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The changing nature of nursing work in rural and small community hospitals

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ABSTRACT

Introduction: The nursing literature includes descriptions of rural nursing workforces in Canada, the United States of America and Australia. However, inconsistent definitions of rural demography, diverse employment conditions and health care system reorganization make comparisons of these data difficult. In 2007, the Ministry of Health and Long-term Care in Ontario, Canada, transferred responsibility for decision-making and funding to 14 regional governing bodies known as Local Health Integration Networks (LHINs). Little is known about rural–urban variations in the nursing workforces in the LHINs because existing data repositories do not describe them. This study investigated the influence of demographic characteristics, provincial policies, organizational changes and emerging practice challenges on nursing work in a geographically unique rural region. The purpose was to describe the nature of nursing work from the perspective of rural nurse executives and frontline nurses. The study was conducted in 7 small rural and community hospitals in the Hamilton Niagara Haldimand Brant LHIN.

Methods: Data collection occurred between August and November 2007. A qualitative descriptive study design was chosen to facilitate exploration of nursing in the rural setting. Study participants were identified through purposive snowball sampling. All nurses, nurse managers and nurse executives currently employed in the 7 study hospitals were eligible to participate. Data collection included the use of questionnaires and semi-structured interviews. Memos were also created to describe the relevance and applicability of concepts, categories and properties emerging from the data. Themes were compared across interviews to determine relevance and value.

Results: Twenty-one nurses from 7 different hospitals participated. The nurses reflect the aging trend in the provincial and regional workforces of Ontario. All study participants anticipate a substantial increase in retirements during the next decade, which will alter the structure and capacity of the rural workforce. Rural nursing practice is generalist in nature, requiring personal flexibility and a broad knowledge base. The nurses in the study preferred this type of practice. However, they felt that new nurses have different values and goals and are more likely to choose the specialized practice opportunities available in urban tertiary centres. Structural changes to the health system influenced relationships between hospitals and altered the internal organization of individual hospitals. Nurse executives were positive about new opportunities for cost savings, sharing best practices and continuing education. Yet they also felt that organizational changes significantly increased their administrative responsibilities and limited their opportunities for communication with frontline nurses. The nurses thought that the changing organizational structures increased opportunities to seek multiple employers to augment the lack of full-time positions in the region. Many reported that part-time and casual nurses often seek employment in other hospitals and long-term care homes to supplement their income. However, multi-site employment within and across healthcare organizations contributes to scheduling issues because casual nurses are unavailable to fill vacant shifts. Patient transports, the implementation of e-technology and emerging disease patterns in the patient population were identified as additional practice challenges.

Conclusion: This study has implications for health human resource planning in rural and small community hospitals. The findings indicate that demographic trends pose an immediate threat to the sustainability of the nursing workforce in the rural setting. Many nurses are nearing retirement, but the lack of opportunities for full-time positions as well as specialized and expanded nursing practice are attracting younger nurses to urban centres. Government policies focussing on the retention of clinical expertise, the recruitment of new graduates and expanding the role of registered practical nurses have been more difficult to implement in the rural setting. Implications for future research include the need to address data gaps to facilitate workforce planning and to evaluate the effectiveness of provincial recruitment and retention strategies in the rural context.

Key words: Canada, nurse, Ontario, regional health planning, rural hospitals, workforce.

Introduction

Researchers in Canada, the United States of America and Australia have contributed to a growing body of literature exploring rural nursing work. In 2004, the first comprehensive, national study of nurses working in Canadian rural and remote areas was conducted[1]. Rural nursing education and practice issues have been extensively documented in the USA[2-9]. Likewise in Australia, various studies have contributed to the understanding of rural nursing workforces[10-14].

Nevertheless, the term *rural* encompasses many degrees of rurality, and the literature does not always differentiate rural from remote locations[15]. Studies have begun to focus on specific regions along the rural–urban continuum to identify the scope of variation in nursing work. For example, an exploratory study was recently conducted in Canada to describe nursing practice in a large, predominantly rural region in southern Ontario[16].

The study presented in this article focuses on the nature of nursing work in rural hospitals in a south-eastern region of Ontario, Canada. The region is characterized by small rural areas bordering large and mid-sized urban centres. The study investigates the influence of demographic characteristics, provincial policies, organizational changes and emerging practice challenges on nursing work in a geographically unique rural region. The objective of this study was to describe the demographic characteristics of the nursing

workforce, the nurses' perceptions of the local health system and the nature of nursing work in this setting.

Background

Study setting

In 2007, the Ontario Ministry of Health and Long-Term Care (MOHLTC) transferred responsibility for decision-making and funding to 14 regional governing bodies, known as Local Health Integration Networks (LHINs). This study was conducted in LHIN 4 (ie the Hamilton Niagara Brant Haldimand LHIN). The boundaries of the region encompass 20 census subdivisions with populations ranging from 6300 to 490 300[17].

A total of 1 352 500 people, 10.9% of the Ontario population, reside within the region and approximately 15% of the residents are 65 years or older. Compared with the province overall, the region has a higher prevalence of activity limitations and arthritis/rheumatism. Furthermore, age-standardized mortality and hospitalization rates exceed provincial averages[18].

No standard definition of rural exists in Canada to facilitate comparison of research data and policy direction[1,16]. Rural locations have been identified by population sizes (eg less than 10 000)[19], postal codes[20] and self-identified measures such as communities of interest[21]. However, the communities in LHIN 4 vary in their rural type.

Situated between Lake Ontario and Lake Erie, the study area includes large vineyards, retirement communities along the lakeshores and 2 First Nations reservations near the largest urban centre. Consequently, the working definition of rural employed by the Ontario Ministry of Agriculture, Food and Rural Affairs was used in this study[22]. This definition encompasses most of the LHIN 4 region, including all municipalities with populations below 100 000.

Although the 7 hospitals in the study are located in rural communities, 5 of the hospitals are linked with large tertiary centres. Three hospitals belong to an amalgamation (ie a fusion of 2 or more hospitals into one corporation) and 2 belong to an alliance (ie an agreement to combine services only)[23]. The remaining 2 hospitals are independent, but have linkages with all hospitals in the region.

All the study hospitals provide general services through their acute and chronic care beds[24]. Acute bed occupancy rates varied from 75.7% to 113.7% in 2007. The hospitals maintained occupancy rates above 90% for chronic care beds during the study period, with one exception[25]. Newborn bassinets are available at 3 of the study hospitals, with an occupancy rate below 42% in each hospital. Finally, there are no mental health beds in any of the study hospitals.

Nursing health human resources in rural Ontario

The Canadian Institute for Health Information provides a broad overview of the rural nursing workforce in Ontario[26,27]. This national database defines rural and remote Canada as all communities with populations less than 10 000[26]. In 2006, 86.9% of employed registered nurses (RNs) and 81.4% of employed registered practical nurses (RPNs), also known as licensed practical nurses, lived in urban centres.

In contrast, 10.3% of RNs and 14.3% of RPNs resided in rural areas of the province. The remaining 3% of RNs and 4.5% of RPNs lived in remote areas. Among the nurses living in rural areas, 69% of RNs and 46% of RPNs commute to urban centres for employment[26,27]. Therefore, across Ontario, only 3.2% of RNs and 7.7% of RPNs actually lived and worked in rural areas during 2007.

Local data on the rural nursing workforce in the Hamilton Niagara Haldimand Brant LHIN region is not available. Smaller hospitals do not have the resources for data collection and analysis common in larger organizations. Thus they cannot easily monitor and document workforce

trends. Similar limitations in nursing health human resource data have been reported in the rural hospitals of an adjacent region of southern Ontario[16].

Nursing demographic trends and policy initiatives in Ontario

Impending retirements among older nurses and urbanization will exacerbate shortages in all rural regions of Ontario. In 2006, more than 54% of RNs and RPNs working in Ontario were over 45 years of age[28]. In 2007, the regional workforce in this study was slightly older than the provincial average: 58.7% of RNs and 57.7% of RPNs were aged 45 and older[28].

As this cohort approaches retirement, researchers and policy-makers have begun to look at the demographic trends among younger nurses. In Canada, the number of people between the ages of 20 and 44 years in rural areas is decreasing. This urbanization trend results from younger people migrating to urban centres for education and employment[29]. This trend is reflected in the Ontario nursing workforces as both RNs and RPNs gravitate to urban centres for employment[26,27].

The Ontario MOHLTC introduced the Late Career Initiative (LCI) and the New Graduate Guarantee (NGG) to address impending nursing shortages. The LCI provides opportunities for senior nurses to participate in projects away from the bedside and remain in the workforce[25]. The purpose of the NGG is to increase the opportunity for full-time employment of new graduates. Full-time supernumerary positions with financial support from the government for up to 6 months are designed to provide an extended orientation with mentoring to ease the transition of new graduates into permanent full-time positions[30].

Another significant policy change for the nursing workforce in Ontario is the evolving scope of practice for RPNs. As of January 2005, the educational requirements for an Ontario RPN increased from a certificate program to a two-year diploma program[31]. As a result, the scope of practice for the RPN expanded to include some skills previously initiated by RNs only.

Methods

The study design

This qualitative study explores nursing work within rural and small community hospitals from the perspectives of nurse administrators and frontline nurses. A qualitative descriptive study design[32] was chosen because it is a low inference method. Information is analyzed and interpreted in simple language from the perspective of the participants to facilitate straightforward answers to health services research questions. The study design was approved by the Hamilton Health Sciences/Faculty of Health Sciences and Niagara Health System Research Ethics Boards.

Data collection and analysis

Study participants were identified through purposive snowball sampling[32,33]. All RNs, RPNs, nurse managers and nurse executives currently employed in the 7 study hospitals were eligible to participate in the study. The chief nursing officer in each of the 7 study hospitals was recruited for interviews via telephone or email. They were also asked to identify 2 staff nurses (RNs and RPNs) from each of the 7 hospitals who would be willing to participate in the study. Twenty-one interviews with 8 nursing administrators, 7 RNs and 6 RPNs from the 7 study hospitals were held on site. Data collection occurred between August and November 2007.

The semi-structured interview process was informed by an ethnographic approach[34] and an interview protocol appropriate for the rural context[17]. This technique encourages the integration of structural questions into an informal, conversational style of interviewing. During the interviews, 2 research team members alternated between primary interviewer and observational roles. The interviews were digitally recorded, transcribed and coded simultaneously. Transcripts were uploaded into NVivo v1.3 (QSR International; Cambridge, MA, United States) for data management.

Transcripts were initially analyzed using established coding techniques[35] and data saturation was apparent during the final interviews. The process of data reduction began with open coding. All transcripts were read and re-read to identify possible meanings and concepts within the data. Memos were also created to describe the relevance and applicability of concepts, categories and properties emerging from the data. The observations and questions raised in the memos assisted in the development of an initial coding scheme. The developing codes were clarified and refined during subsequent interviews. The research team achieved consensus on the coding scheme via discussion during four team meetings. Themes were compared across interviews to determine relevance and value. The remaining themes were then clustered by characteristic similarity[36].

Results

Demographic trends and the future of the nursing workforce

The average age of the 7 RN and 6 RPN participants was 52.2 years. The highest level of education was a diploma for the RNs and a certificate for the RPNs. On average, the nurses' had 27.5 years of experience and had worked 22.7 years for their current employer. Nine participants had grown up in a rural or small community, and 6 of them were employed in their community of origin.

The aging nursing workforce: The nurses employed in the study hospitals reflect the aging trend in the provincial and regional workforces of Ontario. Study participants anticipate a substantial increase in retirements during the next decade. They considered this to be a significant trend that will alter the structure and capacity of the rural workforce, as reflected in the following statement by one RN:

> *It's only going to get worse 'cause you figure they're telling us there's at least half of us right now that given the next 10 years could retire. Well, you're already short now and you get another half going out the door?*

Retaining clinical expertise in rural nursing work: The study participants believed that their hospitals would face significant challenges in maintaining the current level of clinical expertise as the older nurses begin to retire. Anticipating the needs of the aging patient population in this region, one nursing administrator stated that managing patient care quality amid the large scale retirement of the rural nursing workforce was her first priority:

> *Sustaining the high level of care that's provided here as the most senior nurse retires . . . that is number one for me, absolutely.*

In expectation of these retirements, the hospitals actively pursued MOHLTC funding for late career nurses as a strategy to retain senior nurses and maintain a high level of clinical nursing expertise. Nursing administrators believed that the future nursing workforce would benefit from late career projects that update organizational policies and procedures for nursing practice. A nursing administrator shared her expectations for the outcomes of these projects on nursing work in the study hospitals:

> *It's easier for a new person to come in; they don't have to have . . . tenure of experience in order to cope. There can be strong policies and strong practices already in place that they can work from.*

However, all of the study participants reported that their hospitals had difficulty implementing the LCI because of staffing and scheduling challenges. For example, a nursing administrator commented that although they had received funding for late career projects, it was difficult to provide protected time for the nurses to participate in the initiative:

> *We have great ideas, but they don't . . . always pan out because at* [any] *minute the nurse could be pulled back to the clinical area because of being short staffed.*

Perceptions of urban drift: Rural nursing practice is generalist in nature, requiring personal flexibility and a broad knowledge base. These experienced, older frontline nurses prefer this type of practice, but they believe that new RNs are more likely to choose the specialized practice opportunities available in urban tertiary centres. One RN empathized with the younger nurses who leave rural regions for the cities:

> *The newer people, like younger grads starting off , . . . want the bigger hospital atmosphere or whatever to put their nursing skills to work,* [for] *which I don't blame them, and then they leave for the bigger centres.*

Frontline nurses suggested that new RPNs are also seeking opportunities to practice to their full scope. Organizational policies in the study hospitals limit the skills RPNs can use. Consequently, the nurses observed a drift of RPNs to larger hospitals and communities offering a more comprehensive experience. An RPN explained this trend in the following statement:

> *Well I think the new people coming, like the new RPNs, because they don't get to practice within their scope* [and] *don't want to lose their skills . . . they don't want to stay.*

Recruiting and retaining the next generation of rural nurses: The frontline nurses indicated that older and younger nurses have vastly different values and goals. These generational differences affect recruitment and retention. For example, short commuting distances and community connections are significant retention factors for the older generation of nurses, as illustrated by an older RN:

> *What keeps me here is the closeness to home, like I love . . . that I'm 10 minutes from my kids and from home. Mostly that's true and I do like the community atmosphere here. I really do love that.*

The study participants perceived the new generation to have priorities and values that are inconsistent with their beliefs. They also felt that the differing value systems of the younger generation influence their lifestyle choices. For example, one RPN compared her own needs and those of the younger generation of nurses in the region:

> *I got my house, I got what I need, but these young girls they're starting, they have payments too and . . . their expectations of life are maybe more than what I needed at that time. It's totally different, they all have cell phones, they all have computers . . . they all need two cars now . . . it's a whole different ball game than when I worked.*

The nurses believed these generational differences extended to employment choices. They indicated that younger nurses were unwilling to continue working in environments that limit their ability to hone specialized skills, practice to the full scope of their role and obtain full-time employment. The nurses believed that these career limitations encouraged urban drift among younger nurses who are seeking a stimulating and stable work environment. One RN described the difficulty of retaining nurses:

> *Newer people that have come have left, they've only been here a few months and then left . . . they* [have] *either gotten full-time employment or better employment someplace else.*

The incongruence between the expectations of younger nurses and practice realities in this setting alarmed the older nurses. As nurses and community members they expressed uncertainty about the sustainability of the nursing workforce in these rural and small community hospitals. One RPN remarked:

> *It scares me to death 'cause we're going to have, well* [in the] *next 10 years or even less, we're going to have a major change over here, and that's scary and . . . unless they move to the community to raise a*

family. . . . I don't know what's going to happen. I don't know what the answer is.

The nurses in this study were also asked to describe the influence of the NGG on recruitment and retention of younger nurses. The rural hospitals had expressed interest in the NGG. However, there are significant barriers to participating in this initiative, including a general lack of interest among new nursing graduates and the cost incurred to the organization. As a result, study participants felt that this policy has little influence on nursing recruitment and retention in rural hospitals. One nursing administrator indicated that despite the success of the policy in urban centres, rural hospitals were unable to benefit from the initiative:

It's a great idea in theory, but the way it's been rolled out it's just not doable . . . this new grad initiative is actually putting the hospital in a financial risk.

Changing organizational structures

Changes in regional organization relevant to this study include historical amalgamations, new alliances and the establishment of LHINs. These structural changes to the health system influenced relationships among hospitals and altered the internal organization of individual hospitals. The nurses discussed the effect of these changes on the role of the nursing leader and on scheduling practices at the frontline.

Effects of organizational change: Nurse administrators spoke positively about their respective hospital amalgamations and alliances. They described new opportunities for cost savings, sharing best practices and continuing education. However, they felt that organizational changes significantly increased their administrative responsibilities and limited their opportunities for communication with the frontline nurses.

The nursing leadership role in these hospitals now includes managing multiple sites or multiple units spread across sites. Nurse administrators cautioned that the heavier workload will lead to burnout if it is not addressed. One nursing administrator shared her personal experience of being a nursing leader in this setting:

I'm overwhelmed with my span of control, with not having resources to call upon to help with different projects . . . . As much as I actually do love my job, I can't keep up the pace . . . . Increasingly, there are more and more expectations . . . none of the load ever gets removed.

Nevertheless, the nurse administrators expressed optimism for the future of local health care. They identified opportunities to share best practices and provide collegial support at the regional level as immediate benefits of the LHINs. A nursing administrator described the networking opportunities created by the LHIN system:

I think that it's been a very, very powerful opportunity, the opportunity to network, the opportunity to hear what others are doing, either reaffirming that we are heading in the right direction or what a great idea, we should try that.

Scheduling and staffing challenges: The frontline nurses thought that the changing organizational structures gave nurses more opportunity to seek multiple employers to augment the lack of full-time positions in the region. Many nurses reported that part-time and casual nurses often seek employment in other hospitals and long-term care homes to supplement their income.

Multi-site employment within and across health care organizations in the region contributes to scheduling challenges because casual nurses are unavailable to fill vacant shifts. One RPN clearly articulated this issue:

> *We don't have a whole lot of staff to choose from because also a lot of these girls have other jobs in other areas or in other hospitals, so a lot of times they're not available when we need them . . . that's a problem.*

Nurses stated that scheduling conflicts occur daily in the study hospitals. In particular, nurse executives reported that limited nursing capacity made it difficult to ensure all vacation hours are granted. A nursing administrator summarized this staffing challenge:

> *It is a huge problem . . . it's hard sometimes for staff to get exactly the vacation they want. To have the right coverage, we can only have, you know, 1 or 2 people off at one time when you're just a small group. And when you think about the amount of seniority and the staff that we've got, they're entitled to a lot of time, and it's hard for them to get that time.*

Patient transports are an additional staffing challenge. Transfers to large tertiary centres for diagnostic testing and specialized critical care are often necessary because of the limited services available in the smaller hospitals. Although commuting distances are relatively short, these patient transfers exacerbate staffing shortages in the study hospitals, as illustrated by another nursing administrator:

> *It takes a whole person right out of maybe a complement on nights from emerg or ICU, it takes a whole person out . . . and you don't have any flexibility.*

Nurse executives noted that nursing overtime is a significant hospital budget item. One strategy to contain costs has been to centralize administrative services such as scheduling among hospitals. However, the frontline nurses contended that centralized scheduling systems have done little to alleviate daily scheduling challenges.

Although the nurses expressed their frustration with the increased hours, most felt compelled to work overtime to support their colleagues. One RN shared her experience of explaining to her family why she accepts overtime shifts:

> *I don't mind doing the odd overtime shift and I don't think anybody does but . . . the amount that we're doing right now . . . we can only keep this up for so long . . . . The extra money's great at the end of the pay cheque, but I said, 'I'm going in . . . for my co-workers'.*

Professional practice challenges

Professional practice challenges identified in this study included adapting to changing professional roles, the implementation of e-technology and emerging disease patterns in the patient population.

Redefining professional practice roles: All of the study participants described the new scope of practice for RPNs as difficult to implement because it challenged established patterns of nursing practice. Although new RPNs welcome the changes, RPNs approaching retirement were content with their current scope of practice and did not wish to change. This preference is reflected in the remarks of an older RPN:

> *I don't know how that will work 'cause all us old girls will have to increase our skills . . . a lot of them I don't know would be too happy with that at this point . . . 'cause they're all near 60, 58, 59.*

In addition, RNs indicated that their colleagues had mixed reactions to the new RPN role. From the RN perspective, changing RPN functions encroach on their position. Furthermore, they are not confident that the new RPNs will be prepared for the additional responsibility of the expanded scope of practice. One RN clarified the nature of this concern in her peer group:

RN-wise I think the RNs are seeing it as . . . a threat to what they've done for several years, to their job, and I don't think that they're fully confident that the RPNs have the background and the theory to . . . take all this on.

E-technology for nursing practice: The frontline nurses discussed challenges arising from the increasing use of e-technology in the study hospitals for charting, information sharing and corporate communication. They explained that just familiarizing themselves with a computer and operating systems requires the acquisition of additional knowledge. This is a significant practice challenge for the aging nursing workforce with limited computer skills, as illustrated by one older RN:

Some people had difficulty catching on to the system and knowing how to access it quickly. . . it's the added skills in becoming computer literate, which I wasn't when it first started, and if you ask my son, he'd say, 'You're still computer illiterate'.

Disease patterns in the rural patient population: The recent emergence of 'super infections' in the rural patient population contributes significantly to scheduling pressures. The frontline nurses explained that these infections, particularly *Clostridium difficile*, methicillin-resistant *Staphylococcus aureus* (MRSA), and vancomycin-resistant enterococci (VRE) increase nursing workload exponentially.

Nursing care of this patient population includes carrying out all routine tasks encumbered by infection control equipment and procedures that isolate both the patient and the nurse. One RPN summarized the nursing concern that super infections will be an ongoing challenge in the study hospitals:

I think a lot of the challenge . . . now is the outbreaks . . . . I think they have 6 rooms maybe isolated, and yesterday was national swab day, you know, once-a-week everybody gets swabbed . . . . It's almost like a chronic thing with these people.

Discussion

The findings of this study have implications for health human resource planning in rural and small community hospitals. Future research and policy directions to address the issues identified by the study participants are included. In addition, the study limitations are examined in relation to the study purpose, setting and sample.

Address demographic trends in the workforce

Immediate strategies are needed to offset the loss of staff and clinical expertise resulting from impending large-scale retirements and urbanization in the rural workforce. This study did not include nurses under the age of 30 years. However, age was identified as a significant factor for recruitment and retention in the study hospitals. Canadian research has previously noted that younger rural nurses are more likely to be employed part-time and have multiple employers[37]. In addition, high levels of perceived stress and dissatisfaction with scheduling processes have been associated with intent to leave among rural nurses[1]. Similarly, the nurses in this study indicated that multi-site employment, limited full-time opportunities and continual scheduling conflicts are a source of frustration and dissatisfaction for their younger counterparts.

Understanding the values and preferences of younger nurses is important for rural hospitals that might benefit from recruitment and retention strategies initiated during nursing education.

The literature indicates that providing student placements is a successful recruitment strategy for rural settings[38-42]. Therefore, programs and initiatives to encourage and sustain collaboration among nurse educators and administrators are needed. Providing educational opportunities for nursing students to familiarize themselves with this unique practice setting may encourage new nurses to seek employment in the region upon graduation.

It would be beneficial for policy makers to evaluate the feasibility of implementing policy initiatives such as the LCI and NGG and significant nursing role expansion in rural hospitals. Although urban centres have benefited from the initiatives, the findings of this study indicate that these policies are unsuccessful in the rural setting because of the small size and limited resources of this workforce. Other studies have noted similar gaps between provincial nursing policies and the capacity of rural hospitals to implement broad initiatives[15,43].

Explore nursing workload, job satisfaction and practice challenges

Nursing roles have expanded in the rural and small community hospitals in the study region. However, additional information is required to determine the long-term impact of organizational changes and centralized decision-making on the workload of nursing administrators and frontline staff. The nurse administrators indicated their increasing span of control is unsustainable. The addition of multi-site or multiple-unit responsibilities has significantly reduced the amount of time that the administrators can spend in direct contact with frontline nurses.

As a result, both nursing administrators and frontline staff identified lack of communication as a side-effect of the organizational changes in many of the study hospitals. Studies have noted that in a complex network of organizations, communication plans are vital to sustaining the job satisfaction of nurses[44,45].

The frontline nurses in this study indicated that they are frustrated with extended work hours. However, accurate measurement of overtime rates and exploration of nurses' experiences working extended hours in rural hospitals is limited by the hospitals' capacity to collect and analyze workforce data. Longitudinal examination of staffing and scheduling patterns in this setting could identify trends and provide data for workforce projections and plans.

Exploratory research focussing on the current and potential role of RPNs in rural hospitals is required. In addition, the implementation of new technology in the hospital setting could be enhanced by providing educational support for nurses. Finally, monitoring nosocomial trends at the regional level would assist policy-makers and administrators to allocate appropriate financial and human resources to the study hospitals.

Study limitations

The transferability of the study findings is limited by the unique geographic setting and the characteristics of the participants. Rural and urban areas in LHIN 4 exist in proximity to one another. Nurses in other rural regions with less urban accessibility may have different perceptions of nursing work. Moreover, the 21 nurses who participated in this study are primarily older females with extensive nursing experience. Younger, less experienced nurses and male nurses may provide an alternative perspective on the nature of rural nursing work.

Conclusion

The nurses in this study are multi-skilled generalists. Their clinical expertise is the foundation of nursing practice in the rural and small community hospitals where they work. However, new practice requirements and organizational processes are changing the nature of nursing work and workloads for administrators and frontline nurses.

The nurses are required to increase their knowledge and acquire new skills in response to evolving professional roles, e-technology in the workplace and super infections in the patient population. Little is known about the long-term effects of these challenges. Therefore, further research is needed.

The findings of this study clearly indicate that demographic trends are immediate threats to the sustainability of the nursing workforce. Many rural nurses are nearing retirement.

Yet the lack of rural opportunities for full-time positions, specialized nursing practice and RPN expanded practice are attracting younger nurses to urban centres. Furthermore, government policies focussing on the retention of clinical expertise, the recruitment of new graduates and expanding the role of RPNs have been more difficult to implement in the rural setting.

Research examining the values and beliefs of younger nurses is required to inform recruitment and retention strategies. Provincial nursing policy initiatives and corporate programs that address the impending generational turnover are urgently needed to sustain nursing human resources in this region.

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