

Rural Nursing and Synergy

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Abstract

Purpose: The purpose of this writing is to evaluate the utility of the Synergy Model for Patient Care as a theoretical foundation for rural nursing practice.

Process: An analysis of the four major concepts of the metaparadigm was completed to evidence the applicability of the Synergy Model to rural nursing practice. The use of case study examples demonstrates the congruence between the Synergy Model, Rural Theory, and rural nursing practice.

Findings: The Synergy Model can be expanded beyond critical care and applied to rural nursing practice. Evidence-based practice supports the utility of the Synergy Model for application within rural environments and populations.

Keywords: Rural nursing, Rural Nursing Theory, Synergy Model, Synergy

Rural Nursing and Synergy

The Synergy Model for Patient Care (SM) provides the ideal theoretical foundation for nursing care delivery in rural healthcare settings (American Association of Critical Care Nurses [AACN], n.d.). The basic tenants of the SM complement the rural nursing theory and constructs of rural nursing as outlined in *Rural Nursing: Concepts, Theory, and Practice* (Lee, Winters, Boland, Raph, & Buehler, 2013) and allow clinical nurses the ability to meet the needs of patients from the time of conception to end-of-life. The SM is applicable to current nursing practice, and it is currently being utilized as a framework for professional nursing. Working in congruence with rural nursing constructs, SM illustrates the true value of patient-centered care and the achievement of optimal health status. This paper will further investigate the SM, and introduce the model's utility in rural nursing practice.

Analysis of the Theory

The AACN's model (n.d.) provides a rich foundation that can be utilized in rural nursing and can be adapted to work in congruence with the outlined rural nursing constructs (Lee et al., 2013). The SM recognizes the uniqueness every patient and family unit while still acknowledging the common needs that patients and families experience along the continuum of health and illness. Matching nurse competencies to patient needs on a model that allows for the integration of specific patient needs demonstrates versatility. According to Kaplow (2002); "since the implementation of the SM, numerous exemplars have been published illustrating its incorporation into clinical practice." (p.77). There are eight characteristics embedded into the SM, and they allow for numerous nursing competencies to be incorporated into daily nursing

practice. This assemblage of nurse attributes includes: clinical judgment, clinical inquiry (innovator/evaluator), facilitation of learning, collaboration, systems thinking, advocacy and moral agency, caring practices, and response to diversity. There are eight patient attributes identified within the theory which are resiliency, vulnerability, stability, complexity, resource availability, participation in care, participation in decision-making, and predictability (Hardin & Kaplow, 2005). Synergy occurs when the institutional needs, nurses' competencies and the patient needs are in harmony. Optimal patient care outcomes are the cumulative result of the nurse and patient's coordinated efforts within the framework of the institution.

The SM can be expanded beyond the acute care setting. Collins and Strother (2008) stated that unswerving preparation and substantiation of nurses "in key behaviors improve the assessment and recognition of complications and prompt interventions regardless of the location of the patient" (p. E7). The improvement of assessment and clinical inquiry skills for rural nurses will likely maximize the patient care outcomes for patients with emergent care needs in rural areas.

Nurse competencies vary greatly over the present continuum of care within the United States resulting in many variables to be considered. The SM offers a simplistic method to measure and assign nursing competencies and optimize patient care while addressing the unique needs of each patient care experience. The model offers a novice to an expert level for each nurse characteristic (Hardin & Kaplow, 2005). Aligning nurse characteristics to patient care needs creates a mode for unlimited usage of this model, as well as optimal patient-centered care regardless of the patient's location or level of vulnerability.

The four major concepts of the nursing metaparadigm described within the SM allow for its application to nursing care delivery in all patient care settings. The concepts of human beings, environment, health, and nursing are identified as the major concepts for providing humanistic care (Fawcett & DeSanto-Madeya, 2013). Human beings are defined as the recipients of care or the patients, and they are continually changing, holistic systems. Mind, body, and spirit are all included in the human experience (Hardin & Kaplow, 2005). The SM allows for a holistic view of the patient with its eight intertwined patient needs. For example, resource availability can be related to the isolation of a rural patient in regards to the accessibility of nurses with advanced clinical inquiry skills, the predictability of their physical, mental, and emotional needs, and the patient's ability to actively engage in decision making. It is also incorporated into nurse competencies. The systems thinking competency identifies environmental factors. The environment as defined by the SM embraces the patient, family, and community (AACN, n.d.). The meaning of health within the SM is what the patient decides it is. This model preserves the patient in the center of care, allowing patient needs to drive health care delivery. Three levels of outcomes are described: patient-level, unit-level, and system-level. This allows the patient to remain as the center of the continuum and actively participate in their own care. The needs or characteristics of the patients and their families continually influence and drive the characteristics of nursing interventions. The SM allows the patient to be a holistic 'being', with their own ideas and concerns, instead of a human 'doing', that is required to conform to someone else's preconceived notion of their health status. As defined by the SM, "A goal of nursing is to restore a patient to an optimal level of wellness as defined by the patient. Death can be an

acceptable outcome, in which the goal of nursing care is to move a patient toward a peaceful death” (AACN, n.d.).

The fourth major concept of the metaparadigm is nursing. Nursing is defined as “the nursing actions or processes that are beneficial to human beings” (Fawcett & DeSanto-Madeya, 2013, p. 6). The nurse competencies listed in the SM define the nurse’s role and actions within the framework of the nurse’s environment, scope of practice, and expertise. Listing the nurse’s competence from advanced beginner to expert in each category creates a medium to streamline optimal care by evaluating the nurse’s eight competencies and identifying areas that may be deficient (Kaplow, 2002). The SM, while supporting the patient, allows for the identification of nurse competency development in differing professional environments.

Application to Current Practice

There is a growing body of knowledge related to the application of the SM as a foundation for nursing practice (Kaplow, 2002). In critical care, acute care, and progressive care settings, The SM is providing a foundation for relationships and patient-centered care. The model is applicable in current nursing practice as evidenced by its adoption as nursing model by magnet hospitals like Baylor (2005), and University of Alabama at Birmingham (UAB) Hospital. The model has also been used to identify needed reform in the educational components of hospital competencies. Collins and Strother (2008), stated that within the SM, “a clinical nurse specialist (CNS) and nurse educator intervene on the individual patient-family level, the nurse to nurse level, and systems level to improve outcomes in the critical care setting”(p. E1). The model centers on the patient and their needs as the focal point of care.

Academic institutions are utilizing synergy to improve student outcomes. Applying the SM to identify the student as the patient within the model, colleges like Duquesne University, Pittsburg, PA have adopted it as their basic framework for the education of nursing students. This unique application of the SM emphasizes its flexibility and utility as a foundation for both nursing practice and education. By creating synergy between the university, educators and student, rather than the hospital, patient and the nurse, this model was easily adjusted (Duquesne University, 2008). Collins and Strother (2008), educators at UAB hospital identified a need and developed a competency assessment tool that highlights an example of the versatility of the model. The SM creates an environment that allows for assessment of the patient and the nurse; it defines the relationship in such a dynamic manner that it can be utilized universally in all types of patient care settings.

Congruence with Rural Nursing Constructs

The SM acknowledges that all patients have similar needs and experience these needs across varied continuums from health to illness (AACN, n.d.). Working in congruence with a developing Rural Nursing theory presently defined by constructs of rural nursing practice (Long & Weinert, 1989), the SM illustrates the impact that nursing care can have on the continuum of health to illness. These statements highlight the rural nursing theory and correlate within the framework of the SM.

The definition of health that is often used to express the lived experience of rural residents is directly related to individuals and their ability to be productive members of their communities (Lee et al., 2013). Rural residents achieve health when they have found a balance in every area of their individual lives. Older rural residents are more likely to define health in ways that relate

directly to their capacity to work, be useful and complete typical responsibilities (Shreffler-Grant, Nichols, Weinert & Ide, 2013). Rural patients typically view health in the context of functioning, particularly within rural areas with extractive industries. The SM acknowledges that human beings possess differing views of health.

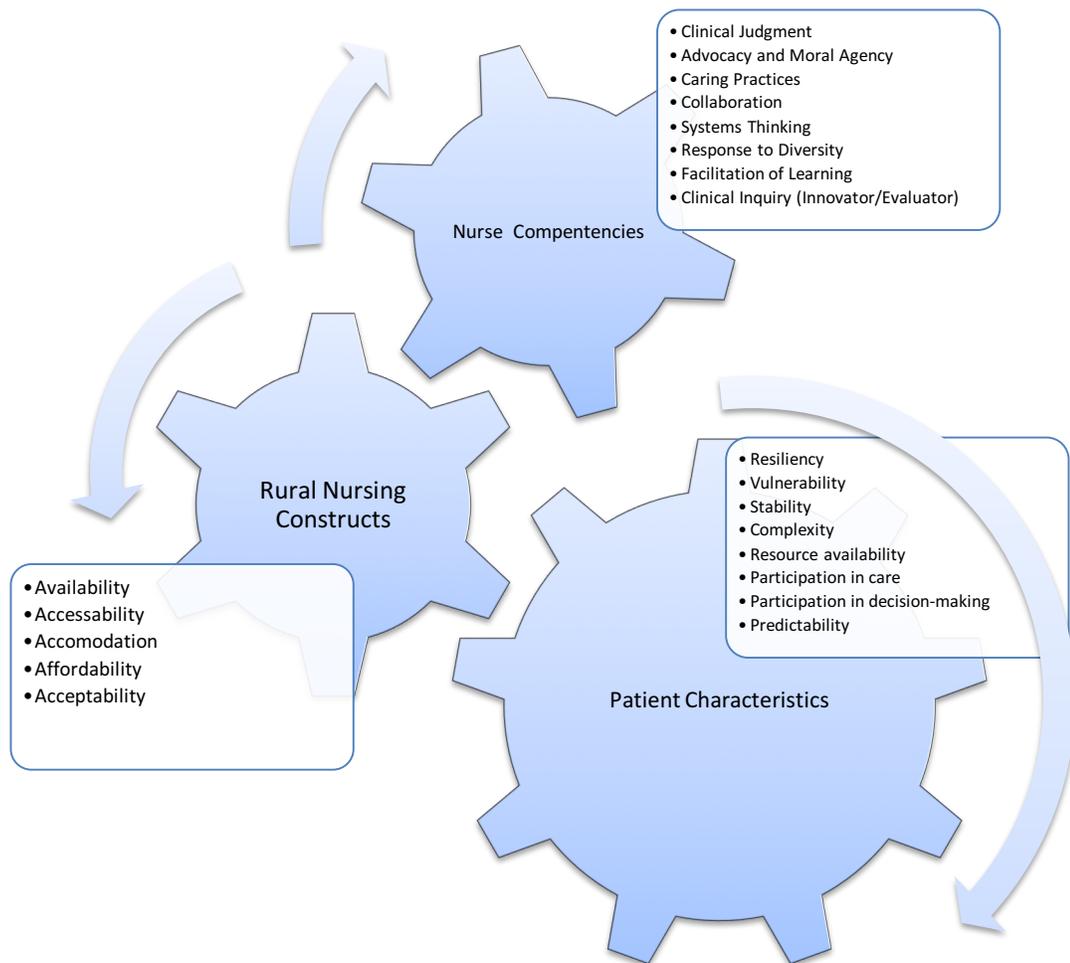


Figure 1

Rural Nursing Constructs, Patient Characteristics, and Nurse Competencies.

Incorporation of the prominent view of health in rural populations and the goal of nursing within the SM to “restore a patient to an optimal level of wellness as defined by the patient” (AACN, n.d., p. 1) would foster rural cultural beliefs about health with focus on the goal of remaining functional. In a case study conducted by Bales, Winters, and Lee (2013) included in the book entitled *Rural Nursing* (Winters, 2013), six major themes emerged from the data: (a) self-reliance, (b) hardiness, conscientious consumer, informed risk, community support, and inadequate insurance. This qualitative, descriptive study was informed by a primarily female sample (n = 5) and one male. Ages ranged from 37-76 years of age. The participants included newcomers and old-timers having lived in the Montana community between 3-30 years. Globally the residents tried to engage in self-care behaviors (prior to seeking medical care), but there was a varied degree of self-reliance notably based on length of time within the community. A married couple participating in the study had only lived in the rural community for a brief period after retiring. They admittedly accessed formal health care more quickly than longtime residents and factors influencing their self-reliance included quality health care, easy access health care prior to moving to Montana City and the diagnosis of a chronic health condition. Another example within this case study involved that of a woman planning a non-emergent surgery to allow safer, easier travel in the area despite still having to use a snowmobile in a heavily laden snow region.

With respect to hardiness, an older participant demonstrated endurance while caring for her terminally ill husband after undergoing a shoulder surgery herself. Prior to her discharge from the hospital, the woman was informed that she was not ready for discharge and her extended stay left her without care for her husband. The woman was told that she would be charged \$118.00

per-day for her husband's care. Due to this extreme financial and emotional burden, she was forced to abandon recommendations for her own health and solicit help within her family to assist in providing end-of-life care for her beloved spouse.

Informed risk was a theme of great discussion among the study participants. Despite warnings from their physicians (with respect to individuals who retired to the rural community), these people understood their risk with limited access to health care, especially in an emergency. They agreed that one day they may be forced to move again because of their health, but wished to stay put until that time came. One participant commented, "Those of us who have been here for years, we just try to take care of ourselves without having to get any medical attention. Sometimes that is okay. We realize the risk we are taking" (Bales et al., 2013, p. 73).

The above case provides a clear example of the harmony that exists between the rural nursing theory and the SM. The characteristics of patients that can be easily identified in the SM include resiliency, predictability, resource availability, and participation in decision-making. Similarly, the SM emphasizes the congruence between longevity of residence being positively related to the themes of resiliency, predictability, resource availability, and participation in decision-making.

Access to health care is both literal and figurative. Congress attempted to address it from a literal standpoint with the passing of the Health Professions Educational Assistance Act of 1976 (HPSA) and Affordable Care Act of 2010 (ACA) out of concern for the maldistribution of primary care physicians. At this writing, there is uncertainty regarding how the ACA will be changed in the future. The hope would be that one of these pieces of legislation would increase access to primary care physicians in underserved areas. This legislation was thought to help

provide affordable healthcare options. Over 40 percent of people living in rural counties travel outside their home county for physician services for reasons such as high local physicians' fees, inadequacy of local physicians' skills or medical equipment, and inability of local physicians to meet community health needs (Gamm, Castillo, & Pittman, 2010).

Rural inhabitants are very independent. They make decisions to seek care for infirmity, disease, or injury depending on their ideas of harshness of the present health problem and their perception of the available resources. The exception is rural residents with infants and children (Rasmussen, O'Lynn, & Winters (2013). Rural dwellers will seek care more quickly for their children than for themselves. As discussed earlier within the SM eight patient characteristics are identified. The model intrinsically recognizes the patient's resource availability, and participation in care. These patient characteristics support the rural patient and their decisions of when to seek care. It enables the identification of specific areas of need within the rural community. The SM realizes that different patients operate with differing contexts. The person, their direct support system and their kinship reinforce the foundation of the nurse-patient relationship (AACN, n.d.). This also supports the rural patient and their decision of when to seek a relationship with the nurse.

“Health care providers, in rural areas, must deal with a lack of anonymity and much greater role diffusion than provides in urban or suburban areas” (Long & Weinert, 1989, p. 120). The nursing characteristic as outlined by the SM recognizes that different nurses have differing competencies. The greater role diffusion required to fulfill the requirements of rural nursing can be found within the caring practices, response to diversity and collaboration. Unified nursing

characteristics draw a picture of the nurse who is capable and competent to deliver care within the more rural areas.

Summary

In summary, evidence-based practice supports the utility of the SM for application within rural environments and populations. The SM was designed specifically for use on critical care units within medical institutions; however, its implications are far reaching. Rural nursing's theoretical foundation can be easily interjected into the SM. The eight characteristics of the patient and the nurse allow for synergy within acute, chronic, and community-based health care organizations. The adaptation within rural nursing that would create synergy between the nurse, patient and rural health delivery system would create a streamline effect. This effect could maximize resources, and create optimal patient-centered outcomes.

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