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| **Name:** | Clare Cole | **Student ID:** | 3000010 |

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| **Objectives**  | **ANMC Competencies** |
| **1.** | Discuss the role of the nurse within a rural setting, identifying skills, knowledge and attitudes required to work effectively in a rural area of Australia. | 1.1, 1.2, 1.32.1, 2.3, 2.5, 2.6, 2.73.1, 3.2, 3.34.1, 4.2, 4.3, 4.46.37.2, 7.3, 7.4, 7.7, 7.88.1, 8.29.2, 9.4, 9.510.3 |
| **2.** | I will develop an understanding of chronic disease management in the community setting. |  1,3,4,5,6,8,10 |
| **3.** | I will have increased my knowledge on the use of interprofessional practice and autonomous practice within a rural/remote location  | 6.1, 6.2, 6.4, 10.1, 10.2, 10.3 |
| **4.** | Discuss the ways in which Ballarat Community Health Centre is improving the health of those in the community. | **2, 3, 5, 6, 7, 8 & 10** |

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| **Objective 1** | **Discuss the role of the nurse within a rural setting, identifying skills, knowledge and attitudes required to work effectively in a rural area of Australia.** | 1.1, 1.2, 1.32.1, 2.3, 2.5, 2.6, 2.73.1, 3.2, 3.34.1, 4.2, 4.3, 4.46.37.2, 7.3, 7.4, 7.7, 7.88.1, 8.29.2, 9.4, 9.510.3 |

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| **Date** | **CPD Activity** | **Evaluation** |
|  | To achieve this objective I will:* Ask the nurses themselves about their roles, what they do every day, what kinds of people they see, what health practices they do to these people and are they in their scope of practice.
* Be involved in the active nursing care being given to the patients, observe what the nurses do and how they interact with the patients, also how they educate the patients.
* I will read hospital protocols and other documentation including the CARPA manual.
 | * The role of the nurses in the rural setting was much more detailed then a nurse in a city hospital. Nurses in rural and remote areas work not only as nurses but counselors, educators, advocates, and mediators. They are highly respected members of the communities.
* These nurses, over time, develop a relationship with those members of the community which can aid greatly in their care as they are more likely to talk to someone they trust and respect when it comes to issues such as domestic violence and abuse.
* The nurses in rural and remote settings are required to be the ‘jack of all trades’, especially in the remote clinics as there is no doctor present to assess and diagnose the patients.
* In Tennant Creek Hospital they were fortunate to have a few doctors at the hospital therefore they were able to diagnose the patients and decide the care that was required.
* Due to the presence of the doctors I found that the nurses weren’t able to work as independently and autonomously as I expected. I believe partaking in a placement in a remote area would have been more beneficial in terms of building autonomy and self-confidence with assessment and diagnosis of conditions.
* The CARPA manuals were a fantastic reference if unsure of the best treatment options. They also had a manual for procedures, which had a step-by-step outline of how to perform a large variety of procedures.
* There were also books for women’s business and men’s business and it was important for male nurses to perform the procedures and examinations on other males and the same for women, they preferred the same sex nurse to assist them with those types of issues.
* Nurses in the rural and remote communities need to have a large knowledge base as they are exposed to a large variety of cases and need to know what to do in emergency situations.

Some of the nurses seemed to be experiencing some form of burnout, as they were not as culturally aware and respectful as I expected them to be. Although it would be frustrating to see the same patients come into hospital on numerous occasions, especially if it was for an issue that is preventable with active self-management. |

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| **Objective 2** | I will develop an understanding of chronic disease management in the community setting. | ANMC: 6.1, 6.2, 6.4, 10.1, 10.2, 10.3 |

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| Date | CPD Activity | Evaluation |
|  | To achieve this objective I will:Assist with running chronic disease programs such as cardiac rehabilitation, pulmonary rehabilitation and diabetes exercise groups | Will enable me to:* Develop an understanding of chronic diseases
* Develop an understanding of physical, emotional and social implications of chronic diseases
* Work with families and carer’s to achieve optimal care for patients outside of the hospital setting
* Reduce fears and anxieties patients and their families may be experiencing through education and ongoing professional support

Links patients to further services if requiredChronic disease management involves health promotion education to empower clients to take control of their condition. In rural Australia hospitalisation rates for manageable chronic diseases are higher than in metropolitan areas. This is why managing these conditions in the community setting in a supportive social environment is so important. These programs such as cardiac and pulmonary rehabilitation combine an education session and exercise component which gives clients increased understanding as well as improving health physically and socially in optional programs running from 6 to 8 weeks. According to Australian hospital data clients who undertake chronic disease management programs are 75% less likely to be readmitted to hospital with further complications. Anxiety and depressive disorders are common after a heart attack or cardiac surgery. These programs reduce these anxieties by giving the patients opportunities to talk to social workers, pharmacists to discuss their medications and their side effects and dietitians to help improve their lifestyle. The social worker can assure patients that their feelings are common after heart complications and also that it may be affect of their medications. These programs can also link patients with further ongoing services in the area such as Heart Smart, a supported exercise program in the region. |

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| **Objective 3** | I will have increased my knowledge on the use of interprofessional practice and autonomous practice within a rural/remote location  | ANMC: 6.1, 6.2, 6.4, 10.1, 10.2, 10.3 |

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| Date | CPD Activity | Evaluation |
|  | To achieve this objective I will:Independent patient consultations | * Developed an understanding of the level of autonomy associated with remote area nursing
* Was able to identify areas of clinical skills I felt needed improvement and self directed learning to improve on
* Develop an understanding of the role of remote area nurse-each patient presented for a variety of different health reasons. For example, with one consultation my role as a RAN included being a midwife, a diabetes educator, a counsellor, and a wound care nurse
* Conduct thorough and meticulous patient assessments based on the conditions associated with the environment
* Was able to follow my patients through, and ensure compete care was given
* Learned and delivered the concept of opportunistic nursing

Deliver healthcare based on primary prevention |

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| **Objective 4** | **Discuss the ways in which Ballarat Community Health Centre is improving the health of those in the community.** | **ANMC 2, 3, 5, 6, 7, 8 & 10** |

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| Date | CPD Activity | Evaluation |
|  | To achieve this objective I will:Work on understanding the social model of healthcare used by Ballarat Health Services |  By providing an extensive range of public services that encourage health promotion and prevention. BCH work under the social model of health BCH has a strategic plan that structures the delivery of health service for the region and is revised every two years. There is also a committee that evaluates the progress of the strategic plan and monitors the quality of the health care delivered.  -Such services include the ‘living longer, living stronger’ program which is exercise classes aimed to improve the overall health and fitness of those aged over 50 years. ‘No Falls’ fall prevention program for the elderly persons of the community that aims to improve the participant’s coordination and balance. Also a Parkinson’s exercise and support group and Zumba dance classes.-Chronic disease management such as the diabetes educator offers assessments and advice for a small fee. We were able to attend some appointments involving aboriginal members of the community; these sessions were modified for this demographic as statistics have shown that they are at a higher risk of obtaining the disease. Clients were educated and assessed on their individual situation and were given a booklet full of useful information about the disease process.-There are dietetic services available for people of all ages. The consultations are compulsory for anyone being managed with diabetes by BCH. Programs offered include MEND which is an exercise program aimed at childhood obesity.-The smoking cessation program is also an effective way of assisting the community by promoting quitting with withdrawal methods and counselling as needed.-The sexual health clinic is provided to assist members of the community, of all ages and backgrounds, to obtain confidential assessment and advice on their sexual health and function. The clinic provides such services as free pap tests and contraception.-There are ample mental health services in place including home based outreach support and a psychosocial rehab day program.Alcohol and drug services-counselling, withdrawal clinics and youth outreach. Family violence counselingYouth housingPrimary health direct care-community health, family planning and chronic disease management.Allied health-dietetics physiotherapy and podiatry.All the above services work towards a common goal of improving and sustaining the health status of the Ballarat region through health service provision, education and promotion. |