REGISTERED NURSES' INTENTION TO STAY WORKING IN ONTARIO RURAL HOSPITALS

A Thesis Submitted to the Committee on Graduate Studies in Partial Fulfillment of the Requirements for the Degree of Master of Science in the Faculty of Nursing

TRENT UNIVERSITY

Peterborough, Ontario, Canada

Nursing Graduate Program

September, 2024

ABSTRACT

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The significance of nursing retention in today's healthcare system is more prominent than ever before. The purpose of this study was to answer the question: What do Registered Nurses understand about their intention to stay at Ontario rural hospitals? A qualitative descriptive phenomenological approach was used to conduct this study. Ten Registered Nurses from rural hospitals were interviewed regarding their experiences working in rural hospitals. Seven themes were developed including: Sense of Community, Pride and Identity, Weight of Responsibility, Feeling Alone, Questioning Commitment, Rural Reality, and Feeling Misunderstood. Participants shared that their nursing co-workers were the reason they continued to stay working in their rural hospitals, with the essence of the themes being *we are there for each other*. The findings of this study can be used to influence nursing practice, nursing education, healthcare leaders, and areas of future research.

Acknowledgements

I would like to start by giving my deepest appreciation to my research supervisor Dr. Amy Hallaran for her wisdom, guidance, and support throughout this process. Next, I would like to express my gratitude to my research committee members Dr. Catherine Thibeault and Dr. Dana Edge for sharing their expertise and providing constructive feedback on my research. To the ten nurse participants in this study, thank you for sharing your stories and experiences with me, and making this research possible. I would like to extend a special thank you to my family and friends for encouraging and checking in on me as I moved throughout my research; their supportive and kind words helped me persevere throughout this process. Lastly, I would not have been able to complete this research without the support of my husband Tanner. He encouraged and inspired me to stay positive, and never let me forget how important my work was, and how much he valued and appreciated my perseverance and eagerness to learn.

Table of Contents

List of Tables

CHAPTER ONE: INTRODUCTION

The significance of nursing retention in today's healthcare system is more pronounced than ever before. Ontario, Canada, is experiencing a nursing shortage and has a lower Registered Nurse (RN)-to-person ratio than the Canadian average, with approximately one RN for 149.7 people in Ontario compared to one RN for 120.4 people in Canada [Ontario Nurses Association (ONA), 2022]. It is estimated that the province requires 24,000 nurses to meet the national average ratio (ONA, 2022). The recruitment and retention of nurses in rural areas is a recognized concern worldwide, and challenges the sustainability of healthcare delivery (Kulig et al., 2015; MacKay et al., 2020). The World Health Organization (WHO) (2010) reports that the lack of health-care providers is one of the primary causes of health inequities among people living in remote and rural communities.

Approximately half of the global population lives in rural areas, yet only 38% of the global nursing workforce provides care in these settings (WHO, 2010). As the rural Canadian population slightly increased to 18% in 2020, totalling 6.6 million, the number of nurses registered in all classes working in rural areas was only 10% of all Canadian nurses, totalling 41,071 (Pavloff et al., 2022). In Ontario, the total population living in rural areas in 2021 was 2.5 million, or 17% of the provincial population (Government of Ontario, 2023). In 2022, 6% of Ontario nurses, registered in all classes, reported working in rural areas [Canadian Institute for Health Information (CIHI), 2023]. It is important to note that the CIHI defines urban as areas with greater than 10,000 people, with rural and remote defined as communities outside of urban boundaries (CIHI, 2023); this definition of rural differs from Ontario's provincial government and professional association definitions.

While the importance of nursing retention in rural hospitals is highlighted in current literature, there is limited research on nursing retention in rural hospitals within Ontario. Much of the available literature regarding rural retention in Canada does not reflect the current nursing shortage. This study uses a qualitative, descriptive phenomenological approach to understand the lived experiences of nurses working in rural hospitals within Ontario and its influence on nurses' intent to stay.

Significance of problem

Nursing shortages are a priority issue in today's healthcare system, with a projected nursing shortage of 33,000 nurses in Ontario by the year 2028 (Casey & Jones, 2023). Recruiting and retaining nurses is imperative for rural hospitals in order to ensure quality of care for patients. Canadian rural populations are older and have less formal education (RNAO, 2015), increased rates of chronic illness, and less access to preventative health programs (RNAO, 2015; Smith et al., 2019; Stroth, 2010). These concerns can create increased stress on the health care system of rural areas, including the nurses working in rural hospitals. Ensuring that the rural health workforce is operating at its fullest capacity, with a stable nursing workforce, should be a priority for nursing and healthcare leaders to address the unique concerns of rural residents and communities.

There is great value in Canadians receiving quality health care close to home, and for small rural communities, the local hospital is a symbol of viability (Medves et al., 2015). In recent years, many Ontario rural hospitals have required emergency department closures for safety reasons, and the struggle remains for small community hospitals to cover all shifts with adequately prepared nurses and healthcare professionals (Miller, 2023). One hospital network in

midwestern Ontario has been unable to provide full-time emergency services for their rural communities at three of their four hospitals (Miller, 2023).

The uniqueness of rural hospitals, and the importance of nursing retention within rural settings was included in the literature reviewed, but little was shared about the lived experiences of nurses working within rural hospitals and how it impacts their intent to stay. Rural healthcare is often discussed from a deficit framework, with a focus being on what is lacking, when it should focus on its strengths (Kulig et al., 2015). The aim of this study was to answer the question, what do RNs understand about their intention to stay at Ontario rural hospitals? By completing this study, the researcher may gain a better understanding of RNs' experiences of working in rural hospitals, and their choices about staying in the rural setting. Health care leaders, including nurse managers and hospital administrators, can use the findings of this study to promote and build on the positive aspects, while trying to reduce the negative experiences in order to foster nursing retention. RNs can reflect on their own practice environments, and advocate for retention strategies that they may infer from the study's findings.

Background

The RNAO defines rural communities in Ontario as "those with a population of less than 30,000 that are greater than 30 minutes away in travel time from a community with a population of more than 30,000" (RNAO, 2015, p.12). The Ontario Ministry of Health uses a Rurality Index for Ontario (RIO) score to determine which communities are considered rural; communities with a score greater than 40, are considered rural communities (Institute for Clinical Evaluative Sciences, n.d.; Ontario Ministry of Health, 2019). Based on this index, there are 214 communities within Ontario that are considered rural (Ontario Ministry of Health, 2019). The Ontario Hospital Association (OHA) identifies 62 of the province's 140 hospitals as "small

hospitals" (OHA, n.d.). The OHA describes small hospitals as the "focal point" for the coordination and delivery of a broad range of primary and selected secondary services to their communities (OHA, n.d.).

High rates of nursing turnover and a lack of retention are great concerns in nursing practice, especially in rural hospitals (Sellers et al., 2019). Rural hospitals have a higher RN-to-patient ratio, and are found to have a lower proportion of RNs in comparison to overall staffing (Smith et al., 2021). Some rural hospitals have employed agency nurses as a strategy to address nursing shortages, but this does not come without concern (Newberry, 2022). Newberry (2022) reported that one northern Ontario hospital's dependence on agency nurses negatively influenced their quality improvement development, as the hospital focused on remaining open instead of investing in reliable and sustainable care.

A significant change to the healthcare system occurred during the COVID-19 pandemic. The global pandemic overpowered many aspects of society including supply chains, educational systems, personal milestones, and the healthcare system (LoGiudice & Bartos, 2021). In their mixed methods study, LoGiudice and Bartos (2021) desired to understand the experiences of 43 RNs during the COVID-19 pandemic and examine their resiliency. Participants from the study were located across the United States (U.S.), working in a wide variety of hospital settings. The RNs reported feelings of stress, frustration, and anxiety while trying to care for patients under the unknown circumstances of COVID-19 (LoGiudice & Bartos, 2021). Increased moral distress amongst nurses was reported due to contributing factors such as the reuse of personal protective equipment, influx of high-acuity patients, increased patient censuses, and lack of protocols based on scientific evidence (LoGiudice & Bartos, 2021). In contrast, the authors reported a common theme of "proud to be a nurse", where nurses felt pride for working on the front-lines during the

pandemic (LoGiudice & Bartos, 2021). Only one of the RNs in the study identified as working in a rural hospital; differences between care settings were not part of the study.

Robinson et al. (2022) used a phenomenological approach to interview 19 frontline nurses in U.S. rural hospitals during the COVID-19 pandemic. Their findings were similar to LoGiudice and Bartos (2021), reporting that rural nurses experienced feelings of stress and anxiety, as well as role frustration related to changes in protocols and practices. The researchers did report that differences in experiences of rural nurses to their urban counterparts included close, social connections to patients, families, and community members, stating that this social connectedness had both positive and negative effects on the support and cohesiveness of these groups to the nurses (Robinson et al., 2022).

The need for nurses in rural hospitals is evidenced by the Ontario government incentives to encourage nurses to work in rural communities. The Ontario Government has implemented the *Ontario Learn and Stay Grant* which provides funding for students studying in postsecondary programs in underserved and growing communities within Ontario who work in the region where they studied (Government of Ontario, 2024). Ontario offers eligible RNs within their first year after graduation tuition reimbursement for return-of-service in eligible rural communities anywhere in Ontario (Kulig et al., 2015; Ontario Ministry of Health, 2023). Mbemba et al. (2013) synthesized five systematic reviews in their article exploring the effectiveness of financial incentives as interventions for nursing retention in rural hospitals. The authors reported that although financial incentives are effective to improve recruitment and short-term retention of healthcare workers, they are less effective as a long-term retention strategy. Other non-financial incentives, such as housing and quality working conditions, may have more impact on the decision for healthcare workers to stay in rural areas (Mbemba et al., 2013).

With a notable number of the Ontario population living in small or rural communities, the large number of small hospitals dispersed within the province, and a broad number of communities considered to be rural, there needs to be a focus on improving the quality of care received in rural areas. One of the driving forces for providing quality healthcare in rural areas is related to nursing availability (MacKay et al., 2020; Smith et al., 2019). Rural hospitals must determine what factors contribute to retaining nurses within the working environment (MacKay et al., 2020; Sellers, 2019).

Definitions

The following definitions will be used throughout this paper.

Intent to Stay: an individual's expressed intent to voluntarily stay with his or her current occupation (Owens et al., 2021).

Retention*:* the ability of an organization to retain employees and ensure sustainability, alternatively defined as turnover (Sellers et al., 2019).

Rural Hospital: a hospital located in a community with less than 30,000 people that is more than 30 minutes away from a community with greater than 30,000 people (RNAO, 2015).

Turnover: the rate at which employees leave the workforce and are replaced (Sellers et al., 2019).

CHAPTER TWO: LITERATURE REVIEW

This chapter will provide an overview of the literature reviewed prior to data collection and analysis of this study. Literature was selected for review based on its relevance to the focus of this research. An overview of the common themes found within the literature will be presented.

Search Strategy

A literature review was conducted using the Cumulated Index to Nursing and Allied Health Literature (CINAHL) database from January to August 2023. The search was limited to articles published in English between 2007-2023. The year of publication search strategy was selected to provided articles within fifteen years of the start of the literature review. Key search words used to obtain results included: *nurse* or *nurses* or *nursing, rural hospital(s), retention, challenges, experience(s), recruitment, Canada* or *Canadian,* and *strategy* or *strategies*. Results were filtered by the researcher for relevancy to the research question and phenomenon. A total of 15 journal articles were reviewed consisting of qualitative and quantitative studies, and literature reviews. The majority of articles were American (n=7), with the next largest group being Australian (n=5), and the smallest number being Canadian (n=3). A secondary literature review was conducted with additional searches of the CINAHL database, papers found in article references, and articles provided by nursing research experts. Six of the additional articles reviewed (n=10) were Canadian, and published between 2015-2023.

No study reviewed directly addressed the research question, although many offered related insights. For example, in two studies, researchers explored the lived experience of nurses working in rural hospitals and its impact on retention and recruitment, but the study was limited to new-graduate nurses (Hoppe & Clukey, 2020; Rose et al., 2023). Another study (Smith et al.,

2019) explored experiences of Australian nurses working in rural hospitals with the development of retention strategies, and used an integrative review approach.

Multiple themes were found in the reviewed literature, including rural hospitals, quality of care, resources, multi-specialist skill set, support, new-graduate nurses, contributing factors of rural recruitment and retention, and sense of community felt by nurses working in rural areas. These themes, and related literature, are reviewed below.

Rural Hospitals

Rural hospitals are fundamentally different from non-rural hospitals, in terms of community context and characteristics, as well as human and technological resources, and pose unique challenges (Sellers et al., 2019; Smith et al., 2021). These challenges include unpredictable fluctuation of patient census and change in community population size due to temporary residents during summer and tourist seasons (Hunsberger et al., 2009; Twigg, 2016; Smith et al., 2019). In their integrative review, Smith et al. (2019) set out to gain an understanding of nurses' experiences working in rural hospitals to inform strategies around job satisfaction. In their study, Smith et al. (2021) report that hospitals are an integral resource in rural towns, with nurses being the foundation of rural hospitals. The researchers found that because rural hospitals are unique, due to fluctuating census numbers and a small staff pool, staffing strategies used at metropolitan hospitals cannot simply be applied to rural hospitals (Smith et al., 2019). Staffing and unpredictable scheduling are major sources of stress for nurses working in rural hospitals, and affects nurses' job satisfaction within their workplace (Smith et al., 2019). There was no evidence from the literature review of a direct comparison on retention between rural and urban hospitals, with the exception of researchers noting that nursing retention in rural hospitals is more complex (Smith et al., 2021; Twigg, 2016).

Quality of Care

Quality of care as it relates to rural hospitals and nursing retention was a common theme of the literature reviewed. Regardless of the hospital setting, poor retention of nurses has consequences for the quality of care and the health and wellbeing of patients, organizations, and society (Sellers et al., 2019). Stroth's (2010) discussion paper explored job embeddedness as a potential retention strategy for rural hospitals and how it can prevent nurse turnover. The researcher reports that turnover of nurses leads to inadequate staffing and negatively affects the quality of care for patients (Stroth, 2010). Inadequate levels of RN staffing leads to increased infection rates, length of stay, medication errors, and patient falls (Stroth, 2010). Providing safe quality care for patients in rural settings is reliant on having a skilled and experienced nursing workforce (Owens et al., 2021). Nurses who have not had sufficient rest, or feel pressured to work overtime are at a higher risk of developing burnout, which decreases the quality of care provided to patients (Smith et al., 2019).

Resources

Smith and colleagues (2021) suggest that "rural nurses are known for their resilience, stoicism, and ability to work in environments with fewer resources than nurses working in urban hospitals" (p.473). This sentiment aligns with other researchers' findings. Twigg (2016) utilized focus groups and interviews of 17 nurse leaders to explore staffing issues and drivers of nursing workload in small rural hospitals. Twigg (2016) found that nurses in rural hospitals have multiple roles, deal with a complex patient population, and lack overall resources. Limited medical, clinical, and administrative support impacts nursing workloads and can result in increased stress and precipitates nurses' intent to leave. Due to the multitude of non-nursing activities that nurses perform in rural settings that are undocumented (such as clerical work,

housekeeping, porting, etc.), it is difficult for nursing leaders to fully understand the work that nurses do in small hospitals, which can also impact patient safety and quality of care (Twigg, 2016).

It is challenging for rural hospitals to provide the resources to support nurses in their professional roles. Similar to Twigg's (2016) findings, others report that nurses working in rural hospitals have limited back-up from other healthcare providers, resulting in nurses perceiving themselves as the responsible care provider (Hunsberger et al., 2009; Lea & Cruickshank, 2007; Medves et al., 2015; Stroth, 2010). It is often assumed that rural nurses experience the same level of organizational challenges as urban nurses, but the resources available to rural nurses needs to be taken into account (Stewart et al., 2020). Smith et al. (2021) in their Australian integrative review of both qualitative and quantitative research explored nurses' experiences of working in rural hospitals. They identified that the lack of resources available to nurses working in rural hospitals is a negative aspect of their job, and can result in nurses wanting to leave their rural workplace (Smith et at., 2021).

Multi-Specialist Skill Set

Nurses in rural hospitals are referred to as multi-specialists who have an advanced skill set and broader responsibility (MacLeod, Stewart, et al., 2019; MacKay et al., 2020; Medves et al., 2015; Pavloff et al., 2022). Nelson-Brantley (2018) reviewed 34 studies from the U.S. exploring critical access hospitals and reported that the skill set required by rural nurses is often underestimated, noting that rural nurses are often considered to be generalists, when they should be recognized by having multi-specialist knowledge. Similarly, Hoppe and Clukey (2020) describe rural nurses as generalists but agree that they must have an advanced skill set. The abilities required to work as a multi-specialist, who can adapt quickly to different ways of

working in rural areas, is more advanced than what is traditionally experienced in urban settings (Medves et al., 2015). The rural nurse role, within the rural hospital, encompasses acute and aged care services, emergency care, community focused services, preventative measures, management, clerical, and leadership qualities (Hunsberger et al., 2009; Lea & Cruickshank, 2007).

A challenging aspect to the multi-specialist skill set of rural nurses is the infrequent exposure to certain procedures and illnesses. Rural hospitals require nurses to be proficient in a multitude of skills while providing sporadic opportunities to practice such skills (Seright, 2011). MacKay et al. (2020) synthesized 40 articles in a systematic review to determine what influences nurses' decisions to work in rural and remote settings. MacKay and colleagues report that as the population size decreases in rural areas, the greater the generalist role becomes for nurses. The researchers report that although it is difficult for rural nurses to maintain skilled and competent care due to a lack of exposure to certain procedures, nurses report a sense of pride in being able to 'make it work' for patients through responsive and creative work (MacKay et al., 2020). The infrequent requirement for performing specialized skills can result in nurses having reduced confidence and competence in performing them (Hunsberger et al., 2009; Smith et al., 2019). Educational courses for specialized skills such as advanced cardiovascular life support (ACLS) are more geared toward urban settings where there are more people, and specific teams available to respond to emergencies, making it difficult for rural nurses and health care workers to apply what is learned into their own practice (Medves et al., 2015).

Another component of rural nurses having a multitude of skills, knowledge, and responsibility is the concern that nurses are working beyond their scope of practice. Examining rural nursing across Canada, MacLeod, Stewart, et al. (2019) report that as resources related to

staffing and time decreases, RNs were more likely to perceive that they were working beyond their scope of practice. Similarly, Hunsberger et al. (2009) stated that when rural nurses are forced to make critical decisions without appropriate support, they may feel pressured to act beyond their scope of practice. Hunsberger et al. (2009) used semi-structured interviews to investigate if nurses in Ontario rural hospitals had the necessary resources and support to meet the challenges of rural practice. Participants in the study felt it was difficult to maintain competency to care for all kinds of patients due to the infrequency of exposure to certain illnesses and interventions (Hunsberger et al., 2009). Research exploring how to address these concerns was not found, other than the overall concept of the need for continued education and training for nursing staff within rural hospitals (Nelson-Brantley, 2018).

Support

Support is required for rural nurses' development of confidence and competence, areas that are crucial to the quality of care that is provided to rural people (Penz et al., 2018). With these concerns of scope and practice experiences, support from coworkers and managers is important for rural nurses. Workplace support can come from both colleagues and managers, both of whom are imperative in the professional development of new-graduate and experienced nurses working in rural hospitals (Hoppe & Clukey, 2020; Hunsberger et al., 2009; Rose et al., 2023; Stewart et al., 2020). MacKay et al. (2020) report that "the sustainability of rural nursing is threatened when nurses lack resources, support, and influence" (p.21). Support received from managers, colleagues, and communities can increase nurses' intention to stay working in rural settings (Robinson et al., 2020).

New-Graduate Nurses

New-graduate nurses in rural settings face additional challenges. The transition from nursing student to practicing nurse is a struggle for many new-graduate nurses, but is more profound in rural hospitals, where nurses take on more responsibility, require an increased skill set, and have heavier patient assignments (Lea & Cruickshank, 2007; Owens et al., 2021). New-graduate nurses are often treated the same as experienced nurses in rural hospitals, taking on equal patient assignments, and leaving new-graduate nurses working beyond their level of experience and knowledge (Lea & Cruickshank, 2007; Penz et al., 2018). Strategies to support new-graduates in rural hospitals include residency programs and mentorship. Participation in rural nurse residency programs, where nursing students have practicums at rural hospitals prior to being employed, have been attributed to increased retention of new-graduate nurses (Seright, 2011). Following the orientation period, new-graduate nurses value having a mentor who checks in and is available to them throughout their shifts (Rose et al., 2023).

In a U.S. qualitative descriptive study (Owens et al., 2021), 228 graduating nurses participated in focus groups to determine their intent to stay within their workplace and rural setting. Owen and colleagues found that new-graduate nurses are influenced to stay at their workplace when supervisors provide support, communication, and encouragement (Owens, et al., 2021). New-graduate nurses also reported satisfaction in working in rural settings in a generalist role with autonomy, having a variety of patients, and having the ability to collaborate with their peers (Owens et al., 2021). In addition to supportive supervisors, Penz et al. (2018) suggest that new-graduate nurses would benefit from greater mentorship to reduce their high risk of perceived stress and burnout. In their descriptive phenomenological study of new-graduate nurses working in U.S. critical access hospitals, which included those in rural areas, Hoppe and

Clukey (2021) reported that support from all members of the healthcare team was influential to the experience of new-graduate nurses. Seright (2011) examined decision-making of new-graduate nurses working in an U.S. rural hospital and found that despite having access to a multitude of resources, collaborating with their coworkers was the most frequent strategy used by new-graduate nurses when making decisions.

Contributing Factors of Rural Retention and Recruitment

Contributing factors are reported for why nurses choose to work in rural hospitals. These factors include nurses living and working in rural communities in which they were born or raised in, raising a family in the area, the proximity of the rural hospital to their homes, the value of a small-town feeling, and the preferred influences of rural living (Hoppe & Clukey, 2020; Owens et al., 2021). Successful recruitment and retention of nurses in rural settings can occur with an understanding of the perceptions of rural practice and communities, as well as in partnership with the communities themselves (Kulig et al., 2015; Medves et al., 2015).

In their national cross-sectional survey of RNs in rural and remote Canada, Stewart et al. (2011) explored predictors of intention to leave a nursing position in a rural setting. The researchers developed a framework with determinants that influence rural RNs intention to leave. These determinants included: workplace organization, job satisfaction, community characteristics, and community satisfaction (Stewart et al., 2011). Of the 3,051 RNs surveyed in the study, 17.2% intended to leave and 82.8% did not intend to leave their current nursing position within the next 12 months (Stewart et al., 2011). The researchers found that participants reported high job satisfaction in rural settings, and that RNs who reported higher satisfaction with the level of autonomy in their job were more likely to be retained in the workforce (Stewart

et al., 2011). Satisfaction with the rural community was identified as an influence on retention, as it was lower among RNs who intended to leave their current position (Stewart et al., 2011).

Sense of Community

The overall sense of community was a factor that contributed not only to nurses wanting to work at rural hospitals, but also why nurses choose to stay working in rural hospitals (Hoppe & Clukey, 2020; Stewart et al., 2011). Researchers reported that nurses stay at their job because of their pride and sense of identity, commitment to their community, and close-knit ties to community members and families (Hoppe & Clukey, 2021; Hunsberger et al., 2009; Medves et al., 2015; Sellers et al., 2019; Smith et al., 2021; Smith et al., 2019). In the second pan-Canadian cross-sectional study initiated by Stewart and colleagues (2020), 3,065 nurses across Canada were surveyed regarding their intention to leave their rural and remote areas of practice. The researchers found that the community in which nurses work was a factor influencing nurses' intention to stay working in rural communities. Nurses who are less satisfied with their primary work community have higher levels of intention to leave (Stewart et al., 2020).

In rural communities, personal and professional lives are often intertwined, with the healthcare facility being a major part of the community; team dynamics, everyday practices, and available workplace and community support strongly influence nurses' commitment to their organization (Stewart et al., 2020). Medves et al. (2015) reported that although nurses acknowledged reduced resources available when working in rural hospitals, nurses were confident that the care they provided to patients was appreciated by their rural communities, and that community relationships played a large role in their decision to stay working in rural hospitals.

Summary of Literature Review

From this literature review it is evident that rural hospitals have unique challenges that are faced by their nurses and hospital leaders. Rural nurses are required to have a multitude of skills and knowledge, while caring for a diverse population and working with limited resources and support. Factors that have increased nurses' intention to stay working in a rural hospital are reported as having support from managers, community satisfaction, and mentorship for new-graduate nurses. The literature reviewed did not specifically explore RNs' understanding of their intention to stay working in rural hospitals. Literature reviewed that did explore intention to stay was from a quantitative perspective, leaving room for a qualitative understanding of how RNs' experiences influence their intention to stay working in rural hospitals. The majority of recent literature on rural nurses' intention to stay has not been conducted in a Canadian context. Further research is required to reflect the current Ontario healthcare system, nursing shortage, and the unique rural nursing challenges.

CHAPTER THREE: RESEARCH METHODOLOGY

The following chapter includes a detailed description of the research methodology and methods used in the study which included the selected setting, sampling strategy, data collection, data analysis, rigour, personal reflexivity, and ethical considerations. The purpose of this study was to explore the lived experiences of RNs working in Ontario rural hospitals, and how such experiences influence their intention to stay. To explore this, research was conducted using a qualitative, descriptive phenomenological approach.

Methodology

Phenomenology is both a philosophy and a method of inquiry that allows researchers to understand the fundamental structures of experiences (Wirihana et al., 2018). Phenomenology gained prominence as a philosophy in the early 20th century (Dowling, 2007; Giorgi et al., 2017). The word phenomenon originates from the Greek word *phainesthai* meaning to show itself, flare up, or to appear (Dowling, 2007). Phenomenology is the study of phenomena as they manifest in one's experience, of the way one perceives and understands phenomena, and of the meaning phenomena have in one's subjective experience (Neubauer et al., 2019; Northall et al., 2020). It is an approach to research that seeks to describe the essence of a phenomenon by exploring it through the perspective of those who have experienced it first-hand (Neubauer et al., 2019).

Phenomenology is most often separated into two main approaches: descriptive and interpretive (Dowling, 2007; Matua & Van Der Wal, 2015). Many historians credit Edmund Husserl for defining descriptive (transcendental) phenomenology, and Martin Heidegger, a student of Husserl, as the founder of interpretive (hermeneutic) phenomenology (Dowling, 2007; Matua & Van Der Wal, 2015; Neubauer et al., 2019). Descriptive phenomenology requires the

researcher to explore, analyse, and describe a phenomenon while maintaining its richness so that others are able to, in a way, see and feel it (Abalos et al., 2016; Matua & Van Der Wal, 2015). In descriptive phenomenology, the researcher must avoid any pre-conceptions of the phenomenon, allowing them to achieve a more direct contact with the phenomenon as it is lived, rather than as it is conceptualized (Matua & Van Der Wal, 2015). An interpretive (Heideggerian) phenomenological approach is focused on understanding what Heidegger termed *Dasein,* or *Being-in-the-world,* or the meaning of everyday ("lived") experience, rather than core concepts of the experience (Reiners, 2012). A hermeneutic approach presupposes that the ontology of being is part of a circle of understanding, always open to change. For that reason, Heidegger suggests that it is not possible to avoid pre-conceptions of a phenomenon (Reiners, 2012).

Husserl's descriptive phenomenology, also referred to as transcendental phenomenology, dates back to 1900 with his publication of *Logical Investigations* (Giorgi et al., 2017; Neubauer et al., 2019). The inspiration for Husserl's use of the term phenomenology is from the work of Franz Brentano, a German philosopher and psychologist, who employed the term "descriptive psychology or descriptive phenomenology" (Dowling, 2007). Husserl's approach to philosophy equally valued both objective and subjective experiences, which to Husserl meant that subjective and objective knowledge were intertwined, and that phenomena perceived by an individual's consciousness should be the focus of study (Neubauer et al., 2019). Brentano's account of intentionality was adopted by Husserl as the fundamental concept for understanding conscious acts and experiential mental practices (Dowling, 2007). Husserl believed that phenomenology was rooted in an epistemological attitude, with his question of investigation being "what is it for an individual to know or to be conscious of a phenomenon" (Neubauer et al., 2019, p.93).

Husserl refers to phenomena as objects as they appear in the consciousness (Kim et al., 2020). The way in which these objects become phenomena is not limited to the way in which they are perceived, remembered, expected, believed, and distinguished (Kim et al., 2020). For Husserl, to understand the reality of a phenomenon is to understand how that phenomenon is lived by a person (Abalos et al., 2016). Phenomenology is an approach to research that attempts to describe the *essence* of a phenomenon through the perspective of those who experience it (Abalos et al., 2016; Neubauer et al., 2019). Husserl defines essence as the very central core of reality, representing the true nature of a phenomenon (Abalos et al., 2016; Neubauer et al., 2019). Essence is what makes something what it is; and may be understood as a meaning, as to say one has understood the essence of a thing, is to say that one has understood its meaning (Abalos et al., 2016; Dowling, 2007).

In his work, Husserl brought forth many key ideas that act as principles for descriptive phenomenology including *lifeworld*, *intentionality*, and *eidetic reduction*. Husserl stated that lifeworld is the base of all knowledge for lived experiences (Neubauer et al., 2019). *Lifeworld* refers to the idea that individuals' realities are influenced by the world in which they live, and cannot resort to interpretations, since they cannot remove themselves from their own lifeworld (Dowling, 2007; Matua & Van Der Wal, 2015; Neubauer et al., 2019). *Intentionality* is another key concept of Husserl, referring to the internal experience of being conscious of something (Dowling, 2007). Intentionality is the principle that all thinking is related to an object and implies that all preconceptions have meaning (Dowling, 2007). *Eidetic reduction* is a principle in Husserl's phenomenology and requires the researcher to look at a particular phenomenon and then systematically reduce it to determine its essence (Giorgi et al., 2019). Eidetic reduction involves the identification and removal of any accidental features of experiences from one's

experiences in order to discern the invariant features of one's experiences (Kim et al., 2020). Some philosophers such as Giorgi and Colaizzi have replaced eidetic reduction with a stepwise analysis method, which results in the identification of essential meanings (Kim et al., 2020).

Bracketing

Using Husserl's descriptive phenomenology, the researcher must achieve a transcendental state, "wherein the objective researcher moves from the participants' descriptions of facts of the lived experience, to universal essences of the phenomenon at which point consciousness itself could be grasped" (Neubauer et al., 2019, p.93). To achieve such a state, researchers must utilize bracketing to set aside their existing knowledge on the phenomenon in order to grasp the essences of its elements (Abalos et al., 2016; Matau & Van Der Wal, 2015). Bracketing enables the researcher to achieve a direct contact with the phenomenon as it is 'lived' rather than as it is conceptualized (Matau & Van Der Wal, 2015, p.23).

Bracketing involves the researcher suspending all previous understandings, knowledge, and assumptions about the phenomenon of interest and their judgements of the natural world and its existence (Ahern, 1999; Kim et al., 2020; Neubauer et al., 2019). Bracketing is done to achieve transcendental subjectivity, involving constantly assessing the object of a study without allowing preconceptions and biases to interfere with it (Abalos et al., 2016). Phenomenological reduction begins with bracketing, setting aside knowledge of the phenomenon, and ends with accepting the phenomenon as it occurs without any preconceptions (Northall et al., 2020). To ensure objectivity of researchers, bracketing should occur during all stages of research (Ahern, 1999; Kim et al., 2020). Bracketing is a means of demonstrating rigour of data collection and analysis, allowing readers to assess the validity of research studies that presume to be free of researcher influence (Ahern, 1999; Kim et al., 2020).

Reflexive bracketing combines both bracketing and reflexivity within research. Ahern (1999) discusses the concepts of bracketing and reflexivity and suggests how researchers can perform reflexive bracketing throughout the research process. Ahern (1999) reports that it is impossible for researchers to remain totally objective in research, but that it is expected that researchers make a sincere effort to put aside their knowledge and value to describe others' life experiences. The ability to set aside one's feelings and preconceptions is a function of one's reflexivity (Ahern, 1999). Reflexivity involves the realization that the researcher is involved in the social world in which they study; it is the responsibility of the researcher to reflect on their own judgements and preconceptions and how it may impose on their research (Ahern, 1999). Ahern (1999) describes bracketing and reflexivity as "fruit from the same tree" (p.410), noting that one must be reflexive in order to bracket. How the researcher used reflexivity and bracketing within this study will be discussed later in this chapter.

Rationale for Approach

Phenomenology has become a leading means in the pursuit of knowledge development in nursing and is a popular approach for nursing researchers as it allows researchers to understand and value people's unique experiences in the context of nursing practice (Dowling, 2007; Kim et al., 2020; Wirihana et al., 2018). Phenomenology allows nursing researchers to seek perspectives of those who experience a phenomenon first-hand, critically examining experiences that are often taken for granted, and revealing hidden meanings (Matua & Van Der Wal, 2015). It has created a foundation for theoretical knowledge and methodological clarity and rigour for qualitative nursing researchers (Kim et al., 2020).

With the unique environment of rural hospitals, the specific challenges rural nurses face when working in rural areas, and the paucity of current Canadian literature, it is meaningful to

gain a better understanding of the lived experiences of RNs working in rural Ontario hospitals. The lived experiences of RNs and their intention to stay working in Ontario rural hospitals is the phenomenon of interest in this study. Husserl's descriptive phenomenology was deemed most appropriate for this study because it allows the researcher to explore, understand, and describe the experiences of RNs who experience the phenomenon first-hand (Neubauer et al., 2019).

Setting

Recruitment took place in three rural hospitals in Eastern Ontario. Each of these hospitals was in a rural community, as defined by the RNAO (2015). Each hospital varied in size in regard to the number of inpatient beds, but all hospitals had an emergency department, diagnostic imaging department, and laboratory.

Following approval from the Trent University Research Ethics Board on August 02, 2023 (Appendix A) the nursing leaders of the three hospitals were contacted by the researcher, and information regarding the study provided. Approval to conduct research from each hospital was received in August and September 2023 (Appendix B). Each site's nursing leader was provided with a recruitment email (Appendix C) and a recruitment poster (Appendix D) for email distribution to RNs working in their hospital. The researcher received confirmation from each of the nursing leaders that they had emailed out the recruitment information to potential participants, and that the recruitment poster was dispersed in nursing areas of the hospitals. A total of 115 RNs were included in the recruitment portion of the study.

Sampling

Samples in qualitative research tend to be smaller in size to support the depth of case-oriented analysis that is essential to the method of inquiry (Vasileiou et al., 2018). For this descriptive phenomenological study, criterion purposeful sampling was used to recruit

participants who could provide in-depth information about the phenomenon. Many qualitative samples are purposive, meaning participants are selected by their ability to provide rich, in-depth information that is relevant to the phenomenon of interest (Creswell & Poth, 2018; Vasileiou et al., 2018). Qualitative researchers argue that there is no straightforward answer to how many participants should be included in a sample (Vasileiou et al., 2018). Although there can be a vast range in the number of participants in qualitative studies, most of researchers recommend three to ten participants for phenomenological studies (Creswell & Poth, 2018). One of the most widely used principles to determine sample size and evaluate its efficiency is through saturation, providing an ample opportunity to identify themes between interviews (Cresswell & Poth, 2018; Morse, 2015; Vasileiou et al., 2018). For this study, a sample size of ten participants was sought out. There was no minimum threshold per site for the sample size.

Inclusion criteria for the study participants was RNs who were employed at one of the selected rural Ontario hospitals for at least two years and English speaking. Participants were screened for the inclusion criteria prior to scheduling interviews. Four RNs expressed interest in participating in the study following the initial recruitment email, and seven additional nurses expressed interest in participating in the study following a reminder email and invitation. A total of eleven nurses expressed interest in the study, with ten nurses returning signed consent forms (Appendix E), scheduling an interview, and participating in the study. In addition to written consent, each participant gave verbal consent at the beginning of each interview.

Data Collection

Qualitative data collection methods can include interviews, surveys, focus groups, participant observation, and field notes (Squires & Dorsen, 2018). In phenomenological studies, interviews are the most common approach to data collection (Squires & Dorsen, 2018). Data

collection occurred through virtual interviews. Interviews were scheduled to be approximately 60 minutes in length and were conducted through Zoom™ and ranged from 34 to 73 minutes. The virtual interviews allowed for increased privacy; participants were not seen meeting with the researcher in a local area within the small community.

An interview guide (Appendix F) was used, which consisted of questions and prompts, geared toward the participant sharing their experiences with the phenomenon. Demographic questions regarding participant time spent in nursing practice and working in a rural setting was included. Additional prompting questions were asked during each interview so that the participant could provide a deeper insight of their experience.

Each interview was recorded through Zoom™, as well as through a secondary audio recording device. Participants were asked for verbal consent at the beginning of the interview to be recorded. Notes were also taken during each interview in regards to participant responses. Researcher journaling to document bracketing and experiences during and following each interview was conducted (Ahern, 1999; Creswell & Poth, 2018; Kim et al., 2020).

Data Analysis

The researcher completed data analysis for this research. The Zoom™ transcription feature was utilized, and all completed verbatim transcriptions were reviewed for accuracy by replaying the live recordings and comparing them to the transcripts by the researcher. The data analysis period overlapped with data collection, with the researcher transcribing verbatim transcripts directly following participant interviews. A modified Colaizzi's analytic method (Edward & Welch, 2011; Northall et al., 2020) was used for data analysis in this study.

Colaizzi's approach to data analysis is consistent with descriptive phenomenology, providing a decision trail and a rigorous way to analyze qualitative data (Abalos et al., 2016;

Northall et al., 2020). Colaizzi's method includes the following steps (Edward & Welch, 2011; Wirihana et al., 2018):

1. Transcribe interviews held with each individual. Read and reread each transcript to obtain a familiarity and sense about the whole content.
2. Extract significant statements that pertain to the phenomenon.
3. Create formulated meanings from significant statements.
4. Aggregate formulated meanings into theme clusters and themes.
5. Develop an exhaustive description of the phenomenon's essential structure or essence. An exhaustive description is developed through a synthesis of all theme clusters and formulated meanings.
6. Develop a description of the fundamental structure of the phenomenon. The fundamental structure refers to the essence of the phenomenon as it is revealed by rigorous analysis of the exhaustive description of the phenomenon.
7. Confirm findings of the study through participant feedback.

In this study, the researcher did not seek participant feedback. Although this final step can be used within qualitative research, its inclusion in phenomenology is controversial (Northall et al., 2020). Within a phenomenological perspective, the researcher moves from the participants' descriptions of their experiences to a reflective consideration of the meaning of their experiences (Northall et al., 2020). The consideration of meaning may not be in line with the participants' understanding of their experiences, which could lead to participants disagreeing with the analyses (Northall et al., 2020). Depending on the time frame between interviews to the final review of analysis, participants may think differently; this time gap may also cause participants to re-live emotional experiences expressed in the original interview (Northall et al.,

2020). For these reasons, participants' review of the findings was excluded from the analysis. In the absence of confirming the analysis with participants, the researcher had research supervisors check data collection and analysis procedures, and engaged in an ongoing bracketing process (Northall et al., 2020).

The analysis process started during the data collection phase by the researcher reviewing and reading each transcript following participant interviews. The researcher read through each transcript while listening to the audio recording of each interview to ensure proper transcription. Prior to the analysis of the transcripts, each transcript was sent to the participant via email to review for proper transcription and representation. This process included parts of Step 1 and the substitute for Step 7 of Colaizzi's approach to data analysis. Step 1 was further completed by the researcher rereading each transcript for familiarization of the interview data.

In Step 2 of Colaizzi's method, the researcher identified significant statements from the transcripts. This step involved reading through each transcript and highlighting significant participant statements. A significant statement was any participant statement that related directly to the phenomenon of interest (Edward & Welch, 2011), or that seemed to be emotionally laden. The researcher pulled the statements from each transcript and gathered them into a single document to review. In Step 3, the researcher read through each significant statement and formulated its general meaning. The process of steps one to three were cycled throughout the analysis process, with transcripts being constantly reviewed, and formulated meanings being adjusted.

Step 4 of Colaizzi's approach is the development of thematic clusters and themes (Abalos et al., 2016); this is a two-step process. First, formulated meanings of similarity were gathered together and then assigned a thematic cluster by the researcher. Next, thematic clusters were

sorted into emergent themes. Transcripts were reviewed once more, to validate that thematic clusters and emergent themes were in line with the transcripts themselves. Step 4 resulted in the development of 21 thematic clusters and seven emergent themes.

In Step 5 of Colaizzi's approach, the researcher developed an exhaustive description of the phenomenon by synthesising the themes and formulated meanings (Edward & Welch, 2011). The researcher completed this by writing a detailed description of each theme and thematic cluster incorporating formulated meanings and significant statements. The exhaustive description developed by the researcher was sent to the research team for comments before moving onto the last step of analysis. Step 6 involved identifying the fundamental structure of the phenomenon. An informative statement was developed by the researcher completing a rigorous analysis of the exhaustive description of the phenomenon and ensuring it was in line with the research question.

Rigour

The requirements of rigour including credibility, dependability, confirmability, and transferability were fulfilled. *Credibility* relates to the confidence that the data is a true representation of the information that the participant provided for the study (Wirihana et al., 2018). This was achieved as each participant had the opportunity to review their transcribed interview, ensuring correct transcription of what they said. Transcripts were sent by email to each participant. Participants were asked if they were comfortable participating in a second interview in the event clarification or elaboration is required on something they shared during their primary interview. Secondary interviews were not needed for any of the participants within this study. *Dependability* was achieved by accurately documenting all processes undertaken, allowing the reader to determine whether appropriate research methods were adhered to (Wirihana et al., 2018). A detailed description of the research methods, including a step-by-step

description of the data collection and analysis process was created. *Confirmability* is obtained by two or more auditors agreeing to the meaning, relevance, and accuracy of the data presented (Wirihana et al., 2018). In this study, the research team reviewed and agreed with the researcher's data analysis. *Transferability* refers to the ability to apply results of a study to other situations or populations (Wirihana et al., 2018). Although results of the study have not been published, the findings of this study should be transferable for other rural hospital nurses outside of Eastern Ontario. Recommendations made from the study findings can be applied to multiple areas including rural nursing practice, nursing education, and healthcare leaders.

Personal Reflexivity

As a RN who has worked in a rural hospital, I have seen first-hand the struggle rural hospitals have with retaining nurses. Along with this, I have experienced nursing managers applying strategies for retention that they successfully used in urban hospitals, but not achieving the same results within the rural setting. I believe that rural nurses have a unique experience within their rural practice environments that affects nursing retention. I anticipate these lived experiences have both a negative and positive impact on nurses' intent to stay working in their rural hospital. It is important to explore the experiences of rural nurses, and share their thoughts, opinions, and practices to gain a stronger understanding of how such experiences can impact nursing retention.

For this study, I bracketed my own experiences and knowledge of working in a rural hospital to be able to gain a raw, and full appreciation for the participants' lived experiences. I kept a journal throughout the research process to write down my own thoughts and experiences, separating them from the data being collected (Adhern, 1999; Kim et al., 2020). As Adhern (1999) noted, it is impossible for the researcher to be totally objective, but that they must make a

sincere effort to put aside their values and accurately describe the respondents' life experiences. For this study, I recognized my connection to the phenomenon, and identified why I was pursuing this topic of interest. I felt very cognizant of my connection to rural nursing during the research process, but always ensured my focus was on the experiences shared by the participants. During participant interviews, I made participants aware that I worked as a rural nurse, but I tried to stay in an unknowing state of mind when asking the participants questions and clarifications. I believe that participants knowing my connection to rural nursing allowed them to speak more freely, as if they were talking to a co-worker. I attempted to ask further questions on experiences shared by the participant, that I may have experienced myself, but wanted to hear the experience in more depth from the participants perspective and not interpret it from my own thoughts.

During data analysis, I focused on what was said by the participants and how they said it. I bracketed my own thoughts and experiences, so that there was no influence on the analysis that was outside of the participants' experiences. I did worry that my data analysis would be portrayed by my research team as my interpretation of rural nursing, rather than from the experiences of the participants. To prevent this, I provided an audit trail of how I went through the data analysis process and ensured that each conclusion I made came from a participant source (i.e., themes developed were linked to direct statements and experiences from participants). I kept a reflexive journal throughout the research process, writing down my thoughts and feelings, as a self-reflective awareness process (Kim et al., 2020). I also completed a declaration of personal interest prior to beginning my study, where I disclosed my connection to rural hospitals.

Ethical Considerations

Participants were encouraged to not speak with their supervisors or colleagues regarding their participation in the study, to protect their own privacy. All participants within the study were assigned a pseudonym, and all personal information and identifiers were removed from the transcriptions to ensure privacy and confidentiality. Hospital, town, city, or landmark names/titles were removed, and replaced with a generic term placed in square brackets (i.e., [hospital], [city], etc.).

All personal information that was stored electronically was encrypted and password protected. Data was accessed on a password protected personal laptop and remote access was through a Virtual Private Network (VPN) connection. Upon completion of interviews and sending transcripts for accuracy, participant names and email addresses were deleted. Any paper forms of data collection, journaling, notes, etc. were secured in the home of the researcher, in a locked file cabinet. All data will be destroyed after five years.

Potential risks of the study to participants were that participants may become upset or distressed due to bringing up personal sensitive experiences during the interview process. Direct quotes from participants may be used in published material and presentations. Although every attempt has been made to remove personal identifiers, there is a risk that someone may recognize the pattern of speech of the participant. There were no direct benefits to participants for participating in the study. Participants were made aware of the risks and benefits of the study prior to participating, within the consent form, and by the researcher prior to the start of each interview. Participants were encouraged to reach out to the researcher if they had any questions or concerns following the interview. No participant reached out following the interviews with concerns.

CHAPTER 4: RESULTS

This chapter includes a brief description of the study participants, followed by the findings collected through virtual interviews and analyzed using Colaizzi's modified approach to data analysis. Seven major themes were developed, an exhaustive description was created, and a fundamental structure of the phenomenon was produced.

Participant Characteristics

A total of ten RNs participated in the study, two participants from Hospital A, and eight participants from Hospital B. No RNs expressed interest to participate from Hospital C. The participants held different roles in their rural hospitals, including one team lead, one nursing educator, three emergency room nurses, and five inpatient nurses. The participants' length of time in practice ranged from three to 25 years, with experience working in a rural hospital from three to 15 years. Four participants had only worked in a rural setting during their time as a RN, and six participants had RN experience in both rural and urban settings. Participant employment status included full-time (n=8) and casual (n=2).

Process and Findings Using Colaizzi's Modified Approach

Step 1

Step 1 of Colaizzi's modified approach to data analysis began in this study with the researcher transcribing each transcript following participant interviews. Completed transcripts were then sent to each participant for review, to ensure everything that they shared was captured correctly. Participants were encouraged to provide any feedback they had regarding the transcript with the researcher. One participant replied to the researcher after receiving the transcript, in which they stated that "everything looked good" (RN1).

The second part of Step 1 in Colaizzi's modified approach includes reading and rereading transcripts to gain familiarity. This step was done multiple times throughout the data analysis process, with the researcher rereading each transcript after each step within Colaizzi's approach to ensure analysis aligned with the essences of the transcripts.

Step 2

Step 2 of Colaizzi's modified approach involves extracting significant statements from the transcripts. After rereading the transcripts, the researcher began to highlight statements within each transcript that were significant to the phenomenon of interest, and that were said with emotion by the participant. Highlighted significant statements were then organized into a Word document table. Adjustments to the list of significant statements occurred throughout the data analysis process, as transcripts were reread, and further steps were taken. An insight taken from Step 1 and 2 of the data analysis process was that participants shared more negative experiences of working in a rural hospital than positive experiences. Common experiences were shared amongst the participants, and similarities were noted between the participants' feelings and thoughts of their intention to stay working at their rural hospitals.

Step 3

In Step 3 of Colaizzi's modified approach, the researcher assigned formulated meanings for each significant statement. Each significant statement was assigned a generalized meaning within a Word document table (Table 1). The researcher went through this step a second time after rereading the transcripts, to ensure each formulated meaning coincided with its significant statement.

Table 1

Examples of Significant Statements and Formulated Meanings

Participant Statement	Formulated Meaning
"My peeps, you know, my family and being part of that team."	Co-workers feel like a family
"I've definitely thought okay maybe that is the better thing to do is to work in a bigger center and where you're, you know, your focus is just nursing."	The nurse feels that they could focus more on nursing if they worked at a larger centre.
"You've gotta know what you're doing as a nurse when you work in a rural hospital."	Nurses have to know their stuff to work at a rural hospital.

Step 4

In the fourth step of Colaizzi's modified approach, formulated meanings are sorted based on similarity and assigned a thematic cluster and a theme. This step of the analysis resulted in the researcher returning to the transcripts and reviewing them again, multiple times. The first part of Step 4 is to sort formulated meanings based on similarities. This may include similarity in words within significant statements or similarity between the assigned formulated meaning. Once sorted, groups of similar formulated meanings were assigned a thematic cluster. Next, thematic clusters were aggregated into themes. Transcripts were reviewed again, validating that thematic clusters and themes were cohesive with the experiences described in the transcripts. From this step, twenty-one thematic clusters were identified, and seven themes were developed (Table 2) which included: Sense of Community, Pride and Identity, Weight of Responsibility, Feeling Alone, Questioning Commitment, Rural Reality, and Feeling Misunderstood.

Table 2

Thematic clusters aggregated into themes

Theme	Thematic Cluster
Sense of Community	Internal connectedness External connectedness
Pride and Identity	Recognition I have a skill set no one else has This is where I belong Sense of accomplishment Rural nursing is different
Weight of Responsibility	Wearing too many hats Pushed beyond comfort
Feeling Alone	The nurse is the resource You're on your own Lack of Support
Questioning Commitment	Would it be better somewhere else Lack of fulfillment Can I keep doing this
Rural Reality	Limited resources Stress of patient transfers Not able to meet patient standards Challenges with infrastructure
Feeling Misunderstood	People don't know what to expect What rural nurses do

The researcher returned to steps one through four after each time the transcripts were reread to ensure accuracy between the transcripts and data analysis. This process involved rereading transcripts, adjusting the list of significant statements, reviewing formulated meanings, and re-organizing formulated meanings into thematic clusters.

Step 5

Step 5 of Colaizzi's modified approach to data analysis resulted in the development of an exhaustive description, which included the synthesis of all formulated meanings, thematic clusters, and themes. During this step, the entire structure of the phenomenon was extracted, with description given to all themes developed from the transcripts. A description of each theme,

identified in Step 4 is presented, followed by an in-depth look into how each theme was developed, including descriptions of thematic clusters, and verbatim quotes from participants.

Sense of Community. The first theme provided significant insight on what participants understand about their intention to stay working at Ontario rural hospitals. This theme was endorsed by all ten participants, and came with the most positive experiences shared by the participants. Regardless of their shared negative experiences, all participants returned to the connections that they have with their nursing co-workers and their rural hospitals. *Sense of Community* incorporates the relationships that participants have with their nursing coworkers, hospital staff, and the hospital as a whole, as well as the relationship between the rural hospitals (including the participants) to the external communities. The theme *Sense of Community* was divided into two thematic clusters: internal connectedness and external connectedness.

Internal connectedness signifies the relationships participants had with their nursing co-workers as well as other staff within their rural hospitals. Participants described strong relationships with their nursing co-workers, often describing themselves as a family. One participant stated,

> I find in the smaller hospital I enjoy the kind of almost family dynamic that we have that you get so close to your co-workers when you're, there's so few of you, you get to know people so well and like on a personal level… (RN6)

Participants have developed a bond with their nursing co-workers, considering themselves friends both within and outside of the hospital,

> We've kind of become a close-knit family in a sense. I know like, we know everybody. I know everybody I work with. I know everybody's spouses that I work with. I know everybody's children that I work with, like their names. So, I feel like when you're that

> close with your co-workers, you develop kind of like a bond in the sense that you will always be there for each other. (RN10)

The relationships among nursing co-workers generated meaning behind the participants' conceptions of work; participants expressed that their reason for continuing to work at a rural hospital, despite challenges, was their relationships with their nursing co-workers. One participant explained,

> Sometimes, 'cause we're so close like we're quicker to like, I don't know, the people pick up shifts they don't really want to do. People stay late when they don't really want to do it because we know everybody and you don't want to let these people down. You don't want to leave them hanging and you don't want to see your friends struggle. (RN5)

The participants described a connection between themselves and the hospital as a whole. The atmosphere of their rural hospitals was described as caring and friendly, with one participant describing "...something that I've never encountered anywhere else" (RN3). Participants expressed that they feel like a person with a name and a life at their rural hospital, rather than as just an employee number. All staff at the rural hospitals were recognized as being helpful and supportive, with participants expressing their appreciation for staff who go out of their way to lend a helping hand.

> Christmas time, one of the housekeeping staff and his wife, who is one of our clerks in emerge, cook Christmas dinner for everybody in the kitchen. You don't get that in the big hospitals. You personally thank everybody, like someone comes and cleans a room for you, takes 10 minutes extra off their shift or someone stays for half an hour because you're busy or they see it's chaotic. Because they care. (RN1)

External connectedness was identified as part of the sense of community for the relationships between the rural hospitals as a whole (including the participants) to the external communities (the towns in which the hospitals are located, and the people within it). Participants described a strong connection between their hospitals and the external communities, stating that the communities love their rural hospitals. The external communities are supportive of the rural hospitals and staff within them, assisting in fundraising efforts, and donating items for patients and staff. The participants have developed connections with the people of their communities, and due to a repetition in patient encounters, nurses develop a familiarity of patient comorbidities, lifestyle, and family dynamics, leading to the participants feeling that they are able to provide better care to their patients. One participant shared an experience with a patient's family member,

> …the family was like so happy that she was with me and then also so happy that she was in [hospital] because she feels like the hospital knows her mom really well and provides the best care for her mom and she just really, really trusts and likes what we do at [hospital], so that was kinda nice to see. (RN4)

Participants expressed that they enjoy working with the patient population within the external communities, and felt that they are providing a service to their communities by working at their rural hospital. The participants commitment to their rural communities was also evident, with one participant stating, "...the fact that it is small, that it is personal. That you have a commitment to your community. You have ties to that community" (RN1). Participants also reported that they have built connections with local first-responders within the communities, "in a small town you do develop relationships with, you know, with the EMS and police and you have that level of respect for one another and trust" (RN7).

Pride and Identity. The second theme was the next emerging reason for participants' intention to stay working at rural hospitals. In this theme, the participants discussed their feel-good moments working in a rural hospital that were associated with pride and identity. *Pride and Identity* are divided into five thematic clusters: recognition, I have a skill set no one else has, this is where I belong, sense of accomplishment, and rural nursing is different. Each thematic cluster title was selected from specific phrases within the significant statements of the participants.

Recognition from co-workers, patients, families, and management was identified as a way in which participants felt good within their rural hospitals. Receiving recognition from a patient or family member was very important to the participants, who expressed that at times it feels that they are not able to do enough, but hearing positive feedback from patients and families helps them to keep going. One participant experienced this and stated,

> You don't think that you've made that big of an impact, then you get like these long thank you cards about how you guys like we made the stay so well and supported them and they felt so comfortable and things like that. (RN4)

Participants appreciated when they were recognized by their managers or by a co-worker for the work they had done, "I've had lots of circumstances too when management comes down and say they received a phone call or a letter talking about care for a specific patient and that's I think that's positive reinforcement too" (RN7).

The next thematic cluster, *I have a skill set no one else has*, signifies the pride that participants felt for their knowledge and skill set as a rural nurse. Participants stated that they must be well versed in a variety of patient illnesses, nursing interventions, and critical care situations when working at their rural hospitals. Due to this, participants have developed a vast knowledge and skill set, one that the participants see as being more advanced than a non-rural

nurse. One participant described their knowledge and skill set as a "superpower that no one else has" (RN6). Despite the stress of critical situations, participants expressed that they enjoy some of the challenges they are faced with working in their rural hospitals, including being hands-on in critical patient situations and having the autonomy to make decisions independently. One participant commented, "as far as, like professionally, I honestly, most of the time probably, 90% of the time enjoy the challenge. I enjoy the chaos" (RN5). Another participant shared their experience for returning to their rural hospital after being a student there,

> I really liked the idea that there's like no one else to take over for your patients, like if your patient starts doing unwell it's you, and I was really interested in critical care and I knew if I started somewhere else where there was an ICU, where there was a code team, and a rapid response team, and all of that that, it would kind of be taken from me. So, for those reasons I chose to come back to [hospital] as well. (RN10)

This is where I belong was a feeling that the participants expressed in regards to working at their rural hospitals. Participants believed they had found a place that they truly enjoyed working at, and did not consider leaving their rural hospitals, "I strangely feel like I've found a little bit of a place where I actually, as much as you do get burnout, I feel like I enjoy being there and I've now been there for almost like 4 years and I really do enjoy it" (RN4). Participants felt there was value in working as a nurse in a rural setting, "I can honestly tell you with a hundred percent certainty that I don't know that I could ever go back to a large size center or even a, I guess, a medium center" (RN3).

Sense of accomplishment was felt by participants when they were able to see their patients getting better from the care that they provided. Participants felt good when they could help patients get better on a daily basis, "I feel like any time I can make somebody suffering a

little better I feel pretty good" (RN8). Feeling good came from participants seeing patients getting better, being able to spend time with their patients, and being able to accomplish something as a team. Participants felt a *sense of accomplishment* when they were able to support patient families during difficult times, such as palliation. One participant shared their experience with helping families during a patient's death,

> At the end of somebody passing the family members are, you know, giving you a hug because they're so appreciative of what you've done, right? Like, because these are people that you're their nurse and the fact that they feel comfortable enough with you to like show a physical connection with you is pretty meaningful. (RN2)

A *sense of accomplishment* was experienced by the participants when the team was able to work together to stabilize and transfer out a critical patient, "... as a team, you work together and you were successful" (RN1).

The thematic cluster *Rural nursing is different* signifies the way that participants identified rural nursing as its own specialty. Participants believe that rural nurses are a different "breed of nurse" (RN9), and consider nursing at a rural hospital to be vastly different from nursing at a non-rural hospital. One participant stated, "nursing is nursing no matter where you are, but nursing in a rural hospital and nursing in a non-rural hospital are very different" (RN9). Participants described rural nursing as being different because of the increased responsibilities of RNs, having to work more independently, having less resources to work with, and having fewer specialties and staff to provide patient care. Prior to joining the rural hospital, many of the participants were naïve to the fact that nursing in their hospitals would be considered rural, and that it would be so different from their previous nursing experiences at non-rural hospitals.

> I had no idea what rural nursing was, and like, what was different to me. It was just a hospital and hospital nursing was hospital nursing until you get there and you're like oh wow no, this is hospital nursing but much different. (RN4)

Weight of Responsibility. The third theme in this study demonstrates the beginning of the impact that negative experiences have had on participants. The participants described many challenges, stressors, and negative experiences that they have encountered while working at their rural hospitals. *Weight of Responsibility* includes participants expressing that they have to wear too many hats as a frontline nurse, and moments when the participants felt that they were pushed beyond their comfort level or beyond the resources of the hospital.

Wearing too many hats was a phrase expressed by each participant, indicating that rural nurses take on many roles at the same time. Participants felt they had multiple nursing and non-nursing responsibilities as a RN in their rural hospitals, “having to wear so many hats because you know, yes I'm the nurse, but then now I'm the person answering the phone and booking the transfer and you get kind of caught sometimes” (RN1). The rural hospitals lacked many support services, leaving tasks such as portering, administration, clerical work, and housekeeping for the nurses to complete. Many of these tasks took place after regular work day hours, when available support staff leave the building, and nurses were the only ones working. Having to take on multiple roles at once caused stress and exhaustion for the participants.

> Times with the lack of RN resources where you're having to be like charge nurse and unit nurse and then somebody crashes and you're pulled in like a million different directions people needing your support. It's very, it's exhausting and stressful. (RN5)

Participants felt that the responsibility of having multiple roles was unmanageable for one person to do, and takes them away from focusing on patient care, “... you're now starting to wear too

many hats as a frontline nurse and not being able to concentrate on the direct patient care or the families" (RN3). Two participants described themselves and their roles as being a "jack of all trades", stating that they are trying to do everything at once, and that they aren't able to just focus on patient care (RN5, RN6).

Pushed beyond comfort illustrates the situations that participants felt pushed beyond their own comfort level, and beyond the resources of their hospitals. Multiple comments by participants revealed that they had been put into situations for which they did not feel prepared or did not feel comfortable with, including fears of risking their nursing license when put into critical situations or when facing extremely high nurse-to-patient ratios. Following these situations, participants feared they had missed something or made a mistake, leaving them with a feeling of dread and anxiety. One participant shared a stressful experience they had when a baby was delivered in their rural emergency department,

> Like any time when I have something that pushes me beyond my comfort zone. And that's not like a trauma where you got somebody's foot. Like we know how to do stuff. And we do it all the time, but it's when those things that you don't do very often, like deliver a baby. (RN1)

Participants described how easily a rural hospital can be pushed beyond capacity and abilities if more than one critical situation happens at a time (i.e., if a multi-vehicle accident were to occur).

> That's the other thing being small is, you know, it doesn't take much to push us into a code orange type situation. If we were to get a multi vehicle accident like we'd pretty much be taxed on resources right there. (RN3)

Feeling Alone. The fourth theme was a feeling mentioned by many of the participants regarding how they feel as a RN working at a rural hospital. This included participants physically

being the only nurse in their department, or mentally feeling on their own due to staffing ratios or a lack of support. Three thematic clusters were formed for this theme: the nurse is the resource, you're on your own, and lack of support.

When participants talked about nursing in a rural hospital, the researcher noted the thematic cluster of *The nurse is the resource*. Due to rural hospitals being smaller in size and staff complement, there are limited resources and people for rural nurses to depend on while providing care. One participant commented "so, when you work at a small hospital, you're sort of it, like you are the resource kind of thing. And, that made me very nervous at first" (RN3). This theme was clearly indicated when participants discussed taking part in code blue situations. Participants did not have extra people to lean on during critical situations, with many of the participants referring to "we're it" when it came to code teams within the hospital. At their rural hospitals, all nurses are expected to be well versed in code blue training due to a lack of a rapid response team.

> …In the hospital previous, you know you'd call a code blue, you pull the button, you would get the patient laying down and maybe get oxygen on the patient and the code cart to the room. And then the full team would be there to take over and you could just sort of back out of the way. Now, you have to be pretty well versed in running codes…I'm aware that there may be situations that, you know, I might be the one or working with other staff who we have to figure this out together, and get through that. (RN2)

You're on your own was a feeling multiple participants expressed that was accompanied with feelings of anxiety, dread, fear, stress, and frustration. One participant commented "just being such a small hospital and being in a rural community when you are a short staff you can sometimes feel very alone" (RN7). On multiple occasions the participants had felt isolated, and

that they were working on their own. This feeling was both a psychological and a physical occurrence. At times, the participants were the only RN working, as either the only RN accompanied by Registered Practical Nurses (RPNs), or as the sole nurse working in the department.

> You are pretty much by yourself when you're nursing at [hospital] in the sense that you don't have these like specialists, you don't have cardiology or surgery and all these specialized physicians that might be able to come in and help you. It's just you and your one lone doctor. (RN10)

Participants felt they had no one to depend on or help them when working as the only RN. Recollecting the experience of being the only RN working in their rural emergency department, one participant reported "it is an anxiety knowing, okay, my number 2 isn't here and I'm just here by myself" (RN6). One participant expressed the feeling of *you're on your own* due to working with agency RNs,

> I mean, they're lovely people, but they don't have the skill set or like the experience that we need. So, a lot of times you do have other RNs on paper, but a lot of times you feel like you're probably like the only registered nurse trying to hold the floor together. (RN4)

Lack of support was evidenced by the participants as a perceived feeling of being unsupported by management or feeling that they did not have anyone to lean on during critical situations. Participants described support as feeling listened to, having what they needed to provide patient care, being assisted in making decisions, being fully staffed with nurses, and having someone to mentor new nurses. A perceived feeling of being unsupported from previous management contributed to a negative working environment for many of the participants.

> Just because there have been so many changes and they (management) don't seem to, didn't really seem to care. They didn't really seem invested. They didn't really seem to want to support their nurses. And so, if you were short on a shift, it was on you to figure it out. (RN8)

Lack of support was expressed as a reason the participants had thought about leaving their rural hospital. One participant commented, “but I think honestly, the change in leadership, like the continuous changes and lack of consistency, lack of support, all those things have played a huge role in people choosing to leave long before they ever would have normally” (RN5). Lack of support was expressed when discussing new nurses, with participants expressing empathy for their new nursing co-workers who were put into the charge role position without mentorship or support.

> And you come to a hospital and you may be a nurse for not even six months and you're being thrown in a charge position. You’re being thrown into positions that you're not feeling supported. And unfortunately, that's not okay, really. Because I remember what it was like being a new grad, right? And those are the things that a new grad needs to feel supported in order to want to stay somewhere. (RN2)

Lastly, participants expressed there being limited support at night time, especially when a patient is not doing well and there are no extra staff to support them, including not having the primary physician onsite. “There's no doctor to help you on nights. There's not a lot of extra services so you need to be a strong nurse, you need to be able to hold your own and advocate for your patients” (RN8).

Questioning Commitment. *Questioning Commitment* arose from participants sharing challenging experiences, and included the thoughts that the participants had following negative

situations, including if they wanted to continue working at the rural hospital. This theme involved nurses discussing whether it would be better to work at a different hospital, having a lack of fulfillment within their work, and nurses questioning whether they were able to continue working at their rural hospital.

Would it be better somewhere else was a thought that many of the participants experienced following challenging situations. The participants asked themselves if they would be better off working at a bigger hospital where there would be more support, nurses, and less responsibility put on the nurse. One participant (RN10) discussed a critical situation and questioned leaving to go to a bigger hospital where doing the same things would come with fewer costs. The participant elaborated that fewer costs included somewhere where they could do their job safer, where they would feel better, and where they would have less fear of losing their license over something they missed.

> I had thought to myself, I could leave and do this exact thing that I like doing at a different facility with way less costs. Like I could do it without worrying about my other patients without being the charge nurse without being the ward clerk. I could do it all safely. I would feel better. I would have less fear of losing my license over something that I missed. (RN10)

Other participants commented that turnover, the loss of a nurse, may not be felt as strongly at a bigger hospital compared to their rural hospital.

> …if I was in a bigger hospital, I don't know if that would be the same because you're like just one of however many. But because I know I'm only one of like 10 staff downstairs and it will create so much stress on my co-workers if I did. So, I don't (leave). (RN1)

Lack of fulfillment had been felt by participants during their time working at their rural hospitals. At times, participants did not always feel fulfilled with their job. Participants described a feeling of numbness in regards to their work, no longer feeling surprised by high workloads or a lack of accomplishment. One participant (RN6) described that they did not feel the same joy from their job as they once had, expressing that everyone (staff, patients, and families) was exhausted and burnt out. This participant expressed that giving from their cup every shift without being able to refill it led to feeling miserable at work and within their own personal life, "this isn't fulfilling anymore. This isn't worth, you know, killing myself over and then at the end of the day being miserable every day and being miserable in my own daily life" (RN6). A second participant shared that they felt stuck, and that there wasn't anything else they could do to make things better, "we're just like helpless little worker elves, and yeah, we're stuck" (RN9). This participant described their emotions and actions as a rollercoaster, stating they were stuck in this continuous cycle of wanting to make a change, to no longer caring about making a difference. In moments when feeling unfulfilled, participants were less likely to try to make or advocate for changes.

Can I keep doing this? was a question participants had at some of their lowest times, typically following very challenging situations, where they did not know if they would be able to continue working at their rural hospitals. Participants questioned whether they could physically, mentally, and emotionally continue working at their rural hospitals due to the challenges they faced. Experiences that led to participants feeling this way included being overwhelmed as a new-graduate nurse, arguing with a manager who did not provide support, working critically short-staffed multiple shifts in a row, being yelled at by patients and families, and following a critical patient situation where the nurse was on their own. One participant shared,

> I remember working a night shift where I was the RN in charge and I had the telemetry monitors. And I had one RPN for one hallway and one brand new new-grad RN for the other hallway, there were three of us. And that was like one of those moments where I was like, how am I supposed to do this for the rest of my career? (RN4)

Another participant recollected their thoughts following a difficult shift working as the only RN and caring for a critical patient,

> If I had to come in for another day shift, I would have been calling in sick. I was on, I was looking for other jobs at larger facilities. Yeah, and expressing that I did wanna, that I did wanna quit. (RN10)

Lastly, one participant commented on an experience where they had questioned their commitment to the hospital and whether they could continue working there due to an argument with a non-responsive nursing leader within the organization.

> This person just always had like just like an answer for everything like, just argued everything like nothing you said they would actually listen to. There's just like an argument, like a defense, like they wouldn't believe you or wouldn't trust you or didn't care to listen to what you actually had to say. And I'm not a super emotional person, but I remember one day they just would not stop and were not listening and I was like basically at my breaking point and I just like beginning of the shift was in tears, had to leave sat in the break room for, I don't know, probably an hour and I was like, why am I even doing this? Like why do I care so much? Why am I having to fight with this person? Like this is not worth it. Like this is not me. This is not doing anything for me and I like, after that I was so close to leaving. (RN5)

Rural Reality. This theme refers to some of the challenges that participants face that are specific to working in their rural hospitals. *Rural Reality* included participants discussing the challenges of having limited resources at a rural hospital, the stress that comes from transferring patients to other facilities, participants feeling that they were not able to meet patient standards at times when working in their rural hospitals, and the challenges participants faced in their daily work due to issues with the infrastructure of their rural hospitals.

Limited resources were expressed as the biggest challenge for the participants while working in their rural hospitals. Participants considered limited resources to include specialties, equipment, staff, and finances. These limited resources resulted in many stressors and challenges for the participants.

> I recently had another shift where… I just went in for like a four-hour shift and it was very busy. Offload delays and a full waiting room and we literally didn't have enough like IV pumps. And, so in situations like that it can be really stressful because you can run things by gravity, but it comes down to time and stuff too and you can work so much more efficiently when you do have the supplies that you need, right, and the resources. (RN7)

Participants stated it was more difficult to do their daily jobs due to a lack of resources, and recognized that limited resources affected the abilities of managers and senior leaders, when it came to making decisions. One participant expressed their thoughts on their hospital's limited resources,

> You're expected to do everything that the big hospitals are in terms of, you know, the policies you have to put out. All the background stuff that needs to happen to make a

> hospital a hospital but you're getting much less of the funding that they're entitled to, which significantly reduces your resources. (RN3)

Stress of patient transfers was the second biggest challenge participants expressed due to working in a rural hospital. Due to a lack of specialties, many patients in rural hospitals must be transferred to larger hospitals for diagnostic imaging, consults, surgeries, and critical care management. One participant felt that patient transfers were the biggest challenge for their rural hospital,

> The biggest challenge I would say working in any type of rural hospital is just the reality that you deal with a lot of transfers. That would be, that would be a huge one. That impacts both, you know, patients, their families, staff, logistics. It just hits so many different targets. (RN3)

Participants expressed frustration with transferring patients, noting that it is stressful for the nurses to balance staffing when a patient needs to be transferred out and requires a nurse to go with them.

> You have to figure out whether you're going to give up a nurse to send somebody for a scan or they're going to miss their scan like which is the lesser of the two evils when it comes to that kind of thing, because obviously missing a scan can be detrimental to the patient, but having one registered nurse on the floor can also be detrimental to the rest of the patients. So, it's a balancing act sometimes for sure. (RN4)

One participant shared their experience on a transfer with a critical patient going to a larger hospital, “and I can remember just praying in the back of the ambulance that nothing bad happened on the way. Because I didn't know if I was equipped to deal with this situation if

something bad was to happen" (RN2). Due to this stressful experience, the participant no longer volunteers to go on ambulance transfers with critical patients.

Not able to meet patient standards was a feeling the participants had at times when providing care to their patients at their rural hospitals. One participant described their patients as second-class citizens due to a lack of resources provided at the hospital,

> And so, in that way sometimes you find your caught, but if we don't get our patients out, sometimes they're stuck there and we said why should our patients be second-class citizens when if that patient had a shown up in that emergency department, they would have been seen right away or they would have got that CT scan, right? (RN1)

Participants wondered if their patients would receive better or faster care if they had gone to a bigger hospital instead of a rural hospital,

> We have to send all of our patients out, which means a lot of transfers, which means a lot of waiting for appointments. I feel like if the patient was in a bigger center they would have gotten a lot quicker than they would have got in [hospital]. (RN10)

Another participant expressed being angry and frustrated when they know there are sick patients, but that their rural hospital is not able to provide the needed care, or there is no availability of resources to provide immediate care to the patient,

> It is stressful in that you don't want anything poor happen to the patient but it's like you feel like, okay, this is not what I signed up for. We are supposed to be providing you know, quality care to people, you know where they need to go. It's like helplessness, okay, I know this is the plan, we need to get them here. I know I'm not providing good care in an emergency department. This is not what we're built for. (RN6)

Challenges with infrastructure refers to challenges participants faced in their daily work due to issues with the physical structure of their rural hospitals. Participants expressed stress in basic duties such as toileting a patient or moving a patient in or out of a patient room due to small spaces,

> Even little things like sometimes it's down to the building structure, like to get a patient to the bathroom and rearranging furniture and finding a walker that literally can fit through the door. Things like that can be really frustrating, when you know it could be done more effectively, safely, and more efficiently if you just had, you know, maybe a newer facility or just more resources, I guess. (RN7)

One participant expressed the anxiety and stress they feel if the second patient in the room has to be moved out of the room to receive critical interventions, due to the complexity that comes with moving patients out of rooms,

> Trying to get a patient from a stretcher onto a bed that is in bed two is like, next to impossible, trying to get a patient out of a room to go for a test or if God forbid they code and trying to get them back to the OR is like impossible. (RN2)

Another participant shared a frustrating experience of when they were a new nurse at the hospital and the department did not have hot water for over a year,

> The first year and a half that I worked there, there was no hot water on the inpatient unit. So, we would have to go to our break room and boil a kettle, and then dispersed that into basins and then dilute it with colder water so it wasn't burning in order to wash our patients. (RN9)

This same participant reported that they felt that because their rural hospital was small, there are too few people trying to do too many things, not allowing there to be enough focus on things that needed to be fixed.

Feeling Misunderstood. The final theme that emerged from this study is *Feeling Misunderstood*. This theme represents that participants did not feel that their rural hospitals or their rural nursing roles were understood by others. Participants stated that others (patients, families, new staff, and staff from larger hospitals) did not understand the differences between rural and non-rural hospitals, and that others outside of the rural nurse role did not understand what rural nurses have to do each shift, or have unrealistic expectations of rural nurses.

People don't know what to expect was expressed by participants, stating that they did not feel that others outside of a rural hospital understand the differences between rural and non-rural hospitals. This was often described as others (patients and staff from larger hospitals) not understanding the limitations of a rural hospital.

> I think rural nursing is probably one of the best types of nursing that there is, but you have to be a MacGyver, and you have to be able to deal with not having those resources, and you just wished other people, other sites understood what you don't have, right? (RN1)

This misunderstanding resulted in nurses feeling stressed due to being questioned or yelled at by patients and families for not offering certain services, or by being belittled by staff from larger hospitals who questioned why a patient being transferred did not have a certain intervention done.

> Same with other family members as well, when they ask why a patient hasn't had their MRI yet or why a patient is still waiting on a PICC line. And as many nurses know, it's

> kind of the nurse that takes the brunt of it because they're the ones kind of talking to the family most often. But yeah, you do feel kind of like you're inadequate when those things are brought up to you or brought to your attention. (RN10)

Participants expressed that they do not feel that new nurses understand the complexity and responsibility of a nurse working in a rural hospital,

> I think absolutely people have no clue when they come in, I would say, 90% that come in that have worked in a bigger hospital have no clue, sort of what they're heading into. And I think that's a big part of why we don't retain staff sometimes. (RN2)

Some of the participants expressed being naïve themselves before starting at their rural hospital, not knowing the difference between rural and non-rural nursing and hospitals, "you almost believe like, hospital nursing is just like hospital nursing and you don't really consider [hospital] to be rural because it's 45 minutes away from another town. So how is that really rural?" (RN4)

What rural nurses do was shared by the participants for people outside of the rural nurse role not understanding what the nurse has to do each shift, or having unrealistic expectations of the rural nurse. Many participants expressed that they did not feel that their managers or senior leaders did not truly know the responsibility level of rural nurses,

> Our CEO doesn't. I know they did a shadow shift with me one day, but they didn't get it…It was an off day of course, so everything was going smoothly. And we had enough staff, of course. But yeah, they were like, well, this is good. And you shouldn't need to do this and you shouldn't need to do that. And I'm like, if we don't do it, then nobody else does. Like they don't seem to understand that it's us. Like things are going to magically happen. (RN8)

Other participants shared experiences they had with their own friends and families who did not know that rural nurses provided basic hygienic care.

> A big one from friends and family who are not nurses or not in healthcare are flabbergasted that I have to wipe butts. They are completely derailed by that. They mostly say like, aren't you an RN, though? And I say yes. And they're like, so why are you wiping butts? Isn't that a PSW job? Yeah, in larger centers, PSWs get to do that, but we don't have that so I do everything for my patients from the moment they wake up until the moment they go to bed that night... (RN9)

These participants expressed frustration that people didn't realize that rural nurses do everything for their patients, both nursing and non-nursing tasks. These tasks included, but were not limited to, administering medications, providing patient hygiene, portering patients for diagnostic tests, bed-flow planning, and answering the telephones.

In this step of the analysis process, the researcher attempted to describe notable features and give structure to the intentional, lived experiences of participants. The experiences shared by participants allowed the researcher to develop themes, with the majority portraying negative experiences and feelings. The consistent theme, even among the negative experiences, was that rural nurses continue to stay working at their rural hospital because of their co-workers and the relationships they have built with them. Many of the participants expressed being stressed by critical situations, but that overall, they enjoy the challenge and chaos that comes with working in a rural hospital. Almost every stressful or unpleasant situation that was reported, returned to participants appreciating their co-workers, feeling valued by their team, cherishing the relationships they have with their nursing co-workers, or having pride in their role as a rural nurse.

Step 6

Step 6 of Colaizzi's modified approach, and the final step within the data analysis process for this study was the development of the fundamental structure of the phenomenon. For this step, a reduction of the findings was done to remove redundant descriptions and emphasize the fundamental structure. By completing this step, the essence of the phenomenon and answer to the research question was discovered. The following fundamental structure and description of the essence was developed by the researcher.

Fundamental structure. Participants' understanding of their intention to stay working at rural hospitals derives from positive and negative experiences. Participants faced many challenges working in their rural hospitals including increased responsibility, working independently, having limited resources, and feeling misunderstood within their role. Despite challenges, participants had pride in their knowledge and skills, and viewed rural nursing as a speciality. Overall, participants believed that because their nursing teams are small within their rural hospitals, they form a bond with their nursing co-workers, considering themselves to be a type of family, and believe that they will always be there for each other. This was best described by one participant, who shared, "We've kind of become a close-knit family in a sense… I know everybody I work with… I feel like when you're that close with your co-workers, you develop kind of like a bond in the sense that you will always be there for each other" (RN10).

Description of the essence. In this descriptive phenomenological study, the researcher uncovered the essence of the experience of rural nurses' intention to stay at their work: *We are there for each other*. This essence represents the lived experiences of the ten participants who work in Ontario rural hospitals. Each participant spoke highly of their nursing co-workers, describing a bond that has formed between them, and often describing themselves as friends,

siblings, or a close-knit family. Participants commented on the support that they felt from their nursing co-workers, with participants sharing “we support each other” (RN2, RN5, RN6), “we help each other out” (RN7), and “will always be there for each other” (RN10). *We are there for each othe*r represents the bond that is formed between participants and their co-workers, which encourages participants to stay working in their rural hospitals despite challenges, as they understood they are there for each other during both professional and personal highs and lows.

Personal Bracketing Process

I utilized reflexive bracketing throughout this study to ensure that my knowledge and experience of working in a rural hospital did not influence the direction or findings of the study. During participant interviews, I considered myself to be neutral, being able to communicate with participants about general nursing events but asking participants to further explain or share their experiences from their rural perspective, to ensure I was not using my own rural nursing experience to infer what they were sharing. Rereading the transcripts helped me to ensure that significant statements I highlighted were common themes amongst participants, and not what I felt was significant from my own experiences. When developing themes, I thought about what was being said by the participants, and how their significant statements contributed to the themes I was developing. I constantly returned to the interviews, picturing in my head how a participant said something, while keeping my own similar experiences out of the picture.

Sinfield et al. (2023) explored how novice researchers go through the research process using descriptive phenomenology as their research method. The researchers discuss that within descriptive phenomenology, researchers move from *understanding* to *Understanding*, highlighting the different layers of understanding, and how researchers can move to a more complete *Understanding* of the research (Sinfield et al., 2023). This article, and the concept of

understanding versus *Understanding* resonated with me and my research process as a novice researcher. Reviewing the data analysis process multiple times allowed me to go deeper into the experiences of the participants, and allowed me to move to a more complete *Understanding* of the phenomenon. Similar to what was reported by Sinfield et al. (2023), I felt that this *Understanding* was a process, and not a single step. I believe that the process of *Understanding* was enriched by my reflexive bracketing, moving myself further away from my own perceptions, and assimilating myself into the data.

Bracketing throughout the research process allowed me to focus on the perceptions of rural nursing from the participants' experiences. While completing data analysis I utilized statements from all participants, ensuring that I was not quoting from one or two participants that had experiences similar to my own. Unveiling the essence of the phenomenon involved immersing myself in the data, and coming out with a common understanding of all participants. The essence came from similar words and phrases used by the participants that had meaning and feeling behind them. I believe the essence represents the experience of the ten participants in this study who work in rural hospitals, and does not reflect on my own rural nursing experiences. To assist with bracketing, I kept a journal throughout the entire research process to write down my thoughts and feelings, assisting me to further focus on what was shared by the participants. I was able to recognize that although my experiences of rural nursing are important to me, they needed to be separated from the study in order to gain a raw perspective of participants' experiences working in rural hospitals.

CHAPTER 5: DISCUSSION

The following chapter discusses the themes and essence that were identified in the study, and provides a comparison of the findings to the literature. Limitations of the study and recommendations for nursing practice, nursing education, healthcare leaders, and future research are suggested.

Themes

Sense of Community

Sense of community included two thematic clusters, internal connectedness and external connectedness. *Internal connectedness* referred to the relationships between the participants and the staff within the rural hospitals, especially with nursing co-workers. Participants shared that everyone knows each other within the hospitals, and that the atmosphere within the rural hospitals is friendly and caring. Participants expressed relationships they have with staff outside of the nursing group, including staff in housekeeping, laboratory, radiology, and dietary. Strong relationships between participants and physicians were noted, with participants stating that physicians rely on the nurses within the hospitals, and respect and value their knowledge and opinions.

Rural nurses' intention to stay and job satisfaction are positively influenced by relationships amongst hospital staff (McCallum et al., 2023; Sellers et al., 2019; Smith et al., 2021; Stewart et al., 2020). In order for rural nurses to function in their role, they must work as a team within their nursing groups (Medves et al., 2015; Smith et al., 2019). In their ethnographic study of rural nurses working in small community hospitals in Southern Ontario, Medves et al. (2015) found that participants were more likely to pick up overtime to help out their nursing co-workers, explaining how they knew how it felt to be short-handed. Hunsberger et al. (2009) had

a similar finding from one of the participants in their study of rural hospital nurses in Ontario, Canada, who noted that when they get called in to work, it's not just work calling, it's someone they know, which made them more likely to go in. This corresponds with the response of a participant (RN5) in this study, who noted that nurses are more likely to pick up overtime shifts or stay past their scheduled hours, as they did not want to see their friends struggling. Positive relationships between all hospital staff, including laboratory technicians, pharmacists, cleaners, and physicians, was expressed by participants in studies by Smith et al. (2021) and Hoppe and Clukey (2020), with participants from both studies stating that everyone in their hospitals were supportive of each other. The same supportive feeling was expressed by participants in this study, with one participant (RN7) sharing that they had good relationships with all staff within their rural hospital.

External connectedness is the second thematic cluster within the theme *sense of community*. *External connectedness* refers to the relationships between the rural hospitals as a whole (including the nurses) to the external communities (the towns in which the hospitals are located, and the people within it). Participants described a strong connection between their hospitals and the external communities (including community members, patients and families who live in the communities, and local first-responders).

The rural community in which nurses work is discussed within the literature, and is often cited as a factor influencing intention to stay or leave the rural hospital (McCallum et al., 2023; Penz et al., 2018; Sellers et al., 2019; Stewart et al., 2010). Smith et al. (2022) stated that positive satisfaction with rural communities can attract nurses to rural communities, and in turn, employment in rural hospitals. In their qualitative study of 13 RNs working in rural or remote hospitals in Australia, Rose et al. (2023) found that their participants wanted to give back to their

community, and working in their rural hospital allowed them to do so. This is similar to participants in this study, who felt that by working in their rural hospitals, they were providing a service or giving back to their communities.

Rose et al. (2023) also found that relationships with patients were deeper and more fulfilling for nurses working in a rural hospital. Relationships between patients and nurses were discussed by Medves et al. (2015), who noted that in rural hospitals, nurses get to know their patients and their histories well, contributing to relationships being formed between patients, their families, and the nurses working. In this study, participants commented that they are able to build better relationships with their patients because they spend more time with them (RN8), allowing them to know their patients' health history and social dynamics, and to form connections with patients and their families (RN1, RN4).

Pride and Identity

The theme *Pride and Identity* was divided into five thematic clusters: recognition, I have a skill set no one else has, this is where I belong, sense of accomplishment, and rural nursing is different. This theme included experiences shared by the participants that made them feel good, appreciated, and valued within their work.

Recognition from co-workers, patients, families, and management was identified as a way in which participants felt good, and motivated them to continue to work within their rural hospitals. *Recognition* was important for the participants, especially on days when they felt like the work they were providing was not enough for the patients. In their study surveying 436 nurses working in a rural hospital network in northeast U.S., Sellers et al. (2019) noted that nurses reported moderately high levels of recognition within their work. Smith et al. (2019)

found that despite the stress of staffing and workload pressures, nurses stayed working in their rural hospitals because they felt valued by patients, families, and the community.

Pride as it relates to nursing knowledge and skill was expressed frequently by participants in this study, and is heavily accounted for within the current literature. In this study, participants discussed having a knowledge base and skill set that they viewed as being advanced, and was required due to the variety of patient illnesses, nursing interventions, and critical care situations they are exposed to when working in rural hospitals. Along with this, participants expressed that they enjoyed being more *hands-on* while working in their rural hospitals, noting that they are more autonomous, and rely upon critical thinking skills.

Rural nurses are described in the literature as being expert generalists, with a diverse knowledge base and skill set (MacKay et al., 2020; McCallum et al., 2023; Medves et al., 2015; Penz et al., 2018; Smith et al., 202l; Smith et al., 2019). This was expressed in this study by RN6, who commented that their knowledge and set of skills was like a superpower that no one else had. Nurses working in rural hospitals report high levels of autonomy and input (Sellers et al., 2019), which increases the likelihood of being retained within the workforce (Stewart et al., 2010). In this study, participants noted that they have a lot of autonomy working in a rural hospital, with one participant (RN3) stating that they had never worked somewhere where their knowledge and opinion was so trusted and valued. Rural nurses often describe their work as exciting, being able to learn new things and use a vast array of skills on a daily basis (Hoppe & Clukey, 2020; Hunsberger et al., 2009). Similar to a participant in this study noting that the job "keeps them on their toes" (RN5), a participant in the study by Hoppe & Clukey (2020) also commented that they feel like they are always on their toes when working in their rural hospital. MacKay et al. (2020) found in their systematic review of qualitative studies of nurses' decision

to work in rural healthcare settings that there was a strong sense of pride from nurses in being able to make things work with less, and that these challenges are appealing to some nurses. Participants in this study voiced similar feelings, stating that they enjoyed the challenges that they are faced with within their work and that they would be bored if they had more help like at a larger hospital.

This is where I belong illustrates a sense of belonging felt by participants in this study, who believe that they have found a place where they truly enjoy working, and do not consider leaving their rural hospitals. Participants shared that they did not have any intention of leaving their rural hospital, with one participant (RN3) stating they would not be able to work at a non-rural hospital again. The literature reviewed included many factors that influence nurses' intention to stay working in rural hospitals, but little was found in the literature search of nurses expressing a feeling of belonging at their rural hospitals. Hoppe and Clukey (2020) reported that new rural nurses identified themselves as a nurse, regardless of if they were on or off shift, having a sense of belonging as a nurse to the rural hospital and community.

A *sense of accomplishment* was felt by participants when they were able to see their patients getting better from the care that they provided. Positive feelings resulted from participants seeing patients getting better, being able to spend time with their patients, and being able to accomplish something as a team. A sense of accomplishment was experienced by the participants when they worked as a team to stabilize and transfer out a critical patient or support palliation. Rural nurses find meaning in their work and believe they provide good care to patients, families, and community members (Hunsberger et al., 2009; Medves et al., 2015). Participants in the study by Hoppe & Clukey (2020) shared a great sense of identity, describing their job as rewarding and contributing to the community.

The last thematic cluster within this theme is *rural nursing is different*. Participants in this study considered nursing at a rural hospital to be vastly different from nursing at a non-rural hospital. These differences included the increased responsibilities of RNs, having to work more independently, having less resources to work with, and having less specialties and staff to provide patient care. Rural nurses having to provide care for a wide variety of patients is not a new occurrence, with MacLeod and Zimmer (2005) finding that nurses are expected to provide care to complex patients, who would receive care from specialized teams of nurses in urban hospitals. Sellers et al. (2019) note that rural nursing practice has unique challenges that impact recruitment and retention, in comparison to urban practice, including understaffing, the professional work environment, and lower compensation. One participant in Medves et al. (2015) study commented that they felt rural nursing was a speciality, whereas a participant in the study by MacLeod et al. (2008) compared themself to a city hospital nurse, stating that they were a different kind of nurse. Participants in Rose et al. (2023) study acknowledged that their rural hospitals allowed them to become more skilled in many areas of nursing practice in comparison to an urban setting.

Weight of Responsibility

The theme *weight of responsibility* highlights some of the challenges that the participants faced working in rural hospitals and includes two thematic clusters: wearing too many hats and pushed beyond comfort.

Wearing too many hats was a phrase expressed by each participant in this study, indicating that rural nurses take on multiple nursing and non-nursing responsibilities and roles while working in rural hospitals. Trying to balance the multitude of responsibilities and roles created stress, anxiety, and frustration for the participants, who felt that they were not able to

focus on patient care due to being overrun with responsibilities. Due to the diversity of work and a lack of resources, rural nurses become a *jack of all trades*, having to be prepared and willing to undertake any tasks or responsibilities that come their way (Hoppe & Clukey, 2020; MacKay et al., 2020; Smith et al., 2019).

In their qualitative study of nurse staffing and workload in small rural Australian hospitals, Twigg et al. (2016) found that nurses regularly undertake clinical activities associated with stocking of supplies, pharmacy, radiology services, and clerical work, in addition to their patient workload. Due to these tasks being undocumented as nursing time and activities, it was difficult for nurse leaders to fully determine what nurses do and their impact on patient safety and quality of care (Twigg et al., 2016). Participants in this study felt that their workload was unrecognized by their management, expressing that their managers or senior leaders did not understand what they did as nurses. This may relate back to the fact that much of the tasks performed by nurses are undocumented, and therefore, leaders do not recognize the amount of work nurses are doing during their shifts.

McCallum et al. (2023) also discussed the workload of rural nurses, noting that tasks completed by support staff or other professionals are frequently shifted onto nursing. These increased responsibilities for nurses often come without recognition, compensation, or education for the additional workload expectations (McCallum et al., 2023). Participants in this study frequently discussed taking on multiple roles including portering, administration, clerical work, and housekeeping, yet shared it was unmanageable to balance these additional tasks with their patient loads.

The theme *pushed beyond comfor*t illustrates the situations in which participants felt pushed beyond their own comfort level, and beyond available resources of their hospitals.

Multiple comments by participants revealed that they had been put into situations in which they did not feel prepared or did not feel comfortable when put into critical situations or when facing extremely high nurse-to-patient ratios. Although rural nurses have a broad range of knowledge and skills, the infrequency in performing certain skills can create stress and anxiety for nurses (Smith et al., 2019). Rural nurses may feel vulnerable or unprepared when they have to rely on rarely used skills during a critical situation, especially when there is no one more experienced than them in the hospital to assist (Hunsberger et al., 2009). During these times, nurses experience increased anxiety, while potentially placing the patient at risk (Smith et al., 2019). Participants in this study experienced situations as the only RN working in their unit, and having to rely on knowledge and skills they had never used before.

In this study, no participant directly spoke about working beyond their scope of practice, but they did feel they were risking their nursing licenses when put in critical situations with less staff and resources to support them. Rural nurses often work within a broad scope of practice (MacCallum et al., 2023; Smith et al., 2019). In a cross-sectional survey of nursing practice in rural and remote Canada, MacLeod, Stewart, et al. (2019) looked at RNs' perceptions of working beyond their scope of practice and found that 84.6% of rural and remote RNs perceived their work to be within their scope of practice, 9.8% reported working beyond their scope of practice, and 5.6% reported working below their scope. In rural and remote settings, where no physician is on site, RNs are expected to perform interventions to support patients' survival, which may be perceived as working beyond their scope of practice (Hunsberger et al., 2009; MacLeod, Stewart, et al., 2019). Intention to leave is greater among rural nurses who work beyond their scope of practice (McCallum et at., 2023; Stewart et al., 2020). Participants in this study expressed having feelings of intention to leave when they were pushed beyond their comfort.

Feeling Alone

Feeling alone was a sense that many of the participants expressed regarding how they feel as a RN working in their rural hospitals. Participants were physically the only nurse in their department, or mentally felt on their own due to staffing ratios or a lack of support. Three thematic clusters were formed for this theme: the nurse is the resource, you're on your own, and lack of support.

When working in a rural hospital with limited supplies and specialties, nurses do not have extra people on which to rely. In this study, many participants used the phrase "we're it" when it came to responding to critical situations; this is signified by the theme *The nurse is the resource*. In 1999, MacLeod examined RN practice in small hospitals in northern British Columbia, and titled the study *We're It* (MacLeod, Kulig, et al., 2019). The *We're It* study was the first of its kind in Canada, describing how the nurses' practice was multi-specialist in nature, and that rural nurses care for a wide variety of patient ages with many comorbidities, requiring knowledge and preparation for any situation (MacLeod, Kulig, et al., 2019). The nurses in MacLeod's study coined the term "we're it" to describe the frequent situation in which they held the burden of responsibility for knowledgeable action, despite having limited resources and backup (MacLeod, Kulig, et al., 2019).

Hoppe & Clukey (2020) had a similar finding to the term "we're it", with one of their participants stating "I'm it" (p.261) when referring to their sense of responsibility. Comparable to this, a participant in the Ontario study regarding resources and support for rural practice by Hunsberger et al. (2009) shared that when someone calls them to prepare the trauma team, they respond with "I am the trauma team" (p.20). Participants in this study had to rely on their own

experience, knowledge, and skills as resources when working in their rural hospitals due to limited supplies, staff, and specialties.

You're on your own was a feeling multiple participants expressed when talking about their experiences working in their rural hospitals. Participants expressed that being on their own was accompanied with feelings of anxiety, dread, fear, stress, and frustration. On multiple occasions the participants had felt isolated, and that they were working on their own. Professional isolation is a concerning aspect of rural work, requiring nurses to practice with a broad skill set, and overcome fears of unfamiliar situations (MacKay et al., 2020; Smith et al., 2019). The feeling of being alone for the participants in this study was both a psychological and a physical occurrence. At times, the participants were the only RN working, as either the only RN accompanied by RPNs, or as the sole nurse working in their department. This finding is collaborated by the existing literature, as many researchers report that rural nurses are the only health care professionals available at the hospital, managing an array of patients and departments (Smith et al., 2021; Twigg et al., 2016).

One participant (RN4) in this study discussed feeling alone as the only RN while working with agency nurses. The participant stated that agency RNs do not always have the skills and knowledge required to function within the rural hospital. Therefore, although there are multiple RNs working, the participant feels like the only RN. The use of agency nurses in rural hospitals is discussed within the literature, but there was no mention of how hospital employed nurses feel while working with agency nurses, specifically regarding the feeling of being alone.

The last thematic cluster within this theme was lack of support. *Lack of support* was expressed by the participants as feeling unsupported by management or within a critical situation. Participants described support as feeling listened to, having what they need to provide

patient care, being supported in decisions, being fully staffed with nurses, and having someone to assist new nurses. Penz et al. (2018) suggests there needs to be improvement to ensure that younger nurses are provided with adequate mentorship and are supported before being put into leadership positions. A lack of support was expressed by participants in this study during critical patient situations such as code blues. Rural nurses must rely on each other for support during critical situations due to a lack of resources, including not having backup from physicians who do not always stay on site at rural hospitals (Hunsberger et al., 2009).

Lack of support from management was expressed by participants in this study. Multiple participants stated that poor management created negative work environments for the nursing staff. Participants felt that previous managers were not present, did not listen, did not advocate for change, and did not provide support to the nursing staff. Participants in Smith et al. (2021) study experienced similar situations, with participants stating that management would pretend to listen but never followed through. Participants in the study by Hoppe & Clukey (2020) also experienced a reduction in management support, expressing a lack of presence and no follow-through. Supportive nurse managers are relevant to all areas of nursing, and critical in rural areas where demands can be high, teams are small, and the need to reduce burnout is crucial (Smith et al., 2022; Stewart et al., 2020). Participants in this study expressed improvements with new management within their hospitals, with RN8 sharing that their new manager listens and makes things happen. Nursing management is responsible for promoting a safe work environment, ensuring a supportive staff mix, and alleviating RNs' sense of isolation and responsibility (MacLeod et al., 2019; Smith et al., 2019). Senior support and management are identified as a key to morale and the retention and sustainability of staff (Jones et al., 2019).

Questioning Commitment

Questioning commitment often arose from a challenging experience, and included the thoughts that the participants had following negative situations, including if they wanted to continue working in their rural hospital. This theme was split into three thematic clusters: would it be better somewhere else, lack of fulfillment, and can I keep doing this.

Participants in this study expressed that following difficult situations they considered leaving their rural hospital and had asked themselves the question, *would it be better somewhere else*? The participants questioned if they would be better off working in a bigger, non-rural hospital where there would be more support, nurses, and less responsibility put on the nurse. Literature involving rural nurses' perceptions of potentially working in non-rural hospitals was overall lacking. Jones et al. (2019) found that rural nursing may potentially be an unattractive role compared to urban counterparts due to the requirement for increased skills, unfavourable working conditions, and lack of financial incentives. Factors for intention to leave are discussed within the literature, but do not address rural nurses' perceptions of working elsewhere, where things may be better.

Some participants stated that they did not experience their work as fulfilling, describing a feeling of *being numb* in regards to their work, no longer feeling surprised by high workloads or a lack of accomplishment. The loss of RNs from rural hospitals can create feelings of low morale, dissatisfaction, and distrust among remaining employees (Stroth, 2010). One participant in this study expressed similar concerns, sharing that at one point some of their nursing co-workers had expressed wanting to leave their rural hospital, and they did not know if they wanted to stay if everyone was leaving.

Some participants in this study expressed burnout from their work at their rural hospitals. Burnout has been included in many studies, including some specific to rural nurses. In their national cross-sectional survey, Smith et al. (2022) explored job satisfaction among rural hospital nurses in Australia. Smith et al. (2022) report that burnout can impair the attention nurses give to their patients, affect the way they deal with day-to-day stresses, and may cause a lack of motivation and disconnection. Participants discussed feeling burnt out, and were no longer able to find the same joy in their work as they once had. Subsequently, participants with high levels of emotional exhaustion reported lower levels of job satisfaction, which is a significant factor in nurses leaving their job (Smith et al., 2022).

Can I keep doing this was a question participants had at some of their lowest times, typically following very challenging situations; they did not know if they would be able to continue working in their rural hospitals. Participants questioned whether they could physically, mentally, and emotionally continue working in their rural hospitals due to the challenges they faced. Turnover and staff shortages in rural hospitals lead to higher nurse-to-patient ratios and longer working hours for many nurses, which causes stress and leads to intention to leave (Rose et al., 2023; Smith et al., 2022; Stroth, 2010). Nurses resign from rural hospitals when the values of the hospital conflict with the values of the nurse; this change in values may be the result of new leadership within the rural hospital (Bragg & Bonner, 2015). Positive management, including exchanges between supervisors and nurses is shown to positively impact retention (De Vries et al., 2023). Productive leadership styles are identified as authentic, upbeat, and ethical, while paternalistic leadership negatively impacts retention (De Vries et al., 2023). Participants in this study commented on their previous and current management teams, sharing that supportive managers and senior leaders aid in their intention to stay at the rural hospital.

Rural Reality

Rural reality refers to the challenges that participants faced that were specific to working in their rural hospitals. This theme was divided into four thematic clusters that represent the challenges expressed by participants: limited resources, stress of patient transfers, inability to meet patient standards, and challenges with infrastructure.

Participants stated that the most significant challenge they faced in their rural hospitals was the availability of resources, including limited access to medical specialties, lack of equipment, fewer nursing and support staff, and restricted budgeting. The lack of resources resulted in many stressors and challenges for the participants. Limited resources are a recognized issue for rural hospitals within the literature, with rural hospitals often being described as unique, operating with fewer staff and resources (Jones et al., 2019; Smith et al., 2021). McCallum et al. (2023) reported a similar finding in that the unique demands of rural nursing affect the transferability of policies, practices, and education influenced primarily by urban settings. Having fewer resources and access to other services requires rural nurses to have a much broader scope of clinical practice compared to urban counterparts (Rose et al., 2023). MacLeod, Stewart, et al. (2019) reported that as resources related to staffing and time decreased, RNs were more likely to perceive that they were working beyond their scope of practice. Participants in this study felt that because of the limited resources in their rural hospitals, they were not equipped to care for more complex or critical patients, a similar feeling experienced by participants in Medves et al. (2015) study, who felt they did not have the resources needed to provide the level of care to their patients that they would like to.

The second most significant challenge to working in a rural hospital that participants in this study shared was transferring patients out of the hospital. Due to a lack of specialties, many

patients in rural hospitals must be transferred to larger hospitals for diagnostic imaging, consultations, surgeries, and critical care management on a daily basis. Although patient transfers occur between urban hospitals, transferring patients to urban facilities with the required services for patient care needs is more common in rural and remote regions (MacKay et al., 2020; Pavloff et al., 2022). Twigg et al. (2016) reported that one rural hospital's overtime worked by RNs for patient transfers amounted to an additional full-time equivalent nurse. Staffing to accompany patients on transfers was viewed as a stress for participants in this study, who noted that nurses are often pulled to go on transfers, leaving one department or the entire hospital short staffed. Having to accompany a patient on a transfer can further stress nursing resources due to delays with the transfer services or accepting facilities, which prolongs RNs time away from providing care at the rural hospital (Twigg et al., 2016). Hoppe and Clukey (2020) found that participants in their study did not feel confident or comfortable with accompanying unstable patients on transfers to other facilities.

At times, participants in this study did not feel that they were able to meet patient standards when providing care to their patients at their rural hospitals. Quality of nursing care is affected by staffing shortages and inconsistent scheduling of shifts within rural hospitals (Smith et al., 2019). One participant (RN7) expressed their frustration working in a rural hospital when they are short staffed, reporting that it affects their care for the patients. Regardless of the hospital setting, inadequate RN staffing results in negative patient outcomes including increased falls, medication errors, and increased hospital acquired infections (Stroth, 2010). In this study, a participant (RN6) felt that their hospital was not built for the level of care patients required, stating that they did not feel like they were able to provide good care to patients in their emergency department.

The last thematic cluster within the theme *rural reality* was *challenges with infrastructure*. This referred to challenges participants faced in their daily work due to issues with the physical structure of their rural hospitals. Participants experienced increased levels of stress while performing basic nursing duties such as toileting a patient or moving a patient in or out of a patient room due to their hospitals lacking space. Smith (2020) reported that financial constraints of rural hospitals often halt progress on making repairs to older buildings. If financial conditions do not allow for repairing the building, rural hospital administrators must consider non-traditional methods to allow nurses to provide care to patients in safer built environments (Smith, 2020).

Feeling Misunderstood

Feeling misunderstood is the final theme representing that participants did not feel that their rural hospitals or rural nursing was understood by others, including patients, families, new staff, and staff at larger hospitals. This theme was divided into two thematic clusters: people don't know what to expect and what rural nurses do.

People don't know what to expect was expressed by participants, stating that people outside of their rural hospitals did not understand the differences between rural and non-rural hospitals. Participants stated that non-rural nurses did not understand the limitations of their rural hospitals, which includes people and equipment. This frustration from rural nurses is discussed throughout the literature, with rural nurses feeling underappreciated and perceived as uneducated by nurses at larger centres (Jones et al., 2019; Medves et al., 2015; Smith et al., 2019). Some nurses believed they are required to defend the patient care they provided when dealing with their counterparts at an urban hospital, often receiving judgemental responses from the nurses working in larger settings (MacKay et al., 2020). Similar to how participants in this study wished

non-rural nurses understood what nurses in rural hospitals are and are not able to do, participants in Medves et al. (2015) study felt that the generalist-specialist role of rural nurses was often misunderstood by their peers in larger centres.

Lastly, participants in this study believed that people outside of the rural nurse role do not understand what the nurse has to do each shift, or have unrealistic expectations of the rural nurse. Participants expressed that they wished senior leaders better understood the roles and responsibilities of the nurses; this is consistent with Smith et al. (2021), who reported that nurses need to feel respected and listened to by management, and know that their input is valued in solving unit issues and making decisions. Participants in the study by Hoppe and Clukey (2020) believed that non-rural nurses do not realize the advanced level of skill and knowledge of rural nurses, sharing that rural nursing often gets a bad reputation by non-rural nurses. Participants in this study shared similar experiences, reporting that their non-rural nursing colleagues were naïve to the complexity of rural nursing.

Discussion of the Essence

Participants spoke highly of their nursing co-workers, describing them as friends, siblings, and a family. Support and team-work between nursing co-workers was strong, with participants referring to the fact that because the team is small, co-workers become very close with one another. Participants described a bond that has formed between their nursing co-workers, stating that they know they will always be there for each other through personal and professional highs and lows.

Although nursing relationships, and its impact on nurses' intention to stay in rural hospitals, is discussed within current literature, only one article reviewed referred to nursing co-workers as a family. Hoppe and Clukey (2020) conducted a descriptive phenomenological study

of new nurses working in critical access hospitals (which served rural communities) in three midwestern states in the U.S. and reported that participants spoke highly of their relationships with rural hospital co-workers. Participants expressed that they enjoyed working in a small community hospital, as it was easier to get to know all the staff, which made them feel more comfortable and less stressed (Hoppe & Clukey, 2020). One participant stated that because of the hours nurses spent together at work, the co-workers had become a family; a second participant stated that the reason they stay at their hospital was because of the family atmosphere (Hoppe & Clukey, 2020).

The description of nursing co-workers as a family was used by multiple participants in this study, who stated that their main reason for staying within their rural hospitals was because of the people with whom they work. Some of the participants in this study had left the rural hospital to pursue other nursing careers, or had changed their employment status, but stated that the reason they came back to the rural hospital is because of the relationships they had built with their nursing co-workers. One non-healthcare related study exploring the effects of employee relationships on employee well-being commented that social bonds between co-workers are more commonly formed when organizations increasingly employ team-based models that heighten the need for social interaction to reach independent goals (Simon et al., 2010). Rural nursing is often described as using team-based approaches through team nursing care (Sellers et al., 2019) due to the small team size, which may provide insight on why participants in this study felt such a bond with their nursing coworkers.

Limitations

Limitations exist for this study. The first limitation of this study was that participants were only from two hospitals. Although a third hospital was included in the recruitment process,

only participants from two of the three hospitals volunteered to take part in the study. Of the ten participants, eight were from Hospital B. Similarities existed between all participants regardless of their hospital, but a better mix of participants may have provided further credibility of the findings.

Next, step 7 of Colaizzi's approach to data analysis, confirm findings through participant feedback, was not sought out for this study. The purpose of step 7 in Colaizzi's approach is to confirm that the exhaustive description and fundamental structure developed accurately depicts the participants' experiences of the phenomenon, with revisions being made based on participant feedback (Wirihana et al., 2018). This step was not included in this study as individual participant perceptions of the phenomenon may differ from the collective description of all participants' experiences of the phenomenon developed by the researcher, and to reduce participants having to relive any upsetting experiences they may have shared during their interviews (Northall et al., 2020). Although other methods to confirm findings were made, the inclusion of participant feedback as the last step within the analysis process for this study may have provided further credibility of the findings.

Another potential limitation to this study was the relationships between the participants and the researcher. The researcher was a co-worker of some of the participants prior to the study, which may have influenced participants to volunteer to take part in the study. The researcher utilized bracketing and reflexivity to ensure previous knowledge, relationships, and experiences did not influence the data collection, analysis, or findings of this study.

Lastly, a limitation exists due to the inexperience of the primary researcher. As a novice researcher, guidance from the research team was utilized to support the researcher throughout the

study. The researcher also worked diligently to learn about descriptive phenomenology, bracketing, and Colaizzi's modified approach to data analysis.

Recommendations

The purpose of this descriptive phenomenological study was to explore RNs' understanding of their intention to stay working in Ontario rural hospitals. Based on the findings of this study, and current nursing research, recommendations are made for nursing practice, nursing education, healthcare leaders, and future research.

Nursing Practice

Factors influencing job satisfaction in rural hospitals include nurse-physician relations, adequate staffing and resources, nursing manager availability, and leadership support of nurses (Smith et al., 2022). A nurturing team, where one feels supported, appreciated, and valued was pivotal to participants deciding to continue working in their rural hospitals. Rural nurses must work as a team, have strong communication, and help one another through difficult times (Smith et al., 2019). Participants in this study expressed having pride in their broad range of knowledge and skills; having to maintain such a broad range of skills can be both a stressor and motivator for nurses and continuing education (MacKay et al., 2020). Rural nurses should continue to seek opportunities to further their knowledge and stay up to date on best practices. Rural nurses who have opportunities for career and educational advancement report increased intention to stay in their current environment (Nowrouzi et al., 2015). Nurses who report job satisfaction are more likely to be retained in their nursing environment and retention strategies for rural nurses should include factors that promote job satisfaction.

One strategy to improve collegial support, nurse engagement, and job satisfaction is through the implementation of shared governance councils (McClarigan et al., 2019). Shared

governance initiatives lead to improved patient safety and satisfaction, and quality outcomes (McClarigan et al., 2019). One rural health system in Northern New York implemented a shared governance model after recognizing disengagement and poor satisfaction among their rural nurses (McClarigan et al., 2019). The organization created shared governance councils throughout their healthcare sites, which after laying down the foundation of the councils, saw great success for staff, patients, and their organization (McClarigan et al., 2019). The councils recognized areas of improvement throughout their organizations, and implemented further committees, practices, programs, and pathways to address the issues (McClarigan et al., 2019). Shared governance councils are an excellent way for rural nurses to become more engaged in their work, while providing insight on improvement initiatives (McClarigan et al., 2019).

Participants in this study discussed negative experiences they have had within their rural hospitals, which provided insight on what rural nurses could do to create changes in their environments. Rural nurses can advocate for patient safety measures, appropriate nurse-to-patient ratios, proper staffing of RNs, and take part in decision-making processes within their hospitals (Smith et al., 2022). By advocating for the implementation of shared governance councils within their rural hospitals, nurses are more likely to have their voices heard and create change within their working environments. Participants in this study expressed feelings of burnout, including working excessive overtime, or staying past their scheduled shift in order to not leave their co-workers short staffed. Limiting the amount of overtime that nurses feel they need to work (due to staffing shortages) can assist in better work-life balance, with nurses who work less than one hour of overtime per week being more likely to stay in their current position (Nowrouzi et al., 2015).

Nursing Education

This set of recommendations focuses on the educational needs of rural nurses, nursing students, and new-graduate nurses transitioning into rural practice. The need for rural nursing education is evidenced in the literature, and is imperative for rural nurses to stay up to date within their nursing practice. Greater opportunities for educational advancement are associated with the retention of rural nurses (Nowrouzi et al., 2015). Rural nurses require a diversity of educational needs, highlighting that rural nurses need to be proficient in routine practice, as well as prepared for infrequent critical situations (Corner et al., 2023). Educational needs for rural nurses include cardiac arrest, critical care, trauma, labour and delivery, pediatric care, health assessment and triage, care of older adults, palliative care, wound care, and mental health and addictions (Corner et al., 2023). Barriers for rural nurses pursuing education include financial costs, distance from their community, travel costs, organizational restraints such as lack of relief staff to cover nurses taking educational programs, and family commitments (Corner et al., 2023; Penz et al., 2018).

Nursing student placements often take place within larger, urban hospitals, with few placements occurring at rural hospitals (Smith et al., 2022). Creating more rural nurse placements may attract more nursing students to rural areas, and increase their likelihood to return to the rural hospital for employment (Smith et al., 2022). This strategy can also increase recruitment of other members of the healthcare team, including physicians (De Vries et al., 2023). Collaborations between rural hospitals and university programs, as well as subsidies for nursing students to travel to clinical placements may aid in students attending more rural placements (Corner et al., 2023; Smith et al., 2022). Alberta Health Services has partnered with the University of Calgary to offer a bachelor’s of nursing degree program to provide education

within local communities (Alberta Health Services, 2024). This program gives individuals opportunities to become trained healthcare professionals within their small towns (Alberta Health Services, 2024). Courses are offered online, with labs and clinical practice placements being delivered in-person at sites within the available communities (Alberta Health Services, 2024).

Participants in this study shared that they have a broad scope of knowledge and skills, and although they see some things more infrequently than others, they need to be ready to do anything. Education for rural nurses should be readily available and accessible, and be offered through a variety of modalities, including mentoring programs, online modules, simulations, group learning, and interprofessional education (Corner et al., 2023). The University of Calgary offers several continuing education and professional development courses offered both in person or virtually (University of Calgary, 2024). In-person courses include pediatric fractures, trauma nursing, emergency medicine, and rural anesthesia (University of Calgary, 2024). The University of Calgary (2024) also offers a rural virtual conference, with weekly virtual seminars presented by clinical experts which focus on evidence-based information that is applicable to rural and remote primary care and hospital environments. Similarly, the University of Northern British Columbia (UNBC) offers a rural nursing certificate program that provides learning through distance education, workshops, and clinical placements (UNBC, 2024). To cover the vast knowledge required for rural RNs, the program's coursework focuses on health assessment, chronic disease management, palliative care, wound care, perinatal care, care of older persons, emergency and trauma nursing, and mental health and addictions (UNBC, 2024). These educational opportunities can be explored by rural hospitals, with healthcare leaders providing time for rural nurses to participate in continuing education courses outside of work hours.

Financial support is available for both hospitals and nurses to explore continuing education opportunities. Ontario Health, in collaboration with the Ministry of Health have established *The Emergency Department Nursing, Education, Retention, and Workforce Program* in 2023 (Ontario Health, 2023). This program aims to support recruitment, retention, and training for emergency department nurses by providing virtual training modules, in-person department training, educational grants, and establishing regional emergency department nurse educators (Ontario Health, 2023). This program is available for all Ontario emergency departments, but would be an excellent avenue for rural hospitals to explore funding and educational opportunities for their rural emergency nurses. For rural nurses, education reimbursement is available on an annual basis from the RNAO and Registered Practical Nurses Association of Ontario.

Healthcare Leaders

Healthcare leaders can use the findings of this study to promote and build on the positive aspects, while trying to reduce the negative experiences in order to foster nursing retention. One common aspect expressed by participants was the need for supportive managers and senior leaders, and the effect that turnover of hospital leaders has on nurses. Participants in this study commented that they believed that the change in leadership, continuous hospital changes, lack of consistency, and lack of support played a large role in why colleagues chose to leave. Significant predictors of intention to leave rural hospitals include nurse manager ability, leadership, and support of nurses (Smith et al., 2022). Supportive managers are those who accessible and engage staff in decision making about ward and hospital issues (Smith et al., 2021; Stewart et al., 2020). Nursing managers and leaders play a vital role in creating a safe and cohesive work environment, and can influence job satisfaction among nurses (Sellers et al., 2019; Smith et al., 2022).

Nursing leaders can advocate for shared governance councils within their hospitals, helping to facilitate decision making that is driven by nursing decisions (Medeiros, 2018). From this study, participants expressed wanting more presence from senior leaders, having better avenues for communication, and including nurses in decision-making processes. Other recommendations for healthcare leaders from the results of this study include ensuring appropriate staffing for nursing departments, facilitating a better process for patient transfers, providing in-house educational opportunities, creating an in-depth orientation plan for new staff, and exploring all opportunities for funding to help address the lack of resources.

Nursing Research

This study contributes to current literature of RNs' intention to stay working in Ontario rural hospitals, but more avenues for research still exist. Participants shared that the most important reason for continuing to work at their rural hospitals was because of the relationships that they had formed with their nursing co-workers, describing their co-workers as friends, siblings, and a family. Researchers have explored rural nurse relationships, but little is said about rural nurses' perception of their co-workers as a family or about the bond formed between nursing co-workers. The question remains of whether this bond or connection is unique to rural nursing groups, or if it is found within their urban counterparts as well. Although the bond felt between co-workers in this study was positive, some rural nurses may feel obligated to stay at their workplace to support their co-workers, giving it a negative association. This association could be further explored in nursing research.

Participants in this study discussed that they felt more support from their nursing co-workers compared to their managers or senior leaders. An exploration into rural nurses' perceptions of support within their environment, and how it affects their job satisfaction and

intention to stay or leave can be explored. Lastly, participants discussed that turnover and changes in leadership created stress on the nursing staff. Researchers have explored how rural healthcare leaders can affect intention to leave or stay, but examination of the relationship between management turnover and nurses' perceptions of their work, job satisfaction, and intention to leave or stay in their rural work environment is needed.

CHAPTER SIX: CONCLUSION

The purpose of this descriptive phenomenological study was to explore RN's understanding of their intention to stay working in Ontario rural hospitals. Nurses' experiences working in rural hospitals have been well studied, but a gap existed regarding RNs' understanding of their intention to stay working at rural hospitals. Much of the research available regarding intention to stay is from a quantitative perspective, leaving an opportunity for a qualitative understanding of how RNs' experiences influence their intention to stay working in rural hospitals. Findings of this study contribute to current research regarding RNs' experiences working in rural hospitals and their intention to stay.

A descriptive phenomenological approach was used to answer the question: what do RNs understand about their intention to stay at Ontario rural hospitals? Data collection included virtual interviews with ten RNs working in rural hospitals in Eastern Ontario, Canada. The researcher completed data analysis using Colaizzi's modified approach. The analysis led to the development of seven themes, a fundamental structure of the phenomenon, and a description of the essence. The seven themes developed from participants' experiences were: Sense of Community, Pride and Identity, Weight of Responsibility, Feeling Alone, Questioning Commitment, Rural Reality, and Feeling Misunderstood.

What the researcher understood to be the essence from the themes of this phenomenological study was *we are there for each other*. This essence represents the ten participants' experiences working in Ontario rural hospitals. Participants in this study spoke highly of their nursing co-workers, often describing themselves as a group of friends, siblings, or a close-knit family. Participants believed that because their nursing teams were small, they had formed a bond with one another. Participants described feeling strong support from their nursing

co-workers, and forming relationships both within and outside of their rural hospitals. *We are there for each othe*r represents the bond that was formed between participants and their co-workers, which encouraged participants to stay working in their rural hospitals despite challenges, as they believed they are there for each other during both professional and personal highs and lows.

Recommendations for nursing practice, nursing education, healthcare leaders, and nursing research have been made based on the findings of this study. For nursing practice, rural nurses value supportive co-workers who work as a team, have strong communication, and help one another through difficult times. Rural nurses are required to hold a broad scope of knowledge and advanced skill set, which requires ongoing education and training to allow rural nurses to stay up to date on practice changes.

Greater opportunities for nursing education can aid in the retention of rural nurses. Education should be offered through a variety of modalities including mentoring programs, online modules, simulations, group learning, and interprofessional education. Rural nurses need to advocate for increased education and training within their rural hospitals.

Health care leaders can use the findings of this study to promote and build on the positive aspects, while trying to reduce negative experiences of nurses in order to foster nursing retention. Participants in this study valued supportive managers, while commenting that turnover of leaders and managers who were unsupportive or did not listen to nurses increased thoughts of intention to leave. Managers and senior leaders should be present among nursing staff, have strong avenues for communication, and include nurses in hospital related decision-making processes.

Participants in this study described a bond formed between their nursing co-workers, often describing themselves as a type of family. Relationships among nursing co-workers have

been explored in the literature, but a gap remains regarding nursing bonds and views of being a family. Participants expressed that they help their co-workers out, and are more likely to pick up extra shifts in order to prevent their co-workers (and in the participants' view, friends) from being short staffed. Future research can explore nursing loyalty to their co-workers and its positive and negative associations on nurses' perceptions of their work. Lastly, further research can be conducted to examine the relationship between management turnover and nurses' perceptions of their work, job satisfaction, and intention to leave or stay in the rural work environment.

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Appendix A

Trent University Research Ethics Board Approval letter

August 02, 2023
File #: 28631
Title: Registered Nurses' intention to stay working in Ontario rural hospitals
Dear Mrs. Coady,
The Research Ethics Board (REB) has given approval to your proposal entitled "Registered Nurses' intention to stay working in Ontario rural hospitals".
When a project is approved by the REB, it is an Institutional approval. It is not to be used in place of any other ethics process.

To maintain its compliance with this approval, the REB must receive via ROMEO:

An Annual Update for each calendar year research is active;

A Study Renewal should the research extend beyond its approved end date of April 26, 2024;

A Study Closure Form at the end of active research.

This project has the following reporting milestones set:

Annual progress report-2023/12/31
Renewal Due-2024/04/26

To complete these milestones, click the Events tab in your ROMEO protocol to locate and submit the relevant form.

If an amendments to the protocol is required, you must submit an Amendment Form, available in the Events tab in your ROMEO protocol, for approval by the REB prior to implementation.

Any questions regarding the submission of reports or Event forms in ROMEO can be directed to Anna Kisiala, Coordinator, Research Conduct and Reporting, at annakisiala@trentu.ca
On behalf of the Trent Research Ethics Board, I wish you success with your research.
Best Wishes,

Dr. Liana Brown
REB Chair
Phone: (705) 748-1011 ext 7238
Email: lianabrown@trentu.ca

c.c.: Anna Kisiala
Coordinator, Research Conduct and Reporting

Appendix B

Hospital Recruitment Approval Letters

[redacted]

September 22, 2023

Ms. Ashley Coady
C/O Trent University
Master of Science in Nursing Program

Re: "Registered Nurses' intention to stay working in Ontario rural hospitals

Dear Ms. Coady

Thank you for submitting your proposal "Registered Nurses intention to stay working in Ontario rural hospitals" to [redacted] Health's Research Ethics Board (REB).

I am writing to you today to confirm that members of the REB reviewed your proposal and have no issues with approving it for the period of one year from the date of approval.

All the best with regards to your study, if you have any questions, please feel free to contact our office.

Regards

[redacted]

Research Ethics Board

[redacted]

[redacted]

[redacted]

August 30, 2023

Ashley Coady, RN
[redacted]

Re: Application to Conduct Research at [redacted] Hospital [redacted]

Dear Ashley,

To support your Masters of Science in Nursing Program, I am pleased to confirm that your application to conduct research at [redacted](re. RNs intention to stay working in Ontario rural hospitals) has been approved.

If you require anything further, please feel free to reach out to me.

Regards,

[redacted]
RN, BScN, ENCC, MBA
Vice President Patient Care and
Chief Nursing Executive

[redacted]

Appendix C

Recruitment Email

Dear Registered Nurses,

My name is Ashley Coady, I am a Master's of Science in Nursing student at Trent University. I am conducting a research study to explore Registered Nurses' experiences working in rural hospitals, and their understanding of their intent to stay.

I will be conducting individual interviews over Zoom©. Interviews will be approximately 60-minutes in length and will take place between October-November 2023, scheduled at your availability. Interviews will be recorded, including an audio recording. All personal information and identifiers will remain anonymous, and each participant will be given a pseudonym. For this study, I am looking for participants who meet the following criteria:

- Is a Registered Nurse (RN)
- Is currently working at a rural hospital in Ontario for minimum of 2 years
- Is English speaking
- Is willing to share their personal experiences working as a nurse in a rural hospital.

Volunteering for an interview is greatly appreciated. The data gathered from this research is intended to assist rural hospitals in working towards nursing retention initiatives, understanding nursing needs, and opportunities for nursing support. There is no direct benefit or compensation for participating in this research study. This study has been reviewed by the Trent University Research Ethics Board (file # 28631) on August 02, 2023.

For more information regarding this study, please reach out by email and review the corresponding recruitment poster.

If you are interested in participating in this study, please connect with me by email at asbuck@trentu.ca by October 22, 2023.

If you have further questions, please do not hesitate to email me.

Sincerely,

Ashley Coady, BScN, RN
asbuck@trentu.ca

Appendix D

Recruitment Poster

PARTICIPANTS NEEDED

EXPERIENCES OF RNS WORKING IN ONTARIO RURAL HOSPITALS

PARTICIPANT CRITERIA:

- Registered Nurse
- Work at an Ontario Rural Hospital for > 2 yrs
- English speaking

STUDY PURPOSE:

- The purpose of this study is to gain a better understanding of RNs experiences and their intention to stay working at an Ontario rural hospitals

DATA COLLECTION:

- Information will be collected through a virtual Zoom interview, approx. 60 min in length. Interviews will take place Fall 2023, at the convenience of the participant.

BENEFITS & RISKS:

- There are no known benefits or compensation for participating.
- Risks may include participants becoming upset or distressed due to discussing sensitive experiences.

SCAN CODE TO SEND AN EMAIL TO THE RESEARCHER

RECRUITMENT DEADLINE: OCTOBER 22, 2023

FOR MORE INFORMATION OR IF INTERESTED IN PARTICPATING CONTACT:

Ashley Coady, BScN, RN
asbuck@trentu.ca

This study has been approved by the Trent University Research Ethics Board (File #. 28631)

Appendix E

Participant Consent Form

Informed Consent:
You are invited to participate in a research study *"Registered Nurses intention to stay working in Ontario rural hospitals"*

Principal Investigator (PI): Ashley Coady BScN, RN
Contact information: asbuck@trentu.ca

Research Supervisor: Amy Hallaran PhD, RN
Contact Information: amyhallaran@trentu.ca

Department and institutional affiliation: Master of Science in Nursing, Trent University

Introduction

Please read this consent form carefully and feel free to ask the researcher any questions that you might have about the study.

This study has been reviewed by the Trent University Research Ethics Board (application file # 28631) on August 02, 2023.

You have been invited to participate in this study because you are a RN working in an Ontario rural hospital. You are being asked to participate in a study that will help us to understand how the experiences of nurses working in rural hospitals influences their intent to stay in their job. In this study, you will participate in an individual interview using Zoom©. It will take approximately 60 minutes of your time. The purpose of the interview is to explore your personal experiences, thoughts, and feelings of working as a nurse in a rural hospital. The PI will be asking questions related to your feelings toward your job, the challenges you face, how you are supported in your work, etc.

Before agreeing to participate in this study, it is important that you read and understand the following explanation of study procedures. The following information describes the purpose, procedures, conditions, risks, and benefits associated with this study and your right to refuse to participate or withdraw from the study at any time. You should understand enough of the study risks and benefits to be able to make an informed decision before deciding whether you wish to

participate. This is known as the informed consent process. Please inquire with the PI via email to explain anything you do not understand before signing the consent form. Make sure all of your questions have been answered to your satisfaction before signing this document.

Purpose and Procedure

We are recruiting participants who are RNs, and who currently work in a rural hospital in Ontario (for a minimum of 2 years). Participants must also be English speaking. Participating in this study will be conducted online over the online Zoom© platform.

Once consent is given, you will be provided with a checklist to prepare yourself for the Zoom© call (approximately 60 minutes in duration). This checklist includes: installing Zoom© on your computer, changing your name on the display (if you prefer to use a pseudonym), checking the internet connection, ensuring you are located in a quiet, distraction-free location, ensuring the background of your display is blurred or displays a plain background or the camera is turned off if desired. On the day of the Zoom© call, you will be emailed the call details. During the interview, you will be asked questions about your personal experiences, feelings, challenges, support systems, and thoughts. Afterwards, the PI will send you a transcribed transcript of the interview (with no personal information or identifiers). You will have the opportunity to review this transcript to ensure everything has been properly captured.

Information will be collected from participants at various times during the project. The PI will gather information in the following ways:

- Through observation during the Zoom© online session by taking notes about how you participate in the Zoom© sessions, comments you make and/or ideas you share.
- While the meeting will be recorded, only the audio files will be kept. Zoom© creates independent audio-only and audio/video files when a meeting is recorded. The audio/video file will be deleted immediately after the meeting.

Findings from this project may be published in journals and presented at conferences. Your identity will always remain anonymous. If any quotes are used, participants will be referred to using a pseudonym or participant assigned number. This research will begin in September, 2023 and will span an expected period of 9 months.

Potential Benefits

We cannot guarantee any direct benefits from being in this study. The data gathered from this research is intended to assist rural hospitals in working towards nursing retention initiatives, prioritizing nursing needs, and increasing nursing support. Information learned from this study may help to find new data on how to improve nursing needs, support, and retention in rural hospitals. As a participant, you may find that reflecting and describing pleasant aspects of working in a rural hospital provides feelings of joy and comfort.

Potential Risk

There are minimal risks associated with this study. Potential risks include feeling upset, embarrassed, or worried while sharing work experiences during the interview. We ask that you keep your participation in the study private, and do not share your participation or what you have said during interviews with your colleagues. This will help prevent the professional risk of managers or administrators learning what you have shared during the interview regarding your

work. Direct quotes from participants may be used in published material and presentations; although every attempt will be made to remove personal identifiers, there is a risk that someone may recognize the pattern of speech of the participant. If you experience any risk or harm as a result of this study, please contact the PI Ashley Coady (asbuck@trentu.ca).

Storage of Data

Personal information such as email will be collected, which will be used to send call details to participants individually. Information regarding your nursing status, years of service, and working environments may be asked verbally during the interview. Data from the interviews includes audio-only, as well as researchers notes and anonymized audio transcripts. Video will be destroyed immediately after the call. Audio will be transcribed by the researcher and destroyed at the end of the study.

All information collected during the study, including your name, place of work, and nursing status, will be kept confidential and will not be shared with anyone outside the study unless required by law. You will not be named in any reports, publications, or presentations that may come from this study.

Data collected will be aggregated for publication. Quotes will be mentioned using a pseudonym or participant number. Only the PI and the research team will have access to the interview data. Research data will be encrypted and password protected. Data will be accessed on a personal laptop; remote access will be through a Virtual Private Network (VPN) connection. If there is a data breach, the PI will contact Trent University's Research Ethics Board to discuss the recommendations for the next steps of action. All data will only be kept for 5 years post study completion should there be any concerns of scientific misconduct. After this time period, all data will be properly destroyed.

Confidentiality

Your privacy shall be respected. In order to protect your anonymity. The information you provide in this form will not be stored with personal identifiers, nor will you be identified in any recorded or published comments. The transcripts from the Zoom© calls proceedings, as well as any other data collected, will be stored securely and will be destroyed after 5 years or once all data has been published. By consenting to participate, you do not waive any legal rights or recourse.

This research study includes the collection of demographic data which will be aggregated (not individually presented) in an effort to protect your anonymity. No information about your identity will be shared or published without your permission, unless required by law. Confidentiality will be provided to the fullest extent possible by law, professional practice, and ethical codes of conduct. Please note that confidentiality cannot be guaranteed while data is in transit over the Internet. We ask that you not discuss your participation in this research study with your colleagues or supervisors to ensure both your and other participants' confidentiality and privacy.

Voluntary Participation & Right to Withdraw

Your participation in this study is **voluntary** and you may partake in only those aspects of the study in which you feel comfortable. You may refuse to answer any question you do not want to answer. If during the Zoom© interview you decide to no longer participate, please inform the

researcher you no longer want to participate and exit the Zoom© call. You may leave the study at any time, without affecting your relationship with the institution or researcher. If you chose to withdraw from the study before the end of the interview process, all data provided by the participant will be destroyed immediately. If you decide to withdraw from the research study after interviews have taken place, and the PI has completed analysis of the data, your data will remain within the research findings.

Conflict of Interest
Researchers have an interest in completing this study. Their interests should not influence your decision to participate in this study. If you have a prior relationship with the researchers, those relationships are in no way affected by your participation in this project.

Compensation
There is no compensation related to participating in this research study.

Debriefing and Dissemination of Results
A copy of the final report and publications can be shared with study participants once available, if requested at time of interview completion or transcript checking. An email address must be provided to receive study results and notification of any publications, which will be optional to provide and collected separately from the study data. Those who have chosen to receive study results will be emailed independently through the email address that has been set up for these studies (asbuck@trentu.ca) and that is managed by the PI.

Participant Rights and Concerns
Please read this consent form carefully and feel free to ask the researcher any questions that you might have about the study. If you have any questions about your rights as a participant in this study, complaints, or adverse events, please contact the Research Ethics Office at Trent University: Anna Kisiala, Coordinator, Research Conduct and Reporting (annakisiala@trentu.ca)

If you have any questions concerning the research study or experience any discomfort related to the study, please contact the PI Ashley Coady by email asbuck@trentu.ca.

By consenting to participate you do not give up any of your legal rights against the investigators, sponsor or involved institutions for compensation, nor does this form relieve the investigators, sponsor or involved institutions of their legal and professional responsibilities.

Consent to Participate

1. I have read the consent form and understand the study being described;
2. I have had an opportunity to ask questions and my questions have been answered. I am free to ask questions about the study in the future.
3. I agree to the audio taping of the interview and understand that the video taping of the interview will be deleted immediately.
4. I freely consent to participate in the research study, understanding that I may discontinue participation at any time without penalty. A copy of this Consent Form has been made available to me.

By filling out the below information, you are agreeing to participate in this research study.

Name of Participant: _____

Signature of Participant: _____

Date: _____

Thank you very much for your consideration. Please reach out should you have any questions.

Ashely Coady, BScN, RN
Principle Investigator (PI)
asbuck@trentu.ca

Appendix F

Interview Guide

Hello, and thank you for volunteering to participate in this interview today. My name is Ashley Coady. I am a graduate student at Trent University in the Masters of Science in Nursing Program. My research interest involves the lived experiences of nurses working in rural hospitals, and how it influences the nurse's intent to stay working in Ontario rural hospitals. As a nurse who also works at a rural hospital, I believe your feelings, thoughts, and experiences are important and need to be understood and shared.

The interview process should take approximately 60 minutes of your time. Please take your time when answering questions, there is no time limit per question, so please do not feel rushed. Please provide as much detail and personal examples when answering questions so that I can fully understand your experiences. There are no wrong answers; answer questions honestly, and to the best of your ability. If you do not feel comfortable answering a question, please let me know, and we will move on to the next question.

This Zoom® call is currently being recorded, and I will also be using an audio-recording device to record this interview to ensure I do not miss any details. The audio file will be securely stored, and will only be used for transcription purposes. Once the audio file is transcribed, it will be destroyed. Please be assured that all of your personal information is confidential, and no personal identifiers will be shared with anyone. You will be given a pseudonym in place of your name in regards to reporting of any direct quotes. I will be taking notes during the interview to capture your responses to each question.

Before we begin, do you have any questions I can answer? Let's begin.

Guiding Questions:

1. Tell me what it is like for you to nurse in your hospital.
    a. How long have you worked as a nurse?
    b. How long have you worked at your rural hospital?
2. Describe the rural hospital you work at, and the area that it is located in?
    a. What is the population of the community?
    b. What types of patients (age, diagnosis) do you care for?
3. Tell me about a time when you felt supported at work.
4. Tell me about a time when you felt good about your work.
    a. What were others doing or saying that made you feel this way?
5. Tell me about the challenges that you face working in a rural hospital?
    a. How do they make you feel?
6. Tell me about a time where you felt stressed within your work?
    a. What did you feel or think at that time?
    b. Tell me more about what was happening on the unit at that time.
7. Can you tell me about a time where you might have considered leaving your rural hospital, or taking on another job?
8. What factors have influenced you to continue working at your current job?
9. Tell me about an experience you may have had where you felt that you were not fully understood or appreciated by others outside of your role?
    a. What were others doing or saying during that time?
10. Before we wrap up, perhaps you have other comments, thoughts, or experiences that you might have that you would like to discuss that we did not cover in this interview?

*Summarize key points/comments back to the participant

Thank you for participating in today's interview. Your thoughts and experiences on this subject are very valuable to this study. Once the transcription of today's interview is complete, the transcribed text will be sent to you from a secure email address to review. Please review this transcription and let me know if you feel that what you said today was transcribed and portrayed appropriately, and if there are any concerns that you have. The file you receive will have all identifiers removed. If you have any other questions or concerns, please reach out via email at asbuck@trentu.ca

Thank you so much for your participation.