Goin' Bush: The nursing experience of working in remote Australia

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Abstract

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Personal experience of working as a remote nurse in Australia has brought an awareness that the uniqueness and complexity of this nursing brings challenges that are significantly different from those experienced by nurses in other clinical contexts. While there has been literature published around remote nursing mainly regarding violence, stress, education, and scope, little has been documented about the nature of nursing in the remote context and how nurses experience working in these environments. The purpose of this qualitative study was to take a holistic look and investigate a nurse's experience of working in remote Australia. Case study research, which is an empirical inquiry that investigates a contemporary phenomenon in depth within its real-world context was selected. The single case study design was undertaken using Yin's guidelines for a descriptive study. An in-depth interview with a remote area nurse was held and thematic analysis undertaken utilising the framework by Braun & Clark (2006). The thematic analysis discovered themes within the data that together gave an overall picture of the phenomenon studied. Three themes were generated: adapting, constantly preparing, and wellbeing and safety. There are several groups or individuals that may benefit from the findings of this study such as new to remote area nurses, nurses aspiring to work in the remote context and those that employ remote nurses. Recommendations for practice and further research provided based on the findings of the study.

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Attestation of Authorship

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning."

Signed:

Melissa Howard

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Chapter one: Introduction

Title

Goin' Bush: The nursing experience of working in remote Australia

Question

What is the nursing experience of working in remote Australia? And how can this experience guide nurse's new to remote and their employers?

Aim

The purpose of this dissertation is to explore the experience of nursing in the rural and remote (RAR) areas of Australia. By exploring and unpacking one nurse's experience, my research will provide guidance for nurses who are considering a similar role or are new to the role. This will assist nurses better prepare for the environment and new challenges that come from working remotely. Additionally, this research will be useful for those hiring remote area nurses (RAN) to determine suitability for a remote nursing role.

Foreword

In 2015 I graduated with my Bachelor of Health Science in nursing and took a new graduate position in a local emergency department (ED). After several years working in the ED, I decided to travel. I had colleagues that had worked in RAR areas of Australia on short contracts (4-12 weeks), returning to New Zealand (NZ). I started in rural Victoria with a six-week contract then returned to NZ. After another year working in NZ, I committed to working in RAR regions in Australia while travelling to other areas of the world between contracts.

I have since worked in Victoria (VIC), Western Australia (WA) and Queensland (QLD). I have worked in mining towns, remote islands, and remote Aboriginal communities. Each contract is an adventure and challenge with new work environments, communities, and cultures to adapt to. I learnt as I went and felt that I had been underprepared when starting out on my RAR journey. Employers seemed interested in relevant education and experience, with ED experience being very attractive. Most RAR positions are at multi-purpose sites (MSP) where the ward, primary health care (PHC) clinic and ED are in one building with the nurses working responsible for all areas. This means nurses need to be multi-skilled and competent in a broad range of specialties. They need to be confident to work in environments without doctors, or the staff and skill mix they are accustomed to in larger hospitals. Alongside clinical practice issues, I felt most underprepared for the cultural differences and adjusting my practice to be culturally safe when I was unsure of what that looked like. There were new learning

opportunities and challenges that are unique to the RAR environment. I found myself struggling with the lack of support, resources, equipment, staff and experienced conflicts and dilemmas in my practice. This led me to reflect deeply on my scope of practice, standards of care, ethics, equity, cultural and patient safety. RAR nursing challenged me mentally, physically, ethically, culturally, and spiritually. Ultimately, it gave me the best and worst experiences of my life. This has led to an interest in researching RAR nursing through the eyes of another nurse.

Background

Approximately 7 million people or 28% of the Australian population live in rural and remote areas, which encompass many diverse locations and communities; see figure 1.1 (ABS 2019). The Australian Statistical Geography Standard (ASGS) (2018) defines 5 classes of remoteness based on a measure of relative access to services. The 5 categories are:

1. Major Cities of Australia
2. Inner Regional Australia
3. Outer Regional Australia
4. Remote Australia
5. Very Remote Australia

Australians living remotely in categories four and five have less access to healthcare than those living in metropolitan areas, they also have a higher burden of disease with increased rates of chronic disease and premature death rates. Data shows that people living in rural and remote areas have higher rates of hospitalisations, deaths, and injury. They have poorer access to, and use of primary health care services compared with people living in major cities (Department of health, 2019). Additionally, a large percentage of Aboriginal and Torres Strait Islander people live in remote areas (21%) and make up approximately 45% of the population living in very remote Australia (AIHW, 2020). The poor health and decreased life expectancy of Aboriginal and Torres Strait Islander people is well established compared to those of non-indigenous people. Statistics show their health status deteriorates the more remotely they reside (AIHW, 2020).

The challenges of geographic spread, low population density, limited infrastructure, and the higher costs of delivering rural and remote health care can affect access to health care (AIHW, 2020). RAR areas have smaller facilities, fewer doctors and other health professionals, less infrastructure and fewer specialty services than metropolitan areas. These remote facilities are tasked with delivering services to a more diverse population. Australians living in Remote and Very Remote areas experience health workforce shortages with a high turnover

of RNs, despite having a greater need for medical services and practitioners with a broader scope of practice (AMA 2017). The Government of Australia has acknowledged the inequitable disparities in health for those living in RAR areas and created the National Strategic Framework for Rural and Remote Health with the primary goal of equal access to healthcare for everyone regardless of geographical location and access to an "appropriate, skilled and well supported health workforce" (Australian government: Department of Health, 2011). Nursing services in Australia are funded in several different ways with no one consistent model. Additionally, there are a variety of staffing models depending on the needs of the population and factors such as isolation, staffing, and facilities. There are no mandatory courses or formal qualifications for RAN nurses and preferences vary between states.

When choosing my dissertation topic and undertaking a literature review, I found a lack of depth in the research about the nurses' experience of nursing in a remote environment. Most research focused on specific care given, resources, or education about how to maintain skills remotely. This is a gap in the literature. By exploring one nurse's experience I will gain a greater understanding of how the nurse experiences the environment and the challenges of remote nursing. This information may be useful to others considering remote nursing.

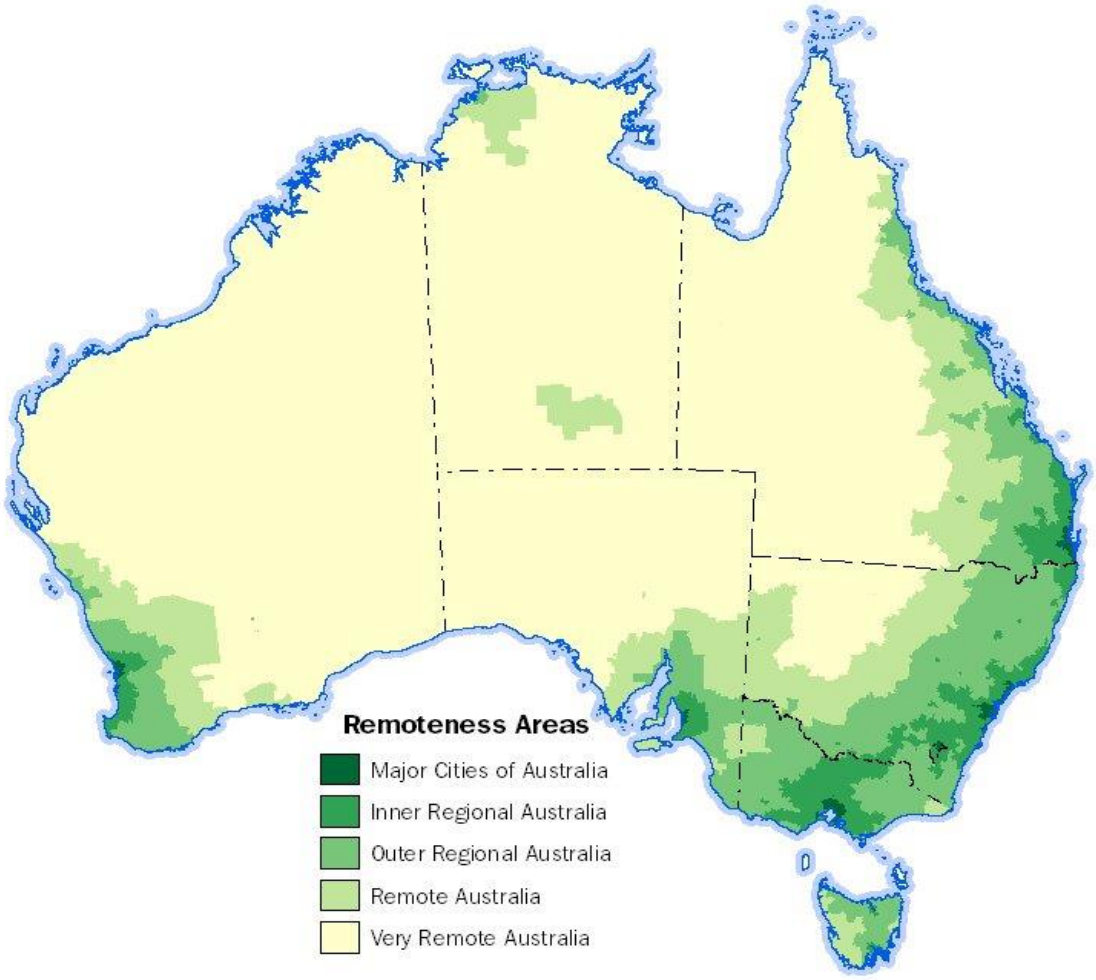

Figure 1: Map of Australia showing areas of remoteness (ABS, 2016)

After finding a lack of research specifically on the nurse's experience of remote nursing I decided to explore more in-depth the nurse's experiences of working in the RAR environment. This research was undertaken using a qualitative approach. A case study method was used to unpack the experience of one nurse working in remote Australia. As an exploratory approach, a case study method seeks to identify themes, categories or behaviours and events (Taylor & Thomas-Gregory, 2015). The case study method was chosen to investigate in-depth a phenomenon within its real-world context (Yin, 2014).

Findings

My findings chapter explores the themes drawn from a semi- structured interview. This interview approach has been chosen because it allows predetermined questions to be answered while allowing flexibility to probe more deeply into areas of interest. Data analysis was achieved using thematic analysis to identify and describe themes or patterns from within the data. Stories and examples arising from the interview are in italics, with an explanation of the relevance to practice and to central themes. Stories often arise in the nursing profession as ways to articulate experiences and give examples of phenomenon that have occurred in practice. This aligns with the case study methodology which seeks not to prove a hypothesis but to draw themes, categories, or behaviours.

Conclusion

This dissertation is an opportunity for me to reflect on my own practice and learnings from working in RAR Australia while providing the opportunity to learn from another nurse and gain their perspective about their experience working in remote Australia. After discovering themes in my findings section, the concluding chapter links themes and experiences to showcase the experience of nursing in RAR Australia. To end this dissertation, I offer guidance to those seeking work as a remote area nurse (RAN) and those employing RANs. This research aims to inform and empower nurses seeking to make a difference in the challenging outback areas of RAR Australia.

Chapter two: Literature Review

This literature review takes a thematic approach to explore current research on remote area nursing (RAN) to establish themes relating to working in rural/remote areas. I conducted research focusing on research only pertaining to rural and remote Australian locations and did not limit the field (e.g., not ruling out specialty nursing such as mental health) to determine overarching themes in remote nurses' challenges and unique characteristics. A literature review was conducted using databases, including EBSCOHost, ProQuest, CINAHL, Google Scholar, and the Auckland University of Technology's (AUT) online database. I used various terms in various combinations: 'remote' 'Australia' 'nurse' 'rural' 'outback' 'experience' 'perceptions.

The purpose of this dissertation is to explore the experience of nursing in remote areas of Australia to guide nurses who are considering or are new to remote nursing and those that employ them. Evaluation of the literature revealed a lack research about nurses' experience of remote nursing with studies focusing on stress, education, staffing shortages, retention, and the role of the RAN. Many texts contained only a few sentences of relevant information but often led to other texts. The type of literature found was mainly academic articles, qualitative studies, and literature reviews. I included research that was from reliable, trustworthy and peer reviewed sources. These studies enabled me to look more broadly at RAN and the contextual factors influencing RAN's nursing practice and lifestyles. I found that there was not a large amount of literature and that many relevant studies were older with some seminal papers and authors that dominate the field. I included older studies that are relevant research which helps understand the nature of the work and challenges facing RNs working remotely. From the literature review I began to see emerging themes of RAN roles shaped by community context, being multi-skilled and multipurpose, isolated, and underprepared, and experiencing stress and violence.

Unpacking the role of RAN's

RAN nurses are crucial health professionals in the RAR setting; they are "specialist advanced practice nurses who provide and coordinate a diverse range of healthcare services for remote communities, which are predominantly aboriginal" (Weymouth et al., 2007). Issues of isolation, burnout, poor management, stress, and a lack of organisational commitment (Stewart et al., 2020) have negatively impacted RAN retention. The RAN scope of practice has expanded with time, and many extend their practice to prescribe, initiate medications, order tests and referrals (Whiteing et al., 2021). These extended skills are crucial to those working remotely where access to resources is sparse (Francis et al., 2016). Regulatory frameworks and legislation govern an RNs scope of practice; however, the extent to which the RN works to their full scope

is defined by the context, the needs of the community, and the availability of technology (Stockton et al., 2021). In contrast to their metropolitan counterparts, RANs tend to work to their full scope due to the generalised nature of the work and the increasing roles they must take on (Whiteing et al., 2021).

The more remote and inaccessible the community, the less sustainable it is to provide the resources of a metropolitan area. Health services in rural and remote areas have decreased access to resources, and the communities have less choice of service or service provider (Francis et al., 2016; Stockton et al., 2021). Often the nurse is the first point of contact in the healthcare system, with remote communities having no other onsite medical services. In remote areas, RANs take on multiple roles and working autonomously. They are the paramedic, doctor replacement, transport system, mental health worker, social worker, etc. (Francis et al., 2016). Working in these unique environments demands a large amount of responsibility. There are also thrilling challenges as a RAN, where nurses are pushed to their limits trying to provide care with scarce resources and help. This often results in RANs working beyond their scope of practice (Francis et al., 2016; Stockton et al., 2021; Whiteing et al., 2021).

RAN roles and experience shaped by community context

The notion of roles and experience being shaped by community context was a theme drawn from articles that discuss the influence the context has on the RANs role; this includes the size of the facility along with the community's needs. For example, some RAN's live and work permanently within communities, choosing to commit to longer times in the community they work. In contrast, others spend weeks or months doing shorter contract work to make up nursing numbers if there are shortages (Bourke et al., 2021). A study by Bourke et al. (2021) interviewed six remote NT communities to identify dominant discourses underpinning RAN practice in the NT. Almost all 29 RANs indicated they loved Aboriginal people, loved the autonomy of the work, and enjoyed their work and lifestyle. The study identified themes and discourses such as permanent RANs are preferable, that RANs need to be experienced and confident, RANs use independent clinical judgment, that Aboriginal staff must be in the clinic, and a feeling of making a difference. This study represents voices from 29 RANs from only 6 of 53 government run clinics in remote Northern Territory at the one point in time. This study is limited by using a small number of clinics and limiting to only government run clinics, however the analysis of the study allowed examination beyond the individual and the intermediate by emphasising challenges embedded in the RAN role and practice across these clinics.

Many studies have found the size of the health service corresponds with the services offered, finding smaller facilities had fewer services present; here, RANs need to work under a

generalised scope to fill gaps by service providers that would usually be available in metropolitan areas (Courtney et al., 2002; Hegney et al., 1999; Twigg et al., 2016). For example, a large-scale seminal study by Hegney et al. (1999) of 129 rural facilities across Australia analysed the activities undertaken by RNs. The study found a substantial difference in the activities of RNs relating to the size of the health facilities, with RNs from smaller facilities needing a more comprehensive range of skills and knowledge (Hegney et al., 1999). In addition, the study established the smaller the facilities, the less support and access there was to medical and allied health services. Therefore, the nurse's role was extended to fill these gaps (Hegney et al., 1999). The study by Hegney et al (1999) reviewed 14 papers of which 9 had publication dates over 10 years old, this could be seen as a limitation and may also indicate that little research has been undertaken on the roles of rural and remote RNs. Later studies back up this report with similar findings, such as a study by Courtney et al. (2002), where nurse executives in QLD were found to have much broader roles with more hands-on clinical focus the further away from cities they worked. The study compared the roles and professional development needs of nurse executives where a cross sectional self-report descriptive study was used, however the study is limited by a response rate of 52% (Courtney et al, 2002).

The review by Mills et al (2010) updates and develops on the seminal Hegney et al (1999) paper by undertaking an integrative review of the same topic from 1996 to 2008. Mills et al (2010) findings show there are a range of influences on RNs roles when working rurally which include community, social determinants of health, population number, culture, and levels of support from other health professionals. A major strength of this review is the direct replication of the earlier Hegney et al (1999) study. This is valuable to judge how rural nursing has changed over the timeframe. The study was also strengthened by its clear presentation of the impact of context on the RNs role with small populations needing a generalist role where RNs need to work across the lifespan. However, the paper does not list roles but does provide good descriptions of what nurses do with consideration to influencing factors such as culture, community, social determinants of health. A further limitation of the Mills et al (2010) review is that the number and details of the papers they reviewed is not stated. Hegney et al (1999) and Mills et al (2010) did both have relevant findings on the scope of RNs who work remote, however due to the date of publication, further research is now needed as they were both published before the merger of nursing boards and the establishment of Australian Health Practitioner Regulation Agency (AHPRA) the nursing regulatory body that introduced competencies and standards.

The context and needs of the community impact the experience and the roles RANs have while working. For example, the Council of Remote Area Nurses of Australia (CRANA)

states most members live and work in Aboriginal communities across Australia. There are also nurses in mining communities, farming communities, fishing hamlets, offshore drilling rigs, and islands, tourism & railway towns (CRANA, 2003). Greene and Burley (2006) analyse how nursing practice in outback bush centers in Victoria is influenced by social, economic, and demographic developments such as increasing mental health needs, aging population, health concerns of farmers and families. The paper discusses that the nurse's role has had to adapt and change in response to these external forces specific to the context of the Victorian bush communities (Greene & Burley, 2006). The study details specific roles of RNs and how their traditional roles are widening in response to the needs of the community as well as advances in nursing practice. This study uses a relatively small sample of 5 bush nursing centres in Victoria and does not detail their remoteness using a classification guide which limits its findings; however, it does state only single nurse posts where there is no doctor or pharmacist and details that these are non-indigenous communities.

Several other authors have also established that RNs roles require flexibility to cater to the community's context and needs (Al-Motlaq et al., 2010; Cathryn et al., 2017; Taylor et al., 2013). For example, the socioeconomic determinants of health and chronic disease patterns in Torres Strait Island and Aboriginal communities are contextual factors that influence the roles and scope of RANs. RANs in these contexts need to manage prevention and health promotion alongside chronic disease management and emergency/acute presentations (Cathryn et al., 2017; Taylor et al., 2013; Twigg et al., 2016). For example, Taylor et al. (2013) found that the significantly high rates of diabetes in the Torres Strait Islands give RANs many challenges, as there are no specialist diabetic nurses present as in Metropolitan areas. Similarly, a multi-case study approach explored how RANs address chronic disease and the burdens that accompany them and found RNs from predominantly aboriginal communities were more focussed on chronic disease management and education; conversely, RNs from a non-indigenous community prioritised trauma and acute care services (Al-Motlaq et al., 2010). Further, Cathryn et al. (2017) reports a large prevalence of anaemia, malnutrition, and acute illness in remote NT Aboriginal communities required the RANs to focus intensely on child health.

Knight et al. (2015) talk about how the nurse's integration into the community affects their work in both positive ways as well as causing potential issues. The understanding of the community built from relationships can aid nurses in clinical decisions. Suitable suggestions for care can be formed on the nurse's knowledge of community' resources achieved through living and working in the community (Knight et al., 2015). Being incorporated into the community can however come with the risk of making false

assumptions formed by personal knowledge of cases. The study done by Knight et al (2015) is limited by having no male RNs participating and the data was taken on descriptions from participants as opposed to direct observation which could have led to researcher bias.

Multi-skilled and multipurpose

An integrative review on rural and remote nurses identified the themes of nurses as doctors' substitutes, nurses being multi-skilled, and having advanced practice (Muirhead, 2020). The study found that RNs in rural and remote Australia have diverse contexts which have a major influence on their role and leading to nurses needing to be multi-skilled and practice at an advanced level, including responsibility of some tasks and roles traditionally undertaken by medical practitioners. The idea that in small communities the nurse often takes on different roles outside their scope of practice was repeated in multiple studies (Cathryn et al., 2017; Muirhead, 2020; Crossland, 2011). The National Rural Health Alliance (NRHA) state it is crucial for all RANs to practice at an advanced level in a general role where they are expected to deliver care for all lifespans from; maternal, infant/child, adolescent, mental health, women's/men's health, palliative care, elderly, acute/emergency, public health, chronic and communicable diseases as well as managing retrievals and transfers (NRHA, 2005). Alongside advanced generalist, clinical skills nurses were also found to take on an array of clinical and non-clinical roles such as pharmacy dispensing, Xray, cleaning, food preparation, repairs, security, reception work, filing/admin, vehicle maintenance, and animal health (Crossland, 2011; Greene & Burley, 2006; Smith & Jones, 2007).

Most articles agree that RANs need to be practicing at an advanced level and be multi-skilled (Birks et al., 2010; Hegney, 1997; Timmings, 2006). Findings suggest that the more remote the facility, the higher the expectation that RANs become a doctor substitute. RANs work with General Practitioners (GP's) and other health professionals remotely using various communication methods (e.g., video calls) showing that proficiency with latest technology is imperative (Al-Motlaq et al., 2010; Birks et al., 2010; Greene & Burley, 2006). In a study of rural and remote Northern Queensland communities, Crossland (2011) concludes it is standard practice for nurses to assess medical history, complete examinations, order diagnostic tests, and make a diagnosis. In a community of 200 people, the community and facility did not perceive the services provided by a RAN as different from that of a GP, with patients not concerned by the absence of a doctor onsite (Crossland, 2011). Other studies also found that the community generally accepts that RNs provide primary health services. There is an expectation that nurses will assume the role of a doctor when there is no GP around (Greene & Burley, 2006; Hegney, 1997).

A study by Dunbar et al. (2019) aimed to identify remote area nurse staffing issues perceived by clinic managers, nurses themselves, Aboriginal colleagues, and community members in seven remote communities in the Northern Territory of Australia. Participants identified the importance of clinical and cultural skills and reiterated that getting the "right" Remote Area Nurse was more important than simply recruiting more nurses (Dunbar et al., 2019). The study was restricted by short time frames for field work which limited availability of participants; the analysis is also descriptive and synthesised. Despite these limitations, all the stakeholder groups were clear that the recruitment of RANS is about recruiting a competent RAN that needs to be equipped with multiple clinical skillsets while also being culturally skilled to work in Aboriginal communities. This can be a challenge in RAN as Australia has over 500 different clan groups or 'nations' around the continent, many with distinctive cultures, beliefs, and languages (Australian government, 2021).

Isolated and underprepared

The feeling of isolation is common for rural and remote nurses who usually work away from their usual home and friends/family. Being geographically isolated and working far from large tertiary hospitals means this is a common theme in the literature. Working in isolation is the most inescapable feature of remote area life (Lenthall et al., 2009). Isolation expands beyond simple geography to include social and professional life. For example, if the support of colleagues, friends, and family is not available, it can increase a person's vulnerability both professionally and personally (McCarthy et al., 2002). Due to remote area communities being both geographically isolated and small, RANs are often accommodated in or near their workplace and live in constant contact with work and the community they are serving (McCullough et al., 2012). Nurses often report maintaining privacy as impossible due to home and work being inseparably linked (McCarthy et al., 2002).

Being isolated was reflected in all remote specialty services, such as mental health nurses who felt their skills were tested by the autonomous and isolated practice found in remote nursing (O'Brien & Jackson, 2007). Nurses are often in remote areas as sole practitioners or with no doctors. A study of 240 remote health sites found that nurses felt "alone, with or without someone," reflecting the contextual factors that go along with being remote (Whiteing et al., 2021). This study also reported nurses experiencing "spiralling wellbeing" and cited this as a reason for poor retention in remote areas. Whiteing et al (2021) uses the term "spiralling wellbeing" to encompass the wellbeing of self, others and organisations interwoven, each affecting the other. In the study nurses discuss their own reasons for their wellbeing to spiral downwards with stress and burnout reported by seventy percent of participants. The theme "spiralling wellbeing" reflects the isolation of nurses in remote areas (Whiteing et al., 2021). The

study was limited to NSW and QLD, therefore, findings outside of these states should be applied with consideration to the states practicing guidelines and regulatory policies.

The preparation of RANs is a generalist role requiring both advanced clinical and management skills (Birks et al., 2010; Lenthall et al., 2011). A factor causing stress in RANs was poor access to qualified support and education (Francis et al., 2016; Lenthall et al., 2011). One study indicated that education for RANs should be through postgraduate courses (Lenthall et al., 2009). RANs have more access to funding for professional development and employer support due to incentive schemes and recruitment initiatives (Henwood et al., 2009). However, RANs have reported being unable to access education opportunities due to no staff to replace them (Francis et al., 2016; Wakerman et al., 2019). Poor access leads to a great deal of stress and raises concerns regarding how nurses meet the regulatory education requirements to maintain their license (NMBA, 2016). Currently, there is no regulation for preparing RANs; few possess specialty qualifications and face considerable barriers to gaining them (Francis et al., 2016; Wakerman et al., 2019). Due to the nature of RAN and the high population of indigenous people in remote Australia; RANs not only need to be clinically competent; but practice in a culturally safe manner. They must be aware of differences in social norms, gender roles, language, religious and spiritual practices, and values and beliefs related to health and illness (Quinn et al., 2015).

Whiteing et al. (2021) conducted a study interviewing nurses over concerns about safety, quality of care, wellbeing of nurses, and retention of the nursing workforce. 240 remote Australian clinic sites analysed the complexities of working remote. A significant theme found was "the medley of preparation for rural and remote work" along with being "alone or without someone" (Whiteing et al., 2021). The study reported nurses feeling underprepared and out of their depth working across multiple lifespan groups and specialties they are not practiced in. They were the sole nurse available (specialist areas included sexual health, neonatal, antenatal, maternity, renal, and mental health nursing). The study by Whiteing et al (2021) was all qualitative with no quantitative data. This could mean the themes generated from the reviewed qualitative studies could be seen as subjective with potential for bias as the review process was led by a single author. However, Whiteing et al (2021) does state there was a second author verifying the process and findings.

One grounded theory study found positive aspects to being underprepared. The study discusses nurses being enraptured or transformed in ways they did not prepare for, such as "it had a profound effect on their worldview" and "you get to understand the indigenous people's connection to the land" (O'Brien & Jackson, 2007). Josif et al. (2017) interviewed four RN's

providing child health services to two remote Aboriginal communities in the NT; they reported generally feeling unprepared for this role and voiced concerns that it was an employer expectation to do the role regardless of their nursing background. Although RNs often reported feeling unprepared for the role, many studies found that they still filled the positions to meet the community's needs (Al-Motlaq et al., 2010; Cathryn et al., 2017; Coyle et al., 2010).

Stress and violence

The above themes that have been discussed highlight the context of the RANs workload and their demands. Whiteing et al., (2021) states seventy percent of RANS work in indigenous communities with high morbidity and mortality rates; therefore, a RANs workload is high. Nurses in advanced roles can develop feelings of fatigue, low morale, and unrelieved stress (Lenthall et al., 2009). The volume and complexity of the work are significant for RANs who work long days and are then expected to be on call (Hegney et al., 2002; Joiner et al., 2004). One paper document's 100 days of on calls with no break (Yuginovich & Hinspeter, 2007). Excessive overtime and on-call are significant factors contributing to the mental and physical exhaustion of RANS (Hegney et al., 2002; Joiner et al., 2004). The community and managers often misjudge the workload of RANs and hold idealistic expectations of nurses, which are unachievable (Hegney et al., 2002; Weymouth et al., 2007).

RANs experience elevated levels of occupational stress and a high turnover which can significantly impact the quality of care given to patients. The research on stress experienced by RANs in Australia is dominated by the studies of Lenthall, Opie, Dunn, Wakerman, and Knight, with most of their work stemming from the collective project "Back from the edge: reducing and preventing occupational stress in the remote area nursing workforce" (Lenthall et al., 2018). The project aimed to; illustrate stressors of RANs, calculate stress levels, develop, apply, and assess several interventions that aim to decrease stress levels (Lenthall et al., 2018). The process evaluations of workshops resulting from the study were positive, but the outcome evaluations found low implementation of interventions as well as low impact on sources and outcomes of stress in the workplace (Lenthall et al, 2018). Other limitations of this study were documented as political issues such as changes to welfare provision, law enforcement, land tenure and other measures introduced by the Australian government that caused turmoil within remote Aboriginal communities and health services in remote NT (Lenthall et al, 2018). Alongside this a further limitation was H1N1 swine flu that caused staffing shortages and increased workload which made it hard for some units to attend the workshop and therefore limited the study's findings. Regardless of this, knowledge newly found in this study is useful and aid in informing policy and practice with respect to services delivered in remote areas.

Stressors affecting rural and remote nurses can be broken into job demands and job resources; Job demands are parts of a job that involve a constant ongoing effort by staff, either physical, mental, or both, leading to exhaustion. Such job demands include isolation, bullying, personal safety, increased or multiple responsibilities, and poor infrastructure (Opie et al., 2010). Job resources are aspects of a job that may or may not motivate an employee to attain their goals (personal or professional) (Lenthall et al., 2018; Opie et al., 2010). Examples of job resources negatively impacting RANs and adding to stress include the inability to take leave due to poor staffing and workload and limited educational and professional development opportunities (Hegney et al., 2002; Lenthall et al., 2018). A thorough review of the literature for the "back from the edge" study by Lenthall et al. (2018) identified four themes of occupational stressors: isolation and boundaries, workload and scope of practice, poor operational management and finally workplace and community violence. Lenthall et al (2018) described inadequate support from management, doctors and other health professionals, alongside on-call hours, and concerns of violence and safety which caused considerable stress.

While there is a body of literature about workplace violence and nursing generally, studies specific to RANs are limited. The foundational work by Fisher et al. (1998) and later sequel study by Opie et al. (2010) reveal a rise in violence towards RANs over the 13 years between the studies. İn the follow up study, sixty six percent of the RANs stated they worried about their safety. Incidences of violence included damage to property, verbal aggression, sexual abuse/harassment, lewd behaviour, threats over the phone, physical violence, and stalking (Fisher et al., 1996; Opie et al., 2010). Violence is found to be a considerable stressor for RANs and is a significant contributory cause for the high frequency of RAN turnover in remote services (Lenthall et al., 2009). Evidence from multiple studies emphasises that the retention of experienced RANs provides benefits in terms of patient and community outcomes through continuity of service, which is fiscally beneficial to all (Birks et al., 2010; Buykx et al., 2010; Fisher et al., 1996). Consequently, tackling the problem of violence to RANs helps the nurses and the whole community's health.

Conclusion

At the beginning of this thesis, I reviewed the literature directly relating to nursing in remote Australia. I discovered foundational researchers that dominated the field. Some texts focus on negative aspects of being remote such as isolation, violence, and danger, while others concentrate on skills and the clinical aspects of being a RAN. The research explored ideas of being remote and the factors that accompany this. However, there is a lack of research from the nurse's perspective and most research focused on specific cares, resources, or education on maintaining skills remotely. It was evident at the end of the literature review that the focus in

the field of rural/remote nursing research has been concerned with emphasising the stressors on nurses, rather than creating a background that is reflective of their daily working lives. I concluded from this literature review; the experiences of RANs have not been well described within the research. Using a case study approach this study will examine one individual nurse's experience as a way of gaining a more in-depth understanding of the nurse experiences and the environmental challenges of remote nursing. This information may be used to prepare others considering remote nursing.

Chapter three: Methodology

Introduction

This section will review the chosen research method which is case study. Social and political factors are an integral aspect of case study research. Therefore, constructivism is epistemologically connected and deemed a fitting philosophical worldview to place this study. The philosophical reasons for constructivism are discussed in this section. According to Yin's principles, this section will also describe the concepts and processes to be followed when utilising case study research. Yin's guidelines include the type of question, the control the investigator has over the study, the current nature of the phenomenon, case study design, the use of multiple sources to maintain a sequence of evidence. This section aims to illustrate how case study research was applied in this study, beginning with Yin's five fundamental principles (Yin, 2014), which are:

- The study question/s
- Study propositions
- The case
- The logic linking the data to the propositions
- The criteria for interpreting the findings

It is imperative to acknowledge the philosophical underpinnings used to undertake this thesis but equally essential to recognise this is a small thesis for a master's project and not a doctoral study. Consequently, my journeying of philosophical approaches was limited by the timeframes allowed.

Philosophical underpinnings

Qualitative research aims to increase understanding of complex phenomena (Bryne, 2001). Conventional qualitative research methods include phenomenology, ethnography, and grounded theory. Case study research takes a similar qualitative approach and aims to understand phenomena or cases from multiple perspectives in a real-world context (Taylor & Thomas-Gregory, 2015).

Early in the research process, I recognised a philosophical position in which this study will fit. This allows the researcher to acknowledge the beliefs and expectations that the researcher has (Guba & Lincoln, 1989). This research takes on a constructionist epistemological hue consistent with my worldviews. Using a constructionism lens allows the views and experiences of my participant to be heard and expressed. Crotty (1998) states that there are different views of the world and different ways to research the world. Constructionism argues that truth or meaning cannot be subjective or objective but rather that the experience we have of and in the world is the product of social processes and how people build ways of understanding between these processes (Crotty, 1998; Lock & Strong, 2010). These are the complexities I aim to find by listening to the experiences and views of the participant to gain an insight into their multiple realities.

Work by seminal case study researchers (Merriam 1998; Stake 1995) promotes the use of the constructionist paradigm. For this study, constructivism is true to the author's beliefs that knowledge is created through people's experiences and interaction with their social context (Patton 2002). Intrinsically this study is placed within the constructivist paradigm, which presumes that reality is socially fabricated through numerous realities or understandings of a phenomenon (Merriam, 2015; Patton, 2002). By comprehending this, the researcher positions themselves to discover the outcomes of a person's constructs and how they react or respond to them (Patton, 2002).

The researcher for this study aims to understand, describe, and interpret how these RANs experience working in remote environments, their practice, and how they prepare for practice to inform or give advice to those considering nursing remotely. In line with Yin (2014), both social and historical context is relevant, and constructionism establishes this as these aspects directly impact others formed social constructs. Both constructionism and Yin's principles highlight the significance of the case being studied as context bound. The constructivist view fits within Yin's (2014) guidelines as it recognises the limitations of the phenomenon studied and the social and historical contexts of studied phenomena. Social constructivism is therefore fitting as the fundamental paradigm for this thesis.

Case Study research

Yin (2014) defines case study research as "an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-world context, especially when the boundaries between phenomenon and context may not be evident" (p. 16). Case study research was selected for this thesis as it is a valuable method to answer the research question. Case study research has its history in social sciences, health, and education and has been used to explore roles in nursing (Yin, 2014; Sangster-Gormley, 2013; Luck, Jackson & Usher, 2006). Case study research is a flexible yet challenging methodology; however, it has had the least support and attention due to a lack of precise protocols (Donnelly & Wiechula, 2012; Taylor & Thomas-Gregory, 2015; Yin, 2012, 2014). There are many understandings and definitions of case studies with more than 25 different definitions, each with specific directions and emphases (Van Wynsberghe & Khan, 2007; Zucker, 2009). However, case study research shares common factors such as a comprehensive focus on a particular unit of analysis, a contextualised high detail analysis of a case, particular space and time boundaries, and the use of multiple sources of data (Yazan, 2015; Zucker, 2009).

After deciding to use the case study methodology, the next step was to define the specific case study approach. The viewpoints of seminal authors Yin (2003, 2009, 2014), Stake (1995), and Merriam (1998) were explored as these theorists each define their take on case study research and how it should be applied. Two significant approaches direct case study research: one purported by Stake (1995) and the other proposed by Yin (2003). Stake (1995) categorised case study research into three types: collective, intrinsic, and instrumental. An instrumental case study seeks to understand a question theorised or a problem to understand a specific issue; the case is of secondary importance as the focus is on one concern that the case serves to illuminate. In an intrinsic case study, the aim is to understand more about an exclusive phenomenon of a specific case (Stake, 1995).

Conversely, Yin (2003) distinguished three case study types: explanatory, exploratory, and descriptive. An exploratory case study aims to explain the study's research question or establish the viability of research processes. Descriptive studies fully explain a phenomenon within the phenomenon's context. An explanatory case study chases the cause-and-effect relationship to demonstrate how events happen and what events can affect specific outcomes. The descriptive case study, which describes a phenomenon in the context of its reality, was the most suitable type of case study for this thesis. In the case of this study, I wanted to understand a nurse's experience (this being the case/phenomenon) in remote (context=geographical) Australia (context=national).

Case Study Design

Flyvbjerg (2004) states a case study is a virtual reality where the reader is brought into this reality to explore it to gather a deep understanding of the issue the case addresses. Yin's method was determined as the most suitable for this study, so the option for either qualitative or quantitative data could be used if needed. This thesis was accomplished using qualitative data and sits within the constructivist paradigm. After deciding to use a descriptive case study, the decision to use a multiple or single case study design and whether any embedded analysis units would be needed. A single case study design examines details and intricacies of one case and looks for interactions of that case's particular context (Stake, 2006). Single case studies are valuable for studying a specific interest within the case, and the findings lead to a broad illustration of the case for readers. The academic restrictions of a 45-point dissertation also influenced the decision to use a single case study. Yin (2014) depicts four design types for case study: Single case- holistic, single case- embedded, multiple case- holistic, and multiple case- embedded (see figure 2).

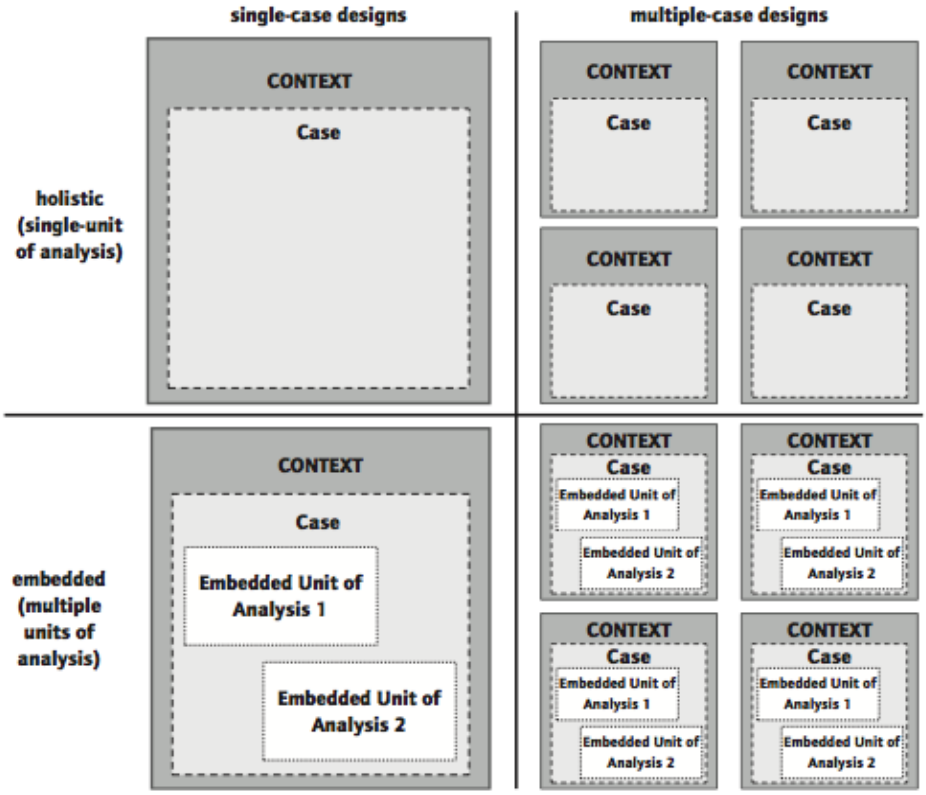

Figure 2 Yins Case study design. Retrieved from: Case study research, design and methods (p.50). Yin (2014), California: Sage

Yin (2014) argues that multiple case designs may be more robust and have more strength than a single case. In multiple case study design a number of cases are selected which allows comparisons to be made across several cases, the results of multiple case studies therefore have greater generalisation and theoretical and literal replication (Crowe et al, 2011). Multiple case studies require more resources, time, and finances; while it would be ideal for carrying out a stronger, more robust study, this was not achievable within the size and time constraints of this thesis. Although the nature of this research may mean results are not generalisable for all nurses, the case study demonstrates a nurse's experience in which readers may find helpful information on which further research could be based. I acknowledge that additional work is needed if the findings are to be generalisable Australia-wide. The intent is to inform readers of a single nurse's experience to give them insights into life as a RAN and assist with the transition to rural and remote nursing.

Applying the Case Study principles of Yin

By selecting Yin's (2003, 2009, 2014) method for this study, five elements crucial to his case study design will be examined. These are:

1. **The study question:**

   The first step in case study research is to determine a solid focus and aim for the research, which is completed by creating the research question(s) (Yin, 2014). Case study research usually answers 'how,' 'what,' and 'why' questions to comprehensively explain the case (Yin, 2014).

   The aim: To holistically explore the experience of a Registered Nurse working in rural and remote areas of Australia and gain a deeper understanding of how the nurse experiences all aspects of living and working remotely.

The research question asked: What is the nursing experience of working in remote Australia? And how can this experience guide nurse's new to remote and their employers?

2. **Study propositions**

   Theoretic propositions are created before collecting data, with the propositions guiding data to areas that should be explored within the scope of the study (Yin, 2009). Researchers' propositions help establish the study's direction, helps focus the collection of data, form the conceptual foundation's structure, and finally direct the discussion (Yin, 2009; Baxter & Jack, 2008; Stake, 1995).

Propositions can be created from exploring literature, professional or personal experience, generalisations/theories built on data (Yin, 2009; Baxter & Jack, 2008). Yin (2009) states clearly that case study research will not attempt to generalise results to a larger population. In addition to leading data collection and aiding discussion for the study's questions, Baxter and Jack (2008) state that adding propositions increases the chance of the study's scope being limited and, consequently, decreases the feasibility of finishing the study. I ensured that along with the creation of theoretical propositions (see table 1), I kept the number of cases to a single case, so my thesis is within the scope of my masters.

Table 1:

Research Question	**Propositions**
What is the nursing experience of working in remote Australia? And how can this experience guide nurse's new to remote and their employers?	• Nurses are influenced by economic, social, and political factors and their workplace/community context. These can lead to clinical issues that RANS will be exposed to, treat, and manage. (E.g., farming, mining, access, and availability of resources). These contextual factors affect the personal and professional experience of RANs and therefore nurses' experiences are individual and multifactorial. • Those seeking remote nursing experience will come with various backgrounds and skills and will face several barriers and challenges that will influence their practice. • New to remote nurses have their own circumstances and reasons for moving into remote nursing, impacting their experiences.

3. The case

The second principle of Yin (2014) is about defining the case. The case may be a program, a process to be implemented, an organisational change, a decision, or individual (Yin, 2014). The case should be a particular phenomenon arising in a constrained context (Creswell, 2003). The context is crucial in case study research and differentiates case study from other research methods. In this case, the contextual circumstances, such as the remote environment, are essential to the phenomenon studied (Yin, 2009). The case is best defined after the research question is developed, but it can be altered after data collection and analysis as the research can alter its course (Yin, 2009, Zucker, 2009). The case for this research was a nurse who works in remote Australia.

4. **The logic linking the data to the propositions**

Yin's fourth principle guides the researcher on applicable data collection methods to best work with the theoretical propositions (Yin, 2014). Yin (2014) states there needs to be a coherent approach to link the data to a proposition. For example, the phenomenon in this thesis was the experience of a nurse working in remote Australia. The propositions and other influencing factors are vital to the phenomenon, and collected data is needed to reflect these. The data collection was a semi-structured interview undertaken to gather more significant insights into the factors and propositions identified to examine the nurses' experiences in detail.

5. **The criteria for interpreting the findings**

Lastly, Yin's final principle involves the criteria for interpreting collected data (Yin, 2014). Yin (2014) recommends four analytical strategies (working data from the ground up, developing a case description, relying on theoretical propositions, and examining opposing explanations). This thesis used all four of Yin's analytic strategies; firstly, the data collection led the analysis, patterns and themes were sought, and new concepts transpired. Throughout this process, I remained aware of my initial theoretical propositions. Therefore, the themes and ideas developed through the analysis were viewed considering my initial theoretical propositions. The final analytic strategy of examining rival or opposing explanations was undertaken by continually seeking reasons for the evolving themes to establish if there may be other reasons for these to occur.

Ethics and Recruitment

Consultation with research ethics advisors and my supervisor informed me that this project was not required to go through the ethics committee at Auckland University of Technology. As per the Health and Disability Ethics Commission (HDEC) flowchart retrieved from https://www.aut.ac.nz/__data/assets/pdf_file/0011/117893/HDEC-scope-summary.pdf my research did not require HDEC review. Ethics approval was not required for this case study research as I undertook an interview with one nurse from my social network that I have worked with on a remote contract. Pseudonyms are utilised to protect any need for names of other nurses, managers, or patients as required. The study uses a semi-structured interview to draw out themes and ideas; any identifying factors and details have been changed to protect anonymity. The aim was to explore experiences while keeping others involved anonymous. I have changed any identifying features such as age, gender, patient condition to maintain

anonymity as these potentially identifiable features have little impact on the overall story. I feel this allows further confidentiality while permitting me to delve into the experiences of others. The participant was made aware that she had the right to not answer questions and could withdraw from the interview at any time. As the data from the interview is unidentifiable as per the AUT data matrix found from: https://aut.acnz/data/assets/pdf_file/0009/398691/Data-management-matrix-14072020.pdfit it can be considered public Data. Following the matrix, the information from the interview will be stored electronically on OneDrive with a password protected backup file on the AUT network drive. I have member checked the interview by sending the audio file and transcribed data to the participant to ensure she feels it is a correct reflection.

Data collection

As described above, data was collected through semi-structured interviewing with one nurse I know from my practice, having worked with her in a remote setting. This nurse has worked remotely in various states of Australia. I undertook this interview using zoom calling to accommodate Covid levels. I recognise that there are certain limitations to zoom interviews, including an inability to analyse body language and tone of voice; however, I used a camera and observed what I could. Due to current travel restrictions and Covid levels, this was the only option. I obtained written consent as well as verbal consent before the interview. The interview was audio-recorded and transcribed. I sent both the audio and transcript to the participant to check.

The interview and data I gathered from the literature review enabled in-depth probing instead of surface-level descriptions. Semi-structured interviews created a conversational approach (Yin, 2011), with the nurse interviewed leading the discussion at times (Lincoln & Guba, 1985). The semi-structured interview comprised primarily open-ended questions, enabling freedom of expression and explaining the participant's experiences (Braun & Clark, 2013). While keeping within the interview guide framework, questions were developed throughout the interview to allow topics or experiences that the participant spontaneously spoke about to be heard in the context of answering/replying to other questions and during their descriptions of experiences. During the interview, I considered which questions to next ask and, alongside recording, made notes of specific points or issues to revisit. Please see appendix 1 for indicative topics used in the interview.

Data Analysis

Data analysis requires meticulous attention to the question and aim as well as creative insight to make the invisible come to light and take significance from things that appear unimportant, all while finding and reporting facts (Stake, 2010). Thematic analysis was used in phase two when the data was joined for an in-depth analysis to classify, analyse, and report themes within the data to give a thorough overall picture of the phenomenon studied. (Braun & Clarke, 2021). In this thesis, the thematic analysis took an inductive method as data was not coded to suit into a coding framework but conversely, it was determined solely by the data. Alongside Yin's method for thematic analysis, the framework by Braun & Clark (2006) was utilised as a method for data analysis as it gives clear step-by-step instructions for the analysis of data and is easier to follow for a 1-case study. Yins thematic analysis was similar, however I found it more suited to a multiple case study design and it was more complex and time consuming for the size and design of this thesis. The stages of Braun & Clark (2006) thematic analysis are as follows:

1. Data familiarisation (recognising themes to be used as codable)
2. The initial generation of codes
3. Theme identification
4. A review of the themes
5. Naming and defining themes
6. Creating the report

This six-step method is similar to Yins five-phase method of compiling, disassembling, reassembling, new narrative, and conclusions (Yin, 2016). Following the 6-step approach of Braun & Clark (2006) I transcribed the interview myself to assure I became fully immersed in the data (Braun & Clarke, 2006). I then read the transcript together with the recording to guarantee that the transcription was accurate. For familiarisation I read the transcript multiple times, attaching notes on keywords and important comments to help organise the content. This beginning analysis process later enabled new components to be revealed and new theories, thoughts, and rival explanations to be studied (Yin, 2014; Oppenheim 1992). Not only did I read the transcript multiple times for familiarisation but to gain initial codes. When Initial codes were gathered from the ınterview, I then collated these codes into potential themes, selecting relevant data from the transcript. These themes were then reviewed in the context of the data in its entirety, and further refining of each theme continued until clear themes could be defined and named. Many potential themes were generated during this analysis phase, leading to similar initial themes being combined. The result of this was the generation of 3 significant themes (see appendix 2).

The second analysis process was to read the transcript over again to make sure no areas had been skipped in the early analysis of the data. It also allowed me to re-read the transcript considering the three chosen themes and determine if they allowed a thorough representation of the overall data. Once assured that the themes represented the data, I submitted my themes to my supervisor to review how she interpreted the data and double-check if anything had been missed. The themes were agreed as an accurate representation of the data, and I continued to name and define the themes, conclude the findings, and create my report.

Reflective analysis

Researchers bring their individual life experiences and views/understandings of the world (Gbrich, 2007). As a nurse that has worked across multiple states in rural and remote areas of Australia, I was mindful of the significant amount of knowledge and experience I brought to this research. Despite this current knowledge, it was my own, and I still had significant gaps and desire to get an in-depth look at how another nurse experiences the remote nursing context. I was cautious and acknowledged my ideas and experiences when interviewing and analysing data. I ensured my participant double-checked my data and that my supervisor was involved in the analysis process to help reduce bias around selecting themes. I was very aware of the potential adverse effects of bias on data collection and analysis; Costley et al. (2010) state data analysis is jeopardized by significant familiarity, which can cause a lack of objectivity. This becomes a more significant risk when there is a vested interest in particular results being attained.

Maintaining rigor

Qualitative research is frequently criticised for lack of scientific rigor (Polit & Beck, 2006). It is generally accepted that the positivist criteria used to create rigor in quantitative research, such as reliability, validity, and internal/external validity, are not appropriate for determining rigor in qualitative research (Polit, 2012; Polit & Beck, 2006). However, Polit (2012) states that using different criteria to that used in quantitative study does not mean qualitative researchers are not concerned with quality data; therefore, I have selected the following criteria as appropriate for determining the study's rigor: Trustworthiness, transferability, and credibility.

Trustworthiness

As this thesis was a single case study, the focus was on particularisation and uniqueness rather than generalisation (Stake, 1995; Zucker, 2001). The case (Nurses' experience) is tied to specific details such as specific nursing area (rural and remote) and location (Australia), which are factors that make this research less generalisable. Therefore, the suggestion that outcomes

from this study may be applied more widely are contradictory and not valid; the results are not generalisable to other locations, populations, or professions. However, this is a descriptive case study, which aims to describe the phenomenon in the context of its reality. The aim is to understand how a nurse experiences the remote environment. The results offer connections to similar situations, aiming to help other nurses and employers be informed about working remotely. To achieve this, the study results need to accurately reflect the participant's opinions. The emphasis is on one nurse's experience and perception of her own experiences. Thus, the descriptive case study method is appropriate as it emphasizes the description of things and the discovery of phenomena in the context of its reality (Zucker, 2009; Yin, 2014).

Trustworthiness established there was no pre-determined outcome and no vested interest in establishing one answer over another. From the start of this thesis, I acknowledged my own experience and bias, and maintained my intention to review a fellow nurses' experiences to reflect on how they experience working in remote Australia. By allowing myself to remain open to learning and gaining new insights. This gave my research transparency, honesty, and openness, which differs from more structured and rigid research methods (Smythe et al., 2008). Ezzy (2002) states that qualitative research demonstrates trustworthiness when the researcher can prove they worked to understand the nature of participants' interpretations and meanings. Throughout this study, I have been clear about the purpose and processes used, which assists in establishing the Trustworthiness of the data (Griffiths, 2004).

Credibility

An essential criterion qualitative researchers utilise is credibility; credibility implies there is honesty and plausibility in the findings and is accomplished when participant/s identify and accept the research is about understanding their described perspectives, beliefs, and opinions (Hays & Singh, 2011; Cooney, 2011). To obtain credibility in this research, I forwarded the data collected to my supervisor and participant so impartial checks of themes and interpretations could be undertaken. Audio recording and transcript checking was also done to reinforce credibility. Showing the participant research findings allowed them to express their views and opinion of the credibility of the findings. Although, I was aware that my position as a nurse that has worked in remote areas may have influenced my participant in their responses as it could be seen as coercion to give the desired feedback. To ensure credibility, the researcher needs to declare their background, thoughts, and emotions and maintain an audit trail (Hays & Singh, 2011). My influences and research processes are acknowledged throughout the study. There is no direct line management with my participant. The participant was informed of my

nursing roles before participating. Consent and study information was discussed before the interview. The participant had the opportunity to decline before starting the interview.

Triangulation is a method used to demonstrate credibility and Trustworthiness in this thesis. Using triangulation is a way to bring together the different data sources to compare/contrast and verify findings. Patton (2002) describes the four methods of triangulation as:

1. **Methodological triangulation:** Consistency checking of findings by comparing findings from different data sets; if different sources describe similarities, we can have greater confidence in the findings.
2. **Triangulation of sources:** Double-checking the consistency of the different sources of data collected within the same method
3. **Analyst triangulation:** The use of another analyst or multiple to review findings
4. **Perspective triangulation:** The use of multiple theories or perspectives to interpret data.

Transferability

Transferability refers to the extent to which the research findings can be transferred and used in other settings (Polit et al., 2012). To create transferability, the researcher needs to give a comprehensive description of the research's setting, transaction, and observed processes throughout the study (Polit et al., 2012). To attain transferability, I included thorough rich descriptions of the research and processes used so readers can decide if the findings resonate with their own experiences, aims, and objectives. Of course, qualitative research findings do not provide for every individual response. However, providing details of the processes and context studies allows readers to decide whether the findings are relevant to them, potentially useful for them, albeit if they have somewhat different circumstances.

Conclusion

The methodology section described the case study method and the underlying principles of Yin which guided the research process. This qualitative study used a semi-structured interview to collect data which was then analysed using thematic analysis following the six-step method of Braun & Clark (2006). Initial codes resulted in three significant themes to be discussed in the following chapter. Trustworthiness and credibility were strengthened by acknowledging researchers bias and experience as well as participant and supervisor double checking of transcript, themes and findings. Ethics and data storage have been discussed and

although ethics approval was not needed for this study, data storage is undertaken to ensure confidentiality is maintained.

Chapter 4: Findings

Introduction

This chapter presents the study's findings, by detailing one nurses experience of rural and remote nursing within the Australian context. The data findings are presented in themes which are interconnected; there are three main themes encompassing the smaller sub-themes. I generated a table to show the process of theme coding, subtheme identification and the generation of the main themes (see appendix 1). I have used the participants words to allow their words to illuminate and give meaning to the themes. The three main themes are: adapting, constantly preparing, and wellbeing and safety.

Participant

Leah (pseudonym) has been a nurse for 11 years with 6 years spent in Australia. Leah trained and started her career outside of Australia in one of the largest and busiest emergency departments in Australasia where she worked for 5 years giving her a solid foundation of emergency skills and experience. Leah began her journey by completing her Australian nursing registration and from there joined nursing agencies who helped her secure her first contract. Since this time Leah has worked in farming towns starting off in regional Australia and moving to rural and then remote. She has worked in 4 different states and now resides in Australia where she works as a contract nurse, undertaking remote contracts in communities with the most need. She is now mainly based in Northern Queensland and mainly works in the remote island of Queensland's Torres Strait of which she discusses her rationale in the below findings. To ensure confidentiality pseudonyms have been used and locations removed.

Adapting

The theme of adapting describes Leah's experiences of transitioning to rural and remote nursing as well as how she adapts to new environments, challenges and having to adapt her clinical practice. This theme encompassed smaller themes such as, having to be multi-skilled and multi-scoped, adjusting practice to suit the context, being out of depth and being able to manage change.

After a solid 5 years of being in the same ED she had seen other senior nurses go to Australia to do rural and remote contracts and they would come back to tell her their experiences prompting her to try it for herself.

> *"I had always thought about going but I think I had a romantic view about what it was versus what it actually is". "I always had the image of Alice Springs as the most outback place I had heard of, but in reality, it is really different".*

Leah recalls not knowing what to expect but took her first contract in a small farming town in a regional hospital and reports *"the change in scope of practice from [home county] and Australia was the biggest change"* she feels her background may have influenced this as she reports coming from such a large ED meant she had more autonomy such as standing orders for medications, ordering bloods and x-rays, plastering to name a few and was surprised this was not common in regional Australia. Leah talks about moving into rural and remote nursing to find more autonomy and get a team approach as she found *"Australia very restrictive in their nursing practice with nurses very much working under the doctor and not being able to do a lot of skills I undertook in [home country]".* With a solid ED background Leah describes the challenges of moving remote such as scope and working in areas outside of her comfort and skill base. She describes ego as a major challenge:

> *"Definitely ego was the biggest thing, I thought I knew it all coming from a big ED, I feel like I knew and had experienced a lot. Then you come remote and it's a whole different catchment of disease processes".*

Leah acknowledges that her experience in ED was relevant and was thankful to have worked in a poorer socioeconomic area as she was exposed to some common diseases seen in the outback.

> *"I was glad I had some experience with poor socioeconomic areas. The prevalence and types of diseases you see remotely are mainly associated with socioeconomic status and are so common out here, it's things you don't see in the city".*

Leah admits that *"I think coming from an acute background I definitely underestimated the primary health care approach and models".* Leah describes the level of responsibility that comes with remote and having to look after the needs of the whole community where it was not just the emergencies, she had to manage but the preventative care which is an area she needed to adapt her practice. Leah acknowledges that it is not only her skills that need to adapt but the way in which the skills need to be adapted to best suit the community.

"Depending on the community I can be doing only acute as there may be another GP service, or I have worked in places with barely any acute presentations, and it is all primary care which I have had to learn on the go".

Leah tells of her experience moving to the remote islands in the Torres Strait:

"As well as managing walk ins, I am also managing the programs going on; the Rheumatic heart disease (RHD, making sure we are up to date with everyone needing their bicellin injections. That we don't need to bring anyone in, no one is missed".

Working in smaller communities means Leah needed to adapt her knowledge and skills beyond emergency management, she talks of the comprehensive context that nurses must work in and details the need for nurses to have a wide scope and be multi-skilled. When discussing the level of responsibility Leah details some areas she has needed to adapt to:

"*Looking after the general health and wellbeing of the whole community across the lifespan, like immunisations, wound care, aged care, palliative care, maternity and antenatal while at the same time managing acutes and trying to assist in prevention and promotion to make people more autonomous in their own healthcare".*

Leah recalls the experience of working with poor access to other services

"I find the access to services really poor the more remote you go, especially mental health it is virtually non-existent" and *"after hours, it takes a lot to get someone on a telehealth conference. With women's health no one has been running the clinics during covid so there is a lot of women due STI checks, smears, implants, mirenas and all that sort of stuff, you are reliant on outreach clinics".*

Leah then goes on to explain the impact that lack of services has on the community:

"When they stop you get an unwell community. There are many things' nurses can step up and do and I will do things outside of my scope if safe but things like dental is very bad in these communities".

These stories not only highlight the isolation and lack of support nurses face they also show that nurses are the ones that are forced to step up and adapt to ensure the community's needs are met. Even though these skills were unfamiliar to Leah she acknowledges that she has learnt to adapt to the needs to of the community by stepping in to fill many shoes while being aware of the limitations of her scope. Leah describes adapting to many different areas and learning as she goes because there are different policies, requirements, and certifications state to state and

often she must use her own judgement as to whether she feels she is safe and competent to perform tasks.

> *"I am having to fill so many gaps where I am now, like here I am doing immunisations and I have done a lot of these in [home country] where I am certified, and I have done them in Australia with another nurse on a previous island but here I am the sole nurse". "I feel comfortable as I know the mechanics behind it but it's the actual schedules and certifications. It's adapting and triple checking yourself. The paperwork state to state is so frustrating, always changing and its why many people don't do the course or get signed off".*

This example demonstrates the need for nurses in remote areas to adapt to local policy as well as state requirements due to the fact there is no one set pathway and standardised certifications controlling remote area nurses Australia wide.

Leah reveals that being a remote nurse often involves *"being thrown in the deep end"* and being able to *"hit the ground running".* "*Island A was my first clinical nurse consultant (CNC) position and I turned up to no permanent staff only 1 casual nurse"* she describes a very poor orientation

> *"The causal nurses didn't really give me any guidance or orientation or any kind of anything. She left after a couple of days, so I basically hit the ground running". "I had to do all the on call, all the weekends"*

which she describes as stressful given she was *"trying to navigate a new environment that is busy and challenging".* She describes having to adapt quickly and learn on the job.

> *"I was treating it like a walk-in clinic and eventually I tried to then figure out how to manage the programs and clinics and being led by the other health workers".*

Leah believes that after working rural and remote for the last few years she now feels more confident and competent to adapt to the challenges remote nursing throws at her and has learnt to not have any expectations and "go with the flow".

Leah believes that you need to be "*flexible and adaptable*" but also that nurses need:

> "*Good skills and experience to back themselves up. It's one thing having the education and acronyms behind you but if you haven't got practical experience you will struggle".* She states, *"people out here get sick quick, and you are it, if you don't have the skills, you and the patient are in trouble"*.

Leah talks about the privilege of city hospitals and conversely describes the lack of support in remote areas. In an emergency there is not the luxury like in a large hospital where you have

multiple nurses, technicians and doctors all competent and trained to take on a variety of roles. Leah talks about having to adapt to suit the situation, she shares her experiences of dealing with emergency presentations:

> *"It can be me running the resus and if I have another nurse we can pick roles, we have telehealth where a doctor will dial in, but you don't get this everywhere you go". "Depending on what it is you are it. If there is a resus you must manage it until a doctor gets there and if its bad weather, the planes are down or doing something else you are stuck managing them for 12 hours".*

Leah talks about some of the perks for working remote and states *"flexibility and lifestyle"* are some of the positives that come from choosing to work remotely, however she acknowledges that because of the nature of rural and remote work she always goes into a contract *"not expecting anything"* she continues to say, *"nurses coming over need to adapt to the community and adjust expectations"*. She describes nurses as needing to be multi-scoped:

> "*You may have to be the taxi and ambulance driver, yes, you may need to check the shop and ask around for a patient you needed to see urgently 2 days ago and no, there is no letterbox numbers because everyone knows that John lives just around the bend with the mango tree at the front".*

Leah's description of expectations and adapting highlights how different nursing can be in remote areas and shows that nurses need to have a willingness to be flexible and not bring to many expectations with them.

Similarly, Leah talks about being culturally safe and explains why being able to adapt is crucial to developing rapport with the community:

> *"there's no cut and paste to Australia culture, there is so many tribes and languages that I try and wait till I am there. I rely on the staff to tell me about the people, history, and culture"* and *"I just go into every contract with an open mind, respect, and willingness to learn.*

Leah knows that to create the best health outcomes for the community she needs to work with them and provide care that is culturally appropriate and adapt to the context quickly. Leah sums this up by saying: "*I aim to work alongside instead of taking over".*

The theme adapting is a broad umbrella theme that encompasses not only Leah's journey into remote nursing but the ongoing adapting that aligns with the nature of nursing in remote areas. For Leah adapting started with adjusting expectations and recognising ego played an element in this. For Leah adapting meant being multiskilled and multipurpose; having to fill gaps, working

with poor access and services, and adjusting credentials for each state's requirements. Leah acknowledges cultural differences in practice and that cultural safety is something that you need to be respectful of, not make assumptions and be open to learning from others. Ultimately the theme of adapting to Leah is about being flexible, going with the flow and being able to hit the ground running.

Constantly preparing

The theme of constantly preparing was chosen as it encompassed a variety of subthemes that were presented in the interview. These other subthemes included preparing yourself, ensuring your practice is safe, education, preparing to change and being underprepared. The theme of constantly preparing illuminated many challenges and issues Leah faces working remotely and how she aims to cope with the unknown nature of remote nursing by preparing but ultimately Leah acknowledges that you cannot always be prepared for every situation and nursing in the outback involves continually learning and developing. *"It will be challenging, and you need to mentally prepare yourself and have good self-awareness".*

Working rural and remote as an agency nurse means Leah does contracts Australia wide and goes to where she is needed most. When asked how she prepares herself on arrival she states,

> *"I just look around everywhere, it sounds simple, but it is by doing the daily checks that I get familiar with things"*.

The frustration of moving from place to place and state to state is evident when Leah talks about completing checks

> *"The resus trolley should be standardised throughout Queensland but no matter where you go people will put different things in different places".*

When discussing practice development and opportunities Leah talks about how she has had doubts about working rural and remote and the opportunity to develop her practice and talks of having to self-motivate and prepare as no one will do it for you. Leah states there is no educator putting you on courses and not much pressure to do courses this means you have to do your own research and decide what courses are right for you. Leah states some courses are compulsory for most contracts such as

> *"of course, there is the ones the agency makes you do like ACLS [Advanced cardiac life support] but often the facilities are so short staffed some of the other courses become non-compulsory". "I've recently signed up to do my immunisation course and pharmacotherapeutics. I am paying for it, and I don't want to, but I have enough time and it's beneficial to my practice"*.

Leah talks about plenty of opportunities to develop and has taken the time to research her best options such as *"trauma courses" "REC [remote emergency care] and MEC [maternity emergency care] are good".* When asked for advice on education and professional development Leah states:

> *"Get the paperwork you feel you need for example if you know you lack maternity skills or you cannot suture. Invest in courses and skills you feel that you need to ensure your practice is safe".*

Being prepared encompasses preparing your practice and having a good awareness into your skill level, your boundaries and knowing these in the context of where you will be working. Leah encompasses this with *"know your scope and your skills, if you are by yourself will you be able to manage safely".* Leah describes having a range of experience before choosing to go remote :

> *"I had worked a few years in farming and mining towns, in regional areas and rural before going to remote. I knew the systems and knew I could do it".*

She talks of working in the Torres Strait Islands which are very remote with some closer to Papa New Guinea (PNG) than they are to mainland Australia. When asked if the Torres Strait is good for new to remote nurses Leah states: *"no I wouldn't recommend it. There are plenty of remote clinics that vary in size and resources".* Leah encourages people *to "do your research"* to prepare before accepting any contract.

> "*Get some experience at a larger facility where there are more nurses and a doctor so you can get a good grip on how things run, cultural changes, work and life expectations*".

Leah admits that with how short-staffed things are that more agencies have started to send poorly equipped nurses. *"I have been on the receiving end of getting agency nurses that haven't done it before and I think it's irresponsible".* She describes the nurse accepting the contract as "*not prepared at all*" and thinks

> "*They [new to remote nurses] need to figure out things at a larger facility, it's so different how things work up here with no doctors and no resources some experience at other bigger Queensland health clinics would help so much".*

She goes on to describe a nurse ready for the remoteness of the Torres Strait by saying

> *"If you have a good ED background and you've done some small clinics elsewhere, your passionate- that's the game changer. If you are not coming just for the money, if you are coming to get invested in the community and their health".*

Leah raises some points about being prepared to come in more ways than being physically and professionally ready, she feels it is important to be mentally ready for the responsibility and commitment:

> *"I think as a nurse you need to take some responsibility and make sure you aren't putting yourself or the community in danger. You can't have just done the paperwork or study, you need to have solid skills, be competent and have the right attitude".*

When discussing advice for new to remote nurses Leah recommends strong experience in emergency:

> *"Don't go rural and remote without making sure you have a solid ED base and can manage an emergency with little staff and no doctor".*

Leah has plenty of stories about times when she has had to manage emergency presentations solo or with little help, she states that "*indigenous communities are filled with unwell people"* these small communities still get people *"collapse, come in seizing, have horrific car accidents, get strokes and significant head injuries and children and babies with significant airway issues*". She describes working remotely *as*

> *"You never know what you will get, you must hit the ground running and be prepared for anything and everything including no orientation"*.

Leah talks about being on an island close to PNG *"I'm in Island B there's 400 people here, last week I was on island A where there is 900"*. She discussed no permanent staff and a poor 2-day orientation. Leah states a patient came in critically unwell from PNG and she needed to run the resus.

> *"I had been called in 3 times overnight there was no one else to cover". "The next day I get an unwell adult and they are having a heart attack and it's all hands-on deck, my two hands. I had other staff from the clinic, but they aren't nurses or doctors".*

Leah discussed practice development in the form of further courses related to pharmacology and immunisations. Leah is very passionate about the fact that ED experience is critical to ensure the safety of the community. On multiple occasions she draws on the idea that ED is critical to prepare for the transition to remote

> *"If you don't have the skills your kind of screwed", "you need to realise you are responsible for the care of the community". "You need to consolidate your knowledge and skills before you go somewhere where you are it".*

Another crucial aspect of constantly preparing is community context and ensuring your practice is culturally safe. Cultural differences are something a lot of nurses going remote need to prepare for, Leah admits to not being as prepared as she needed to be. When asked about preparing from a cultural perspective she states

> *"I investigated a little bit, it's a lot of learning when you get somewhere as everywhere is different. There are things I learned along the way like sorry business and how to behave when someone passes away, men's business and how the Aboriginal culture can be a lot more conservative and private".*

For Aboriginal and Torres Strait Islander people, the time of passing is very traumatic for family and friends of the deceased with the time before and after death being subject to several sacred customary practices (Queensland Health, 2015). In rural and remote areas, the whole community will experience grief and mourning, and business may shut down for a time out of respect for the loss. In Queensland alone there are over fifty Aboriginal language groups and two primary languages in the Torres Strait, therefore, a single hospital/health service may be accessed by several tribal groups, each with their own cultural practices, language, and a different view on caring for a person at the end-of-life stage (Queensland Health, 2015).

Leah recommends "*there are courses you can sign up to do to learn the basics and I wish I did that earlier"*. Leah shares a recent experience

> *"We had one of the well-respected elders pass away, we were managing him palliatively at home. I compared it to Māori culture where there were some similarities, but it was so different to anything I was used to. It was interesting to see that from a cultural perspective, like how people manage death at home, elders, and hierarchy".*

Leah remembers her first contracts and thinks about being unprepared for culture to play such a large role in her nursing practice, learning as you go is not the ideal situation if you can be better prepared you will enjoy the experience more and be able to provide better care. Leah recalls her first time in the Torres and learning new cultural norms:

> *"Eating dugong and turtle is common here in the Torres Strait and that was a culture shock for me. If I was offered it, and it was going to really offend someone if I didn't then I would eat it".*

For Leah she recommends

> *"Being as prepared as you can be. But at the end of the day, you're not going to know until you hit the ground running". "You must prepare for a real lifestyle change, a change in your attitude. I think be as prepared as you can be skill wise".*

Constantly preparing plays a major role in the life of a remote nurse and this theme embodies Leah's thoughts and views about nursing remotely in a holistic manner from preparing for the role to preparing while you are on contract. Education played a big role in this theme starting with educating yourself, becoming familiar with equipment and knowing your scope and limits. Learning from others particularly from a cultural perspective was discussed as Leah points out the importance of keeping an open mind and learning from local workers about the history and culture of a place given that *"there is no cut and paste to Australian culture".* Leah feels strongly that a solid ED skillset is crucial for working remote as you never know what you will get giving rise to the term 'constantly preparing' as in Leah's view this is an ongoing process where being prepared is never fully achievable.

Wellbeing and safety

The theme of wellbeing and safety was chosen as it covered a range of smaller subthemes that arose during the interview such as stress, support and needing support, violence, taking care of yourself, mental health, and wellbeing. This theme talks about these factors from a holistic point of view encompassing both the nurse's professional practice, mental, emotional, and social aspects of wellbeing.

From a professional perspective, Leah discussed some stressors that had negatively impacted on her experience. These mainly included poor management, poor rostering, and poor or inadequate staffing.

> *"I mean one of my contracts was incredibly challenging. Just being thrown in the deep end with very acute unwell patients, unfamiliar with their computer system and no clinical support or management support".*

Leah went on to talk of another contract where she discusses the professional stressors:

> *"One of my biggest challenges was in far north QLD on the mainland which is now a big reason of me working in the Torres Strait. It was a toxic culture and unsupportive management and unsafe practices in the department. I spoke up as much as I could. But at the end of the day, I'm agency and I was just ignored".*

Leah talks about this particular contract having multiple serious assessment codes (SAC) events.

> *"So, there was a SAC 1 I was involved with, a SAC 3 and another SAC. A SAC 1 is death and three is a severe illness. So, I struggled with the low standards of the management and the unsafe practices. And it was professionally a struggle".*

When recalling these incidences Leah reflects on working in certain areas and of never going back, she states:

> *"No way unless I found out something drastic had changed. It's not worth my registration or the stress. It takes a toll on your mental health when you are alone in these unfamiliar places with no support".*

Conversely, Leah also talks about the positives of working rural and remote *"for me the flexibility with the lifestyle is a plus"* and talks about the perks of working agency *"I do contracts so I work in the most needy communities which is really rewarding"* and *"I don't have to fight for annual leave or education allowances, I can come and go and do contracts that suit me and my plans*". Leah also reports perks being *"adventure and money"* but talks on multiple occasions of nurses needing to realise the isolation and lack of support when nursing remote:

> *"I think a lot of people look at it as an adventure and better pay-check, but you also need to realise that you're responsible for the care of that community". "Nurses wanting to go remote for a change of pace, they think it will be easier, more money but they lack skills to back them up. And these communities don't have any backup".*

This highlights the lack of support from a professional perspective.

Leah views violence and safety as one of the hardest aspects of working remotely when your community is your workplace, and you cannot leave it.

> "*I have felt unsafe in a few places and it's just unsettling and scary. You feel alone and your mental health, your sleep, your anxiety goes up and affects the time you have there personally and clinically".*

Leah shares some personal experiences of feeling unsafe in multiple places.

> "*On Island C (pseudonym), they have a massive problem with homebrew so it's just rioting every other day with aggressive drunk people coming to hospital for treatment". "At location D I had people trying to break into my accommodation most nights".*

When Leah was asked about how this was resolved she reports:

> *"At location D, I tried to escalate as much as possible. The police never took it seriously. They're an hour away in another location and they just tell you there is nothing they can do".*

When asked about support from management Leah describes "*management to a degree did, we got Q-build in to try and safety up the accommodation".* Leah reports that this often puts nurses off going to these communities as

> *"Nurses talk, agency nursing is small, there is Facebook pages where you can see reviews other nurses have left so it's an awesome way to review places before you go". "On Island A it's well documented, it's well known how dangerous it is there. And it's just being safe and staying off the streets during rioting. But I don't think management really do anything about it there and this really is a shame as staff won't go there." I won't go back and put myself in danger".*

Leah also illuminates the experience working rural and remote has on her personal life

> *"It can get lonely; I'm not super stressed a lot of the time and I do like my own time but when you've had a hard day there's no one really there*". *"If you have had a bad day there's no one to offload to, there's no one. A phone call is not the same as having a person there. And if you're having struggles with staff or whatever and you just need to unload, there's no one there*".

From this we can see that isolation is a major challenge. Leah also discusses the lack of support

> *"it's hard when no one has your back. You must fight your own battles and be an advocate for yourself. So, it's learning how to fight for yourself, even with your agency its learning how to advocate and speak for yourself eloquently enough to be heard".*

Leah is aware of wellbeing and reports *"taking care of yourself"* is a huge priority. In the beginning when I first started contract nursing *"I would only go to places with a gym. It's a mental health thing, especially when you're by yourself, it's nice to keep active and have your time"*. Now Leah enjoys mainly working on smaller islands as her home base is in the Torres strait it's not possible to get contracts with a gym but reports she feels the

> *"Community makes a huge difference, in terms of how welcoming and accepting. This is something that makes your job a whole lot easier and more enjoyable".*

Leah talks about coping with stressful or challenging situations and describes a particular case: *"while on the Torres, I had a case of domestic violence where a child was targeted, a baby. That was really shocking for me"* she acknowledges the normalisation of violence but that this was *"horrific"* and details her coping mechanisms*:*

> *"Trying to compress with other health professionals, because there's a lot, I don't tell my family or my partner because it's a different burden. If you don't have that callus of being in healthcare for so many years, sharing that can be distressing for them. It's just giving them the burden as opposed to offloading it with someone who will help you decompress it".*

She goes on to say *"I had a wine, made nice food, walking to clear my mind. Just talking is helpful, I know there is a bushland support number I haven't needed to call but it's nice to know that's there".* Leah talks a lot about acknowledging your feelings and being able to recognise when you need support.

> *"Nurses here need to have a lot of self-awareness not just about their clinical skills but about their wellbeing, their ability to cope with no supports and be honest with themselves about if remote is the best fit for them right now".*

Wellbeing and safety is a broad theme holistically encompassing many aspects of life for a remote nurse. From a professional point of view workplace issues such as poor rostering, staffing, management are all stressors. Theses factors went hand in hand with Leah feeling unsupported and thrown in the deep end. The issues of violence and feeling unsafe are aspects of remote nursing that Leah discussed and alongside geographical isolation she associates with mental health effects such as poor sleep, anxiety, and loneliness. Leah talks of taking care of yourself and strategies she uses to self-care. Leah draws on the fact that you need good self-awareness and resilience to even contemplate working in the remote environment both from a professional and personal perspective. Despite some negative aspects Leah also draws on the positives of working remote such as flexibility, lifestyle, rewarding and challenging your practice.

Summary

The purpose of this chapter is to describe the experiences as a nurse working in the rural and remote Australian context. Analysis of the data revealed that the experience of nursing in this area is associated with the themes: adapting, constantly preparing, and wellbeing and safety. It was my hope that this analysis would provide useful insight into the experiences of a remote nurse to assist others wishing to embark on a journey into rural and remote nursing. As discussed, there is an inherent feeling of not knowing and constantly preparing that comes with the isolation and remoteness of nursing in the outback. Due to the nature of working remote nurses need to be adaptable, to be prepared as much as possible and be wary of their practice, wellbeing, and safety. In the next chapter I will discuss the findings, the implications for practice and give advice to those considering remote nursing.

Chapter Five: Conclusion

Discussion

Theoretic propositions were created before collecting data, with the propositions guiding the study's direction, helping focus the collection of data, forming the conceptual foundation's structure, and finally direct the discussion areas that should be explored within the scope of the study (Yin, 2009). My propositions will be discussed below:

1.) **Nurses are influenced by economic, social, and political factors and their workplace/community context. These can lead to clinical issues that RANS will be exposed to, treat, and manage. (E.g., farming, mining, access, and availability of resources). These contextual factors will affect the personal and professional experience RANs have had, and therefore nurses' experiences are individual and multifactorial.**

Community context was discussed in the interview with Leah talking about how the community and its context affected her experiences and the type of nursing she undertook. Although this didn't dominate the discussion or generate a theme, it is heavily intertwined in the three main themes with community context impacting how Leah adapted and prepared as well as how the community impacted her wellbeing. Leah talks about under resourcing, geographical isolation, access, socioeconomic status, population (age, gender, culture), nursing scope and breadth (primary health care, nursing across the lifespan, multipurpose), cultural practices and violence and safety within the community. I believe this proposition was correct and expanded on in the interview.

2.) **Those new to remote nursing will come with various backgrounds and skills and will have to face several barriers and challenges that will influence their practice.**

I believe this proposition to be correct, Leah discusses her background and how this impacted her working remotely. Leah talks about having a solid ED skillset and that she faced several barriers including ego, needing to adjust her primary health care skills and education as well as needing to complete courses to ensure her practice was safe such as the MEC course. Leah also talks of coming from a large well-resourced ED and the challenges she found moving to a remote environment (multiskilled and multipurpose, under resourced, poor access, cultural differences, stress, and lack of support).

3.) **New to remote nurses have their own circumstances and reasons for moving into remote nursing, impacting their experiences.**

This proposition was not deeply explored in the interview although it was discussed. Leah discussed her reason for going remote such as adventure, money and flexibility which are also the main reasons she stays working remote alongside finding it rewarding and challenging. These factors do impact Leah's experiences as she believes it is not just about the experience and money and does believe that she wants to be the best nurse for the community and enjoys going to under serviced communities with the greatest need. Leah also expresses criticism to those who just do it for the money or who don't have the experience to back them up and are coming remote for the wrong reasons such as

> *"If you have a good ED background and you've done some small clinics elsewhere, your passionate- that's the game changer. If you are not coming just for the money, if you are coming to get invested in the community and their health".*

This proposition was not a large component of the interview with Leah touching on some of her personal reasons. I believe further exploration is needed with a larger population.

In the previous chapter the experience of a nurse working remote was explored and represented in themes that reveal the essential parts of the phenomenon. This final chapter discusses the discoveries made throughout this research journey piecing them together alongside existing literature to provide guidance for those seeking to work remotely and for those that are involved in hiring new to remote nurses.

Adapting

Adapting was revealed as being one of the central parts of being a remote area nurse. This finding was in line with other studies which discuss remote nurses as being "multiskilled" and often having to take on roles and responsibilities of other health professionals especially doctors (Muirhead, 2020). In exploring the unpredictable nature of remote nursing; it is found that nurses are expected to assume the roles needed (Greene & Burley, 2006; Hegney, 1997) as well as "be the right" nurse for the job with skills needed not only clinically, culturally and nurse able to cope in solo situations (Dunbar et al, 2019; Muirhead, 2020). Leah normalises adapting throughout the interview by acknowledging that things are out of her scope, but she accepts this is the way things are: "I will do things outside of my scope if safe***".*** Leah suggests that the experience of working in remote is one of "going with the flow", "being thrown in the deep end" and being able to "hit the ground running".

Several authors established that RANs roles require flexibility to cater to the community's context and needs (Al-Motlaq et al., 2010; Cathryn et al., 2017; Taylor et al., 2013). The interview findings correspond with this with Leah discussing the socioeconomic determinants of health and chronic disease patterns in Torres Strait Island and Aboriginal communities influence the roles and scope of RANs. Leah discusses ego, adjusting her expectations and adding primary health to her skillset to work in the remote contexts. RANs work in prevention and health promotion alongside chronic disease management and emergency/acute presentations (Cathryn et al., 2017; Taylor et al., 2013; Twigg et al., 2016). This is something Leah had to adapt to as an ED trained nurse with little knowledge and primary health experience.

Leah emphasises the fact that nurses are often the first point of contact with remote communities having no other onsite medical services, therefore, RANs take on multiple roles and need to work autonomously. The literature review saw many authors found RANs needing to multi-skilled and multi-purpose whereas the interview data saw Leah viewing this as more of a process from her experience where she felt nurses needed to adapt. Adapt to the community, adapt your expectations, adapt your practice and being able to be flexible. While the theme adapting did cover adapting your practice to be multi-skilled and multi-purpose; the interview gave a more holistic view about what this meant and looked like from Leah's experience. The literature did aim to define the breadth in scope such as Francis et al (2016) who states nurses are the paramedic, doctor replacement, transport system, mental health worker, social worker, etc. While others acknowledge the nurses need to adapt their scope; Working in unique environments demands a large amount of responsibility where nurses are pushed to their limits trying to provide care with scarce resources and help resulting in RANs working beyond their scope of practice (Francis et al., 2016; Stockton et al., 2021; Whiteing et al., 2021).

The theme of adapting was a large theme that reflected the nature of the remote context and how Leah adjusts to it. The interview data discusses more of the lived experience of a nurse which gives valuable insights for those looking to work remotely. Recognising and letting go of ego, adjusting expectations, being multiskilled/multipurpose, filling gaps, adapting to new areas, cultural adjustments and being flexible are all crucial parts of this theme that illuminate Leah's experience and journey of being a RAN.

Constantly preparing

This important thematic finding describes how Leah views the nature of remote nursing as a constant process of preparing but never being able to achieve being 100% prepared. The feeling of always being on the edge and never truly knowing what you are going to get is central to this theme and to Leah's experience of how she experiences nursing in the remote context. The theme of constantly preparing was found in the literature however, when comparing interview findings to the literature review, I found Leah's experience was much more focussed on being prepared and the heightened state of having to be constantly ready. The literature review revealed that the current literature focused more on being underprepared, how to prepare and expectations of remote nurses in terms of education, scope, and requirements for RANs.

The literature review found a common theme of nurses being multi-skilled and multipurpose which aligns with the interview findings. Birks et al (2010) and Lenthall et al (2011) state the preparation for RANs must be in line with a generalist role and requires both advanced clinical and management skills. This finding is in keeping with the study by Whiteing et al (2021) which reported nurses feeling underprepared and out of their depth working across multiple lifespan groups and specialties they are not practiced in. This reflects the experience of Leah who reported filling gaps of other health professionals and working outside her scope to ensure the needs of the community were met. Although RNs often reported feeling unprepared for the role, many studies found that they still filled the positions to meet the community's needs (Al-Motlaq et al., 2010; Cathryn et al., 2017; Coyle et al., 2010). The findings from the interview echo this feeling of being underprepared and doing it anyway.

Within this study, Leah aimed to articulate what it was to be a RAN and how she experiences working remotely. Within this Leah describes important aspects of how she prepared and continues to prepare for this work. Leah starts with a solid foundation of working in ED which she believes is a non-negotiable prerequisite to working remotely. This aligns with research as the literature is clear RANs need to manage prevention and health promotion alongside chronic disease management and emergency/acute presentations (Cathryn et al., 2017; Taylor et al., 2013; Twigg et al., 2016). Next Leah talks about being prepared by undertaking education whether it is on a basic level of familiarising herself with resus equipment to choosing courses she believes will improve her practice. This involves a strong degree of self awareness into your practice and being honest with yourself about if you are safe to practice in the remote environment. Currently, there is no regulation for preparing RANs; few possess specialty qualifications and face considerable barriers to gaining them (Francis et al., 2016; Wakerman et al., 2019).

Leah talks of education as a constant process of learning, due to the nature of RAN and the high population of indigenous people in remote Australia; RANs not only need to be clinically competent; but practice in a culturally safe manner. Leah believes that courses can help prepare you, however learning from others, keeping an open mind, and taking direction from the locals is a good way to ensure your practice is culturally safe and in line with what is right for that specific community. The literature also highlighted that RANs must be aware of differences in social norms, gender roles, language, religious and spiritual practices, and values and beliefs related to health and illness (Quinn et al., 2015). In choosing to undertake case study research I have been able to unlock the lived experiences of a RAN and I believe this has given a more in-depth look into every aspect of life as a RAN from preparing, maintaining, and managing both professional and personally.

Wellbeing and safety

The adverse effects on health and wellbeing on nurses working in rural and remote areas have been well documented within the literature. Leah addresses many issues in the interview with the theme of wellbeing and safety encompassing many subthemes. The geographical isolation of remote nursing is a major catalyst for issues such as poor access, resources, feeling alone, stress and lack of support. However, there are other major issues that need further research such as poor management, safety, violence, and mental health concerns that are more prevalent in remote areas. Increasing rates of violence towards nurses regardless of location or country have been reported for a long time (Ramacciati & Giusti, 2020; Gabrovec, 2017). Violence towards rural and remote nurses is less frequently researched and where research does exist it focuses on remote area nurses, often working as sole practitioners. Research carried out amongst remote area nurses raised the issue of increasing and alarming levels of violence (McCullough, Lenthall, Williams & Andrew, 2012; McCullough, Williams & Lenthall, 2012; Opie et al., 2010b) and made recommendations at individual, environmental, organisational and community levels to address the ongoing problem (Lenthall et al., 2018). Despite these recommendations nurses are still facing verbal and physical abuse from patients and community members.

The findings of this study align with findings from the literature review which suggest the experience of violence, safety and wellbeing is multi-faceted and the experience and effects of these effect the nurse in many ways on both a personal and professional level. For Leah she talks about feeling unsafe in some communities where she has experienced break ins, riots, and abuse. In turn these factors go on to influence the community as Leah reports future nurses may not wish to work in places with known safety concerns. The theme 'wellbeing and safety' is central to how a nurse experiences working remotely. For Leah this is a huge aspect of remote

nursing that has positive and negative effects on both her professional and personal life. Leah discusses professional stressors from her experience of working remotely such as poor management, unsafe staffing and practices, toxic culture, no support, and poor orientation. Leah also discusses her personal life and mental health with stress, poor sleep, anxiety, and violence all contributing negatively to her wellbeing.

Despite the above negative experiences Leah does highlight some positives of working in the rural and remote environment. For Leah she enjoys the flexibility and lifestyle of working contracts. Alongside this a big part of her staying as a RAN stems from challenging her practice and that it is rewarding. Leah enjoys working where there is a greater need and making a difference in the lives of the community. A crucial aspect of working remote is taking care of yourself, this is addressed by Leah who gives advice on debriefing, taking time out to enjoy the things you like e.g., food, wine, walking and exercise. Leah raises good points about nurses becoming normalised to violence and trauma and this is something that can be highlighted when working remote due to the isolation and loneliness as well as the lack of support from other health professionals, management, and police. Wellbeing and safety were discussed in literature with a greater emphasis on violence and safety. Wellbeing and mental health are not well enough researched and I believe this study provides an insight into how a nurse experiences these aspects, which gives a more thorough picture of life as a RAN. I believe this will help future nurses and employers be illuminated as to the experiences of a RAN from a holistic point of view.

In summary, I have argued that adapting, constantly preparing and wellbeing and safety, collectively provides a different and deeper insight of how a nurse experiences working in the rural and remote context of Australia than has been previously articulated in the literature.

Advice to nurses new to rural and remote nursing

From analysing the literature and interview findings, I now offer advice to nurses who may be contemplating taking on a remote nursing role.

Define your role

Know your skill and comfort level to define your scope of practice. Be clear within yourself with what you are comfortable doing and identify what your boundaries are. Let your employer and colleagues know what these are. This will allow you to accept your practice and/or create further discussion around further education and upskilling. Reach an understanding with colleagues, employers, and management about realistic expectations of the job so you can safely manage your practice as well as your role as part of the wider team.

Education

Make sure you are aware of courses that are mandatory from your employer to ensure your practice is safe and indemnity insurance will cover your practice. Be aware of courses that you feel will add value to you and your practice by evaluating your skills, practice and how confident you are with certain skills or areas. Ensure you educate yourself about the community before you enter to ensure culturally safe practice and that you are physical prepared. When you arrive to the workplace educate yourself on the policies, procedures, emergency equipment, common presentations, and general orientation. Education goes hand in hand with defining your role and having good self-awareness.

Self-awareness

Before accepting a remote nursing position, be mindful of the isolated nature of the role and the challenges professionally and mentally that accompany it. Consider that you may be required to do a large amount of on-call work and may need to deal with an emergency at any time. Evaluate your suitability, resilience and previous experience that may prepare you for a role such as this.

Support

Based on the study's findings I would advise nurses new to remote nursing to ensure they have adequately researched remote nursing and have a way to keep in touch with other nursing professionals who can be used as a source of support. Resources could include agency nursing groups, rural and remote nursing pages on Facebook or nurses that are part of your social network. Debriefing is a crucial aspect of rural and remote nursing, it allows you to reflect, process and provides mental and emotional support. Ensure that you know where to seek

support and help for each place of work should you need this in an emergency (such as important numbers, security, police, management, charge nurse number). Also be aware of national numbers such as Crana Bush Support Line: 1800 805 391, which is a high quality, free, confidential, 24/7 telephone support line for the current and emerging rural and remote health workforce, and their families.

Equipment

Know your equipment. In any facility you are working in it is crucial to know your equipment and surroundings to maximise your preparedness.

Advice to employers

Employers carry the responsibility of hiring suitable nurse's, therefore it is in their best interest to be mindful of considerations relating to both hiring and working with the nurse.

Discuss scope of practice

Based on the results of the study I would advise employers to have honest discussions with potential nurses about their scope of practice. An environment of shared understanding and respect will create openness and allow trust to develop. Having knowledge of a futures nurse's capabilities, expertise and weaknesses enables the employer to form a trust over the nurse's ability to make decisions and provide safe care. It also allows for the employer to assist where needed such as providing extra training, education, or support and how the nurse can best be integrated into the existing team.

Be conscious of personal characteristics needed

Nursing in the remote context is very different to nursing in regional or metro-based hospital settings. It is important for employers to be mindful of this difference and understand how this geographical difference impacts not only the clinical environment but can have more holistic effects for those new to remote. It is important this information is shared with new employees so that they have some perspective about their role in its entirety. Further to this it is wise for employers to determine if the applicant is prepared and appropriate for the role and can safely accept the responsibility of being the sole nurse including being on call in an emergency.

Reflections:

My personal research journey has been an experience of learning, frustration, and acceptance, fuelled by a great passion for nursing in the remote areas of Australia. Exploring the experiences of a nurse who works remotely has gathered meaning in the three themes that emerged from the interview. Choosing to use the case study methodology was not straightforward for me as it was a research methodology I had not studied or had experience with, and it is not widely used. This provided me with a challenge as I struggled to understand a qualitative methodological approach that has no set guidelines. I also started this journey at a time of covid lockdowns in NZ, the works of seminal researchers of case study design Stake, Yin and Merriam were difficult to access without library access in these lockdowns. Alongside the methodological challenges I did not have much experience with researcher interviews and as a nurse, I have grown accustomed to acknowledging and reshaping what people say to encourage their participation and confirm my understanding of their views. My supervisor encouraged me to use open ended indicative questioning and not direct or influence the interviewee on what to discuss. I had formed some questions but started with something open: "tell me how you got into RAN nursing". I found it was a learning process to make my participant feel at ease and carry out my role as an active interviewer, all while granting the participant to verbalise their own opinions. Next time I would spend more time listening to other research interviews to gain more experience and ask for advice earlier from my supervisors, so I felt more confident.

Limitations of the study

This research was carried out for a dissertation that aids in completing the Master of Health Science degree, as such this thesis was subject to time and size restraints. The research exemplifies one nurses experiences, to gain a greater understanding of how nurses experience remote nursing more participants would be useful. The findings are not able to be generalised to all nurses or other settings as this is a qualitative research project that aimed to gather the opinions and experience of one nurse. Due to the researcher having experience as a remote nurse, I have views and experiences that could have influenced the findings, my strategies for reducing bias are discussed in the methodology section. I used the voice, stories, and words from the participant Leah to ensure the findings and themes created were developed from her own words and views not my own.

Further research

Involving more participants in this study would have allowed for a wider range of insights into how nurses experience rural and remote nursing in Australia. It may also be beneficial to then compare these with other nursing roles that involve working in isolated environments as this could lead to the development of insights about the differences and similarities between nursing roles in a variety of remote/isolated contexts. A further recommendation for future research would be input from managers and employers to gather their experiences of working with nurses in remote Australia. This may help to better establish the role of the nurse in remote contexts and create understandings about challenges and problems that exist and how these can be better managed.

Recommendations for practice and education

The findings of this study are important suggestions for practice, particularly in the areas of education, support and being prepared. After completing this thesis, I understand there is a need for standardised education and protocols across all the states. A difficulty remote area nurses face is that each state has its own requirements for education and thus nurses qualified to give immunisations in one state will not have the required certificate in another state where a different course is accepted. A standardised pathway for common courses and education would assist in keeping nurses up to date and ensuring nurses can move more easily between states while keeping the same level of practice and autonomy. There may be a knowledge gap for those new to remote who have skills but lack experience when moving to more remote contexts. It is hard to get experience without having a go and getting this in a more supported environment would benefit those considering the leap into remote areas. Again, it would be beneficial if the health services were coordinated and standardised, however this is currently not the case in Australia with multiple states and differences in services and how things operate within the same state. Systemic change is needed at a higher level which is challenging. It would be good to see an Australia wide recognised remote area postgraduate certificate or course that focuses on the remote context including clinical decision making, autonomy in practice, emergency and maternity management and other skills that come with the remote environment such as suturing, immunisation, pharmacology.

Conclusion

This study has examined the experience of a nurse working in rural and remote Australia. The participants stories and experiences have revealed what it is to be a RAN and how this impacts you from a professional and personal point of view. Being a RAN differs drastically from other types of nursing and is a unique autonomous form of nursing where nurses are pushed to be working at the top of their scope and beyond and mentally pushed and resilience tested. The challenges and rewards that come from nursing in such contexts are explored and this provides a good insight to those exploring the idea of nursing in Australia's rural and remote areas. The themes that arouse from the interview: adapting, constantly preparing and wellbeing and safety aim to provide an overall picture about how a nurse experiences every aspect of remote nursing. The findings of the study revealed that the remote environment is multi-faceted with roles and responsibilities that vary based on the context and what each service requires. This requires RANs to be multiskilled, adaptable, constantly prepared, and willing to fill the gaps. The nurse works across all areas of the lifespan in all roles from preventative, management, palliative, and emergency care. The advice to new nurses and employers is developed from the literature review and interview data. The advice from Leah of having solid ED skills, having good self-awareness, knowing your scope and competency as well as being able to be flexible and adaptable embodies what is needed to even consider remote nursing work.

Appendices

Appendix 1: Indicative Interview Questions

These are sample indicative interview questions I used as a guide to direct topics; however, I wanted the questions to be open ended and flow from the participants answers as to not direct the participant towards answers I expected to hear.

The only planned question I used were these open-ended introductory questions:

"Tell me about how you got into RAN nursing" and "could you tell me your story about RAN and how it has been for you"?

From here I let the interview flow to enable the interviewee to give the information free from influence. This allowed the conversation to flow around barriers and surprises.

Further indicative topics and questions that I used to guide myself are detailed below:

- Initial expectations of working rural and remote?
- Communities you have worked e.g., mining, agriculture, Indigenous
- Community/ context effect experience practice
- Main clinical roles and responsibilities
- What does a typical day look like for you working remote?
- resources and staffing to manage patient presentations at any time.
- Your biggest challenge to working in rural and remote nursing?
- What motivates you to continue to work in rural and/or remote nursing?
- learning curve or obstacles
- Tell me about a time when you have felt underprepared or unsupported?
- Safety/violence/drug and alcohol
- Professionally and/or personal challenges
- What are your top recommendations to those that are wanting to try remote nursing?
- Favourite aspects of rural and remote nursing?
- Stress and how do you cope/manage?
- What experience/skills do you think are needed before heading rural and remote?
- Scope of practice
- Education
- Professional development opportunities
- Do you do any checks or have any requirements before committing to a placement?
- Difficult presentation or situations
- Are there any skills and/or courses that you feel you would personally benefit from or that you think RNs working in rural and/or remote locations should have?
- Do you have any advice to those thinking of nursing in remote areas?

Appendix 2: Thematic analysis and coding table

Theme	Sub-theme	Interview data
Adapting		
	Multi-scope	- No clinics running (women's clinic, dental), community overdue STI checks, smears, contraception. - No immunisation nurse- needing to work outside scope - Different roles and responsibilities compared to hospital she trained at - Sole practitioner filling the gaps to ensure health needs are met as best they can
	Multi-purpose	- Managing acute walk ins as well as programs - Taking care of the community across the lifespan like Immunisations, wound care, palliative - Trying to prevent and promote - Make people more autonomous in their healthcare
	Adjusting practice	- Ego. "I feel like I knew it all coming from a big ED" - Whole different catchment of diseases to learn about/manage - Needing primary health care alongside ED - Sole practitioner- needing to do the job of others even if not competent
	Out of scope/depth	- Sole practitioner - No doctors or other health professionals - Managing a resus until someone else can get there. - Doing jobs of others even though unskilled - "If you don't do it no one will". - Not being signed off but doing things within reason e.g., immunisations not dental.
	Expectations	- "If you don't have the skills, you're in trouble" - Expected to fill gaps - Expected to be able to do on calls, in charge, manage without a doctor - "Have an open mind, don't go in with any expectations" - "don't expect luxury accommodation" - Expect things to be very different e.g., food, accommodation, lifestyle, access, expenses.
	Managing change	- "it's adapting and triple checking - Paperwork is always changing state to state - "If it's bad weather or the planes go down you are stuck managing a resus for 12 hours plus" - "You never know what you will get, you must hit the ground running and be prepared for anything and everything.
	Poor access	- Access to services poor the more remote you go - After hours it takes a lot to get someone on telehealth conference. - No clinics running - Covid worsening shortages - Geographical isolation - Plane delays, staffing delays, weather delays. "You could be managing a resus for 12 hours"
Constantly preparing		
	Yourself	- Getting the education, you feel you need - Self-awareness of skills and abilities - Familiarising to place and equipment - Responsible for your own practice and education. - "Take some responsibility and make sure you aren't putting yourself or the community in danger". - "Be prepared for a real lifestyle change, a change in your attitude" - "Be as prepared as you can skills wise"
	Safe practice	- Cultural safety and being culturally aware and respectful - Having the right skills and experience for the context - Poor staffing

		- "Unsafe practices in the department" - "You can't just have done the study; you need to have solid skills and be competent" - No orientation
	Education	- Familiarising yourself to equipment - Room to develop- trauma courses, MEC and REC emergency courses - Indigenous study - Educate yourself about the town and history. - Learn from others. - Cultural practices and appropriate attire/behaviour - Choosing education to keep or acquire skills - Paying for your own education - Flexibility to study - Need the experience not just the education or "acronyms" - Researching places using social media before committing to a contract. - Cultural norms if the place you're visiting. "Eating dugong and turtle" - Seeing the staff as a valuable source of information - Being taught by the staff and indigenous health workers - "Get the paperwork you feel you need". "Invest in courses and skills to keep your practice safe.
	Preparing to change	- Fighting your own battles - Being an advocate for yourself. "It's just learning how to advocate and speak for yourself". - "Having the right motives for going remote". - "Keeping an open mind and being open to changing your practice" - "there's no cut and paste to Australia culture". "Keeping an open mind, respect and willingness to learn from others". - "It will be challenging, and you need to mentally prepare yourself and have good self-awareness"
	Underprepared	- "I definitely underestimated the primary health approach and models" - Ego- "I felt like I knew it all" - Different disease catchment - Poor or no orientation - "Thrown in the deep end" - Not knowing what will come in the door - Needing to "hit the ground running"
Wellbeing and safety		
	Stress	- "Professionally, it [management] was a struggle" - Not knowing what is coming next - "It's not worth my registration or the stress". - Mental health issues related to sleep, anxiety, and feeling alone. - Feeling "rundown" - Stress related to isolation, pandemic, management, and poor support. - "Stressing that I'm on call"
	Support	- "You are it"- no doctors or allied health professionals - "No clinical support" - "No management support" - Poor support as an agency nurse because "you will be gone soon". - "Being ignored" when speaking up - Police far away- no backup or safety net.
	Violence	- Abuse- "aggressive drunk people coming to the hospital" - Alcohol and drugs - Not feeling safe - Accommodation unsafe - Riots - "Unsettling and scary"

		- Police far away- "nothing they can do" - "I won't go back and put myself in danger".
	Taking care of yourself	- Gym and exercise - Going on walks - Debriefing with colleagues - Having a glass of wine - Good food - "There is more money to be earnt in rural and remote and I think for a lot of people this is a big factor in deciding to try it out" - "decompressing" - Crana bush support phone line - Self-care can't replace poor staffing and resourcing
	Mental health	- "It takes a toll on your mental health when you are alone in these unfamiliar places" - Isolated from friends and family - Good flexibility and lifestyle - Feeling like you are "making a difference in the community". - Abuse and violence - Domestic violence and non-accidental injuries- needing to "decompress" with other nurses. - Not feeling safe in the community - "You feel really and your mental health, your sleep, your anxiety goes up" - "You need to mentally prepare yourself and have good self-awareness" - "Callous of being in healthcare" and "normalising" violence and trauma. "Realise later that they really impacted you".
	Management/policies	- Different states having different paperwork and requirements - Poor management and support from management - "Toxic culture with unsupportive management and unsafe practices in the department". - "I struggled with the low standards of management and the unsafe practices"
	Community context	- Welcoming - Grateful to have you there - Aware of short staffing - Socioeconomic factors - Farming, mining, and indigenous communities. Socioeconomic, age of the population and common presentations. - Access to other services dependant on geographical context and socioeconomic factors. - Crime and violence/not feeling safe in accommodation and at work - Outer islands in the Torres Strait versus mainland- more welcoming in the islands and less abuse - On call 24/7. "Not wanting to destroy their trust".
	Work environment	- Toxic work culture - Poor staffing - Under resourced - No clinical support - SAC and "being ignored" when speaking up - Live where you work- being on call 24/7 - "If I don't answer the phone, someone's going to come to the house". - No orientation

Figure 3:Thematic analysis and coding table

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