



PALLIATIVE CARE BY NURSES **IN RURAL AND REMOTE PRACTICE**

An Evaluation Report **Queensland Health Southern Zone**

John Rosenberg RN BN GDNsg(PallCare) MPallC MRCNA
Research Officer

Debbie Canning RN OncCert GDNsg(PallCare) MNsgLeadership
Director of Education

Centre for Palliative Care Research and Education
Floor B, Block 9
Royal Brisbane and Women's Hospital
Herston 4029 Queensland

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EXECUTIVE SUMMARY

The practice of palliative care in rural and remote communities is a tremendous challenge to nurses who contend with geographical and professional isolation. Nurses providing palliative care in these communities are typically in diverse roles, have occasional – rather than frequent – palliative care clients, and have limited access to resources. Opportunities for networking and professional development are constrained by distance, staffing difficulties, and the often-prohibitive costs involved in travel to educational events.

In 2000, Queensland Health [QH] Southern Zone Management Unit [SZMU] produced its *Palliative Care Services Plan 2000 – 2005*. Its aim was to provide a broad strategic direction for the development of strategies and structures that ensure:

- sufficient palliative care service capacity;
- appropriate location of services;
- high quality service delivery;
- effective service links and clinical networks; and,
- adequate resources.

The Plan identifies the need for the establishment of intra- and inter-zonal networks; access to specialist of higher level advice and services, and identification of workforce and educational needs.

With this in mind, the Centre for Palliative Care Research and Education [CPCRE] was approached by SZMU staff and asked to assist them in their attempts to meet the needs of its isolated palliative care nurse providers through a two-day workshop. This event took place in Warwick in late October 2002 and was attended by 31 nurses rural and remote districts in Queensland's south-west.

Participants' responses regarding the workshop, professional development networking and peer support were retrospectively evaluated using a mixed method questionnaire comprising a 23-item, four-point Likert scale and twelve open-ended questions to obtain descriptive data. With a response rate of 55%, data were statistically and thematically analysed.

The results of this evaluation demonstrated congruence between the challenges faced by this group of nurses and those reported in the literature. These nurses identified the importance of professional development and peer networking as integral parts of their work, which enhanced their potential as rural and remote palliative care providers. This benefit was linked to client outcomes, best illustrated by this respondent who indicated her potential would be realised when:

“...I can see the client is comfortable, pain free, when I can see that their family are [sic] content with the care, respect and dignity that their loved one is receiving.”

RECOMMENDATIONS

1. A comprehensive needs analysis of professional development requirements in end-of-life care for nurses in rural and remote practice is indicated.
2. Development of context-specific professional development activities for rural and remote nurses is fundamental. This target group's endorsement of these activities should be sought.
3. Development of accessible and affordable modes of education delivery is required, which address the identified barriers to professional development in rural and remote communities.
4. Consideration of the establishment of a self-sustaining peer-support network, which is supported by Government and non-Government health care providers, similar to that used in New South Wales and more recently launched in QH Central Zone.
5. Enhance professional development through improved library access or retrieval skills supported by employer-sponsored time to access electronic information.
6. Exploration of formalised palliative care clinical placement opportunities, which address the specific characteristics and needs of nurses in rural and remote practice.

INTRODUCTION

The practice of palliative care in rural and remote communities is a tremendous challenge to nurses who contend with geographical and professional isolation. Nurses providing palliative care in these communities are typically in diverse roles, have occasional – rather than frequent – palliative care clients, and have limited access to resources. Opportunities for networking and professional development are constrained by distance, staffing difficulties, and the often-prohibitive costs involved in travel to educational events. This paper aims to describe experiences of a group of rural and remote nurses involved in the delivery of palliative care and discuss the implications of these accounts for the development and implementation of strategies that support nurses providing palliative care in rural and remote settings.

In 2000, Queensland Health's SZMU produced its *Palliative Care Services Plan 2000 – 2005*. Its aim was to provide a broad strategic direction for the development of strategies and structures that ensure:

- sufficient palliative care service capacity;
- appropriate location of services;
- high quality service delivery;
- effective service links and clinical networks; and,
- adequate resources.

The Plan identifies the need for the establishment of intra- and inter-zonal networks, access to specialist of higher level advice and services, and identification of workforce and educational needs.

With this in mind, CPCRE was approached by SZMU staff and asked to assist them in their attempts to meet the needs of its isolated palliative care nurse providers through a two-day workshop. This event took place in Warwick in late October, 2002 and was attended by 31 nurses from rural and remote districts in Queensland's south-west.

AIMS

This project sought to explore the perceptions of rural and remote registered nurses who provide palliative care in the Queensland Health Southern Zone, about:

- the importance of core concepts in networking and professional development as described in the literature;
- the effectiveness of the workshop held in October 2002 in addressing these key concepts; and,
- the strategies for sustaining appropriate levels of ongoing networking and professional development that will limit the negative impacts of geographical and professional isolation, enhance peer support, and promote a network of peers support within and between districts.

In particular, the survey hoped to identify strategies that could be trialed and implemented by Queensland Health to assist this population of health professionals in their attempts to deliver high quality palliative care despite the professional and geographical challenges.

OBJECTIVES

This project addressed these aims by:

1. reviewing the literature regarding the issues around networking and professional development, rural and remote nursing, and palliative care;
2. identifying the core concepts relating to the place of networking and professional development in palliative care nursing in rural and remote areas;
3. constructing a survey tool which elicits both quantitative and qualitative data regarding these issues;
4. distributing the survey to attendees of the workshop held in October 2002; and,
5. collating and analysing the data collected to make recommendations relating to the project aims described.

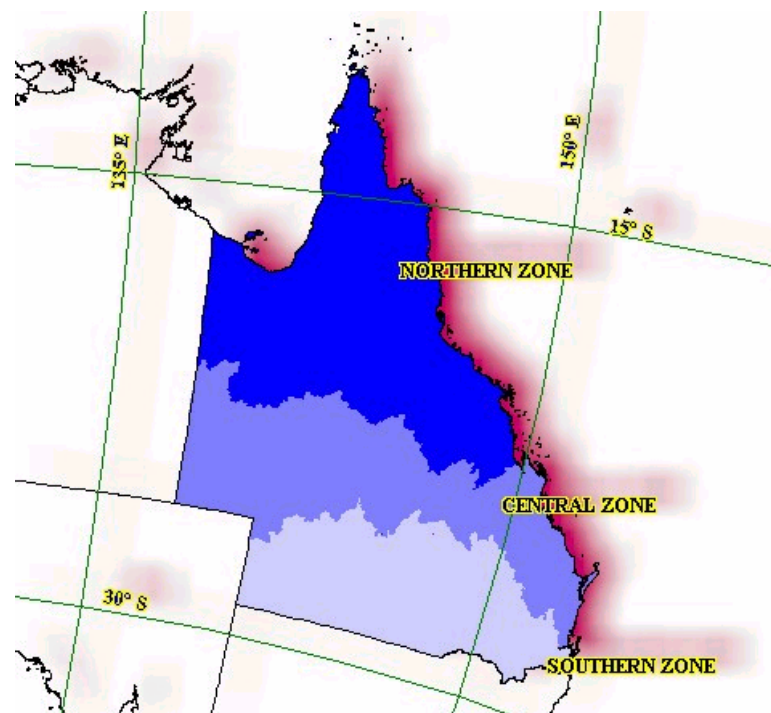
ANTICIPATED BENEFITS

1. Provide data to the SZMU personnel of possible strategies to employ in the support and development of their rural and remote nursing staff towards provision of palliative care; and,
2. Potentially lead to a more comprehensive study across Queensland utilising research grant monies.

BACKGROUND

Queensland is one of the largest states in Australia, with a substantial area designated as rural and remote. Queensland Health is the State department charged to oversee the government health care system. To assist the department in the operationalisation of its health care strategies, the State's Health Districts have been divided geographically into three Zones – Southern, Central, and Northern – with each Zone being administered by a Zonal Management Unit. Each Zone takes in densely populated metropolitan and regional centres, and significantly remote and low-population areas, extending from the eastern coast westward as far as the Northern Territory/South Australian borders (see Figure 1 below).

Figure 1: Queensland Health Zones



The Southern Zone is made up of ten Health Districts, including four that are designated rural or remote areas. Notably, differing models of palliative care delivery are in use in each of the district health services within Southern Zone, as well as across Queensland's three Zones.

The SZMU sponsored the inaugural two-day workshop in 2001 for nurses practising palliative care in the four main rural and remote Health Districts. The event was held in the regional centre of Dalby, and aimed to give the nurses an opportunity

to network, pool ideas, share problems, and take advantage of a professional development program.

In 2002, the SZMU invited CPCRE to participate in the planning and implementation of the second rural and remote palliative care workshop. With a similar format to the first, this workshop was held in October 2002 near the regional town of Warwick.

LITERATURE REVIEW

The **characteristics** of rural and remote health care practice have been variously described in the literature. Importantly, these features are experienced by a range of practitioners and across a number of clinical areas; consequently, there is some transferability of these descriptions to the experiences of rural and remote palliative care nursing. Indeed, the benefits of shared knowledge and expertise between rural and urban allied health professionals (Parkin *et al*, 2001) and GPs (McConigley *et al*, 2000) has been demonstrated.

Geographical isolation is, not surprisingly, identified as the key influence upon the provision of care in rural and remote settings (McCarthy & Hegney in Aranda & O'Connor, 2001), which underpins the character of palliative care nursing in these settings.

A defining feature of rural and remote nursing practice is that of *role diversity*, where nurses describe the need to acquire and maintain a broad scope of practice (Fitzpatrick, 2001; McCarthy & Hegney in Aranda & O'Connor, 2001). Within this range of skills and responsibility, the care of people at the end of life is identified as a common responsibility of rural and remote nurses (Fitzpatrick, 2001).

Professional isolation relates closely to its geographical counterpart, with nurses identifying limited access to a number of key means of support and professional development. Specifically, these include educational programs, professional gatherings and other resources (McCarthy & Hegney in Aranda & O'Connor, 2001; Fitzpatrick, 2001; McConigley *et al*, 2000) and clinical advice and information plus legal support (Fitzpatrick, 2001; McConigley *et al*, 2000).

Similarly, Elsey & McIntyre's study (1996) identified the 'problem of keeping in contact and communication with each other, usually for the purpose of pooling ideas about work, offering mutual support and sharing resources' (p.159). This *lack of opportunity for supportive collegial connections and private debriefing* was considered to be the source of increased personal demand. Moreover, the nurses' own families were identified as a primary source of support in lieu of formalised professional support (McConigley *et al*, 2000). Rural and remote nurses described the need for an inner resolve in order to sustain their practice (Morgan, 1997).

These characteristics of rural and remote practice are viewed as having negative impacts on knowledge, skills and practice, and the management of personal burden and stress. Elsey & McIntyre (1996) found that nurses felt their geographical isolation and its consequences affect their doing a good job and delivering a more effective service. Indeed, recruitment and retention are threatened by the demands of these settings (Hegney *et al*, 2002). Fitzpatrick's respondents (2001) have

asserted that addressing these features would have positive outcomes not only for the practitioners, but also for their clients.

The literature also describes a number of **barriers** to overcoming these features of rural and remote palliative care nursing practice. Fitzpatrick (2001) suggests that a fundamental lack of recognition of the unique role played by rural and remote nurses leads to many of the difficulties experienced by them.

Clearly, *distance* is of itself the overriding hurdle to handling these demands (McCarthy & Hegney in Aranda & O'Connor, 2001; Cupitt 2000). Distance is the progenitor of numerous obstacles, including *costs* incurred for both travel, accommodation, and staffing replacement (McCarthy & Hegney, 2001; Pearson & Care, 2002; McCarthy & Hegney in Aranda & O'Connor, 2001). These difficulties are exacerbated when there is organisational inflexibility or incapacity to arrange staffing backfill, and budgetary constraints (McCarthy & Hegney, 2001; Pearson & Care, 2002; McConigley *et al*, 2000).

A further barrier to resolution of these challenges lies in the perceived lack of support of, and limited access to, *peer networks* due to both geographical and professional isolation (McCarthy & Hegney, 2001; McCarthy & Hegney in Aranda & O'Connor, 2001).

The available *modes of education delivery* presented obstacles also (McCarthy & Hegney, 2001; Pearson & Care, 2002). Face to face teaching and learning, whilst preferred by some (McCarthy, *et al* 2002), is seen to be impractical due to cost. Limited Internet access also means that some remote practitioners cannot utilise electronic learning opportunities (McCarthy & Hegney, 2001; Hegney *et al* 2002).

Consideration and evaluation of proposed or trialed **strategies** is evident in the literature. McCarthy and Hegney (2001) and Fitzpatrick (2001) assert the importance of *needs analysis* as a basis for planning in professional development. Indeed, the design and delivery of *context specific educational packages* for rural and remote nurses generally (McCarthy & Hegney, 2001; Pearson & Care, 2002) and for isolated individuals specifically (Fitzpatrick, 2001) is proposed as an essential first step.

It is proposed that *formal educational preparation* of nurses should include a rural and remote stream (Fitzpatrick, 2001; McConigley *et al*, 2000). *Flexible delivery methods*, such as CD-Rom, web-based or mailed, are predicted as the most efficacious means of providing learning opportunities (Fitzpatrick, 2001; Cupitt, 2000; McConigley *et al*, 2000). Access to specific training with a high level of practical input is nominated in one study as most desirable (McCarthy *et al* 2002). Others

suggest a competency-based focus is the most reliable form of learning (Fitzpatrick, 2001), including coping skills (McConigley *et al*, 2000). Travel and education subsidies are viewed as a practical means to overcome the high costs incurred by rural and remote nurses (Hegney *et al*, 2002; McCarthy *et al*, 2002).

A number of authors found *peer support* improved feelings of isolation (Willson *et al*, 2001; Pearson & Care, 2002). Formal and informal networking groups are described in various forms (Fitzpatrick, 2001) with study groups being one incarnation of the formalised approach (Cupitt, 2000). Clinical exchange programs between urban and rural settings have been trialed successfully in other disciplines (Parkin *et al*, 2001).

Attaining *organisational support* is a key strategy for addressing these problems (Pearson & Care, 2002; McCarthy *et al*, 2002). This should include practical issues such as providing staffing backfill and covering travel and accommodation costs where necessary, and acquiring Internet access (McCarthy & Hegney, 2001; Hegney *et al*, 2002).

Mentoring and sole practitioner support are mentioned as means of providing the psychological, clinical and emotional assistance identified as a need by rural and remote nurses (Fitzpatrick, 2001). *Clinical supervision* where a nurse links with other palliative care practitioners, was a vital source of support (Willson *et al*, 2001). Indeed, the lead clinician holds a pivotal role in support and professional development (Sach, 1997). Notably, however, such support mechanisms are mostly informal (McConigley *et al*, 2000). Hall (1997) identified a *professional mentor* as a person who takes a personal interest in the career of another, offering guidance and serving as a career role model, actively promoting their career and training. Mutual support, information sharing, and empowerment are seen as benefits of networking (Elsley & McIntyre, 1996).

METHODOLOGY

Sampling & Data Collection

A mixed method questionnaire was developed to explore the perceptions of nurses practising palliative care in the rural and remote Health District services of Southern Zone. The survey tool was structured into three sections:

1. *Professional Development*: relating to formal and informal activities that enable the nurse to improve knowledge, skills and other professional attributes. It may include education, training, and mentoring;
2. *Support and Guidance*: relating to those links nurses may have with others which enable them to seek assistance, share information, and debrief; and,
3. *The Workshop*: requesting a retrospective evaluation of the workshop's effectiveness. Provision was made in this section for general comment also.

The tool comprised a 23-item, four-point Likert scale measuring level of agreement with key concepts derived from the literature. Responses were weighted as follows:

- Strongly agree = 4
- Agree = 3
- Disagree = 2
- Strongly disagree = 1

Mean and standard deviation are indicated in Tables. Twelve open-ended questions were included to obtain qualitative descriptions relating to the key concepts. The survey tool is attached as Appendix 1.

The questionnaires were coded by geographical district, and approximately six weeks following the Warwick workshop, all thirty-one [31] workshop participants were mailed the questionnaire to their workplace. Each was given two weeks to complete the tool and asked to return it via a reply paid envelope. Participants were subsequently sent two reminder letters three/four weeks apart.

Data Analysis

To summarise responses to the fixed response items, quantitative data were analysed for mean and standard deviations utilising a web-based computer software package.

Qualitative data obtained through open-ended questions were analysed to identify emergent and recurring themes, through reading and re-reading by the research team members. Key concepts found in the literature were located in the data and discrepancies noted.

RESULTS

Response Rate

A total of seventeen [17] responses were received, representing a response rate of 55% (54.8%).

Professional development

Respondents considered themselves working to their potential in palliative care when they had a mix of knowledge, skills and confidence, which facilitated good care and accurate advice. Table 1 shows predominantly high levels of agreement with core concepts derived from the literature:

Table 1: Descriptive Data – Professional Development

Statement	n	mean [standard deviation]
I have to wear many hats as a nurse.	16	3.9 [0.34]
Palliative care is one of many clinical areas in my area of nursing practice.	17	3.7 [0.61]
It is difficult for me to access educational activities in palliative care.	17	2.9 [0.86]
My employer supports me to attend educational or conference events in palliative care.	17	3.4 [0.80]
I am motivated to continue my professional development in palliative care.	17	3.6 [0.62]
Internet or CD-ROM would be the best ways for me to learn more about palliative care.	16	2.8 [1.05]
Local seminars and conferences would assist my professional development.	17	3.7 [0.47]
I would benefit from linking with a palliative care nurse elsewhere for clinical advice.	16	3.6 [0.50]
I have library access/support.	16	3.0 [0.63]
Library access/support does/would assist me in my professional development.	16	3.2 [0.54]

This respondent considered herself working to her potential when:

“...I have researched enough and acquired the knowledge and confidence to offer advice to my patients to enable them to experience as good as possible ‘quality of life’.”

Several nurses saw that working to their potential meant bringing about positive outcomes for clients and their families. This respondent’s measure of her potential had very tangible parameters:

"...I can see the client is comfortable, pain free, when I can see that their family are content with the care, respect and dignity that their loved one is receiving."

A number of respondents noted the infrequency of palliative care patients in their care as limiting their potential, which could be enhanced if:

"[I was] able to work one month per year to gain experience in a busier locality. Great if this could be developed with a "mentor" to remain in contact with through the year"

Time constraints were seen as a barrier to both access to professional development opportunities and the provision of care. This respondent felt she could work to her potential if:

"...I could develop skill and devote adequate time to update and clients."

Moreover, these time constraints were exacerbated by an apparent unwillingness by some managers to backfill absent staff:

"...lack of time to attend prof [sic] development – lack of back filling of my position."

Respondents' geographical isolation increased the time required to attend educational functions and consequently the demands on their workload. Similarly, the nurses' workloads were not only demanding, but were applied across a range of clinical areas of which palliative care was only one:

"Presently I am expected to work in a full time position (which is not palliative care related) as well as my part time pall [sic] care position. I have been stretched beyond my capacity and there is no room/time to develop my pall [sic] care skills."

Access to information and mentorship was acknowledged as a component of professional development. This respondent saw possibilities for professional development if she was:

"...able to work one month per year to gain experience in busier locality. Great if this could be developed with a 'mentor' to remain in contact with through the year."

Others felt they could sustain their professional development if there was employer-sponsored time to access electronic information:

"...[if] I was allocated time and financial assistance."

Support and Guidance

Collegial relationships were acknowledged as an essential influence in the quality of support provided. Table 2 shows moderate to high levels of agreement with the core concepts derived from the literature:

Table 2: Descriptive Data – Support and Guidance

Statement	n	mean [standard deviation]
I have limited opportunity for privacy, working and living where I do.	16	2.8 [1.05]
My family provides me with support relating to the demands of my palliative care work.	16	2.8 [0.68]
I have a colleague with whom I can get things off my chest.	17	3.5 [0.51]
My employer has encouraged me to find a professional person to debrief with.	15	2.6 [0.83]
I have the confidence and skill to provide support and guidance to my peers.	16	2.9 [0.85]
I would like to link with another palliative care professional for support.	16	3.0 [0.53]
Forming a group for support would assist me in my coping with the demands of work.	14	2.9 [0.77]
It is my employer's responsibility to organise a network of support for me.	14	2.2 [0.58]
Going to Brisbane or Toowoomba for a brief clinical placement would help sustain me in my work.	16	3.1 [0.77]

This respondent linked her somewhat strained relationship with work colleagues to patient outcomes, suggesting that optimal support could occur with:

"...all co-workers realising if everyone worked together as a team for the client, the client would be most benefited." [sic]

Other respondents indicated their view of the best support as when:

"...I am conversing and working with nursing colleagues who have attended recent palliative care workshops and have similar goals.

and when:

"...the relevance and support for debriefing is essential for all staff, to debrief over all stressful issues."

Indeed, some respondents were clearly satisfied:

"Happy with present support available – I am comfortable telephoning others for advice and support."

Others, however, were not, and identified barriers to adequate support as including:

“Working with nursing colleagues who have not kept up to date with the latest information and research on palliative care.”

and

“My supervisor not understanding palliative care issues within our community and does not have an understanding of what/how other communities work re pall [sic] care issues.”

Geographical isolation, time and staffing constraints were again mentioned as contributing factors to inadequate support. These factors impinged upon access to educational resources, whether seminar/conferences or simply:

“Access to info on the Internet prn.”

Respondents were able to identify strategies to assist them to manage these work demands including support from colleagues and education. One respondent specifically sought:

“Acknowledgment of capabilities and supervisory support was consistent and maintained regularly.”

There were a few mentions of the type of relationships with colleagues that would offer optimal support to cope with the demands of work:

“...knowledgable nursing colleagues, who understand what we are trying to achieve for our patient, such as good as possible a ‘good quality of life’.”

including this reference to mentorship, where the demands of work would be more manageable if:

“I have a person I can contact when I need advice.”

Other respondents were more explicitly aware of the presence of formalised mentorship arrangements:

“I envisage support I would need would be professional mentoring/networking.”

The Workshop

Overwhelmingly, respondents identified the value of the workshop as a strategy for their professional development, which Table 3 demonstrates:

Table 3: Descriptive data – The Workshop

Description	n	mean [standard deviation]
My attendance at the workshop in October assisted me in my professional development and networking.	17	3.8 [0.39]
The workshop gave me the opportunity to develop strong and supportive networks with other nurses and resources throughout the districts.	17	3.6 [0.51]
I found the workshop to be a useful strategy to link nurses within the zone and foster professional support and development.	17	3.7 [0.47]
I was able to offer and receive mutual support and pool ideas about work and resources during the workshop.	17	3.5 [0.62]

In particular, networking was identified as a key benefit of workshop attendance. This included debriefing, sharing problems, and identifying potential links for support:

“networking...potential to gain experience...potential for finding [a] mentor.”

The attainment of new knowledge and skills, and identification of useful resources were also described as benefits:

“...networking, new products, new ideas, sharing common problems, humour (very important), and caring for self, learning that your are giving food care (working alone makes it difficult to benchmark.”

Broad suggestions were made for content of future workshops, although no single topic emerged. One respondent, however, felt a broader target group would be valuable:

“Involvement of all streams eg ENs...to gain knowledge and better understanding of PC. These people are often forefront workers dealing with patients.”

An invitation for any other comments drew some remarks of interest:

“Benefits gained by networking with other PC workers, and realising the extent of the common problems etc is invaluable.”

and

“Hearing how other nurses/health professionals dealt with particular problems and bring back their ideas (some not in books) is enormously helpful.”

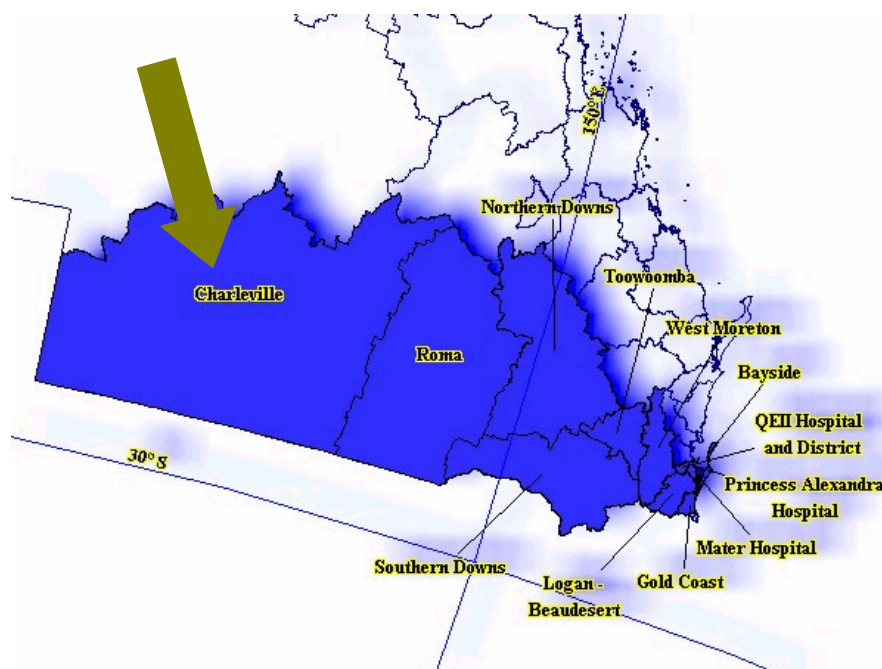
DISCUSSION

In the seminal Palliative Care Australia scoping study to determine priorities for palliative care research in Australia (PCA, 2000) the call was made for a concerted research effort across a number of core areas, including rural and remote communities. In particular, the study asked how the support and education needs of rural palliative care practitioners might be best met. These issues, and those raised in the literature regarding the nature of rural and remote nursing practice, were, for the most part, supported in this sample group. These nurses strongly acknowledged role diversity as a core characteristic of their practice.

Despite other characteristics, including the constraints of professional and geographical isolation, and the diverse demands of rural and remote practice, these nurses also viewed palliative care as integral to their role. However, the infrequency of palliative care client admissions limited their opportunity to work to their potential in practicing end-of-life care whilst they were also required to keep pace and meet the needs of patients with a broad range of other health care issues.

Geographical isolation was reiterated by this group as a key influence upon the provision of care (McCarthy & Hegney, 1999). To put this in perspective, the palliative care coordinator of Charleville Health District – an Enrolled Nurse – oversees palliative care delivery across an area of 23,000sq.kms, and coordinates the recruitment, training and support of volunteers as just one of her “other hats” (see Figure 2 below).

Figure 2: Charleville Health District



When geographical isolation is combined with professional isolation, it erodes the ease with which practitioners access professional development and support (McConigley *et al*, 2000; Fitzpatrick, 2001; Elsey & McIntyre, 1996). This was evident in this sample which described specific barriers that limited their potential to provide quality end-of-life care. Limited availability of resources, the logistical issues of access to educational activities and resources, time absorbed in travel, and the substantial costs involved in educational activities, were all highlighted. For one nurse, travelling to a distant 1½-day seminar required four days leave. A few nurses also reported employers who were unwilling or unable to backfill nurses' positions during their absence, limiting their access to available educational opportunities.

Nevertheless, these nurses showed a high level of enthusiasm for professional development in palliative care. However, along with the quantitative and qualitative data demonstrating a consistency with features of rural and remote practice, it also reinforced that specific strategies are required to optimise care and promote professional development for such a group. For example, although clinical placements have been noted as a useful strategy for palliative care development (Willson *et al*, 2001) learning can be nullified if the context is not aligned with the realities of rural and remote practice. This was highlighted by one of the sample group who cited a clinical visit to provincial centre that did not enhance her ability to contend with work demands, as the context of the practice was distinct from rural or isolated practice.

Other positive professional development strategies highlighted by the group as being compatible with rural and remote issues included the use of peer networks and locally accessible educational events. Some of the group already identified and shared with a professional colleague and felt confident enough to provide support and guidance to other peers. In particular, peer support and networking was thought to improve feelings of isolation, and descriptions indicated a strong support of mentorship, although mostly in an informal way. Interestingly, there was a strong view held by this group that it was not the responsibility of their employer to organise networks of support for them. Rather, they sought more practical organisational support, in the form of backfilling when attending professional development activities, having lighter workloads, and a variety of electronic library and other resources, and the available time to use them.

This group overwhelmingly found the two day workshop held in Warwick to be a positive experience, where networking, the sharing of ideas, problem-solving, skills

attainment, and resource sharing significantly helped them to overcome the barriers of rural and remote practice.

The participants' experience was central to planning. The workshop was designed for their needs, and in particular, to enable sharing and networking to a key component of the event. However, whether the ideas or benefits of the workshop can be translated into strategies for ongoing peer support for the Southern Zone remains to be seen.

Strategies identified for nurses generally in regards to professional development in palliative care cannot be imposed upon rural and remote practitioners. The context in which they live and work vary significantly from their more provincial and metropolitan peers. However, there is a need for further study to review how the support and education of this specific group of health practitioners can be met. In particular, strategies need to be identified that are consistent with the context of this group's practice and the communities in which they live. Nevertheless, the challenges of providing professional development opportunities are immediately evident when this group indicate a strong preference for locally held, face-to-face learning rather than flexible delivery, despite the prohibitive cost to education providers.

LIMITATIONS

The generalisability of these results is limited by the small sample size. Further studies of other rural and remote groups of nurses would enable validation of these findings.

Self-report is acknowledged by the authors as a measurement limited to the use of descriptions of attitudes and self-perception.

CONCLUSION

The Centre for Palliative Care Research and Education has addressed the project aims through its review of the literature, the development and use of a survey tool distributed to workshop participants, and the formation of recommendations relating to the practice of palliative care by nurses in the rural communities of Southern Zone.

The results of this evaluation demonstrated congruence between the challenges faced by this group of nurses and those reported in the literature. These nurses identified the importance of professional development and peer networking as integral parts of their work which enhance their potential as rural and remote palliative care providers.

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APPENDIX 1 – SURVEY TOOL

Where appropriate, circle the answer closest to your view of the statement:
SA = strongly agree A = agree D = disagree SD = strongly disagree
 Please add your comments where indicated.

SECTION A: PROFESSIONAL DEVELOPMENT (relates to formal and informal activities that enable you to improve your knowledge, skills and other professional attributes. It may include education, training, and mentoring.)		SA	A	D	SD
A1.1:	I have to wear many hats as a nurse.				
A1.2:	Palliative care is one of many clinical areas in my area of nursing practice.				
A1.3:	It is difficult for me to access educational activities in palliative care.				
A1.4:	My employer supports me to attend educational or conference events in palliative care.				
A1.5:	I am motivated to continue my professional development in palliative care.				
A2.1:	In regard to professional development, I would consider myself working to my potential in palliative care when...				
A2.2:	In regard to professional development, I am prevented from working to my potential in palliative care by...				
A2.3:	In regard to professional development, I could work to my potential in palliative care if...				

A3.1:	Internet or CD-Rom would be the best ways for me to learn more about palliative care.	SA	A	D	SD
A3.2:	Local seminars and conferences would assist my professional development.	SA	A	D	SD
A3.3:	I would benefit from linking with a palliative care nurse elsewhere for clinical advice.	SA	A	D	SD
A3.4:	I have library access/support.	SA	A	D	SD
A3.5:	Library access/support does/would assist me in my professional development.	SA	A	D	SD
A3.6:	I could sustain my professional development in palliative care if...				

SECTION B: SUPPORT AND GUIDANCE (relates to those links you may have with others which enable you to seek assistance, share information, and debrief).					
B1.1:	I have limited opportunity for privacy, working and living where I do.	SA	A	D	SD
B1.2:	My family provides me with support relating to the demands of my palliative care work.	SA	A	D	SD
B1.3:	I have a colleague with whom I can get things off my chest.	SA	A	D	SD
B1.4:	My employer has encouraged me to find a professional person to debrief with.	SA	A	D	SD
B1.5:	I have the confidence and skill to provide support and guidance to my peers.	SA	A	D	SD
B2.1:	In regards to support and guidance, I would consider myself supported best when...				
B2.2:	The support I need is limited by...				

B2.3:	I would be best supported by...				
B3.1:	I would like to link with another palliative care professional for support.	SA	A	D	SD
B3.2:	Forming a group for support would assist me in my coping with the demands of work.	SA	A	D	SD
B3.3:	It is my employer's responsibility to organise a network of support for me.	SA	A	D	SD
B3.4:	Going to Brisbane or Toowoomba for a brief clinical placement would help sustain me in my work.	SA	A	D	SD
B3.5:	I could continue to contend with the demands of my work if...				

SECTION C: THE WORKSHOP					
C1.1:	My attendance at the workshop in October assisted me in my professional development and networking.	SA	A	D	SD
C1.2:	The workshop gave me the opportunity to develop strong and supportive networks with other nurses and resources throughout the districts.	SA	A	D	SD
C1.3:	I found the workshop to be a useful strategy to link nurses within the zone and foster professional support and development.	SA	A	D	SD
C1.4:	I was able to offer and receive mutual support and pool ideas about work and resources during the workshop.	SA	A	D	SD
C2.1:	The most helpful aspect/s of the workshop were:				

C2.2:	The least helpful aspect/s of the workshop were:
C2.3:	Any future workshops could be enhanced by:
C2.4:	Any other comments:

Thank you for your participation in this survey. We appreciate your contribution at such a busy time of the year.