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A case study of factors influencing remote university nursing graduates and their decision to work in a remote hospital

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Chapter 2
Background and context to the study

Introduction

This chapter introduces the geographical location of the study and sets the scene for the context of the study. The concept of remoteness, the nursing workforce and the provision of pre-registration nursing education in remote areas of Australia will be elucidated. Since the focus of the study are the graduates from Notre Dame, Broome School of Nursing and Midwifery, explanation about the curriculum is also provided.

The location of the study

The Kimberley is a region in the north of WA and is the setting for this study. The region has a low-density population and covers a landmass of 423,517 square kilometres, which is approximately 3 times the size of England. In 2013, the population of the Kimberley was nearly 39, 900, which was 2% of the total WA population (Government of Western Australia Department of Regional Development, 2014). Currently, the population growth rate in the Kimberley is 2.5% in comparison to the rest of WA, which is 1.4% (Kimberley Australia, 2014). Notably, 43.5% of the Kimberley population is of Aboriginal and Torres Strait Islander origin, with parts of the population living in communities with as few as 50 residents (Australian Bureau of Statistics [ABS], 2011a). The region also has a large transient population, with an extensive increase during tourist season. Visitors to the Kimberley exceed 340, 000 per annum (Kadar, Pearson & Partners, 2009). Broome is the largest town in the Kimberley and has a population of 14, 997 (42% of the total Kimberley population) and is the location of the University of Notre Dame, Australia, Broome Campus.

The Kimberley comprises areas that are considered remote and very remote (Australian Government Department of Health [DoH] 2015; ABS, 2011a). Studies of people living in regional and remote areas of Australia revealed that; compared to people living in urban areas they have poorer physical and mental health and lower levels of education as a consequence of reduced access to medical care and educational facilities (Australian Institute of Health and Welfare [AIHW], 2014;

National Rural Health Alliance, 2013). The level of health is also known to decline relative to remoteness and a further subsequent reduction in healthcare availability (DoH, 2008; Miller, 2011). Quantifying these differences and providing relevant resources relies on an understanding of the concept of remoteness and a system to enable comparison of the data collected.

Defining remoteness

Distance is central to the concept of being remote. The Oxford Dictionary provides a definition of remote as "far away in place or time: out of the way: situated from main centres of population, society etc" (Remote, 2004, p. 1195). Living in a remote area means being part of a sparsely distributed population and a long way from services. Remote communities have been defined as, "spatially defined communities which are distant from urban centres where supplies of goods and services, and opportunities for social interaction are concentrated" (Faulkner & French, 1983, p. 3). The term distance requires further explanation. It can mean different things to people who live in remote areas. Distance when measured, in a straight line, as the "crow flies" (The phrase finder, 2015) or by driving on bitumen roads can be quite a different concept to a remote community where travels on dirt roads that are inaccessible during the wet season are the only means of access.

The Kimberley region experiences a tropical monsoon climate and is separated into two seasons, the dry season from May to August and the wet season. During the dry season daily temperatures are usually between 25 – 30 degrees centigrade. During the build up to the monsoonal rains the temperature and the humidity increase. Cyclones are known to occur from November through until April, when the daily, average temperature increases to above 30 degrees centigrade. Extensive rainfall, at times in excess of 200mm per day increases the amount of water in the rivers and creeks causing swift torrents over the roads making them impassable to all traffic. As perishable goods and other groceries are delivered by road train, it often means towns and communities in the Kimberley have few supplies during the wet. It is the degree of accessibility to overcome the distance that is important to those living in remote communities and defines their concept of remoteness; not just the distance measured in kilometres between towns.

There have been a number of different models to conceptualise remoteness. These different models can be divided into two main approaches. The first is a sociological approach that concentrates on the socioeconomic characteristics of a population that impact on access to goods and services. The second is a geographical approach that defines remoteness in terms of physical distance with the major focus being on distance affecting social interaction (ABS, 2011b; Kaltenbrunner, Volkovich, Currie, Jutemar, Scellato, Laniado & Mascolo, 2012). The literature argues that socioeconomic disadvantage can greatly exacerbate locational disadvantage by reducing mobility (Ryan & Whelan, 2010). In order to study the relationships between distance and socioeconomic status the ABS (2011b) adopted a geographical model to define remoteness.

There is little consensus in the literature with the use of the terms rural, regional and remote. Commonly the term remote is subsumed into rural or included as an addition to regional even though there is clear distinction between regional and remote areas according to classification systems, healthcare, education and resource allocation. A shared definition would be helpful for applicability of research findings to remote areas to be able to determine difference which in turn could lead to appropriate policy development, planning and resource allocation. The most commonly discussed geographical classification systems in Australia include: The Rural, Remote and Metropolitan Area; the Australian Standard Geographical Classification (ASGC); the Accessibility/Remoteness Index of Australia (ARIA); and the Remoteness Area Structure (ABS, 2011b).

The Department of Primary Industries and Energy and the, then, Department of Human Services and Health developed the Rural, Remote and Metropolitan Area classification system in 1994 (AIHW, 2015). The system was based on Statistical Local Areas. These areas were allocated to a category based on population numbers and an index of remoteness. The index of remoteness was based on population density and the distance to a centre with a population of 10,000 or more (AIHW, 2015). Australia was separated into seven categories, 2 metropolitan, 3 rural and 2 remote areas, however, anomalies were noted in this system. Both the size of Statistical Local Areas and the distribution of the population within them varied. This meant, for example, that within a remote Statistical Local Area there could be

pockets that were rural rather than remote, and vice versa (AIHW, 2015). The outcome for resource allocation and policy development was the potential to either favour or disadvantage an area.

In the late 1990's, the Commonwealth Government agency determined a need for a better definition process for remote areas. A review of the Australian Standard Geographical Classification system by the ABS, considered the issue of remoteness. At the same time the then Commonwealth Department of Health and Aged Care commissioned research into the development of a geographic measure of remoteness by the National Key Centre for Social Applications of Geographic Information Systems.

The result of the consultation process was the creation of the ARIA (ABS, 2001). This system classified remoteness in a physical, geographic way and was constructed on a continuous measure of remoteness based on terms of accessibility and distance by road. An index score between 0 and 12 was assigned by population and distance to service centres, such as health and social services. Any site in Australia could then be attributed an ARIA score. These scores were then further grouped and classified as: highly accessible, accessible, moderately accessible, remote, and very remote depending on the ARIA index it was assigned (AIHW, 2004).

In 2001, the ABS released the Australian Standard Geographical Classification Remoteness Area Structure (AIHW, 2004). According to ABS (2011b) this particular remoteness structure was designed as a reference to interpret the geographical context of ABS statistics. The system was based on an extended model of the ARIA and became known as ARIA+, which had scores of 0 to 15. These scores are defined after each census collection, providing an opportunity to evaluate population changes (ABS, 2012).

The terms regional, rural and/or remote, in previous studies, has been a confusing issue, thus, it was important to define the terms for this study. For consistency the ASGC Remoteness Areas structure that uses the ARIA+ scoring system, was used to measure remoteness (DoH, 2015). Australian Standard

Geographical Classification -Remoteness Area scores of RA4 (labelled Remote) and RA5 (labelled Very Remote) were classified together and are referred to as remote areas. Inner Regional (RA2) and Outer regional (RA3) were classified together and are referred to as regional areas. Major cities (RA1) are referred to as Metropolitan, City or Urban areas (see Figure 2.1). Throughout this study when referring to Broome and the Kimberley, the term remote is used. In the literature, however, rural and remote are characterised as the same entity, which has led to much confusion with respect to studies related to this thesis.

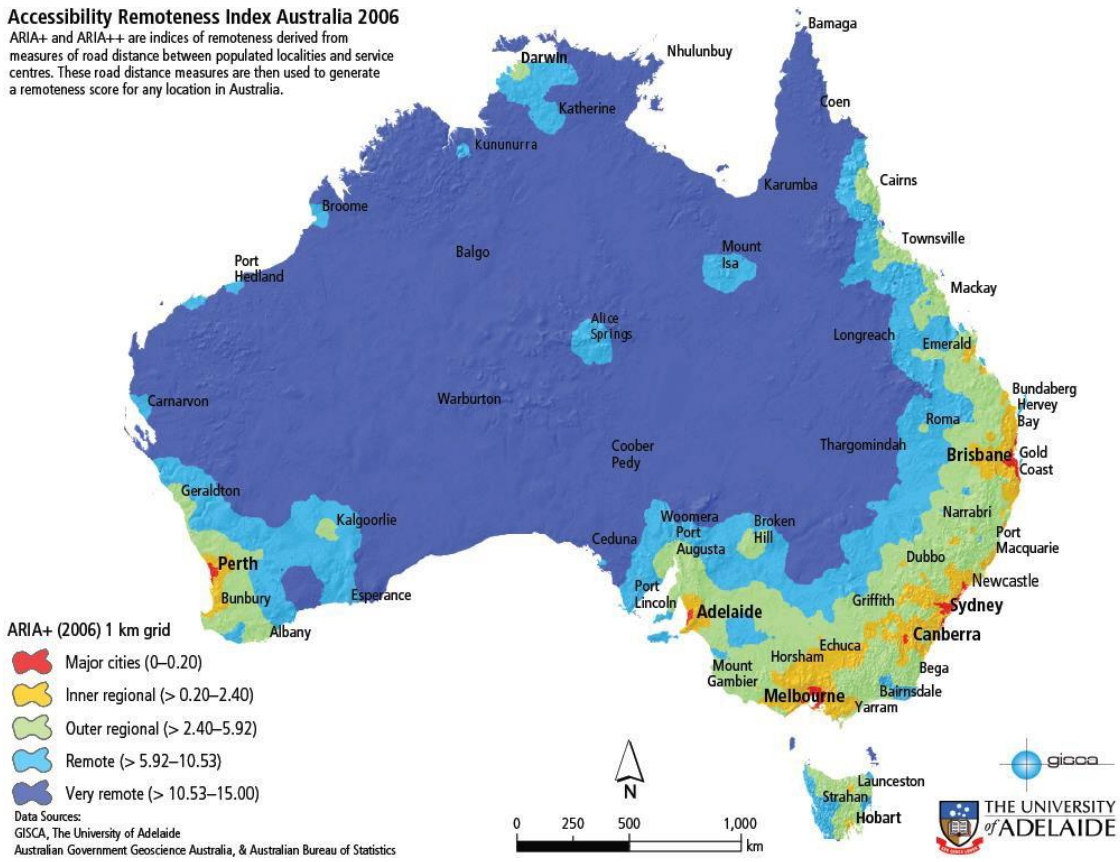

Figure 2.1 Accessibility Remoteness Index Australia

The map of Australia (Figure 2.1) identifies very remote, remote, outer regional, inner regional and major city areas according to ARIA+ and the ASGC classification system. The areas in red are the major cities, yellow and green the regional areas and remote and very remote regions of Australia are light and dark blue. The map highlights the notion of remoteness illustrating the distances between remote areas, towns and cities. It clearly identifies the south west of Australia and the

Eastern seaboard as containing the most regional and urban areas of Australia. In Western Australia remote areas stretch from Geraldton in the south, to Kununurra in the north. In particular, the distance between Perth, the capital city of Western Australia, and Broome is clearly demonstrated. Thus, this study highlights the separation of rural and remote concepts since peoples' experiences differ. For example the distance between Perth, and Bunbury - an inner regional centre considered rural, is 172kms, and both towns have a university school of nursing. When the term rural is used there are differences in for example resources commodities and healthcare services. Broome whilst being rural needs to be considered very remote, owing to the distance (2240 kilometres) from the capital city.

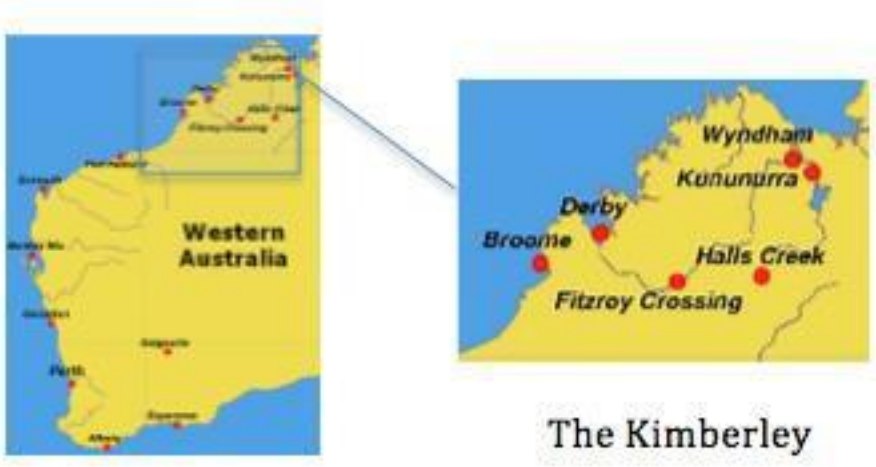

Figure 2.2 Towns in the Kimberley (Kimberley Australia Travel guide, 2015)

The Kimberley region is located in the Northwest of WA with Broome being situated on the coast of the Indian Ocean (see Figure 2.2). As can be seen in the above maps the Kimberley has six towns. Two of the towns, Broome and Kununurra are considered remote and the four towns Derby, Fitzroy Crossing, Halls Creek and Wyndham are considered very remote (AIHW, 2004; DoH, 2015). In addition there are also over 150 Aboriginal communities (not identified on the map), which are significant in terms of potential patients and clients that access the healthcare services in Kimberley towns. All Aboriginal communities are situated in very remote areas.

The Kimberley region has a higher level of people living with disadvantage compared to other regions in Australia. In 2011 the Socio-Economic Indexes for areas (SEIFA) within the Kimberley were all below 1000. The SEIFA are calculated from responses to the ABS Census and a score below 1000 indicates an area of relative disadvantage. At least one third of people living in the Kimberley live in areas with scores in the lowest 10% in Australia (ABS, 2011c). Notably the more disadvantaged an area the higher the risk factors for ill health and self-reported ill health (ABS, 2008).

Mining, tourism, construction and agricultural production are the major contributors to the economic output of the Kimberley region (Kimberley Australia, 2014; Government of Western Australia Kimberley Regional Development, 2014). The three biggest employment industries are: health care and social assistance; public administration and safety; and education and training. Most mining industry workers fly-in-and-fly-out to their homes in other parts of WA between work commitments.

Remote healthcare practice in Australia can be defined as having the following characteristics: geographical and social isolation; a multidisciplinary approach; high level of skill in public health, emergency and extended clinical skills suited to a cross cultural context; providing a service to small, dispersed and highly mobile populations with high healthcare needs (Wakerman, 2004). Healthcare provision in remote Australia is provided through clinics and hospitals. These institutions provide primary healthcare and acute services (Taylor, 2008). Services are provided through a range of funding providers including Federal, State, Territory Government or Non Government Organsations. Regional and individual Aboriginal Community Controlled health services and private aged care providers also provide healthcare services (Taylor 2008).

The hospitals in the Kimberley have been designed to respond to the lack of private general practices in the region. This accounts for the large number (75%) of emergency department attendances being classified as semi or non-urgent (triage 4 or 5). This proportion is more than 10% higher than the overall number of all Western Australian Country Health Service (WACHS) sites. The large influx of tourists

during the cooler months of the year, is in excess of 300,000 (Kimberley Health Profile, 2015). This number of people increases the workload of healthcare professionals and pressure on the regions healthcare services.

The size of the hospital facility, in each of the towns, reflects the population catchment area and range from an eight bed inpatient facility in Wyndham, to a 57 bed inpatient facility in Broome (Government of Western Australia Department of Health [WADoH], 2012a). A number of services are provided at each hospital and include: a multidisciplinary group of health professionals; a Day Hospital; Accident and Emergency unit; High Dependency Unit; Maternity Unit; Medical Imaging; Mental Health; Paediatrics Unit; Palliative Care; and Specialist Outpatient Clinics. Operating theatres are available in Kununurra, Broome and Derby (WADoH, 2012b). The Paediatric and Mental Health wing are discrete areas at Broome hospital as this is the regional health campus. In addition to these services a number of health clinics are spread throughout the Kimberley. Tele-health, and visiting medical and nursing staff specialists, provide a range of services which complement the care provided by the clinic nurses and Aboriginal Health Workers. When necessary patients are flown to Perth or Darwin for specialist treatment that cannot be provided by regionally based services or visiting specialists (Consumer health services directory, 2012).

Nursing workforce

Human resources for regional and remote healthcare have been noted as entering a critical period from a global, national and state perspective (Buchan & Aiken, 2008; Bushy, 2002; Duffield & O'Brien-Pallas, 2002; Smith, 2008). In 1999, the Australian Commonwealth Government health policy clearly indicated that strategies to encourage healthcare professionals to work in regional and remote areas were crucial to the local population (Healthy Horizons, 1999). In 2007 the then Prime Minister requested the Department of Health and Ageing (DoHA) to undertake an audit of the healthcare workforce, in regional and remote Australia with the aim of identifying where shortages existed (DoHA, 2008). The audit provided confirmation of previous anecdotal comments that the number of healthcare professionals working in regional and remote areas was insufficient to meet the

healthcare needs of the community.

In a workforce with limited supply of other health care professionals, nurses form the major professional group and are often the first point of contact in remote healthcare services (Burley & Greene, 2007; Lenthall et.al, 2011). Nationally, nurses are the largest profession in the healthcare workforce. In 2012, this number represented 60% of the entire professional healthcare workforce (DoHA, 2008; AIHW, 2014; Nugent et al., 2004). This is nearly three times as many as that of the next largest profession, medical practitioners (AIHW, 2014).

In Australia nurses working in remote areas are often described as RANs (Remote Area Nurses). The context of practice for a RAN most closely resembles the role of nurses in a primary healthcare clinic in a remote, or very remote region of Australia (Lenthall et al., 2011). There are, however, nurses who work in other settings including hospitals in remote and very remote areas of Australia. It is these nurses that are the context of this study.

Nursing education and registering authorities

The Nursing and Midwifery Board of Australia (NMBA) is the registering authority and accredits courses of study. It developed standards, codes and guidelines for nursing and midwifery (NMBA, 2015a). The Australian Health Practitioner Regulation Agency (AHPRA) manages the registration and renewal process for all nurses working in Australia (AHPRA, 2015). Accreditation by the Australian Nursing and Midwifery Accreditation Council (ANMAC) is required of all courses leading to nursing registration to ensure academic quality, public accountability and public safety. Once accreditation has been confirmed the NMBA lists the program as an approved program of study on their website (NMBA, 2015b).

In Australia an Enrolled Nurse (EN) completes a Diploma of Nursing (DN) as a Vocational Education and Training (VET) qualification, at a Registered Training Organisation (RTO), or at a University that incorporates an RTO within its university status. The education program is usually 18 months and on completion the graduate applies for registration through AHPRA. The role of the EN is to provide nursing

care under the supervision of a registered nurse (RN).

A RN completes an undergraduate degree, through a university, that is usually of three or three and half year's duration. Graduates of these programs are also required to register with AHPRA prior to employment. The range of responsibilities for a RN extends from direct patient care to coordination of healthcare delivery, health promotion, education and research (WADoH, 2015a). Experience is noted by the number of years following graduation, which is also equivalent to the annual salary increase. A RN progresses from a Level 1.1 to a Level 1.9 over 9 years of full time work.

Healthcare workforce in the Kimberley

There are no private hospitals in the Kimberley and as such only the Western Australian Country Health Service (WACHS) hospitals (public hospitals) were considered in this study. In WA the Nursing Hours per Patient Day model determines nursing staff numbers in public hospitals (WADoH, 2015b). This provides a shift profile and full time equivalent (FTE) cover for a ward or department. Nursing numbers are determined by the diversity and complexity of nursing tasks required. The career structure described earlier assists to provide an appropriate skill mix in relation to nursing numbers.

Whilst nurses, both RNs and ENs, have a wide range of employment opportunities in the Kimberley, public hospitals are the predominant employer. There are, however other employment areas such as: Regional Aboriginal Medical Services, Renal Dialysis Centres, the Royal Flying Doctor Service (RFDS), General Practice clinics and Remote Community clinics governed by WACHS or Aboriginal Community Controlled Health Services (ACCHS). There are limited employment opportunities for RN and EN graduates in these specialised areas. Some graduates, however, do obtain employment in some areas of high need such as the Renal Dialysis Centres, or Aboriginal Medical Services.

Aged Care services within the Kimberley are privately owned or governed by WACHS. These areas have limited employment opportunities for RNs and ENs as

they predominantly employ unqualified staff, or staff with certificate III, or IV level qualifications. The RFDS does not offer employment for RN graduates or ENs. Nurses in RFDS are often required to hold a midwifery certificate with an additional 3-5 years postgraduate experience in emergency or critical care. This requirement means a graduate would need to move to the city for at least 5 years to gain the qualifications and experience. Private general practices in the Kimberley have little staff turn over and require a RN to have a number of years of experience before employment will be considered.

Working in a remote area clinic as a RAN requires experience beyond that of a graduate RN or enrolled nurse (Lenthall, Wakerman & Knight, 2009). These nurses are required to work independently, but as part of a multi disciplinary team in a remote Aboriginal community. They are also required to have broad nursing experience with recent accident and emergency skills, relevant university qualifications and or post-basic qualifications such as midwifery, child health, psychiatry, primary healthcare or remote area practice (KAMSC, 2012).

Kimberley graduate programs

Graduate programs offer newly registered ENs and RNs support in their transition from student to clinical practice. Whilst undertaking a graduate program is not obligatory for employment, they do provide the novice nurse with additional support. The programs are structured, with some supernumerary time in clinical practice and paid study days. Nurses in these programs are part of the staffing skill mix at the same time as gaining exposure in a variety of clinical settings, while consolidating theoretical learning and critical clinical skills and judgment (WADoH, 2015c).

GradConnect is a streamlined online recruitment system that provides a wide choice of employment opportunities for newly qualified nurses and midwives (WADoH, 2015d). This is a collaborative system that works with WA public hospitals and healthcare services and participating private hospitals. The Nursing and Midwifery Office, located in WADoH, centrally coordinates applications for all graduate programs offered via GradConnect. The online system allows applicants to

apply for graduate opportunities in all of the participating hospitals and healthcare services across WA.

Currently, the Kimberley graduate program is only offered to RNs. Nine programs are offered each year and include six rotational programs and three Broome based programs. The rotational programs consist of a minimum of 16 weeks in Broome, Derby and Kununurra with some graduates being offered a 4 week rotation in Fitzroy Crossing or Halls Creek (WADoH Country Health Service, 2011). The number of graduates accepted into the Kimberley graduate program ranges from 9 to 12. The Broome based programs are dependent on the successful applicant being able to provide their own accommodation. Enrolled nurses are not offered a graduate program and thus seek direct employment from a hospital in the region.

Nursing education in regional and remote Australia

In the Australian context, pre-registration undergraduate nursing programs are primarily offered from regional or city based university campuses, or RTOs. The majority of the Australian population is situated on the Eastern seaboard and consequently this is where the majority of education providers can be found (see Figure 2.3).

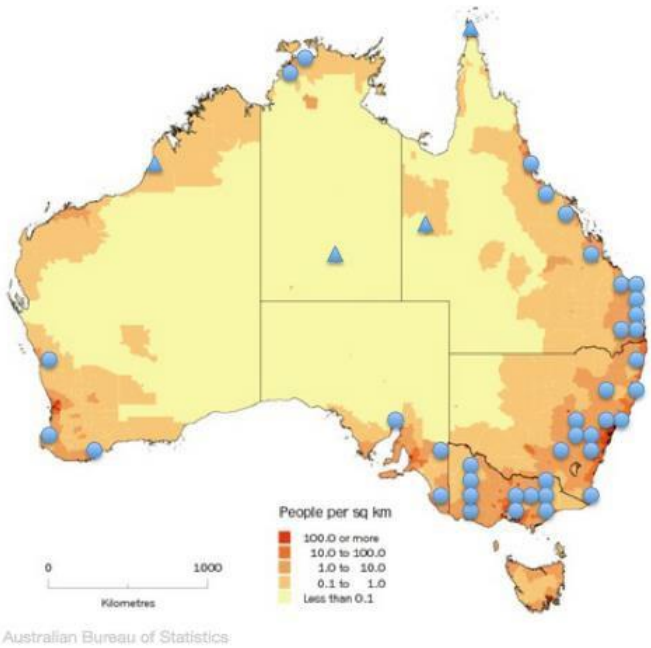

Figure 2.3 Regional and remote universities in Australia

The above map of Australia identifies population density and the location of Schools of Nursing. Population density of Australia is identified with the shaded orange areas; very light colouring identifies the remote and very remote areas of Australia (ABS, 2011b). The dots and triangles identify Schools of Nursing (CDNM, 2007).

Universities in regional areas offering RN education can be identified in the above map by a blue dot. Figure 2.3 draws attention to the vast distances that students have to travel from a remote area to a regional university campus. The remote campuses (identified by the blue triangle) are a significant distance from available resources, major tertiary healthcare services and are in low-density population areas (ABS, 2013). Providers of EN programs are also situated throughout Australia in a similar fashion to the RN providers (NMBA, 2015b). The map also identifies Notre Dame, Broome as the only remote campus in WA offering an RN program.

The majority of Australian pre-registration nursing programs are delivered through face-to-face study options where students live in the locality of the education provider (NMBA, 2015b). Teaching across geographical boundaries is where students reside in a geographical area other than where the course is being delivered. It is this type of delivery that enables students in remote and regional areas to access educational opportunities without having to relocate. This requires delivery to learners by distance mode rather than a face-to-face onsite program. Notre Dame, Broome offers both the BN and DN programs through distance learning across geographical boundaries.

Context of the case

In this study the case is the influencing factors on remote university nursing graduates decision to work in a remote hospital. The context refers to the internal and external environment that nurse graduates have studied and practiced. Thus, a description of the Broome campus and the nursing curriculum, including clinical placements will be highlighted in this section of the thesis.

The University of Notre Dame, Australia's first campus, was founded in 1989 in Fremantle, a major city in the southern part of WA. A second campus was established in Broome in 1994, at the invitation of the Bishop of Broome (Bishop John Jobst) with the aim of being a centre of reconciliation between Aboriginal and non-Aboriginal Australians (Tannock, 2014). The fundamental objective of the campus was to meet the needs of the people of the Kimberley region in terms of tertiary education and in particular to provide education for the professions of nursing and education in a context of Catholic faith and values.

Currently, Notre Dame, Fremantle, through its School of Nursing and Midwifery in Broome offers DN and BN programs together with the Certificate II in Health Support Services and the Certificate III in Health Services Assistant. These certificates can be used as entry-level qualifications to the DN program.

The BN program offered through Notre Dame, Fremantle and Broome follow similar curricula. This model provides the students the opportunity to travel between campuses for part or all of their studies. Some Notre Dame, Fremantle students take this option with some deciding to stay for their graduate year. The point of difference between the campuses is the core curriculum units. There are three core curriculum units which are designed to act as a: Central platform through which the University aims to achieve its intention of producing graduates of outstanding quality, whose personal spirituality and public spirit allow them to take their place in public life, and to make a significant contribution to the human, economic, social and spiritual development of Australia and its region (Notre Dame, 2015).

The three Notre Dame, Fremantle core units are: Introduction to Philosophy, Ethics and Introduction to Theology. In keeping with its focus of reconciliation Notre Dame, Broome, replaced the Philosophy and Ethics units with Aboriginal People and Spirituality and Challenges of Reconciliation. The three core units for Broome are designed to "challenge the students to consider the theological and spiritual foundations of the Christian faith in dialogue with the history, worldview and political context of our time and particularly with the Aboriginal people of Australia" (Notre Dame, 2012b. p.24). Whilst the DN does not have a core curriculum the theme of reconciliation through cultural awareness is interwoven

throughout the program.

Contextualisation of the curriculum

The Registered Nurse Accreditation Standards allow for course contextualisation when delivered in different modes and from different campuses as long as equivalence of outcomes can be maintained (ANMAC, 2012. p13). This criterion has enabled Notre Dame, Broome to focus tutorials and simulated clinical situations to the remote context where there is a predominance of Indigenous people.

A particular focus of the curriculum for Notre Dame, Broome is the way it addresses the Aboriginal and Torres Strait Islander Peoples' history, health, wellness and culture. It exceeds the minimum of a discrete unit as directed by the Registered Nurse Accreditation Standards (ANMAC, 2012, p. 14) through its core curriculum and cultural awareness sessions for clinical placement. Students are also exposed to the chronic disease and mental health conditions prevalent in the Aboriginal population.

Local nurses provide the tutorials and customise the tutorial content with scenarios and case studies with a remote healthcare focus. This focus enables students to learn about healthcare provision in dialysis units, hospital settings and remote health clinics. Clinical laboratory sessions provide students with the practice necessary to enable them to function in an independent fashion while on placement. Engaging tutors from the local healthcare workforce creates opportunity for students to become intrinsically aware of the nature of the workplace and to understand that being prepared for the clinical practice setting is essential.

Clinical placements and supervision

Students in both the DN and BN are immersed in the culture of the region and the workplace during their clinical placement. Both courses provide significantly more workplace experience hours, than directed by accreditation authorities. Students in the DN attend 600 hours of clinical placement throughout the 18 month program, 200 more hours than the minimum set by the accreditation body (ANMC,

2009). Students in the BN attend 1240 hours of clinical placement over a three-year program (440 hours more than the minimum 800 hours set by the accreditation body (ANMAC, 2012).

Clinical placements are organised throughout WA with placement availability governed by the appropriate healthcare facility. All students undertake their first placement within the aged care sector followed by placements in acute healthcare settings. The majority of students attend clinical placements at hospitals in towns of the Kimberley such as Broome, Derby, Fitzroy Crossing, Halls Creek and Kununurra. Other remote areas hospitals south of Broome may also be utilised such as those in the regions of the Pilbara, Midwest and Gascoyne. Some placements are also provided in regional settings such as Geraldton and Albany. Students can also request a clinical placement throughout the Perth metropolitan area in a variety of hospitals and healthcare agencies, but are required to enrol through the Fremantle campus.

There are also opportunities for students to attend the Renal Dialysis Centres and the Aboriginal Medical Services in Broome and Derby. The remote communities managed by WACHS including Lombadina, Looma, One Arm Point, Kalumburu and Warmun are also sites of clinical practice for BN students. Currently, there are limited opportunities for DN students at these remote clinic sites.

All students experience aged care, medical and surgical care, paediatrics, community health settings, primary healthcare, mental health and midwifery. Bachelor of nursing student's, gain additional experience in accident and emergency departments and the peri-operative setting. Formal agreements with the healthcare facility provides the framework for the provision of clinical placements. These agreements (see Appendix A) stipulate the support provided by the health service and the responsibility of the education provider and include such items as access, supervision, emergency care, orientation, patient care requirements, disciplinary action, security and safety.

All placement bookings are approved by the Director of Nursing and managed by staff development nurses. In the Kimberley, staff development nurses

occupy a senior position and are situated within the ward areas of the hospital. These nurses (usually one at each site) coordinate the rosters and arrange mentors for the students. Student nurses sign a declaration acknowledging their clinical placement takes precedence over work and social commitments (see Appendix B). This process enables students to be placed on a 24/7 roster system similar to all other nurses. This means students can attend placement on any of the three shifts (0700-1530; 1300-2130 or 2100- 0730).

Students on clinical placement are supernumerary to staff in the healthcare facility (see Appendix A, p. 5). This means that students do not form part of the workforce case mix. This supernumerary status provides learning opportunities across the facility. The mentor model of clinical support utilised by Notre Dame, School of Nursing and Midwifery ensures that the student is immersed into the life and culture of the remote healthcare workforce. Mentors are "chosen as role models for the profession and excellence in practice" (Notre Dame, 2012, p. 12). The mentor's role is to challenge the student to develop new skills and to seek out excellence in a relationship that provides support, open communication and guidance. This relationship enables students to learn the nuances of remote nursing practice in a supportive collegial fashion.

Conclusion

This chapter has described the geographical location of the study and the concept of remoteness. The geographical spread of nursing pre-registration providers has also been displayed. The chapter presented a description of the nursing workforce in a remote context with specific emphasis on the Kimberley and the Graduate Program. Since the context of this study is the remote campus of Notre Dame, Broome a brief description of the curriculum has also been provided.