Australian Government
National Rural Health Commissioner

National Rural and Remote Nursing Generalist Framework

Analysis of Responses from Public Consultation

June 2022

Acknowledgement of Country

The National Rural Health Commissioner (the Commissioner) and her Office acknowledges the Traditional Owners and Custodians of Country throughout Australia. The Commissioner recognises and deeply respects the strength and resilience of Aboriginal and Torres Strait Islander people and their continuing connections and relationships to community, rivers, land and sea.

The Commissioner and her Office pay respect to Elders' past, present and emerging and extend that respect to all Traditional Custodians of this land and Aboriginal and Torres Strait Islander people reading this document.

The Office of National Rural Health Commissioner

The *Health Insurance Act 1973* (the Act) provides the legislative basis for the appointment and the functions of the Commissioner and the Office of the National Rural Health Commissioner.

In accordance with the Act, the functions of the Commissioner are to provide independent and objective advice in relation to rural heath to the Minister responsible for rural health.

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Summary

The Chair of the National Rural and Remote Nursing Generalist (NRRNG) Steering Committee, Deputy National Rural Health Commissioner Adjunct Professor Shelley Nowlan, announced the National Rural and Remote Nursing Generalist Framework (the Framework) was open for online public consultation in February 2022. Public consultation closed in March 2022.

The intent of the Framework is to describe the unique context of practice and core capabilities for rural and remote area nursing practice. It is designed to be a tool and guide to benefit Registered Nurses in rural and remote practice settings, their employers, mentors, education providers, and nursing and midwifery colleagues working in health care in general.

This report has been prepared from an analysis of submissions made to the public consultation process on the draft Framework, overseen by the NRRNG Steering Committee (the Committee), and it's workstream leads. The Committee appreciates the strong collegial contribution from key stakeholder organisations who engaged in this public consultation.

The Chair of the NRRNG Steering Committee and members have accepted the feedback and acknowledge the rural and remote nurse contribution to the Framework draft Domains and capabilities through public consultation. The Framework will be completed by the Office of the National Rural Health Commissioner and made publicly available by late 2022.

Introduction

The intent of the Framework is to describe the unique context of practice and core capabilities for remote area nursing practice, and rural nursing practice. The Framework has been designed as a tool and guide for Registered Nurses in rural and remote settings, their employers, mentors, education providers, and for nursing and midwifery colleagues working in health care in general.

The development of the Framework is a priority for the National Rural Health Commissioner to support the attraction and retention of the nursing workforce in rural and remote Australia. The Framework is underpinned by the Nursing and Midwifery Board of Australia's seven Registered Nurse Standards for Practice.

This report does not preclude further review of the submissions, as results are built into it.

Methodology

The Deputy National Rural Health Commissioner wrote to peak nursing bodies and jurisdiction Chief Nursing and Midwifery Officers (CNMOs) in February 2022, inviting them to complete a national online survey on the Framework's draft Domains and capabilities. The online survey was hosted on the Department of Health's (the Department) Citizen Space consultation hub. Steering Committee members were advised that the NRRNG Steering Committee Chair was available for online question and answer, or yarning sessions, during the public consultation period. Steering Committee members were encouraged to

engage their members, rural and remote area nurses, and those with a rural and remote health service delivery interest, in the consultation. Steering Committee members reported that they emailed, provided face-to-face sessions and/or used social media to engage these broader groups.

A letter and communique on the Framework were provided to peak medical, allied health and Aboriginal and Torres Strait Islander health bodies, with a hyperlink to the online survey. They too were advised of the Deputy National Rural Health Commissioner's availability for question and answer, or yarning sessions for consultation. Written, free format submissions from peak bodies were encouraged, to allow peak bodies to give broader feedback on the draft Framework.

The Survey

The online survey had 14 questions that included:

- respondent demography
- respondent qualifications
- respondent professional experience
- rating their agreeance to the draft Domains and capabilities using a five-point Likert scale of strongly agree through to strongly disagree (Westland, 2015, pp. 118-125)
- free text fields to provide comments against the draft Domains and capabilities.

The key questions focused on the four draft Domains of the Framework, as developed by the NRRNG Steering Committee:

Domain 1. Culturally safe practice
Domain 2. Critical analysis
Domain 3. Relationships, partnerships and collaboration
Domain 4. Capability for practice

The four draft Domains were elaborated by draft capabilities.

A Microsoft Word document version of the survey was made available on the online survey page on the Department consultation hub, to ensure equitable access for all. Respondents using this format emailed their completed document to the NRRNG Steering Committee Secretariat email.

Social Media

To engage the broader public in the consultation, the Department's social media channels were utilised. Posts across the Department's four channels Facebook, Twitter, LinkedIn and Instagram were published on 21 February 2022 and 3 March 2022, with hyperlinks to the online survey. The Department's social media team was provided by the NRRNG Steering Committee Secretariat with suggested responses to social media users to streamline answers. Steering Committee members were given a social media pack with suggested post wording, images and responses for social media user questions.

As a result of social media outreach, eight published pieces reached over 121,616 people. 465 of these interacted with the content through likes, clicks, comments or shares. The

Facebook posts reached the most people, however on LinkedIn the audience were more likely to engage, achieving a 2.62% interaction rate.

Responses

In total, 157 responses and submissions were received during the public consultation on the Framework survey. Of these, 147 individual submissions arrived through the Citizen Space consultation hub and 14 submissions were from peak bodies that included 4 jurisdictional CNMOs. Three organisational and online individual responses were duplicated submissions and have been factored to comprise the total.

A number of peak organisations provided separate written submissions. These written, free format submissions were accepted until 24 March 2022 and were submitted via email to the NRRNG Steering Committee Secretariat. Two of the peak organisations used the Likert scale in their submission and the quantitative results have been adjusted to include their responses against each Domain.

Analysis

In late March 2022, the Steering Committee Secretariat undertook the first analysis of the 147 responses received, using the Citizen Space platform. This involved keyword tagging, coding the qualitative responses for themes and creation of analysis notes. Ten organisational responses received via email were analysed only using Microsoft Excel and summarised to compare emergent key themes. Quantitative results and an early indicative analysis of qualitative themes were presented to the NRRNG Steering Committee in March 2022. The final, most frequent themes were presented to the Steering Committee in April 2022.

Key Findings

The total number of submissions received was 157. Respondents had the choice of making an online submission via the survey itself or to make a submission directly to the Office of the National Rural Health Commissioner by email. Of the total, 147 submissions were received through the Citizen Space online consultation hub and 14 written, free format submissions came from peak organisations and jurisdictional representatives from email to the Secretariat. Of the Citizen Space consultation hub responses, 61.9% were Registered Nurses, 20.4% were dual Registered Nurse and Midwife and 2.7% were Midwives. Nurse Practitioner respondents made up 5.4%.

A total of 51.7% of respondents were from remote or very remote locations and 37% rural. All states and most territories were represented. These figures include responses from some organisations that submitted via the Citizen Space consultation hub, and therefore representation of qualified professionals, for example, will include some qualifications of representatives responding on behalf of an organisation. It is deemed this anomaly is inconsequential given the percentage of organisation response rate on the Citizen Space consultation hub. Questions like this were not mandatory for organisations to answer. The

survey findings provided a strong representation of Australian rural and remote nurse experiences and views.

Demographics

Respondent qualifications

Option	Total	Percent
Nurse Practitioner	8	5.44%
Registered Nurse	91	61.90%
Registered Nurse/Midwife	30	20.41%
Midwife	4	2.72%
Enrolled Nurse	1	0.68%
Assistant in Nursing	0	0.00%
Medical	4	2.72%
Allied Health	1	0.68%
Aboriginal and/or Torres Strait Islander Health Practitioner	0	0.00%
Aboriginal and/or Torres Strait Islander Health Worker	0	0.00%
Other	13	8.84%
Not Answered	9	6.12%

Some respondents ticked more than one qualification and the data reflects this.

Respondent Residence by Rurality

Option	Total	Percent
Remote/very Remote (MMM6-7)	76	51.70%
Rural (MMM3-5)	55	37.41%
Regional (MMM2)	37	25.17%
Urban (MMM1)	23	15.65%
Not Answered	0	0.00%

Respondent Residence by Jurisdiction

Option	Total	Percent
Australian Capital Territory	1	0.68%
Indian Ocean Territories	0	0.00%
New South Wales	26	17.69%
Northern Territory	27	18.37%
Queensland	35	23.81%
South Australia	20	13.61%
Tasmania	6	4.08%
Victoria	22	14.97%
Western Australia	15	10.20%
Nationally/Australia-Wide	4	2.72%
Not Answered	0	0.00%

Respondent Primary Work Setting

Option	Total	Percent
Primary Health Care Centre/Service	55	37.41%
Aboriginal Community Controlled Service/Aboriginal Medical Service	18	12.24%
Hospital/Health Service	64	43.54%
University/Other Tertiary Institution	13	8.84%
Non-government Organisation	10	6.80%
Professional / Policy Organisation	7	4.76%
Other	8	5.44%
Not Answered	0	0.00%

Rural and remote healthcare is frequently provided across more than one service and location., The data reflects this, with some people working at both a primary health service and at a hospital and health service.

Summary of Quantitative Data

For each Domain, respondents were asked how they agreed with the Domain. This was based on a five-point Likert scale from strongly agree to strongly disagree. Across each Domain, between 85-89% of respondents either strongly agreed or agreed with the Domain, and 8-10% were neutral. Those who disagreed or strongly disagreed on Domains were between 0-4.7%, making the average disagreement statistically insignificant (1.6%). The majority agreed with Domain one Culturally Safe Practice. Many commented on the importance of Domain one to the other three Domains: Critical Analysis, Relationships, Partnerships and Collaboration, and Capability for Practice.

Domain 1: Culturally Safe Practice

Option	Total	Percent
Strongly Agree	77	51.68%
Agree	51	34.23%
Neutral	16	10.74%
Disagree	4	2.68%
Strongly Disagree	1	0.67%
Not Answered	0	0.00%

Domain 2: Critical Analysis

Option	Total	Percent
Strongly agree	61	40.94%
Agree	68	45.64%
Neutral	13	8.72%
Disagree	7	4.70%
Strongly disagree	0	0.00%
Not Answered	0	0.00%

Domain 3: Relationships, Partnerships and Collaboration

Option	Total	Percent
Strongly agree	75	50.34%
Agree	59	39.60%
Neutral	11	7.38%
Disagree	4	2.68%
Strongly disagree	0	0.00%
Not Answered	0	0.00%

Domain 4: Capability for Practice

Option	Total	Percent
Strongly agree	83	55.70%
Agree	50	33.57%
Neutral	12	8.05%
Disagree	4	2.68%
Strongly disagree	0	0.00%
Not Answered	0	0.00%

Qualitative data

It is valuable to underline the results showed respondents were in principle strongly in favour of the Framework and agreed with its four Domains. Individuals and peak organisations also provided a large quantity of in-depth advice on where to strengthen and refine capabilities across the Framework.

Of the qualitative feedback, respondents provided between 39-47 qualitative responses in each Domain. Organisation submissions were analysed with greater emphasis to determine any thematic differences, and to ensure analysis placed appropriate weight to these submissions. However, it was deemed there were no significant thematical differences so individual and organisation responses were themed together.

To guide initial analysis, 22 conceptual tags were created on the Citizen Space platform to gain insight into likely factors or issues expected from the results. The platform calculated the frequency that respondents tagged areas of concern, reflection or gave advice, for example. This highlighted where respondents thought improvements or considerations to strengthen the Framework were needed. and led to a second analysis to produce themes. In order of highest to lowest frequency, across all four Domains, the most frequent tags were:

1. Not representative, gap, weakness, concern, excludes
2. Skill, scope, proficiency, novice, expert
3. Safety and risk
4. Digital, technology
5. Education
6. Employment (this included human resources, recruitment and retention)
7. Culture (included both workplace and community culture)
8. Training
9. First Nations, Aboriginal and Torres Strait Islanders
10. Multidisciplinary care.

Themes

A list of core themes that emerged from the analysis, followed by discussion, is given below. It is important to note the broader context that these themes sit within as being overall supportive of the Framework and Domains. Accordingly, the themes ought to be considered as opportunities for strengthening and refining the Framework within this favourable context.

Domain 1 Themes

Culturally Safe Practice: Knowledge and understanding of how one's own culture, values, attitudes, assumptions and beliefs, influence interactions with people, families, community and colleagues.

1. Language suggests it is exclusive of culturally and linguistically diverse (CALD) backgrounds or CALD inclusion needs strengthening
2. Capabilities were not unique or specific enough to rural and remote settings
3. Specific language required to properly explain or elucidate a capability
4. The Domain was too political, and some terms/capabilities could be removed
5. For culturally safe practice to be defined in Framework with suggestions of what to include (NACCHO feedback).
6. Recommended additional capabilities to Domain 1 (NACCHO feedback).
7. NMBA standards appear to be replicated (ANMF feedback).

Recommendations to strengthen the inclusion of CALD people, or opinions that Domain one seemed to be exclusive of CALD people was the most prominent theme across all four Domains. This feedback was given in the context that CALD people and refugees also live in rural Australia, that international nurses work in rural Australia, and that culturally safe practice should also encompass their culture.

The second dominant theme was that culturally safe practice is not unique to rural and remote nursing, or that the capabilities are not unique to rural and remote settings. This theme overlapped with the second and fourth themes that sought to illuminate capabilities unique to remote and remote practice. The ANMF provided similar feedback that it appears the seven Registered Nurse NMBA Standards appear to be duplicated, but this was applicable to all Domains and capabilities.

Some feedback included suggested changes to terms or words used, that they were either too political or not respectful.

A submission from the National Aboriginal Community Controlled Health Organisation (NACCHO) was very comprehensive and highlighted the importance of this Domain to Closing the Gap objectives and priorities.

Domain 2 Themes

Critical Analysis: Uses Critical Analysis in the assessment, planning, delivery, and evaluation of safe, quality, person-centred, evidence based, individual care, and population and public health programs.

1. Capabilities were not unique or specific enough to rural and remote context, need to be made more specific
2. Strengthen language within the concepts and capabilities
3. Infrastructure/ Telecom/Broadband barriers to digital communications (out of scope of the Framework).

Respondents provided many constructive suggestions on how the Domain capabilities within critical analysis could be strengthened to clearly elucidate the rural and remote practice. A strong element of this theme. was the need to develop and maintain engagement with community representatives, to support and sustain implementation of evidence-based health programs, to meet community needs and priorities.

Also highlighted as important for comprehensive critical analysis was a need to encompassing rural generalist nursing across the full continuum of care from birth to palliation, including Nurse Practitioners and understanding the mental health needs of rural families.

Many respondents spoke of the ethical challenges faced by rural and remote nurses in delivering healthcare. Some examples were working with members of the community in which they lived and remaining impartial, and critical analysis required to support Aboriginal and Torres Strait Islander women to birth on country, weighed up against safety. Whilst this is also linked to Domain 3 on relationships, partnerships and collaboration, respondents emphasized the critical analysis skills in a rural and remote context. Other examples were the level of critical analysis skills relevant needed for co-design with communities, and how to address the mental health impact of community trauma and recovery related to natural disaster and climate in rural and remote low resource settings.

Requests to review language choices to ensure more appropriate descriptors was recommended. For example, because the Framework is not designed to be used by employers or educators for assessment, suggestions were made to remove any references to competency and replace with proficiency or capability instead, aligned to a skill and knowledge-based development path. Other language considerations included to use ‘reflexivity’ instead of ‘reflection’ in professional development. This was considered a more active descriptor, especially for critical analysis of culturally safe practice. Analysis of this

theme also raised a need to define strength based, person centred and placed based care in relation to co-design, because the concepts tended to be referred to interchangeably.

There were many comments on digital infrastructure and broadband barriers in rural and remote areas to communication for consumers and workforce. These are structural barriers outside the scope of influence of the Framework. The Office of the National Rural Health Commissioner will raise such issues in its advocacy role with the Department of Health.

Two important areas that were deemed to be essential for critical analysis came through from organisational feedback as the need to build in:

- capability for research, received from the Council of Deans for Nursing and Midwifery
- the perspective of the colonised in relation to culturally safe practice, including to remove the ambiguous phrase "our history" on the basis that history is not shared equally, from CATSINaM and NACCHO.

Domain 3 Themes

Relationships, Partnerships and Collaboration: Engages in professional, culturally safe, and open engagement with the person and their full range of care partners to ensure effective delivery of holistic, comprehensive primary health care. This includes collegial generosity in building mutual trust and respect in professional relationships to optimise health outcomes.

1. Strengthen the emphasis upon multidisciplinary care capabilities and referrals as fundamental to rural and remote generalist health care. (Emerging Minds and AMA).
2. Identify duplications and rationalise capability statements with other Domain areas.
3. HR issues in recruitment and retention in rural and remote healthcare settings.

The need to provide fuller statements of the role of effective relationships through multidisciplinary team care and referrals as being core to rural and remote generalist healthcare was reflected strongly in this theme. This included the opportunity to build more resilient relationships by providing and receiving mentoring across disciplines within the rural and remote multidisciplinary practice setting.

There emerged a strong emphasis on culturally safe partnerships and relationships that tied into critical reflection for healthcare free of racism. The need for practitioners to recognise the collective nature of many communities' ways of understanding healthcare needs rather than individual was also valued to foster culturally safe engagement.

This theme included many recommendations to reduce content duplications, including:

- How to utilise innovation with skills and knowledge in low resource settings that could be migrated to Domain 4 Capability for Practice
- To migrate critical evaluation and implementation of standards, policy guidelines and legislation into practice into Domain 2 Critical Analysis
- Opportunities to promote the nursing role to highlight health inequities and social injustice to also sit within Domain 2 Critical Analysis.

There were many comments on recruitment and retention issues in rural and remote health workforce. These were framed as challenges to attracting and retaining nurses, including

the high turn-over of agency nurses that presented barriers to person centred planning and continuity of care. It also affected relationships between more established nurses in the rural and remote setting and those there for a shorter term, less invested in the community.

Without negating the importance of fostering supportive collegial relationships and inclusive work environments in all healthcare settings, it is acknowledged that addressing the structural drivers that shape rural and remote health workforce are outside the bounds of the Framework. Other areas for policy advocacy such as remote are a nurse safety and digital technology that respondents commented on are more fitting to be addressed through the wider policy role of the Office of the National Rural Health Commissioner.

Domain 4 Themes

Capability for Practice: Demonstrates accountability for ensuring capability for practice, responding constructively when there is concern about other health professionals' capability for practice.

1. Lifelong learning should specify the multifaceted learning required of a rural and remote generalist across the lifespan
2. Unmeasurable capabilities that put nurses at risk to unfair treatment by superior or employer (ANMF)
3. Not unique to rural and remote nurses with the need to contextualise capabilities more accurately to the setting
4. Review all Domains to ensure synergy with NMBA standards for practice (NMBA)

This theme reflected a dominant emphasis on the need to demonstrate accountability for capability to full scope of practice with advanced generalist skills across the lifespan. This was described in various forms:

- Recognising the demands of rural and isolated practice on self and other, ability to provide comprehensive assessments in arrange of settings, often with reduced access to immediate clinical supports to plan, treat and evaluate care to full scope of practice
- Commitment to lifelong learning across the full care continuum strengthening evidence-based knowledge and skills to full rural generalist nursing scope of practice. Respondents wanted to ensure that basic maternity and emergency skills, child, mental health, aged care and palliative care skills were reflected.
- Softer skills such as resilience, courage and flexibility needed in lower resource, often isolated primary health care settings.

The Australian Medical Association highlighted the decline in rural birthing services and also emphasised that the Framework build in midwifery capabilities for rural and remote nurses.

Several respondents commented that there was a risk the Framework could be used to justify unfair treatment by employers or supervisors. The Australian Nursing and Midwifery Federation and the Queensland Nurses and Midwives' Union also raised this as a concern. This is a valuable insight that underscores that the purpose of the Framework is not for it to be used in competency assessment, or as a standardised measurement tool. The Framework

is a guidance tool for individual reflection and evaluation to strengthen rural and remote nurse practice; it is a supportive tool for educators, employers, and mentors to assist in a pathway of development for the rural nurse and remote nurse. It will be important that the final Framework demonstrates this to avoid misuse. A summary of next steps is provided below and it includes how the Steering Committee has agreed to address this concern.

The unique safety requirements of nurses in rural and remote settings were reflected in this theme with many noting the relevance of South Australia's Gayle's Law. The focus here was on bolstering capability for safe practice whilst isolated from full clinical supports and networks, linked to cultural safety, personal wellbeing and resilience.

Many commentators referred to links between elements of Capability for Practice and the seven Nursing and Midwifery Board of Australia (NMBA) Registered Nurse Standards for Practice. Some took a view of unnecessary duplication of the standards, where others recognised the Framework is underpinned by the standards and highlighted where points of synergy could be made more explicit in the Framework. The NMBA recognised the important link with the seven Registered Nurse Standards for Practice. It did not view the Framework content as a duplication.

Organisation Submissions

Submissions were received from:

- Australian College of Nurses (ACN)
- Australian College of Rural and Remote Medicine (ACRRM)
- Australian Medical Association (AMA)
- Australian Nursing and Midwifery Federation (ANMF)
- Australian Primary Health Care Nurses Association (APNA)
- College of Emergency Nursing, Australasia (CENA)
- Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM)
- Council of Deans of Nursing and Midwifery (Australia and New Zealand) (CDNM)
- Emerging Minds, National Workforce Centre for Child Mental Health (EM)
- National Aboriginal Community Controlled Health Organisation (NACCHO)
- National Rural Health Alliance (NRHA)
- Nursing and Midwifery Board of Australia (NMBA)
- Nursing and Midwifery Office, New South Wales (NMO NSW)
- Office of the Chief Nursing and Midwifery Officer, Queensland (OCNMO Qld)
- Office of the Chief Nursing and Midwifery Officer, Safer Care, Victoria (OCNMO, VIC)
- Office of the Chief Nursing and Midwifery Officer, Tasmania (OCNMO, TAS)
- Queensland Nurses and Midwives Union (QNMU).

A range of smaller rural and remote nursing organisations, regional health and hospital services, local health networks, one university and one primary health network also provided submissions on the Citizen Space consultation hub.

Most organisational responses were detailed and comprehensive. Thematic highlights from these are provided below.

All submissions welcomed the inclusion of Domain 1 – Culturally Safe Practice. Many endorsed it as a 'wrap around' Domain for the whole Framework. NACCHO viewed this as a very positive step towards addressing the harmful health impacts of racism and colonisation, as they noted is too often experienced by Aboriginal and Torres Strait Islander people in rural and remote health settings. The feedback from NACCHO also provided constructive suggestions to strengthen culturally safe practice and to contextualise the Framework in relation to:

- National Closing the Gaps objectives
- The United Nations Declaration on the Rights of Indigenous Peoples, and
- National policies on Aboriginal and Torres Strait Islander Health Workforce and healthcare outcomes.

NACCHO also recommended the Framework include a discussion of Aboriginal and Torres Strait Islander concepts of health, as reflected in the unique ACCHO model.

The OCNMO Tasmania observed that the Framework as written did not draw a clear enough difference between the contexts of rural and remote settings, noting an opportunity to reconsider the language to be more specific in drawing out this distinction. This was also noted by several individual respondents. They also recommended revising the content of capabilities against and between Domains to be more succinct, reducing unnecessary words. Again, this aligned with individual and peak organisational responses to the survey that asked for refinements to reflect plain language.

The ACRRM submission observed that the context of rural and remote nursing is almost identical to that of Rural Generalist Medical Practitioners. ACRRM fully supported the key principles of the Framework. It framed this as rural and remote nurses working to full scope of practice in a range of settings, often with reduced access to clinical supports compared to metropolitan-based health workers, for optimum delivery of care across the patient lifespan. ACRRM's view was that the Framework would complement the National Rural Generalist Medical Pathway and Allied Health Pathway to help grow a sustainable clinical workforce for rural and remote Australia and, ultimately, assist to improve access to health care services in rural and remote areas.

Several respondents, including the NMBA recommended the inclusion of Aboriginal and Torres Strait Islander Health Workers who often play a critical role in health care service delivery in rural and remote settings. As noted within the themes, they requested the NRRNG Steering Committee and Secretariat review the Framework further to incorporate additional synergistic alignment to the standards for practice across all four Domains. The NMBA recognised that criteria for standards 2 and 3 were most applicable to Domain 4 of the Framework.

CATSINaM and NACCHO requested the provision of accompanying resources and guidance materials to assist nurses, midwives and employers to consider their capabilities against the Framework.

Organisational submissions overall strongly supported the development of the Framework as a tool and guide to describe the unique context of rural and remote nursing and its capabilities. Only one submission declined to support the Framework. This was on the basis that it needed to clearly illuminate rural and remote nurse experience, and a preference to separate the Framework into two distinct bodies: one for remote and one for rural nurses.

Next Steps

At the NRRNG Steering Committee's meeting on 22 April 2022, five steps were agreed upon to respond to the public consultation:

1. Refine the capabilities under each capability statement within the four Domains to reflect plain language, cultural awareness, colonised history, CALD populations, specific theme responses and organisational feedback.
2. For the Framework document to reflect the seven Registered Nurse NMBA Standards as a foundation and the uniqueness of rural and remote context within Domains. It will also reference the *Advanced Nursing Practice – Guidelines for the Australian Context*, aligned to the context of generalist practice, noting specialist practice follows and builds on a base of generalist preparation. This does not preclude areas of specialisation such as emergency, primary health care and mental health within rural and remote nursing. The NRRNG Steering Committee expected that some content in the final Framework would be similar to the seven NMBA Standards for Practice because the Framework should still be recognisable as Registered Nurse practice.
3. For the Framework to be supported by the provision of scenarios for how it can be used by rural and remote nurses, educators, employers and mentors.
4. To replace novice to expert in the Framework to include developing, intermediate and proficient knowledge and skills as an annexure for rural and remote nurses to strengthen their capabilities as a self-directed exercise. This would be similar to the approach of the Australian Institute of Digital Health Nursing and Midwifery Framework.
5. To recognise the National Rural Health Commissioner and Deputy Health Commissioner Nursing and Midwifery advocacy roles to acknowledge feedback and incorporate what is out of scope of the Framework into other areas of work such as aspects of remote nurse safety, workforce and access to digital technology.

Conclusion

The public consultation process has provided strong support for this Framework. The Office of the National Rural Health Commissioner will embed the endorsed four Domains developed by the NRRNG Steering Committee, as a result of the feedback, into the Framework:

1. Culturally safe practice
2. Critical analysis
3. Relationships, partnerships and collaboration, and
4. Capability for practice; to be underpinned by supporting capabilities.

Because the Framework is intended to describe the unique context of practice and core capabilities for rural and remote area nursing practice, the Steering Committee considered some feedback to be out of scope for the development of the Framework. Wherever possible the National Rural Health Commissioner and Deputy National Rural Health Commissioner will acknowledge feedback and incorporate what is out of scope of the Framework into other areas of work such as support for remote nurse safety, workforce development and access to digital technology.

The development of the Framework continues as a priority for the National Rural Health Commissioner to assist the Australian Government to attract and retain the nursing workforce in rural and remote Australia.

References

Westland, JC 2015, *Structural equation models: from paths to networks*, Springer, Cham.