ATHABASCA UNIVERSITY

A DOUBLE WHAMMY! NEW BACCALAUREATE NURSE GRADUATES' TRANSITION INTO RURAL ACUTE CARE

BY
JEAN CAROLYN SMITH

A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE
DEGREE OF MASTER OF NURSING

FACULTY OF HEALTH DISCIPLINES
CENTRE FOR NURSING AND HEALTH STUDIES
ATHABASCA UNIVERSITY
MAY 7, 2014

Athabasca University
FACULTY OF GRADUATE STUDIES

The future of learning.

Approval of Thesis

The undersigned certify that they have read the thesis entitled

"A Double Whammy! New Baccalaureate Nurse Graduates' Transition into Rural Acute Care"

Submitted by

Jean Smith

In partial fulfillment of the requirements for the degree of

Master of Nursing

The thesis examination committee certifies that the thesis and the oral examination is approved

Supervisor:

Dr. Virginia Vandall-Walker
Athabasca University

Committee members:

Dr. Sharon Moore
Athabasca University

Dr. Bob Barnetson
Athabasca University

Dr. Monique Sedgwick
University of Lethbridge

April 30, 2014

1 University Drive, Athabasca, AB, T9S 3A3 Canada
P: 780.418.7536 | Toll-free (CAN/U.S.) 1.800.561.4650 (7536)
fgs@athabascau.ca | fgs.athabascau.ca | athabascau.ca

Dedication

This thesis is lovingly dedicated to the memory of my parents, Francis and Lily Simpson, who instilled within me a thirst for knowledge, a strong desire to question the status quo, the fortitude to forge my own path, and a relentless determination to accomplish anything I set my mind to.

As well, I wish to dedicate this thesis to those new baccalaureate nurse graduates who graciously agreed to describe their experiences of transitioning into the rural acute care environment. Each was interested in sharing his or her transition experience so as to benefit other new nurse graduates who may choose rural nursing as their career paths.

Acknowledgements

Several individuals played significant and supportive roles during the time I have dedicated to "working" on my Master of Nursing degree. Most supportive has been my husband, Peter Smith, who began each new day by listening to my progress and offering encouraging words of wisdom. He was the "rock" who supported me whilst simultaneously keeping our family life harmonious. I acknowledge my two beautiful daughters who always understood that scheduling of activities had to be organized around mom's "thesis" and "work" times.

I admiringly acknowledge Dr. Virginia Vandall-Walker, my thesis supervisor, who through countless phone calls, emails, and visits supported me with her unwavering patience, in-depth knowledge, attentiveness to scholarly detail, and uncanny ability to always steer me in the right direction. Virginia's passion for research is contagious; our robust discussions about research were exhilarating. As well, I acknowledge the members of my Thesis Advisory Committee, Dr. Sharon Moore, Dr. Bob Barnetson, and Dr. Monique Sedgwick who provided valuable insights and feedback to enhance the quality of my work.

I humbly and admiringly acknowledge Megan Fischer, a friend I met during the master's program. Her fortitude and humour have, on countless occasions, inspired and supported me to keep "inching" forward with my work. As well, the support I have received from the many colleagues I work with at Red Deer College and Rocky Mountain House Health Centre must be acknowledged because they have generously shared not only their time, but also their listening ears, and appropriate words of wisdom and encouragement.

Abstract

Some new baccalaureate nurse (BN) graduates will transition into rural acute care nursing. While Canadian (CA) and international studies about new degree and diploma nurses' transition have been conducted, findings were based on data from urban or mixed rural–urban samples. Consequently, little is known about new degree nurses' transition into rural environments. Exploring this phenomenon is timely in light of high CA registered nurse (RN) retirement rates and low new RN retention rates in rural communities. An interpretive description study involving face-to-face interviews with 12 new Alberta BN graduates was conducted. Constant comparative data analytic techniques revealed an overarching theme of *A DOUBLE WHAMMY!* and two nondiscrete interconnected subthemes: *I'M A GENERALIST! and I'M IT!* The experience was *An Emotional Roller Coaster Up! Down!* influencing *The Decision: Stay? Go?* These findings can inform future research and rural educational, policy, and practice strategies aimed at recruiting and retaining new nurses.

Table of Contents

Dedication iii

Acknowledgements iv

Abstract v

Table of Contents vi

List of Tables xii

List of Figures xiii

CHAPTER 1 INTRODUCTION 1
- Purpose of the Study and Research Question 3
- Significance of the Study 4
- Background Information 4
  - Definitions 4
    - Experience 4
    - Interdisciplinary team 4
    - New degree and diploma nurses 5
    - New nurses 5
    - Novice nurse 5
    - Rural 5
      - Rural acute care 5
      - Rural RNs 5
    - Transition 6
  - Characteristics Related to Rural Nursing 6
    - Rural nurse characteristics 6
    - Challenges with developing and maintaining generalist skills 7
  - Canadian Rural Acute Care Context 7
    - Rural-urban health differentials 7
    - Access 7
    - Confidentiality 8
    - Cultural safety 8
    - Team practice 8
- Summary 9

CHAPTER 2 REVIEW OF THE LITERATURE 10
- Review of the Literature 10
- Theories of Transition 11
- Themes Related to Transition 13
  - Role Stress 13
  - Moral Integrity 15

Relationships with the Other 16
Working Conditions 20
Doubt in Knowledge 23
Management and Orientation Influences on Transition 26
Nurse Managers 26
Mentorship Programs 27
Clinical Nurse Educators 29
Nurse Residency Programs 30
Canadian Nurse Demographics 32
Summary 33

CHAPTER 3 METHODS 35
Methods: Study Design and Research Question 35
My Philosophical Underpinnings 36
Philosophical Underpinnings of Interpretive Description 36
My Theoretical Allegiances 37
My Disciplinary Heritages 37
My Positioning Ideas 37
Ethical Considerations 38
Data Collection 38
Inclusion Criteria 39
Recruitment 39
Sample 39
Interview Process 40
Notes 42
Data Management and Analysis 43
Know the Data 43
Move From Patterns to Relationships 44
Unitizing and categorizing 44
Constant comparison 44
Document Analytic Thinking 48
Complete the Final Analysis 49
Ensuring Rigour 49
Investigator Responsiveness 49
Analytic logic 49
Representative credibility 50
Interpretive authority 50
Verification Strategies 51
Methodological coherence 51
Sampling sufficiency 51
Active analytic stance 51

Thinking theoretically....52
Summary....52

CHAPTER 4 FINDINGS....53
Transition into Rural Acute Care: A DOUBLE WHAMMY!....53
The Context of Transition into Rural Acute Care: PARTICIPANTS AND FACILITIES....56
The Participants....57
Education program....57
Rural placements....59
Previous experiences....59
Reasons for choosing rural acute care nursing....59
The Facilities....60
The Transition Experience: A DOUBLE WHAMMY!....61
The First WHAMMY: I'M A GENERALIST!....63
THE PLACE: The facility....63
Services....64
Physician services....64
Pharmacy services....66
Nursing services....68
Unit culture....69
Educational supports....71
Financial....71
Orientation....71
Equipment....73
THE PLACE: The community?....73
Confidentiality....73
Lack of anonymity....74
THE PEOPLE: Who are they? How do I fit in?....75
Staff in general....76
Nurses....77
Nurse managers....79
Clinical nurse educators....80
Physicians....80
Clients....82
THE PEOPLE: Who am I? How do I cope?....84
Confidence level....84
Values....86
Likes and ambitions....86
Personal coping strategies....87
THE RURAL RN ROLE: What do I need to know?....88

How to change hats....88
Adaptability....89
Prioritizing....89
Anticipatory planning....90
How to manage the role....90
Related to policies, procedures, and protocols....90
Related to routine care....91
Related to team nursing....92
Related to taking call....93
Related to helping out wherever....93
Related to acting as a resource....93
Related to being "it"....94
The Second WHAMMY: I'M IT!....94
I'M ALONE!....96
The sole RN in the hospital....97
As the only available body....98
With no on-site physician....98
I'M IN CHARGE!....99
Of the hospital....99
Of the unit....100
Of the team....101
Of contingent and emergent situations....102
I'M A JACK OF ALL TRADES!....103
A DOUBLE WHAMMY: How do I Manage All of This Learning and Responsibility?....104
On the Fly....104
By Accessing Resources....105
What's what?....105
When do I need to call for help?....105
What procedures, policies, or protocols do I need to use?....106
What are the idiosyncrasies of the physicians?....106
What information do I need to access and how?....107
Who's who?....109
Work supports....109
Social supports....112
A DOUBLE WHAMMY! An Emotional Roller Coaster Up! and Down!....113
A DOUBLE WHAMMY! The Decision: Stay? or Go?....115
Summary....117

CHAPTER 5 DISCUSSION....120
A DOUBLE WHAMMY! New Knowledge....120

Contextual Factors 120
The Transition Experience 121
A DOUBLE WHAMMY! The Context 124
The Participants: Prepared—or Not! 124
The Participants: Rural by Choice—or Not! 125
The Facilities 126
A DOUBLE WHAMMY! The Experience 127
I'M A GENERALIST! and I'M IT! So Much to Learn and Even More Responsibility 128
The rural RN role 130
I'M A GENERALIST! Changing hats 131
I'M A GENERALIST! How to manage the role and responsibilities 133
I'M IT!—I'm in charge! 135
I'M IT!—I'm a Jack of all trades! 138
I'M IT!—I'm alone! 140
Learning on the fly 142
Accessing resources 142
The team 143
I'M IT!—I'm in charge! 148
The organization 149
Orientation support 149
Unit culture 150
The clients, family, and community 152
Personal coping strategies 152
An Emotional Roller Coaster Up! and Down! 154
Staying or Going! 155
Limitations 157
Implications 159
Summary 161

CHAPTER 6 CONCLUSION 163

REFERENCES 164

Appendix A: Sample Research Questions 178

Appendix B: Sample Research Questions 179

Appendix C: Sample Research Questions Based on Evolving Themes 180

Appendix D: Athabasca University's Interim and Final Research Ethics Approval 181

Appendix E: Letter of Information for Participants 183

Appendix F: Informed Consent 186

Appendix G: Letter to College and Association of Registered Nurses of Alberta.....187

Appendix H: Demographic Data Form 189

List of Tables

Table 1 Studies About Theories of Transition 12

Table 2 Studies Informing Themes Related to Transition: Role Stress 14

Table 3 Studies Informing Themes Related to Transition: Moral Integrity 15

Table 4 Studies Informing Themes Related to Transition: Relationships with the Other 18

Table 5 Studies Informing Themes Related to Transition: Working Conditions 22

Table 6 Studies Informing Themes Related to Transition: Doubt in Knowledge 24

Table 7 Studies Informing Management and Orientation Influences on Transition: Nurse Managers 27

Table 8 Studies Informing Management and Orientation Influences on Transition: Mentorship Programs 28

Table 9 Studies Informing Management and Orientation Influences on Transition: Clinical Nurse Educators 30

Table 10 Studies Informing Management and Orientation Influences on Transition: Nurse Residency Programs 31

Table 11 Studies Informing Canadian Nurse Demographics 32

Table 12 Participant Demographic Information 58

Table 13 Hospital Services 61

Table 14 By Accessing Resources 105

Table 15 A Double Whammy!—An Interplay of the Findings 129

Table 16 How do I Manage All of This Learning and Responsibility? 130

List of Figures

Figure 1. A Double Whammy! 54

Figure 2. I’m A Generalist! 64

Figure 3. I’m It! 95

CHAPTER 1
INTRODUCTION

A number of new baccalaureate-educated nurses will choose to work in Canadian (CA) rural acute care nursing, a generalist specialty that is as diverse as it is complex (Scharff, 2006). To practice as generalist specialists in Canada requires rural registered nurses (RNs) to be equipped with the skills to care for diverse clients of any age with dissimilar diagnoses (Baumann, Hunsberger, Blythe, & Crea, 2006; Kulig, 2005; MacLeod, 1998, 1999). Typically, rural RNs rotate between several focal points of care in the hospital, including medical–surgical, emergency, labour and delivery, palliative, and constant care. Additionally, MacLeod (1998) coined the phrase "we're it" (p. 1) and Baumann et al. (2006) coined "being it" (p. 19) to represent the "generalist" specialty of rural RNs who work alone and autonomously in emergency departments (EDs) and who fulfill the duties of members of other professions when they are off site (see also MacLeod, 1999). Baumann et al. (2006) further suggested that the rural RN "generalist" specialty requires an array of complex and diverse skills consisting of, but not limited to, strong critical thinking, excellent multitasking, superior leadership, exceptional flexibility, and an innate ability to deal with ambiguity and contingency. Transitioning to become one of these generalist specialist RNs takes time on the job and ideally, the support of seasoned colleagues, but a review of CA RN workforce demographics spanning the past 11 years revealed how difficult these supports have been to guarantee.

In terms of time on the job, Adams et al. reported in 2003 that only 22% of CA rural communities were successful at retaining novice RNs during their first year of practice; similarly, in 2006, Baumann et al. reported that many new baccalaureate nurse (BN) graduates in several Ontario rural acute care hospitals were at great risk for leaving. Overall, turnover intention and attrition rates of CA novice RNs, be they practicing in urban or rural acute care environments, have been identified as significant workforce issues. Recently, Lavoie-Tremblay, Paquet, Marchionni, and Drevniok (2011) found that turnover intention rates among some Québec novice RNs were as high as 49%, which is not surprising since, as stated earlier, the transition was reported as the most stressful time in CA nurses' careers and was the main reason for novice CA nurses quitting nursing (Godinez, Schweiger, Gruver, & Ryan, 1999).

Although current data about recruitment of new BN graduates into CA rural acute care facilities are lacking, the Canadian Advisory Committee on Health Human Services reported in 2002 that many new CA RNs had migrated to other countries searching for work due to the lack of full-time employment in Canada (Baumann, Blythe, Kolotylo, & Underwood, 2004). This lack of full-time employment was corroborated in a separate report by the Canadian Institute for Health Information (Canadian Institute for Health Information [CIHI], 2002) and was a finding in the study of Baumann et al. (2006), which revealed that younger CA nurses were most likely to be employed part time and to have more than one employer. Of note is that Baumann et al. (2006) were specifically referring to new BN graduates in rural acute care settings. As well, MacLeod et al. (2004) reported that recruitment and retention of RNs for rural communities have consistently been significant issues, which have not been adequately addressed by hospital administrators and health care policy-makers. In all, it becomes apparent that insufficient numbers of novice RNs will choose rural acute care nursing as a career path in the first place, and that few will remain working rurally long enough to become generalist specialists. Who will then provide the transition support needed for future novice rural RNs?

In terms of transition support from senior colleagues, CA nurse demographic information points to low numbers of experienced rural RNs coupled with high RN retirement rates. In 2010, the distribution of CA RNs employed in rural and remote nursing was 10.8%, a significant drop from 17.1% in 2005 (CIHI, 2012) and 18% in 2000 (MacLeod et al., 2004). Of further concern are statistics that nurses under age 30 constituted only 11.8% of the 2010 CA RN workforce distribution, and those aged 50 plus and nearing retirement comprised over 40% (CIHI, 2012). Therefore, an important question to consider is: how much longer will these senior nurses remain in the workforce to provide novice nurses with transition support? For some rural communities migration has been a larger issue than senior RN retirement rates, wherein senior RNs have needed to leave their communities for education or alternate employment, and then have not returned (MacLeod et al., 2004). This situation may be even bleaker than has been depicted, as some of the RNs identified as rural may in actuality be working in home care, community health, or commuting to urban centres. Thus overall, there are

diminishing numbers of seasoned RNs to provide support to transitioning new BN graduates. Add to this mix an increasing absolute rural population (MacLeod et al., 2004), and it is conceivable that a crisis is looming on the horizon for rural nursing and will become more profound as this trend continues.

While it is well documented that transitioning from the role of student to graduate nurse in urban acute care settings is often stressful, leaving RNs discouraged, frustrated, and disillusioned (Bowles & Candela, 2005; Duchscher, 2008, 2009; Hazard Munro, 1982; Kelly & Ahern, 2008; Lavoie-Tremblay et al., 2008; Lavoie-Tremblay et al., 2011), a thorough review of the literature revealed a paucity of research specific to new BN graduates' transition into CA rural acute care nursing. Consequently, it is not known whether transitioning into these rural acute care hospitals is similar or different to transitioning into urban facilities, both in degree and in kind. Although theories about new BN graduates' transition into acute care nursing have been generated over the past 37 years, CA studies have been based on cohorts that have included exclusively urban acute care settings (Duchscher 2008, 2009; Nour, 2009); similar studies in the United Kingdom (Kelly, 1996, 1998) and United States (Kramer, 1974) have incorporated a mix of rural and urban acute care environments. In light of this gap in the literature, and keeping in mind the alarming CA nurse workforce demographics coupled with rising rural populations, the phenomenon of transition as it relates to new BN graduates in CA rural acute care settings needed to be explored.

Purpose of the Study and Research Question

The purpose of this study was to explore the transition experiences of new Alberta BN graduates into rural acute care hospital nursing. Specifically, the goals were to identify, understand, and describe new BN graduates' transition experiences (i.e., learning, emotions, events, and challenges) and the issues surrounding their recruitment and retention. The central question guiding this study was as follows: How do new BN graduates describe the transition experience into the rural acute care hospital environment?

Significance of the Study

The findings of this study begin to address the current gap in the literature about new BN graduates' transition into CA rural acute care hospital nursing, by identifying and describing this phenomenon and the similarities or differences, be they in degree or in kind, with urban and rural–urban acute care hospital transitions previously reported. This knowledge can inform CA rural acute care educational, organizational, and policy initiatives targeted at recruiting and retaining new BN graduates, as well as indicate future directions for nursing research.

Background Information

Several definitions of key terms are provided in alphabetical order to clearly delineate concepts referred to in this thesis. Other definitions are provided in the body of this document as they arise in the discussion. Additionally, characteristics about rural nursing are provided as contextual information to both inform and highlight the complex and diverse nature of the rural nursing specialty where one becomes a specialist at being a generalist.

Definitions

Experience. According to Bolander et al. (1988), as a verb, the term experience is defined as "to undergo, [or] feel" (p. 333). As a noun, experience is defined as

> The knowledge or feeling obtained through direct impressions … the skill or judgment gained by practice … an interesting or remarkable event in a person's life, or something suffered … [or] all that has happened to a person in his [or her] life or in a particular … activity. (p. 332)

Interdisciplinary team. The term interdisciplinary team refers to "a group of health care professionals from diverse fields who work in a coordinated fashion toward a common goal for the patient" ("Interdisciplinary Team," 2014, para. 1). The interdisciplinary team in this study consisted of staff in general (i.e., RNs, licensed practical nurses [LPNs], health care aides [HCAs], agency or travel nurses, charge nurses, other new RNs, unit clerks, and support staff), nurse managers, clinical nurse educators, physicians, pharmacists, respiratory therapists, and experts in urban facilities. The interdisciplinary team is discussed in the Findings and Discussion chapters of this thesis.

New degree and diploma nurses. Some studies referenced in this thesis included cohorts of new nurse graduates who had graduated with diploma-level education, as well as those who had graduated with a baccalaureate-level degree. To prevent confusion, the term *new degree and diploma nurses* refers to new degree- and new diploma-educated nurses who have been in the nurse workforce less than 3 years.

New nurses. Unless otherwise stated, the term new nurses, refers to nurses who have graduated from a baccalaureate-level nursing program and who have been in the nurse workforce less than 3 years. Nurses other than new BN graduates will be referred to as diploma nurses, senior nurses, and so on. In this thesis, the terms new nurses and new BN graduates are used interchangeably.

Novice nurse. The term novice nurse refers to a beginning RN who "has no experience in the situations in which [he or she] is expected to perform. The novice [nurse] lacks confidence to demonstrate safe practice and requires continual verbal and physical cues … and is unable to use discretionary judgement" (Benner, 1984, p. 13).

Rural. In the literature a wide diversity of definitions were ascribed to the term rural. For this study, rural is defined in two ways: (a) as "towns and municipalities with populations of less than 10,000 people" (duPlessis, Beshiri, Bollman, & Clemenson, 2001, p. 1), or (b) towns and municipalities with populations of greater than 10,000 people, but deemed as rural by Alberta Health Services or Covenant Health.

Rural acute care. Rural acute care refers to hospitals in which emergency, medical, palliative, paediatric, and in some facilities surgical, obstetrical, or constant care services are provided to people living in rural communities (Smith, 2011).

Rural RNs. For the purposes of this study, rural nursing is the provision of nursing services by RNs, LPNs, and sometimes HCA to patients admitted to rural acute care. To promote readability rural acute care RNs will be referred to in this thesis as rural RNs. Rural nursing practice in relation to rural RNs is considered a specialty practice wherein the RN becomes a specialist at being a generalist, caring for patients of dissimilar diagnoses of any age in multiple areas of rural acute care (Baumann et al., 2006; Kulig, 2005; MacLeod, 1998, 1999, Scharff, 2006). This "generalist" specialist requires an array of complex and diverse skills consisting of, but not limited to, strong critical thinking, excellent multitasking, superior leadership, exceptional flexibility, an

innate ability to deal with ambiguity and contingency, and the capacity to practice independently (Baumann et al., 2006; Scharff, 2006).

Transition. Transition is "a change or passage from one place … to another" (Bolander et al., 1988, p. 1048). New nurses' transitions involve changing from the role of student within the relative comfort of the educational setting into the new role of professional nurse in the workplace (Brown, 1999; Duchscher, 2009; Kramer, 1974). Transition, in relation to the nursing profession, is a concept subsumed by the concept of professional socialization, wherein new nurses must learn the norms, expectations, roles, ethics, and cultures of RNs (i.e., staff nurses, nurse managers, charge nurses, and clinical nurse educators) in the workplace (Brown, 1999).

Characteristics Related to Rural Nursing

While many similarities and differences may exist between CA rural and urban acute care nursing practices, the intent of the subsequent discussion is not to compare the two, but rather to provide insight into rural nurse characteristics and the CA rural acute care context so as to highlight the complexity and diversity of rural nursing. However, some rural–urban comparisons are provided to emphasize the significance of certain concepts in relation to the rural context. While the focus of this thesis is on the rural acute care situation, some information cited below also encompasses remote nursing.

Rural nurse characteristics. In the literature a competent rural RN was described as someone who is a generalist specialist, possessing a wide range of nursing skills, a broad understanding of clinical nursing knowledge, excellent critical thinking skills, and an innate ability to be flexible whilst caring for diverse and complex patients over the lifespan (Baumann et al., 2006; MacLeod, 1998, 1999; Scharff, 2006). As stated earlier in this report, MacLeod (1998) coined the nursing practices of rural RNs as "we're it" (p. 1) and Baumann et al. (2006) noted that some rural RNs have expressed "being it" (p. 19). In either case, "we're it" and "being it" are both terms that refer to rural RNs' specialty practices of working alone and autonomously without the support of experts no matter what the crisis and multitasking by taking on the roles and responsibilities of other disciplines within the rural facility during evenings, nights, and weekends.

Challenges with developing and maintaining generalist skills. To practice as a generalist specialist among various departments, as is needed in a rural acute care hospital, has required RNs to have a broad knowledge base beyond that taught in basic BN programs (Baumann et al., 2006). This level of knowledge can only be gained through a more comprehensive clinical experience and ongoing post-hire education in the environment (Baumann, Crea-Arsenio, Idress-Wheeler, Hunsberger, & Blythe, 2010). However, the RNs in these samples contended that the complexity and diversity of rural nursing were grossly underestimated by nurse educators and policy-makers; as a result, supports for basic and continuing nursing education have been inadequate. Consequently, this lack of educational support has made it very challenging for some rural RNs to develop and maintain the skills needed to work as generalist specialists.

Canadian Rural Acute Care Context

Although the Canadian Association for Rural and Remote Nursing had identified several commonly accepted characteristics of rural and remote nursing settings in Canada (Canadian Association for Rural and Remote Nursing [CARRN], 2008), no research-based organizing framework specific to CA rural acute care settings has been proposed. Consequently, the organizing framework related to the Australian (AU) rural context, proposed by Bourke et al. (2004) in a discussion paper, was found to be a good fit and adopted to help explain the CA rural acute care context.

Rural-urban health differentials. In 2006, CA rural residents were identified as less healthy than their urban counterparts (CIHI, 2006). Rural dwellers were more likely to be less educated, have poorer socioeconomic situations, partake in unhealthy behaviours, and have higher overall mortality rates than urban residents (CIHI, 2006). In the absence of more current data, I have assumed that this situation has changed little in the intervening years.

Access. Access to health care services in rural Canada has been significantly influenced by geography, travel, weather, distance (MacLeod et al., 2004), and the associated costs of each. Distance to urban specialty services varies among rural communities and can be far greater for some rural residents as compared to others (CIHI, 2006). In addition, CA nurse workforce issues have influenced people's access to rural health care services (MacLeod et al., 2004).

In 2002, CA rural nurses were challenged with consistent shortages and increased absolute rural populations (MacLeod et al., 2004). The result was fewer RNs per population in rural areas, as compared to urban centres (Advisory Committee on Health Human Resources, 2002; Canadian Nurses Association, 2005). In fact, 18% of the CA RN workforce provided care to 22% of the national population; that is 62.3 rural RNs per 10,000 people, as compared to 78 urban RNs per 10,000 people (MacLeod et al., 2004). MacLeod et al. (2004) warned that these statistics must be viewed with caution, as some of the RNs identified as rural may in fact have been urban nurses who lived in rural areas but commuted to work in the city, so the total number of working RNs per 10,000 people could be significantly less than 62.3. Additionally, these nurse-to-population ratios did not take into account the differences in nursing services provided in rural and urban areas and the geographic problems such as distance and isolation that can present challenges to rural RNs.

Previously, Baumann et al. (2006) identified RN staffing dilemmas in many Ontario rural acute care hospitals as contributing to decreased patient access to care. For these facilities, a lack of full-time employment opportunities and small staffing complements had caused RN shortages, which resulted in disruptions to available patient services.

Confidentiality. Fitting into CA rural communities has required many RNs to integrate themselves into their locales through interweaving their personal and professional lives (Crooks, 2007; MacLeod et al., 2004). Knowing people both personally and professionally has created ethical dilemmas for these RNs due to the lack of anonymity and the need to maintain patient confidentiality.

Cultural safety. A significant proportion of First Nations populations in Canada have been identified as located in the catchment areas of rural practice settings (CARRN, 2008; CIHI, 2006), but little attention has been paid to educating nurses in how to provide culturally appropriate care (MacLeod et al., 2004). Additionally, international RNs hired to work rurally have added to the diversity in cultures between nurses and patients, which has created unique workplace issues for those nurses.

Team practice. Rural RNs have required the knowledge and skills to effectively collaborate with multidisciplinary teams located in specialty urban centres (CARRN,

2008), as well as, with community service providers for First Nations, community health, home care, mental health, long-term care, and primary care networks (Smith, 2011). For instance, advancing technology and its increasing use in rural facilities to extend urban specialists' care to some patients has required rural RNs to be technologically savvy with an ability to accommodate the needs of urban specialists and their rural patients, but with few educational supports (MacLeod et al., 2004).

Although rural RNs are central to team practice, at times they must work autonomously and independently without the support of team members, other hospital personnel, or physicians (Andrews et al., 2005; Baumann et al., 2006; MacLeod et al., 2004). In CA rural EDs, it is not uncommon for RNs to work alone during night shifts and to be the first point-of-entry to the health system for patients because rural physicians are seldom on site during the night, only on call (Baumann et al., 2006). In these situations health care leaders have set an expectation for RNs to make decisions about the severity of patients' conditions and to perform certain aspects of care that would commonly be classified as physicians' responsibilities. Additionally, some RNs who have worked by themselves in rural EDs have expressed concern about feeling unsafe due to being alone with confrontational patients or families without the backup of security personnel (Baumann et al., 2006).

Summary

In this chapter I have provided an overview of the research problem, the purpose of this study and research question, and the significance of the study. I also defined key concepts underpinning this thesis to prevent ambiguity and to provide clarification. Finally, I presented background information to clarify definitions used throughout this thesis and to highlight the complex and diverse nature of rural nursing.

CHAPTER 2
REVIEW OF THE LITERATURE

In this chapter I present a review of the literature related to the transition of new nurses into the rural acute care environment to demonstrate the significance of the current study by providing a critical reflection on what knowledge does and does not exist and how this study was grounded within this existing knowledge (Thorne, 2008). I included literature based on research conducted in Canada, the United States (US), the United Kingdom (UK), Australia, and New Zealand (NZ). This review encompasses the following: (a) three theories based on research about new nurses' transition into urban acute care environments and three theories based on mixed study cohorts of new diploma and degree nurses who had transitioned into rural or urban acute care settings; (b) literature related to new diploma and degree nurses' transitions into rural or urban acute care settings categorized into the themes of role stress, moral integrity, relationships with the "other," working conditions, and doubt in knowledge; (c) research about management and orientation influences on transition; and (d) literature highlighting CA nurse workforce demographics. I found no literature that specifically addressed the research question driving this study: How do new BN graduates describe the transition experience into the rural acute care environment?

Review of the Literature

Initially, I accessed four different electronic databases (i.e., CINAHL, Google Scholar, ProQuest, and PubMed) using the terms "transition" and "rural acute care" and several related keywords to obtain CA studies from 2003 to 2011. Due to the paucity of CA literature found, the search was broadened to include 1982 to 2008 studies from Australia, NZ, the UK, and the US. In addition, article reference lists, the Internet, colleagues, and librarians provided other sources of literature. In total I included 33 studies (19 qualitative, eight quantitative, two mixed methods, and four program evaluations) in the review. I present the literature review in terms of the following subsections: Theories of Transition, Themes Related to Transition, Management and Orientation Influences on Transition, and Canadian Nurse Demographics. Although the theories are presented separately, findings informing the theories are also included as appropriate under the various themes discussed. In addition, I include tables within the

discussions about each of the categories to summarize the studies reviewed and the various research approaches and methods used.

Theories of Transition

The study of new nurses' transition experiences over the last four decades received its initial impetus from the seminal work of Kramer (1974), a nurse researcher who studied new nurses' transition into U.S. rural and urban acute care settings. Kramer termed the transition experience Reality Shock theorizing that the values students learn in nursing school readily conflict with those they experience as novice nurses in the real world. She found that many new nurses in the US were not adequately prepared for hospital practice settings; while they could readily analyze and synthesize the needs of their patients, they did not know how to provide the hands-on care needed at the bedside. UK and CA researchers have generated five qualitatively derived theories stemming from Kramer's work (see Table 1).

Kelly proposed the first two theories reviewed: It's a Battle (Kelly, 1996) and Preserving Moral Integrity (Kelly, 1998). It's a Battle encompasses the role stress experienced by new nurses in the UK transitioning into rural and urban acute care settings, and refers to the internal sense of responsibility felt to uphold the values of UK baccalaureate-level nurses in practice settings dominated by diploma-prepared nurses. New nurses interviewed had perceived that they worked doubly hard to convince hospital staff that baccalaureate education was not an impediment to being a good practical nurse.

Kelly's (1998) theory of Preserving Moral Integrity represents a six-stage basic psychosocial process that occurs when new nurses who are transitioning into UK rural and urban acute care settings adapt to the real world of hospital nursing. The six stages of this theory include "vulnerability; getting through the day; coping with moral distress; alienation from self; coping with lost ideals; and integration of [a] new professional self-concept" (Kelly, 1998, p. 1137). Based on the data from new nurses, Preserving Moral Integrity involves using self-protective strategies to cope with the vulnerability and moral distress felt during transition. To deal with feeling vulnerable, new nurses will sacrifice their own standards of care to meet workplace demands (Kelly, 1998). To preserve dignity when feeling humiliated, new nurses will blame and criticize themselves for not being the kind of nurses they aspired to be (Kelly, 1998). To manage moral distress, they

will (a) avoid workplace issues by leaving the unit, working fewer hours, dropping out of nursing, blaming others, or avoiding patient interactions; (b) become alienated from themselves through adopting behaviours inconsistent with their conceptions of who they are as nurses; (c) cope with lost ideals by justifying why they are no longer using nursing practices they valued; and (d) eventually integrate a revised professional self-concept as a means to rebuild their self-esteem (Kelly, 1998).

Table 1

Studies About Theories of Transition

Researcher & Location	Theory	Acute Care Settings or Hospitals	Approach or Method (sample size)
Duchscher (2008), CAN	A Process of Becoming	Urban	Interpretive Inquiry (n = 14)
Duchscher (2009), CAN	Transition Shock	Urban	Interpretive Inquiry (n = 15)
Kelly (1996), UK	It's a Battle	Rural–Urban	Grounded Theory (n = 10)
Kelly (1998), UK	Preserving Moral Integrity	Rural–Urban	Grounded Theory (n = 13)
Kramer (1974), US	Reality Shock	Rural–Urban	Mixed Methods (N = 218)
Nour (2009), CAN	Becoming Alive	Urban	Grounded Theory (n = 14)

Note. CAN = Canada; UK = United Kingdom; US = United States.

Duchscher proposed the third and fourth theories reviewed: A Process of Becoming (Duchscher, 2008) and Transition Shock (Duchscher, 2009). A Process of Becoming represents female new nurses' professional role transition into CA urban acute care settings as a journey, which consists of "the stages of doing, being, and knowing" (Duchscher, 2008, p. 441). This journey spans the first 12 months of professional practice and is not prescriptive, linear, nor always progressive. Transition Shock

represents the initial stage of "doing" (Duchscher, 2008, p. 441) in the transition journey, wherein new nurses become disoriented in their professional roles, feel a sense of loss due to separation from student peers, are confused by new professional responsibilities, and doubt their previously acquired knowledge. Duchscher (2009) claimed that Transition Shock is marked by new nurses' feelings of anxiety, insecurity, inadequacy, and instability as they learn, perform, adjust, and accommodate to new professional nursing roles, responsibilities, relationships, and knowledge.

Nour (2009) generated the fifth theory, which represents theoretical classroom learning as Becoming Alive and as active, manifested, and meaningful for new nurses in real-life situations in CA urban acute care settings. Nour claimed that Becoming Alive was necessary for new nurses to succeed.

While the theories generated by Kramer (1974), Kelly (1996, 1998), Duchscher (2008, 2009), and Nour (2009) have contributed significantly to health care professionals' understandings about new nurses' transition experiences, I found no theories that specifically addressed the transition experiences of new nurses into CA rural acute care hospital settings. Therefore, it remains unclear as to whether or not new nurses who transition into these environments experience or perceive similar or different learning, emotions, and challenges as compared to those discussed thus far.

Themes Related to Transition

Five interconnected themes related to transition were evident in the literature reviewed. They included (a) Role Stress, (b) Moral Integrity, (c) Relationships with the Other, (d) Working Conditions, and (e) Doubt in Knowledge.

Role Stress

Role Stress was a common theme found in three of the 19 qualitative studies reviewed (Kelly, 1996; Kelly & Ahern, 2008; Lea & Cruickshank, 2007; see Table 2). Kelly (1996) found "role stress" (p. 1065) to be an overarching theme in the theory of It's a Battle, wherein new nurses' transitioning into rural and urban AU acute care hospitals feel an obligation to uphold the banner of baccalaureate-educated nurses to senior staff nurses and nurse managers; consequently, new nurses work doubly hard to prove themselves as good practical nurses.

Table 2

Studies Informing Themes Related to Transition: Role Stress

Researcher & Location	Aim, Purpose, or Question	Approach or Method (sample size)
Kelly (1996), UK	Recollection of new nurses regarding their first year as qualified nurses in hospital nursing in the UK	Qualitative Retrospective Grounded Theory (*n* = 10)
Kelly and Ahern (2008), AUS	Experiences of new nurses during their first 6 months as RNs	Qualitative Husserl Phenomenology (n =14)
Lea and Cruickshank (2007), AUS	Role transition for new nurses in rural practice in AU	Qualitative Hermeneutic (n = 10)

Note. AUS = Australia; UK = United Kingdom; RNs = registered nurses.

Similarly, Kelly and Ahern (2008) found that some new nurses who transitioned into AU rural and urban acute care environments felt that even though they worked hard, they received little assistance and support from senior nurses and were expected to learn routines on their own by simply doing them. These new nurses described role transition from student to professional nurse as very stressful due to feeling "not really prepared" (Kelly & Ahern, 2008, p. 914), wherein they experienced "role conflict" (p. 915), being "thrown in at the deep end" (p. 915), and "double reality shock" (p. 915). Role conflict for these new nurses refers to feeling unprepared for the decision making and responsibility associated with their new professional RN role. "Thrown in at the deep end" (Kelly & Ahern, 2008, p. 914) represents the stress experienced by these new nurses because some senior RNs would not assist them with learning unfamiliar tasks and held the view that the way to learn was to sink or swim. "Double reality shock" (Kelly & Ahern, 2008, p. 915) represents the anxiety and apprehension experienced by these new nurses when they tried to adapt to working rotating shifts on various wards.

Another AU research team reported that rural interviewees complained about seasoned staff providing poorly delineated roles and role expectations whilst expecting

the new nurse to keep up with busy ward routines and complex patient care (Lea & Cruickshank, 2007). For these new nurses, role overload and role ambiguity were identified as contributing to their role stress.

In summary, role stress was found to negatively impact new nurses' transition into AU rural acute care environments (Lea & Cruickshank, 2007) and AU (Kelly & Ahern, 2008), and UK (Kelly, 1996) rural and urban acute care environments. While role stress is encompassed within Duchscher's (2009) theory of Transition Shock, CA research about new nurses' role stress during transition into specifically rural acute care environments is lacking.

Moral Integrity

Moral integrity was a shared theme found in three of the 19 qualitative studies examined (Kelly, 1998; Lea & Cruickshank, 2007; Romyn et al., 2009; see Table 3). According to Kelly (1998), practicing with moral integrity was linked to possessing a moral sense, wherein individuals treat each other with kindness and consideration, whilst practicing within a professional code of ethics.

Table 3

Studies Informing Themes Related to Transition: Moral Integrity

Researcher & Location	Aim, Purpose, or Question	Approach or Method (sample size)
Kelly (1998), UK	Preserving moral integrity of new nurses	Qualitative Retrospective Grounded Theory (n = 22)
Lea and Cruickshank (2007), AUS	Role transition for new nurses in rural practice	Qualitative Hermeneutic (n = 10)
Romyn et al. (2009), CAN	Understanding transition from student to new nurse	Qualitative Description (n = 147)

Note. AUS = Australia; CAN = Canada; UK = United Kingdom.

In Kelly's (1996) theory of It's a Battle (1996), the researcher postulated that maintaining professional standards in hospital nursing is a "constant battle" (p. 1066) that involves "pressure to conform" (p. 1067) and "hard work" (p. 1067) for new nurses,

because UK rural and urban acute care cultures demand that ward routines should prevail over good safe care. Linked to this is Kelly's (1998) later theory of Preserving Moral Integrity, previously discussed, wherein new nurses' perceive themselves as not living up to their personal moral convictions and standards of a good nurse because they are too busy trying to keep their "heads above water" (p. 1139) and to prove themselves as good practical nurses to the more senior staff. The most pervasive attributes of these new nurses are self-criticism and self-blame, wherein they question their professional knowledge, the kind of nurses they are, and the kind of nurses they are becoming.

Correspondingly, heavy workloads coupled with high levels of responsibility had contributed to new nurses' reports of high levels of stress, nervousness, and overwhelming feelings of unpreparedness when working in some AU rural and urban acute care facilities (Kelly & Ahern, 2008; Lea & Cruickshank, 2007). These new nurses questioned their abilities and who they were as nurses when expected to care for diverse clients over the lifespan.

Similarly, new nurses in some Alberta rural and urban acute care settings described fear of not doing a good job, missing some critical piece of information, or making mistakes due to trying to keep up with busy ward routines and overwhelming responsibilities (Romyn et al., 2009). On difficult days, these new nurses questioned who they were as nurses and whether or not they should even remain in nursing.

In summary, moral integrity was found to negatively influence new nurses' transition into some AU (Lea & Cruickshank, 2007), CA (Romyn et al., 2009), and UK (Kelly, 1998) rural and urban acute care settings. While Kelly (1998) did suggest that a new nurse's moral integrity could be preserved by the structural supports of positive nurse managers and empowering staff role models, some rural and urban acute care settings were found to contribute to reduced new nurses' moral integrity due to heavy workloads, overwhelming responsibilities, and difficult relationships with the "other" (Lea & Cruickshank, 2007; Romyn et al., 2009).

Relationships with the Other

The authors of five of the 19 qualitative (Ellerton & Gregor, 2003; Kelly & Ahern, 2008; Lea & Cruickshank, 2007; McKenna & Newton, 2007; Romyn et al., 2009) and four of the eight quantitative (LaSala, 2000; Lavoie-Tremblay et al., 2008;

McKenna, Smith, & Poole, 2002; Parker, Plank, & Hegney, 2003) studies examined, revealed that relationships with the other, or senior nurses impacted new degree and diploma nurses' perceptions of transition into acute care settings. These authors found that new degree and diploma nurses' transitions were positively and negatively influenced by relationships with the other (see Table 4).

Many new degree and diploma nurses transitioning into AU rural and urban acute care settings have described interactions with senior nurses as vital to effective transition (McKenna & Newton, 2007). These new degree and diploma nurses equated positive relationships with senior staff as necessary to belonging in workplace cultures.

Conversely, horizontal violence has been identified as the norm in many AU and NZ rural and urban acute care hospitals and has negatively impacted new degree and diploma nurses' relationships with the other and how they fit in (Kelly & Ahern, 2008; Lea & Cruickshank, 2007; McKenna & Newton, 2007; McKenna et al., 2003). Through conducting a survey of 551 NZ new degree and diploma nurses transitioning into rural and urban acute care settings, McKenna et al. (2003) operationalized the construct of horizontal violence as neglect, unjust criticism, and rude and humiliating statements. A total of 31% of McKenna et al.'s (2003) respondents were subjected to horizontal violence perpetrated by a senior nurse colleague (charge nurse, nurse coordinator, supervisor, unit manager, duty leader, acting charge nurse, clinical coordinator, staff nurse, or preceptor) during their first year of practice. Many others in this study perceived that poor relationships with the other contributed to hostile undercurrents, negative ward dynamics, and mistrust of senior colleagues.

Likewise, new nurses who transitioned into specifically rural AU hospitals stated that they experienced aggressive behaviours of "bitchiness" (p. 4) from senior staff on a daily basis, which left them afraid to trust those nurses and unwilling to ask for help when they needed it (Lea & Cruickshank, 2007). Additionally, those transitioning into other AU rural and urban acute care settings portrayed senior RNs' negative behaviours as "eating their young" (Kelly & Ahern, 2008, p. 913), which included "power games" (p. 913), "hierarchy" (p. 914), and "bitchiness" (p. 914).

Table 4

Studies Informing Themes Related to Transition: Relationships with the Other

Researcher & Location	Aim, Purpose, or Question	Approach or Method (sample size)
Ellerton & Gregor (2003), CAN	Preparation of new nurses for transition at 3 months	Qualitative Interpretive Social Science Approach (*n* = 12)
Kelly (1998), US	"Preserving Moral Integrity" of new nurses	Qualitative Retrospective Grounded Theory (*n* = 22)
Kelly and Ahern (2008), AUS	New nurses' experiences during the first 6 months	Qualitative Husserl Phenomenology (*n* = 14)
LaSala (2000), US	Distribution of RNs in rural & urban settings; recruitment & retention strategies & barriers	Quantitative Survey (*N* = 131)
Lavoie-Tremblay et al. (2008), CAN	New degree and diploma nurses' psychological distress in acute care workplaces	Quantitative Correlative Descriptive (*N* = 309)
Lea & Cruickshank (2007), AUS	Role transition for new nurses in rural practice	Qualitative Hermeneutic Phenomenology (*n* = 10)
McKenna et al. (2002), NZ	Horizontal violence experienced by new degree and diploma nurses	Quantitative Survey (*N* = 551)
McKenna and Newton (2007), AUS	Development of new degree and diploma nurses' knowledge over the first 18 months of practice	Qualitative Phenomenology (*n* = 25)
Parker et al. (2003), AUS	Adequacy of support offered to new degree and diploma nurses during transition	Quantitative Survey (*N* = 1477)
Romyn et al. (2009), CAN	Understanding transition from student to new nurse	Qualitative Description (*n* = 147)

Note. AUS = Australia; CAN = Canada; NZ = New Zealand; UK = United Kingdom; US = United States; RN = registered nurse.

It is no surprise then that some new nurses who have transitioned into AU rural facilities felt unsupported overall and afraid to ask for help even from those few nurses who were supportive (Lea & Cruickshank, 2007). Interestingly, the results of a survey of 1,477 AU rural RNs revealed that senior nurses believed that there were adequate supports for new degree and diploma nurses' transition experiences; however, the less senior nurses in this sample did not (Parker et al., 2003).

While examples of horizontal violence specific to new nurses in CA rural acute care settings are lacking, the AU and NZ study findings do raise the questions of whether there may be sufficient cultural differences among the three countries to account for the fact that this horizontal violence is not explicitly reported in the CA research or whether it is just an uninvestigated and, therefore, unreported phenomenon. What remains evident is that in Australia and NZ, horizontal violence and trying to belong have left many new degree and diploma nurses feeling stressed about their relationships with the other.

Unfortunately, many CA (Ellerton & Gregor, 2003; Lavoie-Tremblay et al., 2008; Romyn et al., 2009) and AU (Lea & Cruickshank, 2007) rural and urban acute care practice settings have been less than inviting to new degree and diploma nurses who have required the nurturing support of seasoned coworkers to develop their foundational knowledge and critical thinking skills. For instance, some CA new nurses have perceived transition into rural and urban acute care environments as frustrating due to challenging relationships with senior staff (Ellerton & Gregor, 2003). This finding was corroborated by Lavoie-Tremblay et al.'s (2008) survey results, which revealed that new degree and diploma nurses' psychological distress during transition into the Québec nurse workforce was inversely dependent upon colleague and nurse manager social support. In fact, greater than 53% of the new degree and diploma nurse respondents in this sample had experienced low social support and subsequent high psychological distress during transition (Lavoie-Tremblay et al., 2008).

Likewise, some new nurses transitioning into Alberta rural and urban acute care settings have "expressed a 'fear of burdening' experienced nurses with questions or requests for assistance" (Romyn et al., 2009, p. 8). In this sample, some senior RNs were receptive to new nurses' questions about the environment and nursing practices; however, others, who portrayed negative attitudes, would ask the new nurses questions,

such as “what do you mean you don’t know?” (Romyn et al., 2009, p. 9). The new nurses who experienced these negative situations learned to avoid asking senior RNs for help, which left them at greater risk for making errors. A figure of speech used by these new nurses to depict a difficult day was to describe it as “a quitting day” (Romyn et al., 2009, p. 8), which reflected the reality of them possibly leaving nursing. At times, they described their dissatisfaction with nursing as related to negative attitudes of the other.

Conversely, some new nurses transitioning into CA rural and urban acute care environments have felt that when relationships with experienced nurses were strong, fear was less dominant and professional socialization was attainable (Lavoie-Tremblay et al., 2008; Romyn et al., 2009). One new nurse in Romyn et al.’s (2009) study reported, “If you are with the right people, you can get through anything” (pp. 8–9). These findings corroborate the results of an earlier U.S. survey of 131 rural and urban acute care hospital administrators, which revealed that higher percentages of positive peer relationships between new degree and diploma nurses and senior colleagues existed in rural facilities as compared to urban hospitals, and those relationships were the main incentive for new degree and diploma nurses remaining in rural nursing (LaSala, 2000).

In summary, the authors of three separate quantitative studies (LaSala, 2000; Lavoie-Tremblay et al., 2008; Parker et al., 2003) and one qualitative study (Romyn et al., 2009) revealed that some new degree and diploma nurses experienced positive working relationships with the other when transitioning into rural and urban acute care settings. However, the predominant theme in Australia (Kelly & Ahern, 2008; Lea & Cruickshank, 2007) and NZ (McKenna et al., 2003) was horizontal violence, which was supported by the survey results of U.S. researcher LaSala (2000) and CA researchers Ellerton and Gregor (2003), Lavoie-Tremblay et al. (2008), and Romyn et al. (2009). While the theme of relationships with the other is alluded to within Duchscher’s (2009) theory of Transition Shock, it remains unknown as to what the impact relationships with the other has on new nurses’ transition into CA rural acute care hospital nursing.

Working Conditions

The influence of working conditions was a common finding in six of 19 qualitative (Gibb, Forsyth, & Anderson, 2005; Kelly & Ahern, 2008; Lavoie-Tremblay et al., 2011; Lea & Cruickshank, 2007; Romyn et al., 2009; Wolff, Regan, Pesut, & Black,

2010) and two of eight quantitative (Bowles & Candela, 2005; Hazard Munro, 1982) studies reviewed (see Table 5). Working conditions had both positive and negative influences on new degree and diploma nurses' transition experiences into AU, CA, and U.S. rural and urban acute care settings.

In some CA rural and urban acute care facilities, staff shortages and complex patient loads have created work environments in which new nurses have needed to "hit the floor running" (Romyn et al., p. 8; see also Wolff et al., 2010, p. 7). In these hospitals, senior staff have expected new nurses to function at a much higher level than novices or beginners and to keep up with full heavy load assignments involving complex high acuity patients. Conversely, other senior nurses in these facilities felt that to maintain safety, the new nurse should only be expected to function independently in stable and predictable situations.

However, senior RNs in Romyn et al.'s (2009) study acknowledged that previously used strategies for "pulling new staff along [such as] spreading heavy patients around to lighten new nurses' workload[s]" (p. 8) were no longer possible due to the numbers of high acuity patients and frequent staffing shortages. The new nurses in these situations used analogies such as "in over my head" (Romyn et al., 2009, p. 8), "barely treading water" (p. 8), and "almost sinking" (p. 8) to describe their transition experiences. Romyn et al. equated readiness for practice with new nurses' ability to provide safe patient care whilst keeping up with busy ward routines.

Similarly, working conditions for new nurses in AU rural acute care hospitals were found to be very stressful due to frightening professional responsibilities and unsafe workloads (Lea & Cruickshank, 2007). Some of these new nurses were expected to go beyond a novice or beginner's knowledge and skills and were placed in charge of entire wards or responsible to autonomously provide care to emergent patients (Lea & Cruickshank, 2007). While Gibb et al. (2005) had proposed the restructuring of AU rural ward cultures to improve working conditions in rural settings (Gibb et al., 2005), more recent data revealed that working conditions in many AU rural and urban acute care settings have been less than ideal (Kelly & Ahern, 2008; Lea & Cruickshank, 2007).

Table 5

Studies Informing Themes Related to Transition: Working Conditions

Researcher & Location	Aim, Purpose, or Question	Approach or Method (sample size)
Bowles and Candela (2005), US	RNs' retrospective perceptions of their first nursing experiences and if they quit (new degree and diploma nurses)	Quantitative Descriptive Survey (*N* = 352)
Gibb et al. (2005), AUS	Culture of workplace learning in 8 small hospitals in rural AU (new degree and diploma nurses)	Qualitative Critical Social (*n* = all nurses in 8 hospitals)
Hazard Munro (1982), US	Correlates of job satisfaction of new degree and diploma nurses	Quantitative Survey (*N* = 329)
Kelly and Ahern (2008), AUS	Experiences of new nurses during their first 6 months as RNs	Qualitative Husserl Phenomenology (*n* = 14)
Lavoie-Tremblay et al. (2011), CAN	Aspects of the nursing work environment related to turnover of new degree and diploma nurses	Qualitative Critical Social (*n* = all nurses in 8 hospitals)
Lea and Cruickshank (2007), AUS	Role transition for new nurses in rural practice	Qualitative Hermeneutic Phenomenology (*n* = 10)
Romyn et al. (2009), CAN	Understanding the transition from student to new nurse	Qualitative Description (*n* = 147; 14 nurse graduates & 133 staff nurses, employers, & educators)
Wolff et al. (2010), CAN	Meaning of new nurse 'readiness' for practice	Qualitative Focus Groups (*n* = 150)

Note. AUS = Australia; CAN = Canada; US = United States; RN = registered nurse.

As previously discussed, Hazard Munro (1982) identified the top two predictors of U.S. new degree and diploma nurses' job dissatisfaction as overwhelming responsibilities and negative working conditions. Correspondingly, a U.S. survey of 352 new degree and diploma nurses who had transitioned into rural and urban acute care settings revealed poor nurse–patient ratios as the greatest negative influence on transition and the predominant reason for quitting nursing (Bowles & Candela, 2005). Recently, high new degree and diploma nurse turnover intention rates in Canada were linked to negative working conditions in some Québec rural and urban acute care facilities (Lavoie-Tremblay et al., 2011). In addition, new nurses in some Alberta rural and urban acute care settings have described chronic understaffing and insufficient orientation periods as contributing to their dissatisfaction with nursing as a career (Romyn et al., 2009). Were these then more examples of Duchscher's (2009) Transition Shock?

On a positive note, some CA (Romyn et al., 2009) and U.S. (Hazard Munro, 1982) researchers revealed that rural and urban acute care environments have provided positive working conditions for transitioning new degree and diploma nurses. However, overall, in seven of the nine studies examined, working conditions were revealed as difficult and responsible for precipitating one or more of the following: new degree and diploma nurses' reduced job satisfaction, decreased retention, or increased intent to leave nursing (Bowles & Candela, 2005; Hazard Munro, 1982; Kelly & Ahern, 2008; Lavoie-Tremblay et al., 2011; Lea & Cruickshank, 2007; Romyn et al., 2009; Wolff et al., 2010).

Doubt in Knowledge

Doubt in knowledge was identified as a shared theme in eight of the 19 qualitative (Ellerton & Gregor, 2003; Kelly, 1998; Kelly & Ahern, 2008; Kenny & Duckett, 2003; Lea & Cruickshank, 2007; McKenna & Newton, 2007; Romyn et al., 2009; Wolff et al., 2010) and one (Lavoie-Tremblay et al., 2008) of the eight quantitative studies examined (see Table 6). Doubt in knowledge predominated new degree and diploma nurses' transitions.

Table 6

Studies Informing Themes Related to Transition: Doubt in Knowledge

Researcher & Location	Aim, Purpose, or Question	Approach or Method (sample size)
Ellerton and Gregor (2003), CAN	Adequacy of preparation of new nurses for transition at 3 months	Qualitative Interpretive Social Science (*n* = 12)
Kelly (1998), UK	Preserving moral integrity in new nurses	Qualitative Retrospective Grounded Theory (*n* = 22)
Kelly and Ahern (2008), AUS	Experiences of new nurses during their first 6 months as RNs	Qualitative Husserl Phenomenology (*n* = 14)
Kenny and Duckett (2003), AUS	Issues that impact the ability of rural acute care hospitals to provide effective health care	Qualitative Descriptive (*n* = 60)
Lavoie-Tremblay et al. (2008), CAN	New degree and diploma nurses' psychological distress in acute care workplaces	Quantitative Correlative Descriptive (*N* = 309)
Lea and Cruickshank (2007), AUS	Role transition for new nurses in rural practice	Qualitative Hermeneutic Phenomenology (*n* = 10)
McKenna and Newton (2007), AU	How new degree and diploma nurses develop knowledge over the first 18 months of practice	Qualitative Phenomenology (*n* = 25)
Romyn et al. (2009), CAN	Understanding the transition from student to new nurse	Qualitative Description (*n* = 147);
Wolff et al. (2010), CAN	Meaning of new nurse readiness for practice	Qualitative Focus Groups (*n* = 150)

Note. AUS = Australia; CAN = Canada; UK = United Kingdom.

Expecting new nurses to be as competent and confident in their knowledge levels as rural generalist specialists immediately postorientation was identified as grossly unrealistic by some AU new nurses (Lea & Cruickshank, 2007). Some other AU new degree and diploma nurses felt that both time and guidance were required to gain the knowledge needed to practice effectively in rural and urban acute care settings (McKenna & Newton, 2007). Although Kenny and Duckett (2003) previously identified the need for courses specific to rural nursing practices to appropriately educate AU new degree and diploma nurses about rural nursing, Kelly and Ahern (2008) found that some new nurses transitioning into AU rural and urban acute care settings experienced inadequate human and educational supports, which left them feeling exceedingly stressed during their transitions.

While some Alberta new nurses have felt that meeting urgent patient needs in rural and urban acute care environments was indeed a top practice priority, they also identified lacking the confidence in knowing whether or not they had successfully recognized those needs (Romyn et al., 2009). In a separate CA study, some new nurses described readiness for practice in rural and urban acute care hospitals as involving the application of theoretical knowledge to practical experiences as a means of putting things together through doing, knowing, and thinking (Wolff et al., 2010). This finding supports components of Nour's (2009) theory of Becoming Alive and Duchscher's (2008) Process of Becoming theory.

Although some CA rural and urban acute care new degree and diploma nurses previously described feeling unprepared for practice, they did not feel incompetent; they worked in the present without the expertise or experience to critically think like seasoned practitioners, but with an inherent trust in their coworkers (Ellerton & Gregor, 2003). Once CA and UK new nurses realized the breadth and depth of knowledge needed to practice in rural and urban acute care environments, they tried to keep up with senior nurses, which resulted in self-doubt about their knowledge, levels of preparedness, and clinical abilities (Kelly, 1998; Wolff et al., 2010).

In summary, the findings of many AU (Kelly & Ahern, 2008; Lea & Cruickshank, 2007), CA (Ellerton & Gregor, 2003; Romyn et al., 2009; Wolff et al., 2010), and UK (Kelly, 1998) studies have revealed that new degree and diploma nurses

experienced doubt in their knowledge during transition due to being expected to keep up with busy and complex ward routines. In some AU rural (Lea & Cruickshank, 2007) and a few CA rural and urban acute care settings (Romyn et al., 2009) new nurses doubted their knowledge because they were expected to practice at a higher level than a novice or due to inappropriate or inadequate management and orientation influences.

Management and Orientation Influences on Transition

Of the 33 studies reviewed, 14 outlined additional factors related to management and orientation initiatives that influenced new degree and diploma nurses' transition into rural and urban acute care settings. These factors included nurse managers, mentorship programs, clinical educators, and residency programs.

Nurse Managers

The findings of one quantitative (Bowles & Candela, 2005) and three qualitative (Gibb et al., 2005; Lea & Cruickshank, 2007; Romyn et al., 2009) studies pointed to the impact of nurse managers' behaviours on new degree and diploma nurses' transitions into rural and urban acute care settings (see Table 7). These behaviours both positively and negatively affected these new degree and diploma nurses' transitions.

A few Alberta rural and urban acute care units stood out as extremely positive work environments (Romyn et al., 2009). The nurse managers on these units indicated that one of the best rewards of the job was when a student on their unit became an RN on that unit. Similarly, some rural AU nurse managers reported they found joy in mentoring new staff and that mentorship promoted an increase in new degree and diploma nurses' confidence and well-being (Gibb et al., 2005). Conversely, some U.S. rural and urban acute care nurse managers were identified as responsible for directing horizontal violence toward new degree and diploma nurses (Bowles & Candela, 2005) and a few rural AU acute care nurse managers were perceived by some new nurses as ambivalent to reports of horizontal violence occurring on their units (Lea & Cruickshank, 2007).

Table 7

Studies Informing Management and Orientation Influences on Transition: Nurse Managers

Researcher & Location	Aim, Purpose, or Question	Approach or Method (sample size)
Bowles and Candela (2005), US	RNs retrospective perceptions of their first year & if they quit (new degree and diploma nurses)	Quantitative Descriptive Survey (*N* = 352)
Gibb et al. (2005), AUS	Culture of workplace learning in 8 small hospitals in rural AU (new degree and diploma nurses)	Qualitative Critical Social (*n* = all nurses in 8 hospitals)
Lea and Cruickshank (2007), AUS	Role transition of new nurses into rural practice	Qualitative Hermeneutic Phenomenology (*n* = 10)
Romyn et al. (2009), CAN	Understanding transition from student to new nurse	Qualitative Description (*n* = 147)

Note. AUS = Australia; CAN = Canada; US = United States; RNs = registered nurses.

Mentorship Programs

Three qualitative studies (Mills, Francis, & Bonner, 2007, 2008; Romyn et al., 2009), one program evaluation (Mills, Lennon, & Francis, 2007), and two mixed-methods studies (Baumann et al., 2006; Kulig & Stewart, 2006) were found that offered insight into the impact of mentorship programs on new degree and diploma nurses' transitions into rural facilities (see Table 8). Mills, Francis, et al. (2007) theorized that many experienced AU rural RNs are accidental mentors; that is, they offer short-term relationships to new degree and diploma nurses who are experiencing critical incidents. Their argument indicated that informal mentoring is akin to relationships with the other, but is presented here nonetheless, as it deals specifically with mentoring.

Table 8

Studies Informing Management and Orientation Influences on Transition: Mentorship Programs

Researcher & Location	Aim, Purpose, or Question	Approach or Method (sample size)
Baumann et al. (2006), CAN	Implications of changing employment patterns in rural & community hospitals	Qualitative Exploratory (*n* = 21 nurse administrators & 44 staff nurses working in 21 rural acute care hospitals with fewer than 100 beds)
Kulig & Stewart (2006), CAN	The nature of rural & remote nursing: Aboriginal nurses in rural & remote CAN	Mixed Methods (*N* = 210 Aboriginal RNs)
Mills, Francis et al. (2007), AUS	The accidental mentor: Developing supportive relationships in the workplace (new degree and diploma nurses)	Qualitative Grounded Theory (*n* = 7)
Mills et al. (2008), AUS	Rural nurses' experiences of mentoring (new degree and diploma nurses)	Qualitative Grounded Theory (*n* = 9)
Mills, Lennon, et al. (2007), AUS	A mentor development& support project for rural nurses (new degree and diploma nurses)	Program Evaluation (*N* = 101 nurses)
Romyn et al. (2009), CAN	Understanding transition from student to new nurse	Qualitative Description (*n* = 147)

Note. AUS = Australia; CAN = Canada; RN = registered nurse.

In an evaluation of their mentorship program, Mills, Lennon, et al. (2007) found that experienced AU RNs' capacities to mentor contributed to more positive workplace cultures for new degree and diploma rural nurses. These authors suggested that teaching senior rural RNs to mentor novice nurses was fundamental to the development of

effective mentorship relationships. In a separate study, Mills, Francis, et al. (2008) again proposed that positive mentorship relationships assist AU new degree and diploma nurses with keeping things in perspective and that mentoring requires seasoned RNs to create safe work environments, act as role models, and to be good friends who offer both positive and constructive feedback to support transition.

In Canada, many rural acute care hospitals have not provided mentorship or appropriate orientation programs to support transitioning new degree and diploma nurses (Baumann et al., 2006; Kulig & Stewart, 2006; Romyn et al., 2009). Romyn et al. (2009) found that new nurses and senior nurses in some Alberta rural and urban acute care facilities recommended mentor positions as a good strategy to foster new nurses' transitions into the workplace. In these situations, a portion of an experienced nurse's time would be protected to enable time for teaching new nurses. The authors of the three CA studies all identified that professional and educational supports were lacking, but needed to support new degree and diploma nurses' transition into CA rural and urban acute care nursing, which in turn, would reduce turnover rates (Baumann et al., 2006; Kulig & Stewart, 2006; Romyn et al., 2009).

Clinical Nurse Educators

The findings from one qualitative study highlighted the negative impact of the erosion of the clinical nurse educator role on the transition of new nurses into Alberta rural and urban acute care settings (Romyn et al., 2009; see Table 9). These workplace circumstances perpetuated by provincial budgetary cuts were described by both senior nurses and new nurses as setting Alberta new nurses up to fail due to the lack of necessary educational supports previously provided by clinical educators.

One nurse manager in Romyn et al.'s (2009) study suggested that every unit manager should attempt to find funding to support full-time employment of clinical nurse educators in order to support new nurses' learning needs. The new nurses in this sample suggested that an increase in access to certification courses provided by clinical nurse educators prior to or during orientation would support their skill development, which in turn would reduce not only the teaching burden, but also the increased workload placed on senior staff during new nurses' transitions.

Table 9

Studies Informing Management and Orientation Influences on Transition: Clinical Nurse Educators

Researcher & Location	Aim, Purpose, or Question	Approach or Method (sample size)
Romyn et al. (2009), CAN	Understanding transition from student to new nurse	Qualitative Description (*n* = 147)

Note. CAN = Canada.

Nurse Residency Programs

Three program evaluations of U.S. new degree and diploma nurse residency programs (Keahey, 2008; Meyer Bratt, 2009; Ulrich et al., 2010) and one CA study in which residency programs were recommended to support new nurses' transition (Romyn et al., 2009) were found (see Table 10). Programs similar to those offered for novice physicians have been developed in the US to increase new degree and diploma nurses' retention rates in rural and urban acute care environments.

The Versant Residency Program offered new degree and diploma nurses "classes with case studies, structured clinical immersion experiences with team precepting, structured mentoring and debriefing or self-care sessions, looping to related departments, and competency validation" (Ulrich et al., 2010, p. 365). The Wisconsin Nurse Residency Program provided new degree and diploma nurses with "formalized preceptor training, monthly daylong educational sessions, and mentoring by clinical coaches" (Meyer Bratt, 2009, p. 1). The results of an evaluation of the 5-year-old Wisconsin residency program instituted in 50 rural and urban acute care hospitals supported nurse residencies as an effective way to recruit and retain new degree and diploma nurses (Meyer Bratt, 2009). The results of a 10-year longitudinal study of 6,000 new degree and diploma nurses who had completed the Versant residency program offered in rural and urban acute care settings revealed new degree and diploma nurses' increased competence and self-confidence, decreased intent to change jobs, and reduced turnover rates (Ulrich et al., 2010). However, after evaluating one rural residency program, Keahey (2008) determined that generic residency programs, such as the previous two discussed, were not suitable for new degree and diploma nurses transitioning into U.S. rural acute care

hospitals and suggested tailoring residency programs to suit each rural site. The residency program Keahey recommended for new degree and diploma nurses in one rural facility included 8 days of didactic perinatal classroom instruction, 10 weeks of clinical nursing with a preceptor, 12 weeks leading patient care with the preceptor shadowing the resident and providing assistance, 4 weeks on night shift working independently with the preceptor as backup, and additional time to complete in-house certification courses and out-of-house (urban) practical experiences such as on the tertiary neonatal intensive care unit. Positive outcomes to this residency program included new degree and diploma RNs who demonstrated confidence and excellent clinical decision-making skills, flexibility, and the capacity to handle emergencies; a shift from senior staff pessimism to optimism; and an 80% new degree and diploma nurse retention rate 2 years later.

Table 10

Studies Informing Management and Orientation Influences on Transition: Nurse Residency Programs

Researcher & Location	Aim, Purpose, or Question	Approach or Method (sample size)
Keahey (2008), US	Residency program for rural acute care hospitals (new degree and diploma nurses)	Program Evaluation (N = 5)
Meyer Bratt (2009), US	Nurse residency program provides support for new degree and diploma nurses	Program Evaluation (N = 50 urban & rural acute care hospitals)
Romyn et al. (2009), CAN	Understanding transition from student to new nurse	Qualitative Description (n = 147)
Ulrich et al. (2010), US	Improving retention, confidence, & competence of new degree and diploma nurses	Program Evaluation: 10-Year Longitudinal (N = 6000)

Note. CAN = Canada; US = United States.

In summary, residency programs have positively influenced new degree and diploma nurses' retention in many U.S. rural and urban acute care environments (Keahey, 2008; Meyer Bratt, 2009; Ulrich et al., 2010); however, generic residency

programs were identified as not suitable for rural facilities (Keahey, 2008). No literature was found that identified residency programs in Canada; however Romyn et al. (2009) had recommended that CA residency programs be considered to support new nurses' transitions into rural and urban acute care settings.

Canadian Nurse Demographics

Three studies informing the state of CA nurse demographics were found (CIHI, 2010, 2012; MacLeod et al., 2004; see Table 11). Information reported from CIHI (2012) indicated that in 2010 the distribution of CA RNs employed in rural and remote nursing was 10.8% (4.5% rural, 6.1% remote, and 0.2% territories), an increase of 0.1% in rural nurses since 2009, but still a significant drop from 18% in 2000 (MacLeod et al., 2004) and 17.1% in 2005 (CIHI, 2012). This 2010 figure equated to 28,999 rural nurses, an increase of 500 (0.1%) since 2009 (CIHI, 2010), but a staggering reduction of 12,503 since 2000. Extrapolating this information to solely rural acute care settings is impossible due to lack of available demographic information, but would be less than the 4.5% identified as rural, because some of these nurses would work in community health and home care, and others would commute to urban centres.

Table 11

Studies Informing Canadian Nurse Demographics

Researcher & Location	Aim, Purpose, or Question	Approach or Method
CIHI (2010), CAN	Regulated nurses: Canadian trends, 2005 to 2009	Quantitative Survey of all Canadian RNs entered into database
CIHI (2012), CAN	Regulated nurses: Canadian trends, 2006 to 2010	Quantitative Survey of all Canadian RNs entered into database
MacLeod et al. (2004), CAN	The nature of nursing practice in rural and remote CAN	Mixed Methods

Note. CAN = Canada; CIHI = Canadian Institute for Health Information; RNs = registered nurses.

Of further concern are statistics that nurses under age 30 years constituted 11.8% of the 2010 CA RN workforce distribution (only a slight increase of 0.2% since 2009) and those aged 50 and up constituted 40.4% (CIHI, 2012). If these 2010 statistics are extrapolated to rural and remote settings, it can be predicted that over 11,600 CA rural RNs will retire by 2025; 13,891 will be between the ages of 30 and 49; and only 3,421 will be under the age of 30 (Smith, 2011). These numbers must be viewed with caution, as some nurses identified as rural will be working in urban areas, community health, home care, or long-term care. Therefore, the rural acute care RN workforce could be devastated by increasing absolute rural populations (MacLeod et al., 2004), low numbers of CA rural RNs, and high CA RN retirement rates (CIHI, 2012).

Summary

Despite a thorough search of numerous databases, the research I found related to new nurses' transitions into rural acute care settings was sparse. Of the 33 articles I reviewed, six theories about new nurses' transition into acute care environments were found: A Process of Becoming, Transition Shock, It's a Battle, Preserving Moral Integrity, Reality Shock, and Becoming Alive (Duchscher, 2008, 2009; Kelly, 1996, 1998; Kramer, 1974; Nour, 2009). However, none were specific to CA rural nursing.

I found Role Stress, Moral Integrity, Relationships With the Other, Working Conditions, and Doubt in Knowledge to positively or negatively influence new degree and diploma nurses' transition into rural and urban acute care settings located in Australia (Gibb et al., 2005; Kelly & Ahern, 2008; Kenny & Duckett, 2003; Lea & Cruickshank, 2007; McKenna & Newton, 2007; Parker et al., 2003), Canada (Ellerton & Gregor, 2003; Lavoie-Tremblay et al., 2008; Lavoie-Tremblay et al., 2011; Romyn et al., 2009; Wolff et al., 2010), NZ (McKenna et al., 2003), the UK (Kelly, 1996, 1998), and the US (Bowles & Candela, 2005; Hazard Munro, 1982; LaSala, 2000). Again, none were specific to CA rural nursing.

Management and orientation influences revealed some very supportive rural and urban acute care work settings for new degree and diploma nurses' transitions located in Australia (Gibb et al., 2005; Mills, Francis, et al., 2007; Mills et al., 2008; Mills, Lennon, et al., 2007), Canada (Romyn et al., 2009) and the US (Meyer Bratt, 2009; Ulrich et al., 2010); however, I found many rural and urban acute care settings located in Australia

(Lea & Cruickshank, 2007), Canada (Baumann et al., 2006; Kulig & Stewart, 2006; Romyn et al., 2009), and the US (Bowles & Candela, 2005) to be very unsupportive. Once again, none of the studies were specific to CA rural acute care settings.

CA nurse demographics are alarming because they point to a crisis looming on the horizon for CA rural nursing. New degree and diploma nurses' recruitment and retention issues (CIHI, 2010, 2012), high CA RN workforce retirement rates (CIHI, 2012), and an increasing absolute CA rural population base (MacLeod et al., 2004) are current and future challenges facing rural nursing.

The information I obtained in this literature review has revealed the following: (a) new nurses' transition into the rural acute care environment remains unclear, (b) the similarities and differences between new nurses' transition into rural acute care as compared to other acute care environments remain unclear; and (c) the issues surrounding the recruitment and retention of new nurses in relation to the rural acute care setting remains unknown. Consequently, the purpose of this study was to identify, understand, and explain how new BN graduates describe the transition experience into the rural acute care hospital environment. The findings from this study can inform Alberta rural acute care educational, organizational, and policy initiatives targeted at recruiting and retaining new nurses, as well as future directions for nursing research.

CHAPTER 3
METHODS

In this chapter, I describe my theoretical underpinnings as the researcher and those of the interpretive description (ID) research approach; address ethical considerations; provide descriptions of the data collection techniques I used for recruitment, sampling, interviewing, and constant comparative analysis; present the activities in which I engaged to ensure rigour; and address strategies I used to attend to ethical considerations. Of note, to avoid confusion, from herein the new nurses who participated in this study will be referred to as "participants."

Methods: Study Design and Research Question

Direction for this study was taken from a qualitative ID research approach developed by Thorne, Reimer Kirkham, and MacDonald-Emes (1997). The research question driving this study was: How do new baccalaureate nurse graduates describe the transition experience into the rural acute care hospital environment? I chose ID to answer this research question because this approach (a) facilitated my interpretation of the perspectives of new nurses about the phenomenon of transition as it related to the rural acute care hospital environment without losing sight of individual variations within that group; (b) was particularly helpful in contributing to my understanding of how new nurses perceived and experienced transition into rural nursing; and (c) enabled me to identify strategies, which can inform future directions in CA rural nursing practices, policies, educational curricula, and research.

Additionally, the nature of the ID approach provided me with a coherent set of strategies for carrying out the inquiry, as well as a framework for understanding the philosophical underpinnings from which to launch the study. The ID approach aided me in knowing who I was, what I was representing, and what I was trying to accomplish before entering the study (Thorne, 2008). In the following discussion my philosophical underpinnings, the philosophical underpinnings of the ID research approach, and my philosophical allegiances are made explicit. As well, ethical considerations are addressed.

My Philosophical Underpinnings

As an RN, philosophically I am a pragmatist—I find meaning in nursing by living my values day by day and forging my own path using both scientific knowledge and artful practices to best suit the needs of my patients in particular moments of time. I tend to co-participate with patients and colleagues alike through multidimensionally structuring co-created realities in rhythmical paradoxical patterns of relating (Parse, 2006) using the expressions of joy–sorrow, happiness–sadness, and hope–fear. I believe that 25 years of rural acute care bedside nursing practice, 5 years of teaching baccalaureate nursing students, and 11 years of being a postsecondary nursing student, as well as my pragmatic philosophical underpinnings have provided me with the attributes necessary to effectively support students during their nursing educations.

As a nurse educator, I draw from an eclectic blend of philosophical views, but my most dominant beliefs are based in humanism. I believe that every person must be respected for who he or she is as an autonomous individual and that each individual possesses unique learning needs. My humanistic side leads me to believe that knowledge and emotion are interactive and that environments which are too stressful hinder learning. Therefore, I attempt to promote students' self-esteem by matching high expectations with high levels of emotional support. Humour, caring, and flexibility are tools that I use to support students' learning.

Philosophical Underpinnings of Interpretive Description

Interpretive description (ID) is philosophically underpinned by the naturalistic orientations of Lincoln and Guba (1985) and, as such, "is grounded in an interpretive orientation that acknowledges the constructed and contextual nature of … health … experiences, whilst allowing for shared realities" (Thorne et al., 1997, p. 172). In addition, the ID approach (a) extends a form of empirical understanding that is of practical importance to a discipline such as nursing within the context of its distinctive social mandate; (b) enables the generation of knowledge "that straddles the chasm between objective neutrality and abject theorizing" (Thorne et al., 1997, p. 26), and (c) offers a set of principles and strategies rooted in nursing.

When using an ID design (Thorne, 2008), the researcher is explicitly identified as an instrument. Therefore, as the researcher, I needed to locate myself within the field to

be studied and the theoretical world surrounding it. To do so, I explicitly identified my theoretical allegiances, disciplinary heritages, and positioning ideas.

My Theoretical Allegiances

According to Thorne (2008), ID does not require that all studies be explicitly located within one or another formal theorization. Researchers can borrow analytic methods from traditional qualitative approaches as long as justification for what has been borrowed is provided along with adherence to the assumptions and linguistics of each research culture (Thorne, 2008). My theoretical allegiances are distantly related to the research cultures of psychology, philosophy, and sociology because I borrowed data analysis techniques from naturalistic inquiry (Lincoln & Guba, 1935), hermeneutic phenomenology (Wilding & Whiteford, 2005) and grounded theory (Strauss & Corbin, 1998). Descriptions of each borrowed technique are provided in the Data Management and Analysis section of this chapter.

My Disciplinary Heritages

My disciplinary heritage is rooted in nursing: 14 years of nursing education, 25 years of rural acute care bedside nursing, and 5 years of teaching baccalaureate nursing students. This heritage influenced what I saw and heard during interviews and what sense I made of data during analysis. Prior to beginning the study I generated sample research questions based in the disciplinary heritage of nursing (see Appendix A), after the construction of some categories (see Appendix B), and again after the construction of some themes (see Appendix C). The first and second sets of questions were used during initial interviews and the third set, during re-interviews. Discussions about how I made sense of data can be found in the Data Management and Analysis and Ensuring Rigour sections of this chapter.

My Positioning Ideas

Ideas, thoughts, perspectives, or personal experiences influencing my angle of vision in this study were explicitly identified in a reflexive journal prior to and during the study. These disclosures positioned me within the study in a way that enabled me to appropriately counter my biases. Descriptions of how I countered bias and its potential influence on this study are addressed in the Ensuring Rigour section of this chapter.

Ethical Considerations

I obtained ethical approval for the study from Athabasca University's Research Ethics Board (see Appendix D). There were no tangible benefits to the participants, although some stated that they benefited from the opportunity to talk about their transition experiences. At the beginning of each face-to-face interview, I introduced myself as a Master of Nursing student and RN to all respondents and then provided an explanation of the study both verbally and in written form (see Appendix E). I advised participants that consent to participate in the study was entirely voluntary, could be withdrawn at any time, and that nonparticipation would not result in any recriminations or harm to themselves. I also reassured participants that their identities would be kept confidential, and known only to me, and as needed, my thesis supervisor. Any questions or points requiring clarification were discussed fully. Each participant signed two copies of the Informed Consent form (see Appendix F); I kept one and he or she kept the other.

During the interviews, I consistently and continually appraised each participant's level of comfort and anxiety. Although two individuals became quite upset, both denied the need to terminate the interviews. At the end of each interview, I informed participants that summaries of the research findings would be made available to them when the study was completed and that if the findings were to be published the data would be summarized in a way that would not make them identifiable. I assigned pseudonyms chosen by the participants to the transcripts and notes and did not include any identifying information in the notes. I kept the informed consent forms and demographic information separate from the transcripts in separate locked boxes in my office.

Data Collection

Initially, I obtained the support of the College and Association of Registered Nurses of Alberta (CARNA) to assist with distributing letters of information to prospective participants. I then used both convenience and theoretical sampling to recruit voluntary participants. I conducted audio-recorded face-to-face interviews that were later transcribed verbatim by a transcriptionist. My observations about each participant's environment, emotions, and behaviours during those interviews were also audio-recorded and transcribed.

Inclusion Criteria

I invited new nurses to participate in the study, who had worked (full time, part time, or casually) more than 1 month and less than 2 years in one or more Alberta rural acute care hospitals. CARNA facilitated their recruitment.

Recruitment

Following ethical approval, I contacted the Director of Corporate Services for CARNA (see Appendix G) to distribute an Information Letter for Participants (see Appendix E) to a potential cohort of new nurses across rural Alberta who had self-identified to CARNA their willingness to participate in research. In total, 60 prospective participants were initially mailed the letters of information asking if they wished to voluntarily participate. In addition, one individual voluntarily contacted me and asked about participating in the study after hearing about it from a friend. I emailed her the information letter. The letters of information included my contact information, as well as that of my thesis supervisor; background information about the study; inclusion criteria; benefits and risks of participation; descriptions of voluntary participation and confidentiality; and how to contact Athabasca University's Research Ethics Office. In keeping with voluntary participation, prospective participants initially contacted me by telephone, email, or verbally to indicate their interest in participating in the study. Following this initial contact, I telephoned or emailed each participant to arrange a meeting.

After conducting 11 initial interviews and three re-interviews, I submitted a second letter of information to CARNA for distribution to a prospective theoretical sample of eight male participants in an effort to recruit some additional males. This letter was similar to the previous letters of information except it included the following sentence: "I currently have some participants but would like to obtain the perspectives of more male rural nurses." Unfortunately, the two men who did respond to this letter did not meet the inclusion criteria and could not be recruited. In all, I received 16 prospective participant responses; however, only 12 met the inclusion criteria and could be recruited.

Sample

Initially, I used convenience sampling to recruit 11 participants who were working in various rural acute care hospitals across Alberta. One additional participant

was recruited through snowball sampling. I used theoretical sampling to re-interview four participants who were identified as able to provide more in-depth clarification about new nurses' transition into rural nursing. The final number of participants recruited was 12 (see The Context of Transition into Rural Acute Care: PARTICIPANTS AND FACILITIES section of Chapter 4 for further information), a sample I believe was adequate as there was depth and breadth in the data set generated from participants' descriptions about the experience of transition; negative cases revealed less than obvious aspects of the findings, including anomalies; and repetition from multiple sources generated a comprehensive and complete data set (Morse, Barrett, Mayan, Olson, & Spiers, 2002).

Interview Process

During the initial phone call and to better ensure confidentiality, I suggested meeting in locations not associated with participants' places of work. In my subsequent face-to-face contact with each participant I discussed the contents of the Information Letter for Participants (see Appendix E), answered questions, and reviewed points requiring clarification. I then asked each participant to sign two copies of the Informed Consent form (see Appendix F); I gave one to the participant and filed the other in a locked box in my office.

Prior to commencing each initial interview I completed a Demographic Data Form (see Appendix H) to elicit contextual information about the participant and to serve as an ice-breaker (Vandall-Walker, 2006). Throughout the entire process, from the initial contact to the interview completion, my previous experience as a rural acute care RN, baccalaureate nursing instructor, and Master of Nursing student, informed my actions. I was attentive to each participant's level of anxiety. As stated earlier, two participants did become quite upset during their initial interviews so I asked each if they wished to terminate the discussions; both denied a need to do so. Upon completion of those interviews I did feel confident that each individual was emotionally okay, drawing on my skills of assessment to make this judgment.

Initially, I collected data through semi-structured, audio-taped (with participants' permission) face-to-face interviews, which lasted approximately 1 hour. The interviews were later transcribed: I transcribed the first two, and a professional transcriptionist

completed the rest. Participants each chose the locations for their interviews: seven in their homes, one in a spouse's parents' home, one in a friend's home, two in my car, one in a library, and one in a participant's place of work (even though I advised against this). With each initial interview, I used the following open-ended statement to encourage participants to share their experiences: "Please describe your transition experience into rural acute care." Some chose to respond to this statement by describing how the transition experience felt, while others described the events leading up to transition. Subsequent to this initial statement, I used open-ended questions to encourage elaboration of participants' thoughts or ideas in an effort to ensure their responses were not prematurely narrowed. I used probes such as "Please tell me more about that," or a question such as "Can you describe what you are saying in relation to transition?" to encourage each participant, to lead the direction of the interview, and at times to redirect the conversation to the topic of transition. As data analysis revealed areas requiring further exploration, my interview questions became more purposive (see Appendix B).

The first few interviews were exploratory in nature. Frequently, participants described transition in relation to situations and type of work; in these interviews, in an attempt to uncover the emotional side of the experience, I asked participants the question, "How did that make you feel?" Some participants were hesitant to describe their feelings, while others identified feeling relieved with the opportunity to share their emotions. I asked participants who they felt had been supportive or unsupportive during their transitions. I then encouraged them to more deeply describe the behaviours of those individuals and what they did that made transition easier or more difficult. During each interview, I encouraged the participant to elaborate further about specific situations or thoughts through the use of statements or questions such as "Please tell me more," "Can you describe that further for me," or "Can you please clarify?"

Subsequent to the first few interviews and with guidance from my supervisor, I began unitizing and categorizing each participant's data set (Lincoln & Guba, 1985). This analytic technique enabled me to find the "WHAT" (Morse, 2007, p. 2727) in the data and to place similar units together in a Microsoft Word journal. I continued this process with each interview and, eventually, categories and subcategories evolved (Morse, 2008).

To generate themes, I read and reread each interview paragraph by paragraph while listening to the audio-recording, asking "What is this about?" (Morse, 2008, p. 727), and thinking interpretively. I then spent considerable time analyzing the data through asking myself the following questions about the evolving themes to be sure that the themes threaded through the data: Why is it this? Why not something else? How does it fit or not fit with transition? Then to tease out the evolving themes and to further refine the analysis I re-interviewed four participants who had initially provided rich data. The questions I asked in these re-interviews were based on the emerging themes (see Appendix C) and provided each participant an opportunity to modify or confirm the themes and subthemes. I conducted these re-interviews face-to-face in each participant's home over approximately 1 hour. The re-interviews were audio-taped (again with participants' permission) and transcribed verbatim.

I then spent considerable time immersed in the data to be sure that the findings were true to the participants' experiences. This immersion involved letting go of and generating ideas that fit the data set. The end result was the construction of one core theme—***A DOUBLE WHAMMY!*** I also found two major subthemes ***I'M A GENERALIST! and I'M IT!*** as well as several subthemes.

Notes

Notes to record impressions and observations about the context of the interviews were audio-taped and transcribed following each interview; I transcribed the first two, and a professional transcriptionist created transcripts of all subsequent interviews. Notes included a description of the setting; the participant's nonverbal behaviours and emotional state; distractions and interruptions before, during, and after each interview; and my responses to the interview. I used this contextual information to inform analysis of the environmental contextual factors and interview data. For example, the level of anxiety displayed by two participants and documented in the notes influenced how I interpreted the importance of some specific events to them. This led me to further explore in subsequent participants' interviews whether or not they had experienced similar situations or events during their transitions.

Data Management and Analysis

In congruence with ID methodology, the data analysis process I used was inductive and iterative (Thorne et al., 1997), wherein data analysis occurred simultaneously with data collection, with exception of the demographic data, which I list in The Participants section in Chapter 4. I used data immersion techniques borrowed from Hermeneutic phenomenology (as cited in Wilding & Whiteford, 2005) to immerse myself in audio-recorded and transcribed interview and note data before I began to code, classify, or create linkages. I used unitizing and categorizing techniques borrowed from naturalistic inquiry to uncover commonalities and patterns within the participants' data sets (Lincoln & Guba, 1985) and constant comparative analysis and memoing techniques borrowed from grounded theory to simultaneously collect and analyze data (Strauss & Corbin, 1998). I used a Microsoft Word program to manage the transcribed interview and note data and to generate and manage diagrams. Other diagrams I drew by hand.

To ensure appropriate data analytic techniques were used, my supervisor reviewed the analysis at a number of points in time: during my initial immersion in the data and after some patterns and relationships had been generated, after my initial analytic thinking had been documented, after I had generated some themes and subthemes, and when I had completed the final analysis. To analyze the data I followed these steps: know the data, move from patterns to relationships, document analytic thinking, and complete the final analysis.

Know the Data

Initial analysis of each participant's data was based on Heidegger's hermeneutic tenets (as cited in Wilding & Whiteford, 2005) and involved immersing myself in the data. Each audio-taped interview and accompanying note was transcribed to text. To correct the transcription, become immersed in the data, and form an initial impression, I listened to each audio-tape in its entirety. Subsequent to this, I entered each interview transcription into a Microsoft Word document in the form of a table. I then listened to each audio-recording again line-by-line and entered the basic units next to the raw transcriptions in the table. As the analysis progressed I added new columns to the table, consisting of categories and subcategories, and eventually, themes and subthemes. During this process, I embraced an attitude of passivity—I sat back, watched, waited, and

created a space in which phenomena were revealed (Wilding & Whiteford, 2005). I also used deep meditation and reflection to understand and interpret what was seen, heard, and read in the data (Wilding & Whiteford, 2005). I went for numerous walks in the fresh air and openly talked through my reflections and interpretations with myself. I also engaged in frequent conversations with colleagues to acquire other perspectives about my findings. I repeated these steps numerous times over several months as the analysis progressed, which enabled me to intimately know each individual's data set (Thorne, 2008).

Move From Patterns to Relationships

To move from patterns to relationships, I organized units of data into various groupings, made sense of the relationships between those groupings, and constructed a coherent whole using an iterative reasoning process (Lincoln & Guba, 1985). I also used Heidegger's (as cited in Wilding & Whiteford, 2005) data immersion techniques and Lincoln and Guba's (1985) unitizing and categorizing techniques in conjunction with Strauss and Corbin's (1998) constant comparative techniques to assist in the analysis.

Unitizing and categorizing. Lincoln and Guba's (1985) approach of unitizing and categorizing of data began after I had conducted the first two interviews. To gain an overall impression of each participant's transition experience, on initial reading of each interview I asked the question, "What is going on here?" These impressions were found to range over two separate continuums, from not difficult to overwhelming and supported to unsupported. In addition, I found descriptions of varying degrees of emotions ranging from comfortable to terrified to be associated with the amount of support participants' encountered during transition and how difficult they perceived transition to be.

Subsequent to forming an overall impression, I went back to the raw data and coded sentence by sentence; concepts referred to in each sentence were entered into a third column in the Microsoft Word table. At times I found more than one concept for each sentence; I entered all ideas into the table next to the raw data. I asked additional broad questions of the data, such as "What am I learning about this?" (Thorne et al., 1997, p. 174), to begin making constant comparisons within the data set.

Constant comparison. Employing Strauss and Corbin's (1998) technique of constant comparison, I compared incident (unit) to incident (unit) searching for

similarities or differences. I coded each unit in a way that made it comprehensible to others, placed it (unit) into a broad provisional category (consisting of a word, sentence, or quote), which appeared to be related to the same content, as well as, into a separate blank Microsoft Word journal. For example, I initially assigned the broad category of *Learning with Health Care Providers* to the unit of data "when the RN is stuck in the labour and delivery room the LPN is responsible for managing the floor," a comment shared by the first participant. I based this choice of signifier on this participant's experience of learning about the people she worked with. I then placed the broad category of *Learning with Health Care Providers* into a blank Microsoft Word journal. In addition, I placed a comment within the table next to the signifier as a reminder for me to ask subsequent participants about the meaning of the word "stuck."

To be sure that their inclusion was justified, I reviewed the units in each category several times; if they were not, I removed the units and placed them into a miscellaneous pile. Once all units were exhausted, I reviewed the miscellaneous pile to explore if any bits of data fit with existing categories or if new categories needed to be created.

Once there was enough data to generate critical-sized categories, I used a propositional statement about the properties in each category to characterize the units of that category by defining the category and searching for concepts that captured the essence of the category. I also identified each category's opposite definition so as to become sensitive to the potential relevant properties in the data. I then analyzed each category for its properties and dimensions to identify specific attributes or characteristics so as to locate those properties in a range along a continuum. I used an online thesaurus to assist with adequately identifying the various terms for each category's attributes or characteristics. To ensure homogeneity within each category and heterogeneity between categories, I reviewed each category again in search of ambiguities, inconsistencies, and overlap by looking for relationships between them (Lincoln & Guba, 1985). Some categories were subsumable by others and became subcategories and others were homogeneous with existent categories and were collapsed. Missing, incomplete, or unsatisfactory categories were earmarked for follow up during subsequent interviews. For example, the definition of the category *Learning* was found to be "the acquisition of knowledge or skills through study, experience, or being taught" ("Learning," 2014, Noun

section, para. 1) and the extreme opposite to be "No Learning," whereby one would not acquire knowledge or skills. I then assigned the category of *Learning* the property "degree" and analyzed its range along a dimensional continuum of some to a lot. As well, I analyzed *Learning* from a third viewpoint of "Inappropriate or Incorrect Learning" using the property of "degree" again. I also assigned other properties to learning such as "how fast" with a dimensional range of easy or quickly to painstakingly or slowly and "how much" with a dimensional range of gradual to steep.

Subcategories were also analyzed for properties and dimensions. For instance, one of the subcategories of *Learning* included *Learning About Oneself* in which the property "amount of insight" dimensionally ranged from moderate to deep. Another example was when I analyzed the category of *Fitting In* and compared it to its opposite of "Not Fitting In." One property in this case was "how well" with a dimensional range of very well to not at all. To assist with revealing the relationships among concepts within each category, I drew diagrams. In addition, I continually explored relationships between concepts within each category and subcategory through using the data generation strategies of surfacing, extension, and bridging (Lincoln & Guba, 1985) to confirm, elaborate, validate, or limit each concept's applicability (Vandall-Walker, 2006).

Surfacing involves identifying new categories because the logic of the situation demands them; extension involves inching from the unknown to the known; and bridging enables establishing relationships between known but disconnected categories (Lincoln & Guba, 1985). Using these data analytic techniques simultaneously enabled me to intimately know the data set from each individual case, generate relevant common themes from within those individual cases, and form new knowledge based on interpretations of individual data sets, all whilst constantly comparing interview and observational data to already generated data (Thorne, 2008).

For example, surfacing occurred with the broad category of *Learning with Health Care Providers* because the logic of the situation demanded that a new category be created; consequently the categories of *Learning* and *Fitting In* were generated. The first was central to the concept of *Learning* and the second to the concept of *Being with Health Care Providers*. Asking "What is happening here? … What am I learning about

this?" (Thorne et al., 1997, p. 174) enabled me to inch from the unknown to the known (extension) to make a decision about the unit of data associated with *Learning with Health Care Providers,* wherein it would remain in the category of *Learning,* and *Health Care Providers* could be subsumed (bridged) by the category of *Fitting In.*

To push the analysis further, I consistently used deep meditation and reflection to understand and interpret what I saw, heard, and read in the data (Wilding & Whiteford, 2005). This assisted me with interpreting each category at graduating levels of abstraction until a collection of interconnected themes and subthemes evolved. To generate themes, I read and reread each interview paragraph by paragraph while listening to the audio-recording, asking "What is this about?" (Morse, 2008, p. 727) and thinking interpretively. I then used a white board and blank notes to highlight keywords and phrases and spent considerable time asking myself the following questions about the evolving themes: Why is it this? Why not something else? How does it fit or not fit with transition? I used this process to be sure that the themes went through the data (Morse, 2008). Throughout the analysis process I communicated with my supervisor frequently to ensure that I was interpreting data appropriately. We had lengthy telephone discussions about the evolving themes, and she assisted me with consistently comparing back to the whole and to the research question driving the study. Eventually, one core theme, two major themes, and several subthemes emerged, all grounded in data.

For example, I constructed one overarching theme of ***A DOUBLE WHAMMY!*** consisting of two subthemes *Being a Rural Nurse Generalist* and *I'm It* based on interpretations of the participants' accounts of what was needed to fit in, learn, access supports, and be it in the rural acute care environment. Initially, the theme ***A DOUBLE WHAMMY!*** appeared differently with the subthemes of *Becoming a Rural Nurse Generalist* and *Becoming a Professional Nurse*, wherein *Becoming a Rural Nurse Generalist* subsumed the theme of *I'm It,* but through discussions with my supervisor I was able to identify new themes because the logic of the situation demanded them (surfacing). Together, we had the realization that some of these participants were actually already *It*; that is, short orientations and staff shortages had placed them in situations in which they were expected to take on the roles of the rural nurse generalist and *I'm It* very soon after being hired. As well, as I inched from the unknown to the known (extension)

and was trying to establish relationships (bridging) between the theme of *Becoming a Professional Nurse* and what was really occurring during transition, I realized that there was a disconnect between this theme and what was different about rural nursing. To comprehend this disconnect I kept asking, "What is going on here?" (Thorne et al., 1997, p. 174), and what is different about rural acute care environments? It finally occurred to me that ***A DOUBLE WHAMMY!*** really was about ***I'M A GENERALIST! and I'M IT!*** because the difference for these participants transitioning into the rural acute care environment as compared to new nurses transitioning into other settings was that they were expected to be "it" as well as to be rural nurse generalists. Consequently, the theme of *Becoming a Professional Nurse* was discarded in favour of the new ***A DOUBLE WHAMMY!—I'M A GENERALIST! and I'M IT!*** As well, I generated the subthemes of (a) ***How Do I Manage All of This Learning and Responsibility?***, (b) ***An Emotional Roller Coaster Up! and Down!***, and (c) ***The Decision: Stay or Go?*** to describe the supports participants accessed, the feeling aspects of the transition experience associated with the themes ***I'M A GENERALIST! and I'M IT!***, and the influences affecting participants' ultimate decision of whether or not to stay in the rural acute care environment.

I terminated data collection when there was repetition of themes, there was an emergence of core themes within the data set, no one else met the inclusion criteria, and I sensed that the new information being generated was very far removed from the core of the existent themes (Lincoln & Guba, 1985). The result was the collection of an array of interconnected themes and subthemes that were grounded in the data.

Document Analytic Thinking

During the initial analytic process, I entered memos into a blank Microsoft word journal and diagrams into a hardcopy journal. As the analysis progressed, I jotted notes into the margins of the hardcopy journal and diagrams. These memos were used to stimulate my thinking about the data and emerging themes and to create a decision trail. They assisted me with (a) uncovering the properties of categories; (b) generating rules for assigning incidents (units) to categories; (c) replacing tacit judgments with propositional rule-guided judgments (Lincoln & Guba, 1985); and (d) asking increasingly complex and skeptical questions of data, such as, "Why is this here? Why

not something else? And what does it mean?" (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004, p. 7). These questions helped me to broaden rather than narrow conceptual linkages, by creating data collection pathways that challenged, rather than reinforced my earlier conceptualizations.

Complete the Final Analysis

During the final steps of data analysis I compared the themes and subthemes with the original and ongoing literature review to analyze whether or not they shed any new light on the original theoretical platform (Thorne, 2008). The consequence was the creation of coherent, rich interpretations in the form of themes and subthemes beyond the study's initial theoretical platform (Thorne, 2008), which described the transition experiences of the new nurses in this study into the rural acute care environment. Although in the proposal phase of this thesis I had identified that I would write the findings in the form of a vignette consisting of participants' interwoven voices, this notion was discarded when I felt that the voices were being forced. Consequently, I have written the findings in the general style by including my descriptions of participants' experiences intermingled with their quotes.

Ensuring Rigour

Qualitative "research is only as good as the investigator" (Morse et al., 2002, p. 10). I ensured the reliability and validity of this study through my use of investigator responsiveness and verification strategies (Morse et al., 2002).

Investigator Responsiveness

I maintained investigator responsiveness through the use of analytic logic, representative credibility, and an interpretive authority throughout the entire process of the inquiry (Thorne, 2008). Explications are as follows.

Analytic logic. Analytic logic or transparency of my reasoning was ensured through the documentation of a decision trail providing explicit evidence to demonstrate links between the indicators in the data set and the analytic categories (Thorne, 2008). The raw data and decision trail together became the audit trail and included my transcribed interviews and notes, products of coding and analysis activities, products of

reconstruction and synthesis activities including diagrams and tables, and memos of rationale for decisions made (Vandall-Walker, 2006).

Representative credibility. Representative credibility refers to theoretical claims consistent with the manner in which the phenomena were sampled (Thorne, 2008), which I ensured through my use of theoretical sampling techniques, willingness to adopt or abandon evolving categorization themes, and explicit identification of a priori knowledge and biases (Vandall-Walker, 2006).

I conducted interviews at times and in places identified as convenient by participants. I used inductive and iterative data analysis techniques that determined the need for theoretical sampling (four participants were re-interviewed), ensured appropriateness and adequacy of data, and ensured the sample was as representative as possible (given the constraints of time and money) of new nurses transitioning into the rural acute care environment.

My openness, sensitivity, creativity, and insight enabled me to seek evidence to adopt or abandon the categorization themes and to relinquish poorly supported ideas. The result was the generation of themes with stability.

I borrowed data analysis techniques from the research traditions of naturalistic inquiry, hermeneutic phenomenology, and grounded theory; therefore, my biases and a priori knowledge were not "bracketed" from the interpretive process. To counter this, I assumed responsibility for interpreting data and was aware of my unique perspective and how my prejudices, philosophical traditions, and a priori knowledge influenced the analytical process. I documented these preunderstandings and any biases that arose during the study in a reflexive journal.

Interpretive authority. Interpretive authority refers to the ability to reveal truths representative of participants' views external to a researcher's biases and knowledge (Thorne, 2008). To ensure interpretive authority I exercised active listening during interviews and reflexive journaling throughout the duration of the study. Despite my disciplinary heritage, I was a learner in this situation, not an expert. This knowledge supported my awareness about the importance of listening to the participants' perspectives. My primary activity during all participants' interviews was to listen, not

talk—the latter being the activity of experts (Glesne, 2011). Discussions with my thesis supervisor about my biases ensured that they were visible and challenged.

Verification Strategies

Morse et al. (2002) defined verification as "the process of checking, confirming, making sure, and being certain" (p. 9), which I upheld through weaving verification strategies into every step of the inquiry. Consequently, the analysis was self-correcting because I identified and corrected errors before they were built into the design and subverted data analysis. Four verification strategies woven into the fabric of this study included methodological coherence, sampling sufficiency, an active analytic stance, and thinking theoretically.

Methodological coherence. Maintaining methodological coherence ensured that I generated "a defensible line of reasoning from the assumptions [I] made about the nature of knowledge through to the methodological rules by which [my] decisions about the research process [were] explained" (Thorne, 2008, pp. 223–224). I ensured that there was congruence between (a) the research problem (low new degree and diploma nurse retention rates in CA rural communities and high CA senior RN retirement rates) and question (how do new BN graduates describe the transition experience into the rural acute care environment); (b) the research question and methodology (ID); and (c) the methodology and methods (inductive and iterative with immersion in data and constant comparative data analysis techniques).

Sampling sufficiency. Sampling sufficiency has been previously discussed as representative credibility. To ensure sampling sufficiency, I (a) re-interviewed some participants with the purposes to deepen and broaden emerging themes, (b) searched for negative cases to reveal less than obvious aspects of the developing analysis, and (c) sampled until repetition from multiple sources ensured a comprehensive and complete data set (Morse et al., 2002).

Active analytic stance. My ability to maintain an active analytic stance assisted with ensuring interpretive authority, as previously discussed. Data generation was inductive and iterative (Thorne, 2008), whereby my concurrent collection and analysis of data formed a mutual interaction between what was known and what still needed to be

known (Morse et al., 2002). Maintaining an active analytic stance promoted my ability to think theoretically.

Thinking theoretically. Thinking theoretically was ensured because I maintained macro–micro perspectives, inched forward without making cognitive leaps, constantly checked and rechecked the data; and built a solid foundation (Morse et al., 2002). I confirmed emerging ideas with original ideas in the data sets so that new ideas were always verified in already generated data. The result was the generation of a stable schema grounded in data.

Coupling an active analytic stance with thinking theoretically enabled me to move the data analysis beyond the knowledge of the original philosophical platform (i.e., my expert knowledge of rural acute care bedside nursing practices, knowledge of teaching and learning in rural acute care environments, and recently acquired knowledge gained during the initial and ongoing literature review) to generate new knowledge grounded in data about the transition experiences of new nurses into the rural acute care environment. Not only are these study findings retraceable, but they are also defensible.

My investigator responsiveness and verification strategies incrementally and interactively contributed to the reliability and validity of this study. Together, they ensured that the study was rigorous.

Summary

In this chapter I have described in detail the methods I used to conduct this study. I have identified my philosophical underpinnings and those of an ID research approach, my theoretical allegiances, disciplinary heritages, and positioning ideas, the activities I engaged in to attend to ethical considerations, a detailed description of the techniques used for data collection, and the methods used to ensure rigour.

CHAPTER 4
FINDINGS

In this chapter I present the findings related to the transition of new nurses into rural acute care. First, I provide an overview of the participants' transition into rural acute care, entitled ***A DOUBLE WHAMMY!***, followed by contextual information about the participants and their various rural acute care work environments. In the last section, I explore further the overarching theme of ***A DOUBLE WHAMMY!*** and include in-depth descriptions of the subthemes ***I'M A GENERALIST!*** **and** ***I'M IT!*** as well as the associated subthemes.

Transition into Rural Acute Care: A DOUBLE WHAMMY!

Analysis of data gathered from 12 participants in relation to 14 facilities revealed that the transition experience into rural acute care constituted ***A DOUBLE WHAMMY!*** (see Figure 1). That is, participants lived through two interconnected nondiscrete experiences, at times, simultaneously: ***I'M A GENERALIST!*** *With So Much Learning* and ***I'M IT?*** when expected to manage *Even More Responsibility* (see Figure 1). In terms of the current study, the slang term "double whammy" was purposefully chosen as best representing the transition experience, as it captures the challenges each participant experienced as ***I'M A GENERALIST! and I'M IT!***, and his or her corresponding roller coaster of emotions, which ranged from exhilaration (surprise) to panic (shock). Overall, participants' transition experiences were conceptualized as falling along a continuum: At the one end, the experience was very challenging, fast paced, and overwhelming and at the opposite extreme it was easy, slow paced, and sometimes boring. Of importance is that many and varied contextual factors influenced the transition; these factors related to the participants' demographics and the information surrounding staff mix and services available in the facilities where they transitioned (see The Context of Transition into Rural Acute Care: PARTICIPANTS AND FACILITIES section of this chapter for further information).

Contextual factors deemed most significant to address, in terms of the participants, included education program, rural clinical placements, previous experiences, and reasons for choosing rural nursing. In relation to the facilities, the type of hospital and whether it was a generalist or an urban model was considered noteworthy to discuss.

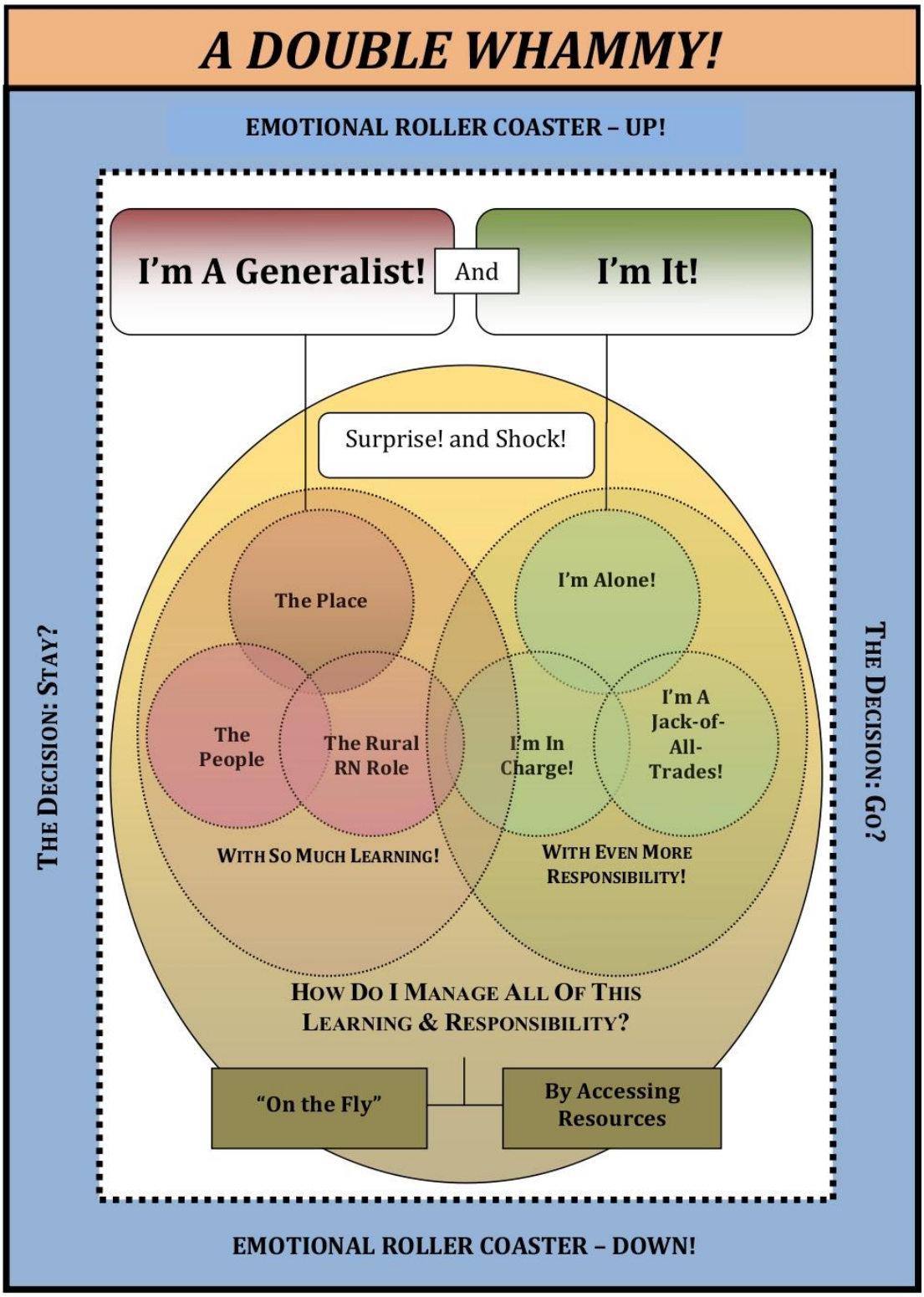

Figure 1. A Double Whammy!

Note. RN = registered nurse.

The transition experience ***I'M A GENERALIST!*** encompassed the emotions and knowledge acquisition that occurred as participants were faced *With So Much Learning* about ***The Place, The People***, and ***The Rural RN Role*** (see The Transition Experience: A DOUBLE WHAMMY! section in this chapter for further information). Learning about ***The Place*** involved acquiring knowledge about the rural acute care hospital where participants worked and the rural community in which that hospital was situated. To do so, participants pondered the question: *What do I need to know* about *The facility* and *The community?* In answering the question participants came to understand the services, educational supports, and unit cultures of the rural facilities in which they worked; how to manage the lack of anonymity that could result when working with rural clients and families; and strategies for maintaining patient confidentiality. In addition, learning about ***The Place*** informed participants about the related subthemes of ***The People,*** and ***The Rural RN Role,*** and the second experience of ***A DOUBLE WHAMMY!–I'M IT!***

Learning about ***The People*** in the rural setting involved participants acquiring knowledge about staff in general, nurses, nurse managers, clinical nurse educators, physicians, and rural clients and their families through pondering: *Who are they? How do I fit in?* Answering those two questions enabled participants to begin to understand the individuals with whom they came in contact and to determine how to gain their trust and acceptance, be they clients or coworkers. Additionally, to fully comprehend their new role as RNs, participants learned about themselves through asking: *Who am I? How do I cope?* Understanding themselves in relation to ***The Place*** and ***The People*** informed learning about ***The Rural RN Role***, which required asking the following question: What do I need to know about how to change hats and how to manage the role essential for providing care to complex and diverse clients over the lifespan? In addition to learning ***The Rural RN Role***, participants also managed the responsibilities of the second whammy experience of ***I'M IT!***

I'M IT! involved participants managing *With Even More Responsibility* and encompassed ***I'm Alone!***, ***I'm In Charge!***, and ***I'm A Jack of All Trades!*** (see The Second WHAMMY: I'M IT! section in this chapter for further information). ***I'm Alone!*** involved managing working as *The sole RN on shift, The only body available*, or *With no on-site physician.* ***I'm In Charge!*** entailed managing the role of being in charge of *The*

hospital, *The unit*, *The team*, and *Contingent or emergent situations*. ***I'm A Jack of All Trades!*** involved fulfilling duties of others in addition to RN responsibilities.

In order to deal with this ***DOUBLE WHAMMY!*** participants utilized two very different ways to address the question: ***How Do I Manage All of This Learning and Responsibility?*** The first method was "*On the Fly"* by learning tasks, procedures, or protocols "on the go" whilst providing patient care or calling for help (see A DOUBLE WHAMMY: How do I Manage All of This Learning and Responsibility? section of this chapter for further information). The second method was *By Accessing Resources* to learn *Who's who?* and *What's what?* Knowing *Who's who?* encompassed learning *Who will support me? At work? Outside of work?* Knowing *What's what?* involved learning *When do I need to call for help? What procedures, policies, and/or protocols do I need to use? What are the idiosyncrasies of the physicians?* and *What information do I need to access and how?*

Interwoven into the experiences of learning and responsibility associated with ***I'M A GENERALIST! and I'M IT!*** were an array of emotional experiences that situated participants on ***An Emotional Roller Coaster Up! and Down!*** The degree of emotional fluctuation within each participant's ride varied and was dependent upon how prepared and supported he or she felt during transition. For those who were well prepared or supported, rural nursing was a good fit, and the decision to stay was not in question. However, for others, lack of support compelled them to contemplate ***The Decision*** about whether to ***Stay?*** in the rural acute care setting or to ***Go?*** and find work elsewhere in another part of the same hospital, a different rural facility, or on an urban unit. For a few, the type of work and a desire to specialize beyond the generalist role influenced ***The Decision: Stay? or Go?*** I begin this discussion by addressing the several contextual factors that influenced the transition experience.

The Context of Transition into Rural Acute Care: PARTICIPANTS AND FACILITIES

I present the context of new nurses' transition into rural acute care in terms of the 12 individuals who participated in this study and the 14 facilities wherein they experienced transition. Additional contextual information is provided within the

description of the transition experience of ***A DOUBLE WHAMMY!*** as it relates to a particular theme or subtheme.

The Participants

Participants' perceptions of transition were influenced by a number of contextual factors related to demographic information. The relevant factors that I collected at the beginning of each interview included age, marital status, number of children, type of university program attended, rural placement during BN program, previous health care experience, months working in rural areas, and employment full-time equivalencies (see Table 12). Additionally, I explored whether each individual had been raised rurally, moved for the job, commuted for work, and intended to stay in his or her current location. To protect the privacy of the one male participant, gender is not included in Table 12. In the subsequent discussion, those variables found to be most significant are explored in more detail.

Education program. Most participants believed that they were provided with opportunities to acquire a strong foundation in nursing knowledge, very good medical surgical skills, competence in critical thinking, and the ability to learn independently no matter what type of program they had been enrolled in. Nonetheless, many felt inadequately prepared for the *"big leap"* from university and urban practice settings to the rural acute care practice setting. Clinical experiences with urban medical and surgical clients and rural long-term care clients were insufficient for preparing individuals to manage the complexity and diversity associated with rural acute care clients. As one participant expressed, "*Nursing school experiences are not the same as rural acute care. They definitely did not prepare me for rural."* Most disconcerting was the fact that the instruction received in university programs had not provided many participants with enough emergency, paediatric, or maternity clinical experiences.

> *I felt very uncomfortable working in maternity, and I think that's everywhere in rural because you don't get the proper training. I got only post-partum experience, and one labour and delivery shift in my entire education.… Paediatrics for sure, because you don't have any of that* [during nursing education]. (Interviewee)

Table 12

Participant Demographic Information

Participant No.	Age Range	Marital Status	Type of BN Program	Rural Placement During BN Program	Previous HC Experience	Raised Rurally	Moved for Job	Months Working	FTEs	Intent to Stay in Rural Acute Care	No. of Interviews	Commuting
1	23-25	S	CBL	Precept clinical rotation	Urban HCA	yes	Y	13	.8	No urban	1	yes
2	23-25	S	CBL	No	Urban Rural AC/UG	yes	Y	24	Data not avail -able	No urban	1	no
3	23-25	M	Lecture	No	Urban UG HCA	yes	N SO	12	.5	No diff unit	1	no
4	26-28	M	CBL	No	Rural EMR	yes	N SO	12	.65	Yes rural hosp	1	no
5	29-31	M	Lecture	No	Rural LPN NA	yes	N SO	7	.42	No diff unit	1	yes
6	29-31	M Ch	Lecture	Precept	Urban HCA	no	yes	14	1	Yes	1	no
7	32-34	M Ch	Lecture	No	Rural AC/UG HC	yes	Y	24	1	Yes	2	yes
8	23-25	C/L	CBL	No	Urban AC/UG Rural LTC/ UG	yes	N SO	24	C	No diff unit	1	no
9	26-28	M Ch	Distance	Clinical rotation	Rural Psych HCA	yes	Y	8	1	No diff unit Stayed Casual	2	yes
10	23-25	C/L	Lecture	No	Urban ER/UG/ LTC/HCA	no	N	7.5	.6	No urban	2	yes
11	23-25	S	Lecture	Clinical rotation	None	yes	Y	13	.64	Yes rural hosp	2	no
12	38-40	C/L	Lecture	No	Rural LTC/NA	yes	Y	17	.7	Yes rural hosp	1	yes

Note. BN = baccalaureate nurse; HC = health care; S = single; M = Married; C/L = common law; Ch = has children; CBL = context-based learning; Precept = precepted; Y = Yes; N = No; FTEs = full-time equivalents; C = casual; diff = different; hosp = hospital; HC = Home Care; AC = acute care; UG = undergraduate; LPN = licensed practical nurse; NA = nursing aide; HCA = health care aide; EMR = emergency medical responder; LTC = long-term care; ER = emergency room; SO = has a significant other.

Some participants did have urban experiences that helped. Participants identified competencies learned during final preceptorship experiences in urban emergency, intensive care, or paediatrics as beneficial preparation for practicing in rural acute care settings. One participant expressed, *"Because I came from Emergency I felt like I had a fairly good skill-base … like IVs* [intravenous injections], *Foleys* [catheters] *and G-tubes* [feeding tube]. *So I felt really good about that part of things."*

Rural placements. The rural acute care clinical rotations that participants experienced while they were BN students deserves elaboration, as these significantly impacted each individual's transition experience. Participants who had opportunities to experience rural acute care practice during the final year of university nursing education reported these opportunities to be beneficial to some degree because they provided a *"general idea of how it* [health care] *worked"* (Interviewee) in the rural acute care environment, offered opportunities to boost confidence levels through hands-on experiences and to learn to think like nurses, and sometimes resulted in exposure to rural pharmacy services or managing the care of maternity clients.

> *My saving grace was the rural rotation. It wasn't long; it was only six weeks, but we went to little rural acute care hospitals, and that's where you got a general idea of how it worked. I was trained to think like a nurse, and respond like a nurse and everything like that. Was it enough? Not at all.* (Interviewee)

Previous experiences. Participants who had previously worked as undergraduate nurses, LPNs, or HCAs found that those experiences had minimal impact on their transition experiences. Interestingly, although not specifically asked, some participants volunteered that knowledge and skills learned in previous work experiences, even though not health related, did help to ease their transitions. As one participant conveyed, *"I had previous work experience and previous education that I fall back on. So I felt like I transitioned well into fitting in with the rest of the unit."*

Reasons for choosing rural acute care nursing. In addition to the information in Table 12, participants identified a multitude of reasons as to why rural nursing was their first job choice. Participants' most predominant motives related to the type and scope of nursing work, wanting to live in a small community, and personal relationships.

> *The reason I wanted to work in rural was because of the variety … you get to do a little bit of everything. Growing up in a small community I missed that small town feeling. I got that … feeling from working there.* (Interviewee)

However, one participant chose rural nursing because there were no jobs in urban:

> *I threw out my resumes all over the province and* [this town] *gave me the best offer. So it was a huge step for me because I didn't want to leave* [the city]. *I left lots of friends and family behind.*

The Facilities

The context of transition included information about the staff mix and the various services available at the facilities in which participants worked, which included obstetrical, surgical, on- or off-site physicians, on- or off-site pharmacists, and on- or off-site clinical nurse educators (see Table 13). Each of these factors is addressed in more detail in the discussions of the themes and subthemes of ***A DOUBLE WHAMMY!***

An unexpected finding was that the hospitals referred to in this study were of two types: a generalist and an urban model. These models impacted participants' transitions differently. This difference had not been identified in the proposal stage of this study. Generalist-model facilities were organized into two or three different units depending upon the types of services available. In the smallest facility, the acute care unit was organized into medical–surgical, palliative, and constant care services. In the other facilities, obstetrical or surgical services were offered in addition to the previously mentioned services. Professionals such as on-site pharmacists and clinical educators were available to nursing staff in some, but not all hospitals. After-hours physician services were generally available on call. Most participants who transitioned into these settings described their learning as *"hands on," "huge,"* and sometimes *"overwhelming,"* and they described their responsibilities as oscillating between *"terrifying"* and *"unsafe,"* and *"wickedly awesome."*

Urban-model rural acute care hospitals were organized into completely separate units consisting of medical, surgical, obstetrical, paediatric, and emergency services. Pharmacists and clinical educators provided on-site services and physicians provided 24-hour on-site emergency services. The participant who transitioned into this environment described her learning as *"slow"* and the orientation as somewhat *"frustrating"* because she considered herself as already possessing some of the knowledge and skills that were offered. Nonetheless, she felt very well supported and safe and reported her responsibilities as readily manageable.

Table 13

Hospital Services

Facilities	Obstetrical Services	Surgical Services	Physicians off-site	Pharmacist on-site	Nurse Staffing Mix	Clinical Nurse Educator On-site
1	Yes	Yes	Yes	Yes	RNs/LPNs	No
2	Separate unit	Separate unit	No	Yes	RNs/LPNs	Full time
3	Yes	Post-op	Yes	No	RNs/LPNs	No
4	Yes	Yes	Yes	Yes	RNs/LPNs	No
5	Yes	Yes	Yes	Yes	RNs/LPNs	No
6	Yes	Yes	Yes	Yes	RNs/LPNs	No
7	Yes	Yes	Yes	Yes	RNs/LPNs/HCAs	.8 FTE
8	Emergencies only	No	Yes	Yes	RNs/LPNs/HCAs	No
9	Yes	Yes	Yes	Yes	RNs/LPNs	No
10	Yes	Yes	No	Yes	RNs/LPNs	No
11	No	No	Yes	Yes	RNs/LPNs	No
12	Yes	Yes	No	No	RNs/LPNs/HCAs	No
13	Yes	No	Yes	Yes	RNs/LPNs/HCAs	No
14	Yes	Yes	Yes	Yes	RNs/LPNs/HCAs	No

Note. FTE = full-time equivalent; HCAs = health care aides; LPNs = licensed practical nurses; RNs = registered nurses.

The Transition Experience: A DOUBLE WHAMMY!

The etymology of the term “double whammy” lies in the 1950s Al Capp cartoon strip *Li’l Abner*, wherein Li’l Abner would wink one eye to place a spell on someone, a “single whammy” (Capp, as cited in Martin, 2014, Origin section, para. 7) and blink both eyes to deliver a “double whammy” (Origin section, para. 7). By the definition of the term, the person who receives the double whammy is challenged with two simultaneous

difficult events ("Double Whammy," 2014). However, the phrase double whammy has expanded from the original definition, which had to do with bad luck, to include any situation in which challenges or problems "pile up suddenly" (wiseGEEK, 2014, para. 5). For instance, a student might say, "I have a final exam tomorrow and I have a paper due as well, so the instructor has really hit me hard with a double whammy." In this case, luck is not really involved, but the two challenges, which have surfaced at the same time, need to be overcome. For the purposes of this study, the two experiences, which at times were simultaneous or challenging, are comprised of ***I'M A GENERALIST! and I'M IT!*** as well as the oscillating emotions of surprise and shock associated with each.

Surprise refers to "an unexpected or astonishing event, fact, or thing" ("Surprise," 2014, Noun section, para. 1) and encapsulates the positive emotions that participants experienced during transition, which included *"wickedly awesome," "exhilaration," "excitement,"* and so on. During those moments, the transition experience encouraged, satisfied, and inspired participants. Shock refers to "a sudden upsetting event or experience" ("Shock," 2014, Noun section, para. 1) and encompasses the negative emotions that participants experienced during transition, which consisted of *"being overwhelmed," "terror,"* or *"panic,"* to name a few. In those instances, transition was discouraging, frustrating, and disillusioning.

I identified new nurses' transition into rural acute care as ***A DOUBLE WHAMMY!*** based on participants' perceptions of their experiences, as this term encapsulates the breadth and depth of those experiences. The following excerpt poignantly depicts one participant's perception of her transition experience when asked if the double whammy metaphor fit:

> *I think it's a good description.… In the city hospitals, the units are so specific that you're learning about heart clients or renal clients or maternity clients. Whereas in rural, you're learning about all of them. You have to have a general basic idea of what's involved with each condition and then have to learn the other things that are thrown at you, like charge nurse, and janitor, and pharmacist, and respiratory technician. There is a lot coming at you from all different areas that you have to make sure you deal with and being the RN in charge you are expected to be able to deal with it all, and … in a timely fashion.… You're learning to become what kind of nurse you want to be and all of these new things all at once. When I went into rural it was a surprise in some ways, but I also knew that I would be dealing with cardiac clients, and maternity clients but I didn't think I*

> *would be in charge as soon as I was. And I didn't think I'd be cleaning rooms, I thought those kinds of supports would just be there.*

The First WHAMMY: I'M A GENERALIST!

I'M A GENERALIST! was one of the two major themes I interpreted from participants' descriptions about transitioning into the rural acute care hospital environment—the first whammy of the pair (see Figure 2). The complexity and diversity of rural nursing necessitated that participants learn about being generalists. To do so, they needed to learn a broad range of clinical skills, be flexible, multitask, undertake a high level of responsibility, and manage contingent and emergent situations. The transition experience into generalist nursing consisted of participants acquiring knowledge about ***The Place, The People,*** and ***The Rural RN Role.*** This theme involved *So Much Learning,* which encompassed four dimensions: difficulty, time, amount, and the potential to learn misinformation. I conceptualized each dimension along a continuum. Difficulty ranged dimensionally in difficulty, from easy to difficult; in time, from now to later; and in amount, from some to a lot. The potential for learning inaccurate information ranged in amount from a little to a lot, as well as in importance from insignificant to significant. The placement of each dimension along a continuum must be understood as fluid, in that participants' experiences of learning at any given point during transition were influenced by personal or contextual factors that moved them toward either end of the different learning continua.

THE PLACE: The facility. Learning about ***The Place*** encompassed answering the question *What do I need to know?* and this included *The facility,* so as to be aware of the services offered, unit culture, educational supports, and equipment in the rural acute care environment. Learning about *The Place* also involved answering the question *What do I need to know* as it relates to *The community,* so as to understand how to manage lack of anonymity and maintaining confidentiality when working with rural clients and their families. In rural settings, the norm is for rural nurses to care for both the client and his or her family; consequently, throughout the rest of this thesis, the term clients will be used to denote rural clients and their families. A few participants described learning about the generalist facility as relatively easy, but the majority found it quite difficult because it differed significantly from what they had encountered during their BN programs.

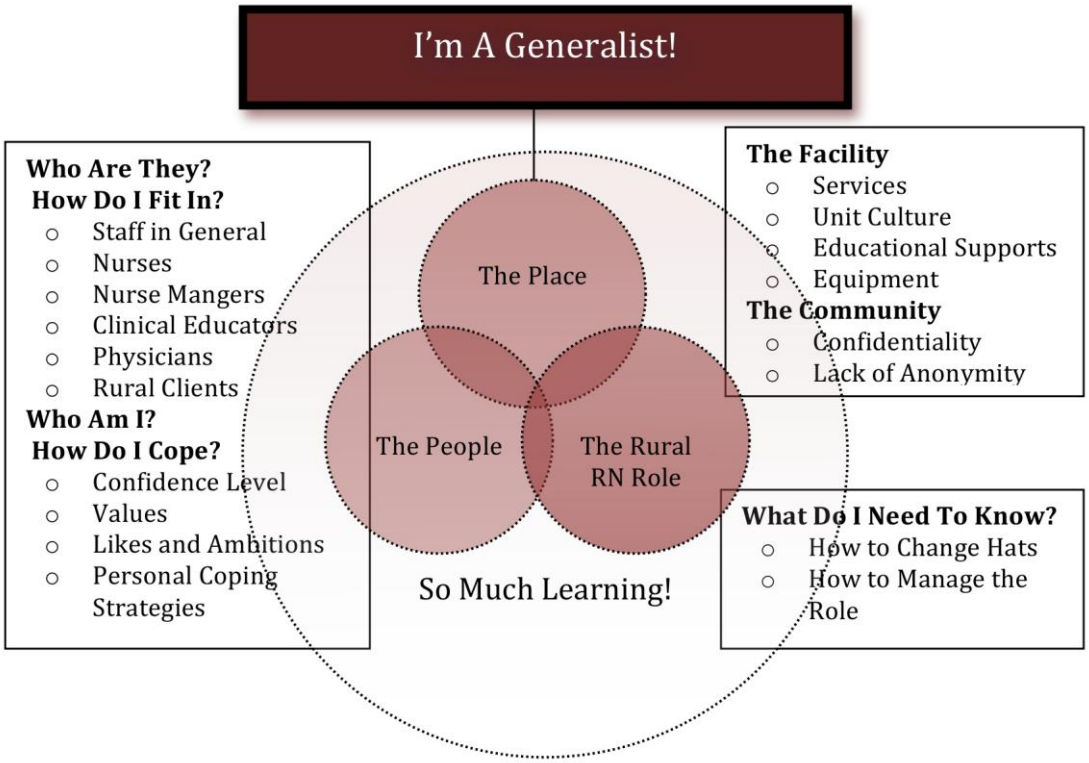

Figure 2. I'm A Generalist!

Note. RN = registered nurse.

Services. Participants learned about physicians' services, pharmacy services, equipment, and nursing services. Each of these services impacted participants' transition experiences along a continuum ranging from positive to negative.

Physician services. The number of physicians who held privileges in the different rural facilities varied significantly from two in the smallest hospital to several in the larger facilities. The types of services provided were wide-ranging, varying from basic medical, mental health, palliative, paediatric, and emergency services in the smaller hospitals to a full range of medical, surgical, obstetrical, paediatric, mental health, emergency, oncology, and constant care services in the larger facilities. Physicians were generally on site for a short portion of the day and then were on or off site working in medical clinics within the community for the rest of the day. Physicians in generalist-model facilities typically were on call and off site during the evening and night and were only called in by the nurses as needed. The exception to this practice was evidenced in an urban-model facility, where the physicians were on site in the EDs 24 hours per day.

Off-site on-call physician services impacted the degree of responsibility taken on by participants, especially during the night shift. Participants reported many occasions when they were immediately required to fulfill aspects of the role of physicians such as delivering babies or managing trauma or emergent clients, which they described as generating paradoxical emotions that oscillated between *"awesome"* and *"exhilarating"* (surprising) and *"overwhelming"* and *"terrorizing"* (shocking), because participants lacked the knowledge level, experience, and confidence needed to effectively function in this expanded practice role. In many situations, the degree of stress experienced when making assessments and then telephoning them to off-site physicians was related to participants' lack of confidence in their abilities and the number of times they had needed to call during a shift. Some felt empathy toward overworked and tired physicians and, consequently, would hesitate to call them. Those situations left participants questioning their values, as they were *"torn"* between what should happen and what was happening.

> *One night Dr.* [name] *was exhausted* [but] *I had to phone him. I didn't mind phoning him for that one because it was the first call of the night, so we settled. Someone else came in, I had to call him,* [but it had] *only been an hour, it was only an hour and a half later, and I had to phone again. It wasn't because I was afraid to phone him, it was because he was so tired.* (Interviewee)

Additionally, there were times when physicians would not *"come in"* when telephoned by participants. Those situations were described as highly stress inducing. "[I asked,] *'Can you come in?' And he* [said]*, 'No, just do this first.'... I can understand why he didn't, but that's his job. So you get torn."*

Conversely, the participant who worked in an urban-model facility with 24-hour physician services in the ED found it reassuring to know that there was continuous physician back up in the department. This participant stated, "*If something were to happen in the facility, I'd never have to worry about, 'Oh man, the doctor's half an hour away….'"*

Physician shortages in some hospitals influenced how some participants viewed their workloads. Some admitted to feeling guilty for complaining about their heavy workloads because they knew that their physician colleagues were experiencing critical shortages and situations of extreme overwork. One participant expressed, "*I feel bad for complaining about how much we work, because they are around the clock; they have a*

severe physician shortage here." In one small hospital, physician shortages had resulted in hospital closures, which dramatically affected the medical and nursing services provided in that community. That participant felt bad for the responsibility that was shouldered by those physicians. She stated, "*If they* [the physicians] *take call, we stay open. If they're not there, then we close the acute and Emerg. It doesn't happen often, but it does happen."*

Pharmacy services. Although many of the rural acute care hospitals were staffed with a pharmacist, a few were not. Participants found that the degree of challenge they experienced to know and perform the tasks associated with medication systems and processing was dependent upon whether or not they had learned about similar pharmacy services during their nursing education or were managing heavy workloads coupled with fulfilling pharmacists' duties.

Only a few participants found the task of medication processing and administration similar to what they had learned in nursing school. In those situations, learning to give medications to several clients using the rural pharmacy system was described as *"easy."*

On the other hand, participants who had learned a different pharmacy system during their nursing degree programs as compared to what they were expected to use in the rural acute care setting found the new system very challenging. These challenges were mainly due to four different expectations, requiring participants to (a) administer medications to a greater number of clients—sometimes up to 18, as opposed to four or five; (b) use a mode of documentation that required paper instead of online systems; (c) mix intravenous (IV) medications themselves; and lastly (d) combine medication administration with other nursing duties such as team leading, providing basic care, and performing dressing changes and assessments. Additionally, some participants were expected to learn the new system quickly with few interdisciplinary team or educational supports. Thus, many participants described the rural acute care pharmacy system as *"a huge learning curve," "overwhelming," "intimidating,"* and *"unsafe,"* wherein one described that *"there were days where* [I] *just wanted to cry."* Another participant found it challenging to become proficient at drawing up the medications and *"frightening"* to administer them to a large number of patients.

> *In* [urban] *they have the pre-packaged ones, and you have maximum four clients. So that was completely different, and a huge learning curve. Here, you have to mix all of your antibiotics and you're administering medications to 13 clients rather than just four. It's frightening.* (Interviewee)

Furthermore, lack of BN program activities surrounding mixing IV medications left some participants feeling unprepared for this responsibility. One participant stated, "*My preceptor went over that … in second year. There were a few times when we had to add Lasix to a mini bag, but it wasn't something that was taught in the classroom."*

Although most pharmacists worked on site, there were some hospitals in which the pharmacists were located off site. Participants who worked with off-site pharmacists described medication processing and administration as *"very time-consuming"* and *"frustrating"* because they were responsible for checking physicians' orders, ensuring they were faxed to the city pharmacy and returned by taxi, and processing and preparing the returned medications. One participant expressed concern that patient access to timely appropriate care was reduced because, all too frequently, the required medications were not in stock.

> *They're* [pharmacist and assistant] *supposed to come out once a week, but they don't. It's really frustrating, especially if we don't have something in house, because, by rights, they* [clients] *deserve the best care possible, and if we can't give them the medication they need; if we don't have it in stock, we either have to use it from their supply, or get it cabbed in from* [town]. (Interviewee)

Participants found managing the mixing of IV medications coupled with heavy workloads to be very challenging because these practices challenged the values and standards they had learned during their BN programs. Several participants compared their experiences in the rural setting to what they had experienced during their nursing education practical experiences in urban facilities and described inequities between urban and rural acute care environmental supports. For example, pharmacy staff mixed most of the IV medications in urban settings, but RNs did the bulk of this work in rural facilities.

> *It's different than in the city* [where] *the IV medications are mixed for them. We don't do that. We have a nice big wall of everything, and we have to look how to dilute things, and we mix all of our own IV meds, so that's quite time-consuming when you have nine clients.* (Interviewee)

One participant described heavy workloads coupled with lack of time as *"overwhelming"* and underpinning reasons to sacrifice what she had been taught during

her nursing education about never prepouring medications. She was routinely expected to administer medications to nine clients in the acute care ward, as well as care for ED clients. To keep up with this heavy workload, she prepoured the IV medications, which resulted in the nurse manager frequently yelling at her for doing so. She believed that this type of *"double standard"* was unique to rural facilities and would not have occurred in an urban setting.

> *I have been yelled at multiple times for prepouring. But when you have an hour to get through nine clients, it's impossible to meet that when you're mixing your medications. It's definitely overwhelming, and what makes it worse is you are expected to go to ER so … you have to leave and then come back and start back where you left off, and in* [urban]*, that's not the issue, so it's a double standard.* (Interviewee)

Conversely, heavy workloads and lack of time resulted in another participant becoming a change agent, wherein she maintained her nursing education values even when challenged by senior RN counterparts. She replaced the status quo of prepouring medications with new innovative practices to administer medications.

> *Just because they prepour doesn't mean you have to. I said, "I'm never doing that," and one of the ladies* [said]*, "Good luck in trying to get your work done."* [I said,] *"I realize that and I'll just do it differently."* (Interviewee)

Nursing services. Staffing of nurses in the various rural acute care hospitals differed significantly and consisted of a mix of RNs and LPNs or a blend of RNs, LPNs, and HCAs. Staff schedules ranged from casual to full-time equivalencies. In a few facilities RNs were hired from private agencies to fulfill short-term contracts in efforts to manage RN shortages.

A shortage of RNs was the norm in most hospitals and impacted participants in the following ways: increased workloads and RN turnover rates; prevented adequate breaks; reduced the ability to attend educational sessions; shortened the length of orientations; mandated to work; vacations revoked; and, in one instance, threatened hospital closure. Participants described heavy workloads as requiring *"running"* to keep up, which was *"exhausting"* and *"overwhelming."*

> *There are so many demands … always five things on your brain you have to do at once. It can be overwhelming; many days I do not take my proper breaks.… I take one 5-minute break where I'm just scarfing down all of my food as fast as I can.* (Interviewee)

At times, RN shortages left participants feeling very unsafe. Night shifts were highlighted as particularly challenging because the workloads ranged from barely busy to running flat out, frequently without adequate RN staffing to support times of increased workloads. As one participant conveyed, "*Nights is either you're caught up and everything's good, or you're running off your feet after bells; and then maternities come in; we are just very short-staffed on nights when it's busy."*

In some facilities, RN skill gaps were the result of senior RN attrition. In those situations, participants were expected to be in charge, mentor new nurses, or preceptor students, all of which were expectations of senior RNs.

> *When the Urgent Care opened, a lot of our more senior Emerg nurses went, "Really? Day and evening shifts only? I'll go work there,"… so we experienced a vacuum that had to pull some of us up.* (Interviewee)

It was surprising to participants that nurse managers would ask them to take on the responsibilities of mentoring and preceptoring so early in their nursing careers; however, some felt empowered by this request, as well as obligated to *"step up"* to the challenge in order to maintain hospital services or to promote recruitment of newer RNs.

> *We've lost some nurses; I feel like I need to step up because if somebody doesn't, and there's nobody to train these nurses, then they're not going to stick around. And at the same time, a grad nurse coming and seeing where they could be in a year and that it is possible to survive here. I think that's a good thing for them.* (Interviewee)

Unit culture. Positive or negative unit cultures influenced participants' perceptions of whether or not they felt welcomed. Participants identified positive unit cultures most and described these as consisting of friendly, welcoming staff who supported participants to feel as if they fit in because they felt valued, respected, trusted, and accepted while learning their new professional roles. One participant expressed, "*I felt that the staff were very supportive if I had any questions. I didn't feel like I couldn't ask a question. They were always friendly and helpful."* Another participant described the nurses and physicians as a team and like family, because they supported her *"holistically"* both at and away from work.

However, there were a few instances where negative unit cultures resulted in participants feeling unwelcome, as if they didn't belong, which in turn made their transitions very difficult. Those cultures consisted of RNs who ostracized participants,

excluded them from conversations, elicited *"swim or sink"* attitudes, demonstrated poor practices, participated in intentional and unintentional undermining, and used belittling, "*snobbish,"* or *"rude"* forms of communication.

One participant was told by senior RNs, "*We didn't have more than 5 days* [of] *orientation,* [so] *why should you?*" She perceived that those senior RNs did not support her "*because they were chucked in,* [and as a result] *wanted to watch her crash and burn*" (Interviewee). Although she had to fight for more orientation days in the ED, she also tried to keep up with the heavy workload and complex nursing care expected of her, all of which generated paradoxical emotions that oscillated between being "*excited*" and "*overwhelmed*." Eventually, she took a job in another part of the hospital. Another participant who was ostracized and excluded from conversations between senior RNs was made to feel so uncomfortable in her work setting that she made the decision to seek work elsewhere.

Some participants found the poor practices exhibited by a few older senior RNs to be stress inducing, to the point where one participant made the decision to seek work elsewhere. In those situations, participants worried about adopting the poor practices and found it challenging to share their new knowledge in the face of others' *"this is the way I've always done it"* attitudes. Some senior RNs who exhibited poor practices reflected the saying, *"the old eat their young,"* by intentionally undermining the new nurses through informing clients that the new practices were incorrect or incident reported the new practices. Those power games left participants feeling *"frustrated," "stupid,"* or *"disrespected."*

> *It's frustrating because … you're younger, so it feels like the patient assumes that you don't know what you're doing if someone older comes in and does something different and says, "That's not the way we do it."* (Interviewee)

Unintentional undermining occurred when senior RNs answered clients' questions before participants had opportunities to do so. One participant believed that the senior RNs were trying to be helpful, but lacked insight into the fact they were perpetuating a lack of trust between her and the clients.

> *Sometimes a patient asks you a question or the family, and they swoop in and just answer. I didn't even get a chance to prove …* [myself], *and then the clients tend to always talk to that nurse instead of you, so I find that kind of frustrating. I*

> *don't think they even realize what they're doing. When you're new, you feel like you have to prove yourself to everybody.* (Interviewee)

One participant who believed in teamwork and the provision of excellent client care felt very conflicted in her values because some RNs on the unit spoke to clients in medical jargon and refused to assist other levels of nursing staff with basic client care such as toileting or washing. She expressed intent to leave her job.

> *There's "RN-itis" really badly here. Some RNs get snobbish because they're RNs. And they have charge duties, and they have this, and they have that, which makes them less likely to ask for help … to answer your questions … to be personable. It's been a very difficult transition to this.* (Interviewee)

***Educational supports*.** Adequate educational supports or lack of those supports dramatically influenced how participants felt about their transitions. Educational supports included financial and orientation supports. For those who were adequately supported, transition was described as *"good"* and, for a few participants, even a *"little slow"* and *"boring,"* but for those who were not well supported, the transition was described as generating fluctuating emotions that oscillated from *"great"* and *"overwhelming"* to *"startling"* and *"terrifying."*

Financial. All participants were pleasantly surprised with the financial support they were provided to participate in courses. In some cases, financial supports were above and beyond the allocated amount in union contracts. One participant expressed, *"If we make the time to do it, study for it, we can take whatever course we want, even over and above the three courses allotted per year."*

Orientation. When hired, participants had expected lengthy orientations that would support transition, but in actuality only a few participants received such supports. Adequate orientation supports or lack of those supports markedly influenced participants' perceptions of their transition experiences. Some participants experienced lengthy orientations; senior RN mentors, buddies, or partners; on-call back-up support; or the opportunity to orient in a transitional graduate position, which they found to be extremely supportive to transition.

> *I did online training, workshop training, and then mentoring with a preceptor in the LDR* [Labour and Delivery Room]. *I've slowly been rolled out into a more independent role* [with] *buddy shifts, as well as, I have had an on-call person I could call in if a labouring Mom came in … and* [now] *I am transitioning from*

> *somebody being on site specifically assigned to buddy me, to somebody being off site and called in if I need them.* [I orientated for] *4 months, and close to 20 to 30 labour and delivery experiences* [with] *a variety of complexities—still low-risk. Now, I'll be working independently, but if I have questions, I will always have somebody I can telephone.* (Interviewee)

One participant described the transitional graduate position as quite *"frustrating"* because the length of the orientation was not tailored to her needs and the senior RN was perceived as not wanting to be in the buddy role.

> [The] *RN should be somebody who volunteers to do it, want*[s] *to do it. I felt that this person was just chosen to do that position, and I could feel* [that she] *did not really want to be in that role.* (Interviewee)

Interestingly, a few participants considered orientations to be *"slow"* and *"boring."* For one participant, the length was perceived as too long. She lamented, "*By the time it was getting near the end, I felt like it was enough.* [I had] *had enough of orientation; I just wanted to start getting to work."* For another participant, the amount and type of learning did not equate to the knowledge that she had acquired in a previous rural acute care RN position. She confided, *"They didn't want me to start IVs; they didn't want me to do anything like that because I was too young, and wouldn't know how to do it."* She admitted to feeling devalued and crying a lot.

On the other hand, some orientations were lacking in both length and content. Participants perceived 10-day orientation periods into generalist facilities as too short because there was not enough time for participants to acquire the knowledge needed to work in multiple or complex areas such as obstetrics or emergency. For one participant, "*getting used to that environment was just all hands-on learning. I had 10 shifts, which I didn't feel was enough because we were in three different areas, so you got a couple of shifts here and there."* Another participant described experiences orienting to ER: *"They gave me five shifts and I fought for five more; I needed more than 5 days to be in charge of the ER!"* Orientations that lacked adequate content created situations in which participants' learning was never solidified because a procedure or skill would be demonstrated once or twice, not used for a significant period of time, yet participants were expected to have mastered these skills.

> *So, you can see it once, and you are almost expected to know it, or understand it, or draw from it. So I think that's probably the number one issue, so in the first two years,* [the learning was] *steep.* (Interviewee)

Equipment. Participants raised concerns about the lack of up-to-date equipment in some rural acute care hospitals as compared to what they had experienced in urban facilities during their nursing degree programs. Equipment such as oxygen saturation and cardiac monitors, which were considered integral to providing adequate care for clients, were described as *"obsolete"* and in disrepair. One participant described the hospital where she worked as *"in the boonies"* and *"forgotten."* Others found issues with equipment *"frustrating"* and *"ridiculous"* because they believed that poor equipment prevented them from providing appropriate patient care.

> *There was one time we had someone who was really super critical and I had to tape the oximeter on his finger because it wasn't working. The clasp kept breaking and I was like, "This is ridiculous. This is wrong."* (Interviewee)

THE PLACE: The community? Some participants lived in the communities where they worked, but many commuted to work from another rural town or the city. Those who lived locally found that caring for clients they knew was *"stressful"* and required learning how to manage maintaining confidentiality and dealing with lack of anonymity. Participants learned *"how to approach them* [clients] *in a nurse–patient way,"* but also stated that time and experience made it *"easier to relate to them."*

Confidentiality. It was not unusual for participants who lived in the communities where they worked to meet clients in the grocery store or coffee shop and to be asked about what was happening at the hospital or with specific clients.

> *The really hard spot is in the palliative situation. I offer them care in the hospital, and then I see them at coffee three days later and they are still seeking support. And it's tough for me, because it's that confidentiality thing. I'm talking to this person who is my friend at coffee, and she is having something of a crisis because her friend's dying, but I can't refer to my experiences and relationship with that dying person, in the coffee shop.* (Interviewee)

Participants found those situations stressful because this type of relationship conflicted with their nursing degree education value of avoiding self-disclosure when establishing and maintaining therapeutic relationships with clients. Therefore, they found it necessary to develop one or more strategies to protect this value, including intentionally remaining

quiet when visiting with friends, setting communication boundaries, skirting around the conversation, and denying knowledge about what was happening at the hospital.

> *At work, I might have interacted with a client in a certain way, and then I see them with their family, and they approach me and want to talk as if it's not confidential, and I just change the subject or let them say what they want, but I don't really add anything to it.… People come in and ask about other people; I just say, "Well, I didn't see them here." It's hard because they know that I'm lying.* (Interviewee)

One participant learned to state up front "*what happens in the hospital stays in the hospital"* to ensure her clients that their confidentiality would be maintained.

Conversely, participants who commuted found it advantageous because there were fewer issues with maintaining confidentiality. One participant conveyed, "*I find it really nice knowing that my work's in one place and my home life is in another … where I can really stay away from any* [confidentiality problems]*."* Another participant identified commuting as a *"plus"* because the clients knew her face, but otherwise knew nothing about her. For her, there were no issues with lack of anonymity.

Lack of anonymity. Lack of anonymity was found to be advantageous by many participants because knowing the clients made their jobs more fulfilling and easier. They appreciated *"getting to know"* their clients, which ultimately increased opportunities to provide consistent follow through in nursing care.

> *You see them over and over,* [so] *you know what they're coming in for. You can ask them, "Oh, how's your niece or nephew doing?" or "Did you win your basketball game?" So they feel like they can talk to you, and it's not like in the city, where you never see the same person twice or you might only see a few people again. The rapport makes a difference.* (Interviewee)

For one participant, dealing with lack of anonymity in relation to a coworker as a client was a pivotal moment in her career, because she experienced acceptance and trust by her coworkers:

> *The first time I ever had to care for a coworker's family with an extensive illness was a pivotal moment in my career because I became one of them. The bonds became completely stronger after that, which … I didn't expect.*

However, the lack of anonymity was disadvantageous for some because it presented ethical issues surrounding scope of practice and remaining objective. One participant

discovered that she was always considered *"the nurse"* by clients even when away from the hospital, which caused everyone involved considerable frustration.

> *They know you're a nurse, but they think that's all you are, so it gets a little bit hard sometimes. It puts you in an ethical battle almost, because all you can say is, "You need to go to the hospital and get it assessed by a doctor." But you've built that rapport, so … sometimes they get frustrated and sometimes you just want to be a person and not a nurse.* (Interviewee)

For another participant, remaining objective in critical situations when working with people she knew was very challenging.

> *It's hard to stay objective when you have to work on someone you know who's seriously injured who might be your friend, who might be a relative. And it's not like you can say, "No, I can't do this," … you can't switch nurses because that's all there is.* (Interviewee)

Consequently, to effectively deal with lack of anonymity participants learned to be honest and genuine. One stated, *"There are lots of times people* [ask] *what happened? Who died? And you just have to say, "I can't talk to you about that."*

> *You walk into the Labour and Delivery room, and there's your buddy, legs up in the stirrups … you're like, "Oh, hey, how's it going? Congratulations! "Give Dad a hug, and get on with it … and … maybe you don't get to give Dad a hug in the city, but Dad's going to feel really weird if you went to a barbecue with them a week ago, and he got a hug there, but he didn't get a hug … 20 minutes after he had his first baby.* (Interviewee)

THE PEOPLE: Who are they? How do I fit in? Participants reported that transitioning to become a generalist involved learning about ***The People*** who worked in the rural acute care environment, ***The People*** who accessed that environment, and themselves. To do so, participants pondered the following questions: *Who are they? How do I fit in? Who am I? How do I cope?* Learning about ***The People*** began the moment participants entered the rural acute care hospitals and consisted of learning about the interdisciplinary team, which consisted of staff in general (i.e., RNs, LPNs, HCAs, agency or travel nurses, charge nurses, other new nurses, unit clerks, and support staff), senior RNs, nurse managers, clinical nurse educators, physicians, pharmacists (previously discussed), as well as learning about rural clients. For the most part, ***The People*** were very supportive and helped to ease participants' transitions.

Staff in general. Overall, participants found staff in general were very supportive and assisted them in feeling valued, respected, and accepted while learning their new professional roles. Participants felt as if they fit in, as portrayed by one participant in the following excerpt: "*The staff are probably the biggest support. It seems like everyone works really well together. I never really feel like I'm alone floating."* Another participant shared that her coworkers meant more to her than her own family; they had become her family.

Supportive behaviours included staff who promoted teamwork, embraced change, were protective, shared strong knowledge bases and skill sets, welcomed different ethnic backgrounds, and assisted or helped participants to fit in. One participant shared the following about the staff: "*My coworkers work hard. They're good at their jobs, and they're very open to helping—so you don't feel like you're as alone as much as you are." Similarly,* another participant expressed, *"Our unit clerks are fantastic; they hold our hospital together."*

It was mentioned that there were a few nurses in each facility who were not supportive of transition, which caused participants to feel frustrated, undervalued, and unwelcome. Unsupportive behaviours included showing resentment of participants' new knowledge, remaining set in old ways, unwilling to provide *"back up,"* demonstrating jealousy, not working to full scope of practice, lacking in knowledge, or participating in cliques.

> *New people come in, they don't like the new knowledge, they feel threatened, they have their way of doing it.… It's frustrating because you're already being thrown into an overwhelming experience, and then to not have someone back you up.* (Interviewee)

Cliques included strained relationships between some RNs, tensions between diploma- and baccalaureate-educated nurses, strain between ER RNs and acute care nurses, and hierarchies between RNs and LPNs or HCAs. One participant described the LPNs as *"glorified health care aides"* because many of the older RNs had "*suppressed* [them] *to the point where they only did personal care and meds if they were asked."*

Consequently, participants learned varied strategies to counteract the unsupportive behaviours of staff. Some avoided conflict while others openly confronted individuals about negative comments or behaviours.

> *She was saying it behind my back, so when I heard it, I took her aside and said, "If you have anything that you need to tell me, can you just bring it to me in the form of constructive criticism so I can learn."* (Interviewee)

On a more positive note, some engaged in teaching other staff to work to their full scope of practice and to apply new research and current practices. One participant would say to LPNs who were learning, "*'Oh, of course you can do that,' but … would also supervise them to make sure that they were doing it properly."*

Nurses. Overall, senior RNs and charge nurses were very supportive of participants' transitions and significantly helped to ease the transition experience because they openly and immediately welcomed the new nurses.

> *My first day, as I was walking in she stopped and said, "Hey, you're new, right? Welcome!" And that was so different from my experience as a new face on any unit in the city, as a student that it shocked me. It was like, "Wow!" Somebody said, "Welcome!" and smiled at me within 10 minutes of walking through the front door." It made me feel fantastically welcome.* (Interviewee)

Supportive senior RNs possessed some or all of the following attributes. They were humorous, approachable, accepting, protective, and nurturing.

> *There are definitely a few nurses who take you under their wing*[s] *and teach you, and want to make you a good nurse. They make your experience positive, and they make you want to stick it out.* (Interviewee)

In addition, participants described some experienced RNs as good teachers or mentors because they were *"helpful," "knowledgeable,"* and *"challenging,"* but not *"intimidating."*

> *She's a phenomenal nurse because she gets you right in there. It's her personality. She's not overly intimidating, but she'll push you enough and ask questions to make you understand what you're doing, and it's her attitude. She doesn't make you feel stupid when you have questions.* (Interviewee)

Conversely, a limited number of senior RNs were unsupportive of participants, which made their transitions significantly more difficult. Unsupportive behaviours included intentional and unintentional undermining, *"swim or sink"* attitudes, *"butting heads"* about practices, *"RN-itis,"* and *"bullying,"* previously discussed in this chapter (see the subtheme "*THE PLACE: The facility,"* in the subsection titled "*Unit Culture"*). As well, a few senior RNs were described as *"negative"* by nature. That is, they were constant complainers *"who would just rather sit at the desk and complain"* (Interviewee)

instead of doing the work. Consequently, participants developed strategies to fit in and cope with *"difficult"* senior RNs, which, for some, involved quitting their jobs.

One participant revealed, "*I don't usually say anything because I don't want to cause any conflict."* Others chose to verbally stand their ground; role model current procedures, protocols, and policies; lead by example; exercise patience; demonstrate good work ethics; or share new information in ways that were *"informative"* but not *"pushy*."

> *It's not about telling the other person* [what] *to do. It's sometimes you have to lead by example to make people change. You can't be too different, too abrasive, too much too fast.* (Interviewee)

> *The difficult thing is because I'm fresh out of school and there's a lot of new research about things and I bring things up and* [they say,] *"Oh no, I've done this for 20 years, this is how I'm always going to do it." There's a fine line to draw between pushy and informative.* (Interviewee)

One male participant who had previously worked different labour-type jobs found that he quickly fit in with the nursing staff. He recommended the following strategies to fit in with nurses: *"Just do your work. Do what you're supposed to do,* [and] *don't complain about it. People tend to have a little more respect for someone who comes to work and just does their stuff."* However, he also found the need to be quite assertive with one senior RN who exhibited bullying behaviours: "*So the one time I told her, 'So look, this is how I would like things to be.' And I've never really had a problem with her since."*

Most charge nurses were supportive of participants' transition because they were good role models, assigned lighter patient loads, were willing to teach, and empathized with the participants' challenges. One participant found, *"If you're in situations and unsure what to do, you can talk to them about it, and they'll recommend things for you."*

Conversely, unsupportive charge nurses were unwilling to address participants' concerns, exhibited *"offensive"* attitudes when asked questions, or lacked insight into the issues of the unit, particularly regarding evening or night shift challenges. One participant described her charge nurse who had only worked in urban centres as *"very difficult"* because she did not possess the *"insight"* to comprehend what the nursing staff were experiencing and needed.

Nurse managers. A few nurse managers were very supportive of participants' transitions, wherein they helped out when the load was heavy, were willing to teach, offered educational supports, were approachable, promoted autonomy, supported charge decisions, and were stern when needed.

> *The unit manager I have right now is fantastic. She goes out of her way to help. She does her best and comes in and offers support. She offers courses. She says, "If you need a few extra days, or extra help, we can do that." She stays after her shifts, hours sometimes, to teach, to help out. If the load is heavy, she'll go in and start helping with clients, and she's one of those people you can phone at home if you have questions. She's stern when she has to be, but she's also approachable.* (Interviewee)

One nurse manager was considered highly supportive because she enabled shift swapping between the nurses so that all could attend on- and off-site educational sessions.

On the other hand, the majority of nurse managers were described as unsupportive of participants' transitions because they exhibited one or more of the following negative behaviours: micromanaging; not supporting learning; denying time off to attend certification courses; bullying; not providing timely approvals for course registrations; chastising individuals for missed breaks and overtime claims; ambivalence toward staffing issues on night shifts; and assessing practice abilities according to age, not skill set. Such behaviours left some participants feeling disrespected and undervalued.

> *I said, "Should I go look around Emerg to see where they keep everything in case I have to give them a hand?" She said, "No, you will not go …, you will be on acute care, and it will be at least 3 years before you have enough experience for me to consider you doing anything in Emerg."* (Interviewee)

> *The manager above her sometimes doesn't understand our situation. And she's come down quite a few times and asked why there's so much overtime and meal breaks missed on our time cards. But sometimes it's not possible when the bells are going off and people are in pain and there's one-to-one nursing. A lot of times, we miss our breaks. It's not because we're trying to get extra money.* (Interviewee)

A few participants acknowledged that their nurse managers were responsible for managing more than one rural facility and that this influenced how often they were on

site and whether or not they were in tune with the issues surrounding one-to-one maternity care, nurse shortages, and night staffing.

Clinical nurse educators. Clinical nurse educators were both supportive and unsupportive of participants' transition. Educators who were on site and at least .8 of a full-time equivalency were described as meeting the learning needs of participants and were highly influential in bolstering the new nurses' confidence levels because they were readily accessible, approachable, and willing to role model.

> *You can go to her and say, "Look, I need to make sure I get these two courses this year." She keeps a close eye so that the people who need them … are scheduled and supported so that they can attend the classes.* (Interviewee)

Nevertheless, many participants seldom saw clinical educators during the transition period. This lack of contact was *"tough"* and *"frustrating"* because it influenced whether or not they would complete courses and in turn, feel like an *"asset"* or *"a hindrance"* to the team.

> *She's supposed to be at our hospital once a week, but we never see her. She's based out of the city, and she's in charge of all the rural acute care hospitals in our area. I found it really frustrating when I first started because I wanted to be competent and get all my education done, so as to be an asset … instead of a hindrance.* (Interviewee)

***Physicians*.** Most physicians were very supportive of participants' transition. Notably, it was the younger physicians who were friendly, approachable, wanting to be on a first-name basis, willing to teach, understanding, willing to provide both positive and constructive feedback, and who responded well to structured communication styles such as the Situation Background Assessment and Recommendations approach (SBAR).

> *It's like I've never worked in a better place. You're a team. We all hang out after work, and it is first-name basis all around, and you work with them in emergency, and in chemo and you follow through with them about things. You can call down to the clinic. It's so open; they're all fantastic.* (Interviewee)

> *They would sit down with you and say, "Hey, this is how we deal with this. This is what we need you to do. This is how you do it," and "don't worry about it we all have to learn somewhere." Taking me aside and showing me different things "Hey, look at this case,"* [or] *"This is what you did good. This is what you did wrong. This is what we need to improve on." Some of them are just awesome teachers. Some are also brand new and say, "Hey, let's work through this together."* (Interviewee)

However, participants described some older physicians as *"old school,"* wherein they expected to be served by the nurses, to be called *"Dr. So and So"* (never by their first names), and for the nurses to anticipate their needs. One participant used the name "*old crusties"* to describe these physicians; others expressed their behaviours as *"frustrating"* and their relationships with them as *"love–hate"* in nature.

> *A couple of them expect you just to know what they're thinking because that's how the other girls who've been working there for 40 years* [function]. *I'm like, "I don't know what's on your mind," so I get frustrated.* (Interviewee)

Strategies used by some participants to cope with older physicians' hierarchical behaviours included conforming to the status quo, or conversely, standing one's ground to be treated as an equal.

Learning to effectively communicate with physicians was challenging for many participants because this was not something they had learned during their BN programs. Participants recognized that the senior RNs and physicians functioned in relationships of mutual trust and understanding and that personalities played a significant role. Many participants learned to observe and listen to their respected senior RN counterparts when they were communicating with physicians and then would ask them for advice.

> *I was able to watch how the more senior charge nurses interacted with them, and to learn, "Okay, Dr. So-and-So is doctor, and he likes it done this way. So when I approach* [him or her]*, this is how I'm going to do it." As I transitioned into the more charge role, I sought that mentorship. I would sit down with the charge nurses who I valued and appreciated, and say, "How do you communicate with So-and-So? What are your styles with so-and-So?" They were very approachable with sharing those experiences.* (Interviewee)

One participant discovered that preparation ahead of time was essential when communicating with physicians. She highlighted that clear and succinct SBAR communication was an effective tool to use with physicians who expected quick, accurate descriptions of concerns, whereas conversation-style communications were appropriate to use with physicians who were more relaxed and approachable.

> *Some you absolutely show up with your SBAR and your head. Others, it's more of a conversation, you end up hitting all the points of your SBAR, but you aren't given 30 seconds to come to your recommendations; it's a little more of a process, more of an interaction, rather than a* [snaps fingers]*, "I need a decision."* (Interviewee)

Another strategy used by some participants to create and maintain trusting and respectful relationships with physicians was to be honest about their uncertainties and lack of knowledge. In those situations, the physicians generally supported participants' learning through teaching or mentoring them.

> *My best experiences are in deliveries when I say, "I'm still learning. I have no idea what I'm doing. If you could just bear with me, you may get a few extra phone calls than* [from] *the regular experienced nurse." They are usually receptive to that, as long as I lay it on the line that I'm not comfortable. They are pretty good at coming in earlier and mentoring me.* (Interviewee)

On the other hand, in most facilities there was at least one physician who was unsupportive of participants' transition. He or she was impatient, unwilling to teach, and used poor communication techniques that consisted of yelling, passive aggressiveness, name calling, telling not asking, or intimidation.

> *There are certain situations where they would yell at you, and not really teach you. There's ones who had no patience and were mad that, "Why would they put inexperienced nurses in Emerg?" So instead of showing us how to do something right, they would just yell at us and walk away.* (Interviewee)

Accordingly, participants developed varied strategies to cope and fit in with physicians, which included *"yelling back," "standing* [one's] *ground," "not taking them to heart," "accepting them,"* learning their idiosyncrasies, avoiding conflict, and empathizing with them about heavy workloads.

> *I didn't accept the way he treated me. I stood my ground, but you have to build a relationship with the doctors in a rural hospital, because at night time we're the only ones there … and they have to be able to trust you.* (Interviewee)

> *I've gotten confident enough to be able to stick up for myself if one treats me rudely, or not to take it to heart because they've probably been up for three nights in a row. It's a love-hate relationship.* (Interviewee)

Alarmingly, patient care was sometimes negatively impacted by the aggressive behaviours of certain physicians. One participant explained, *"Because of the doctor I didn't do anything, because it would* [have made] *life a living hell. It wouldn't be me suffering, it would be the clients."*

Clients. Supportive clients were friendly, encouraging, and appreciative. One participant shared, *"Most of them are really good and they'll encourage you and are glad that you're working at this hospital. We definitely have a big turnover rate, so they*

want to keep us here." The amount of time it took for participants to be accepted and trusted by clients varied. Initially, most clients were uncertain about participants' knowledge levels and abilities. They would question the ages, skills, and abilities of young-looking participants, ask for other senior nurses with whom they were familiar to provide care or to answer questions, or prejudge participants' abilities based on others' perceptions. The "word" of others travelled fast in the rural communities and significantly influenced whether or not participants were trusted and accepted by clients.

> *In Emerg, a lot of people look at me and say, "Oh, is there another nurse?" or "Are you old enough to be a registered nurse?" Or "Oh, okay, is this nurse here?" or they won't even let you try it* [a procedure such as starting an IV] *because they're scared that you're learning.* (Interviewee)

Participants who appeared older in age reported that clients perceived them as possessing maturity and experience; therefore, they were more readily trusted and accepted. One participant shared with another new colleague, *"I have an advantage over you because when I walk into a patient's room I look older than you, so I look like I've had 21 years experience, when in reality, I might have had only two months."*

Honesty, good communication skills, and innovative teaching techniques were some of the strategies used by participants to gain clients' acceptance. One participant shared, *"When there are family members there who I know are active in the patient's care, and the patient wants to know stuff I'll tell them what's going on, or if they have questions I'll inform them."*

Conversely, a participant of a different ethnic background found it very challenging to be accepted and trusted by *"White"* clients among predominantly *"White"* nursing staff. She believed that to ensure her own safety, she consistently needed to portray a professional RN appearance.

> *White people question, "Oh, is she capable of doing this?" and you have to think about it all the time. I wear white to look like a nurse. I wear my stethoscope, and I always wear my badge. Because it'll never be a question of my appearance, so* [I] *do it for my clientele, and for my safety.* (Interviewee)

Although many clients were frequently very helpful and supportive of participants as they transitioned, some were also quite demanding. Some participants described feelings of *"sinking"* because they found it difficult to manage heavy workloads constrained by time, as well as, the concerns of their clients.

> *Families can be the biggest help to you or they can be a pain in your butt. And I totally get why. It's because they're worried. But sometimes we just don't have the time to sit and talk to a family and address all of their concerns because we're stretched so thin.* (Interviewee)

The candour of many rural people was surprising to some participants and created challenges when they tried to maintain nurse–client boundaries.

> *Everybody wants to know everything. So then you really have to guard what you're willing to share. They're helpful, but they're a hindrance too because they make you challenge what you're supposed to say.* (Interviewee)

Strategies used by participants to fit in with unsupportive clients consisted of accessing the support of senior nursing staff, bargaining with clients through asking "*give me one shot, and if I miss, then we'll talk,"* nonjudgmentally allowing clients to vent frustrations, and choosing not to take things personally.

> *I try not to get involved with their family dynamics but I let them vent and walk away; generally they're okay with it. You know sometimes they come apologize right away and other times it takes a day or so, but little things like that I've learned to deal with and try not to take anything personally.* (Interviewee)

THE PEOPLE: Who am I? How do I cope? During transition, participants were not only learning about the people they worked with and cared for, but also components of their own personalities, which included confidence levels, values, expectations, likes, and ambitions. Additionally, they were learning and using personal coping strategies.

Confidence level. At the beginning of transition each participant's confidence level was generally low; however, their confidence grew with time, experience, further education, and opportunities to observe the skills of more senior nurses. One participant admitted, "*I did not have a lot of confidence when I started here, and it came as I saw different situations, how to handle them, and how other nurses handled them."* Confidence level was closely linked to participants' own perceptions of their skill sets, knowledge bases, communication skills, and expectations, and impacted whether or not they perceived themselves as competent RNs. This was apparent when one participant expressed, "*If I look at myself last year when I graduated* [as compared] *to this year, holy man, have I come a long way!"*

Moreover, participants contended that knowing one's abilities and competencies and having the confidence to identify them was highly important. Participants needed to know what they could and could not do, what they could and could not take, and when they were in over their heads and needing to ask for assistance. Sometimes this meant having to say *"no"* to nurse managers.

> *You really have to know what you can and can't do. They* [management] *will abuse you if they can, and try to push you to do things that* [are] *unsafe for your clients, and put you at risk, and your license at risk.* (Interviewee)

Individuals who were well supported with orientation and education supports described feeling very confident about acquiring new knowledge. One participant who began with a low confidence level learned that she was actually a lot more skilled and knowledgeable than she had originally thought:

> *When I first started I had an expectation of myself that I'd know nothing and it took my realization that I didn't* [know nothing], *and that I could do it, and that I could hit this independent practice thing and run with it.* (Interviewee)

Conversely, participants' who were unsupported generally lacked confidence and perceived themselves as inadequate because they were not living up to what was expected of them.

> *My fifth shift ever … at night, I'm looking at the ECG* [electrocardiogram] *going, "Oh my God, this doesn't look right," and that's all I could tell because it was the first cardiac rhythm I'd seen, but that's where he's* [the physician's] *expecting me to tell him, "T waves, and da-ta-da," and, "I don't know, I just know it's not good." That's all I could tell him. My communication and my experience were lacking, obviously.* (Interviewee)

Even after several months of transitioning, some participants still lacked confidence when working in certain areas. One participant confessed, "*It's just a lack of experience, and then you don't feel confident. I try to do as much as I can, but I'm not afraid to ask for help."* Another stated, "*I thought it would be quite easy seeing as how I'd worked already as an LPN, but I found as an RN, I was automatically supposed to know everything."* However, most participants had learned to build confidence through engaging in strategies that included embracing learning opportunities, building upon previous experiences, remaining calm, persevering, and asking other members of the interdisciplinary team for assistance. One participant conveyed, *"I just feel like I've*

grown by leaps and bounds, even just with my ability to cope with things, and cope with stress."

Values. Most participants experienced a degree of tension ranging from some to a lot, between their personal and learned nursing education values and those of the senior nurses in the rural acute care practice setting. One participant expressed, "*Sometimes I do feel bad for clients because there is some negativity. Oftentimes I feel they* [clients] *are in with a legitimate problem and we are just labelling them as something else, so I feel that isn't fair."*

Additionally, participants placed great value on whether or not they were providing good care and adequately performing in their new role. For many participants, heavy workloads and team nursing responsibilities often tested their values during the first few months of practice, as they were worried about making *"dumb little mistakes"* and being unsafe. Some learned to sacrifice their nursing education values in order to keep up with heavy workloads.

> *I like getting to know my clients and really being able to understand what's going on with them and having hundreds of meds for 18 different rooms is crazy. Of course you are bound to make a med error eventually.* (Interviewee)

Whereas other participants challenged the status quo, became change agents, and restructured the *"this is the way we've always done it"* procedures.

Caring for palliative clients tested the values of some participants. Generally, they found this work to be very rewarding, as it promoted self-growth, but sometimes managing the care of younger palliative clients was difficult and stressful, because it was too relatable to one's own life and loved ones. One participant stated, "*I just really struggle with these young 50-year-olds* [who] *are around my parents' age. They're just dying* [cries]. *But it makes me grow because I'm faced with it just about every shift."*

Likes and ambitions. Most participants, including those who had moved on to urban jobs, stated that if they had it to do over again, they would initially choose rural nursing as their first job choice. Participants offered four main reasons for enjoying rural nursing, which included: (a) the relationships developed and maintained with rural clients and health care providers, (b) the opportunity to provide care to a wide variety of clients, (c) the chance to work autonomously early in one's career, and (d) the opportunity to expand nursing practice knowledge and experience as far as possible.

> *I really liked the people I worked with and I got a variety. We did surgery, and medical, and delivery. So I got a good idea of different types of nursing, which I think has helped lead me to where I am now.* (Interviewee)

Some participants liked the *"adrenaline rush"* of emergency situations. One participant excitedly expressed, "w*hen a code gets called, I always get a shot of adrenaline."* Another participant described rural nursing as *"exhilarating"* because it was challenging and forced perpetual learning:

> *I love the challenge of it. I love the constant growth that it forces you to have to know more.… My first STARS* [Shock Trauma Air Rescue Society, a helicopter ambulance service,] *was absolutely exhilarating. And then I wanted to know what I could do better for next time.… I want to learn. I want to grow. I never want to be stagnant or think I know everything.*

Conversely, some participants admitted that juggling high acuity responsibilities with lower acuity tasks such as managing long-term care and medical clients was not for them. Others acknowledged that the experiences obtained by working in rural acute care were *"stepping stones"* to working in urban facilities. One participant divulged that she, as well as other new nurses with whom she worked, accepted rural nursing positions for the work experience: "*A lot of us are using this as an experience, and eventually we'll go elsewhere."*

***Personal coping strategies*.** To find the strength to cope with challenging situations and stress, some participants accessed spirituality through connecting with nature. One participant stated, "*I'm not a religious person. I don't attend church. I like nature and exercise. So if I ever feel stress, I always go for a long walk. That's my church."* Others prayed to God or relied on inner faith.

> *When things didn't seem to be going well, I would pause and ask God for guidance, and that was the one thing I have really depended on and has been vital to the care that I give my clients.* (Interviewee)

> *What keeps me together is I have faith in knowing that, whatever walks through the door, wouldn't unless I could handle it. When the ambulance tones go off, and they say, "Train versus car," I start to panic,* [I] *think I can't do it, but if I couldn't, it wouldn't be happening while I was there.* (Interviewee)

> *I'm a very spiritual person. I think it's helped me adjust a little more to people passing away. It helped ease that burden. Just the way I internalize it, definitely helps me take care of those people and their families.* (Interviewee)

THE RURAL RN ROLE: What do I need to know? Learning ***The Rural RN Role*** began the first day participants stepped into the generalist-model hospitals and was interconnected to learning about ***The Place*** and ***The People***. In terms of this role, participants pondered the question *What Do I Need to Know?* This consisted of learning *How to change hats* and *How to manage the role* and was associated with providing appropriate care for clients. Participants quickly discovered that learning the generalist role required the acquisition of a tremendous amount of knowledge. According to one participant, "*Transitioning into a rural position is a huge learning experience, and you're just like a sponge, and you've got to soak it all up."*

Factors influencing participants' knowledge acquisition, as was previously discussed in this chapter (see the subtheme "*THE PLACE: The facility,"* in the subsection titled *"Services"*), included length and content of orientation and the amount and type of human and educational supports. Participants who experienced long orientations with an adequate amount of support perceived their learning as reasonably paced, sometimes even a little slow, but manageable and good. Conversely, those who experienced short orientations, which were lacking in content and supports, described the learning as immediate, *"steep"* and generating paradoxical emotions that fluctuated between being excited and frightened and empowered and overwhelmed. Participants were learning how to care for a variety of clients representing a mixture of ages, life stages, diagnoses, and cultures, while moving from room to room, area to area, or unit to unit, frequently all within one shift (i.e., obstetrics to emergency, to paediatrics, to palliative, and so on), which necessitated a speedy change of hats.

How to change hats. Learning how to skilfully change hats was particularly challenging for most participants. It was something that was new and very different from what they had learned during their BN programs, where they had cared for a small number of clients with similar medical diagnoses.

> *Managing all those different clients, a surgical, post-partum, medical, or geriatric patient, all in one day, was a big learning experience because you constantly have to switch your thinking. There was a lot of learning … with prioritization, and I did have a bigger patient load.… There was a lot of making sure I was delegating so that everything got covered, and being responsible for anything serious that was happening* [was stressful]. (Interviewee)

Frequently changing hats required participants to constantly realign their thinking to deal with changing situations by refining their skills to include adaptability, prioritizing, and anticipatory planning.

Adaptability. Adaptability involved learning to be flexible and open to respond to new, different, challenging, or critical situations and to competently perform infrequently used skills. Adaptability included learning to care for clients of all ages with a range of diagnoses as well as clients of diverse cultures. As one participant explained, "*so on one shift I can be caring for somebody who had a heart attack, as well as paediatric and suicidal clients and somebody who is palliative."*

Many participants found adapting to working with people of different cultures without adequate supports very challenging. While most participants found that the facilities in which they worked were in the catchment areas of First Nations, Hutterite, and Mennonite populations, few were provided with liaisons or translation aids to assist with managing language barriers and cultural rituals.

> *If they're under, eight, they don't speak a lick of English, and sometimes the parents don't either.… And the kids are just looking at you and they're terrified of you because you can't even say one word that is comforting to them. You want to help so badly, but you can't.* (Interviewee)

Additionally, some participants were confronted with the need to independently learn information about how to provide culturally competent nursing care with respect to death and dying, special dietary regimes, and specific diseases prevalent in those communities.

> *We have a palliative care room, so with Hutterites, their practices for someone who is dying are completely different than what I knew of. If we have a Native individual die in our Emergency Room, there are certain rituals that their family will do before we can move the body out.* (Interviewee)

Prioritizing. While prioritizing is part and parcel of being a nurse, it becomes critical when changing hats. For participants, learning to prioritize involved starting a shift and asking questions of themselves about the acuity levels and needs of their clients and quickly identifying where their priorities should be placed.

> *It's a, "Who gets what care, when?" and, "Who gets what medication first?" and, "Who gets most of my attention or who doesn't?" and, "Who do I need to help …, delegate to, to get them cared for too?"* (Interviewee)

Some participants appreciated this level of autonomy, but others found it dissatisfying because they experienced *"sink or swim"* feelings, which were in reference to their perceptions of having inadequate knowledge, ability, confidence, and instincts.

Anticipatory planning. Learning to use anticipatory planning was exciting and empowering for some participants because it created situations of new learning. However, it was also stressful and frightening because it required that participants deal with contingent situations and lack of structure, which were skills they had not learned through their BN programs.

> *Your responsibilities are so vast and general…. You don't know what's going to be there. It's very nonstructured, so some days you could have 10 clients in the whole hospital, and you can have four each, or you come on and there's two babies being delivered, and a cardiac in the ER, and then you have two people dying and so you have to switch your hats and your way of thinking very quickly, so it's stress, stress, stress.* (Interviewee)

For the most part, anticipatory planning was a key component to participants feeling prepared and safe. They learned that knowing which tasks, procedures, or policies suited specific situations was integral to managing ambiguous and contingent situations, especially on night shifts when hospitals were minimally staffed with no on-site physician or surgical back-up services to deploy.

> [Cesarean sections] *need to go to* [the city]—*that's our backup…. We had one girl who did a year in L and D* [Labour and Delivery in the city], *and she's in a temporary position in our hospital. She was, "Oh we don't have to do that. We only do that every hour."* [I said], *"No, no, no, no. We're in a rural setting. We're doing that every 15 minutes because if she starts bleeding out, we need to send her. We don't have the luxury of having blood downstairs or having the OR* [Operating Room]. *It's 45 minutes to* [city]*…. That's life or death."* (Interviewee)

How to manage the role. Participants found that the rural RN role required them to learn how to fulfill a multitude of diverse responsibilities related to policies, procedures, and protocols; routine care; team nursing; taking call; helping out wherever; acting as resources; and being "it." They also learned that they needed to know how to effectively collaborate with members of the interdisciplinary team in order to provide safe patient care.

Related to policies, procedures, and protocols. The degree of difficulty associated with providing nursing care according to policies, procedures, and protocols was

dependent upon factors such as the acuity levels of clients, ward workloads, staffing levels, and whether participants were learning new knowledge with or without the support of structured orientation programs, senior RNs, clinical nurse educators, or physicians.

Participants who worked in hospitals in which obstetrical services were provided learned that there were routines in place to manage the policy of one-to-one RN care for maternity clients in active labour. In those cases, the rest of the nursing team was required to pick up the slack, which at times dramatically increased their workloads.

> *The float nurse … would cover for the Maternity, and then we would all have to cover for her.… Say if they have five clients, then we'd basically all cover for her so that she would just have that mat. Sometimes she has two mats … three mats—sometimes it can be pretty crazy.* (Interviewee)

In some facilities, participants were learning to perform procedures and protocols immediately, quickly, and alone whilst providing patient care. Participants described those situations as *"scary"* and *"nerve-wracking,"* because all too frequently they were working with minimal or no senior RN support and on-call physicians who were off site.

> *It's been completely overwhelming. You go to work every day and feel stressed that you're going to do something wrong because you haven't learned it yet. If someone comes in, you're learning on them. If they come in with their stroke, you learn stroke protocol on that person. You can read it all, you can read all the protocols, but until the situation actually happens, "I have to mix up this vial and just start from one. What does one say?" It's the worst feeling in the world because this is an emergency.* (Interviewee)

Participants who worked without the support of clinical educators found that new protocols were not readily shared with the staff and were sometimes *"learned on the go"* whilst providing patient care, which they found to be *"really frustrating."*

> *The other day someone said, "Oh, this is the cardiac profile on him. Whoa! I was never taught that, and I've been doing cardiacs for two years now. I didn't know I had to do a chest x-ray; no one told me these things."* (Interviewee)

Related to routine care. Knowing and performing routine care in the rural acute care environment was described as challenging by most participants because it required becoming one of the interdisciplinary team. Routines ranged from the work nurses were doing on a daily basis with clients to the work related to the various expectations of off-site physicians. Some participants found it difficult to get *"up to speed"* with ward

routines due to *"time constraints."* Consequently, they sometimes felt intimidated by their efficient colleagues and unsafe because they were challenged to keep up.

> *It's just that they know what they are doing to a tee, but it is intimidating for a new person coming into it.…* [It is] *unsafe in the fact that I don't know my clients very well, and you're under time constraints.* (Interviewee)

One participant experienced a lot of anxiety associated with learning the different expectations of multiple off-site physicians, even when supported by senior RNs.

> *We had this labouring lady come in. It was five in the morning. I said, "She can come back at 0800 to see* [the doctor]*" and that day, the doctor came in and was rip-roaring pissy at us because we didn't notify her, but did we know that?* (Interviewee)

Related to team nursing. Many participants noted that working in nursing teams or modified nursing teams was the norm in the hospitals in which they transitioned. While one participant preferred team to primary care nursing, most described team nursing as posing challenges because it required new learning about sharing workloads, team leading, delegating tasks and workload, and trusting team members. As one participant lamented, "*You have 10 to 12 clients that you and an LPN are caring for. Some of the older LPNs have different ideas of what should be done first."* Another participant expressed,

> *In a team, as the RN, you're expected to be the team leader, which I wasn't expecting. So I've had to tactfully… get an LPN to do work that I expect and* [I'm] *also assigning duties. It's huge responsibility with an Aide and an LPN. I don't think I was confident enough, and I didn't have enough exposure to that role prior to becoming an RN to be in that role. So it took me a good three months before I was comfortable approaching, designating,* [and] *delegating, duties.* (Interviewee)

One of the biggest worries for participants who worked in nursing teams on night shifts was the responsibility of sharing workloads when providing one-to-one nursing care for maternity clients in the labour and delivery room, while simultaneously being in charge of the acute care unit. Participants found it difficult to trust and appropriately delegate responsibilities to newer LPNs who lacked knowledge and experience about the rural acute care environment and sharing workloads.

> *You were leaving the floor, the 25 clients, for the LPN. It was often a scary feeling. It all depended on which LPN you were working with. There were some who I felt okay with … and then there were other LPNs* [who] *I was always*

> *worried things might not get done. But also I was in charge, so I was responsible for all those other clients on the floor, even though I was in the Labour and Delivery Unit.* (Interviewee)

As well, many participants found it challenging to work with senior LPNs who did not work to full scope of practice. The practices of these LPNs had consistently been suppressed by some of the senior RNs or their nurse managers. Some participants described this LPN–RN hierarchy as very stressful because they wanted to support full scope of practice for LPNs, but knew that challenging the status quo would result in conflict with the senior RNs or nurse managers, but not challenging it would contribute to their increased workloads.

Related to taking call. Taking call was described by one participant as challenging and exhausting because she was expected to be on call; come in when called, no matter what the time of day; and then to work a full shift the next day.

> *If you get called in at one in the morning, you work until four, you are still expected to show up at seven in the morning, because we don't have anyone to cover for us, so you're sometimes just exhausted.* (Interviewee)

Related to helping out wherever. Helping out wherever in the rural acute care hospital, without the adequate orientations was stressful and frustrating for participants. One participant who had not been oriented to labour and delivery and was expected to cover for breaks in the case room refused because she had not felt ready to accept that added learning and level of responsibility. This participant was still trying to *"wrap* [her] *head around"* learning about her roles and responsibilities in other areas. Another participant identified feeling stressed when expected to help out wherever because she lacked the knowledge needed to work in those situations.

> *That's one thing that really has frustrated us. We were being pulled* [from the Operating Room] *just because they were so desperately short, it was unsafe out there, so we were going out there to put out the fires without proper orientation.* [For example]*, if there was something wrong like a flat kid, they'd call me and I'd do whatever I could.* (Interviewee)

Related to acting as a resource. Taking on the responsibilities of mentoring new staff or preceptoring nursing students during the first year of transition was described by participants as *"confusing," "surprising,"* and *"scary."* As was previously discussed in

relation to nursing shortages, one participant felt obligated to *"step up"* and meet this challenge.

> *I was very confused when they wanted to change my rotation around and have me mentor this new nurse. Well, I'm still learning so many things myself. The thing is, there's such a shortage of nurses here. We don't have the capability to replace those nurses with anyone because we don't have anyone to replace them with.* (Interviewee)

Another participant was surprised that other RNs would consider her as a resource and admitted to finding this level of responsibility *"awesome"* but *"nerve-wracking."*

> *I'm two years out of school. I really shouldn't be in this role. There's just a high turnover* [and] *new people coming. It's a different role now. I became a resource person. People are now coming to me with their questions.* (Interviewee)

Related to ***I'M IT!*** The ***I'M A GENERALIST!*** theme, requiring a steep learning curve about ***The Place***, ***The People,*** and ***The Rural RN Role***, was only the first aspect of the ***DOUBLE WHAMMY!*** of transitioning into rural nursing. The second aspect of ***A DOUBLE WHAMMY!—I'M IT!*** is related to all the additional responsibilities that were associated with working in the rural acute care hospital. These responsibilities are a further extension of those associated with the rural RN role in the ***I'M A GENERALIST!*** theme. As a result, I found considerable overlap between the two major themes of ***A DOUBLE WHAMMY!***, which the following discussion will confirm. Nonetheless, subtle differences between these two major themes and their associated subthemes necessitate presenting them separately as the two whammies of the ***DOUBLE WHAMMY!***, that in reality, are inextricably interrelated.

The Second WHAMMY: I'M IT!

I'M IT! was experienced when participants were expected to manage the additional generalist role responsibilities of ***I'm Alone!***, ***I'm In Charge!***, or ***I'm A Jack of All Trades!*** (see Figure 3). The theme ***I'm Alone!*** involved being *The sole RN on shift*, being *The only body available*, or working with *With no on-site physician*. ***I'm In Charge!*** entailed being in charge of *The hospital*, *The unit* (i.e., acute care, emergency, labour and delivery, or special care), *The team*, as previously discussed, or *Contingent or emergent situations*. ***I'm A Jack of All Trades!*** involved fulfilling the duties of *Other professions* and *Ancillary staff*. This included managing some of the responsibilities of

physicians, pharmacists, unit clerks, environmental services personnel, medical records technicians, and so on.

> *You do everything. You do palliative one minute, you deal with a jaundiced newborn the next, the next minute you've got a mom walking in, in labour. Half an hour later, you're on the phone to a family talking about transition services because you don't have a transition services nurse—you're it. You are handing out taxicab vouchers to folks who need to get across town but can't afford it, so you're working in a social work role because you don't have a social worker. At four o'clock in the morning, you're the unit clerk, entering clients' demographic information into the system, so you can give them care because you're it.* (Interviewee)

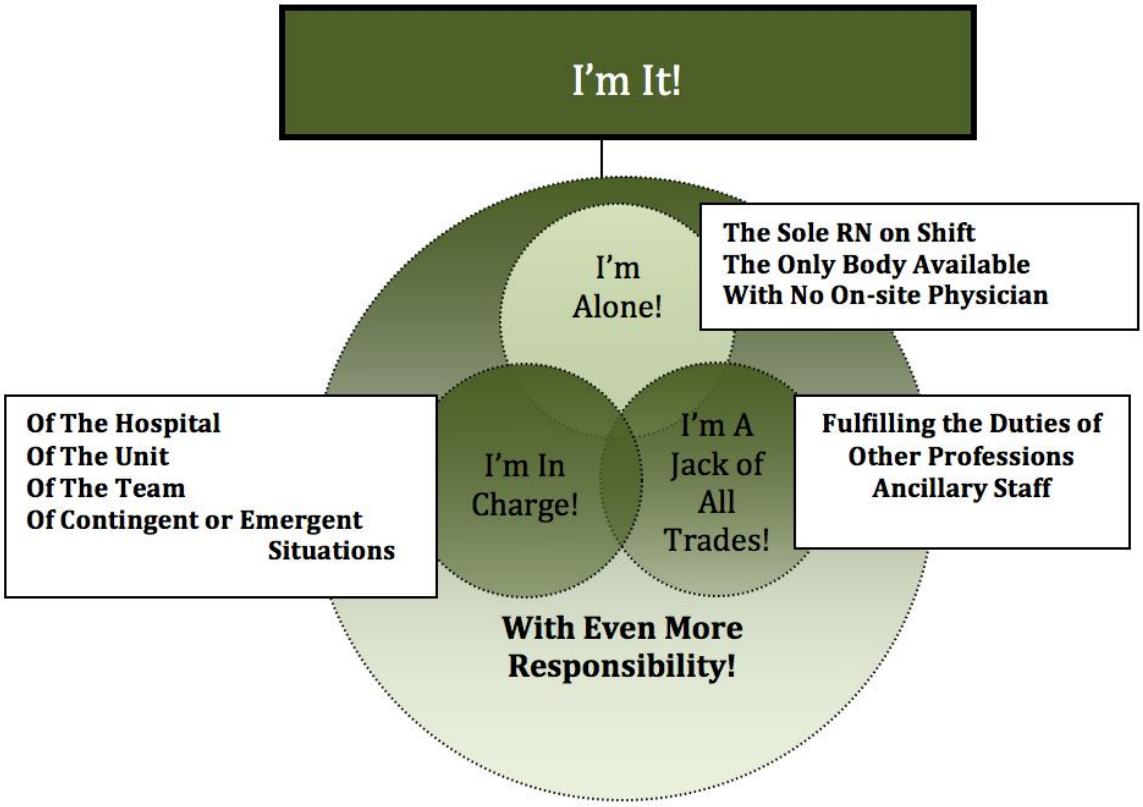

Figure 3. I'm It!

Note. RN = registered nurse.

For the most part, participants transitioning into smaller facilities were immediately and often expected to work alone, be in charge, and to fulfill the responsibilities of others. Participants found such expectations to be generally shocking.

> *There's only one person running around. It's absolutely overwhelming until you get your footing. It is terrifying! There came a moment when I realized how much*

> *I was responsible for and it startled me! It's staggering, the load of that.* (Interviewee)

The emotions experienced by participants when expected to be it, included both surprise and shock and were linked to the characteristics of timing and frequency, as well as the degree of consistent and adequate human and educational supports. In terms of timing and frequency, a few participants were expected to manage the responsibility of ***I'M IT!*** immediately and often, while for others, ***I'M IT!*** was expected much later and seldom. In terms of consistency and adequacy of supports, some participants were provided with very steady and appropriate interdisciplinary team and educational supports, while others were not. However, for some, the responsibilities of ***I'M IT!*** were eased because they were well supported by the nursing staff and physicians who were very approachable, nurturing, and willing to teach. As one participant expressed, "*They are more supportive to me in every aspect of my life than my own family. The only reason I'm still there is because of my coworkers. They have helped me 110%."*

The immediacy of the responsibility ***I'M IT!*** differed for participants transitioning into larger facilities as compared to those in smaller hospitals because they experienced a range of how quickly (immediately to several months later) and how much (some to a lot) they were expected to be it. I found it noteworthy that participants who were given adequate time to learn their responsibilities and were supported by consistent and sufficient interdisciplinary team and educational supports experienced minimal shock and were merely surprised with the expectations of ***I'M IT!***, whereas those who were not provided sufficient supports experienced quite the opposite, as is portrayed in the following excerpt:

> *I know exactly how much responsibility I have, and that's what scares the crap out of me, because I don't know everything, and I am new at this. And if someone comes in and something is really, really wrong, then am I going to be able to pick it out right away?* (Interviewee)

Also worth mentioning is that only a few nurse managers and clinical nurse educators were considered supportive, which is an issue that has already been discussed within this report.

I'M ALONE! The participant who transitioned into an urban-model facility was seldom expected to manage the responsibility of being alone. Accordingly, she

expressed, *"I never really feel like I'm alone floating because there's always lots of staff, there's always doctors in the facility. In Emerg, there's always at least one doctor down there with another one on call."*

Similarly, participants who transitioned into generalist-model facilities and were provided structured orientation programs such as a transitional graduate nurse position or a consistent buddy for the first 3 months of practice, seldom experienced the responsibility of ***I'm Alone!*** during their first few months. One participant expressed feeling somewhat *"uneasy"* and *"frightened"* about *"what"* types of clients might *"come through the door"* when she was alone during her senior counterpart's nutrition breaks, but certainly not overwhelmed.

Conversely, participants who transitioned into generalist-model facilities and were expected to immediately work alone as *The sole RN on shift* or *As the only body available*, or *With no on-site physician* described experiencing *"panic"* and *"fear."* These participants had stark realizations that they were all by themselves, making critical decisions that could impact the safety of their clients. The skills to prioritize, delegate, and do, although previously learned, were not ingrained enough to instil confidence in these participants.

The sole RN on shift. For one participant, ***I'm Alone!*** involved working alone with no other RNs on site, which meant that there was no one in her profession readily available to support her decision making and learning.

> *I'm the only RN on, so as a new grad, I walked into being charge and having one other nurse* [LPN], *and nobody else in my discipline. It does get a little freaky … my first code…it wasn't bad, but definitely, I would have liked to have somebody to talk to.* (Interviewee)

The following excerpt poignantly describes how this participant managed her first code and highlights that her fear was associated with not knowing how to promptly access help from the other members of the interdisciplinary team, not with lack of knowledge and skills.

> *My first code, by myself.… My LPN is my only other person there until the doctor gets there—so once he gets there, then I can delegate to the LPN to find somebody else. But to keep all of that straight, and to not panic when you need more hands, but you can't get them because you can't send up a flare. Everything else I was taught how to deal with—the medications and compressions and the intubating. That isn't actually what scared me. It was that I didn't know how to*

> *get help.* [I felt] *alone, incredibly alone. And* [when the physician arrives] *there's verbal orders flying around, and you really have to have your head on your shoulders and, to be so young, and so new to where this stuff isn't ingrained—it's been taught, but it's not ingrained—it was definitely challenging.* (Interviewee)

The only body available. Sometimes managing the responsibility of ***I'm Alone!*** even when other RNs or physicians were in the building, particularly on night shifts, was challenging and stressful for participants. For instance, when maternity clients were in active labour it was the responsibility of one RN to provide one-to-one nursing care for those clients leaving the responsibilities of the ward to the other RN or LPN, as was previously mentioned in this chapter (see the *subtheme "THE RURAL RN ROLE: What Do I Need to Know,"* in the subsection titled "*How to Manage the Role"*). However, in some facilities the other RN was also responsible for the ED and any other contingent situation that may have arisen (i.e., another labouring patient or someone experiencing chest discomfort and so on); therefore, the other RN was not always physically available to offer support. Such situations were described as *"harrowing"* and *"unsafe"* and rendered feelings of helplessness and fear for participants. Additionally, lack of support by some nurse managers to address the issues associated with ***I'm Alone!*** left some participants feeling frustrated and truly unsupported.

> *She was haemorrhaging a lot, and I'm massaging* [her fundus], *and calling the doctor that I need help and she couldn't come because* [she was in the next room delivering a baby]. *It was just crazy! I felt very helpless! I definitely needed more hands in there. It was nights—we only had an RN and an LPN and me. So they were both in there with the* [other] *delivery, and I was stuck with this Mom who was bleeding all over the place. I've talked to the Charge Nurse about having an extra LPN on nights, or just to have that extra set of hands to help. But that's an old issue with them. We've all asked for it but the budget isn't there apparently.* (Interviewee)

With no on-site physician. Managing the responsibility of ***I'm Alone!*** with no on-site physician required participants to be resourceful and self-reliant when trying to prioritize and manage critical situations on their own. Participants described experiencing an array of paradoxical emotions that oscillated between surprise and shock. The following excerpt is one participant's poignant description of the emotions she experienced when delivering a baby alone without the backup of a physician:

> [I was] *scared out of my wits—just, "I don't want to be there." But I'm glad I'm there because she can't do it by herself, so it's overwhelming, and it's because*

> *you don't have much to draw from. Then it's like, "Oh my gosh, thank God!" When baby's okay, you start worrying about Mom. But usually the worst part is over, you're over the hump, and almost done.* (Interviewee)

I'M IN CHARGE! Contextual factors including participants' competence levels and arising contingent situations influenced how ***I'm In Charge!*** unfolded for each shift.

> *It's context of the day. If I walk in and my staffing on site is a little weak, I'm the senior person and a colleague who graduated at the same time I did—if she's my Emerg nurse, and the two of us are running the hospital that makes me nervous.* (Interviewee)

In addition, ***I'm In Charge!*** required knowing how to collaborate with the varying members of the interdisciplinary team, understanding the scope of practice of each team member, and having the ability to coordinate the team to provide safe patient care. Participants who were well supported by their nurse managers described ***I'm In Charge!*** as an empowering and good experience.

> *I actually really liked it. It's not like, "Oh, I have all this power," but the manager having that confidence in me to do that at that point. It was really good because she didn't just* [say]*, "Oh, you're in charge now." We had about an hour and a half meeting; we went through the charge nurse manual and responsibilities. So I wasn't just thrown to the wolves, there was a lot of support there.* (Interviewee)

However, participants who were not suitably supported by the interdisciplinary team described ***I'm in Charge!*** as *"scary," "unsafe,"* and a *"huge responsibility."* One participant recommended that *"a better orientation even if …* [it is only for] *an hour—outlining the duties expected of* [her]*"* was needed to support taking on the responsibilities of the charge role.

Of the hospital. Participants in the smaller hospitals who were quickly and immediately expected to manage the responsibility of ***I'm In Charge!*** of the entire hospital without the on-site support of any other RNs described those responsibilities as *"freaky"* and *"hard,"* as has been addressed previously in this chapter (see the subtheme *"I'M ALONE!"* in the subsection titled *"The sole RN on shift"*).

For some participants, ***I'm In Charge!*** of the hospital generated paradoxical *"love–hate"* emotions. On the one hand, having to make quick decisions in critical, ambiguous situations without having the experience of similar incidents to draw from felt burdensome, but on the other hand, it was exciting to participate in new learning.

Participants also described times when they felt inadequate in their charge role, because they were chastised by oncoming senior RNs who disapproved of the decisions that had been made.

> *I was the "it" girl going, "Should we do this?" and I'm the one with the least … experience, but for the nursing staff, I was most senior, and I had to make the decision—that is crazy. That's such a burden on me, but it was exciting at the same time because I got to see it, I got to participate in it,* [and] *I got to do it. And then the next crew comes on, and "You shouldn't have done that here," and then you question yourself and you feel bad.* (Interviewee)

Of the unit. Managing the high degree of responsibility associated with the dual roles of ***I'm In Charge!*** of the unit and heavy patient loads or labour and delivery clients was very stressful and *"hated"* by some participants.

> *I'm in charge most of my shifts now. I really hated it at first because trying to do all the charge work and keep contact with the doctors and take care of my clients was really difficult. It's better now, but when the floor is full, even the charge has five clients. It's very, very difficult.* (Interviewee)

Others felt *"stuck"* physically, emotionally, and cognitively, when responsible to provide one-to-one nursing care for maternity clients, while simultaneously supervising the nursing care provided by other members of the health care team.

> *So I would be in that room, but thinking about the other clients and what needed to be done, but also thinking of what needed to be done in that room. So I just had this big, stuck place. There's a lot of anxiety.* (Interviewee)

All too frequently, participants' nursing school values were tested because they could not physically provide timely care to clients who needed it.

> *So often on nights, the floor is left for a period of half an hour, 45 minutes* [during a delivery]. *Sometimes you hear a bell and you run out and do a quick run and you just have to tell your patient, "We're really busy you have to wait." And it's usually someone who needs to go to the bathroom, who ends up wetting themselves. So you feel crappy for that person, that you couldn't give them good care. But you're stretched.* (Interviewee)

One participant who experienced a shortened orientation and lack of educational and interdisciplinary team supports described ***I'm In Charge!*** of the unit as eliciting *"sink or swim"* feelings because she perceived herself as inadequate in her knowledge, abilities, confidence, and instincts. Accordingly, she felt frightened and *"unsafe."*

> *When I orientated to Emerg I didn't have my ACLS* [advanced cardiac life support], *ENPC* [emergency nursing paediatric course] *or any of the courses. It was, "Okay, go. You are the Emergency Room nurse." I felt* [that] *if something really big did come in, that I might make a mistake because I didn't have the courses behind me yet! It made me feel unsafe.* (Interviewee)

Another participant described being in charge of the ED as *"the toughest part of transition just because you don't have any experience, and then all of a sudden you're "it." You are the one in Emerg, and so that was difficult."*

All too frequently participants were considered *"senior"* staff on night shifts and as such, were expected to manage ***I'm In Charge!*** of the unit, but without the appropriate educational supports. One participant worried that she was jeopardizing her license when making critical decisions associated with managing emergent situations because she believed that she lacked the knowledge to adequately make those decisions.

> *So sometimes when we're waiting for either STARS* [Shock Trauma Air Rescue Society, a helicopter ambulance service,] *or the NICU* [neonatal intensive care unit] *teams to come, it takes forever when you're not comfortable dealing with an unstable baby. If there's a lawsuit that happens, your license is on the line. And when you're not fully educated, it's tough. I'm finding that now, since I've been there for a year, I'm sometimes a senior staff, which is terrifying.* (Interviewee)

Another participant questioned her knowledge level when working with emergent paediatric clients. While she felt *"lucky"* that the paediatric surgical rotation during her nursing education had somewhat prepared her for working with those clients, she also recognized that she did not possess the experience to provide timely care.

> *Kids come in—I have the ABCs* [airway, breathing, circulation knowledge], *but I don't have that, "Okay, I've seen this before, and it was because of this reason."... I can work through the path,* [but] *it's slow for me. "Why would they be seizing? What can I do about it? What do we typically do in this situation? Let me look it up in the book." It's not just* [snaps fingers]. (Interviewee)

Of the team. Participants who were in charge of nursing teams discovered the importance of knowing the abilities of their team members. Prioritization and delegation of duties and responsibilities depended on who was on the team and whether or not they could be trusted. When working with seasoned knowledgeable nurses, participants generally felt equipped to take on ***I'm In Charge!*** According to one participant, *"It always depends on who it is. If it's* [name], *you know that things are taken care of, and she'll do whatever. And if she needs us, she'll let us know."* However, when working

with new inexperienced nurses, ***I'm In Charge!*** of the nursing team was generally challenging and overwhelming for participants because learning to communicate with new team members who were unsure of their roles and responsibilities added to participants' own uncertainties about what to prioritize or who to delegate.

> *I expect her* [a young nurse] *to do these things because that's what the* [senior] *LPN did before. And so in the back of my mind, as a charge nurse, I'm like, "They're forgetting about the in-clients." I find it really difficult because you're still responsible.* (Interviewee)

Of contingent and emergent situations. Managing contingent or emergent situations required participants to adapt, prioritize, and anticipatory plan. Those who were well supported by the interdisciplinary team and received back-up support from skilled senior RNs, nurse managers, physicians, or had previous nursing degree education experiences felt *"nervous"* about the responsibilities, but that they were manageable.

> *Now, here's my scenario … at midnight, 40 weeks plus two day*[s] *waddles in. Well, there I've lost my float* [to care for the maternity]*.… I'm the baby nurse if they deliver, which is potentially going to take me off the floor for up to 90 minutes. Now Emerg has something that they need a hand with … who do I send? Having said that, we can call in an on-call, and our on-call's always a senior, more experienced nurse.* (Interviewee)

On the other hand, participants who were not well supported by the interdisciplinary team or educational supports and were expected to manage responsibilities including providing direction to new locum physicians during specialized procedures in the ED described those situations as generating paradoxical emotions. One participant felt *"lucky"* because she had learned how to manage a particular procedure during her BN program, yet she also felt frightened and unsafe because she did not feel confident enough in her knowledge level and experience to direct a physician.

> *We ran the stroke protocol and it was a physician* [who] *didn't work in Emergency very often, and I found that I was* [explaining], *"This is* [what]*… we need to." He's trying to get the drug into him. I'm* [saying]*,"Well, we need to get it in an extra line, we need to get in the catheter, we need to…." And he was helping me do that …. because it's only me right. I just found … that I had to direct him, and it's just lucky that I had previous experience in school with it.* (Interviewee)

Another participant described a critical incident on a night shift in which she felt unsupported by the travel nurse with whom she was working when faced with managing

the contingent situation of four maternities in active labour. She doubted her knowledge and instincts when questioning the more experienced travel nurse about a plan of care for one maternity client, who subsequently delivered in bed without the physician present. This situation left her feeling *"helpless"* and *"panicky"* and resulted in difficult communications with the client's physician.

> *The one night was absolutely horrible because it was me … and this travel nurse* [who] *had only been there a few days, and we had four women in labour* [who] *came in within two hours of each other. It was ridiculous!… Two of them delivered that night … and there's me and her and an LPN, and the floor was full.* (Interviewee)

To survive ***I'm In Charge!*** and feelings of *"sink or swim"* participants relied on the skill sets of their colleagues and the knowledge gained in nursing school to support their decisions. A few even prayed to God for guidance.

> *You get thrown into things you're not comfortable with quite quickly, and you don't feel like you're competent enough to handle some of those situations. But you have to rely on the other staff, or what you've learnt in school to get you through. So you just really pray that nothing bad happens.* (Interviewee)

I'M A JACK OF ALL TRADES! ***I'm A Jack Of All Trades!*** encapsulated participants assuming the additional responsibilities of other professionals and ancillary staff or *"wearing mini-hats"* in addition to their own workloads. Managing this role was both surprising and shocking for most participants because they were required to take on the duties of the interdisciplinary team, which included physicians, pharmacists, or respiratory therapists, as well as the work of unit clerks, laboratory technologists, maintenance personnel, environmental services workers, kitchen staff, and so on. For most, these were not skills that had been learned during their BN programs. The fact that participants never knew from one shift to the next which responsibilities might be required added to the degree of shock and surprise they experienced.

> *We do everything. Well, sometimes you feel like a really highly paid housekeeper, because if there's lots of bugs and stuff, in that Emergency doorway, you have to vacuum it.… It's overwhelming at times, and then depending on the time of day, we also do labs, draw blood, run blood, run urines, do pregnancy tests, our own ECGs* [electrocardiograms], [and] *light the pilot light if it blows out in the kitchen.* (Interviewee)

Many participants found themselves fulfilling the duties of physicians during contingent or emergent situations because the physicians were on call, but off site. As one participant conveyed, "*When someone comes in, imminently in labour, and you have to catch a baby, that's not … a nursing role, but it's something you have to do."*

Fulfilling the duties of pharmacists was time consuming and frustrating for participants because it impinged on their time available to provide patient care.

> *We were often going to the night cupboard to get medications because we only had Pharmacy there till 4:00 p.m. They weren't there on weekends, so if anything needed to be replaced, or new clients came in, we had to go and get all of their meds from Pharmacy. That took a long time … and* [it is] *not what I'm there to do.* (Interviewee)

Performing the duties of ancillary staff was sometimes annoying to participants because it was not what they had signed up for.

> *We only had a janitor and housecleaning, until 3:00 p.m. So if we had discharges and we needed the beds, we were cleaning the rooms. The same as with the Labour rooms—we were cleaning if it was after hours, which I didn't go to school to be a janitor.* (Interviewee)

A DOUBLE WHAMMY:

How do I Manage All of This Learning and Responsibility?

A few hours into their first shifts, participants realized the importance of developing strategies to manage the learning and responsibility necessary to survive in the rural setting. Managing occurred in two separate ways: "*On the Fly"* and *By Accessing Resources.*

On the Fly

One participant used the phrase *"on the fly"* and described it in two different ways based on having to manage the entire ED with only 10 days of orientation, a minimal number of certification courses, and without the direct back up of senior RNs. This participant explained that the phrase *"on the fly"* encompassed *"being chucked into"* situations with heavy responsibilities without the direct support of senior RNs. Participants ultimately assumed the responsibility for learning procedures or protocols for the first time at the bedside while providing patient care or by paging *"overhead for help, and someone comes and helps … and that's how you learn"* (Interviewee). For this participant, on-the-fly learning was described as eliciting paradoxical emotions ranging

from *"totally stressful"* to *"wickedly awesome,"* wherein the first emotion was related to self-doubt in her knowledge level and decision-making skills, and the second was associated with the opportunity to exercise autonomy. Similarly, one participant described on-the-fly learning as challenging but *"fantastic."*

> *The "fast" part means you have to learn on the fly every day. You are challenged and pushed to grow beyond* [your] *wildest expectations. It's like being in a snowball downhill. You just go. You roll with what comes in, and you use your critical thinking as best as you can. My first chest pain* [I] *didn't really know what to do,* [I] *took cues, second one* [snaps fingers], *you've got it better and you just keep going.* (Interviewee)

By Accessing Resources

Besides learning "*On the Fly"*, participants were consistently *Accessing Resources,* which involved asking the overarching questions of *What's what?* and *Who's who?* (see Table 14). Finding the answers to those two questions enabled participants to locate appropriate resources when needed.

Table 14

By Accessing Resources

What's What?
When do I need to call for help?
What procedures, policies, and/or protocols do I need to use?
What are the idiosyncrasies of the physicians?
What information do I need to access and how?
Who's Who? (Who will support me?)
Work Supports
Social Supports

What's what? Knowing what's what? involved learning the following: When do I need to call for help? What procedures, policies, or protocols do I need to use? What are the idiosyncrasies of the physicians? What information do I need to access and how?

When do I need to call for help? Participants learned that it was imperative to recognize early on when they should be calling for help. "*Knowing"* in this sense, involved realizing when a situation warranted more nursing staff or a physician. Very few participants felt comfortable with making such decisions, but those who did had been

supported by ready access to on-call senior RNs or nurse managers. As one participant stated in reference to calling in staff, *"At this point, I'm too acute I need my on-call* [support]*, and I call them in, and nobody's going to blink an eye on that … from the management point of view."*

Nonetheless, there were others who recognized when they needed help, but help was not available. Those situations were stress inducing to the point that one participant *"felt extremely helpless and almost panicky."* She acknowledged that she "*did start phoning around for extra help even though it was two in the morning, but nobody picks up their phones at two in the morning"* (Interviewee).

What procedures, policies, or protocols do I need to use? Knowing the intricacies associated with providing client care in specific situations was challenging for many participants because of the scope of the generalist RN role. One described the responsibilities as *"huge"* and most were surprised that those responsibilities encompassed not only nursing duties, but also policies, procedures, or protocols associated with other services in the hospital.

> *There's a huge workload on rural nurses. It's unbelievable how much you need to know. That's one of the scary parts; it's not even the actual nursing duties but, "Do you know how to turn on the STARS* [the helicopter ambulance service] *lights when they come in?" or, "Do you know how to axe if there's a fire?" It's phenomenal how much I think I've learnt in the past year.* (Interviewee)

What are the idiosyncrasies of the physicians? Knowing the idiosyncrasies of physician colleagues was deemed very important by most participants and influenced how, when, and what participants communicated with physicians. For the most part, participants who were well supported by senior RNs, who took it upon themselves to buffer the new nurses and to share their knowledge of what's what? about physicians' idiosyncrasies, felt that they belonged on the interdisciplinary team and experienced easier transitions.

> *As soon as I got there* [the senior RNs started saying], *"Okay, these are the three doctors you don't want to suggest anything because they'll do the opposite." "Now with this one, if you want something done, you've got to do it this way." "With this doctor, you can just tell him…." So I think knowing that … allowed me never to get in the bad graces of the physicians.* (Interviewee)

Knowing what's what about physicians also involved learning how to change communication styles in the moment to suit each physician: *"To be a chameleon,"* as one participant expressed, *"it depends* [on] *who you're working with, who's the doctor? It all changes.… It's like, "How am I being today?"*

What information do I need to access and how? To support learning during transition, participants accessed as many resources as possible: education days, independent learning resources, on-site in-services, and on- or off-site certification courses recommended for rural. Access to information was significantly influenced by whether or not participants were well supported by nurse managers, clinical nurse educators, and learning resources. Those provided with timely and supported access to appropriate information experienced easier acquisition of knowledge than those who were not.

To increase their knowledge levels and skills sets surrounding maternity care, a few participants asked their nurse managers to provide them with paid education days at urban labour and delivery units. As one participant explained, *"One thing I have done, is ask the manager to send me to* [the city]. *Because as far as vaginal checks go, I don't get enough experience in the rural acute care hospital to do that."* However, those urban experiences were hit and miss in supporting the educational needs of participants. Some were able to experience multiple deliveries, while one was not, because "*unfortunately, the times* [she] *went, no babies* [were] *born."*

Although some nurse managers had promoted on-site in-services very well, accessing in-services was often problematic for participants because "*there were not enough people to cover.… Someone had to watch the clients"* (Interviewee).

Telehealth conferences were somewhat beneficial or *"okay*" in providing participants access to learning resources, but challenging due to the lack of in-person interaction and poor sound and visual quality of the technology used.

> *I missed the interaction that you got with the instructor. Plus you always had technology difficulties with hearing or seeing. It still worked okay* [because] *we had a leader … who was familiar with the Telehealth stuff.* (Interviewee)

Independent learning resources accessed by participants and deemed useful and necessary for knowledge acquisition included hardcopy nursing school texts and in-house manuals, online medical and nursing journals, and online certification courses. Some

participants found *"it hard to keep up since school had been out; to have the time to research and look at journal articles."* One participant became quite frustrated with the lack of resources provided by on-site, CARNA, and local libraries. In addition, only a few nurse managers supported participants through providing access to independent online certification courses.

The in-person certification courses (as opposed to online), recommended for rural nurses, were many and varied, and were generally found to be highly beneficial to support participants' learning.

> *I have NRP* [neonatal resuscitation provider course] *and fetal heart monitoring. We have the STORC* [strategies for teaching obstetrics to rural and urban caregivers] *modules that I haven't finished completing yet. I got to be in MOREOB* [managing obstetrical risk efficiently program] *because one of the nurses dropped out, so that's actually been a huge help because we do have lot of bad deliveries, so it does help to practice the skills.* (Interviewee)

However, some participants found the dual workload of orienting into the rural acute care hospital and managing multiple certification courses *"tough"* and *"a little bit overwhelming."*

> *Once I got the little piece of paper saying I was an RN, that's when it got a little more tough and purely because, within a week, I was signed up for … all of these courses just so they could get me into Emergency.* (Interviewee)

Additionally, many certification courses were scheduled during day shifts, which was exhausting for some participants because they needed to attend courses before working an evening shift or after working a night shift.

> *I've never taken CTAS* [Canadian triage and acuity scale], *which I think is a shame, because every time they've offered it, I've been working a stint of four nights in a row, and it's on the second night. "I can't do that. That's too crazy!"* (Interviewee)

Accessing certification courses was frustrating for many participants because they filled up quickly, were offered infrequently, and in some rural facilities were regularly cancelled "*because no one* [went] *to them"* (Interviewee).

> *I am signed up to take TNCC* [trauma nursing core course], *PALS* [paediatric advanced life support]. *They're all kind of in the future just because they're so hard to get into. PALS, the one that's on site, is fully booked. It was only 16 people. So I booked in for* [the city], *which is a ways for me to go.… So it's one of those things where there's not an abundance of classes there. They're not*

> *running them very frequently and in the whole area that was the only PALS class coming up, and then the rest were either too far away, or it's getting so far into the future almost. To even book that far ahead is tough.* (Interviewee)

Other issues that impacted whether or not participants were able to access certification courses included the need to travel long distances to attend courses (often greater than 3 hours), sometimes in inclement weather and requiring hotel and childcare costs. One participant recommended that clinical educators improve rural nurses' access to these courses by travelling in teams to provide on-site in-services at rural facilities.

> *As a new nurse, there's so many things I'd like to learn and I can't always be up and going to* [the city 2.5-hours away] *for a course. I do have children. It would be nice to be able to do something here that* [does not involve] *having to stay in a hotel overnight.* (Interviewee)

Who's who? Knowing who's who? required participants to learn about the work supports within the hospital and health care system and the social supports outside of the facility and involved asking the question *Who will support me?* Accessing work supports encompassed knowing who to call for help and who could assist with managing day-to-day nursing duties and included the following interdisciplinary team members: nursing staff, experts in urban hospitals, physicians, and support staff. Accessing social supports involved maintaining relationships with BN program peers, friends, and significant others or families, and developing new relationships within the rural community.

Work supports. Knowing who's who required participants to learn who to call for help, who to trust, and who had what skill set: It influenced how delegation of tasks would be managed. Experience, role, effort, and personalities all contributed to the dynamics of the interdisciplinary team and who could be trusted.

> *There's certain ones* [LPNs] *I trust; I say, "Go do this assessment; I have other things." Or I'll let them do meds. But there's some of them I don't trust that it'll get done, and* [that] *it'll get done right.* (Interviewee)

Sometimes individuals were accessed on-site, at home, and in certain situations, through telephoning an urban facility and speaking to the emergency, labour and delivery, or laboratory personnel.

> *We could always call* [urban Labour and Delivery] *with any questions. They were good with that. We've called the lab there when we were unsure of the test that needed to be done, or the value. They were good about answering questions.* (Interviewee)

Nevertheless, the degree of support experienced when accessing colleagues on site frequently depended on the knowledge and skill set of the interdisciplinary team including nursing staff and physicians, which ranged from strong to weak; staffing numbers; and whether or not teams were managing contingent or emergent situations.

Strong interdisciplinary teams were reassuring to participants because they consisted of senior staff, mentors, or physicians with expert knowledge, excellent skills, the capacity to manage multiple demands, the ability to communicate clearly and effectively, and being friendly, all of which provided excellent back up. One participant identified that she always walked through the ED on her way to the unit so that she could determine the strength of her back-up staff. She believed that it dictated the way the shift would unfold. However, even when strong interdisciplinary teams were on site, contingent situations and staff shortages sometimes prevented back-up staff from responding when participants needed help. In addition, there were situations when less approachable colleagues were the only people available for participants to access. One participant described a situation in which, despite the challenge of communicating with someone who was *"snarky"* and *"mean,"* she found it necessary to access this senior RN because she provided "*another opinion, another somebody saying, 'Yes, that's right,' or, 'No, that's not, and this is why.'"* This helped the participant to ensure the provision of safe patient care.

Participants who worked with weaker interdisciplinary teams often felt uncertain in their decision making, had difficulty trusting their counterparts, and were concerned for the safety of their clients. Weaker teams consisted of staff or physicians who did not possess the knowledge and competence to manage critical decisions, contingent situations, or infrequently used procedures or protocols. One participant found it challenging when working with other inexperienced nurses to know how to manage specific procedures in the ED. She described the following situation, "*The* [physician] *put in the chest tube, but he didn't know anything about managing the drainage system, and that's what* [the three of us] *were trying to figure out"* (Interviewee).

While a few nurse managers did provide participants' access to on-call senior RNs during evening and night shifts, most did not. In one facility, on-call RNs were scheduled, whereas in another hospital, organizing senior RNs for back up was the

responsibility of the participant. This participant stated, "*If I don't say 'hey, do you want to be on call for me?' … They're not going to do it for me."*

In some facilities participants and coworkers managed the learning and responsibility associated with working in the rural acute care environment by capitalizing on each other's strengths.

> *Everybody has their own area of expertise. She worked ER overseas for 3 years. If I'm having trouble with an IV, she can … get it every time, but if there's a maternity patient, she's just lost, so we help each other.* (Interviewee)

As well, some sought support from other new nurses who worked in the same facility. They would get together to discuss issues, *"compare notes,"* vent, and socialize. One participant expressed, "*We talk about our experiences … we're pretty supportive* [of each other]. *We're great friends outside of work and we go out."*

Participants noted that the United Nurses of Alberta members were occasionally accessed to assist participants with generating strategies to manage unsafe work situations, but to no avail. Interestingly, most participants admitted to having very little to do with their local unions and professional college, CARNA.

On-site clinical nurse educators were described as very easy to access and, as such, were considered highly supportive of participants' transitions. In some situations, the clinical nurse educator would map out a plan of learning for the participant. One described her clinical nurse educator as "*really good,"* and described the support in the following way: *"If you're unsure about stuff, she's great to phone, and she runs classes there quite frequently."*

Conversely, many participants found the process of accessing clinical nurse educators who were seldom on site and responsible for teaching nurses in several rural acute care hospitals to be difficult and frustrating.

> *She's supposed to be at our hospital once a week, but we never see her. She's based out of the city, and she's in charge of all the rural acute care hospitals in our area. So it's sometimes tough. In her defense, she's not a full-time position, and then spread quite thin between all of us.* (Interviewee)

Of concern, was that in a few of the smaller rural acute care facilities no clinical nurse educators were available, which participants found to be exceedingly difficult. In one case, the nurse manager would organize educational sessions such as "*STARS* [Shock

Trauma Air Rescue Society, a helicopter ambulance service,] … *coming out to do cardiacs"* (Interviewee). However, this participant also recognized that her nurse manager was fiscally constrained. Some participants in other rural acute care facilities were not provided this kind of support, so they were responsible to access certification courses elsewhere. As one participant pointed out, "*If you want education, you go on the Internet, look what courses are available, and you're responsible for putting in requests. And unless you do that, you're not going to get anything."*

A few nurse managers were very accessible and supportive to participants' transitions. One participant felt well supported because her nurse manager "*had an open-door policy"* and encouraged discussions about issues or concerns. On the other hand, many nurse managers were described as inaccessible because they were difficult to talk to and did not encourage open communication.

Younger physicians were frequently accessed for support because they promoted interdisciplinary team work through *"always* [being] *very approachable … nice, and lots of fun."* As one participant conveyed, *"I can text them about something, and they're great, or call them and they're really good."* While a few older physicians were accessed for support because they were patient and approachable, most were not because they did not encourage interdisciplinary collaboration and portrayed an air of not having *"the time of day"* to assist nurses and often *"got a little cranky"* (Interviewee) when asked questions. As well, off-site physicians on night shifts were sometimes found to be unsupportive because they were very *"grouchy"* or refused to come in. One participant expressed, *"Oh, I want*[ed] *him to come in. But he wouldn't.… But that's his job right, so I felt torn."*

Most participants found language barriers to be a considerable issue for communicating with patients because they did not have access to Aboriginal Liaison workers or people who could translate for them. However, one participant who worked in a larger facility experienced few issues with language barriers because support staff could be accessed to provide assistance.

Social supports. Accessing social supports consisted of participants maintaining relationships with BN peers, friends, and significant others or family. For the most part, relationships with BN peers were described as very supportive of participants' transitions

because each party possessed a mutual understanding of what the other was experiencing: "[When] *the gloves were off, we could talk about everything because we're all in the same boat"* (Interviewee).

Conversely, some BN peers who worked in urban facilities were described as *"tough"* support because they did not "*understand what it* [was] *like"* for their peer in the rural acute care environment. One participant described her urban BN peers as assuming responsibilities significantly different than her ***I'M IT!*** role, because they were *"just finishing their courses and starting to be independent in ICU* [the intensive care unit]*."*

One participant who was working where she had lived for several years sought support from long-standing friends within the community. However, she found that her peers who were nurses more readily understood and empathized with her concerns than those who were not, because they seemed to *"get it."*

Some participants who lived where they worked found it *"tough"* to make new friends in the rural community because they were concerned about breeching their clients' confidentiality. A few chose not to make new friends in the rural community because they could not *"really talk about work with them*" and really had nothing else to converse about. Similarly, participants who sought emotional support from their significant others or family found it difficult to share work issues and concerns with them. One participant found it challenging to discuss her work with her husband because he would no doubt *"hear about it at* [work] *the next day."*

A DOUBLE WHAMMY! An Emotional Roller Coaster Up! and Down!

Participants' transition into the rural acute care environment generated an array of emotions that have been interpreted as ***An Emotional Roller Coaster Up! and Down!*** An emotional roller coaster is defined as behaviours, events, or experiences characterized by sudden and extreme changes" ("Roller Coaster," 2014, "Full Definition," para. 2). The degree of fluctuating emotions was much greater for some participants as compared to others and was influenced by what was happening at the time or the amount of available work-related or social support: It was situation and context dependent. Those who experienced adequate interdisciplinary team and educational supports experienced less intensity in their emotional roller coasters than those who did not.

One participant described minimal fluctuation in her emotions. She felt *"nervous"* when starting her new job in an urban-model facility, but did not consider it ***An Emotional Roller Coaster Up! and Down!*** She linked this lack of emotional fluctuation to the support that she had received from the nurse manager and clinical nurse educator, as well as knowing that there were always multiple back-up staff and a physician available in the hospital to support her.

> *I was nervous at first, but I'm nervous with starting any new job. I've heard that before, people say, "Your first little while of nursing's kind of up and down." But I never really felt like I was going all over the place. I think the biggest thing for me is I always felt supported.* (Interviewee)

Conversely, most participants confirmed experiencing ***An Emotional Roller Coaster Up! and Down!*** filled with great intensity in emotions that oscillated between *"happy"* and *"sad," "awesome"* and *"overwhelmed,"* and *"safe"* and *"scared shitless."* When asked, one participant described her emotional rollercoaster as follows:

> *One day would be a really good happy shift. Then the next day, we would be so run off of our feet that I would go home just scared I'd missed something. So then that wasn't such a good day. My stress level on nights was so much higher because there were only the two of us … the "being it." So then, knowing that I was going into that was … oh I can feel the stress even* [now]. *So it definitely felt like a rollercoaster with emotions.*

Another participant described transition as *"difficly* [*sic*] *awesome"* and a love–hate relationship: *"Difficulty"* was related to the degree of responsibility encountered, and *"awesome"* was associated with becoming a well-rounded nurse. When asked if she experienced ***An Emotional Roller Coaster Up! and Down!*** during transition she stated, "*It is true, your emotions run high or low. There are so many reasons why everything could be up and down. The variables change every day."* I asked another participant who had experienced a very fast-paced, overwhelming, and difficult transition what she would say to a new nurse who was about to transition into the rural acute care environment, and she candidly remarked,

> *I would tell them, "It's a really awesome job, and you're really going to love it. But you're going to be scared shitless every day. So make sure that you are willing to walk in and have your mind open to having to learn everything and understanding that if you're going to go rural, you're going to get all that responsibility put on you. Are you going to be able to deal with that? Because*

> *you're going to get a wicked experience, but you're also going to be really overwhelmed all of the time."*

A DOUBLE WHAMMY! The Decision: Stay? or Go?

As a consequence of their transition experiences, participants made the decision to stay in the job or go and seek nursing work elsewhere. Alarmingly, within the first 2 years of transitioning, nine of the 12 participants had already changed jobs or were searching for employment elsewhere: three had moved to urban units, three had moved to another rural acute care facility, and three had applied for positions in another area of their current workplaces. ***The Decision: Stay? or Go?*** was described as a difficult one that was influenced by many factors.

For some participants, working in a rural acute care hospital was not their first choice for employment and was only picked because urban jobs were not available. However, one participant described the countryside and type of work as good reasons to stay. However, an oppressive housing market and lack of urban-type resources were influencing her decision to go. This participant had found that *"houses in* [the city] *cost less than"* in the rural community where she lived and that options like spontaneously shopping at *"Wal-Mart"* were not available.

On a different note, team nursing was a *"huge"* change for one participant and almost scared her away from rural nursing in the first 2 months of practicing *"because as the RN,* [she was] *expected to be the team leader,"* which was something she had not been prepared for. Nonetheless, she did stay in the job because her significant other needed to remain in that community for employment.

Other reasons to stay in the job included liking the people, the small-town feeling, the work schedule, and the scope of practice, wanting to live rurally, and feeling supported by the nursing staff and physicians.

> *I like the staff. A lot of the girls are super nice to work with, and it's fun. I guess growing up in a small community I missed that small-town feeling and … I got that … feeling working there.* (Interviewee)

> *I can't imagine being in an urban centre. I don't want to specialize into one thing. I want to know bits of everything and excel at everything. I love prioritizing and being flexible and thinking on your feet and juggling 45 things at the same time!* (Interviewee)

Interestingly, one participant who was working in an urban-model facility had considered leaving the rural acute care environment *"to get some … specialization experience so that if* [she did] *end up at a really rural facility* [she would have] *some of that experience to fall back on."*

However, a few participants admitted to being excited about landing jobs elsewhere. Reasons for leaving were many and varied. For one, critical incidents involving the unsafe practices of older senior RNs left her worrying about picking up bad habits and losing her licensure. She admitted to using her rural acute care job to obtain enough experience to find work in an urban facility.

> *I can't wait to get out of there because I honestly feel like there's going to be a huge lawsuit one day just slapped upon that hospital, because there's just so much bad practice. I try to practice the best I can, but I get worried that I'm going to pick up bad habits from these nurses.* (Interviewee)

The emergency experience obtained in a rural acute care facility led another participant to realize that while she loved emergency work, she did not appreciate caring for long-term care clients. So she sought work in an urban hospital where she could work with emergency clients only.

> *I've* [been] *bitten by the Emerg bug, and I love it! I love trauma; I love everything like that, and I just want to work that. And in rural, you have to work Emergency, and the floor. And now that the floor has turned into long-term care; that's not what I signed up for.* (Interviewee)

Similarly, another participant sought work on an urban "*labour and delivery unit"* because she thoroughly enjoyed maternity nursing. However, she did admit to retaining her rural acute care position as a leave of absence.

Of concern is that one participant felt so undervalued by her nurse manager and unwelcome by the senior RNs and the negative unit culture that she began seeking work elsewhere:

> *I don't like it here. I don't feel valued here, I don't feel like I'm having the opportunities to grow here because of my age and basically how young I am, are huge determining factors.* (Interviewee)

As well, another participant was anxiously awaiting a position in a different department so that she could *"get out"* of acute care and away from her bullying manager. Similarly,

another participant had quit in one facility and moved elsewhere, because of the frequent *"straight up bullying"* she had been subjected to by some senior RNs.

> *I remember sitting and charting and they were having a conversation through me about their hiking trip the day before, so I thought I'll be sociable, I'll pipe in and I got the, the whole "uh?"— a pause with the funny look. I eventually moved because I was made to feel so uncomfortable and unwelcome. That wasn't the only time I was made to feel invisible by some of the nurses.* (Interviewee)

Summary

Participants' transition experience into the rural acute care environment was ***A DOUBLE WHAMMY!*** consisting of two simultaneous nondiscrete experiences of ***I'M A GENERALIST! and I'M IT!*** These experiences were influenced by contextual factors including educational preparation, other work experiences, reasons for choosing rural nursing, and the type of hospital in which they transitioned, whether it be an urban-type or generalist-type model. ***A DOUBLE WHAMMY!*** began a short time after participants entered the rural acute care setting and continued throughout their transitions. The few participants who were provided ample supports experienced moderately paced, manageable, good transitions, but those who were not, experienced fast-paced, difficult, frightening transitions.

The first whammy experience, ***I'M A GENERALIST!*** encompassed *So Much Learning* as participants acquired knowledge about ***The Place***, ***The People***, and ***The Rural RN Role***. Those who were well supported found this learning manageable and good; however, those who were not experienced paradoxical emotions that oscillated between excitement and panic.

In terms of ***The Place***, participants learned that human resource shortages influenced the services provided in *The facility* by physicians, pharmacists, and nurses, as well as educational supports. Participants learned that unit culture, be it negative or positive, influenced how transition unfolded. Those who experienced negative unit cultures had either left that rural acute care environment or expressed intent to do so. A few participants learned about issues surrounding working with old equipment in disrepair. In terms of *The community*, some participants learned the challenges to managing confidentiality and lack of anonymity when working and living in a rural community; however, these participants also expressed that knowing one's clients

beyond the hospital setting was very rewarding and made the job easier. Those who commuted appreciated the lack of anonymity associated with living elsewhere.

Participants learned that overall, ***The People*** in the rural acute care environment were very supportive of their transitions, but also that lack of support from some members of the interdisciplinary team including clinical nurse educators, nurse managers, and a few senior RNs or physicians was difficult to manage and influenced their decision to stay or to find work elsewhere. Participants learned about their own confidence levels, values, and likes and ambitions, and personal strategies to cope with learning about ***The Place***, ***The People***, ***The Rural RN Role***, and fitting in.

In relation to ***The Rural RN Role***, participants acquired knowledge about *How to change hats* and used their skills to adapt, prioritize, and anticipatory plan. Additionally, they learned about *How to manage the role* related to policies, procedures, and protocols; ward routines; teams; taking call; acting as a resource; and ***I'M IT!***

The second whammy experience, ***I'M IT!*** involved managing *With Even More Responsibility*, as participants tried to manage the responsibilities of ***I'm Alone!***, ***I'm In Charge!***, and ***I'm A Jack of All Trades!*** in addition to ***The Rural RN Role***. Those responsibilities generated paradoxical emotions that oscillated from awesome and annoying to exhilaration and panic.

For one participant, ***I'm Alone!*** meant working alone as *The sole RN on shift* with only one LPN for on-site support. As well, ***I'm Alone!*** involved being *The only body available* during emergent or contingent situations when other RNs or the physician were busy elsewhere in the hospital, or working *With no on-site physician* when he or she was on call and off site.

Some participants managed the responsibility of ***I'm in Charge*** of *The hospital*, *The unit* (acute care, ED, labour and delivery), *The team* (RNs, LPNs, and HCAs), and *Contingent or emergent situations* (essentially everyone who came through the door), immediately and with little senior RN support. However, a few of the participants were provided with structured orientation supports and were not expected to manage those responsibilities until much later.

I'm A Jack of All Trades! required participants to assume some of the responsibilities of other members of the interdisciplinary team (physicians, pharmacists,

or respiratory therapists) and ancillary staff (unit clerks, medical records personnel, environmental services staff, maintenance workers, etc.) when they were off site or off duty.

Participants engaged in learning *"On the Fly"* and *By Accessing Resources* to survive and to determine ***How Do I Manage All of This Learning and Responsibility?*** Learning "*On the Fly"* occurred when participants assessed situations and then called for help or learned policies, procedures, and protocols at the bedside while providing patient care, which they described as awesome but overwhelming. Learning *By Accessing Resources* required knowing *What's what?* so as to know when to call for help, what policies, procedures, and protocols were needed, the idiosyncrasies of physicians, and what information was required. Knowing *Who's who?* enabled participants to identify their work and social supports which assisted them with managing all of the needed learning and responsibility.

As has been emphasized throughout this discussion, each participant experienced on ***An Emotional Roller Coaster Up! and Down!*** Those who were well supported by the interdisciplinary team and educational supports experienced minimal amplitude in their emotional rides, whereas those who were not experienced extreme fluctuations. In terms of ***The Decision: Stay? or Go?***, some participants found rural nursing very appealing and happily stayed, while others left because their likes and ambitions led them to more specialized work in urban centres or they felt like they did not belong due to lack of support from the interdisciplinary team. In all, participants' transition experience was ***A DOUBLE WHAMMY!***

CHAPTER 5
DISCUSSION

In this chapter, I first highlight unique findings from the current study, which add significantly to the extant knowledge about transition for new nurses into rural acute care. I then compare the context and experience of transition, labelled ***A DOUBLE WHAMMY!,*** which includes the two major nondiscrete interrelated subthemes of ***I'M A GENERALIST! and I'M IT!***, to previously published AU, CA, NZ, and U.S. research about new degree and diploma nurses' transition experiences. I chose to include published research on RNs' experiences within both rural and urban acute care settings because research specific to the rural situation was limited. These comparisons reveal how the findings of this study augment, correspond with, or differ from the extant knowledge about this phenomenon. I close this chapter with a discussion of the limitations of this study along with recommendations for rural acute care nursing education, research, practice, and policy.

A DOUBLE WHAMMY! New Knowledge

Overall, the finding revealed in this study (i.e., the phenomenon of new nurses' transition into the CA rural acute care environment was experienced as ***A DOUBLE WHAMMY!***) contributes significantly to current knowledge about transition, as to date, no researcher has published such a finding, nor have previous studies specifically targeted new rural acute care nurses. In all but one of the previous transition studies, the samples were comprised of mixed cohorts including both rural and urban nurse graduates. I also highlight other findings unique to the current study related to both contextual factors and the transition experience of ***A DOUBLE WHAMMY!***

Contextual Factors

Two new findings are related to contextual factors: information about two types of rural acute care hospitals and broad scope of practice as a reason for choosing rural acute care, discussed first. The reasons for choosing rural nursing as a first job choice were many and varied for participants, but one factor that had not previously been reported in the literature was that some participants desired a career with a broad scope of practice that promoted and enabled opportunities for independence. In particular,

participants who had previously worked in healthcare under the limited scopes of practice of HCAs or LPNs, recognized that rural nursing was a means, which offered opportunities for autonomy. While numerous researchers have identified autonomy as a hallmark of rural nursing (Baumann et al., 2006; MacLeod, 1998, 1999; MacLeod et al., 2004; MacLeod et al., 2008; Scharff, 2006, 2013; Sedgwick, 2008; Stewart et al., 2006), I found no studies to indicating that this was a reason new nurses made rural nursing their first career choice.

Interestingly and unexpectedly, as participants discussed their experiences, it became clear that there were two different types of rural acute care hospitals being referred to. For discussion purposes, I have assigned these the following two labels: the generalist-model and the urban-model. The significance of this finding is highlighted by the very different experience of the one participant who transitioned into an urban-model facility. This individual was well supported by an on-site clinical nurse educator and an on-site 24-hour ED physician and was not expected to learn the ***I'M A GENERALIST!*** role or to manage the ***I'M IT!*** role. As a result, she experienced minimal emotional fluctuation. On the other hand, participants who transitioned into generalist-model facilities experienced a wide range of emotional fluctuation, generally had no on-site clinical nurse educators or 24-hour, on-site physicians, and were expected to quickly enact the generalist role and ultimately to be *"It."* This finding speaks to the importance of researchers who may conduct future inquires in this area to clearly identify a priori the type of rural acute care hospital from which participants are to be recruited.

The Transition Experience

New findings related to the transition experience into rural acute care include the impact of nurse staffing shortages, participants' youthful or mature appearance, commuters, supportive relationships with physicians, RNs' medication work, and spirituality. What is most significant in setting this study apart from other descriptions of the transition experience, however, is the fact that the participants experienced paradoxical emotions that oscillated between being exhilarated (surprised) and overwhelmed (shocked) as they transitioned into the rural acute care environment.

The findings in this study revealed that, in order to handle critical nurse staffing shortages, many rural nurse managers fill staff shortages with agency RNs. While it is

common knowledge that this practice has gone on for years, the new findings revealed in the current study highlight the impact of those types of human resources on participants' transitions. Participants in this study found it challenging and frightening to be expected to delegate to agency RNs on night shift when no other senior RNs were available to support their decisions. According to MacLeod (1998, 1999), the availability of senior RNs is critical to assist new rural RNs in building confidence with managing ambiguous situations and deploying human resources.

Participants who appeared older in age and more mature found they were more readily trusted and accepted by rural clients because they were perceived as possessing practice maturity. This is an interesting finding that was not previously referred to in the literature, although other researchers have discussed nurses' acceptance into the community (Crooks, 2012; MacLeod, 1998, 1999; Sedgwick, 2008; Yonge, Myrick, Ferguson, Grundy, & Cockell, 2011).

The finding that nearly half of the participants commuted and, therefore, did not have to deal with issues related to lack of anonymity was significant, as these participants still felt accepted by their rural clients. They did not have to engage in community activities to gain acceptance, as others researchers have found (Crooks, 2012; MacLeod, 1998, 1999; Sedgwick, 2008). Additionally, unlike findings from other researchers (Crooks, 2012; MacLeod, 1998, 1999; Sedgwick, 2008; Stewart et al., 2006; Yonge et al., 2011), participants in the current study who commuted did not link job satisfaction, and therefore retention, with community involvement.

Working in interdisciplinary teams in the rural acute care setting involved participants learning how to effectively work and communicate with other disciplines including physicians. Overall, participants described younger physicians as most supportive and older physicians as less helpful, a finding that has not previously been reported. While Penz and Stewart (2008) had linked rural RNs' positive interactions with physicians to increased job satisfaction, they had not delineated the dynamics of those relationships. In the current study, some participants described their interactions with rural physicians as *"love-hate"* in nature, a description that both Sedgwick (2008) and MacLeod (1998, 1999) alluded to, but did not specifically report.

Although Folkmann and Rankin (2010) had identified the term "medication work" (p. 3218) in their literature review of how medication work is currently conceptualized, this work was not specific to transitions into rural nursing. Rural RNs' medication work, as described by participants in the current study, encapsulated a broad range of responsibilities and activities, which included managing the dual responsibilities to process, prepare, and administer medications while being in charge of clients, team members, and sometimes the entire unit or hospital. For some participants, these responsibilities also included managing the duties of pharmacists who worked off site. Although previously discussed by Baumann et al. (2006), MacLeod (1998, 1999), Scharff (2006, 2013), and Sedgwick (2008), none of these researchers mentioned what constituted this medication work, nor did they discuss how the associated responsibilities were experienced by new nurses.

Participants found various ways to cope with the challenges of managing the generalist role and the responsibilities of ***I'M IT!*** Three strategies that differed from any found in the literature were associated with spirituality, in which participants stopped for a moment during a crisis situation and prayed to God for help, accessed inner faith for the strength to manage difficult situations, and embraced nature to resolve inner turmoil after experiencing a challenging and stressful shift.

As previously mentioned, what most sets this study apart from other studies about transition is the fact that participants experienced ***An Emotional Roller Coaster Up! and Down!*** feeling exhilarated (surprised) one minute and overwhelmed the next (shocked). This finding contrasts markedly with the results of many CA and international studies regarding new degree and diploma nurses' transition into rural and urban acute care nursing, including literature from Australia (Kelly & Ahern, 2008; Lea & Cruickshank, 2007); Canada (Duchscher, 2008, 2009; Ellerton & Gregor, 2003; Lavoie-Tremblay et al., 2008; Lavoie-Tremblay et al., 2011; Nour, 2009); the UK (Kelly, 1996, 1998); and the US (Bowles & Candela, 2005; Hazard Munro, 1982; Kramer, 1974). These authors identified transition as a predominantly negative and shocking experience. Conversely, Baumann et al. (2006) reported that, for new nurses in Ontario, working rurally was merely "problematic" (p. 31), while MacLeod (1998, 1999) found that for British

Columbian new nurses, transition was a source of both pleasure and stress, certainly not the emotions associated with only shock.

A DOUBLE WHAMMY! The Context

Transition was influenced by many and varied contextual factors that were related to participants' demographic information (see Table 12), as well as information about the staff mix and services available in the facilities (see Table 13). In relation to the participants, contextual factors included educational preparation, rural clinical placements, previous experiences, and reasons for choosing rural: in other words, whether or not they felt prepared for practicing in the rural acute care environment and whether or not taking a rural nursing position was by choice. In terms of the facilities, the types of hospitals in which participants transitioned are addressed in the following sections.

The Participants: Prepared—or Not!

Overall, most participants in the current study perceived that their nursing education programs had not adequately prepared them for rural nursing, which is consistent with research reported over the past 30 years, wherein new degree and diploma nurses have generally felt educationally under prepared for the work encountered in acute care practice environments, be they urban or rural (Duchscher, 2009; Ellerton & Gregor, 2003; Hazard Munro, 1982; Kramer, 1974; Lee & Cruickshank, 2007; Molinari, Jaiswal, & Hollinger-Forrest, 2011; Romyn et al., 2009; Wolff et al., 2010). Participants' lack of preparedness in the current study was primarily associated with minimal exposure to labour and delivery, paediatric, and emergency patients during nursing education.

The participants who reported feeling somewhat prepared for practice in the rural acute care hospital environment were those who benefited from relevant hands-on experiences during rural clinical rotations, rural preceptorships, or tertiary emergency preceptorships during their basic nursing educations. These findings support earlier research, which indicated that rural preceptorships increase students' clinical competencies, self-confidence, critical thinking skills (Myrick, 2002; Yonge et al., 2011), and feelings of belonging to the rural acute care interdisciplinary team (Sedgwick, 2011;

Yonge, Myrick, Ferguson, & Grundy, 2013). MacLeod et al. (2008) recommended that nursing education should be as "hands on as possible" (p. 2) to promote critical thinking skills and to reduce the "fear factor" (p. 2) that is a "big limiting factor" (p. 2) in the rural acute care environment. Had Baumann et al.'s (2006) rural Ontario participants who reported transition as merely "problematic" (p. 31), experienced an increase in rural content in their curricula? This contextual information was not included in their study results. Therefore, while researchers have repeatedly recommended including content and practice specific to rural nursing in entry-level nursing education programs (Baumann et al., 2006; Kenny & Duckett, 2002; MacLeod et al., 2008; Wolff et al., 2010), current CA entry-level educational preparation initiatives for rural nursing are not easily discoverable beyond mention that rural acute care hospitals can provide a good context for the acquisition of entry-level competencies (College and Association of Registered Nurses of Alberta, 2013; College of Registered Nurses of British Columbia, 2013).

In terms of past experience, participants who had previously worked as undergraduate nurses, LPNs, or HCAs found that those experiences had minimally eased their transition experiences. However, some participants mentioned that skills learned in previous nonhealth related work helped to ease their transitions because they had some experiences to "fall back on." These findings support Lea and Cruickshank's (2007) contention that previous employment of any kind reduced the fear of the unknown associated with new nurses' transition into AU rural practice settings.

The Participants: Rural by Choice—or Not!

Predominant motives for choosing to work rurally were related to participants' type and scope of practice, desire to live in a small community, and personal relationships. As previously discussed, the type and scope of practice, as a reason for making rural acute care a first job choice, was a new finding, both in relation to individuals who had worked in rural acute care hospitals in different capacities or to those who had experienced rural nursing as students. Additionally, one participant mentioned a nurse educator who had influenced her desire to work rurally because she had repeatedly stated, "*If you can work rural, you can do anything."* This finding supports the work of Kanto (2004), who wrote that early health care exposure and health

care professionals' advice could impact students' career decisions, as well as the work of Hendricks, Mennenga, and Johansen (2013) and Yonge et al. (2011), who opined that positive rural clinical placements were a good recruitment strategy for rural acute care hospitals.

The desire to live in a rural community and the influence of personal relationships align with Molinari et al.'s (2011) U.S. findings about lifestyle preferences and Baumann et al.'s (2006) findings, that new nurses in Ontario tended to seek employment in rural nursing if they had been born and raised in a rural area or were accompanying a partner who wished to reside in a rural area. Winters and Lee (2010) later posited that emotional ties to the land and familial or social networks influenced new nurses' job choice.

The Facilities

An unexpected and new finding was that the hospitals referred to in the current study were of two types: a generalist model and an urban model. It is important to note that the definition of rural used to recruit participants for the current study (a facility located in a community of greater than 10,000 people, and designated as rural in one of Alberta's health services regions) fits best with the urban-model facility, although this distinction had not yet been identified and indeed was not revealed until near the end of data collection. Only one participant was recruited from that type of facility, and she did not experience the full impact of ***A DOUBLE WHAMMY!*** Could it be that this was simply her personality, or did the supports and type of hospital model influence her transition?

All other participants in the current study had transitioned into rural generalist-model facilities that were comprised of two or three units consisting of an acute care ward, ED, and in some facilities also an operating room and labour and delivery room. Most participants described their learning as *"hands on," "huge,"* and sometimes *"overwhelming,"* and their responsibilities as oscillating between *"wickedly awesome"* and *"exhilarating"* to *"terrifying"* and *"unsafe."* Some of the findings from the current study are in keeping with new nurses' emotions of feeling overwhelmed and fearful, which Lea and Cruickshank (2007) found to be associated with new nurses' transitioning into AU rural acute care environments. However, the feelings of *"exhilaration"* (surprise) experienced by participants in the current study differ significantly from the

emotions signifying shock described by most new degree and diploma nurses as reported in the literature (Bowles & Candela, 2005; Duchscher, 2008, 2009; Ellerton & Gregor, 2003; Hazard Munro, 1982; Kelly, 1996, 1998; Kelly & Ahern, 2008; Lavoie-Tremblay et al., 2008; Lavoie-Tremblay et al., 2011; Lea & Cruickshank, 2007).

A DOUBLE WHAMMY! The Experience

Based on the study findings, I have labelled the transition experience of participants in the current study into the rural Alberta acute care environment ***A DOUBLE WHAMMY!*** While no other nurse researchers have used similar terminology to describe this phenomenon, Vapor and Xu (2011) had used the term to describe Filipino physicians-turned nurses' transition into U.S. hospitals, wherein adjustment to a new culture and work environment was one whammy, and role change from physician to nurse was the other. The only other information found in the nursing literature pertaining to a "double whammy" (CITE) was a report from the U.S. National Broadcasting Corporation (September 3, 2013), which indicated that lack of nurse faculty and frontline nurse shortages have created a double whammy for health care in the US. Other studies that included mention of a double whammy were from the social sciences in relation to foster children who have dealt with the dual challenges of disabilities and foster care (Keon & Kirby, 2006), and in the technology literature in reference to female students' who were transitioning into computer science programs (Lang, 2001). I could find no literature associated with new nurses' transition that included any findings similar to the themes of ***I'M A GENERALIST! and I'M IT!***, or the paradoxical emotions experienced by participants in the current research. However, Vapor and Xu (who, as mentioned earlier, had used the term double whammy) had identified that Filipino physicians-turned nurses did experience shock similar to that described by Kramer (1974), Duchscher (2009), and Nour (2009).

Interestingly, I retrieved several studies in which the findings or results held strong similarities to the major themes and categories generated in this study including ***I'M A GENERALIST!***, which encompassed *How to change hats, How to manage responsibilities,* and *Confidentiality and lack of anonymity* ***and I'M IT!***, which encompassed ***I'm Alone!***, ***I'm In Charge!***, and ***I'm A Jack of All Trades!*** (Baumann et al., 2006; Crooks, 2007, 2012; Hegney, Pearson, & McCarthy, 1999; Long & Weinert,

2013; MacLeod, 1998, 1999; Rosenthal, 2006; Scharff, 2006, 2013; Sedgwick, 2008; Yonge et al., 2011). Although the labels these researchers chose differed, the findings from this study do support previous research findings, as well as shed new light on them.

Two studies had informed the original literature review for this study because the samples included new nurses working in rural acute care hospitals; however, the findings of those studies did not pertain specifically to transition. MacLeod (1998, 1999) had included RNs who had worked rurally at least 1 year, in northern British Columbia rural and remote hospitals; and Baumann et al. (2006) had included new nurses working in Ontario rural acute care hospitals. Nonetheless, findings from the current study support many of their findings, as evidenced in the discussion that follows.

To capture the interplay and overlap between participants' often simultaneous experiences of ***I'M A GENERALIST! and I'M IT!*** (see Table 15) and the concomitant learning and responsibilities associated with these experiences, along with ***How Do I Manage All of This Learning?*** — *"On the Fly"* and *By Accessing Resources* (see Table 16), the ensuing discussion comparing the findings to the literature incorporates both experiences together under the following subheadings: The Rural RN Role, The Team, The Organization, and The Clients, Family, and Community. This approach ameliorates some of the repetition inherent in a discussion of such interwoven, nondiscrete categories.

I'M A GENERALIST! and I'M IT! So Much to Learn and Even More Responsibility

The major themes of ***I'M A GENERALIST! and I'M IT!*** support the findings of studies from Australia (Lea & Cruickshank, 2007; Hegney et al., 1999; Kelly & Ahern, 2008), Canada (Baumann et al., 2006; MacLeod, 1998, 1999; Sedgwick, 2008), and US (Rosenthal, 2006; Scharff, 2006, 2013) investigating the role and practices of rural generalist RNs. In study after study, rural generalist RNs have been described as nurses who need to have a broad range of knowledge and clinical skills; the ability to be flexible; the skills to multitask; the capacity to competently and adeptly manage contingent situations; and the capability to undertake a high level of responsibility, including being "it" (Baumann et al., 2006; Hegney et al., 1999; Long & Weinert, 2013;

MacLeod, 1998, 1999; MacLeod et al., 2008; Rosenthal, 2006; Scharff, 2006, 2013; Sedgwick, 2008).

Table 15

A Double Whammy!—An Interplay of the Findings

I'M A GENERALIST! (with so much learning)	***I'M IT!*** (with even more responsibility)
The Rural RN Role (What do I need to know?) How to Change Hats Adaptability Prioritizing Anticipatory planning How to Manage the Role Related to policies, procedures, protocols Related to routine care Related to team nursing Related to taking call Related to helping out wherever Related to acting as a resource Related to ***I'M IT!***	**I'm Alone!** The sole RN on shift As the only body available With no on-site physician **I'm in Charge!** Of the hospital Of the unit Of the team Of Contingent or emergent situations **I'm a Jack of All Trades!** Fulfilling the duties of: Other professionals Ancillary staff
The People Who are they? How do I fit in? Staff in general Nurses Nurse managers Clinical nurse educators Clients Who am I? How do I cope? Confidence level Values Likes and ambitions Personal coping strategies	
The Place The Facility Physician services Pharmacist services Nursing services Unit culture Educational supports Financial Orientation Equipment The Community Confidentiality Lack of anonymity	

Note. RN = registered nurse.

While these researchers have clearly identified rural nurses' perceptions of their generalist role and being "it" (Baumann et al., 2006; Hegney et al., 1999; Lea & Cruickshank, 2007; Long & Weinert, 2013; MacLeod, 1998, 1999; MacLeod et al., 2008; Rosenthal, 2006; Scharff, 2006, 2013; Sedgwick, 2008), none have specifically studied the impact of that role and being "it" on the phenomenon of transition as it relates to new nurses in the rural setting. Therefore, findings in the current study not only reveal new knowledge about this phenomenon, previously discussed, but also add to the existing knowledge about the role and practices of rural generalist RNs.

Table 16

How do I Manage All of This Learning and Responsibility?

On the Fly
By Accessing Resources
What's What?
When do I need to call for help?
What procedures, policies, or protocols do I need to use?
What are the idiosyncrasies of the physicians?
What information do I need to access and how?
Who's Who? (Who will support me?)
Work Supports
Social Supports

The rural RN role. Enacting the role of the rural RN, required participants to learn new knowledge related to the role of the generalist nurse, including such things as changing hats, policies, procedures, protocols, ward routines, as well as diagnoses, skills, treatments, and about how to manage the new responsibilities of helping out wherever, taking call, acting as a resource, and ***I'M IT!*** The role of ***I'M IT!*** required participants to manage the responsibilities of ***I'm Alone!***, ***I'm In Charge!***, and ***I'm A Jack of All Trades!***

The discussion will begin with the skill of changing hats because participants found that immediately upon entering the rural acute care environment they were required to constantly realign their thinking in order to provide care to complex and

diverse patients with dissimilar diagnoses and of varying ages. Consequently, transition began with participants attempting to learn as much as they could about the skill of *Changing hats* so as to be nurses who could manage the responsibilities associated with ***I'M A GENERALIST! and I'M IT!***

I'M A GENERALIST! Changing hats. Changing hats is a skill that has been discussed by numerous researchers in terms of senior rural RNs (Baumann et al., 2006; Hegney et al., 1999; MacLeod, 1998, 1999; MacLeod et al., 2008; Rosenthal, 2006; Scharff, 2006, 2013; Sedgwick, 2008; Yonge et al., 2011). In fact, Hegney et al. (1999) previously referred to this skill of changing hats as that of being a "jack of all trades" (p. 25), "wearing many hats" (p. 25), and "being flexible" (p. 25). Long and Weinert (2013) also referred to this skill as being a "jack of all trades" (p. 10).

However, the data from the current study indicated that changing hats and ***I'm a Jack of All Trades!*** represented two relatively distinct findings. Changing hats was in reference to participants engaging in the range of nursing work and roles related to patients representing a mixture of ages, life stages, diagnoses, and cultures, while moving from room to room, area to area, or unit to unit, frequently all in one shift. Changing hats required nurses to adapt, prioritize, and anticipatory plan, findings that support Hegney et al.'s (1999) earlier descriptions of the skills needed by rural generalist RNs. On the other hand, ***I'm a Jack of All Trades!*** constituted the additional responsibilities of ***I'M IT!*** and of participants fulfilling the duties of other professionals on the interdisciplinary team (e.g., physicians, pharmacists, and respiratory therapists) and ancillary staff (e.g., unit clerks, maintenance staff, environmental services personnel), in addition to managing their own nursing workloads, which supports Long and Weinert's (2013) description of a Jack of all trades.

The changing hats skill of adaptability required participants to learn how to be flexible and open to respond to new, different, challenging, or critical situations, to competently perform infrequently used skills, and to care for clients of all ages, of diverse cultures, and with a range of diagnoses, which supports previous descriptions of the role of a rural RN (Baumann et al., 2006; Hegney et al., 1999; MacLeod, 1998, 1999; MacLeod et al., 2008; Scharff, 2006, 2013; Sedgwick, 2008). Participants learned about differences in cultures and subcultures when managing cultural norms and rituals

surrounding death and dying, dietary regimes, and specific diseases prevalent in some ethnic groups, which support Bushy's (2012) descriptions about the dissimilarities in health problems and diverse values surrounding health and illness in relation to U.S. rural patients. Participants were challenged with language barriers, an issue previously reported by the Canadian Association for Rural and Remote Nursing (2008) as problematic in rural acute care environments. Of concern was that, although Srivastava (2007) had recommended that Aboriginal liaison personnel or language translators provide support to ensure culturally competent care, few participants reported receiving this form of support. These participants were learning *"on the fly"* about how to provide culturally sensitive care and to creatively adapt their care practices to accommodate each situation. While the term *"on the fly"* was not found in the literature relating to rural acute care hospital nursing, it was used similarly by Manitoba home care nurses to describe how they were learning to care for culturally diverse rural palliative patients (Kaasalainen et al., 2012).

Changing hats as the rural RN required participants to learn to care for palliative patients as they moved from room to room. This type of nursing tested their values and generated paradoxical emotions of reward and personal growth (surprise), but also stress and anxiety (shock), similar to Ontario home care RNs who were caring for rural palliative patients in their homes (Sevean, 2012). However, the emotions of surprise and shock experienced by participants in the current study differed from the high levels of anxiety (shock) experienced by new nurses in CA urban settings who were caring for critically ill or dying patients (Duchscher, 2008).

Changing hats required participants to learn how to prioritize, especially when managing emergent situations, which is consistent with earlier studies in which the role of the rural RN has been described (Baumann et al., 2006; Hegney et al., 1999; MacLeod, 1998, 1999; Scharff, 2006, 2013; Sedgwick, 2008). While some participants appreciated the autonomy associated with prioritizing, others were dissatisfied with this aspect of their role, which supports Hegney et al.'s (1999) earlier findings surrounding senior RNs' emotions associated with prioritizing. Participants described prioritizing as sometimes generating *"sink or swim"* feelings in reference to their perceptions of having inadequate knowledge, ability, confidence, and instincts. These feelings echo Romyn et

al.'s (2009) findings in which rural and urban new nurses described being "in over my head" (p. 8), "barely tread[ing] water" (p. 8), and "almost sinking" (p. 8).

Changing hats required participants to use anticipatory planning so as to be able to manage ambiguity and contingent situations and was a key component to them feeling prepared and safe in their practices, which supports MacLeod's (1998, 1999) earlier contention that the role of the rural generalist RN required nurses to deal with lack of structure, think one's way through a situation, anticipate what would need to happen, and determine what resources to mobilize. As a result, changing hats could initially be intimidating and stressful for participants, a finding reported by Lea and Cruickshank (2007) and MacLeod (1998, 1999). However, at other times, changing hats was exciting and empowering for participants, thereby corroborating the experiences of pleasure described by MacLeod (1998, 1999).

I'M A GENERALIST! How to manage the role and responsibilities. Although most participants were provided with adequate access to policies, procedures, and protocols, recommendations previously made by MacLeod (1998, 1999) and Tupper et al. (2008), they often learned roles and responsibilities "*on the fly"* because they lacked access to adequate post hire educational supports due to heavy workloads, inadequate staffing, lack of clinical educator support, and professional isolation. Other rural CA (Penz et al., 2007; Stewart et al., 2006; Stewart et al., 2011) and U.S. (Hendrickx, 2006; Jukkala, Henly, & Lindeke, 2008) nurses have reported these same barriers. The findings from the current study are in stark contrast to recommendations from earlier research (Baumann et al., 2006; MacLeod et al., 2008; Penz et al., 2007) that appropriate and adequate educational supports should be provided to RNs in CA rural acute care hospitals.

The findings in the current study revealed that participants who worked in hospitals at which obstetrical services were provided learned about the policy of one-to-one RN care for maternity clients in active labour. This policy was challenging for participants to follow because it required the rest of the team picking up the slack, which supports MacKinnon's (2011) earlier descriptions about the many and varied responsibilities of managing maternity patients in rural acute care hospitals in British Columbia. Participants who were expected to manage the dual roles of one-to-one

maternity nursing care and being in charge without the support of *The team* or *The organization* found the responsibilities very challenging, not unlike the British Columbian nurses (MacKinnon, 2011). Those challenges will be addressed under the category ***I'M IT!—I'm In Charge!***

Learning about taking call was described by one participant as challenging and exhausting because she was expected to be on call, come in when called no matter what the time of day, work a full shift the next day, and perform advanced practices, as previously reported by Stewart et al. (2006). In fact, Stewart et al. referred to taking call as one of the predictors of intent to leave the rural acute care environment. In addition, participants found that learning how to help out wherever needed in the rural acute care hospital, without orientation, was stressful and frustrating, as Duchscher (2008) and Nour (2009) previously reported.

The findings in the current study revealed that participants were expected to mentor new staff within their first year of practice due to senior RN shortages, which Duchscher (2008) previously described in a study examining new nurses' transition into urban acute care environments. Participants in the current study also preceptored nursing students, but no other researchers had reported this. These findings are not surprising considering the current high CA senior RN retirement rates (CIHI, 2012). Participants in the current study described this level of responsibility as *"surprising," "confusing,"* and *"scary";* I interpreted these latter two feelings as *"shock."* While the feeling of shock parallels Duchscher's (2008) report of new nurses' disillusionment and fear, the current study's participants' feelings of surprise differed and were rooted in thinking they had little to contribute to other new RNs' and nursing students' learning. *"Stepping up"* to the challenge helped to ensure that there would be enough nurses to provide care, a finding that supports MacKinnon's (2011) earlier contention about rural British Columbian nurses. Another participant who had worked in the rural acute care environment for nearly two years was surprised when newer RNs considered her a knowledge resource, not unlike new nurses in Duchscher's (2008) study who had gradually, and without realizing it, grown in their abilities to assist others. However, unlike the new nurses in Duchscher's (2008) study who found this level of responsibility

stressful, the participants within the current study found mentoring other nurses to be *"awesome"* as well as *"nerve-wracking."*

I'M IT!—I'm in charge! Participants in the current study learned that managing the responsibility of ***I'M IT!—I'm In Charge!*** required learning how to collaborate with the varying members of the interdisciplinary team, which takes time according to Sedgwick (2011) and Yonge et al. (2013) in terms of CA rural acute care hospital interdisciplinary teams; understanding the scope of practice of each team member, as reported by Kvarnstrom (2008) on Swedish rural and urban interdisciplinary teams and Nolte (2005) in relation to CA rural and urban interdisciplinary teams; and an ability to coordinate the patient-care team as reported by Propp et al. (2010) in reference to U.S. urban acute care interdisciplinary teams. In addition, the experience of ***I'm In Charge!*** was influenced by contextual factors including participants' confidence and competence levels and evolving contingencies that unfolded on each shift; these factors were linked to the stress experienced by participants when managing ambiguous and critical situations, which corroborates researchers' findings from previous studies of senior rural RNs (Baumann et al., 2006; Hegney et al., 1999; MacKinnon, 2011; MacLeod, 1998, 1999; Scharff, 2006, 2013; Sedgwick, 2008). The current study participants' perceived their confidence levels to be based on their skill sets, knowledge bases, communication skills, and expectations, and found these attributes to be challenged when they were immediately expected to manage the responsibility of ***I'm In Charge!*** These findings support MacLeod's (1998, 1999) previous contentions about confidence levels of rural RNs in British Columbia and Kvarnstrom's concerns regarding the need for interdisciplinary team members to be confident in their knowledge bases and skill sets in order to effectively collaborate with their team members.

Participants in the current study reported worrying about managing the responsibility of ***I'm In Charge!*** of the acute care unit while simultaneously expected to manage one-to-one nursing care of maternity patients because nurse shortages, lack of experienced senior RNs, and the need to manage contingent and emergent situations left them feeling unsafe, which corroborates MacKinnon's (2011) earlier findings of rural British Columbian RNs. One-to-one nursing care is a standard recommended by the Society for Obstetricians and Gynaecologists of Canada entitled *"Recommendation 8:*

Professional One-to-One Care and Intrapartum Foetal Surveillance" (Liston, Sawchuck, & Young, 2007, p. S28).

Participants in the current study who were supported by experienced nurses either on site or off site and on call, described feeling better able to manage the dual responsibilities of ***I'm In Charge!*** and the standard of one-to-one nursing care. Of note is that only one participant described feeling well supported by adequate nursing team and educational supports, a finding that differs from MacKinnon's (2011) contention that rural RNs in British Columbia safeguarded their maternity patients by providing unpaid on-call services. While a few participants worked with senior RNs who would provide unpaid on-call support if they were asked, some participants had no back up at all; those situations were described as *"harrowing"* and *"unsafe"* because participants knew that they needed help, but help was not available, as MacKinnon previously reported.

Consequently, participants were stressed when in charge and providing one-to-one nursing maternity care because they were unable to provide timely care to those on the ward who needed it, which differs from MacKinnon's (2011) finding that British Columbian nurses were afraid of losing their nursing licenses due to not meeting the Society for Obstetricians and Gynaecologists of Canada standard (Liston et al., 2007). In fact, only one participant expressed worry about jeopardizing her nursing license, but, differing from MacKinnon's findings, her concern was due to feeling inadequate to make accurate decisions about emergent maternity situations that involved transfers out, which supports researchers' earlier reports about new nurses' lack of confidence (Duchscher, 2008; Kramer, 1974; Nour, 2009).

On a different note, but still in terms of managing the responsibility of ***I'm In Charge!***, most participants in the current study were expected to fulfill the dual roles of "medication work" (Folkmann & Rankin, 2010, p. 3218) and ***I'm In Charge!*** of the hospital, the unit, the team, or managing contingent and emergent situations. Participants in the current study reported medication work, which encapsulates a broad range of activities and responsibilities well beyond obvious medication administration practices (Folkmann & Rankin, 2010), coupled with other responsibilities to challenge their moral integrity because it differed from the values and standards they had learned in their nursing education, which supports Kelly's (1998) theory of Preserving Moral Integrity.

In a recent conversation, Folkmann (now Dyjur), noted that the literature related to rural medication work is scant at best (L. Dyjur, personal communication, January 24, 2014); therefore, the findings in the current study related to medication work are new and significant.

Participants who were well supported by senior RNs, the interdisciplinary team, and educational supports described ***I'm In Charge!*** as an empowering and good experience that made them *"nervous"*; this finding was similar to RNs in MacLeod's (1998, 1999) study who were well supported, and was certainly not the shock described by new nurses who had transitioned into rural and urban acute care units located in Australia (Kelly & Ahern, 2008; Lea & Cruickshank, 2007), Canada (Duchscher, 2008, 2009; Ellerton & Gregor, 2003; Lavoie-Tremblay et al., 2008; Lavoie-Tremblay et al., 2011; Nour, 2009), NZ (McKenna et al., 2003), and the US (Bowles & Candela, 2005; Hazard Munro, 1982).

Conversely, participants who were immediately managing the responsibility of ***I'm In Charge!*** without the support of senior RNs or the interdisciplinary team described it as generating paradoxical emotions that oscillated between exhilaration and panic, which differs from the shock experienced by numerous other new degree and diploma nurses' during transition (Bowles & Candela, 2005; Duchscher, 2008, 2009; Ellerton & Gregor, 2003; Kelly, 1996, 1998; Kelly & Ahern, 2008; Lea & Cruickshank, 2007; McKenna et al., 2003; Romyn et al., 2009). Participants in the current study encountered situations in which there was no one to rely on or to ask questions when they lacked the knowledge needed to manage critical situations and deploying of resources; this is a recurring issue in rural acute care environments that Hegney et al. (1999), MacLeod (1998, 1999), Baumann et al. (2006), Scharff (2006, 2013), and Sedgwick (2008) previously reported. The fact that participants lacked senior RN support is concerning because MacLeod (1998, 1999) had previously contended that a great majority of rural RNs' learning is accomplished through verbal communications, not documentation, and this learning is essential for nurses to function effectively in the rural acute care hospital environment. The current study's findings corroborate researchers' earlier concerns about the impact of senior RN turnover rates, RN shortages, and inadequate staffing on inexperienced staff (Baumann et al., 2006; MacKinnon, 2011).

I'M IT!—I'm a Jack of all trades! Participants in the current study were expected to be ***A Jack of All Trades*** assuming the responsibilities of other professionals on the interdisciplinary team and ancillary staff, in addition to meeting the responsibilities of their own workloads; this finding has been repeatedly reported in the literature as characteristically unique to rural nursing (Baumann et al., 2006; CARRN, 2008; Hegney et al., 1999; MacLeod, 1998, 1999; Rosenthal, 2006; Scharff, 2006, 2013; Sedgwick, 2008). A key expectation of being ***A Jack of All Trades*** for participants was to move from role to role, which, according to Scharff (2013), requires being an "ace" (p. 252) and "pinch hitter" (p. 252) or someone who can effortlessly and seamlessly move from role to role and manage any role that is required (see also Scharff, 2006). I found it noteworthy that Scharff (2013) also referred to "aces" and "pinch hitters" as "expert generalists" (p. 247). Why is it then that some participants were immediately expected to manage the responsibilities of expert generalists while others were not?

System issues of RN shortages and lack of senior RNs (CIHI, 2012) had catapulted participants into taking on the responsibilities of ***I'm A Jack of All Trades!*** and trying to manage the advanced practices of off-site on-call physicians, which corroborates Lea and Cruickshank's (2007) earlier findings relating to the responsibilities taken on by new nurses in AU rural acute care environments. ***I'm A Jack of All Trades!***, in this sense, required participants in the current study to deliver babies without a physician present, to manage trauma or emergent patients in the ED until the arrival of the off-site, on-call physician, or to provide direction to new locums during specialized procedures in the ED; Scharff (2006, 2013), Rosenthal (2006), and Sedgwick (2008) described these practices as those of expert generalists. The participants in the current study reported often performing those practices *"on the fly at the bedside"* without the experience, knowledge level, and confidence needed to effectively function in this expanded role, which supports Lea and Cruickshank's (2007) earlier findings about the responsibilities expected of new nurses in AU rural acute care hospital environments. While the interdisciplinary boundaries between rural acute care hospital physicians and nurses have previously been documented as blurred (Scharff, 2013), it is worrisome that in the current study some participants were placed in positions, in which they felt unable to maintain safe nursing practice boundaries.

Participants who were well supported by the nursing team, interdisciplinary team, or *"the organization"* admitted to being quite confident in their abilities to make good assessments and to effectively communicate those assessments to off-site physicians, which differs from Kramer's (1974), Duchscher's (2008), and Nour's (2009) contentions that new nurses lack the confidence needed to function in critical situations at the bedside. However, participants who were not well supported acknowledged that they indeed lacked the confidence needed to manage those types of responsibilities, as previously contended by MacLeod (1998, 1999) about inexperienced rural British Columbian RNs. One participant was even managing those responsibilities alone as the sole RN in the hospital, which supports Andrews et al.'s (2005) and Stewart et al.'s (2006) earlier results in relation to RNs working in CA rural and remote hospitals alone.

Surprisingly, participants in the current study described the responsibility of ***I'm A Jack of All Trades!*** for physicians as generating paradoxical emotions that oscillated between *"exhilaration"* (surprise) and *"panic"* (shock), similar to the pleasure and stress identified by British Columbian rural RNs (MacLeod, 1998, 1999). These findings differ from the shock previously described in the literature in relation to new nurses who had managed higher level responsibilities in urban settings (Duchscher, 2009; Kramer, 1974; Nour, 2009).

Another challenge for participants was the system issue of pharmacist shortages (Alberta Health and Wellness, 2008; "The Role of Pharmacists," 2012) that contributed to lack of on-site pharmacists in some facilities. In those situations, participants were expected to be ***A Jack of All Trades*** for the off-site pharmacists, which is a new and significant finding. Although MacLeod (1998, 1999), Scharff (2006, 2013), Stewart et al. (2006), MacLeod et al. (2008), and Sedgwick (2008) alluded to rural RNs routinely taking on the responsibilities of pharmacists, none completely described how those duties have been fulfilled. One participant believed that lack of pharmacy services where she worked created inequities for her rural acute care hospital patients because she was unable to provide them with timely and appropriate care, which supports Kaasalainen et al.'s (2012) concern regarding issues surrounding inequities in care for Manitoba rural home care patients.

Most participants were expected to be ***A Jack of All Trades*** and to fulfill the duties of ancillary staff, which is in keeping with earlier findings in the literature (Baumann et al., 2006; Hegney et al., 1999; MacLeod, 1998, 1999; Scharff, 2006, 2013; Sedgwick, 2008). Some described managing those duties as annoying because it was not what they had signed up for and frequently pulled them away from providing patient care, which echoes concerns previously expressed by Hegney et al. (1999). Many participants in the current study deemed their role to be different from their urban counterparts because of the need to fulfill the duties of others, which corroborates earlier findings within the literature (Hegney et al., 1999; MacLeod, 1998, 1999; Scharff, 2006, 2013).

I'M IT!—I'm alone! Participants in the current study who transitioned into smaller facilities were immediately and often expected to work alone, which supports Lea and Cruickshank's (2007) previous findings about new nurses located in Australia being expected to manage alone. However, participants described that expectation as surprising and shocking, a finding which differs from the shock experienced by AU new nurses (Lea & Cruickshank, 2007). One participant in the current study, who worked as the sole RN in the hospital, was immediately expected to be ***A Jack of All Trades***, and manage the advanced practice role for physicians, felt comfortable and confident with the knowledge and skills needed to manage her first code alone, which differs from MacLeod's (1998, 1999) contention that inexperienced rural RNs often narrowly focus their attention when managing critical situations and Benner's (1984) and Duchscher's (2008) arguments that novice nurses are not equipped to manage the critical thinking required in emergent situations. However, this participant did admit to feeling frightened, but only because she was unsure of how to rapidly mobilize limited resources, thereby supporting MacLeod's (1998, 1999) earlier finding about inexperienced rural RNs in British Columbia. I found it interesting that this participant felt confident enough in her skills and abilities to manage those advanced practice responsibilities. Could it be that she had been well prepared for working alone or was well enough supported by the off-site interdisciplinary team to manage being alone? Notably, she had participated in a rural preceptorship during her basic education and was supported by interdisciplinary team members she considered to be like family, similar to Sedgwick's (2008) construct

of "we're family" (p. 66). She certainly did not fit Benner's (1984) definition of a novice nurse.

Notably, Andrews et al. (2005) identified RNs who worked alone in rural and remote settings as significantly older than other nurses practicing in similar settings and as nearing retirement. There is no doubt that high current CA senior RN retirement rates (CIHI, 2012) will impact the number of inexperienced new nurses who will soon be working alone in rural acute care hospitals.

Low staffing levels, particularly on night shifts, left some participants in the current study experiencing ***I'm Alone!*** as the only body available and needing to be a ***Jack of All Trades*** for physicians even when other RNs or physicians were in the building due to simultaneously occurring emergencies and lack of adequate staffing, which supports previous reports by Baumann et al. (2006), MacLeod (1998, 1999), Scharff (2006, 2013), and MacKinnon (2011) about the nature of the rural acute care hospital environment. Participants and their colleagues would stretch resources in every direction they could in order to provide adequate care for their patients; these situations were described as *"harrowing," "unsafe,"* and rendering feelings of helplessness and panic, as MacLeod (1998, 1999) and MacKinnon (2011) previously reported.

On the other hand, the participant who transitioned into the urban-model facility with 24-hour physician support in the ED was not expected to be a ***Jack of All Trades*** by fulfilling the responsibilities of physicians or managing the responsibility of ***I'm Alone!***, which lends to Duchscher's (2008) and Nour's (2009) previous findings regarding new nurses transitioning into urban acute care environments. This participant from the current study experienced very little fluctuation in her emotional roller coaster, which differs significantly from the shock described by Kramer (1974), Duchscher (2008, 2009), and Nour (2009). Similarly, participants who had transitioned into generalist-model facilities and were well supported by structured orientation programs seldom experienced the responsibility of ***I'm Alone*** during their first few months of practice, which corroborates reports about AU posthire transition programs (Cubit & Ryan, 2010; Ostini & Bonner, 2012) and US posthire residency programs (Keahey, 2008; Meyer Bratt, 2009; Ulrich et al., 2010).

Learning on the fly. The fact that participants in the current study were learning *"on the fly"* is alarming because many researchers have suggested that new degree and diploma nurses do not have the knowledge, confidence, or critical thinking skills needed to manage such situations (Benner, 1984; Duchscher, 2003, 2008, 2009; Lea & Cruickshank, 2007; MacLeod, 1998, 1999; MacLeod et al., 2008). In conjunction with learning *"on the fly,"* participants readily recognized the need to support their learning *By accessing resources*.

By Accessing Resources. Participants were accessing resources including education days, independent learning sources, on-site in-services, and on- or off-site certification courses recommended for rural acute care hospital nursing, which is consistent with continuing education resources accessed by other CA rural RNs (Baumann et al., 2006; MacLeod et al., 2004; MacLeod et al., 2008). On a positive note, financial support was readily available for participants to attend educational sessions, which differs from a report by Baumann et al. (2006) and the results of a CA national survey conducted by Penz et al. (2007), wherein rural RNs were expected to assume their own professional development costs. Perhaps times have changed?

Nonetheless, findings from the current study did reveal numerous barriers to continuing education for participants consisting of facility, time, and access constraints, as researchers have previously identified (Baumann et al., 2006; Jukkala et al., 2008; MacLeod et al., 2004; MacLeod et al., 2008; Penz et al., 2007; Stewart et al., 2011). Of those, the three most significant barriers that impacted participants' continuing education were nurse shortages, lack of access to clinical nurse educators, and courses that required travel and the extra costs associated with travel.

Nurse staffing shortages were the norm in the current study and influenced whether or not participants could attend continuing education courses, as often there were not enough staff left on shift to care for clients, which corroborates previous results from Penz et al. (2007) and Stewart et al. (2011). Consequently, a greater burden was placed on the experienced overworked RNs to complete tasks the new nurses had not learned and unsafe practice situations prevailed because some participants were expected to manage the responsibilities of ***I'M A GENERALIST! and I'M IT!*** without timely access to appropriate educational supports, both of which corroborate previous findings

regarding RNs' lack of education supports (Lea & Cruickshank, 2007; Romyn et al., 2009).

Lack of on-site clinical nurse educators was an issue that significantly influenced the degree of difficulty associated with participants' accessibility to continuing education. The greatest influence has been the erosion of the clinical nurse educator role in rural and urban hospitals across Canada (Romyn et al., 2009). Three previous CA studies by MacLeod et al. (2008), Penz et al. (2007), and Stewart et al. (2011) and one U.S. study by Olade (2004) revealed that many rural RNs lacked access to clinical nurse educators, which had contributed to lack of evidence-based practices in those environments. One participant in the current study recommended that clinical nurse educators travel in teams to provide on-site in-services at rural acute care facilities to keep rural nurses' practices up to date, which supports previous recommendations put forth by MacLeod et al. (2008) and Habjan, Kortes-Miller, Kelley, Sullivan, and Pisco (2012) regarding the need to improve rural RNs' access to continuing education.

Most participants in the current study described travelling for education as extremely burdensome, which differs from MacLeod and Zimmer's (2005) earlier findings that travelling for education was not an issue for some senior rural RNs in British Columbia. However, this finding does support concerns expressed within the literature relating to other CA and U.S. rural RNs' lack of access to continuing education (Jukkala et al., 2008; Penz et al., 2007; Stewart et al., 2006).

The team. The ***I'M A GENERALIST!*** theme encompassed participants learning about ***The People*** who worked in the rural acute care environment. Participants typically worked in interdisciplinary teams that consisted of nurses (RNs, LPNs, HCAs), senior RNs, nurse managers, clinical nurse educators, physicians, pharmacists, support staff, and sometimes experts from urban facilities. Participants in the current study learned that fitting in with the interdisciplinary team was integral to managing the responsibilities associated with ***I'M IT!—I'm In Charge!*** (as previously discussed) and required understanding each team member's scope of practice (Kvarnstrom, 2008; Nolte, 2005) and learning how to collaborate with the various members of the team (Propp et al., 2010; Sedgwick, 2011; Yonge et al., 2013). In addition, they were learning about their

own confidence levels, values, likes and ambitions, spirituality, and personal coping strategies.

Participants in the current study learned that rural RNs possessed an unspoken knowledge about their interdisciplinary team mates and that each member's experience, role, effort, and personality contributed to the dynamics of the team. These are findings that MacLeod (1998, 1999), Sedgwick (2008) and Scharff (2013) previously reported. Knowing the traits of team members enabled participants to know who could be trusted, who had what skill set on the team, and whether or not the team was strong or weak, knowledge that influenced prioritization and delegation of duties and which corroborates MacLeod's (1998, 1999), Scharff's (2013), and Sedgwick's (2008) earlier findings.

For participants in the current study, their fit with the interdisciplinary team was unique to each individual, central to their transition experience, and depended on how well they were able to establish and maintain positive working relationships with the various team members, as other researchers previously reported (McKenna & Newton, 2007; Romyn et al., 2009). Positive working relationships took time to develop, and consisted of collaborative and supportive communication among interdisciplinary team members. These findings support those of Sedgwick (2011), Propp et al. (2010), and Yonge et al. (2013). Positive working relationships also required participants to understand each member's scope of practice, as contended by Kvarnstrom (2008) and Nolte (2005). In these situations participants felt confident and competent to communicate their ideas to other members of the team, which supports the notion put forth by several researchers that good communication is essential to effective interdisciplinary teamwork (Kvarnstrom, 2008; Nolte, 2005; Propp et al., 2010; Sedgwick, 2011; Yonge et al., 2013). Participants who felt accepted by the interdisciplinary team reported feeling supported. These participants experienced easier transitions, which corroborates Sedgwick and Yonge's (2008) construct of "we're a team" (p. 1) and McKenna and Newton's (2007) findings about the sense of belonging.

However, participants who lacked confidence in their knowledge and abilities found it difficult to collaborate with members of the interdisciplinary team, and in particular, with those team members who overstepped their boundaries in regard to scope of practice and who used challenging forms of communication, as previously reported by

Kvarnstrom (2008). Consequently, these participants, who did not perceive a sense of belonging to the interdisciplinary team did not trust themselves because their thoughts and actions were not validated by other members of the team whose opinions they respected and trusted as has been reported in the literature (Duchscher, 2008; Ellerton & Gregor, 2003; Kelly, 1996, 1998; Kelly & Ahern, 2008; Kvarnstrom, 2008; Lea & Cruickshank, 2007; McKenna et al., 2003; Nour, 2009; Romyn et al., 2009; Wolff et al., 2010).

Several participants in the current study worked with strong interdisciplinary teams consisting of senior RNs, LPNs, and physicians who were friendly and who acted as mentors, sharing expert knowledge, excellent skills, the capacity to manage multiple demands, and the ability to communicate clearly and effectively, all of which support previous findings by MacLeod (1998, 1999), Sedgwick (2008), and Scharff (2006, 2013) with regard to strong, functional rural acute care interdisciplinary teams. Participants depended on the supportive senior nurses because they were approachable and challenging, but not intimidating; they were nurses who participants could trust, which supports McKenna and Newton's (2007) and Romyn et al.'s (2009) descriptions of supportive senior nurses. Trust in those situations was equated with each individual's level of proficiency, which, according to MacLeod (1998, 1999), requires maturity, self-confidence, and experience, attributes that few participants possessed; this finding supports previous findings in the literature regarding new degree and diploma nurses' lack of confidence and experience (Duchscher, 2008, 2009; Ellerton & Gregor, 2003; Kelly, 1996, 1998; Kelly & Ahern, 2008; Kramer, 1974; Nour, 2009; Romyn et al., 2009; Wolff et al., 2010).

Participants in the current study also learned that some strong interdisciplinary teams consisted of less approachable nurses as the only available help, and accessing their opinions was essential to providing safe patient care, which is consistent with Sedgwick's (2008) findings that dissension sometimes occurs amongst rural team members, but that personality conflicts are generally set aside in order to provide smoothly functioning care. Those situations were challenging for participants because senior nurses would sometimes chastise the less experienced RNs about the decisions that had been made, which corroborates findings in the previous literature regarding

senior RNs who have been described as less than supportive to new degree and diploma nurses (Bowles & Candela, 2005; Duchscher, 2008, 2009; Ellerton & Gregor, 2003; Kelly, 1996, 1998; Kelly & Ahern, 2008; Lea & Cruickshank, 2007; Lavoie-Tremblay et al., 2008; Romyn et al., 2009). According to Scharff (2006, 2013), newcomers' acceptance into the group in the rural acute care hospital environment is dependent on each individual's level of proficiency and ability to socially relate to the group. Could it be that rural senior nurses chastise newcomers to assess them for fit with the group?

Another aspect of interdisciplinary team work that was particularly challenging for participants in the current study was working with senior LPNs who had been so suppressed by senior RNs or nurse managers that they did not work to their full scope of practice; this finding was previously reported in Oelke et al.'s (2008) and White et al.'s (2008) research in relation to Saskatchewan and Alberta urban acute care environments. Those behaviours presented difficulties for participants when trying to belong to the interdisciplinary team. On the one hand, they perceived acceptance by senior RNs if they conformed to the status quo, but on the other hand, knew that supporting the status quo would result in conflict with the LPNs and add to their already heavy workloads, as Oelke et al. reported earlier. Interestingly, several participants supported the LPNs and assisted them with working to full scope of practice, as Oelke et al. previously reported. Could it be that participants had learned how to effectively work in interdisciplinary teams during their nursing education?

While a few nurse managers were described as supportive of participants' transitions, which corroborates Gibb et al.'s (2005) and Romyn et al.'s (2009) earlier findings, most were described as highly unsupportive, as Bowles and Candela (2005) and Lea and Cruickshank (2007) reported. Of note, is that some nurse managers were considered unsupportive because they would not address the issues associated with ***I'M IT!—I'm Alone!*** on night shifts as the only body available. A few participants acknowledged that their nurse managers were responsible for managing more than one rural facility and that this had influenced how often they were on site and whether or not they were in tune with the issues surrounding one-to-one maternity care, nurse shortages, and night staffing, which corroborates previous reports by Baumann et al. (2006) in relation to Ontario rural nurse managers and MacKinnon (2011) with respect to British

Columbian rural nurse managers. Without a doubt, many factors influence nurse management decisions, which are beyond the scope of this thesis. However, this issue does raise concerns about what supports are in place to assist nurse managers with managing rural nurse staffing issues and the provision of safe patient care.

Working in interdisciplinary teams required participants to learn how to effectively work and communicate with physicians. For the most part, physicians were supportive of the participants' transitions, which supports reports from MacLeod (1998, 1999), Scharff (2006, 2013), and Sedgwick (2008) that physicians generally work in collaborative relationships with rural RNs. Overall, younger physicians were described as most supportive and older physicians as least helpful, which is a new finding that was not found in the literature. Some participants described their interactions with physicians as *"love–hate"* in nature, which are words that Sedgwick and MacLeod alluded to, but did not previously report. Participants learned that senior RNs and physicians function in relationships of mutual trust and understanding, wherein personalities play a significant role, communications depend on how well each knows the other, individuals' expectations relating to advanced practice roles affect the relationship, and knowing physicians' idiosyncrasies is fundamental to the care provided, as reported earlier by MacLeod, Scharff, and Sedgwick.

Participants in the current study learned that knowing the idiosyncrasies of physician colleagues influenced how, when, and what RNs communicated with them and that most senior RNs were willing to teach their newer counterparts about those idiosyncrasies and dynamics of working with physicians, which MacLeod (1998, 1999), Scharff (2006, 2013), and Sedgwick (2008) contended are typical of the rural acute care environment. However, adapting nursing care to the idiosyncrasies of each physician was difficult for some participants in the current study as it meant conforming to a hierarchy; MacLeod also reported this issue. This type of relationship challenged participants' values and learned practice standards that all individuals should be treated as equals and interdisciplinary collaboration is a key element to safe patient care (College and Association of Registered Nurses of Alberta, 2013), which supports Kvarnstrom's (2008) findings about challenges with teamwork.

To cope with communicating with physicians and the blurring of professional boundaries, participants in the current study developed various strategies, which supports Sedgwick's (2011) and Yonge et al.'s (2013) previous findings about interdisciplinary teamwork within the rural acute care hospital environment. Some participants were very honest about their knowledge deficits; in many cases the younger physicians would support them with mentoring and teaching, which is a new and unreported finding. Other participants found that SBAR communication was an effective way to communicate with physicians when communicating with them face-to-face or calling them in from off site, which supports Thomas, Bertram, and Johnson's (2009) previous findings on the use of SBAR in the practice environment.

Conversely, when communications with physicians were poor, participants felt inadequate, incompetent, and powerless, as is consistent with previous reports by MacLeod and Zimmer (2005), and Sedgwick (2008). These findings support Kvarnstrom's (2008) contention that challenging communications negatively influence effective interdisciplinary collaboration and ultimately, patient care. One participant found that some physicians became angry when a new, inexperienced nurse would be working in the ED and instead of supporting the nurse would yell and walk away, which corroborates Stewart et al.'s (2006) earlier results on aggressive behaviours of physicians and previous findings by MacLeod and Zimmer and Sedgwick regarding strained relationships between rural physicians and nurses. Power imbalances between physicians and nurses are well documented in the literature (Freshwater, 2000; MacLeod & Zimmer, 2005; Sedgwick, 2008; Street, 1992) and, from the findings in the current study, continue to be problematic in some rural facilities and do influence the effectiveness of interdisciplinary team work.

I'M IT!—I'm in charge! Being in charge of the nursing team was the norm for participants in the current study; this position required them to learn the underlying team dynamics and to develop trust with team members, which MacLeod (1998, 1999), Scharff (2013), and Sedgwick (2008) earlier described as integral to providing well-organized care in the rural acute care environment. Some participants found developing trust to be challenging because it required a certain level of knowledge, skill, proficiency, and confidence, which, according to MacLeod, take time to develop. Participants

sometimes experienced conflict when in charge of the nursing team because they were inexperienced, but expected to delegate to others who may have worked in the facility a long time and possessed years of practice experience, issues which are consistent with earlier reports within the literature (Duchscher, 2008; Kelly, 1996, 1998; Kelly & Ahern, 2008; Lea & Cruickshank, 2007; McKenna et al., 2003; McKenna & Newton, 2007).

In addition, at certain times, managers expected participants to be in charge of nursing teams that participants described as weak, because the nurses were new, inexperienced, or agency nurses who did not necessarily possess the knowledge and competence to manage critical decisions, contingent situations, or infrequently used procedures or protocols in the rural acute care environment, issues which corroborate MacKinnon's (2011) previous concerns surrounding nurse shortages and challenges with maternity care in some rural acute care hospitals in British Columbia. In those situations, participants in the current study depended on their coworkers to assist and support them with making difficult decisions, with each capitalizing on the other's strengths, which corroborates MacLeod's (1998, 1999) earlier findings in terms of the support rural team members provide each other in order to manage challenging situations. While it is common knowledge that agency or travel RNs have long been used to combat critical recurring RN staffing shortages in a number of CA rural and remote areas, the impact of this type of staffing solution on transitioning new nurses has not been reported and, therefore, constitutes a new and significant finding.

The organization. When participants began working in the rural acute care environment they found that they were either well supported by lengthy structured orientation programs or provided minimal orientation and were *"chucked in."*

Orientation support. Participants who received structured orientation support and slowly segued into ***The Rural RN Role***, described their transitions as manageable and *"good"* with minimal fluctuations in their emotions because they felt confident and competent in their abilities; these findings corroborate researchers' contentions that AU transition programs (Cubit & Ryan, 2010; Mills, Francis, et al., 2007; Mills et al., 2008; Mills, Lennon, et al., 2007; Ostini & Bonner, 2012) and U.S. residency programs (Keahey, 2008; Meyer Bratt, 2009; Ulrich et al., 2010) have improved new degree and diploma nurses' confidence and competence levels. Of note, is that two of the three

participants in the current study who experienced this type of orientation support chose to retain their jobs, which supports reports that transition or residency programs have significantly reduced new degree and diploma nurses' turnover rates (Cubit & Ryan, 2010; Keahey, 2008; Meyer Bratt, 2009; Ostini & Bonner, 2012; Ulrich et al., 2010).

In the current study, most participants had not been provided the support of a structured mentorship program, even though findings in the literature had previously identified mentorship as an effective way to support and retain new degree and diploma nurses in AU rural acute care environments (Mills, Francis, et al., 2007; Mills et al., 2008; Mills, Lennon, et al., 2007) and Baumann et al. (2006) had recommended them for Ontario rural acute care hospitals. However, some participants readily recognized the need to choose a senior RN as a mentor early on in their transitions, which corroborates Romyn et al.'s (2009) findings about the need for the establishment of positive relationships between new nurses and senior RNs. In fact, many participants in the current study described their accidental mentoring relationships with senior RNs as progressing into full mentorships, and eventually deep friendships, which lends to the progression of mentoring outlined by Mills et al. (2008). This is an interesting finding because Mills, Lennon, et al. (2007), had contended that to contribute to a culture of learning, mentors must be educated in how to mentor appropriately through learning problem-solving approaches and the boundaries associated with mentoring. These contentions raise concern because several participants were buddied with senior RNs who acted as mentors and had not received any formal training. In addition, some participants were expected to buddy newer RNs or to precept nursing students themselves, without any educational supports, which they found very challenging. This finding supports Duchscher's (2008) previous concerns that expecting new nurses to mentor new RNs is stress inducing and unrealistic and raises the question, did these participants have an adequate knowledge base to mentor others?

Unit culture. Participants in the current study described positive unit cultures as the norm and as contributing to good transition experiences because they felt respected, trusted, and accepted by the members of the interdisciplinary team, which corroborates earlier findings found in the literature (McKenna & Newton, 2007; Romyn et al., 2009), but differs significantly from issues of horizontal violence reported in the AU, NZ, and

UK literature (Kelly 1996, 1998; Kelly & Ahern, 2003; Lea & Cruickshank, 2007). I find it noteworthy that participants who did experience negative unit cultures made "*the decision* [to] *go"* and find work elsewhere.

One participant worked in a hospital in which the RNs were divided between the young new nurses and the older senior diploma-educated RNs, and the two sides battled about best practices, a unit culture issue that Kelly (1996, 1998) had previously reported. This participant found herself frustrated by the archaic ways of thinking of those senior RNs, which supports Duchscher's (2008) and Romyn et al.'s (2009) earlier findings. She also described the senior RNs' attitudes as *"swim or sink,"* thereby supporting Kelly and Ahern's (2008) concern about AU new degree and diploma nurses "being thrown in at the deep end" (p. 916) and Romyn et al.'s findings that CA new nurses were "almost sinking" (p. 8) and "barely treading water" (p. 8). Senior RNs told this participant, *"We didn't have more than 5 days orientation, why should you?"* So this participant fought for more orientation days, but also tried to keep up with busy ward routines and complex patient care, which corroborates Lea and Cruickshank's (2007) previous concerns about lack of orientation supports in AU rural acute care environments. However, this participant communicated assertively with the senior RNs who were bullying her, challenged the status quo, and role modelled best practices to preserve her moral integrity (Kelly, 1998), thereby supporting Enns' (2014) theory of "Finding My Own Way" (p. 1), wherein new nurses' inherent values predicate their behaviours in the practice environment. This finding differs from Kelly's (1998) and Kelly and Ahern's (2008) findings, wherein bullied new nurses have felt vulnerable and alienated from themselves and questioned their inherent and learned values. Could it be, then, that this participant's inherent values shaped her subsequent workplace behaviours? Or was it that the values and communication skills she had learned during her nursing education had assisted her with knowing how to manage workplace conflicts? Regardless, this participant eventually took a job in another area of the rural acute care hospital.

A second participant experienced a negative unit culture in which she was repeatedly ostracized from conversations between senior RNs when trying to communicate with them, a finding which supports the descriptions of AU senior RNs' "bitchiness" (Kelly & Ahern, 2008, p. 914). She quit her job and sought work in another

rural acute care hospital, which supports Kelly's (1998) theory that some new nurses who feel alienated by senior RNs preserve their moral integrity by quitting their jobs.

A third participant found that the unit culture in which she worked was influenced by RNs who possessed "*RN-itis*," a term that has not previously been reported in the literature, but is akin to the "power games" (Kelly & Ahern, 2008, p. 913) and "hierarchy" (p. 914) in relation to AU rural acute care environments. This participant described hating her job because she felt *"undervalued"* and *"disrespected"* by her nurse manager and the senior nurses, which corroborates Kelly's (1998) contention that some new nurses feel vulnerable and alienated when treated poorly by senior RNs. At the time of her interview, she too, sought work elsewhere.

A fourth participant was subjected to a negative unit culture, wherein she was undermined in front of her patients and made to feel *"stupid"* and *"disrespected"* when asking questions, which again supports Kelly and Ahern's (2008) notion of "power games" (p. 913) and Kelly's (1998) theory of Preserving Moral Integrity—she also had begun to search for employment elsewhere. Could it be, as Kelly and Ahern have contended, that a few senior nurses continue to retain the 19th century hierarchical traditions of nurses "eating their young" (p. 913)?

The clients, family, and community. The *I'M A GENERALIST!* theme required that participants learn about rural clients and themselves as aspects of learning about ***The People***, as well as about the rural community as an aspect of ***The Place***, and how to address issues of *Confidentiality* and *Lack of anonymity*. The two new findings in the current study related to the clients and community have previously been discussed (i.e., clients' acceptance of participants was found to be related to how old the participants appeared to be and was not influenced by whether or not the participants commuted and were minimally involved in the community).

Personal coping strategies. Participants placed great value on whether or not they were providing good care and adequately performing in their new role, which corroborates earlier research findings (Duchscher, 2008; Ellerton & Gregor, 2003; Enns, 2014; Kelly, 1996, 1998; Lavoie-Tremblay et al., 2008; Nour, 2009). For many participants, heavy workloads and team nursing responsibilities often tested their values during the first few months of practice due to worrying about making *"dumb little*

mistakes" and being unsafe, findings which support Duchscher's (2008) theory of "A Process of Becoming" (p. 441), wherein new nurses worry about "missing something" (p. 445) or unintentionally harming someone due to their ignorance and inexperience.

Consequently, participants engaged in varied strategies to cope with the roles and responsibilities of ***I'M A GENERALIST! and I'M IT!*** in the rural acute care environment. To build confidence and develop proficiency, participants used strategies such as reading their texts, taking certification courses, and learning from senior RNs, techniques Stewart et al. (2011) and Penz et al. (2007) previously reported were used by other nurses to cope in the rural acute care environment. The knowledge that these nurses gained became more ingrained with experience, which supports MacLeod's (1998, 1999) finding that confidence is both an outgrowth of experience and a facilitator to further learning. However, one new and significant finding is that some participants accessed spiritual supports through praying, identifying with nature, or depending on their inner faith to guide them through difficult situations.

Another means of coping used by participants was to access social supports outside of the rural facility through maintaining relationships with friends, family, and BN peers, which supports Rush, Adamack, and Gordon's (2013) finding that peer and social supports were maintained by new nurses in British Columbia acute care hospitals to support their transitions. This last point differs from Duchscher's (2009) Transition Shock model, whereby significant loss was due to new nurses' separation from their BN peers. Could it be that current technology had enabled participants and the new nurses in Rush et al.'s study to stay in better contact with their peers?

The findings in the current study that participants felt stressed and as if they were *"sinking"* because they could not attend to the needs of their clients due to time constraints and heavy workloads lend support to the findings of Romyn et al. (2009) and Wolff et al. (2010). In addition, participants who lived where they worked initially found managing confidentiality and lack of anonymity surprising and challenging because they were always viewed as the nurse and consistently expected to be in the role of the nurse and able to answer medical questions asked by community members, or to discuss other clients even when in the grocery store, arena, and so on, as reported in the literature (MacLeod, 1998, 1999; Scharff, 2013; Sedgwick, 2008; Stewart et al., 2006). The

approach taken by participants in the current study that *"what happened at the hospital stayed at the hospital"* had been discussed previously by Crooks' (2012) in terms of secret keeping and was pivotal to nurses sustaining a successful connection to the rural community.

Some participants who lived where they worked found making new friends in the rural community to be challenging because they were concerned about maintaining client confidentiality. A few chose to avoid making new friends in the rural community, similar to Sedgwick's (2008) finding of RNs who chose "doing the hermit thing" (p. 77). While Crooks (2012) had previously reported on the ethical challenges of confidentiality in rural nursing, she did not comment on the challenge of garnering emotional support from loved ones when one could not easily share their work issues and concerns with them.

In time, and with the generation of strategies to cope with maintaining confidentiality and lack of anonymity, and the development of interconnected bonds with community members, participants developed a sense of belonging to the community, a finding supportive of the findings of MacLeod (1998, 1999), Scharff (2008), Sedgwick (2008), and Stewart et al. (2006). In addition, participants became appreciative of the unique rural relationships they were developing and found that knowing their clients made their jobs more fulfilling and easier, as previously reported by Crooks (2012), MacLeod, Scharff, Sedgwick, and Yonge et al. (2011).

An Emotional Roller Coaster Up! and Down!

Participants described experiencing emotions that oscillated between surprise (feeling exhilarated) and shock (feeling overwhelmed), which landed each on ***An Emotional Roller Coaster Up! and Down!*** during their transitions, a finding that is very different from the negative emotions that have consistently been found to exemplify new degree and diploma nurses' transition into rural and urban acute care environments and which have been discussed earlier in this chapter (Duchscher, 2008, 2009; Kelly, 1996, 1998; Kelly & Ahern, 2008; Kramer, 1974; Lea & Cruickshank, 2007; Nour, 2009).

I found it noteworthy that the emotional roller coasters experienced by participants were very similar to the emotions described by new RNs transitioning into Manitoba rural home care environments (Sevean, 2012). RNs in the current study and in Sevean's (2012) study used similar terms such as *"intimidation," "being thrown in,"* and

"it's fascinating, but it's overwhelming." These findings have left me wondering about transitions into all rural environments (hospital and community-based) and whether or not they are similar or different.

Staying or Going!

Most participants, including those who had moved on to urban jobs, stated that if they had it to do over again, they would initially choose rural nursing as their first job choice, as alluded to within the literature in terms of senior rural RNs and their desire for a rural lifestyle or history of familial roots in the rural community (Baumann et al., 2006; MacLeod, 1998, 1999; Scharff, 2013; Sedgwick, 2008). However, some participants had been using the rural experience as a precursor to working in an urban facility because full-time urban jobs were not available; this finding supports earlier literature (Adams et al., 2003; Baumann et al., 2006).

The findings in the current study offered three main reasons for participants enjoying rural nursing that were consistent with the literature: (a) the relationships RNs had developed with rural clients (Crooks, 2012; Scharff, 2013; Sedgwick, 2008); (b) RNs' feelings of belonging to an interdisciplinary team or family (LaSala, 2000; Lavoie-Tremblay et al., 2008; Romyn et al., 2009; Sedgwick, 2008, 2011; Sedgwick & Yonge, 2008; Yonge et al., 2013); and (c) job satisfaction, which was associated with the type and scope of nursing work (Bushy, 2002; MacLeod et al., 2004; Stewart et al., 2011). However, unlike the literature, in the current study participants' job satisfaction was not linked to community involvement for those who commuted, as was previously discussed. This is a significant finding, as the link between job satisfaction and community involvement has repeatedly been identified by rural researchers as integral to RNs' retention in the rural setting (Crooks, 2012; MacLeod, 1998, 1999; Sedgwick, 2008; Stewart et al., 2011; Yonge et al., 2011).

The decision to switch jobs was common amongst the participants in the current study. Nine of the 12 participants had either changed jobs or intended to do so in the near future, which was a significantly higher turnover rate than the 49% of 145 Québec new degree and diploma nurses who previously reported intent to leave their jobs (Lavoie-Tremblay et al., 2011). One predominant reason for participants to leave was to pursue employment in a specialized urban unit, as Skillman, Palazzo, Keepnews, and Hart

(2006) previously reported in their U.S. based research. Additionally, characteristics of the participants were similar to some of the predictors of intent to leave among rural and remote CA RNs previously reported in Stewart et al.'s (2006) research, which included having no dependent children or relatives, or employment for a short period of time.

Another reason for participants to leave was due to the characteristics of the environment in which they did not feel adequately supported, as reported within the literature (Bowles & Candela, 2005; Lavoie-Tremblay et al., 2011; Penz et al., 2007; Stewart et al., 2011). Baumann et al. (2006) discussed the realities confirmed by the findings in the current study in relation to chronic understaffing and insufficient orientation. This overall lack of support is not surprising when considering current CA RN workforce demographics (CIHI, 2012) and dwindling numbers of senior RNs across Canada (Baumann et al., 2004; CIHI, 2012).

Some participants felt *"thrown to the wolves"* or placed in vulnerable situations with no protection, which differs from Sedgwick's (2008) finding that precepted nursing students felt well supported in rural areas and not "thrown to the wolves" (p. 7); however, this finding does support contentions by numerous researchers that new degree and diploma nurses have not been supported well during transition (Baumann et al., 2006; Bowles & Candela, 2005; Duchscher, 2008, 2009; Ellerton & Gregor, 2003; Kelly, 1996, 1998; Kelly & Ahern, 2008; Lavoie-Tremblay et al., 2008; Lea & Cruickshank, 2007; Parker et al., 2003; Romyn et al., 2009). Perhaps there is a difference between how nursing students and new nurses are treated in some rural acute care environments.

Lack of access to clinical nurse educators was highly evident in the current study, which corroborates Romyn et al.'s (2009) discussion on the erosion of the clinical nurse educator role in CA rural acute care hospitals as well as previous reports by Penz et al. (2007) and Stewart et al. (2011) on this gap for continuing education. These findings are extremely worrisome because numerous researchers indicated that the rural acute care environment requires nurses to work as a part of an interdisciplinary team (Sedgwick, 2011; Yonge et al., 2013) and to develop advanced skills through supporting each other (MacLeod, 1998, 1999; Rosenthal, 2006; Scharff, 2006, 2013; Sedgwick, 2008; Sedgwick & Yonge, 2008; Yonge et al., 2011). On the plus side, none of the participants in the current study had quit nursing altogether, a significant issue highlighted by many

researchers in Canada (Baumann et al., 2006; Godinez et al., 1999; Lavoie-Tremblay et al., 2011) and the US (Bowles & Candela, 2005; Godinez et al., 1999).

Limitations

The key limitation of this study related to the sample. The data were limited to one province of Canada, Alberta, but with participants from across the province. Participants self-selected in two different ways. First, they had previously self-identified to CARNA their willingness to participate in research. Second, they responded to letters that were mailed to them by CARNA. This process resulted in a convenience sample (Richards & Morse, 2007) comprised of individuals who responded to the *Letter of Information for Participants* (see Appendix D); four individuals were excluded because they did not meet the inclusion criteria as new rural nurses. One participant asked to be involved after hearing about the study from a friend. As only one male participated, in terms of gender, the sample was nearly homogenous. Based on theoretical sampling principles, the emerging analysis influenced who was selected for re-interviews (Richards, & Morse, 2007). Participants who I identified as able to provide more in-depth clarification about their transition experiences were chosen because of their knowledge of the topic and abilities to articulate their experiences, which had potential to promote bias. I countered this potential for bias by asking questions that stemmed from the evolving themes based on the data obtained from all of the initial interviews and by revisiting concepts that were highlighted as important by the other participants.

An additional limitation to the sample was the problematic definition of the term rural. This became obvious to me as the study progressed, obscuring clear delineation for identifying the inclusion and exclusion criteria. It was only after interviewing participants that this confusion came to light, when I found that some participants worked in rural generalist-type facilities, while others worked in urban-type facilities. The two types were quite different, as were the transition experiences of those participants, although they were all considered rural. Additionally, the parameters of rural previously referred to by researchers (duPlessis et al., 2001; Kulig et al., 2010) did not accurately reflect the current parameters in terms of population served and services provided. The differing rural acute care hospital models and increasing rural populations must be considered when investigating rural health care issues and defining what constitutes rural.

At the beginning of this study, rural postal codes were used by CARNA to send letters of information to potential participants. Upon receiving either emails or telephone calls from potential participants, the definition of "rural" outlined by duPlessis et al. (2001), wherein rural constituted "towns and municipalities with populations of less than 10,000 people" (p. 1), was initially used to exclude potential participants who lived in communities with populations of greater than 10,000 people. However, discussions with my local rural clinical nurse educator revealed that many communities identified as rural by the health authorities in Alberta were no longer within the 10,000 population mark. I reviewed the census data for the applicable communities and found five communities from which participants were recruited had grown well beyond 12,000–15,000 people (Statistics Canada, 2013). In addition, definitions of rural that included commuting zones were problematic, as many current Alberta rural communities include increasing numbers of acreage residents. Interestingly, nearly half of the participants in the current study commuted either from a different rural small town or an urban centre to work in rural.

Kulig et al. (2008) generated four themes to define rural or remote, which fit better with the findings from the current study. These included (a) geographical location, (b) community characteristics, (c) health human and technical resources, and (d) nursing practice characteristics. According to Kulig et al. (2008), rural communities are semi-isolated, located 20 minutes to 5 hours or 20–200 km from an urban centre, consist of population sizes of < 500 to < 50,000 people, and include economic–industrial infrastructures of agriculture, fishing, or ranching. In terms of health care resources, small hospitals in rural communities have 40–80 beds and available physician and emergency services (Kulig et al., 2008). Rural nursing practice characteristics focus on the degree of responsibility held by nurses to fulfill physicians' duties, a broad knowledge base, and the responsibility of caring for people one knows while fulfilling the dual role of professional and community member (Kulig et al., 2008).

However, despite the broader definition proposed by Kulig et al. (2008), there are still problems in terms of rurality for the current study: (a) it is not clear as to whether or not the community sizes outlined in the definition include catchment areas, which in rural Alberta have become quite populated due to rising numbers of acreage dwellers;

(b) economic–industrial infrastructures in the western provinces should also encapsulate oil, forestry, and potash industries to name a few; (c) downsizing in some rural acute care hospitals in the current study has decreased the number of beds well below the 40–80 mark that Kulig et al. used to define small rural acute care hospitals; and (d) nearly half of the 12 participants in the current study commuted to work and, therefore, did not provide nursing care for people in the community they knew.

Consequently, the definition of rural used in the current study included communities of less than 10,000 people as well as those with populations greater than 10,000 people, but were designated as rural by either Alberta Health Services or Covenant Health. While there is wide diversity in the definitions ascribed to the term rural, they are problematic because they are out dated.

Implications

The findings of this study revealed the experiences of new nurses as they transitioned into the Alberta rural acute care environment and provided information on the challenges and supports to those transitions. ***A DOUBLE WHAMMY!*** constitutes one explanation of that experience. However, these findings may present readers with recognizable similarities to situations that resonate with their own experiences about new nurses' transition experiences, thereby enabling them to make generalizations about transition to their own contexts (Melrose, 2009). Additional exploration of the transition experience into rural acute care is indicated, using sampling that is more systematic and widespread than what was used in the current study. As the participant cohort was only drawn from one province in Canada, it may be helpful to explore the perspectives of other new nurses transitioning into rural acute care from across Canada to explore if their experiences are similar or different to those studied. As well, exploring the perspectives of other health care providers may provide insight into their perspectives about new nurses' transition into the rural acute care environment in order to obtain a broader understanding of other dynamics surrounding transition.

Research examining current government policies and organizational structures related to new nurse recruitment and retention within the context of the rural acute care environment is warranted. As well, exploration of educational curricula in terms of the preparation of new nurses for employment in rural acute care environments is justified.

Based on what is now known about ***A DOUBLE WHAMMY!*** new nurses' transition into rural acute care, I recommend the following research questions be investigated:

1. What process do new nurses engage in when transitioning into the CA rural acute care environment?
2. How do senior RNs, nurse managers, clinical nurse educators, physicians, and pharmacists in rural Canada perceive their roles in supporting new nurses' transition into the rural acute care environment?
3. How do nursing education programs across Canada prepare new nurses for transition into the rural acute care environment?
4. What is the turnover rate of nurses in their first 2 years of employment in the CA rural acute care environment? What is the correlation between the costs associated with turnover rates and those of orientation and mentoring?
5. What are the transition experiences of new nurses into rural community care?

The following are recommendations to enhance workforce planning for rural acute care environments and respond to issues of new nurses' recruitment and retention.

I recommend the following four strategies be implemented at a policy level:

1. Offer scholarships to nursing students from rural areas committed to returning to a rural community for a designated number of years.
2. Establish funding to support orientation and mentorship programs in rural facilities.
3. Make available funding to support on-site certification and recertification education programs in rural acute care hospitals.
4. Provide funding to hire on-site full time clinical nurse educators in all rural acute care hospitals.

I recommend the following five strategies be implemented at the educational level:

1. Organize rural facilities for undergraduate clinical experiences, both in acute and extended care.
2. Provide nursing students with knowledge and opportunities to learn how to manage collaborating within interdisciplinary team members.

3. Collaborate with senior RNs and nurse managers in rural organizations to develop a final year nursing course with a focus on rural nursing theory, simulation, and practical experiences that support learning to manage the rural generalist role including ***I'M IT!*** and learning "*On the Fly*," especially in relation to labour and delivery, emergency, and paediatric patients.
4. Ensure that ample simulation opportunities for labour and delivery, emergency, and paediatric care are used to enhance students' learning during basic nursing education programs. According to Bushy and Hewett (2012), simulation and simulated experiences can be useful means of augmenting learning about rural nursing care because they enable hands-on practice (MacLeod et al., 2008), without the risk to the patient.
5. Develop on-line leadership programs or modules for nurse managers to assist them with supporting new nurses during transition.

I recommend the following four strategies be implemented at the practice level:

1. Provide structured orientation programs such as residency programs that are tailored to each new nurse and his or her preceptor, but with check-in points to review progress with the nurse manager.
2. Increase the length of orientation and mentoring of new nurses transitioning into rural acute care to a minimum of 3 months.
3. Offer incentives and on-site mentorship education for senior RNs who volunteer to mentor new nurses.
4. Provide rural RNs the educational support of clinical nurse educators in every rural facility.

These recommendations are by no means exhaustive of the possibilities to support new nurses' transition into rural nursing. However, they do offer a starting point for addressing the challenges surrounding their transitions.

Summary

In this chapter, I compared the experience of ***A DOUBLE WHAMMY!*** as one explanation of the transition of new nurses into the rural acute care environment with existing literature. I also compared contextual factors and the two major themes of ***I'M A GENERALIST! and I'M IT!***, the subthemes of ***An Emotional Roller Coaster Up! and***

Down!, and ***The Decision: Stay? or Go?*** to relevant rural and urban acute care nursing literature. This comparison revealed that findings from the current study reinforce~~d,~~ differe~~d~~ from, and contribute~~d~~ to the current knowledge about the phenomenon of transition and indicates that transition into rural acute care nursing then, is overall, a difference in degree rather than a difference in kind from transition into urban acute care nursing. Additional research is needed to further confirm and extend these findings.

In this report I presented the schematic I developed for ***A DOUBLE WHAMMY!*** offering a graphic representation of the phenomenon as two constructs**:** ***I'M A GENERALIST!*** (see Figure 2) *With So Much Learning* ***and I'M IT!*** (see Figure 3) *With Even More Responsibility*. The finding that transition placed participants on ***An Emotional Roller Coaster Up! and Down!*** experiencing paradoxical emotions of surprise and shock is significant because it differs from the negative experience of shock that has predominated the literature and offers a new perspective to be considered when investigating the phenomenon of transition in the future. Limitations of this study included the homogeneity of the participants' characteristics and issues with the definition of rural. This study has generated numerous recommendations for future qualitative and quantitative studies about the phenomenon of transition as it relates to rural nursing, as well as many strategies to address issues at rural acute care educational, practice, and policy levels.

CHAPTER 6
CONCLUSION

This study originated from a broad question about the transition experiences of new BN graduates into the rural acute care environment. The core them that emerged, ***A DOUBLE WHAMMY!*** was generated from the data provided by one male and 11 female participants in 16 individual interviews and serves as one proposed description of new nurses' transition into the rural acute care environment. The findings from this study are significant because they begin to fill the gap in the extant literature in relation to contextual factors and the experience of transition. In terms of contextual factors, new findings indicated a broad scope of practice as an additional reason for new nurses to make rural nursing their first career choice and that there are two different models of rural acute care hospital, a generalist-type and an urban-type. In terms of the transition experience, new findings included descriptions about the influence of nurse staffing shortages, new nurses' youthful or mature appearance, commuting, supportive relationships with physicians, RNs' medication work, and spirituality. However, what sets this study apart from transition studies spanning the past 25 years, in which the predominant experience of new nurses transitioning into urban acute care has been described as one of shock, is that the transition into rural acute care generated paradoxical emotions that oscillated between feeling exhilarated (surprised) and feeling overwhelmed (shocked), revealing that transition into rural acute care nursing constitutes a difference in degree rather than a difference in kind from transition into urban acute care nursing.

This study was not without its limitations, which for the most part had to do with the sample and recruitment (see the Limitations section found in Chapter 5). The problematic definition of rural influencing as it did the recruitment, and the homogeneity of the participants, taken together, limit the strength and transferability of the resultant description. Nonetheless, it is conceivable that the experiences described by participants may resonate with others and, in doing so, may inform them about this phenomenon. The findings from the current study also provide a basis from which to suggest recommendations for further research and strategies to support new nurses' transition into the rural acute care environment at policy, educational, and practice levels.

REFERENCES

Adams, O., Buske, L., Marcus, L., Chauhan, T., Little, L., Teperman, L., … Woodend, K. (2003). *The development of a multistakeholder framework/index of rurality*. Retrieved from http://www.cna-aiic.ca/~/media/cna/page%20content/pdf%20fr/2013/09/05/19/20/final_report_e.pdf

Advisory Committee on Health Human Resources. (2002). *Our health, our future: Creating quality workplaces for Canadian nurses: Final report of the Canadian nursing advisory committee.* Retrieved from http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/2002-cnac-cccsi-final/2002-cnac-cccsi-final-eng.pdf

Andrews, M., Stewart, N., Pitblado, R., Morgan, D., Forbes, D., & D'Arcy, C. (2005). Registered nurses working alone in rural and remote Canada. *Canadian Journal of Nursing Research, 37*(1), 14–33.

Alberta Health and Wellness. (2008). *Vision 2020: The future of healthcare in Alberta/Phase 1.* Retrieved from http://www.health.alberta.ca/documents/Vision-2020-Phase-1-2008.pdf

Baumann, A., Blythe, J., Kolotylo, C., & Underwood, J. (2004). *The international nursing labour market: Building the future: An integrated strategy for nursing human resources in Canada.* Retrieved from http://www.cna-aiic.ca/~/media/cna/page%20content/pdf%20fr/2013/09/05/19/18/international_nursing_labour_market_e.pdf

Baumann, A., Crea-Arsenio, M., Idress-Wheeler, D., Hunsberger, M., & Blythe, J. (2010). *A made-in-LHIN solution: Identifying local needs in 70% full-time nursing employment* (Health Human Resource Series No. 23). Retrieved from http://www.nhsru.com/wp-content/uploads/2010/11/Series-Report-23-LHIN-Workshop-Central-West1.pdf

Baumann, A., Hunsberger, M., Blythe, & Crea, M. (2006). *The new healthcare worker: Implications of changing employment patterns in rural and community hospitals* (Health Human Resources Series No. 6). Retrieved from http://www.nhsru.com/wp-content/uploads/2010/11/Series_6_The_New_Healthcare_Worker-Rural_low_res11.pdf

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice.* Menlo Park, CA: Addison-Wesley.

Bolander, D., Bolander, A., Boak, S., Buonocore, G., Burke, S., Churchill, J., … Vreeland, J. (1988). *The new Lexicon Webster's encyclopaedic dictionary of the English language* (Canadian ed.). New York, NY: Lexicon.

Bourke, L., Sheridan, C., Russell, U., Jones, G., DeWitt, D., & Liaw, S. (2004). Developing a conceptual understanding of rural health practice. *Australian Journal of Rural Health, 12,* 181–186.

Bowles, C., & Candela, L. (2005). First job experiences of recent RN graduates: Improving the work environment. *Journal of Nursing Administration, 35*(3), 130–137.

Brim, O., Jr. (1966). Socialization through the life cycle. In O. Brim Jr. & S. Wheeler (Eds.), *Socialization after childhood: Two essays* (pp. 1–49). New York, NY: Wiley.

Brown, P. (1999). Graduate nurses: What do they expect? *Kansas Nurse, 74*(5), 1–12.

Bushy, A. (2002). International perspectives on rural nursing: Australia, Canada, USA. *Australian Journal of Rural Health, 10,* 104–111.

Bushy, A. (2012). The rural context and nursing practice. In D. Molinari & A. Bushy (Eds.), *The rural nurse: Transition to practice* (pp. 1–21). New York, NY: Springer.

Bushy, A., & Hewett, B. (2012). Simulation in nursing continuing education: There wherefore's and when-to's. In D. Molinari & A. Bushy (Eds.), *The rural nurse: Transition to practice* (pp. 305–322). New York, NY: Springer.

Canadian Association for Rural and Remote Nursing. (2008). *Rural and remote nursing practice parameters: Discussion document.* Retrieved from http://www.carrn.com/files/NursingPracticeParametersJanuary08.pdf

Canadian Institute for Health Information. (2002). *Supply and distribution of registered nurses in rural and small town Canada, 2000.* Retrieved from https://secure.cihi.ca/free_products/NursingRuralSmallTownCanada2000.pdf

Canadian Institute for Health Information. (2006). *How healthy are rural Canadians? An assessment of their health status and health determinants.* Retrieved from https://secure.cihi.ca/free_products/summary_rural_canadians_2006_e.pdf

Canadian Institute for Health Information. (2010). *Regulated nurses: Canadian trends, 2005 to 2009.* Retrieved from https://secure.cihi.ca/free_products/nursing_report_2005-2009_en.pdf

Canadian Institute for Health Information. (2012). *Regulated nurses: Canadian trends, 2006 to 2010*. Retrieved from https://secure.cihi.ca/free_products/RegulatedNursesCanadianTrends2006-2010_EN.pdf

Canadian Nurses Association. (2005). *Resolution 16: Supporting the rural and remote nursing workforce*. Retrieved from http://www.cna.ca

College and Association of Registered Nurses of Alberta. (2013). *Nursing practice standards*. Retrieved from https://www.nurses.ab.ca/Carna-Admin/Uploads/Nursing%20Practice%20Standards.pdf

College of Registered Nurses of British Columbia. (2013). *Competencies in the context of entry-level registered nurse practice in the province of British Columbia.* Retrieved from https://crnbc.ca/Registration/Lists/RegistrationResources/375CompetenciesEntrylevelRN.pdf

Crooks, K. (2007). *Where everyone knows your name: An ethnographic exploration of rural nursing* (Doctoral dissertation). University of Calgary, Calgary, AB, Canada.

Crooks, K. (2012). Dual relationships and rural nurse's transition to practice: A CA ethnographic study. In D. Molinari & A. Bushy (Eds.), *The rural nurse: Transition to practice* (pp. 47–60). New York, NY: Springer.

Cubit, K., & Ryan, B. (2011). Tailoring a graduate nurse program to meet the needs of our next generation nurses. *Nurse Education Today, 31*, 65–71. doi:10.1016/j.nedt.2010.03.017

Double Whammy. (2014). In *Dictionary.com: The free online dictionary*. Retrieved from http://dictionary.reference.com/browse/double+whammy?s=t

Duchscher, J. E. B. (2003). Critical thinking: Perceptions of newly graduated female baccalaureate nurses. *Journal of Nursing Education, 42*(1), 14–27.

Duchscher, J. E. B. (2008). A process of becoming: The stages of new nursing graduate professional role transition. *The Journal of Continuing Education in Nursing, 39*, 441–450.

Duchscher, J. E. B. (2009). "Transition shock": The initial stage of role adaptation for newly graduated registered nurses. *Journal of Advanced Nursing, 65*, 1103–1113. doi:10.111/j.1365-2648.2008.04898.x

Duchscher, J. E. B. (2012). *From surviving to thriving: Navigating the first year of professional nursing practice*. Saskatoon, SK, Canada: Nursing the Future.

duPlessis, V., Beshiri, R., Bollman, R. D., & Clemenson, C. (2001). Definitions of rural (Catalogue No. 21-006-XIE). *Rural and Small Town Canada: An Analysis Bulletin, 3*(3), 1–17.

Ellerton, M., & Gregor, F. (2003). A study of transition: The new nurse graduate at 3 months. *Journal of Continuing Education in Nursing, 34*, 103–107.

Enns, B. (2014). *Finding my own way: Nursing identity development from layperson to new BN graduate*. Unpublished manuscript, Centre for Nursing and Health Studies, Athabasca University, Athabasca, AB, Canada.

Folkmann, L., & Rankin, J. (2010). Nurses' medication work: What do nurses know? *Journal of Clinical Nursing, 19*, 3218–3226. doi:10.1111/j.1365-2702.2010.03249.x

Freshwater, D. (2000). Crosscurrents: Against cultural narration in nursing. *Journal of Advanced Nursing, 32*, 481–484. doi:10.1046/j.1365-2648.2000.01499.x

Gibb, H., Forsyth, K., & Anderson, J. (2005). Culture of rural nursing practice: A critical theoretical analysis of determinants of power. *Australian Journal of Advanced Nursing, 23*(2), 34–40.

Glesne, C. (2011). *Becoming qualitative researchers: An introduction* (4th ed.). Boston, MA: Pearson.

Godinez, G., Schweiger, J., Gruver, J., & Ryan, P. (1999). Role transition from graduate to staff nurse: A qualitative analysis. *Journal for Nurses in Staff Development, 15,* 97–110.

Government of British Columbia, Ministry of Health. (2007). *Rural health care: Part II: Summary of input on the conversation on health*. Retrieved from http://www.health.gov.bc.ca/library/publications/year/2007/conversation_on_health/PartII/PartII_RuralCare.pdf

Habjan, S., Kortes-Miller, K., Kelley, M., Sullivan, H., & Pisco, L. (2012). Building capacity in rural health services: The effect of continuing education. In J. C. Kulig & A. M. Williams (Eds.) *Health in rural Canada* (pp. 118–136). Vancouver, BC, Canada: University of British Columbia Press.

Hazard Munro, B. (1982). Job satisfaction among recent graduates of schools of nursing. *Nursing Research, 32*, 350–355.

Hegney, D., McCarthy, A., & Pearson, A. (1999). Effects of size of health service on scope of rural nursing practice. *Collegian, 6*(4), 21–26. doi:10.1016/S1322-7696(08)60605-8

Hendricks, L., Mennenga, H., & Johansen, L. (2013). The use of rural acute care hospitals for clinical placements in nursing education. In C. A. Winters (Ed.), *Rural nursing: Concepts, theory, and practice* (4th ed., pp. 293–301). New York, NY: Springer.

Hendrickx, L. (2006). Continuing education and rural nurses. In J. J. Lee & C. A. Winters (Eds.), *Rural nursing: Concepts, theory and practice* (pp. 248–256). New York, NY: Springer.

Interdisciplinary team. (2014). In *The free dictionary.* Retrieved from http://medical-dictionary.thefreedictionary.com/interdisciplinary+team

Jukkala, A., Henly, S., & Lindeke, L. (2008). Rural perceptions of continuing professional education. *Journal of Continuing Education in Nursing, 39*, 555–563. doi:10.3928/00220124-20081201-08

Kaasalainen, S., Brazil, K., Williams, A., Wilson, D., Willison, K., Marshall, D., & Taniguchi, A. (2012). Barriers and enablers to providing palliative care in rural communities: A nursing perspective. *Journal of Rural and Community Development, 7*(4), 4–19.

Kanto, W. P., Jr. (2004). Influencing career decisions in pediatrics. *Journal of Pediatrics, 144*, 693–694. doi:10.1016/j.jpeds.2004.02.001

Keahey, S. (2008). Against the odds: Orienting and retaining rural nurses. *Journal for Nurses in Staff Development, 24*(2), E15–E20. doi:10.1097/01.NND.0000300875.10684.be

Kelly, B. (1996). Hospital nursing: '"It's a battle!"' A follow-up study of English graduate nurses. *Journal of Advanced Nursing, 24*, 1063–1069. doi:10.1111/j.1365-2648.1996.tb02944.x

Kelly, B. (1998). "Preserving moral integrity": A follow-up study with new graduate nurses. *Journal of Advanced Nursing, 28*, 1134–1145. doi:10.1046/j.1365-2648.1998.00810.x

Kelly, J., & Ahern, K. (2008). Preparing nurses for practice: A phenomenological study of the new graduate in Australia. *Journal of Clinical Nursing, 18*, 910–918. doi:10.1111/j.1365-2702.2008.02308.x

Kenny, A., & Duckett, S. (2003). Educating for rural nursing practice. *Journal of Advanced Nursing, 44*, 613–622. doi:10.1046/j.0309-2402.2003.02851.x

Keon, W. J., & Kirby, J. L. (2006). *Out of the shadows at last: Transforming mental health, mental illness and addiction services in Canada*. Retrieved from http://www.parl.gc.ca/Content/SEN/Committee/391/soci/rep/pdf/rep02may06part1-e.pdf

Kramer, M. (1974). *"Reality shock": Why nurses leave nursing*. St. Louis, MO: CV Mosby.

Kulig, J. (2005, May). *The nature of rural & remote nursing: Fact sheet 2: What educational preparation do nurses need for practice in rural and remote Canada?* Retrieved from http://www.carrn.com/files/factsheet2.pdf

Kulig, J., Andrews, M. E., Stewart, N. J., Pitblado, R., MacLeod, M. L., Bentham, D., … Smith, B. (2008). How do registered nurses define rurality? *Australian Journal of Rural Health, 16,* 28–32. doi:10.1111/j.1440-1584.2007.00947.x

Kulig, J., & Stewart, N. (2006). Fact sheet 4: Aboriginal nurses in rural and remote Canada. *The Nature of Rural & Remote Nursing, 4*, 1–2. Retrieved from http://www.carrn.com/files/factsheet4.pdf

Kvarnstrom, S. (2008). Difficulties in collaboration: A critical incident study of interprofessional healthcare teamwork. *Journal of Interprofessional Care, 22*, 191–203. doi:10.1080/13561820701760600

Lang, C. (2001). *Transition, females and computing: A double whammy?* [Abstract]. Swinburne University of Technology, School of Information Technology: University of South Carolina.

LaSala, K. (2000). Nursing workforce issues in rural and urban settings: Looking at the difference in recruitment, retention and distribution. *Online Journal of Rural Nursing and Health Care, 1*(1), 8–17. Retrieved from http://www.coloradonursingcenter.org/sites/default/files/Nursing%20Workforce%20Retention%20and%20Recruitment%20Issues%20in%20Urban%20and%20Rural%20Settings%202000.pdf

Lavoie-Tremblay, M., Paquet, M., Marchionni, C., & Drevniok, U. (2011). Turnover intention among new nurses: A generational perspective. *Journal for Nurses in Staff Development, 27*(1), 39–45. doi:10.1097/NND.0b013e31819945c1

Lavoie-Tremblay, M., Wright, D., Desforges, N., Gélinas, C., Marchionni, C., & Drevniok, U. (2008). Creating a healthy workplace for new-generation nurses. *Journal of Nursing Scholarship, 40,* 290–297. doi:10.1111/j.1547-5069.2008.00240.x

Lea, J., & Cruickshank, M. (2007). The experience of new graduate nurses in rural practice in New South Wales. *International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy, 7*, 814–825. Retrieved from http://www.rrh.org.au/publishedarticles/article_print_814.pdf

Learning. (2014). In *Oxford dictionaries*. Retrieved from http://www.oxforddictionaries.com/definition/english/learning

Lincoln, Y., & Guba, E. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.

Liston, R., Sawchuck, D., & Young, D. (2007). Fetal health surveillance: Antepartum and intrapartum consensus guideline [Supplement 4]. *Journal of Obstetrics and Gynaecology Canada, 29*(9), S1–S56. Retrieved from http://sogc.org/wp-content/uploads/2013/01/gui197CPG0709r.pdf

Long, K. A., & Weinert, C. (2013). Rural nursing: Developing the theory base. In C. A. Winters (Ed.), *Rural nursing: Concepts, theory, and practice* (4th ed., pp. 1–14). New York, NY: Springer.

MacKinnon, K. (2011). We cannot staff for 'what ifs': The social organization of rural nurses' safeguarding work. *Nursing Inquiry, 19*(3), 259–269. doi:10.1111/j.1440-1800.2011.00574.x

MacLeod, M. L. P. (1998). *"We're it": The nature of rural nursing practice in very small rural and remote hospitals in northern British Columbia*. Prince George, BC, Canada: University of Northern British Columbia.

MacLeod, M. L. P. (1999). *Health in rural settings: Contexts for action*. Prince George, BC: University of Northern British Columbia.

MacLeod, M. L. P., Kulig, J. C., Stewart, N. J., Pitblado, J. R., Banks, K., D'Arcy, C., … Bentham, D. (2004). *The nature of nursing practice in rural and remote Canada*. Retrieved from http://www.cfhi-fcass.ca/Migrated/PDF/ResearchReports/OGC/macleod_e.pdf

MacLeod, M. L. P., Misener, R., Banks, K., Morton, A. M., Vogt, C., & Bentham, D. (2008). "I'm a different kind of nurse": Advice from nurses in rural and remote Canada. *Nursing Leadership, 21*(3), 40–53.

MacLeod, M. L. P., & Zimmer, L. (2005). Rethinking emancipation and empowerment in action research: Lessons from small rural acute care hospitals. *Canadian Journal of Nursing Research, 37*(1), 68–84.

Martin, G. (2014). *Double whammy.* Retrieved from http://www.phrases.org.uk/meanings/119750.html

McKenna, B. G., Smith, N. A., Poole, S. J., & Coverdale, J. H. (2003). Horizontal violence: Experiences of registered nurses in their first year of practice. *Journal of Advanced Nursing, 42*(1), 90–96. doi:10.1046/j.1365-2648.2003.02583.x

McKenna, L., & Newton, J. M. (2007). After the graduate year: A phenomenological exploration of how new nurses develop their knowledge and skill over the first 18 months following graduation. *Australian Journal of Advanced Nursing, 25*(4), 9–15.

Melrose, S. (2009). Naturalistic generalization. In A. J. Mills, G. Durepos, & E. Wiebe (Eds.), *Encyclopedia of case study research* (Vol. 2, pp. 599–600). Thousand Oaks, CA: Sage.

Meyer Bratt, M. (2009). Retaining the next generation of nurses: The Wisconsin nurse residency program provides a continuum of support. *Journal of Continuing Education in Nursing, 40,* 416–426. doi:10.3928/00220124-20090824-05

Mills, J., Francis, K., & Bonner, A. (2007). The accidental mentor: Australian rural nurses developing supportive relationships in the workplace. *International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy, 7,* 842–853. Retrieved from http://www.rrh.org.au/publishedarticles/article_print_842.pdf

Mills, J., Francis, K., & Bonner, A. (2008). Walking with another: Rural nurses' experiences of mentoring. *Journal of Research in Nursing, 13*, 23–35. doi:10.1177/1744987107078907

Mills, J., Lennon, D., & Francis, K. (2007). Contributing to a culture of learning: A mentor development and support project for Australian rural nurses. *International Journal of Nursing Practice, 13,* 393–396. doi:10.1111/j.1440-172X.2007.00656.x

Molinari, D. L., Jaiswal, A., & Hollinger-Forrest, T. (2011). Rural nurses: Lifestyle preferences and education perceptions. *Online Journal of Rural Nursing and Health Care, 11*(2), 16–26.

Morse, J. M. (2008). Confusing categories and themes. *Qualitative Health Research, 18,* 727–728. doi:10.1177/1049732308314930

Morse, J. M., Barrett, M., Mayan, M., Olson, K., & Spiers, J. (2002). Verification strategies for establishing reliability and validity in qualitative research. *International Journal of Qualitative Methods, 1*(2), 1–19.

Myrick, F. (2002). Preceptorship and critical thinking in nursing education. *Journal of Nursing Education, 41*(4), 154–164.

Nolte, J. (2005). *Enhancing interdisciplinary collaboration in primary health care in Canada*. Retrieved from http://www.eicp.ca/en/resources/pdfs/enhancing-interdisciplinary-collaboration-in-primary-health-care-in-canada.pdf

Nour, A. V. (2009). *Theory "becoming alive": The learning experiences of newly graduated nurses* (Doctoral dissertation). Available from ProQuest Dissertations and Theses database. (UMI No. NR54460)

Oelke, N. D., White, D., Besner, J., Doran, D., McGillis Hall, L., & Giovannetti, P. (2008). Nursing workforce utilization: An examination of facilitators and barriers on scope of practice. *Nursing Leadership, 21*(1), 59–71.

Olade, R. (2004). Evidence-based practice and research utilization activities among rural nurses. *Journal of Nursing Scholarship, 36,* 220–225. doi:10.1111/j.1547-5069.2004.04041.x

Ostini, F., & Bonner, A. (2012). Australian new graduate experiences during their transition program in a rural/regional acute care setting. *Contemporary Nurse, 41,* 242–252. doi:10.5172/conu.2012.41.2.242

Parker, V., Plank, A., & Hegney, D. (2003). Adequacy of support for new nurses during their transition into the workplace: A Queensland, Australia study. *International Journal of Nursing Practice, 9,* 300–305. doi:10.1046/j.1440-172X.2003.00433.x

Parse, R. (2006). Nursing science: The transformation of practice. In W. K. Cody (Ed.), *Philosophical and theoretical perspectives for advanced nursing practice* (pp. 65–72). Toronto, ON, Canada: Jones and Bartlett.

Penz, K. L., D'Arcy, C., Stewart, N., Kosteniuk, J., Morgan, D., & Smith, B. (2007). Barriers to participation in continuing education among rural and remote nurses. *Journal of Continuing Education in Nursing, 38*(2), 58–66.

Penz, K. L., & Stewart, N. (2008). Differences in autonomy and nurse-physician interaction among rural and small urban acute care registered nurses in Canada. *Online Journal of Rural Nursing and Health Care, 8*(1), 39–53.

Propp, K. M., Apker, J., Zabava Ford, W. S., Wallace, N., Serbenski, M., & Hofmeister, N. (2010). Meeting the complex needs of the health care team: Identification of nurse-team communication practices perceived to enhance patient outcomes. *Qualitative Health Research, 20*(1), 15–28. doi:10.1177/1049732309355289

Richards, L., & Morse, J. M. (2007). *Readme first for a user's guide to qualitative methods* (2nd ed.). Thousand Oaks, CA: Sage.

Roller coaster. (2014). In *Merriam-Webster's online dictionary* (11th ed.). Retrieved from http://www.merriam-webster.com/dictionary/roller%20coaster

Romyn, D. M., Linton, N., Giblin, C., Hendrickson, B., Limacher, L. H., Murray, C., … Zimmel, C. M. (2009). Successful transition of the new graduate nurse. *International Journal of Nursing Education Scholarship, 6*(1), 1–17. doi:10.2202/1548-923X.1802

Rosenthal, K. (2006). What rural nursing stories are you living? *Online Journal of Rural Nursing and Health Care, 5*(1), 37–47.

Rush, K., Adamack, M., & Gordon, J. (2013). Expanding the evidence for new graduate nurse transition best practices. Retrieved from http://www.msfhr.org/sites/default/files/Expanding_the_Evidence_for_New_Graduate_Nurse_Transition_Best_Practices_0.pdf

Scharff, J. (2006). The distinctive nature and scope of rural nursing practice: Philosophical bases. In H. J. Lee, & C. A. Winters (Eds.), *Rural nursing: Concepts, theory, and practice* (2nd ed., pp. 179-196). New York, NY: Springer.

Scharff, J. (2013). The distinctive nature and scope of rural nursing practice: Philosophical basis. In A. Winters (Ed.), *Rural nursing: Concepts, theory and practice* (4th ed., pp. 247–258). New York, NY: Springer.

Sedgwick, M. G. (2008). *A focused ethnography of preceptorship in rural acute care hospitals* (Doctoral dissertation). University of Alberta, Edmonton, AB, Canada.

Sedgwick, M. G. (2011). Rural acute care hospital interdisciplinary team members' experience of undergraduate nursing preceptorship: A qualitative descriptive study. *Nurse Education in Practice, 11,* 278–282. doi:10.1016/j.nepr.2011.01.004

Sedgwick, M. G., & Yonge, O. (2008). 'We're it', 'we're a team', 'we're family' means a sense of belonging. *International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy, 8,* 1021–1033.

Sevean, P. A. (2012). *Learning to transition: Nurses' entry into cancer nursing practice* (Doctoral dissertation). University of Toronto, ON, Canada.

Shock. (2014). In *Oxford dictionaries*. Retrieved from http://www.oxforddictionaries.com/definition/english/shock

Skillman, S. M., Palazzo, L., Keepnews, D., & Hart, L. G. (2006). Characteristics of registered nurses in rural versus urban areas: Implications for strategies to alleviate nursing shortages in the United States. *Journal of Rural Health, 22*(2), 151–157. doi:10.1111/j.1748-0361.2006.00024.x

Smith, J. (2011). Baccalaureate nurse graduates' transition into rural: An integrative literature review. Unpublished Manuscript, Centre for Nursing and Health Studies, Athabasca University, Athabasca, AB, Canada.

Srivastava, R. (2007). Understanding cultural competence in health care. In R. H. Srivastava (Ed.), *The healthcare professional's guide to clinical cultural competence* (pp. 3–27). Toronto, ON, Canada: Mosby Elsevier.

Statistics Canada. (2013). *Population and demography*. Retrieved from http://www5.statcan.gc.ca/subject-sujet/theme-theme.action?pid=3867&lang=eng&more=0&HPA

Stewart, N. J., D'Arcy, C., Pitblado, J. R., Morgan, D. G., Forbes, D., Remus, G., … MacLeod, M. (2005). A profile of registered nurses in rural and remote Canada. *Canadian Journal of Nursing Research, 37*(1), 122–145.

Stewart, N. J., D'Arcy, C., Kosteniuk, J., Andrews, M. E., Morgan, D., Forbes, D., … Pitblado, J. R. (2011). Moving on? Predictors of intent to leave among rural and remote RNs in Canada. *The Journal of Rural Health, 27,* 103–113. doi:10.111/j.1748-0361.2010.00308.x

Stewart, N. J., Kulig, J. C., Penz, K., Andrews, M. E., Houshmand, S., Morgan, D. G., … D'Arcy, C. (2006). *Aboriginal nurses in rural and remote Canada: Results from a national survey* (R06-2006). Retrieved from http://ruralnursing.unbc.ca/reports/study/Aboriginal_Report_FINAL.pdf

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research* (2nd ed.). Thousand Oaks, CA: Sage.

Street, A. (1992). *Inside nursing: A critical ethnography of clinical nursing practice*. Albany, NY: State University of New York Press.

Surprise. (2014). In *Oxford dictionaries*. Retrieved from http://www.oxforddictionaries.com/us/definition/american_english/surprise

The role of pharmacists in rural practice. (2012). *The Translator, 6*(2), 1–4. Retrieved from http://www.pharmacists.ca/cpha-ca/assets/File/education-practice-resources/Translator2012V6-2EN.pdf

Thomas, C. M., Bertram, E., & Johnson, D. (2009). The SBAR communication technique: Teaching nursing students professional communication skills. *Nursing Education, 34*(4), 176–180. doi:10.1097/NNE.0b013e3181aaba54

Thorne, S. (2008). *Interpretive description*. Walnut Creek, CA: Left Coast Press.

Thorne, S., Reimer Kirkham, S., & MacDonald-Emes, J. (1997). Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing & Health, 20,* 169–177.

Thorne, S., Reimer Kirkham, S., & O'Flynn-Magee, K. (2004). The analytic challenge in interpretive description. *International Journal of Qualitative Methods, 3*(1), 1–11.

Tupper, J., Coburn, A., Loux, S., Moscovice, I., Klingner, J., & Wakefield, M. (2008). *Strategies for improving patient safety in small rural acute care hospitals.* Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK43729/

Ulrich, B., Krozek, C., Early, S., Ashlock, C. H., Africa, L. M., & Carman, M. L. (2010). Improving retention, confidence, and competence of new graduate nurses: Results from a 10-year longitudinal database. *Nursing Economic$, 28,* 363–375.

United States National Broadcasting Service. (2013, September 3). Cited in chapter 5. Please add.

Vandall-Walker, V. (2006). *Delineating the process of nursing support with family members of the critically ill adult* (Doctoral dissertation). Faculty of Nursing, University of Alberta, Edmonton, AB, Canada.

Vapor, V. R., & Xu, Y. (2011). Double whammy for a new breed of foreign-educated nurses: Lived experiences of Filipino physician-turned nurses in the United States. *Research Theory Nursing Practice, 25*(3), 210–226.

White, D., Oelke, N. D., Besner, J., Doran, D., McGillis Hall, L., & Giovannettic, P. (2008). Nursing scope of practice: Descriptions and challenges. *Nursing Leadership, 21*(1), 44–57.

Wilding, C., & Whiteford, G. (2005). Phenomenological research: An exploration of conceptual, theoretical, and practical issues. *Occupation Participation and Health, 25*(3), 98–104.

Winters, C., & Lee, H. (2010). *Rural nursing: Concepts, theory and practice* (3rd ed.). New York, NY: Springer.

wiseGEEK. (2014). *What is a "double whammy?*" Retrieved from http://www.wisegeek.com/what-is-a-double-whammy.htm

Wolff, A., Regan, S., Pesut, B., & Black, J. (2010). Ready for what? An exploration of the meaning of new graduate nurses' readiness for practice. *International Journal of Nursing Education Scholarship, 7*(1), 1–14. doi:10.2202/1548-923X.1827

Yonge, O., Myrick, F., Ferguson, L., & Grundy, Q. (2013). "You have to rely on everyone and they on you": Interdependence and the team-based rural nursing preceptorship. *Online Journal of Rural Nursing and Health Care, 13*(1), 4–25.

Yonge, O., Myrick, F., Ferguson, L., Grundy, Q., & Cockell, J. (2011). *Through their own eyes: Images of rural nursing*. Retrieved from http://www.usask.ca/nursing/docs/ThroughTheirOwnEyes.pdf

Appendix A: Sample Research Questions

1. Please describe your transition experience into rural?
2. What are your most memorable experiences during this transition?
3. What has helped you with your transition?
4. What has not been helpful?
5. Who has helped you in this transition?
    a. Did you feel helped by the staff (managers, nurses, physicians, and so on)
    b. Did you feel helped by patients and/or family?
6. What has been supportive for you as an individual in dealing with this experience?
7. During the transition experience was there a change in what you expected from the staff?
8. During the transition experience was there a change in what you expected from patients and their families?
9. During the transition experience was there a change in how the staff were with you?
10. During the transition experience was there a change in how patients and their families were with you?

Appendix B: Sample Research Questions
Used in Addition to the Original Research Questions

1. Those nurses who have been unsupportive are they baccalaureate or degree educated nurses? Licensed practical nurses? Health Care Aides?
2. Have you found support from the United Nurses of Alberta (UNA) or College and Association for Registered Nurses of Alberta (CARNA) members?
3. Were there supportive or unsupportive physicians? If so, what culture were they? Age?
4. Did you grow up rurally?
5. Do you live in the rural community where you work? Did you move for the job or had you already lived there?
6. Was rural your first choice for work or did you go rural as a fall back because there were no jobs? Why or why not?
7. Would you recommend rural nursing to other new RNs? Why or why not?
8. Have you compared your transition to that of your classmates? Please describe.
9. Did your education prepare you for rural nursing? What would you suggest?

Appendix C: Sample Research Questions Based on Evolving Themes

1. Please describe “learning” in relation to rural during your transition.
2. Please describe “fitting in” in relation to transitioning into rural.
3. Please describe “accessing or seeking support” during transition.
4. Please describe “being ‘it’” during transition.
5. What would have kept you in rural?
6. If you had it to do over again would you choose rural and why?
7. Please describe your transition experience into rural in one phrase or sentence. What emotions come to mind?
8. What would have kept you in rural?

Appendix D: Athabasca University's Interim and Final Research Ethics Approval

DATE: March 6, 2012

TO: Jean C. Smith

COPY: Virginia Vandall-Walker, Associate Professor, Nursing & Health Studies
Dr. Simon Nuttgens, Chair, Athabasca University Research Ethics Board
Janice Green, Secretary, Athabasca University Research Ethics Board

FROM: Dr. Sherri Melrose, Chair, CNHS Research Ethics Review Committee

SUBJECT: Ethics Proposal #CNHS-12-01.: **"***New Baccalaureate Nurse Graduates' Transition into Rural Acute Care"*

The Centre for Nursing & Health Studies (CNHS) Research Ethics Review Committee, acting under authority of the Athabasca University Research Ethics Board to provide an expedited process of review for minimal risk student researcher projects, has reviewed the above-noted proposal and supporting documentation.

I am pleased to advise that this project has been awarded interim **APPROVAL TO PROCEED**. You may begin your research immediately; **HOWEVER, prior to contacting participants** the following documents are required to be submitted **for file purposes only**:

- **C1-14** should be N/A only, as the research is not being conducted at AU or utilizing AU participants.
- **Appendix G (Informed Consent)** page 24, please reword the existing sixth question/**sentence** to read: "Do you understand how measures such as data coding, reporting of grouped data, and the use of pseudonyms will be undertaken in order to maintain confidentiality of your participation and to prevent identification of your contributions in the publication of results of this research?"
- Please note, acknowledging the TCPS2 interpretation, the committee's request for this additional sentence is retracted: **Appendix G (Informed Consent)** page 24, please add the sentence "Have measures to ensure your anonymity been explained to you?" to the consent form.

The approval for the study "as presented, including additions/changes for file only" is valid for a period of year from the date of this memo. If required, an extension must be sought in writing prior to the expiry of the existing approval. **A Final Report is to be submitted when the research project is completed.** The reporting form can be found online at http://www.athabascau.ca/research/ethics/.

This approval will be reported to the Athabasca University Research Ethics Board (REB) at their next monthly meeting. The REB retains the right to request further information, or to revoke the approval, at any time.

As implementation of the proposal progresses, if you need to make any significant changes or modifications prior to receipt of a final approval memo from the AU Research Ethics Board, please forward this information immediately to the CNHS Research Ethics Review Committee via [email address] for further review.

If you have any questions, please do not hesitate to contact [email address].

MEMORANDUM

DATE: March 13, 2012

TO: Jean C. Smith

COPY: Dr. Virginia Vandall-Walker (Supervisor)
Janice Green, Secretary, Research Ethics Board
Dr. Simon Nuttgens, Chair, Research Ethics Board

FROM: Janice Green, Secretary, Research Ethics Board

SUBJECT: Ethics Proposal #CNHS-12-01 *"New Baccalaureate Nurse Graduates' Transition into Rural Acute Care"*

Thank you for your March 12, 2012, resubmitted application arising from the Centre for Nursing and Health Studies' Research Ethics Review Committee's "Approval to Proceed" decision of February 21, 2012. Your cooperation in revising to incorporate minor changes requested was greatly appreciated.

On behalf of the Athabasca University Research Ethics Board, I am pleased to confirm that this project has been granted **FULL APPROVAL** on ethical grounds, and you may proceed with participant contact immediately.

> Please ensure appropriate permissions are in place to access participants for recruitment purposes through non-public venues and lists (e.g. CARNA). As/when available, provide copies of any support or permission documentation for file purposes only (further review is not required).

The approval for this study "as presented" is **valid from the date of this memo for a period of 12 months.** A **Final Progress Report** (form) is to be submitted when the research project is completed. Reporting forms are available online at http://www.athabascau.ca/research/ethics/.

As you progress with implementation of the proposal, if you need to make any changes or modifications please forward this information to the Research Ethics Board as soon as possible. If you have any questions, please do not hesitate to contact [email address]

Athabasca University Research Ethics Board
University Research Services, Research Centre
1 University Drive, Athabasca, AB, Canada T9S 3A3
e-mail: [email address]

Appendix E: Letter of Information for Participants

Athabasca University

New Baccalaureate Nurse Graduates' Transition into Rural
Information Letter

Principal Researcher:
Jean C. Smith, RN, BScN,
Master of Nursing Student
Athabasca University
[email address]
Nursing Instructor, Red Deer College
Staff Nurse, Rocky Mountain House Health Centre
[email address]
[telephone number]

Supervisor:
Dr. Virginia Vandall-Walker
Associate Professor
Faculty of Health Disciplines
Athabasca University
Athabasca, Alberta
[email address]
[telephone number]

Background
I am inviting you to participate in my research study to investigate new baccalaureate nurse graduates' experiences of transitioning into rural acute care environments. This study is partially funded by an educational grant from the Red Deer College.

Purpose
Recent North American studies indicate that many new nurse graduates will either change their place of employment or quit nursing altogether within their first year of practice. CA reports suggest that over the next 12 years the CA Health Care System will be experiencing critical nurse shortages due to high retirement rates and poor new graduate nurse retention rates. The purpose of this study is to examine new baccalaureate nurse graduates' transition into the rural nursing environment. Only those who have gone through or are going through this transition can explain what it is like. The findings may assist us to better understand this transition experience.

Study Procedures
You will be asked to participate in an initial face-to-face interview with me that may last approximately 1 hour. You may be asked to participate in a second follow-up interview with me that may last approximately 1 hour. The initial interview will occur at a location of your choice and will begin with me asking you to fill out a Consent Form that I will ask you to sign after reviewing this information letter with me.

Athabasca University

I will then fill out a Demographic Data Form that consists of questions about

- your age;
- marital status;
- ethnic background;
- duration of employment in rural;
- type of baccalaureate nursing program attended;
- previous rural work experience;
- previous urban acute care work experience;
- previous nursing experience of any type; and
- any additional details that you may wish to include.

I will then ask you to share your story about your first months of working as a registered nurse in a rural acute care hospital. Through the course of the interview, I will ask you some questions that will assist me with understanding your experiences. The follow-up interview will be face-to-face (if possible) at a location of your choice. If a face-to-face interview is not possible, a telephone interview may be considered. During the follow-up interview I will discuss my findings and ask you questions related to those findings. The interview/s will be tape recorded with your permission. All data and forms will be kept confidential and used for analysis only.

Benefits to You

You are not guaranteed any direct benefits as a result of your participation in this study. However, this study will gather knowledge that may benefit others. Findings may be used to inform policy, education, and organizational initiatives that will support new baccalaureate nurse graduates as they transition into rural settings. Participation in this study will not result in any expenses to you beyond the time spent for the interview(s).

Risks

There are no anticipated risks for participation in this study. However, there is a chance that you may not feel comfortable sharing some of your experiences.

Voluntary Participation

Before deciding to participate, it is important that you know that you do not have to take part in the study. Participation is voluntary. You may refuse to participate, and if you do participate, you can refuse to answer certain questions or share certain information. You may withdraw from the study at any time up until the analysis is completed. Even if you agree to be in the study you can change your mind and withdraw. If you decide to opt out of the study before the analysis is completed, the data that you have provided will not be used in the study; it will be destroyed in a way that ensures your privacy and confidentiality.

Athabasca University

Confidentiality
None of your identifying information will be linked to the data. You will be given a pseudonym. This pseudonym will be used to compile data following the interview/s. My thesis supervisor and I will be the only people who will have access to your data and we will keep it confidential. All written data will be kept in a locked cupboard. All electronic data will be password protected, with the file encrypted. Study data, including personal information about you will be securely stored for 5 years after the study is over, at which time paper and audio data will be destroyed by shredding and computer data will be completely destroyed by deletion. Only grouped data will be reported during the dissemination of my findings. Individual responses may be reported as quotations within the context of a story that will include other individual responses. If the results of the study are reported in a publication, this document will not contain any information that would identify you. Within the five years of storage of data, I may wish to use the data for future analysis, but if I do this, it will have to be approved by a Research Ethics Board.

Participation and Further Information
I would very much appreciate your participation in this research project. If you choose to participate in the interview/s please telephone or email me, Jean Smith, utilizing the number and/or address listed below. If you have any questions about this study, please feel free to contact me, Jean Smith, RN, at [telephone number] or email: [email address] or my supervisor, Dr. Virginia Vandall-Walker at [telephone number] or email: [email address].

Ethical Approval
This study has been reviewed for its adherence to ethical guidelines by Athabasca University's Research Ethics Board. For questions regarding participant rights and ethical conduct of research, contact the Research Ethics Office at [telephone number].

Thank you very much for considering my request.

Sincerely,

Jean C. Smith, RN, BScN,
Master of Nursing Student
Principal Researcher,
Athabasca University

Appendix F: Informed Consent

Athabasca University

Version Date: January 29, 2012

Page 1

Title of Study: **New Baccalaureate Nurse Graduates' Transition into Rural**

Investigator(s): **Jean C. Smith, RN, BScN**
Faculty of Nursing
Athabasca University,
Athabasca, AB
Phone: [telephone number]

Virginia Vandall-Walker, PhD
Supervisor
Faculty of Nursing
Athabasca University,
Athabasca, AB

	Yes	No
Do you understand that you have been asked to be in a research study?	_____	_____
Have you read and received a copy of the attached Information Sheet?	_____	_____
Do you understand the benefits and risks involved in taking part in this research study?	_____	_____
Have you had an opportunity to ask questions and discuss this study?	_____	_____
Do you understand that you are free to leave the study at any time, without having to give a reason?	_____	_____
Has the issue of confidentiality been explained to you?	_____	_____
Do you understand who will have access to your records, including personally identifiable information?	_____	_____

This study was explained to me by: _____
Name of Person

I agree to take part in this study: _____ _____
Signature of Research Participant Date

_____
Name

_____ _____
Signature of Witness Date

_____
Printed Name

I believe the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____ _____
Signature of Investigator Date

Appendix G: Letter to College and Association of Registered Nurses of Alberta

Athabasca University

Dear [Name]:

I am an Athabasca University Master in Nursing student who is undertaking a qualitative interpretive description research study in partial fulfillment of my Master in Nursing degree. I am contacting you to request your assistance with the distribution of information letters to prospective participants for my study entitled: *New Baccalaureate Nurse Graduates' Transition into Rural.* I have received approval for this study from Athabasca University's Research Ethics Board. Please find attached Athabasca University's Research Ethics approval letter.

I am asking that you distribute the attached information letter to new baccalaureate nurse graduates across the province of Alberta. Individuals eligible to participate in this study are new baccalaureate nurse graduates inclusive of both genders and different cultures who have been employed in one or more Alberta rural acute care hospitals as registered nurses (on a full-time, part-time, or casual basis) greater than one month and less than two years. I am hoping to recruit at least 15 participants. The overall purpose of this study is to examine the factors influencing new baccalaureate nurse graduates' transition experiences into the rural nursing environment.

I will conduct a maximum of two interviews per participant. Initial interviews will be face-to-face and up and approximately one hour in length. Some subsequent re-interviews may be needed and will be either face-to-face or by telephone and approximately one hour in length. All interviews will be in locations chosen by the participants. To better ensure confidentiality I will suggest meeting in locations not associated with participants' place of work. Each initial interview will begin with a discussion of the study followed by signing of a Consent Form if the individual is willing to participate. Demographic information will be collected and will include questions about participants' age, marital status, ethnic/cultural background, duration of employment in rural and urban acute care, work experience, type of baccalaureate nursing program attended, previous rural work experience, and any additional details that participants may wish to include. Open ended questions will then be asked to encourage each participant to share his or her story about the first months of working as a registered nurse in a rural acute care hospital. During the follow-up interview the initial findings will be discussed with each participant with opportunity for each individual to ask questions related to those findings. Interviews will be tape-recorded (with permission of the participants), kept confidential and secure, and be used for analysis only.

AU Athabasca
1 University Drive
Athabasca, AB T9S 3A3
Canada

Phone: [telephone number]
Toll-free (Canada/U.S.): [telephone number]
Fax: [fax number]
www.athabascau.ca
Enquiries: www.askau.ca

CANADA'S OPEN UNIVERSITY

Athabasca University

In this study, no identifying information will be linked to individual responses. Each participant will be given a pseudonym and transcripts and interview notes will be assigned a numerical code. The informed consents and demographic information will be kept separate from the transcripts. All written data will be kept in a locked cupboard and all electronic data will be password protected, with the file encrypted. After 5 years, a paper and audio data will be destroyed by shredding and all computer data will be destroyed by complete deletion. The rural facilities where participants are employed will not be informed of the participation or non-participation of their employees. Individual responses will be reported as aggregate data, quotes, and in the form of a vignette with no disclosure of participants' identities or places of employment.

Participation in this study is voluntary and there are no known risks associated with this study. Findings may be used to inform policy, education, and organizational initiatives that will support new baccalaureate nurse graduates as they transition into rural settings. Participation in this study will not incur any expenses to participants beyond the time spent for interview(s).

Thank you for your attention in this matter. Please feel free to contact either myself (Jean Smith) or my thesis supervisor (Dr. Virginia Vandall-Walker) as indicated below, should you require more information.

Sincerely,

Principal Researcher:
Jean C. Smith, RN, BScN,
Master of Nursing Student
Athabasca University
[email address]
Nursing Instructor, Red Deer College
Staff Nurse, Rocky Mountain House
Health Centre
[email address]
[telephone number]

Supervisor:
Dr. Virginia Vandall-Walker
Associate Professor
Faculty of Health Disciplines
Athabasca University
Athabasca, Alberta
[email address]
[telephone number]

Appendix H: Demographic Data Form

Revised April 13, 2012

Title of project: New Baccalaureate Nurse Graduates' Transition into Rural

Pseudonym _____ Date of Interview _____

Personal Information

Initials: _____

Address: _____

Phone Number/Email: _____

Age: _____ Gender: _____ Marital status: _____

Cultural background: _____ Type of baccalaureate program attended: _____

Year Graduated: _____ Number of months employed in rural acute care: _____

Are you employed full-time _____ part-time _____ casual _____?

Previous rural work experience:

None _____ Some _____ Amount _____

Details (your status, where, what unit) _____

Previous urban acute care experience:

None _____ Some _____ Amount _____

Details (your status, where, what unit) _____

Previous nursing experience of any type:

None _____ Some _____ Amount _____

Details (your status, where, what unit) _____

Are you currently working in both rural and urban settings?

Yes_____ No _____

Additional Notes

_____