

# The Value of Rural Isolated Practice Endorsed Registered Nurses in a Small Rural Health Service

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## **Abstract**

*Three Registered Nurses (RN's) undertook training and commenced practice as Rural Isolated Practice Endorsed Registered Nurses (RIPERNs) in a small rural Victorian health service, Australia. This advanced practice role is new to the health service and allows RIPERN's to undertake some procedures usually performed by medical practitioners. As a form of evaluation, interviews were conducted with seven General Practitioners (GP's) who have admitting privileges at the health service and three RIPERN's who had commenced the extended scope of practice role.*

*Data was analysed and findings revealed strong benefits from the perspective of the GP's and the RIPERN's. These benefits included overall improved work-life balance for the GP's, increased confidence and capabilities for the RIPERN's and overall perceived improvement in the delivery of services at this small rural health service. Negative findings included misconceptions about the RIPERN extended scope of practice and increased demands experienced by RIPERN's.*

## **Keywords**

*advanced practice nurses, rural health, rural practitioners*

## **1. Introduction**

The Advanced Practice Nurse (APN) role has been adopted internationally and now most countries have a range of positions and practice roles which come under the overarching umbrella term of APN. The development of this role has been driven mainly due to a world-wide shortage of nurses and therefore a greater expectation for nurses to further their skills and cope with a greater acuity of patients and turnover than ever before (Kleinpell, 2014).

Development of the APN role has also been influenced by local, national and international issues, such as changing demographics, consumer demands and associated long-term health needs, which are as relevant in Australia as they are within the global population (Por, 2008; Sheer, 2008; Truscott, 2007). The continued shortage of medical practitioners in certain fields of practice (Kotzer, 2005) and the reduction of GP's working hours in many areas in Australia have also led to the need to develop further APN roles. Additional issues influencing the development of APN roles in Australia include changes to nurse

education programs reflective of the complex array of skills needed for current nursing practice. Education advances also relate to an accumulative desire for professionalisation and autonomy within the nursing community (Wong, 2008).

Differing terminology around the world has led to confusion regarding the roles and boundaries of nurses working in advanced practice (Kleinpell, 2014). There is great ambiguity about the Nurse Practitioner (NP) and APN role. Australian regulators for nurses moved early to standardise the NP role. A challenge now lies to differentiate the relationship between APN and specific roles and titles and to delineate the varying scopes of practice from that of the non-endorsed registered nurse (Gardner, 2013).

In Australia, NPs are a sub-set of nurses with the highest level of advanced nursing skills (State Government Victoria, 2001). NPs have safely and competently been independently prescribing for over a decade in Australia (Australian Nursing Federation, 2012) and work across a broad range of health service settings.

In Australia, a RIPERN is an APN nurse who has undertaken additional training and is able to provide a wider range of primary care and emergency services in rural health. RIPERN's undertake initial assessment and the findings and appropriate treatments are discussed with the medical officer, if there is one available (The State of Queensland (Queensland Health) and The Royal Flying Doctor Services (Queensland Section), 2013). A RIPERN can by law, obtain, possess, supply and administer schedule 2, 3, 4 and 8 medications in rural and isolated areas, but unlike NP's are prohibited from independent prescribing and ordering of diagnostic tests. The RIPERN role extension was designated by the Victorian Minister for Health allowing a broad range of medications to be administered to patients in certain circumstances and supply medications to patients when a medical practitioner is not available. RIPERN's practice in accordance with the Primary Clinical Care Manual (PCCM) (The State of Queensland (Queensland Health) and The Royal Flying Doctor Services (Queensland Section), 2013). This evidence based manual guides assessments and treatments in day to day client care and service delivery.

Studies have been undertaken to identify barriers to the APN role and how they have been overcome. The main barriers included opposition from medical professionals, care and funding mechanisms, types of primary care delivery and payment methods, legislative impact and scope regulation and the capacity of education and training opportunities to prepare nurses for these roles (Bagg, 2004; Kleinpell, 2014; Wallis, 2009). Norris and Melby (2006) found that despite evidence that APNs generally have a positive impact, there was a reluctance on the part of some doctors to allow nurses to practise certain advanced skills (Norris, 2006). Collaboration between RIPERNS and GPs can reduce costs and improve accessible care for patients in rural and remote areas (Siegloff Clark, 2000). However, there is also evidence that the blurring of interprofessional boundaries can result in conflict (Norris, 2006).

The aim of this study was to determine the perception of GP's and RIPERN's about the RIPERN role, and to identify factors that may facilitate or hinder current and further role development in small rural health services.

## 2. Method

### 2.1 Context

The area in which this study was undertaken in Victoria, Australia, has a population of approximately six thousand people. The median age is 44 years with roughly equal gender proportions. It is an ageing population with about 20% of people aged 70-85 years and older (Australian Bureau of Statistics, 2006). The health care service in this town was originally established in 1949 and has since expanded to include 12 acute beds, operating and day procedure unit, palliative care and transitional care, an urgent care centre, 3 bed (un-funded), radiology, community health and community rehabilitation centre, and a 30 bed aged care facility. There are approximately 5,000 urgent care presentations annually.

### 2.2 Ethics

The project was approved by the University of Melbourne Human Research Ethics Advisory Group, and conducted according to the Helsinki declaration on Human Research.

All participants gave consent after receiving written and oral information about the project, including the proposed interview questions. Anonymity is preserved in reporting the findings.

### 2.3 Procedure

Purposive sampling was used, in that all the GP's and RIPERN's who worked in the small rural health service were invited by email to participate in an interview. It was clearly indicated that their involvement was voluntary and anonymous to other staff and management of the health service. A copy of the interview questions was provided to all potential interviewees. Following explanations of why the study was being undertaken, interviews were conducted at mutually suitable times. They were all provided with consent forms to sign prior to the interviews being undertaken.

### 2.4 Interviewer

The interviews were conducted by the principle researcher. The interviewer is a registered nurse who has an existing relationship with the GP's and RIPERN's through research programs and ongoing education. The interviewer does not work clinically with the staff, nor have a position of influence within the organization. The interviewer has previous qualitative research experience.

### 2.5 Participants

The health service has credentialed seven GP's to provide services to patients in the region. Admitting privilege is the right of a doctor by virtue of membership as a hospital's medical staff, to admit patients for specific diagnostic or therapeutic services. These privileges are reviewed yearly to credential that procedures undertaken are in line with their skills and qualifications and the needs of their local community. At the study site, the credentialed GP's years of experience in Australia ranged from 3-20 years.

There are three recently trained RIPERN's at the health service. Employment contracts enable them to cover nine of a possible twenty one shifts per week. The RIPERN's work predominately evening, weekend and night shifts when local medical clinics are closed. Nurses who undertook RIPERN training had an average of 31 years clinical experience (ranged from 28-35 years).

There were three eligible RIPERN's and seven GP's interviewed during the four week time period that interviews were conducted. Of the 11 eligible staff to be interviewed, all consented, with a response rate of 100%.

### *2.6 The Interview Schedule*

The interview schedule was very open ended, with eight questions, allowing further questions to be developed as the interview progressed. The questions were developed by the principal and co-researcher to gain both GP's and RIPERN's perception of the RIPERN role in this small rural health service. GP's interview questions explored the role of the RIPERN, work-life balance for GP's, their involvement in mentoring the RIPERN's, discharge information and recommendations for future RIPERN role development.

RIPERN's interview questions explored their skill and confidence in the new role, mentoring other nurses, executive management support, community education of the RIPERN role and overall limitations to the role. A copy of the interview schedule is available from the corresponding author.

### *2.7 Data Analysis*

The audio recorded interviews were transcribed verbatim. The transcripts were read by two authors (KE and FC), both during and after the interviews. This gave a first impression of the data material as a whole. These two authors collaborated on further analysis of the text. Data relating to the value of the RIPERN role were selected and re-read several times. Each author selected what they found of importance in relation to the research question. Through discussion, the authors agreed upon prominent categories. A third author (GN) independently read the transcripts and agreed with the categories selected by the initial authors. Impressions were presented back to the interviewees to confirm we had captured their meanings. Each concept is illustrated by quotes in the findings.

## **3. Result**

The intention of the interviews was to determine both the GP's and the RIPERN's perception of the value of the advanced practice nurses in their health service. The perceptions were remarkably homogenous, with strong benefits and few barriers perceived by both groups. The GP group articulated concerns about future training, perceiving the current RIPERN's to be particularly skilled and experienced with adequate post graduate training and education to prepare them for the role. The RIPERN's perceived strong support from the GP's overall, with little (though some) interprofessional conflict. Increased demands on the RIPERN's time was reported. Both groups perceived there is confusion about the RIPERN's scope of practice.

Confusion about the RIPERN role:

The findings show there is a great deal of confusion and misconceptions about the scope of the RIPERN's. While most GP's were unsure of what the extended scope of practice actually entailed, all of the GP's interviewed incorrectly perceived that RIPERN's could prescribe medications. Similarly, the RIPERN's reported that nursing colleagues and the patients they treated expressed surprise at some of the

procedures they undertook. RIPERN's believed that more education for community members about the extended scope of practice was required. Comments which illustrate this are:

*"I don't know honestly what they can do that is different to a registered nurse".*

And,

*"Well, the RIPERN's can prescribe medications..."*

And,

*"Sometimes patients are surprised and say 'are you allowed to do that?' ... there was a little article in the annual report ... I think there could be a lot more done community wise".*

Work/life balance:

Without exception the GP's perceived that RIPERN's provided and improved work/life balance for them. This was not limited to less call outs in the evenings, but extended to confidence in the RIPERN's abilities, which allowed them to sleep better and therefore perform better the next day. It was perceived there would be improved retention of medical staff related to work/life balance if more of the nursing staff were trained as RIPERN's. One RIPERN also commented on the aspect of improved work/life balance for GP's.

Some comments included:

*"When the RIPERN's are working I know I'll sleep well, because they have the skills to manage almost everything that presents. If they call, we know that we really are needed".*

And,

*"Very much appreciate their presence and when I speak to them on the phone I have confidence in knowing that they can look after the patient quite safely compared to non endorsed nurses and therefore able to carry out a lot of tasks over the phone without my presence".*

And,

*"When these nurses are on we are able to have more rest at night and then we are able to work better the next day".*

And

*"If they are on I have less stress in my head absolutely, absolutely".*

Training and Experience:

The GP's interviewed expressed that the experience of the currently trained RIPERN's was of benefit and that they would not be as confident in the role without the added experience. This has potential ramifications for future training of staff—GP's may not be as supportive of future staff training of nurses who lack many years of experience. There is currently no prerequisite experience as a registered nurse to undertake RIPERN training.

Although the introduction of this role is relatively new, the GPs interviewed perceived that the current RIPERN's had excellent experience, knowledge and training and required very little mentoring to undertake their new clinical tasks. Some comments included:

*"Current ones are a good example for existing staff. Trailblazers".*

And,

*“They are a good resource, making health delivery more effective”.*

And,

*“... they are very experienced, they don't need mentoring ...”*

The GP's and RIPERN's all expressed support for an approved program of study to prepare them for the new role. RIPERN's identified that a program of study was important. In addition they expressed that it was important to have support from their colleagues, particularly at an executive level, by providing study days and support throughout their training.

*“They need the proper education and training before they can do this role”.*

And,

*“Like doctors, they need training always ... There is various levels between them”.*

And,

*“They need proper education and training before they can do it”.*

And,

*“There's not a huge change in what these people do, because they've always been so good. But I would imagine that if people came along ... it may well require some tweaking”.*

Time burden:

From the perspective of the RIPERNS, the most outstanding finding was the increased time required for the extra tasks associated with the RIPERN role. Increased time was associated with more in depth assessment and decision making as well as performing tasks like suturing. Increased documentation is also required. Comments included:

*“We still have our usual tasks to perform, we don't get extra time allocated for our new roles. We have to try to fit it all in. Sometimes there are presentations that could be managed by a RIPERN, but we call the doctor in, simply because we have so many other demands on our time”.*

And,

*“I am reluctant to start treatment sometimes, I know as soon as I do, another patient will present or I'll be needed on the ward”.*

#### **4. Discussion**

A prominent finding of the study is that participants viewed the benefits of the RIPERN role far outweighed any challenges. This is evidenced, not just by the total number of comments made concerning benefits of the role, but also the breadth and depth of these comments. One of the perceived benefits of the role was improved work/life balance for GP's. There is a clear lack of understanding of the role by other nurses and members of a multidisciplinary health care team and the general public. The training and experience of RIPERN's was perceived as crucial by all participants. RIPERN's themselves identified the extra burden on their time as a result of the training and subsequent endorsement.

Improved work/life balance for GP's as a result of the RIPERN role was frequently cited by interview participants. This is supported by broader literature, which states that these nurses frequently act as a buffer between GP's and patients outside normal working hours (Zeitz, 2006). GP's further commented on not just physical but the psychological benefits provided by the RIPERN role. Their confidence in the skill of the RIPERN's provided peace of mind.

Rural and regional hospitals have a greater difficulty retaining medical staff after recruitment than their urban counterparts as they usually experience higher workloads, less staff to share the on call rosters and less access to specialist services (Zwar, 2007). While GPs continue to provide clinical support in rural areas, they aren't necessarily seen as the essential health care professional. Team based approaches often perceive RIPERN's as similar to GP's but the GP as the leader and the RIPERN as their assistant (Crossland, 2011). Trust takes time to develop and is not always achieved between rural nurses and GPs, but when it does, this form of trust leads to better outcomes (Hegney, 1997).

Education and adequate preparation for undertaking the role was raised by GP's and RIPERN's. Statutory regulations concerning education and registration is an area with continued attention. The Nursing and Midwifery Board of Australia (NMBA) are reviewing the need for approved courses of study for RIPERN endorsement, arguing that a specific standard for registered nurses to obtain, supply and administer scheduled medicines already exists in accordance with the relevant drug therapy protocol. Both RIPERN's and GP's articulated the importance of further education and training for the RIPERN role, and suggested that they would not be confident in the competence of all nurses without further education. The continuing availability of RIPERN's could be threatened by the withdrawal of one of the course providers, the University of Southern Queensland. The final cohort of students associated with this provider will be eligible for endorsement in mid-2016. This means that there is only one provider of training that leads to endorsement. This is a private provider without access to framework and governance associated with a university and highlights a major risk associated with the sustainability of the model (Leading Aged Services Australia (LASA), 2015).

Barriers for nurses studying for an advanced practice role include added workload and stress leading to apprehension regarding further study. It has been noted that nurses who continually update knowledge, make fewer errors than those who do not (O'Shea, 1999). Ongoing education is seen as the key to developing the role of RIPERN's.

The time burden associated with the extended scope of the RIPERN role has been previously reported, especially in relation to documentation (MSPS Project Services, 2015). Unlike many nurse practitioners, RIPERN's are not supernumerary, nor do they have a funding model which allows independent practice. RIPERN's must absorb extra duties and responsibilities within their current employment conditions for which there is currently no extra remuneration. This is potentially a major disincentive for staff considering RIPERN training. Advanced practice nurses research, integrate education, manage, provide leadership and include consultation into their clinical roles (National Rural Health Alliance, 2005).

Driving factors for RIPERN training and endorsement is currently dependent on individual work satisfaction (Adams, 2000), without expectation of reward.

## 5. Limitations

It is acknowledged that the findings of the study may need to be viewed in the context of the study limitations. Due to the small numbers of stakeholders there would be insufficient power to undertake quantitative studies. This problem is inherent in all small rural health studies.

Additionally, the perception of patients treated by RIPERN's was not sought in this study. Previous evaluation of the APN role, reports that the value-added component of the role extends beyond transfer of medical functions (Bryant-Lukosius, 2004) and that APN care is associated with significant improvements in patient satisfaction and quality of care. This is supported by the work of Griffin and Melby (2006) who report similar findings of the enhancement of patient care (Griffin, 2006).

## 6. Conclusions

The aim of the study was to determine the attitudes of the GP's and the RIPERN's at this small rural health service towards the role, and to identify any perceived factors that may facilitate or hinder current and further role development. The findings may be useful for similar sized services initiating the role.

It is clear that a range of factors are perceived by the study respondents as being able to potentially hinder or facilitate the implementation of the RIPERN role in a small rural health care setting. Whilst the views of the respondents are largely positive, there are important issues that need to be addressed.

The challenges RIPERN's face, such as role confusion and extra time burdens, are not unique, but are yet to be addressed in an Australian setting. Continued training and education for the RIPERN role is uncertain, which may result in a loss of confidence by GP's, who currently favour and support the role.

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