Education and Training for Community Nurses working in Remote, Rural and Island Contexts.

Introduction

The purpose of this paper is to highlight an area of potential work that may be of interest to the Modernising Community Nursing Programme Board and the sub-groups.

Remote and Rural Healthcare Context

Over twenty percent of the Scottish population live in a remote or rural community spread over ninety-six percent of the land mass of Scotland. The provision of high quality healthcare services across this widely dispersed geography presents some significant challenges. The Scottish Government published Delivering for Remote and Rural Healthcare (DfR&RH) in 2008 providing a framework for sustainable healthcare services in remote and rural Scotland.

The DfR&RH Report recognises the interdependence of individual services and focuses on the integration between different aspects across what is described as the ‘continuum of care’. This is defined as self care and preventative care within the local community through the different levels of supported care up to that which requires the resources provided by a tertiary centre.

Healthcare is currently delivered by a range of professionals, some working in isolation and others working in teams.
There are a limited number of health and social care professionals within remote and rural areas, therefore skills and expertise need to be broad and shared if communities are to have local access to the widest possible spectrum of care. Future models for healthcare delivery are based on extended care, integrated teams, demonstrating a range of competencies, defined by patient need. These competencies can overlap between traditional professional roles, to the benefit of holistic care and use of resources to better effect. Most of the team will be based within the remote and rural community, in primary or community care, within the hospital service or in combination. Some team members will be based in the larger centre, with responsibility for supporting local delivery and providing a visiting service, where appropriate.

Rural patients’ experience of care differs from that of urban patients in that they often have to travel large distances to receive care. Although the pattern of disease is similar in urban and rural areas, differences do exist:

- Higher suicide rates;
- Higher incidence of alcohol related disease;
- There are a higher number of accidents in rural areas: on roads, through climbing, farming, diving and fishing;
- Palliative Care workload is proportionally higher than might be seen in urban areas, as patients from remote areas often prefer to or are enabled to die at home, rather than in a distant centre;
- Seasonal fluctuation in population.

These scenarios can present challenges in response times for traditional emergency services and emphasise the requirement for immediate care skills for remote practitioners. The GP will often be the principal ‘gatekeeper’ to secondary care, although in many areas it may be necessary and appropriate for care to be provided by nursing staff and/or other practitioners. Remote and rural practitioners are required to undertake the majority of care locally, where it is safe and appropriate to do so. The use of new technologies needs to be increased where this will maximise the amount of care that can be provided locally.
Where there is a requirement for referral to secondary or tertiary care, this should be as part of a robust care pathway.
Remote and rural practitioners must aim to reduce multiple visits to secondary care wherever possible, and to return the patient to care within the community, as soon as is practicable, dependant upon the disease condition and the resources available locally.

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( DfR&RH 2007)

Four key pillars support this model of care: Workforce, including Education, Networks, Infrastructure and Community Resilience.

Professionals working within this model must be robustly trained generalists, with educational packages specifically designed for Remote and Rural Practitioners, have good supporting networks from larger centres, and be supported by technology, transport and retrieval systems. They also require access to ongoing education and training to ensure skills maintenance particularly in areas of low volume experience.

Remote, Rural and Island Nursing
Nurses in remote and rural settings are required to have a wide range of skills often referred to as remote and rural generalist skills. Changes in demography, patient need and workforce across many remote, rural and Island health boards in Scotland have resulted in the need for expanded and developed roles for nurses to meet patient's needs.

There is a need for remote, rural and island nursing models to focus on additional or enhanced skills development in order to ensure ongoing competence and confidence in providing care in a broad range of emergency and/or unpredictable situations.
There is a requirement to identify where nursing roles are most appropriate to meet local needs, where supported nurse led services can be further developed and/or become independently nurse led and agreeing where care needs would be better met by other professions or disciplines.

**Education and Training for Community Nurses working within a Remote/Rural and Island Context**

The following points indicate some of the issues that community nurses working in remote, rural and Island contexts face with regard to education and training:

- Nurses in remote, rural and island settings often experience the most difficulty in accessing ongoing education and CPD and yet have specific needs due to broad range of practice and expertise required to deliver quality care in a remote, rural or Island setting.
- Nurses in remote, rural and Island settings are required to employ additional or enhanced skills in specific areas.
- Nursing practice in remote, rural and Island settings requires an additional or specialist skill set that should be recognised as a remote and rural speciality.
- There is a need to develop accessible and affordable education and training to support the existing and future nursing workforce in these areas.
- There is great interest in developing specific remote and rural nursing education pathways in a similar way to those developed in dentistry and medicine.
- There is a need to look to examples in other international rural communities where specific education and training pathways have been established to support and produce remote and rural nurses.

These points have been raised by practitioners, managers and educationalists and give a flavour of some of the key issues that need to be addressed.

**Potential Educational Initiative**

NHS Education for Scotland (NES) is the special health board in Scotland with responsibility for assisting with delivery of education and training to meet the needs of the NHS workforce.
The Remote and Rural Educational Alliance (RRHEAL) is a directorate of NES charged with ensuring that the specific education and training needs of the remote and rural NHS workforce are met. NES and RRHEAL work in close collaboration with NHS boards to identify priority education needs and solutions through a structured process of strategic and frontline engagement. In this way RRHEAL and NES hold an up to date overview of priority education needs and gaps across all of the Scottish NHS workforce.

Through this process of ongoing partnership with the remote and rural boards in 2009/2010 it became apparent that there is a common and increasing requirement for improved provision of education to meet the specific, changing needs and roles of nursing staff providing care within remote, rural and Island communities.

RRHEAL has been requested to lead in terms of identifying the specific education and training needs for nursing staff across a number of remote, rural and Island NHS board areas. RRHEAL and NES held an initial workshop meeting to discuss educational needs in November 2009. These initial discussions were held with representatives from NHS Highland, Orkney, Shetland, Borders, Dumfries and Galloway and Tayside. In addition to this representatives from a number of Higher Education Institutions; Robert Gordon University, Queen Margaret University and University of Stirling, also contributed.

The intention would be for RRHEAL to contribute in this way to the national programme of work, ensuring it is inclusive of remote and rural workforce needs and assisting in establishing ‘joined up solutions’ where possible. RRHEAL would intend to work collaboratively with NES NMAHP and education partners to achieve this.

Through these initial discussions a number of key needs were identified:

It is recognised that increasing access to affordable and high quality education for nurses operating in remote, rural and islands settings physically very distant from Scottish Ambulance Service, A&E, Doctors and specialist centres, is vital to continued provision of healthcare services. They have a range of identified needs for clinical skills in Paediatric and Adult emergencies, dispensing etc and to date these nurses have received a ‘patchwork’ system of education.
There are already some educational developments that support some of the needs including a BA in professional nursing studies (this includes various modules to support remote and rural practitioners e.g. prescribing) and online Child Health emergency care modules delivered by Higher Educational Institutions; however a high quality, standardised national approach to the educational preparation is required.

**Rationale and Benefits of a National Approach**

A key workstream of *Modernising Nursing in the Community* has been that of ‘Keeping People at Home’.

Amongst other aims, this work sets out to:

- identify innovative services delivery options and interventions that enable self care and independence to improve the overall quality of care and address the needs of vulnerable groups
- analyse existing nursing practice to reveal areas for further development using existing sources of data such as workload tools.
- ensure team structures and individual role characteristic are linked to service need and national/ local priorities

It is clear that consideration of the role flexibility and skill-mix required to meet specific challenges within remote and rural contexts may provide exemplars of innovative delivery models which may translate to the broader national context, and particularly to the management of long-standing conditions and/or acute exacerbations of existing conditions.

Experience from the development of new nursing roles in ‘out-of-hours’ and ‘unscheduled’ care has already demonstrated the benefits of enhanced clinical, assessment and decision-making skills in the nursing team. Such skills have allowed nursing staff to contribute to the clinical team in new ways, to take on some caseloads previously supported by medical staff and to simplify the patient care pathways and/or minimise the need for admission or referral to hospital based services.
In that context, there is merit in further exploring education and development modelling for remote and rural practice both to support sustainability and efficiency of service in those areas and to create new learning and skills development opportunities for the broader community nursing team.

Therefore there are a number of benefits that can be gained from a national broad approach to the education of remote and rural community nurses. These include benefits in terms of:

- Governance – NHS boards will have reassurance that practitioners recruited to posts will be ‘fit for purpose’
- Consistency – recognition that practitioners will have core agreed skills to work in remote and rural communities
- Transferability – practitioners will be able to move to different areas and still be recognised in terms of the agreed core skills
- Transparency – practitioners who wish to work in these locations will be able to engage with appropriate educational preparation
- Efficiency - if a national approach is agreed, there may be economies of scale in supporting the development of the required education

Although a national approach would bring a number of benefits as outlined above there is also recognition that one size will not fit all and there would need to be local flexibility in terms of how any national guidance is developed and indeed implemented. There are key examples of robust and flexible education models that have been developed to meet the needs of all remote and rural health boards.

As already indicated there appears to be some initial agreement that additional support for the education of community nurses working with in remote and rural locations is required. Obviously any work to support this particular education agenda will be integrated into other national community nursing educational developments.

**Next Steps**

This would involve the establishment of a short life remote/rural and island nursing education working group to identify education needs and ensure that R&R workforce education needs are met within the national context.
This group would be set up by NES and link directly into the Modernising Community Nursing Programme Board.

It is anticipated that a key deliverable from this work would be national guidance and/or standards for Boards and HEIs.

References