality Acts; Occupational Health and Safety Acts (Australian Health Practitioner Regulation Agency; Crisp et al., 2013). Therefore, the context plays an important part and a judgement of negligence requires analysis of the actions of the nurse as compared to what would be the expected actions by a 'jury' of peers. Kerridge and associates describe it thus:

> *. . . a modified Bolam Test. . .* [in] *Australia. . . provisions apply to 'professionals'. . . and are not limited to the medical profession . . . A health professional does not incur liability if it can be established that he or she acted in a manner in Australia by peer professional opinion as competent professional practice (Kerridge, Lowe, & Stewart, 2013, p. 209)*

Kerridge et al. (2013) discuss how courts consider the context of an individual case and according to Killman et al (as cited in Kerridge et al. (2013), p.1011) ". . . the standard of care owed by a health professional will be different in a remote community compared with a modern metropolitan hospital". This statement does not excuse poor care, but indicates the importance of understanding the impact of context on practice. Nurses in this study described frequently questioning whether a particular situation was within their scope of practice which indicates confusion about the legal standing of some nursing activities in the remote setting, particularly in situations where the nurse is working alone and needs to attempt a task where they have not been formally instructed or assessed as competent.

Perceived differences in the scope of practice of an experienced RAN or NP and a novice or locum nurse were also described in the current study. These differences were often communicated with consumers and other health team members through the use of professional labels such as Remote Area Nurse (RAN) or Remote Area Nurse Practitioner (RANP). However, the term RAN is currently adopted by nurses who work within the remote setting regardless of how long they have worked there or whether they have any formal qualifications relating to remote nursing. Without a universally accepted framework for who can use the term RAN, it is up to individual nurses to self-identify. This creates a situation in which it can be implied that a nurse has specific knowledge and skills that they may not have. In response to this situation, a professionally credentialed RAN designation has been promoted and administered by CRANAplus, which is the peak professional body for the remote and isolated health workforce of Australia, in order to formally recognise nurses who can demonstrate that they are practicing within the remote standards of practice framework (CRANAplus, 2012a, 2013a, 2016). None of the participants in this study had undertaken the credentialing process at the time of data collection. In the future, as more nurses undertake the process to formally adopt the term RAN, it may easier to describe remote nursing practice as an advanced specialty because research could differentiate between a RN working in a remote setting, a RAN as an advanced practice nurse and an NP.

Although some nurses in the current study discussed anxiety and ambiguity regarding their scope of practice and having to do things that they were not confident or competent to do, other nurses in this study embraced an expanded practice and the opportunity to work within what is traditionally considered the medical domain. This variation is likely due to many of the participants being NPs or having undertaken some form of post-graduate education that was relevant to remote PHC nursing practice. NPs with a remote scope of practice are expert nurses, as evidenced by: successfully completed postgraduate tertiary level qualifications (Masters' degree), a minimum of 5 years' experience in their area of specialty and having undergone a process of independent review. Their scope of practice includes the ability to prescribe medications and order radiology and pathology tests. It is a clinically focussed role and includes research, education and leadership in clinical care (Nursing and Midwifery Board of Australia, 2014). In Canada, NPs are recognised as an essential component of PHC reform (Browne & Tarlier, 2008; Donald et al., 2010). Mills, Lindsay, and Gardner (2011) also claim that NPs in rural and remote areas have the ". . . potential to transform healthcare" and that health authorities should be actively creating NP positions within their organisations. Carryer and Yarwood (2015) also propose that NPs in PHC could be the catalyst for transforming health delivery in New Zealand as a way of better meeting the rising need for health services as a result of aging populations, chronic disease and increasing health inequality.

### 6.2.2 Developing expertise

The current study identified a lack of clinical knowledge and skill as a key condition that contributed to the inability to provide PHC. In response to this condition, nurses engaged in a learning process in order to develop the necessary knowledge and skill to be able to provide PHC. It was apparent that actively engaging in formal and experiential learning opportunities was a strategy to increase clinical competence and decrease feelings of anxiety in clinical practice.

In this study, 'experience', was informally assessed by the participants in terms of length of time spent in the remote context. Experience was a term used interchangeably with 'expert' by the participants. This was due to the largely experiential, on the job learning that occurred and the importance of understanding the social world of the community. An earlier study suggested that it took around four years to become an experienced RAN (McCullough, Williams, et al., 2012). The development process of gaining nursing expertise can be considered in light of Benner's theory: Novice to Expert (Benner, 1984; Benner, Tanner, & Chesla, 2009) in which expertise is described as mature practical knowledge of the patient population within the clinical world. Benner's theory is unidirectional and posits the development of expertise as progressive, however, the current study identified a perceived regression in nursing expertise, as the context was so different to other nursing contexts of practice. This was evident in the participants statements that they 'knew nothing' within this clinical context despite being experts in other areas like Emergency departments in which they were highly skilled and functioning as experts.

Benner et al. (2009) also wrote about nurses needing time to “. . . get settled” (p.142) when caring for a patient for the first time. During this settling time, nurses come to know the patient and this information was integrated into the nurse’s clinical grasp of the situations they were required to deal with. In the current study, the settling time could be considered as the time taken to develop an understanding of the social world and acquisition of nursing knowledge and skill though practical experience. Benner (1984) claims that experience requires “. . . encounters with many actual practical situations” (Benner, 1984p.36). Therefore, it is the acquisition of knowledge and the practical application of that knowledge in a variety of situations that form the basis of nursing expertise. This is relevant in a context of very high staff turnover because nurses are simply not spending enough time within the remote setting to develop expertise.

In this study, the category, continually learning describes an ongoing strategy of personal and professional development in response to identified knowledge deficits. All nurses in this study described engaging in postgraduate midwifery study, remote health practice-related learning or other courses as a way of developing the advanced practice skills necessary to provide PHC. Studying was an important activity for these participants as evidenced by the time and effort they made to engage in study in addition to a full-time workload. One nurse completed her midwifery practicum on her days off committing to a 1600km round trip each time, while others described spending their weekends and evenings studying in order to fill the gaps in their knowledge. Formal learning was motivated by a desire to provide better care to patients, particularly when they were the only practitioner available and were faced with complex clinical situations. These findings are supported by the work of Hallinan and Hegarty (2016) who researched the impact of postgraduate education on the practice of nurses in the Australian primary care setting. Although their sample was predominantly nurses working in general practice, two thirds of their respondents worked in rural or remote settings. One respondent stated that they completed a postgraduate qualification in primary care in order to increase the likelihood of employment in the remote setting. The survey respondents indicated that gaining a postgraduate qualification increased their scope of practice and autonomy, job satisfaction and improved clinical practice. They found that postgraduate education enhanced the ability for nurses to undertake health promotion activities, particularly in response to chronic disease, women’s health and education. Furthermore, in a literature review regarding the impact on nursing practice of Master’s level postgraduate education, Cotterill-Walker (2012) claims that nurses with master’s level qualifications have increased self-esteem and confidence, improved communication skills, personal growth and increased ability to apply theory to practice as well as enhanced analytical and decision-making skills.

### 6.2.3 Nursing knowledge as a community resource

In this study, nurses with higher levels of clinical expertise were considered better able to provide PHC. This was primarily associated with the belief that as nurses extended their scope of practice and were able to offer more health services to the community, particularly in the case of NPs. Indeed, The National Rural Health Alliance Inc. (2005) recognises the importance of clinical, cultural and remote contextual experience and the contribution this makes to improving health. Although Benner's research was conducted primarily in intensive care situations the following description of expertise resonated with the findings of this study,

> The big picture includes a sense of the future, recognizing anticipated trajectories, and grasping a sense of future possibilities for the patient and family. These nurses also have an expanded "peripheral vision", sensing the needs of other patients in the unit and the capabilities of nurses assigned to care for them and recognizing when greater expertise may be required (Benner et al., 2009p.151).

In the current study, seeing the big picture resulted in a change in nurses' perspective from seeing their role as providing acute care towards preventative health care and activities aimed at reducing social inequalities; they could see the future possibilities and were motivated to make a difference. Farmer, Prior, and Taylor (2012) proposed a theory of the contribution of health services to the social capital and sustainability of rural communities. Community capital was considered to be the ". . . sum of the value of all capital goods in a community" (Farmer et al., 2012p.1905), which includes both tangible resources (for example, people or buildings) and intangible resources (for example, qualities or skills). Farmer and colleagues identified contributions made by individual health professionals to social capital in terms of sharing personal knowledge, skills and qualifications, contribution to the social aspects of a community through participation and informal health and social care, and economic contributions from personal consumption of goods and services. This theory resonates with the current study, in which nursing expertise has been positioned as knowledge capital and its value as a community resource confirmed.

In this study, collaborating with others was a strategy employed by the participants that enhanced community access to health care and optimised resources. The nurses in this study described their role as coordinator of both the multidisciplinary team and community member's health care. Nurses described this role as 'linking' people with health services. As the resident health professional, experienced nurses described having an excellent understanding of health needs across the community in which they worked. They also often knew how to contact individuals and how to encourage them to attend the clinic to see visiting specialists or to travel to a regional centre for specialist care. These participants combined this local community knowledge with their knowledge of the health system and professional networks and they were skilled in using technology to overcome the barrier of distance. Their role as facilitator was fundamental to providing PHC because they created an environment where people felt confident and safe to seeking care by building relationships and trust. Participants in this study described these relationship as ‘authentic’. This perspective is important because it shows an understanding that access to health services is more complex than just having a service available (Levesque, Harris, & Russell, 2013). The importance and value of multidisciplinary collaboration in PHC settings has been described, although not within the remote and rural context (Dinh, Stonebridge, & Theriault, 2014; Schepman, Hansen, De Putter, Batenburg, & De Bakker, 2015) and includes a call to move beyond a focus on health to inter-sectoral action on the social determinants of health Anaf et al. (2014). Anaf et al. (2014) described similar constraints on PHC activities similar to what was described in this study, such as, a lack of adequate resources and challenges associated with a lack of shared understanding of the social view of health. When describing good practice in PHC, they emphasised the importance of building relationships and working with a range of community partners outside of health.

In addition to building authentic relationships with the community and broader health network, nurses in this study discussed their role when visiting specialist health teams arrived in the community. Facilitating community access to these services required significant organisational skills and knowledge of the community in order to efficiently use this resource. A recent systematic review related to the provision of visiting services in remote areas (Carey, Sirett, Wakerman, Russell, & Humphreys, 2018) presents evidence that trust and continuity of care is associated with increased effectiveness. Co-ordination and support are considered fundamental in maximising the value visiting services can provide in conjunction with resident health services. The current study lends support to the crucial role that RANs play in optimising access to visiting health resources by the community. Further support for the time RANs spent in facilitating access to care can be found in a work sampling study by Australian researchers, which included (but did not describe separately) NPs in remote areas, which found that service related activities and coordination of care consumed more time than direct patient care (Gardner et al., 2010). Participant data collected in the current study confirms that these activities consume a significant proportion of RANs’ time.

### 6.2.4 Summary

A key finding of this study is that providing PHC in a remote setting required different knowledge and skills to those found in any other nursing practice setting. Nurses described starting work in remote environments as unprepared educationally and clinically for the context, even if they had many years nursing experience and inferred or directly stated that they needed support and time to grow and adapt to this environment. Learning occurred through experience and attainment of formal post-graduate qualifications. Combined with multidisciplinary collaboration, developing clinical knowledge and skill increased the availability of resources and improved access to care for remote communities. Whilst the attainment of knowledge and skill in regards to the social and clinical requirements of providing PHC in the remote setting increased the ability to provide PHC, the current study raised questions about the appropriateness of expectations of providing PHC in the remote setting.

## 6.3 Key finding 3: Is providing PHC an unrealistic goal in the remote setting?

The discussion in this section considers the role of the patient and community in PHC services and the impact of a resource-poor environment on nurses' ability to provide PHC. Key finding 3 casts doubt on the practicality of providing PHC and indeed whether nurses and communities are working towards a common PHC goal.

### 6.3.1 Are there different levels of PHC?

In this study, nurses described PHC as providing holistic care that addressed the physical, social, psychological and emotional needs of the individual and the community. The participants used words such as 'comprehensive', 'holistic', 'complete' and 'whole' to describe quality care within the PHC context. They also described providing this level of care as requiring extensive knowledge of the social world, wide-ranging clinical and health system knowledge and the resources to provide PHC. They measured success in reaching their goal of providing PHC by feelings of satisfaction that they were making a difference to the health of individuals and the community. This view is consistent with other descriptions of providing as a strategy to reduce health and social inequalities (Browne, Varcoe, Ford-Gilboe, & Wathen, 2015; Eckermann et al., 2010; McMurray & Clendon, 2010; Smith, 2016; Talbot & Verrinder, 2018).

A study was undertaken in Australia which developed the Southgate model of Comprehensive PHC applicable to the Australian context (Lawless, Freeman, Bentley, Baum, & Jolley, 2014). The model provided a detailed understanding of the structural elements of providing PHC but did not include the actions of nurses (or other health professionals) within the model. The authors used the term 'comprehensive PHC' which suggested variation in the definition or understanding of PHC although this was not defined as different from simply PHC. Labonté et al. (2008) define comprehensive PHC as an ". . . approach aimed at reducing health inequities that is based on meaningful community participation, multidisciplinary teams and action across sectors" (p.58) they contrast this with examples of selective PHC such as ". . . low cost interventions, mostly directed to child survival" (p.58). Similarly, Talbot and Verrinder (2018) state that PHC, primary care and comprehensive PHC are often used interchangeability. They explain that primary care describes a level of care which is often the first point of contact with the health system, usually through contact with GPs, whereas PHC (or comprehensive PHC) services are ". . . guided by the principles of equity, social justice and empowerment" (p.25)

The idea of levels of PHC was raised in the current study in relation to the inability to provide PHC. Nurses stated that at times they provided 'selective PHC', 'acute care', 'some care' or even 'band-aid' care as opposed to comprehensive PHC. How these levels of care were defined is not known but anything less than the comprehensive PHC described by these nurses is presumably an outcome of the inability to provide PHC. However, this variation also suggests that comprehensive PHC may be an unrealistic or even undesirable objective in some communities. This notion was suggested by participants when they described differing expectations of health service delivery in some communities where managers expected a focus on acute care. It is not known how the provision of services is determined although some research has attempted to describe what health services should be available in remote PHC facilities (Hussain, Robinson, Stebbing, & McGrail, 2014; Thomas, Wakerman, & Humphreys, 2015; Wakerman & Humphreys, 2011). The current study, with its focus on the perspective of nurses, adds to this discussion by emphasising the crucial role of nurses as providers of PHC and a significant community health resource.

### 6.3.2 Who is responsible for health care?

A lack of consensus between nurses and the community around the expectations of what providing PHC entails was evident in this study as some nurses were concerned that communities and individuals did not share their aim of empowerment and personal responsibility for health. This was particularly evident when participants described individuals and communities as being unengaged with health promotion activities. Nurses explained that people often came to the clinic when they had an acute health need but not for routine health assessments, education sessions or preventative treatments.

Government policy notes that health systems oriented towards Primary Health Care have lower hospitalisations, better health outcomes, reduced health inequalities and greater efficiency (Commonwealth of Australia, 2013). Within this framework, PHC services are charged with providing support to patients and families ". . .to be in control and actively supported in decision making. . .helps them to manage their health care needs. . .and empowers the individual in their own self-care and monitoring" (Commonwealth of Australia, 2013p.7). The discourse clearly places responsibility on patients to be active participants in the health system. The current study adds new narrative to the discussion about how much responsibility should nurses carry for ensuring people attend appointments and adhere to treatment regimens and how much of that responsibility should be left to the patient and community.

Nurses in this study described the majority of their work as aimed at management of chronic disease and illness prevention and that these activities were more satisfying than dealing with acute care or emergency situations because they had the potential to make a long-term difference in health outcomes. One measure of success was in the prevention of aeromedical and road evacuations to hospital from the community. They acknowledged the financial and health benefits of people receiving care within their own community (Commonwealth of Australia, 2013). To this end, nurses incorporated health promotion activities and education into an acute care consultation. They called this ‘opportunistic care’ and indicated that this was more likely to occur with experienced nurses who were aiming to provide PHC. They also actively sought out people who did not attend the clinic regularly or missed scheduled appointments. These activities were described as elements of facilitating access to health care and would be considered high level interventions, described as case-management in the National Primary Health Care Strategic Framework (Commonwealth of Australia, 2013). The idea of opportunistic care has been suggested by others who have called for a shift in thinking where emergency departments expand their services to include health promotion and public health activities (Bensberg & Kennedy, 2002; Egerton-Warburton, Gosbell, Moore, & Jelinek, 2015). The benefits have been reported to include recognition that PHC already occurs to varying extents in most EDs and that EDs are a ‘safety net’ for people who are not accessing other services (Rhodes, Gordon, Lowe, & The Society for Academic Emergency Medicine Public Health and Education Task Force Preventive Services Work Group, 2000). Furthermore, evidence suggests that an acute presentation may be an opportunity for education and prevention of health deterioration which may ultimately result in a hospital admission (Rhodes et al., 2000).

However, nurses also described feeling frustrated and in conflict with what they perceived to be taking responsibility for an individual’s health. Some participants saw these actions as ‘nannying’ or ‘paternalistic’ and contra to the PHC goal of self-management and empowerment. There was conflict in the views of participants about what were acceptable actions, given the limited resources and time taken to do these activities, such as driving around looking for patients who needed to be seen by a visiting health specialist or going to people’s homes to provide care if they did not attend the clinic. Some nurses resolved this conflict by either justifying taking responsibility based on apparent inability of the patient to self-manage (e.g. elderly), or a conviction that early intervention and prevention was better and cheaper than dealing with complications at a later date (e.g. RHD prophylaxis). Other nurses adopted a more pragmatic view of “all you can do is offer the services and if people won't use them then that's their choice". This conflict can be understood as part of the sociological structure – agency debate, which considers the influence of structural forces such as health service delivery, colonisation and injustice and community roles and cultural expectations; with the individual's agency, rights and perspectives on what health and wellbeing mean to them (Germov, 2018). Kowal and Paradies (2005) also studied the structure-agency conflict in Indigenous Public Health research and ". . .argue that many public health practitioners are troubled by the possibility that Indigenous rights to self-determination and to define their own notions of health, are in conflict with universal measures of and approaches to improving health" (p1349). Their study helped explain the sense of conflict described by participants in the current study by outlining the moral obligation members of society have to the Government that they will endeavour to be good citizens and make healthy life choices in return for access to government provided health care. The frustration expressed by participants in this study may be due to differences in expectations or moral reasoning in relation to who holds responsibility for health.

Also relevant to the idea of health self-management and negotiating one's own health goals is the perspective of Sadler, Wolfe, and McKevitt (2014), particularly in the suggestion that the health professional's goal of self-management is really an expectation of compliance with medical treatment. Sadler and colleagues described differing expectations of responsibility for self-management and that health professionals made moral judgements about the patient's apparent willingness to self-manage. They also found that at times there was conflict between the health professional's duty of care and self-management. Furthermore, M. Wilkinson, Whitehead, and Crowe (2016) also describe potential tension between the aim of promoting patient self-management and patients' beliefs or ability to manage a long-term medical condition according to best practice. The authors recommend that nurses focus on making it their goal to practice in partnership with patients in an approach where best practice is not privileged over the patient's right to act or make decisions that represent their own perspective of self-management. A partnership approach was evident in this study when nurses described providing PHC within the context of a person's family and community, however the ideal of best practice and negotiation was limited by the resources available.

However, a study conducted in the largely Indigenous Pilbara region of Western Australia, reported that health promotion initiatives, in particular education about healthy lifestyles, were a high priority from the perspective of people in the Pilbara (Walker, Stomski, Price, & Jackson-Barrett, 2014). Their participants described self-empowerment as taking responsibility for improving their own health and role models as having the greatest influence. Community involvement in health care delivery was also a significant activity to improve the health of their communities. These findings suggest that there may not be a difference in perspective of what is important but rather the role and responsibilities in achieving empowerment may need to be clarified. It is clear that dialogue between communities and health providers is necessary in order to clarify and negotiate the responsibility of individuals to seek care and the role of health workers to seek out individuals given the availability of resources.

### 6.3.3 Lack of resources causes stress and reduces the quality of patient care

A lack of resources was a common explanation for the inability to provide PHC. Whilst there were some examples provided of a lack of physical resources such as equipment; overall, nursing practice was constrained by the number of health professionals with which to work. The finding that practical constraints exist on service delivery in remote areas as a result of reduced economy of scale is consistent with earlier work in the field (Humphreys et al., 2008; Paliadelis, Parmenter, Parker, Giles, & Higgins, 2012). These studies support the perspective of nurses in the current study that the remote setting is different and that many services provided in urban areas cannot reasonably be expected to be provided because of the cost of travel and equipment.

Nonetheless, a lack of resources was described by the nurses in the current study, primarily in terms of not having enough staff with the right knowledge and skill to attend to the health needs of the community. This resulted in nurses describing that they did not have enough time to provide PHC in a context of both suboptimal efficiency because of limited access to appropriately skilled staff and the amount of time necessary to spend in engaging community members and learning about the social world. Lack of time has also been identified as a significant factor leading to feelings of dissatisfaction when providing PHC by general practice nurses (Halcomb & Ashley, 2016).

The impact of frequent staff turnover was described as creating a workforce that often lacked the necessary clinical and community knowledge to provide this care. Difficulty in recruiting and retaining health staff in remote areas is a global phenomenon (Atherton & Kyle, 2016; MacLeod et al., 2017; Mbemba, Gagnon, & Hamelin-Brabant, 2016).

This finding also supports research on the topic of reducing occupational stress among nurses in very remote Australia that states: “There was a commonly held view among RANs that the remote communities and health services have unrealistic expectations that cannot be met. This is often exacerbated by the advanced practice role that RANs are required to perform without adequate preparation” (Lenthall et al., 2018p.186).

Variation in the ability to provide PHC services has also previously been described as commensurate with the proportion of staff to population or health need (Thomas et al., 2015). Thomas and colleague's Delphi study recommends that populations over 100 residents should have access to resident health workers who can provide acute care and mental health, sexual health, child and maternal health and public health/illness prevention services. Their study reinforces the perspective of nurses in the current study that providing comprehensive PHC services in remote communities should be the aim. However, the occurrence of high staff turnover and difficulty in recruiting staff to remote areas has been well documented (Garnett et al., 2008; Lenthall, Wakerman, Opie, Dunn, et al., 2011) and suggested to be the main outcome of stress in various nursing contexts (Baernholdt & Mark, 2009; Delobelle et al., 2011; Hayes et al., 2006). The turnover rate for nurses working in remote clinics in the NT is estimated at 150%, this is in stark contrast to other nursing non-remote contexts where a turnover rate of 40% is considered high (Zhao et al., 2018). Reducing staff turnover by providing additional personal and professional support is proposed as the answer to improving quality of patient care and reducing costs (Zhao et al., 2018). Providing this support would require additional resources but these costs are likely to be offset by savings made from lower staff turnover (Zhao et al., 2018).

Like the participants in the current study, Henderson, Koehne, Verrall, Gebbie, and Fuller (2014) identified access to resources, including time constraints, as significant barriers for PHC nurses in a variety of urban, rural and remote settings. The nurses in the current study emphasised that it was not just a lack of staff but rather a lack of staff with the necessary skills and knowledge, a finding also supported by Onnis (2016) in research investigating what characterises a sustainable remote health workforce, found 'suitable' personal characteristics and professional attributes to be essential for meeting the health needs of a community. These characteristics included professional competence but also an ill-defined quality called 'person-fit' that described a match between the individual person and the particular community that they were working in. In the current study, the idea of person-fit can be seen in the nurses' comments about how they felt a sense of belonging in particular communities and a desire to make that community their home. Onnis's (2016) paper also mentions resilience, enjoying living in rural and remote areas, achieving job satisfaction by fulfilling their needs and aspirations and meeting challenges, as personal characteristics that are valuable for the sustainability of the remote workforce. The nurses in the current study also demonstrated these characteristics when they discussed their motivations for providing PHC as wanting to make a difference and then persisting in the face of significant professional challenges and becoming expert nurses.

Nurses in this study described a chronic lack of availability of other nurses, and this meant that those present were required to do more on-call than they would like, and were not able to take leave when required. The resultant stress and fatigue reduced their personal resources and impacted on their ability to provide PHC. The extensive study “Back from the Edge: reducing occupational stress among remote area nurses in the Northern Territory” (Lenthall, 2015; Lenthall, Wakerman, Opie, et al., 2009; Lenthall, Wakerman, Opie, Dunn, et al., 2011; Opie, Dollard, et al., 2010; Opie, Lenthall, et al., 2010; Opie, Lenthall, Wakerman, et al., 2011) also details similar factors that led to stress in the RAN workforce. This participatory action research study, identified lack of emotional support, high levels of responsibility, high workload, social issues and unrealistic expectations from employers and communities as the major job demands that contributed to stress and high staff turnover.

Nurses in the current study also talked about the impact of management on their ability to provide PHC. In particular, poor management was described as a significant stressor (Lenthall, Wakerman, Opie, et al., 2009). Nurses in the study reported in this thesis said there were ‘unrealistic expectations’ from their managers which compounded their feelings of stress. For some participants; there was not a shared understanding with managers of what providing PHC meant, even when there was an organisational policy outlining a PHC approach to the health service. These feelings of a lack of support from managers in the remote setting has also been described by others. For instance, Weymouth et al. (2007) specifically explored the phenomena of ‘distance management’ where managers were based in regional centres away from the remote setting and found that poor management was the motivation for many RANs to leave the remote setting. Similarly, Onnis (2016) described a sustainable, multidisciplinary remote health workforce as reliant on people, place and practice and concluded that, “Management practices were recognised as being critical for developing, implementing and maintaining the sustainability of remote health workforces”(Onnis, 2016p.7). Beyond sustainability of the workforce, a literature review regarding the nursing practice environment found that nurse manager leadership and support has also been linked to patient safety and nurse retention by other authors (Twigg & McCullough, 2014). Therefore, the actions and interactions between nurses and their managers in the remote setting is an important factor in the ability for nurses to provide PHC.

Findings in the current study suggest that stress and dissatisfaction would be reduced if more resources and education were available because they would facilitate nurses to be able to better provide PHC. A recent paper by the Back from the Edge team that described interventions aimed at reducing occupational stress in RANs found that whilst some of their earlier recommendations had been implemented, many had not due to a lack of financial resources and infrastructure, continued high staff turnover and insurmountable contextual issues (Lenthall et al., 2018) and this is certainly borne out by the experience of the participants in the current study. The substantive theory presented in this thesis adds to the understanding of RAN occupational stress by suggesting that an inability to provide PHC is a significant factor in feelings of stress and the resultant high staff turnover rate.

Furthermore, Buckley (2015) studied the experiences of rural nurses using an ethnographic approach. The findings describe nurses struggling to meet the demands of practice within complex healthcare systems that at times facilitate quality care and at other times reduce the quality of care. Findings showed that nurses in rural settings lacked the resources, both physical and human, to implement the expectation of urban-based policy makers. This sentiment was echoed in the perspective of nurses in this study when they expressed frustration at a lack of understanding from management. Recommendations from Buckley's (2015) study included: encouraging practitioner involvement in policy making, furthering educational opportunities and increasing the scope of nursing practice to meet the community need. Whilst 'rural' and 'remote' have different definitions, there are also many similarities. Given the experiences of participants in Buckley's (2015) study echo those of the nurses in the current study, it is likely that the findings from the current study may also resonate with PHC nurses in rural settings.

### 6.3.4 Summary

This study found that the expectation of providing PHC was to provide a service that attended to the individual's biopsychosocial needs within the context of their community and family as well as the health needs of the community as a whole. However, this comprehensive approach may not be appropriate or achievable in all communities. Therefore, from the perspective of nurses in this study, the goal of providing PHC is unachievable with the current availability of resources and this conflict between what is desired and what can be provided reportedly leads to feelings of stress and frustration. Whilst inadequate resources and a lack of time has been described by others as causing stress and contributing to the high rate of staff turnover, this study is unique in its description of the causes of RAN stress as being due to the inability to provide PHC. In addition, the degree of involvement and responsibility accepted by nursing staff for the health needs of individuals and communities, as well as nurses' and communities expectations of self-responsibility for health and wellness, was a significant tension revealed by this study. The substantive theory presented in this thesis sheds light on these tensions and stressors and describes strategies that nurses use to do the best they could with the resources they had and the outcome was found to be making compromises.

## 6.4 Key finding 4: Making compromises to provide PHC

The substantive theory presented in this thesis describes a process by which nurses seek to resolve feelings of frustration and distress because of the inability to provide PHC. The participants were mostly experienced nurses so their collective perspective demonstrates one of persistence within the setting despite the challenges associated with the context and the core issue. They described making compromises to the outcome of providing PHC in order to provide some care even if it is not as comprehensive or complete as they would like. In these situations, they simply did the best they could with what resources they had.

This concept was also identified in a seminal ethnography of RAN practice which was based on field work conducted in 1995 in a remote Western Australian Indigenous community (Cramer, 2005, 2006). Cramer also stated that “Nurses do their best. Their ‘best’ varies widely according to each nurse’s abilities, attitudes and motivations, and the resources available” (Cramer, 2006p.193). Cramer depicted RAN practice as ‘Amorphous’ which she described as the constantly changing practice of the nurse between situations, nurses and teams. The concept of amorphism strongly reflects what emerged from the current study as the process of doing the best you can with what you have and the outcome of making compromises were highly reliant on the conditions and circumstances of each situation.

Underpinning amorphous practice in Cramer’s work was the theme labelled ‘beyond the nursing domain’. Here, she referred to how different remote nursing practice was from other nursing practice settings. She concluded that ‘difference’ was “. . . commonly used to rationalise aberrant norms of practice, implying that the usual rules, scope and accountability for nurses no longer strictly apply [applied]” (Cramer, 2006p.195). The concept of different nursing practice was clearly articulated in the findings of this study. However, it has been 30 years since Cramer conducted her study and in that time, clinical procedures, guidelines and post-graduate education programs have been developed. It is not known whether her statement would still hold true at the time of writing, however the current study revealed that nurses still experience anxiety over their scope of practice and the extension of that practice into what would in other situations be considered the medical domain. Furthermore, and again similarly to the current study participants, Cramer (2006) also described nursing responsibilities as being, “all encompassing” (p.196) because there was a lack of resources and found that, despite their acknowledgement of the paucity of resources, “. . . nurses often still feel entirely responsible for getting something done” (p.196). Part of the all-encompassing nature of RAN practice was recognition in Cramer’s findings of the diversity of expectations from managers, community members and other team members; as well as the lack of separation of “. . .work, home and social life”(p.197). The result of diffusion of responsibility was described in

Cramer's study as  ". . . unrelieved stress, fatigue and low morale in their work" (p.198). It was evident in the current study that core features of RAN practice, namely the differences of the social world, differences in clinical knowledge and skill and limited resources with which to provide comprehensive PHC that Cramer uncovered continue to be relevant today. This current study concluded that the result of doing the best you can with what you have in a given situation was making compromises.

### 6.4.1 Compromise as a continuum

'Compromise' was a complex concept uncovered in the current study that had the potential to include both positive and negative feelings as evidenced by nurses' descriptions of frustration when the compromise impacted on quality of care or nurses personal satisfaction. In contrast, the participants also described positive feelings associated with rising to the challenges of the remote context such as cultural differences and resource limitations. Compromise is defined as "a settlement of differences by mutual concessions" and "something intermediate between different things"(Dictionary.com, n.d.). Scott (1997) describes compromise as an attempt ". . . to reach a win-win solution. . . [which] is based on a willingness to reach a position that is better than the current one for everyone concerned" (p.149) and goes on to state that "The concept of compromise includes basic trust and respect (among) conflicting parties, recognition of the moral legitimacy of the conflicting claims, and a process of rational argument and decision-making. . ." (Scott, 1997p.149). Scott (1997) also proposes that if the basic attributes outlined above are present then the compromise may be considered to be just and reasonable. However, if the basic attributes are not present, then a compromise has not been met and the outcome of negotiation is morally questionable.

The concept of 'compromise' was presented at a recent CRANAplus conference (Appendix C) and the feedback suggested it was universally recognised by the audience. However, attendees were concerned about the negative connotation associated with the word 'compromise' as they thought it inferred poor quality nursing care. They suggested alternative words and phrases such as 'negotiation' and 'finding an acceptable solution given the circumstances' that indicated factors other than nursing care were responsible for the compromise. The concept of making compromises alludes to the potential for compromises that impact patient safety and the quality of care. When nurses in the current study discussed quality care, they often made comparisons with the level of service available in metropolitan areas. They also referred to the disparity in access to care as part of the inequality experienced by residents in remote communities. If the metropolitan level of service is considered to be the 'gold standard' of patient care then the care in remote areas will inevitably fall short of this standard due to a lack of resources and distance to tertiary-level emergency care.

Further consideration of the phrase ‘making compromises’ generated the idea that making compromises described a continuum with ‘satisfactory compromise’ at one end and ‘unsatisfactory compromise’ at the other. Satisfactory compromises described outcomes that may be novel, fit-for-purpose, or even the best care dependant on the perspective of various players. Alternatively, unsatisfactory compromises lead to feelings of frustration and distress as nurses feel that they are unable to provide the care that they want to. Making a satisfactory compromise in a situation where there are limited resources, may at times result in feelings of dissatisfaction, but may also represent a method of justifying the actions taken and as such ease feelings of frustration and stress. Likewise, some compromises from the nurse’s perspective could possibly be beneficial to the patient and in line with PHC concepts of empowerment and patient choice. Nurses talked at length about the extent to which they took responsibility for healthcare as a structural influence on health or whether the individuals’ agency meant that nurses took a more passive approach and waited for individuals to seek out healthcare services. Either response required compromises, in the efficient use of resources and time required to be spent chasing people and compromises in the ideal of empowerment, agency or even concepts of health and wellbeing. Compromises therefore can be satisfactory, or fit-for-purpose; they may produce the same result using a different method or they may even produce a better result by creatively using new procedures or objects. So, in order to provide PHC in a remote setting nurses had to manage situations of frequent compromise. The consequences of constantly ‘compromising’ included: fatigue, stress, frustration and job dissatisfaction but also feelings of satisfaction when a challenge was overcome or a positive compromise was made.

Some nurses in this study seemed to experience a change of attitude and adoption of a ‘pragmatic’ sense where they justified their actions and outcomes in terms of doing the best they can with what they have, which is a phenomenon that has been recognised previously. Wigens (1997) framed it as ‘rationalisation’ and suggested it to be a strategy used by nurses to alleviate the feelings of distress associated with conflict in values and beliefs. According to Wigens, rationalisation occurs in two ways: nurses do their best for those they felt were most in need, and nurses’ justify why they are not providing the care they want to through rationalisation that they give an equal level of care to all patients and see this as equality of care. Both forms of rationalisation described by Wigens were evident in the current study. Specifically, the first form occurred when nurses rationalised the prioritisation of emergency care over preventative care in term of those people needing them at that moment. The second form was evident in participants’ comments about the reality of not having enough resources to provide care akin with what was available in the city and their rationalisation about the level of care that could be provided given this. Making compromises as a coping strategy employed by RANs is further supported by Cramer (2006) who found that, " 'Doing your best' in this context is their pragmatic principle of last resort" (p.199) because 'doing their best'; was an attempt, ". . . to cope as individuals with an impossible array of demands in a context where the systems essential to support a safe and effective health service are not provided" (Cramer, 2006p.201).

Nurses in the current study frequently expressed feelings of stress and frustration at the inability to provide care to the highest standard but they still provided care to the best of their ability; therefore the compromise was to their feelings of satisfaction or professional principles rather than necessarily the quality or safety of the care provided to the patient. Freshwater and Cahill (2010) developed a conceptual framework for work-related stress based on the understanding that healthcare workers experience stress when they do not have ". . . the capacity to deliver the optimum level of care" (p. 173) that helps explain this aspect of the experience of the participants in the current study. Compromise was argued by Freshwater and Cahill (2010) to be a defence mechanism and psychological process of adaptation in response to stress that was rooted in organisational factors and inadequate preparations, skill and support as required by the context. These authors considered the role of compromise in alleviating stress and suggested that, ". . . compromise can occur both externally, through relationships with others. And internally, through intra-personal processes characterised by inner conflict, where the psychological impact of cognitive dissonance can be significant" (Freshwater & Cahill, 2010p.177). Although the framework appears to be still in the development and testing phase at the time of writing, the authors recommend that exploration and management of stress that occurs because of compromising may improve the recruitment and retention of staff. The current study contributes to this effort by describing a process nurses use of managing feelings of stress and frustration associated with the inability to provide PHC.

This study describes making compromises as an outcome of doing the best you can with what you have because these actions and interactions work towards creating consonance within the context of providing PHC and the issue of the inability to provide PHC. As a result, the substantive theory was named *making compromises to provide PHC.* In this study, making compromises is framed as an outcome of the process of doing the best you can with what you have; however, multiple processes are sometimes present in Grounded Theories, especially when describing complex phenomena (Charmaz, 2014). For example, despite contextual differences, a GT study by Irurita and Williams (2001) described *balancing and compromising to preserve integrity* as a basic psychological process used by nurses and patients in an attempt to resolve the problem of the inability to provide high-quality care to all patients. Preserving integrity was a process that patients used to manage the problem of patient vulnerability and nurses used the process of preserving integrity in relation to their professional role and the ability to consistently provide quality patient care. In the current study, preserving integrity could be described in relation to the nurses' desire to provide quality care in the form of comprehensive PHC. This would clearly link the nurses desire to provide holistic care, with a social justice and illness prevention approach to their perception of quality care and explain the feelings of frustration and distress when they encountered situations where they were unable to provide PHC as opposed to situations where they felt valued, satisfied and as though they were making a difference.

In the acute care context described by Irurita and Williams (2001) nursing actions and interactions directed towards balancing and compromising were described as 'selective focussing', which describes a phenomenon wherein nurses balanced work satisfaction with quality patient care. In the current study, the category making compromises describes the outcome of nurse's actions and interactions to balance providing PHC with the resources available. Selective focussing is thus also evident in their comments about providing 'some' care as a resource-driven compromise where acute care needs were given precedence over health promotion or social justice activities.

Irurita and Williams (2001) proposed four phases in the process of balancing and compromising: contributing to care - cooperating; prioritising and rational sacrificing; justifying compromised care and lowering expectations, and protecting self by attracting or repelling. Contributing to care - cooperating is also clearly evident in the current study, specifically the findings relating to structure and agency where nurses described conflict and negotiation about the degree of patient involvement and responsibility in care and the level of care co-ordination and proactive engagement activity undertaken by the nurses.

Prioritising and rational sacrificing was evident in this study around a lack of resources impacting on nurses' ability to provide PHC. Both the current study and Irurita and Williams' (2001) concur that a lack of time represents a lack of human resources, and this situation leads to chronic stress; this in turn impacts on the nurse's personal integrity as patient care is compromised. Furthermore, accepting the resource limitations of the setting changed nurses' perspective so they were more readily able to accept or rationalise making compromises to provide PHC. The notion of making compromises as a coping strategy, which is a concept rooted in the theory of Cognitive Dissonance, helps explain this. Festinger (1957) in his seminal work, Theory of Cognitive Dissonance; proposed that we ". . . seek harmony in our attitudes, beliefs and behaviours and try to reduce tension from inconsistency among these elements" (Vaughan & Hogg, 2014p.598). Dissonance describes the state of psychological unease that occurs when there is a mis-match between someone's knowledge and actions (Vaughan & Hogg, 2014). Festinger (1957) explained that situations of dissonance occur frequently in people's lives and people deal with dissonance by either changing their actions or their knowledge's to create a situation of consonance. This psychological construct is evident in Irurita and Williams (2001) study where dissonance is described as justifying compromised care and lowering expectations. Similarly, justifying compromised care and lowering expectations was also evident in the current study by the process of doing the best you can with what you have. The 'best' care describes providing PHC and the reality of a lack of resources meant that providing PHC was at times considered an unrealistic and unachievable goal. Nurses in the current study described themselves as pragmatic and challenged the benchmark of urban-quality care and even 'best practice'. The complex social world of the remote setting also requires nurses to justify their actions in ways that met the patient, community and employer's expectations.

Protecting self by attracting or repelling, was identified in this thesis when nurses described the impact of social roles and the need to form professional and personal boundaries to preserve and maintain their own sense of integrity. Furthermore, in Irurita and Williams (2001) study, patients implemented strategies to attract and sustain the presence of nurses. This notion resonated with the current study as nurses described creating a health care environment that attracted patients and as such increased access to health services. Similarly, acts of repelling patients were described when nurses discussed attempts to reduce after-hours call outs.

Making compromises describes the outcome, or possibly a separate process that was a consequence of the strategies nurses used to do the best they could with what they had. Although the theory proposed by Irurita and Williams (2001) was conducted in a different setting with different participants to the current study, the concepts and relationships seem to apply and the process of balancing and compromising to preserve integrity is clearly evident in the experiences of participants in the study reported in this thesis.

## 6.5 Chapter summary

As a model of health care delivery, PHC holds promise as a way of reducing morbidity and mortality on a global scale. Whilst there has been a lot written about the importance of PHC, the role and practice of practitioners within this model has not been adequately described. The aim of this study was to describe and explain, from the perspective of nurses, the experience of providing PHC within the remote setting. RANs shared their perspective as the health practitioners who provided the majority of care in remote communities and were often the only resident health care provider.

This chapter has described four key findings and how they relate to existing knowledge. Of particular significance were the links to previous studies of RANs that describe the demands and differences of the remote practice environment. Furthermore, the development of nursing expertise and scope of practice was presented in relation to established frameworks. The impact of resources on the provision of PHC was considered in relation to the aims of PHC and finally the outcome of making compromises was discussed as an application of the theory of balancing and compromising to maintain integrity.

This study found that nurses wanted to provide PHC and that providing PHC meant viewing health from a social, holistic perspective that included the family and community in health care. Nurses valued activities aimed at illness prevention and social justice as ways of reducing health and social inequalities. Nurses discussed feelings of satisfaction when they were able to provide PHC as they felt as though they were making a difference to the community. These findings broadly aligned with the philosophy of PHC.

However, the core issue from the perspective of the nurses in this study was the inability to provide PHC to a degree where they could achieve job satisfaction by making a difference. The degree to which they were able to provide PHC was determined by their understanding of the social world of the community, the availability of resources (especially human resources); the level of clinical knowledge and skill and the availability of shared understanding and support. These variables applied to different degrees in different interactions with patients and between different nurses in different communities. Although the experience of stress within the RAN cohort has been studied before; and indeed the amorphous nature of nursing practice has been described, this study is the first to link these experiences to the delivery of PHC. As such, it contributes to broader discussions about the implementation of PHC models across the spectrum of health care delivery models. Furthermore, the findings describe a process where nurses manage the conditions in order to provide PHC. This process describes strategies used by nurses to increase their ability to provide PHC which alleviates feelings of distress and increases feelings of satisfaction. These strategies were identified to be facilitating access to care, continually learning, seeking understanding and home-making within a work environment. The outcome of making compromises acknowledges that the challenges of the remote setting and the resources needed to overcome them, rarely come together in equal measure. Making compromises seems to be a form of cognitive dissonance where nurses rationalise the rhetoric with the realities of practice. As an outcome, making compromises goes some way to explaining levels of stress, frustration, high staff turnover and poorer health outcomes within the remote setting; however, it also describes outcomes that are derived from efficient use of resources, understanding and negotiation. In this sense, making compromises should be seen as an opportunity for innovation and client centred care.

This study is important because the health of people living in remote communities is significantly poorer than the health of the majority of Australians and the providers of the bulk of this health care are nurses. This study has described the phenomena of providing PHC within the Australian remote setting from the perspective of nurses. This phenomena has not been studied before, therefore, the substantive theory presented in this theory proposes a framework for understanding nursing practice.

Whilst the findings describe the experience of nursing in the Australian remote setting, it is likely that these results would resonate with nurses working in remote areas around the world with common experiences of providing PHC in a resource poor environment (Labonté et al., 2008). In addition, any setting where nurses are required to have a social role within the community that extends beyond normal business hours or any role where nurses are working on their own attending to out-of-hours emergency and urgent care may recognise elements of this theory that relate to their practice.

### 6.5.1 Implications for nursing practice

This study contributes to discourse around the levels of stress and high turnover of nurses in remote areas by explaining that the inability to provide PHC is a significant problem that impacts on the wellbeing of nurses and the quality of healthcare provision to remote communities. As such, this study identifies a pressing need to provide additional resources into the remote health sector that support the education, supervision and social support of nurses. The findings also demonstrate the work of experienced nurses and NPs as significant contributors to the health and wellbeing of communities because they ascribe to a context of care that is grounded in PHC principles such as holistic care and social justice. This knowledge supports global efforts to reorient health care systems by demonstrating the value and role of nurses in this process.

Recommendations arising from this study include:

- enhancing education opportunities in clinical as well as cultural and social areas relevant to remote nursing practice and based on a PHC framework,
- increasing resources for recruitment of additional nursing staff,
- increasing resources for the retention of experienced nurses,
- improved systems for managing after-hours emergency calls and associated nursing fatigue

### 6.5.2 Implications for future research

This study provides a basis for a wide range of future studies. For example; the relationships and variables within the concepts described in this theory can be further tested and refined within, and external to, the substantive area of interest. The substantive theory could be considered a framework for nursing practice and provide structure to education programs and research that aims to evaluate and improve the quality and safety of healthcare in remote areas. The application of this theory to other advanced practice nursing roles and nursing roles where detailed understanding of providing PHC is required, such as in rural areas or general practice, could potentially develop this theory towards a middle-range theory with broader generalisation across settings.

Further research is required to fully understand the complexity of the social world of nurses in remote communities. A conditional matrix developed using GT methods (Corbin & Strauss, 2015) or a study using Clarke's situational analysis (Birks & Mills, 2015; Clarke et al., 2015) could be useful avenues for further research to describe the social world of the remote setting. Likewise, further research that describes the expectations of consumers in regards to the role of nurses in coordinating care and taking responsibility for managing health appointments and treatment regimens is necessary in order to define the facilitation role of nurses in remote areas. Research that explores the perspectives of healthcare consumers is essential in empowering people and providing access to health services where they feel safe (Pons-Vigués et al., 2017). Consideration of the consumer viewpoint, including Aboriginal and Torres Strait Islander peoples is likely to provide greater insight into the interactions between nurses and community members in the remote setting.

Research that describes the perspective of managers and other members of the health team regarding their understanding and expectations of nurses in this setting, may provide opportunities for role clarification and evaluation of strategies to provide personal support and relieve stress. Likewise, work sampling studies may quantify the time nurses spend in activities related to facilitating access to care through collaboration and care coordination.

More research that describes the experience of transitioning from urban acute settings to remote PHC settings would be valuable in finding new ways to support both the new staff member and the existing staff in the supervision role. Further research that describes the process of knowledge and skill acquisition, alongside specific clinical knowledge and skill relevant to the remote context is essential in developing education programs and subsequently improving the quality of care for these communities.

Considering nursing expertise as a health resource that improves the ability to provide PHC, could provide a basis for evaluating the relationship between nursing practice and health outcomes within the remote setting. Further research which measures the difference (if any) in health outcomes for communities served by NPs, credentialed RANs and RNs working in a remote setting, would aid policy makers and employers in their decisions about the resources needed in remote communities

Finally, further development of the concept *making compromises* may provide clarity as to its nature as an outcome or a process in its own right. With further research, compromises may be able to be measured on a continuum from positive compromise to negative compromise and this may help understand how nurses make decisions within the challenging and complex phenomena that is amorphous practice. As is characteristic of many PhD studies, this thesis is likely to form the basis of a lifetime of further research that describes, explains and evaluates the unique contribution to the health of remote communities made by nurses.

### 6.5.3 Limitations

There is one notable limitation in this study, and that is the fact that nurses in this study were RNs, RMs, and NPs (and some were all three), therefore, it was not possible to differentiate the responses according to professional designation. This was because many of the participants held multiple qualifications and in the case of NPs, had worked as RANs whilst building their NP expertise. In fact – one NP was working in a RAN role because she was unable to get a job as an NP. Similarly, one participant was working predominantly in a midwifery role and yet she identified as a RAN and an NP.

As the focus of GT is on theoretical saturation, the concept of representativeness of the participants is less important. Despite this, there was variety in the experience, age and gender of participants and as many of the participants had worked in multiple communities; their experiences extended beyond their current community. The theory presented in this thesis only claims to relate to the context of remote nursing practice although it may have relevance to other nursing or remote settings.

As a constructivist GT, the data has been interpreted through the lens of the researcher and represents a co-construction between the participants and researcher. GT acknowledge that there are potentially many ways that data can be interpreted and this theory may have been presented in multiple ways. Future studies that aim to expand and refine the substantive theory from different perspectives would be of value.

### 6.5.4 Concluding statement

This study originated from a desire to share the amazing and complex phenomena of nursing in the remote Australian setting. My experience as a RAN was life-changing, stressful and a journey of self-discovery that I wanted to share as a way of giving back to those who nurtured, taught and supported me during that time. Constructivist GT provided a framework for bringing together the disparate and unique experiences of RANs to present a theory of nursing practice in remote areas. My study is grounded in the experiences and perspectives of 24 Registered Nurses and Nurse Practitioners who collectively represent more than 200 years of living and nursing in remote areas of Australia. Their perspective has been presented here as an original contribution to discourse and understanding of the phenomena of being a RAN.

My research included nurses who saw people and communities as complex and multi-faceted; where health was not just the absence of disease but included connection to country, culture and family. Nurses who longed to see improvements in the health and lives of some of Australia’s most disadvantaged peoples. Nurses who understood that addressing inequality was a powerful way to make a difference. I found nurses who embraced the challenge of difference and thrived in a different world. These nurses acknowledged their position of power and humbly resolved to listen and learn in order to understand others perspectives.

I listened to stories of nurses trying their hardest to meet the health needs of their community despite struggling without enough resources, with limited experience and minimal social support.

They described working with a wide range of other health professionals and communities in order to ensure the best quality care was available. Some of those stories made me laugh, some brought tears but all revealed a deep connection to the identity of being a RAN.

In describing their practice as, doing the best you can with what you have; I hope that I have captured their personal commitment to developing their knowledge and skill, the personal challenges associated with living and working in communities, the long hours, the demands and rewards of their practice.

Above all, I hope that my work helps others to understand the demands and challenges of providing PHC within the remote setting, and I hope that this research makes a contribution to the ongoing development of Remote Area Nursing and Nurse Practitioner practice. I also hope that this study contributes to discussion about the implementation of PHC because it highlights the value of the PHC workforce. Ultimately, this thesis is one piece of a much larger picture that is the health and wellbeing of Australians living in the outback, on traditional homelands, on isolated islands, coastal hideaways and isolated hamlets.

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## Appendix A: Invitation to participate

To members of the Nurse Practitioner Remote Interest Group,

As most of you know, I am conducting a PhD research project exploring the role of NPs in remote areas. Having received approval to conduct this research project from the School of Nursing and Midwifery and the Human Ethics committee at Edith Cowan University; I am now ready to recruit participants.

I am seeking NPs and experienced RANs who have worked in remote areas who are willing to share their experiences about nursing practice in remote areas during a telephone or face-to-face interview.

Attached is information about the project. Please pass this email on to other people who may be interested, particularly remote nurses who are not members of this group.

Your support is vital to the success of this research. Please contact me directly if you are interested in participating or for more information.

Kind regards,

Kylie McCullough

PhD candidate

School of Nursing and Midwifery

Edith Cowan University

kmccullo@our.ecu.edu.au

# Appendix B: Interview guide and Demographic information sheet

**Section one: About the participant**

Start interview with a broad opening question such as: “Please tell me about how you came to practice as a nurse in remote areas?”

**In addition to gaining an understanding of the participants experience and motivations to work in remote areas, this section aims to collect the demographic data outlined below and build rapport between researcher and participant**

Age:

Gender:

Aboriginal or Torres Strait Islander:

Years as a nurse:

Years working in remote areas:

Years as a NP:

Qualifications:

Employer type: Government:

Aboriginal Medical Service:

Private (e.g. mining company):

Self –employed:

Not currently employed:

Employed as a RN not NP:

Other:

RAN/Nurse Practitioner model: (for example; mental health, chronic disease)

Physical context: (for example hospital, community health centre, Fly-in, Fly-out)

Broad description of population served: (for example Indigenous community, Mine site, tourist community)

**Section 2: Directing interview towards study questions**

“What does it mean to you to be a nurse in remote areas?”
“What are the most important things that nurses do in remote areas?”
“How do you contribute to the heath of people living in remote areas?”
“What does Primary Health Care mean to you?”
“Why have you continued to live and work in remote areas?”

## Appendix C: List of thesis presentations

McCullough, K. M., & Maslin-Prothero, S. (2012). *'Good things take time' improving the practice environment of RANs to encourage retention.* Paper presented at the 30th Annual CRANAplus conference, The Sebel, Cairns.

McCullough, K.M., Maslin-Prothero, S., Lenthall, S. (2013).*Innovations in Primary Health Care services in remote areas: Australian Nurse Practitioner practice*. 31st Annual CRANAplus conference, Double Tree on Hilton, Darwin.

McCullough, K.M., Williams, A.M., Cope, V., Lenthall, S. (2015). Towards a theory of RAN practice – understanding scope of practice. Paper presented at the 33rd Annual CRANAplus conference, Alice Springs Convention Centre, Alice Springs.

McCullough, K.M., Williams, A.M., Cope, V., Whitehead, L. (2017). *Towards a theory of Remote Nursing practice.* Poster presented at the 35th Annual CRANAplus conference, Cable Beach Resort, Broome

# Appendix D: Participant consent form – Adult providing own consent

**Title:** The delivery of Primary health Care in remote Australian communities: A Grounded Theory study of the perspective of nurses.

**Protocol number:**

**Coordinating Principal Investigator:** Ms Kylie McCullough

**Associate Investigator s:** Associate Professor Anne Williams, Dr Vicki Cope (Edith Cowan University) and Ms Sue Lenthall (Centre for Remote Health).

## Declaration by Participant

I have read the Participant Information Sheet or someone has read it to me in a language I can understand.

I understand the purposes, procedures and risks of the research described in the project.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described and understand that I am free to withdraw at any time during the project.

I understand I will be given a signed copy of this document to keep.

| | |
|---|---|
| Name of Participant | |
| Signature | Date |

## Declaration by researcher

I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

| | |
|---|---|
| Name of researcher | |
| Signature | Date |

# Appendix E: Participant information sheet

## Participant information sheet / Consent form

(National Health and Medical Research Council, 2012).

**Title:** The delivery of Primary Health Care in remote Australian communities: A Grounded Theory study of the perspective of nurses

**Protocol number:**

**Coordinating Principal Investigator:** Ms Kylie McCullough

**Associate Investigators:** Associate Prof Anne Williams, Dr Vicki Cope,

## Part 1: What does my participation involve?

You have been invited to take part in this study because you have knowledge and experience regarding nursing practice in remote areas. Your contact details were obtained from membership of the 'Nurse Practitioner Remote Interest group' convened by the Centre for Remote Health.

This participant information sheet/consent form tells you about the research project. Please read this information carefully. Ask questions about anything that you don't understand or want to know more about.

Participation in this research is voluntary. If you do not wish to take part, you do not have to.

If you decide you want to take part in the research project, you will be asked to sign the consent section of this information brochure. Alternatively you may give verbal consent directly to the researcher at the start of the interview. By signing you are telling us that you understand what you have read.

You should keep a copy of this Participant Information and Consent Form.

### 1. What is the purpose of this research?

This study is a three year PhD project which aims to describe and explain nursing practice within a Primary Health Care model in the remote Australian context.

### 2. What does participation in this research involve?

Participation in this research will involve a face-to-face or telephone interview of approximately 1.5 hours. You may be invited to participate in additional interviews or provide answers to questions via email as the project develops. You are under no obligation to participate in any interviews.

Interviews will be conducted at a time and place convenient to the participant and the researcher. The interview will be audio recorded and transcribed. Any identifying information will be removed from the transcripts and pseudonyms will be used.

This research project has been designed to make sure the researchers interpret the results in a fair and appropriate way and avoid bias.

### 3. What are the possible benefits of taking part?

We cannot guarantee or promise that you will receive any benefits from this research; however possible benefits may include contribution towards the evidence base required for sustainability and future growth of the remote nursing workforce. You may also reference your participation in this project as evidence of professional development.

### 4. What are the possible risks and disadvantages of taking part?

It is not anticipated that you will feel any distress as a result of participating in this research. However, if you feel that any of the questions are stressful or upsetting, you may skip those questions and go on to the next question, or you may stop immediately. If you become distressed or upset you may contact the researchers or Bush Support Services for 24hr free telephone counselling on **1800 805 391.**

### 5. What if I decide to withdraw from this research project?

If you do consent to participate, you may withdraw at any time. If you decide to withdraw from the project, please notify the researcher by email at k.mccullough@our.ecu.edu.au. You should be aware that data collected up until the time you withdraw will form part of the research project results. If you do not wish your data to be included, you must tell the researcher when you withdraw from the project.

### 6. What happens when the research project ends?

At the conclusion of the interview you will be asked if you are willing to be contacted in regard to the additional interviews or observations of practice. If you agree, you will be sent information regarding these aspects of the study as it becomes available. Your consent will be sought separately from this consent form.

Results from this study are expected to be published in peer-reviewed journals. This process can take many months. Participants will be emailed copies of the published articles as they become available.

## Part 2 How is the research project being conducted?

### 7. What will happen to information about me?

Any information obtained in connection with this research project that can identify you will remain confidential and be securely stored. It will be disclosed only with your permission, or as required by law. Your information will be combined with other participant's information to reduce the likelihood of identification. You will be identified via a pseudonym and demographic data will only be used to describe the participants as a group.

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that you cannot be identified, except with your express permission.

In accordance with relevant Australian privacy and other laws, you have the right to request access to the information about you that is collected and stored by the research team. You also have the right to request that any information with which you disagree be corrected. Please inform the researcher if you would like to access your information.

### 8. Concerns and complaints

If you have any concerns or complaints regarding the conduct of this research project, they may be directed to any member of the research team or the contact person for the approving HREC details in question 12.

### 9. Who is organising and funding the research?

This research project is being conducted by Ms Kylie McCullough, PhD candidate from the School of Nursing and Midwifery, Edith Cowan University with support from supervisors Assoc/Prof Anne Williams, Dr Vicki Cope and Ms Sue Lenthall. Kylie McCullough has received funding from Western Australian Department of Health 'Advancing the Nursing Profession' fellowship to assist with travel and other project associated costs.

### 10. Who reviewed the research project?

All research in Australia involving humans is reviewed by an independent group of people called a Human Research Ethics Committee (HREC).The ethical aspects of this project have been approved by the HREC of Edith Cowan University.

This project will be carried out according to the *National Statement on Ethical Conduct in Human Research (2007).* This statement has been developed to protect the interests of people who agree to participate in human research studies.

### 11. Further information and who to contact

If you would like more information about this project or if you have any problems that may be related to your involvement in the project, please contact the primary researcher, Kylie McCullough on k.mccullough@our.ecu.edu.au or [redacted]. Alternatively, you may contact Assoc/Prof Anne Williams on a.williams@ecu.edu.au.

If you have any complaints about any aspect of the project, the way it is being conducted or any questions about being a research participant in general, then you may contact: Edith Cowan University Research Ethics Officer, on research.ethics@ecu.edu.au or telephone 6304 2170.