

ORIGINAL RESEARCH

A double whammy! New baccalaureate registered nurses' transitions into rural acute care

AUTHORS



Jean C Smith¹ MN, Nursing Faculty *



Virginia Vandall-Walker² PhD in Nursing, Associate Professor, virginia@athabascau.ca

CORRESPONDENCE

*Ms Jean C Smith jean.smith@rdc.ab.ca

AFFILIATIONS

¹ Red Deer College, Red Deer, AB, Canada

² Athabasca University, Athabasca, AB, Canada

PUBLISHED

20 December 2017 Volume 17 Issue 4

HISTORY

RECEIVED: 23 October 2016

REVISED: 2 May 2017

ACCEPTED: 23 May 2017

CITATION

Smith JC, Vandall-Walker V. A double whammy! New baccalaureate registered nurses' transitions into rural acute care . *Rural and Remote Health* 2017; **17**: 4256. <https://doi.org/10.22605/RRH4256>

© Jean C Smith, Virginia Vandall-Walker 2017 A licence to publish this material has been given to James Cook University, jcu.edu.au

ABSTRACT:

Introduction: Transitioning into the Canadian rural acute care environment can be challenging for new RNs, and so retention is of concern. Currently, few seasoned registered nurses (RNs) are available to support new RNs during transition because (a) the Canadian RN workforce countrywide is aging and significant numbers are retiring, and (b) the number of Canadian RNs working rurally has plummeted in the past 10 years. Investigations into the phenomenon of new RNs' transitions into the workforce have been conducted, but little is known about this phenomenon as it relates to Canadian rural acute care hospitals. Most findings have been based on data from urban or mixed rural–urban samples.

Methods: An interpretive description research approach was used to understand new RNs' transition experiences into the Alberta, Canada, rural acute care environment including supports and challenges specific to recruitment and retention. Face-to-face interviews were conducted with a convenience sample of 12 new RNs who had been employed in one or more Alberta rural acute care hospitals from 1 month to less than 2 years.

Results: In this study, participants experienced a *double whammy* consisting of learning *I'm a generalist!* and managing the responsibility of *I'm it!* Participants experienced contradictory emotions of exhilaration and shock that set them on an emotional roller

coaster, a finding that differs from previously reported findings, wherein transition was frequently identified as only shocking. The few participants who were well supported by their colleagues and employers reported experiencing minor emotional fluctuations and described transition as *exciting, good, and manageable*. Those who were not experienced major fluctuations from exhilaration to shock. They described transition as *exhilarating, but overwhelming, and unsafe*. Notably, 9 of the 12 participants changed jobs within their first 2 years of practice. Other significant findings included problems with the outdated definitions of *rural* and *rural acute care hospitals*, which currently do not accurately address rural population growth and the services provided at rural acute care hospitals. Populations of some communities identified as *rural* by Alberta Health Services exceeded the upper limit of 10 000, the level long used to distinguish between rural and urban in the Canadian literature. As well, two different types of rural hospitals exist in Alberta: generalist types and urban types. The transition experience into these two different types of hospitals varied significantly.

Conclusions: While *double whammy* offers only one description of new RNs' transition experiences into rural acute care, it may present readers with recognizable similarities about transition that resonate with their own learning and responsibilities. Transition supports and challenges learned from this study can assist rural healthcare providers, policymakers, and educators in developing strategies to support and retain new RNs in rural acute care environments. Additionally, researchers must consider *a priori* whether or not different types of rural acute care hospitals exist in their study locale and if rural population growth is a factor when conducting future investigations related to rural acute care.

KEYWORDS:

Canada, new RNs, new registered nurses, transition, recruitment and retention, rural nursing, rural acute care.

FULL ARTICLE:

Introduction

Rural acute care nursing is a generalist specialty that is as diverse as it is complex.¹ Newly graduated registered nurses (RNs) who choose to work rurally will need to care for clients of all ages, most with unrelated diagnoses, while rotating between several focal points of care, including medical–surgical, emergency, labor–delivery, palliative, and constant care.^{2–4} They will also be expected to work autonomously and to fulfill additional duties when other professionals are off site or off duty.^{2–4} Developing and maintaining this array of skills will take time on the job and the support of seasoned colleagues; however, predictions about the numbers of senior RNs who will be available for this supportive role, based on Canadian RN workforce trends spanning the last 14 years, are alarming.^{5–11}

For the purposes of this article, the term RN will refer to individuals with either a baccalaureate- or diploma-level nursing education.

Background

In response to a dearth of full-time jobs in 2002, many new Canadian RNs migrated to the USA to find work.⁵ In 2003, the last year for which data was published, only 22% of Canadian rural communities were successful at retaining new RNs during their first year of practice.⁶ Data about retention rates in acute care in general are alarming. In 2011, turnover intention rates among Québec new acute care RNs were high at 49%⁷ and in 2015, new RN turnover intention rates across Canada were reported to be as high as 57%.⁸ These findings are not surprising since transition has been reported as the most stressful time in new Canadian RNs' careers and the main reason they leave the profession.⁹

Recent reports indicate that the future of the Canadian rural RN workforce appears bleak. While the percentage of RN positions across Canada increased by 18.5% between 2006 and 2015¹⁰, the rural and remote RN population plummeted nearly 10%.¹¹ Additionally, 2014 Canadian nurse workforce demographic information pointed to high RN retirement rates.¹¹ Will new RNs choose to work in rural acute care and will there be senior RNs to support their transitions?

Literature review

A systematic integrative review¹² of the extant qualitative and quantitative literature about new RNs' transitions into acute care was conducted in 2011¹³ and updated in 2017. Canadian literature specific to rural settings was sparse, necessitating the inclusion of studies from Australia, New Zealand, the UK, and the USA. Of the 38 studies included, only eight were specific to rural settings; none were Canadian. The other 30 studies involved urban or mixed rural–urban settings. Themes about transition arising from this review include theories, internal influences, and external influences.

Theories: While theories of transition into acute care have been generated over the past 42 years, none are specific to rural acute care settings. Three Canadian theories, Duchscher's 'A process of becoming',¹⁴ and 'Transition shock',¹⁵ and Nour's 'Becoming alive',¹⁶ are based on urban acute care settings. Two UK theories, Kelly's 'Hospital nursing: It's a battle!'¹⁷ and 'Preserving moral integrity',¹⁸ and one US theory, Kramer's 'Reality shock',¹⁹ only incorporate mixed samples of rural and urban acute care RNs. Notably, all paint

transition as a predominantly negative and shocking experience.

Internal influences: Internal influences on transition included role stress, moral integrity, and doubt in knowledge. Overall, these influences negatively impacted new RNs' transitions into Australian rural settings²⁰⁻²² and Australian,²³⁻²⁵ Canadian,^{7,26-34} New Zealand,³⁵ UK,^{17,18} and US³⁶⁻³⁸ mixed rural–urban acute care settings.

External influences: External influences on transition included relationships with the other (i.e. RNs, nurse managers, and clinical nurse educators), working conditions, residency programs, mentorship programs, transition to practice programs, and certification courses.

Staff nurses and nurse managers were both supportive and unsupportive of new RNs' transitions into rural settings in Australia²⁰⁻²² and mixed rural–urban acute care settings in Australia,²³⁻²⁵ Canada,^{7,26-34} New Zealand,³⁵ the UK,^{17,18} and the USA.³⁶⁻³⁸ Recently in Canada, it was reported that nurse managers who acted as authentic leaders played a significant role in creating positive working conditions for new RNs, which in turn reduced reports of new RNs' burnout and poor mental health.³⁹ Previously, the erosion of the clinical nurse educator role in acute care settings in Alberta, Canada, was reported by researchers as negatively influencing new RNs' transitions.²⁷

In 2016, researchers indicated that working conditions of new RNs in Canadian mixed rural–urban acute care settings were generally positive and stable over time, but that workplace mistreatment was a significant issue warranting change.⁴⁰

To adequately orient and support new RNs transitioning into US rural and urban acute care environments, three program reviews recommended residency programs be used to increase new RNs' confidence and competence levels, and to reduce turnover rates.⁴¹⁻⁴³ To support new RNs' transitions into Australian rural environments, researchers recommended implementing mentorship programs⁴⁴⁻⁴⁶ or rural transition to practice programs.⁴⁷ To support new RNs' transitions into rural and urban hospitals in British Columbia, Canada, a transition to practice program was developed.⁴⁸ A review of this program completed in 2015 indicated that orientation for new RNs should be at least 4 weeks in length and new graduates should work at least 49 hours in 2 weeks.⁴⁹ Based on province-wide research about educational needs of rural nurses in British Columbia, a rural-focused nursing certificate program was developed.⁵⁰ A review of this program indicated that rural RNs' competence, confidence, and job satisfaction increased. Most recently (2017), an online rural certification course was developed in Ontario, Canada, to support educational needs of rural nurses.⁵¹

While it is well documented that transitioning from the role of student to new RN in urban acute care settings is often stressful, leaving new RNs discouraged, frustrated, and disillusioned,^{7,14,15,25-38,52} it is unknown how transitioning into rural acute care hospitals is similar to or different from urban environments. Although the supports and challenges surrounding new RNs' recruitment and retention in urban environments have been addressed,^{14,15} they remain unclear in relation to rural environments.

Purpose of the study and guiding question

The purpose of this study was to identify, understand, and explain how new RNs perceive the experience of transitioning into the rural acute care environment and the supports and challenges surrounding their recruitment and retention.⁵³ The central questions guiding this study were 'What are the experiences of new RNs transitioning into the rural acute care environment' and 'How do these experiences influence recruitment and retention?'⁵³

Methods

An interpretive description design⁵⁴ was used for this study. This approach facilitated interpretation of new RNs' perspectives about (a) the phenomenon of transition in relation to the rural acute care hospital environment without losing sight of individual variations within that group, (b) the supports and challenges to rural recruitment and retention, and (c) strategies to inform future directions in rural acute care nursing at practice, policy, educational, and research levels.⁵³

Setting

This study was conducted in 14 rural communities across the province of Alberta, Canada. The Alberta Health Services definition of *rural acute care hospital* was used to situate this study (acute care hospitals other than suburban or regional hospitals located in rural communities), in which emergency, medical, palliative, pediatric and, in some, surgical, obstetrical, or constant care services are provided.⁵⁵

Participants

The College and Association of Registered Nurses of Alberta provided support for this study by distributing recruitment information to prospective participants. Inclusion criteria consisted of RNs with full-time, part-time, or casual employment of more than 1 month and less than 2 years in one or more Alberta rural acute care hospitals.⁵³

Data generation

Over the course of 10 months, 16 semi-structured face-to-face, audio-recorded interviews were conducted and transcribed verbatim. Twelve new RNs were interviewed; four participated in second interviews guided by emerging categories; two of these four had changed job sites, hence the difference between number of settings (14) and number of participants (12). Notes to capture contextual data were audio-recorded following each interview. Pseudonyms were used to protect participants' privacy.

Data analysis

The data analysis process was inductive and iterative.⁵³ In keeping with the Interpretive Description⁵⁶ approach, various techniques borrowed from other research domains were used to complete data analysis: data immersion from Hermeneutic phenomenology,⁵⁷ unitizing and categorizing from naturalistic inquiry,⁵⁸ and constant comparative analysis and memoing from grounded theory.⁵⁹

Ethics approval

Ethics approval was received from the Athabasca University Research Ethics Board #CNHS-12-01.⁵³

Results

Transition into the rural acute care setting involved participants learning and enacting the role of the rural generalist RN. Most described it as a *huge learning curve* that placed them on an emotional roller coaster. The few who felt well supported by interdisciplinary teams and with educational resources reported minimal fluctuations in their emotions; those who were not reported extreme fluctuations. Participants' experiences ultimately impacted their decisions to remain in their current jobs or to seek work elsewhere, be it in rural nursing or not.

The context

The contextual factors influencing transition included the facilities in which participants worked and their educational preparation, other work experiences, and reasons for choosing rural nursing (Table 1).⁵³

The hospitals where participants worked were of two different types: urban and generalist models. The services available and the participants' transition experiences in these two different models of hospitals varied markedly.

The urban-model rural hospital was organized into separate medical, surgical, obstetrical, pediatric, and emergency units. A new RN was only expected to work on one unit and was well supported with an extended orientation and onsite clinical nurse educator. Learning was described as safe and *manageable*, but *slow* and *frustrating*.

Generalist-model hospitals were organized into two or three units (emergency department (ED), operating room, and acute care, which included a combination of medical, surgical, palliative, and obstetrical patients). Eleven of the 12 participants transitioned into this type of facility and were expected to work on the different units. They described their transitions as *exhilarating*, but *overwhelming* and *frightening*.

When asked what she would say to a new nurse transitioning into a rural generalist-model hospital, Mia candidly remarked:

I would tell them, 'It's a really awesome job, and you're really going to love it. But you're going to be scared shitless every day. So make sure that you are willing to walk in and have your mind open to ... learn everything and understand that ... you're going to get all that responsibility put on you. Are you going to be able to deal with that? Because you're going to get a wicked experience, but you're also going to be really overwhelmed all of the time.'

Table 1: Contextual factors influencing transition⁵³

Demographics	Reasons for choosing rural	Nursing education	Work experiences
Ages 24–34 years	Grew up rurally	Inadequate preparation for labor and delivery, emergency and pediatrics	Previous healthcare work experience – minimal preparation for rural
Female: 11 Male: 1	Autonomy of practice	Good preparation for urban medical–surgical patients	
Single: 4 Married or common law: 8	Partner's work	Rural clinical rotations/preceptorships – provided a <i>taste of rural</i>	Other work experiences – good preparation for rural nursing
Employed: 7–24 months Full-time: 3 Part-time: 8 Casual: 1	Lack of urban jobs		
Intent to or changed jobs: 9	Lived rurally		

The consequences

Decision to stay or go: Alarming, 9 of the 12 participants had changed jobs or sought other employment within their first 2 years of practice. Three had moved to urban units, three to another rural acute care facility, and three had applied for positions in another area of their current workplaces.

Reasons to stay in the job included liking the people, small-town feeling, work schedule, and scope of practice; preferring rural living; feeling supported by staff and physicians; and supporting a significant other's need to work rurally.

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

Reasons to leave the job included fear of critical incidents, desire for a different specialization, or feeling undervalued and bullied. For Kelly, critical incidents involving the unsafe practices of older senior RNs left her worrying about *picking up bad habits and losing her licensure*.

Tina sought work in an urban labor and delivery unit because she thoroughly enjoyed maternity nursing. Betty sought work in an urban ED because she *loved trauma and everything like that* and caring for the many awaiting placement patients in the rural hospital was not what she had *signed up for*.

Notably, John anxiously awaited a different position in the same hospital so that he could get away from his bullying manager. Xeno felt so undervalued by her nurse manager and unwelcome by senior RNs that she sought a job in a different rural hospital. Christina moved to another rural hospital because of the frequent *bullying* she was subjected to by senior RNs.

An explanatory model of transition: a double whammy!

The findings in this study revealed that participants' transitions into the rural acute care environment constituted a *double whammy* consisting of two simultaneous non-discrete experiences of *I'm a generalist!* and *I'm it!* (Fig1).⁵³

A DOUBLE WHAMMY!

EMOTIONAL ROLLER COASTER - UP!

I'm A Generalist!

And

I'm It!

Surprised! and Shocked!

The Place

The People

The Generalist Role

SO MUCH LEARNING!

I'm Alone!

I'm In Charge!

I'm A Jack-of-All-Trades!

SO MUCH RESPONSIBILITY!

HOW DO I MANAGE ALL OF THIS LEARNING & RESPONSIBILITY?

"On the Fly"

By Accessing Resources

THE DECISION: STAY?

THE DECISION: GO?

Figure 1: Illustration of the *double whammy*.⁵³

I'm a generalist!

For participants, *I'm a generalist!* involved learning about the people, the place, and the generalist RN role.

Participants learned about the *people* (staff and physicians who worked in the rural hospital and the patients and family members who accessed the hospital). For example, they reported that the staff and younger physicians who worked in the rural hospital were generally very supportive of their learning. Madeline highlighted:

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

Oprah expressed:

It's like I've never worked in a better place. You're a team. We all hang out after work, and its first-name basis all around ... you follow through with them [physicians] about things. You can call down to the clinic. It's so open; they're all fantastic.

However, participants also reported that their personal and professional values were sometimes challenged due to senior RNs performing tasks *the way they had always been done*, rather than based on evidence. In most facilities, there was at least one person (RN, older physician, or nurse manager) who was impatient, unwilling to teach, and used negative communication techniques that consisted of yelling, passive aggressiveness, name-calling, telling not asking, or intimidation. Betty described the behaviors of some older physicians as follows:

There are certain situations where they would yell at you, and not really teach you. [Some] had no patience and were mad that inexperienced nurses were put in Emerg. So instead of showing us how to do something right, they would yell at us and walk away.

Participants learned that many patients and their families were friendly, encouraging, and appreciative, but that it took time to be accepted and trusted. Initially, most patients were uncertain about participants' knowledge levels and abilities and trusting the new RNs was significantly influenced by the *word* of others, which travelled fast in the rural community. For Xeno, the candour of many rural people was shocking and created challenges when she tried to maintain nurse–client boundaries:

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

The environmental dynamics of the *place* wherein there could be a lack of onsite pharmacists and physicians left a few participants feeling *overwhelmed* and *unsafe* because of the responsibility to make high-level decisions about *medication work*⁶⁰ and medical care. While lack of an onsite clinical nurse educator negatively affected participants' learning and confidence levels, they also recognized this as a greater systems issue:

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

Enacting the *generalist RN role* required participants to learn *on the fly* and to skillfully *change hats*. They learned how to care for a variety of clients representing a mixture of ages, life stages, diagnoses, and cultures. They learned a broad range of clinical skills, as well as how to be flexible, undertake high levels of responsibility, and manage any kind of contingent or emergent situation, prioritizing care, and using anticipatory planning to access human and educational resources.

Mia described *on the fly* in two different ways based on having to manage the entire ED with only 10 days of orientation, a minimal number of certification courses, and without the direct back up of senior RNs. She assumed the responsibility of learning procedures or protocols for the first time, at the bedside while providing patient care, or by paging overhead for help from the nurses in the acute care ward. When Xeno was asked what *on the fly* meant to her, she described it as:

Like being in a snowball downhill. You just go. You roll with what comes in, and you use your critical thinking as best as you can. My first chest pain [I] didn't really know what to do, [I] took cues. Second one [snaps fingers], I had it better and just kept going.

To *change hats* participants had to move from room to room, area to area, or unit to unit, frequently all within one shift (obstetrics to emergency, to paediatrics, to palliative, etc.). It was particularly challenging for most participants because it was new and very different from what they had learned during their baccalaureate nursing programs and involved prioritization, anticipatory planning, and delegation skills. Betty described it as:

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

I'm it!

For participants, *I'm it!* involved tackling even more responsibility in addition to learning to be generalist RNs. It included working alone, being in charge, and being a jack-of-all-trades. Christina found that:

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

Working alone for Xeno meant that she was the sole RN on shift with only one licensed practical nurse (LPN) for onsite support. She described her first code alone as follows:

My LPN is my only other person there until the doctor gets there – so once he gets there, then I can delegate to the LPN to find somebody else [to come in]. But to keep all of that straight, and to not panic when you need more hands, but you can't get them because you can't send up a flare. Everything else I was taught how to deal with – the medications and compressions and the intubating. That isn't actually what scared me. It was that I didn't know how to get help. [I felt] alone, incredibly alone.

In other situations, working alone meant there was no available physician, which required participants to be resourceful and self-reliant when trying to prioritize and manage critical situations. Sally described her emotions when delivering a baby alone without the backup of a physician:

[I was] scared out of my wits – I didn't want to be there! But I'm glad I was there because she couldn't do it by herself, so it's overwhelming, and it's because you don't have much to draw from. Then it's like [the baby's born], Oh my gosh, thank God!

Being in charge was very manageable and empowering for the few participants who were provided structured support and were not expected to manage charge responsibilities until later in their transitions. Gretta described being in charge as:

I actually really liked it ... It was really good because she didn't just [say], 'Oh, you're in charge now'. We had about an hour and a half meeting; we went through the charge nurse manual and responsibilities. So I wasn't just thrown to the wolves, there was a lot of support.

Conversely, those who were immediately, and with little or no senior RN support or structured orientation, expected to be in charge, experienced emotions of exhilaration and panic. For some, this responsibility meant being in charge of the team of RNs, LPNs, and healthcare aides. For others, it meant being in charge of the acute care unit or ED and contingent or emergent situations (essentially every patient or family member who came through the door), which could be exciting, but also frightening. In some instances, it meant being in charge of the entire hospital:

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

Being a jack-of-all-trades required all participants to assume some of the responsibilities of other members of the interdisciplinary team (physicians, pharmacists, or respiratory therapists) and ancillary staff (unit clerks, medical records personnel, environmental services staff, maintenance workers, etc.) when these staff were off site or off duty.

Ultimately, participants' transitions into the Alberta rural acute care environment constituted a *double whammy! I'm a generalist! and I'm it!* as described by Tina:

In the city hospitals, the units are so specific that you're learning about heart clients or renal clients or maternity clients. Whereas in rural, you're learning about all of them. You have to have a general basic idea of what's involved with each condition and then learn the other things that are thrown at you, like charge nurse, janitor, pharmacist, and respiratory technician. ... When I went into rural it was a surprise ... I didn't think I would be in charge as soon as I was ... I didn't think I'd be cleaning rooms. I thought those kinds of supports would just be there.

Discussion

Although this explanatory model of a *double whammy* is being proposed as providing a beginning understanding of transition into rural acute care nursing, the data suggest that comprehending the contextual factors influencing transition, as well as the *I'm a generalist!* and *I'm it!* components of the generalist role are foundational to rural new RN recruitment and retention.

Contextual factors

Notable is the finding that there are two models of acute care hospitals in Alberta deemed to be rural: the generalist model and the urban model. Participants who transitioned into generalist-model facilities experienced a wide range of emotional fluctuation, principally related to no onsite presence of physicians, pharmacists, or clinical nurse educators, and being expected to quickly enact the generalist role and be *it*. This finding speaks to the importance of researchers more clearly identifying *a priori* the type of rural hospital from which participants will be recruited.

Most participants felt inadequately prepared to work with maternity, emergency, and pediatric patients. Those who had participated in rural acute care clinical rotations or preceptorships during their nursing education had at least experienced a *taste of rural*, which they still considered insufficient for what was required of them.

A new contextual finding of this study was that the broader scope of practice of rural nursing, wherein autonomy is promoted, was a key reason for participants who had previously worked in health care under more limited scopes of practice to choose rural nursing as their first career choice. While autonomy has been identified by researchers as a hallmark of rural nursing,^{1-4,61,62} none have indicated this as a reason for new RNs to choose rural nursing.

The transition experience

Most of the findings in this study support and extend what has been reported in the literature.^{1-9,14-47,60-65} What sets this study apart from others is the fact that participants experienced fluctuating emotions that left them feeling exhilarated (pleasantly surprised) one minute and overwhelmed (shocked) the next. This finding contrasts with the results of many Canadian^{7,14-16,27,30-34,52} and international^{9,17-25,35-38,41-43} studies, wherein transition has been described as a predominantly negative, shocking experience.

Transition supports: Most participants identified feeling a strong sense of family or being a member of a supportive team, a finding well documented in the literature.^{1,4,62} However, a new finding in this study was that younger physicians provided significant support to participants during their transitions. While rural RNs' positive interactions with physicians have been linked to increased job satisfaction, the dynamics of those relationships have not been delineated.^{1,4} In this study, some participants described their interactions with rural physicians as *love-hate* in nature, a description alluded to in the literature,^{4,63} but not specifically reported.

The fact that nearly half of the participants commuted is noteworthy, as they did not deal with issues related to lack of anonymity. Commuting participants felt accepted and supported by their rural patients despite not fully engaging in the community, as previously identified by researchers as integral to outsiders gaining acceptance in rural communities.^{1,4,63,64} Importantly, commuting participants did not link job satisfaction, and therefore retention, with community involvement, differing significantly from the findings of other researchers.^{4,63,64}

Participants who appeared older and more mature found they were readily trusted and accepted by rural patients because they were perceived as possessing practice maturity. This is an interesting and new finding, although other researchers have discussed, in general, nurses' acceptance into the community.^{1,4,63,64} It bears noting because many nursing programs in Canada are admitting students with previous education and life experiences.

Some participants embraced spirituality to cope with transition, a finding only alluded to in the literature as a *spiritual tone*.⁶⁵ They

incorporated prayer, faith, or nature into their work and or home lives to support their fitness to practice.

Transition challenges: To handle critical staffing shortages, many rural nurse managers contract agency RNs. The findings in this study highlighted how participants found it challenging and frightening to delegate work to agency RNs on night shift when no other senior RNs were available to support decisions. Previously, senior RNs had been integral to assisting new rural RNs with building the confidence needed to manage ambiguous situations and deploy human resources.⁴

Notably, a few participants were expected to assume the role of offsite pharmacists while in charge of clients, team members, and sometimes the entire unit or hospital, a finding not previously documented in the transition literature. This *medication work*⁶⁰ was described by many participants as a *huge learning curve, that was overwhelming, intimidating, and unsafe*.

One participant was supported by a 3-month transitional graduate program similar to one⁴⁸ created in British Columbia in 2013. She described the program as *too generic* and suggested she would have been better supported if the program had been *tailored to her learning needs*. She recommended *weekly check-ins with the manager and preceptor to assist with identifying challenges and strategies to support those challenges*. Interestingly, this program has since been discontinued in many Alberta rural hospitals, due to lack of funding.

Recommendations to support transition

At the policy level: It is recommended that funders consider the benefits of providing supports for new RNs transitioning into rural environments including onsite full-time rural clinical nurse educators, onsite transition to practice,⁴⁸ certification,^{50,51} and mentorship programs,⁴⁴⁻⁴⁶ and new RN incentive scholarship programs.

At the education level: It is recommended that baccalaureate nursing students be exposed to rural learning opportunities including simulations of rural labor and delivery, emergency, and pediatric patient care; clinical practica in rural acute care hospitals; and final year nursing courses focused on the rural generalist role. It is also suggested that nurse educators collaborate with senior rural RNs and nurse managers to develop continuing education online leadership modules that include content about authentic leadership skills³³ and how to support new RNs during transition into rural environments.

At the practice level: It is recommended that rural nurse managers provide longer structured orientation programs tailored to each new RN and his or her assigned mentor, but with check-in points to review progress.⁴³ It is also suggested that rural nurse managers consider the benefits of providing incentives and onsite mentorship education for senior RNs who volunteer to mentor new nurses.

Limitations

The definition of the term *rural* was a significant limitation for two reasons. One, the classifications of *rural* previously referred to by researchers^{66,67} do not accurately address Canadian rural population growth and type of rural hospital. In this study, the populations of some communities deemed to be rural by Alberta Health Services exceeded the 10 000 population mark, a classification long used to delineate the upper end considered as rural in the Canadian literature.⁶⁶ Two, the study was well under way before it was learned that the two different types of rural acute care hospitals obscured sample inclusion and exclusion criteria. Other limitations included that data were limited to one province of Canada, Alberta; participants self-selected, which resulted in a convenience sample;⁶⁸ and males were not adequately included in the sample.

Implications for future research

The definition of *rural* and the different types of rural acute care hospital models must be considered *a priori* when researchers are investigating rural healthcare questions. Research examining current government policies and organizational structures related to recruitment and retention of new rural acute care RNs is warranted. Research exploring undergraduate educational methods and curriculum options related to preparing new RNs for employment in rural acute care environments is justified.

Conclusions

The explanatory model of a *double whammy* offers only one description of new RNs' transition experiences into rural acute care, but may present readers with recognizable similarities about transition that resonate with their own learning and responsibilities.⁶⁹ The supports and challenges to transition learned from this study can assist rural healthcare providers, policymakers, and educators in supporting and retaining new RNs in rural environments. Participants' retention issues and current Canadian RN workforce demographics warrant further exploration of educational curricula and rural practice supports. While the findings from this study shed light on new RNs' transitions into rural acute care, there are still many unanswered questions.

Acknowledgement

Jean Smith acknowledges Athabasca University, Red Deer College, and the Alberta Nurses Educational Trust for funding this study.

- 1 Scharff JE. The distinctive nature and scope of rural nursing practice: philosophical bases. In: HJ Lee HW, CA Winters (Eds) (Eds). *Rural nursing: concepts, theory, and practice*. 2nd edn. New York, NY: Springer, 2006; 179-196.
- 2 Baumann A, Hunsberger M, Blythe J, Crea M. *The new healthcare worker: implications of changing employment patterns in rural and community hospitals*. Health Human Resources Series No. 6. Ontario: McMaster University, 2006.
- 3 Kulig J. What educational preparation do nurses need for practice in rural and remote Canada? *The Nature of Rural & Remote Nursing*. 2005; **2(1-2)**. Available: <http://www.carm.com/files/factsheet2.pdf> (Accessed 20 September 2016).
- 4 MacLeod M. We're it: the nature of rural nursing practice in very small rural and remote hospitals in northern British Columbia. In: W Ramp, J Kulig, I Townshend, V McGowan (Eds). *Health in rural settings: contexts for action*. Lethbridge, AB: University of Lethbridge, 1999; 165-178.
- 5 Baumann A, Bythe J, Kolotylo C, Underwood J. *The international nursing labour market: building the future: an integrated strategy for nursing human resources in Canada*. 2004. Available: https://cna-aiic.ca/~media/cna/page-content/pdf-fr/international_nursing_labour_market_e.pdf (Accessed 20 September 2016).
- 6 Adams O, Buske L, Marcus L, Chauhan TS. *The development of a multistakeholder framework/index of rurality: final report to Health Canada: rural and remote health innovations initiative*. 2003. Available: https://www.cna-aiic.ca/~media/cna/page-content/pdf-fr/final_report_e.pdf?la=en (Accessed 20 September 2016).
- 7 Lavoie-Tremblay M, Paquet M, Marchionni C, Drevniok U. Turnover intention among new nurses: a generational perspective. *Journal for Nurses in Staff Development* 2011; **27(1)**: 39-45. Available: <http://dx.doi.org/10.1097/NND.0b013e31819945c1> (Accessed 20 September 2016).
- 8 Laschinger HKS, Leiter M, Cummings G. New graduate nurse retention: a national study of factors influencing new graduate nurses' job and career transition in the first two years of practice. 2015. Available: http://hrh-rhs.ca/index.php?option=com_content&view=article&id=356:test&catid=143:hrh-planning&Itemid=141&lang=en (Accessed 18 December 2017).
- 9 Godinez G, Schweiger J, Gruver J, Ryan P. Role transition from graduate to staff nurse: a qualitative analysis. *Journal for Nurses in Staff Development* 1999; **15(3)**: 97-110.
- 10 Canadian Institute of Health Information. *Regulated nurses, 2015*. 2016. Available: https://secure.cihi.ca/free_products/Nursing_Report_2015_en.pdf (Accessed 20 September 2016).
- 11 Canadian Institute of Health Information. *Regulated nurses database*. 2015. Available: https://secure.cihi.ca/free_products/Nursing_Report_2015_en.pdf (Accessed 29 November 2017).
- 12 Whittemore R, Knafk K. The integrative review: updated methodology. *Journal of Advanced Nursing* 2005; **52(5)**: 546-553.
- 13 Smith J. New BN graduates' transition into rural acute care: an integrative literature review. Section of unpublished Master's thesis. Centre for Nursing and Health Studies, Athabasca University, 2011.
- 14 Duchscher JEB. A process of becoming: the stages of new nursing graduate professional role transition. *The Journal of Continuing Education in Nursing* 2008; **39(10)**: 441-450.
- 15 Duchscher JEB. Transition shock: the initial stage of role adaptation for newly graduated registered nurses. *Journal of Advanced Nursing* 2009; **65(5)**: 1103-1113. <http://dx.doi.org/10.1111/j.1365-2648.2008.04898.x>
- 16 Nour AV. *Theory 'becoming alive': the learning experiences of newly graduated nurses*. Doctoral dissertation. University of Calgary, 2009.
- 17 Kelly B. Hospital nursing: it's a battle! a follow-up study of English graduate nurses. *Journal of Advanced Nursing* 1996; **24(5)**: 1063-1069. <http://dx.doi.org/10.1111/j.1365-2648.1996.tb02944.x>
- 18 Kelly B. Preserving moral integrity: a follow-up study with new graduate nurses. *Journal of Advanced Nursing* 1998; **28(5)**: 1134-1145. <http://dx.doi.org/10.1046/j.1365-2648.1998.00810.x>
- 19 Kramer M. *Reality shock: why nurses leave nursing*. St. Louis: CV Mosby, 1974.
- 20 Lea J, Cruickshank MT. The experience of new graduate nurses in rural practice in New South Wales. *Rural and Remote Health* 2007; **2007(7)**: 814-825. http://www.rrh.org.au/publishedarticles/article_print_814.pdf (Accessed 20 September 2016).
- 21 Gibb H, Forsyth K, Anderson J. Culture of rural nursing practice: a critical theoretical analysis of determinants of power. *Australian*

- 22 Kenny A, Duckett S. Educating for rural nursing practice. *Journal of Advanced Nursing* 2003; **44(6)**: 613-622. <http://dx.doi.org/10.1046/j.0309-2402.2003.02851.x>
- 23 McKenna L, Newton JM. After the graduate year: a phenomenological exploration of how new nurses develop their knowledge and skill over the first 18 months following graduation. *Australian Journal of Advanced Nursing* 2007; **25(4)**: 9-15.
- 24 Parker V, Plank A, Hegney D. Adequacy of support for new nurses during their transition into the workplace: a Queensland, Australia study. *International Journal of Nursing Practice* 2003; **9**: 300-305. <http://dx.doi.org/10.1046/j.1440-172X.2003.00433.x>
- 25 Kelly J, Ahern K. Preparing nurses for practice: a phenomenological study of the new graduate in Australia. *Journal of Clinical Nursing* 2008; **18(6)**: 910-918. <http://dx.doi.org/10.1111/j.1365-2702.2008.02308.x>
- 26 Ellerton ML, Gregor F. A study of transition: the new nurse graduate at 3 months. *Journal of Continuing Education in Nursing* 2003; **34(3)**: 103-107.
- 27 Romyn DM, Linton N, Giblin C, Hendrickson B, Limacher LH, Murray C, et al. Successful transition of the new graduate nurse. *International Journal of Nursing Education Scholarship* 2009; **6(1)**: 1-17. <http://dx.doi.org/10.2202/1548-923X.1802>
- 28 Wolff AC, Regan S, Pesut B, Black J. Ready for what? An exploration of the meaning of new graduate nurses' readiness for practice. *International Journal of Nursing Education Scholarship* 2010; **7(1)**: 1-14. <http://dx.doi.org/10.2202/1548-923X.1827>
- 29 Laschinger HKS. Job and career satisfaction and turnover intentions of newly graduated nurses. *Journal of Nursing Management* 2012; **20(4)**: 472-478. <http://dx.doi.org/10.1111/j.1365-2834.2011.01293.x>
- 30 Laschinger HKS, Grau AL. The influence of personal dispositional factors and organizational resources on workplace violence, burnout, and health outcomes in new graduate nurses: a cross-sectional study. *International Journal of Nursing Studies* 2012; **49(3)**: 282-291. <http://dx.doi.org/doi:10.1016/j.ijnurstu.2011.09.004>
- 31 Laschinger HKS, Grau AL, Finegan J, Wilk P. New graduate nurses' experiences of bullying and burnout in hospital settings. *Journal of Advanced Nursing* 2010; **66(12)**: 2732-2742. <http://dx.doi.org/10.1111/j.1365-2648.2010.05420.x>
- 32 Laschinger HKS, Grau AL, Finegan J, Wilk P. Predictors of new graduate nurses' workplace well-being: testing the job demands-resources model. *Health Care Management* 2012; **37(2)**: 175-186. <http://dx.doi.org/10.1097/HMR.0b013e31822aa456>
- 33 Laschinger HKS, Grau AL, Finegan J, Wilk P. The influence of authentic leadership on newly graduated nurses' experiences of workplace bullying, burnout and retention outcomes: a cross-sectional study. *International Journal of Nursing Studies* 2012; **49(10)**: 1266-1276. <http://dx.doi.org/10.1016/j.ijnurstu.2012.05.012>
- 34 Laschinger HKS, Wong C, Regan S, Young-Ritchie C, Bushell P. Workplace incivility and new graduate nurses' mental health: the protective role of resiliency. *Journal of Nursing Management* 2013; **43(7/8)**: 415-421. <http://dx.doi.org/10.1097/NNA.0b013e31829d61c6>
- 35 McKenna BG, Smith NA, Poole SJ, Coverdale JH. Horizontal violence: experiences of registered nurses in their first year of practice. *Journal of Advanced Nursing* 2003; **42(1)**: 90-96. <http://dx.doi.org/10.1046/j.1365-2648.2003.02583.x>
- 36 Bowles C, Candela L. First job experiences of recent RN graduates: improving the work environment. *Journal of Nursing Administration* 2005; **35(3)**: 130-137.
- 37 Munro BH. Job satisfaction among recent graduates of schools of nursing. *Nursing Research* 1982; **32**: 350-355.
- 38 LaSala KB. Nursing workforce issues in rural and urban setting – looking at the difference in recruitment, retention and distribution. *Online Journal of Rural Nursing and Health Care* 2000; **1(1)**: 8-17.
- 39 Laschinger HKS, Borgogni L, Consiglio C, Read E. The effects of authentic leadership, six areas of worklife, and occupational coping self-efficacy on new graduate nurses' burnout and mental health: a cross-sectional study. *International Journal of Nursing Studies* 2015; **52(6)**: 1080-1089. <http://dx.doi.org/10.1016/j.ijnurstu.2015.03.002>
- 40 Laschinger KHS, Cummings G, Leiter M, Wong C, MacPhee M, Ritchie J, et al. Starting out: a time-lagged study of new graduate nurses' transition to practice. *International Journal of Nursing Studies* 2016; **57**: 82-95. <http://dx.doi.org/10.1016/j.ijnurstu.2016.01.0>
- 41 Meyer Bratt M. Retaining the next generation of nurses: the Wisconsin nurse residency program provides a continuum of support. *Journal of Continuing Education in Nursing* 2009; **40**: 416-426.
- 42 Ulrich B, Krozek C, Early S, Ashlock CH, Marquez Africa L, Carman ML. Improving retention, confidence, and competence of new graduate nurses: results from a 10-year longitudinal database. *Nursing Economic\$* 2010; **28(6)**: 363-375.

- 43 Keahey S. Against the odds: orienting and retaining rural nurses. *Journal for Nurses in Staff Development* 2008; **24(2)**: E15-E20. <http://dx.doi.org/10.1097/01.NND.0000300875.10684.be>
- 44 Mills J, Francis K, Bonner A. The accidental mentor: Australian rural nurses developing supportive relationships in the workplace. *Rural and Remote Health* 2007; **7**: 842-853. Available: http://www.rrh.org.au/publishedarticles/article_print_842.pdf (Accessed 20 September 2016).
- 45 Mills J, Francis K, Bonner A. Walking with another: rural nurses' experiences of mentoring. *Journal of Research in Nursing* 2008; **13**: 23-35. <http://dx.doi.org/10.1177/1744987107078907>
- 46 Mills J, Lennon D, Francis K. Contributing to a culture of learning: a mentor development and support project for Australian rural nurses. *International Journal of Nursing Practice* 2007; **13(6)**: 393-396. <http://dx.doi.org/10.1111/j.1440-172X.2007.00656.x>
- 47 Lea J, Cruickshank M. Supporting new graduate nurses making the transition to rural nursing practice: views from experienced nurses. *Journal of Clinical Nursing* 2014; **19(20)**: 2826-2834. <http://dx.doi.org/10.1111/jocn.12890>
- 48 Rush KL, Adamack M. *Expanding the evidence for new graduate transition best practices: a provincial perspective*. 2013. Available: <http://research.fraserhealth.ca/media/Rush-and-Adamack-March-30.pdf> (Accessed 20 September 2016).
- 49 Rush KL, Adamack M, Gordon J, Janke R, Ghement IR. Orientation and transition programme component predictors of new graduate workplace integration. *Journal of Nursing Management* 2015; **23(2)**: 143-155.
- 50 MacLeod M, Place J. Rural-focused nursing education: a summative evaluation of RNs' experiences of the rural nursing certificate program. *Quality Advancement in Nursing Education* 2015; **1(2)**: 1-14. <http://dx.doi.org/10.17483/2368-6669.1029>
- 51 Fleming College. *Rural and remote nursing graduate certificate*. 2017. Available: <https://flemingcollege.ca/continuing-education/certificates/rural-and-remote-nursing-graduate-certificate> (Accessed 30 April 2017).
- 52 Lavoie-Tremblay M, Wright D, Desforges N, G elinas C, Marchionni C, Drevniok U. Creating a healthy workplace for new-generation nurses. *Journal of Nursing Scholarship* 2008; **40(3)**: 290-297. <http://dx.doi.org/10.1111/j.1547-5069.2008.00240.x>
- 53 Smith J. *A double whammy! new BN graduates' transition into rural acute care*. Master's thesis. Athabasca: Athabasca University, 2014.
- 54 Thorne S, Kirkham SR, MacDonald-Emes J. Interpretive description: a noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing & Health* 1997; **20(2)**: 169-177.
- 55 Alberta Health Services. *Rural health*. Available: <http://www.albertahealthservices.ca/info/Page878.aspx> (Accessed 30 April 2017).
- 56 Thorne S. *Interpretive description*. Walnut Creek, CA: Left Coast Press, 2008.
- 57 Wilding C, Whiteford G. Phenomenological research: an exploration of conceptual, theoretical, and practical issues. *Occupation, Participation and Health* 2005; **25(3)**: 98-104. <http://dx.doi.org/10.1177/153944920502500303>
- 58 Lincoln YS, Guba EG. *Naturalistic inquiry*. Beverly Hills, CA: Sage, 1985.
- 59 Strauss A, Corbin J. *Basics of qualitative research*. 2nd edn. Thousand Oaks, CA: Sage, 1998.
- 60 Dyjur L. Medication work: the social organization of rule breaking to keep patients safe. Doctoral dissertation. Calgary: University of Calgary, 2015.
- 61 MacLeod MLP, Kulig JC, Stewart NJ, Pitblado JR, Banks K, D'Arcy C, et al. *The nature of nursing practice in rural and remote Canada*. 2004. Available: http://www.fcass-cfhi.ca/Migrated/PDF/ResearchReports/OGC/macleod_e.pdf (Accessed 20 September 2016).
- 62 Sedgwick MG, Yonge O. 'We're it', 'we're a team', 'we're family' means a sense of belonging. *International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy* 2008; **8**: 1021-1033.
- 63 Crooks K. Where everyone knows your name: an ethnographic exploration of rural nursing. Doctoral dissertation. Calgary: University of Calgary, 2007.
- 64 Crooks K. Dual relationships and rural nurse's transition to practice: a Canadian ethnographic study. D Molinari, A Bushy (Eds). *The rural nurse: transition to practice*. New York, NY: Springer, 2012; 47-60.
- 65 Moszczyński AB, Haney CJ. Stress and coping of Canadian rural nurses caring for trauma patients who are transferred out. *Journal of Emergency Nursing* 2002; **28(6)**: 496-504. <http://dx.doi.org/10.1067/men.2002.129727>
- 66 du Plessis V, Beshiri R, Bollman, RD, Clemenson H. Definitions of rural (catalogue no. 21-006-XIE). *Rural and Small Town Canada* 2001; **3(3)**: 1-17.

67 Kulig JC, Andrews ME, Stewart NL, Pitblado R, MacLeod MLP, Bentham D, et al. How do registered nurses define rurality? *Australian Journal of Rural Health* 2008; **16**: 28-32. <http://dx.doi.org/10.1111/j.1440-1584.2007.00947.x>

68 Richards L, Morse JM. *Readme first for a user's guide to qualitative methods*. 2nd edn. Thousand Oaks, CA: Sage, 2007.

69 Melrose S. Naturalistic generalization. In: AJ Mills, G Durepos, E Wiebe (Eds). *Encyclopedia of case study research*. Vol. 2. Thousand Oaks, CA: Sage, 2009; 599-600.

This PDF has been produced for your convenience. Always refer to the live site <https://www.rrh.org.au/journal/article/4256> for the Version of Record.