

A Story of Emergent Leadership: Lived Experiences of Nurses in a Critical Access Hospital

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Abstract

Purpose: The purpose of this study was to understand the lived experiences of nurses working in a predominantly rural care setting. In order to meet the needs of an aging population with multiple comorbidities, it is essential for leaders to understand the strategies to recruit and retain highly qualified nurses in CAHs settings.

Sample: Nine registered nurses working both full and part time with one to 40 years of experience participated in the interview process that queried their attitudes regarding working in a rural setting.

Findings: Five major themes included self-reliance, social responsibility, empathy, isolation, and emergent leadership.

Conclusions: The findings from this study support the notion that there is not a universal response to the lived experience of nurses working in CAHs. The unique needs of each nurse should be considered to enhance the practice environment and diminish experiences that result in feelings of isolation. Isolation impacted the five themes; if nurses are not able to maintain current knowledge and skills in a supportive environment, their self-reliance is compromised.

Keywords: Rural, Nursing, Self-reliance, Emerging leader

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Nursing in a rural setting is very different than nursing in an urban area. Nurses work and live within close proximity of their patients and their extended families. They usually know how a patient will handle a hospital admission, who will be their support after discharge, and who to call if there is no support for the patient. Rural nursing practice is generalist in its nature, requiring broad knowledge and flexibility (Montour, Baumann, Blythe & Hunsberger, 2009). An understanding of the lived experience of rural nurses is imperative as rural hospitals and healthcare settings face financial struggles, shortages of providers and an aging nurse and patient population. The examination of the daily practice of nurses working in critical access hospitals (CAHs) is the phenomenon that is the focus of this research. Examining this phenomenon provides foundational evidence to better understand the challenges and opportunities of rural nursing practice and the development of recruitment and retention strategies for nurses who are willing to continue to provide leadership in nursing care for a diverse rural population.

Rural nursing kind of has a rap, like when you say “rural”, a new graduate may be thinking nursing home and it’s not like that at all. Rural nursing is the heart

of nursing and there are wonderful opportunities for young nurses to learn and grow.

Literature Review

Many times, nurses who work in a rural setting have made a decision to return to live in the small community where they grew up (Bushy & Leipert, 2005). Rural, defined by The U.S. Census Bureau, encompasses all population, housing, and territory not included within an urban area (U.S. Census, 2016). Urban areas represent densely developed territory, encompassing residential, commercial, and other non-residential urban land uses. Two types of urban areas are the Urbanized Areas (UAs) of 50,000 or more people and Urban Clusters (UCs) of at least 2,500 and less than 50,000 people.

Rural nurses are required to handle every clinical issue that presents in their practice setting. They come with a general knowledge and willingness to make a contribution to their family and home community. The lack of access to primary care and specialty services, such as mental health supports, can create situations where the nurse generalist may need to assume multiple roles in order to meet the needs of the patient population (Bushy, 2014). Nurses who are working in CAH settings must continually redirect their care and skills to adapt to changing situations of census, culture, patient needs, and acuity of care (Cramer, Jones & Hertzog, 2011). They might be working with minimal support of other healthcare professionals, simply as a result of limited personnel resources available. Rural nurses, especially nurses working in CAHs face both positive and negative challenges related to whether the support and resources are available to manage these situations (Hunsberger, Bauman, Blythe & Crea, 2009).

Nurses in CAHs predominantly are educated at the associate degree level and typically care for patients of various ages and diagnoses (Newhouse, Morlock, Pronovost & Sproat, 2011). Due to limited staff, nurses frequently float between units (Havens, Warshawsky, & Vasey, 2012; Newhouse et al., 2011), adding to the need to be cross-trained to work in multiple clinical areas. Even with cross-training, nurses working in a CAH setting feel overextended related to fluctuations in staffing patterns (Cramer et al., 2011). This situation highlights the need for increased knowledge in a more robust patient population. Economies of scale that encompass practice knowledge often represent barriers for nurses and providers from being able to participate in mentoring and professional practice experiences that simply don't exist outside of urban settings (Lovelace, n.d.). Hunsberger et al. (2009) found the balance between practice demands and resources influenced workforce sustainability in rural healthcare settings. "With patient acuity increasing and experienced nurses approaching retirement, the imbalance between demands and resources may become critical" (Hunsberger et al., 2009, p 22).

Chief nursing officers (CNOs) from rural health settings reported they need to create practice environments that "provide resources and support nurses to design and deliver excellent patient care" (Havens et al. 2012, p. 519). Without qualified nurses working in rural areas, the access to quality healthcare is at risk. Many CAHs face challenges related to recruitment as they are in competition with urban hospitals offering higher salaries, specialized clinical practice area, and educational opportunities (Havens et al., 2012). The consequence of not providing these types of environments often results in nurses becoming dissatisfied and choosing to commute long distances to work in urban settings. Urban settings offer broader opportunities for professional advancement tied to continuing education and tuition reimbursement along with higher salaries.

The ability to be flexible and resolve issues in their clinical practice that may not even be identified appear to be common attributes of rural nurses. There is a better need to understand the attributes influencing nursing practice in CAHs and their impact on the recruitment and retention of nurses, in order to design interventions to attract nurses to rural settings, retain existing nurses, and encourage the return of those who have left rural settings to practice in urban locations. These attributes may be described as self-reliance or resilience. Resilient people have an awareness of both their capabilities and limitations (Wagnild, 2014). In order to understand the attributes of rural nurses working in a CAH were interviewed to determine how resources and environmental support impact career satisfaction, recruitment and retention.

Methodology

Study

The study took place in a CAH located in a predominantly rural northwestern state in the U.S. Criteria for CAH designation includes transfer or discharge of a patient within 96 hours and a capacity of 25 inpatient beds. A CAH must be more than 35 miles from another hospital. This particular facility serves a community with a total population of 8,796 (U.S. Census, n.d.) and is approximately 140 miles from a larger tertiary center. This CAH employs 75 registered nurses, has an average daily census of 15 and became a CAH in 2010. The facility has had a recent high nurse turnover, requiring augmentation of staffing with temporary nurses as well as current representation with a collective bargaining unit. These circumstances presented an opportunity to explore the phenomena of nurses who practiced in one unique rural setting.

Research Design

In order to understand the role of the bedside nurse in a CAH setting located in rural northwestern US, a collaborative effort was initiated. The collaborative team included a hospital

board member who is also a nurse researcher, a newly appointed Chief Nursing Officer, and a nurse researcher from New England who had previously studied nurses working in a CAH in New Hampshire. This group of long-distance nursing professionals organized, implemented, and analyzed findings from a qualitative study utilizing Colaizzi's method of descriptive phenomenology (Colaizzi, 1973) with the additional step cited by Edward and Welch (2011) to better understand the lived experiences of nurses caring for individuals and families in a rural hospital located in a small community in eastern Montana. Utilizing a purposeful convenience sample, nine participants with 1 - 40 years of nursing experience were interviewed. Each participant was scheduled for an initial 30-minute audio-taped interview that included open-ended questions about their personalities, attributes, and coping strategies utilized to enhance their clinical practice in a rural setting. Each participant received a written transcript of their interview via a secured server so that they could validate the transcript from the initial interview. Key themes were extracted from the data. To avoid potential identification of nurses who were interviewed, resulting themes were not provided to the participants. However, an experienced qualitative researcher familiar with Colaizzi's techniques was asked to review the themes identified through the process of bracketing participants' comments and responses. This outside reviewer validated identified themes after reading all transcripts.

Recruitment

Nurses were notified of the research opportunity via the hospital intranet approximately four weeks prior to the onsite visit. Schedule of the interview times was extensive, to accommodate maximum participation. A two-day interview schedule allowed for weekday and weekend nurses who worked days or nights to participate in the study. Posters were placed

throughout the CAH, reminding participants of the times the researcher would be present for the opportunity to participate and the purpose of the study.

Sampling

The sample of participants was from a pool of all current nurses employed at the selected CAH. Participation was voluntary. Participants came to the researcher at their own convenience. Each participant consented prior to the start of the interview. This study was reviewed and approved by the Montana State University Institutional Review Board, protocol number PP072415-EX. Signature of the consent form indicated willingness to participate in the study.

Limitations

Nine (9) individuals were participants. This sample size represented 12% of the total nursing staff of the facility. An additional limitation was characteristics of the study location. The participant pool was homogenous; all nurses were female, all but one nurse was Caucasian with a history of family living and working in this northwestern rural community. Data collected included the responses of nurses employed at only one CAH in a rural northwestern state. Rural communities are different from one another and thus the workplaces and roles of the nurses who work in these communities will also vary (MacLeod et al., 2004).

Data Analysis

Interview data were transcribed using Dragon Naturally Speaking™. Utilizing Colaizzi's method of phenomenological inquiry, the following steps with the inclusion of the additional step noted by Edward and Welch (2011) resulted in five major themes.

- Step 1 involves transcribing the interviews to gain a feeling and understanding the meaning behind the words. Interviews were sent to each participant to ensure accuracy

and to allow for the expansion of ideas or comments. The participants returned the transcripts with their approvals and/or additional comments one week after receiving the initial documents. Three of the nine participants expanded their statements. All nine validated their statements for accuracy.

- Step 2, the researchers reviewed each transcript and extracted significant statements. When duplication or repetition of statements occurred, repetitions were eliminated.
- Step 3 of Colaizzi's method required the researchers to extract a meaning for each significant statement. This required a thorough review on the part of the researchers to determine the meaning behind the words of each research participant ensuring to stay within the boundaries of the subjects' lived experiences (Colaizzi, 1973).
- Step 4, all of the formulated meanings from the significant statements were grouped into categories that reflect a cluster or theme. Similar meanings are placed into groups of similar type (Edwards & Welch, 2011). Once completed, groups of clusters or themes were integrated to form a unique construct of the 5 themes.
- Step 5 included defining all evolving themes into a thorough description of the phenomenon being studied. Once this thorough description emerged, the entire structure of the phenomenon of study became apparent.
- Step 6 the researcher interprets the analysis of symbolic representation from participant interviews (Edward & Welch, 2011). This additional step was added to Colaizzi's previous phenomenological inquiry methods.
- Step 7 encompassed the development of a complete description or fundamental structure of the phenomenon of study. During this process, changes were applied to elucidate clear relationships between clusters of theme and their extrapolated meanings. Data were

collected through 9 interviews with data saturation. After data collection and coding, members of the research team provided feedback on categorization of data. Throughout the data analysis process, discussions of the data occurred among the research team to ensure each researcher analyzed data in the same way.

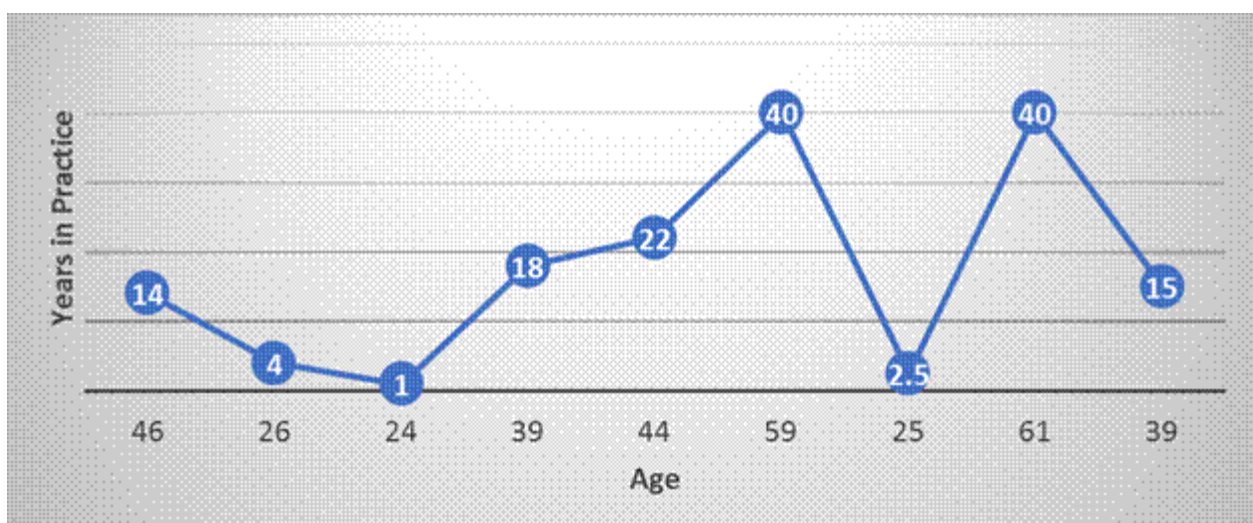
- Step 8, findings were validated. The process of validating requires the researchers to return the transcripts to the study participants. Although transcripts were returned; due to the small sample size, and potential to disclose participant identity, the resulting themes and phenomenal essence were not provided for review.

Results

Participant Characteristics

Nurses working in this CAH who participated in the study were all female, primarily educated as associate degree registered nurses. Age ranged from 24 to 61 years, with years of practice from 1 year to 40 years (figure 1). They were all members of a collective bargaining union.

Figure 1. Age of participants and years of practice



Participant Responses

Five major themes were identified, including self-reliance, social responsibility, empathy, isolation, and emergent leadership. These themes were consistently echoed in the analysis of interviews that were conducted with the bedside nurses at the research site. The participants who had twenty or more years of experience in rural settings emphasized their added responsibility to “teach” or “instill” a sense of self-reliance in nurses with less experience. The experienced participants readily acknowledged that sharing their experiences provided a common ground for new graduates who may feel alone and isolated in their nursing practice.

Self-Reliance

Participants discussed constraints related to continuing their education stating “there is no motivation to pursue an advanced degree at this facility. Your pay doesn’t go up with additional degrees and they don’t offer any educational assistance.” In addition to limited motivation, participants also found financial constraints impacted their ability to attend college courses and/or conferences. They had to pay for college and conferences on their own. “We don’t get too many opportunities to go elsewhere for educational offerings.” To help facilitate educational opportunities for the rural nurse, continuing education has expanded to online learning and teleconferences. However, the respondents were not comfortable with online learning, one nurse stated, “I don’t really like online anything so I know it is going to be a hard transition for me.”

Despite limited funding and career advancement, the nurses continued to feel an obligation to remain current in yearly competencies. They felt they were accountable for their own learning. “Each nurse must have self-motivation to want to stay current, improve, and learn. Each nurse should believe that they need to better herself in order to better serve her patients.”

Nurses employed various techniques to continue their learning, to remain current in their skills, and to have information at their fingertips allowing them the ability to be self-reliant.

Everything that I learn ... I write down in two little books. Because we are a small facility and I don't see everything, every day I write down everything... If you don't do these things every day it is easy for them to slip out of your mind.

Social Responsibility

The nurses felt they had a commitment to the community. One participant stated, "We need to let our patients know that we want to know about them, what they do for a living, tell us what is bothering them, we need to show patients that we care enough to communicate and that their lives and health are important to us." Caring for the community expanded to offering shelter to community members in need. "We ... use the swing bed for ... a homeless patient that has no place to go, we will ... for a month or two."

Empathy

The nurses spoke of having empathy for their patients. One nurse spoke about caring for a patient in need, "Today, I am caring for a new patient, a young patient, with Hep-C and she is devastated by it so I am trying to educate her about the disease and what we can do to help her to succeed outside of here once she's over the initial shock of the diagnosis." "You get to know your patients. I know that other nurses who are actually from here, know their patients in and out of the hospital and that is one of the things that makes a rural setting special."

The nurses discussed that they lived in "a small, intimate community" where "you ... get to know the people and you have to be caring", that unfortunately the caring continues when the patient is transferred to another hospital. One nurse mentioned empathy for the families of patients that had been transferred to a hospital that was located 150 miles away. "Due to the

distance, family members were not able to be with their loved one during their illness or transition into death.

Nurses also talked of empathy for each other by supporting each other when necessary. When an emergency occurs or a unit is short staffed “we go and offer consult, support, and whatever we can to help. We are always a resource for the other departments, especially if they have questions or if they need some extra help or some extra expertise.”

Isolation

Respondents stated they enjoyed face-to-face networking with other conference attendees, “It would be interesting to hear from other nurses, I like the idea of networking” and that without the opportunity to travel outside their local area, they felt isolated, “it is so easy to become closed off here.” One of the participants recalled a missed opportunity to achieve emergency certification when a severe storm closed a highway: “I had waited two years for the training to come to our area, and now it will be another two years before I have another chance.” The nurses felt isolated by not having the option to go to conferences. “There are some, not a lot of opportunities to go to conferences. I want to get my CEN but there are no certification classes in Montana this year to do that. Last year we had two and I scheduled myself to attend and we got snowed in and they shut the freeway down so I never made it.”

Another form of isolation mentioned was the staffing levels that do not allow for a nurse to actually leave the unit to participate in educational offerings at the CAH. They did not have the opportunity to view this offering within the unit or perhaps even accessing it at a convenient time. “It would be nice for the hospital, for example, to bring in a group of nurses to cover a floor so that a group of nurses could attend a conference and know that the floor and patient care needs were covered.” One nurse mentioned that she felt isolated from others in the hospital, “if

the internet was compromised, there was no one to contact in the middle of the night; there was no IT support.” One nurse thought this isolation forced you to work harder to be competent in all areas. “I worry about being good at assessing patients that we just don’t get here, it is isolating here, for example the biggest hospital is in Billings and it is 2 hours away so, of course it can be isolating.”

Emergent Leadership

The setting for this study had recently employed a new Chief Nursing Officer (CNO). This was the first leadership role for this CNO. One staff nurse spoke about “the nurses trusting their new nursing administrator.” Nursing administration had changed three times in a short period of time. The staff nurse discussed nursing morale, stating “morale is better than it was since the change in nursing leadership. . . there had been morale improvement throughout the facility since that leadership change.” However, there were times when staff were apprehensive about a new leader. “I can understand that the staff is reluctant to trust administration. This is not personal, they simply have been exposed to multiple changes in leadership and that would make any team reluctant to trust leaders.”

As a result of the changing nursing leadership, many of the experienced nurses had assumed an informal leader role. “I am a mentor here because I have been here 15 years. I’ve helped with orientees and I’ve been on our main Nurse Council here.” Tied to the theme of self-reliance, many of the senior nurses felt a responsibility to mentor the younger or newer nurses on each of their units, evolving into an emergent leader.

Discussion

Utilizing the steps outlined by Colaizzi (1973), once consistent themes were identified, the groups of clusters or themes were integrated to form a unique construct of theme. These

evolving themes then provided the researcher with a thorough description of the phenomenon being studied, leading to the entire structure of the phenomenon of study. Five themes that were identified include self-reliance, social responsibility, empathy, isolation, and emergent leadership.

Self-reliance

Self-reliance, defined as having the capacity to provide for one's own needs (Agich, 1993), includes self-confidence and allows for a certain degree of freedom, providing the opportunity to make one's own decisions (The Pulp, 2012). Self-confidence allows an individual to make decisions necessary to complete daily tasks that are affected by changing circumstances (Chafey, Sullivan, & Shannon, 1998). Changing circumstances might include a change in job requirements, including floating to a different unit or a change in patient status. This is essential for the registered nurse as they move from novice to expert (Benner, 2001). As the nurse grows professionally and moves towards expert level, they demonstrate autonomy in their practice stimulating personal and professional growth (Hanson, Jenkins & Ryan, 1990). Many of the nurses talked of floating to a unit, which they also correlated to enhancing their knowledge but at times, felt overextended as there were limited opportunities for formal learning of these different patient foci. The study participants experienced barriers in this professional development, which influenced their self-reliance. These barriers included a lack of a career ladder to encourage professional growth, promotion opportunities that were not correlated to advanced level of education, and there was no tuition reimbursement benefit. With this better understanding of the nurses' resilience as an attribute, influencing nursing practice interventions can be designed to attract nurses to rural settings, retain existing nurses, and encourage the return of those who have left rural settings to practice in urban locations.

Social responsibility

Social responsibility is demonstrated by meeting the social and health needs of the community (International Council of Nurses, 2012), having a sense of duty to help others. All nurses have a sense of this responsibility due to the association between social responsibility and professional values. But are rural nurses different than urban nurses? Do they have a stronger sense of social responsibility? Due to the close ties of rural communities, lack of services, and social injustice, can it be assumed rural nurses engage more with their patients and community than their urban counterparts? “Socially responsible nurses should all have professional self-confidence” (Faseleh-Jahromi, Moattari, & Peyrovi, 2014, p. 292), but are rural nurses more self-confident? What are the influences that may enhance a sense of social responsibility for rural nurses? The answer to these questions lies in the deep connectedness that rural nurses feel towards the patients they encounter. Often these individuals are friends, relatives, or others who are known to the nurses that are providing care. To remain a nurse in the rural setting, a strong sense of social responsibility is vital, as demonstrated by these participants.

Empathy

Dinkins (2011) defines empathy as understanding another’s feelings, instincts, worries, or desires. Empathy was apparent in three areas; nurses had empathy for the community, their patients, and among their fellow nurses. Living in a small intimate community impacts a nurse’s relationship with their patients. They know their patients and they know the patient’s families; they are part of the community. Thus, caring for patients is not limited to one individual or to one community. They felt empathy for the families trying to care for an ill family member, and this extended to times patients were transferred to a hospital that was located many miles away. Due to distance, sometimes family members were not able to be with their loved one during their

illness or transition to death, leaving the rural nurse to assume the role of a surrogate member of the family.

Isolation

Rural nurses can experience isolation in a variety of ways. Isolation can be geographic, such as living in an area that is a great distance from family, friends, and services. Isolation can be professional when the nurse is unable to contact other members of the healthcare community for consultation or support. Isolation can affect professional growth; nurses can experience limited access to continuing education opportunities. When the number of nurses is limited, the idea of exclusion from social and professional development situations only further contributes to a sense of isolation. Our findings concur with past research. Professional, geographic, social, and feeling like an outcast were identified through a meta-analysis conducted by Williams (2012). The majority of the literature focused on the geographic and social isolation.

Emergent Leadership

The setting for this study had recently employed a new Chief Nursing Officer (CNO). This was the third CNO for the facility in the past year. While the nurses were accepting of changes that impacted the quality of patient care, the multiple changes in leadership may have influenced the emergence of this theme. It is difficult to assess how the appointment of a new CNO may have impacted the participants' responses but the frequency of their remarks indicated concern for nursing leadership support. With the instability of nurse leadership, informal leadership positions emerged and senior nurses, many times, found themselves in a leadership position.

Implications for Practice

The themes that were identified from this study emphasize the sense of self-reliance that nurses feel to maintain current knowledge and skills in the care of patients at all points in the life

cycle. One benefit mentioned was the opportunity to care for all types of patients with a wide scope of care issues. One nurse had taken the opportunity to float to labor and delivery, an area that she had not been in since her nursing education. The nurse expressed frustration as she was not sure of the consistency of that experience again. This is not the case for nurses who practice in an urban setting, who might have daily chances to float to a new area. Critical access nurses often feel disenfranchised from the larger nursing community due to geographic distances or limited access to technology and educational opportunities. Because of these challenges, critical access nurses need unique support to maintain linkages to the larger community of nurses.

Identifying how nurses in this setting perceive their role and experience has provided insight into the systems and supports that will be necessary to recruit new nurses and retain emergent leaders among this unique population. Providing cognitive and affective support for nurses working in rural settings is inexplicably connected to maintaining and growing the nursing workforce in these practice settings. This type of support might take the form of travel to a larger facility to expose nurses to new practice standards, current professional issues or trends in nursing and patient care. The ability to collaborate with a peer group could prove valuable for retention. Likewise, the circumstances of the generalist CAH nurse might enlighten urban nurses who lack knowledge of rural healthcare and its challenges. Understanding the experiences of critical access nurses will broaden our understanding of why these nurses chose to stay and work within this practice setting, impacting nurse populations in rural settings.

Implications for Education

While some argue about what features cause rural practice to be unique, other suggest rural practice should be considered a specialty (Bushy & Leipert, 2005). Interviews with rural nurses working in CAHs have shown the differences in rural practice. Due to these differences, it is

imperative nursing students be educated about the uniqueness and benefits of working in a rural setting. Rural nursing requires additional skills and modifications to care for patients due to limited access to healthcare, fewer resources, and limited specialties. Students can learn about the uniqueness of rural practice through changes in didactic and clinical components of nursing education programs. One solution could include inviting rural nurses as guest lecturers and exposing student nurses to rural areas through clinical placements allowing the student familiarity with rural nuances (Sharp, 2010).

Previous research indicates having a rural background positively affects future employment in a rural community. Along with a rural background, the number of years an individual lived and worked in a rural setting impacted their decision to accept a rural clinical placement. Financial and family considerations also influence clinical placement. Students needing to work while completing their education often choose a clinical placement near their place of employment. Rural clinical placement improves student clinical skills needed for rural practice. Through rural placement, students with no previous rural experience can appreciate the rural practice environment (Edwards, Smith, Courtney, Finlayson, & Chapman, 2004).

An understanding of rural communities can also be provided by mentors who can expose students to both the social and professional community (Sharp, 2010). Mentoring should include knowledge outside the clinical setting. This is important in rural areas, as knowledge related to the distinctive factors of rural living gives the student an understanding that rural practice extends past the hospital walls. Links between rural roots established during childhood and a desire to practice in a rural location reinforce the need to recruit nursing students from rural areas. Increased access to educational programs can minimize the students commute from rural

areas (Kippenbrook, Stacy, & Gilbert-Palmer, 2004). Through the use of current technology, students can remain in rural settings and care for rural residents while advancing their education.

Conclusion

Interconnected themes emerged from the analysis of data throughout this research process. Isolation is a result of geography, compromised technology, lack of access to continuing education, and challenging internet connectivity. Isolation impacts all other themes; if nurses are not able to maintain current practice knowledge in an environment that they find supportive, self-reliance is compromised. Feelings of social responsibility and empathy are diminished as the nurse no longer feels he or she have the expertise for their rural community. This results in inadequacies, limiting each nurse of their growth potential as an emergent leader. Certainly, more research is needed to identify the contributing factors that pose both challenges and opportunities for rural nurses working in critical access hospitals. However, with the strides in technology and its role in patient care, it is important to know what role this technology has in supporting rural nursing practice.

CNOs in rural health settings need to create practice settings that provide resources and support nurses in their efforts to design and deliver excellent patient care. Without qualified nurses working in rural areas, the access to quality healthcare is at risk. Ultimately, the findings from this study support the notion that there is no universal meaning to the lived experience of nurses working in CAHs. Individual needs should be considered to enhance the practice environment and diminish experiences that result in feelings of isolation. The lived experiences of rural nurses are influenced by multifactorial challenges that require further focused research.

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