

The Good Rural Hospital

New Zealand 2017

Edition 1

A medical perspective

*Written by the students and faculty of the Rural Postgraduate Programme,
University of Otago.*

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Foreword

In 2002 students and faculty of Otago University’s postgraduate rural programme, (then in the Department of General Practice and Rural Health, Dunedin School of Medicine), wrote a document titled ‘The Good Rural Hospital’ which has since been core reading for the paper GENA724: ‘The Context of Rural Hospital Medicine’.(1) The intent in writing this 2017 document was to update the original document given the intervening period of 15 years.

This document was written by the 2017 students and faculty of GENA724 ‘The Context of Rural Hospital Medicine’ paper (now part of the post-graduate rural programme, Department of the Dean, Dunedin School of Medicine) with input from the wider post graduate rural programme faculty.

This is an aspirational document describing the specific role of the hospital as one part of wider rural health services. While recognising that there is and needs to be a wide variation of rural hospitals in New Zealand the document’s focus is on commonalities that define rural hospital practice.

The document (like the 2002 version) is written by doctors and as such represents a significant bias towards the views of the medical team. We acknowledge that other members of the rural hospital team and the community may have a significantly different, but equally important, view of the place of the rural hospital.

Opening Statement

A rural hospital can be compared to a keteⁱ - whereby like the flax strands, culture, ideology and values are interwoven with systems, workforce, facilities, social and geographical context to become a purposeful provider of rural health care.

A rural hospital in New Zealand (NZ) has been defined as ‘a hospital staffed by suitably trained and experienced generalists, who take full clinical responsibility for a wide range of clinical presentations. While resident specialists may also work in these hospitals, specialist cover is limited to 24 hr / 7 day cover in no more than one specialist area.’(2)

The good rural hospital shares the values of the community in which it lies and strives to provide comprehensive equitable health services for that community. Care is taken not to increase any existing inequity, striking the right balance between services that can be provided locally and those better provided at a distance.(3) Where possible health services are delivered locally: by locals, for locals.(4) Rural communities are diverse and heterogeneous and the rural hospital considers and responds to the unique social, geographical and resource determinants of rural health care. The rural hospital is a strong advocate for the community and communicates broadly with local community and stakeholders, regional, national and international network.

Key features of rural practice include: geographical distance from: large urban hospitals; specialist services; and diagnostics; breadth of practice and services; a diverse and complex caseload

ⁱ Basket, kit

undertaken by a relatively small generalist health professional team with a broad range of knowledge, skills and interest areas; professional isolation and limited resources demanding resourcefulness, innovative use of technology and integrative and co-operative practice. (5, 6)

Principles of Service Provision: relevant to the community and culturally appropriate

- The rural hospital provides 24/7 inpatient and acute emergency care providing care for a broad range of clinical presentations. It may also provide other often integrated services (e.g. outpatient and community based care).
- Services meet and are responsive to the health needs of the community.
- There is a close working relationship with community based health services that are adapted to the specific circumstances of each locality. There is frequently and necessarily blurring of the primary and secondary care boundaries that have become standard in urban areas.
- Service provision adheres to the framework laid out in the Treaty of Waitangi:(7)
 - Protection.
 - Participation.
 - Partnership.
- Services are patient centered, with patient safety, care and well-being at the centre of all activities and holistic encompassing the four pillars of health as described in the Te Whare Tapu Wha model: (8)
 - Te Taha Hinengaro (*psychological health*)
 - Te Taha Wairua (*spiritual health*)
 - Te Taha Tinana (*physical health*)
 - Te Taha Whanau (*family health*)
- Services are provided in accordance with the Health and Disability Commissioner's Code of Patient's rights.(9)

- Services are delivered in an appropriate, cost effective and efficient manner.
- Services operate within concurrent policy guidelines and other relevant operational standards for health care provision.
- Services are provided by staff in an environment that is welcoming, inclusive, accessible, co-operative, and culturally appropriate.
- Services provided are clinically effective, evidence based and consider international best Rural Health practice.
- Services are responsive to local, regional, and national emergencies, and the effects of global phenomena such as pandemics and climate change.
- A safe and secure environment is provided for patients, whanau, staff and visitors.

Service delivery; ensuring safety and clinical effectiveness

Human resources

All health professional staff:

There are a large number of non-medical health professional team members that are crucial to the services and running of a good rural hospital particularly nursing staff. Other groups that make up this team may include: radiographers, physiotherapists, occupational therapists, speech language therapists, social workers, mental health providers, pharmacists, phlebotomists and laboratory technicians. Rural hospitals rely on small inter-professional teams where individual roles often overlap and there is a high level of interdependence between different ‘teams’ and individuals. In order to achieve this there needs to be the right culture and each group needs to be empowered with the right leadership and support to meet their professional needs, including recognition of their distinctly rural scope.

- Each rural hospital ascertains and employs the right staffing mixture in terms of variety, numbers, skill, and experience to suit their service and available local and regional resources.

- All health professionals are registered with their respective New Zealand regulatory body, and hold a current annual practicing certificate.
- Where possible, all health professionals have rural specific training with relevant and appropriate skills, experience, knowledge and attitude.
- The members of the health professional team should reflect the social, cultural and demographic makeup of the community that the rural hospital serves and as such, the team members are an integral part of the community.
- Workloads are sustainable and fair with adequate staffing numbers to provide clinical care, with safe rostering patterns in line with industry best standards.(10)
- Remuneration is in recognition of the skills, knowledge, experience, level of responsibility and ongoing commitment to further professional development.
- All staff communicate effectively, accurately, regularly, consistently and in a timely manner while respecting the privacy of the patient to other clinical staff and staff of supporting services involved in the welfare of the patient, both internal and external to the rural hospital and with the management team.
- Teaching and mentoring of undergraduate and postgraduate students and trainees is adequately supported by experienced and appropriate relevant health professionals.
- Staff undertake continuing professional development that meets the requirements of their relevant professional body and ensure they are equipped to meet the evolving health care needs of their community.

Medical staff

Rural Hospital Medicine has been recognised in NZ as a distinct vocational scope of medical practice since 2008.(2, 11) Where possible, registered Fellows of Rural Hospital Medicine (FDRHMNZ) should provide care at rural hospitals in New Zealand.

FDRHMNZ is frequently held in combination with fellowship of another vocational scope, most commonly FRNZCGP (dual fellowship)ⁱⁱ. Other training pathways that combine Rural Hospital

ⁱⁱ The RNZCGP with its DRHM is the professional body which provides the training programme and ongoing professional development for both General Practice and Rural Hospital Medicine.

Medicine with Emergency Medicine, Urgent Care, and Internal Medicine are being undertaken. It is also possible for an experienced practitioner with sole fellowship of another vocational scope (e.g. General Practice) to provide services in a rural hospital.

The importance of the rural generalist (as defined by the Cairns Consensus) in meeting the healthcare needs of rural communities is acknowledged. The 2014 Cairns consensus statement defined rural generalist medicine as a broad scope of rural medical care that encompasses comprehensive primary care, hospital or secondary care, emergency care and advanced skill sets. It emphasises population health and multidisciplinary team approaches that align with, and are responsive to, the health needs of rural communities.(12) Accordingly, rural generalist training in NZ is dual fellowship in General Practice and Rural Hospital Medicine.

The ideal qualifications of an individual practitioner will vary considering the location and wider rural health services milieu into which the hospital fits, such that for each community the medical workforce, as a whole, practices across the scope of rural generalist medicine.

Although the medical workforce has a predominately broad skill-base, within this group there will be those with more specialised skills and interest areas. Practitioners may come to a rural hospital armed with these skills, or it may be necessary to develop and foster these once obtaining a post at the rural hospital.

Care in rural hospitals may also be provided by other appropriately skilled and experienced medical officers (e.g. general registrants or non-vocationally trained RMOs) who may be part of training programs or pathways to become vocationally registered rural hospital doctors themselves.

The good rural hospital provides:

- Well supported and supervised rotations for rural hospital registrars and any other medical trainees/registrars.
- Rostered non-clinical time to allow for completion of administration tasks and further development of services such as teaching, quality assurance measures and continuing medical education (CME).

- A clear and well documented system to provide back-up to the on-call hospital clinician when needed.

Other (non-health professional) Staff

There are a large number of non-health professional team members that are crucial to the services and running of a good rural hospital, including:

- Hospital management team,
- Reception staff,
- Administrative staff,
- Estate and infrastructure management.

Service facilities

Facilities that are appropriate to the location and provide the necessary health services which are safe, well maintained, adequate to withstand and protect from natural disasters (including earthquakes and regional flooding) for both staff and patients. There is appropriate resourcing and review of equipment, including upgrades when required.

Acute Emergency facilities

- An area to receive and manage acute /emergency presentations.
- Monitoring, treatment, resuscitation and diagnostic equipment; in particular for the management of:
 - Airway and ventilation issues,
 - Circulation issues including:
 - Treatment of cardiac arrest,
 - Control of major haemorrhage.
- Laboratory testing, which maybe point of care.
- Radiology.
- Ultrasound (which includes Point of care ultrasound).
- 24-hour access to specialist advice.
- Access to a 24-hour retrieval service with a “single phone call policy”.

Inpatient facilities

- On-site 24-hour staffing of the inpatient unit by nursing staff.
- Medical staff are available on-call or on-site at all times.
- Facilities are fit for purpose and support patient privacy and confidentiality including appropriate ward rooms, treatment rooms, equipment, pharmacy services, catering, laundry, provision and space for whanau and visitors.

Out-patient/Elective/Visiting facilities

- Visiting health professional clinics which deliver specialist services not provided locally. These may be provided in person or virtually.
- Facilities are fit for purpose with a suitable number of rooms, adequate and well-maintained equipment, administrative support for booking and managing referrals and support from suitably trained local staff.
- It may be necessary for the visiting team to bring their own resources if they are not available locally (e.g. the mobile surgical bus.)

System structures

Rural hospitals:

- Invest in digital technologies, including telehealth.
- Anticipate transition to paper-less digital systems and divest in non-digital technologies (e.g. pagers, faxes).
- Develop and maintain robust and secure patient information systems that integrate relevant patient information including: laboratory and imaging results, discharge summaries, out-patient letters, and clinical information from other health care providers.
- Have systems that link with the primary care, the base hospital and the tertiary referral centre record systems and can be upgraded to integrate with future systems (e.g. electronic prescribing and national health record).

- Have a system for triage, whether onsite or provided external to the hospital e.g. by local general practice. This should be in-line with national standards.(13)

Education and training

Rural hospitals:

- Promote a culture which values learning and are committed to the ongoing training, education and development of all staff, including leadership development.
- Encourage inter-professional teaching and learning, including simulation team training.
- Recognise that rural health professionals require particular investment in training, due to the rural context in which they practice.
- Can provide valuable and unique learning opportunities to medical, nursing and allied health students, apprentices and trainees.
- Support the development of rural specific training pathways/qualifications for all health professionals.
- Facilitate educational opportunities for patients and the wider community e.g. pertinent health issues.

Research and development

Rural hospitals:

- Demonstrate and promote rural hospitals as valued and essential components of the National Health Service.
- Actively encourage staff to participate in postgraduate study and research, including contributing to databases and data collection for regional, national and international research, audit, quality assurance and continued advancement in rural practice.
- Promote and actively participate in academic Rural Health.
- Promote and participate in research that informs rural health care delivery.
- Promote membership of national and international organisations which support and advance Rural Health.

Transfers/transport

Rural hospitals:

- Provide appropriate and timely patient referral to the base hospital and tertiary referral centres.
- Establish transfer and retrieval processes for emergency and elective interventions.
- Have referral mechanisms in place, e.g.: phone consultation, telehealth, electronic referrals.
- Enable repatriation back to rural facilities for patients from base hospital or the tertiary referral centre.
- Work closely and collaboratively with ambulance staff.

Emergency transfers

- Emergency transfer destinations are pre-negotiated and understood by both the referrer and the receiving service.(8)
- For urgent retrieval for patients with a life-threatening condition, communication to the receiving service is facilitated through a single pre-negotiated point of contact: usually the coordinator of the retrieval service. Appropriate staff are brought to the rural hospital by the retrieval service dependent on clinical scenario after discussion with the rural medical officer caring for the patient.
- Where possible, patients are transferred directly to the location where definitive care will take place.
- There are direct links to national clinical specialist networks (e.g. interventional cardiac care, neurosurgery, major trauma, burns and spinal injury.) (14-16)
- Resources available in the event of emergency transfers are known and defined. Use of these resources should not deplete the local area of emergency services.
- Appropriate and supported staff accompany patient transfers. Care en-route is equivalent to the care received at the rural hospital.(17)

Elective transfers

- Elective transfers are anticipated and planned to occur within high resource times of the day or week.

- Arranged transport to regional centres is available, resourced and advertised for appropriate community use (with no financial barrier to the rural patient).(18)
- Appropriate and supported staff accompany patient transfers. Care en-route is equivalent to the care received at the rural hospital.(17)

Access and Integration

Relationships

Rural hospitals value, support and foster respectful professional relationships. They recognise the importance of effective communication between all members of staff. Rural hospitals have strong relationships with other health providers that provide care to their communities. In particular, the rural hospital has a very strong symbiotic relationship with general practice and primary care. The boundaries that define scope of practice are often much more blurred between primary and secondary care than found in more urban areas. Other key relationships include external allied health teams, base hospitals and other government and non-government agencies.

Organisations/Stakeholders

With its many stakeholders locally, regionally, nationally and internationally, the rural hospital fosters:

- The commonality in scope and services between rural hospitals and other rural providers and organisations across New Zealand and internationally.
- Linkages with urban and city based organisations and health providers
- Linkages within the community, recognising the key role of the community in providing support for the rural hospital including, in many cases, financial support.

Local stakeholders include:

- The community and its visitors.

Communities make significant contributions to their hospitals. Process is in place to ensure this contribution is documented and recognised.

- Volunteers- individuals and groups.
- Community groups.
- Other health care providers.

Regional stakeholders include:

- Other rural hospitals, rural health services, rural practitioners,.
- District Health Boards.
- Primary and community health care organisations
- Base hospitals and tertiary referral centres
- Transport services.
- Regional agencies.
- Local government.

National stakeholders include:

- Rural Health organisations including rural health academic departments.
- Government and associated agencies.
- Professional colleges and bodies including trainees and apprentices
- National clinical care networks: e.g. major trauma, burns, spinal injury.
- Tertiary education providers and academic centres including undergraduate and postgraduate students.

International stakeholders:

Rural and remote health practitioners (those working in geographically isolated places) have synergy in scope and day to day practice. Rural hospitals in NZ forge links and foster established links with rural practitioners and rural health services internationally as well as with representative

vocational bodies (e.g. ACRRM), international organisations (e.g. WONCA) and academic institutions.

Particularly relevant for NZ are those countries with which we share a common history and geographical region such as Australia and Pacific Island countries.

Accountability and Governance

Governance

- The rural hospital is part of the community's health service. Those involved in the governance of health services foster the sense that the service is owned by the community.
- The community and the health providers are represented in the hospital's governance structure. All consumers and providers have access to their representatives.
- There is accountability and transparency in all activities.
- The representative structure must be responsible for the election and appointment of a competent and balanced administrative body or board with a broad mix of interests and skills that mirrors the community. This board is then otherwise unencumbered and charged with directing the operational aspects of the health service.
- The representative body is responsible for communication between the community and the hospital administration. There should be well designed policies and procedures for public involvement. This may include dialogue with community leaders and consumers, and public meetings. Where a rural hospital is part of a larger regional institution and governance structure (e.g. a District Health Board), formally recognising the rural specific differences in health services will allow the rural hospital to be better represented within the institution. Accountability and transparency will also improve, especially if it is a separate strand of all audit and reporting processes.
- Hospital governance should aim to balance the interests of the many stakeholders involved in health care delivery.

Clinical governance.

- The rural hospital has a clinical governance structure that meets regularly, and is responsible for maintenance and improvement in standards of clinical care.
- The rural hospital advocates for improving the overall health of the community through developing and supporting public health initiatives and wider local issues such as infrastructure and services available in the region. The rural hospital encourages roles of responsibility to review services and outcomes.
- The rural hospital has an established clinical medical director role and similar leadership roles for other health professionals within the hospital.

Quality assurance

- Guidelines and protocols that are consistent with those of the base or tertiary hospital but adapted for the local context and resources.
- The revision of statements has a clear and documented schedule and a member of staff assigned to perform this task.
- The informal giving and receiving of feedback is part of the culture of rural hospital practice.
- The hospital culture encourages all staff to raise and openly debate issues that impact on the quality of patient care, in both an informal and formal setting.
- All documentation and clinical hand-over is high quality and is regularly audited.
- Formal feedback processes are scheduled, regular, routine, robust and well-respected to allow issues to be dealt with openly and with the full confidence of the staff involved.
- Professional appraisals are undertaken by the relevant clinical leader on an annual basis.
- Peer review sessions are undertaken regularly and protected by a formal process.
- Robust, regular, and effective clinical and system audits are performed.
- Clinical audits are undertaken to improve patient outcomes and safety and ensure compliance with best practice.
- Audit directed towards system service delivery is performed with aim to influence and direct policy, and the principles and methods of service delivery.

- Regular review of reported adverse events and sentinel events. (e.g. Significant events/M&M meetings)
- Quality assurance processes (i.e.: feedback, audit, sig events, peer review) should be inclusive and encourage inter-professional participation where appropriate should involve other providers based in the community or other organisations.
- Patient feedback is encouraged through surveys, suggestion boxes and complaints procedures. Community meetings for two-way communication and to get the pulse of the community on their requirements.
- There is a clear process for the timely management and resolution of complaints, and for investigation of adverse event/sentinel events.

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