

How do Rural Nurse Specialists in South Westland Perceive Their Personal
Safety Whilst Working in Isolation?

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Abstract

Rural nurse specialists (RNSs) frequently work in relative isolation which has the potential to increase the risk to their personal safety. RNSs working in New Zealand (NZ) are often required to do sole postings and on-call with no locator beacons and intermittent communication. Weather and geographical challenges dictate how easily support can be accessed. Those working in such isolated environments require a good knowledge of the available resources. Their location and environment are often reliant on good judgement rather than good systems (Bell, 2015; Howie, 2008; Kemp, 2012). While a few previous studies have identified some concerns related to the personal safety of rural nurses, these have generally related to nurses working in either Australia or Canada. There is little known about how RNSs working in NZ experience their personal safety when at work.

This study aimed to identify how RNSs currently working in South Westland (SW), NZ, perceive their personal safety. A qualitative approach using a focus group was used to explore responses. Thematic analysis, based on Braun and Clarke's (2006) framework, guided the process of data analysis and the development of themes identified in regard to nurse safety working in such unique and isolated environments.

The results from the analysis of the transcribed data from the five RNS participants formed three main themes: 1) Community, 2) Pressure to perform, 3) Safety: Luck versus planning. Congruence was evident between the findings which emerged from this study and the literature in relation to current issues around rural nursing and the issues specific to SW. Recommendations for future practice and continued research are suggested.

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Chapter One: Background

Introduction

This research was undertaken in order to gain a greater understanding into personal safety and broader safety aspects of the RNS role in SW. While there has been no specific event or incident that has led to the initiation of this study, the researcher having worked in the RNS role has experienced situations and has been involved in collegial discussions where personal safety was deemed at risk. Through these discussions and work experience, the researcher felt that this would be an interesting concept to explore further considering the unique environment that the RNS works in and to relate findings to current practice and policy.

Background information in relation to the environment in which rural nurses work and the development of rural nursing in New Zealand is provided in this chapter to aid in understanding what it is like to work as a nurse in remote and isolated environments. Further exploration of the published literature pertinent to this topic will be presented in chapter two as part of the literature review.

Aim of the Study

RNSs work in relative isolation in SW with one rural nurse in each town from Hari to Haast. Working in isolated environments may have different risks in regard to personal safety when compared to more urban environments. The research reported in this dissertation aims to identify how RNSs currently working in SW perceive their personal safety whilst at work and may provide insight into the realities of providing rural nursing services.

Rural

A consensus definition of rural and remote has traditionally been difficult to achieve with researchers stating that these terms are poorly defined globally. Researchers relate these difficulties to aspects such as the perception

of accessibility and geographical distances from urban services (Bell, 2015; Howie, 2008; Jervis-Tracey et al., 2016; MacLeod, Browne & Leipert, 1998). Embedded within these definitions of rural and rurality, researchers discuss the need to consider the following: community needs; geographical distance from the nearest urban centre; weather; available resources; access to support; services and transport options to access these services (Bell, 2015; McLeod et al., 1998).

Howie (2008) and Jervis-Tracey et al. (2016) explore the concept of rurality in their research suggesting it is a phenomenon that requires further understanding but is a core component in the definition of 'rural'. Rurality according to Howie (2008) is socially and culturally constructed with links to rural people's sense of community, attachment to nature, familiarity to one another, and mechanisms of support (Howie, 2008). Jervis-Tracey et al. (2016) used several approaches to determine rural remoteness, for example accessibility/remoteness index tools when looking at geographical distances, and other tools to assess degrees of disadvantage and population size.

CRANApplus, the main organisation representing the remote health professional workforce in Australia, provides advice to the Government, service providers, clinicians, and consumers on equitable access to safe, high-quality health care (Malone, & Cliffe, 2018). Malone and Cliffe (2018) have worked with CRANApplus to provide a comprehensive list that identifies what many researchers have reflected in their definitions of rural or rurality. Within this document, remoteness is influenced by geography, terrain, means of access and what transport is required, quality of the roads, whether there are mountains or islands, available resources, social/cultural influences, environmental, weather, likelihood of natural disasters, as well as distances between services and towns (Malone, & Cliffe, 2018).

Rurality impacts on the delivery of health care with research by Bourke et al. (2012) contributing a framework to assist understanding of some

complexities of rural health. In this research many of CRANaplus's identified influences stated above are also acknowledged by Bourke et al (2012), as impacting the delivery and access of health care, highlighting the complexities of rural or remote living.

Australian literature provides insight into the constraints and difficulties of providing services to remote areas, some which are transferrable to NZ's rural and remote areas, and some that are particular to working in indigenous communities. When researching NZ literature and definitions of rural, Statistics New Zealand (2004) defines rural in relation to the community's dependence on its neighbouring urban centres. A rural settlement was defined as having a maximum population of 10,000 (Statistics New Zealand, 2004). In more recent definitions published by the same governing department, rurality was based on dependence on near-by urban counterparts for services and employment (Statistics New Zealand, 2017).

Westland is considered highly remote and rural as it is isolated from its urban centres and contains mountainous and uninhabitable terrain (Statistics New Zealand, 2017). The Ministry of Health (MoH) reported that one in four New Zealanders lived rurally with higher numbers of children, older people, and Māori living in these areas (2011). When considering the West Coast of the South Island in relation to other rural areas within NZ, the population of the West Coast region is approximately 32,000 (Statistics New Zealand, 2017). Put in context, this represents less than one percent of NZ's population. The 4000 people living within the Westland region of the West Coast are widely dispersed from Hokitika to Haast (an approx. 300 km long stretch of land), with one quarter of the population in Westland identifying as Māori (Statistics New Zealand, 2017; Westland District Council, 2018).

To summarise, the definition and concept of rural or remote is formed based on a foundation of many things from environmental and geographical to individual aspects that comprise a community in regard to population and

culture. This is reflective in the literature within both NZ and internationally, all drawing on similar points but measured in individual ways.

Rural Nursing

Molinari and Bushy (2012) provide a comprehensive review of the development of rural nursing, mostly from an American context. Rural nursing in America originated from the Red Cross Nursing service which was initiated back in 1912. Prior to this, rural health care was provided by informal support systems within the community (Molinari & Bushy, 2012). Insight into the history of rural nursing within NZ is illustrated by Ross (2008) in a book compiled of chapters written by rural nurses throughout NZ. Whilst this piece of literature is now ten years old, the information and stories shared are still reflective of rural nursing today.

The World Health Organisation (WHO) (2010), in a document on rural health workers, focusses the attention on the need to increase access to services and improve staff retention. Globally, it was acknowledged that health equity and meeting health needs is a challenge in all areas; however, one of the most challenging and complex environments is delivering health care to people living in rural and remote areas (WHO, 2010). Attracting and retaining rural health workers, including nurses, is acknowledged as an issue by health workforce NZ and the current Minister of Health (MoH, 2018; New Zealand Government, 2018).

Internationally, there are insufficient numbers of qualified health workers in isolated environments, yet half of the world's population lives in rural areas. Surprisingly, only 38% of the total nursing workforce serves these isolated areas (WHO, 2010). This is particularly problematic in countries such as Bangladesh and South Africa where access to essential health-care services is poor if not inaccessible. With ongoing shortage of healthcare workers in rural areas related to the international data, it is not necessarily generalizable within NZ where there is a much higher urban population (WHO, 2010).

Articles regarding rural and remote nursing from within the Australian and Canadian context appear dominant in the research literature. A common theme found within this literature is that healthcare to communities is complex and unique in nature with many barriers and challenges (Anderson, 2012; Hunt and Hunt, 2016; McCullough, 2011; Mills, Birks, & Hegney, 2010). Professional isolation, lack of educational support and opportunities as well as a lack of organizational support are difficulties highlighted. Anderson (2012) identifies a high turnover of staff as attributable to these challenges and adds that the cross-cultural component can be an additional barrier when working in indigenous communities.

WHO (2010) acknowledges health workers in rural communities are often providing services beyond their formal training due to the absence of more experienced health workers, and an enhanced scope of practice is often necessary to provide the tasks required of them (WHO, 2010). Brown, Eckhoff, Lindley, and Jones (2002) described the rural nurse as a generalist requiring a wide range of knowledge and skills. These authors described the nurse in this setting as likely to experience unpredictable work, with a lack of resources and the level of support at hand which can bring about a feeling that is unsettling. They also identified that these nurses working in rural communities report they enjoy the challenges, autonomy, and independence along with the sense of respect they receive from both communities and professional teams alike (Brown et al., 2002). These statements are reinforced in the WHO report which states that an enhanced scope of practice is likely to lead to an increased level of job satisfaction and retention (WHO, 2010).

Knowledge about the nature of nursing in rural areas has developed over time. Research and education associated with rural nursing practice has had some positive influence on policy and government legislation improving access to health care for those living rurally in some capacity (Ross, 2008).

Rural Nurse Specialist Definition and Role

RNSs working in NZ are often required to undertake sole postings in remote locations, including on-call work with no locator beacons and intermittent communication. Weather and geographical challenges dictate how support is accessed and those working in such isolated environments require knowledge of available resources, location, and their environment which can be reliant on good judgement rather than good systems (Howie, 2008; Ross, 2008).

In order to gain a greater understanding of the RNS role, Dean (2015) on behalf of the West Coast District Health Board (WCDHB), undertook a review of the components and relevant challenges of the RNS role on the West Coast of NZ. Part of this review looked at the beginnings of the RNS role and how this position evolved. Dean (2015) reports the RNS role in SW emerged from the District Nurse role in order to meet the needs of the community.

In order to meet the needs of the community, RNSs within SW and across other parts of NZ have incorporated two aspects into this role: one, providing primary health care in the general practice setting, and the other providing urgent and emergency after-hours care (Bell, 2015; Dean, 2015; Kemp, 2012). As a result, there is a large on-call component and nurses need to be multi-skilled including a requirement for advanced assessment and diagnostic skills to provide this level of care within remote and rural communities (Bell, 2015; Brown et al., 2002; Dean, 2015; Kemp, 2012).

Armstrong (2008) discusses the realities of sole on-call as a rural nurse in NZ. Issues faced in her daily practice speak of a sense of isolation, lack of support and lack of role recognition. She described a concern in rural nursing in regard to recruitment and retention, with nurses working in these environments often feeling increased professional risks and a sense of invisibility within the health care arena (Armstrong, 2008).

RNSs working rurally providing sole on-call are discussed by Bell (2015) and Kemp (2012) who report rural nurses require an advanced skill set to enable them to work in remote environments. Both these studies reflect Armstrong's (2008) statements of a sense of isolation both professionally and geographically felt by these nurses. Enhancing the feeling of isolation were aspects such as weather, communication challenges, and difficulties transporting patients, and key facilitators were the need for good support systems and relationships within the multidisciplinary team (Bell, 2015; Kemp, 2012). Providing on-call services and working in isolation has shown to increase the risk to safety of nurses in Australia and the subsequent need to improve safety policies and procedures in remote workplaces (Anderson, 2012; McCullough, 2011).

One part of the on-call service for the RNSs in SW is providing Primary Response in Medical Emergency (PRIME). PRIME is a 24-hour emergency service initiated by Ambulance Communications in order to provide timely access and expertise to care for patients in rural areas (MoH, 2017). To perform all of these duties, the RNS in NZ works within a Registered Nurse (RN) scope of practice utilising Standing Orders (SO). SO have been developed within the rural setting as a framework to support those working in isolated roles so that legally under the RN scope of practice, RNSs can provide both emergency and primary health care autonomously (Dean, 2015; MoH, 2016).

SO in NZ are defined as:

A standing order is a written instruction issued by a medical practitioner, dentist, nurse practitioner or optometrist. It authorises a specified person or class of people (e.g., paramedics, registered nurses) who do not have prescribing rights to administer and/or supply specified medicines and some controlled drugs. The intention is for standing orders to be used to improve patients' timely access to

medicines; for example, by authorising a paramedic in an emergency or a registered nurse in a primary health care setting. (MoH, 2016, p. 1)

Rural nurses have an advanced skill set and some have specialised skills. These skills are often developed and influenced by the context in which the RNSs work and the people who make up their communities (Brown et al., 2002; Jones & Ross, 2003). Age, occupation, tourism, culture and the nature of the population in regard to permanence or transience influence the skills required of the nurses due to the impact of these factors on types of patient presentations (Bell, 2015; Jones & Ross, 2003). The paradox is that although the RNSs have a range of specialised skills due to their rurality, they are also likely to be generalists as their scope must contain a broad range of skills and expertise to provide nursing care for people across the lifespan (Jones & Ross, 2003).

Workplace Safety and Current Legislation

New Zealand Nurses Organisation (NZNO) highlights the right for all workers to a safe and healthy workplace under the Health and Safety at Work Act 2015 (NZNO, 2014). By law employees have the right to request a health and safety policy, system or process that they agree upon. This Act also states that it is the employer's responsibility to provide a safe working environment (NZNO, 2014).

Physical safety is one aspect of a safe working environment with stress and fatigue management remaining a considerable safety risk that needs to be managed within the workplace (WorkSafe New Zealand, 2017). Legislation states that any physical or mental fatigue or condition which affects a person's behaviour is deemed a workplace hazard (NZNO, 2014). As part of keeping nurses safe in all workplaces, employees have a responsibility to comply with the Health and Safety at Work Act 2015 and the Employee Participation Agreement in each District Health Board or in their place of work. It remains the employer's responsibility to ensure each workplace meets the required

standards and adequate safety equipment and procedures are provided to safely achieve this (NZNO, 2018).

WorkSafe NZ reflects similar statements in that workers have a responsibility to maintain their own safety whilst on duty taking reasonable care to keep themselves and others safe in the work that they are doing (WorkSafe New Zealand, 2017). Worker involvement in staying safe is a critical component in achieving any type of safety performance within the work setting with noted differences across differing work places. This can be due to methods of reporting, data recording or type of hazards in the workplace (Ministry of Business, Innovation and Employment, 2018).

As the legislation indicates, maintaining personal safety and ensuring a safe working environment is deemed to be of high importance in the workplace setting within NZ. Safety whilst at work starts with achieving a healthy workplace, with the most recent NZNO/employer agreement having a strong focus on achieving this nationally (NZNO, 2018). Areas identified as needing improvement as part of this agreement were staffing levels and experience, resourcing, and matching demand and capacity. These identified aspects focused on improving the safety of staff and patients who access health services covered under this agreement (NZNO, 2018). The Health and Safety at Work Act 2015 promotes a safety system that includes participation, leadership, and accountability. The purpose of the Act is to ensure that workers and other persons are given a high level of protection to their personal safety and welfare whilst at work by eliminating and minimising risk (WorkSafe New Zealand, 2017).

The WCDHB's policy is based on the Health and Safety at Work Act 2015 and government policy. The Board provides online access to support and guidance related to assisting employees in managing fatigue and encouraging workplace wellness. There is also access to counselling if it is required, through the Employee Assistance Programme (EAP) counselling service. Specific

information relating to the context in which the RNSs work was not found, with the policy more generally referring to hospital-based practice (WCDHB, 2018).

Background of the Researcher

I, the researcher, am an RNS currently employed in SW by the WCDHB. I have been working in the rural setting providing primary health care and emergency after-hours care for nearly five years in SW. Prior to this I worked in public health, emergency, and general medical areas. This study follows a participatory approach, which will be described in the methods chapter. As I am currently an RNS and undertaking this research, I am both the leader of the focus group and a colleague of the participants.

Structure of the Dissertation

The dissertation is composed of five chapters. This first chapter has provided context to the topic being discussed and the following four chapters are outlined below:

Chapter two. A literature review that discusses relevant and current literature that is associated with the research question, giving more in-depth background and insight into safety aspects related to nurses in remote and rural areas.

Chapter three. Describes the research design and methods used to collect the data, including ethical considerations and how the data was analysed.

Chapter four. Presents the results from the focus group findings, identifying the themes that emerged through the conversations and experiences of the RNSs in South Westland (SW).

Chapter five. Discusses the research findings with links to current research and recommendations for future research, practice, policy and education.

Conclusion

This chapter has introduced the layout of the dissertation and has provided key definitions and practice aspects that relate to rural nursing and the RNSs in South Westland. The purpose of this is to provide some understanding of the role and environment in which they practice. Rural nursing is composed of many elements which hold both similarities and differences to other urban counterparts. Insight into factors that may influence the RNSs working environment is essential in order to understand some of the safety aspects associated specifically to this role.

Further research into personal safety of RNSs within SW may identify risks that are more specific to the context and the environments in which they work. Identifying the risks specific to the RNS role may improve the policy that applies to them within their organisation and procedures which overall could reduce risks to staff. RNSs provide nursing care both within the clinic setting and out in the community which can expose the RNS to different safety factors when accessing and treating patients. RNSs in SW will have an opportunity to suggest changes to practice or preventative measures that may improve personal safety from this study's findings.

Chapter Two: Literature Review

Introduction

This chapter provides a review of the literature related to the safety of nurses working in isolation both in New Zealand and internationally. The purpose of the literature review is to explore the research that currently exists regarding safety of nurses working in isolation to provide a foundation of current evidence and background to the topic and inform the context in which the RNSs in SW work.

Search Strategy

In order to gain an initial perspective of what is known about the personal safety of nurses working in rural areas, literature was gathered using the databases: Google Scholar, PubMed, Science Direct, CINAHL and ProQuest Central accessible via the University of Otago Library Website. The search terms used included: rural nursing, personal safety, remote, isolation, violence and nursing, and on-call. Limitations to the search included: full text articles, English language only and publication between 1998-2018. Search terms were combined in different ways in attempt to access a wide range of articles, and publication years were adjusted to gain current literature relevant to practice today (See Appendix 1).

In addition to research reports, government legislation and policy were included, along with two dissertations associated with the RNS role. A book edited by Jean Ross (2008) proved a valuable resource to provide insight into the general topic due to the emphasis on rural nursing practice in New Zealand.

Articles that were included in the final selection required a focus on personal safety of the nurse rather than patient safety, be undertaken or have relevance to rural or remote nursing, and be applicable to the NZ setting. This was to ensure that the contexts were similar and possibly transferrable to the

RNS setting in SW. Rural hospital literature was excluded as it was felt the context was not relevant to the RNS role.

The majority of the nine articles included in the review were qualitative research with the participants involved in the studies being nurses. Most of the research was based in Australia, and one study was from Canada (Appendix 2).

Overview

Rural research is becoming more accessible, yet in comparison to urban research appears to be less prominent amongst the literature. When researching rural/remote, the representation of the issues and challenges experienced by nurses working in these geographically isolated environments is seen only within a handful of studies, and most research into safety related aspects appears to be reflected within the Australian studies and some within Canada.

Workplace health and safety issues for nurses working in rural communities were identified as challenges associated with geography, organisational aspects and environmental factors (McLeod et al., 1998; Terry, Lê, Nguyen, & Hoang, 2015). Rural challenges were not always seen in urban settings such as: long travel distances, working in isolation for long periods of time, inadequate communication, and environmental issues, i.e. client's homes, smoking, animals, as well as violence and burnout all factored into the heightened safety risk when working rurally (Terry et al., 2015).

Despite these highlighted issues that rural nurses face, most of the studies also reflected on how rural professionals perceived their careers as rewarding. Retention was considered problematic often influenced by the factors stated making the areas in which they worked unique and challenging (Anderson, 2012; Terry et al., 2015; WHO, 2010).

Nurses in rural environments managed and strategized despite these challenges to ensure they continued to achieve good patient outcomes and meet their community's needs. This was deemed easier if the nurses had the

support of their managers in ensuring safety was maintained and processes were implemented (Anderson, 2012; Terry et al., 2015; WHO, 2010).

Violence towards Nurses

Safety can be defined as a state of being away from harm or danger, encompassing measures that are intended to protect or make something less dangerous (Collins Dictionary, 2018). Embedded in the literature, evidence of personal safety (both physical and emotional) was an area of concern for those working in healthcare, both in rural and urban environments internationally (Hutchings et al., 2011; McCullough, Lenthall, Williams, & Andrew, 2012; Richardson, Grainger, Ardagh, & Morrison, 2018).

McCullough et al. (2012) based in Australia, and Hutchings et al. (2011) in Canada, both demonstrated violence as a concern. McCullough et al. (2012) used a Delphi method and a risk management approach with a participant panel of expert Remote Area Nurses (RANs) (n=10). These RANs were from geographically diverse communities across Australia and they identified and prioritised hazards that they perceived as increasing the risk of violence to nurses. The participants on the panel reported frequent encounters of hazards and violence in the work place. Environmental hazards, relationships, support, RAN experience, community knowledge, mental health, and alcohol were all identified in this study and felt to be compounded and complicated by remote living. It was identified that the support and the resources to deal with these hazards were not sufficient (McCullough et al., 2012).

Hutchings et al (2011) in their Canadian based study expressed difficulty quantifying the size of the workplace violence issue and felt that it was on the increase with documentation being reflective of an increase in aggression and violence towards healthcare providers. This increase, however, was difficult to capture in a statistical sense with limited evidence on actual incidences for those working as community providers. This lack of data was thought to be due to the documentation requirements associated with reporting such an

incident, or that due to their professional work the healthcare providers felt a need to protect the client (Hutchings et al., 2011).

Kemp's (2012) study utilised a qualitative, general inductive approach with a participant population of five rural nurses within NZ. This study found that the rural nurses and doctors working remotely in isolation had potential for security issues especially whilst performing on-call duties in the night. Kemp's (2012) study did not elaborate further on violence towards nurses or personal safety aspects.

Anderson (2012) and Hutchings et al. (2011) undertook studies designed to develop strategies to maximise safety in the rural environment. Anderson (2012), in Australia, implemented a safe community stakeholders group aiming at a whole community strategy with the hope that this would create an increased awareness of how to manage potentially dangerous situations. Hutchings et al. (2011) implemented a buddy system in which a sign in/sign out system and a risk assessment tool were provided after health care providers had expressed they felt unsafe while performing home visits. The evaluation of both of these initiatives showed that these strategies were effective and could be implemented in other workplaces (Anderson, 2012; Hutchings et al., 2011).

External Factors

Violence towards nurses and safety of nurses is not always related to patient interaction as will be discussed in further detail in this section. Bell (2015) used a descriptive exploratory methodology with four RNSs reviewing the core components of the RNS role. Bell (2015) does not discuss personal safety as a theme or a finding but rather identified the stress that the nurses face working in such isolation and geographically isolated environments with the concern for safety focused on environmental areas such as weather and roads (Bell, 2015).

Similar findings were seen in Kemp's (2012) study of rural nurses in NZ where both environmental and geographical factors contributed on a daily basis to the challenges of the RNS role and at times played a significant part in the nurse's ability to safely access, assess and treat the patient. This rural uniqueness was seen to mostly impact the emergency on-call aspects of the role rather than the general practice consultations. Weather, communication, isolation, and geography were often variable and posed challenges to the nurses in regard to accessing and treating the patient safely as well as transporting to the nearest hospital (Kemp, 2012).

The feeling of isolation was a strong theme throughout the literature where rural health providers had a sense of being alone physically, out of their normal environment, and at times felt this was very unsettling. This was more significant for those used to working in urban environments where support was easily accessed if required (Anderson, 2012; Crowther & Smythe, 2016; Kemp, 2012). There was a sense of social isolation in regard to nurses feeling like the only people they interacted with were their patients (Crowther & Smythe, 2016). A combination of factors influenced the impression of isolation and the possible impact that this had on retention. Some rural practitioners stated that working in such environments was both unsustainable and unsettling with an increased concern for their safety in a professional sense and in a practical sense (Anderson, 2012; Crowther & Smythe, 2016).

Professional Safety and Professional Boundaries

As identified in the previous chapter, the NCNZ has identified challenges for nurses working in small communities in relation to professional safety and boundaries (NCNZ, 2012). Jarvis-Tracey et al. (2016) undertook a study which illustrates these points well. This study was undertaken over three years and was funded by the Australian Research Foundation in order to investigate some issues impacting rural professionals and reasons why job retention was difficult in rural and remote areas. Using a mixed method

approach, 801 participants from a variety of rural professions participated in an online survey. It was noted that professionals who work in rural and remote communities are often required to juggle multiple roles between their personal and professional lives, which at times can cause ethical dilemmas. Work–life balance is very important, and at times it is difficult to negotiate statutory responsibilities and living within the community where you provide a service (Jarvis-Tracey et al., 2016).

One area of difficulty discussed was the issue of professional and social boundaries being pushed. Friendships could be blurred and complicated in difficult situations or impacted by the information shared. Life was like living in a fish bowl; you could never not be the job that you performed and there was often a high community expectation of skill and immediate availability of the nurse. Scrutiny from the public eye was felt over the nurses' professional and private lives (Jarvis-Tracey et al., 2016).

Community tensions were another concern when carrying out requirements of one's role, and particular difficulties were expressed about safety aspects around domestic or family issues. When dealing with complex situations associated with the above, many professionals expressed feeling isolated and unsupported in regards to professional safety and professional boundaries. Threats were often made against these rural professionals when decisions were made that were part of their job requirements (Jarvis-Tracey et al., 2016).

In a qualitative study using a hermeneutic phenomenology, thirteen female healthcare providers were asked to share their experiences of rural maternity care. Some of the themes emerging were that of isolation, professional disharmony, and living with discord, all creating a sense of being unsafe. Professional safety was highlighted to be of significant importance when working so autonomously (Crowther & Smythe, 2016).

Reflections similar to the Jervis-Tracey et al. (2016) and Crowther and Smythe (2016) studies were seen in Kemp's (2012) NZ study where an understanding of scope and boundaries was deemed of high importance. Links to broad scopes of RNSs raised the concern of boundaries and professional safety due to the expectations of the nurse and the pressure on them to perform in certain situations. The nurses in these situations felt legal responsibilities weighed heavy on them, heightened by a lack of clarity around these boundaries or scope and concerns about repercussions from medical staff when they were so blurred (Kemp, 2012).

Supports and Collaboration

As identified above, support and collaboration are crucial to the success of the RNS working autonomously and safely. From the literature it was possible to identify strategies that might improve personal safety for nurses working rurally. Support was also identified in many studies as a key factor in staff retention, professional guidance, physical access to patients, and also for counselling and personal support (Anderson, 2012; Kemp, 2012; Terry et al., 2015). Management infrastructure was deemed to be pivotal in staff satisfaction and in the ability to reduce burnout, improve education and development, improve staff safety, and increase support (Anderson, 2012). One study suggested that there was little support or advice when starting at a new rural role and the 'sink or swim' approach was often applied (Jervis-Tracey et al., 2016).

Distance and isolation from other agencies made treating patients and maintaining professional safety difficult (Anderson, 2012; Jervis-Tracey et al., 2016). Anderson found that to enable rural nurses to provide comprehensive care to patients, health professionals needed to work in collaboration. Nurses working to the top of their scope allowed health care to be delivered in areas where access to a doctor was difficult and was one method around this;

however, this requires the authority and support to do the work from a government and management level (Anderson, 2012).

Anderson (2012) discussed cultural safety as a component of professional safety, which if utilised appropriately, gave the health care provider the ability to connect and collaborate with the community more effectively. It was thought that if the rural professional working in an aboriginal community developed a connection and gained acceptance, their personal safety would be better protected. To assist with acceptance into these communities, it was considered essential that the nurses and doctors received a proper orientation to the culture within the community and a strong understanding of what this meant. A commitment from employers to ensure that all staff were properly orientated was essential and allowed the health worker to explore how best to support the communities and the people residing in it (Anderson, 2012).

Lastly, Kemp (2012) reported that the rural nurses in her study found that support from partners played an important role in regard to safety when on-call (Kemp, 2012). This was a point that was not discussed or revealed in the other literature.

Conclusion

Whilst Australian literature dominated this literature review, many of the articles provided information applicable to rural nursing within the NZ context. From reviewing the literature, a solid foundation and insight into the issues faced internationally by health professionals working in rural and remote environments has been identified and has enabled exploration of aspects of safety associated with rural and remote practice.

The literature related to safety in rural often focused on professional safety and boundaries with personal safety a less prominent theme. Personal safety from a nursing perspective within rural NZ is not well represented, and at the time this was mentioned briefly as a consideration. Nurses in rural

practice in NZ have not directly had an opportunity to reflect on the factors impacting their personal safety. Since these studies have been produced, policy may have changed and new strategies may have been implemented that may alter the perspective of safety both professionally and personally. Populations and communities may have changed or the expectation of the nurse's role working in these areas might be different, creating new risks or challenges for the nurses. This study therefore provides an opportunity for the rural nurses in SW to share their perceptions that may increase our understanding of what personal safety means and how it may be improved.

Chapter Three: Methods

Introduction

This chapter will discuss qualitative research as a methodology, the use of focus group discussion and Braun and Clarke's (2006) six-steps to thematic analysis as a research method. Through a participatory research approach the student researcher led a focus group with her colleagues to explore aspects related to their personal safety when working in isolation. How the researcher utilised a general qualitative approach for recruitment and Braun and Clarke's (2006) steps for data analysis will be discussed. Links to ethical considerations related to this piece of research will be outlined.

Qualitative Methodology

This study explored the perspectives and experiences of rural nurses with the aim of gaining insight into areas that may impact personal safety when working in isolation. A qualitative methodology was selected as it focuses on the human experience and was considered more applicable to the research topic (Braun & Clarke, 2013; Schneider, Whitehead, Elliot, LoBiondo-Wood, & Haber, 2003).

This method supported the ability to use words as data and provided a flexible approach to data gathering compared with other methods such as quantitative research. This is because quantitative research is often science based, is useful when analysing reports, observations and for research that is free of the ideas or influences of other people (Roberts & Taylor, 2002).

Thematic analysis was chosen as the framework for data analysis and development of themes from the data (Braun & Clarke, 2013). Discussions within the qualitative methodology allowed the values of the RNSs to be captured through their shared stories and from this interpreted into themes (Braun & Clarke, 2013). This method was chosen to allow for a greater

understanding of the meaning behind the data and generate knowledge of the RNS perception of safety.

Qualitative methodologies are appropriate when looking at the personal experience, understanding and perceptions of the participants as well as when capturing accounts of practice. It is also suitable for focus groups, small sample groups and where participants might have a personal stake in the topic such as the rural nurses in this study (Braun & Clarke, 2013). In addition, taking a broadly qualitative approach is compatible with action research, which can be seen to underpin the role of the student researcher within this study (Roberts & Taylor, 2002). That is, the student researcher as a colleague of the participants was exploring this topic to address an issue related to practice that could best be explored collaboratively (Roberts & Taylor, 2002).

Aim

This study aimed to identify how RNS's currently working in SW perceive their personal safety whilst working in isolation. This research hopes to generate meaning from their lived experiences and if necessary, inspire change as well as discussion regarding future research into this area.

Setting and Sampling

This study took place in SW with the RNSs following Ethical Approval from the University of Otago (Appendix 6), Māori consultation (Appendix 7), and Locality Approval (Appendix 8) from the West Coast District Health Board (WCDHB). As part of the broad consultation process, and in keeping with action research strategies, advice was sought from the potential participants about the best approach for data collection. A purposive sampling method was used to ensure that the participants included in the study could best represent the issue being researched and to capture the accounts and perceptions of the rural nurses working in South Westland (Burns & Grove, 2007).

Inclusion Criteria:

- Current full-time, part-time or casual RNSs employed by the WCDHB within SW.
- Able to attend the Focus Group meeting in person or via video-link.

Recruitment

RNSs eligible for the study received information via email which included an information sheet, consent form, and an invitation to contact the student researcher or her primary supervisor if they had any questions regarding the study (Appendix 3). The RNSs who agreed to participate were required to sign a consent form and return it to the student researcher. On receipt of the consent form a letter was sent, inviting them to attend a focus group. Participants had identified that a focus group was the best method of data collection and this was planned for a regular meeting day due to the geographical challenges regarding distance and availability of resources for people to travel. The focus group was held at the Fox Glacier Medical Centre in August 2018 with one nurse attending via video conference. There were five nurses in total who were able to attend the focus group and who met the inclusion criteria.

Demographics

Demographic data on age, length of experience in rural nursing, gender, and ethnicity was collected as part of the project. Geographically, the participants were well spread out over SW, allowing representation from each area which enhanced the diversity and quality of the data collected.

Data Collection

A focus group was particularly suited to this research because it enabled the RNS team to concentrate on the research topic, working together to collaborate and share their individual knowledge and life experiences as RNSs working in isolation (Jirojwong, Johnson & Welch, 2014). The focus group allowed for multiple participants to contribute data at the same time in a

relatively unstructured nature guided by the research topic (Braun & Clarke, 2013; Polit & Beck, 2012). Data collection by this method allowed for an open and supportive environment to discuss issues related to personal safety when working as RNSs in SW. Holding the focus group on a planned meeting day was an efficient and practical means of data collection for a group such as the RNSs who are so geographically dispersed (Braun & Clarke, 2013).

The RNSs identified their monthly peer meeting day as their preference for the focus group and it was noted that the peer meeting was in winter. Participants were advised of potential adverse weather and the possibility of not being able to attend due to safety and road conditions. A video conference option was available as an alternative method of attendance and the possibility of rescheduling the focus group remained an option.

Prior to commencing the focus group, the student researcher consulted with her supervisors regarding the planning of the focus group and discussed the use of a semi-structured question guide to utilise throughout the focus group to ensure the topic of conversation remained focused on the research aim.

To open the focus group, an introduction of the researcher and a recap of the purpose of the study occurred within the private space at the Fox Glacier Medical Centre. This environment was considered a familiar and comfortable place for the RNSs. Part of the preparation before commencing the focus group discussions, included setting out some procedural rules and processes to ensure that respect and appropriate conduct were maintained as well as the expectations from participants (Appendix 4). One participant was on the Video Conference tool, and acknowledgment was made to this being a more disjointed arrangement. The student researcher as the facilitator conducted the focus group utilising the semi-structured question guide as needed to initiate and guide the conversation (Appendix 5).

Throughout the focus group the student researcher as the facilitator of the group aimed at guaranteeing respect was maintained and that all participants felt involved in the group. Part of the focus group was to observe non-verbal communications and to guide the focus group conversations if necessary. A note taker was present to document group interactions and to be available to assist with support should the need arise (Gerrish & Lacey, 2006).

The question guide (Appendix 5) enabled the researcher to focus conversation around the topic at hand during pauses, or where the conversation appeared to have lapsed, or when the focus of the group needed to be drawn to the topic. Exploration of safety was aimed at exploring multiple dimensions in relation to: personal, geographical, interpersonal, climate, transport, terrain, communications, on-call, hours of duty, and patient interactions. Other areas where potential harm, actual harm or perceived anxiety regarding personal safety that was experienced was incorporated. Discussion was encouraged in relation to current workplace policy and personal protective measures utilised in their current work environment with any potential solutions, protective factors, or what the RNSs saw as requirements to safety incorporated.

The focus group encouraged group interaction and attentive listening to gather the stories and experiences of the RNSs with examples being shared freely. In this way, examples could trigger another's story and enable the conversation to flow naturally. During this time, the RNSs had the opportunity to explore and clarify meanings from one another's experiences in a way that would be difficult to achieve from an individual interview or survey results. Conversation was enhanced by the diversity of the RNSs experiences, skill sets and individual communities, with each nurse having faced different issues and challenges but at the same time having a strong connection to their colleagues.

During the focus group, any points that were thought to require clarification was attempted, with reflection and confirmation of statements

occurring periodically as needed to ensure that the data collected was a true and correct account of the experiences shared. The focus group was audio recorded and transcribed to ensure that no data was missed and so the researcher could reflect on the conversation during data analysis (Roberts & Taylor, 2002).

Data Analysis

Braun and Clarke's (2006) six steps to conducting thematic analysis guided the data analysis process. The six steps are: 1. Familiarisation of data, 2. Generating initial codes, 3. Searching for themes, 4. Reviewing themes, 5. Defining and naming themes, 6. Producing a report. These steps allowed the researcher to easily interpret the data and identify emerging themes within the dataset (Braun & Clarke, 2006). Consistency throughout this process was maintained by the student researcher as the sole person coding and evaluating the data. Discussions regarding coding occurred with the student's supervisors (Polit & Beck, 2012).

Verification of the main points of the discussion occurred with the participants at the conclusion of the RNS focus group. Accuracy of the transcribed data was confirmed by emailing the main points to each respondent who was asked to review and return any comments within 14 days. This process allowed the participants the opportunity to clarify their meanings and make any amendments. No amendments were advised therefore accuracy of the main points was achieved by listening, recording and transcribing the data as it was intended.

Data familiarisation included re-reading the transcribed data, reviewing notes about interactions within the focus group and listening to the audio-taped recordings prior to analysis. This data was then semantically analysed using Braun and Clarke's (2006) steps, to develop an understanding of the nurses' perception of safety. Main themes and ideas were noted down and once the researcher was familiar with all the data collected, identification of preliminary codes of data that appeared meaningful

occurred in the context that the conversations were had (Braun & Clarke, 2006). The third step in the data analysis process was interpreting the data and searching for themes. As part of this process, data was initially sorted into categories based on descriptive patterns. As the process developed, some of these categories were combined.

Once the data was coded into categories, further review occurred to refine the data and draw further meaning. Data was combined or discarded to develop subthemes. Step five of the thematic analysis involved refining and defining the potential subthemes within the data set so that clear and descriptive themes developed. Further analysis occurred to enhance the identified themes and renaming of the emergent themes to represent the essence of which each theme represented (Braun & Clarke, 2006).

Finally, the researcher developed the analysed data into an interpretable report with examples illustrating the themes with links made to relevant literature (Braun & Clarke, 2013). Discussions occurred throughout the analysis process with the student researcher's supervisors from the Otago University.

Maintaining Rigour

Rigour in qualitative research is important as it brings credibility and enhanced worth to the findings. Rigour is defined differently in qualitative research with a focus on detail in the study design, carefulness during data collection and thorough analysis. An open mind must be maintained throughout to allow for true meaning to come through (Grove, Gray & Burns, 2015).

Reflexivity was used throughout the research process to ensure the researcher remained mindful of their shared identity with the participants of the study in order to reduce bias or influence (Braun & Clarke, 2014). To assist in maintaining rigour, the student researcher discussed the process and examples of data analysis with her supervisors. Participants were offered

opportunity to feed-back comments on the validity of the data. (Webb & Kevern, 2001).

The researcher conducted stakeholder checks and member validation during the focus group and the data collection process to ensure credibility of data and a true reflection of the information shared. Audio-taping the focus group and having a note-taker transcribing allowed the researcher to return to the information collected and re-familiarise with the data as required. This ensured themes that emerged were conveyed accurately from the data collected. Before the end of the focus group participants were offered the opportunity to correct or change their statements and to verify their meaning. The researcher utilised para-phrasing as a means of feeding back the data and ensuring correct interpretation of the participants' statements.

Ethical Considerations

Informed consent. Prior to commencing the study ethics approval was sought and granted by the Otago University Ethics Committee's and the reference code for this project is 18/092. The Ethics approval confirmation is attached as (Appendix 6). In recognition of the Crown's commitment to the Treaty of Waitangi, Māori consultation and guidance were sought (Appendix 7). Locality approval was gained from the West Coast District Health Board to undertake the research in July 2018 (Appendix 8). Following distribution of the consent forms and information by email participants signed and returned as an indication of willingness to participate. The purpose, process, potential outcomes and all potential risks were made clear to the participants during the consent process (Appendix 3).

Potential conflict of interest related to recruitment and analysis. Prior to planning this project, it was discussed with the rural nurse team the role of the researcher in the study and a potential conflict of interest that may arise due to the researcher being a colleague of the participants. This declaration of the researcher's role within the team prior to commencing the research was to

ensure transparency and trust prior to the participants consenting to the study and prior to the data collection process.

While the student researcher does not have a recognised power relationship with the group members, the researcher remained conscious of how she conducted herself through the stages of recruitment and in facilitating the focus group ensuring that there was no coercion for RNSs to participate.

While facilitating the focus group, the researcher encouraged participants to share their experience, valuing all contributions. Due to the stated preference of colleagues to have the focus group on a regular peer meeting day, it was incorporated into the lunch break to ensure that any nurse who did not want to participate remained unaffected by the focus group meeting. Researcher bias was minimised by regular supervision with the researcher's supervisors and by providing participants the opportunity to check the themes that may emerge from their shared experiences.

Potential distress or risks to participants during or after the focus group. No physical harm was predicted to come to any participants. Participants were made aware of the predicted risks on the information sheet and reminded again prior to the focus group. Maintaining personal integrity and professional responsibility was achieved by ensuring processes were transparent throughout all phases of the research study.

A set of group ground rules was established prior to commencing the focus group discussion (Appendix 4). Setting some basic ground rules prior to commencing the focus group interactions aimed at ensuring all participants felt comfortable to give honest feedback without worrying about aspects such as internal politics or barriers that may have prevented them from being open. Creating a comfortable environment and working within the set ground rules allowed the facilitator to redirect conversation and include participants who were more reserved as engagement of all participants is a key component to a successful focus group (Braun & Clarke, 2013).

While this did not occur, there was potential for participants to become upset by information shared so a second person, the RNS Team Leader was available to assist. The Team Leader of the rural nurses in SW has been in the post for the past year. She has extensive experience in leadership and management of nursing teams and has a background in rural nursing herself. She was identified and accepted as an appropriate person by the researcher and the participants to assist as a first point of contact if a participant had a concern or experienced emotional distress during the focus group or after. The role as the team leader, however, may be associated with a power imbalance. Therefore, to mitigate the influence of the team leader role on information shared in the focus group, she was available for support outside of the focus group meeting room situated in an office within the same building.

Other means of managing distress that was in place for the focus group was allowing time out, utilising collegial support and the offer of assistance to seek further help via workplace programmes such as Employee Assistant Programme (EAP). There was an option to withdraw from the study at any point with no negative consequences.

There was no perceived threat to the researcher in terms of violence, unsafe environments or emotional distress. The same EAP counselling services and support persons are available to the researcher as to the participants. Minimising other potential harms such as conflict between participants, organisational or minor inconveniences were controlled by ensuring informed consent and processes were well understood prior to commencement of the study. During the focus group the researcher was able to facilitate the conversations and de-escalate any conflict if it had occurred. Anyone that wished to leave or withdraw from the focus group had the option to do this although this did not occur.

No financial reimbursement was offered as an incentive to participate in this study. However, a token of appreciation was offered and chocolate fish were given to those at the focus group.

Managing confidentiality and privacy. The RNS group is small and therefore it was important to consider carefully how confidentiality and anonymity was achieved and maintained. As part of the information and consent forms, participants were advised to not share any information unless they were comfortable disclosing the information. Participants were advised that all examples shared must be limited to general statements directly relevant to the safety issue and not breach patient privacy and confidentiality.

Demographic data (such as age and years of nursing) was presented in ranges and not specific to the individual. Accounts and experiences were represented as broad statements and themes so as not to identify the nurse or any other person involved. Ethnicity data was collected using the standard Statistics New Zealand categories. As above, gender, age range, and experience of the nurse was also collected and used to broadly describe the sample group.

All conversations had in the focus groups were to remain confidential to the group of participants involved. Should revelation of a criminal or legal issue occur, in the overriding interest of personal safety or protection of any vulnerable persons, participants were aware that disclosure to appropriate people would occur (Gerrish & Lathlean, 2015). Patient privacy and confidentiality was maintained at all times under The Privacy Act 1994 and the Health Information Privacy Code 1994 (Privacy Commissioner Te Mana Matapono Matatapu, 1994).

A note-taker was utilised in the focus group to record the audio transcript, observations, order of people talking, and any obvious body language. This person was the off-site practice receptionist who works remotely from Greymouth. She was considered acceptable by the RNSs, bound by the same confidentiality clauses required by the organisation and

considered an appropriate person for this role as she was not involved in the clinical practice of the rural nurses. There was deemed less risk of a potential power imbalance that may have impacted on the sharing of information or the risk of participants feeling uncomfortable to share information.

The student researcher and the note-taker knew who was taking part in the focus group. The support person also inevitably knew who was participating even though she was not in the room. The student's supervisors were able to access to participant names, contact details and the coded transcript. All are subject to confidentiality agreements through their employment and professional bodies.

Participants were able to access their personal data for the purposes of correction. To provide confidentiality for all participants, the transcribed focus group recording was unavailable to the participants. The researcher acknowledges that anonymity when reporting results may be difficult. All attempts to maintain this were taken. Information such as names, areas in which RNSs are working and time frames of incidents/experiences were not included in order to minimise identification of situations and people involved. There was no identification of dates of events or specific locations of examples. All discussions were written as general themes or examples with minimal identifying elements. Some small features of the data were changed to assist with anonymity, as long as it did not impact on the meaning in the data. Pseudonyms were used on the transcript and when writing results.

Data was stored in a password protected computer with the student researcher having access to the password. The personal information and key to participant codes is kept separate from the coded transcript of the focus group meeting. The student researcher separated the personal information from the transcript and ensured the codes are applied to the transcript. All of the original transcribed data will be stored for ten years after publication as per the University of Otago's policy. After this period the data will be disposed of by the University of Otago's designated person.

Chapter Four: Results

Introduction

This chapter presents the results and findings of the focus group and from the data analysis. Following a broad description of the participants, the three themes identified through the process of analysis will be presented and supported with quotes.

There was five nurses that attended the focus group, three contributed more actively, sharing multiple examples and thoughts. Two were more reserved and tended to nod in agreement, with one of these participants on Video Conference, which may have been a contributing factor.

For the purpose of reporting results, participants' names are not used and identifying information is withheld to maintain their anonymity. All participants were female, within the age range of 40-65 years old and had varied years of experience in rural nursing from one to twenty plus years. Some participants had worked rurally only in SW, while others had a broad experience of rural nursing.

Three participants identified as NZ European, two participants identified as Other European; no participants identified as Māori.

Three overarching themes were identified from the data. While the themes are different, the data reflects an inter-connection between some themes. Throughout the results chapter, square brackets have been used within quotes to assist with meaning where necessary. The major themes identified were:

Theme One: Community

Theme Two: Pressure to Perform

Theme Three: Safety: Luck versus Planning

Sub-theme one: population.

Sub-theme two: equipment and systems.

Sub-theme three: environmental.

Theme one: Community

Community as a theme emerged out of the data from examples that represented struggles and challenges that the RNSs had as a result of being a provider of a service in their rural and remote communities within SW and also as a member of a community. The nurse's role within the community and subsequently the acceptance of the community was deemed a vital part in their ability to provide a service.

"You are a member of the community but you are also a provider of a service."

This quote from one participant resounded strongly and agreement amongst the group signalled that all had felt the quandary of having two roles, one that could never be dropped even whilst off duty. The blurring of both personal and professional lives occurred as part of being an RNS and having the support of the community appeared to play a pivotal role in the acceptance of the nurse however, support could never be assumed.

Another participant stated that "it's all very well when the community is supporting the nurse ... but if the nurse finds them-selves in a position where they don't have the support of the community for whatever reason ... it can be quite devastating for the nurse". Indeed, members of the community could present a threat to the nurse's safety.

One participant shared the following experience:

A few years back when I first started here, the local community were unhappy about the local nurse at the time not living in their community but living out of town, and I was driving along and they must have thought that it was the other nurse and one of the locals tried to run me off the road. I felt like my safety was really compromised that day.

While this experience had been previously shared amongst some of the focus group members, it drew out shocked expressions from those who hadn't heard it before. Comments from the other participants following this story reflected how they felt some of the community's aggression towards the nurse to be related to other systems that were not directly part of the nurse's role. One participant commented on the introduction of a new phone triage service, "Just look at the fall back from the introduction of the new phone service". The implementation of this new service had stopped community members being able to contact the nurse directly and had left some community members feeling frustrated and angry because of the difficulties they now had trying to reach them. The nurses could not change this situation but often were the ones left facing aggression.

A participant, who had not yet shared, continued this topic, stating that "you are expected to wear so many hats- you are meant to take money, chase up debts all things that cause people aggression". This resonates with the realities of rural nurse life, acting as not only the provider of health care but also receptionist, practice manager and many more roles often intertwined as one and frequently unavoidable. While the participants described examples of experiencing community angst and aggression, they also reflected on the positive support networks they had found within their communities.

Your personal safety when things haven't gone well and you are back in your community ... I have such a supportive team. I remember at a car accident here with the team I work with now and the support ... it made for a completely different experience. When this young man died, it was such a pleasure to work with such a respectful team, who were professional and competent and this young man was dealt with such kindness and humanness and to be part of that gave me such confidence in my team ... totally gives you security if you are in a good team.

Thus, it was evident that feelings of personal safety and, at times, actual threats to personal safety could be related to the community and the support available to the nurse. Each individual community provided the nurse an individual context for their nursing practice however; their day-to-day experience of safety also came down to specific situational factors which are drawn out in more detail in the following themes.

Theme Two: Pressure to Perform

This theme developed from examples linking relationships with people in the community to the expectation of the nurse and the difficulties felt by the nurse when there was pressure to perform or provide a service. Although this theme connects with theme one, the difference in this theme is the concept of professional boundaries and professional safety.

Professional boundaries and safety were not defined or outlined by the participants however, there appeared to be a mutual understanding when these concepts were discussed in examples and general agreement about what those terms represented to the RNSs in the focus group.

The stories shared throughout this theme show interplay between professional safety and the impact this has on their sense of self as a nurse. There is a perceived threat to professional integrity and a sense of anxiety if they (the nurse) do not perform to the level of expectation of the community or those around them at the time. The interpretation of professional safety is linked to professional boundaries, but these two concepts have a strong influence and consequence on how the nurse perceives her personal safety.

One participant with many years of practice in rural nursing in different areas was more prominent in this area of discussion sharing multiple examples to which the other participants signalled their agreement and support of her ideas through body language, verbal supports and often the sharing of their own examples allowing the conversation to flow easily.

She stated that “you can be in a situation where your clinical and professional safety and your boundaries can be battered by the feeling of having to do something Your professional boundaries can be battered due to other factors.”

Professional boundaries were often felt to be ‘battered’ or ‘pushed’ due to environmental or circumstantial influences relating to the situation (that they were in at the time) with expressions of feeling pressure to make decisions or perform tasks. “I feel pressure because somebody’s life is in danger and it will be me as the RNS- my responsibility for providing care.” The similar feeling was quoted by a different participant: “You have a responsibility to go and the expectation to go. It is outside of the role and boundaries but you feel you have to do it.”

This pressure to perform or attend a situation was acknowledged by the group and triggered another example from one participant where she felt similarly during a storm:

It’s all very well to have done it at PRIME [Primary Response in Medical Emergency] course however, we are not doing it every day—say, thrombolysis—I have never done one and I wasn’t allowed to go to the training and I just think you can be in a situation where your clinical and professional safety and your boundaries can be battered by the feeling like I have to do something.

The participants supported this story with low toned “mms” and concerned facial expressions and the same participant continued:

“I ran up to the man in SVT [Sinus Ventricular Tachycardia— abnormal heart rhythm]. It was so hot and it was the end of the day; I had no water with me and I thought, right, I will go and the crew [first aid volunteers] will be behind me, which they weren’t ... so I took what I could carry and I put myself out there—blisters weren’t going to kill me but the heat and dehydration could have. But once I got up there, I

thought, what can I do? I didn't have an IV [Intravenous device for administering medications into the vein], I could do airway and shade him, I could do Life-Pak [Transportable defibrillator and monitor] things but you just know that you need to be doing something, but you don't have all your stuff or your CPGs support [Clinical Procedure Guidelines produced by the ambulance company] and I think if you can't stand firm and think, if I know I safely cannot do anything, then that's better than being influenced by those saying 'why don't you do this' etc., as I felt that it was not safe.

From sharing this example, the participant continued on, expressing concerns about level of experience in rural nursing and how a younger, inexperienced nurse may struggle to maintain their safety.

I do think it is essential that there is a required level of years in nursing prior to being put in this role. I think definitely proper role descriptions, training and experience is essential. Safety of nurses alarms me. That's around safety aspects of role changes, people coming into rural nurse roles and not having good job descriptions or the scope behind them. I just think it's probably less to do with age but more of a mind-set. You can feel so vulnerable and isolated.

Vulnerability and isolation were two strong features highlighted in these examples and following this story participants nodded, although no comments were given a pause and conversation accompanied by some concerned expressions signified these feelings might have been felt by the other participants in their own practice.

After a brief pause and a moment of reflection, one participant continued the conversation in relation to professional scope: "We are expected to stay within our scope but often I think we are over and there are huge grey areas." This was a statement that not all of the participants agreed with, and a different participant added: "Extended scope but RNSs are not considered this

yet this is what we are doing all the time.” A third participant who still didn’t quite agree with the definition of scope added: “We are at the *edges* of our scope not over it—it’s how council define it.”

Some non-verbal cues signified disagreement amongst the group around scope of practice suggesting how each nurse defined their scope or perceived their level of practice varied. Potentially this was impacted by how they saw the level of support in their areas, or how they felt in terms of their role description.

When working in remote settings, the RNSs in SW are seeing and treating patients autonomously. To practice autonomously and remain within scope, nurses utilise Standing Orders (SO). One participant reflected on the SO process as enabling RNSs to work to the top of their scope and also once having completed online guidelines they were legally able to administer certain medications and treat certain conditions autonomously.

“The protection is there but you can’t complete it and you don’t have the time to do it, and patients come first and you can’t protect that time.”

Around the group, this statement was acknowledged with agreement, suggesting that all had faced similar struggles with the SO process. The utilisation of SO was the mechanism which allowed the RNSs to practice so autonomously; yet it was felt by some that although the resource was available, the application of SO in remote and isolated settings was impractical.

I couldn’t tell you how many I have done; if you asked me if I could recall the finer details of the Standing Orders, I had done I can’t tell you, so it is one form of learning that doesn’t make you a safer, better practitioner. So, if you can’t access them, how are you going to apply them correctly and safely? And you can’t ask any of the volunteers you work with to double check doses etc. when you are out of comms [communications range] to check as they don’t know.

While Standing Orders provide nurses with autonomy in some situations, the nurses felt that consistent GP support would also assist nurses to feel safer in their practice. It was apparent that all of the nurses felt collegial support was imperative in their daily practice and that an increase in time to access collegial support was valued. “For the first time in years I get some GP [General Practitioner] time due to finally a roster change which is great. I have missed out on so much.”

The nurses reported that it was the intermittent doctor support provided by locum cover that left the nurses feeling patients were more at risk and that they (as nurses) were carrying greater responsibility and hence of greater professional risk. This lack of consistency translated into the lack of opportunity for professional support and supervision for the RNSs.

Patients sitting on symptoms when they [the patients] don't show up for GP an appointment creates anxiety when you are the only person. We need medical oversight to share the load ... are we seeing what we need to see? What are we missing?

This lack of consistency of medical oversight translated into the lack of opportunity for professional support and supervision. For example, a concern expressed by one participant was when patients ‘sit on symptoms’, which increased the anxiety of the participant. She stated that:

You feel much more responsibility for everyone, and keeping your finger on the pulse with GPs rotating as the risk for missing something is so much more. This is increased if a nurse is covering or sharing the work load as there is another person that can miss a result or doesn't know the systems and patients etc. ... added responsibility and stress. With a doctor only there once every two weeks, your word against patients—so important to document everything—often I am getting advice from a doctor that has never met me or doesn't know my practice. They are usually really supportive.

While recognising that most GP locums were generally supportive, the reliance on getting advice from a doctor also created a tension for the nurses. Each participant had experienced working under a number of doctors transitioning through the practice; some had been more supportive of the autonomous nature of the RNS role than others. Each individual doctor practiced in individual ways, therefore the nurses adjusted communication to suit the doctor covering at the time with the fact that “I am getting advice from a doctor that has never met me or doesn’t know my practice,” affecting their feeling of professional support and safety.

It was evident in this theme that personal safety, professional safety and professional boundaries were interconnected. It appeared that pressure and expectation strongly influenced the level of anxiety a nurse felt in certain situations and the impact that had on her safety both professionally and personally. Professional and personal safety appeared difficult to separate at times and the impact of certain situations or outcomes affected the nurse in a personal way. The level of support received in regard to GP and community impacted their perception of safety. Further exploration into safety in relation to policy, practice, and environment will continue throughout the remaining themes.

Theme Three: Safety: Luck versus Planning

This theme most closely aligned to the research topic, analysing aspects related to personal safety and vulnerability whilst undertaking the RNS role. Three sub-themes supported the over-arching theme to encompass the major areas where RNS safety was impacted.

Sub-theme one: population

Sub-theme two: equipment and systems

Sub-theme three: environmental

It was apparent when reflecting on the situations where RNS safety was felt to have been compromised, that the RNSs felt the outcomes of some of the

situations they described were often due to luck rather than the outcome of planning.

Population. As highlighted in earlier chapters, populations in rural areas are extremely diverse. The nurses' work could bring them into contact with people who might respond in ways that they did not anticipate and, due to their isolated practice, increased their risk to personal safety. The examples that the nurses shared made it evident that remote area living attracts a variety of different people. Some of these staying for seasonal work, some remaining for years, and others being fairly transient. Personal safety was felt to be more at risk when the nurses encountered transient populations coming into the area, such as tourists or white-baiters (people from outside the West Coast who come during the three months of whitebait season).

One participant noted that,

You don't know people or their history, there is a lot of drug seekers and different types of people that tend to be attracted to these remote areas and alternative life-styles. They go down there to hide from the police.

While all the RNS participants acknowledged the influence of certain populations in relation to their feelings of safety, the two participants who work in communities with more stable populations did not appear to relate as strongly to this and they contributed less to the discussion at this point. The following quote from one participant illustrates how RNSs perceived their personal safety can be at risk within these more isolated areas:

Last whitebaiting when this person who had been in a fight and wanted an assessment ... He demanded controlled drugs and I said no, and he sat and wouldn't leave. I then thought, how do I get out of here? ... That was really tricky ... I couldn't take the phone off and call the police, there is no cell cover, there is no emergency thing ... You don't know people, their history, there is a lot of drug seekers and different types of

people that tend to be attracted to these remote areas and alternative life-styles. They go down there to hide from the police.

When asked how they managed such situations, the nurses identified that, on the whole, their local population were supportive but also that asking them to “come and hold your hand” was not an appropriate solution and that factors such as confidentiality could be breached. Moreover, it was often the unknown factors surrounding the patient presentation or a situation which evolved once the RNS arrived that increased the safety risks. Therefore, such unpredictability of situations at times made it difficult to protect their safety.

Equipment and systems. Questions about the role of equipment and safety systems supporting RNSs to feel safe in their practice were included in the question guide for the focus group. Interestingly, comments related to these aspects were not triggered until the question was asked, with the exception of SO. All of the participants identified (either verbally or by shaking their head) that they did not know much about the current safety policy or systems in place within the WCDHB.

The earlier discussion about SO was identified by one participant as an illustration of a safety procedure that they had in place. This process was identified as a system to keep them professionally safe however, they all recognised that the previously mentioned challenges with SO made this difficult to achieve. Most of the participants felt safe in their work place but the clinic spaces remained a concern for the participants as some of the clinics needed great improvements to ensure personal safety was achieved.

One participant who shared an example above in regards to a drug seeking patient, further elaborated on the situation when she was isolated in her clinic with the drug seeking patient in the whitebait season:

He still wouldn't leave, and I was very lucky it was handover day
[occurs once a week] ... I would have been on my own if it wasn't and I

couldn't take the phone off and call the police, there is no cell cover, there is no emergency thing.

This example reflected how timing of a handover coinciding with the presentation of an aggressive patient was simply luck rather than suitable measures being in place to enable the protection of personal safety. The other participants who were in similar clinic settings expressed similar worries, whereas some of the RNSs worked in newer buildings which had two separate entry/exit points should the nurse need to escape. This contributed to greater feelings of personal safety for those RNSs.

During further discussion around safety in relation to patient interaction and where the nurse's personal safety was potentially at risk, a participant shared the following example:

A guy was going to be discharged through the court system to an address—he had to go and stay there. It turned out the people he was meant to go to knew nothing about them and it was all Alcohol and Drug related. The nurse that was discharging him ... had a list of his description and his aggressive manner. ... The police didn't even know he was coming down. It should never have been allowed as the discharge planning was so loose. ... Personally, I felt very unsafe; I have never felt so unsafe ... I just thought why should we be put in these situations and our safety be compromised?

Participants shook their heads with disappointment at the process and poor planning in a system that put their colleague in a compromising situation where her safety was at risk. The statement "I have never felt so unsafe" resonated strongly with the group, who paused for a brief moment whilst taking in what their colleague had shared.

Within the nurse's work setting, there are no locator beacons, no emergency buttons, and some of the clinics are in very isolated locations. The increased anxiety following some of the situations shared above can be

unsettling for the nurse. As a result of the above examples shared, the participant had reported her concerns back to the DHB and she discusses some of the changes that were made.

However out of that—we did manage to get an E-perb [Emergency Locator Beacon] thing which we keep in the car as it is pretty useless in the clinic, as you have to be outside, undo a thing, pull up something, push something, and it is a bit difficult to use so its practical for outside but totally useless in the clinic. So out of that the more I thought about what could have happened the more it scared me.

It appears that at times even some safety measures provided did little to ease the anxiety that came with working alone in isolated environments. The other participants responded to her statement and shared her frustration about the impractical aspects of the beacon illustrated by eye rolls and some laughter. No further comments were made as none of the other participants had received their locator beacons yet.

From this situation, two of the participants contributed to the conversation reflecting on policy in Australia where sole charge clinics were a thing of the past and they supported the changes that Australia had made following some major incidents. The other nurses who didn't have such strong connections or knowledge of working in Australia sat quietly, nodding.

This change of topic and sole on-call triggered a discussion around gender. “Well, we are all single females and no one really knows where we are and when we are meant to be home—well most of us are, anyway.” The rest of the participants showed agreement, acknowledging the vulnerabilities related to gender and females living alone. One other participant whose husband lived elsewhere had developed her own system for monitoring her safety:

My husband calls every night and if I didn't answer he would think what's going on? The clinic is too isolated where it is. There is no one

really at hand—everyone is away through the day in the nearby houses it's very isolated. I have been so aware of how unsafe it is.

After a brief pause following the example above, the conversation was re-started by the focus group leader and the initiative to add further comments or statements was declined by the participants. The researcher then asked an open question regarding equipment which stimulated discussion on the topic of vehicles. Opinions ranged from "I love my car, I feel it is safe and I know it well", to "I don't like mine; the lights don't work, and my radio won't work unless the car is on idle, which is different to the rest".

The logistics of carrying all of the PRIME equipment required was raised by one participant, and all participants showed through their facial expressions they related to the struggle of carrying all the gear required. This was considered to be a potential injury risk to the nurse through weight.

Following a brief pause the topic of communications was triggered by the focus group leader. One participant reflected on communication during a weather event:

I had a situation with flooding and all ambulance volunteers got a page to warn about the road closures and dangers, and I never knew until I drove to work—which I thought, if I had a call in the middle of the night and went driving into it, that would have been very dangerous.

The conversation continued with another participant suggesting a solution. "I get opus and west roads text which wouldn't be suitable for no service areas." Communication issues appeared to be individual to each area depending on where the RNS was located and whether there was access to cell phone coverage. Access to communication was dependent on technology which was mostly reliant on cell coverage. Hand-held radios were mentioned as being a potential benefit to maintain good communication and safety whilst out in the remote areas on-call. No disagreements or further comments were added by the group.

It therefore appears that equipment and systems in the nurses' rural areas provide some struggles and challenges potentially increasing the risk to their safety in some situations. Communication between services was lacking when planning treatment or care of a patient and appears to be an essential component to maintaining safety. Some nurses had therefore developed their own systems to manage this and decrease the anxiety of being out on-call in unpredictable situations.

Environmental. As described in the background, SW is a narrow piece of land bordered by sea on the one side and mountains on the other. This geographical reality posed major personal safety concerns for some of the nurses. The RNSs work environment was so varied on a daily basis with the weather, geography, and the elements all factoring in to the safety of the participants. One participant shared an example of her experience in a storm:

We have three rivers throughout our community, and one storm I was nearly cut off, and I remember driving over a river and looking up at the sea, and I didn't figure out what I was seeing but it was the river merging with the sea and the wind was holding up the waves. It was so scary, plus flooding.

The same participant continued with another example from a different time:

We had those huge winds that blew the van off the bridge and shut roads. And you have to strategize how you are going to get people out and which road to take when you are isolated from the base hospitals.

This triggered another participant to share their example: "I had a situation with flooding and all of the ambulance staff got a page to warn about the road closures and dangers and I never knew until I drove to work."

The examples above highlight not only a weather issue but also communication issues that could potentially increase the risk to personal safety whilst at work. These examples are closely linked with the theme of luck versus

planning where often the nurses were faced with unpredictable environmental factors.

After a brief pause whilst participants considered other ways their safety was impacted by the environment in which they worked, a participant shared a story where the environment she thought she was going into changed:

I thought I was attending a call out to a burn—I didn't realise there was a drug explosion. There was inadequate information from the triage call, and in this case the St Johns were there, and then I was unsure of my role in that situation as the medical professional to call the police.

This example raised questions amongst the group and they were intrigued as to how the participant handled it. Again, it appeared safety measures came down to luck rather than planning. Although her safety was at risk that day, the situation did not eventuate into an incident.

The same participant continued with another example where she felt her safety was compromised due to environmental aspects:

I had to go down the river track on the back of a truck and in a jet boat to get to a patient ... and you would say, technically, why you went— your safety is important — you have to trust others this man needed help immediately It is outside of the role and boundaries but you feel you have to do it.

The examples contributing to this sub-theme related to a range of environmental factors which encompass location, weather, geography, and distance to support. Environment to the RNSs can be the environment they walk into when they are seeing a patient in their own home such as in the burns example, where remoteness can impact access to timely support thus increasing the risk to the nurse. The final example shared relates to the environment in relation to transportation, access to patients due to geographical isolation, and also links to the theme of community, issues of professional boundaries, and the role of the RNS. Environment is a broad

concept but an important one when thinking of the safety of the RNS working remotely.

Conclusion

The purpose of this chapter was to present the experiences and examples shared in the focus group by the participants, all of whom are from individual communities, have individual skill sets and work in slightly different environments within SW. The findings and themes were drawn from interpreting and analysing the data gathered from the focus group, note taker comments and focus group transcriptions. The participants related the concept of safety both to professional and personal aspects with these concepts often being interconnected and difficult to separate.

Luck versus planning was seen as a factor contributing to the way situations evolved and often the nurses had felt lucky when things had worked well. Transient populations and many environmental aspects increased the nurse's anxiety around risks to safety and the situations in which they were placed. The following chapter provides discussion and interpretation into these findings in relation to current and existing literature.

Chapter Five: Discussion

Introduction

Key findings from the data within this study are summarised in this chapter. The purpose of this study was to explore how RNSs in SW perceived their personal safety whilst working in isolation. This included their daily practice running nurse-led clinics as well as sole on-call in some of NZ's most rural and remote areas. Findings of this research have been linked and compared with current literature.

To conclude this chapter, a reflection of the relevance of this study to current practice has been outlined and recognition of limitations within this research highlighted. This discussion enabled a robust review of outcomes to support suggestions towards future research, practice, and policy.

Summary of Key Findings

The results from the focus group analysis described in chapter four are reflective of the challenges faced by RNS's which incorporate systems, community, work environment, professional role highlighting similarities and differences that make working in remote NZ a unique experience. From the data analysis it was possible to compare some of these main points to existing literature.

Community

Within the theme of community, the following statement was shared: "You are a member of the community but you are also the provider of a service." This quote aptly summarised many of the examples shared and reflected a true reality for the nurses living and working in their small communities. The participants often spoke within their examples of the critical importance of their relationship with their community and the influence this had on their level of comfort undertaking their role. Community support was considered a vital component contributing to fully working as an RNS.

One of the difficulties described in working rurally was the ethical dilemma of dual relationships in rural practice, that of being a community member and that as a professional serving the community. Jervis-Tracey et al. (2016), Terry et al. (2015), and Anderson (2012) discuss the challenges health professionals experience working in small rural communities, and these authors acknowledge similar challenges inherent in these dual relationships.

Aotearoa/New Zealand is a small country. Nurses are members of their communities with the phenomenon of existing and dual relationships occurring between nurse and patient. Nurses must be aware of their power and the authority inherent in their professional role, the specialised knowledge they carry and their role within these communities (NCNZ, 2012).

The NCNZ acknowledges that when establishing therapeutic relationships with Māori, trust and connection are an important part of culturally safe care. The principles of the Tiriti O Waitangi/Treaty of Waitangi, partnership, protection, and participation reflect the foundations of building relationships with Māori. Due to interconnecting relationships as both a community member and nurse, rural practitioners can at times feel like there are blurred boundaries (NCNZ, 2012).

Maintaining professional boundaries can contribute to a sense of social isolation. Evidence of vulnerability of rural health providers due to isolation is well documented and comes with a sense of being alone both physically and socially, contributing to difficulties in retention of the rural workforce (Anderson, 2012; Crowther & Smythe, 2016; Kemp, 2012).

Due to small populations in the remote areas that the nurses in the current study resided, social isolation was common. This isolation resulted in increased social interactions within the community. Professional boundaries had the potential to be blurred with health professionals having limited opportunity to socialise outside of their client base (Jervis-Tracey et al., 2016).

Jervis-Tracey et al. (2016) and Howie (2008) describe life as a rural health provider like living in a fish bowl, and the impression was the health professionals could never fully remove themselves from the job they performed. Molinari and Bushy (2012) discuss similar realities as a feeling of lack of anonymity and the challenges of familiarity amongst the residents within the community. RNSs in SW reported struggles with these aspects of maintaining personal and professional boundaries whilst providing a health service to the community within which they were a community member themselves.

As providers of a health service the nurses shared examples within the theme of community, some reflecting support, and one example where aggression impacted the personal safety of the nurse quite significantly. The example shared where a nurse was nearly run off the road by a disgruntled community member shocked her colleagues. Although the majority of examples shared did not include aggression to this level, this experience illustrates the spectrum of aggression and threat to personal safety in the rural setting and the importance of community support.

Within the published literature, physical violence and aggression towards nurses was more commonly found in the hospital context but is documented within Australian literature in both rural and urban settings. Two theses explained the issue of violence in rural settings. Luck (2006), using a mixed method study explored violence against nurses in a rural and regional Emergency Department (ED) and McCullough (2011) looked more specifically at violence towards remote area nurses. Research by Richardson, Grainger, Ardagh and Morrison (2018) focused on violence in NZ ED, which supports Luck's (2006) earlier findings of increased prevalence of violence towards nurses.

Richardson et al. (2018) report the rate of physical assault among employees in the health sector was 28.9% which increased to 55.3% when

reflecting on all types of violence. These statistics are significant; however, they aren't necessarily able to be directly translated to the rural setting. Research and statistics on violence towards nurses have been reported by some studies internationally in the rural setting, but there was an absence of data available within the rural NZ literature.

Work Environment

McCullough (2011) stated within her original thesis and later in a published article, that RAN's frequently encounter violence in their workplace and highlighted the need to adopt a risk management approach. Prioritising hazards included building maintenance, clinic set-up, attending call-outs, staff inexperience, community knowledge and moving away from the cultural theme that accepts things as part of the job (McCullough et al., 2012). This study was one of few that mentioned clinic set-up and building maintenance as a hazard in providing health care to rural communities. This was an important finding, in relation to the RNSs, where the clinic set-up had been a major factor in the nurses' anxiety when dealing with an aggressive patient.

An aspect that makes SW unique in regard to the nurses' work environment is remoteness of their clinics. This remoteness alongside the sole nature of the way in which RNSs work increased the anxiety and vulnerability of the nurses. This was further compounded for those nurses who had faced aggressive patients within their clinic setting, raising concerns due to the way in which clinics were set up with a lack of separate exit, no emergency buttons and no-one to call upon to get timely support. McCullough et al. (2012), as cited above, reflect on the importance of adequate building set-up and equipment when applying risk management strategies.

Literature regarding RNSs safety and risks associated with NZ focused on the on-call aspect of the role and did not explore the risks associated with the daily duties of providing health care to a community in remote clinics (Bell 2015; Kemp, 2012). McCullough et al. (2012) and Hutchings et al. (2011)

perceived the risk of violence towards nurses to be increasing, requiring better management with more resources to deal with the problem. Within NZ, Kemp (2012) discussed potential security issues due to working in isolation, but provided no description of actual events recorded or expressed by participants.

Personal safety was linked to vulnerability and isolation by the RNSs in SW. This finding that emerged from the data was often individual to each community with each RNS having slightly different experiences and interpretations of this. Aspects such as transient populations, communication between services, clinic set-up, geographical isolation, and weather influenced how personal safety might be compromised. Increased risk of violence to nurses has been linked to alcohol, mental health issues, unpredictability, workload, and pressure (Molinari & Bushy, 2012; Richardson et al., 2018).

Violent encounters shared within the RNS focus group during which the nurses had felt most at risk were associated with mental health, alcohol, and drugs. One incident, however, resulted from the community's expectation of the nurse. This finding is not widely reflected in NZ literature and it is a difficult finding to compare with the hospital setting or Australian literature where the patient population and expectations can vary due to their unique environments. Australia has a large cultural component and the expectations from an aboriginal community are likely to be very different to rural NZ.

Perception of safety was at times influenced by transient populations mostly due to whitebaiting or tourism in SW. This exposed the nurse to some patients that were 'down there to hide away from something' or alternatively people that were unknown to the nurse but had complex mental health or aggressive tendencies. The nurse felt the most vulnerable and at risk in those situations, and personal safety was significantly compromised.

Within NZ literature, rural nursing personal safety was not identified as a theme or finding but rather the stress of working in such isolation and the geographical challenges they face has previously been recognised (Bell, 2015;

Kemp, 2012). These authors link stress to the nurse's ability to safely access, assess, and treat the patient with this mostly affecting the on-call component of the RNS role. There is an expectation from both employee and employer to be safe in the work place, regardless of where your place of work may be (WorkSafe NZ, 2017). Therefore, further policy development to encompass the individual demands and perceived risks to the nurse when on duty is required so that nurses working in the rural setting are safe at work.

Communication proved to be a factor in the perception of personal safety and as highlighted in some examples from the results chapter. Communication between services posed a potential safety issue with communication often influencing the feeling of professional safety which was reliant on access to technology and cell phone coverage. Communication between services and in planning appears to be an essential component to maintaining safety, and some nurses had developed their own systems to manage this and decrease the anxiety of being out on-call in unpredictable situations. Relying on the nurses to develop their own systems is not adequate to minimise risk and more formal safety management plans would benefit those RNSs working in SW.

Increased anxiety was held amongst the nurses when working in isolation related to lack of personal alarms or locator beacons should their safety be compromised. Weather impacted the personal safety of the nurse and with the SW region being very mountainous and having a high rainfall, storms frequently impacted access and roads for the RNSs. Geography, weather, and distance to support was part of the environment in which the nurses worked, seeing patients in a range of locations and situations thus exposing the nurse to potential risks and challenges.

Some participants in the study had developed their own strategies, and discussion amongst the group showed concern about privacy and confidentiality, when relying on locals to support them during call-outs or

when seeing people they were wary of. Nurses are required to provide health care under the NCNZ Code of Conduct and the Privacy Act 1994, and taking another community member or their husband to call outs potentially breached these legalities of practice. This strategy was deemed inappropriate by the RNS team and not a suitable safety system to manage these potential situations (NCNZ, 2012; Privacy Commissioner Te Mana Matapono Matatapu NZ, 1994).

As part of identifying risks, strategies to counter or minimise the perceived risks to safety should be developed. Anderson (2012) and Hutchings et al. (2011) aimed to develop strategies to maximise safety in the rural environment. Anderson (2012), in Australia, implemented a safe community stakeholders group aiming at a whole community strategy with the hope that this would create an increased awareness of how to manage potentially dangerous situations. Hutchings et al. (2011) in Canada implemented a buddy system which consisted of a sign in/sign out system and a risk assessment tool. The evaluation of both of these initiatives showed that these strategies were effective and could be implemented in other workplaces as a mechanism to help mitigate some of the risks the RNSs face daily (Anderson, 2012; Hutchings et al., 2011).

WCDHB (2018) and WorkSafe New Zealand (2017) define actions should an incident occur. This includes avoidance, prevention, diffusion and de-escalation. Employees of the WCDHB are directed to call for help from others and arrange security to attend by calling 777 or 111 for police. This guidance has a very urban centred approach and is not overly applicable to the RNSs. Reflection on recommendations of current policy and drawing on strategies in place internationally could provide a good foundation to base a rural policy for the RNSs both in SW and elsewhere in NZ.

Professional Role

During the focus group, participants appeared to link the concept of personal safety to their professional safety. Pressure to perform was one aspect

of professional safety with many of the participants having felt this way at some point in their rural practice experience. This pressure was felt to be due to the community's expectations of the nurse and their duty to provide care. There was evidence of interplay and connectedness between professional safety and the impact this had on their moral compass as a nurse. This perhaps resulted in a perceived threat to professional integrity.

RNSs identified that their scope of practice was component of professional safety; however, not all were in full agreement and it appeared RNS perception of the definition of their scope varied. Perceptions varied from working outside of scope, performing at an expanded scope to an advanced scope. The RNS scope is defined in the background chapter and this role falls within the RN scope of practice. There are clear parameters to the RN scope of practice and it is well defined by the NCNZ (2012). What this finding suggests is that perhaps some of the nurses performing the duties of an RNS have felt outside of their scope possibly due to feeling unsupported to perform certain tasks and thereby contributing to a lack of feeling safe. Role recognition may also be perceived as being undervalued for RNSs working under the RN scope of practice when performing such a broad multi-level range of duties in such an autonomous environment.

There was concern from all the participants regarding the need for consistent doctor support for patients and for professional supervision. The role of the RNS provided continuity of care however, the assumption of ongoing monitoring of the community's health and well-being, raised anxieties amongst the nurses about missing something. Therefore, collegial collaboration was perceived as an important component in delivering rural health care as well as access to professional development. Clinical case consultation with the doctor at the time and working under the SO process posed some challenges, specifically in regard to access and protected time to achieve these. It was felt that the SO process was as a poor solution to safely achieving autonomous

practice and care of patients within these communities. An identified solution to achieving safe autonomous practice is for RNSs to achieve nurse prescribing or Nurse Practitioner status, which would decrease the reliance on access to medical practitioners to deliver this service (NCNZ, 2012).

Molinari and Bushy (2012) discuss an increase in vulnerability to violence or safety if nurses felt unsupported at work. This could extend to community support which was valued as an important component when considering professional safety. Linkage between professional safety, professional boundaries, and organisational or community support may influence how the nurse perceives her personal safety.

Ducat, Martin, Kumar, Burge and Abernathy (2015) explored the usefulness of professional supervision to nurses working in rural areas. This included enhanced clinical skills, knowledge and confidence in practice. A reduction in professional isolation and improved safety were acknowledged as benefits from professional supervision and an area that all the participants valued as important. Bell (2015), Brown et al. (2002), and Hunt and Hunt (2016) all reflect how important education and contact with professional support or supervision minimises the feeling of isolation and are pertinent when maintaining safe clinical practice.

Future Research and Implications for Practice

Significant findings have been identified from the studies specific to the RNSs in SW. Many of the struggles and challenges that the RNSs described are reflective of the isolation, vulnerability and at times violence towards nurses echoed in the literature in rural settings (Jervis-Tracey, 2016; Mills et al., 2010; Terry et al., 2015).

Specific examples of violence and aggression towards nurses in rural NZ are not well documented; however, this does not suggest this phenomenon does not occur but perhaps reference to this phenomenon is more widely reported in areas such as the ED. Policy directed to workplace safety is not

currently inclusive of the RNS duties or environment and therefore makes it difficult to implement or apply (Richardson et al., 2018).

This study is a relatively small study however, can provide some valuable information on the topic of personal safety of rural nurses. Little has previously been researched about this topic in rural NZ and this study, whilst small, provides unique insight into the difficulties traversed by rural nurses in SW when they go to work. This study explores real world examples from nurses with many years of rural and remote nursing experience and found consistency of concern in several areas.

Significant and important issues were identified that need to be recognised and addressed to ensure not only the future safety of these essential health workers but which also could contribute to attracting and retaining skilled nurses into the future. Issues were not limited to one particular aspect of workplace safety but spanned a range of issues crossing areas of policy development, communication, equipment and all of which need urgent attention. These are all factors that appear to increase the anxiety of RNSs working in SW and impact the service that they provide.

To explore these concepts further, a risk analysis of the RNS role within remote SW would be a starting point to develop an individualised workplace safety policy that is relevant and applicable to the areas in which the RNSs work. It needs to encompass the daily risks of scheduled nurse-led clinics and on-call demands. Consideration to available communication, transport, supports and resources available whilst at work is important. Gathering statistical evidence of reported incidents and the nature of these would be useful when considering and prioritising hazards.

Due to the remoteness and individual geographical areas of each nurse, identifying specific risks for RNSs would enable specific concerns to be detailed. Developing policy around these identified risks will create a solid

foundation and enable a fit for purpose policy and application of safety measures in the rural setting.

In response to some adverse situations where a nurse's personal safety was compromised, a locator beacon was issued to one area. Since the last meeting of the focus group, all of the areas have been given locator beacons and satellite phones. Although there was discussion around the impractical aspects of this, it is a step in the right direction. Part of policy development should include required training in and application of these safety tools to ensure that new and existing staff are aware of the purpose of them and how to use them.

The nature of clinic spaces was identified as an area that needed a lot of work. Review of the setup of clinics and safety in regard to escape routes and ability to contact someone for help would be essential measures to initiate in the near future.

The initiation of a lone worker document produced by the Canterbury District Health Board has begun since this study commenced with only verbal mention to the RNS team and no reference of this able to be provided as no formal documentation has been cited; however, it will hopefully include the challenges that are associated with remote nursing in SW. This study could add valuable insight into these challenges and realities of rural nursing and contribute necessary information to the lone worker document. It should include aspects of the RNSs duties that are identified as risks and ensure there are strategies in place to manage these risks with the resources available in the rural setting.

Aside from the identified physical risks to personal safety, an interesting finding in this study was that nurses often did not separate personal safety from professional safety. This was thought to be due to personal integrity as a nurse and the moral values that nurses bring to this role. Support was an identified factor in the feeling of safety, and without adequate support or

access to this, participants expressed anxiety for both their safety as practitioners and the safety of their patients. Support was identified in the form of consistent doctors rather than transient locums and accessible education. This study can provide some valuable insight into the realities of providing rural nursing services with transient locum cover and suggests exploration of differing models of doctor support to RNSs that enhances safe practice and sustainability when providing health care to rural communities.

Future research could explore in greater detail what professional safety and professional boundaries means to the RNSs and how they relate this to their personal safety. Exploring moralities and expectations of oneself in regard to professional or personal safety may shed a different light onto some of the experiences the RNSs shared. Exploration of the RNS role from the perception of different RNS groups with consideration to influences such as age, generation, and location, all of which might impact on how professional safety and professional boundaries is interpreted.

In relation to the rest of NZ, SW is small, and this study may provide benefits to rural practice elsewhere; however, further research should explore safety aspects related to nurses working in rural and remote areas throughout NZ. Expanding this research into other areas of remote nursing in different parts of NZ and including areas where remote nursing is provided in the North Island. Communities throughout NZ are made up of a variety of populations and ethnicities, some areas in the North Island have much higher Māori populations and care may be provided quite differently. These nurses could contribute valuable information and exploration of different experiences or risks related to safety in their workplace setting. Future research would benefit from including males in the sample group, as they have potential to feel unsafe in different settings or experience safety differently than females.

Future research could also include exploration of the experience required to be a rural nurse or the type of experience required and the risks to

rural nurses should they not have this background experience. This being an area of concern raised by one participant that may hold different views internationally and in other areas of NZ.

Limitations

The literature review for this study was limited for the purpose of a dissertation and was never intended as a full systematic review. Final selections of the articles included in the review were decided based on the content having a focus on personal safety of the nurse rather than the patient. Articles had to have a rural or remote focus similar to the RNSs work environment and had to be relevant to New Zealand so that the contexts were similar. Rural hospital was excluded due to the context of this area being considered not transferrable to the autonomous work environment of the RNS's. A broader search as part of formulating the discussion revealed further articles with terms such as 'violence' and allowed for inclusion of some hospital-based articles, highlighting that a broader initial search could have enhanced the literature review.

For this study, it was hoped to capture the full workforce both casual and permanent within SW. Five RNSs were able to attend the focus group, which still provided representation from all areas but means the sample group was small. One attended via Video Conference, allowing better access; however, a limitation of this could be that it was more difficult for her to interact than if she had been available in person.

The participants were all female; therefore, the perception of personal safety from a male working in the RNS role was not captured in this study. As part of the demographics of the sample group, no RNSs identified as Māori, therefore, the experiences as a Māori nurse providing health care in a rural community may present different challenges or experiences to those reported by the RNSs in this study.

The qualitative thematic analysis study design used was applicable and appropriate to the research aim and adds strength to the findings due to the ability to explore the participants' view. There are some limitations associated with this data collection process. Firstly, the small sample population and secondly the single focus group limits the number and detail of experiences that could be explored. By holding one focus group, some good information and data was gathered, but if a longer timeframe and more resources permitted, a second focus group could have explored some concepts further.

A focus group allowed for free-flowing conversation and a means of bouncing ideas off one another; however, there is potential for some of the participants to feel less confident in sharing. Another limitation of holding a single focus group was that some couldn't attend due to the geographical distances. Allowing for alternative or additional means of data collection such as semi-structured interviews via telephone or a survey may improve capture of data, provide new data and enhance the richness of data (Braun & Clarke, 2013; Webb & Kevern, 2001).

The experience of the researcher is considered a limitation. Inexperience of a researcher can influence how results and data are interpreted and may reduce the validity of results. This limitation was minimised and managed by the researcher having access to two supervisors and being guided through the research process.

In this research, the researcher had a vested interest and knowledge of the topic potentially introducing bias or assumptions into what the data represented. Furthermore, exploration of certain aspects may not have occurred to the same extent if someone external was running the focus group or reviewing the data. This was mitigated as far as possible by processes of member checking, reflexivity, and supervision (Taylor, Kermode & Roberts, 2011).

Dissemination of Findings

This study will be released in the format of a dissertation as part of a Masters of Health Sciences (Nursing-Clinical) qualification and will be available at the University of Otago (Christchurch) Library. The findings may be used in a conference presentation or an article for publication. Māori consultation included a request to ensure that other rural nurses working in Aotearoa New Zealand were made aware of the findings; therefore, Kai Tiaki as the principal nursing journal for the country is likely to be one avenue for publication.

The outcomes of this study will be fed back to the West Coast District Health Board and The Māori Health Advisor would be consulted about any change to policy and the impact that this may have on iwi (Māori community or people) within the local communities. Discussions may be facilitated through nursing networks within the DHB regarding impact to policy, process or population. There is an expectation that a draft review of any changes will be distributed to local iwi, rural nurses that were unable to attend the focus group, and other staff involved in providing health care within the South Westland Medical Centre to whom there may be an impact.

Conclusion

The aim of the research was to investigate how RNSs in SW perceived their personal safety whilst working in isolation in order to understand how it impacted their unique roles in this part of New Zealand. This topic reflected the experience of the researcher as an RNS herself, and her interest in enhancing policy and practice to provide a safe environment for this group of RNSs and to assist in retention of the workforce.

Relevant concerns of the participants came to the fore as they highlighted situations where physical aggression, pressure to perform and the expectations of the community increased their anxiety, thus impacting on their feelings of safety. The complexity of judging safety was evident as they

reported that each situation was influenced by the environment, weather and communications, supporting other research in rural and remote nursing which identifies the role as being complex for many different reasons.

Furthermore, RNSs found professional and personal safety difficult to separate at times and the impact of certain situations or outcomes affected the nurse in a personal way and was often related to the level of support they had at that time. RNSs had strong connections to their communities and the level of support received both from the community they resided in as well as their professional supervision or support impacted their feelings and perception of personal safety.

Evolving from this study is the opportunity to reflect on some of the challenges that the RNSs face. Identification and mitigation of risks and reflection on current policy in conjunction with this study provides a strong foundation to improve and structure future policy and practice, thus creating a supportive and safe working environment. Future benefits of addressing issues highlighted in this study could improve the experiences of RNSs working in rural areas, decrease anxiety regarding working in isolation and improve recruitment and retention.

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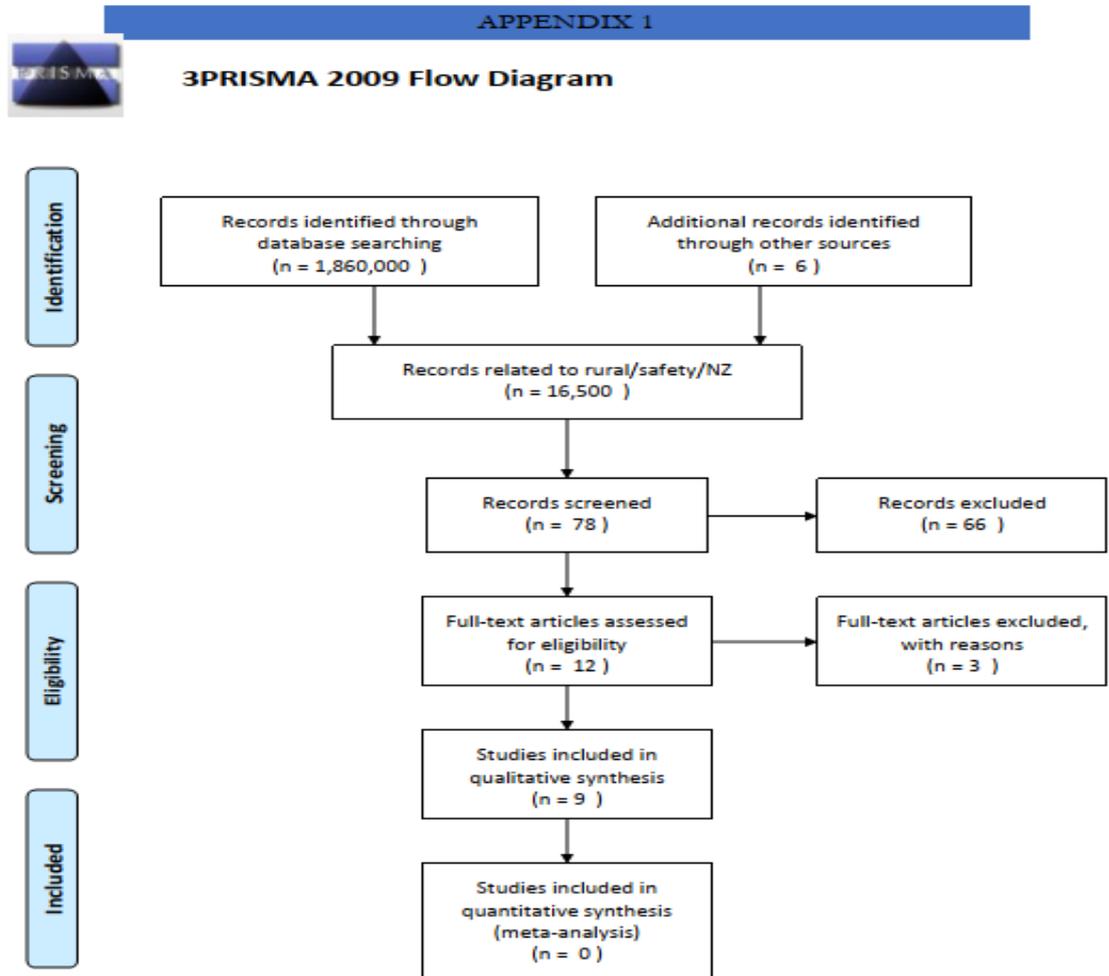
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Appendices

Appendix 1: Search Strategy



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(6): e1000097. doi:10.1371/journal.pmed1000097

For more information, visit www.prisms-statement.org.

Appendix 2: Literature Review

Reference	Type	Description	Included
<p>Anderson, K. (2012). <i>Working rural and remote: rewards and challenges</i>. Australian nursing journal. 19(7), 22-5.</p> <p>Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/22390010</p>	Qualitative	<p>Rural nurses working in Australia providing health to indigenous communities. Pros: increase scope and variety, increasing access of health care to remote areas. Challenges: lack of resources, difficulty retaining staff, geographical challenges, cross cultural issues, poor pay, no clarity of professional role, poor management infrastructure, unsupportive work environment and lack of professional development/supervision. Safety: security is not as accessible as urban areas, safe housing and strategies in managing</p>	Yes

		violent situations are in place. Formed a Working Safe in Rural and Remote Australia project.	
<p>Crowther, S., & Smythe, E. (2016). Open, trusting relationships underpin safety in rural maternity a hermeneutic phenomenology study. <i>BMC pregnancy and childbirth</i>. Retrieved October 14, 2018, from https://www.semanticscholar.org/paper/Open%2C-trusting-relationships-underpin-safety-in-a-Crowther-Smythe/359f02642662d992912db7e5e1572c8ab53c77fd</p>	Qualitative	<p>This study reveals how relationships are an important and vital aspect to the lived-experience of rural maternity care. Professional isolation is unsustainable and unsettling. Working alone, feeling isolated, brings into relief how relationships are vital. Sustainable practice requires reciprocal relationships. Professional isolation can lead to safety being compromised. Challenging communications and professional disputes create potential for misunderstandings and</p>	<p>Yes— although focused on midwifery in NZ some points and aspects related to working in isolation and rural challenges</p>

		undermines accessibility to supportive local networks.	
Mills, J., Birks, M., & Hegney, D. (2010). The status of rural nursing in Australia: 12 years on. <i>Collegian</i> , 17(1), 30-37. doi:10.1016/j.colegn.2009.09.001	Qualitative	Based on the Australian health care system, nurses and midwives are more generalists than specialists due to the remote natures in which they work, increased scope of practice, workforce is older in rural areas, limited access to professional development, ineffective relief through locum programmes, unacceptable housing and no partner employment inhibitors in growing the workforce. Predominantly female work force. Aspects related to increasing and growing this workforce.	Yes—no discussion regarding personal safety aspects however discusses other areas related to working in isolation and areas that may be similar to RNS work environment

<p>Hutchings, D., Lundrigan, E., Mathews, M., Lynch, A., & Goosney, J. (2011). Keeping Community Health Care Workers Safe. <i>Home Health Care Management & Practice</i>, 23(1), 27-35.</p> <p>https://doi.org/10.1177/1084822309360383</p>	<p>Qualitative</p>	<p>Newfoundland health care providers reported feeling unsafe while conducting home visits. Safety initiatives were explored, and a safety program was implemented within this region to address safety concerns. The safety program includes three key components: a risk assessment screening tool, a sign-in/sign-out system, and a buddy system. This article describes the evaluation process and outcomes of these three components. The evaluation process and outcomes may be useful to other health care organizations interested in promoting workplace safety.</p>	<p>Yes—very relevant—looks directly at safety issues; Canadian based; reviews systems and effectiveness.</p>
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<p>Khamisa, N., Peltzer, K., & Oldenburg, B. (2013). Burnout in relation to specific contributing factors and health outcomes among nurses: a systematic review. <i>International journal of environmental research and public health</i>, 10(6), 2214–2240. doi:10.3390/ijerph10062214</p>	Qualitative	<p>The majority of the articles included in this review have revealed that high levels of work-related stress, burnout, job dissatisfaction and poor health are common within the nursing profession. This is supported by literature suggesting that nurses experience longer working hours as well as frequent direct, personal and emotional contact with a large number of patients in comparison with other health professionals.</p>	<p>No—articles included are based on urban centres and article relates to burnout rather than safety.</p>
<p>McCullough, K. M., Lenthall, S., Williams, A. M., & Andrew, L. (2012). Reducing the risk of violence towards remote area nurses: A violence management toolbox. <i>Australian Journal of Rural Health</i>, 20(6), 329-333. doi:10.1111/j.1440-1584.2012. 01313.x</p>	Qualitative	<p>Australian based on Remote area nurses who encounter a wide variety of hazards. Environmental hazards are complicated by living in remote areas and practicing in different</p>	<p>Yes—very relevant to safety and working in isolation/remote areas.</p>

		<p>locations. Relationships between the nurse and the community can be complex and lack of experience and organisational support may contribute to an increased risk of violence. Hazards prioritised as 'major' or 'extreme' risks included: clinic maintenance and security features, attending to patients at staff residences, RAN inexperience and lack of knowledge about the community, as well as intoxicated clients with mental health issues. A work culture that accepts verbal abuse as 'part of the job' was identified as a significant organisational risk to RANs. A lack of action from management when</p>	
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		hazards are identified by clinic staff and insufficient recognition of the risk of violence by employers were also significant hazards.	
Newman, A. H., Nielsen, I. L., Smyth, R. L., & Hooke, A. (2015). Examining the relationship between workplace support and life satisfaction: The mediating role of job satisfaction. <i>Social Indicators Research</i> , 120(3), 769 – 781. https://doi.org/10.1007/s11205-014-0613-y	Qualitative	This paper examines the influence of perceived organizational support and perceived supervisor support on employee life satisfaction. Structural equation modelling on data from 393 nurses from two Chinese hospitals revealed that job satisfaction fully mediated the relationship between perceived organizational support and life satisfaction.	No—Urban hospital based—not relevant to rural nursing and safety.

<p>Terry, D., Lê, Q., Nguyen, U., & Hoang, H. (2015). Workplace health and safety issues among community nurses: a study regarding the impact on providing care to rural consumers. <i>BMJ Open</i>, 5(8), e008306. Doi:10.1136/bmjopen-2015-008306</p>	<p>Qualitative</p>	<p>A number of workplace health and safety challenges were identified and were centred on the geographical, physical and organisational environment that community nurses work across. The workplace health and safety challenges within these environments included driving large distances between client's homes and their office which lead to working in isolation for long periods and without adequate communication. In addition, other issues included encountering, managing and developing strategies to deal with poor client and carer behaviour; working within and negotiating working environments</p>	<p>Yes</p>
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		such as the poor condition of patient homes and clients smoking; navigating animals in the workplace; vertical and horizontal violence; and issues around workload, burnout and work-related stress.	
Jervis-Tracey, P., McAuliffe, D., Klieve, H., Chenoweth, L., O'Connor, B., & Stehlik, D. (2016). Negotiated policy spaces: Identifying tensions for rural professionals in delivering their statutory responsibilities. <i>Journal of Rural Studies</i> , 45, 123-133. doi: 10.1016/j.jrurstud.2015.12.016	Both Qualitative and Quantitative	Included rural professionals from not only health care but police teachers and social workers. Large sample group with findings showing lack of professional support, isolation and community tensions affecting all working professions. Blurring of boundaries, privacy issues and living in a fishbowl.	Yes—issues related to safety, working in isolation and remote.

Appendix 3: Consent Form

APPENDIX 3

INFORMATION SHEET FOR PARTICIPANTS



[Reference Number 18/092 as allocated upon approval by the Human Ethics Committee] [21.06.2018]

A qualitative analysis of how Rural Nurse Specialist's in South Westland New Zealand perceive their personal safety when working in isolation.

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

What is the Aim of the Project?

The aim of this study is to look at the impact of personal safety when working in isolation as a Rural Nurse (RNS) in South Westland. Research into this area of practice may lead to identification of ways in which risks to nurses working in isolation can be reduced and an increase in the provision of care to patients in rural communities. There is potential to identify strategies and preventative measures that could increase the personal safety of RNS's whilst improving organizational policy and current procedure.

What Type of Participants are being sought?

To be included in this study you must be a current full-time, part-time or casual Rural Nurse Specialist employed by the West Coast District Health

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Board under the South Westland geographical area. You may not be part of this study if you are not employed as a Rural Nurse Specialist in South Westland or if you are unable to attend a face to face focus group in July 2018. Please be aware that this may be held out of work time or in a lunch break.

Rural nurses eligible for the study will receive information via email. This will include the information sheet and consent forms. They will be invited to contact the student researcher or her primary supervisor if they have questions. Those nurses who agree to participate will be required to sign a consent form and return it to the student researcher. On receipt of consent forms a letter will be sent, inviting you to attend the focus group. This focus group is predicted to occur in July 2018. This study is unfunded and is part of a Master's dissertation. The student researcher will provide coffee for the participant's as a thank you for your time contribution towards this study.

What will Participants be Asked to Do?

Should you agree to take part in this project, you will be asked to take part in a focus group interview. The focus group is expected to be held in July 2018 on a peer meeting day at the Fox Glacier Medical Centre. It will be led by Gemma Hutton, with Deb McCarthy acting as note-taker. It is anticipated that participating in this study will take no more than 1 hour of your time.

There are no anticipated risks to you taking part in this focus group, however, in the event that the line of questioning, or, the focus group process, does develop in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s) or withdraw from the project. If you wish for additional support on the day, Janet Hogan will be available on site should you wish to access her. Janet will not be present in the focus group but available in another room. Furthermore,

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the Employment Assistance Programme offered through the WCDHB is available for you to access at a later time.

Please be aware that you may decide not to take part in the project without any disadvantage to yourself of any kind.

What Data or Information will be Collected and What Use will be Made of it?

At the focus group, you will be asked to share your perception and experience of your personal safety at work. Questions will include at what support and protective factors are currently in place to maintain your personal safety whilst working in isolation. Further exploration will look at risks and experiences that you have had that have put you in an unsafe situation and how this made you feel.

Contact information (name and address) will be used solely for that purpose. To provide a broad description of participants, your age, ethnicity, years of experience and geographical location will be collected but each category will only be reported as a range.

The information that is collected will be available to Gemma Hutton, Deb McCarthy (at the time of the focus group only), and supervisors, Dr Jenny Conder and Deb Gillon.

The data collected will be securely stored in such a way that only Gemma Hutton and her supervisors at the University of Otago will be able to gain access to it. It will be stored on a password protected computer during the study and any data obtained as a result of the research will be retained for 10 years in secure storage through an arrangement with the Centre for Post Graduate Nursing Studies. Personal information will be destroyed at the

APPENDIX 3

completion of the research, even though the data derived from the research will be kept for much longer.

Every attempt will be made to ensure your privacy is maintained. When writing reports material which could personally identify will not be used. The findings will be reported as themes. Please be aware that due to the nature of your role in the small team, even with the most rigorous processes, there is the risk that other team members who have not participated in the focus group might recognise some aspect of your contribution as coming from you. Please only share information that you feel comfortable with.

You will be able to access your personal data for the purposes of correction, however, to provide confidentiality for all participants, the transcribed focus group recording will not be available. You are welcome to approach the researcher after the focus group and before completed analysis if you wish to have your information removed or corrected.

At the conclusion of the study you will be provided with a summary of the results.

Can Participants Change their Mind and Withdraw from the Project?

You may withdraw from participation in the project at any time during the focus group or prior to it commencing and without any disadvantage to yourself of any kind.

What if Participants have any Questions?

If you have any questions about our project, either now or in the future, please feel free to contact either: -

Dr Jenny Conder

APPENDIX 3

Primary Supervisor/Researcher – University of Otago, Centre of Post Graduate Nursing

Telephone: 034798689

Email: jenny.conder@otago.ac.nz

Gemma Hutton Rural Nurse Specialist Franz Josef, Student Researcher

Telephone: 0272501989

Email: hutge414@student.otago.ac

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph. +643 479 8256 or email gary.witte@otago.ac.nz). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.

APPENDIX 3

Consent Form

[Reference Number 18/092 as allocated upon approval by the Human Ethics Committee] [21.06.2018]



**“How do Rural Nurse Specialist’s in South Westland New Zealand
perceive their personal safety when working in isolation?”**

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that: -

1. My participation in the project is entirely voluntary;
2. I am free to withdraw from the project before its completion (*December 2018*);
3. Personal identifying information may be destroyed at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for at least ten years;

APPENDIX 3

4. Participants will be taken out for a coffee or provided a small snack such as chocolates following the completion as a token of appreciation towards the time invested.
5. The results of the project may be published and will be available in the form of a dissertation in the University of Otago (Christchurch) Library but every attempt will be made to preserve my anonymity.

I agree to take part in this project.

.....

.....

(Signature of participant)

(Date)

.....

(Printed Name)

.....

Name of person taking consent

This study has been approved by the University of Otago Human Ethics Committee. If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph. +643 479 8256 or email gary.witte@otago.ac.nz). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.

Appendix 4: Focus Group Procedural Rules

APPENDIX 4

Focus Group Procedural Rules

1. Maintain confidentiality at all times when discussing experiences
2. Respect others by attentively listening
3. Be open and contribute thoughts and knowledge
4. Be honest and non-judgemental of others
5. Feel safe in the focus group environment and if affected by aspects or shared experience be aware of support person Janet Hogan, who is available in Clinical Room 1. Please excuse yourself and if everybody is comfortable the focus group will continue with minimal disruption to the flow of discussion.
6. Share only experiences that you are comfortable with
7. The interviewer will be guided by the semi-structured topic questions and will be the facilitator of the interview.
8. Deb McCarthy will be the note taker and will help to attend to the needs of the group members.

Appendix 5: Focus Group Question Guide

APPENDIX 5

Focus Group Questions Guide

1. What are some safety issues or aspects related to safety that you feel you face working as a Rural Nurse Specialist (RNS) in South Westland?
2. What are some protective factors that you utilise as part of your practice as an RNS?
3. What supports or policies are currently in place in your workplace to prevent/promote or protect your personal safety?
4. Do you feel these supports are adequate and/or relevant to your current work environment?
5. Can you identify any ways in which you think personal safety could be improved in your current work environment?
6. Do you think personal safety of RNS's is an issue in retention of staff?
7. Do you think current safety policies are current and applicable for the unique environment in which RNS's work?
8. Are there any other areas of safety that you would like to discuss or experiences that you have had that you wish to share as examples of compromised safety?

Appendix 6: Ethics Approval



18/092

Academic Services
Manager, Academic Committees, Mr Gary Witte

Dr J Conder
Centre for Postgraduate Nursing Studies (Chch)
72 Oxford Terrace, Levels 2 and 3
University of Otago, Christchurch

21 June 2018

Dear Dr Conder,

I am writing to let you know that, at its recent meeting, the Ethics Committee considered your proposal entitled **“How do Rural Nurse Specialist’s in South Westland New Zealand perceive their personal safety when working in isolation?”**.

As a result of that consideration, the current status of your proposal is:- **Approved**

For your future reference, the Ethics Committee’s reference code for this project is:- **18/092**.

The Committee would like to commend you for the consideration and response given to the potential ethical issues.

Approval is for up to three years from the date of this letter. If this project has not been completed within three years from the date of this letter, re-approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

Upon approval, it is expected that all members of the research team are made aware of what the standard conditions of ethical approval covers. This includes the date ethical approval expires, as well as the process regarding applying for amendments to the research.

The Human Ethics Committee asks for a Final Report to be provided upon completion of the study. The Final Report template can be found on the Human Ethics Web Page

<http://www.otago.ac.nz/council/committees/committees/HumanEthicsCommittees.html>

Yours sincerely,

Mr Gary Witte
Manager, Academic Committees
Tel: 479 8256
Email: gary.witte@otago.ac.nz

c.c. Dr P Seaton Director, Senior Lecturer Centre for Postgraduate Nursing Studies (Chch)

Appendix 7: Māori Consultation



CHRISTCHURCH

29 May 2018

Dr Jenny Condor
Centre for Postgraduate Nursing Studies
University of Otago, Christchurch

Mā te rangahau Hauora e tautoko te whakapiki ake te Hauora Māori.
All health research in Aotearoa New Zealand benefits the Hauora (health and wellbeing) of tangata whenua.

Tēna kōe Jenny,

Thank you for taking the time to teleconference me at my office at the University of Otago, Christchurch on the 28th May 2018, to discuss your research study titled:

“How do Rural Nurse Specialists in South Westland New Zealand Perceive their Personal Safety when Working in Isolation?”

I note that you are the Principal Investigator for this research study and that Ms Gemma Hutton, a post-graduate nursing student completing the requirement for a Master of Health Sciences degree will also be involved.

Commentary on Proposed Research Project

Rural Nurse Specialists (RNSs) are described as generalist nurses as the context in which this role exists necessitates a broad range of knowledge in order for them to deliver health care in a variety of settings. Whilst RNSs work under the Registered Nurse (RN) scope of practice, due to the utilisation of standing orders, RNSs are able to practice autonomously in remote settings and frequently work in relative isolation in South Westland with a single nurse situated in each town from Hari Hari to Haast. In rural communities the nurse can be the sole person delivering health care to the community. This can mean a sense of isolation, lack of support and aspects of this demanding role neglected by professional and political legislation.

A recent literature review found minimal research articles on the personal safety of New Zealand (NZ) nurses working in isolated environments. Therefore, the aim of the proposed study is to explore and identify how RNSs currently working in South Westland perceive their personal safety. A qualitative approach using focus groups will be used to explore the nurses' perceptions. Purposive sampling will be used to capture the experiences and perceptions of the current permanent RNS workforce in South Westland. Focus group questions will relate to the nurses' perception of safety and their responses will be analysed to identify the main areas of concern and strategies for improvement of RNSs safety while at work. Focus group meetings will be held in Fox Glacier at the local medical centre. It is anticipated that up to 10 RNSs will be recruited to participate in this study.

Māori Health Gain

Around one in three Maori (32%) live in rural areas. One in five rural people (19%) are Māori. The age structure of the rural Māori population is younger than that of the non-Māori rural population, with a significantly higher proportion of children and young people. Of particular

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otago.ac.nz/christchurch

concern however, is the relatively poor health status of rural Māori, compared with urban Māori and with rural non-Māori. You also acknowledge that although this is a small qualitative study, this research may contribute to identifying strategies to increase the personal safety for both Māori and non-Māori RNS's working in other rural isolated areas in New Zealand and improving organisational policies and current procedures. This provides the appropriate context to the importance of this research and improving health services delivery and health status of rural Māori populations. In addition, you advise that the perception of safety is likely to vary amongst RNSs and that study participants will be asked about the influence of culture in relation to this.

Ethnicity

As discussed, ethnicity data is a key variable for understanding the health experiences and priorities of different population groups leading to the development of more effective policies and programmes. Ethnicity data is also necessary for monitoring the performance of the health system. Although this study does not target Māori participation specifically, it is recommended that ethnicity data is collected from each participant in accordance with the New Zealand Ministry of Health guidelines, which involves the use of the Census 2013 question. Your study should also acknowledge the issues associated with ethnicity data collection.

Consent

Issues regarding informed consent for participants who are recruited to the study were discussed. With this in mind, you must ensure that study participants are aware that consent will be for this single study only.

Partnership

I understand that you have consulted with Mr Gary Cogland, Māori Health Advisor from the West Coast District Health Board, Greymouth and that he has agreed to be an advisor for this research. In addition, I understand that you will also be making contact with Rangi Tinirau and Kimmy Nolan (from local iwi) to discuss your research project.

Potential Further Support Resources

Further resources that you might want to access to strengthen your responsiveness to Maori within your research are: 1. HRC's Ngā Pōu Rangahau Hauora Kia Whakapiki Ake Te Hauora Māori 2004-2008, 2. Article by Dr Papaarangi Reid (2017). "Achieving Health Equity in Aotearoa: Strengthening Responsiveness to Māori in Health Research." and 3. The Health Research Strategy to Improve Māori Health and Well Being 2004-2008. For regional data relating to Māori in each District Health Board (DHB) region, the District Health Board (DHB) Māori Health Profiles (2015) published by the Ministry of Health New Zealand will help to create a picture of the health status of a DHB's population at a given time. The other reference that is available is 3. Hauora Māori Standards of Health IV: A Study of the Years 2000-2005 by Bridget Robson and Ricci Harris, Māori Health Research Unit, Wellington School of Medicine, University of Otago, Wellington. The publication Tātau Kahukura: Māori Health Chart Book 2015, Ministry of Health, 2010 (3rd edition) is an update relating to the socio economic determinants of health, health status and service utilisation of the Māori population. Further references are available from the HRC's Guidelines for Researchers on Health Research Involving Māori. All provide Maori specific information on a range of health issues.

Dissemination of Results

The HRC's Guidelines for Researchers on Health Research Involving Māori, is important in terms of how your research results may contribute to Māori health gain. Therefore, it is important that appropriate Māori organisations and/or researchers are aware of your findings. This should occur not only in an academic forum, but also within the community from where study data is drawn. You inform that a summary of your study findings will be available to all study participants including Māori Health Advisor, Mr Gary Cogland and West Coast District

Health Board nursing management staff. I have recommended that you be guided by Rangi Tinirau and Kimmy Nolan in terms of exploring local hauora Māori forums or hui for the dissemination of your research. In addition, a copy of the findings from your study will be published in the New Zealand Nursing Organisation's Kai Tiaki journal. As such, these avenues may provide an opportunity for the consideration of Māori feedback into any discussion going forward with regard to your study.

Ka nui tonu ngā mihi,

A handwritten signature in black ink, appearing to read 'K Keelan', written in a cursive style.

Karen Keelan
Kaitohutohu Māori/Māori Research Advisor



Appendix 8: Locality Approval

APPENDIX 8



6/07/18

Hello Gemma

Thank you for sending the documentation relating to the WCDHB Locality Research Approval for your research project "*How do Rural Nurse Specialists in South Westland, New Zealand, perceive their personal safety when working in isolation?*"

The West Coast District Health Board Locality Research Approval Group has reviewed your documentation and approval has been given for you to profess the research in line with your Research and Proposal and within the Ethical Approval conditions.

All the best as you progress this mahi. We wish you well with your research and would be pleased to receive a copy of your final report. Please provide this to the WCDHB Librarian, Marie McCrudden.

Kindest Regards

Carol Gaskell

Coordinator Rural Learning Centre

West Coast District Health Board

Phone (03) 769 7400 Ext 2620