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More than just numbers!

Perceptions of Remote Area Nurse staffing in Northern Territory Government Health Clinics

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Abstract

Objective: The need for more Remote Area Nurses (RANs) in the NT is clear. This paper investigates perspectives of RAN workforce issues among multiple stakeholders. The aim is to identify how RAN staffing issues are perceived by clinic managers, RANs themselves, Aboriginal colleagues and community members in seven remote communities in the NT.

Design: This is a qualitative study that uses interviews and focus groups to identify key messages of local stakeholders about RAN workforce issues. A content analysis was used for data analysis.

Setting: Seven diverse remote Aboriginal communities in the NT with government-run health clinics were visited.

Participants: Non-random sampling techniques were used to target staff at the clinics at the time of fieldwork. Staff and community members who agreed to participate were interviewed either individually or in groups. Interviews were conducted with 5 Managers, 29 RANs, 12 Aboriginal staff (some clinics did not have Aboriginal staff) and 56 community residents. 12 focus groups were conducted with community members.

Results: Content analysis revealed that participants thought having the 'right' nurse was more important than having more nurses. Participants highlighted the need for RANs to have advanced clinical and cultural skills. While managers and to a lesser extent RANs prioritised clinical skills, Aboriginal staff and community residents prioritised cultural skills.

Conclusions: Participants identified the importance of clinical and cultural skills and reiterated that getting the 'right' RAN was more important than simply recruiting more nurses. Thus, retention strategies need to be more targeted and cultural skills prioritised in recruitment.

Key words: Aboriginal and Torres Strait Islander Health, remote health, cultural competence, clinical competence, recruitment

What is already known on this topic?

- There is a high turnover and shortage of RANs in remote NT
- RAN work is stressful and challenging
- RANs have suggested that infrastructure, employment conditions and regular leave are important for recruitment and retention

What this paper adds?

- The perspectives of community members, Aboriginal staff and clinic managers on issues related to RAN staffing
- The imperative for RANs to be both culturally and clinically competent
- Rather than filling positions, retention needs to be more targeted

Article type : Original Research

More than just numbers!

Perceptions of Remote Area Nurse staffing in Northern Territory Government Health Clinics

Introduction

Given that residents of remote Aboriginal and Torres Strait Islander communities have the poorest health outcomes in Australia,[1] quality healthcare in remote clinics is imperative. Workforce shortages in these clinics are also high[2-5] and recruitment and retention are difficult and expensive.[4,6-9]

Remote Area Nurses (RANs) have particularly high turnover rates in the Northern Territory (NT)[2] yet government-run remote health clinics rely on them.[3] Reasons for high turnover are many. Significantly, RANs experience high levels of psychological distress and emotional exhaustion.[4,5,] Lenthall et al suggest RANs have reported a lack of staff, being tired of orienting new staff, being concerned about the capability of in-coming short-term staff, being concerned about continuity of care, and feeling that remote communities can be demanding, detract from the RAN role.[10] RANs have also reported being overwhelmed by the work and the after-hours on-call duty for emergency care.[10] Further, poor management has been cited as a cause for high turnover. Poor retention has also had a negative impact on healthcare.[4,9,11] Many new RANs report feeling "thrown in" and lacking in cultural orientation.[12] To encourage nurses to work in remote NT, RANs are provided with individual incentives, usually subsidised accommodation, relocation expenses, continuing

professional development, higher salaries, extra travel/leave allowances and remuneration for after-hours on-call duty.[12,13] The focus has been on increasing the number of RANs working in remote NT and retaining them for as long as possible.[12]

Research relating to recruitment and staffing of RANs has focused primarily on the views of RANs.[4-6,8,10,11] This paper investigates perspectives of RAN workforce issues among multiple stakeholders. The aim is to identify how RAN staffing issues are perceived by clinic managers, RANs themselves, Aboriginal colleagues and community members in seven remote communities in the NT.

Methods

As an indicator of staffing issues, data from the NT Department of Health were analysed to identify staff turnover rates for all government-run remote health clinics across the NT.[2,14] From the analysis, seven remote Aboriginal communities were selected for further analysis. Communities selected varied in staff turnover, location, size and remoteness. Three communities were located in the Central Desert Region and four in the Top End.[15] Researchers utilised interviews and focus groups to gain the perspectives of staff working in these clinics as well as community members who use the clinics. Ethics approvals were gained from Central Australian Human Research Ethics Committee, Department of Health and Menzies School of Health Research Top End Human Research Ethics Committee, Monash and Melbourne universities to analyse perspectives of RAN workforce issues in these communities.

Between November 2015 and October 2016, three researchers visited the seven remote communities. In each, all staff working in the local health clinic at the time of the visit were asked to be interviewed. Researchers also approached key organisations in these communities as well as residents in public places, at local events and bar-be-ques hosted by researchers to ask for the opportunity to explain the study to local residents. In some communities, a local resident was employed to assist with promotion of the study, recruitment and data collection. Using this approach, a range of interviews and focus groups were conducted (see Table 1).

TABLE 1

Using a semi-structured interview protocol, participants were asked about the health of their community, access to healthcare in the community, the clinic, staffing and turnover, and what local healthcare issues could be improved. All these topics were asked in all interviews/focus groups but wording, question order and follow-up questions varied. Notes were taken in all interviews/focus

groups and 43 were also audio-recorded with participants' permission; all were then transcribed. The three researchers read each transcript to identify common codes relevant to RAN workforce issues. The major code identified by all three researchers independently was the importance of recruiting the 'right' RAN. Focusing on this one code, the researchers discussed its meaning and then the first researcher re-coded the patient interviews and focus groups, and the second researcher re-coded the staff interviews (managers/RANs/Aboriginal staff) to explore sub-codes relating to this issue. The coded data were then synthesised and reduced.[16,17]

Results

Staff in each of the seven clinics wanted more RANs. Further, all clinics had vacancies at the time of fieldwork and some were observed to be severely short-staffed. However, while wanting more RANs, participants from all stakeholder groups were clear they did not want "just any nurse." They considered qualifications and experience of both clinical skills and cultural skills prior to recruiting were important.

Managers' perspectives

Recruitment and retention of RANs were constant issues for managers who were frustrated with the continual process of trying to increase the number of RANs at their clinic. Managers were clear that any RAN coming to their clinic needed to be (1) clinically competent, (2) culturally competent and (3) able to work with the team. Poor clinical skills were said to result in other team members having to undertake their work and poor team engagement was reported to result in team friction. Poor cultural skills resulted in patients not returning to the clinic and not engaging with healthcare; the impacts were long-term. Several managers said it was difficult to discern cultural skills from a resume.

While frustrated with the lack of staff, managers were more frustrated with having staff come to their clinic who they described as "unsuitable." They were clear that their clinic was "better off with no-one than the wrong person." One manager stated that, "stories about people coming out that are from agencies that say that 'they're well experienced and confident' but then they come out and they're not… their skills don't add up to what's on paper, which makes it really difficult." This included poor clinical and cultural skills, despite training. Managers wanted more flexibility in employment arrangements, quicker employment processes to recruit and better ways to screen for "suitable" RANs. Two of the five managers interviewed had ended RAN contracts early because of under-performance.

RANs' perspectives

Most RANs stressed the importance of "good staff." Perceptions of "good staff" varied but often related to experience, getting along with the team and working hard. RANs also talked about the stress and demands of the work and the lack of resources and infrastructure. They worried about leave allowances, burnout, having enough staffing and feeling pressured to both work long hours and not take leave. RANs also wanted better housing, Internet access, equipment at the clinic, access to clinic vehicles for personal use, and more training. However, key to leaving/staying was the "...group of people that you work with, that makes the difference," including the manager, RAN colleagues, Aboriginal staff and local community. Many RANs said they applied to work where "I heard the manager was good." Another stated "I'd only go if there were Indigenous staff."

RANs highlighted the importance of cultural and clinical skills and said these skills were intertwined: "…you've got to [have], there's the cultural stuff, there's the clinical stuff, there's the good common sense stuff, the autonomy… there's… confidence in your own practice." Some RANs talked about the importance of cultural skills for good clinical practice: "I think some of it [misdiagnosis] is because we're not reading Aboriginal people, because yeah, that communication… we don't read them as well and then we misunderstand what they're telling us." Most RANs said they had received little general cultural training prior to working in remote areas and no specific local cultural training in the particular community; rather they "learned on the job."

Aboriginal staff perspectives

Aboriginal staff, including receptionists, drivers, community liaison, administrative officers and Aboriginal Health Practitioners, were aware of high staff turnover and concerned about its impact on their community. One suggested, "you get people in the waiting room always asking who's this new person, who's that, and a lot of the community members sometimes are scared because new faces all the time, and they're like, is that a real nurse or is that a real doctor, why are they always changing?"

Primarily, all Aboriginal staff wanted "good" nurses. When asked what makes a "good" nurse, one respondent stated nurses who are:

> …getting to know the people, wanting to work with them, understanding both sides, not just laying their way of doing something down. Trying to really understand the [local language] and what happens in the community and how they believe in things, cultural beliefs and sicknesses and things like that. We know which are 'good' nurses

> and not, you know, we pick that up within the workplace, and how they're treating people and how they're speaking to them.

Cultural competence was at the heart of what Aboriginal staff wanted in RANs, including listening, respecting, understanding and responding appropriately. It involves staff "…work[ing] with the community but in a way that the community will understand it, and what I'd like to see, more outside things going on, not bringing everyone into the health centre." Many Aboriginal staff were sceptical of the cultural training non-Aboriginal staff had received. One commented:

> But we get a lot of people coming, nurses saying I've worked remote, I've worked in other communities, but [this community] is different. Like they all say they've all been trained in cross-cultural courses and all things like that, but a lot of things I've picked up… with the nurses, it's like they haven't been through those types of courses.

Local community perspectives

Overall, the biggest factor influencing use of the clinic by patients was how staff related to them. When spoken to "rough," or "lectured to" about health behaviours, or when things were not explained to patients, interviewees said they would not return to the clinic. In some communities, sick people and those with chronic disease reported that they did not use the health service because of how they were treated. Others said they only used the clinic "when I must, when I need," waiting until they were very unwell. Furthermore, when children or Elders were unwell and staff did not take their concerns seriously, family members said they felt disrespected. Others told stories of medical conditions being missed which resulted in severe sickness and even death. Using these messages, key attributes of a culturally competent practitioner, from the perspectives of these participants', were identified (see Table 2). Importantly, both cultural and clinical skills were reported as important and interconnected. Further, researchers observed that some clinics were busy while others had few patients in each day despite significant ill-health apparent in the community.

TABLE 2

Discussion

In this study, stakeholder groups reported similar perceptions of staffing issues. RANs in particular identified factors which the literature has previously found to be relevant to their recruitment,

retention and job satisfaction.[4-9] All stakeholder groups identified the importance of both clinical and cultural skills and reiterated that getting the 'right' RAN was more important than simply recruiting more nurses. While RANs and managers prioritised clinical skills, Aboriginal staff and community residents prioritised cultural skills. And some talked about the interconnection of cultural and clinical skills.

This suggests that recruitment processes need to be more rigorous and seek RANs who are appropriate for practice in specific places. This relies on RANs receiving effective cultural and clinical training, managers being able to identify cultural and clinical skills, and recruitment processes matching RANs to particular communities/clinics. However, research suggests that training does not always equate to competence, particularly in relation to cultural safety.[7,18,19] Training in cross-cultural practice can lack depth and effectiveness and needs to extend beyond training to behaviour, attitudes and policies.[7,20,21] Further, if training in local culture is lacking, practitioners can misdiagnose key conditions.[7] How to provide quality cultural training requires further analysis[22] but understanding local and broader history, having empathy, listening, being respectful, allowing for patient choice and providing support and input were important for consumer participants.[18-20,23]

This study was limited by short timeframes for fieldwork that restricted recruitment of participants to who was available within the visit and input from local researchers into data analysis. Further, the analysis here is descriptive and synthesised. Despite these limitations, all stakeholder groups were clear that recruitment of RANs in remote Aboriginal communities is not about recruiting *any* nurse, but recruiting RANs who are competent in cultural and clinical skills required for remote practice in a specific Aboriginal community.[24]

References

1. AIHW. Indigenous Health. In AIHW Australia's Health 2018, Cat. No. AUS 221. AIHW, 2018. Available https://www.aihw.gov.au/getmedia/90aca084-da1c-4536-9ff4-14a536d41113/aihw-aus-221-chapter-6-0.pdf.aspx.
2. Russell DJ, Zhao Y, Guthridge S, Ramjan M, Jones MP, Humphreys JS, Wakerman J. Patterns of resident health workforce turnover and retention in remote communities of the Northern Territory of Australia, 2013–2015. *Human Resources for Health* 2017; 15, 1: 52.
3. RANS are "specialist advanced-practice nurses who provide and coordinate a diverse range of healthcare services for remote communities, which are predominantly Aboriginal." See Weymouth S, Davey C, Wright JI, Nieuwoudt, LA, Barclay L, Belton S, Svenson S, Bowell L.

What are the effects of distance management on the retention of remote area nurses in Australia. *Rural and Remote Health* 2007; 7: 652. (Accessed at https://www.rrh.org.au/ journal/ article/652)

4. Lenthall S, Wakerman J, Opie T, Dollard M, Dunn S, Knight S, MacLeod M, Watson C. What stresses remote area nurses? Current knowledge and future action. *Australian Journal of Rural Health* 2009; 17: 208-13.
5. Opie T, Dollard M, Lenthall S, Wakerman J, Dunn S, Knight S, MacLeod M. Levels of occupational stress in the remote area nursing workforce. *Australian Journal of Rural Health* 2010; 18: 235-41.
6. Hegney D, McCarthy A, Rogers-Clark C, Gorman D. Retaining rural and remote area nurses, the Queensland, Australia experience. *JONA* 2002; 32, 3: 128-135.
7. Lindeman M, Dingwall K, Bell D. Towards better preparation and support for health and social care practitioners conducting specialised assessments in remote Indigenous contexts. *Australian Journal of Social Issues* 2014; 49, 4: 445-465. (Quotes page 460 and 450)
8. Lenthall S, Wakerman J, Opie T, Dunn S, MacLeod M, Dollard M, Rickard G, Knight S. Nursing workforce in very remote Australia, characteristics and key issues. *Australian Journal of Rural Health* 2011; 19: 32-37.
9. Garnett ST, Coe K, Golebiowska K, Walsh H, Zander KK, Guthridge S, Li S, Malyon R. *Attracting and Keeping Nursing Professionals in an Environment of Chronic Labour Shortage: A Study of Mobility among Nurses and Midwives in the Northern Territory of Australia.* Darwin: Charles Darwin University Press, 2008.
10. Lenthall S, Wakerman J, Dollard M, Dunn S, Knight S, Opie T, Rickard G, MacLeod M. Reducing occupational stress among registered nurses in very remote Australia: A participatory action research approach. *Collegian* 2018; 25, 2: 181-191.
11. Hegney D, McCarthy A, Rogers-Clark C, Gorman, D. Why nurses are resigning from rural and remote Queensland health facilities. *Collegian* 2002; 9: 33-39.
12. Coyle M, Al-Motlaq MA, Mills J, Francis K, Birks M. An integrative review of the role of registered nurses in remote and isolated practice. *Australian Health Review* 2010; 34: 239-245.
13. Buykx P, Humphreys J, Wakerman J, Pashen D. Systematic review of effective retention incentives for health workers in rural and remote areas: Towards evidence-based policy, *Australian Journal of Rural Health* 2010; 18: 102-109.
14. Wakerman J, Humphreys J, Bourke L, Dunbar T, Jones M, Carey TA, Guthridge S, Russell D, Lyle D, Zhao Y, Murakami-Gold L. Assessing the Impact and Cost of Short-Term Health

Workforce in Remote Indigenous Communities in Australia: A Mixed Methods Study Protocol. *JMIR Research Protocols* 2016; 5, 4: e135. Available at http://doi.org/10.2196/resprot.5831.

15. The seven communities were selected by identifying levels of staff turnover in all government-run remote clinics in the NT. The seven were chosen to reflect high, medium and low staff turnover (2, 3 and 2 communities, respectively) with consideration given to diversity in geographical location, clinic size, population size and remoteness. Three communities are located in the Central Desert region (south-central NT) and four in the Top End (northern area of mainland NT).
16. Miles MB, Huberman AM & Saldana J. *Qualitative Data Analysis: A Methods Sourcebook 3rd Edition*. Los Angeles: Sage, 2014. Bryman A & Burgess B, eds. Analyzing Qualitative Data. London: Routledge, 2002
17. Bryman A & Burgess B, eds. Analyzing Qualitative Data. London: Routledge, 2002.
18. Ward, R., Gorman, D. Racism, discrimination and health services to Aboriginal people in south west Queensland. *Aboriginal & Islander Health Worker Journal* 2010; 34, 6, 3-5.
19. Downing R, & Kowal E. Putting Indigenous cultural training into nursing practice, *Contemporary Nurse*; 2011: 37, DOI: 10.5172/conu.2011.37.1.010
20. Coffin J. Rising to the challenge in Aboriginal health by creating cultural security. *Aboriginal & Islander Health Worker Journal* 2007; 31, 3, 22-24.
21. Bainbridge R, McCalman J, Clifford A, and Tsey K. *Cultural competency in the delivery of health services for Indigenous people.* Issues paper no. 13 produced for the Closing the Gap Clearinghouse. Australian Instutite of Health and Welfare, 2015 http://apo.org.au/system/files/56408/apo-nid56408-39711.pdf (accessed 17 December 2018).
22. Beach MC, Price EG, Gary TL, Robinson KA, Gozu A, Palacio A, Smarth C, Jenckes MW, Feuerstein C, Bass EB, Powe NR, Cooper LA. Cultural Competency: A Systematic Review of Health Care Provider Educational Interventions. *Medical Care* 2005; 43, 4: 356–373.
23. Rix EF, Barclay L, Wilson S. Can a white nurse get it? Reflexive practice and the non-Indigenous clinician/researcher working with Aboriginal people. *Rural and Remote Health* 2014; 14, 2679 (Accessed at https://www.rrh.org.au/journal/article/2679).
24. Liaw ST, Lau P, Pyett P, Furler J, Burchill M, Rowley K, Kelaher M. Successful chronic disease care for Aboriginal Australians requires cultural competence. *Australian and New Zealand Journal of Public Health* 2011; 35, 3: 238-248.

Table 1: Types of respondents interviewed

Type of health professional	Number interviewed
Managers	5
RANs (short-term and permanent)	29
Aboriginal Staff[+]	12
Community members (Indigenous)	
Interviews	56
Focus groups	12 groups (3-18 participants in each group)

+ Aboriginal staff includes Aboriginal Health Practitioners, Aboriginal Health Workers, Community Liaison Officers, receptionists, administration workers and drivers; they tended to group together and talk about themselves as a group and for this reason clinical and non-clinical Indigenous staff have been grouped together.

Table 2: Aboriginal participants' perceptions of a culturally competent practitioner for remote Aboriginal practice

Skill type	Approach to cultural competency	Example
Cultural skills	Understanding the history of Indigenous oppression, dispossession and the determinants of health	RANs identifying that issues of cost, housing and family obligations may impact health, how health services are utilised and how advice is acted upon.
Cultural skills	Having empathy for past injustices	Demonstrating understanding of and acknowledging the injustice of dispossession of land and the removal of children; expecting patients to find trust with care providers difficult.
Cultural skills	Understanding local history	RANs come to a community and ask

		about the local history, listen to what is said about the local community and learn some local language.
Clinical skills	Listening; the ability to listen, to be still, present and listening with all of one's body using mindfulness and similar techniques	RANs listening to why a treatment plan has not been followed with genuine interest in understanding both the enablers and barriers to following the plan and how the plan can be revised to be helpful to the patient.
Clinical and cultural skills	Respecting the patient's concern and not dismissing patient concerns as minor ailments but seeking to understand the reason for the concern and what can be done to alleviate the concern	Being able to hear an approach to health you disagree with while having the respect to seek understanding of the patient's approach (rather than seeking to change the patient's approach through education, etc.).
Clinical and cultural skills	Demonstrating respect for the Indigenous patient by speaking with, not at, the patient to ensure understanding of their health issues and medications	Developing actions and plans with the patient that are based on their lives and how healthcare and treatments can be included (rather than proposing care and treatment as first priority).
Clinical and cultural skills	Allowing the patient to have family with them when language is a barrier	Respecting patient's choice of who will translate and spending the time to have the selected person come and a genuine attempt to work with the selected person.