

RESEARCH LETTER

Nurse-led remote primary healthcare service

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Remote Australia, including areas classified as remote and very remote¹, accounts for 86% of Australia's land mass but only 3% of the population². Health care provided to this population is delivered through a number of models and configurations but predominantly provided by remote area nurses. The scope, quantity and diversity of the health care is not well described and for the most part is anecdotal and experiential based. In turn, the activity counting and funding models are disparate and are not consistent across the jurisdictions of Australia. There is a need to gain more detailed understanding of the diversity and unique characteristics of health service delivery provided in remote Australia, the type of care delivered and the workforce providing the services³.

Here we report on a small study set in a remote community, with a permanent population of less than 1000, which significantly increases in tourist season. The primary health care clinic is permanently staffed by a nurse practitioner and a remote area nurse, with supporting fly-in/fly-out medical

officers (general practitioners) and a range of allied health services.

The project was a pilot study using a mixed methods exploratory design⁴. The three phases included a desktop research activity, local validation and collection of service provision data.

The desktop research accessed Australian Bureau of Statistics Census of Population and Housing (eg age, sex, indigenous status, family status, income, industry, occupation, education) and local government data to develop a population profile and mapping of local service delivery models. Phase 2 used semi-structured interviews with key health professionals to verify the population profile, the service delivery models and to gather workforce profile data. This informed the development of the survey tool used in phase 3.

The survey tool was designed to capture relevant data in a structured way and included the direct client activities (elements of care) broken down into types of activity such as



history and assessment, procedures, following up results, consultation with other health professionals, family/carer liaison and documentation. The non-direct activities were the pre-identified common tasks and were entered as blocks of time.

A wealth of information was collected in this pilot case study, whereas operational data traditionally is just a count of services and diagnosis, without breaking down the elements of care provided. There was an average of 13 patients per day per nurse and on average patients had three elements of care (range=1–7). The non-direct care data reflected there was an average of 255 minutes, or 4.2 hours per day, per nurse (range=35–775).

This body of knowledge provided a comprehensive description of the current model of primary healthcare service and provided clarity on the roles of nurses supported by multi-disciplinary fly-in/fly-out services. A longer data collection period would assist to strengthen data validation.

Future research considerations include repeating the study in different remote settings to enhance the tool and validate the classifications of activities undertaken. In addition, research to further analyse this model or similar nurse-led models would provide opportunities for service planning and analysis from the health economic perspective.

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