A Day in the Life of a Rural Public Health Nurse

Submitted By Jane Palmer, RN, BSN, Nursing Director, Klickitat County Health Department

One of the mantras I live by is, "Change IS Good!" For the last 33 years, I have devoted my professional career to working in rural public health settings. Each day is a new adventure and filled with endless change.

Work begins at 8:00 a.m. with coffee in hand and a conference call with state peers discussing an upcoming quarterly meeting of leadership heads. The issues are broad and the solutions complex.

Having an "open-door" policy with staff I supervise seldom leaves uninterrupted time. The prevention coordinator needs to brainstorm on how best to move the "needle" in a stymied collaboration with a community partner. The tobacco lead staff is wondering how best to approach one of the county's incorporated cities to move a policy agenda item forward.

Of course, I have time to discuss the WIC expansion in a rural part of our county and who best to meet with the new Early Head Start staff person to coordinate our services to those VERY rural clients, and oh, by the way, would it be OK to send a clerical person along too? Now, let's talk about inter-agency communication and how best to get that departmental support while juggling in-house coverage. Don't forget to plan the rural visit on a day when we aren't busy with our family planning clinic, or immunizations.

"Sure, I have a minute to give a ppd. Of course it's no problem. I understand it's the only time they could make it." Never a dull moment…

A break for lunch and then the merry-go-round begins again. The 96 unread emails must be attended to. It seems as if each one requires action on my part. I must get a purchase order ready for the MCH curriculum needed. Call and schedule a meeting date with the local mental health agency. We really do need to coordinate better.

Let's try and revise the electronic survey to send to our communicable disease partners. Knowing how better to respond to threats will make this a healthier and safer place. Oh, by the way, it's time to update the contact list for our emergency communication plan. I wonder if one of the front office staff would have some time. I'll have to check with their supervisor.

The phone call from DSHS about our contract amendment will cause some grief. I must let our fiscal person know as well as the line staff. They'll just not be able to do so many of those visits.

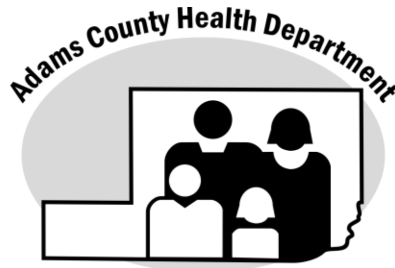
The RN meeting agenda: What? Sure it would be great to have you present updates on your program content. I must get that done and out to staff soon.

Let's see, it's time to meet with the principal from the local grade school. It sure is great to have partners willing to work on policy level strategies to improve the health of our kids. This may lead to a work group tackling revamping the school food program. It would be great to at least offer healthy options and remove the pop machine from the high school.

It's nearly 4:00 and I must get my time sheet done by the end of the day.

A few more emails, phone calls and an occasional interruption and it's 5:00.

WHEEW! I'm exhausted, but glad to show up again tomorrow to do it all again.



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Contributed by Callie Moore, Nursing Director for Adams County Health Department

A "typical day" for a public health nurse is hard to describe. Much of the time every day is different and certainly different for each public health nurse. I'll try to describe a typical day for each public health nurse. Although each is different, together the whole encompasses what "typical" is in Adams County.
What a day looks like for a rural public health nurse….. Adams County.

PHN #1: She is in charge of TB and Immunizations and most of the CD program. She is the main clinic nurse, giving immunizations, applying fluoride varnish, checking blood pressures, overseeing WIC activities on WIC days, conducting clinic and home visits on MSS/ICM clients. A typical day see's her arriving at work, checking the refrigerator to assure the vaccine is kept in the correct temperature range, giving immunizations to families that have come from Mexico, some are very large and have confusing immunization records, she explains what she is giving and why and what side effects to watch for. She goes on an MSS home visit, instructing a new teen mom on how to take care of her new baby, making sure she has connected with the doctor and scheduled her post partum appointment and one for the baby, she goes to the local clinic to discuss what is needed for the upcoming immunization site visit. She has done a PPD skin test that turns out to be positive. The client arrives and she completes the client assessment and refers for a chest X-ray. She sends the X-ray and assessment to the health officer for review via email. She receives a CD report and follows up with the health care provider. She enters the data into PHIMS.

PHN#2: She is in charge of Tobacco and Child Care consultation and one of the leads on the Healthy Communities team. She is the health department public information officer and in charge of teaching the First Aid/CPR classes. She takes a turn in the clinic giving immunizations, PPD's, BP's, answering questions. Her day may include a site visit to a tobacco retailer to provide education or assess compliance. She may be consulting with child cares about the child's immunization compliance or communicable disease control. She has held the community meeting to assess county needs and strategies to improve and make the community a healthier one to live in, she is now writing the report and planning next steps to implement the community action plan. She is ending the day by teaching First Aid/CPR classes to child care providers in the evening.

PHN#3: She is in charge of assessment and is learning all that encompasses. She is one of the leads on the Healthy Communities program team. She collects the lab reports from PHRED and follows up to assure the information is entered into PHIMS. She is earnestly working to collect the STD reports and assure there is partner notification and follow up treatment through the newly established EPT program in our county. She has conducted the first ever obesity assessment project in our county and is now preparing to present the results at the state assessment meeting. She is also back up for immunizations and TB. She is preparing the annual communicable disease report for the next all staff meeting. She has completed graphs and tables to assist staff to look at data and include it in reports and presentations, and especially to assure activities are addressing the most pressing concerns.

PHN#4: She is the WIC coordinator, MSS coordinator, jail nurse, HIV/AIDS coordinator and ABCD coordinator. She takes her turn in the immunization clinic too. She is working to get the ABCD program implemented. She is preparing a training and getting forms and information to the dentists. She works with a large clinic to get information about how children are being enrolled. She may be on a home visit to assess a new MSS client. She goes to the jail to check the inmate's health and concerns. She works with jail staff to assure health concerns are addressed. She does an HIV test on a concerned inmate with a possible exposure. She returns to the office to meet with a WIC client and changes a food package for a child who cannot tolerate the formula.

PHN#5: She is the CSHCN coordinator, Oral health coordinator and Public Health Emergency Response coordinator. She takes her turn in the clinic. She is writing the after action report for the H1N1 response from the health department for the last

several months, it's due soon. She is scheduling the last schools for the smile survey for the oral health program, it needs to be completed by the end of May. This afternoon she went on home visits. She has visited 3 clients today. Two are siblings with developmental concerns who are changing providers and she is gathering information to share with the new provider to facilitate a smoother transition. One is a new client with feeding concerns who needs help to schedule upcoming appointments. She weighs and measures the child to assess growth and show mom progress and will send a note to the primary care provider.

There is great value to being a part of a small rural LHJ. The client contact, working with like-minded nurses, working in our communities to improve health status, and the cooperative spirit that prevails in this agency is rewarding.

Submitted by Marjorie Hancock, RN, Moses Lake Community Health Center

Marjorie Hancock has been a rural health nurse since 1993. This might seem like a huge leap when you consider that Marjorie was born and raised in Folsom, California, the home of Johnny Cash and the Folsom Prison Blues! She graduated from Big Bend College/Columbia Basin College with a Registered Nurse degree. She accomplished her education while raising 5 children; when she began school her oldest was in the 8th grade and the youngest in the 1st grade. She chose to be a nurse because it gives her a great deal of satisfaction teaching people how to take care of themselves. Her nursing career began in long term care working with Alzheimer's patients which is a passion of hers. In her words, “How could a person not want to make grandma and grandpa’s last days not be filled with smiling faces and warm hugs?”

After leaving long term care Marjorie worked for the Grant County Health District. She was in charge of the immunization department, but also assisted in investigating active TB cases, communicable diseases, high lead levels in children, and outbreaks in mumps and measles. She states, “When working at the health district you really never know what you were going to hear when you picked up your phone.” Since leaving the health district, Marjorie has worked in the primary care setting for the Mattawa Community Health Clinic, and now for Moses Lake Community Health Center.

Marjorie enjoys the rural health care setting because it allows her to know the patients on a more personal level. They rely upon you when they call the clinic and they have a familiar face when they come in for a medical visit. For Marjorie this kind of care fills a personal need to take care and educate those with whom she comes into contact. Marjorie fondly recalls a special 83 year old patient with whom she had nearly daily contact. She had an anxiety disorder and extreme pain in her back; to the patient this was debilitating. The patient would call every day and they would talk until the patient felt she could make it on her own. After several appointments and a referral to a pain management specialist she is now free of pain. This is just one of the many examples of the rewards of working with patients on daily basis and brings a smile at the end of a long day.

Submitted By Ruch Pechin, Mt Carmel

Rural healthcare has come a long way in Stevens County in the last 10 years, no longer are nurses and physicians in danger of being out of date or out of touch because of living far from the downtown medical centers. The revolution in distance learning, and the internet has lessened the gap between city health care and rural health care delivery.

The advent of the Critical Access Hospitals changed the face of healthcare for our communities. This has made rural healthcare a financial viable possibility. The 25 bedded hospital concept and the growing outpatient services that they are able to offer the community has allowed hospitals to expand their scope. . Unlike in a previous time, many studies and surgeries can now be performed at the local hospital instead of traveling to big cities or further afield.

Today with the addition of the Rural Outreach Nursing Education better known as the RONE program, local hospitals are finally able to grow their own nurses. This is an amazing benefit to rural communities. There is no longer in many communities the need to send potential nurses far away from home and family to study. In addition, the fact that hospitals now have student nurses means that long time nurses are brushing up on their skills.

For the last few years we have seen an influx of new arrivals to our communities coming with a myriad of health problems that in previous years would have prevented their relocation to the more remote parts of Washington and their hospitals. This has meant that education of staff has had to step up also. With patients who have pacemakers and AICD's , patients who have undergone solid organ transplants or stem cell transplants today's rural nurse needs to keep up to date with research and evidence based practice. Today patients are living longer with more diseases and more complications than ever before.

It corresponds therefore, that the nurses that work at these facilities must be able to work in many different environments and care for the whole spectrum of life literally from life to death and everything in between. It is fortunate then that many rural hospitals, clinic and home care services have been able to recruit quality nursing staff, who are looking for a different pace of life. This influx has brought nurses with many skill sets.

No two days are the same in a rural hospital, staff, are equally prepared to deliver babies or treat multiple trauma patients. The stressors can be different however. The rural communities these facilities serve are tight-knit. It is not unusual for the nurse to be treating someone they know, the bank teller, teacher, next-door neighbor. Treating patients with life threatening conditions who you personally know takes an emotional toll on staff. However, on the other hand it provides comfort to families seeing a familiar face, someone who can explain what is happening.

Every day the rural nurse can use technology to help in the care and treatment of their patients. Fast CT Scans, the mobile MRI or the ability to send images over the internet to Radiologist in Spokane or as far away as Australia to be read, improves patient care in a timely fashion.

In Eastern Washington, we are lucky to have such services as the INHS and Med-Star who provide ongoing education without having to travel to Spokane or further a field. A dedicated trauma staff at Sacred Heart Medical Center also provides on going education for emergency room nurses and other staff. This is accomplished using the internet and the Tele-Health system.

However, there are some difficulties in rural healthcare just as in urban care. The uninsured and the underinsured cause a huge financial burden to all our rural health care facilities. Added to that there are very few resources where people can go for help.

Nurses, who work in rural hospitals, are well skilled in nursing as well as being exceptionally innovative and inventive. It is important to remember that they are a vital part of our health care.

Submitted by Raine Beeson, RN, Okanogan-Douglas Hospital, Brewster WA

Report at 0700. I'm in charge. Assignments are made and we are off and running at 0730. Across from the nurse's station, we have a high visibility room with an elderly, confused, agitated gentleman trying desperately to get out of bed. That's my first stop. I re-orient him as I get him up out of bed, take him to the bathroom, wash him up at the sink and gave him a shave. I dress him in his own clothes and then help him eat breakfast. As I stared into his eyes, I could only think of the strong, kind gentleman that I once knew around town. As he held my hand, he conveyed to me how hard it was to accept help for just the basic things. I reminded him of all the kind and helpful things he once did for others and now, it was my honor to return some of that to him. He asked me to pray with him and I did and he quietly drifted off to sleep. Not a lot of skill involved but a little time and a lot of compassion can go a long way.

That's rural nursing.

As I exit his room, I'm quickly rushed into a room two doors down to assist with the delivery of a gravida 4 para 3 mother who is not waiting for the provider! As the baby is born and begins to cry, I smile as I am reminded of the saying "from cradle to grave" that is often heard regarding rural nurses. And it is true. That's what we do.

That's rural nursing.

Next comes our first ambulance of the day. A male patient having an acute MI. We quickly assemble our "cardiac team" and place a call to the city. The patient is assessed, EKG, monitors, oxygen, IV's, aspirin, nitro, heparin, has lytics on board and an air ride to the city in 28 minutes!

That's rural nursing.

I have a little time now to start a pediatric IV, sign off some orders from morning rounds and obtain some medications from the pharmacy. Soon I receive a phone call from the operating room supervisor and they need a second room opened up. Off I go to change my clothes and circulate until a second crew can get here from home. The surgical tech is having difficulty handing instruments and holding retractors at the same time, so I also step in to fill that role.

That's rural nursing.

Before the shift has ended, I have assisted with an intubation and cardioversion in the ICU, provided conscious sedation in the MRI department and placed a PICC line for long term antibiotic therapy. I end my day sitting with a family who has tragically lost their son in an auto accident. It's never dull, never the same, highly demanding and extremely rewarding. It takes more breadth and depth than any other nursing specialty. That's rural nursing.....
I could not truly tell you about rural nursing without including a bit about "our family". Everybody knows everybody here and we love each other. It does not matter if you are in the billing office, housekeeping department or the CEO, we will walk through the trials of life with you. We will hold hands and share tears. We will laugh together and have celebrations. We will have baby showers and attend funerals together….because that is who we are and what we do….we are all family…..

That's rural nursing!

The Life of a Rural Nurse

Submitted by Anita Beaver, Charge Nurse and Education Coordinator, Ferry County Public Hospital District #1

My name is Anita and I live in a mountain town in northeastern Washington. I work in a 25 bed Critical Access Hospital (CAH). After moving here from the Seattle area, I quickly learned the myths about rural nursing were not true. One myth about rural nursing is that it is like being semi-retired, sitting and knitting all shift, helping to bandage toes, kissing babies and enjoying a quiet life. Wrong! This is one of most exciting and energizing types of nursing I have found. Life as a rural nurse is like a box of chocolates, there is a never ending variety of opportunity to provide quality care.

A rural nurse's experience must be diverse, have expert knowledge, master the skills of multiple specialties, and have the ability to quickly change from one nursing specialty to another with very little notice. Rural nurses must possess advanced critical thinking skills necessary to function independently within the professional standards and guidelines of nursing practice. On an average shift I could be responsible for passing medications in the long term care unit, caring for a dying geriatric patient and their family, placing a cardiac patient on a nitro drip, administering hourly breathing treatments to a patient with pneumonia, or suddenly being called to the ED to assist with the delivery and care of a newborn.

We have to be experts at multi-tasking, while working with tireless tenacity, within difficult, stressful situations and without the resources of other wards to call for help. We are resourceful; often the off going shift and the oncoming shift will combine forces exhibiting exemplary professionalism, dedication, and team work to help each other get through a difficult situation. The patients are our neighbors, friends, or family members. We must be able to expertly manage interruptions, juggle family dynamics, and collaborate with team members while providing quality care for our patients.

Rural nurses are required to obtain and remain current with many advanced training certifications. At our facility we have five required certifications: Advanced Cardiac Life Support (ACLS), Trauma Nurse Core Course (TNCC), Pediatric Advanced Life Support (PALS), Neonatal Resuscitation Provider (NRP), and Cardio-Pulmonary Resuscitation (CPR). Some of us have additional training certificates in Labor and Delivery, Emergency, Medical Surgical, and Procedural Sedation. In addition, nurses at our facility are encouraged to obtain education and training in a specialty of their choice.

The truth about rural nursing is, it is not for the semi-retired; however, it is the most exciting, rewarding, and diverse job a nurse could have. Rural nursing is for those that strive for excellence, like variety, and enjoy working in an atmosphere of teamwork and fair play. It is for those that love their jobs and patients and want to become personally involved in the enhancement of their community. I love rural nursing. **It is the pace, variety, team work, and personality of rural nursing that I enjoy most.**

THOUGHTS ON BEING A RURAL NURSE

Submitted by Rachel Weber RN, BSN, Trauma Program Manager, Critical Care Services Manager, Mid-Valley Hospital

I graduated from the University of Washington School of Nursing in 1977. I was a hot shot RN working ICU/CCU at Swedish Hospital in Seattle, never even knowing or caring where Omak, Washington was.

Then I went to Southern California to work in a Trauma Center, still single and loving the sun. On returning to Seattle I said to myself "I want to be a pediatric nurse", and went to work for Mary Bridge Children's Hospital in Tacoma.

I married, and my husband said he wanted to live in a small town and moved me and our daughter to Omak, Washington. I was very nervous about having good health care for ourselves and the prospect of going to work for a clinic, a nursing home, or a 40 bed "Hospital".

I quickly became confident in the healthcare. I went to work for a clinic and found the Family Practice Doctors friendly, non-threatening, and best of all, extremely skilled. They performed c-sections and took out tonsils as well as assisting the local surgeon with larger bowel surgeries. I got acquainted with many people, caring for them in the clinic and sometimes seeing them at social gatherings the next day.

I found myself wanting to return to hospital nursing, so the local Mid-Valley Hospital hired me. On my first orientation day I had a post-partum patient and I was told to chart on the height of the fundus. I said, "What's a fundus?" Being well-versed in anatomy, I was very embarrassed and did not remember learning this in school. Next, I had to set up traction for a fractured femur. Needless to say, I had to dig deeply back to my Med/Surg nursing clinicals and refer immediately to a Lippincott manual and a Med/Surg text book. The OB text book I held onto came in handy as well. Welcome to Rural Nursing and putting this big city girl to shame. Well, that was 20 years ago now, hard to believe. I still tell nursing students each year during their orientation how I have learned more about nursing being a rural nurse than in any other job I have held. Though I have enjoyed my entire nursing career, I have experienced the whole text book here in Omak and more variety than I can say!!! That's the challenge. The Rural Nurse must give the same standard of care as any other nurse, caring for the same patient population. Today my pt load was from neonate to geriatric. It's wild!!!The challenge of course is knowledge base. That is why we are very pro education. We attend conferences both out of town and on telehealth. There are always good webinars to view as well that are helpful in keeping current. Thank goodness for resources and the internet!

So what's a day like for a Rural Nurse Manager?

In the same day I could be pulled to help in the ICU to OB and then to ER. Yesterday I started a 24g IV on a 3 month old and was called to ER for a trauma and started a 16g IV 15 minutes later. We ARE the IV team and oh yeah, we are also R.T./EKG, the Ostomy RN, Wound specialist, the diabetic educator and sometimes we even mix our own T.P.N. when the pharmacist is gone!!!

That brings up the most important thing about being a rural nurse, and I speak for all Mid-Valley hospital nursing staff, and that is The Team. We are always thinking about who is in house as your "go to" for expertise and skill level as we can't accomplish any of this challenge on our own. I am talking about using all our staff, including housekeepers, who keep a watchful eye out for our Fall Risk pts and our beloved Security Guard/Floor Care "man of the hour", who steps in to help any way that he is able. We continually keep in mind a plan A,B,C and, if needed, we pull out a plan D to handle the patient care needs of our community with limited staff and resources. We know who we can call in if patient care levels and acuity rise. We also pray a lot!!!

Best of all, though, after living in this small community now for 20+ years, I have had the opportunity and great honor of taking care of my friends and their loved ones. I can put a name to every face and we either already know our patients or will be getting to know our patients well. We see them out in our community returned to health and their lives. It brings a different dimension to what we are doing. We live down the road from our Doctors and see them at social and athletic events. We know their families and work so closely together on our patients. This is so priceless, I don't know why they pay me!!!
Thank you for this opportunity to share my wonderful job with you and shed some light on what it is to be a Rural Nurse.

RURAL NURSING –
WHAT IT IS ALL ABOUT

Submitted By:
Torrie Matlock, RN – Clinical Coordinator Willapa Harbor Hospital and
Jan Ritzman, RN – Clinical Coordinator Willapa Harbor Hospital

Nurses from a small community have a lot in common. Most are summoned to return to their place of birth, feeling an irresistible kinship to the land, blood ties to family, and a longing to honor rural nursing. Most nurses stay in rural nursing until they retire.

What is a typical day for a rural nurse; many of you can probably imagine that it varies a great deal, depending on the type of work the rural nurse is doing on any given day.

A typical day for a nurse working a twelve hour shift looks something like this. It all begins at 6:15 AM with reporting for duty and receiving report from the off going night shift. Then patient rounds are made by you the "Charge Nurse" of the day and then repeated when the physicians arrive for their morning rounds. The first of your physicians always arrives at, of course the same time breakfast is scheduled—7:30 AM. Depending on the daily census it can be challenging to get all patients prepared for breakfast, which includes bathing, treatments, dressing changes and passing of some but not all medications. Thanks to the help of your support staff which consists of LPN's and certified nursing assistants. Depending on the patient census most morning care is all done. Except for patient teaching this is continued throughout the entire shift.

Now it is time to take off the physicians latest set of orders. This is done the old fashioned way via pen and paper. The physician hand writes the orders and you get to spend the next ten minutes trying to read the handwriting. This is all done without electronic medical records. Then it is time to start all over again with the next physician coming down the hall to make rounds with the "Charge Nurse" of the day!

Now it is time to carry out the new sets of orders. This can sometimes be a problem especially when it comes to changes in medications. The hospital pharmacy is not staffed with full or even a part-time pharmacist. The pharmacist comes once and maybe sometimes twice a day to fill orders. There are stock bottles of medications available, but not everything you need is there. So either the orders have to wait or you and only you, the "Charge Nurse" can enter the pharmacy to try to find the desired medications.

Then the emergency room nurse calls for back-up. Guess what? You are the back-up nurse for the day! The emergency room can go from sheer boredom to absolute pandemonium on a moments notice, especially on the weekend with no urgent care available.

By the time you and ER nurse gets the emergency room back in control it is time to go back to the floor and work to discharge patients and get set up for lunch. Discharging patients can sometimes be a challenge, especially on a Sunday. There is one pharmacy in town open for one hour on Sunday. So if your patient is going home and needs medications, then they better be moving out the door by 12:30 PM at the latest. The pharmacy closes at 1 PM. Of course, if you call ahead and give them a heads up of a customer coming down in need of some medication, they are more than happy to wait!

Now it is time work on admitting the two new patients from the emergency room. One is your favorite teacher from elementary school. She is admitted with shortness of breath and needs to have a VQ scan done as soon as possible to rule out a pulmonary embolism. Now here is the tricky part, not only do you have to schedule this test for this patient at another facility but you also have to arrange an ambulance to transport the patient to and from the procedure. Not always is this an easy task to complete. Many times other facilities are booked up with their own patients and have to "squeeze" our patients in or are not able to do them at all. When this happens you need go to the next available facility to get the test done and eventually your patient goes off with the ambulance crew.

Now back to the emergency room for a woman that just walked in the back door. Could she be? No, we don't deliver babies here anymore. But wait, oh yes, she is—pregnant and in labor. She has been in labor since last night and is now feeling lots of pressure. After rushing her into a room and gown on, guess what? It is now time to

have a baby! Now you are frantically calling available in house staff needed to help with this delivery. The ER physician arrives just as the 7 pound 10 ounce baby boy is born! Thank goodness all went well and again for all support staff. Team work is so very important!

After mom and baby stabilize now it is time to find a bed for them. Then just as it is time to give report to the oncoming shift, the ambulance crew is just arriving with your shortness of breath patient. As you are giving report the ambulance tones go off for the fifth time today for an unresponsive person with CPR in progress. This is actually one of the better times of the day to have this type of situation. Now there is plenty of staff from both shifts available to help this person receive the best care available in our rural area. As it turns out this patient ends up being related to a member of our staff. This can be very tough for all involved. At least we can all feel that we did the best we could with the knowledge we have to get this patient airlifted to larger facility to continue their fight to survive.

The nursing staff is one thing remains the same when the people in our small community are anxious and frightened. We are that familiar face you see in the local grocery store, school functions, or just around town. We're here to offer a kind word and caring touch in times of need. Despite all the technological advances nursing has made over the years, the neighbor to neighbor part of caring cannot be replaced. A smile, words of comfort and caring, tears and the holding of a hand are all very real to a small rural nurse. This is why we continue to flourish as nurses in rural America!