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Commuting Away: The Experiences Of RNs Who Live In Rural Communities And Commute Away For Employment In Non-Rural Communities

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COMMUTING AWAY: THE EXPERIENCES OF RNs WHO LIVE IN RURAL
COMMUNITIES AND COMMUTE AWAY FOR EMPLOYMENT IN NON-RURAL
COMMUNITIES

by

Laurie Jo Johansen, MS, RN
Bachelor of Science in Nursing, South Dakota State University, 2004
Master of Science in Nursing, South Dakota State University, 2008

A Dissertation
Submitted to the Graduate Faculty

of the

University of North Dakota

in partial fulfillment of the requirements

for the degree of

Doctor of Philosophy in Nursing
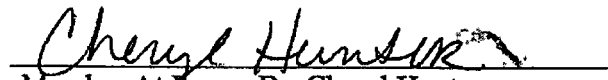

Grand Forks, North Dakota

May
2017

This dissertation, submitted by Laurie Jo Johansen in partial fulfillment of the requirements for the Degree of Doctor of Philosophy from the University of North Dakota, has been read by the Faculty Advisory Committee under whom the work has been done and is hereby approved.
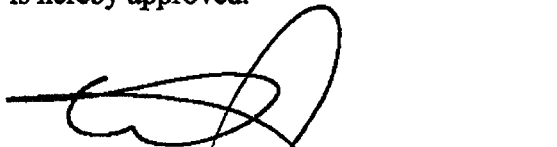
Dr. Tracy Evanson: Chairperson

Member: Dr. Jody L. Ralph

Member: Dr. Gary Hart

Member At Large: Dr. Cheryl Hunter

This dissertation is being submitted by the appointed advisory committee as having met all of the requirements of the School of Graduate Studies at the University of North Dakota and is hereby approved.

Dr. Grant McGimpsey,
Dean of the School of Graduate Studies

April 27, 2017

Date

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PERMISSION

Title   Commuting Away: The Experiences of RNs Who Live in Rural Communities and Commute Away for Employment in Non-Rural Communities

Department   Nursing

Degree   Doctor of Philosophy

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Laurie Jo Johansen
April 25, 2017

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ACKNOWLEDGEMENTS

I would like to express my gratitude to the many individuals who have supported me throughout this life-changing dissertation adventure. Writing this acknowledgement puts the finishing touches on my dissertation, which has been a once in a lifetime opportunity for me.

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ABSTRACT

A lack of healthcare providers, including RNs, creates barriers for the U.S. rural population to access adequate healthcare services. One contributing factor to the scarcity in rural areas is the increasing numbers of RNs commuting away from rural communities for employment—14% in 1980 to 37% in 2004 (Skillman, Palazzo, Doescher, & Butterfield, 2012).

This descriptive phenomenology study investigated the experiences of RNs living in rural communities who commuted away to non-rural settings for employment. Purposeful sampling with snowballing was used to recruit 16 RNs for the study, allowing for understanding a rich variation in the professional experiences of RNs, as well as experiences surrounding where they lived, through analysis of data obtained using semi-structured interviews. The essence, or core meaning, of nurses commuting away from their rural, home communities was found to be "Commuting to Achieve Personal and Professional Goals While Being a Nurse in a Rural Community." The overall findings included multifaceted reasons for nurses to commute to non-rural healthcare settings, including more noteworthy findings, such as nurses' desires to seek specialized areas of nursing practice, and opportunities for advancement in nursing. Additionally, it was notable that all nurses felt valued as a nurse in their rural, home community.

The findings from this study can be used to benefit nursing practice, policy development, employers of nurses in rural settings, and nursing education, impacting recruitment and retention

efforts that focus on nurses in rural settings. In the end, it was apparent that recruitment and

retention efforts in rural areas need to be unique, without a "one size fits all" application.

Keywords: Nurse, Rural, Commuting, Recruitment, Retention

CHAPTER I

INTRODUCTION

The achievement of health equity for all Americans through the access of comprehensive, quality healthcare is a goal of Healthy People 2020, a national effort to prioritize and support improvements in health and healthcare disparities through policies and services (US Department of Health and Human Services [HHS], 2014). Despite this goal, the U.S. rural population faces significant healthcare disparities, which creates challenges in obtaining quality healthcare (HHS, Health Resources and Services Administration [HRSA], 2009).

The uniqueness of healthcare disparities in the rural United States parallels the uniqueness of rural cultures and communities. One distinctive feature of healthcare disparities experienced by the rural population has been the scarcity of available healthcare providers, including RNs (Hart, Salsberg, Phillips, & Lishner, 2002; Larson et al., 2003; MacDowell, Glasser, Fitts, Nielsen & Hunsaker, 2010; National Rural Health Association [NRHA], 2016). This shortage has led to challenges in the rural population's access to healthcare.

One factor that contributes to this disparity is the increasing number of RNs commuting away from their rural, home communities for employment (Skillman, Palazzo, Keepnews, & Hart, 2006). In 2004, the National Sample Survey of Registered Nurses (NSSRN) revealed that 37% of RNs living in rural communities commute for employment. In addition, the percentage of RNs commuting away from their rural, home communities had increased from 14% in 1980 to 37% in 2004, and the percentage of RNs commuting was greater than 60% in isolated small rural communities (Skillman, Palazzo, Doescher, & Butterfield, 2012). Healthcare employment

options vary in rural, home communities. Some rural communities lack healthcare employment opportunities for RNs living there, forcing the RN to commute for employment. On the other hand, other rural communities have employment opportunities for RNs; despite these employment opportunities, RNs commute for employment. Current commuter trend data for these nurses is not found in the literature.

Little is known about the experiences of nurses commuting away from their home communities for employment (Buerhaus, Staiger, & Auerbach, 2009), and the reasons behind the phenomenon of commuting away. This knowledge is needed in order to appropriately and adequately inform nursing practice, policy development, employers of nurses in rural settings, and nursing educational agencies in the United States about the experiences of these nurses. In the end, this knowledge will prepare RNs to practice in rural healthcare settings, and inform recruitment and retention efforts, ultimately creating access to quality healthcare for the rural population.

Problem Statement

The defined problem for the current study is the rural population's lack of access to adequate healthcare, in part because there is a lack of sufficient numbers of healthcare providers, including RNs, in rural areas. This problem was formulated based on the premises that (a) rural populations face health disparities not experienced by non-rural populations; (b) there are consistent disparities faced by the rural population with a scarcity of healthcare providers, including RNs; (c) recruiting and retaining nurses and other healthcare providers to rural areas has been historically difficult; (d) one of the contributing factors to the scarcity of RNs in rural areas is that RNs living in those communities commute for employment in non-rural areas; and,

e) the trend of an increasing percentage of nurses commuting away will only make the scarcity of nurses in rural areas a bigger problem in the future.

There was a notable gap in the literature regarding causes of nurses' commuter trends in rural settings. Skillman et al. (2012) assumed that wages were the primary driving force for RNs to commute away, but little research focused on other reasons. The extant literature regarding workforce issues in rural healthcare facilities was predominantly quantitative in nature, and left questions unanswered regarding the driving forces behind the phenomenon and the experiences of nurses who commute away from rural, home communities. Additionally, a majority of the literature related to nursing in rural communities originated in Australia and Canada, with a gap in the literature regarding commuter experiences among RNs from rural communities in the United States.

In a comprehensive literature review regarding influences on the retention of rural nurses, Roberge (2009) identified the need for further research to describe and understand the complexities of RNs living in rural communities. Furthermore, the Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI) Rural Health Research Center supported the need for further examination of the phenomenon of *"commuting away"* to help understand the impact on rural communities (Skillman et al., 2012).

In the current study, a qualitative approach, focused on RNs' personal experiences of commuting from their rural communities, allowed formulation of a description that led to a deeper and fuller understanding of the factors involved in the phenomenon of *"commuting away."* It is important to stabilize or diminish disparities affecting rural healthcare through adequate healthcare services and a sufficient number of healthcare professionals. Further research regarding *"commuting away"* is needed in order to understand the phenomenon, and

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inform nursing practice, policy development, employers of nurses in rural settings, and nursing educators.

Phenomenon, Population of Interest, Purpose, Goal, and Specific Aims

Phenomenon and Population of Interest

The phenomenon of interest for the current study was *"commuting away."* Additionally, the population of interest in which the phenomenon of interest was studied was within a sample of RNs living in rural communities, with those rural communities having healthcare facilities within their boundaries.

Purpose

The purpose of the current study was to describe the phenomenon of *"commuting away"* to non-rural settings, as experienced by RNs living in rural communities. The current study went beyond the assumptions that wages are one of the primary factors leading to commuter trends in order to discover all aspects of the phenomenon and the meaning it has for those RNs who live it.

Goal

The overall goal of the current study was to provide knowledge that will inform future RN recruitment and retention strategies, leading to improvements that will reduce or eliminate the scarcity and misdistribution of RNs in the rural United States.

Specific Aims

The specific aims of the current study were to:

1. Describe the context of living in a rural community, experienced by RNs who commute away to a non-rural setting,

2. Describe factors involved in the RNs' decisions to commute away to a non-rural setting, and

3. Describe how *"commuting away"* from a rural community affects the personal and professional lives of RNs who experience it.

Definition of Terms

Commute is to "travel regularly to and from a place and especially between where you live and where you work" ("Commute," 2015, para. 2).

Commuter is "a person who commutes" ("Commute," 2015, para. 1).

Commuting away, for the purpose of the current study, is defined as traveling away from the rural, home community for conventional employment in non-rural settings.

Critical Access Hospital is defined as "a hospital certified under a set of Medicare Conditions of Participation (CoP), which are structured differently than the acute care hospital CoP" (HHS, HRSA Health Information Technology, n.d., para. 1). "The Critical Access Hospitals (CAH) program works to improve access to rural healthcare and reduce rural hospital closure... [by providing] essential services to a community" (Rural Assistance Center [RAC], 2014a, para. 1). Some of the location requirements for a CAH include either being located more than 35 miles away from another hospital, or being located 15 miles from another hospital that is located in an area with mountainous terrain or in an area that has only secondary roads (RAC, 2014a).

Non-rural areas, for the purpose of the current study, are defined as communities with 2,500 or more inhabitants. This definition goes beyond the rural definition to include both urban areas, which are defined as "50,000 or more people" (U.S. Department of Commerce, United States Census Bureau, 2015, para. 3) and urban clusters, which are defined as "at least 2,500 and fewer than 50,000 people" (U.S. Department of Commerce, United States Census Bureau, 2015, para. 4).

Phenomenon is defined as "an object, a matter, a 'thing' or a 'part' of the world, as it presents itself to, or, as it is experienced by, a subject" (Dahlberg, Nyström, & Dahlberg, 2008, p. 33). Thus, a phenomenon is an occurrence of something that a person experiences. In nursing research, phenomena that are subjects of study are typically concepts related to humanity or human conditions.

Residential is defined as the place where people lived.

Rural is defined as a community of less than 2,500 inhabitants as specified in the U.S. Census Bureau's definition: "all territory, population, and housing units located outside urban areas and urban clusters" (U.S. Department of Commerce, United States Census Bureau, 2015, para. 1).

Significance

The phenomenon of *"commuting away,"* among RNs living in rural communities, leaves the U.S. rural population at risk because of the scarcity of RNs working in rural healthcare settings. With the increase in RNs *"commuting away,"* there is a need to know more about the experiences of these RNs and the factors involved in this phenomenon of *"commuting away."* Previous research and recruitment efforts assumed that the primary driving force behind this phenomenon of *"commuting away"* was primarily due to higher wages offered in non-rural areas (Skillman et al., 2012). However, little empirical evidence exists to support this assumption, little was known about effective retention strategies for nurses living and practicing in rural communities, and little was known about the experiences of these RNs *"commuting away."* Thus, in order to develop the most effective RN recruitment and retention strategies for rural healthcare facilities, a full understanding of the experiences of those RNs who commute away was necessary.

This descriptive phenomenological study informs future recruitment and retention efforts by describing the experiences of RNs living in rural communities who commute away to non-rural healthcare settings. With generalizable data not being the goal of qualitative research, the findings from this study do not represent all rural nurse experiences. However, the added depth of understanding *"commuting away"* benefits nursing practice, policy development, employers of nurses in rural settings, and nursing education as they pursue unique educational, recruitment, and retention strategies specific to rural settings. Furthermore, the foundational knowledge from the current study, including the description of *"commuting away,"* from the perspective of those who live it, will inform future research, leading to strategies that address the growing shortage and/or misdistribution of RNs in rural areas.

Innovation

There was minimal extant knowledge of factors contributing to RNs *"commuting away"* from rural communities. The current study will greatly augment the existing research on this phenomenon, which was largely limited to quantitative data, by revealing the context of *"commuting away"* and the meaning of the phenomenon for those RNs who live it. While previous research was undertaken to quantify the problem, qualitative inquiry will provide a rich description of the phenomenon, in order to afford an opportunity to gain a deeper understanding of why the phenomenon exists. No other studies that provide this perspective could be located in the published literature. Thus, the current study addressed an important gap in the extant, empirical knowledge.

Overview of Approach

Phenomenology was the philosophical foundation for the research approach in the current study used to describe the experiences of RNs who commute away. This approach led to the

pragmatic use of a deeper understanding of the topic at hand, rather than seeking a surface description of a large sample population (Streubert & Carpenter, 2011). Phenomenology is grounded in the philosophy of Edmund Husserl, who criticized the oversimplification of complex topics measured in scientific research. Husserl's premise was that such oversimplification resulted in the dehumanization of humanity and created a distance between science and the human world (Dahlberg et al., 2008).

In the current study, oversimplification of the phenomenon of *"commuting away"* from rural, home communities was exemplified by the assumption that higher non-rural wages were the primary reason for commuter trends among RNs in rural communities, without consideration of the experiences of those RNs, or other factors, that may contribute to the phenomenon. Dahlberg et al. stated the philosophy of phenomenology mandates that the everyday human world be used as the basis of science while ensuring researcher objectivity with the research project. According to Husserl, the mandate of phenomenological philosophy is to go "to the things themselves" (Dahlberg et al., 2008, p. 32). Phenomenological inquiry gives meaning to participant's perceptions of their experiences living in rural communities and *"commuting away."*

The goal of descriptive, phenomenology is to identify the essence, or the core meaning, of the phenomenon and the accompanying structure in which the phenomenon presents itself. Thus, descriptive phenomenology was the research approach most appropriate to achieve the aims of the current study and describe the phenomenon of *"commuting away."*

Researcher as Instrument

Throughout the current study, I was immersed in my own existence and experiences, as well as the existence and experiences of the study participants. Having lived in a rural

community my entire life, my history included more than 30 years of nursing practice in a rural setting. This created the benefits of a profound sense of contextual credibility, along with the challenges of researcher bias, assumptions, and personal impositions intruding into the study. It was important that I reflect on the world in which I lived in order to allow the phenomenon to present itself as it was lived through the participants' experiences, and not how it had been lived through my own. Reflexive journaling was used throughout the current study to substantiate detachment from my previous lived experiences, allowing abstract thinking to guide the research while minimizing the effects of my assumptions (Glaser, Strauss, & Strutzel, 1968). Such reflexivity created the ability for me to uncover my own presuppositions and professional perspectives, leading to the achievement of phenomenological insights during the current study without influencing the participants' understandings of the phenomenon (Dahlberg et al., 2008). An explication of my beginning assumptions about the phenomenon is covered in Chapter III.

Summary

The Institute of Medicine (IOM), Committee on the Future of Rural Health Care (2005) called for "a renewed and vigorous effort [that] must be made to enhance the health professions workforce in rural areas" (p. 7) and goals for achieving health equity for everyone in the United States through the access of comprehensive, quality healthcare, as outlined in Healthy People 2020 (HHS, 2014). To meet these goals, actions need to be taken regarding the uniqueness of healthcare disparities in the rural United States that lead to challenges in accessing healthcare. Included among these healthcare disparities is the scarcity and misdistribution of RNs in rural communities. The knowledge gap related to the understanding of RNs who commute away from their rural, home communities for employment in non-rural areas needs to be explored. This

knowledge is critical in order to create meaningful and effective recruitment and retention strategies in rural areas.

The remainder of the current study is organized in the following four chapters. Chapter II includes a literature review focusing on rural health, disparities in accessing rural healthcare, scarcity of rural healthcare professionals, rural nursing theory, nurse job satisfaction, and recruitment and retention of nurses in rural communities. It also includes recommendations for nurse recruitment and retention in rural settings, aligning the phenomenon of RNs *"commuting away"* from rural, home communities in a context for inquiry. Chapter III focuses on the research design for the current study. Chapter IV presents the findings of the current study, while Chapter V includes a discussion of the findings and implications of the current study.

CHAPTER II

LITERATURE REVIEW

The purpose of this phenomenological study was to describe and better understand the experiences of RNs commuting to non-rural settings, as experienced by RNs living in rural communities. Phenomenology, as a research method, traditionally follows data collection with a literature review as part of the data analysis. However, with respect for such practices, this research could not begin without an awareness of the need for the context of the study at hand. The current study was supported by the following review of literature that was used as an impetus for the study but not to formulate pre-theoretical ideas to the researcher or participants in this study. Chapter II builds a case for this research through a review of literature related to rural health, disparities in accessing rural healthcare, scarcity of rural healthcare professionals, rural nursing theory, nurse job satisfaction, recruitment and retention of nurses in rural communities, and recommendations for nurse recruitment and retention in rural settings.

Rural Health and Disparities in Accessing Rural Healthcare

Quality of life is a goal of individuals, communities, and governmental agencies, and the delivery of quality healthcare to all citizens in the United States is a part of ensuring quality of life for Americans. Achieving health equity, while removing disadvantages that can result in health disparities, leads to improved health and quality of life for all people (Larson et al., 2003; US Department of Health and Human Services [HHS], Agency for Healthcare Research and Quality [AHRQ], 2016). Disadvantages leading to health disparities, such as disparities in

accessing healthcare, are associated with suboptimal levels of health and have led to the prioritization of equitable access to healthcare throughout the nation (HHS, AHRQ, 2016). Reducing healthcare disparities with the delivery of quality healthcare can lead to an improved quality of life for all.

Healthcare needs and challenges faced by the rural population are demographically distinct. Recent data demonstrates that an estimated 46.2 million U.S. inhabitants are rural residents living in areas known as nonmetropolitan, resulting in approximately 14% of the U.S. population living on 72% of the nation's landmass (United States Department of Agriculture [USDA], Economic Research Service, 2016). Many of the healthcare needs and challenges faced by the rural population are similar to those experienced by their non-rural counterparts; however, distinct challenges are faced by the rural population with such a small population being spread over a large region (Bellamy, Bolin, & Gamm, 2011).

Historically, minimal data have been available regarding rural health needs. Thus, Rural Healthy People came to fruition to provide data specific to rural populations (Gamm & Van Nostrand, 2003). Rural Healthy People is a companion to Healthy People and was created in 2010 at the Office of Rural Health Policy and the Southwest Rural Health Research Center. The purpose of Rural Healthy People was to substantiate the health needs of the rural population. Since rural health is not a subset in Healthy People, Rural Healthy People addressed this absence, as well as the problems of obtaining reliable rural data. Rural Healthy People 2010 and Rural Healthy People 2020 were focused efforts to prioritize rural health and healthcare disparities in order to support improving rural health through policies and services (Bellamy et al., 2011; Bolin & Bellamy, 2012; Gamm & Van Nostrand, 2003). Such resources help identify

the unique needs of the rural population as well as the challenges they experience accessing quality healthcare.

Health Status Disparities

Significant health status disparities have been identified within the rural, as compared to the non-rural, U.S. population. Rural residents are typically older (Meit, 2004) and more likely to be in fair to poor health. Rural populations have increased frequencies of chronic diseases (Institute of Medicine [IOM], Committee on the Future of Rural Health Care, 2005) with at least one major chronic illness affecting nearly 50% of rural residents (HHS, 2006), as well as higher self-reported rates of obesity among women (Rural Health Research & Policy Centers, 2014). Several years ago, data utilized by Rural Healthy People 2010 revealed rural dwellers, in comparison to non-rural counterparts, have significantly higher use and abuse rates of tobacco and alcohol (Gamm & Van Nostrand, 2003). More recently, data reveals that adolescent most likely to smoke lived in the most rural U.S. counties and adults most likely to smoke lived in nonmetropolitan U.S. counties (Rural Health Research & Policy Centers, 2014). Suicide rates are also found to be higher for rural U.S. residents, with suicide rates between 2008-2010 increasing as the level of rurality increases (Rural Health Research & Policy Centers, 2014).

Inequalities in overall life expectancy between non-rural and rural residents have substantially increased (James, 2014; Pesek et al., 2010; Singh & Siahpush, 2014). In fact, the annual age-adjusted death rate from the five leading causes of death in the United States, between the years of 1999 and 2014, were lower in metropolitan areas in comparison to nonmetropolitan areas. It is important to note that the five leading causes of death in the United States are cancer, cerebrovascular diseases, chronic lower respiratory disease, heart disease, and unintentional injuries (Moy et al., 2017).

Specifically, infant mortality rates in rural U.S. communities are higher than non-rural

areas (HHS, 2006; Rural Health Research & Policy Centers, 2014). More specifically, infant

deaths per 1,000 live births had a mortality rate of 6.5 deaths nationally in comparison to a rate

of 6.9 deaths in nonmetropolitan counties. Additionally, death rates for young adults, and

children, in the United States was highest in the counties that were most rural (Rural Health

Research & Policy Centers, 2014). Higher rates of morbidity and mortality in rural areas are

because, in part, of higher rates of chronic disease, obesity, substance use and abuse, and infant

mortality, in addition to deaths resulting from unintended occupational, recreational, and

environmental injuries and accidents (Gamm & Van Nostrand, 2003; IOM, 2005; National Rural

Health Association [NRHA], 2016). The health status of the rural population is significantly

different from the non-rural population.

Access to Healthcare

Rural residents have fewer options for healthcare, reducing the likelihood of equitable

access to healthcare (Litaker, Koroukian, & Love, 2005). In 2003, Gamm and Van Nostrand

examined the Healthy People focus areas and noted "Access to Quality Health Services . . . is the

Healthy People 2010 focus area most frequently selected as a rural health priority in a survey of

state and local rural health leaders" (p. 5). In 2006, it was noted that 20 million rural residents

had inadequate access to healthcare services (HHS, 2006).

Challenges in accessing healthcare for the rural population are increasingly evident

within the U.S. political environment. Healthcare policy changes have led to drastic reductions

in healthcare services, including the closures of hospitals and the decreases in services provided

by homecare agencies (Graves, 2008). Areas of rural healthcare service deficits include

emergency, hospital, primary care, long-term care, and public health, as well as mental health

and substance abuse services (HHS, 2006; Johnson, 2006; Thomas, Ellis, Konrad, Holzer, & Morrissey, 2009).

Rural residents are a vulnerable population with challenges related to accessing quality health services, and overcoming these challenges is one of the top priorities espoused in the Healthy People 2020 (Bolin & Bellamy, 2012). The distinctive disparities experienced by the rural population create continued, persistent challenges in accessing healthcare. The delivery of quality healthcare to the rural population is part of ensuring a quality of life for rural residents. Challenges accessing healthcare for rural populations lead to rural populations that have access to a lower quality of healthcare (Baldwin et al., 2004) and poorer patient outcomes (HHS, AHRQ, 2012). For example, higher mortality rates are found in rural hospitals for those individuals with acute myocardial infarctions (Baldwin et al., 2004). Rural residents report fewer healthcare provider visits and fewer preventive health screenings (Jackson et al., 2009) which, along with a shortage of healthcare providers, is supportive evidence that rural residents are less likely to receive recommended preventive services than those in non-rural areas (HHS, AHRQ, 2012; NRHA, 2016). Additionally, many rural dwellers have undiagnosed and untreated substance abuse disorders and mental illnesses because of the lack of access to appropriate healthcare services (HHS, 2006; NRHA 2016). The healthcare infrastructure in rural settings intensifies the challenges rural dwellers face in accessing quality healthcare. Acknowledging and addressing the access disparities is necessary in order to enable the rural population to thrive and achieve their quality of life goals (Nelson, Pomerantz, Howard, & Bushy, 2007).

Economic Factors

Economic factors play a significant role in the healthcare access disparities experienced in rural populations (DeVoe, Krois, & Stenger, 2009). The recent economic recession has led to

the highest historical poverty rates in rural areas since the recession in the mid-1980s, and the rural rates of poverty are recovering at a slower rate than those in non-rural areas (Farrigan, 2014). In fact, poverty rates for metropolitan areas have consistently remained lower than non-metropolitan areas over time (USDA, Economic Research Service, 2012). The wages for rural workers tend to be lower than the wages for their non-rural counterparts (Ziller, 2003) leading to a greater likelihood of rural dwellers living below the poverty line (NRHA, 2016). Approximately 25% of the rural residents who are not elderly have an income below the federal poverty level, compared to about 20% of same population in metropolitan areas (Newkirk & Damico, 2014).

In addition to the higher likelihood of rural dwellers being poor (USDA, Economic Research Service, 2012), employer-provided insurance coverage is less likely in rural areas (NRHA, 2016). These uninsured rates are associated with a lower-paid labor force and smaller employers who are less likely to offer benefits, such as insurance coverage. Higher poverty rates and the higher likelihood that rural employers will not offer health insurance (Gamm & Van Nostrand, 2003) result in a rural population that is less likely to be insured (Newkirk & Damico, 2014). Rural counties have the highest percentage of uninsured people in the United States. The Centers for Disease Control (CDC) reported that from 2009-2011, 35% of adults, aged 18-34 in rural counties in the United States, were uninsured, compared to 25% in large fringe metropolitan counties (2012).

Ultimately, rural residents are more vulnerable than their non-rural counterparts to the recent economic changes due, among other things, to the current poverty trends in the United States, being uninsured or underinsured, and the shifts in Medical Assistance and Medicare reimbursements.

Rural hospitals are also more dependent on government payments than their non-rural counterparts because of their modest financial reserves and higher percentage of Medicare patients. Financial stability of rural hospitals is challenged by less predictable and lower patient volumes than non-rural hospitals. In the past 25 years, more than 470 hospitals in the rural United States have closed and rural hospital closure rates are higher than those of non-rural hospitals, in part because of their economically fragile statuses (NRHA, 2016). An unfortunate outcome resulting from the previously mentioned low wages and the higher likelihood of being uninsured is the need for rural healthcare facilities to determine whether to provide access to care for the people in their communities, knowing that they will receive little or no reimbursement. Furthermore, because of the higher proportion of Medicare patients in rural communities, any cuts or changes in the Medicare program have a disproportionate effect on rural hospitals (American Hospital Association [AHA], 2014). Financial instability has created drastic reductions in healthcare services, closures of hospitals, and decreases in services provided by homecare agencies leading to even fewer available healthcare resources for the rural population, in comparison to their non-rural counterparts (Graves, 2008). Recent healthcare policy changes have increased the financial jeopardy for rural hospitals because of substantial cuts in Medicare payments (AHA, 2011). The subsequent repercussions for the rural population further increase the likelihood of being underserved in the healthcare arena.

Political Environment

With the political environment surrounding the Patient Protection and Affordable Care Act (ACA) (US Government Printing Office, 2010), there was optimism for a potential decline in the number of uninsured in the near future (Bellamy et al., 2011). The ACA was created to make healthcare coverage affordable and accessible for everyone in the United States while

addressing the inequities of health coverage. Part of the ACA was the expansion of Medicaid for those with incomes at, or just above, the poverty level. It was projected that, beginning in 2014, the ACA would create opportunities for more than seven million nonelderly, uninsured rural residents of the United States to enroll in affordable insurance coverage (HHS, 2013). This did not come to fruition in part because of a Supreme Court ruling in 2012, making the expansion of Medicaid optional for states. As of May 2014, nearly one-half of the states were not expanding Medicaid coverage, leaving many individuals at, or just above, the poverty line without affordable options for insurance. About 66% of the uninsured rural population resided in states that had not expanded Medicaid coverage. As a result, rural residents continued to be more likely to be uninsured than their urban counterparts (Newkirk & Damico, 2014). Given the wage status of the rural population, it is ironic that, as more rural residents live below the poverty line, they are less likely to have Medicaid benefits for healthcare coverage (NRHA, 2016). In the end, it is evident that one of the results of the changing economic and political environment is a disparity between rural and non-rural populations with respect to access into healthcare (Lenardson, Ziler, Coburn, & Anderson, 2009).

Transportation Challenges

In addition to economic factors, the rural population faced unique transportation challenges when accessing healthcare. Long travel distances to healthcare facilities, and a lack of public transportation, created challenges for rural dwellers trying to receive essential healthcare services (Mason, 2004; Merwin, Snyder, & Katz, 2006) or specialized care found only in non-rural areas (Johnson, 2006; HHS, 2006; HHS, AHRQ, 2012; NRHA, 2016). Having a driver's license or using other transportation resources, such as family and friends, improved rural dwellers' access to healthcare and increased their number of healthcare visits (Arcury,

Preisser, Gesler, & Powers, 2005). However, rural dwellers must still contend with unique transportation challenges in order to live in rural areas and have the ability to receive needed healthcare services.

Distance and travel required by rural healthcare providers also add additional financial implications for rural hospice organizations and the rural population. Cost per hospice visit can be increased by the costs and time associated with the distance traveled by providers in order to deliver hospice care in rural communities. With no additional compensation for the added costs of distance and travel for rural hospices, the financial implications can lead to economic struggles for rural hospice organizations (Gibbens, Schroeder, Knudson, & Hart, 2015).

Scarcity of Rural Healthcare Professionals

Within the U.S. healthcare system, the availability of healthcare professionals is an essential component of accessing quality healthcare. A consistent disparity for the rural population has been the scarcity of healthcare providers (Hart, Salsberg, Phillips, & Lishner, 2002; Larson et al., 2003; NRHA, 2016). In 2006, Merwin et al. used a correlational design study involving all U.S. counties, identifying that metropolitan areas had nearly two times more physicians, per capita, than nonmetropolitan areas. The numbers of all kinds of healthcare professionals had decreased in most rural areas, resulting in shortages of available healthcare providers, with MacDowell, Glasser, Fitts, Nielsen, and Hunsaker (2010) stating that shortages included RNs, physical and occupational therapists, and pharmacists. More recently, in North Dakota, there has been more of a balance found between the supply and demand of healthcare professionals (University of North Dakota School of Medicine and Health Sciences, 2017). The reality is that the overall availability of healthcare providers does affect the ability of the rural population to access quality healthcare in their communities.

Primary Care

A shortage of primary care providers, as well as the smaller number of physicians available in general, has affected all rural regions of the United States (Gamm & Van Nostrand, 2003; Thrall, 2007). In 2007, Thrall noted that the number of rural areas experiencing primary care shortages had more than doubled since 1990, due, in part, to insufficient numbers of healthcare professionals. Currently, within North Dakota, most people live within a federally designated shortage area for primary care providers (University of North Dakota School of Medicine and Health Sciences, 2017). The availability of physicians in large metropolitan counties was four times greater than in counties in the rural United States containing only small towns. A disparity in the availability of specialists was also apparent, with the rural population (Denham, Wood, & Remsberg, 2010) having one-sixth the number of specialists per 100,000 residents compared to their counterparts located in large metropolitan areas (Johnson, 2006). In 2002, Hart et al. noted increasing numbers of rural areas experiencing primary care shortages because of insufficient numbers of healthcare professionals, including RNs. Since then, Doescher, Skillman, and Rosenblatt (2009) reported that 77% of rural counties in the United States had primary care health professional shortages.

Insufficient numbers of healthcare providers can lead to decreased services for the rural population. Recent demographic data revealed primary care physicians in small and isolated rural areas of North Dakota had more than twice as many patients in comparison to providers in urban areas (Center for Rural Health, 2015b). Direct care physicians in small and isolated rural areas of North Dakota had more than five times as many patients when compared to physicians in urban areas (Center for Rural Health, 2015a). The lower number of physicians in rural communities leads to decreased availability of comprehensive services such as Medicare-

certified hospice programs (Campbell, Merwin, & Yan, 2009), ultimately affecting essential components of quality healthcare.

Registered Nurse Scarcity and Misdistribution

Nursing is the largest health profession in the United States (Buerhaus, Staiger, & Auerbach, 2009) and the impact of RNs on the assurance of access to healthcare is known. However, one of the healthcare professions having insufficient numbers in rural populations has been the RN. In 2010, a study of chief executive officers of rural hospitals found an inadequate number of nurses to be one of the most frequently reported shortages among healthcare professionals (MacDowell et al., 2010). Utilizing the National Sample Survey of Registered Nurses (NSSRN) data, Skillman, Palazzo, Hart, and Butterfield (2007) found the number of RNs working in rural hospitals declined since 1980. Insufficient numbers of healthcare workers, along with the unequal distribution of RNs, can affect the rural population's access to quality healthcare.

Misdistribution of RNs was studied in 2004 by Macleod et al. Data that revealed an unequal distribution of nurses along with a greater shortage of nurses in rural settings, compared to non-rural settings, with 18% of employed RNs working in rural Canadian regions where 22% of the Canadian population resided. Cramer, Nienaber, Helget, and Agrawal (2006) studied the RN workforce demand and found little attention was being paid specifically to the nursing shortage in the rural United States. Results of the 2006 Cramer et al. study included evidence that the methodologies previously used to study the nursing workforce were inadequate to describe the distribution of nurses in rural areas. Those methodologies failed to consider rural counties without hospitals, even though those counties had other types of healthcare facilities utilizing RNs. Cramer et al. (2006) believed that the largest need for RNs was in rural settings.

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Specific data regarding current distribution of RNs in rural settings is not currently available, however scarcity and misdistribution of healthcare workers is further assessed by available workforce data. Since 1977, the NSSRN has reported nurse workforce trends in the United States using quantitative, longitudinal data. The NSSRN data was collected every four years through 2008 in the form of a survey using randomly sampled licensed RNs. Nursing characteristics, demographics, and employment characteristics were analyzed using this database, providing data with which to compare nurses in rural and urban areas (Skillman, Palazzo, Hart, & Keepnews, 2010). Skillman, Palazzo, Keepnews, and Hart (2006) used the 2000 NSSRN data, utilizing the rural-urban commuting area (RUCA) classification system, to identify rural categories in which RNs resided. Large rural (10,000-49,999 residents), small rural (2,500–9,999 residents), and isolated rural (less than 2,500 residents) areas were combined into one category by Skillman et al. to describe rural RNs in the NSSRN study. The 2000 data revealed 20.8% of U.S. RNs lived in rural residences, with a majority of those living in areas classified as large rural areas. Only 6.7% lived in small rural areas and 4.9% lived in isolated areas.

Per capita rates of employment were also determined using the 2000 NSSRN data. The number of RNs working in urban areas was 839 per 100,000 people, large rural areas was 836 per 100,000 people, small rural communities was 679 per 100,000 people, and isolated rural communities was 411 per 100,000 people (Skillman et al., 2006). Following the study by Skillman et al. (2006) in 2008-2010, the Health Resources and Services Administration (HRSA) found the per capita rate of RNs living in rural areas in the United States to be 852.7 per 100,000 people, compared to 934.8 per 100,000 people in urban areas (HRSA, 2013). In Minnesota, the 2011-2012 data of RNs showed 75% of RNs living in urban areas, 12% living in large rural

areas, 6% living in small rural areas, and 8% living in isolated rural areas (Minnesota

Department of Health [MDH], 2015). Worldwide, approximately 38% of the nursing workforce

practices in rural settings in which one-half of the world population lives (World Health

Organization [WHO], 2010). In 2008-2010, HRSA reported that 16% of RNs lived in the rural

communities in the United States where 17% of the U.S. population resided, with non-rural

communities having higher numbers of RNs per capita (HRSA, 2013). This appeared to indicate

that there might have been adequate numbers of nurses to meet the needs of the 17% of the U.S.

population who lived in rural areas. Rather, knowing that 16% of RNs were living in rural

communities did not indicate that 16% of RNs were practicing in rural settings. What was not

considered in the data was the number, or percentage, of those nurses living in rural areas who

were commuting, and that urban communities continued to have higher rates of RNs per capita

(HRSA, 2013). Continued trends of RNs commuting from rural settings make the

misdistribution of RNs practicing in rural settings significant.

Registered Nurse Commuter Trends

One contributing factor to the decline in RNs working in rural healthcare settings is that

many RNs who reside in rural communities commute for employment. The RNs living in small

rural and isolated rural communities were found to be the most likely to commute to non-rural

settings. With a special use agreement with HRSA to expand available respondent zip code data

within the NSSRN database, an enhanced rural geographical analysis was conducted using

survey information from 1980 to 2004 (Skillman et al., 2010).

Over the years, the commuting trends grew sharply between RNs in rural and non-rural

settings. The number of RNs commuting from their rural, home communities for employment

significantly increased from 14% in 1980 to 37% in 2004 (Skillman, Palazzo, Doescher, &

Butterfield, 2012). In 2004, RNs in rural settings commuted to different geographic areas 3.5 times more frequently than RNs in urban settings, and the percentage of RNs commuting increased to greater than 60% in isolated small rural communities (Skillman et al., 2006).

Among RNs commuting, some commuted to a similar rural setting, while others commuted to a different type of geographic region, with the greatest proportion commuting to a more urban setting. For RNs living in isolated small rural areas, 19% commuted to small rural areas, 18% commuted to large rural areas, and 23% commuted to urban areas. Among RNs living in small rural areas, 5% commuted to isolated small rural areas, 13% commuted to large rural areas, and 20% commuted to urban areas. For RNs living in large rural areas, 2% commuted to isolated small rural areas, 4% commuted to small rural areas, and 15% commuted to urban areas (Skillman et al, 2006).

Commuter trends of RNs living in rural communities may be attributed to the lack of healthcare facilities in their home communities. Nonetheless, RNs who live in rural areas with healthcare facilities may choose to commute away from their home communities for employment. The significant increase in the numbers of RNs commuting from rural, home communities created a drop in the percentage of RNs practicing in healthcare facilities in those rural, home communities, leading to fewer RNs being available to practice in rural healthcare settings, especially when the population is in small rural and isolated rural areas (Skillman et al., 2006). The resulting misdistribution of healthcare professionals impacts the availability of such healthcare providers in rural settings (Rural Assistance Center [RAC], 2014b). The persistent challenge of access to healthcare for the rural population is heightened by such misdistributions of RNs.

Comparative rural/non-rural commuter trend data have not been reported since 2004. Although there is no more recent data to indicate the percentage of nurses commuting from rural areas, recent changes in the political environment and population demographics suggest that this trend would not have diminished. The calculations of current and future commuter trends, once found by utilizing NSSRN data, are not expected because of the discontinuation of the collection of NSSRN data in its traditional format as of 2012 (Auerbach, Staiger, Muench, & Buerhaus, 2012). With or without current commuter trend data, the insufficient numbers of RNs continues to complicate access to healthcare for the rural populations.

Economic Factors

Factors influencing employment rates, beyond commuter trends in rural areas, were noted by Skillman et al. (2006), including the differences in numbers of healthcare facilities, with a smaller number of hospitals in rural communities compared with urban communities. Additionally, a sharp growth in salary gaps between RNs in rural and urban settings had developed (Skillman et al., 2012). Based on 2004 NSSRN data, salaries for RNs residing and working in urban areas were 22% higher than those of RNs residing and working in rural areas (Skillman et al., 2007). Among RNs living in rural communities, salaries for RNs commuting for employment were, on average, $3,000 higher annually in comparison to RNs who lived and worked in rural communities (Skillman et al., 2012).

It appears that higher wages in more urban areas are a consideration of RNs commuting (Skillman et al., 2012). However, beyond the higher wages in non-rural areas, causes of the increased commuter trends are not identified in the extant literature. Potential explanations for increased commuter trends may go beyond wages to include closures of healthcare facilities in rural communities, lack of employment opportunities in rural settings, appealing employment

opportunities outside of the rural, home community, and the possibility that some nurses work in both non-rural and rural areas concurrently.

Future Projections

Beyond past commuter trends, future projections regarding the availability of RNs in the United States creates additional concerns about the scarcity and misdistribution of healthcare providers. Various data have been used to determine projections of the future supply of RNs in the U.S. workforce. In 2009, it was predicted that the nursing shortage would increase by 20% by 2015 (Wing, McGinnis, & Moore, 2009) and an estimated shortfall of RNs was projected at 36% by the year 2020 (National Advisory Council on Nurse Education and Practice, 2010). In conjunction with an estimated shortfall of future RNs, the aging nursing workforce creates additional future nursing scarcity concerns. Data from 2004 showed approximately 20% of the nursing workforce at that time were over the age of 54 (Skillman et al., 2007). More recent data from 2008 to 2010 indicated a continued trend of an aging RN workforce, with approximately one-third of the nursing workforce being older than 50 (HRSA, 2013). The aging nursing workforce brings concerns about the future availability of nurses in general (Skillman et al., 2007) and a loss in nursing leadership and experiential knowledge (HRSA, 2013).

On a more positive note, HRSA recently reported a nursing workforce growth rate that surpassed the growth of the U.S. population. The growth in the number of RNs was more than 24%, as determined utilizing data from the U.S. Census Bureau's American Community Survey 2008 to 2010 and the Census 2000 Long Form. The positive outlook shed by the HRSA (2013) report lessens concerns somewhat regarding the projected nursing shortage, but does not "necessarily indicate that the nurse supply is more adequate now than it was in 2000" (p. 19). The data presented by HRSA does not account for the trends of increased acuity levels of

patients, the aging population, or the changes in RN staffing and hiring patterns (HRSA, 2013). Projections of future available RNs to meet the needs of the population in the United States continues to add to concerns of future access to quality healthcare for the rural population.

Rural workforce trends increase the risks rural populations face in accessing healthcare due not only to healthcare worker scarcity concerns but also the misdistribution of quality healthcare providers, including RNs. Buerhaus et al., (2009) noted a gap in understanding the significance of the changing RN workforce. Increasing commuter trends of RNs living in rural communities, the overall aging workforce, the looming nursing shortage, and the potential for healthcare disparities result in increasing issues accessing quality healthcare, experienced by the rural population (RAC, 2014). Shortages of healthcare professionals, including physicians and nurses, as well as the healthcare facilities themselves, can lead to rural dwellers not having the ability to access and receive needed healthcare (HHS, 2006). The scarcity, and misdistribution, of quality healthcare providers increases the risks faced by rural populations.

Rural Nursing Theory

Improving access to healthcare and the quality of life for the rural population requires approaches that meet the distinctive needs of the rural population. In 1989, Long and Weinert acknowledged the unique needs of the rural population, noting the necessity to apply different care models to attend to rural dwellers, in comparison to non-rural dwellers. In their study of nurses and people residing in rural areas, Long and Weinert (1989) were able to identify key concepts that led to an understanding of the health needs of the rural population and rural nursing practice. The concepts identified in Long and Weinert's Rural Nursing Theory are: "work beliefs and health beliefs; isolation and distance; self-reliance; lack of anonymity; outsider/insider; and old-timer/newcomer" (Long & Weinert, 1989, p. 113) as well as role

diffusion among nurses. A baseline understanding of these concepts may help provide some context regarding the phenomenon of *"commuting away."* Work and health beliefs, the concept of self-reliance related primarily to the beliefs and values held by rural populations, and outsider/insider and old-timer/newcomer concepts are relevant to the rural population. The concepts of lack of anonymity, role diffusion, and isolation are most relevant to the work of nurses in rural populations using supporting literature.

Lack of Anonymity

Lack of anonymity, a concept specific to Rural Nursing Theory (Long & Weinert, 1989), is commonly reported among rural nurses in the nursing literature. In rural communities, the relationships of RNs with community and family members are unique, with the ability to create persisting relationships in both healthcare and non-healthcare settings (Evanson, 2006). One result, which is not common to their non-rural counterparts, is the experience of a lack of anonymity for RNs living and practicing in rural communities. Increased visibility of healthcare professionals and their families in rural communities leads to overlapping personal lives and professional roles of RNs (American Nurses Association [ANA], 2013; Bushy, 2002; Bushy & Leipert, 2005; Evanson 2006). Personal and professional lives are not distinct, with both occurring simultaneously. The natural occurrence of nurses meeting patients in non-professional settings outside the rural healthcare setting, such as the grocery store, church, or local school, creates a perceived challenge for RNs to maintain clear professional boundaries (Brems, Johnson, Warner, & Roberts, 2006; Franche et al., 2010). Some RNs take measures in order to be comfortable with the lack of boundaries between personal and professional lives (Evanson, 2006). In other cases, difficult consequences of anonymity become evident; one example being professional mandatory reporting obligations of RNs for vulnerable populations (Leipert, 1999;

Stewart et al., 2011). This overlap in professional and personal relationships within rural communities creates intimate circumstances with unique ethical implications and challenges to form professional relationships (Nelson & Schmidek, 2008). Lack of anonymity is a common consideration of RNs practicing in rural communities.

The ramifications of the lack of anonymity in rural settings include the lack of confidentiality and privacy for RNs and the people they serve. Challenges of ensuring patients' confidentiality in a rural setting are problematic because of the geographic nature of small rural communities. Entrances to healthcare facilities can be visible to the public, and the familiarity with healthcare provider vehicles parked by patient's homes allows recognition by other community members (Evanson, 2006). Circumstances of patient's declining care, because of the sensitive nature of their health condition and the potential for their confidentiality being jeopardized, have been reported. The lack of confidentiality and privacy are perceived as a challenge in rural communities with RNs caring for friends, families, and neighbors in their home communities (Lyckholm, Hackney, & Smith, 2001). It is common in close-knit rural communities that everyone knows everyone else. This creates a unique challenge with respect to confidentiality in the rural population (Brems et al., 2006). Thus, the ramifications of the lack of anonymity in rural settings are characteristic to the rural population.

Role Diffusion

Role diffusion is also a concept within the Rural Nursing Theory (Long & Weinert, 1989), which addresses the wide knowledge base and diverse roles of nurse generalists in rural healthcare settings. Autonomy and independence are the norm for RNs practicing as nurse generalists in rural healthcare settings (Bushy, 2002; Drury, Francis, & Dulhunty, 2005; Molinari & Bushy, 2012; Stewart et al., 2011; Winters, 2013). Because of fewer types and numbers of

healthcare professionals, and increased exposure to a wide range of medical conditions in rural settings (Bushy, 2002; Drury et al., 2005; Kenny & Duckett, 2003), the nurse employs their full scope of practice out of a necessity to meet the needs of rural dwellers (Brems et al., 2006).

Self-reliance is often needed among RNs because of expectations that they will practice independently in isolated practice settings and work in complex situations while making critical decisions and exercising a broad scope of practice (Goodyear-Smith & Janes, 2008; Hunsberger, Baumann, Blythe, & Crea, 2009; MacKinnon, 2011; Nankervis, Kenny, & Bish, 2008). Many nurses find satisfaction in the fulfillment associated with such autonomous professional roles in rural settings (Atencio, Cohen, & Gorenberg, 2003; Baernholdt & Mark, 2009; Hunsberger et al., 2009; Penz & Stewart, 2008; Stewart et al., 2011). In the study by Roberge (2009), a strong positive correlation between nurses' autonomous roles and their job satisfaction was found. Conversely, RNs were frequently not prepared to fill the expert generalist role needed in rural healthcare settings. The nurses needed to be proficient in more than one area of nursing, competent in crises assessment, and flexible in management and delivery of care for rural patients with diverse clinical needs (Hunsberger et al., 2009; Molinari & Bushy, 2012; Winters, 2013). Thus, practicing rural healthcare professionals could find enriching professional opportunities with varying levels of satisfaction correlated to autonomous practices, thereby affecting the retention of rural healthcare professionals (Ingersoll, Olsan, Drew-Cates, DeVinney, & Davies, 2002).

Isolation

In the context of rural healthcare facilities, isolation, a concept found in the Rural Nursing Theory, is an important consideration for RNs practicing and living in rural communities. The isolation familiar to many rural communities (IOM, 2005) lends itself to

professional isolation where nurses in rural settings have less access to professional networks and resources, and fewer peers with whom to collaborate (Hunsberger et al, 2009; Stroth, 2010). Expectations to make decisions independently, while lacking access to healthcare professionals and/or peers with whom to consult, add to feelings of isolation (Hunsberger et al., 2009; Stroth, 2010; Williams, 2012; Winn, Chisholm, & Hummelbrunner, 2014). Furthermore, isolation creates unique safety concerns in rural nursing practice (Bushy & Leipert, 2005; Hunsberger et al., 2009; Molinari & Bushy, 2012; Winters, 2013). Considerations of unique security resources might be necessary in rural healthcare facilities because security measures in place might not lend to feelings of safety and security for all practicing nurses.

Nurses in rural settings face unpredictability in their practice and work environments. Major concerns of healthcare workers in rural settings are exposure to violence and insufficient access to support and protection (Franche et al., 2010). Nurses described "feeling threatened and were concerned about their safety in unpredictable situations. Many nurses worked alone after 9:30 pm without maintenance or security personnel in the building" (Hunsberger, et al., 2009, p. 20). Mental health nurses working in rural communities reported visiting patients in remote, isolated sites where cell phone coverage was unavailable (Drury et al., 2005). Geographic and professional isolation affected the healthcare professional's practice in rural settings (Brems et al., 2006; Bushy, 2002; Bushy & Leipert, 2005; Molinari & Bushy, 2012; Newhouse, 2005; Williams, 2012). Feelings of isolation associated with rural practice can deter professionals from deciding to practice in rural settings (Richards, Farmer, & Selvaraj, 2005; Williams, 2012). Thus, isolation and safety are an important consideration for RNs practicing and living in rural communities.

Lack of resources is another component of rural isolation (Baernholdt & Mark, 2009; Bushy & Leipert, 2005; Franche et al., 2010). Access to educational resources has been found to have a substantial influence on RNs living and practicing in rural communities. With patient acuity levels increasing in rural hospitals (Hunsberger et al., 2009), it is vital to meet the rural dweller's complex healthcare needs through creative ways of maintaining and expanding professional competence (McCoy, 2009). The need for continued competency development is a life-long reality for RNs, and a lack of education and training opportunities creates a potential hazard for patients (Hunsberger et al., 2009; Kwansah et al., 2012). The opportunities available to rural nurses to advance their education is more limited, presenting a challenge creating a highly educated workforce that can meet the needs of rural populations (Kenny & Duckett, 2003; McCoy, 2009; Stewart et al., 2011). Healthcare providers in rural settings have less access to training because of limitations imposed by distance and staffing (Brems et al., 2006; Drury et al., 2005). In 2003, Kenny and Duckett noted the difficulties nurses living in rural communities had pursuing postgraduate studies, limiting further education opportunities and giving them cause for relocation from rural communities in order to obtain advanced degrees. The educational preparation and maintenance of competence of rural healthcare professionals are central to recruiting and retaining rural healthcare professionals and providing quality healthcare that is accessible for the rural population (Hegney, McCarthy, Rogers-Clark, & Gorman, 2002; IOM, 2005; Rural Health Information Hub, 2017). Creative technological strategies now deliver distance education and can be beneficial in preparing individuals to become rural healthcare professionals (Hunsberger et al., 2009). Ultimately, educational resources determine the level of competence of rural healthcare professionals and are a fundamental resource necessary to ensure rural dwellers have access to quality healthcare.

An additional component of rural isolation, besides professional isolation and lack of resources, is the consistent lack of opportunities for professional development for healthcare providers in rural healthcare settings (Bushy & Leipert, 2005; Franche et al., 2010). Limited career opportunities (Kwansah et al., 2012), with fewer prospects for choice of specialty areas, are indicators for potential retention issues faced by nurses practicing in rural settings (Stewart et al., 2011).

Rural Community Environmental Context

The health needs of rural populations, and the practice of nurses in rural settings, are influenced by the environmental context of rural communities. Lee and McDonagh (2013) completed a literature review to evaluate the viability of Rural Nursing Theory. Findings revealed environmental context was an important component in the rural nursing literature. Lee and McDonagh (2013) proposed that environmental context was an emerging concept for updating the Rural Nursing Theory.

A healthcare worker's quality of life on a personal level is a significant component when deciding to live and practice in rural communities and meet the healthcare needs of rural dwellers. 3RNET (2015), a nonprofit organization focused on jobs in rural and underserved areas across the United States, reported living in rural areas is becoming increasingly popular for many reasons. A sense of community, importance of family, and less crowded communities make rural areas attractive, and many community members and nurses find solitude in a quiet, rural environment. In 2005, Bushy and Leipert studied nursing students and the self-identified areas that created interest in practicing in rural communities. Personal experiences in rural settings created an interest in returning to a rural setting to practice nursing. Those who enjoyed a rural lifestyle, and made personal connections to rural settings, were more interested in

practicing in rural settings. The simplicity of life, knowing their neighbors, less crime, and feelings of the small town lifestyle were positive influences found by those preferring to practice in rural settings. Additionally, nurses in rural communities were generally highly esteemed and acknowledged as a valuable resource to the community (Bushy, 2002; Evanson, 2006). All of these factors have the potential to influence the quality of life for RNs living in rural communities.

Recognition of the importance of social capital, and the satisfaction of living and practicing in rural communities, confirms that RNs professionally and personally depend on social networks in the communities in which they live. Social capital is defined as "the networks of social relations that may provide individuals and groups with access to resources and supports" (Government of Canada: Policy Research Initiative, 2005, p.12). The rural community has been found to not just be the local determinant of the patient population that healthcare providers will care for, but also a critical provider of a broad base of social supports for the nurse (Bushy, 2002; Kulig et al., 2009; Manahan, Hardy, & MacLeod, 2009; Mason, 2004; Stewart et al., 2011). The social dynamics of small communities differ from non-rural areas and have pros and cons for healthcare professionals in rural communities. Informal networks within communities are important to support healthcare professionals, creating a connectedness among rural dwellers.

Many RNs who choose to work in rural settings have lifestyle or family connections to the rural community (3RNET, 2015; Bushy, 2002). Healthcare professionals with a rural background are more likely to practice in rural settings (3RNET, 2015; Kulig et al., 2009; Manahan et al., 2009; Playford, Larson, & Wheatland, 2006) because of the importance of a rural lifestyle in the job selection process (Molinari & Monserud, 2008). Being raised in a rural

community increases the RNs' satisfaction with their rural, home community and the likelihood of returning to a rural area to practice nursing (Kulig et al., 2009). Nurse commitments to the population served are correlated to nurse familiarity with the healthcare systems in rural areas. Committed RNs are more likely to address the perceived healthcare system inequities for the people they serve (Bushy & Leipert, 2005). The social networks of rural communities create nurses' connection to the people they care for, as well as opportunities to be involved in the rural community (Leipert, 1999). A healthcare worker's personal life is significant to employment and residential decisions.

While many RNs chose to work in rural settings for individual, personal choices, additional deliberations also include family considerations (Betkus & MacLeod, 2004; Smith, Edwards, Courtney, & Finlayson, 2001). Personal motivations for practicing in rural communities include partner satisfaction, as well as the partner having a rural background (MacPhee & Scott, 2002). Financial implications associated with work opportunities for family members also influence healthcare professionals' employment decisions, depending upon whether or not family members can acquire employment (IOM, 2005). Intrusion of employment into family lives, because of fewer opportunities for diverse job scheduling, can also create potential retention issues and challenges for healthcare providers practicing in rural communities (Stewart et al., 2011). Furthermore, the quality of schools for family members (Betkus & MacLeod, 2004) and availability of rural recreational pastimes typically differ from those available in urban areas and can increase or decrease satisfaction with living and practicing in rural settings (Bushy, 2002). The variety of recreational opportunities in rural areas, including outdoor activities, indoor recreational activities, and unique cultural opportunities, are hidden treasures (3RNET, 2015). Consideration of family needs, and varying stages of life, is an

important component of successful recruitment and retention of providers who will live and practice in rural communities.

Nurse Job Satisfaction

Within the U.S. healthcare system, the availability of healthcare professionals is, in part, affected by the job satisfaction of healthcare professionals, including nurses. Roberge (2009) completed a comprehensive review of literature to examine rural nurse studies regarding retention and job satisfaction, including personal characteristics and experiences of nurses. Roberge (2009) found that the dynamics of rural practice impact job satisfaction, and the dynamics of job satisfaction impact the duration of practice in rural settings. Results revealed nurses in rural communities, as well as their family members, felt highly visible in public. Findings suggested decreased satisfaction among nurses in rural communities because of this lack of anonymity. Needs specific to nurse anonymity were found to be unique for RNs living and practicing in rural communities. However, limitations of Roberge's study included the lack of identification of the number of articles used in the study, as well as the potential for diminished access to articles from the United States because of the use of Canadian based website search engines. This study provided insight into reasons for satisfaction and dissatisfaction among nurses practicing in rural settings. No details were included in the study to identify those nurses commuting to non-rural areas from their rural, home residences, or the specific experiences of those nurses. In the end, it is evident that the availability of nurses in rural settings is, in part, affected by the job satisfaction.

Stewart et al. (2011) studied factors predictive of nurses intending to leave rural healthcare settings. Eight satisfaction variables were considered potential predictive factors, including autonomy. The research team mailed a survey to a stratified random sample of nurses

in rural and remote areas of Canada. The survey was created using empirical and conceptual issues noted in previous research in the United States, Canada, and Australia. Findings indicated work satisfaction associated with autonomy was related to lower levels of nurse intentions to leave rural healthcare settings. In fact, higher levels of satisfaction with autonomy were the only significant predictor of nurse retention in rural healthcare settings, with higher satisfaction levels indicative of nurses who would remain in the rural workforce. One factor for RNs leaving their current positions in rural healthcare settings was the desire to seek career advancements elsewhere. A limitation of the study was decreased generalizability because the sampling did not include nurses from the United States. Additionally, generalizability to current conditions was decreased because the data was collected in late 2001 and 2002 (Stewart et al., 2011). On a positive note, Penz and Stewart (2008) found that RNs were satisfied with the professional development of nurse-physician interactions in rural settings. This satisfaction with nurse-physician interactions needs to be acknowledged as important, unique, and beneficial to rural healthcare providers, including nurses and physicians. The autonomous roles of RNs in rural settings may create a level of recognition and respect for those RNs, ultimately improving interactions between nurses and physicians. Thus, the satisfaction observed in the professional development of nurse-physician interactions in rural healthcare settings influenced RNs' satisfaction with the resources and opportunities available.

Betkus and MacLeod (2004) examined public health nurses' (PHNs) satisfaction with their jobs and communities. The PHNs' satisfaction was correlated with decisions where to accept employment, and decisions whether to continue to be employed, in rural communities. Enhanced social well-being in the communities, in which PHNs lived and practiced, was found to be an important component for the rural healthcare workforce. The people living in the rural

community created a sense of belonging in the community that could lead to retention of professionals (3RNET, 2015; Betkus & MacLeod, 2004).

The adoptions of a rural lifestyle, and the integration of the healthcare provider into the community, are associated with satisfaction and retention of healthcare workers (Kulig et al., 2009; Richards et al., 2005). Richards et al. (2005) studied determinants of rural healthcare provider retention. Healthcare workers living and practicing in rural communities felt more a part of their community than healthcare providers living and practicing in non-rural areas. Healthcare providers commuting from rural communities felt less a part of the communities in which they lived compared to healthcare workers living and practicing in rural or non-rural communities. A healthcare worker's personal life is significant to employment and residential decisions.

Another important aspect to job satisfaction, in the context of rural healthcare settings, is the scarcity of economic resources. Salaries for healthcare providers are an important economic consideration. Salary is a frequently referenced job satisfaction indicator, and one economic consideration for RNs employed in rural healthcare settings is the disparities in salaries. Higher pay scales are typical of employment in more urban areas (Delobelle et al., 2011; Newhouse, 2005), adding to the problem of retaining nurses in rural settings (Newhouse, 2005). Over the years, salary gaps have grown sharply between RNs in rural and urban settings (Skillman et al., 2012). Using NSSRN data ranging from 1980 to 2004, Skillman et al. determined RNs in urban areas earned approximately 22% more than those living and working in rural areas (Skillman et al., 2006; Skillman et al., 2007). In 2013, mean hourly wages for RNs in the nonmetropolitan areas of southwest Minnesota were $28.56, compared to $31.26 in the nearest Minnesota metropolitan area of Mankato, MN (U.S. Department of Labor, n.d.). However, smaller

communities may offer significant economic advantages including a lower cost of living and healthcare worker eligibility for federal and state loan forgiveness programs (3RNET, 2015). Economic resources are important considerations in satisfaction, and the successful recruitment and retention, of healthcare providers.

Recruitment and Retention of Nurses in Rural Communities

Recruiting and retaining healthcare professionals in rural areas has historically proven to be difficult (Blaauw et al., 2010; HHS, HRSA, 2012; Murray, 2011). Given the scarcity and misdistribution of rural healthcare professionals, the need to recruit healthcare professionals to rural settings is evident and necessary in order to provide accessible, quality healthcare services (Allan, Ball, & Alston, 2008). In 2012, Minnesota data showed that the geographic location of the healthcare setting outside the metro areas of Minnesota was a strong factor related to recruitment challenges of RNs (Leibert, 2013). The presence of an adequate number of nurses also influences whether or not a rural community is able to recruit and retain health professionals to the region, reported by Bushy and Leipert (2005). This anecdotal evidence evolved from rural studies and exposure to nursing shortages in rural areas (Angeline Bushy, personal communication, March 12, 2015).

An important recruitment consideration for rural healthcare professionals is the recruitment time needed. In 2000, recruitment in rural areas took 60% more time in comparison to non-rural areas (Long, 2000). Another consideration of recruiting healthcare professionals is the financial implications, with Jones and Gates (2007) reporting costs associated with the turnover of a nurse ranging from $22,000 to $64,000 per nurse, and the Nursing Solutions, Inc. (NSI) (2016) reporting the costs to be $37,700 to $58,400 per nurse. In 2009, the Robert Wood Johnson Foundation reported this cost was $36,567.

The projection that adequate numbers of rural nurses will dwindle as a growing number of baby boomers retire (Pong & Russell, 2003) creates a demographic trend that will threaten the sustainability of providing quality care to rural populations (Montour, Baumann, Blythe, & Hunsberger, 2009). Furthermore, the projection of a shortage of academic nurse educators jeopardizes increasing numbers of nurses needed in the future (American Association of Colleges of Nursing, 2015; Frontier Education Center, 2004). With policymakers and university systems failing to recognize the differences between non-rural and rural practices, the future of our rural population is less than promising without innovative approaches to meet the diverse needs of rural healthcare professionals and the populations they serve (Kenny & Duckett, 2003). The IOM is committed to increasing efforts to enrich the rural healthcare workforce and improve access to healthcare for all (IOM, 2005) in response to rural healthcare professional shortages. Addressing the challenge of recruitment and retention of healthcare providers in rural settings in the United States will not completely fix, but aid in, the achievement of health equity for all Americans through access to comprehensive, quality healthcare for the rural population.

Federal and State Programs

Federal and state governmental efforts have been initiated to improve the rural population's access to quality healthcare. In 2002, Hart et al. noted that the need for recruitment and retention of healthcare providers in rural areas was a priority that had been addressed for 30 years by state and federal policy-makers. Scholarships and loan repayment programs were made available in designated healthcare shortage areas with the objective of recruiting new healthcare professionals to rural areas (HHS, HRSA, 2012; IOM, 2005). Although the budgets for rural healthcare professional recruitment programs increased between 2005 and 2006, more than 75% of rural counties in the United States were still designated primary care health professional

shortage areas (Doescher et al., 2009). Despite these efforts to increase the number of healthcare providers in rural areas, the persistent shortage of healthcare providers continues to create challenges for the rural population (NRHA, 2016; Thrall, 2007).

Economic rural recruitment efforts have been supported by HRSA using scholarships and loan repayment programs available in designated healthcare shortage areas. The objectives of such efforts are to recruit healthcare professionals to rural areas of need while following the program service commitments for multiyear service (IOM, 2005). As a result of the continued rural recruitment and retention challenges, the budgets for rural healthcare professional recruitment programs increased by 48% between 2005 and 2006 (Thrall, 2007). Recently, improvement of recruitment and retention efforts of rural healthcare professionals has been supported by the Obama Administration through the Improving Rural Health Care Initiative (IRHCI). Under the IRHCI, the Office of Rural Health Policy (ORHP) works to enhance health professions programs by assisting with the recruitment and retention of healthcare professionals. ORHP's annual budget includes $138 million to support grant programs. The specific focus of these grants is not explicitly rural workforces, but rural healthcare facilities are potential beneficiaries as a large portion of the programs are administered through HRSA's Bureau of Health Professions (BHPr) and the Bureau of Clinician Recruitment and Service (BCRS) (HHS, HRSA, 2012). Ultimately rural residents may be the beneficiaries of the ORHP grants because of their reliance on the healthcare providers in their local communities for access to healthcare.

The challenges of recruiting and retaining healthcare providers in rural settings may be diminished through state and federal grants. A brief description of key HRSA workforce grants will portray the broad range of funding available to help address the scarcity and misdistribution

of rural healthcare providers. This is not an all-inclusive list of grants, but includes key programs integral to the nursing workforce.

Area Health Education Centers (AHEC) program. With an emphasis on rural and underserved delivery sites, the AHEC program works to improve the number and quality of healthcare personnel, as well as the distribution and diversity of those personnel, while serving as a community link to academic establishments (HHS, HRSA, 2012).

Nursing programs. Nursing programs, referred to as Title VIII grants, are awarded to eligible training institutions, such as accredited schools of nursing. Funding is used to expand training opportunities in community and non-hospital sites (HHS, HRSA, 2012), which may include rural sites.

Nurse Education, Practice, Quality and Retention program (NEPQR). NEPQR addresses the nursing shortage by expanding admission to baccalaureate nursing programs, forming internship and residency programs, and making education through new technologies available. Another focus of NEPQR is the creation or expansion of care for underserved populations while improving quality of care and the retention of RNs (HHS, HRSA, 2012).

Individual nursing support programs. The Nursing Education Loan Repayment Program (NELRP) provides RNs with assistance in loan repayment while working in a Critical Shortage Facility (CSF), which would include many rural facilities, or employed as a faculty member of an accredited nursing school. Another nursing support program, the Nursing Scholarship Program (NSP) offers scholarships to nursing students who work at a CSF (HHS, HRSA, 2012).

State programs. State policy-makers have addressed the need for recruitment and retention of healthcare providers in rural areas as well. Many states have supplemented HRSA

grant opportunities through placement incentives such as loan forgiveness programs for healthcare workers serving underserved areas. Examples include the Minnesota Loan Forgiveness Program (MDH, 2015) and the South Dakota State Loan Repayment Program (Nursing Scholarships, 2015), which offer a range of loan forgiveness programs for nurses serving in designated rural areas.

With the historical challenges of recruiting and retaining RNs in rural settings, as well as the misdistribution of rural healthcare providers, the need to improve human capital is crucial to the improvement of the rural population's health. Federal and state initiatives to address these challenges will aid in the achievement of health equity for the rural population through the access of comprehensive, quality healthcare. Ultimately, if nurses can effectively be recruited and retained in rural healthcare facilities, the improved access to quality healthcare will lead to an improved quality of life for the rural population.

Recommendations for Nurse Recruitment and Retention in Rural Settings

Future recruitment and retention efforts for healthcare professionals will require targeted and diverse strategies, with limited evidence available to support effective retention strategies for nurses living and practicing in rural communities (Trépanier et al., 2013). Recruitment and retention of nurses in rural communities is a concern not only in the United States, but internationally, because of its impacts on the lack of access to healthcare for populations in rural areas.

Mbemba, Gagnon, Paré, and Côté (2013) reviewed previous systematic reviews to produce a record of retention strategies, evident through the extant literature, that impact the retention of nurses in rural communities. The search of the literature was international, and language requirements were English, French, or Spanish. The inclusion criteria limited the

publications to a 22-year timeframe from 1990 to 2012. The review included many studies of

healthcare workforces in general, in addition to nursing. Thus, the diminished generalizability to

the United States nursing workforce is noted in this systematic review, as well as the time

periods of some of the studies being somewhat out-of-date. However, the potential strategies

revealed in this study might impact future recruitment and retention strategies for the rural

nursing workforce. The systematic reviews, by Mbemba et al. (2013), led to the identification of

four intervention themes that apply to improving nurse retention. The themes included (a)

financial incentives for return of service, such as scholarships, educational loans, loan repayment

programs, and direct financial incentives; (b) supportive relationships within the nursing field,

such as mentoring, clinical supervision, and preceptorship; (c) support with technologies

involving information and communication, such as telehealth; and, (d) the creation of rural

career pathways, such as creating structured contact between nursing students and rural health

professionals while exposing students to the rural context, as well as recruiting students who

originate from rural settings and have an attachment to rural practice. Among the interventions

identified, only the financial incentives were evaluated to a large extent, with limited support for

financial interventions. The overall conclusion by Mbemba et al., regarding the limited evidence

about rural retention strategies, was that there is a need for more research to inform future

retention strategies for nurses practicing in rural healthcare settings. Lack of access to

healthcare, because of nurse retention concerns in rural communities, supports the need for

successful retention strategies.

Internationally, WHO (2010) acknowledged the misdistribution of healthcare workers,

noting that throughout the world, most healthcare workers reside and are employed in cities.

This misdistribution affected access to healthcare. Thus, WHO disseminated recruitment and

retention strategies for healthcare workers in rural settings. Categories of interventions included education, regulatory, financial incentives, and professional and personal support, supporting the findings of Mbemba et al. (2013). Educational interventions included rural educational settings and curriculum, recruiting students most likely to practice in rural settings, and continuing professional development opportunities for nurses and other healthcare workers in rural settings. Regulatory interventions included subsidizing the education of students in return for students returning to work and compulsory service requirements. Various financial incentives were included to "make it worthwhile to move to a remote or rural area" (WHO, 2010, p. 28). Personal and professional support interventions included addressing living conditions while providing safe environments that support work conditions. Outreach support with programs developing careers and the development of professional networks were acknowledged. Additionally, the need to "raise the profile of rural health workers" was a strongly recommended intervention (WHO, 2010, p. 34). The relevance of interventions to specific rural communities needs to be determined to address the misdistribution of healthcare workers in those specific communities.

Concerns about retention of nurses in rural communities have also been a specific focus in the United States. In 2004, the Frontier Education Center, part of the National Clearinghouse for Frontier Communities in partnership with HRSA, conducted an assessment of the nursing shortages and strategies through a literature review. The intention of the study was to assess interventions to address the rural nursing shortage and present a broad range of interventions, highlighting creative interventions rather than those based in best practices. Intervention categories identified included (a) education, such as the development of nursing curriculum with rural components, funding of nursing education in rural settings, and making service

commitments to rural areas; (b) retention and job satisfaction, such as the development of recognition programs for rural service and setting employment standards for nurses employed in rural settings; (c) service delivery, such as telemedicine; and, (d) policy, such as different reimbursement structures to lessen the rural reimbursement penalties. Intervention strategies in each of these categories required unique applications suited to nurses practicing in rural settings. Additional specific educational strategies for recruitment and retention of nurses in rural settings included economic assistance for nurses receiving and advancing their educations, early introduction of young adults to nursing careers, the establishment of more nursing programs with rural specific coursework and clinical opportunities, and recruitment of underrepresented individuals (Frontier Education Center, 2004).

Recruitment and retention strategies interplay with the education of undergraduate nursing students. Playford, Wheatland, and Larson (2010) conducted a longitudinal study to examine the correlation between the recruitment of nurse graduates to rural healthcare settings and the receipt of an undergraduate education in a rural nursing program. The results of the study revealed significant success, and rural nursing programs were found to be an effective strategy for recruiting nurses in rural settings. To address inadequate retention of newly hired nurses, Keahey (2008) developed an educational orientation residency program for RNs practicing in rural healthcare settings. Completion of the residency program led not only to improved retention, but increased knowledge, skills, and attitudes among new nurses. Educational opportunities for nurses in rural settings play a key role in the recruitment and retention of RNs.

Recruitment and retention strategies for nurses in rural settings include the needs to set standards and implement certification programs in rural employment settings (Frontier Education

Center, 2004). Support for such interventions are found through the Pathway to Excellence certification program, a designation of the American Nurses Credentialing Center. This multifaceted program stresses the importance of quality care and job satisfaction leading to increased retention of nurses in rural settings. Important considerations for the Pathway to Excellence designation include operating procedures and management practices that lead to the ability to provide quality care and increase job satisfaction (American Nurses Credentialing Center, 2014; Bushy, 2009).

As noted by Mbemba et al. (2013), creating supportive relationships within the nursing field is a part of retention efforts for nurses in rural settings. Rohatinsky and Ferguson (2013) identified approaches to support new nurses in rural settings. One significant advantage of the rural setting was the smaller staff size, allowing new nurses to integrate with their colleagues in the work setting and quickly develop relationships. Formal and informal mentoring approaches supported new staff. Intentionally staffing experienced nurses with new nurses combated uneasy feelings associated with new responsibilities. Additionally, all employees of the healthcare facility, regardless of title, were responsible for mentoring the new nurse, with each employee offering a unique perspective. The importance of socialization into the new community was also acknowledged and mentors helped new nurses get acquainted with the greater community through community activities and providing information about community resources. The supportive relationships found in mentoring new nurses assisted with the retention challenges in rural settings.

Summary

The very nature of rural settings creates challenges for rural dwellers to gain access to quality healthcare systems in environments where the services and providers they need are

available (HHS, AHRQ, 2012). Rural populations do have unique challenges with access to healthcare, including fewer healthcare professionals and healthcare organizations, and wide-ranging variations in accessibility (IOM, 2005), adding to the vulnerabilities of the rural population.

Existing trends, and projected shortages of RNs, endanger current and future access to healthcare in the rural United States. Current health status disparities of the rural population, including increased frequencies of chronic diseases (IOM, 2005), lead to predicted increases in healthcare needs of the rural population at a time of anticipated decreases in supplies of healthcare professionals and continued rural healthcare disparities. Many factors increase the future challenges for the rural population to access quality healthcare. An important factor is the reality that the recruitment and retention of healthcare professionals to rural areas has historically been more challenging compared to non-rural areas (Blaauw et al., 2010). Registered nurses are one of the most challenging healthcare professionals to recruit and retain in rural settings (Blaauw et al., 2010). With the trend of RNs commuting from their rural, home communities for employment, and with the potential for inadequate numbers of nurses in the near future, the rural population continues to be vulnerable to healthcare disparities when accessing quality healthcare.

The rational given for RNs commuting from their rural, home communities is grounded on the assumption that higher wages in more urban settings are of key importance to employment decisions. This assumption is based on the generalizable NRRSN data for all nurses in non-rural and rural communities (Skillman et al., 2006). However, the synthesis of literature and review of preliminary studies reveal employment decisions faced by RNs living and practicing in rural communities include, and go beyond, wage disparities between rural and urban settings. There are a large number of programs that have focused on increasing the

number of nurses working in rural settings, yet the shortage of RNs in rural healthcare settings persists. Clearly there are reasons why RNs are leaving their rural, home communities for employment that are unknown in the extant literature. More needs to be known about the experiences of RNs living in rural communities as well as the reasons behind the phenomenon of *"commuting away."* It is important to stabilize or diminish disparities in rural healthcare through an adequate number of healthcare services and professionals. The knowledge gained from the current study is needed in order to appropriately and adequately recruit and retain RNs in rural healthcare settings.

CHAPTER III

RESEARCH DESIGN

The qualitative research approach used in the current study was descriptive phenomenology. It benefited the study by leading to a better understanding of human experiences. The purpose of this phenomenological study was to describe and better understand the phenomenon of *"commuting away"* and experiences of RNs living in rural, home communities who commute to non-rural areas for employment. An overview of the elements that shaped the design of the current study, including the phenomenological philosophical underpinnings and the resulting descriptive phenomenological approach, are presented in Chapter III. Details of researcher assumptions and reflections are given. Additionally, descriptions of participant sampling and recruitment processes, data collection, and data analysis, including the inquiry and analysis processes, are presented for this descriptive phenomenological study.

Husserl's Philosophy

The beginning concepts that laid the foundation for the philosophy of phenomenology appeared in the 18th century as a philosophical science, with the description of the meaning of the philosophy of phenomenology developed by Edmund Husserl at the turn of the 19th century. Husserl's philosophy of phenomenology was cultivated around the criticism of the scientific ideals of positivism that demand every justifiable meaning can, and should, be verified with facts. Husserl desired to escape the positivist extremes that reduced "the laws of thought to contingent qualities of a certain species, that destroys the objective validity of our knowledge

and that regards the truth as a property of our behavior" (Kolakowski, 1975, p. 23). Husserl criticized the oversimplification of complex topics measured in scientific research on the premise that such oversimplification resulted in the dehumanization of humanity and created a distance between science and the human world. Husserl believed that the positivist paradigm of the natural sciences was inadequate to describe human phenomena. To avoid the oversimplification of human science, Husserl's philosophy recognized the foundation of science to be everyday human experiences that guide scientific thinking, with a premise of going "back to the things themselves" (Dahlberg, Nyström, & Dahlberg, 2008, p. 32). To "go back to the things themselves," according to Husserl, means to have scientists lay aside their presuppositions, hypotheses, and positions in order to "go back to the things themselves" and develop a true understanding of human phenomena that is grounded in human experiences. Since the 19th century, Husserl's philosophy of phenomenological has straddled the ideas of objective realism and subjective idealism, functioning as a link between the two domains (Dahlberg et al., 2008).

Husserl went into great detail to describe human nature as being part of the everyday world in his philosophy of phenomenology. Much emphasis was placed on the immersion of individuals in their everyday world, which led to his notion of a natural attitude in which the everyday world was taken for granted. In the natural attitude of the everyday world, individuals assume that other people perceive and experience an everyday world similar to their own. The result of the natural attitude is a naïve approach to understanding the world, an important consideration in the philosophy of phenomenology (Moran, 2012).

Intentionality

Husserl introduced several key ideas within his philosophy of phenomenology, including the concept of intentionality, which is a central theme of Husserl's philosophy. Prior to the

development of the philosophy of phenomenology, Husserl studied under Franz Brentano, one of the originators of experimental psychology. Brentano characterized descriptive psychology as a scientific inquiry in which he "identified intentionality as the chief characteristic of 'mental phenomena'" (Moran, 2012, p. 20). Expanding beyond Brentano's more narrow understanding of intentionality, Husserl viewed intentionality as mental acts, or conscious experiences, that were considered much more complex than how Brentano had identified intentionality. To Husserl, intentionality was central to his philosophy of phenomenology, being a distinct way to look at "all aspects of consciousness, meaning and knowledge" (Moran, 2012, p. 20). As human beings, we are consciously aware of things in our world, including people, concrete and abstract objects, and our perceptions and feelings that give us a sense of being a part of something in our world. This is intentionality, a focused realization of things or events in the world (Dahlberg et al., 2008) revealing, "every object and every meaning must be understood not solely as it is 'in itself' but in relation to the subjective acts which disclose it" (Moran, 2012, p. 21). Intentionality continues to be an important theme of Husserl's philosophy of phenomenology.

Husserl's idea of intentionality centered on an individual's focused realization of things or events in their world, implying that all perceptions had meaning (Owen, 1994). Husserl described an individual's preunderstanding and appresentation as key components of intentionality that consciously gave meaning to experiences without truly examining the phenomenon. Preunderstanding included having "an emotional attachment to a phenomenon or simply be[ing] used to be the phenomenon as an ordinary part of life, and thus fail[ing] to see anything other than a familiar landscape" (Dahlberg et al., 2008, p.134). Dahlberg et al. (2008) described appresentation as follows:

> When the appearance of . . . [a] person presents itself in the experience, it is presented as a whole (living) person. The parts that we do not immediately and concretely experience

are presented. For Husserl, this means that perceiving goes beyond what is actually present and these appresentations could always be made present (p. 58-59).

Schuback (2006) painted a brilliant picture of appresentations when she described the varying meanings of phenomenon.

> The perceived tree, the remembered tree, the imagined tree are and are not the same tree. Their difference however does not lie in the fact that only the perceived tree exists in reality whereas the remembered and the imagined tree lack reality. They present different realities (p. 136).

Schuback went on to discuss perceptions being more or less than what an individual can actually perceive.

> We see the tree but we cannot see the whole tree. Several sides and qualities that cannot be seen in the present act of perception are seen together with what we actually see. We see sides, parts, shadows and incomplete structures. We do not see everything, we see more than we can see, and further, we never see 'the tree' (Schuback, 2006, p. 136).

Epoché

Along with intentionality, the epoché is an important theme to Husserl's philosophy of phenomenology. In keeping with Brentano's teachings, Husserl described a lack of critical reflection because of the intentionality of researchers (Husserl, Alston, & Nakhnikian, 1964). Intentionality led to barriers for researchers to describe participant's experiences. The lack of the researcher's consideration of the natural attitude, including the assumptions that the participant's views were similar to the researcher's view of their everyday world, revealed a lack of critical reflection. That is why Husserl said that the natural attitude was a naïve approach to science. He contended the need to leave the natural attitude, or transcend it, thru the process of reduction or engaging the "epoché."

Engagement of the epoché led to transcendentality (Moran, 2012), when individuals consciously interrupted their natural attitude and reduced their naïve understandings of the world. Husserl's conception of epoché was central to the philosophy of phenomenology, leading

to rich and new understandings of humans' experiences while deeming the need for the researcher to withhold all preunderstandings and position taking. This was accomplished by examining "the sheer presence of the object and refrain[ing] from saying that it exists in the way that it present[s] itself to us" (Giorgi, 2005, p. 77). In research, reduction of naïve understandings takes the form of bracketing. With the use of bracketing, the natural attitude will be interrupted (Moran, 2012). Consequently, past knowledge about the phenomenon of interest is set aside, and what comes to the researcher's consciousness is unaffected by the usual automatic conceptions of reality (Giorgi, 2005). Such bracketing allows the researcher to break free from the previous beliefs and understandings found in their natural attitudes, and allows the phenomenon, with its essences, to present itself (Giorgi, 1997). With this, the researcher will find the essential components of a phenomenon while withholding all position taking. The epoché is essential to the philosophy of phenomenology, as it allows the essences of the phenomenon of interest to appear.

Intersubjectivity

An additional core idea in the philosophy of phenomenology is the concept of intersubjectivity, which speaks to researchers creating a phenomenological frame of mind in order to place themselves in a position to see all aspects of everyday experiences. Thus, as researchers experience themselves as a subject among the participants, they will be open to identifying the essence of the phenomenon and gaining a new understanding of the phenomenon. Husserl explained that "being-in the world is being-with others" (Dahlberg et al., 2008, p. 57). In such a position, the researcher will not experience what participants have experienced directly, but will be able to know and describe the meaning of participant's experiences through their

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descriptions. A phenomenological frame of mind is essential to the successful integration of the concept of intersubjectivity in the philosophy of phenomenology.

Essence

The central core of the philosophy of phenomenology is that it seeks to discover the true essence of a phenomenon. Essences are new understandings that are not created, but that already exist within the phenomenon. Essences present themselves with meaning originating from the lived experiences of individuals. Such essences are essential to the phenomenon; the essence is what makes the phenomenon what it is. Dahlberg affirms this when she states "when the phenomenon presents itself as something, it presents its essence" (Dahlberg, 2006, p. 12). The essential components of a phenomenon, the essence(s), will give cohesive meaning to the phenomenon (Dahlberg et al., 2008).

Essences can best be explained through the use of a description noted during one of my qualitative research courses. In this class, essence was described as the red thread that runs through a phenomenon. Within the context of the phenomenon, this common red thread would be seen throughout all aspects of the phenomenon. The red thread may not always be evident, but would always be present and could actually be hidden. The phenomenon would not be able to present itself without the essence, or red thread, becoming evident (Dr. T. Evanson, personal communication, February 26, 2013). As the researcher seeks the essence of the phenomenon, Husserl suggested using free imagination variation to discover the essence. In doing so, the researcher freely alters parts of the phenomenon to see if the essence, or red thread, of the phenomenon remains, even though an aspect of the phenomenon was changed or varied (Giorgi, 1997).

Ultimately, the core meaning of the phenomenon, the essence(s), will be revealed and stay true, even though experience with the phenomenon may vary. The essence is truly what makes the phenomenon what it is. The phenomenon would not exist without the essence (Dahlberg, 2006). Husserl's epoché allows the essence of the phenomenon to present meaning through the lived experiences of individuals.

Translation of Philosophy into Method

Husserl's philosophy of phenomenology preceded the development of phenomenological research, in which the human lived experiences are considered. This approach to research follows Husserl's phenomenological philosophical premise of going "to the things themselves" (Dahlberg et al., 2008, p. 32) while upholding the integrity of the everyday human experience, including the need to approach lived experiences in all of their variety. The phenomenon is a central concept within phenomenological research, understood as a thing of the everyday world that "present[s] itself to, or as it is experienced by, a subject" (Dahlberg et al., 2008, p. 33). Resulting phenomenological research encompasses the phenomenon of the human lived experiences.

Descriptive phenomenology is used to describe particular phenomena in order to clarify the meanings of the phenomena from lived experiences. Husserl's philosophy of phenomenology shapes the foundation of the development of descriptive phenomenological research in which the lived experiences of humans are considered. Descriptive phenomenology is used to describe and seek patterns of meaning, resulting in descriptions of the experiences of humans that may be used to expand the understandings of phenomena. Such an approach avoids positivist reductionist methods and leads to descriptions of how the world is experienced and the meanings of the world to humans (Moran, 2012). Descriptive phenomenology is epistemological

in nature, because of the underpinnings of Husserl's philosophy, contemplating how we come to know the world.

Several approaches to descriptive phenomenology have been developed and have been used to guide research. Several are based upon Husserl's philosophy. One such approach, Dahlberg et al.'s (2008) open lifeworld approach, was used to guide the current study. Dahlberg et al. (2008) describe their approach as a phenomenological approach used in human science to create a means to explore the phenomena of interest. Such an approach creates a design for phenomenological research, rather than a method, with the only requirement to begin the research being the identification of a phenomenon of interest that has been defined as the central focus of the research. Dahlberg et al. (2008) discussed Gadamer's warnings against allegiance to following a strictly prescribed methodology, with such prescribed methodology risking the degradation and undermining of the realization of the true meaning of the phenomenon of interest. Thus, the use of this reflective phenomenological research design will be void of fixed rules, allowing an open, flexible approach in uncovering the essence of the phenomenon of the study at hand.

Open Lifeworld Approach

The open lifeworld approach is a reflective research design. In this design, the lifeworld is defined as a "world of perception" (Dahlberg et al., 2008, p. 37) with a researcher's understanding and awareness of the lifeworld being a pre-scientific and pre-reflective state, much like Husserl's description of the natural attitude. This lifeworld includes a focus on the experiences that make up the participants' everyday world (Dahlberg et al., 2008). Core concepts of the open lifeworld approach include openness, uniqueness, and experiential horizons creating a framework for the current study.

Openness. The open lifeworld approach is considered open in many aspects, with an open stance crucial to the researcher's approach to the phenomenon of interest. The means of the researcher engaging in an open attitude to the phenomenon involves Husserl's premise of going "back to the things themselves." The researcher, in an open position, sets aside previous beliefs and understandings to allow the phenomenon to come forth, while illuminating the essence(s) of a phenomenon. This open position is a shift away from the natural attitude and intentionality, utilizing Husserl's central theme of epoché to develop a phenomenological frame of mind. Openness speaks to the researcher's ability to listen, see, and understand experiences as they relate to the phenomenon of interest, exercising patience while waiting for the essence to reveal itself. This open stance is not a methodological process, but rather a curious attitude open to discovery, marked by sensitivity, flexibility, and respect toward the phenomenon of interest.

Dahlberg et al. (2008) utilize the construct and practice of bridling, rather than bracketing, as the means for the researcher to set aside their pre-understandings related to the phenomenon of interest. Husserl introduced bracketing, a means of an open stance which sets aside researcher understandings and assumptions about phenomenon (Morin, 2012). Bridling expands beyond Husserl's concept of bracketing to not only direct a particular pre-understanding, but to focus on the understanding of the current whole event, using active waiting for the essence of the phenomenon to surface, while not making definite what is not definite. Dahlberg et al. (2008) describe the focus of bridling of current, whole events as a forward movement that directs the researchers energy into the open attitude, in contrast to bracketing that focuses on a backward movement, keeping preunderstanding and appresentations in check (Dahlberg et al., 2008). Being open "entails both assuming a stance of vulnerable engagement with a phenomenon while maintaining a disinterested attentiveness" in order to see the

phenomenon outside of the natural attitude (Dahlberg et al., 2008, p. 99). Such a shift from the natural attitude creates the ability for the researcher to maintain the open stance needed to allow the essence to surface, and perhaps even surprise the researcher (Dahlberg et al., 2008).

Achieving an open attitude requires purposeful thoughts and actions as a researcher prepares to approach, and perform, a study. During the current study, I purposefully prepared my stance as a researcher by keeping a reflexive journal, identifying potential biases, attitudes, opinions, and experiences that could influence my ability to have an open attitude. I reflected on my standpoint and practice orientation in relation to the phenomenon of interest, mentally assessing my ability as a researcher for the study. Additionally, I did not search the literature to seek answers about the phenomenon of interest, adding to potential biases and preunderstandings. Such purposeful actions helped prepare me as a phenomenological researcher.

In the open lifeworld approach, immediate openness is required of the researchers, thereby creating a researcher's receptivity to the relationship of the participants and phenomenon of interest. The central theme of intersubjectivity, noted in Husserl's philosophy of phenomenology, speaks to the phenomenological frame of mind needed for immediate openness. Achieving immediate openness allows researchers to immerse themselves in the phenomenon by being physically and mentally present, creating an immediate intersubjective relationship between the researcher and the participants. Such a relationship is necessary to give rise to encounters that will result in a greater likelihood of the essence surfacing, ultimately resulting in the development of increased understanding. Immediate openness is key to the researcher's receptivity to the phenomenon of interest.

Achieving immediate openness in the current study was accomplished through several strategies. First, I engaged with my participants to establish a genuine level of trust and a level of immediacy through listening skills that presented my willingness to give myself to the intersubjective relationship. I created an interview environment that was comfortable for the participant, through participant choice of site. I immersed myself in what the participant had to offer about the phenomenon of *"commuting away,"* keeping an atmosphere free of a specific goal to be obtained, allowing the essence of the phenomenon to surface. The immediate openness created by these strategies added to the quality to the study.

Uniqueness. In phenomenological research, the researcher is allowed to be open to the phenomenon of interest and the many unique and particular meanings of the phenomenon. The participants in the current study are unique in themselves as well as unique to the phenomenon. In descriptive phenomenological research, such uniqueness requires an understanding that the "individuality of participants takes priority over their position as representatives of a larger group. Lifeworld researchers are not interested in controlling, as potential bias, the unique perspective of individuals" (Dahlberg et al., 2008, p. 119).

The descriptive phenomenological researcher recognizes the value of the uniqueness and particularities of their participant's lived experiences. Participants bring their unique lived experiences to the study. Beyond uniqueness, the researcher values the uniformity, along with the generalities, of the lived experiences of the participants as well, with typical, fundamental experiences seen in every participant situation. The resulting variations of descriptions and understanding of the phenomenon of interest are found in a paradox of the lifeworld, particularity and generality, facilitating the phenomenon's generality. The researcher must be attentive to what is unique and different in each participant, while at the same time paying

attention to what is similar between experiences with the phenomenon. While each person has unique experiences, there are similarities within those experiences that help the researcher identify the essence of the phenomenon. In order for the researcher to create contextual meaning through the essence of the phenomenon, generality among the participants, along with the unique and particular, is needed.

Experiential horizons. Another theme of the open lifeworld approach is the concept of experiential horizons. Dahlberg et al. (2008) describe experiential horizons utilizing Husserl's concept of appresentation. Experiential horizons take perception beyond what is actually present to what is pre-understood, contributing to the perception of the phenomenon even though the experience is not immediately present. Husserl deemed the need for the researcher to withhold all position taking in such cases. His reduction of naïve understandings was described as the bracketing of past knowledge about the phenomenon of interest, including the withholding of previous perceptions.

Lifeworld research is not a method, per se, but a variety of means to facilitate the gathering of rich information from the lived experiences of participants. The activities included in seeking descriptions of the lived experiences follow an open and bridled approach to find meaning in many types of expressions of the phenomenon of interest. Exact sample size numbers cannot be predetermined, with the focus on rich variations of experiences rather than specific numbers of participants. Interviews are open dialogues collaboratively produced by the researcher and participants, with the researcher facilitating the participant's ability to share lived experiences of the phenomenon. Researcher immediacy in the interview settings creates an atmosphere of presence that develops an interpersonal relationship between the researcher and participants. The ability of the researcher to verbally recall and ponder the participant's lived

experiences during the interview increases the possibility of gathering meaning about the participant's lived experiences. The analysis of the rich information about the lived experiences of the phenomenon of interest will describe the essential structure of the phenomenon and its meanings (Dahlberg et al., 2008).

Researcher as instrument. In lifeworld research, "the researcher should always be the researcher, despite other identities" (Dahlberg et al., 2008, p. 173). Researchers preparing to undertake descriptive phenomenological research need to identify the meaning of their personal experiences with the phenomenon in order to carefully prepare for the research and create the open attitude needed to understand the essence of the phenomenon. For transcendentality to occur, researchers utilize processes of reflection, turning their consciousness towards themselves; examining their prejudices (Dowling, 2007), allowing the creation of a distance between themselves and the natural attitude, all while striving for objectivity with respect to the phenomenon. Researchers' backgrounds, including familiarity with the phenomenon and/or emotional attachments, need to be identified in order for the researcher to do more than confirm what is already known about the phenomenon and actually create new understanding. As Dahlberg et al. (2008) stated, "We hear ourselves and create a silence sufficient to hear and respond to others" (p. 20).

In the current study, my identification of the meaning of personal experiences started by reflecting on my personal background, which originated in a rural community. Born and raised on my parent's rural farm, I married another lifelong member of the same community. We have been married for 37 years and continue to live in the same rural community where we raised three children. In this community, we are surrounded by parents, siblings, children, and

grandchildren, along with life-long friends and acquaintances. The meaning this community has to me is embedded in my history and current status as a rural community member.

My growth as a nurse developed within this community, with my first nursing role being a licensed practical nurse at the community's healthcare center in the early 1980s. Since then, I advanced my education as a nurse, transitioning to the current status of PhD candidate. With the advancement of my education, I transitioned through many roles as a nurse in this community, practicing in acute care, long-term care, clinic, administration, homecare, and hospice, to name a few. I also broadened my professional experiences by working as a nurse educator at a local university while continuing to practice nursing at my home community's healthcare facility for many years. As a nurse educator, I have had the opportunity to combine my roles of educator and practicing nurse while teaching nursing students in the community's healthcare setting. The many nursing roles I have been afforded in and near my community have led to my growth as a professional nurse.

My community's healthcare center has provided healthcare services to the people of the surrounding community throughout my life. My role as a board member for the community's healthcare center has kept me abreast of the challenges faced by the facility, including economic and staffing concerns. I am well aware of the significance of the healthcare facility to the community; the rural community's per-capita income would be substantially reduced if the healthcare facility were to close (American Hospital Association, 2011). The importance of providing healthcare to members of the community, including my family and friends, has been evident, along with the positive economic impact on the community, with the healthcare center being the largest employer in the community. Lack of adequate staffing and economic

challenges, however, have threatened the continued viability of the healthcare facility, the people it serves, and the community in which it is located.

Over the past three decades, during my years as a nurse in my rural, home community, I have made decisions to practice nursing in my home community as well as to commute to non-rural settings. Dahlberg et al. (2008) suggested self-scrutiny questions in order to reflect on pre-understanding of the topic at hand, including:

- What has been my experience of this phenomenon?
- What do I know or do I not know about the phenomenon?
- What is it that I want to know?
- How is my way of understanding?
- Am I too quick in making decisions about what I see?
- Do I see nuances or the broad outlines?
- Is it hard for me to be surprised? (p. 202)

The reasons leading to my choices to practice in my rural, home community varied over the years and included employment opportunities available in my community, convenience of working near the daycare of my young children, time it takes to commute, costs of commuting, feelings of obligation to my community, familiarity with the people served in my community, familiarity with the healthcare system in my community, and comfort working in the community. In the past 12 years, I have commuted away because of professional teaching opportunities at a nearby university. My initial teaching opportunities became viable because of my enrollment in a university's Master in Nursing program, allowing me to integrate employment at the university with employment in my rural, home community. The teaching opportunities at the university allowed me to bring nursing students to my rural, home community for clinical experiences, providing students the opportunity to experience nursing in a rural setting while caring for rural members of my community. My decisions to practice in my rural, home community have varied, leading to many professional opportunities.

Throughout the past three decades, I have known nurses who lived in my rural, home community who commuted away to non-rural facilities. Reasons they shared with me about their decisions to commute were multifocal, including professional opportunities, wages, increased anonymity, fear of the broad range of skills needed to practice in a rural facility, personality conflicts with other nurses or administration in the rural facility, and the desire for a second source of income. I have also known nurses who lived in non-rural communities who commute to my rural, home community. Reasons they shared with me about their decisions to commute to a rural community included stability of hours, availability of employment opportunities, and lack of nursing labor unions.

Additionally, over the past three decades, I experienced many changes in the healthcare arena. I recently pondered many questions about the current status of rural healthcare. What does the future hold for rural healthcare facilities? Will there be enough healthcare providers, including RNs, to provide adequate care in these facilities? Why are RNs commuting from the community's healthcare facility for employment? Does the nurse living in a rural community have a personal obligation to practice nursing in the community's healthcare facility? How would healthcare change for members of the community if the healthcare facility became economically non-viable? What is needed to create sustainable, adequate staffing for rural healthcare facilities?

Through the above questions, self-reflection, discussions with peers and advisors, and journaling, my critical examination of self-awareness provided a state of pre-understanding in regards to the phenomenon of interest. I continued to reflect and journal throughout the entire inquiry and analysis process of the current study, increasing self-awareness through critical examination.

Researcher assumptions and reflections. Prior to beginning the current study, some of my personal assumptions related to the phenomenon of *"commuting away"* for RNs living in rural, home communities had been identified. Assumptions and reflections included:

1. The role of rural nurses is to advocate for their patients, including those in their communities.

2. Nurses in rural communities have unique bonds to their communities and there is a built-in connectedness among community members.

3. Living and working in a rural community as a nurse presents challenges, including lack of anonymity, lack of confidentiality, safety concerns for self and family, and blurring of professional and personal boundaries.

4. Benefits of living in a rural community as a nurse include a sense of belonging as well as a natural position as a community leader.

5. RNs' decisions to commute away from their rural, home communities to non-rural healthcare settings entail more than the potential for increased wages in other healthcare facilities.

6. RNs commuting from their rural, home communities for employment in non-rural healthcare settings need to consider the effects of their decision: they leave the community's healthcare facility, and community members, vulnerable.

7. I have personal feelings of responsibility to the people of my community to assure their healthcare needs are met.

8. I have personal feelings that RNs living in my rural community have an obligation to serve the members of their community to meet their healthcare needs.

9. I fear the consequences the people of my community will experience if they no longer have a healthcare facility in their rural, home community.

10. I have a personal appreciation of the opportunity to live and work in a rural community, along with my feeling of frustration with those who speak negatively of such opportunities.

11. I personally feel that nurses who have opportunities to practice nursing in rural settings are very fortunate.

Having explicated some of my own assumptions and beliefs, I realized that I had some personal values that cause me to have a bias against, and place some judgment upon, those nurses who commute away from their rural communities. Having come to realize this, I also knew how important it was for me to be able to lay aside these personal assumptions, beliefs, and values in order to be open to the true meaning of the participants' experiences. I continued to be reflexive through journaling and having regular discussions with my advisor throughout the current study.

Sample Setting

In an effort to gather information for this descriptive phenomenological study, a sample selection approach was utilized to seek varied descriptions of the phenomenon of *"commuting away"* by RNs living in rural, home communities. Dahlberg et al. (2008) illuminated the need for rich variation in the information gathered, with the strength of the data generated not related specifically to the number of participants as much as the depth of information that was obtained from the participants who had experienced the phenomenon. As the sample selection process sought participants who could describe the phenomenon of *"commuting away,"* additional consideration was needed to include participant variations such as varying ages, genders, work

experiences, work sites, and connections to the rural community, like those who were born and raised in the community versus those who had moved to the community either in the recent or distant past, adding to the rich variation in data. Additionally, consideration of nurses who commuted to small rural areas, large rural areas, and urban areas were sought to add rich variation in the various experiences of these nurses.

Unlike quantitative research, in phenomenology the number of participants are not generally defined prior to initiation of the study, and additional participants are included in the study as needed after the initial collection of information has been completed. Dahlberg et al. (2008) suggested beginning with five interviews if the research surrounds a phenomenon that is not complicated. While it was difficult to determine the sample size a priori, given the amount of variation in participant characteristics that may result in varied experiences with the phenomenon of *"commuting away,"* it was anticipated that somewhere between 15 and 20 participants would be needed for the current study. In the end, determining the adequacy of the sample size required flexibility in order to achieve maximum variation in the phenomenon of interest, with the exact number in the sample deemed not as important as the reason for the final number of participants (Dahlberg et al., 2008). Ultimately, representation of the phenomenon in all its varied forms was of the utmost importance, rather than sample numbers.

Purposeful sampling with snowballing was utilized in the current study with a focus on experiences and not nurses per se (Kleiman, 2004). Using purposeful sampling, participants were selected based on their experiences of commuting, and their willingness to share their experiences of the phenomenon. Beyond initial purposeful sampling, a specific purposeful sampling technique, snowballing, was used to find additional participants. Because rich variations of participants was difficult to locate, participants in the current study were asked to

assist the researcher to find other participants, using snowballing, to add to the rich variation of the sample (Streubert & Carpenter, 2011). The result was a sample of RNs rich in experiences of commuting.

Recruitment

Recruitment of participants occurred through a specific sampling process. The selection process was guided by the boundaries of the current study as defined in the inclusion criteria for participants. The target population was currently licensed RNs living in rural communities with healthcare facilities located within those communities.

Inclusion criteria for the participants was as follows:

1. Currently licensed RN in Minnesota, South Dakota, North Dakota, or Iowa;

2. Resident in a defined rural community (population < 2,500) with a Critical Access Hospital (CAH);

3. Registered nurse *"commuting away"* from his or her home community for employment in a non-rural setting; and,

4. English speaking.

Participants living in communities with a population less than 2,500 people represented RNs living in the smallest of rural settings, being a very small subset of the overall numbers of RNs in the United States. In order to achieve rich variation in the information gathered about these nurses, a variety of RNs were initially targeted to include their years of nursing experience, level of education, work situations, location of residence, length of residence, and commuting practices in the sample selection process. Particular attention was paid to purposefully recruit RNs who possessed characteristics resulting in variation of experiences with the phenomenon. These characteristics included: RNs who (a) had been life-long members of a rural community;

(b) were new members of a rural community; (c) had practiced nursing in the rural community in the past but now commuted away; (d) had always commuted away to their places of employment; (e) had become RNs in the past two to four years; (f) had been RNs for five years or longer; (g) had earned an associate degree in nursing; (h) had earned a bachelor degree or higher in nursing; (i) were employed at a CAH; (j) were employed at a non-CAH; and (k) commuted to a small rural area, large rural area, and/or an urban area, utilizing the rural-urban commuting area (RUCA) classification system (US Department of Agriculture [USDA], Economic Research Service, 2014).

To gain access to prospective participants, a sample of RNs residing in communities with CAHs was used. The inclusion of communities with CAHs was used to establish the potential opportunity for employment for the nurse in the participants' home communities. The employment opportunities associated with a CAH in the participant's home community demonstrated the employment potential for the RNs in their rural, home community from which they commuted. Utilizing the US Census Bureau (2015) and the Flex Monitoring Team: University of Minnesota, University of North Carolina at Chapel Hill, and University of Southern Maine (2015), communities with less than 2,500 inhabitants in which a CAH was located were identified.

Prior to Institutional Review Board (IRB) approval, the Minnesota, North Dakota, and South Dakota Boards of Nursing were contacted, informing them of my study and my interest in the RNs in their states. Each Board of Nursing verified that I would be able to obtain data for RNs in the state, including names and addresses for those RNs. North Dakota was included in the IRB request in case additional recruitment was needed beyond Minnesota and South Dakota. Additionally, RNs licensed in Iowa were in the inclusion criteria because of the potential that

some RNs living in Minnesota, near the border of Iowa, may practice in Iowa rather than Minnesota. Initial recruitment began with those communities located within a 100- mile radius from my residence, which included 14 Minnesota communities and 3 South Dakota communities. Subsequently, following IRB approval, the Minnesota and South Dakota State Boards of Nursing were contacted to acquire the names and contact information of RNs living in qualifying communities within 100 miles of my residence. Nurses who specifically did not live in areas that met the definition of rural (communities of less than 2,500 persons with a CAH) were excluded, along with RNs who lived in a rural community and did not commute to non-rural settings for employment. Prior to the receipt of the Minnesota and South Dakota Boards of Nursing data, I did not know the number of prospective participants located within a 100-mile radius of my residence. My original plan was to recruit nine participants from each of the communities of interest, recruiting at least 150 total prospective participants. Supposing that 37% of the prospective participants in the Boards of Nursing data commute away, utilizing Skillman's RN commuter trend data (Skillman, Palazzo, Doescher, & Butterfield, 2012), and supposing that I would achieve a 30% response rate from prospective participants invited to my study, I thought I would potentially recruit 16 participants from the data obtained from the Boards of Nursing. If enough participants were not recruited, I planned to expand the area in which I recruited participants by inviting prospective participants in a larger Minnesota region, a region surrounding Grand Forks, North Dakota, or a region further into Iowa.

Data received from the Minnesota and South Dakota Boards of Nursing revealed a total of 620 prospective participants in the 17 identified communities of interest. Found among the names of nurses received from the Minnesota Board of Nursing were RNs, as well as advanced practice registered nurses (APRN), because of the requirement for every person who practices

professional nursing in Minnesota to hold an RN license. The number of prospective

participants was large enough that that there was potential for more participants than would be

needed for the current study. Thus, participants were selected from the data to give the greatest

variability in the sample. A total of 170 prospective participants, 10 from each community, were

selected in a generally random manner, with the exception of purposefully selecting male nurses,

to include variability in the sample. As data collection progressed, more specific variations in

the state of licensure, age, gender, worksite community census, and rural urban continuum codes

(RUCC) (USDA, Economic Research Service, 2013) were sought to assure rich variation in the

study sample.

Prospective study participants received a participant letter of invitation, along with a

reply form via United States Postal Service, to participate in the current study (see Appendix A).

Following Dillman's (2007) tailored design method for mail surveys, careful attention was paid

to the details of the mailings. Letters of invitation were drafted to introduce the reason for the

letter, why the request was being made, how the participant was selected, why this request was

important, my appreciation of their consideration to participate, my willingness to answer

questions about my request, and my willingness to provide information about how to contact me.

The letter of invitation also included personal touches such as a date and the participant's name,

rather than a preprinted salutation such as "Dear Nurse." Each letter of invitation was also

individually signed with contrasting blue ink to add a personal touch (Dillman, 2007).

The function of the mail out envelope, in which the letter of invitation was mailed, served

more of a purpose than just delivering the enclosed letter. The envelope appearance functioned

to draw the attention of the recipient and bring about the opening of the letter. Letters of

invitation were mailed in regular, business sized, #10 envelopes with unique postal stamps,

rather than being stamped from a postage meter. A personally stamped envelope was used to increase response rates from the mailing. Dillman no longer perceives computer generated labels as impersonal, in this day of technology; thus, computer generated address labels were used on the envelopes to assure accuracy of addresses on the envelopes (Dillman, 2007).

A self-addressed stamped return envelope was included with each invitation letter. Again, a unique stamp was placed on each envelope to give a more personal touch to the request for return of the reply form. The stamped envelope was intended to be seen as a helpful gesture. Increased return rates may have occurred, as it may have been difficult for some recipients to throw away a stamp that has monetary value, rather than returning the envelope. This stamped envelope could also have been viewed by the recipient as a token of appreciation (Dillman, 2007).

To prevent the recipient from losing enclosures in the mail out envelope, a #9 self-addressed stamped return envelope was utilized to prevent the need to fold the envelope prior to placing in the mail out envelope. The letter of invitation, together with the reply form, was folded in thirds; the bottom one-third of the letter and form folded up first, and the top one-third of the letter then being folded down. To prevent the enclosures from getting separated, the folded letter and form were then tucked in the flap of the return envelope and strategically placed in the mail out envelope. In this manner, when the recipient removed the inserts of the mail out envelope, the potential for components being left in the mail out envelope were minimized and the personal salutation on the letter would immediately be visible to the recipient when the letter was removed from the mail out envelope. Lastly, timing of the mailing of the letters was also considered, avoiding the rush of mail during the Christmas holiday week (Dillman, 2007).

Within the letter of invitation, recipients were asked to contact me via return of the Invitation Letter Reply Form or by email. The reply form asked for contact information, including phone and email contact information, and preference for future contacts (see page two of Appendix A).

Upon return of the reply forms by mail, the recipients indicating a preference to be contacted by email were emailed with a brief introduction to the study and a request for a reply email to myself. Additionally, the recipients, indicating a preference to be contacted by phone, were called and given a brief introduction to the study.

Thirty recipients replied, either via email, mail, or phone, noting they did not meet inclusion criteria. When these email or mail replies included email and/or phone contact information, recipients were contacted to verify ineligibility. Eight other recipients replied and were found to not meet eligibility requirements, or did not reply to researcher attempts to talk via phone to screen for eligibility. Three invitation letters were returned because of incorrect addresses, with forwarding addresses in a qualifying community noted on the return envelope. All were forwarded on to prospective participants. Two of those recipients eventually returned the reply form.

A spreadsheet was utilized to track the prospective participants. Spreadsheet documentation included the (a) names of all of the RNs who were mailed an invitation letter; (b) date the invitation was sent; (c) date invitation letters were returned with forwarding/unacceptable addresses; (d) date the reply form/email/or phone call was received; (e) ineligibility; (f) screening date; (g) eligibility; (h) interview date; and (i) date the pre-interview letter was sent. Contact information was updated on the spreadsheet as additions/corrections to email addresses and phone numbers were received from recipients.

A screening tool was used to collect complete screening data for the respondents not immediately deemed ineligible to determine eligibility using the inclusion criteria (see Appendix B). Data from the screening tool was placed on a screening matrix to allow a visual display of the similarities and variabilities of the eligible participants.

In the beginning of the current study, once eligibility for the study was determined, an initial interview date/time was set up with the participant. As the study progressed, interviews were set up with only those participants who added to the variability of the study. Some eligible participants were informed that I would contact them in the future after determining need for an interview, after explaining the need for variability in the study.

The setting for the interview was determined by the participants in order to maximize the potential to create a comfortable environment in which to converse and share their experiences. Concerns of convenience for the participant, quiet environment, and privacy, in addition to the amount of time needed for the interview and time to build rapport between participant and researcher, were all considerations when determining the interview setting (Mateo & Kirchhoff, 2009). Time allowing, a pre-interview letter was sent to the participant prior to the interview, affirming date, time, and location, and sharing the opening questions of the interview (Appendix C).

When approximately ten interviews had been completed, it was beginning to be evident that specific variations in the experiences of the participants lacked the richness desired. The first indicator was a lack of participant experiences commuting to urban, as well as small rural, areas. Subsequently, to seek participants commuting to urban areas, qualifying Minnesota communities located within an hour of the metropolitan area of the Twin Cities were identified. The Minnesota Board of Nursing was contacted to obtain names and contact information of RNs

living in two of those communities. The contact information shared by the Minnesota Board of Nursing included email addresses of the RNs. Thus, RNs with email addresses specific to healthcare facilities in the metropolitan area were targeted for inclusion in the current study. To explain, the domain of my email address, laurie.johansen@my.und.edu, is *my.und.edu*. An example of an urban healthcare system email address could be laurie.johansen@urbanhealthcare.org. Thus, the domain of this email address, *urbanhealthcare.org*, could identify the email as one originating from an urban healthcare organization where the participant was employed. Invitations were sent to ten prospective participants from each of the two communities. From those invitations, five responses from prospective participants were obtained; one commuting to an urban healthcare facility, one commuting to a small rural facility, one not commuting, and two not adding to the rich variation needed for the current study. Additionally, the need for participants commuting to small rural areas was addressed through the identification of two prospective participants through snowballing to meet these criteria.

As data collection continued with participant interviews, another area was identified as needing greater depth in variation. Only one participant was newly licensed as an RN in the past nine years. Thus, using the data from the Minnesota Board of Nursing, I screened all of the names of the RNs in the communities near my residence. I used the Minnesota Board of Nursing online license verification system to identify each nurse's original date of licensure. I also completed the same process for all the RNs from the South Dakota communities included in the current study, because there were also a limited number of participants licensed in South Dakota. Invitations were subsequently sent to fourteen RNs who had been identified as RNs being licensed for only two to four years in both states.

As data collection in the current study progressed, the need to include newly licensed RNs, and those commuting to urban areas, continued to be an identified need. The current study still only had two participants who were commuting to urban communities and one participant who was newly licensed in the past four years. In order to better understand the worksite geographic areas of the participants already enrolled in the current study, the population of each of the communities that participants were commuting to was identified using the 2010 United States Census data (US Census Bureau, 2015). Additionally, each of these community's county was classified according to the 2013 rural-urban continuum codes (RUCC) to distinguish counties by degree of urbanization and adjacency to metro areas. The RUCC codes were then used to identify communities that would add rich variation to the current study. At that time, contact was made with the North Dakota Board of Nursing to obtain names of currently licensed RNs, to recruit participants to meet the identified areas of need. The North Dakota Board of Nursing informed me that I would not be able to obtain data for nurses currently licensed in North Dakota, as they no longer distributed contact information about their licensed nurses. Thus, to add rich variation to the study sample, four Minnesota communities, bordering North Dakota urban communities, were identified, with a goal to add participants commuting to urban areas, as well as participants being newly licensed. The Minnesota Board of Nursing was contacted to obtain the names and contact information of the RNs from those four Minnesota communities. The names of the RNs from these communities were screened for years of licensure using the Minnesota Board of Nursing online verification system. Seventeen of the RNs who had been licensed for two to four years were sent invitations. Additionally, email addresses were screened, looking for email addresses from urban healthcare facilities in North Dakota. Nine of the RNs email addresses were identified as being from urban healthcare

facilities in North Dakota. Of interest, only RNs with seven of more licensure years were found within those prospective participant email addresses from urban North Dakota healthcare facilities, with licensure years ranging from seven to thirty six.

One last effort was made to add rich variation to the current study by screening all of the RNs from the two Minnesota communities near the metro area of the Twin Cities. Years of licensure were identified, with 24 invitations sent to prospective participants in those towns who had been licensed for two to four years. At the completion of recruitment efforts, 22 prospective participants were recruited, with 16 included in the current study for rich variation in the experiences of participants.

Data Collection

In the chosen qualitative research design, a common data collection tool is the use of interviews (Mateo & Kirchhoff, 2009). The focus of the current study was RNs living in rural communities who commute away, and participant interviews were used to inquire about the participants' lived experiences in regards to the phenomenon. The inquiry process occurred through a series of participant interviews in which an open dialogue was used to engage the participant while minimizing the impact of the researcher. The goal of this open dialogue was to facilitate candid expressions of the participants' experiences.

Briefing and debriefing (Brinkman & Kvale, 2015) informed participants about the purpose of the current study and the procedures that would be followed. Briefing occurred at the beginning of the interview session, when I explained the interview process, purpose of the interview, and use of technical equipment. The use of interview materials, including confidentiality of study materials and the researcher's publication rights, were reviewed during the briefing session (Brinkman & Kvale, 2015). Audio recording of the interview was explained

and a signed informed consent was obtained from each participant prior to commencement of the interview. Participants were offered a copy of the informed consent, and a second copy of the informed consent form was completed and given to the participant if desired. Following the receipt of the informed consent, demographic information was collected using a tool developed for the current study (see Appendix D). Demographic information was collected to describe the characteristics of the sample, allowing recognition of contextual elements that were used during the recruitment and analysis phase of the study. This information was completed prior to the first interview and took approximately five minutes to complete. Participants were informed that the interview would take approximately 60-90 minutes, with a possibility of a second or third interview in the near future if the data analysis revealed the need for additional interviews. Debriefing occurred at the conclusion of the interview, at which time I asked the participants if they had anything else to say or bring up prior to ending the interview. This gave the participant the chance to talk about issues they had been thinking about during the interview. It was also a time when I could reiterate the purpose of the current study and use of the interview materials. In addition, at the conclusion of interviews, participants were asked to put me in contact with any other rural nurses who might be prospective participants for the study. Participants were given my business card and asked to share my contact information with prospective participants, and have those prospective participants contact me.

In the current study, interviews did not purposefully seek specific replies from the participants. Semi-structured life world interviews were utilized to obtain descriptions of the participant's experiences (Brinkman & Kvale, 2015). I lead the beginning of the interview, and the first question of the interview generally started by asking the participant to tell me about their experiences as an RN living in a rural community. The structure of the question was clear and

simple, leading participants to begin to describe their experiences in their own way. The interview structure eventually transitioned to a conversation that allowed the participants to lead the interview, as I followed that lead, supporting and encouraging the participant while keeping the phenomenon in focus. My questions, at this point, were used for clarification, expansion, elaboration, and to pay attention to the participant reactions and emotions while facilitating the movement towards the "unexpected, the unknown, and unreflected, in order [for the participant] to reflect in a new way and come closer to the phenomenon" (Dahlberg et al., 2008, p. 192).

Brinkman and Kvale (2015) further described the semi-structured, phenomenological interview through the identification of key aspects of the phenomenological stance:

- "Life world. The topic of qualitative research interviews is the interviewee's lived everyday world" (Brinkman & Kvale, 2015, p. 32). The interview attempted to obtain unprejudiced descriptions of commuting. Interview questions allowed the participant to share their experiences without researcher explanations.

- "Meaning. The interview seeks to understand the meaning of central themes of the subject's lived world" (Brinkman & Kvale, 2015, p. 32). Meanings were interpreted by not only what was said during the interview, but also how the participant responded, including vocalizations and facial/body gestures. I confirmed what the participant was saying during the interview.

- "Qualitative. The qualitative interview seeks knowledge as expressed in normal language; it does not aim to quantification" (Brinkman & Kvale, 2015, p. 33). The interview aimed at various aspects of the participant's life experiences.

- "Descriptive. The qualitative interviewer encourages the subjects to describe as precisely as possible what they experience and feel and how they act" (Brinkman &

Kvale, 2015, p. 33). With this, I led each interview towards the participant's unique descriptions of "*commuting away*" in order to include a variety of experiential descriptions rather than descriptions that fit into preconceived, fixed groups of descriptions.

- "Specificity. Descriptions of specific situations and actions are elicited, not general opinions" (Brinkman & Kvale, 2015, p. 33). During the interview process, interview questions were focused and refocused to the phenomenon, with resulting descriptions leading to concrete meanings rather than beliefs or opinions.

- "Deliberate naiveté. The interviewer exhibits openness to new and unexpected phenomena, rather than having readymade categories and schemes of interpretation" (Brinkman & Kvale, 2015, p. 33). I did not pose questions with respect to fixed groups of descriptions. Rather, researcher bridling of any presuppositions allowed curiosity and sensitivity to create a critical awareness of the participant's world.

- "Focus. The interview is focused on particular themes; it is neither strictly structured with standard questions, nor entirely 'Nondirective'" (Brinkman & Kvale, 2015, p. 34). I used an interview guide to lead the participant towards the phenomenon to focus on the experiences of RNs commuting. I was not bound to the interview guide, as it was not the interview guide, but the participant, that presented the aspects of the phenomenon they felt were important.

- "Ambiguity. The interviewee's answers are sometimes ambiguous" (Brinkman & Kvale, 2015, p. 34). During the interview, the participant may have made statements that could be interpreted in several different ways. When this was the case, I clarified these statements as far as possible. Clarification served to verify if ambiguous

statements were present because of a faulty communication between the interviewer

and participant, or whether the ambiguous statements were actual reflections of

contradictions in the participant's world. This was key to identifying the true

meaning of the phenomenon of *"commuting away."*

- "Change. In the course of an interview, subjects can change their descriptions of, and

  attitudes toward, a theme" (Brinkman & Kvale, 2015, p. 34). Participant reflections

  occurred during the interview, allowing the participants to discover new aspects of

  the phenomenon of interest. Thus, occasionally, meanings of their lived experiences

  changed for the participants during the interview.

- "Interpersonal situation. The research interview is an inter-view where knowledge is

  constructed in the inter-action between two people" (Brinkman & Kvale, 2015, p. 35).

  A phenomenological frame of mind was used by myself in order to be open to

  gaining new understanding. The knowledge produced in the interview was formed by

  the interaction between the interviewer and participant, with the participant and

  myself influencing each other.

- "Positive experience. A well-conducted research interview may be a rare and

  enriching experience for the subject, who may obtain new insights into his or her life

  situation" (Brinkman & Kvale, 2015, p. 35).

The interview stage, as described by Brinkman and Kvale (2015), was structured using an

interview guide during the course of the interview. An interview guide, where the aims of the

study were reflected, was created for the current study (see Appendix E). The interview

questions were developed based on my knowledge and experience of the phenomenon. This

guide contained some topics, or lines of inquiry, to be covered with suggested questions that

would lead the participant to the desired topics. Core questions were used in order to assure that the data collection met the specific aims of the study. The guide was not be used to provide detailed questions that were necessarily included in the interview. Instead, it was used as a reference and as needed to ensure that all lines of inquiry were pursued in the interview. Two dimensions of interview questions were considered in my phenomenological interviewing. One dimension was the thematic dimension, in which the interview questions were relevant to the research theme (Brinkman & Kvale, 2015). The opening question, "What is it like to be an RN living in a rural community?" was an example of an interview question with a thematic dimension. The other dimension was the dynamic dimension, which was the interpersonal relationship between the participant and myself. Those interview questions encouraged positive interactions between myself and the participant while keeping verbal interactions flowing and stimulating the participant to share feelings and life experiences (Brinkman & Kvale, 2015). "How did that make you feel?" would be an example of an interview question with a dynamic dimension.

A pilot interview was conducted with a nurse living in a qualifying rural community who *"commuted away."* The purpose of this pilot interview was for me to acquire self-confidence conducting interviews, including practical and technical issues of the interviewing process, to create options for improving the interview question, to increase awareness of my body language, and to become skilled at the art of using semi-structured interview questions (Kvale, 2007). Feedback was requested from the pilot study participant to improve the interview process. The pilot interview was not used in the data collected for the current study because of the expected learning curve during the pilot interview. Feedback from the participant guided me towards better redirection of the participant toward the phenomenon. Also, revisions were made in the

demographic questionnaire, and in my presentation of the study, clarifying the definition of rural being less than 2,500 people.

Following every interview, I wrote field notes, adding insight and validity into the inquiry process (Thomas & Magilvy, 2011). The field notes contained descriptions of observations not recorded in the audio recordings of the interview, including participant non-verbal communications and environmental observations. They also contained any interactions between the participant and myself, any assumptions I may have had about the interview data, and my personal narrative about the interview experience, including what I believed went well or what I believed I could improve on for future interviews (Streubert & Carpenter, 2011). The insight created with the use of field notes added to the strength and validity of the current study, along with adding depth to the audit trail of the study. In between the timeframe of each interview, I also used a personal reflective journal to allow for the expression of my personal beliefs, reflections, insights, and preunderstandings throughout the study (Thomas & Magilvy, 2011).

Human Subjects Protection

Approval for the current study was obtained from the Institutional Review Boards for the University of North Dakota (the researcher's academic setting) and Southwest Minnesota State University (the researcher's employment setting). The institutional review process considered the research protocol, prospective participants, participant recruitment process, participant selection, protection of participants, benefits of the study, and any risks to participants in the study. A participant consent form was used to describe the purpose of the study and how the data would be collected, and also contained a statement informing participants that they could withdraw from the study at any time without explanation or consequences (see Appendix F).

Participants were offered a copy of the signed, written consent. The form included information about the researcher and the participation process.

Assurance was given that privacy would be protected, participant names would not be disclosed, and that any other identifying information would be removed from the transcripts and the study so that readers could not identify any participant. Participant's names would not be used in the transcripts, with participants being identified with numeric identification on the transcripts. Direct quotes may be used in the dissemination of the study results, with alternative identification used, including numeric identification numbers, rather than participant names, used to de-identify the data. Screening documents, transcripts, consent forms, and demographic questionnaires were stored in a locked cabinet in the researcher's locked work office, at the researcher's place of employment, with only the researcher having access to the cabinet. Documentation defining numeric identification was stored in a separate locked cabinet in the researcher's work office. Computer storage of recordings and transcripts occurred on a password-protected computer with researcher access only. Backup of computer storage occurred on a flash drive that was stored in a locked cabinet in the researcher's locked work office, at the researcher's place of employment. Recordings were removed from the digital recorders and the computer storage system once the transcripts have been verified. Paper copies of screenings, transcripts, computer storage of transcripts, consent forms, demographic questionnaires, and participant identifying information will be kept for a minimum of three years after completion of the study. Paper documents will then be destroyed by shredding, with computer storage deleted from computer storage systems.

There were no known risks to the participants in the current study. A potential minimal risk may have been some emotional discomfort during the study if the interview led to sensitive

topics for the participant and/or inadvertent disclosure of private information. If participants had experienced any emotional distress, the interview would have been paused (for minor emotional stress) or gently terminated (for more minor distress), and counseling may have been advised. With this, the research may have involved minimal risk. There were also no known individual benefits to the participation in the study. A potential benefit to the participant was that the interview might have created a reflective process for the participants, which could have added to their own understanding of their personal experiences. Another potential benefit of the current study could have been that the participants may have been able to inform nursing practice, policy development, employers of nurses in rural settings, and nursing educational agencies about the experiences of RNs commuting to non-rural healthcare settings in order to adequately prepare, recruit, and retain future RNs into rural healthcare practice. This is needed knowledge that is currently lacking in nursing research. In addition, the participants in the current study may have felt pride that they contributed to research that may improve access to healthcare for the rural population while decreasing health care disparities.

Analysis Plan

The open lifeworld approach continued to guide the study during the analysis phase. Unlike quantitative research that includes interpretations and explanations, the analysis process for the open lifeworld is meaning oriented. To give meaning to the current study, the descriptions contained in the participant interviews were analyzed following a tripartite structure, moving between the whole, to the parts, and back to the whole. This progression was crucial to descriptive phenomenology; the three distinct steps of analysis striving to reveal meaning for each part, with each part adding meaning to the whole (Dahlberg et al. 2008). Ultimately, the aim of the analysis of the current study was a synthesis of the essence of the phenomenon, how

the essence of the phenomenon was defined, and the relationship of the whole to the part, and the part to the whole. In the end, once the essence of the phenomenon and all of its constituents, or varied parts that make up the essence, were defined, the whole of the data was greater than the sum of the parts (Dahlberg et al., 2008).

In order to analyze the data, all the interview data were transcribed into a text format by a qualitative research transcription service, and reviewed for accuracy by myself. All participant names were identified with assigned numeric identification numbers. Next, as I read my transcripts, the movement between the whole, to the parts, and back to the whole of the data was central to analysis within the scientific attitude of phenomenology. Becoming familiar with the whole required openness to prepare for new understanding. It also required immediacy in order to grasp a sense of the whole text and its overall theme.

To become familiar with the whole, I examined the transcripts and field notes while avoiding the temptation to "go beyond the presentation of the meaning of the phenomenon" (Dahlberg et al., 2008, p. 237) to explain the phenomenon. I read the transcripts several times to develop a sense of the whole text while I explicitly practiced having an open mind, preparing for my new understanding. I ignored any personal intentions in order to see something new or to see something in a new way. It was at this point that I used immediacy to immerse myself in the data in order to allow curiosity to impact my desire to understand. When I was able to grasp the whole transcript and briefly convey an overall summary of the data, I had completed the initial analysis of the whole.

After completion of initial analysis of the whole, I focused on the parts of data. The data were broken down into smaller units called meaning units. "The term meaning units signals that the division of the whole of data in to parts is not carried out randomly, but with respect to the

meaning that one sees" (Dahlberg et al., 2008, p. 243). Subsequent readings of the data focused on meaning units, within the whole, to understand the emerging meanings within those units. Individual meaning units were identified when there was a shift in meaning in what the participant was saying. Each meaning unit was given a code, with the words of the participants being used to describe the individual codes whenever possible (Dahlberg et al., 2008). NVivo 10.0 (QSR International Pty. Ltd., n.d.) was the software platform used to organize such data. Once all of the transcripts had been coded in this way, 2371 meaning units, or individual codes, were again analyzed, looking for patterns, similarities, and relationships between the meaning units/codes. Clusters of meanings were then assigned new categories, or codes, which were higher levels of abstraction, but which still continued to use the participant's words whenever possible. Throughout this process, the analysis of the parts required me to devise analytical procedures, such as schematic drawings, to understand how the different codes, or categories of codes, were related to each other, and created a structure of the findings to make sense of the web of relationships.

Once the analysis of the parts led to the data being emptied of all meaning, I returned to the whole. Relating the codes and clusters of meaning to each other led to the identification of the essence, or core meaning, of the phenomenon (Dahlberg et al. 2008). A broader and more abstract level of understanding emerged. The whole structure of analysis included the essence of the phenomenon, with its constituents, or particulars of the structure of the essence, giving context to the description of the essence. Imaginative variation played an important role in the validation of the essence of the phenomenon at this point in the analysis of the data. Variations in experiences were considered to ensure the presence of the essence in all variations of the phenomenon (Dahlberg et al., 2008).

Rigor

The quality of the study findings was dependent on the rigor of this descriptive

phenomenological research. Lincoln and Guba (2000) recognize the importance of rigor in

qualitative research, demonstrating the researcher's attention to the discoveries of the study.

Like quantitative research, qualitative researchers seek quality standards to ensure validity of

findings. The means of describing the rigor of the qualitative research study differ from the

rigors of quantitative studies by using the concepts of credibility, transferability, dependability,

and confirmability rather than the concepts of internal validity, external validity/generalizability,

reliability, and objectivity used in quantitative research. The concepts of credibility,

transferability, dependability, and confirmability of the current study were demonstrated

throughout the current study and are summarized in the following paragraphs.

Credibility

The ability to demonstrate credibility in the current study can be affirmed through the

development of confidence in the results of the study. Open-mindedness is a key concept that

was used consistently throughout the study to develop credibility. During the study, as stated

previously, I purposefully prepared my stance as a researcher for the study by keeping a reflexive

journal, identifying potential biases, attitudes, opinions, and experiences that may influence my

ability to have an open attitude. I reflected on my standpoint and practice orientation in relation

to the phenomenon of interest, mentally assessing my ability as a researcher for the current

study.

Credibility was also determined through the logic of sample selection and consistent

interview techniques, all leading to dependable study results. Additionally, an audit trail was

created throughout the data collection and analysis processes. The transcripts were typed, with

each recording listened to and compared to the written transcript to ascertain credibility. Credibility was also strengthened through the use of an audit trail, which included my reflective journals, field notes, transcripts, and analysis notes. Continued consultation with my dissertation chairperson throughout the research process also strengthened the credibility of the study. Additionally, I did not search the literature to seek answers about the phenomenon of interest, adding to potential biases and preunderstandings. Such an open attitude shifted me away from my natural attitude and intentionality, to prepare my phenomenological frame of mind.

Transferability

Transferability is understood as the extent to which the research findings have applicability in other contexts. Transferability was achieved when I provided sufficient information about myself as a research instrument, along with the context of the research, inquiry and analysis processes, and research participants, in order for the audience to determine transferability of the research results. Transferability was also sought through the follow-up and prompted interview questions, deepening the descriptions of the experiences of the participants.

Sufficient context and direct quotations from the nurses were included in the presentation of results in order for the reader to assess transferability to other settings. Such descriptions will allow the reader to judge the transferability of this research to other settings and contexts. Determination of transferability was ultimately determined when the analysis of the data had brought forth the essence of the phenomenon with its constituents. In the end, however, the reader is ultimately responsible for transferability of the study results (Lincoln & Guba, 2000).

Dependability

The results of the current study include claims of dependability, demonstrating consistency of research processes and findings. This was accomplished through the audit trail,

giving a detailed chronology of the data collection and analysis processes along with influences on the research processes and the resulting description of the essence of the phenomenon. Also, continued consultation with my dissertation chairperson throughout the research process strengthened the dependability of the study.

Confirmability

Confirmability is defined as the integrity of the research findings. The integrity of the research findings were demonstrated through the extent of neutrality found in the current study results, with results shaped by the participant's experiences and not by my biases or interests. The data collection processes, including use of researcher as an instrument, along with transparent analytic processes, gave the audience a means to confirm the adequacy of the research findings. Many of the procedures used to accomplish previously mentioned concepts were also applicable here, including the use of an audit trail. Continued consultation with my dissertation chairperson throughout the research process also strengthened the confirmability of the study.

The quality of the study findings is dependent on the rigor of the descriptive phenomenological research. The rigor described will affirm the quality of the current study.

Anticipated Challenges and Solutions

Throughout the current study, there were challenges that were anticipated to accompany the sample selection, inquiry, and analysis processes. Anticipating those challenges with possible solutions strengthened the study outcomes. Potential challenges were identified with the sample selection processes, including the possibility of not getting the rich variation needed in the sample within a 100-mile radius from my home to the participant. The solution to this challenge included traveling a greater distance for a small number of interviews. Another

potential challenge with sample selection involved the inclusion of participants who are friends/coworkers/acquaintances of the researcher. A solution to this challenge was to include reflection on my part to determine if openness could be assured with such participants. Potential challenges with the interview processes also included technical difficulties with equipment. One solution was to always have a second means of recording the interviews available at all interviews. This was an effective plan, as one of the digital recorders did not record during one of the interviews.

Beyond sampling and technical challenges, an expected challenge was the avoidance of imposing my personal experiences and biases on the participants during interviews as well as in the descriptions or analysis of the experiences shared by the participants. A solution to this was to continue the reflective process of journaling throughout the entire dissertation process and continue consultation with my dissertation chairperson throughout the process. Lastly, a predicted challenge during the interview process included the potential desires of participants to hear my lived experiences as a nurse. My solution was to maintain intersubjectivity while directing the interview back to the focus of the phenomenon. It was important to identify potential challenges as I prepared to successfully complete the current study.

Summary

As described, the research approach used in the current study was descriptive phenomenology. The purpose of this phenomenological study was to describe and better understand the experiences of RNs commuting from their rural, home communities. Husserl's philosophical underpinnings shaped the research approach, with the use of purposeful sampling of participants and an interview process for inquiry. A tripartite process of analysis, moving

between the whole, to the parts, and back to the whole, led to the identification and description of

the essence of the phenomenon. In Chapter IV, the findings of the current study are presented.

CHAPTER IV

FINDINGS

The research approach used in the current study was descriptive phenomenology; the purpose of the study was to describe and better understand the phenomenon of *"commuting away"* and the experiences of RNs living in rural, home communities who commute to work in non-rural areas. Semi-structured interviews were conducted with 16 RNs working in a tristate, Midwest region of the United States. The Minnesota Board of Nursing requires every person who practices professional nursing in Minnesota to hold an RN license; therefore, both RNs and advanced practice registered nurses (APRN) were included as participants (nurses) in the sample.

Nurses presented a rich variation of experiences involving various residential histories, worksites, and diverse professional nursing and educational backgrounds. From this data emerged the essence, or core meaning, of the phenomenon of *"commuting away,"* along with accompanying constituents, or components that made up the essence, and relationships between those constituents, as well as a contextual meaning of the phenomenon. Chapter IV provides a description of the nurses, as well as the essence of the phenomenon, *Commuting to Achieve Personal and Professional Goals While Being a Nurse in a Rural Community*, the accompanying constituents; *Being a Nurse in a Rural Community*; *Personal and Professional Goals*; *Commuting*; and *Different Professional Connections*, and the relationships between constituents.

Demographics of Study Participants

All nurses met the inclusion criteria for the current study:

1. a currently licensed RN in Minnesota, South Dakota, North Dakota, or Iowa (although, in the end, no nurses living in North Dakota or Iowa were recruited);

2. a resident in a defined rural community (population < 2,500) with a critical access hospital (CAH);

3. an RN *"commuting away"* from his or her home community for employment in a non-rural setting; and,

4. English-speaking.

A total of 60 nurses responded to recruitment letters. Among those, 22 nurses met the criteria for inclusion. Sixteen of those nurses were chosen to participate in the study, and were selected based upon purposeful sampling and the variation of experiences they would contribute to the study. Six nurses who responded to the letter of invitation and met inclusion criteria were not included in the study as they did not add any deeper variation in experiences (size of community to which they commuted, type of work setting, and years as a practicing RN) beyond the group of those who were already accepted as participants.

At the time of the interviews, all the nurses held RN licenses in the states of Minnesota, South Dakota, and/or North Dakota, with the majority (86%) of nurses from Minnesota. One nurse held nursing licenses in more than one state. Nurses were working either as RNs or APRNs. As indicated in Figure 1, eight of the nurses (50%) had associate degrees in nursing (ADN), six (38%) had bachelor degrees in nursing (BSN), and two (13%) had master degrees in nursing. Minnesota nursing workforce statistics (the state where the majority of participants lived) revealed similar data, with 46% of RNs in Minnesota holding associate degrees, 37%

holding a bachelor degrees, and 11% holding Master degrees or higher (Minnesota Department

of Health [MDH], 2014). Nurses reported the length of time they had practiced as RNs; number

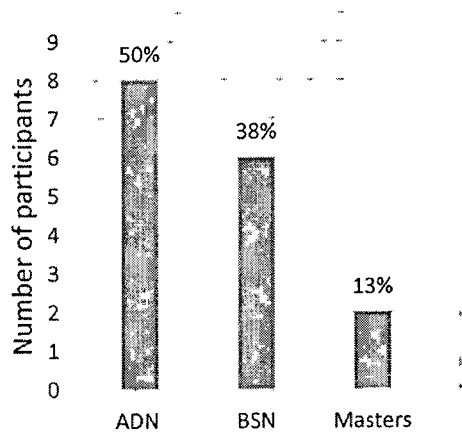of years ranged from 2–57 as shown in Figure 2, with a mean of 19.6 years.
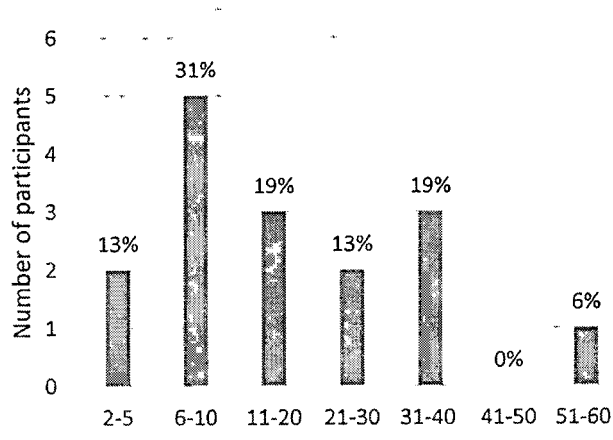

Figure 1. Education.   *Figure 2.* Years as registered nurse.

The mean age of the nurses was 44.6 years, with a range from 24–78 years, as noted in

Figure 3. This is identical to the national mean age of RNs, with national statistics of the RN

workforce being 44.6 years (Health Resources and Services Administration [HRSA], 2013).

Males represented 12% of the nurses, as shown in Figure 4. This is slightly greater than

the 9.1% of male RNs in the national workforce (HRSA, 2013). All (100%) of the nurses were

Caucasian. This is higher than the national average, with 75.4% of RNs being Caucasian, but

coincides with state statistics in Minnesota, in which 95% of RNs are Caucasian, and 97.3% of

RNs in rural Minnesota counties are Caucasian (MDH, 2008).

In terms of the nurses' residential history of years living in their current rural, home

communities, the mean number of years was 23.2 years, with a range of from 1–70 years, as

shown in Figure 5. Ten nurses (62%) had lived in other rural communities prior to residing in

their current rural, home communities, with years of residence in those rural communities

ranging from 3–27 years, with a mean of 12.6 years. The remaining six nurses (38%) had never

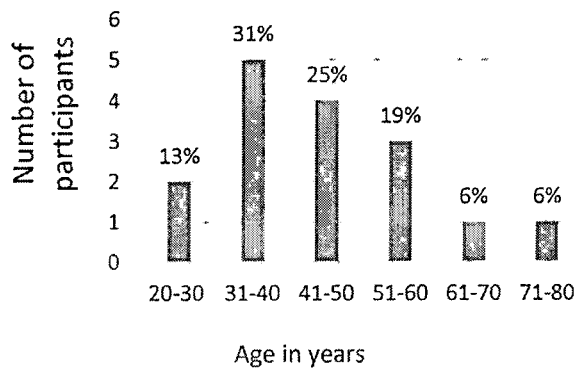lived in other rural communities in the past, as shown in Figure 6.
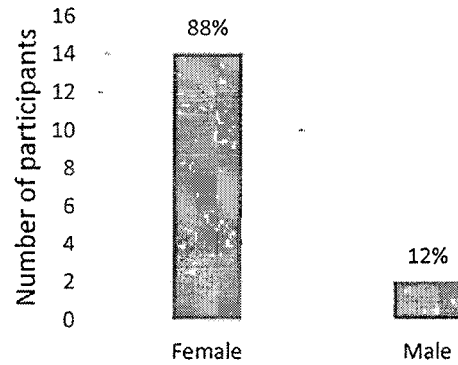

Figure 3. Age of nurses.

Figure 4. Gender distribution of nurses.
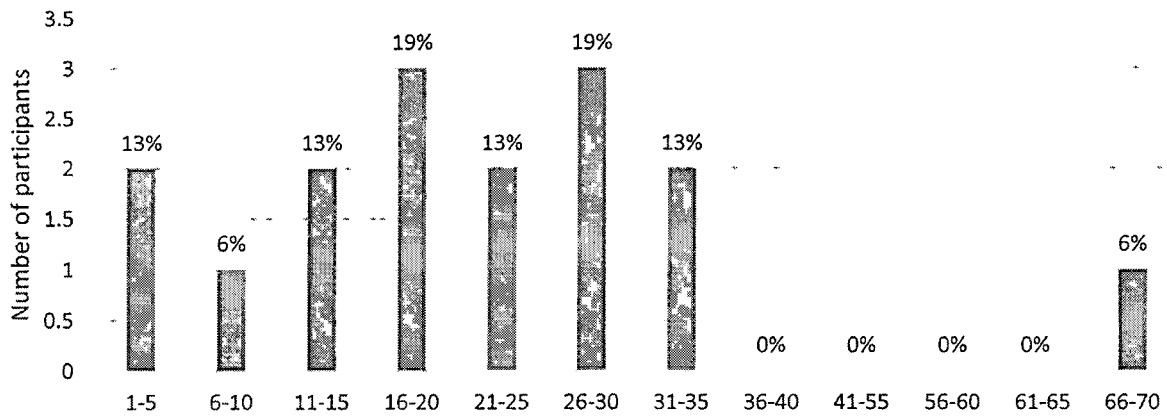
Figure 5. Years living in rural, home community.
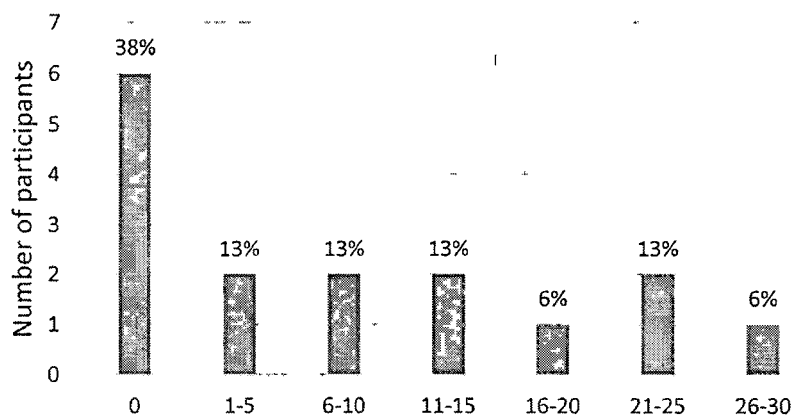
Figure 6. Years living in rural, other community.

Nurses working a variety of settings were recruited in order to obtain rich variations in experiences. There was a variety of work roles within the sample, including staff nurses, administrators, and APRNs. There were also a variety of practice areas, including: medical-surgical units, operating rooms, homecare, hospice, clinic, maternity care, and pediatrics. Hours worked ranged from 22–44 hours per week, as shown in Figure 7, with a mean of 34.5 hours per week.
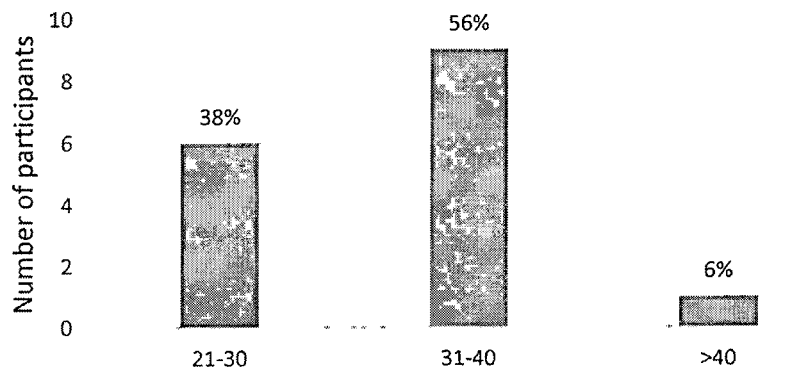
Figure 7. Hours worked per week.

Nurses' work histories varied, with seven (44%) having always commuted away from their rural, home community for employment, and nine (56%) having practiced nursing in a rural community in the past, as shown in Figure 8. Years commuting ranged from 1–32 years, as shown in Figure 9, with a mean of 10 years.
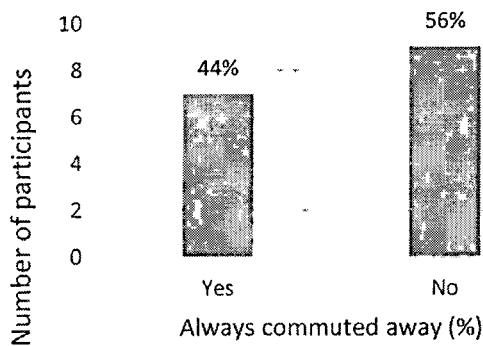
Figure 8. Number of nurses who have always commuted away.
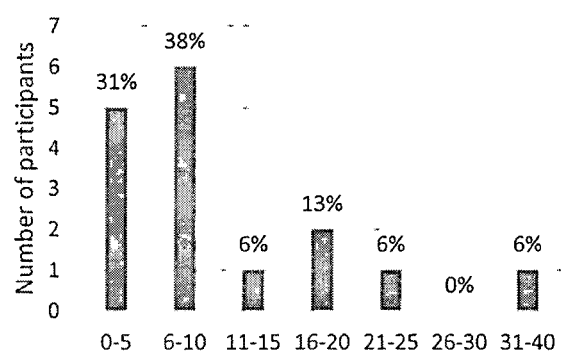
Figure 9. Years commuting.

As noted in Chapter III, nurses were initially classified using the Rural-Urban

Commuting Area (RUCA) classification system. Figure 10 represents those classifications and

shows three nurses (19%) commuted away to small rural communities (population 2,500-9,999),

nine (56%) commuted away to large rural communities (population 10,000-49,000), and four

(25%) commuted away to urban communities (population >49,000).
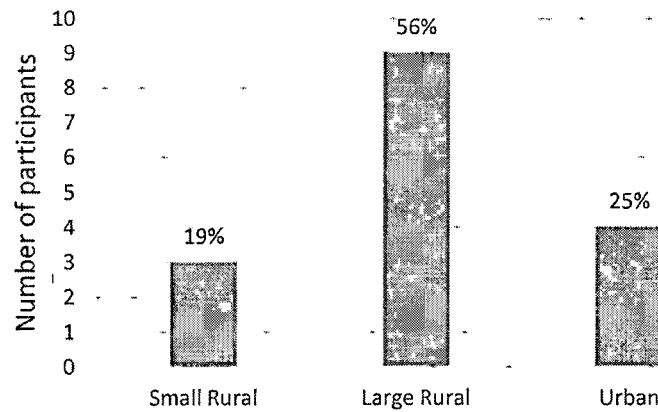
Figure 10. Commute away to RUCA areas.

In order to further delineate variation among those three RUCA categories, the populations of

each of the communities to which the nurses were commuting were classified using the 2010

United States Census data, as shown in Figure 11.
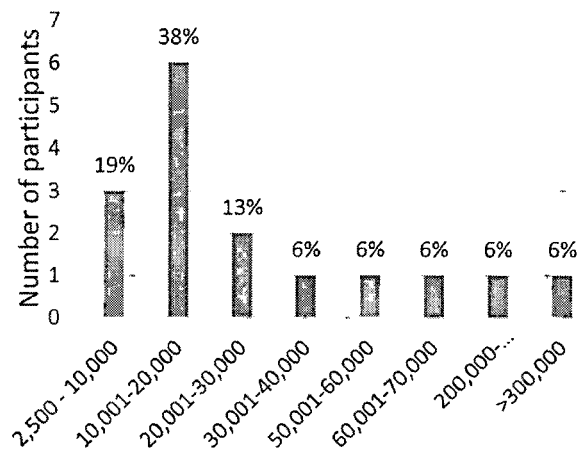
Figure 11. Worksite census.

Additionally, the county in which each community is located was classified according to 2013 Rural-Urban Continuum Codes (RUCC) in order to distinguish counties by degree of urbanization and adjacency to metro areas. Rich variation was subsequently found; four nurses (25%) commuted away to an area classified as a RUCC 1 area, two nurses (13%) to a RUCC 3 area, two nurses (13%) to a RUCC 5 area, three nurses (19%) to a RUCC 6 area, and five nurses (31%) to a RUCC 7 area, as shown in Figure 12. Throughout Chapter IV, when providing a quote from a nurse where the size of the community to which they were commuting may be relevant for the context of the quote, the descriptor of the community will be provided using RUCA codes (small rural, large rural, or urban), with RUCC codes provided in parentheses. For example, "a nurse commuting to a small, rural area (RUCC 3) . . ."
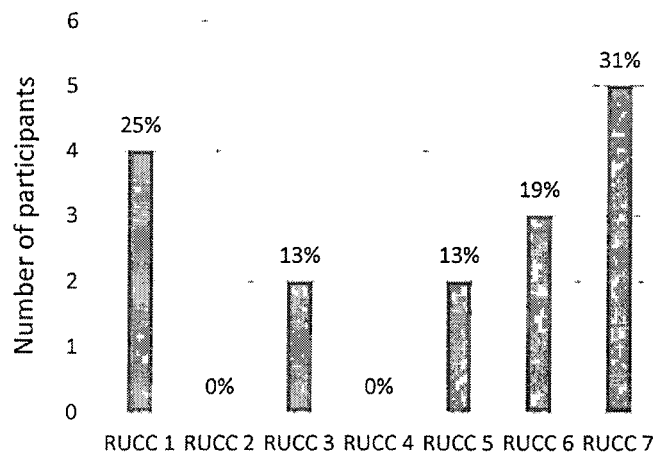
Figure 12. RUCC codes.

RUCC 1: Metro - Counties in metro areas of 1 million population or more
RUCC 2: Metro - Counties in metro areas of 250,000 to 1 million population
RUCC 3: Metro - Counties in metro areas of fewer than 250,000 population
RUCC 4: Nonmetro - Urban population of 20,000 or more, adjacent to metro area
RUCC 5: Nonmetro - Urban population of 20,000 or more, not adjacent to metro area
RUCC 6: Nonmetro - Urban population of 2,500 to 19,999, adjacent to metro area
RUCC 7: Nonmetro - Urban population of 2,500 to 19,999, not adjacent to metro area

Essence: Commuting to Achieve Personal and Professional Goals
While Being a Nurse in a Rural Community

The goal of this descriptive, phenomenological study was to identify the essence, or the core meaning, of the phenomenon of *"commuting away,"* along with the accompanying constituents in which the phenomenon presents. Through the lived experiences of the nurses, the essence, or core meaning, of *"commuting away"* was identified as *Commuting to Achieve Personal and Professional Goals While Being a Nurse in a Rural Community.* The essence of *"commuting away"* began by *Being a Nurse in a Rural Community.* For these nurses, *Being a Nurse in a Rural Community* was part of the reason that *Personal and Professional Goals* could not be met in their rural, home community, which led to *Commuting.* In doing so, the nurse experienced *Different Professional Connections.* Figure 13 depicts the essence in phenomenological terms with the main constituents including: 1) *Being a Nurse in a Rural Community,* 2) *Personal and Professional Goals,* 3) *Commuting,* and 4) *Different Professional Connections.* Under each of these constituents, several themes and subthemes developed.
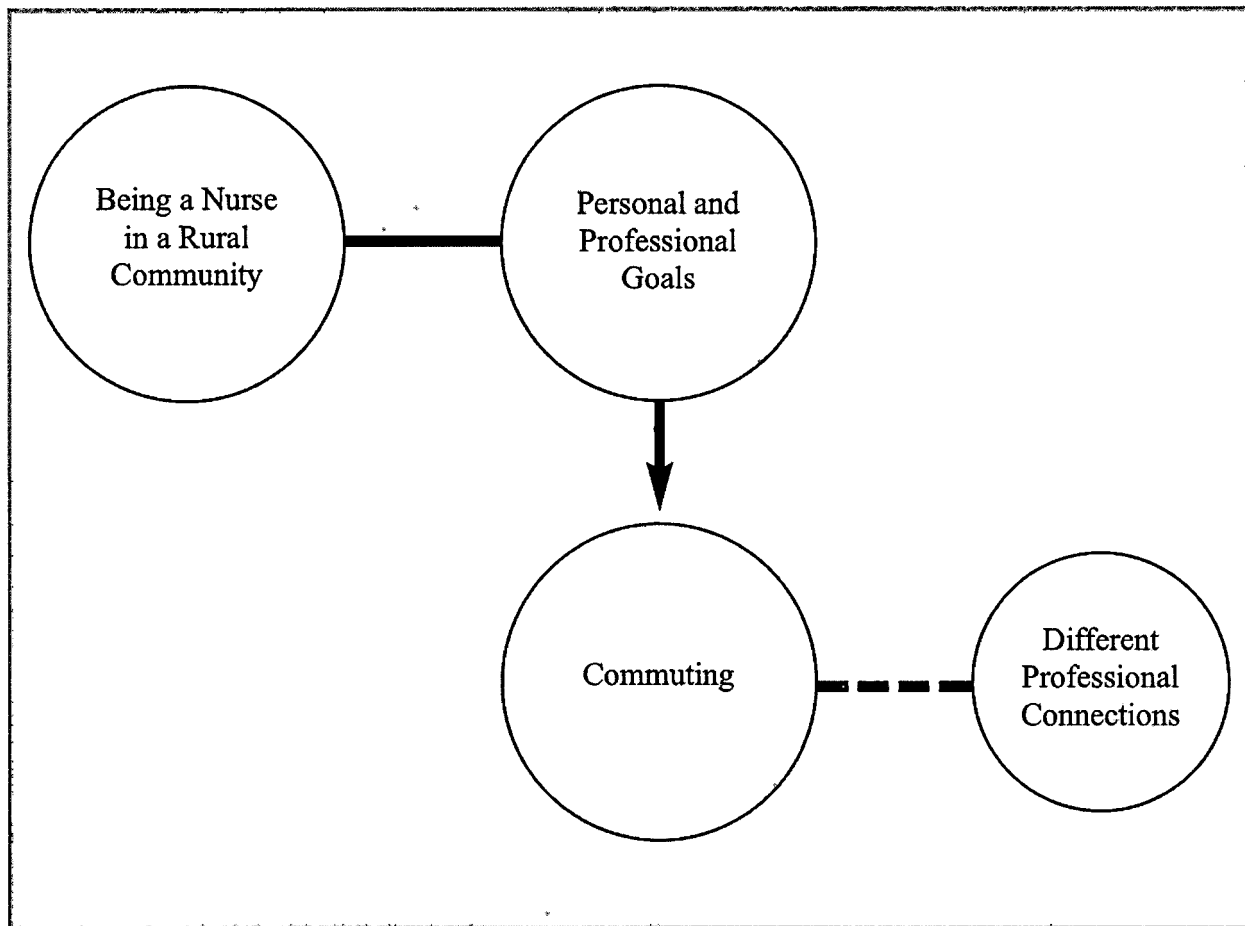
Figure 13: Essence of *"Commuting Away"*: Commuting to Achieve Personal and Professional Goals While Being a Nurse in a Rural Community

The phenomenon of *"commuting away"* presented itself through its constituents. The

first constituent was *Being a Nurse in a Rural Community*, described by all the nurses through

many unique, as well as similar, experiences. Nurses' experiences included their rural residential

histories, as well as professional nursing experiences living in their rural, home communities.

Variations in rural residential histories were found, ranging from some nurses having lived in

their rural, home community their entire life, to other nurses having recently moved to their rural,

home community. Furthermore, professional nursing experiences also varied. Some of the

nurses had a history of working in rural healthcare facilities and others, while they currently

lived in a rural community, had never worked there. Nonetheless, with the varying levels of

experiences shared, commonalities were found, with all of the nurses experiencing connections to their rural, home communities, and all of them having either experience with, or perceptions of, working as a nurse in the rural community.

The constituent, *Being a Nurse in a Rural Community,* was closely related to the next constituent, *Personal and Professional Goals*. As the nurses experienced *Being a Nurse in a Rural Community*, they were able to attain some of their personal and professional goals. However, they also had other personal and professional goals that they were not able to attain while living in their rural, home community. Thus, the constituent, *Personal and Professional Goals,* presented itself as the nurses shared their experiences surrounding employment opportunities, and benefits, within and beyond their rural, home community. *Being a Nurse in a Rural Community* and *Personal and Professional Goals* were closely related, with nurses unable to meet some of their personal and/or professional goals while being employed in their rural, home communities, leading to the next constituent, *Commuting*.

Commuting presented as nurses shared their experiences seeking *Personal and Professional Goals*. All the nurses shared the actual experience of *Commuting*, defined as the act of driving to a non-rural community for the purpose of employment. Nurses experienced benefits, as well as challenges, with the driving experience as they commuted.

Different Professional Connections were experienced as a result of the previously noted constituents. Connections to nurses' work roles changed, or were viewed differently, as they worked in non-rural healthcare settings, with different work responsibilities and different feelings of connections to the nurse's work environments and home communities. The constituent, *Different Professional Connections*, was closely related to *Commuting*, because *Different Professional Connections* would not have been experienced without the nurses

commuting to non-rural areas for employment. Detailed descriptions of all the constituents, as well as the themes and subthemes, will be presented in the remainder of this chapter.

Constituent: Being a Nurse in a Rural Community

The data obtained during the research inquiry process included nurse's experiences living in a rural community as well as experiences being a nurse, leading to the first constituent, *Being a Nurse in a Rural Community*. While each nurse had a unique experience of *Being a Nurse in a Rural Community*, there were also similarities within their experiences, resulting in several themes, including *Practicing Nursing in the Rural Community, Connections to the Rural Community,* and the *Respect, Trust, and Confidence in Competence* experienced within the rural, home communities. The themes, along with their subthemes, are exemplified in the following figure, Figure 14, with themes displayed within the trapezoids and subthemes within the squares. These shapes will be used throughout the remaining chapter, using figures to exemplify all the themes and subthemes of the remaining constituents. *Being a Nurse in a Rural Community* is further described.
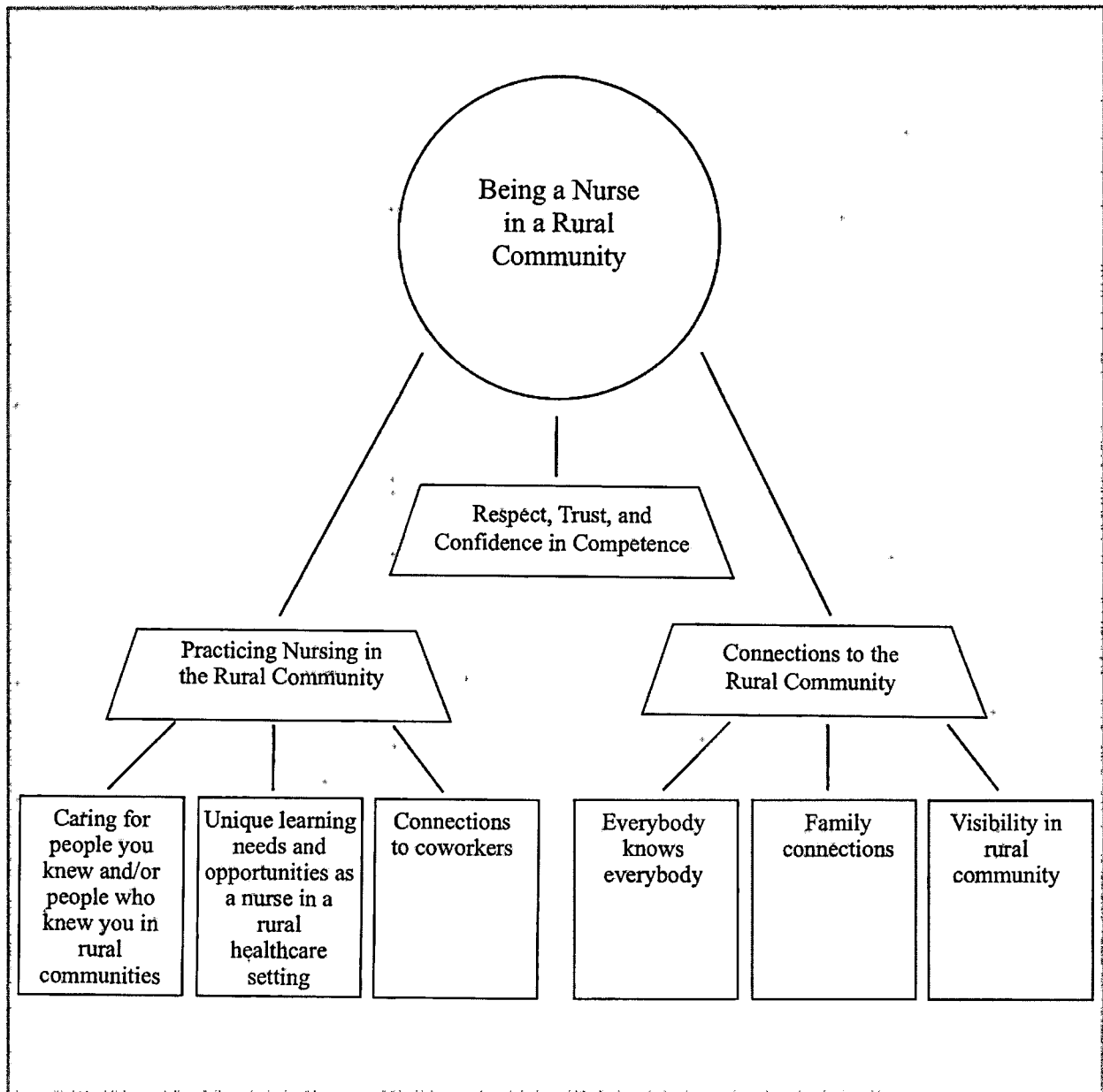
Figure 14: Being a Nurse in a Rural Community

Practicing Nursing in the Rural Community

Nurses shared varying experiences working as a healthcare professional in a rural setting;

some nurses had a work history in a rural setting, others had indirect experiences, such as being

an emergency medical technician or a certified nursing assistant in a rural setting, and some had

never practiced as a healthcare provider in the rural setting. Regardless of their previous

experiences, nurses revealed their perceptions of what these experiences would be like. Many unique aspects of practicing nursing in rural settings were shared, comparing nursing in rural healthcare settings with nursing in other healthcare settings.

Rural nursing required a broad scope of practice and the need to be "a jack of all trades." The nurse practicing in a rural setting needed to have a broad range of skills, specifically having good assessment skills:

> In a rural setting you need to have a broader range of knowledge, and stay current and up-to-date on different areas of healthcare. . . . You can be well-rounded living and working in a small town hospital setting. I think you see the most diverse presentations and you get to utilize your full scope of nursing practice in a smaller setting.

Because of the broad range of experiences, some nurses believed that their skills were utilized more fully while practicing nursing in a rural setting, compared to experiences while they were working in a non-rural healthcare setting:

> I think that my skills were better used when I was in a rural community, my nursing skills because . . . you just had more of a broader experience. . . . In the defense of rural, you're doing ER, you're doing the hospital, and you're doing the swing beds. You know what I mean? You're answering all the phones. You don't have all these extracurricular services available like you do in the bigger hospitals.

The necessity to use a broad scope of practice for nursing was found by some nurses in rural healthcare settings. On the other hand, other nurses believed they lost nursing skills while practicing in rural settings, because the opportunity to use certain skills sometimes did not present often enough.

> If you don't use it, you lose it and that's what I was noticing with my nursing was when I was in the more rural settings. I was losing a lot of my skills. . . . That's another thing that made me go to a bigger setting, just because at a smaller hospital you maybe put in two IVs a day.

Different types of care given by nurses in rural healthcare settings were compared to cares given in non-rural healthcare settings. Cares given in rural settings were found to be more hands on.

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I felt like it was just kind of more hands off [working in urban area], and I love that hands on. So when we came back to rural and you're doing everything because you don't have those resource people . . . I think you give them more care. In a bigger community . . . we had a lot more people to take care of during the day than what we do in rural. But you also had tons of other people that did other things that you didn't have to do. So you're in and out of their room but you didn't really do a lot with them because somebody else came in and did that.

Similarly, nurses also believed there was a difference in the environment of the rural healthcare setting, compared to working in a non-rural healthcare setting. The atmosphere was more personal and caring in the rural healthcare setting.

I just feel like it's not just people by numbers in and out. I think you take more of a face on them and you take more of an interest because they are in your community and your community is not that big. . . . I feel like it's a more caring atmosphere in rural nursing. . . . I love the more caring atmosphere that I think rural nursing brings to the table. . . .

One other difference, in the environment of a rural healthcare setting, was the variations found in safety policies. One nurse found significant differences in safety policies while practicing nursing in a rural, healthcare setting, in comparison to more urban healthcare settings. Rural healthcare facilities had less strict safety policies in place, as one nurse found:

I was amazed at the hospitals and nursing homes that didn't lock their doors at night. . . . Anybody could walk into that facility at 3 o'clock in the morning and scare the pants off you, and usually they're not causing any harm. They're just looking for somebody, or they're lost, or want to see their mom. It just amazed me. I'm so used to everything being locked down at 8 p.m., and even security guards being at doors, and things like that [in an urban setting]. . . . There's that level of trust and safety in a rural community. . . . I can't say I felt unsafe. I felt uneasy, because I knew that the doors were not locked, and I was a sitting target, and I didn't like that feeling. Nothing ever happened. Nothing ever bad happened, but it always gave me a very uneasy feeling to know that I was in a place that was not locked.

Considering the descriptions of nursing skills used, and nursing care given, in rural healthcare settings, one nurse's comment spoke volumes: "Rural nursing is something that takes a special person. It is out of a lot of people's comfort [zone]." Feelings of anxiety were frequently associated with the need to be "a jack of all trades," while utilizing the nurse's full scope of practice in the rural healthcare setting. Several nurses were uncomfortable with these

expectations, and felt unsure of their abilities to practice in the rural setting. Most nurses were more comfortable and confident with their work roles in non-rural settings because they had less isolation and more resources available. The idea of returning to work in the rural setting was a challenging thought. One nurse revealed, "Rural nursing scares me . . . it would be hard to go from what I'm used to, to try something new [like that]."

Practicing Nursing in the Rural Community entailed several subthemes, describing the unique features of these experiences, including caring for people you knew and/or people who knew you in rural communities, learning needs and opportunities as a nurse in the rural setting, and connections to coworkers.

Caring for people you knew and/or people who knew you in rural communities. *Practicing Nursing in the Rural Community* involved having connections with patients in rural communities, while caring for people the nurses knew, and/or people who knew them, including family and friends. They viewed themselves being more connected to the rural community because of these associations. One nurse stated:

> Your connections, I think, are a little stronger when you work in a small community, like your connections to people and just the trust that they put in you, versus going out of town. . . . I think you get more of that when you're more rural. It's a little closer to home, I guess, is how I would put that.

Benefits and challenges arose from the lack of separation between the nurse's personal and professional lives. The benefits of caring for rural community members included the nurse knowing their patients better, having closer connections to those patients. Nurses could consequently communicate more readily with their rural patients:

> They trust you . . . they remember you. . . . Families could talk to me easier than some of the pool nurses that were coming in . . . . You know . . . their background better. . . . You use those connections to connect with like the elderly. . . . Just kind of getting the family connection. . . . They respond better to you.

Patients, and families of patients, being familiar with the nurse's personal life, would also have

closer connections to the nurse and their family. Thus, they would inquire about the nurse's

personal life and family. For some nurses, this lack of separation from personal and professional

lives made them uncomfortable. This nurse shared:

> And then other people [patients] will say, "How's your family, too?" Even when you're
> at work, they'll bring your personal life into work, and some people like to just leave
> their personal life away from work. That's kind of difficult too, I guess.

> Nurses faced challenges caring for rural community members. Maintaining patient

confidentiality was one challenge. The requirements of confidentiality in the work setting, as

dictated by Health Insurance Portability and Accountability Act (HIPPA) requirements,

sometimes were in conflict with the close personal relationships of friends and family of patients

outside of the work setting, as described in the following quote:

> I have one resident out there that I did get really close with. I knew him; I knew his
> family; I went to prom with one of his grandsons, but I can't say anything to his
> grandkids about him because, even though they're friends of ours and they come over to
> our house and whatever, you can't really say anything. Even now that I don't work there,
> I still feel like I can't ask, "How is so-and-so doing?" It's family; they would probably
> tell me anyway, and knowing that I used to work out there, but for HIPPA reasons again.
> I'm a nurse; I understand that you shouldn't be asking things like that. There are just
> some fine lines that you've got to walk.

Caring for patients in the rural emergency department was a setting that was of particular

concern among some nurses. Concerns ranged from the immediate experience of being the

primary person responsible for their family or friends needing urgent or emergency care, to the

future experiences of interacting with the family or friends in the community after a death.

Some nurses truly feared such experiences:

> I don't want my neighbor and my family coming into the Emergency Room and I have to
> work on them [in rural, home community]. That scared me terribly. It still does. I don't
> want to be that first person that sees them and has to do that, and thank God we've got
> nurses that do that, but it's you have to be able to disconnect right now and I just think
> that would be so hard. . . . That was like a huge thing. . . . If you're the one that's working
> in the small [facility] those ambulances that come in, those people that are in accidents or

come in with their heart attacks, you are it. And then you're seeing those people, whether it turns out good or bad, all the time, and it's hard. . . . You're with those people all the time and so what if things don't go right? Then you have that where people hold you accountable for that whether you could have done something different or not, and I just think its way, way, way more personal and hard. I want to avoid that conflict I guess, get away from that.

The nurse's involvement, surrounding legal implications for people served in the rural community, led to areas of concern unique to nurses living in rural, home communities. Nurse's professional roles could involve them in legal aspects of patient's lives. Participation in legal aspects of friends and neighbors lives created situations that were uncomfortable for the nurse. One nurse encountered challenges while caring for a neighbor, when legal consequences led to a negative outcome:

> I had a situation where it was a neighbor . . . and there was alcohol involved. By law, I have to report it, and I knew that if I did, [the neighbor] would be in a lot of trouble again, and it was really hard, because I knew I wanted to help . . . it was really hard. . . . I was like, "I have no choice. I have to notify the police." I remember hugging [the neighbor's spouse], and I started crying, and I was like, "I feel really bad, because I know this is going to be a bad outcome." . . . In time, it has been better. Sometimes the community would say, "How could you do that?" I'm like, "Oh, you just don't understand."

Another challenging aspect, of caring for people that they knew, was the experience of having knowledge about a patient before the family had that knowledge. This was a source of discomfort among the nurses who had the experience. One nurse portrayed how this felt:

> Experiences that I had, like working on ambulances, if we would bring in a full cardiac arrest patient. . . . Being on ambulance, 95% of the patients you run into you know, both personally, community, you know them. That's very hard . . . always knowing the patients and you see them at vulnerable times. Sometimes that's just kind of hard to get out of your mind, too. Car accidents I always think of, where there is a death and you're on call and you know them. You know before their family even knows.

Caring for people they knew was common for several nurses, but was not only unique to nurses practicing in the rural community. Nurses who worked in non-rural healthcare settings had similar experiences caring for people they knew. However, these experiences were less

frequent. Furthermore, nurses had additional staff resources available working at a non-rural healthcare facility, thus avoiding the necessity to be the primary person responsible to care for family and friends.

Unique learning needs and opportunities as a nurse in a rural healthcare setting. Learning needs and opportunities among nurses in rural communities were unique. Nurses needed to learn and develop a vast array of skills to practice nursing in a rural healthcare setting, and appreciated experiential learning opportunities. One nurse explained, "You learn a lot, because you do everything; you have to know a little bit about everything. You need to be a nurse generalist and know something about everything. It was a good learning experience. It was."

Formal opportunities to learn in the rural settings were appreciated by nurses. Educational opportunities were provided by rural healthcare facilities, such as Advanced Cardiac Life Support and the Trauma Nursing Core Courses, in order to make the nurses feel more comfortable.

Connections to coworkers. Nurses had a variety of social and professional connections to their coworkers, when employed within their rural, home community. A lack of delineation between personal and professional connections for the nurses and their coworkers existed. Nurses felt obligated to their rural healthcare facilities, because of connections with coworkers, the patients they served, and the facility at which they worked. Nurses went back to work on their time-off when needed, feeling obligated to pick up hours, feeling like they were at work all the time, and feeling that, because of their residence being located near to their work location, it was convenient to be called back into work. One nurse stated that with so few people working in

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rural, it was hard to walk away and not think of their coworkers and patients. In contrast, it was

much easier to limit those feelings once they were working in a non-rural healthcare setting.

> When I worked in . . . [rural home community], it was almost too easy for me to pick up [hours] because I was too convenient, and that's where I burned myself out . . . because I was five blocks away; I was way too accessible. . . . There were times where I'd be at a barbeque or something and somebody that was working that had just a simple question was like, "I've got an admission. I don't remember how to put these orders in; can you come and help me put those orders in?" "Yep, I'm right in town; I'll be right there." It was too easy for me to say yes, and I got too involved. . . . When I'm right in town and I'm like, "I'm not really doing anything; yeah, I suppose I can go in."

In comparison to working in a non-rural healthcare setting, nursing in the rural

community involved having more personal connections with coworkers, feeling like part of a

family with their coworkers. One nurse commented, "The relationship that you had with the rest

of your staff, it was a tighter bond, because there were a smaller number of you, and you knew

that you needed to be there for each other." These personal connections with their coworkers

extended outside of work in their rural, home communities. The nurses attended social events

together, including events for their families.

> In the smaller communities you went outside of your job and you went and had supper with them. You went out and your kids played ball together. . . . [While working in a non-rural healthcare setting, there's not] that intimacy level, where they know they're going to see me tomorrow night at the ballgame or at the benefit. In the rural community . . . we'd do all the fundraisers, put baskets together or have the little kiddie park out at the helicopter pad for the ambulance. I don't do any of that stuff anymore [while working in a non-rural healthcare setting]. I think I was a very active participant in that kind of stuff. Yeah, now you don't do it at all. . . . [Coworkers were] family, they're your extended family. Point blank. You walk in and you can instantly tell . . . "Are you OK? There's something wrong; you're off. You're not laughing; you're pale." They instantly know.

Affiliations with medical providers were also part of the connections that nurses felt,

while working in their rural, home communities. Nurses knew the medical providers on a

personal, as well as professional level, and appreciated the relationships that resulted.

> I worked with the rural doctors there, and they were just so good. Because it seems like they knew everybody and it's just so different. . . . I just had a friendship with them. It

was so nice to take your kids there or have your kids delivered there, knowing that I've worked with them and they're my friends. It was just nice. . . . We had a good relationship. I had a good relationship with the doctors, which was nice. By having my children there I got to know them better.

For a nurse who was new to rural living and nursing in the rural community, the close relationships between coworkers could also be problematic. For example, one nurse who had moved to a rural community, and started practicing nursing there, expressed discomfort with the trusting relationships between coworkers. "There's a lot of trust among small town nurses that is not with large town nurses. . . . [Moving to a rural community], I didn't have that same level of trust down here [as I had with my coworkers in an urban area], so that was part of the hard."

As nurses contemplated working in their rural, home community, they took into account who already worked at the rural facility. The nurse's employment decisions were impacted by other people working within the rural healthcare facility. Knowing that nurses work with every professional in the rural healthcare facility, nurses preferences to work, or not work, with other professionals in the rural healthcare facility swayed their decision to work there:

There is also the fact that you know who works there [in rural facility], and you maybe don't want to necessarily work with them and you know you're going to work with them all the time. Whether working with them makes the relationship better, it definitely could, but you don't want to go to work every day and just cringe to go to work . . . because there are only a few people that work there.

Connections to the Rural Community

Nurses had a variety of connections to their rural, home communities. Nurses lived in a rural community where "everybody knows everybody" and where nurses were visible to other community members. Nurses also had family connections in the rural, home community, adding to their sense of caring within the community. The nurses appreciated living life in the quiet, relaxing environment of a rural community.

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Everybody knows everybody. A common statement about life in a rural community was that "everybody knows everybody." In relation to nursing in a rural community, this meant that "In a rural area, people knew everybody's business. They knew who came in [to hospital] before you even did." Nurses were aware of the ins and outs of rural dwellers knowing everything about everybody, with rural residents having a high level of knowledge about what was going on with their neighbors. Many rural dwellers even had police scanners in their homes, so they heard when and where the ambulances and fire trucks would go.

With everybody knowing everybody in the rural community, nurses felt that community members had social expectations of them, because of their role as a professional nurse. Such expectations interfered with the nurse's family and personal lives, like not going to the local bar or club where alcohol was served.

> When you work in the area you grew up in, you know almost all the people and their families, and certain situations are uncomfortable. And seeing them out—like, the older nurses never went to a bar. They never went to the VFW in town, because they worked at the hospital, and they wanted people to respect them. And I kind of felt the same way, so we just didn't go out; because that's not good to have somebody see you intoxicated. It would hurt my mom. My mom's like, "Don't go to the VFW anymore," and "you work here, and we have a certain way that we should be," and I kind of felt that. So just kind of making sure that you represent yourself with respect. My husband says, "Aren't we ever going to have any fun anymore?" And I'm like, "I just don't feel comfortable going to the bars where everybody knows you." . . . Yes. I feel more comfortable going uptown to the VFW now [after starting to work, outside of town, in a non-rural healthcare setting]. . . . I would never go out [in non-rural work community] because maybe somebody would recognize me, but we can go out more [in rural, home community] now.

Members within rural work communities, and rural communities in general, were familiar with not only the nurses, but also with the nurse's families. This presented benefits, as well as challenges, for the nurses. Benefits included nurses receiving help caring for their children from community members. Community members knew how integral the nurse's job was to the health of the community, and so were always willing to help. It was evident that the rural work environment supported the nurse's children:

One time, there was an emergency, and I had to go in, and I didn't have anybody for my youngest, and he was 3, so I just brought him with me, and the kitchen staff took him so I could help with the emergency. . . . They just fed him brownies and juice for 3 hours. But that wouldn't happen in a different place. And they [children], too, were familiar with the people that I worked with, so they would come up or whatever.

There were also challenges with rural community member's familiarity with the nurses and their children. A lack of privacy for the nurse's family exposed their family to judgments by community members.

The relationships with people. . . . In small towns, you not only know them, you see them at the grocery store, you see them at the bar, you see them at the restaurant, you see them at the ball fields, you see them at the school events. It's just constant . . . People know you, and they know who you are, and they know what kind of person you are. . . . In a small town, people judge your kids based on your actions. If they like you, they like your kids; if they don't like you or something that you did, they don't like your kids. Or if your kids did something that was way out in left field, you're going to hear about it first before even the police call you, because someone's going to tell you that your kid did something. . . . I would hear things at work before I ever heard it from my kids or from anybody else, and I would be like "thank you for telling me that my kid was awful at this place," because that wouldn't have happened in a larger city. . . . No, I didn't like that. I wanted to be the first person to know that my kid misbehaved, and I didn't want somebody else to tell me that my kid misbehaved. . . . That happens a lot, especially if they know your kids and your kids misbehave for whatever reason and they see it. "I saw your daughter out with so-and-so at 8 o'clock on Thursday night. Doesn't she have a curfew?" Wow, wait a minute. I think there was pushing of boundaries, and I didn't like that at all.

Having community members familiar with the nurse's personal life brought further challenges, with the nurses feeling judged by community members about their decisions to work, in a non-rural healthcare setting, away from their rural home communities. One nurse felt a need to justify working in a non-rural healthcare setting to rural community members.

"The hospital needs help, why aren't you helping? Why are you going someplace else? You should be here. Quit your job and come here now, because that would be the thing that you should do." You get that strong opinion from the people that say that to you, "Why are you not here?"

In spite of the challenges with everybody knowing everybody in the rural community, one nurse expressed grief, having lost the personal feeling of everybody knowing everybody.

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After years of working in a non-rural healthcare setting, while being less involved in the rural, home community, the nurse no longer knew many rural community members. "One day I went into the hospital [after working in a non-rural healthcare setting for many years]. . . . They didn't know [who I was]. . . I was no longer part of that, which had been so important."

As nurses moved to, or moved back to, the rural community, they found challenges integrating into the social fabric of the community. Not having established friends, neighbors, and colleagues in the community left a void in the social lives of the nurses. Challenges surrounding making connections in a rural, home community were found:

> It's hard to belong . . . because a small community already has their circle; everybody knows them in their group of friends, and they're not going to open up. So I have to say, in that sense we've got closer connections and fellowship yet in [the urban community that moved from] than what we do here other than family.

Benefits were intertwined with the challenges of moving back to the rural community. Nurses could find it comforting to have someone in their home communities that they were familiar with. However, the people nurses were familiar with might expect automatic friendships, creating a challenge that was not desirable.

> When you're in a strange place, and you see somebody you recognize, and you so badly just want to sit by somebody because you're there by yourself, like at a basketball game, and you know you're there, and I'm thankful to see that familiar face, because then I'll go and sit by that familiar face. . . . [On the other hand], sometimes there's an obligation to sit by someone you know if you're both alone, then you have that obligation. . . . But like somebody I went to high school with, and I might've hung out a little bit in high school with them, but really not a lot, and then now they're back and never left, and you're coming back, and that expected friendship, and I'm like "hmm, they're not the kind of person I really hung out with" . . . but yet it was almost like an obligation, because you did know them. You graduated from high school together.

Family connections. Nurse's connections to their rural, home communities included family connections to the rural community. These connections had an impact on decisions to live, or move, to the rural community. Family roots in the rural community sometimes led to decisions to move back, or stay in the rural community, in order to be close to family. Some

nurses met their spouses while at college and moved to the rural communities with them, once

they got married. A common feeling, as the nurses lived in a rural community with family

connections, was a sense of community and feeling safe, with people knowing each other.

> It was more of a personal, private, family decision that we wanted to have our kids raised
> in a smaller, safer town. We both are from . . . small towns. . . . We definitely have
> always had that in the back of our minds that we want to be in a smaller town, not in a
> larger city. . . . We wanted to get back closer to family. . . . My [spouse] and I, we've
> always wanted to be in a smaller town for the kids' education. We just think it's a safer
> environment in the schools, and it's easier to have one-on-one relationships with their
> teachers. We tend to have smaller class sizes in smaller towns versus larger school
> districts. And like I said, our own personal upbringing, me being in a town of 400 and
> [my spouse] in a town of 1,500, that's really the main driver of why we wanted to stay
> living in a small town.

Challenges were found living in a rural community where the nurse's parents, or spouse's

parents, lived. Nurses who moved to a new rural community, after getting married, were

challenged to find their own identities in the communities. Nurses, new to the rural

communities, did not always believe in their abilities to meet their local community members'

expectations.

> Everybody knew my husband's family, and I think they just expected that we would be
> like our parents, or we would be involved in the same things that they did. His mother
> was a farm wife . . . she never worked out of the home. . . . I didn't grow up on a farm; I
> didn't know how to drive those tractors. They scared me. . . . So I chose to work outside
> the home. . . . I think that was a little bit hard, because I went down the path that they
> didn't think I maybe should have. . . . "Oh, she's marrying this person, and this is what
> his parents did."

Many nurses had not lived in their rural, home communities their entire lives. Some were

new community members when they moved to their rural, home communities; others were

returning to the rural community. Experiences were unique, yet had some similarities. Several

nurses, having recently moved to a rural community, found it challenging to meet people and

make connections with community members. Nurses faced the feelings of being outsiders in the

communities, whether they had just moved there, or if they had been gone for many years and

now returned. The importance of family was integral to the nurse's social lives, in all of these situations.

> I think with small towns, you've got your family; you really rely on that close-knit. That's your long-term. So I left and have been gone for 40-some years and come back, I think I'm more of an outsider and not included in that, although you know people and you try to get reacquainted that way.

Visibility in rural community. Being a nurse in a rural community meant being visible in the community and having frequent interactions with community members. It was common to have community members ask the nurses to share their opinions on health-related issues, or ask for advice. Nurses' feelings about this visibility ranged from neutral, that this was just part of living in a rural community, to finding this visibility undesirable or inconvenient. Neutral feelings were illustrated by one nurse who stated:

> A lot of neighbors will call us up and say "Hey, I've got this problem or this problem" or "my grandson got in a wreck and this happened," and they'll bounce things off after the fact. So they had already went to the ER and they've had this, this, and this done, and "do you think that's the right thing?" They'll ask you retrospectively if something was done properly or improperly in your opinion.

Yet other nurses expressed discomfort with similar situations.

> Sometimes in the rural communities . . . they can ask you a lot. "What do you think of this?" Or "what should I do about that?" I'm not here to diagnose you. So you can run into that a lot, too . . . I would say that's probably the biggest negative because people will ask you "I was told this. What do you think?" Or "this is what's happening," and they want you to say. . . . They know you're a nurse . . . they expect you to know everything. They ask you questions on things and you don't really want to commit yourself, because if that's not the right thing for them, they don't get better or something goes wrong, that's just not the situation you want to put yourself in.

Several nurses believed there were professional expectations of them, from community members, because they were nurses. Their professional roles spilled over into events in their personal lives, such as at church or at a ballgame, as well as community members coming to the nurses' homes, asking for help. The nurses knew that if there was a sick child in church, or at a game, they would be asked to help; or their neighbors might ask them to help check their blood

sugar levels. One nurse stated, "I'm a nurse in this community, so at church, when somebody faints, you know, everybody runs to me." Some nurses were uncomfortable with these situations, feeling unprepared to help if the situation was out of their normal nursing experiences. Community members were not always aware of their nursing areas of expertise when asking for assistance. However, even if the community members were asking for help in the realm of the nurse's area of expertise, it could still be an uncomfortable situation, as one nurse expressed:

> [In] rural communities . . . everybody knows what everybody does so your phone might ring. When I was getting my hair cut she's like "I told the PA that if I go into labor, because I have quick labors, I was going to pick her up," and she said "oh no, you're not. You're going to pick up [nurse] on the way because she's the one that does that." So you're like "are you really going to call me?" Just different things like that.

It was not uncommon to have community members ask about patients in their rural communities. Again, confidentiality concerns arose frequently in this context, with nurses being concerned about maintaining confidentiality for their patients in rural communities. In contrast, nurses did not have similar experiences while working in non-rural healthcare settings. Nurses understood that reprimands could occur at work if confidentiality was breached.

> Just the risk of HIPPA is very, very challenging. It's hard even when somebody says, "How is so-and-so doing?" You can't say anything and then they come and visit, so . . . you can't say they're not there because they know they're there. It's like, "Well, you need to come and visit," kinds of things like that . . . they'll still ask, knowing that we can't say anything, but they'll still ask anyway, and it just makes it very difficult.

Encounters with friends and neighbors asking about aspects of the nurses' professional lives were common in multiple places in the communities. "You couldn't go to the grocery store without, 'oh, did you work today?' 'I saw you . . . [at work].' It was definitely a challenge." Some of the nurses actually avoided going to the local grocery store, or church, to keep away from these interactions.

In addition to inquiring friends and neighbors, it was also common for the nurses to encounter their patients in their home communities. Feelings of satisfaction sometimes

accompanied these experiences, but there were also times these experiences made the nurse uncomfortable. This nurse shared both of those feelings:

> That's up to them if they want to come up to you in public and acknowledge that you were their nurse. That kind of opens you up a little bit more freer that you can say something. So there's always the nice side of that, too, because usually they're not going to come up to you if they don't like you. It's that "thank you so much for your help" or "for helping my parents." There is that, too, which is kind of nice in a way because you know them and you've got that connection then. It also makes you worried if something doesn't go right that you're going to have that conflict of personal, too, because it does carry on when you live in a small community. You're going to know.

Feeling uncomfortable talking to community members after "something doesn't go right" was a common concern. If there was an unexpected death, or unforeseen outcome, some nurses had a loss for words when encountering those community members later in the community. They also felt an unspoken sense of blame by community members for the undesired outcome.

Maintaining patient confidentiality with the nurses' own family members was also challenging when living and working in a rural community. It was difficult to come home from work and not be able to talk about what occurred during their work day. In contrast, nurses felt less of this while working in a non-rural healthcare setting. One nurse stated, "You know, it is a little bit challenging when you can't really come home and say, hey, so-and-so is alone up there. . . . [there is] the challenge of coming home and not being able to talk about it." Several nurses found it challenging to come home, needing to talk to someone, and not being able to talk to family members, because they had to maintain patient confidentiality.

Several nurses believed the increased visibility in their rural communities was undesirable or inconvenient, and discovered less of this type of visibility while working in a non-rural healthcare setting. One nurse stated, "Yeah, I kind of like it up here [non-rural healthcare setting], everybody not knowing everything I do all the time." They appreciated the lack of

visibility from the patients and families they were working with while employed in a non-rural healthcare setting:

> I go home and nobody [in non-rural work community] knows what I do at night after [I go home]. . . . I like that people don't know what time I go home at night, and where I live, or what my home phone number is, or anything like that.

Respect, Trust, and Confidence in Competence

All of the nurses felt valued by their rural community members. Regardless of whether they had practiced nursing in their rural, home communities or not, nurses were made to feel valued by their rural community members through perceptions of being respected, trusted, and/or being competent as a nurse. Feeling respected, by virtue of their roles as nurses or for being part of the profession of nursing, was present no matter whether they had previously worked in the rural community, were new to the community, or had always worked in a non-rural healthcare setting.

The connections nurses had with their rural, home community created a context of trust and respect that was not replicated while working in a non-rural healthcare setting. Nurses were trusted in their rural, home communities by virtue of being a member of a close-knit rural community, unlike larger non-rural communities where they did not live. They appreciated being trusted and developing a trusting relationship with rural community members.

> Trust . . . develops, because people know you in a social setting, and then they see you in a professional setting and they had no idea that you could be this. . . . That's something you would've never had in the . . . [urban community].

Nurses believed they were perceived as being competent as a nurse in their communities, adding to their feeling of being valued by their rural community members. One nurse summarized feeling valued by virtue of being a nurse in the rural, home community, saying:

> I feel like I'm respected, that's for sure. They trust you; everybody's very trusting in a small town. When you make little connections and things like that in a small town, they remember you. Just the trust and the confidence that they have in you. Even though I

was a new nurse at the nursing home, and I had like no experience whatsoever, they just trusted me. If something was wrong, they felt confident that they could tell me, and they felt confident that I would pass things on to the doctor or whoever to get resolved. Even the aides, I think they could sense that too. Families could talk to me a lot easier than some of the pool nurses that were coming in. . . . They just trust you a lot more, and they know that you know what they're talking about, and you know kind of their background better. . . . Definitely I feel that people trust me being a nurse, and the confidence they put in me is really nice, too.

Nurses continued to feel valued in their rural, home communities, even when they chose to work in a non-rural community. Nurses felt respected by virtue of being a member of the profession of nursing, stating, "I think nurses were given more respect, just because of their position . . . I felt respected." Regardless of the nurse's longevity in the rural community, or whether they had never worked as a nurse in the rural community in the past, all the nurses felt valued by their rural, home community members. One participant summarized those feelings, stating simply, "Oh, I feel valued."

Constituent: Personal and Professional Goals

As the nurses lived, and experienced, being nurses in rural, home communities, they felt an inability to achieve some of their personal and professional goals in those communities. Nurses were better able to meet some personal goals through employment benefit opportunities in non-rural healthcare settings. Employment benefits were described as benefit packages, wages, work hours, staffing patterns, job stability, and availability of technology. Additionally, nurses' could meet a variety of professional goals through nursing practice, as well as feel an overall general enjoyment of the job, as they worked in a non-rural healthcare setting. Nurses' found an ability to meet goals through professional nursing opportunities, including advancement opportunities and opportunities to practice in specialty areas of nursing. Those same goals generally could not be met by working within their rural, home communities. While all of the nurses indicated that personal and professional goals were primary considerations in their

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decisions to work in non-rural healthcare settings, there were many unique and varied individual goals within the group of nurses. The following figure, Figure 15, exemplifies the constituent, Personal and Professional Goals, with its themes and subthemes.
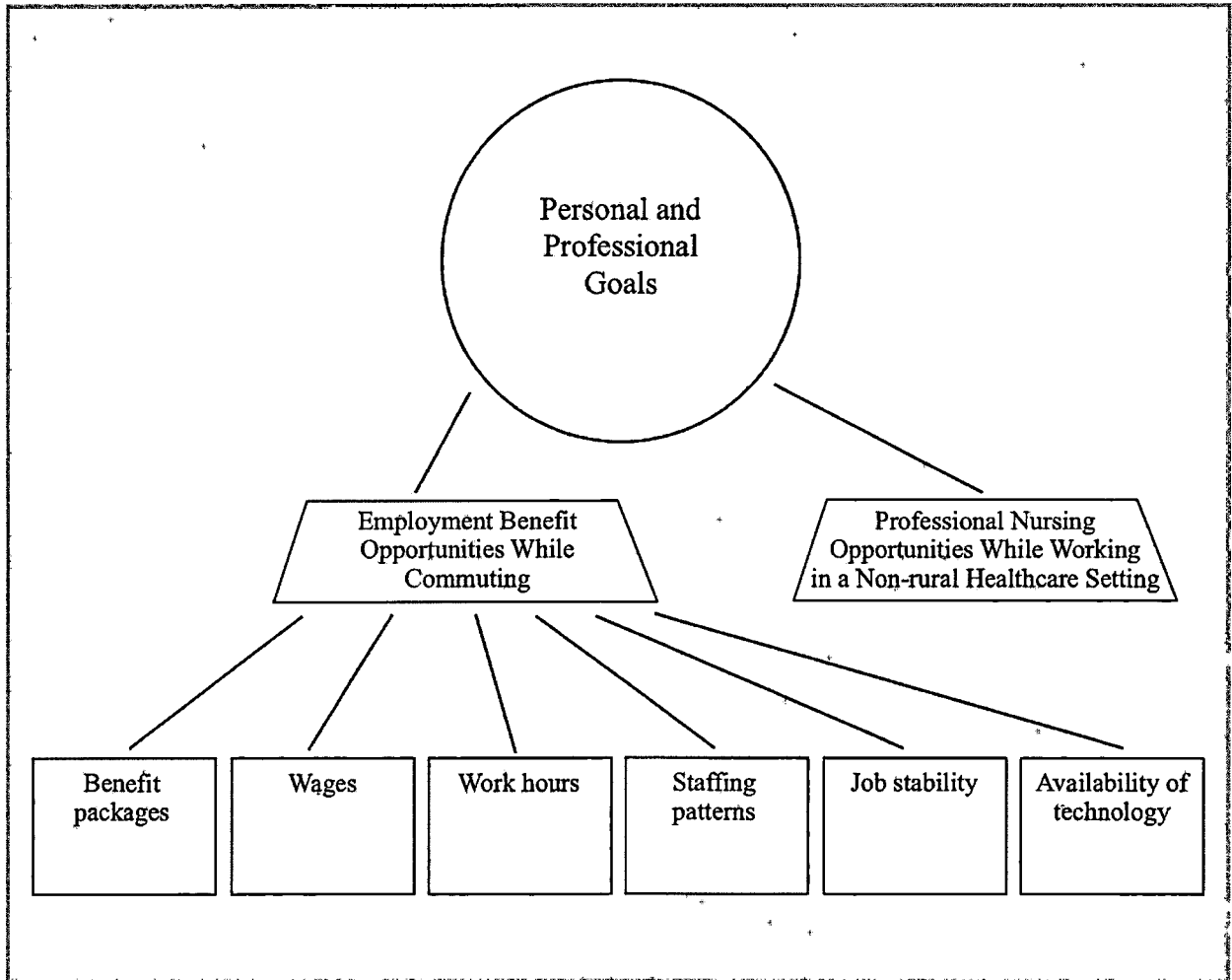
Figure 15: Personal and Professional Goals

Employment Benefit Opportunities While Commuting

Decisions to commute to non-rural areas were, in part, because of the nurses' desires to meet personal goals through employment benefits. Some of the nurse's personal goals included having health insurance, better wages, working hours more conducive to family schedules, and increased comfort levels with staffing patterns. Employment benefits available to the nurses commuting were found to differ from those available in the rural healthcare setting.

Employment benefits were described to be items such as benefit packages, wages, work hours, staffing patterns, job stability, and availability of technology. Nurses experienced an increased ability to better meet their personal goals because of the employment benefits available to them as they worked in non-rural healthcare settings.

Benefit packages. Employment benefits, such as insurance packages, retirement plans, and vacation and sick time benefits, extended to nurses who worked in non-rural healthcare settings, were viewed positively by many nurses as they compared their current benefits with those received, or perceived to be available, in rural healthcare settings. Several nurses indicated that the benefit package, at the employer to which they commuted, was better than what they thought they would be offered in their rural, home community. For example, one nurse, who commuted to a large, rural area (RUCC 7), stated, "The insurance plan . . . I'm the insurance holder, so that's a huge thing. Retirement, 401(k), flex spending, that's huge. Short-term disability, long-term disability–there are so many more compared to what I've ever been offered at other [rural] facilities."

However, not all nurses agreed that employee benefit packages were always better while working in a non-rural healthcare setting. If the non-rural healthcare facility was within the same hospital system that also existed in the rural home community, the benefits were likely the same. Furthermore, one nurse explained that making the choice to commute to another healthcare setting actually resulted in the loss of a benefits package. "I gave those [benefits] up to have the flexibility to stay employed [while working in a non-rural healthcare setting]." Thus, for some nurses, they received a better benefits package as they were employed in a non-rural healthcare setting; for others, it was actually a poorer benefits package.

Wages. Wages were discussed by almost every nurse, and compensation varied throughout all nurse experiences. Many, but not all, nurses reported their wages were higher while working in a non-rural healthcare setting, with wages ranging from $5-20 an hour more. Several nurses stated this was a consideration in their employment decision to work in a non-rural healthcare setting. One nurse, who commuted to a large, rural area (RUCC 7), explained that, "My decision [to commute] was really driven by wage, job opportunity, and benefits." However, the higher wages paid by an employer outside of the rural home community also needed to be balanced with the extra costs associated with commuting, as one nurse explained:

> You get paid more but yet you've got to factor all that other stuff in because then are you just coming out even? So then does it really matter what that pay scale is because you have how much more in gas expense, which leads to more oil changes which leads to more tires.

Conversely, a few nurses reported their wages were comparable, or even lower, while working in a non-rural healthcare setting, and that wages were not the primary factor in their decision to leave their rural community for employment. For example, one nurse, who commuted to an urban area (RUCC 1), remarked, "Where I work now, I make less money. I was making $30 an hour working at the nursing home. . . . I took a $6 an hour pay cut." For these nurses, wages were not the deciding factor in their decision to work in a non-rural healthcare setting and, instead, it was other personal or professional goals that drove that decision.

Work hours. Nurses commonly had a desire to have their work hours interfere less with their personal lives. For some nurses, working in a non-rural healthcare setting allowed them to meet this personal goal by having more desirable work hours through (a) greater flexibility in hours worked; (b) the ability to work part-time; (c) the ability to work fewer weekends; or (d) union regulation of work hours.

Several nurses appreciated more desirable hours found through flexible scheduling in their non-rural employment settings. Flexible hours were available through varying lengths of shifts, an ability to work in a 'flex position' where hours were shared between nurses, and an ability to work twelve hours shifts while being at work fewer days a week. One nurse, who commuted to a large, rural area (RUCC 5), stated:

> So this job became open one day a week. That was perfect . . . the flexible hours I work. . . . The job hours they offered were better than anything else I could have gotten anywhere else at that time in my life that I needed less hours.

Part-time employment options, as well as fewer weekend and night hours, while working in a non-rural healthcare setting, created more desirable work hours for some nurses. Additionally, work hours regulated by union rules were appreciated, with one nurse, commuting to an urban setting (RUCC 1), stating "I very much appreciated our work rules with the union, how they can't mandate overtime. . . . After you become a tenure nurse you get shifts of your choice . . . which is a good balance between home life and work."

Staffing patterns. Staffing patterns experienced by nurses in non-rural healthcare settings were different than the staffing patterns experienced by nurses in rural healthcare settings. Staffing pattern considerations included the number of nurses available per shift, availability of medical providers and ancillary staff, and staffing shortages. Many nurses appreciated the staffing patterns utilized as they worked in non-rural healthcare settings, in comparison to experiences in rural settings.

The staffing patterns used in rural, healthcare settings made several nurses feel uncomfortable. Rural staffing patterns included one or two nurses per shift, supplemented with licensed practical nurses and nursing assistants. Ancillary staff were called in as needed. This created working conditions and situations in which some nurses were not comfortable, as the following quote portrays:

In a rural, when you have a staff of two on nights or three on evenings, it makes it a little more difficult. . . . Here at night, you get a four-vehicle accident with four victims coming and you have two nurses on, and those two nurses are doing your secretarial work, they're caring for the patients already there in the hospital and it's the middle of the night and now you've got to make all these phone calls to try and get people to come in. That would be way too stressful for me. Granted, a four vehicle whatever, four victims coming in is not every day, and just being that piece of it to coordinate everything with very limited. . . . They don't have a button and they can push and everybody is going to come. I've seen the vulnerability of that."

In contrast, an appreciation was found by nurses having immediate availability and support of medical providers, as well as having a wide array of different types of ancillary staff available, at their job to which they commuted. The feeling of having many people to help in a team environment was valued. One nurse, commuting to a large, rural area (RUCC 7), stated, "Yeah, there are definitely pros of the larger places, too, and you do have a lot of help. So if you put the code button on you've got 20 other nurses there, not two, so that helps a lot, too."

A lack of access to, and collaboration with, medical providers, while practicing in rural settings, was also perceived to be a concern. Experiences ranged from the lack of medical providers to challenges with on-call provider availability. One nurse reported working in a rural facility with a dwindling medical provider base, transitioning from two providers, to one provider, to eventually not having a provider at all for a period of time. "It didn't feel safe to be working there. I just felt like I needed to not be there. And that's why I left."

Challenges with medical providers being on call in rural settings were also recounted. In the rural healthcare settings, most medical providers were on call with a 30-minute window of time to report to the rural emergency room. This delay in having a medical provider available created an extra burden of care and responsibility for the nurse practicing in a rural facility. One nurse said:

In a rural area, it is just you that you have to make sure that you do whatever you can for that patient, because sometimes, our doctors didn't get there for maybe half an hour to an

hour. You know it's a rural physician, so it's not like they were there in 5 minutes. So that was hard.

Experiences with differing co-worker demographics, and inadequate numbers of practicing nurses, were found. Working in non-rural healthcare settings, nurses worked with younger nurses, compared to older nurses with greater longevity in more rural healthcare facilities. One nurse, commuting to a small rural area (RUCC 7), stated, "Now I am the 50-year-old; I'm one of the top ones; older ones on the staff, working with these very young ones coming out." In comparison, several nurses found greater employment longevity when they worked in their rural, home communities. One nurse commented "You don't have the new employees all the time [in rural] because you have a nurse that's been there 50-plus years and that's the only place they've ever worked. You don't see the turnaround." The longevity, and decreased turnover, of nursing staff in rural settings were appreciated. However, several nurses found staffing shortages, both in rural settings and while working in a non-rural healthcare setting. One nurse, commuting to a large, rural area (RUCC 7), complained, "There's always a shortage, so then you're always training people in."

Job stability. While working in non-rural healthcare settings, feelings of job stability increased, while experiencing better financial stability of the healthcare facility to which they were commuting. Nurses who had previously worked in a rural healthcare setting, feared the financial instability of rural healthcare facilities. Nurses believed the rural facility might not be able to maintain their wages, that there may be a day that they would not get a paycheck at all, or that the rural healthcare facility could be at risk for closure in the future because of financial instability. On the other hand, nurses believed their jobs were more secure while being employed in larger healthcare organizations, feeling financial security without any fears of the facility closing because of financial troubles. One nurse stated:

I would say there is more job security involved being at that organization [large rural area, RUCC 7]. It's a [regional health system] and it's pretty well run. . . . They're financing it all. So I would say financially it's a very secure and stable security blanket, I guess is what I would call it. There's really no risk of them shutting the place or anything like that."

Availability of technology. The increased use of technology in non-rural facilities was also considered an employment benefit of working in non-rural healthcare settings. Nurses found more technology available as the size of the healthcare facility increased. They appreciated how technology supplemented their work environments in non-rural healthcare settings. One nurse, who at one point had moved from an urban residence to practice nursing in a small, rural setting, stated:

I just felt like everything was backwards. The technology—everything–I just felt like, oh, I moved out to the middle of nowhere. . . . Everything was by hand and I was like, you don't have a computer? You don't order labs on a computer? There's no Pyxis machine to administer meds? It was a whole new learning process for me.

Ultimately, the personal and professional goals that nurses considered when making the decision to commute were truly multifactorial. Many were related to advancement and specialty opportunities as well as employment benefit opportunities and a general enjoyment of their jobs. Regardless of the goals that motivated the individual nurses to commute for employment, the overall opportunities and benefits of commuting outweighed those available to them by being employed in their rural, home communities

Professional Nursing Opportunities While Working in a Non-rural Healthcare Setting

Nurses appreciated the professional opportunities available to them as they worked in a setting other than their rural, home communities. Opportunities to climb the professional ladder were available outside of their rural communities, leading to professional growth while advancing the nurses' professional careers. Many nurses appreciated these advancement opportunities in nursing, viewing this as a benefit working in a non-rural healthcare setting,

while adding to their job satisfaction. At the same time, nurses found a lack of ability for the same professional growth while working in rural settings. A nurse, who commuted away to a large, rural area (RUCC 7), stated, "It's very limited [in rural]. Where in a larger city, your opportunities for growth are much greater and that was big for me, too, being able to advance professionally." On the other hand, not all of the nurses believed that professional opportunities were only available while working in non-rural healthcare setting. The ability to climb the professional ladder was occasionally found while nursing in a rural healthcare setting as well. Another nurse explained that "Just because I'm commuting away from my community doesn't mean that the opportunities aren't there [in rural, home community]. They're there but in a different capacity."

Opportunities were also sought by nurses to meet professional goals related to their desires to practice in a specialty area of nursing. For many of the nurses, working in a non-rural healthcare setting offered them employment opportunities that were more specialized than what they could get in their rural home communities, such as surgery, and labor and delivery. The professional goals of many nurses were the opportunities to work in specialized areas that they enjoyed, and that offered them job satisfaction. They generally found opportunities to practice nursing in a specialty area to be lacking in their rural, home communities. For some nurses, the opportunity for specialized practice was a major factor in their decisions to commute. As one nurse stated, "[Specialty area] was one of the main things that brought me [to commute]."

For many nurses, the opportunity to work in a specialized area of practice led to an increased level of enjoyment in their jobs. One nurse, commuting to a large, rural area (RUCC 7), shared:

It's not a job when you really love it . . . this is a job I love. . . . You just have to find that one area that you love, and once you find that, everything else kind of just falls into place.

On the other hand, a few of the nurses did not share these same feelings of job satisfaction related to opportunities to practice in specialty areas. In fact, some nurses felt confined to one specialty area. One nurse, who commuted to a large, rural area (RUCC 7), lamented, "Now there's so many minute specialties. That's great but you lose that basic skill set of being a nurse. I think people get lost," and noted that "in larger communities, you have to be a specialty."

The nurses acknowledged that practice in rural communities did offer the opportunity to specialize in long-term care with geriatric populations. However, that was typically the only specialized area of nursing practice that rural employment offered them. Long-term care was sometimes viewed as the only rural setting available for professional nurse employment, and many, but not all, of the nurses indicated that they were not interested in working in long-term care with the geriatric population. Reasons for disinterest in working in long-term care included a lack of desire to care for geriatric population and feeling intimidated by long-term care situations. One nurse reacted to the idea of practicing in long-term care settings by stating:

Rural nursing scares me, just for the fact that I don't think I could handle the nursing home aspect of it. . . . Everyone has that one thing that scares them. Some people are afraid of the trauma part of care; nursing home is it for me.

Constituent: Commuting

As the nurses strove to achieve their personal and professional goals, employment decisions led to the nurses commuting to healthcare settings in non-rural areas. *Commuting* was defined as the act of driving to a non-rural community for the purpose of employment. It was differentiated from the term *"commuting away,"* which incorporated the entire phenomenon of interest. *Commuting* is a central component (constituent) that makes up the structure of the

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entire phenomenon of "*Commuting Away.*" Nurses were not asked specifically how many miles they commuted, instead miles commuted were calculated using an online mapping site. Two nurses were excluded from the calculations because their employment involved driving to multiple destinations. The remaining 14 nurses commuted a mean of 30 miles to their employment in a non-rural healthcare setting. Miles commuted ranged from 20-57, with the median number of miles commuted being 28.

Commuting affected both the nurse's personal and professional lives. Both benefits and challenges existed while commuting. Many challenges existed, including personal safety concerns, family considerations, weather, challenges with alertness, and the time spent commuting. However, along with these challenges, there was also an appreciation of the downtime available while commuting. Ultimately, commuting was necessary in order for the nurses to have the ability to achieve their personal and professional goals. The constituent of commuting is exemplified in Figure 16.
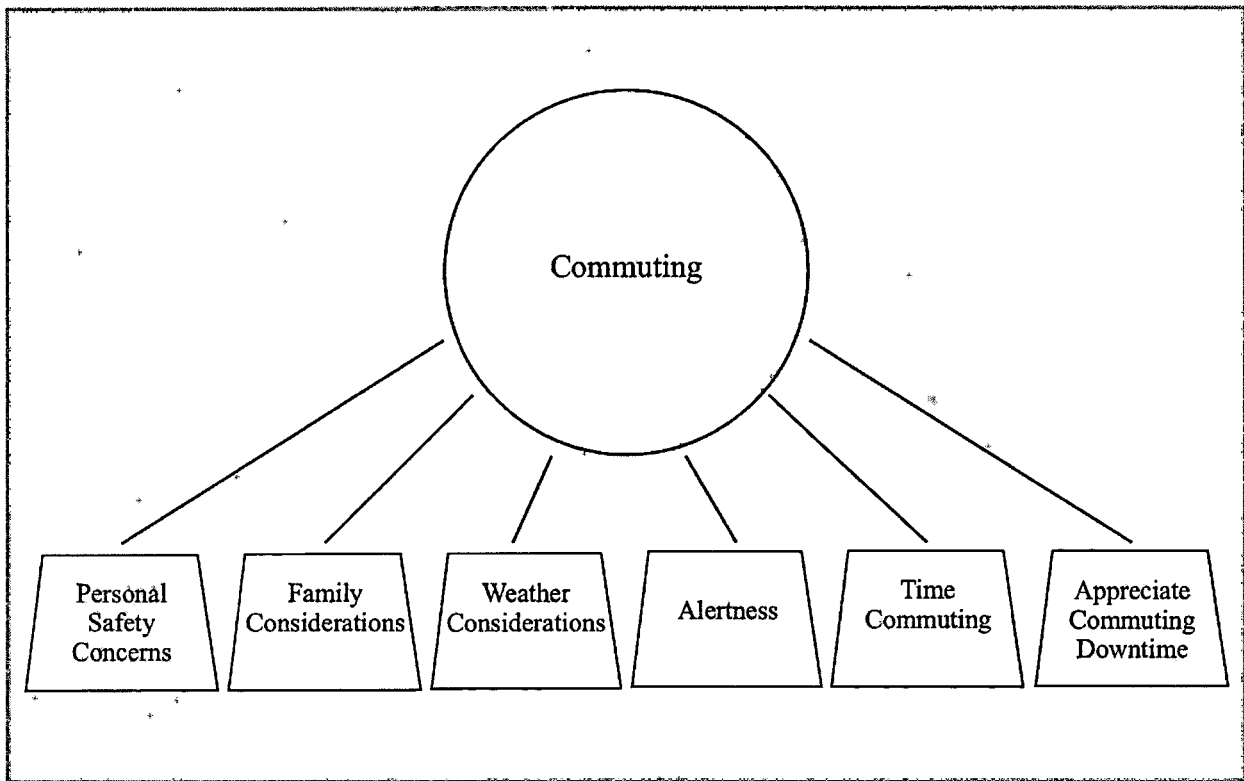
Figure 16: Commuting

Personal Safety Concerns

Personal safety concerns included the potential for vehicular accidents while commuting. Uncontrollable situations, such as road conditions, unexpected obstacles on the roads, and other irresponsible drivers were encountered while commuting. Having personal experiences with car accidents, nurses occasionally felt scared while commuting, creating stressful situations. One nurse commented:

> Perpetual deer that like to jump out in front of your car at dusk and dawn. That is a very big challenge. I don't like it. That's probably the one negative I can think of commuting, is that 35-mile drive out in the country. There are deer everywhere, and just always having to be on guard, looking, watching. When it's deer season, watch out.

Because of personal safety concerns while commuting, nurses occasionally voiced a desire to avoid commuting, by working in their rural, home communities.

It's stressful driving some days. I just think, oh, I wish I could just go to . . . [rural, home community healthcare facility] and go to work instead of having to come all the way up the interstate and be with all these crazy drivers on this interstate.

Family Considerations

Commuting created unique challenges for some nurses with families in the rural, home community. Time spent commuting meant less time with family. Challenges related to the time spent commuting included the need to leave home earlier to get to work on time. The actual time away from home and family, because of commuting, was a concern to many nurses, particularly among those nurses with young families at home. For those nurses, the increased time away from children before or after school was difficult. One nurse lamented:

> When I'm gone, you just might as well mark me off for the day. I'm not going to see you [family]. Especially when the kids were younger. I didn't get home until after they were in bed and I was gone before they got up, so that was hard.

Daycare issues and traveling with children presented challenges. The travel time on the road had to be extended to allow time for the nurses to get their children to daycare prior to work, as well as picking up their children at the end of their shifts. Decisions had to be made where to obtain daycare, whether the nurses obtained daycare in their rural, home communities, in the community to which they commuted, or an entirely different location. For nurses with school-aged children, they also had to consider how to arrange weather related emergency plans during their work absences. Obtaining daycare outside of their rural, home communities required the nurses to travel with their child or children in the vehicle, adding additional concerns surrounding the safety of the actual driving environment. One nurse explained how this frequently meant driving with a tired, crying child in the vehicle at the end of a shift of work. Another nurse spoke to these concerns:

> You have to leave even earlier. So when my kids were little, no day care takes them that early in the morning. . . . Where do you bring your kids when you're commuting? Do you bring them all the way to [non-rural work community] for daycare with you or do

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you find something somewhere here [in rural, home community]? . . . Once they got to school age . . . what if school gets out early? What if they're snowed in here or there? You're that much further away.

As nurses worked outside their rural, home communities, they spent extra time away from adult family members who needed assistance. The experience of being away from adult family member was told by one nurse. "We moved back [to rural, home community] to help [parental] family . . . but then you're that much further away [while commuting] and that much more time commuting that you're not here to help if they needed it."

Weather Considerations

Challenges with weather conditions, especially bad winter weather, were a concern in relation to commuting. Healthcare facilities, to which they commuted, commonly had expectations that the nurses had to be at work regardless of inclement weather, which made bad winter weather a challenge for nurses. One nurse shared her employer's expectations. "We get an email every fall saying, 'You will come to work. If you need to come early because of the weather, you need to come early.'" Subsequently, nurses needed to arrive at work early to assure they were available for their scheduled shifts, and were not always able to return home at the conclusion of their shifts because of inability to drive in the inclement weather or inability of other nurses to get to work. Sometimes the nurses were gone from home for several days during winter storms. One nurse shared a family experience during a winter storm. "A 3-day blizzard. . . . We had small children, and I was stuck away from home. . . . Winter commuting is challenging." Safety concerns, including icy road conditions and lack of visibility during blizzards, added to treacherous travel conditions, and the travel time, commuting.

Alertness

As nurses commuted, a lack of alertness was sometimes a problem. The lack of alertness while driving added to nurses' safety concerns while commuting. Additionally, a continued lack

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of alertness sometimes spilled over into the patient care setting after the nurses arrived at their

places of employment. Concerns of decreased alertness not only involved the nurses as they

commuted, but their patients cared for in their worksites. One nurse shared:

> That drive time, getting up an extra 10 minutes early is difficult depending on when you
> just got off work, but that's one of the downfalls of commuting. The drive can be kind of
> tiresome, even though you get up in the morning and you're kind of awake but you drive
> and you're still kind of tired and you're kind of groggy, and you get to work and you're
> still kind of groggy for the first couple of hours or whatever. Professionally I think that
> can be a factor, especially depending on how far you have to drive. You're not really
> tuned in for a while. That's one thing I did kind of factor in as well, because sometimes
> when you drive you just kind of zone and when you get to work you still just kind of feel
> groggy, even though you've been up for the last couple of hours, because you get up, you
> get ready, then you drive to work, but it's just that drive in the morning. You're not
> mentally with it. I definitely have that.

Time Commuting

The time spent commuting was a consideration that needed to be weighed when making

employment decisions about where to work. Challenges related to the time spent commuting

included the need to leave home earlier to get to work on time, as well as time delays that had to

be factored in because of road construction and traffic. Nurses considered the amount of time

and distance they were willing to travel while commuting. Overall, nurses indicated a

willingness to travel anywhere from 30 minutes to not more than one hour. The time spent

commuting added to the time spent at work, cumulatively resulting in significant time away from

home. One nurse revealed her experiences combining time commuting with her work hours.

> The time that I spend . . . factors in and just being in traffic. . . . There's always traffic.
> Out here, like if I get stuck behind a tractor in the harvest, that's the only traffic I
> encounter ever. But then I hit [traffic] if there's a baseball game going on or football. . . .
> I work a 12-hour shift, so that's usually a 13-hour shift and then I have an hour drive
> there, hour drive home, so that's approximately 16 hours with the drive. And then my
> time, like the minute I get home I know I need to go to bed. I get 6 hours of sleep and
> have go to be back up so that's probably a huge physical [thing] for me.

Many nurses took into account their expenses related to the time spent commuting, including gas, oil changes, tires, and the actual cost of the vehicle, as well as parking fees. One nurse disclosed:

> [Where I work] there's a lot of things that you have to deal with that you don't want to deal with in the rural [area], like parking. There's parking issues and you pay for parking. In the rural, you don't even realize that that exists . . . [then] gas money, repairs on my car.

One consideration of commuting, for several nurses, was whether or not they knew people in the commuter community or on the commuter route. If they did, this familiarity lent reassurance to the nurses, especially if they had car troubles or challenges with the weather. One nurse conveyed:

> I know some people on my route, so if I ever got into trouble, I knew I could stop and this person lives there and I know them. So the route is good . . . I have some relatives that live in . . . [non-rural work community] so if anything like I get stranded, I knew that would be a commute where somebody would take me in.

As nurses talked about the commuting experience, preferences to avoid commuting surfaced. One nurse stated, "Unfortunately I have to commute now. . . . I don't particularly love commuting, but it's tolerable and it's a good job." Nurses may make the decision to not commute at some point in their futures, but have not made that decision at this point in time. While many challenges with commuting existed, the perceived ability to achieve their personal and professional goals outweighed the challenges that they faced when commuting. Thus, the nurses were willing to deal with the challenges in order to achieve their personal and professional goals by working outside their rural, home communities.

Appreciate Commuting Downtime

Along with the challenges of commuting, the time spent commuting also was appreciated by many nurses. Nurses found the commuter downtime beneficial, giving the nurses time for decompression and personal reflections. Commuting allowed nurses to relax with a cup of

coffee, listening to the radio, music, or audiobooks, singing, praying, and having some time to unwind. Many nurses found having downtime, after their shifts, to decompress while driving home to be beneficial. One nurse summarized this by stating:

> The 30 minutes are fabulous to and from work when there are not road conditions or deer issues. Its decompression time for me. In the morning, it's more eating a little breakfast, listening to the radio, pretty relaxed. But then on the way home, if I've had a really stressful day, maybe somebody passed away close to the end of my shift, and I'm still kind of wound up a little bit from that, that 30 minutes before I get home is wonderful, because it's me and the radio again. . . And then when I get home, I'm strictly home with my husband doing our thing. I love that 30-minute commute.

The challenges and benefits surrounding commuting affected nurse's personal and professional lives. Many challenges, including personal safety concerns, family considerations, weather, alertness, and the time spent commuting were common among the nurses, but commuting also provided some much needed downtime to mentally transition from work to home. In the end, the act of commuting was necessary for the nurses to obtain some of their personal and professional goals.

Constituent: Different Professional Connections

As the nurses commuted to achieve their personal and professional goals, they experienced *Different Professional Connections,* as exemplified in Figure 17. Connections to their non-rural healthcare facilities, coworkers, and patients were different than connections experienced when they had practiced nursing in rural healthcare settings. Nurses experienced higher activity levels at work with greater numbers of patients, higher acuity levels of patients, and feeling less connected to their patients, coworkers, work environments, and rural, home communities. Additionally, several nurses were required to be on call, even though they lived a distance from their non-rural place of employment, and this created a different type of work connection.
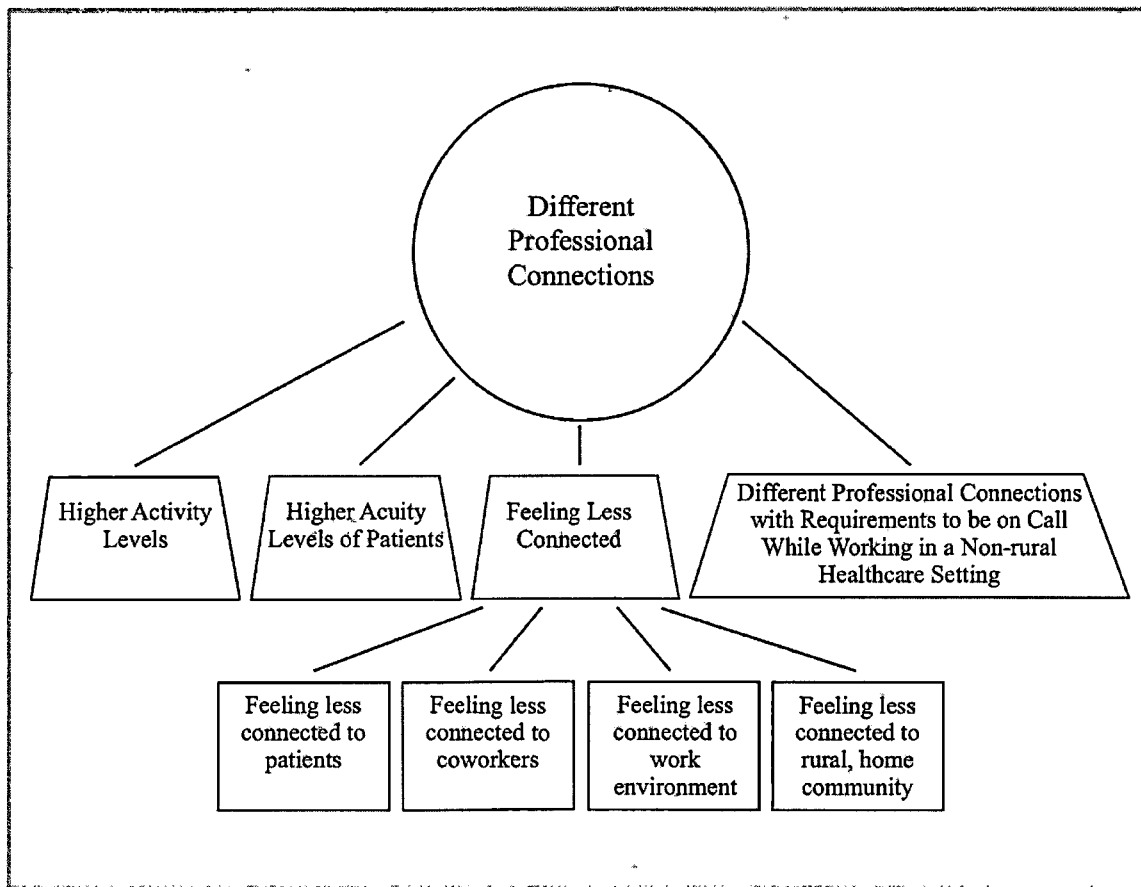
Figure 17: Different Professional Connections

Higher Activity Levels

For some nurses who had worked in rural healthcare facilities, there was a good deal of downtime during work shifts. There was an appreciation of having higher activity levels, and greater numbers of patients, at the healthcare facility to which they commuted. They appreciated being busy while at work, including caring for greater numbers of patients, in comparison to rural settings. One nurse stated, "It is nice to go to work and be busy. . . . There was downtime in rural nursing . . . sometimes you feel kind of [like you were] just setting around putting your hours in." Another nurse, commuting to a small rural area (RUCC 6), revealed, "[I] see a lot more volume of people [working in a non-rural healthcare setting] so that is different. I definitely come home tired from my shift."

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Higher Acuity Levels of Patients

Nurses cared for patients requiring higher levels of care at the facilities to which they commuted. Levels of care, in rural settings, were defined as case management, transitional care, and stabilization and transfer of patients, compared to a higher level of care given to the patients served in non-rural settings. One nurse, commuting to a large rural area (RUCC 7), stated:

> You don't have the patient census and you don't have the constant rotisserie [in rural areas]. Here we have a 25-bed hospital and you're admitting and discharging and you can go through 30, 40, 50 patients, plus your outpatients, plus your surgical admissions. Where at rural communities, you have the swing beds that stay for 2 months. You have almost like a transition unit versus an acute care facility. Or you might have the patients that come to the ER that you stabilize, but you ship out. And that's probably another reason why I left, too, is you felt like it was a step up from the nursing home, versus an acute care facility. . . . In the rural community, you're the one shipping your patients out or getting patients that are ready to go home into a swing bed, but at the larger communities and larger hospitals you are the one getting those patients, getting those surgicals, having the traumas come in.

Nurses appreciated using an increased variety of nursing skills while working in a non-rural healthcare setting. They appreciated feeling challenged in their nursing practices and keeping current in a variety of skills. One nurse, commuting to a large rural area (RUCC 7), stated:

> I want to be starting IVs, inserting Foleys, giving blood, kind of the adrenalin junky I guess you'd say . . . [rather than caring for] one patient, where you want to make a bigger impact. That's where I wanted to broaden my horizons because if you don't use it, you lose it and that's what I was noticing with my nursing was when I was in the more rural settings, I was losing a lot of my skills. . . . That's another thing that made me go to a bigger setting, just because at a smaller hospital you maybe put in two IVs a day, maybe, but where I work now, sometimes you do 15, 20 a day. You know your skills then; I didn't want to lose my skills . . . if you don't use it, you lose it.

On the other hand, a few nurses were concerned about actually losing skills at their non-rural facility, because of focusing on their specialty areas. One nurse, commuting to a large rural area (RUCC 7), shared:

> [At the regional healthcare facility], you've got team members all around you that are specialists in this area, this area, this area and this area, so you don't need to keep up your

skills. . . . They had an IV team, so a lot of nurses lost the skill of starting IVs. There was a urine catheter team that would come and place all Foley catheters, and so nurses weren't placing Foley catheters either.

Feeling Less Connected

Connections with patients, coworkers, work environments, and rural, home communities were more distant, and less personal, as nurses commuted for employment in non-rural healthcare settings. There was a blend of appreciation, and dissatisfaction, for these experiences and the changes in connections leading to feeling more distinct professional boundaries in these relationships.

Feeling less connected to patients. The experience of caring for patients in the facility to which they commuted was different, compared to caring for patients in the rural, home community. Most times, when nurses worked in a non-rural healthcare setting, they did not personally know their patients. This was appreciated by some nurses, while others missed having stronger connections to their patients, knowing them on a more personal level. Some nurses felt an appreciation of having fewer connections with patients, recognizing the work relationship was not based on the nurse and patient personally knowing each other. An appreciation of these feelings, of having a different connection, was conveyed by one nurse, stating:

> That's one relief. [While working in a non-rural healthcare setting,] I don't really know the people; this is just how it is. . . . In the area of chemotherapy . . . here, they're my patients for that day. . . . I'm kind of glad I don't have to do it [chemotherapy] with somebody that I really [know] . . . like if it was a close friend or a family member. . . . I don't really know them; just, they're my patients. I'm their nurse and they're my patients . . . there's a distance.

Along with this, nurses were viewed as outsiders as they worked in non-rural healthcare settings. This made them feel less personally connected to their patients. One nurse found an increased openness of patients because of their stance as an outsider:

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I think that I was able to approach patients differently as an outsider because I was not so close to their base. Confidentiality wasn't such an issue. They were more likely to open up and talk to me.

Even though connections to patients were different while working in non-rural healthcare settings, some nurses appreciated the connections that still could be made with their patients, albeit different. A sense of connectedness was expressed by one nurse:

That sense of connectedness to them when they do come back, like I just had a patient just this last week. I haven't seen her in 3 years. . . . I wasn't even her nurse and I walked into the room to answer her beeping pump and she looks at me . . . and she's like . . . "Is that you?" I was just like, "What, how did you remember my name?" So then I took care of her for 2 days after that.

Nurses also had different connections with patients in public settings within their non-rural work communities. In general, nurses found fewer personal-professional boundary infringement issues, appreciating that they were not asked about confidential matters regarding their patients in public settings within the non-rural work community. However, while nurses spent time outside the healthcare setting in their non-rural work communities, they still could be approached by patients in that community, but not as commonly as within their rural, home communities. Also, similar to nurses traveling for employment, patients travel to receive healthcare. Thus, nurses did care for patients from their rural, home communities, while working in non-rural healthcare settings. Those patients could approach them in their rural, home communities and ask about confidential matters. Additionally, patients travel to other communities for social or business reasons. Thus, patients from the non-rural work community sometimes traveled to the nurse's rural, home community for various reasons, creating opportunities for occasional connections within public settings. Nurses had mixed emotions about those experiences. Patient contacts made the nurses feel uncomfortable at times, making them desire more distance from the patients; however, at other times they felt an appreciation for the contact.

It makes you feel good because they're seeking you out. I about had somebody run into me [shopping] the other day. Unfortunately, I always feel terrible because I don't remember their names. Maybe here in our [rural, home] community I know who they are, but we have 500 deliveries every year, and I'm not in on all 500 but I'm in on a lot. When they are coming up to you a year later, they look different and I just don't remember their names. And so then you feel terrible. I feel bad that way. . . . That's kind of a negative because I'm like "oh, I wish I could just remember their names, because they obviously remember me." So I always feel bad about that, but on the other side, it makes you feel good that they remembered you and you definitely made that impact in their life, or you helped them. And that's what we're there for, so I felt like I did my job. I did help them and I made it a good experience for them, so that's a win for me.

There were also times that the public encounters with patients were in the presence of the nurses' families, adding to the nurses feeling uncomfortable, as they tried to maintain the patient's confidentiality. This was not unlike what nurses working in their rural, home communities experienced on a much more frequent basis.

One last consideration about experiences of interacting with patients in the community was in regards to personal appearance in the community. As noted in the following statement, feeling the need to appear professional, during the nurses' personal time in the communities, was lessened as they worked in a non-rural healthcare setting. This nurse shared:

When you work in rural nursing you will see your patients' families in the grocery store, in the gas station, at the restaurant—lots of different places. Sometimes I feel like it's not okay to look crappy, like not do your hair or have your make-up on, because somebody might see you and go "oh, she looks really tough on her days off." Versus in a larger community [while working in a non-rural healthcare setting] . . . I can't say I do that. . . . Nobody knows me, and if I didn't do my hair that's okay, because nobody's going to say "ooh, she works for so-and-so and looks like that."

Feeling fewer connections to coworkers. Feelings of being less connected to coworkers while working in a facility outside of their rural, home community, were common. Nurses, having worked in rural healthcare facilities, recalled having connections and friendships with their coworkers. Now, while working in non-rural healthcare settings, some nurses were still able to have connections to their coworkers, but with more distance from their personal lives. For some, this level of connection was adequate, as this nurse depicts:

[Coworkers are] from all over so they know you from being at work and not outside of work. That's kind of a nice thing, too; you're going to work and you know the people from work and they talk about some of their personal lives, and you can talk about them or your own, but what happens at work kind of stays at work.

However, some of the nurses missed the closer connections they felt with coworkers while working in their rural community, and missed feeling like part of a family at work. One nurse conveyed:

In the smaller communities you went outside of your job and you went and had supper with them. You went out and your kids played ball together, where now, my kids don't know any of my teammates' kids. All of our kids go to different schools. A lot of the people I work with, their kids are adults and grown. You don't have that kind of connection. . . . I think it's a negative. We all are concerned with each other's health and wellbeing, but not to that intimacy level, where they know they're going to see me tomorrow night at the ballgame or at the benefit.

On the other end of the spectrum, some nurses appreciated feeling disconnected to their coworkers while working in a non-rural healthcare setting. They appreciated the ability to leave work without any commitments to their coworkers:

In eight hours, I'm there and gone, and I didn't have any relations with the workers. It was like they weren't my friends; they were just coworkers, and everybody was there just to put their time in and go home. So it's a different atmosphere than the rural . . . it's just not like a family. . . . It's just a different atmosphere. . . . There's not a connection.

One last detail about connections to coworkers was the nurses' need to have peer support systems at work. While dealing with confidential life and death patient situations, ethical dilemmas, and patient care needs, nurses acknowledged they could not go home and talk about their work experiences with family members. Living within a rural community, the nurses' need to maintain patient confidentiality does not afford them the opportunity to talk about patient situations, as the patient may be identifiable in the small community. Thus, receiving support from family members is minimized. The nurses' desired a support system, having someone to talk to about the joys and sorrows of nursing. Even if they could talk to family, or friends, about their nursing experiences, those people would not understand to the degree a peer could.

Regardless of their experiences as they worked in non-rural healthcare settings, or while practicing in rural settings, they had this same unmet need. There was not a formal peer support system. Once nurses were done with their shifts, they felt a need to leave work as soon as possible, because of the time it took to get home, rather than staying to talk to a peer. They knew they could call their peers for support, but believed they should be able to manage on their own, and wanted to respect their peer's personal time. One nurse stated:

> You can't go home and talk about it and you can't burden [your family]. They're not going to understand even if you could, so I think we try to support each other that way. Now whether we'll do it or not, because a lot of times we feel like we should just handle it ourselves and we're maybe making more of an issue out of it than we should so we don't seek that out. . . . You need that person to talk to or that would understand you and that have probably gone through it, too, at some point.

Feeling less connected to work environment. Several nurses felt differently about their work environment while working in non-rural healthcare settings, having diminished feelings of obligation to their work environment. These nurses were appreciative of feeling that they were not taking their work home with them, or worrying about work once they were home, while working in a non-rural healthcare setting. They valued the physical distance between their personal and work life. They felt less guilty declining requests from the facility they worked at, when they were called at home to work an extra shift. One nurse, commuting to a small, rural area (RUCC 7), summarized this by explaining:

> In eight hours, I'm there and gone. . . . I could walk away. . . . The big thing is I can leave after eight hours, and I don't even think about it. I don't think about that place. I walk out the door and that's it. Where I never did that [working in rural community].

Feeling less connected to rural, home community. As nurses traveled away from their rural, home communities for employment, they felt less connected to their rural, home communities. For several nurses, feeling less connected to their rural, home communities was desirable on a professional level. They appreciated separating themselves from the community,

being less involved in their community while having less of a social connection to the people of the rural, home communities. One nurse summarized this by saying:

> [Commuting] kind of removes you from the community you live in. Because when I come home, I'm just busy doing my stuff, and I don't find myself getting involved hardly at all in the community. So I've kind of lost contact with certain things. . . .It's like I don't have a community . . . so life is much easier I think."

On the other hand, many other nurses felt that having fewer connections to their rural communities while commuting, and the subsequent reductions in connections to their rural, home communities, was a disadvantage. Nurses missed having social connections with their rural community members.

> I can certainly think of a lot of disadvantages [to commuting]. One of them is . . . that social disconnect with the people in my own community. That is a very real thing for me. I certainly have that. . . . I used to be invested in this community and I no longer am. . . . Every small community probably has cliques of people and I am no longer in it. . . . Back in the early days of my life . . . I knew every single person. . . . I grew up here. . . . That would not be the case anymore. I would not know anybody up on Main Street, nor would I feel connected to them. Very different . . . I'm not invested here and I never had been invested in the community where I worked. . . . I never participated in any community events.

A unique perspective was shared by a nurse who had recently moved to a rural community. As a new member of the rural community, the nurse felt disconnected to the community, with commuting adding to that disconnect. Spending more time in the non-rural work community than the nurse's rural, home community, the nurse found: "Now they [rural community members] just see me as a girl who leaves to be a nurse and comes back at night."

Not all nurses felt the disconnection from their rural, home communities. Some nurses continued to feel connected to their rural communities, even while commuting. One nurse attributed this to working only part time while she commuted, leaving more time to spend in their community. Another nurse shared:

I really am active in the community and in church and I really appreciate the community as a whole. I have a lot of great friends in this community. I personally would stay here the rest of my life, because I really like the community.

Different Professional Connections with Requirements to be on Call While Working in a Non-rural Healthcare Setting

The nurse's professional connections to work changed while working in non-rural healthcare settings, with more requirements to be on call. For several nurses, being on call was an inconvenience, interfering with their family and personal time. One nurse shared:

> And then we can be put on call, so if I was right here [rural, home community], I could just run home and I could be home probably when they [children] got home from school. And they could call me back in. . . . Whereas if I'm put on call [while working in a non-rural healthcare setting], I don't come home because I've had a couple times I get all the way home, you're driving in your garage and they call you, and then you've got to go all the way back. So you hang around town where you could be spending that time at home with the family, and you just hang around town for a couple of hours to make sure they're not going to call you back in before you dare wander home, because you don't want to come all the way home and have to go all the way back because of the driving time, and then you get your mind set that you're going to be home and you've got to go back. That's probably a big thing there.

One nurse, an APRN, had an opposing view, finding that a decreased amount of call was required while working in a larger facility.

> Never being on call is great. I'm no longer on call. Whereas, when I was [working in rural, home community], I was responsible for being on call. . . . There's no doubt that being in smaller communities requires . . . advanced practice nurses to take more call. There's no doubt about it.

Relationships between Constituents

Descriptions of nurse experiences, surrounding the phenomenon of *"commuting away,"* have been assembled into the previously described constituents; *Being a Nurse in a Rural Community, Personal and Professional Goals, Commuting,* and *Different Professional Connections.* However, these constituents are not a demarcated collection of the nurses' experiences as presented. In reality, the relationships between constituents bring about the whole picture of the essence of *"commuting away."* As Dahlberg, Nyström, & Dahlberg (2008) state,

once the essence of the phenomenon, and all of its constituents, was defined, the whole of the data was greater than the sum of the parts (Dahlberg et al., 2008). Relationships between constituents, themes, and subthemes need to be appreciated to truly understand the phenomenon of *"commuting away."*

The constituent, *Being a Nurse in a Rural Community,* described nurse's experiences living in their rural, home communities. *Personal and Professional Goals* surfaced as nurses shared employment experiences within and beyond their rural, home communities. These two constituents were closely connected, with the inability of the nurses living in their rural, home communities to meet all of their personal and/or professional goals through employment in their rural, home communities. Subsequently, the relationship of these two constituents led to the next constituent, *Commuting.* In order for the nurses to meet their *Personal and Professional Goals,* they commuted for employment in non-rural settings. While *Commuting,* the nurses all experienced *Different Professional Connections;* experiences that would not have occurred if they were employed in their rural, home community.

Further relationships between constituents were evident between many of the themes and subthemes within the constituents. The theme, *Practicing Nursing in a Rural Community,* involved a broad range of skills used, and hands-on cares given, while practicing nursing in a rural healthcare setting. Comparatively, experiences with *Different Professional Connections,* while working in non-rural healthcare settings, were shared within the themes, *Higher Activity Levels* and *Higher Acuity Levels.* Nurses experienced less downtime and greater numbers of patients needing higher levels of care, while working in a non-rural healthcare setting. Some nurses found themselves more comfortable with the higher activity levels and higher acuity levels, having less isolation and more resources compared to *Practicing Nursing in a Rural*

Community. Along those lines, *Professional Nursing Opportunities While Working in Non-rural Healthcare Settings,* including advancement and specialty opportunities, were appreciated by the nurses when these opportunities were not found *Practicing Nursing in a Rural Community.* Similarly, *Employment Benefit Opportunities While Working in Non-rural Healthcare Settings* varied from those while *Practicing Nursing in a Rural Community,* with many nurses being grateful for the opportunities present, while working in non-rural healthcare settings, that were not found in their rural, home communities.

Examining further themes, *Caring for People You Knew and/or Who Knew You in Rural Communities* was closely related to *Feeling Less Connected to Patients* as nurses commuted. A lack of separation between the nurses' personal and professional lives was found while practicing nursing in the rural, home community, leading to experiences filled with benefits and challenges. *Feeling a Greater Distance to Patients,* while working in non-rural healthcare settings, averted challenges of being responsible for caring for family and friends in the rural setting.

Connections to Coworkers, Feeling Less Connected to Coworkers, and *Feeling Less Connected to Work Environment* were also associated with each other. Nurses had a variety of social and professional connections to their coworkers while practicing nursing in their rural, home communities. These connections included having more personal connections to coworkers, including feeling close connections and feelings of obligation to coworkers, as well as obligations to the work setting. Some nurses appreciated feeling less connected to coworkers and the work environment while working in non-rural healthcare settings, while other nurses longed for more the personal connections found practicing in rural settings. However, nurses

acknowledged the need to have more peer support systems at work, in both rural and non-rural healthcare settings.

Further evaluating the same constituents, relationships between *Connections to the Rural Community*, *Feeling Less Connected to Patients* and *Feeling Less Connected to Rural, Home Community* were found. Nurses had a variety of connections to their rural, home communities, including a lack of anonymity and feelings of social expectations for those in the nursing profession. An appreciation for a sense of community was experienced, along with feeling personal-professional boundary issues, a lack of privacy, and being judged by rural community members. Once nurses were working in non-rural healthcare settings, a distance was felt, finding fewer boundary and privacy issues. They also found fewer connections to their rural, home communities, which some appreciated and others missed.

In order to appreciate the essence of *"commuting away,"* the relationships between the constituents, themes, and subthemes needs to be appreciated in order truly understand the phenomenon of *"commuting away."*

Summary

In Chapter IV, findings from this descriptive, phenomenological study, designed to explore the phenomenon of *"commuting away,"* were presented. Participants included 16 nurses working in a tristate, Midwest region of the United States. Nurses' residential histories and worksite locations, as well as nursing and educational backgrounds, provided a rich variation of experiences. The essence of *"commuting away"* was identified as *Commuting to Achieve Personal and Professional Goals While Being a Nurse in a Rural Community*. *Being a Nurse in a Rural Community* and *Personal and Professional Goals* were two, closely related, accompanying constituents that described nurses' residential and professional experiences, along with personal and professional goals, while living in their rural, home communities. The next

constituent, *Commuting,* was a direct result of the previous constituents, leading to nurses

commuting to non-rural settings for employment. In doing so, the nurses' experienced *Different*

Professional Connections, the last constituent. In Chapter V, a discussion of the findings, along

with the implications of the study, are presented.

CHAPTER V

DISCUSSION OF FINDINGS AND IMPLICATIONS OF STUDY

The purpose of this descriptive, phenomenological study was to describe the phenomenon of *"commuting away"* to non-rural settings, as experienced by RNs living in rural communities. The goal of this study was to provide knowledge that will inform future RN recruitment and retention strategies, leading to improvements that will reduce or eliminate the scarcity and misdistribution of RNs in the rural United States. In Chapter IV, the essence, or core meaning, of the phenomenon of *"commuting away,"* along with the components that made up the essence, constituents, were presented. The essence of the RN *"commuting away"* was identified to be *Commuting to Achieve Personal and Professional Goals While Being a Nurse in a Rural Community.* Discussion of the findings follows, along with implications of the study, recommendations, study limitations, and researcher reflections.

Discussion of Findings

The overall findings from this study included multifaceted reasons for nurses to commute for employment in non-rural settings. No single personal, or professional, goal was found to be the driving factor leading to nurses' decisions to commute. Instead, nurses had multiple and varying goals that were unmet by employment in their rural, home communities. However, some of the goals were more noteworthy than others, namely desires to seek specialized areas of nursing practice, and opportunities for advancement in nursing, being major considerations by a majority of the nurses. Additionally, feeling valued as a nurse in the rural, home community was a noteworthy finding experienced by all the nurses. In the end, it was apparent that recruitment

and retention efforts in rural areas need to be unique, without a "one size fits all" application. Discussion of the findings within the constituents and themes follows.

Being a Nurse in a Rural Community

It was evident in the findings that *Being a Nurse in a Rural Community* was an important part of the life of every nurse in the study. Whether nurses had lived in a rural community their entire life, or had recently moved to a rural community, they had connections to their rural, home communities on a personal and professional level. Likewise, these connections were present regardless of whether nurses had worked in the rural community in the past and now commuted for employment, had always commuted for employment, or were new to the community and commuted for employment. Although these nurses were not currently practicing nursing in their rural, home communities, they all self-identified as a nurse in their rural community, and did not, nor could not, totally separate themselves from their communities. They continued to "be" a nurse, as well as a community member, within the social structure of their community, as they commuted for employment. The context of the rural, home community was the foundation of *Being a Nurse in a Rural Community,* described through the nurses' professional and residential experiences within in their rural, home communities. Themes within this constituent included *Practicing Nursing in the Rural Community* with the subthemes of caring for people you knew and/or people who knew you and connections to coworkers; *Connections to the Rural Community* with subthemes of everybody knows everybody, family connections, and visibility in rural community; and *Respect, Trust, and Confidence in Competence.*

Practicing nursing in the rural community. Within the theme, *Practicing Nursing in the Rural Community*, nurses had much in common. One commonality was that they all lived in rural communities. A number of the nurses had a history of practicing nursing in a rural

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community prior to commuting, while others did not. Regardless of their previous employment experiences in rural settings, they all had perceptions about the role of nursing in their rural, home communities.

Generally, it was found that nurses, practicing in rural settings, needed to have a broad range of nursing skills. These nurses were considered to be a "jack of all trades." Feelings about nursing roles in rural settings varied among the nurses. Some of the nurses felt rural nurses used more nursing skills, compared to those used while working in non-rural healthcare settings. Other nurses shared opposing perceptions, feeling less nursing skills were required and used in rural settings, because certain skills used more often in larger facilities were not always needed in rural settings. Nursing literature has supported the idea of the generalist role of rural nurses. Following a 1987 ethnographic study of nurses and inhabitants of rural, U.S. areas, Long and Weinert (1989) introduced the Rural Nursing Theory, and addressed the role diffusion of nurses practicing in rural settings. The Rural Nursing Theory brought attention to the diverse roles of nurse generalists in rural settings and the wide knowledge base needed by those nurses to be successful. Bushy (2012), a nationally and internationally recognized presenter on rural nursing and rural health issues, also identified the role diffusion of nurses practicing in rural settings. Bushy addressed the need for nurses to be expert generalists, with proficiencies in many areas and wide knowledge bases, in order to meet the diverse clinical needs of patients in rural settings. Several more recent studies, with rural nurses in Canada, support the role of the generalist in rural nursing practice. Although Canada and the U.S. healthcare systems are operated quite differently, the role of nurses in rural settings appears to have similarities between the two countries. Jackman, Myrick, and Yonge (2010), following a review of the literature exploring the role of nurses practicing within the rural populations of Canada, stressed the

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importance of acknowledging the much-needed role of nurses practicing in rural settings. Jackman et al. (2010) found, historically, the role of the nurses in rural settings was not acknowledged in a positive manner within the political arena in Canada, sometimes being presented as inferior to, rather than different from, the nurse's role in more urban settings. Yet, the roles of nurses in rural, versus more urban settings, was found to be important. Jackman et al. (2010) illustrated that without recognition of the importance of nurses in rural settings, policy and political decision making processes would continue to marginalize the rural Canadian population, adding to negative influences on rural healthcare. The role of nurses in each setting needed to be perceived, and represented, as important without diminishing the role of the rural nurse (Jackman et al., 2010). More recently, in a qualitative study of small Canadian community hospitals, Medves, Edge, Bisonette, and Stansfield (2015) used a critical ethnographic approach to determine applicable strategies to retain rural nurses. The results of the study illustrated opportunities for nurses to use all of their nursing skills in rural settings. Nurses practicing in rural settings were found to be more than nurse generalists, with the nurse generalist role truly being a specialty area within itself (Medves, et al., 2015). The broad range of nursing skills utilized in rural settings needs to be acknowledged and regarded as unique and substantive to support the profession of nursing in rural settings.

Nurses, in the current study, had a variety of feelings about the role of the nurse working in a rural healthcare setting. Anxiety about the diverse role of the nurse in a rural setting led to nurses feeling uncomfortable working in the rural setting. Nurses had concerns about their ability to successfully practice in the generalist role as a nurse in the rural setting. As nurses worked in non-rural healthcare settings, they appreciated feeling more confident in their nursing roles, adding to their comfort levels at work. Other nursing literature supports the feelings of

discomfort nurses have felt practicing as nurse generalists in rural settings. In a qualitative study investigating if nurses received the resources needed in a rural practice in Canada, Hunsberger, Baumann, Blythe, and Crea (2009) revealed that nurses found using the full scope of practice as a nurse generalist, in a rural setting, to be stressful. Nurses felt uncomfortable practicing with nursing skills seldom used in their autonomous roles, having limited resources available. Prioritizing education for new and seasoned nurses in rural healthcare settings was suggested as a means of recruiting and sustaining the workforce of nurses in rural settings.

The theme of *Practicing Nursing in the Rural Community* also involved nurses believing the type of care given to patients in rural settings differed from the care given while in non-rural healthcare settings. In general, the nurses viewed the care provided in the rural setting positively. Some nurses described care as being more hands on, provided in a more personal and caring environment. Baernholdt, Jennings, Merwin, and Thornlow (2010) reported similar descriptions of more personal types of care being given in rural, U.S. healthcare settings. Baernholdt et al. found nurses in rural settings strove to create an environment that made patients "feel at home" (2010, p. 1350). In the Baernholdt study, patients acknowledged feeling at home while receiving care in rural settings, adding they felt the "nurses cared about me" (2010, p. 1349). Nurses, and chief administrators, in the Baernholdt study, compared rural, to more urban hospitals, portraying the trademark of rural hospitals as individualized patient care, rather than the specialty care found in more urban settings.

One last area worth noting in the context of *Practicing Nursing in the Rural Community* was the difference in safety policies experienced by one nurse in a rural community. Having previously worked with safety policies used in urban employment settings, one nurse was surprised to find unlocked doors during night hours at the rural healthcare facility. The nurse

was concerned about the unlocked doors, having an open facility without the presence of security staff during night hours. These feelings were not shared by other nurses in the current study, perhaps because they had never had safety concerns in their employment settings, had never experienced safety policies like those in more urban settings, or simply did not share their safety concerns with the researcher because other experiences were more of a priority to share. However, even though only one nurse in the current study reported safety concerns, other studies have reported that the geographic isolation of rural settings created unique safety concerns in rural nursing practice (Bushy & Leipert, 2005; Molinari & Bushy, 2012; Winters, 2013), including the lack of security personnel in rural healthcare settings (Hunsberger et al., 2009).

Caring for people you knew and/or people who knew you. Caring for people you knew and/or people who knew you, a subtheme of the theme *Practicing Nursing in the Rural Community*, entailed both benefits and challenges for the nurses as their personal and professional lives intertwined in their rural, home communities. The context of knowing patients on a more personal level was distinctly more evident while practicing nursing in the rural community, compared to nurses' experiences in non-rural healthcare settings. Maintaining confidentiality while working within the rural context was challenging, because of the common experience of caring for family, friends, or neighbors at critical times in their lives. Again, throughout this subtheme, the context of the rural, home community was a foundation to caring for people you knew and/or people who knew you.

While nursing in the rural community, there were times the nurses believed they knew nearly everyone they cared for. This resulted in being familiar with the social and medical aspects of the patients, as well as their family members. Being acquainted with patient's medical histories helped the nurses provide well-informed care. This context also created a level of trust

between nurses and patients, largely due to their familiarity with each. Previous literature

supports the value of the nurse's familiarity with patients from their rural, home communities.

Scharff (2013), in an ethnographic study of eight nurses working in rural U.S. hospitals, reported

that most nurses believed they could give improved care to patients in rural hospitals because

they knew the patients personally. The following is one example shared by Scharff:

> I recovered my little neighbor girl after her surgery. Most little kids are scared when they
> wake up, but when she woke up she knew me and wasn't afraid and recovered really fast.
> Because fear generates pain, but she wasn't afraid, she recovered faster than usual (2013,
> p. 254).

Extant literature reveals both positive and negative consequences related to the nurse's

familiarity with their patients in rural communities. In an integrative review of literature

surrounding rural professional isolation, Williams (2012) reported that a healthcare practitioner's

familiarity with rural community members could positively influence the care provided in rural

settings, by having personal information about patients and their families. On the other hand, it

was also found that negative patient outcomes could arise when a healthcare professional had

access to sensitive data the patient did not share, nor desired to share, with the healthcare

provider. Furthermore, Malone (2012) provided a real-life account as a healthcare provider

working in rural communities in Canada. Malone reported the ability of rural healthcare

providers to develop relationships with patients and families in rural communities, resulting in a

level of trust that led to the willingness of patients to share information with the provider.

Malone conveyed that these relationships positively influenced the care of patients. However,

Malone went on to describe that as the healthcare provider developed relationships with

community members, beyond the borders of the healthcare setting, additional information about

patients and their families became known. Subsequently, such information could challenge the ability of the healthcare provider to be objective.

Other nursing literature has supported the significance of the rural population's familiarity with their healthcare providers. In the Rural Nursing Theory by Long and Weinert (1989), the concepts of outsider/insider were introduced. People living in rural settings were found to resist help from people viewed as outsiders of their communities. If there was a familiarity between people viewed as insiders by rural community members, more acceptance was experienced. The concepts of outsider/insider continue to be relevant to nurses practicing in their rural, home communities today. In the current study, the acceptance of healthcare providers in rural communities was influenced by the personal relationships between the patients and community members. Knowing each other in the community, perhaps through church or being part of a local family, brought wider acceptance of the nurse, as an insider, in the rural practice setting.

Caring for people the nurses were familiar with in the rural community, such as family, friends, and neighbors, raised concerns, as nurses shared their fears of caring for loved ones and acquaintances. For example, loved ones might come to the rural emergency department for a critical condition, and the nurse would be the primary person responsible for the patient in the rural healthcare setting. Not all nurses were comfortable with these responsibilities. Concerns were escalated when there could be an unexpected negative outcome, such as death, causing great anxiety for some of the nurses. Outside the doors of the rural healthcare facility, the nurse's apprehension continued, knowing that in the future, after a negative outcome, they could, and probably would, encounter family members of their patients in the rural community. Believing that these family members may blame them for the negative outcome, and not

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knowing what to say in those situations, resulted in a desire for the nurses to avoid such

situations. Additionally, the burden of the nurse knowing that a family or community member

had died, before the family knew, was concerning. Other literature supports the nurse's anxieties

caring for family and friends in their rural, home communities. In an ethnographic study of eight

nurses practicing in rural hospitals, Scharff (2013) reported similar findings, with the potential

for nurses to feel fearful caring for family and friends, and noted, for example:

> Being rural means that when a nurse walks into the emergency room, it may be her or his
> spouse or child who needs a nurse, and at that moment, being a nurse takes priority over
> being anyone else. Being a rural nurse means being able to deal with what she or he has
> got, where she or he is, and being able to live with the consequences (2013, p. 243).

Thus, for some of the nurses in the current study, fears and anxieties, produced by the crossing of

personal and professional boundaries in the rural setting, contributed to their desire to seek

employment outside of their rural, home community.

Connections to coworkers. While *Practicing Nursing in the Rural Community* and caring

for people they knew, nurses experienced not only a variety of connections to their patients and

rural community members, they also experienced a variety of connections to their coworkers in

rural healthcare facilities. Close connections to coworkers in the rural healthcare setting, while

sometimes rewarding, also sometimes created challenges.

For some nurses, one of the rewards of personal connections to coworkers was that the

nurses were familiar with everyone they worked with, including all their coworkers and medical

providers. The result was nurses feeling like part of a family within their work environment. In

a qualitative study of nurses working in rural hospital settings, Scharff (2013) found similar

coworker connections in rural healthcare settings. As Scharff conceptualized the practice of

nurses in rural settings, she acknowledged that nurses might create close relationships in any

sized work setting. However, the unique situations in the rural healthcare setting, with the nurse

being personally familiar with everyone in their work setting, added to the potential for deeper connections. The resulting connection between coworkers was found to be unique to the rural healthcare setting, similar to the findings of the current study.

In the current study, close connections to coworkers in the rural setting also sometimes created challenges. Nurses, who had previously practiced in their rural, home communities, often felt obligated to their coworkers, their employer, and the people served. This led to the nurses feeling a duty to return to work whenever needed. When they were not at work, they found it hard to walk away and not think about work, and thus the nurses felt like they were at work all the time. Such feelings were only found in the rural healthcare setting, with the small number of nurses on staff and the close connections to coworkers. Thus, as nurses worked in non-rural healthcare settings, they appreciated feeling fewer obligations associated with their employment. MacKusick and Minick (2010), in a descriptive, correlational study with RNs practicing in southeastern U.S. hospitals, identified that similar feelings of obligation was correlated with nurses leaving clinical practice. In their study, nurses dreaded being called back in to work, feeling they never had time to recover from the pressure of working as a nurse. This led to worker fatigue, and contributed to them leaving clinical nursing practice. While this study was not specific to rural nurses, the correlation between the nurses feelings of obligation and their exit from clinical practice is concerning for any healthcare setting.

Connections to the rural community. Living in a rural community, nurses had many connections, not only to their coworkers, but to their communities as well. *Connections to the Rural Community* was a part of every nurse's *Being a Nurse in a Rural Community.* Nurses' feelings about their connections to their rural, home communities varied. Some nurses lamented that they felt less connected to their rural, home community, as a result of commuting, while

others appreciated this feeling. Either way, the nurse's connections to their community were integrated into their lives.

Social connections with the rural community were part of the nurses' existence within those communities. This was common, as the rural community was generally not only the residential community for the nurse, and the source of consumers for the rural healthcare facility, but also a key source of social support for the nurse (Bushy, 2002; Kulig et al., 2009; Manahan, Hardy, & MacLeod, 2009; Mason, 2004; Stewart et al., 2011). In Canada, the Government of Canada: Policy Research Initiative (2005) recognized the importance of social capital for nurses, along with the pros and cons of the social networks within small communities. Such recognition was needed to understand the experiences of nurses living in rural communities. Research findings revealed that nurses depended on their community's social networks, personally and professionally. Social capital was defined as "the networks of social relations that may provide individuals and groups with access to resources and supports" (Government of Canada: Policy Research Initiative, 2005, p.12). Several more studies support the importance of social networks in rural communities. One study, by Kulig et al. (2009), involved the use of a cross-sectional survey of nurses in rural and remote communities of Canada to describe the nurse's satisfaction with, as well as attachment to, their rural communities. In another study that surveyed 48 small urban and rural communities in British Columbia, Betkus and MacLeod (2004) examined public health nurses' satisfaction with their jobs and communities. In both the Kulig and Betkus studies, a sense of belonging to a community was shown to enhance not only the nurse's social well-being, but also satisfaction with their jobs. For some nurses in the current study, there was an appreciation of the rural community's social networks, and a sense of loss, as they felt less

connected while commuting. This could be a consideration for future recruitment and retention strategies for nurses in rural communities.

Richards, Farmer, and Selvaraj (2005) found workforce challenges, similar to the United States, in the successful recruitment and retention of healthcare providers to rural communities within Scotland. They studied primary healthcare providers in rural areas of Scotland, including nurses, using a survey to determine factors that could lead to the retention of rural healthcare workers. Study results were similar to the nurse's feelings in the current study, in that they felt less connected to their rural, home communities, after they commuted to non-rural areas for employment. Similar to the current study, Richards et al. (2005) found that healthcare workers living and practicing in rural communities felt more a part of their community than those commuting for employment, or those living and practicing in non-rural areas. Ultimately, rural community members could have the potential to create a sense of belonging for healthcare professionals in the community, leading to retention of those professionals (3RNET, 2015; Betkus & MacLeod, 2004). On the other hand, it cannot be presumed that a sense of belonging in the rural community will be important to or desired by all nurses, as some of the nurses in the current study, contrary to findings from other studies in the extant literature, appreciated feeling less connected to their rural, home communities.

In a pilot study of U.S. and Canadian nursing students interested in practicing nursing in rural settings, Bushy and Leipert (2005) identified that the student's personal experiences in rural settings created an interest in returning to a rural setting to practice nursing. Those who enjoyed a rural lifestyle and made personal connections to rural settings were more interested in practicing in rural settings. Also, nurse commitments to the population served were correlated to nurse familiarity with the healthcare systems in rural areas. This familiarity created a unique

relationship between rural healthcare facilities and nurses in those rural communities, with those nurses more likely to address the perceived healthcare system inequities for the people they served. Even though this connection was not identified with the nurses in the current study, this can be an added benefit to rural populations as nurses live, and are employed, in their rural, home communities (Bushy & Leipert, 2005). Discussion of other unique features of connections to rural communities, as experienced by the nurses in the current study, follows.

Everybody knows everybody. One common statement made throughout the study was that, in the rural community, "everybody knows everybody." This led to a lack of privacy for members of rural communities because people knew what was going on with other community members, including the nurse. This is a common finding reported in other studies (Brems, Johnson, Warner, & Roberts, 2006; Lyckholm, Hackney, & Smith, 2001; Malone, 2012; W. K. Kellogg Foundation, 2002). Major medical situations that happened in rural communities were common knowledge. All community members needed to do was watch the parking lot by the local healthcare facility to know who was receiving services, or which nurses were working a specific shift. The concept of maintaining privacy was foreign to rural dwellers, which could present challenges for healthcare providers (Malone, 2012). As Scharff stated: "Being a rural nurse meant that when a nurse saves a life, everyone in town recognizes that she or he was there; and when a nurse loses a life, everyone in town recognizes that she or he was there" (2013, p. 243).

Another consequence of everybody knows everybody was the nurses' perceptions of rural community member's expectations of them, because they were not only a member of the rural community, but were also members of the profession of nursing. This led to nurse perceptions that they needed to meet both social and employment expectations of their rural

community members. For example, nurses believed they should not socialize at local bars or taverns, because community members would consider that activity inappropriate for a nurse. Nurses also believed that community members thought they should be working in the rural, home community, if the healthcare facility needed nurses. Allan, Ball, and Alston (2008) completed a qualitative study exploring the experiences of pharmacists and social workers in rural Australian communities. Similar to the current study, Allan et al.'s (2008) findings revealed that a healthcare professional was visible in the community outside the work setting, with a person's professional role impacting how they fit into their rural community.

Family connections. For many nurses, connections to their own family members in the rural community had an impact on their decision to live in their rural, home communities. Some of the nurses had lived in the rural community their entire lives, having family members in that community. Others moved to the rural community after marrying a resident of the community, or moved back to the community after living elsewhere for a portion of their life. Previous literature supports the impact of connections to family to the nurse living in a rural setting. In the Rural Nursing Theory, Long and Weinert (1989) suggested that emotional ties to rural communities led to having strong social networks in the community, including family members. Molanari, Jaiswal, and Hollinger-Forrest (2011) studied rural nurses' lifestyle preferences and employment decisions in the United States, and found that rural lifestyle preferences, such as being close to family, as well as cost of living, social interactions, and spousal employment opportunities, impacted employment decisions to work in rural communities.

Visibility in rural community. Living in a rural community, nurses experienced a lack of anonymity in their personal and professional lives. The nurse's visibility in the rural community caused a blurring of professional boundaries, resulting in challenges maintaining anonymity,

confidentiality, and privacy for the nurses and their patients. Additionally, whether nurses were practicing in rural communities or commuting, community members frequently contacted them during their personal time asking for medical opinions or advice, as well as asking for help with medical needs. Moreover, as nurses and their patients lived in the same rural community, social interactions between them were commonplace. Nurses frequently encountered their patients in social settings in their rural, home communities, and these encounters would frequently occur with the nurse surrounded by a group of family and friends. In these situations, if the patients talked about their personal, medical information in the presence of the entire group, the nurses were put in a precarious situation, trying to uphold their responsibility to maintain patient confidentiality and privacy. Conversely, when nurses worked in their rural, home communities, they were frequently approached by community members asking them to share confidential information about other people they cared for. However, such encounters diminished when the nurse commuted. Nurses' feelings about their visibility in the rural community varied, ranging from neutral, to uncomfortable, undesirable, and inconvenient.

In the current study, nurses, practicing in a rural community, were challenged with the inability to talk to their families and friends about their work and the people for which they cared. It was possible that, even if the nurse did not use names, their family members' and friends' familiarity with the members of the community would make it possible for them to recognize who was being described. Thus, the nurses were unable to receive emotional support for the burdens of their work as a nurse from those closest to them. Findings in the literature support the nurse's inability to discuss their work with family members, in an effort to maintain patient confidentiality. In a study examining public health nurses experiences in the United States, caring for families where intimate partner violence was occurring, Evanson (2006) also

found that rural nurses were unable to share their work experiences with family members due to the potential to breach confidentiality.

Lack of anonymity, a concept specific to the Rural Nursing Theory (Long & Weinert, 1989), has been commonly reported among other studies with rural nurses (American Nurses Association [ANA], 2013; Bushy, 2002; Bushy & Leipert, 2005; Evanson 2006; Roberge, 2009). Similarly, the blurring of personal and professional lives, as nurses encounter patients in non-professional settings outside the rural healthcare setting, such as the grocery store, church, or local school, has also been commonly reported (Allan et al., 2008; Brems et al., 2006; Franche et al., 2010). Coinciding with findings from the current study, Bushy (2000), in her textbook orienting healthcare professionals to rural topics, stated that rural community members expected nurses to not only be a nurse while at work, but also be a nurse on duty for their community during the nurse's personal time. Roberge's (2009) review of the literature surrounding retention of rural nurses using a Canadian based website search engine, suggested decreased satisfaction among nurses in rural communities due to this lack of anonymity. For some nurses in the current study, the discomfort with this visibility contributed to their decision to commute for employment outside of their rural, home communities. Thus, the lack of anonymity needs to be considered in the retention of nurses practicing in rural communities.

Respect, trust, and confidence in competence. One key theme of *Being a Nurse in a Rural Community* was the *Respect, Trust, and Confidence in Competence* nurses experienced in their rural, home communities. All of the nurses reported feeling valued by members of their rural, home communities. Regardless of their residential or work history in the rural community, nurses felt valued and perceived that they were respected and/or trusted, with community members having confidence in their competence as a nurse. Nurses appreciated these feelings,

which is important as these feelings were not replicated in the communities to which they commuted.

In the United States, nursing has been rated the most trusted profession by the American public for the 15th year in a row. In the most recent Gallop poll, nurses were again rated as an honest profession with high ethical standards (ANA, 2016). Historically, nurses are not only highly respected in general, but also respected and recognized as a valuable resource in the rural community. In an analysis of select Australian, Canadian, and United States literature about nursing in rural settings, Bushy (2002) identified that nursing is valued as a profession, and resource, in smaller communities. Such trust plays an important role of nurses in rural communities. Generally, nurses build trust through their interactions with community members (Malone, 2012), and are confident that their community members appreciate their work (Medves et al., 2015). Similarities were found in the current study, as nurses experienced feeling valued as a professional in their rural, home communities. For some nurses, perceptions of being valued originated from when they worked as a nurse in the rural community many years ago, and continued to the present time, as they worked outside of their rural, home community. However, other nurses had never worked in their rural, home community and still felt valued as a nurse. Nurses sensed an overarching feeling of respect for the profession of nursing, with a built-in level of trust. As nurses commuted, they had fewer connections with their rural communities, and subsequently had fewer interactions with rural community members. Therefore, they shared fewer experiences directly related to feeling valued by their rural community members, but the underlying feeling did not disappear. It continued to be evident that the nurses appreciated the experience of feeling valued in their rural, home communities, which was not paralleled as they

commuted. Future recruitment and retention efforts may benefit by being cognizant of nurses'

appreciation of being valued by rural community members.

Personal and Professional Goals

For the nurses in the current study, *Being a Nurse in a Rural Community* was closely

related to the next constituent, *Personal and Professional Goals*. Nurses lived in their rural,

home communities for a variety of reasons, but all the nurses experienced some *Personal and*

Professional Goals that were not attainable while living and working in their rural, home

community. Themes within this constituent included *Employment Benefit Opportunities*

Working in Non-rural Healthcare Settings with subthemes of benefit packages, wages, work

hours, staffing patterns, job stability, and availability of technology and *Professional Nursing*

Opportunities Working in Non-rural Healthcare Settings. The themes of the constituent,

Personal and Professional Goals, are discussed further.

Employment benefit opportunities working in non-rural healthcare settings.

Striving to achieve *Personal and Professional Goals*, many nurses sought employment benefits

working in non-rural healthcare settings. Nurses described employment benefits to include

benefit packages, wages, work hours, staffing patterns, job stability, and availability of

technology. Benefits available to the nurses in non-rural healthcare settings were different than

those found in rural settings. Many nurses received benefits that better met their needs through

employment opportunities in non-rural healthcare settings. However, there were nurses who

could have received better benefits in their rural, home communities, but chose to commute for

other reasons. Employment benefits are discussed in more detail.

Benefit packages. Many nurses valued the employee benefit packages available to them

through their employment in non-rural healthcare settings. Some of the nurses were insurance

holders for their families and appreciated the insurance benefits offered when they commuted. Others nurses reported the benefit packages to be similar between rural and non-rural settings, because of mergers between those healthcare facilities. Yet other nurses chose to seek employment away from their rural, home communities while receiving modest, or no, benefit packages. Thus, the idea that better benefit packages were typically found at non-rural employers was not always true with the nurses in this study. Furthermore, receiving better benefits, such as health insurance, was not a universal driver in the nurses' decision to commute.

For nurses seeking benefit packages, such as health insurance, employers are found to vary in what they offer for health insurance to their employees, but most employers offered insurance benefits as part of their recruitment and retention efforts (Boress, 2011). Similar to the current study findings, Imerman, Orazem, Sikdar, and Russell (2006), using the Iowa RN licensing database, found that nurses, traveling at least 20 minutes for employment, did not necessarily have better access the benefit packages, such as health insurance. However, they found that nurses in their study had a better chance to work more hours, which could have led to them having better access to health insurance offered because of working full time.

In the recent past, people living in the most rural counties in the United States had the highest numbers of uninsured people, with 35% of adults aged 18-34 being uninsured (Centers for Disease Control [CDC], 2012). Since the initiation of the Affordable Care Act (ACA), dramatic increases in the numbers of people having health insurance occurred. In 2015, non-elderly adults living in rural areas experienced their uninsured rates drop by 15.4% (US Department of Health and Human Services [HHS], 2016). With some of the nurses being the designated insurance holders for their families, the changing dynamics of uninsured rates in rural areas may influence their need to continue to be the insurance holder for their families in the

future. Thus, insurance benefits are an important consideration for recruitment and retention of

nurses in rural healthcare settings.

Wages. Throughout the current study, many nurses shared information about their

current wages, past wages, and/or perceptions of wages at other healthcare facilities. While

many nurses reported higher wages at non-rural healthcare settings, other nurses reported their

wages being comparable, or even lower, after they commuted. The impact of wages on

employment decisions varied, with wages being an influential factor for some nurses, while other

nurses made their decision to work in a non-rural setting, despite the fact that they received

lower wages as a result. Clearly, the ability to obtain higher wages at a non-rural health care

facility was not universally true for the nurses in this study, and neither was it a universal reason

for their decision to leave their home, rural communities for employment.

The literature indicated that, on average, nursing wages have been typically higher in

more urban areas, compared to rural healthcare settings. In a qualitative study, involving focus

groups with nurse executives from 11 U.S. hospitals in rural areas, Newhouse (2005) reported

that rural hospitals faced challenges offering competitive pay for nurses. Data from the 2004

National Sample Survey of Registered Nurses (NSSRN) showed that salary gaps, between rural

and non-rural settings, have dramatically increased (Skillman, Palazzo, Doescher, & Butterfield,

2012). For example, data from the NSSRN, from 1980 to 2004, revealed that nurses working in

more urban areas were paid about 22% more than those working in rural areas (Skillman,

Palazzo, Hart, & Butterfield, 2007; Skillman, Palazzo, Keepnews, & Hart, 2006). Using the

Iowa RN licensing database from 1994 to 2005, Imerman et al. (2006) also found similar data,

with nurses in rural communities earning 22% less than RNs in metropolitan areas. Looking

more specifically at a context similar to the nurses in the current study, mean hourly RN wages

in the nonmetropolitan areas of southwest Minnesota, in 2013, were $28.56, compared to the nearest metropolitan area of Mankato, Minnesota, with mean hourly wages of $31.26 (U.S. Department of Labor, n.d.). Thus, in 2013, the wages in Mankato were about 9% greater than the nonmetropolitan areas of southwest Minnesota.

However, as previously noted in the current study, wages were not always found to be higher for nurses employed in non-rural healthcare settings. There were instances in which the nurse's wages were found to be similar, or even lower, in non-rural healthcare settings, compared to wages available in the nurse's rural, home community. For those nurses, the decision to work in a non-rural healthcare setting was influenced by factors other than wages. This was an important finding coming out of the current study, because previous recruitment efforts have assumed that higher wages, outside of the rural community, have been of key importance to nurses as they made employment decisions, based on the generalizable NSSRN data for all nurses in non-rural and rural communities (Skillman et al., 2006). Additionally, there is some previous evidence to show that lower wages have varying impacts on the recruitment to rural health care facilities. For example, Brewer, Zayas, Kahn, and Sienkiewicz (2006) studied barriers to the recruitment and retention of nurses in a qualitative study using focus groups with both urban and rural nurses in the state of New York. One barrier found in recruiting nurses to rural settings was the differences in wages, with rural wages being lower. On the other hand, Molanari et al. (2011) surveyed 103 rural nurses in northwestern, U.S. hospitals. Study results revealed that nurses were not satisfied with their wages. However, wages were not found to be a significant influence on the nurse's employment decisions. Rather, nurses' considered lifestyle choices, such as recreational, family, and social opportunities in rural areas, as well as reprieves from work, when making employment decisions. Furthermore, when Kovner, Brewer, Wu,

Cheng, and Suzuki (2006) examined influences of RN job satisfaction among more than 1,900 U.S. metropolitan nurses, findings revealed that wages did not lead to job satisfaction. However, even though the amount of pay was not was substantively important to the nurses, the perceived fairness of wages in relation to performance as a nurse was associated with satisfaction. Whether nurses are working in rural or urban areas, it is evident that the assumption that wages drive nurse's employment decisions does not fully capture the context of nurses' decisions regarding where they work.

Work hours. A common goal, among nurses in the current study, was to have work hours interfere less in their personal lives. Working in non-rural healthcare settings helped some of the nurses meet their goal of working more desirable hours. This finding was supported by previous studies. For example, Stewart el al. (2011) studied retention of rural nurses, using a national survey of more than 3,000 Canadian RNs living in rural locations. Similar to the experiences reported by the nurses in the current study, Stewart et al. found that rural facilities had fewer opportunities for varying work schedules for nurses, leading to the intrusion of work hours on the family lives of nurses. Studying rural acute care RN job satisfaction in Canada, Penz, Stewart, D'Arcy, and Morgan (2008) surveyed just under 1,000 RNs living in rural areas. Similarly, Molinari and Monserud (2008) surveyed 103 rural nurses in northwestern, U.S. hospitals to study conditions influencing job satisfaction. Both the Penz et al. and Molinari and Monserud studies found nurses had comparable goals, in relation to work hours, as the nurses in the current study; nurses work schedules, and hours worked, were components of job satisfaction. Penz et al. (2008) recommended increasing efforts to move to a more flexible schedule for nurses, with varying lengths of shifts.

Staffing patterns. It was clear that the nurses in the current study perceived that staffing patterns differed between rural and non-rural healthcare facilities. Staffing patterns in rural settings frequently included only one or two RNs per shift, with additional licensed practical nurses or nursing assistants available as needed. Primary care providers, as well as ancillary staff, were available as needed, usually within a 30-minute timeframe. For some of the nurses, practicing within these rural staffing patterns made them feel uncomfortable. As noted earlier, it was not uncommon for nurses to feel anxious about their responsibilities as a nurse in the rural healthcare setting. If nurses felt uncomfortable with the rural expert generalist role of nursing, rural staffing patterns only added to their uneasy feelings about practicing in rural settings. In a qualitative study, Lea and Cruickshank (2015) studied the transition of new nurses to rural healthcare facilities in Australia, and described perceptions of similar staffing patterns, noting "skeleton type staffing levels" (p. 2833) in rural facilities. Such staffing patterns influenced the availability of support of supervising RNs for new nurses in their rural work facilities. Nursing staff schedules were stretched to cover the needs of the rural healthcare facility. With this, the facilities were not able to provide the learning support new nurses needed.

In the current study, some nurses not only found the staffing patterns of nurses in rural, healthcare facilities challenging, they also found the need for nurses in rural healthcare settings to be expert generalists challenging. In the context of such differences in the nurse's responsibilities, between rural and non-rural healthcare facilities, some nurses did not feel prepared to return to the rural healthcare setting for employment. The thought of transitioning from their current non-rural healthcare setting, to a rural one, presented challenges that they did not feel prepared for, as they would need to deviate from the comfort levels of their current nursing positions. Thus, entities making rural recruitment and retention efforts need to

understand and anticipate the feelings of unease with becoming a nurse generalist that some nurses new or even returning to rural practice may experience.

Job stability. Feelings of job instability in rural settings were a common concern among nurses in the current study, largely because of fears that the rural healthcare facilities were not financially stable. These concerns were relieved when nurses were employed at non-rural healthcare facilities, which were perceived by the nurses to be more financially stable. The nurses concerns about the instability of employment at rural health care facilities are well supported by the existing literature. It is widely accepted that rural hospitals are less financially stable than non-rural hospitals. Rural hospitals are vulnerable, caring for poorer patients and typically providing care for more patients with lower Medicare reimbursements (Rural Health Information Hub [RHIhub], 2015). Not only are rural hospitals more dependent on government payments, they also deal with higher operational costs, creating limitations of cash flow. Added to this, they also have a less predictable number of patients, as well as overall lower numbers of patients, making the financial status of the health facility even less stable (RHIhub, 2015).

Hospital closure rates in rural settings have been higher than non-rural facilities in the past 25 years, with more than 470 rural hospitals having closed in the United States, in part, because of their tenuous economic statuses (National Rural Health Association [NRHA], 2016). Furthermore, 118 rural hospitals have closed since 2005, with these numbers continuing to climb annually since 2010. As recently as 2016, the hospital closure rate of rural facilities was more than two closures a month, in the first six months of the year (Rural Health Research Gateway, 2016).

With the tenuous economic statuses of rural hospitals, Noles, Reiter, Pink, and Holmes (2014) studied rural hospital merger data from 2005 to 2012. Findings revealed that since 2005,

rural hospitals with fragile fiscal performances were more likely to merge. Data, from the Noles et al. study of rural hospital mergers and acquisitions, revealed that 121 acquisitions and mergers occurred between 2005 and 2012. This accounted for 8% of the 1492 rural hospitals in the study (Noles et al., 2014). Further analysis indicated that the number of mergers and acquisitions was anticipated to increase, with rural hospitals being desirable facilities of interest. This pattern of mergers and acquisitions may change the landscape of rural healthcare settings across the United States in the near future (Noles, Reiter, Boortz-Marx, & Pink, 2015).

The nurses' feelings of instability, related to rural healthcare facilities, were substantiated by the evidence. Some of these feelings surfaced from nurses experiences decades ago, yet are still part of those nurses' descriptions of todays' rural healthcare environment. Concerns over financial stability were also part of the nurses' decisions to work in non-rural healthcare facilities.

Availability of technology. Nurses, in the current study, most commonly found technology to be more available in the work settings to which they commuted. Access to appropriate and necessary technology in rural healthcare settings is important. While studying predictors of job satisfaction with rural acute care nurses in Canada, Penz et al. (2008) found the availability of current technological equipment to be a strong predicting characteristic of job satisfaction. Even though only a few nurses in the current study talked about availability of technology at their place of employment, its significance should not go unnoticed for future considerations.

Professional nursing opportunities working in non-rural healthcare settings. The nurses' decisions to work in non-rural communities for employment were truly multifaceted, expanding beyond just employment benefits. Overall, nurses' abilities to meet their professional

goals were improved when they commuted outside of their rural, home communities. It was evident that among the many influences on employment decisions, a priority for the nurses was opportunities for professional growth and advancement, including being able to obtain specialty nursing positions.

Nurses valued the availability of professional development through advancement opportunities. Rural healthcare settings were not always perceived to offer such opportunities to nurses. Lack of opportunities for the professional development of healthcare providers in rural healthcare settings are featured in the concept of isolation in the Rural Nursing Theory (Bushy & Leipert, 2005; Franche et al., 2010) and have also been reported in other studies. While researching job satisfaction of RNs in both U.S. rural and urban settings, Zurmehly (2008) found that a lack of advancement opportunities led to significant nurse dissatisfaction, with a need to recognize this in order to increase retention of nurses. Similar findings in Australia were reported by Duffield, Pallas, Aitken, Roche, and Merrick (2006), who noted that retention might improve for nursing in general when career opportunities were improved, especially with younger nurses.

Nurses in the current study commonly desired the opportunity to practice nursing in specialty areas. The professional goals of many nurses included the opportunity to work in a specialized area they enjoyed, and that enhanced their job satisfaction. Nurses in non-rural healthcare settings sought specific specialty nursing opportunities, including surgery and labor and delivery. Long-term care nursing was perceived to be the only specialty area available in rural settings, and most of the nurses were not interested in this specialty.

The lack of opportunities for nurses to practice in specialty areas within rural healthcare settings is well supported in the literature. As Stewart et al. (2011) studied factors predictive of

nurses intending to leave rural healthcare settings in Canada; they found fewer prospects for specialty areas in rural settings. The literature also supports that the desires of nurses to seek specialty areas is not isolated to only those nurses practicing in rural healthcare settings. Some areas of clinical practice are commonly more popular than others. Highly technical areas and dynamic work environments where lives are saved have been more desired, while caring for older adults and mentally ill patients, have been less popular, particularly among newer graduates (Wilkinson, Neville, Huntington & Watson, 2016). Understanding the importance of professional growth and nursing practice opportunities is key to appreciating nurses' decisions to seek employment away from their rural, home communities.

Commuting

Since nurses were unable to achieve some of their *Personal and Professional Goals* living in their rural, home communities, they chose to drive to other non-rural communities for employment, in order to meet these goals. *Commuting* was defined as the act of driving to a non-rural community for employment. There were several challenges presented by *Commuting*, including personal safety concerns, family considerations, weather considerations, alertness, and time commuting. At the same time, the nurses also expressed appreciating commuting downtime as a benefit.

The literature indicates that, for nurses living in rural communities in the United States, commuting is not an uncommon practice. In an analysis of the 2000 U.S. Census and a survey of newly licenses RNs completed in 2006 and 2008, Rosenberg, Corcoran, Kovner, and Brewer (2011) investigated the travel time nurses experienced in varying geographic areas, as they commuted (the term commute was not defined). Findings revealed the greatest time spent commuting was found with nurses living in primarily small town and rural areas outside of

metropolitan areas, defined by rural-urban commuting areas (RUCA) codes. Just over 10% of nurses in small town and rural areas commuted 50 minutes or longer for one way of their commute. As the nurses experienced fewer employment opportunities in hospitals within their rural communities, the time they spent commuting was particularly long. The nurse's age was correlated with their willingness to commute greater distances. The average amount of time spent commuting rose until the age of 36, at which time it began to slowly decline. Using the Iowa RN licensing database, Imerman et al. (2006) found that 33% of the nurses licensed in Iowa spent more than 21 minutes commuting each way to work, with nurses living in small urban communities, and rural communities, averaging more than 40 minutes. Imerman et al. (2006) suggested that traveling at least 20 minutes to work did not create limitations or barriers for nurses to seek employment at healthcare facilities distant from their home, whether nurses lived in small urban communities, or rural communities. Likewise, the size and age of family members at home did not create limitations or barriers for nurse's to travel at least 20 minutes to work (Imerman et al., 2006).

The nurses in the current study experienced a variety of personal concerns for safety when commuting. Potential motor vehicle accidents while commuting, in both good driving conditions and in hazardous weather, were part of the nurses' concerns. Additionally, they had concerns about their level of alertness while driving. The impacts of decreased alertness and inattention while driving are indisputable. Berthié et al. (2015) studied mind wandering, "an inattentional state caused by a shift in attention from the ongoing task to inner thoughts" (p. 159). Findings from the Berthié et al. (2015) study revealed monotonous driving allowed more mind wandering to occur, negatively impacting driving performance. The repeated practice of driving, such as nurses commuting to the same work setting, accompanied by driving alone, created an

automated driving experience with subsequent increased mind wandering. Even when drivers were aware of the dangers of mind wandering on driving performance, they did not consider intentionally practicing the prevention of mind wandering to increase road safety (Berthié et al., 2015).

Many nurses in the current study believed that a positive benefit of *Commuting* was that the drive allowed them time for decompression and reflection while driving to and from work. However, there is evidence to show that even this type of distraction of thought, while driving, could be a safety concern. The study results by Berthié et al. (2015) also found that when the focus of the driver's attention involved the sorting out of distracted thoughts, such as purposeful reflection and decompression, decreased efficiency of driving performance was experienced. Add this to the monotonous environment of driving the same commuter route routinely, such as was the case for the nurses in the current study, and mental wandering could significantly increase the safety risks for nurses commuting. Although the nurses in the current study were aware of many other legitimate safety concerns related to *Commuting*, none of them voiced concerns about their inattentional state of mind, as they used the downtime while commuting to reflect and decompress. Thus, while using their driving time to decompress and reflect may have provided a benefit to the nurse's psychological health, it also posed a risk to their safety due not only to their mind wandering, but their routine commuter routes. None of the nurses voiced awareness of the risks such commuter practices posed to their personal welfare. Additionally, one nurse shared feeling concerns of decreased mental alertness continuing into the work environment, at the beginning of the work shift following the commute to work. Even though similar evidence is not found in the literature, this is an important consideration for nurses, employers, and the people they serve.

Different Professional Connections

As nurses commuted to achieve some of their *Personal and Professional Goals*, they experienced *Different Professional Connections*. Nurses experienced their connections to healthcare facilities, coworkers, patients, and rural, home communities to be different than the connections found while practicing in rural healthcare settings. Themes within this constituent included *Higher Activity Levels; Higher Acuity Levels of Patients; Feeling Less Connected*, with subthemes that included patients, coworkers, work environments, and rural, home communities; and *Different Connections to Work Roles Being on Call*. Discussion of the themes, from this constituent, follows.

Higher activity levels. Generally, the nurses, in the current study, wanted to be busy at work. Some of the nurses had worked in rural healthcare settings and had experienced downtimes during work shifts, because of factors such as a low patient census. Other nurses lacked personal rural work experiences, but had perceptions that nurses were not very busy while working in rural healthcare settings. These perceptions were grounded in their understanding of average numbers of patients in rural hospitals, believing that nurses in rural settings only had one patient to care for at a time. Furthermore, some of these perceptions were previously formed when the nurses shadowed rural healthcare settings prior to becoming a nurse. Lasting impressions were made at that time, forming perceptions that rural nursing was slow-paced.

Even though no literature was found to support or refute the downtime experienced by nurses in rural healthcare facilities, employers in rural healthcare facilities need to be aware of the nurse's desire to be productive while at work. Employers also need to be aware, when downtime is visible to prospective future nurses and the public, of the lasting impression this could make to the recruitment and retention of future nurses.

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Higher acuity levels of patients. The nurses, in the current study, reported that the types of patients and patient problems differed between rural and non-rural healthcare settings. The greatest perceived differences were in relation to the level of acuity of the patients served. As noted in the literature, rural healthcare facilities care for a wide array of medical conditions in the people served, with care given by a limited number, and type, of healthcare professionals (Bushy, 2002; Drury, Francis, & Dulhunty, 2005; Kenny & Duckett, 2003). In the current study, nurses described that higher acuity level patients in rural facilities were typically transferred to larger facilities to meet their care needs. Thus, when nurses worked in non-rural healthcare settings, they cared for patients with higher acuity needs, using different types of nursing care compared to those provided in rural healthcare settings. Subsequently, some nurses believed that they used more nursing skills compared to nursing practices in rural settings. Conversely, other nurses believed they lost some nursing skills as they worked in non-rural healthcare settings, because they were only using skills specific to the specialty area they were working, rather than that of the generalist in rural settings. In actuality, validating the different skills sets used by nurses in all healthcare settings could support the importance of all nursing roles, realizing that the roles are incomparable, with one skill set no more valuable than others.

Feeling less connected. Not only did nurses feel different personal connections to the type of work, and type of patients served, they also felt less connected to their work environments. Associations were described as having different connections, whether it is with their patients, coworkers, work environments, or their own rural, home communities. Nurses had varying feelings about these experiences, as several types of different personal connections surfaced.

Feeling less connected to patients. As nurses commuted, they felt less connected to their patients. Compared to nursing in a rural setting, nurses frequently did not personally know their patients. Some nurses appreciated feeling less connected to their patients. Nurses viewed themselves as outsiders, which helped to alleviate some of the blurring of personal and professional boundaries that, for some, made them uncomfortable practicing in rural, healthcare settings. Lyckholm et al. (2001) explored the ethical issues found providing healthcare through an outreach program in rural U.S. settings. Challenges caring for friends, families, and neighbors in the nurse's home community were found, creating potential for a lack of confidentiality and privacy. As nurses in the current study worked in non-rural healthcare facilities, such challenges were generally circumvented. This resulted in nurses feeling more distinct professional boundaries, by being less connected, to the people served. Understanding the varying standpoints of these relationships is important, as some nurses in the current study appreciated feeling less connected to their patients, while other nurses yearned for stronger connections to patients.

Feeling less connected to coworkers. Similar to feeling less connected to patients, nurses shared similar feelings about the relationships with their coworkers, as they worked in non-rural healthcare settings. Nurses described working with coworkers in a rural setting as working in a close-knit, family type setting, compared to their work in non-rural settings where they felt less connected to coworkers, with fewer links to their personal lives. Some nurses appreciated more distinct personal and professional boundaries in their relationships with coworkers, while others missed the atmosphere of closeness they had experienced in rural healthcare settings. Nurses in the current study are not alone in desiring a comfortable relationship with their coworkers. In a review of literature looking at job satisfaction for nurses, in English language publications,

Castaneda and Scanlan (2014) found professional and social relationships, among nurses in work settings, to be important sources of job satisfaction. Such relationships were frequently one of the top predictors of job satisfaction. In the current study, with the varying, yet important, coworker relationships experienced by nurses in rural and non-rural work settings, nurse's comfort levels with their connections to their coworkers need to be considered in the retention of nurses in healthcare settings.

Noteworthy to both rural and non-rural settings was the nurses' needs to have peer support systems at work. Regardless of the type, or location, of healthcare facility, nurses identified their needs for peer support, because of the confidential, and personal, nature of their work. As nurses experienced the realities of nursing, they felt isolated with their feelings surrounding the life circumstances of their patients. They yearned for an empathic ear through some form of peer support. However, time during work shifts frequently did not allow for such exchanges between nurses. Moreover, at the end of a work shift nurses quickly left for home. Thus, there was minimal time for peer support during and at the end of a work shift. Even though several nurses shared that they knew they could call their work peers at home for support, if needed, they hesitated to put their needs ahead of their peer's needs for personal time at home. Thus, minimal peer support was available. Additionally, the confidentiality quandary nurses experienced, not being able to go home and talk about the joys and sorrows of their work with those people closest to them, added to their need for peer support. The nurses' appreciation of the downtime for reflection, while commuting, previously identified in the constituent *Commuting*, perhaps tied in with the need for a peer support system, for nurses to cope with the intricacies of nursing.

Feeling less connected to work environment. Yet again, as nurses commuted, feelings of being less connected surfaced, this time in regards to their work environments. The physical distance to the nurses' work facilities had some perceived benefits of being less connected. Feeling less obligated to their work sites, several nurses shared feelings of appreciation, having more distinct boundaries between work and home life that led to fewer connections to the work environment. Working from a distance, surrounded by a larger nursing workforce, nurses did not feel obligated to go back into work when called. Knowing that there were more nurses employed and available, compared to rural healthcare settings, nurses were able to walk away from work without thinking about the work setting on their personal time. Nurses were able to go to work, put in their time, and go home, creating a distinctly different connection to the work environment, compared to their experiences working in a rural setting.

Increased feelings of responsibilities for the rural practice setting are not unique to the nurses in the current study. While researching the diverse roles of nurses practicing in rural settings, Medves et al. (2015) similarly found that the employment of fewer numbers of nurses in rural settings created an added burden on the existing nurses to always be on hand to work. Feelings of obligations to cover shifts needed in the rural facility led to the nurses feeling limited in the amount of days they could be gone for personal, vacation, and educational reasons (Medves et al., 2015). The literature supports nurse's appreciation of the benefits of feeling less obligated to their worksites. Work-life balance has been found to be very important to nurses, allowing non-work days to be free from work burdens in order to prevent work fatigue while creating the ability for nurses to be refreshed when they are at work (Jamieson, Kirk & Andrew, 2013).

Nurses in the current study shared feeling less obligated to their work environments as they commuted. The feelings of diminished obligation to work environments needs to be considered by rural healthcare employers, as they seek to recruit and retain nurses. Minimizing heightened feelings of obligations could prevent work fatigue experienced by nurses, leading to effective retention strategies. Cowden and Cummings (2012), in a literature review, including English language publications, about nurse intentions to continue in their current employment settings, found that commitment to the employment organization was recognized as one of the key predictors of nurses' intentions to continue, or leave, their employment settings. The strength of the nurse' relationship with the employment setting increased their intention to stay. This implores rural healthcare facilities to strive to create relationships that foster dedication of nurses to the healthcare facility. This dedication should not be misconstrued with nurses feeling obligated to the facility, which differs from dedication and can lead to feeling overwhelmed and dissatisfied.

Knowledge gained by the current study included nurses feeling less connected to their work environments as they worked in non-rural healthcare settings. Understanding the nurses' appreciation to have diminished feelings of obligation to their places of employment is key to allowing nurses to develop healthy work-life balances in whatever setting they work. Additionally, it is worthy for healthcare facilities to understand the strength in developing connections to their facilities, without placing the undue burden of obligation on nurses, in an effort to increase retention rates.

Feeling less connected to rural, home community. As nurses commuted, they shared feeling less connected to their rural, home communities. Spending less time within their rural communities, as well as having fewer contacts with the people living in those communities, led

to the nurses feeling less connected to their rural, home communities. While researching factors associated with rural healthcare worker retention in the Scottish Highlands, Richards et al. (2005) found similar reports by healthcare workers traveling to other communities for employment, as they experienced feeling fewer connections to their rural, home communities. In the current study, some nurses appreciated feeling less connected to their rural, home communities as they commuted to another community for employment. On the other hand, other nurses lamented the loss of connections to their rural, home communities. Either way, understanding the nurses' individual feelings is important to gain insight into decisions surrounding commuting.

Different connections to work roles being on call. One of the themes of *Different Professional Connections* surrounded the work expectations of nurses being on-call. Nurses generally found an increased need to be on-call while working in non-rural healthcare settings, with on-call hours interfering in their personal time. Whether nurses were working in rural, or non-rural settings, employment intrusions on personal time could create retention issues for employers (Stewart et al., 2011). Penz et al. (2008) revealed that job satisfaction for acute care nurses in rural settings was correlated with fewer scheduling restrictions. Specifically within rural healthcare environments, Bushy and Banik (1991) found that being on call was viewed negatively by the nurses. Ultimately, no matter where the working setting is for nurses, work hours play an integral role in their job satisfaction.

Summary

Commuting to Achieve Personal and Professional Goals While Being a Nurse in a Rural Community defined the essence of the phenomenon of *Commuting Away*. Results from the current study revealed that all the nurses had the desire to achieve unmet personal and

professional goals, which ultimately guided their decisions to commute. There were multifaceted reasons that guided the nurses' employment choices. However, among all the constituents and themes that surfaced as part of the essence, a few stood out more than others. First, a majority of the nurses emphasized their goals for professional advancement, most specifically specialty nursing opportunities. These goals were better met as they worked in non-rural healthcare settings. Second, a key component to all the nurses' experiences of living in a rural community, as a nurse, was that they all felt valued in their rural home communities, because of their professional standing. For some, this continued to be evident even as they worked outside their rural, home communities. Knowing this, it is apparent that recruitment and retention efforts in rural areas need to be unique, with many considerations beyond just the wages of the nurse. Rural employers must consider the individual goals, needs, and desires of the nurses in their communities, and try to match them with the rural work environment to the best of their capabilities. One-size fits all recruitment and retention strategies will not be effective for rural healthcare facilities.

Implications of the Study

Future rural healthcare facility recruitment and retention efforts can be guided by the understanding of the experiences of nurses *"commuting away."* Past assumptions have been that wages are the impelling cause for nurses to seek employment away from their rural, home communities. In the current study, wages did play a role in some nurses' decisions to commute, but were only one consideration in the many layers of employment deliberations. With the added depth of understanding of nurses' experiences living in rural communities and commuting away, new, unique, and individualized recruitment and retention strategies may be developed to benefit nursing practice, policy development, and employers of nurses in rural settings, along

with the nursing education system within the United States. Exploring previous research about job satisfaction, motivation and dissatisfaction, and recruitment and retention strategies, specific to nurses practicing in rural settings, supports findings from the current study and the need for new recruitment and retention strategies.

Job Satisfaction

According to the Cambridge University Press (2016), job satisfaction is defined as "the feeling of pleasure and achievement that you experience in your job when you know that your work is worth doing, or the degree to which your work gives you this feeling" (para. 1). Job satisfaction is threaded throughout the scholarly literature as an important topic to consider while efforts are made to recruit and retain workers, including nurses. Thousands of studies have focused on this topic. Yet, there are relatively few studies specifically addressing job satisfaction among nurses practicing in rural settings, which makes it difficult to know if nurses practicing in rural and non-rural settings view job satisfaction similarly or differently (Molinari & Monserud, 2008).

In one study, Molinari and Monserud (2008) completed a quantitative study to identify influences on the job satisfaction of rural nurses in the United States. Findings revealed the importance of the nurse's lifestyle to the job they chose. Nurses were more satisfied when they resided near their family members, or their spouse's employment setting. Molinari and Monserud's (2008) research findings were supported by the current study, as many nurse's lived in their residential setting because of their family connections in those communities. Family considerations were part of their personal goals, impacting their residential decisions, and were also part of the employment decisions for nurses living in rural areas.

Penz et al. (2008) researched job satisfaction of rural acute care RNs working in rural and remote Canadian hospital settings. Findings revealed the most highly rated factor related to job satisfaction was technology resources, followed by job schedules with fewer constraints on the nurse's time, and satisfaction with the nurse's rural, home community. Similar findings, regarding the relationship of the nurse's job satisfaction correlating with their rural community, have also been reported by other studies (Betkus & MacLeod, 2004; Frontier Education Center, 2004; Kulig et al., 2009; Richards et al., 2005). These findings differed somewhat from the current study, as technology resources were not found to be something nurses were specifically looking for when seeking employment opportunities. However, findings in the current study did support nurses desiring work hours that interfered less with their personal lives. Additionally, findings from the current study also supported the relationship of nurse's job satisfaction with their rural, home community. Such satisfaction was unique to each nurse, with some desiring close connections to their communities, while others desired more distinct boundaries from community members. Whatever the nurses' desires were, in regards to their satisfaction with their rural, home community, it was evident that the rural, home community was the foundation for *Being a Nurse in a Rural Community*. As Penz et al. (2008) stated, "the RNs' work lives and community lives are inextricably intertwined" (p. 797).

In 2009, Roberge completed a comprehensive review of the literature, examining retention and job satisfaction studies with rural nurses. Findings revealed that not only did the dynamics of rural practice impact a nurse's job satisfaction; they also impacted the nurse's duration of practice in the rural setting. Specifically, findings suggested the lack of anonymity of nurses in rural settings led to decreased job satisfaction. The nurses in the current study supported the challenge of the lack of anonymity. The blurring of professional boundaries and

the lack of privacy in rural communities, with everybody knowing everybody, led to decreased satisfaction in some of the nurse's personal and professional lives.

Since the Roberge review, Stewart et al. (2011) studied factors predictive of nurses intending to leave rural healthcare settings in rural and remote areas of Canada. Findings revealed that nurses' desires for career advancements were predictive of their seeking employment elsewhere. Such findings were supported by the current study. A noteworthy finding in the current study was the nurse's professional goals to seek specialized practice and opportunities for advancement.

Job satisfaction was also examined by Kovner et al. (2006), utilizing a quantitative study of RNs living in metropolitan areas in 29 states and the District of Columbia. Findings revealed that wages were not correlated with job satisfaction. However, findings did reveal that the fairness of wages was associated with job satisfaction. Even though this study did not focus specifically on rural nurses, the relevance may be applicable to the focus of future recruitment and retention efforts for nurses practicing in rural settings. In the current study, despite the fact that wages were not a universal reason the nurses chose to commute, it was not determined if equity of wages was important to nurses. Kovner's study results may be of value when considering future recruitment and retention strategies for rural healthcare facilities and wage implications.

Understanding job satisfaction of nurses practicing in rural settings is complex. Findings from the literature reveal that recruitment and retention efforts need to focus on the personal and professional implications of the job, such as the nurse's lifestyle, community relationships, and anonymity, as well as nurse's schedules and technology available in the workplace. The current study had similar findings, but, what this study found was that nurse's personal and professional

goals varied with each individual. Some nurses yearned for connections to their rural, home communities, while others appreciated more detachment from their community. The intricacies of job satisfaction for nurses in rural settings need consideration with recruitment and retention strategies. Thus, a one size fits all recruitment and retention strategy will not be effective for rural healthcare settings.

Motivation and Dissatisfaction

Frederick Herzberg, beginning in the 1950s, researched what motivates employees. His findings have intrigued those managing employees, while sometimes baffling them. Herzberg stated, "The things that make people satisfied and motivated on the job are different in kind from the things that make them dissatisfied" (Herzberg, 1968, p. 87). The Herzberg Motivation-Hygiene Theory demonstrated that factors motivating people, and causing job satisfaction, at work were different from factors that cause job dissatisfaction. In order to understand people's feelings towards their jobs, the Herzberg Motivation-Hygiene Theory took into account human needs. Herzberg demonstrated that certain factors truly motivated employees; those factors were called motivators. These motivating factors, unique to humans, related to the human's ability to achieve psychological growth. Herzberg categorized such motivators as intrinsic job factors, which included responsibility, the actual work done, recognition of accomplishments, and development or advancement. Herzberg went on to demonstrate that certain extrinsic factors tended to lead employees to dissatisfaction; these factors were called hygiene factors. Basic human needs, such as hunger, created biological drives that correlated with employment and the need for the employee to earn money. Such extrinsic factors included working conditions, wages, work status, work policy and administration, supervision, and interpersonal relationships (Herzberg, 1968).

To understand job satisfaction, in terms of the Herzberg Motivation-Hygiene Theory, one needs to understand the premise that satisfaction and dissatisfaction are not opposing terms. Motivators leading to job satisfaction are different from, and not the opposite of, hygiene factors that cause dissatisfaction. Herzberg defined the opposite of job dissatisfaction to be 'no job dissatisfaction,' rather than 'job satisfaction.' Herzberg found that motivators were the main sources of satisfaction, and hygiene factors were the main sources of dissatisfaction. As organizations work to recruit and retain employees, they frequently address hygiene needs, creating less dissatisfaction. The problem with this type of strategy is that once there is less, or no, dissatisfaction, it does not mean that there is job satisfaction. Additionally, the effect of having less dissatisfaction is only temporary and wears off quickly. Organizations need to understand that addressing hygiene factors alone, such as working conditions, does not create long-term motivation for people. Addressing true motivators can lead to a much deeper fulfillment and feeling of worth for employees (Herzberg, 1968).

The Herzberg Motivation-Hygiene Theory helps to frame the current study. In the current study, findings revealed that nurses sought to achieve unmet personal and professional goals through commuting. A priority for many nurses was the opportunity for growth and advancement, including the ability to obtain specialty nursing positions through employment in non-rural healthcare settings. Following the Herzberg Motivation-Hygiene Theory, such intrinsic factors truly motivate employees, as the nurses achieve psychological growth through the responsibility of such opportunities, along with the recognition of accomplishments as the nurses develop, or advance, their professional careers. Such motivators lead to job satisfaction with a much deeper fulfillment for the nurses. This finding helps explain why hygiene factors, such as wages, are not enough to recruit or retain nurses. Motivating factors need to be

considered by rural healthcare facilities, as they develop recruitment and retention strategies to not only satisfy, but also motivate, nurses.

The other noteworthy finding in the current study was that all the nurses felt valued as nurses in their rural, home communities, through perceptions of being respected or trusted, with community members having confidence in their competence as a nurse. Nurses appreciated feeling valued by their rural community members, a feeling that was not replicated in the communities to which they commuted. The Herzberg Motivation-Hygiene Theory explains the importance of the intrinsic factor of recognition of accomplishments, while being a member of the profession of nursing, with nurses receiving motivation from their rural, home communities. Rural healthcare facilities need to tap into this motivational factor as they strategize to recruit and retain nurses. This motivational factor will be especially important as rural healthcare facilities recruit nurses back to their rural, home communities for employment.

The Herzberg Motivation-Hygiene Theory also helps explain extrinsic factors involved in the nurses' employment decisions. Many personal goals were sought as nurses worked in non-rural healthcare facilities. Employment benefits were highlighted, including benefit packages, wages, work hours, staffing patterns, job stability, and availability of technology. Such extrinsic factors met the basic human needs for the nurses and their families. Thus, these factors need to be considered by rural healthcare facilities in order to prevent dissatisfaction of nurses. However, satisfaction was not exemplified through such employment benefits, as other intrinsic factors surfaced to be more notable and overall satisfying.

A literature review about rural healthcare providers, surrounding the Herzberg Motivation-Hygiene Theory, was performed by Campbell, McAllister, and Eley (2012). The literature used by Campbell et al. (2012) was primarily retrieved from Australian systematic

reviews and studies, supplemented with additional systematic reviews and studies from other countries using English language publications. Campbell et al. (2012) analyzed the literature for motivating factors of allied health professionals (AHP), such as professionals in nursing and medicine, working in rural and remote locations. Motivational, or intrinsic, factors found to negatively impact retention of AHPs in rural and remote locations included a lack of respect for the APHs' work, feeling that their work was not significant. Some of the AHP were concerned that what they did, as professionals, was not valued by those in their communities. This may help explain why it was impactful on the nurses in the current study to feel valued and trusted for their competence within their rural, home communities.

Campbell et al. (2012) also found several hygiene, or extrinsic, factors associated with the jobs held by AHPs in rural and remote settings. A lack of opportunities for development of professional skills accompanied feelings of frustration, and APHs felt challenged to maintain their skills. Other extrinsic factors, including the rural lifestyle, connections to family, and affordability living in rural areas, were viewed as attractive to AHPs (Campbell et al., 2012). The current study supports the value of similar extrinsic factors. Some nurses felt uncomfortable with the professional skills needed to successfully practice in rural healthcare settings, and felt challenged to return to the rural healthcare setting. Additionally, many nurses had family connections to their rural, home communities, which were viewed positively, feeling safe, surrounded by family, with people knowing each other in those communities.

Following their analysis of findings, Campbell et al., (2012), recommended that employers need to realize that retention of AHP can be impacted negatively if they do not feel valued for their work. It was important to the retention of AHPs to feel their work was respected. Considering the Herzberg Motivation-Hygiene Theory, it was found that, even

though there were extrinsic factors that suggested dissatisfied AHPs, findings still revealed some levels of job satisfaction. However, the burdens of extrinsic factors, creating dissatisfaction for AHPs, seemed to prevail over intrinsic factors contributing to job satisfaction. Both intrinsic and extrinsic factors needed to be considered as employers sought retention of AHPs (Campbell et al., 2012), which is valuable information to guide rural healthcare facilities as they create future recruitment and retention strategies for nurses.

The use of the Herzberg Motivation-Hygiene Theory could be useful in healthcare settings, stepping away from a black and white perspective about job satisfaction and motivation issues. Planning for long-term effects on retention of employees requires understanding that the ultimate reward for motivation is personal growth, advancement, achievement, and respect. The results of the current study go beyond the assumptions that extrinsic factors, such as wages, are the driving factors leading to nurses' decisions to commute. Nurses had many motivators that were unmet, along with hygiene factors that were leading to dissatisfaction. It is essential to prevent key retention efforts from primarily focusing on hygiene factors, leading to little motivation. A balance of intrinsic and extrinsic factors needs to be in place for the nurse to be motivated and satisfied, while preventing job dissatisfaction.

Recruitment and Retention

The recruitment and retention of healthcare professionals to rural areas has historically been a challenge (Blaauw et al., 2010; HHS, HRSA, 2012; Murray, 2011). Specific to Minnesota, Leibert (2013) revealed that location of a healthcare setting outside of metropolitan areas was strongly related to challenges recruiting RNs. There is little research supporting effective retention strategies for nurses living and working in rural communities (Trépanier et al., 2013). The current study contributes important knowledge in relation to how recruitment and

retention strategies might be improved in rural healthcare facilities, and a discussion of that knowledge in relation to the existing literature follows.

In 2013, Mbemba, Gagnon, Paré, and Côté summarized previous systematic reviews regarding retention interventions for nurses in rural areas, and produced a list of retention strategies found in the extant literature, having examined publications found in English, Spanish, and French languages. Recommended future retention strategies for rural nurses included (a) financial incentives for return of service, such as scholarships, educational loans, loan repayment programs and direct financial incentives; (b) supportive relationships within the nursing field, such as mentoring, clinical supervision, and preceptorship; (c) support with technologies involving information and communication, such as telehealth; and, (d) the creation of rural career pathways, such as creating structured contact between nursing students and rural health professionals while exposing students to the rural context, as well as recruiting students who originate from rural settings and have an attachment to rural practice. It is important to note that among the potential strategies listed, the only strategy that had been evaluated, to a large extent, was the financial incentive strategies, and the results of that evaluation actually indicated limited support for financial incentive strategies in rural areas.

The World Health Organization (WHO) (2010) has publicized further retention strategies for rural healthcare workers. These were similar to those from Mbemba et al. (2013), with four categories of retention strategies, including education, regulatory, financial incentives, and professional and personal support. The findings from the current study support some of these strategies. Many times the nurses' decisions to live in their rural, home communities were because of the rural context, having previously been a place of residence for that nurse. Additionally, some nurses were uncomfortable practicing nursing in the rural, healthcare

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settings. Thus, increasing the supportive relationships within the rural nursing field could be a valuable retention strategy for nurses in rural healthcare settings.

Specific to the retention of nurses in rural communities in the United States, the Frontier Education Center (2004), part of the National Clearinghouse for Frontier Communities in partnership with the Health Resources and Services Administration (HRSA), summarized strategies to increase the retention of rural and frontier nurses. Strategies specific to the retention of nurses included the development of recognition programs for rural service and setting employment standards for nurses employed in rural healthcare settings (Frontier Education Center, 2004). In support of this HRSA strategy, the current study found that the broad range of nursing skills utilized in rural settings was not always acknowledged and regarded as substantive. Thus, creating environments that respect the values and science of nursing, specific to the profession of nursing in rural settings, could better attract and retain nurses. Additionally, it was evident in the current study that nurses appreciated feeling valued by their rural, home communities. Creating recognition programs for nurses within their rural, home communities could be an effective future strategy for the recruitment and retention of nurses in rural healthcare settings.

Successful recruitment and retention of nurses in rural settings requires unique initiatives, such as innovative mentorships programs. In Rohatinsky and Ferguson's (2013) qualitative study, exploring the value of mentoring cultures on the recruitment and retention of rural healthcare professionals, 27 Canadian nurse managers, in both rural and urban settings, were interviewed. Findings revealed that the rural mentoring programs created relationships that helped the healthcare professional integrate into the work setting, as well as connecting them to the rural community. Such relationships assisted the rural healthcare facility face the challenges

of retaining healthcare professionals (Rohatinsky & Ferguson, 2013). The current study supports the need for mentoring programs, and the need for the development of relationships to help nurse's face the challenges of nursing in the rural setting. As previously noted, increasing the supportive relationships for nurses in rural settings could assist with their feelings of discomfort practicing nursing in the rural, healthcare settings. Additionally, nurses in the current study craved peer support, because of the confidential and personal nature of their work. Future strategies to create peer support relationships for nurses would not only provide valuable and needed support for the nurse, but may add to the recruitment and retention of nurses in rural healthcare settings.

As previously noted, characteristics of rural communities, and the relationships between the rural community and nurse, impact the job satisfaction of nurses (Betkus & MacLeod, 2004; Frontier Education Center, 2004; Kulig et al., 2009; Richards et al., 2005). Molanari et al., (2011) found in their study investigating rural nursing in 22 states, that including leaders from the rural community in the hiring process may increase success of retention by having information, such as opportunities for spousal employment, recreation, and social activities, available during the nurse interview. This may increase the success of recruitment and retention of nurses (Molanari et al., 2011). Once the nurse is hired, close involvement of rural community members with the nurse may create a sense of belonging in the community and job satisfaction for the nurse, leading to successful retention (Kulig et al., 2009). The current study supports and, at the same time, disputes the nurses' needs to feel connected to their rural, home communities. Some nurse's valued feeling connected to their rural, home community, and were displeased by the loss of some of those connections as they commuted. For these nurses, effective recruitment and retention strategies should integrate relationships with the rural community. On the other

hand, some of the nurses appreciated feeling less connected to their rural, home communities, as they commuted. A greater understanding of these feelings needs to be sought to create appropriate strategies for these nurses. Perhaps, underlying causes of these feelings, such as a lack of anonymity for the nurse in the rural community, needs to be addressed. It could be that increasing the knowledge of rural community members about nurses' needs for personal and professional boundaries may alleviate some of the nurse's challenges with their lack of anonymity, and subsequent desires to be less connected to their rural, home community members. Whatever the cause, support for the nurse's desire to be less connected to their rural, home community needs to be respected in recruitment and retention strategies. Thus, as noted previously, unique strategies need to be implemented for successful recruitment and retention of nurses in rural healthcare settings.

The importance of recruitment and retention is especially important to rural healthcare facilities. The loss of one nurse makes a huge impact on the staffing of the rural healthcare facility, having few reserves for replacement of that nurse. The vulnerability of rural populations accessing quality healthcare lies in the ability of healthcare facilities to adequately recruit and retain healthcare professionals.

Recommendations

For employers to recruit and retain nurses in rural healthcare settings, the use of knowledge gained from nurse's experiences *"commuting away"* can lead to understanding the multifaceted reasons nurses commute. As I address the recommendations for nurses, and employers of nurses in rural healthcare settings, I, by no means, aim to be insensitive to the constraints of these healthcare organizations. I understand the challenges rural healthcare systems face, with limited financial and workforce resources available. On the other hand, I also

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understand that employers in rural healthcare settings have historically been resourceful and inventive, in order to meet the needs of the people they serve. I do aspire to present recommendations that may be woven into the fabric of the rural healthcare system, through ingenious and inventive initiatives. Recruitment and retention efforts need to be unique, without a "one size fits all" application in rural healthcare settings. It is hoped that the resulting outcomes will lead to effective recruitment and retention strategies for nurses practicing in rural healthcare systems.

Recommendations for Nursing Practice

Study results demonstrated an appreciation of the downtime experienced by nurses as they commuted. Nurses purposefully reflected and decompressed while driving, finding their commuting time beneficial for this purpose. However, contrary to this perceived benefit, known hazards associated with the mental wandering that occurs in such situations actually leads to increased safety risks as nurses commute. An awareness of safety hazards, associated with mental wandering, needs to be brought to the attention of nurses as they make decisions to commute, or are currently commuting.

The roles of nurses in rural settings may have been considered commonplace for the nurses in the current study. However, the broader body of nurses needs to recognize the wide knowledge base needed to be successful as a nurse practicing in a rural setting. Such acknowledgements may create a positive influence on the value and prestige of nurses who are practicing in rural settings. Frequently, the public misunderstands what nursing is, lacking knowledge about the complexities and responsibilities of nurses (Brewer et al., 2006). This is especially true of nurses practicing in rural settings. Nurses may have a positive influence on the way other healthcare professionals, and the public, view the expertise needed by nurses

practicing in rural settings. Acknowledging, and advocating for, the valuable roles nurses play in

providing healthcare to rural dwellers is imperative to change the perceptions of nurses

practicing in rural settings being less skilled, or less valuable, than nurses practicing in non-rural

settings.

Recommendations for Policy Development

Financial incentives have historically been used for the recruitment of healthcare

professionals in rural healthcare settings. Scholarships, loans, loan repayments, and direct

financial incentives have been used to increase the appeal of working as a rural healthcare

professional. Even with the historic use of financial interventions for recruitment of rural

professionals, there is limited support shown for the long-term success of such programs

(Mbemba et al, 2013). Herzberg's Motivation-Hygiene Theory (Herzberg, 1968) would suggest

that the financial incentives of such recruitment programs lead to low, or no, dissatisfaction

working in a rural setting, but does not lead to job satisfaction. Furthermore, the benefits of

having low, or no, dissatisfaction is typically temporary, wearing off quickly. Following

Herzberg's theory, if recruitment interventions could include not only financial incentives for

recruitment, but also incentives in the form of motivators, such as personal growth and

advancement opportunities, as well as opportunities for recognition of accomplishments, a

complete recruitment and retention strategy could be actualized. Federal rural recruitment

programs, such as those through HRSA, need to incorporate these strategies. The end result

could be an increased success, not only of recruitment, but of retention of nurses in rural settings.

Recommendations for Employers of Nurses in Rural Settings

As one understands the complex roles of nurses practicing in rural healthcare settings, it

is prudent for employers to acknowledge and support the diverse roles required of nurses in such

settings. Some nurses experience feeling unsure of their ability to perform successfully in the rural healthcare settings. Also, nurses have connections to many of the people they serve in the rural community, including their family, friends, and neighbors. This has benefits and drawbacks for the nurses. One benefit is the nurse's appreciation of the individualized care given in rural communities. However, one drawback is the varying comfort levels of the nurses, caring for family, friends, and neighbors. While some nurses may feel comfortable caring for family and friends, perhaps another does not feel prepared to care for a critically ill family member in the emergency room. Or, perhaps a nurse does not feel prepared to know about the death of their neighbor, before the spouse knows. Acknowledgement, that some nurses are very uncomfortable in these situations, is important for the recruitment and retention of nurses in rural healthcare settings. Thus, assessing the needs, desires, and goals of potential nurse candidates and new/current employees could lead to tailoring resources on an individual basis for nurses practicing in rural settings. Such resources could include mentorship/orientation programs, based on the individual nurse's previous exposure to nursing in rural healthcare facilities. Programs could specifically focus on the flexible and creative roles of nurses meeting the broad array of care needs of rural dwellers. Although mentorship/orientation program are not new to rural healthcare settings, additions to the programs could include personal and professional boundary issues found in rural, home communities, Health Insurance Portability and Accountability Act (HIPPA) related compliance challenges in rural, home communities, ethical dilemmas, and interpersonal communication skills needed for the nurse not only working, but living, in a rural community. Prior to identifying such resources, it would again be important to assess the individual comfort levels, needs, and goals of nurses. Each nurse could have different aspects of nursing in their rural, home communities that cause concern, and comfort, for them as

they practice in a rural setting. In knowing each individual nurse's concerns, as well as areas they identify to be comfortable with, individualized supports and resources could be put into place, to the extent feasible, to alleviate the nurse's concerns. Perhaps mentoring programs would influence the scheduling of nurses, considering not only the pairing of nurses with varying degrees of expertise, but also pairing of nurses with various opposing areas of concern regarding practice in a rural setting and comfort levels.

A broad example of a resource, that may be beneficial to both the nurses and patients in rural healthcare facilities, is the use of telehealth services. History reveals that the use of telehealth has increased the rural population's access to healthcare services, such as specialty care, homecare, emergency room care, and intensive care services (HRSA, 2015). Additionally, it is understood that the nurses in the current study appreciated the availability of technology. The use of telehealth services can be an additional resource, and support, for professionals working in rural healthcare settings. As employers recruit nurses to rural healthcare facilities, the availability and capability of telehealth services needs to be made known to demonstrate the impact of the added support provided by telehealth services.

Beyond the consideration of comfort levels of nurses currently practicing in rural healthcare settings, understanding the comfort levels of nurses who are currently working in non-rural settings is important as recruitment strategies are created to draw them to rural healthcare facilities. Recruiting nurses back to their rural, home communities for employment, or recruiting new nurses to the rural healthcare settings for employment, is a strategy needed to maintain adequate numbers of nurses in rural healthcare settings. In the future, nurses currently traveling to non-rural communities for employment may wish to continue working as a nurse while desiring to no longer commute. Such nurses could be experts in their specialty area of nursing in

the non-rural healthcare setting. However, they may feel unprepared to transition to a rural practice setting, feeling uncomfortable meeting the demands the complexities of the nurse generalist role in rural healthcare settings. Offering a "rural nursing refresher" course could assist those nurses to transition back to the rural nurse generalist role. Recruitment interventions need to acknowledge the significance of the nurse's transition to a rural healthcare setting. Aforementioned tailored resources, based on the needs, desires, and goals of the nurse, would be beneficial for transition from a specialist to generalist role in nursing.

Realizing that employers of nurses in rural settings have limitations in staffing and training opportunities, compared to non-rural healthcare settings, creating ingenious strategies is required to meet the nurse's educational needs and provide support for nurses practicing in rural settings. Use of orientation programs specific to the nurse generalist role, use of mentorship programs, and continuing education programs specifically addressing the complex roles of nurses in rural settings, need to occur to assure quality nursing care and the ability to achieve adequate comfort levels of nurses. Even though such programs are already occurring in many rural healthcare settings, with the understanding the vast array of needs, desires, and goals of nurses from the current study, it is again important to assess the individual needs, and comfort levels, of each individual nurse prior to creating such interventions. Each nurse has different aspects of nursing in rural settings that cause concern for them. In knowing each individual nurse's areas of concern, as well as their areas of strength and confidence, a blending of the team dynamics can lead to increased comfort for all while adding strength to the team.

Additionally, understanding nurse's goals for advancement and specialty opportunities is key to the successful retention of nurses in rural settings. Nurses frequently "wear many hats" in rural healthcare settings. Dispersing the "many hats" in rural service delivery systems may

create opportunities for the development of advancement positions for many nurses, meeting the goals of some of the nurses while increasing the motivation of more nurses. Nurses, having gained specialized knowledge in practice areas such as emergency departments, labor and delivery, and pediatrics, could be the rural specialty experts. These nurses could be called upon when needed, giving them an opportunity to practice in their specialty area. They could even make themselves available to share their expertise with nurses in other rural facilities, through telehealth mechanisms. The outcome of being known as the local expert could create a sense of achievement and recognition, important motivators that could lead to the retention of these nurses.

Striving to decrease the dissatisfaction of nurses in rural healthcare settings, employers of rural nurses need to pay attention to the benefits offered to nurses, including benefit packages and wages. Insurance is an important component of the benefit packages nurses' desire, especially when they are the primary insurance holder for the family. Furthermore, even though it should not be presumed that wages are the driving factor leading to nurses commuting for employment, nurses do need to feel an appreciation of equity surrounding their wages and benefits, sensing fairness to what they believe nurses deserve in their work role. Employers of nurses in rural healthcare settings need to realize that nurses, who commute for employment, may have inaccurate perceptions of the benefits available through rural healthcare settings. Some nurses' perceptions were that health insurance benefits in non-rural healthcare settings were better than those available in rural healthcare settings, even though these nurses had never received the benefits offered by those rural healthcare settings. Highlighting the benefits available in rural settings and showing market comparisons may be helpful in recruitment strategies if nurses have inaccurate perceptions of benefits offered by rural employers.

Knowing the research surrounding work schedules for rural nurses, and nurses' desires to avoid their work schedules getting in the way of their personal lives, consideration of unique work schedules needs to be taken into account for the recruitment and retention of nurses practicing in rural settings. Realizing that rural healthcare settings have limited financial resources and staffing constraints, ingenious staffing patterns need to be considered. Because of the variety of work hours required of nurses, the interference of work schedules with the nurses' personal lives may lead to dissatisfaction. Without being insensitive to the blend of workforce and financial constraints of employers of nurses in rural healthcare facilities, and their distinctive staffing patterns currently being utilized, flexible staffing patterns should be integrated in order to blend the staffing constraints and concerns of nurses in these healthcare settings. Flexible scheduling options may be an effective recruitment tool. If not already in place, creating flexibility in nurse schedules through the use of a self-scheduling environment, could allow for the possibility of nurses adjusting work hours around individual and family needs, thereby decreasing dissatisfaction and feelings of stress related to shift schedules (Leineweber et al., 2016). Self-scheduling could also lead to intrinsic factors, such as an increased sense of responsibility and control within workplaces, motivating nurses through shared governance of their healthcare settings (Schullanberger, 2000). Additionally, allowing two or more nurses to job-share one full time position, and leaving it to them to determine the shift coverage needed, may potentially increase nurses' sense of a better work-life balance (Clendon & Walker, 2016). Even though extrinsic factors, such as work schedules, do not typically lead to the motivation of nurses, they can lead to less dissatisfaction, which, along with motivators, could be key to the successful recruitment and retention of nurses.

The significance of the nurse's connections to their rural, home communities needs consideration by employers of nurses in rural healthcare settings. The sense of belonging to the rural community was found to diminish as nurses commuted. For nurses desiring to feel connected to their rural, home communities, enhancing these connections could be an effective recruitment and retention strategy. Employer collaborations with rural community members could enhance the connections nurses make with their rural communities. Suggestions could include providing nurses with opportunities to volunteer in the community, or be involved in community projects as a representative of the healthcare facility. Strategically including community members into hiring processes, and mentorships, could also enhance recruitment strategies.

On the other hand, it is imperative for employers of nurses in rural healthcare facilities to understand that some nurses desire to be less connected to their rural, home communities. As nurses live in their rural, home communities, the boundaries between a nurse's personal and professional life are unclear. Perhaps a nurse desires to be less connected to their rural home community because of the difficulty maintaining patient confidentiality while caring for friends, family, and neighbors. Conceivably, the nurse may desire to not be approached by rural community members asking about confidential patient information. Employers of nurses in rural healthcare settings could create educational interventions for community members. Rural community members could be taught about the responsibility of the healthcare facility to maintain patient confidentiality, along with the anonymity and confidentiality needs and concerns of rural healthcare workers. Such interventions could be powerful, but would need to occur without being disrespectful. It would be imperative to understand that the concept of maintaining privacy can be foreign to rural dwellers. However, if educating rural community

members to the importance of professional boundaries could lead to more clearly defined personal and professional boundaries for nurses, perhaps fewer nurses would desire to be less connected to their rural, home community due to their fatigue surrounding visibility in the rural community. In this case, another education intervention aimed to decrease nurse's concerns about visibility in the rural community would be to offer nurse's interpersonal communication skill training specific to HIPPA related compliance challenges in rural communities. Providing scripting materials while using verbiage from healthcare facility confidentiality policies could strengthen the communication techniques nurses could use when approached by community members about confidential matters. Continuing education sessions that role-play such scenarios may also be helpful.

Along those same lines, the significance of the nurses' connections to their coworkers needs consideration by employers of nurses in rural healthcare settings. The connections between nurses and their coworkers in rural healthcare settings are out of the ordinary. In the current study, nurses who had been employed in a rural healthcare setting felt like part of a family at work. As noted previously, Scharff (2013) found the potential for deeper connections between nurses in rural work settings. For some nurses, deeper connections with coworkers were appreciated. However, deeper connections with coworkers may also lead to nurses' feelings of obligation beyond normal work expectations. In the current study, while working in rural healthcare settings, some nurses experienced feeling the need to frequently come back into work to assist their coworkers, and worried about work while at home, leading to work fatigue and a desire to be less connected to their coworkers. Working in non-rural healthcare settings, nurses appreciated feeling less connected, and less obligated, to their coworkers. Many of the nurses in this study found that they had clearer boundaries between their professional and

personal lives once they were employed in a non-rural healthcare setting. Helping rural nurses achieve a healthy work/life balance through the creation of connections between nurses in rural healthcare settings could lead to dedication and commitment to the healthcare facility, without overriding feelings of obligation. The resulting dedication and commitment could be key to the retention of nurses in rural settings.

In a literature review using a variety of electronic databases, Carver and Candela (2008) found that there was more than the nurse being an employee for an organization to exemplify organizational commitment. True organizational commitment was a complex concept that included the nurse's dedication to the healthcare organizations goals and values. Nurse's dedication and commitment to the healthcare organization was proven to be beneficial to the organization through the increased retention of nurses. Recognition of the differences in personal values throughout the various generations of nurses was important to consider in order to understand each generation's unique perspective of organizational commitment. In an example, it may be that a nurse born between 1943 and 1960 would often "live to work" (p. 988) whereas a nurse born between 1961 and 1981 "works to live" (p. 988). The distinction between such generations creates variations in personal values. Recognition of the differences in the priorities of each of these generations of nurses may lead to understanding feelings of dedication and commitment without overriding feelings of obligation. Perhaps the nurse born between 1943 and 1960 would feel valued, and motivated, by being called to come in to help with an extra shift, without feelings of obligation surfacing. On the other hand, perhaps the nurses born between 1961 and 1981 would only come in for an extra shift because they felt obligated to do so, potentially leading to dissatisfaction. The consideration of strategies surrounding the individual motivation of each nurse could be made to create an environment that makes nurses

feel valued as they make what they feel are meaningful contributions to the organization, while avoiding the dissatisfaction of others. In order to identify such strategies, it is again important to know the individual nurse's values, comfort levels, needs, and goals and what they are seeking from the healthcare organization. Again, assessing each nurse, and understanding their desires in regards to feelings of dedication to work, compared to feelings of obligation, can lead to the possibility of a blend of interventions that may lead to less dissatisfaction and increased retention of nurses.

An important finding in the current study was that all the nurses appreciated feeling valued and respected by their rural community members, and when they commuted they did not have the same feelings from the community members of the non-rural communities to which they commuted. The captivation of rural community member's respect and trust for the profession of nursing could be a powerful recruitment and retention tool. Substantiating the importance of the rural nurse, while recognizing their role to be equal in status to any other nursing role in a non-rural healthcare setting, validates the expert generalist role of nurses in rural healthcare settings. Employers of nurses in rural healthcare settings could seek recognition strategies that would acknowledge the value of the role of the nurse. Tailored recognition programs, created to fit the culture of the healthcare settings and community, as well as employee comfort levels, needs, and goals, could demonstrate appreciation of the nurses, while recognizing their value to the people served by the healthcare facility. It may be that nurses are honored at an annual appreciation dinner, with publicity coverage by the local newspapers. Perhaps the value of nursing could be celebrated in the rural healthcare setting, highlighted using local media, during key weeks such as National Nurses Week. Maybe the value of nurses is called attention to during local celebrations and community events, such as parades. It could be

that recognition occurs on a more personal level, assuring that any comments demonstrating the respect and value of patients for the nurses, whether found on patient satisfaction surveys, within thank-you notes sent to the healthcare facility, or a thank-you placed in local newspaper classified ads by a patient, are shared with the nurses. Taking this one step farther, perhaps a meaningful, useful, and inspirational gift of a personalized journal, including quotes from patients and community members, is presented to the nurses, providing a touching demonstration of how the nurses are valued while also providing a means for reflective journaling. Ultimately, the low-cost benefits of nurses' feeling valued by rural community members could be a strong motivator when mixed with other motivators and benefit packages.

The need for peer support for nurses also needs to be acknowledged. This was a stated need among nurses when they had practiced in rural areas, and it was still a need when they commuted away. Nurses share many joys and sorrows caring for the people they serve. However, because of needs to assure patient confidential and the personal nature of professional nursing responsibilities, they are generally unable to receive emotional support from people closest to them, outside their healthcare facilities. This is especially true of nurses working in rural, home communities, because of the close-knit nature of rural communities and the confidentiality quandary nurses experience. Living within a rural community, the nurse's need to maintain patient confidentiality does not afford the nurse the opportunity to talk about patient situations, as the patient may be identifiable in the small community. This leaves nurses feeling isolated with their feelings surrounding the life circumstance of their patients. Yearning for an empathic ear, they find a void in the support systems. As noted previously, the nurses in the current study utilized their time commuting to reflect and decompress. The need for this personal decompression time may reflect an unmet need for decompression through peer

support. Creating supportive interventions is imperative to the safety and wellbeing of these nurses. An example of a unique supportive intervention was shared by Ellerbe, Ostermeier, and Shelley (2006), focusing on new retention strategies for healthcare professionals. "Sanctuaries of healing" were created for staff respites. These sanctuaries were specific rest areas designed to allow for staff to rest and revitalize in the work environment. Such environments for healthcare professionals were considered retention strategies that addressed the needs of staff. The sanctuaries of healing were one aspect of multifaceted recruitment and retention strategies that led to remarkable improvements in vacancy and turnover rates (Ellerbe et al., 2006, p. 40). Support systems need to be developed to not only provide nurses with the support they need, but to create safe travel experiences as nurses commute. Perhaps informal debriefing sessions could be purposefully created at the transitions of shifts. Additionally, the creation of informal peer support mentors could be used to develop agreements regarding how nurses can best support each other. Conceivably, support hotlines could be created amongst nursing peers. In the end, distinctive support systems need to be created to meet the needs of nurses.

Another important finding from the current study was that the nurses expressed a desire to be busy and productive while at work. If nurses had experienced downtimes during a work shift in rural healthcare facilities, not only were they non-productive, their lack of productivity could have been visible to members of the public, including future nursing students. In the current study, nurses found that observing the downtime experienced by nurses in rural healthcare settings created a negative image for prospective nurses to practice in rural settings. Understanding that rural healthcare facilities are challenged by less predictable and lower patient volumes than non-rural hospitals, it is not unusual for there to be a low inpatient census in the rural healthcare facility. However, it is also understood that the stability of rural healthcare

facilities is dependent on the facility being fiscally responsible. As employers in rural setting already know, having unproductive nurses adds to the financial instability of rural healthcare facilities. In the current healthcare environment, coordination of care leads to improved patient outcomes. Nurses are instrumental in care coordination efforts for patients throughout the United States (Stratis Health, 2017). Nurses practicing in rural healthcare settings have opportunities to assist with care coordination and quality improvement initiatives, while experiencing lower patient volumes. One example is coordination of patient care through the Health Care Home Coordination Program through the Minnesota Department of Health (n.d.). Patients with selected diagnoses have post-hospitalization contacts via phone or electronic contact to improve patient outcomes and prevent re-hospitalizations. Nurse's activities in care coordination, through such programs, creates productive work environments even when patient censuses are low, along with the added benefit of improving patient outcomes. Additionally, with the emphasis on evidence-based nursing practices, nurses can improve the quality of care in rural healthcare facilities through the determination of best practices and protocols that pertain to the people served in their healthcare facilities. Having access to current electronic resources, nurses could use times of low patient censuses to determine quality measures for their organizations.

Lastly, findings from the current study revealed that nurses might be uncomfortable with the risks to their personal safety, as well as the safety of their patients, with the current safety policies in place in rural healthcare facilities. As found in other studies, the geographic isolation of rural settings has created unique safety concerns in rural nursing practice (Bushy & Leipert, 2005; Molinari & Bushy, 2012; Winters, 2013), including the lack of security personnel in rural healthcare settings (Hunsberger et al., 2009). Knowing the concerns and needs of staff at rural

healthcare settings may guide future safety policies and procedures. Examples of collaboration between community resources and healthcare facilities have added to the feelings of safety for those working at healthcare facilities. Collaboration between the local police force and rural healthcare facility can increase safety through increased patrolling of the healthcare facilities parking lots during changes of shifts. Such collaborative safety interventions for healthcare facilities have been created, as found at Avera Marshall in Marshall, Minnesota (Marshall Independent, 2017).

It is meaningful to the future recruitment and retention efforts of nurses to realize that nurse's decisions to commute are multifaceted. The desires of nurses to achieve personal and professional goals are a reality, and the distance to travel to a non-rural community is not necessarily a barrier when rural nurses make the choice of where to seek employment. Employers of nurses in rural settings need to be able to determine the intricacies of the multifaceted reasons to commute. Identifying what causes less dissatisfaction and more motivation of nurses living in their rural, home communities, facilitating distinct resources and interventions, and educating rural community members, could lead to increased success using selective adaptations for effective recruitment and retention interventions. Utilizing the notable features of rural nursing, and rural populations, could aid in the recruitment and retention of efforts for rural healthcare facilities (Aylward, Gaudine, & Bennet, 2011).

Recommendations for Nursing Education

Educational agencies play a critical role in preparing new nurses for future clinical practice. In the current study, nurses frequently did not feel prepared, or comfortable, practicing in rural healthcare facilities. One nurse attributed a lack of nursing experiences in rural healthcare settings in the undergraduate nursing curriculum to her current feelings of being

uncomfortable practicing in a rural healthcare setting. Molanari et al., (2011) studied perceptions of educational preparedness for nurses enrolled in a rural nurse residency program in the United States. Findings indicated a need to increase the exposure nursing students get to rural healthcare settings in order to apply crisis assessment skills. Keahey (2008) found that educational residency programs, created to orient nurses in rural settings, led to improved retention of nurses while increasing their knowledge, skills, and attitudes about nursing. Nursing students need to encounter rural nursing concepts and experiences in their programs, and nursing programs need to convey value and respect for rural nursing and encourage rural employment among future nurses (Kenny & Duckett, 2003).

Evidence from previous studies suggests that the curricula in nursing programs impact nurse's specific career choices. With a disproportionate emphasis being placed on the acute care setting, and the technical skills associated with such settings, nursing curricula may inadvertently discourage students from seeking careers caring for older adults (McCann, Clark, & Lu, 2010). Further, with nurses perceiving high-tech areas of nursing to be better for their careers as nurses (Stevens, 2011), career options in rural areas are viewed as less desirable. The emphasis in the curricula on acute care, high-tech areas is at the expense of more foundational subjects such as mental health nursing and long term care contexts for older people (Gouthro, 2009; Stevens, 2011). Ultimately, this curricular emphasis negatively impacts the recruitment and retention of nurses in rural healthcare settings, as well as other healthcare settings. Furthermore, the focus of healthcare is changing in the United States. With more emphasis on community and population based care, along with measures to control healthcare costs, care for patients is being shifted away from hospital-based care. Yet, nursing education still emphasizes clinical educational experiences within hospital-based care settings (Robert Wood Johnson Foundation [RWJF],

2014). If they are not currently doing so, educators need to strive to change the education of nurses to close the gap between the historical focus on clinical nurse education in acute care settings to meet the needs of the current healthcare landscape. This will not only better prepare nurses for current practice; it will remove the nursing curricular emphasis on acute care, high-tech clinical areas. Ultimately, perhaps the predominant desire of nurses to work in high-tech, specialized areas will diminish, making nursing positions in rural settings, such as long term care, more desirable.

The fears and concerns nurses experienced as they practiced rural nursing, or contemplated practicing in rural settings, demonstrated that they felt unprepared to care for family, friends, and neighbors in critical situations. Nurses may feel prepared for end of life care in general, but not prepared for the sudden death of a loved one under the nurse's care. In addition to that, the communications skills needed to talk to people in the community after such events was lacking, creating great anxiety when contemplating future public interactions with patients and/or their family members. The blurring of professional boundaries and the communication needs of nurses practicing in their rural, home communities need to be included in the curricula of nursing programs as they are portrayed in rural nursing contexts. The use of simulation has been found effective to address real-life situations (RWJF, 2014). O'Hagan et al. (2013) conducted a qualitative study that examined the ability of nurse educators to give feedback on the quality of nurse's communication skills while interacting with simulated patients. Findings revealed that nurse educators were able to address the nurse's approach, techniques of interactions and communications while caring for simulated patients. The fears and concerns of the nurses in the current study could be addressed through the utilization of rural simulations in nursing programs, simulating the nurse caring for a very ill rural community

member, including follow-up communications with family members in the rural community. The use of feedback on the quality of communication skills could be used to provide nursing students opportunities to prepare for communication skills that would be beneficial living and working as a nurse in a rural community. Simulation can also successfully be used outside of academic institutions. Nurses practicing in rural healthcare setting need continuing educational opportunities specific to their area of practice and populations served. Academic institutions and rural healthcare settings could collaborate to create rural simulation training experiences specific to needs identified by nurses in each rural healthcare facility. Such training opportunities could increase the confidence in skills needed to be an expert generalist nurse in a rural healthcare setting.

The role nursing programs play in preparing the rural nursing workforce is important, thus impacting the recruitment and retention of nurses to rural healthcare facilities. In a quantitative study correlating rural nurse recruitment with undergraduate education in Australia, Playford, Wheatland, and Larson (2010) revealed that rural nursing programs created a positive impact on recruiting nurses into rural settings. It was found that the nurses graduating from rural nursing schools were more likely to practice in a rural setting, feeling prepared to practice in rural settings. Thus, in order to meet the growing need for nurses in rural communities, schools of nursing should consider "satellite" programs located in rural communities in order to create opportunities to educate rural students in rural locations where they will then be more likely to stay after graduation.

Beyond the current nursing programs within academic settings in the United States, additional specific educational strategies for recruitment and retention of nurses in rural settings include economic assistance for nurses receiving and advancing their educations, early

introduction of young adults to nursing careers, and recruitment of underrepresented individuals (Frontier Education Center, 2004). New educational opportunities could enhance the development and advancement of nurses practicing in rural healthcare settings. The creation of certificate, or masters programs, focusing on rural nursing as a specialty would recognize the expert generalist nurse practicing in a rural setting. The American Nurses Credentialing Center (ANCC) offers certification programs for nurses, to provide evidence of a nurse's ability to demonstrate their expertise and knowledge. The ANCC currently offers 33 nurse certifications. "Colleagues and employers respect ANCC-certified nurses as experts in their specialties" (ANCC, 2017, para. 1). Advocating to get the ANCC to offer a certification in rural nursing would help nurses working in rural healthcare settings get recognition for their specialized knowledge that they desire and deserve.

Recommendations for Research

Further research is needed to expand the understanding of the experiences of nurses *"commuting away"* to apply the findings from this study to practice. Reviewing the aims of this study, we are now able to describe (a) the context of living in a rural community, experienced by RNs who commute away to a non-rural setting; (b) factors involved in the RNs' decisions to commute away to a non-rural setting; and (c) how *"commuting away"* from a rural community affects the personal and professional lives of RNs who experience it. We need to use this knowledge to develop recruitment and retention strategies that will benefit nursing practice, policy development, employers of nurses in rural settings, and nursing education. Furthermore, the understanding of the experiences of nurses *"commuting away"* can be used as a foundation for future research.

The inception of the current study started with a notable gap in the literature regarding causes of nurses' commuter trends in rural settings. Using the NSSRN data, Skillman et al. (2012) reported the percentage of RNs commuting away from their rural, home communities had increased from 14% in 1980 to 37% in 2004, and the percentage of RNs commuting was greater than 60% in isolated small rural communities (Skillman et al., 2012). The calculations of current and future commuter trends, once found by utilizing NSSRN data, is no longer available because of the discontinuation of the collection of NSSRN data in its traditional format as of 2012 (Auerbach, Staiger, Muench, & Buerhaus, 2012). Even though the current study added greater understanding to the experiences of nurses commuting away, knowing the current commuter trends, as well as the projected commuter trend would be beneficial for rural healthcare facilities as they plan recruitment and retention strategies for the anticipated nursing shortage. Further research regarding commuter trends of nursing living in rural communities would provide this valuable data.

Findings from the current study detailed nurses' appreciation of the time spent commuting in order to decompress and reflect. Even though the opportunity for nurses to reflect while commuting may have provided a benefit to their psychological health, it also posed a risk to their safety, of which they were not even aware. With no research available correlating the association of motor vehicle accidents with nurses who commute, future research needs to be done to shed light on the safety concerns for these nurses. Additionally, one nurse shared feeling concerned about decreased mental alertness continuing into the work environment at the beginning of the work shift, after commuting. Even though no evidence was found in the literature about decreased mental alertness of nurses who commute, this is an important consideration for nurses, employers, and the people they serve. Future research would be

beneficial to determine if commuting increases medical errors, or compromises patient safety or quality of care.

Social capital has been recognized as important to nurses, creating social networks within small communities. Research findings have revealed that nurses depend on their community's social networks, personally and professionally (Government of Canada: Policy Research Initiative, 2005). Additional studies by Kulig et al. (2009) and Betkus and Macleod (2004) found a sense of belonging to a community enhanced not only the nurse's social well-being, but also the satisfaction with their jobs. For some nurses in the current study, there was an appreciation of the rural community's social networks, and a sense of loss, as they felt less connected to their rural, home community while commuting. However, for other nurses, over time, they appreciated feeling less connected to their rural, home communities when they commuted away from them. More research needs to be done to understand the experiences of these nurses. If the lack of anonymity in the rural community has led to the nurses desire to be less connected to their rural communities, perhaps interventions could be created to diminish negative experiences nurses have with their visibility in their rural communities. Perhaps this could lead to increased retention of nurses in rural healthcare settings, which could be evaluated through research.

As recruitment and retention strategies are created and initiated, it is known that job satisfaction is an important consideration for employers of nurses. Many studies have been conducted, focusing on job satisfaction in general, with limited research found specifically addressing job satisfaction for nurses practicing in rural settings. Understanding satisfaction and motivation of nurses, along with dissatisfaction, is essential to the creation of recruitment and retention strategies of employers of nurses in rural healthcare facilities. Following Herzberg's

Motivation-Hygiene Theory, employers of nurses in rural healthcare settings need to tap into both intrinsic and extrinsic factors that drive nurses employment decisions. Further research is needed to understand both hygiene factors that lead nurses to dissatisfaction and motivating factors, such as personal growth, advancement, achievement, and respect that lead to long-term effects on the retention of nurses in rural healthcare settings. It is essential for employers to create a balance of intrinsic and extrinsic factors for the nurse to be motivated and satisfied, while also preventing job dissatisfaction. An assessment tool, based on the understandings of what motivates and dissatisfies nurses living and practicing in rural areas, needs to be developed to assist in recruitment of nurses to rural healthcare facilities, as well as retaining nurses employed at rural healthcare facilities.

Even though the findings from the current study are not generalizable to all nurses living in rural communities, nurses and employers of nurses in rural settings may find the essence of commuting away, *Commuting to Achieve Personal and Professional Goals While Being a Nurse in a Rural Community,* transferable to their own lives and experiences. Additionally, while this study was limited to rural nurses, the themes and subthemes may apply to experiences of other professionals in rural communities, such as physicians, teachers, social workers, and pharmacists. Employers of such professionals may benefit by using the findings from this study to create applicable recruitment and retention strategies.

The study sample provided for rich variations in residential and professional experiences, with the demographic characteristics of the sample reported with clearly detailed descriptions in Chapter IV. The essence, and its constituents, was described in detail, with support from the literature interwoven into the discussion of findings. Sufficient context and direct quotations from the nurses were included in the presentation of results in order for the reader to assess

transferability to other settings and contexts. In the end, the reader is ultimately responsible for transferability of the study results (Lincoln & Guba, 2000).

Summary of Recommendations

In summary, many interventions may be created to recruit and retain nurses in rural healthcare settings. The following bullet points summarize key points from the previously discussed recommendations, in no specific order.

- Acknowledge and advocate for the valuable role of the rural nurse generalist while enhancing the rural community member's respect and trust for the profession

- Assess the values, needs, goals, desires, and comfort levels of potential nurse candidates, and new/currently employed nurses, tailoring resources on an individual basis for nurses practicing in rural settings, including, but not limited to:

  o ingenious staffing patterns

  o interventions to achieve healthy work/life balance, including the formation of dedication to the workplace while preventing overriding feelings of obligation

  o peer support systems

- Conduct research to:

  o Articulate current commuter trends of nurses living in rural areas, similar to what has been done in the past with the NSSRN

  o Determine if there is a correlation between motor vehicle accidents and nurses who commute

  o Determine the concerns and needs of nurses at rural healthcare settings regarding safety policies and procedures

- Create opportunities for individual nurses to have specialized knowledge and develop areas of expertise within rural healthcare settings

- Create or maintain employer collaborations with rural community members to enhance connections to the rural community, for nurses who desire such connections

- Create recruitment and retention strategies that not only address dissatisfiers such as financial incentives, but motivators and satisfiers as well

- Create partnerships between education and rural practice to address:
  - nursing student experiences in rural settings
  - rural nursing refresher courses to assist nurses to transition back to the rural nurse generalist role
  - the education of students, and practicing nurses, regarding strategies addressing the blurring of personal and professional boundaries for nurses in rural settings

- Increase awareness of potential safety hazards associated with mental wandering while commuting

- When recruiting, create accurate perceptions of resources available in rural healthcare settings such as telehealth, as well as available employee benefits

Study Limitations

The sample for this study was from a small geographic region working within a tristate, Midwest region, consisting of a small number of nurses lacking racial diversity, a commonality of the population in the rural areas of these three Midwestern states. This does create constraints on the generalizability to all nurses living in rural communities, however this is not considered a limitation of the study, as generalizability is not a goal of qualitative research. Nonetheless, it

needs to be understood that this is not always as well understood and accepted as quantitative research within the scientific community. Beyond that, other study limitations include the fact that the quality of this research was heavily dependent on my skills as a researcher, with results easily influenced by my personal biases. Also, my presence during interviews could have affected the nurse's responses to the interview questions. Thus, the importance of my phenomenological stance as a researcher was of utmost importance to the rigor of this study. Lastly, maintaining confidentiality and anonymity of the nurses was always a concern and consideration as findings were presented. Such considerations do enhance the development and advancement of nurses practicing in rural healthcare settings

Researcher Reflections

The research procedures outlined in Chapter III were followed for this descriptive, phenomenological study. Nurses were recruited primarily through Boards of Nursing using purposeful sampling, along with snowballing, to obtain a sample of nurses with rich variations in experiences. Upon receiving contact information for nurses in the initial qualifying communities included in the study, there were more potential nurses than I had expected. Thus, I thought I would easily be able to recruit an appropriate pool of nurses. However, unexpected challenges to finding rich variations in nurse's experiences were experienced in the recruitment process. I purposefully wanted to recruit a sample of nurses that would be able to speak to a wide variety of experiences, including those new to the profession as well as nurses commuting to small rural areas and urban areas. This created a need to expand recruitment beyond my initial contact communities to obtain these variations. In an effort to seek participants who were employed in urban healthcare settings in North Dakota, I found that the North Dakota Board of Nursing had changed their policies since my initial contact and were no longer sharing the contact

information of the licensed nurses. I was, however, able to contact nurses commuting to urban communities in North Dakota by using nearby qualifying communities in Minnesota. Strategically identifying the domain of the nurse's email addresses guided me to nurses practicing in urban healthcare settings in North Dakota.

I was also able to contact nurses who had only been in the profession for a couple a years, and nurses who commuted to small, rural areas, through snowballing, in order to further add variation in the sample. Snowballing is a specific, purposeful sampling technique used to find additional contacts for the study. One example of my use of snowballing involved the recruitment of a nurse to specifically add rich variation in years of experience as a nurse. As the study interviews were completed, I asked the nurses if they could assist with finding other nurses who may be eligible for my study. In one instance, I asked if the nurse knew of anyone eligible for my study who had only been a nurse for a few years. The nurse was able to identify an RN living in her community who met the eligibility criteria, who had only been a nurse for two years, and who did subsequently participate in the current study. Additionally, I specifically used the Minnesota Board of Nursing data to search for nurses original date of licensure, targeting nurses having received their licenses between two and four years ago. The result was a sample with rich variations in experiences, in terms of not only size of the community to which they commuted, but also years of experience, and areas of practice.

A form of communicating with prospective nurses needs more consideration for future studies. In this study, I asked the prospective nurses, in their invitation letter, for their preferred means of contact, via email or phone. For those requesting future contacts via email, I experienced challenges making contact, as I was not able to get a reply to all my emails. Whereas, I was always able to make contact when telephone was the preferred means of

communication. However, I do not want to risk decreasing the numbers of willing nurses in future studies, by deleting the use of emails. So more thought will need to go into this.

Throughout the study, I was pleasantly surprised at the efforts some nurses made to inform me that they were not eligible for my study. Nurses called, emailed, or mailed notes, informing me of their ineligibility. However, even though the nurses did not qualify, they voiced support for my research focus on nurses in rural settings, which was encouraging to me.

In this study, interviews were the primary means of collecting data, conducted in person with nurses who met the inclusion criteria. Interview sites were determined by the nurses to maximize the ability to create a comfortable environment for them. For a majority of the interviews, this worked well. However, I found that recording interviews in larger environments, such as coffee shops, led to a resonance in the digital recordings. Smaller, more confined spaces led to more clarity in the digital recordings. Unforeseen events also occurred. One example was when I had arranged for an interview to occur at a restaurant in a neighboring community of the nurse. Upon arrival, it was evident that the restaurant was closed due to recent fire damage. Thus, an alternative site needed to immediately be arranged.

Semi structured interviews were used, creating open dialogues between the nurses and myself. I was able to facilitate the nurses' ability to share their lived experiences of *"commuting away"* through the use of an interview guide, which kept the interview moving in the direction of the study aims. The use of planned questions, as well as spontaneous follow up questions, and probe questions was balanced by allowing the nurse to describe their own experiences in their own way. The end result was a data set with rich descriptions of the nurses' experiences.

In qualitative research, the researcher is the primary instrument in the data collection process. As the researcher, I presented myself to the nurses in a phenomenological stance,

creating an openness that freed myself from any pre-understandings of the phenomenon. Interviews were audiotaped, transcribed, and coded. During the process of verifying transcripts for accuracy, I was able to affirm my previous efforts to maintain a phenomenological stance during the interviews. I found myself surprised by how some of my own previous experiences were similar to the experiences nurses shared. These personal reflections had not occurred during the interview, but later as I was reviewed transcripts. I also found some of my opinions and biases surfacing as I reviewed the transcripts for accuracy, finding myself comparing my opinions with the opinions of the nurses. The reality was that these thoughts and similarities in experiences had not occurred to me while participating in the interviews of the nurses. I believe that this demonstrated my ability to maintain a phenomenological stance of openness during the interviews, blocking out my beliefs and biases about the phenomenon, while being in the moment with the nurses. Throughout the process of reviewing transcripts, I used my reflexive journal to assist in learning about myself throughout these experiences, in order to keep my own personal experiences and biases from influencing my analysis of the nurses' experiences. Thus, as I immersed myself in data analysis, I resumed my phenomenological stance as a researcher, being open to the experiences of the nurses in this study.

Following the data collection process, the subsequent analysis followed a tripartite structure, moving between the whole, to the parts, and back to the whole, to give meaning to the current study. As descriptions, meaning units, and clusters were identified, the words of the nurses were used, whenever possible, to code data. Also, when the essence and constituents were identified, and I assigned meaning to the themes and subthemes of the constituents, the words of the nurses were used whenever possible. Diagrams were developed to visualize the relationships of the essence, and its constituents. Field notes, created immediately after the

interviews, were reviewed as data was analyzed. Field notes and journaling were used throughout the study to identify my potential biases, attitudes, opinions, and experiences. Throughout the analysis process, multiple meetings were held between my advisor and me to discuss my findings. During those dialogues, attention was given to the possible introduction of personal biases into the analysis. In the end of the analysis phase, an audit trail was created through my reflexive journaling, field notes, transcript reviews, analysis notes, diagrams, and continued consultation with my advisor.

Throughout the data collection process, nurses appeared to appreciate the opportunity to share their experiences. Many nurses conveyed their enjoyment of our time together. Several nurses divulged that they welcomed the opportunity to finally tell their story. The chance to tell their stories was long awaited by some, as they had always believed there was no one else they could share their stories with. Nurses had not believed that they could disclose all of their experiences with others.

> I certainly have never told this story before, never pieced it all together, or never really gave a thought to how my life would have been different had I not made the choices that I did. So I think maybe I'm at a stage in my life now of retrospection and wanting just to evaluate better and notice how everything matters. That's one of the truths that I've learned, that everything matters, and at the same time, nothing really matters, at the exact same time.

As I prepared the nurses for the interview process, I mailed a pre-interview letter explaining the primary questions that would be asked during the interview (see Appendix C). Subsequently, several nurses had notes prepared for the interview. This caused me to reflect on the use of the pre-interview letter to prepare the nurses for the interview. It may have been that the pre-interview letter altered the reflective process for the nurses. On the other hand, at the end of an interview with one of the nurses who had prepared notes, the nurse stated:

That's what I know. That's what I wrote down in my notes. I'm surprised that your questions are so hard for me to answer. I'm hemming and hawing and trying to be truthful, but I really don't have strong feelings one way or the other.

Thus, if I had not given the nurse a pre-interview letter, she may have had an even harder time answering the questions without preparation time. More thought will need to go into the pros and cons of the pre-interview letter in future studies.

During the data collection process, I appreciated the time spent with the nurses. I would leave the interview and reflect on their experiences. My emotions would vary from sadness to surprise, to joy, and to pride as I came to understand the nurse's experiences. I would also reflect more on my own experiences, and journal my thoughts and feelings as I continued to create and maintain my open stance as a researcher. In my reflections, I would wonder how people would perceive the findings of the study. Would readers find some of the understandings from the current study surprising when they were not surprising to me? Or vice versa, am I surprised about findings in the study that no one else would be surprised by? I would feel pride as a nurse shared that a woman in labor showed up on her doorstep with delivery imminent. I would feel sad as the nurse shared the hug they gave their neighbor and friend when an event caused a negative outcome for their family. I was surprised to hear nurses share that they did not know if they could perform the skills needed to return to rural healthcare settings and practice nursing. These feelings of surprise made me sad, as I realized that I have not given enough credit, where credit is due, for the importance of the skills possessed by nurses practicing in rural healthcare settings. I would also smile as I reflected on some of the experiences; an example is a nurse sharing his/her history working in a small, rural healthcare setting many years ago. In that setting several years ago, part of the emergency preparedness plan was to have nurses sound the city alarms when they needed to call in extra help to the hospital for a crisis. This alerted not

only the nurses in the town but all community members that there was a crisis situation at the local healthcare facility. This certainly would be a HIPPA violation today!

As I proceeded throughout this study, I noticed how hard it was to put aside all of my previous experiences and preunderstandings to create a phenomenological stance as a researcher. Yet, by reflecting on the nurse's experiences, as well as my own, I was able to create openness to understanding their experiences of *"commuting away."* I have to admit this was harder than I expected, but was very rewarding. I look forward to seeing how transferable the findings from this study will be in the future, and which contexts it is found most applicable.

Conclusion

The purpose of this study was to describe the phenomenon of *"commuting away,"* as experienced by RNs living in rural communities. This study went beyond the previous assumption in the extant literature that wages are one of the primary factors leading to commuter trends, in order to discover all aspects of the phenomenon and the meaning it has for those nurses who live it. The findings from this study indicated that the nurse's decisions to commute were complex and multifaceted. This new knowledge creates an understanding that future RN recruitment and retention strategies need to be individualized, in order to meet the needs of nurses practicing in rural settings. Highlighting the importance and significance of rural nurse, while creating appropriate recruitment and retention interventions, will lead to improvements in the distribution of nurses into rural areas. Such interventions can reduce or eliminate the scarcity and misdistribution of RNs in the rural United States, with the goal to achieve health equity for everyone in the United States through the access of comprehensive, quality healthcare.

APPENDICES

Appendix A
Participant Letter of Invitation and Reply Form

Laurie Johansen
2595 140th Street
Tyler, MN 56178

Address

Date

Dear

You are invited to participate in an important nursing research study designed to determine the experiences of Registered Nurses (RNs) living in rural, home communities who commute to a non-rural community for employment. The study is being conducted by myself, Laurie Johansen, PhD Candidate at the University of North Dakota, College of Nursing & Professional Disciplines. You are being invited to participate in this study because, according to the Board of Nursing licensure data, you are an RN who lives in a rural community, and your experiences are important to be understood.

We currently know very little about the experiences of rural nurses who commute away for employment. It is hoped that by learning from rural nurses, we might better develop recruitment and retention strategies in rural communities. If you are an RN who is living in a rural community (less than 2,500 people) and you are commuting away to an employer in a community larger than 2,500 people, I would be very interested in having you participate in my study.

If you chose to participate in the study, you will be asked to participate in a 60-90 minute interview, in which I will ask you to share your experiences as an RN living in a rural community while commuting away for employment. The location and time of the interview will be arranged between us at a location that is most convenient for you, as long as privacy can be assured. All participants will participate in one interview, and I may ask some to do additional follow-up interviews as well.

If you are interested in participating in this study, please return the enclosed form or reply via email at laurie.johansen@my.und.edu. I will then contact you to discuss the study further and, if you are eligible, set up a time and location for the interview.

Please feel free to get in touch with me at the contact information below if you have any questions. I hope that you will join other rural nurses in participating in this important study!

Sincerely,

Laurie Johansen, PhD Candidate
University of North Dakota, College of Nursing & Professional Disciplines
Principle Investigator
Laurie.johansen@my.und.edu
507-829-8852

Laurie Johansen
2595 140th Street
Tyler, MN 56178

Yes, I am interested in participating in your study!

Name:

Email: _____

Phone: _____

I prefer to be contacted by (circle one):   Phone   Email

Please place this form in the self-addressed, stamped envelope and place it in the mail. I will contact you soon! Thank you very much for your interest in participating in this important nursing study!

Laurie Johansen, PhD Candidate
University of North Dakota, College of Nursing & Professional Disciplines
Principle Investigator
Laurie.johansen@my.und.edu
507-829-8852

**Commuting Away: The Experiences of RNs Who Live in Rural Communities and
Commute Away for Employment in Non-rural Communities
Screening Tool**

1. Name: _____

*2. Currently licensed as RN? _____ State(s)? _____

3. Length of time as RN? _____

4. Education: ADN_____ BSN_____

*5. Residential community (< 2,500) that has Critical Access Hospital?

   _____

6. Length of time as a member of this community? _____

7. Length of time as a member in any other rural communities?

   _____

*8. Currently commuting away from home community for employment to a non-rural setting?

   Yes_____ No _____

9. Employer_____

   Unit you work on _____

10. Commuting history:

    a) practiced nursing in a rural community in the past but now commute away? _____

    b) have always commuted away from rural community for employment? _____

    c) commute away to a Critical Access Hospital? _____

    d) commute away to a non-Critical Access Hospital or other healthcare facility? _____

    e) commute away to a small rural area (2,500 – 9.999 residents)? _____

    f) commute away to a large rural area (10,000 – 49,999 residents)? _____

    g) commute away to an urban area (>49,999 residents)? _____
       *inclusion criteria for eligibility to participate

Appendix C
Pre-Interview Letter to Participants

(Date)

Dear (participant),

Thank you for your willingness to participate in my research study, entitled "Commuting Away: The Experiences of RNs who live in Rural Communities and Commute Away for Employment in Non-rural Communities." As previously arranged, we have scheduled your interview on (date) at (time). As we discussed, the interview will be conducted at (location).

I am looking forward to conducting the interview with you. I anticipate that this interview will take between one to two hours. In order to help you feel prepared for the interview, I want to provide you with the main questions that I will be asking you. These include:
- Tell me about your experiences as an RN living in a rural community.
- Tell me about your decision to commute away from your rural community to work.
- Tell me about an experience you have had since you started commuting away from your work that has had an effect on your personal life.
- Tell me about a different experience you had that affected your professional life.
- Tell me about a situation where your personal and professional lives have overlapped.

As you respond to these questions, I will also likely have other questions that I will follow up with, in order to make sure that I have a clear understanding of your experiences. In addition, it will be most helpful if you can provide me with specific examples that you experienced in relation to these main questions.

At this point, I anticipate conducting one interview with you. However, I may decide that it would be helpful to conduct a follow-up interview or two, and I can discuss this with you after the first interview is completed.

If you have any questions about the interview, or if you should need to reschedule it for any reason, please contact me at laurie.johansen@my.und.edu or at 507-829-8852.

Sincerely,

Laurie Johansen, PhD Candidate
University of North Dakota, College of Nursing & Professional Disciplines
Principle Investigator
Laurie.johansen@my.und.edu
507-829-8852

Appendix D
Demographic Questionnaire

Commuting Away: The Experiences of RNs Who Live in Rural Communities and Commute Away for Employment in Non-Rural Communities

Demographic Questionnaire

Note: This information will only be used to describe the sample of study participants as a whole. Your individual name or information about you as an individual will not be included in any reports that result from the study. You may skip any questions you prefer not to answer.

1. Name: _____

2. Telephone: _____

3. Email Address: _____

4. What is your age?_____What is your gender? _____

5. What is your race/ethnicity (check all that apply)?
   Caucasian_____
   Black_____
   Native American/Alaskan Native_____
   Hispanic_____
   Asian_____
   Other_____

6. What is your highest nursing degree completed?
   Associate Degree_____
   Diploma_____
   Baccalaureate Degree_____
   Masters Degree in Nursing_____
   Masters Degree in another field_____ Degree_____
   Doctorate of Nursing Practice (DNP)_____
   PhD in Nursing_____
   Other_____

7. How many years have you been a registered nurse? _____

8. How many hours per week are you employed as a registered nurse? _____

9. What unit do you work on at your place of employment? _____

10. What is your primary role within the unit at your place of employment? _____

11. How many years have you been a member of your current rural (<2,500) community? _____

12. How many years have you been a member of another rural (<2,500) community? _____

13. Have you practiced nursing in a rural community (<2,500) in the past but now commute away to a larger community? _____

14. Have you always commuted away from a rural community (<2,500) for employment? _____

15. Do you commute away to a Critical Access Hospital? _____

16. Do you commute away to a non-Critical Access Hospital or other healthcare facility? _____

17. Do you commute away to a small rural area (2,500 – 9.999 residents)? _____

18. Do you commute away to a large rural area (10,000 – 49,999 residents)? _____

19. Do you commute away to an urban rural area (>49,999 residents)? _____

20. How many years have you commuted away from your home community for employment to a

    non-rural setting? _____

Appendix E
Interview Guide

Interview Guide

Study Aim	Core Questions/Statements	Follow-up Questions/Statements
Describe the context of living in a rural community, experienced by RNs who commute away.	Tell me about your experiences as an RN living in a rural community.	- Describe your history as someone living in a rural community. - Describe some experiences as an RN living in a rural community that are positive. - Describe some experiences as an RN living in a rural community that are negative. - Tell me how you, as a nurse, are viewed in your home community. Can you give me an example of this?
Describe factors involved in the RNs' decisions to commute away to an urban setting.	Tell me about your decision to commute away from your rural community for work.	- Describe what led up to your decision to commute away. - Were there factors related to your professional life that you considered? - Were there factors related to your personal life that you considered? - Were their family factors that were a consideration? - Were there factors from within your home community itself that led to your decision? - Were there factors from outside your home community that led to your decision?
Describe how commuting away effects the personal and professional lives of rural nurses who experience it	Tell me about an experience you have had since you started commuting away for your work that has had an effect on your personal life.	Tell me about some of the benefits that commuting away for work has had for your personal life. Can you give me an example of this? Tell me about some of the challenges that commuting for work has had for your personal life. Can you give me an example of this?

	Tell me about a different experience you had that affected your professional life.	• Tell me about some of the benefits that commuting away for work has had for your professional life. Can you give me an example of this? • Tell me about some of the challenges that commuting away for work has had for your professional life. Can you give me an example of this?
	Tell me about a situation where your personal and professional lives have overlapped.	
	Concluding questions:	• What else would you like to tell me? • Tell me about what motivated you to join this study. • Of all the things that we've talked about today, what do you think is the most important for me to understand?

Appendix F
Participant Consent

THE UNIVERSITY OF NORTH DAKOTA
CONSENT TO PARTICIPATE IN RESEARCH

TITLE:	**Commuting Away: The Experiences of RNs Who Live in Rural Communities and Commute Away for Employment in Non-Rural Communities**
PROJECT DIRECTOR:	**Laurie Johansen, PhD Candidate**
PHONE #	**507-829-8852**
DEPARTMENT:	**College of Nursing & Professional Disciplines**

STATEMENT OF RESEARCH

A person who is to participate in the research must give his or her informed consent to such participation. This consent must be based on an understanding of the nature and risks of the research. This document provides information that is important for this understanding. Research projects include only subjects who choose to take part. Please take your time in making your decision as to whether to participate. If you have questions at any time, please ask.

WHAT IS THE PURPOSE OF THIS STUDY?

You are invited to be in a research study about the experiences of registered nurses living in rural, home communities because the Board of Nursing has identified you as a currently licensed RN living in a rural community.

The purpose of this research study is to describe and better understand the experiences of rural nurses. The researcher is specifically interested in hearing about (a) your experiences of living in a rural community as an registered nurse who commuted away for employment; (b) factors involved in your decision to commute away for employment to a non-rural setting; and (c) how the experiences of commuting away for employment affects your personal and professional life. This study utilizes qualitative research using interviewing to inquire about your experiences. Your experiences are the information of value. There are no right or wrong answers. The researcher is attempting to understand the meaning that you place on experiences and so does not expect particular answers to the interview questions.

HOW MANY PEOPLE WILL PARTICIPATE?

Approximately fifteen to twenty people will take part in this study at the University of North Dakota. Participants will not be expected to participate while on the University of North Dakota campus, but will be offered a convenient interview location.

HOW LONG WILL I BE IN THIS STUDY?

Your participation in the study will last six months. You will need to meet with the researcher at a convenient time and location once, with a possibility of one to two additional interviews. Each visit will take approximately ninety minutes to two hours.

WHAT WILL HAPPEN DURING THIS STUDY?
If you decide to participate, you will be asked to complete a questionnaire that asks for contact information, age, gender, race/ethnicity, education background, years of practice as a registered nurse, current employment, and years you have commuted away for employment. It will take about 5 minutes to compete this form. You will be free to skip any questions of the questionnaire that you prefer not to answer. You will then participate in an interview in which you will be asked to share your experience as a registered nurse living in a rural community while commuting away for employment. You can expect the interview to last approximately 60-90 minutes. During the interview, you are free to discuss experiences and answer question to the extent that you feel comfortable to do so. You may choose to not answer any question that you are not comfortable with. The interview will be audiorecorded and will be transcribed into a written text. You may be asked for an additional one or two interviews following completion of the initial interview.

WHAT ARE THE RISKS OF THE STUDY?

There are no foreseeable risks to participating in this study.

WHAT ARE THE BENEFITS OF THIS STUDY?

You may not benefit personally from being in this study. A potential benefit is that you may experience a reflective process during the interviews which could contribute to your own understanding of your experiences. However, we hope that, in the future, other people might benefit from this study because the knowledge gained could impact rural nurses and the people they serve, leading to future considerations in recruiting and retaining registered nurses in rural healthcare settings as well as diminished disparities in rural healthcare through adequate healthcare service and professionals.

ALTERNATIVES TO PARTICIPATING IN THIS STUDY

If you chose to participate in this study, you would be free to discontinue participation at any time, without that decision being held against you.

WILL IT COST ME ANYTHING TO BE IN THIS STUDY?

You will have minimal costs for being in this research study. You will be responsible for any travel/parking costs to the interview location of your convenience.

WILL I BE PAID FOR PARTICIPATING?

You will not be paid for being in this research study.

WHO IS FUNDING THE STUDY?

The University of North Dakota and the researcher are receiving no payments from other agencies, organizations, or companies to conduct this research study.

CONFIDENTIALITY

The records of this study will be kept private to the extent permitted by law. In any report about this study that might be published, you will not be identified. Your study record may be reviewed by Government agencies, the University of North Dakota Research Development and Compliance office, and the University of North Dakota Institutional Review Board.

Any information that is obtained in this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law. You should know, however, that there are some circumstances in which we may have to show your information to other people. For example, the law may require us to show your information to a court or to tell authorities if we believe you have abused a child, or you pose a danger to yourself or someone else. Confidentiality will be maintained by means of assigning you an identification number that will be used to mark your interview transcript so that all information is confidential. According to UND's protocol, the data and this consent form will be kept in a separate locked file for at least three years following this study, at which time they will be destroyed. Only the researcher and people who audit Institutional Review Board procedures will have access to the data

If we write a report or article about this study, we will describe the study results in a summarized manner so that you cannot be identified.

The interviews will be audiorecorded and will be transcribed into a written text. Upon request of the researcher, you may receive a copy of the findings of this study. Computer storage of recordings and will occur on a password protected computer with researcher access only. Recordings will be removed from the computer storage system once the transcripts have been verified.

IS THIS STUDY VOLUNTARY?

Your participation is voluntary. You may choose not to participate or you may discontinue your participation at any time without penalty or loss of benefits to which you are otherwise entitled. Your decision whether or not to participate will not affect your current or future relations with the University of North Dakota.

CONTACTS AND QUESTIONS?

The researcher conducting this study is Laurie Johansen, PhD Candidate. You may ask any questions you have now. If you later have questions, concerns, or complaints about the research please contact Laurie Johansen at 507-829-8852. You may also contact Laurie Johansen's advisor, Dr. Tracy Evanson, at 701-777-4559.

If you have questions regarding your rights as a research subject, you may contact the University of North Dakota Institutional Review Board at (701) 777-4279.

- You may also call this number about any problems, complaints, or concerns you have about this research study.
- You may also call this number if you cannot reach research staff, or you wish to talk with someone who is independent of the research team.
- General information about being a research subject can be found by clicking "Information for Research Participants" on the web site: http://und.edu/research/resources/human-subjects/research-participants.cfm

I give consent to be audiotaped during this study.

Please initial: _____ Yes _____ No

I give consent for my quotes to be used in the research; however I will not be identified.

Please initial: _____ Yes _____ No

Your signature indicates that this research study has been explained to you, that your questions have been answered, and that you agree to take part in this study. You will receive a copy of this form.

Subjects Name: _____

_____   _____
Signature of Subject   Date

I have discussed the above points with the subject or, where appropriate, with the subject's legally authorized representative.

_____   _____
Signature of Person Who Obtained Consent   Date

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