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# Lived Experiences of New Nurse Graduates in Critical Access Hospitals

Lesa Ann Hoppe

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UNIVERSITY OF NORTHERN COLORADO

Greeley, Colorado

The Graduate School

LIVED EXPERIENCES OF NEW NURSE GRADUATES  
IN CRITICAL ACCESS HOSPITALS

A Dissertation Submitted in Partial Fulfillment  
of the Requirements for the Degree of  
Doctor of Philosophy

Lesa Ann Hoppe

College of Natural and Health Sciences  
School of Nursing  
Nursing Education

August 2018

This Dissertation by: Lesa Ann Hoppe

Entitled: *Lived Experiences of New Nurse Graduates in Critical Access Hospitals*

has been approved as meeting the requirement for the Degree of Doctor of Philosophy in the College of Natural and Health Sciences School of Nursing Ph.D. in Nursing Program of Nursing Education

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## ABSTRACT

Hoppe, Lesa Ann. *Lived Experiences of New Nurse Graduates in Critical Access Hospitals*. Published Doctor of Philosophy dissertation, University of Northern Colorado, 2018.

The purpose of this descriptive, phenomenological study was to explore and uncover the phenomenon of the lived experiences of new nurse graduates in the first year of employment in critical access hospitals. One-on-one interviews were completed with 13 participants working in critical access hospitals in three Midwestern states. The nurses had between 1 and 12 months' experience in their registered nurse position. Six themes were identified in the study using Colaizzi's (1978) seven-step process for analysis: (a) Always a Professional, (b) Personal Connections, (c) Pride in Work and Community, (d) Always on Your Toes, (e) Everyone Works as a Team, and (f) Essential Preparation Experiences.

Findings indicated the theme of always being seen as a professional as part of their identity as nurses impacted participants' sense of personal identity within the community and community ties impacted their attitudes and perceptions about patient care experiences within the workplace. The culture of a critical access hospital and the feeling of support amongst coworkers and administrators is especially important to foster an environment of teamwork and continued learning. This study could assist leaders in both nursing education and rural hospital settings to recognize and better understand the needs of new nurses as they launch their nursing careers in critical access hospitals.

## ACKNOWLEDGMENTS

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dimension to conversations, projects, and group work, creating a fascinating opportunity and honor to experience a doctoral journey with nurses from all over the United States.

Special thank you to the Nu Rho chapter of Sigma for the grant award for my research project. I also would like to thank Connie Beard for her assistance in editing my final draft of my dissertation.

## DEDICATION

This is for my husband and my children. To my husband, this was truly a joint-venture, a sacrifice of four rigid years of a different lifestyle that felt exhausting and challenging for all at times. You never backed down in supporting me and listening, and were always there, steadfast, to help or round up additional family support when needed for the periods of writing, testing, and thinking while I still maintained a full-time job as well. You helped me keep watch over the holistic health of our family, playing, planning, budgeting, dreaming and taking on so many more roles than we may have realized at the time. To my children, dream big and shine bright, as we always say! I hope that seeing mama complete this endeavor inspires you to value education and new knowledge throughout your lifetimes.

I must dedicate this work to my parents as well, as they've modeled hard work and sacrifice for years for our family, in loving support, teaching and sharing the tools and resources to launch onward, inspiring me to push forward and know that my goals were within reach all along. They've helped make this journey possible, as well. For the friends that have stood by my side in faith—thank you—you know who you are.



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## CHAPTER I

### INTRODUCTION

#### Background

New registered nurse graduates are entering the workforce during a dynamic time in the healthcare industry. To meet the demands of transformative changes in health care with a focus on analytics and patient-centered care, new nurses' skills and enthusiasm are needed to sustain the nursing workforce as additional nurses retire in the future (Salmond & Echevarria, 2017). Registered nurses provide many services to patients in direct care such as disease prevention and health promotion for individual and community health, education, care coordination, and the administration of medications and treatments (U.S. Department of Health and Human Services, Health Resources and Services Administration [HRSA], 2013). As a result of increasing acuties in illness and innovative treatments, nurses must be prepared to be lifelong learners to maintain competencies, develop leadership skills, and adapt to new technology. While some nursing students complete a rotation in rural nursing within the curriculum of a nursing program, the majority of their hospital-based or acute care experiences are usually facilitated through hospitals with an urban-centric perspective (Rural Health Information Hub [RHIH], 2017). Urban hospital settings provide job opportunities for specialization and a wide variety of ancillary services while rural hospitals require nurses to be

competent in providing both general care and being able to call on a specialized skill set on demand to meet the needs of a community.

### **Statement of the Problem**

Supply and demand of nurses in the published projections toward the year 2025 vary greatly. Some reports show positive trends in the increasing percentage of younger nurses as a result of action for increased capacity in nursing programs (HRSA, 2014). These overall positive trends might, however, mask rural shortages or regional differences. An overall shortage in rural areas might younger nurses are not seeking employment in rural areas for various reasons (American Association of Colleges of Nursing [AACN], 2017; National Rural Health Association, 2012). Thus, to sustain the rural nursing workforce, opportunities must be appealing for new graduates in order to promote recruitment and retention in this care setting.

Around one-third of the nursing workforce is age 50 or older (HRSA, 2013). This becomes a concern as an aging nursing workforce exists not only in urban areas but rural areas as well. A loss of experienced nurses due to retirement creates vacancies that might be filled by new graduate nurses. Health Resources and Services Administration (2017) projected in its analyses that more than a million nurses will reach the age of retirement within the upcoming 10 to 15 years (AACN, 2017; American Nurses Association [ANA], 2016). This aging workforce issue presents concerns related to leadership and loss of experience amongst nursing teams with implications for the mentoring of new nursing graduates (Andrews, 2013; Auerbach, Buerhaus, & Staiger, 2015).

As novice nurses transition from their educational programs, they need support and mentoring to assist them in this transition (Prion et al., 2015). Support programs

designed to assist this transition might be lacking in rural areas with fewer resources when compared to urban areas (Sedgwick & Pijl-Zieber, 2015). This study was designed to explore the experiences of new nurses as they begin their practice in rural areas.

### **Retention in Nursing**

In addition to the retirement of experienced nurses, other factors might influence the nursing workforce. Nurses continue to seek out different jobs or leave the profession altogether as a result of dissatisfaction and burnout (Prion et al., 2015). One reason for burnout or increased stress might be the result of inadequate staffing or increasing acuity of nursing care services (AACN, 2017). Although a variety of employer settings and work schedules are available in the nursing profession, the majority of the nursing workforce is employed within hospital settings (ANA, 2016; HRSA, 2013). Nurses are called upon to balance many tasks and expectations. The ability to balance this workload, along with long hours with physical strain, can impact both patient safety outcomes and job satisfaction outcomes (Frith, Anderson, Tseng, & Fong, 2012).

“Job embeddedness” is a construct adopted from the business world and associated with retention and keeping nurses satisfied in their work (Adams, 2016; Reitz, Anderson, & Hill, 2010). While nursing is a unique profession with many possibilities for practice settings, retention is a major focus for all employers due to budget, quality, and safety implications for those receiving nursing care services (Finkman, Leino-Kilpi, & Salantera, 2010). The perceptions of nurses are critical to their feelings of satisfaction, contributions and everyday experiences that account for job embeddedness; the intent to stay in a position tends to be greater amongst nurses as age increases (Reitz et al., 2010). Thus, new nursing graduates of a young age might report lower levels of job

embeddedness compared to their peers. Further exploration of new nursing graduates' perceptions will provide information to support retention strategies.

In an effort to help support new nurse employees, workplaces offer orientation programs that vary by resources, size of facility, and acuity of the clientele. While all new employees are best supported with orientation periods, it has been recognized that new nursing graduates especially benefit from the structure of orientation (Prion et al., 2015). Newer strategies such as nurse residency programs have been introduced successfully in urban settings or larger institutions (Pittman, Herrera, Bass, & Thompson, 2013). However, for rural facilities such as critical access hospitals (CAHs), this type of support might be lacking for new graduates (Sedgwick & Pijl-Zieber, 2015). Hospital administrators must consider investment and positive implications of establishing greater initial support while also monitoring lean budgets to best resource their market share of the local population.

### **Critical Access Hospitals**

General hospital settings account for 57.8% of the nursing workforce and remain an area of focus due to increasing patient acuity despite trends for increased nursing care services in the community setting (ANA, 2016; HRSA, 2013). The hospital setting is also a common area for new graduate employment. Economic and health policy reform will continue to shape the climate for these hospitals as they rely heavily on assistance from federal funding. Nationally, 16% of the nursing workforce lives in rural areas (HRSA, 2013). Critical access hospitals are hospitals designated by Centers for Medicaid and Medicare Services (CMS) as meeting a group of specific criteria in a rural area (HRSA, 2017). Located more than 35 miles away from another hospital with 25 or fewer

beds, these hospitals must maintain 24 hour/7 days a week emergency services and also maintain an average length of stay of 96 hours or less for their acute care patients (Rural Health Information Hub, 2017).

It is important for critical access hospitals to maintain a quality workforce. Acceptance of a new staff nurse position at these facilities can be both exciting and challenging for the new hire. Additionally, goals for administration include ensuring a safe, adequate orientation to all nursing services is offered while maintaining a lean budget. Critical access hospitals typically do not have the level of support for their new hires that larger institutions have due to lower staffing and census needs (Dowdle-Simmons, 2013). Because of this scenario, CAHs might be at risk for retention issues when new hires experience challenges and develop perceptions regarding their job and workplace.

Often, the guidance of a new hire is left to a single preceptor without a structured program and exposure of patient assignments during the orientation period might vary. These assignments might be rather generic or otherwise diverse, depending on the timing and the daily patient census. New nurse preceptors typically strive to collaborate with the new hire in a wide variety of experiences in an orientation period as these situations might be encountered again in the near future. The frequency with which they are encountered is variable. Nurses in rural facilities must be very skilled and prepared for a variety of situations including emergency room and trauma, childbirth, perioperative nursing, specialty services, medical-surgical clients, as well as the ability to help triage and stabilize patients for transfer to higher-acuity care (McCafferty, Ball, & Cuddigan, 2017). Interdisciplinary collaboration and knowledge of these services are also important



when staffing is at a minimum for needs such as pharmacy or rehabilitation resources and care planning.

### **Significance**

To help new graduate nurses successfully transition into their nursing career when they accept a position in a critical access hospital, it is important to learn about the experiences of other new nurses in the rural care environment. These findings could be used to create recommendations for increasing education, preparation, and support. The phenomenological perspective of this study shared the realities of the everyday workplace and the essence of the transition to a new identity as a nurse as experienced from the participants' stories. Critical access hospitals can utilize these findings to customize plans for new employees hired as graduate nurses with the goal of retention and promotion of further professional development amongst their nursing teams.

Implications for nursing education were also developed from the findings of this study. Participants' responses gave insight on themes that guided further preparation for competencies and transition to nursing practice. Nursing education programs desire to validate their ability to support new nursing graduates in passing the National Council of State Boards of Nursing Licensure Exam-RN (NCLEX-RN). This preparation should carry over into readiness for safe nursing care in a variety of healthcare settings. In addition to theoretical knowledge about nursing care, key skills such as professionalism and time management must also be validated in preparation for unique settings such as rural hospitals where nurses might serve a variety of clients with a range of acuities. It is important for nursing schools to be confident in the current curriculum to properly address the needs of graduates entering a rural healthcare setting.

### **Purpose of the Study**

The purpose of this descriptive, phenomenological study was to explore the lived experiences of new nurse graduates in their first year of employment in critical access hospitals. Exploration of these individuals' experiences provided insight on the needs and perceptions of new nurse graduates for rural hospitals struggling with recruitment and retention and could also help identify continuing education efforts for nurses in CAHs. The findings also revealed information on helpful support for new nurses and additional education needs that have not been previously met. This research filled a gap to advance knowledge of new rural nurses' experiences in CAHs and might help provide additional insight on issues in the nursing profession such as retention and job embeddedness. Prior studies have generally only addressed first-year experiences of nurses in urban settings (Clark & Springer, 2012; Martin & Wilson, 2011; McCalla-Graham & De Gagne, 2015; Phillips, Esterman, & Kenny, 2015). Furthermore, nursing programs could use this information in future curriculum development to maintain currency and preparedness for service in both the art and science of nursing practice.

### **Research Question**

This study investigated the phenomenon of lived experiences in new nurse graduates in rural hospitals, specified as critical access hospitals (Creswell, 2014). The following research question was explored by this qualitative inquiry:

- Q1 What are the lived experiences of new nurse graduates in their first year of employment in critical access hospitals?

### **Summary**

This introductory chapter presented a background for the study approach as well as the scope of the problem, the purpose of the study, and the focal research question.

Chapter II presents support for the study by review of literature, supporting the methodology selected for this dissertation.

## CHAPTER II

### REVIEW OF LITERATURE

#### Introduction

Databases such as the Cumulative Index to Nursing and Allied Health (CINAHL), PubMed, and ProQuest Nursing/Allied Health were used to review existing research and publications with a final check of Google Scholar to account for any missed resources that might be of value. Over 1,300 abstracts and entries were scanned, critically reviewed, and generated by the use of key words and phrases such as “rural,” “new,” “nurses,” “graduate nurses,” “critical access hospitals,” “orientation,” “first-year nurses,” and “nurse residency” with several variations of these terms utilized in PICOS search methodology (Grove, Burns, & Gray, 2013; Higgins & Green, 2008). The final articles selected reference relevant theoretical frameworks for further inquiry and covered a wide range of literature available on new nurse graduates. However, a dearth of literature on the experiences of new rural hospital nurses was noted in the search.

A brief review of the literature follows to provide a basis for discussion in the exploration of new graduate nurses’ experiences. Selected articles were carefully addressed to highlight the gap of findings available from only a few studies specifically reporting the experiences of new graduate nurses in either rural settings or critical access hospitals (Bratt, Baernholdt, & Pruszynski, 2014; Lea & Cruickshank, 2017; Sedgwick &

Pijl-Zieber, 2015). Other relevant categories of recent literature describing the background on the phenomenon include literature on the experiences of new nursing graduates and their orientation to the new role, nurse residency programs, rural nursing roles and the experiences of new graduates, and retention and job embeddedness in rural facilities. While this qualitative study's review of literature is shared to help identify the need for the current research, the existing literature is also discussed in further depth and compared in the results and discussion section of the dissertation (Creswell, 2014). This is often a literature review strategy used with inductive methods to reduce bias and to acknowledge that the researcher is learning directly from the participants in an exploratory process (Creswell, 2014). Thus, this literature overview sets the stage for further discussion utilizing the new findings on the phenomenon from the current research study.

Two theories, Benner's (1982) novice to expert theory and Meleis's (2010) transition theory, were used to frame this research study. These theories were considered as semi-structured interview questions were developed. They are also discussed in a reflection on existing literature along with new themes and findings that emerged from the participants and the descriptions of their experiences.

### **Theoretical Framework**

#### **Novice to Expert Theory**

Patricia Benner's (1982) novice to expert theory is commonly used to frame the experiences of new nursing graduates as they advance in their careers. In her qualitative research, Benner applied the earlier Dreyfus and Dreyfus (1980) novice to expert ideas on skill acquisition to the population of nurses moving through the nursing profession.

Benner described five levels of proficiency in nursing. The first level, “novice,” is a title often given to nursing students still learning about the profession, newly licensed nurses, or those nurses starting over in a new care setting (Benner, 1982). Models and nursing theories are introduced to nursing students and referenced in learning to provide a steady foundation for decision-making and guidance of nursing care (Benner, 1984). They often continue to be referenced as the novice nurse. The nurse moves into the “advanced beginner” stage still in need of mentoring and assistance in learning. After two to three years of working within the same area, the nurse is generally labeled as “competent”-- recognizing patterns in practice and developing further reasoning skills (Benner, 1982). Next, the nurse approaches the “proficient” stage nearing five years of experience, continuing to build experiences toward the final “expert” stage with a deeper understanding of his or her work with reliance on intuition (Benner, 1982).

While Benner’s (2004) application has been widely cited with respect to a nurse’s development of competency over his or her career, discussion continues about the balance of theoretical knowledge learned previously and the progression to greater reliance on one’s own intuition through the advancement of the stages. The concept of intuition and its role in progressing to the “expert” stage creates implications for administrators of nursing practice. Nurse leaders amongst nursing staff teams must model and share their decision-making in the progression toward expert practice (Benner, 2004).

Morrison and Symes (2011) published an integrated review of the existing literature (1996 to 2009) on expert nursing practice and asked the following question: “How is expert nursing practice of experienced staff nurse clinicians characterized across

a variety of clinical settings or specialties?” (p. 163). They also sought to determine any contributing environmental factors. Their search of CINAHL and Medline resulted in a final review of five non-experimental quantitative studies and 11 qualitative studies. They arrived at five major themes including (a) “knowing the patient,” (b) “reflective practice,” (c) “risk taking,” (d) “intuitive knowledge and pattern recognition,” and (e) “skilled know-how” (Morrison & Symes, 2011, p. 164). As the reflective practice, pattern recognition, and intuitive knowledge aligned with Benner’s (1982) model, the theme of “knowing the patient” highlighted the importance of feeling involved and engaged with patients in any care setting. For hospital nurses, this is particularly important in the context of their workload and daily patient assignments. To be engaged and emotionally grounded in patient care, nurses must also experience support within their environment.

Environmental factors that were also contributors to expert nursing practice in this review included “nursing leadership, autonomy, positive nurse-physician relationship, nurse-patient relationship, role model mentors, and recognition” (Morrison & Symes, 2011, p. 164). In a rural care context, expectations might be placed on the new graduate nurse to reflect some of the characteristics of the expert nurse due to greater autonomy in some situations or varied scenarios in which patients might need care.

While nurse educators can continue to highlight the importance of experiential learning and clinical experiences in nursing education and orientation programs, their focus is on the development of the novice nurse (Dreyfus, 2001; Gardner, 2012). Further experiential and professional development of working nurses must be nurtured by those

nurse leaders in the field supporting their work and providing leadership in everyday problem-solving and management of relationships.

### **Meleis Transition Theory**

The Meleis (2010) transition theory framed the findings of this study and was considered in the development of the interview guide (see Appendix A). Although it has typically been applied to patients' transitions in health as a theoretical framework in research, the Meleis transition theory could certainly complement the Benner (1982) novice to expert theory in the exploration of new nurse graduates' experiences. Nurses continue to develop their own identities as a nurse as they face the realities of nursing practice on their own beyond the structured experiences of nursing school (Benner, 1984). Meleis developed this theory to help nurses facilitate healthy transitions for patients and families in relation to the health and illness cycle. Key ideas about healthy situational transitions and their impact on well-being could be applied to nurses' personal transitions and formation of nursing identities.

While the theoretical ideas name the role rehearsal, role modeling, and role learning that might take place for nursing students during school, the theory also supports the possibility of role insufficiency that might be experienced as a new graduate nurse (Meleis, 2010). When a new graduate nurse feels like his or her role in transitioning to a rural care setting is poorly defined in areas of where to focus, how to set priorities, or comes to the realization that he or she lacks knowledge necessary for the autonomy expected in this care setting, he or she might experience role insufficiency (Meleis, 2010). The progression toward a healthy role transition might be impeded when the new graduate nurse reacts with frustration, anxiety, unhappiness, or powerlessness according



to Meleis. Role transition in a rural hospital setting might be more difficult for a newly graduated nurse due to unique expectations within the rural healthcare setting (Sedgwick & Pijl-Zieber, 2015).

Conditions of a work environment and personal relationships might influence the transition a nurse makes, creating a perception of a successful or unsuccessful beginning of one's nursing career. Experienced mentors might be able to support new graduate nurses as they transition into their new role (Meleis, 2010). This, in turn, might impact future decisions to stay in a position or consider leaving the profession of nursing altogether. The role mastery described by Meleis (2010) is akin to the cumulative experience gained in nursing practice with a need to find meaning in nurses' presence and everyday work. This research study explored what new graduate nurses identified as supportive and meaningful as they developed role mastery.

Use of the Benner (1982) and Meleis (2010) theories to ground this study provides a framework for the analysis of findings. They were selected due to their fit in framing the phenomenon of beginning a nursing career. Although the intent of qualitative research is to hear about the narrowed experience of participants through their information-rich narratives, it was thought that emerging themes might uncover new information that could be generalized to novice nurses in both rural care settings and other specialty areas. A discussion of existing literature on new nurse graduates follows.

### **New Nurse Graduates and Rural Nursing**

#### **New Nurse Graduates and Orientation to Role**

Several qualitative studies reported nursing students' and graduates' expressions of skills and qualities they perceived as essential to nursing (Cleary, Horsfall, Jackson,

Muthulakshmi, & Hunt, 2013; McCalla-Graham & De Gagne, 2015). For example, a phenomenological study from McCalla-Graham and De Gagne (2015) explored new graduate nurses' experiences working in multiple acute care settings in southwest Florida. These settings represented two major healthcare corporations not likely to be interpreted as rural acute care facilities. A total of 10 men and women in the sample completed interviews, ranging from 22- to 56-years-old; three major themes were revealed in their discussion of new graduate nurses' lived experiences.

Participants acknowledged nursing school provided foundational *knowledge* but the new nurses interviewed did not feel fully prepared for the demands of the acute care setting and the need to prepare for “worst-case scenarios” (McCalla-Graham & De Gagne, 2015, p. 124). Participants also addressed the need for further developing coping *skills* amongst others such as time management and prioritization. A third theme of *environment* was the environmental problem encountered by participants that was described as inadequate staffing, leading to “emotional tiredness” and lack of confidence or comfort in their new role (McCalla-Graham & De Gagne, 2015, p. 125). The themes of environment, knowledge, and skills in the new graduate nurses' experiences were anticipated as findings in the current research study with new graduate participants. As these findings were very broad, this researcher felt another sample in addition to this group in southwest Florida might have greater insight, accounting for regional differences. This current study was carefully planned to address and narrow these broad themes in asking rural new nursing graduates further about their experiences. The characteristics and environment of the workplace impact perceptions and attitudes that

might lead to retention or attrition; these are outcomes that might be affected by new information in future research.

An Australian study tracked 13 nursing students who were interviewed in transition to graduation (Kelly & McAllister, 2013). The students were followed in the study from pre-employment to one month into employment and six months into the job. Themes such as confidence, peer support and friendship, feelings of lack of support, and “being thrown in at the deep end” were summarized as major findings (Kelly & McAllister, 2013, pp. 172-173). The participants explained preceptors played a major role in the participants’ perceptions of self-confidence or lack thereof. One participant expressed concern about the role transition, sharing that while the time of being paired with preceptors is important, a new nurse cannot fully grasp the responsibilities and autonomy of his/her new role as a registered nurse until he/she has tried to fully accept the role independently (Kelly & McAllister, 2013). This was echoed as another perception about experienced nurses. Some new graduates thought experienced nurses were less available for support than they should be for new nurses. This, in turn, created the perception of being “thrown in at the deep end” as the new nurses transitioned with more autonomy than desired or with which they were comfortable (Kelly & McAllister, 2013, p. 174). Peer support seemed to be one area of benefit as it helped to know others were experiencing the same transition of beginning a new nursing career in the workplace (Kelly & McAllister, 2013). This study suggested changes in the Australian curriculum and experiential learning experiences in preparation for licensure and nursing practice. Although these findings might have transferability to a degree, U.S. care models and environmental factors are different, especially within Midwestern rural settings due to

staffing patterns and care standards in the U.S. healthcare system (Salmond & Echevarria, 2017).

Amidst the busy, long shifts in an acute care setting, relationships and the socialization aspect were described as significant in the findings of many qualitative studies with a population of new graduates (Clark & Springer, 2012; Freeling & Parker, 2015; Martin & Wilson, 2011; Phillips et al., 2015). Martin and Wilson (2011) studied the lived experiences of seven nurses in their first year of practice in a similar design as provided in this new study. They found “adapting to the culture of nursing” was a major category involving socialization with themes such as “reality shock: the journey toward adaptation” and “the significance of relationships to adaptation” (Martin & Wilson, 2011, p. 23). While preceptors are typically used in guiding new nurse graduates throughout their orientation to nursing care, the perception of caring and support from the preceptor influences adaptation (Martin & Wilson, 2011). The new nurses’ perceptions of caring or non-caring staff and providers and their desire for collegial relationships impacted their adaptation in a positive or negative manner (Martin & Wilson, 2011).

In the category of “development of my professional responsibilities,” study participants reflected on their progression from “surviving as a novice nurse” to the “excitement in becoming an advanced beginner” (Martin & Wilson, 2011, p. 23). The final theme of “success in achieving competent practice” might be important to highlight in the context of the participants’ length of time in the position (Martin & Wilson, 2011, p. 23). The sampling criteria limited participating nurses to those who had been in practice for at least one year, differing from the criteria for the current study, which was just new nurse graduates within their first year. Martin and Wilson’s study was a

retrospective assessment of the experiences rather than data collection that took place during the first year of practice itself. The current study differed with the intent to capture the essence of the experience as the participants were living the experience of working as a new nurse graduate in a CAH.

Therefore, the experiences of the nurses might be misinterpreted by the article title, “Newly Registered Nurses’ Experience in the First Year of Practice: A Phenomenological Study” (Martin & Wilson, 2011). Although the particular location of the participants was not described, it could be inferred they were all part of a sample from one hospital. Thus, several nurses might have described some of the same colleagues in their perceptions of caring and non-caring support specific to their single institution. More research is needed to assess for the acute perceptions and experiences of nurses as they begin their new position as the findings might be different and less geared toward moving through advanced beginner competencies and into competent practice (Benner, 1984; Martin & Wilson, 2011).

Just as the experiences of new graduate nurses in specialty areas or varied areas of care such as rural nurses are rarely described, the experiences of graduate nurses specifically from minority groups have not been fully investigated. Researcher Esther Morales (2013) interviewed a purposive sample of seven Hispanic new graduate nurses in the United States and found each nurse had a varied period of preceptor guidance, which was dependent on the care setting such as skilled care, community health, obstetrics and gynecology, telemetry, and intensive care. Seven main themes were reported and described in further detail with subthemes. The primary themes included “being an employee,” “an orientation with or without a preceptor,” “a transition,” “shadows of

doubt,” “being Hispanic,” “being bilingual and being pulled,” and “blessed” (Morales, 2013, p. 1294). Prior experiences in employment influenced perceptions of the new experience of “being an employee” as a registered nurse and acute care was a preferred setting for these new nurse graduates (Morales, 2013, p. 1294). Participants desired both organization and consistency in their orientation processes but it was sometimes lacking structure or a specified preceptor; the extent depended largely on the care setting as hospital locations seemed to have greater structure in their orientation processes (Morales, 2013). Participants addressed “being Hispanic” and “being bilingual and being pulled” with stories about the assumptions of the general public and patients in their care (Morales, 2013, p. 1294). The theme of “blessed” emerged after participants described gratitude for the completion of milestones such as nursing school and NCLEX-RN as well as their employment and their opportunity to serve their communities (Morales, 2013, p. 1294).

These themes create additional considerations for orientation and socialization of new nurses while acute care facilities strive to hire nursing staff representative of population shifts and community needs. These considerations could be especially important as rural hospitals recruit new nurses to promote greater service to community members. Facilities should strive for clearly defined functions and responsibilities with the identification of preceptors or staff leaders who are enthusiastic about the mentoring role (Morales, 2013; Parker, Giles, Lantry, & McMillan, 2014).

Laschinger (2012) conducted a cross-sectional survey using a correlational, descriptive design to describe the work-life experiences for first and second year new nurses in Ontario, Canada ( $N = 342$ ). The College of Nurses of Ontario registry list was

utilized in order to obtain a random sample of registered nurses with two or fewer years of experience (Laschinger, 2012). A comparison of perceptions about the working conditions, organizational factors, and personal factors was made between the groups by years of experience. Although few responses differed by experience between the two groups, key findings overall supported literature published on this topic. Both groups reported low intentions to leave their current position and high satisfaction levels with their choice in a nursing career. In the correlational analyses among the variables of job satisfaction, intent to leave the job, career satisfaction, and intent to leave nursing, work engagement was positively correlated with job satisfaction ( $r = .52$ ) for the first year group and higher amongst the second year group ( $r = .56$ ) while also correlated with career satisfaction ( $r = .47$ ; Laschinger, 2012). Work engagement was negatively correlated to intent to leave both the job ( $r = -0.49$ ) and the profession ( $r = -0.44$ ; Laschinger, 2012).

According to Laschinger (2012), when nurses are more satisfied with their initial orientation, they are less likely to leave their jobs. The quantitative data were helpful in identifying priority factors that might impact retention. However, without a mixed-methods or qualitative study to give explanation to some of her findings, less was known about the variance amongst personal factors and some of the areas in work life that might have impacted those nurses' responses. The findings of this study created implications for making sure the introductory phase of an orientation or residency program is effective no matter the length of support provided within an orientation time frame. As orientation periods are likely to vary and are less-prevalent in critical access hospitals, it is important to continue to assess what new nurse graduates in CAHs perceive as an adequate

orientation and how these experiences are labeled by new graduate nurses. This question was emphasized in an interview with participants in the current study.

Parker et al. (2014) conducted a mixed-methods, cross-sectional study in Australia to further explore new graduates' experiences. This study did not focus specifically on rural or CAH new nurse graduates but it did utilize focus groups to enrich the online survey data received from the 282 new graduate respondents. Although 73% of respondents revealed they had prior experience in nursing before, the definition of "experience" and the terminology for categories were not clearly defined (Parker et al., 2014, p. 152). The survey was developed by Parker et al. following a review of literature and another satisfaction survey was modified for use from Hegney and McCarthy (2000) with a review of content validity for this combined instrument prior to use. Cronbach's alpha internal consistency scores of 0.7 and greater were reported with use of the new questionnaire in this sample, which is generally accepted amongst social sciences (Parker et al., 2014). Further validity and reliability testing might be needed prior to future use of this same instrument. Overall in comparing the mean scores of respondents, the findings reflected new graduates' perceptions of high expectations and pressure for performance in the workplace (Parker et al., 2014).

In order to feel the confidence to perform autonomously in the nursing role, the feeling of support amongst coworkers is important. The perceived level of support for respondents was rated highest for support from other nurses (60% responded) and least support came from other professions in the workplace (40%; Parker et al., 2014). The overall mean reported amongst all nurses for "level of support for professional development" on a 1-5 Likert type scale (1 = *lowest perception*, 5 = *highest perception*)



was 3.37; it was reported as even lower for rural facility nurses but not statistically significant (Parker et al., 2014, p. 152). This finding validated that professional developmental opportunities might be lacking in rural hospitals for nurses. None of the findings were statistically significant; however, they did have clinical significance, which prompted further exploration of new graduate nurses' perceptions of support.

The focus groups in the Parker et al. (2014) study were able to highlight key factors related to the transition to practice through a supplemental qualitative approach. Many of the responses focused on the culture of the workplace, such as the need for support, difficulty in asking for help, and workload expectations. Another area reported was shared stories of horizontal violence encountered amongst other staff, which underscored the need to continue to address horizontal violence in negative workplace cultures as it impacts the perception of new graduates and might lead to outcomes such as attrition (Laschinger, Grau, Finegan, & Wilk, 2010, Parker et al., 2014). While some new graduates in the study felt horizontal violence was targeted toward their novice status as new graduate nurses, others felt it was contextual and based upon individual attitude or overall morale (Parker et al., 2014). Participants also noted differences across care contexts such as medical-surgical care or specialty hospital units. Like many other nursing research studies published by Australian authors, they provided useful data but the quantitative results are best generalized when they originate from American-based samples of nurses due to consistency in nursing curriculum, licensure procedures, and the adoption of evidence-based practice in the unique U.S. healthcare system.

## **Nurse Residency Programs**

Many hospitals have adopted a model for new graduates that prolongs a typical orientation period into what is called a nurse residency, nurse residency program, or a transition to practice program (Laschinger, 2012; Martin & Wilson, 2011). The structured and longer-term support of these programs has helped improve outcomes such as the retention of new hires and new graduates (Niemi, McErlane, Vasseur, & Bohl, 2014). Typical employer orientation programs can vary in time, curriculum, and structure. Nurse residency programs have helped in the progression toward a standard that acknowledges new graduates might have more needs than an experienced new nurse hire (Silvestre, Ulrich, Johnson, Spector, & Blegen 2017). Since a common barrier to implementation of nurse residency programs in all hospital facilities is reported to be the cost, Silvestre et al. (2017) conducted a study to evaluate the return on investment for a residency program. They utilized National Council of State Boards of Nursing data from the Spector et al. (2015) study to create intervention and control groups for their analysis of new graduate registered nurses' data. They also collected opportunity cost data for new graduate nurses and preceptors (Silvestre et al., 2017). The control group was created from those facilities classified with "limited" structure in their curriculum surrounding fewer than six elements identified as "essential to transition" (Silvestre et al., 2017). Those elements included patient-centered care, preceptorship, specialty knowledge in the area of practice, informatics, communication and teamwork, quality improvement, evidence-based practice, feedback, and clinical reasoning (Silvestre et al., 2017). The sample included data from newly licensed registered nurses from the states of Illinois, North Carolina, and Ohio (Silvestre et al., 2017).

Amongst 70 hospitals and data from 1,032 new graduate registered nurses, 81.2% of new nurses overall remained in their first job at the end of the first year (Silvestre et al., 2017). Sites with a transition-to-practice program had a turnover rate of 15.5% and those without a transition-to-practice group (considered “limited” control group hospitals) had a 26.8% turnover rate ( $p < .001$ ). In reviewing the descriptive data, new graduate nurses least likely to quit their job were those younger than age 30 ( $p = .0017$ ) and those with a bachelor’s degree ( $p = .062$ ). Nurses were also less likely to leave facilities with Magnet designation ( $p < .001$ ) or if they reported being employed in an Illinois hospital (as compared to the other two states) with 100 to 199 beds ( $p < .001$ ; Silvestre et al., 2017). No statistically significant differences were found in comparisons amongst groups regarding type of organization (for profit, nonprofit, government) and any university affiliation (Silvestre et al., 2017). In comparing the transition program group and the limited control group turnover rates, the transition program group turnover rate of 15.5% was less and statistically significant ( $p < .00$ ) when reviewed against the 26.8% turnover rate of the limited control group (Silvestre et al., 2017, p. 115).

As a result of the program implementation, nurses were retained. Findings showed the implementation of an “evidence-based transition to practice” program was a positive return on investment in decreasing overall turnover of new graduates (Silvestre et al., 2017, p. 116). Although the study only occurred over a year, the cost analysis calculated by the authors showed a savings of \$735 for each new graduate nurse, including residency program implementation costs, for those facilities with structured programs rather than limited programs (basic orientation; Silvestre et al., 2017). If the structured program was already in place, the cost savings almost doubled at \$1,458 per

new nurse graduate in that first year (Silvestre et al., 2017). This research supported a structured type of program for consideration in the transition of new nurse graduates into nursing practice and might provide information for rural hospital administrations considering changes in the structure of orientation for new graduates.

Pittman et al. (2013) administered a web-based survey to 219 members of the American Organization of Nurse Executives to determine the prevalence and nature of nurse residency programs amongst their total membership. In this cross-sectional design, rural hospital respondents accounted for 24.3% of the sample while urban hospital respondents accounted for 75.7%. The total response rate was only 15% as they approached all members of the American Organization of Nurse Executives in their initial recruitment (Pittman et al., 2013). Respondents were asked a number of questions about their institutions such as hospital characteristics and the nature of the program, optional or mandatory residency offerings, and the funding and administration (external and internal sources). Respondents reporting no residency program typically cited cost as the major barrier. Of the total residency programs in place reported by these respondents, 15% originated from rural hospitals and the other 85% were identified from urban institutions (Pittman et al., 2013). The report of 15% of the respondents sharing the existence of a rural nurse residency program was surprising given several authors cited cost as a barrier. However, observing that the majority of those identified were from urban institutions was not surprising information. This showed some facilities were striving toward nurse residency initiatives and others might need help and support.

In a similar design, Barnett, Minnick, and Norman (2014) described nurse residency programs in the United States by sending out a 24-item survey to chief nursing

officers or residency program directors in 1,011 U.S. hospitals. A difference here was the inclusion criteria required hospitals to have over 250 beds, which excluded CAHs in the study design. Hospital characteristics were compared ( $n = 198$ , 19.6% response rate) amongst others in the sample and no significant differences were found amongst regional representation, Magnet status, bed size, or Council of Teaching Hospital membership (Barnett et al., 2014). The presence of a nurse residency program (NRP) was reported by 95 (48%) of the respondents with over half (54%) of that group reporting the use of a facility-based model (Barnett et al., 2014). Although not all NRPs reported the educational level of graduates upon hire, the researchers were able to group categories by Bachelor of Science in Nursing (BSN)-only, BSN + Master of Science in Nursing (MSN), and mixed (Associate Degree in Nursing [ADN] + BSN ± MSN) and found no statistical significance amongst the types of categories ( $\chi^2[4] = 4.115$ ,  $p = .391$ ) represented amongst the three model types of facility-based, University Health Systems Consortium, or “other” (Barnett et al., 2014, p. 178). These implications create opportunities for rural hospitals to consider the needs of their staff nurses to customize a type of residency program or lengthened orientation from their own resources. Options exist to utilize external vendors or commercialized system-based nurse residency programs but these pre-packaged and bundled resources are typically available at a premium for facilities considering these services

A systematic review of 13 studies on the impact of nurse residency programs by Al-Dossary, Kitsantas, and Maddox (2014) revealed much variation in implementation of residency programs, especially in examining increased clinical decision making and leadership skills as outcomes. The best practices for new nurse residency programs were

still not identified by this body of evidence, particularly in the area of clinical leadership at the bedside (Al-Dossary et al., 2014). Many of the studies were reported to be limited in methods with small sample sizes. No research was found especially for the measurement of multiple variables over the time of their participation in the nurse residency program although it could be said nurse residency programs do help new graduates with the development of competencies and skills acquisition (Al-Dossary et al., 2014).

Recommendations from the authors included the need to standardize nurse residency programs so further research can be conducted on the outcomes such as safe and effect patient care and the plea for nurse administrators to seek out funding and support for nurse residency programs (Al-Dossary et al., 2014). In rural care settings, this highlights the need to learn more and customize a program that contains evidence-based elements in the direction of standardization.

### **Rural Nursing Roles**

Recently, an article about new graduate nurses moving into rural practice was published--one of a very few. An Australian qualitative case study was published by Lea and Cruikshank (2017) that disseminating the findings of interviews with new graduate nurses in their transition to rural nursing practice. During three-, six-, and nine-month milestones, new graduate nurses were asked about the support of their managers. In their statements, these nurses shared the importance of managers giving feedback, debriefing, support, advocacy, openness, encouragement, and protection from “requests and demands” of the organization (Lea & Cruickshank, 2017, p. 176). Lea and Cruikshank’s findings mirrored some of the results of their own literature search and they offered

suggestions such as preparing nurse managers in the rural setting for the provision of more support to their new graduate nurses and role modeling for other clinicians in the rural environment. Nurse managers could network with one another to better understand the stages in the role transition of new graduate nurses and collaborate with program planning to meet the incremental needs of these new nurses (Lea & Cruickshank, 2017). Although this information highlighted the importance of managers in rural nursing practice, it did not speak to the role of preceptors or other nurses and the new nurses' experiences overall as did the current study. A limitation of the Lea and Cruickshank study was its location in Australia rather than in the United States.

McCafferty et al. (2017) recently administered a needs assessment survey on continuing education needs for 119 nurses in rural hospitals from the states of Iowa and Nebraska. Their intent was to assess barriers and identify nurses' preferences for continuing education options including modalities for education and topics of interest. A large group of nurses desired a one-day, intensive, seminar-style offering (46%) while other respondents preferred incremental workshops (30%) or multiple-day, less-intensive workshops (24%; McCafferty et al., 2017). Most participants (83%) felt multidisciplinary learning was important given their rural setting; obstetrical/pediatric education topics such as pre-term labor, postpartum hemorrhage, pediatrics, preeclampsia, shoulder dystocia, and embolism were ranked greater than 2.2 for a mean on a 1 to 3 scale of need (1 = *low need* and 3 = *high need*; McCafferty et al., 2017).

This information was helpful as it might supplement findings from research on the experiences of new graduates and support the development of orientation or residency needs. However, the focus of this research was on continuing education of rural nurses

and did not place any emphasis on the experience level of the nurses in its description of the sample (McCafferty et al., 2017). A Midwestern sample was also representative of some of the areas utilized for recruitment for the current study as Rural-Urban Commuting Area Codes (RUCA; 2012) population guidelines were used and were applied similarly in the demographic questions for current study participants to classify demographic information.

### **Retention and Job Embeddedness in Rural Facilities**

In any hospital setting, the retention of nursing staff is an important outcome that branches into other implications such as safety as well as cost-effectiveness (Al-Dossary et al., 2014). New graduates are especially at risk for attrition (Kovner, Brewer, Fatehi, & Jun, 2014). Few studies exist on solely the turnover and retention of nurses in rural settings. As a result, this literature review mostly focused on the retention of new graduates.

A national study by Kovner et al. (2014) found almost 17.5% of newly-licensed registered nurses left their employment in their first year; within two years, the number climbed to a total of 33.5%--one-third of the total sample ( $n = 1906$ ) for nurses meeting the criteria for fewer than 25 months employment. Facilities might be reluctant to implement transition programs but as more information is shared regarding the return on investment (Silvestre et al., 2017), administrators might be more apt to collaborate with similar facilities to propose structured programs or share resources. Collaboration and web-based resources might be a way to share resources if new graduates voice specific needs for continuing education. Rural facilities might have a greater overhead cost when examining the typical lower volume of new graduates to transition and the direct and



indirect costs associated with implementation (Silvestre et al., 2017). In urban areas that often hire dozens of new graduates in one year, administrator and leader time in orientation processes might be utilized more efficiently than in the scenario of rural hospitals. In contrast, rural hospitals often hire only one to two new graduates at a time. This does not allow for cohort-based activities and arrangements often utilized in urban areas. Networking amongst administrators and nurse leaders might provide opportunities for brainstorming and planning for shared resources in the developing of programming resources.

In a Canadian study, Laschinger, Wong, and Grau (2013) utilized a data set from previous research (Laschinger et al., 2010; Wong, Laschinger, & Cummings, 2010) in a secondary analysis containing a sample of new graduates ( $n = 342$ ) and experienced nurses ( $n = 273$ ) with more than two years of experience. They tested a model involving authentic leadership, structural empowerment, emotional exhaustion, and cynicism (Laschinger et al., 2013). Laschinger et al. (2013) hypothesized the relationship patterns amongst the aforementioned variables would not differ between new and experienced nurses and they hypothesized higher perceptions of authentic leadership in administrators and structural empowerment in the work environment would relate to lower emotional exhaustion and lower cynicism in the workplace. These hypotheses were tested through questionnaires sent out to the nurses using instruments previously tested for validity and reliability. Researchers analyzed the results of the Authentic Leadership Questionnaire (Avolio, Gardner, & Walumbwa, 2007), the Maslach Burnout Inventory-General Survey (Schaufeli, Leiter, Maslach, & Jackson, 1996), and the Conditions of Work Effectiveness

Questionnaire II (Cho, Laschinger, & Wong, 2006; Greco, Laschinger, & Wong, 2006; Laschinger et al., 2013).

Authentic leadership was shown to have a positive effect on the structural empowerment of both groups ( $p < .001$ ) and empowerment and authentic leadership both negatively impacted cynicism in the workplace ( $p < .001$ ; Laschinger et al., 2013). Similarly, structural empowerment had a negative impact on emotional exhaustion of the nurses ( $p < .001$  for experienced nurses and  $p = .006$  for new graduate nurses; Laschinger et al., 2013). The findings supported a model that linked the presence of authentic leadership and decreased burnout of nurses and also showed the application of authentic leadership theory in nursing to address issues in current work environments (Laschinger et al., 2013).

One consideration was out of the experienced nurses in the sample, 71.1% were diploma nurses and in the new graduates' sample, 99.4% had completed a bachelor's degree (Laschinger et al., 2013). This might offer some insight on the descriptive findings such as new graduate nurses felt significantly more empowered than their experienced nursing peers ( $t_{(613)} = 4.46$ , reported as statistically significant with no precise  $p$ -value) with higher scores for new graduates on access to resources ( $t_{(613)} = 3.33$ , reported as statistically significant), information ( $t_{(613)} = 5.20$ ,  $p < .05$ ), and opportunity ( $t_{(613)} = 2.33$ , reported as statistically significant; Laschinger et al., 2013). These findings, in addition to previous research by Laschinger (2012), have implications for making sure new nurses in an orientation or residency program experience learning that builds empowerment and perceive their leaders show characteristics of authentic leadership.

Rural, newly-licensed nurses were included in a study comparing their perceptions of job stress, job satisfaction, decisions, performance, and organizational commitment to their urban counterparts (Bratt et al., 2014). This American study was conducted in the state of Wisconsin using a longitudinal cohort design. All nurses were participating in some form of a nurse residency program, which was different from research findings that stated few nurse residency programs, if any, existed in rural facilities. Although the urban new graduate nurses had more preceptors than the rural nurses did during their experience, no significant differences were found in the orientation number of hours between groups, the classroom education hours as a new nurse, or weeks spent working with the preceptors (Bratt et al., 2014).

The study findings showed job stress of rural nurses was lower than that of urban nurses and the rural nurses also had a higher satisfaction rate (Bratt et al., 2014). This contradicted what was found in some literature sources on the experiences of rural nurses (Sedgwick & Pijl-Zieber, 2015). However, the sample of rural nurses was 86 and the sample of urban nurses was 382; thus, this might have been a limitation confounding the findings. The smaller sample size of rural nurses might be expected in terms of the general ratio of nurses classified as “rural” and “urban” and reflected the people in the population (16% of nursing workforce is rural; HRSA, 2013). However, a survey response bias might have also occurred; those rural nurses who did choose to respond replied in a positive manner (Creswell, 2014). This article reported the rural hospitals hired one to six new graduate nurses per year and the urban hospitals generally hired 20 to 80 new graduate nurses per year (Bratt et al., 2014). This study drew a sample from a single state and the current study’s sample included participants from three states to

participate in the research to allow for more new nurse graduates to have an opportunity to share their stories and experiences outside of the context of a single hospital or state. Given that rural and CAHs do not hire the volume of new nurses in a year as do urban hospitals, such as in this study, it was important to provide findings that could support these processes through insight into participants' experiences.

Finally, a review of current and past CAH research and quality improvement projects from the Flex Monitoring Team (2017) or consortium of Rural Health Research Centers revealed several safety and outcomes-driven quality improvement and data projects conducted within rural care settings. However, no projects within this repository were qualitative in nature, describing nurses' experiences in CAHs. Funding opportunities for these projects were often targeted at team-based approaches. Although interprofessional collaboration continues to be emphasized in health care and is highly important, nurses are still the primary ears and eyes for the patient and need to feel their work is validated and supported in hospital nursing shifts. Autonomy is an important skill for development in rural nursing and within the scope of practice in providing nursing care (Sedgwick & Pijl-Zieber, 2015). Thus, this new research on new nurse graduates' lived experiences conveys perceptions and adds to the body of knowledge supporting the career option of rural nursing and supporting retention of nurses in rural hospitals.

### **Summary**

Chapter II presented a review of literature on new nurse graduates, nursing orientation, and residency programs. A summary of the roles of rural nurses was also shared. Benner's (1982) novice to expert theory and Meleis's (2010) transition theory

were used to further understand the current study's findings within the framework of these theories. Chapter III presents the methodology of the study.

## CHAPTER III

### METHODOLOGY

#### Introduction

The methodology for this research project was guided by the theoretical framework of a descriptive, phenomenological perspective backed by Edmund Husserl's (1931) foundational assumptions, which were later modified by philosopher Martin Heidegger's interpretive, hermeneutic ideas on the reality and meanings of everyday experiences (Crotty, 2013). Utilizing this application, the lived experiences and everyday realities were explored in the nursing discipline during a very specific phase of time for new graduate nurses employed in a rural care setting (Moustakas, 1994).

In the discussion of Husserl's transcendental phenomenological epoche by Moustakas (1994), epoche is seen as a clearing of the mind while preparing to obtain new knowledge from the research but abstaining from letting preconceived ideas about the responses and experiences of the participants predict findings and sway interpretations. No ideas about participants' experiences can be determined in advance (Moustakas, 2004). In phenomenological research, the researcher should practice the epoche alone in a "philosophical solitude" while being aware of suspending judgments (Husserl, 1970, p. 184). To capture the essence of the phenomenon, bracketing and an open attitude are

important components in a descriptive, phenomenological approach grounded in Husserl's ideas.

“Phenomenology is rooted in questions that give a direction and focus to meaning, and in themes that sustain an inquiry” (Moustakas, 1994, p. 58). “In phenomenological science a relationship always exists between the external perception of natural objects and internal perceptions, memories, and judgments” (Moustakas, 1994, p. 46). The researcher fully describes the account of an issue with depth and through the essence of participants' experiences. Meaning is discovered in participants' statements with clarity gained through reflective processes.

Strategies such as journaling and bracketing, for example, were used to uphold rigor and disclose any bias or assumptions of the researcher in accordance with Husserl's guidance on descriptive phenomenology (Crotty, 2013; Moustakas, 1994). Interviews were approached with an openness to know the experiences would be heard just as they presented themselves--through the participants' stories (Norlyk & Harder, 2010).

### **Research Participants, Sampling, and Recruitment**

Participants of this study consisted of a sample of the population of novice registered nurses working in rural settings in the United States recruited by use of purposive sampling (Merriam & Tisdell, 2016). Participants were adults over the age of 19; with current registered nurse licensure in their respective state; working 24 to 32 hours per week on average in a CAH; in either Kansas, Iowa, or Nebraska. As qualitative sampling is less direct and not influenced by power calculations, the researcher's goal was to remain reflexive throughout the data collection and consider the process of interpretation with the goal of a rigorous, systematic, qualitative research study

(Creswell, 2014; Guetterman, 2015; Merriam & Tisdale, 2016). Creswell (2014) described phenomenological research as often having 3 to 10 cases. However, the suggestions were approximate; the final sample depended on the rich responses from participants and the researcher's transparency in explaining how data saturation was reached. In this research study, data saturation was reached with 13 participants.

Participants were employed as registered nurses for at least one month and less than 12 months in a CAH setting by the time of scheduled interviews. Critical access hospitals exist nationwide in rural areas and meet uniform federal criteria (Rural Health Information Hub, 2017). These criteria were part of the purposive sample with a focus on the phenomenon of the first-year experience outside of urban settings (Merriam & Tisdell, 2016).

A variety of participant backgrounds and demographic variables amongst the rural nurses was desired so as to best represent rural nurses throughout the region and the demographics of the nursing profession as a whole. Demographic data such as age, type of nursing degree (ADN, diploma, or BSN), gender, and months since employment start date were collected. Participants were asked whether or not they were raised in a rural community or if they had prior experience in employment or volunteer positions at their current facility. Participants were also asked to provide their zip codes. The RUCA (2012) guidelines were used by the researcher to later categorize settings as small rural, large rural, isolated, and urban (more than 50,000 residents).

### **Procedure**

Nurse administrators for CAHs in the tri-state area were contacted by e-mail and phone to assist in advertising the opportunity for the study (see Appendix B). They were



informed potential participants should declare their interest in the study directly to the investigator to protect their privacy as participants unless they chose to disclose that information to their employer. Some administrators reported not having any potential participants meeting study inclusion criteria and others did not respond to contacts. Two hundred thirty facilities were contacted at least once during the recruitment process. In addition, flyers were sent to some hospital administrators and shared with members of a state-wide task force for a local rural health organization as a follow-up with a request to post the flyers in a prominent area and share with nurses (see Appendix C). Flyers were also distributed electronically through two coordinators for state-based nursing coalitions or hospital associations.

After prospective participants contacted the researcher directly about their interest in the study, they were contacted via e-mail and phone to discuss the purpose of this study, to ascertain willingness to participate, and to be pre-screened for inclusion. They were also encouraged to invite other interested candidates to contact the researcher with their interest as snowball sampling was encouraged in recruitment. A consent form was sent via e-mail in advance for each prospective participant's review. Participants had the option to send the signed consent form back via an e-mail attachment prior to the interview or mail it in time to be received prior to the interview as the interviews were conducted via distance methods.

For those completing a face-to-face interview in person, the consent form was signed and collected prior to the start of the interviews. The decision to conduct the interview in-person or via distance such as Zoom, FaceTime, Skype, or phone was dependent on the distance from the researcher (typically greater than two hours away),

participant availability and willingness to meet in-person, and reliability of internet service provider connectivity in remote or rural locations. The interview methods were always mutually agreed upon by the researcher and participants to promote the best environment for participant comfort, privacy, and clarity with data collection.

### **Data Collection and Data Analysis**

#### **Ethical Considerations**

University of Northern Colorado (UNC) Institutional Review Board (IRB) approval was obtained for this exempt study (see Appendix D); following notice of official approval, recruitment began in January 2018 and continued through early March 2018. This timeframe also represented the timing of the interviews. The participants first signed a consent form (see Appendix E) and had the opportunity to ask questions related to the study purpose or procedures. The consent form described the purpose, eligibility of participants, time commitment, discussion of risks and benefits, and confidentiality of the experience. An informative letter was also provided for the nurses during recruitment (see Appendix F). Pseudonyms were selected by each participant prior to the interview to protect confidentiality in the review of findings and dissemination of results.

Recruitment spanned CAHs in a tri-state area by contact of nurse administrators in 230 hospitals. Nurse administrators verified through phone or email contact that they would distribute recruitment materials to their staff for review. Although the primary strategy for sampling was criterion and convenience-based (due to primary residence of the researcher), an effort was made to approach as many CAHs as possible in Iowa, Kansas, and Nebraska; all facilities on the CAH roster in those states were contacted at least once. Potential participants were informed several hospitals in these states were

approached for recruitment, assuring participants the final findings and dissemination of the study included sampling possibilities from 230 CAHs in the region and not just a few hospitals. Participants were informed best efforts were taken and would continue to be taken to secure confidentiality during the study and in any dissemination of the results. The researcher's work to approach participants from 230 possible hospitals was important to assure participants that even though pseudonyms were used in reporting the final findings, they could be assured the sampling was not limited to one location or even close proximity to the researcher's residence or professional network.

Confidentiality was respected in the recruitment process by advising prospective participants they should contact the researcher directly with any interest in participation and not have to inform their administrators or others of their intent to participate in the study. This information was also presented in the letters created for administrators and nurses (see Appendices B and F). Participants were not asked specifically about the name of their employer or the name of town in the interview and demographic questionnaire--only the zip codes for the purpose of determining community size. Any statements shared naming these locations were edited to remove city and employer names prior to dissemination of findings of the study. Any information linking pseudonym choices and contact information was stored privately by the researcher only with password-protected access.

During the interviews, if at any time participants did not desire to answer a question, they could decline. However, all participants answered all questions. If they did not wish to continue in the study, they were informed their participation could be

discontinued without consequences. Only one participant, a 14<sup>th</sup> nurse, signed and sent consent and later decided not to participate after a missed interview meeting.

### **Setting**

Data collection procedures occurred in local settings of each participant's choice as participants might be more comfortable being interviewed outside of their working location to maintain greater confidentiality related to participation in the research. Although face-to-face interviews were preferred by the researcher, requests to interview via phone conversation, Skype, or FaceTime were accommodated, especially when participants lived several hours away or had issues with reliable internet service in remote rural areas. Only audio recordings were utilized in these distance-based instances regardless of the method of data collection; any observations made about the participants' nonverbal behaviors or interview environment were recorded in investigator field notes.

### **Methods for Data Collection**

Participants responded to the researcher indicating their interest primarily through e-mail. Additional communication for questions or discussion of the study interview arrangements took place through participants' preferred contact method and interviews were scheduled. A copy of the informed consent document was sent to each participant again prior to the interview. The interviews were semi-structured with use of an interview guide and several probing questions (see Appendix A) and conducted in an informal nature. The consent form information was reviewed with each participant and signatures were obtained.

The interview guide was first field tested by the researcher with a clinician expert nursing colleague to ensure clarity of the questions. It was also discussed extensively in

conversation between the researcher and research advisor, identifying any needs for additional probing questions or redirection of participants once the interviews began. A demographic questionnaire (see Appendix G) was first presented to the participants for the collection of data in order to describe the general characteristics of those participating in the research. During this time, participants also selected a pseudonym to be associated with their interview statements. The interview opened with a broad question about what it was like to be a new nurse in a CAH; additional questions followed per the interview guide. Interviews were audio-recorded via a digital recorder with a backup recording device, or with a backup audio recording from a video conference call, and were expected to be completed within an hour. The digital recorder was stored in a locked area between interviews. Most interviews on average were between 20 and 30 minutes in length.

Permission for a follow-up phone call or email for data analysis purposes and member checking was discussed with each participant and all agreed to the possibility of future contact for this purpose. After some reflexive bracketing and discussion with the research advisor, it was necessary to contact many of the earliest participants again to help clarify meaning of some of their statements and with descriptive follow-up questions. This added depth and clarity to the information gathered from the interviews.

All participants were also mailed or provided a \$10 Amazon gift card following their participation in the interview as compensation for time. A participant study brief document (see Appendix H) was also available to provide further information on resources for the participants. Following each of the interviews, the audio-recordings were transcribed into text for data analysis by the researcher on an encrypted, password-protected laptop. After the accuracy of the transcription was verified, the audio recorder

was stored in a locked area and the recordings were deleted two months following the final interview. Documents and field notes were stored on password-protected equipment and files accessed only by the researcher and the research advisor. Documents linking specific participant information to pseudonyms were securely stored in a separate file and reviewed only by the researcher. Printed documents used for data reduction and analysis or shared securely with the research advisor did not have any identifying information. Original consent forms were hand-delivered to the research advisor and will be kept secured for three years as directed by research procedures for the University of Northern Colorado. All study data will be destroyed after three years.

### **Trustworthiness**

This researcher conducted all 13 interviews and recorded notes with an openness, as “researcher as instrument,” consistent with the qualitative methodology within the context of nursing. The consistency of these activities, partnered with other strategies, supported trustworthiness in the conduct of this study. Lincoln and Guba (1985) established gold standards for the evaluation of qualitative research methodology; the components of *transferability*, *credibility*, *dependability*, and *confirmability* are summarized as a type of rigor described as trustworthiness.

**Transferability.** Along with the use of an interview guide, probing questions helped ensure the descriptions provided by participants were rich with added depth to contribute to transferability (Lincoln & Guba, 1985). The use of direct quotations in describing the results gave voice to the participants’ experiences. The context of the situation was carefully described and the participant sample was depicted through use of demographic information.

**Credibility.** Credibility was achieved in this study by conducting member checks as needed while coding and interpreting data (Boswell & Cannon, 2017; Creswell, 2014; Lincoln & Guba, 1985). Upon additional contacts, all participants who were contacted for the purpose of member checking for verification of statements or additional questioning responded to the researcher. Their responses provided clarification and further depth in several areas to add to the data saturation in the study. Participants were informed there might be a need to follow up by phone to confirm the meaning of specific statements and responded willingly.

**Dependability.** To plan for dependability, the steps of this study were carefully described and revisited in an audit trail explaining the process of data collection, storage, and analysis (Boswell & Cannon, 2017; Creswell, 2014). Detailed descriptions were created. Observational field notes were recorded prior to and after each interview to further describe the interviews.

**Confirmability.** To support confirmability, bracketing of researcher assumptions and biases was used in an effort to achieve credibility in the methods of this study. Reflective journaling was completed by the researcher prior to beginning the study. In the process of review and analysis, participant transcripts were also shared carefully with the researcher's research advisor for expert peer debriefing and review of bracketing. Preconceived ideas about the participants and their potential responses were journaled prior to the beginning of the study; as statements were analyzed, the researcher worked to consciously push aside any judgments of the participants from the interview process itself or as they described their experiences. This element of trustworthiness was also helped by member checks with participants and the research advisor (Boswell & Cannon, 2017).

This was important as the researcher extracted meaning from the statements about the phenomenon, especially when participants drifted from sharing stories and experiences to listing tasks and skills, in an effort to redirect the participants' interpretation of questions.

### **Researcher Bias and Self-Reflection**

“In a phenomenological investigation the researcher has a personal interest in whatever she or he seeks to know; the researcher is intimately connected with the phenomenon” (Moustakas, 1994, p. 59). This nurse researcher was connected with the phenomenon of interest as she was raised in a farming community and valued the connectedness of local resources for education, health, and economy. Although she never worked as a staff nurse in a CAH, she listened to and shared anecdotal stories with friends and family employed in these settings, comparing and contrasting the unique differences between urban and rural care settings. She cares deeply about the viability of and quality of services in rural hospitals as she still has family ties to a rural area. With ever-changing federal legislation, small hospitals must continue to examine processes and business models to stay competitive, especially in areas closer to urban healthcare systems.

In an effort to promote bracketing and disclose any personal bias that might influence the categories selected for the literature review, the researcher would like to share that she is a nurse educator in an undergraduate nursing program in a Midwestern city with an urban-centric acute care clinical curriculum; like most nursing programs, a rural rotation is included within this curriculum. It was important to identify that the nursing education of the participants might differ in this focus and she asked questions for clarification so assumptions were not made. She had the knowledge that nursing



students typically undergo a short experience of rural nursing preceptored hours and could return to a facility of choice for a concentrated preceptored experience as a senior student in many instances, if desired. However, several students choose specialty areas or urban facilities close to their area of residence while completing their nursing education. In addition, not every nursing education program provides a rural opportunity for its students.

The researcher has served in an advisory role for a newly-implemented nurse residency program and has followed early data and curriculum components for those cohorts with the impression that nurse residency programs do make a difference in retention of new nurse graduate employees. They seem most practical for those facilities with a high volume of new nurse graduate hires and an application to a rural facility such as a CAH might not be plausible in a cost-benefit analysis. Some hospitals, however, continue to explore options for shared services and online-based support programs to mimic the philosophy behind nurse residency programs. It was this researcher's hope the experiences reported by participants in this study would reveal information that might be connected to new ideas for promoting quality and retention in CAHs.

These biases might have impacted the literature review since little research was found on the topic of new nursing graduates' experiences of their first year in CAHs or rural hospitals in the United States. Therefore, the areas of new nurse graduates, orientation to role, nurse residency programs, rural nursing roles, retention, and job embeddedness were selected to highlight the background for new nurses, the existence of residency programs, and to showcase the unique nuances of a rural care setting in comparison and in contrast to urban work environments. Reflective journaling and

bracketing continued throughout the research, facilitating awareness of additional assumptions and biases recorded in the journal and discussed with her research advisor.

### **Methods for Data Analysis**

In this study, interpretation and analysis occurred continually as interviews were completed. While the semi-structured questions were expected to frame each participant's interview, opportunities arose to learn of better probing questions to use in subsequent interviews to obtain richer data from the participants as analysis and interpretation often intermix in qualitative methodology. These adjustments occurred as the researcher and the research advisor discussed the depth of initial interviews and the steps to encourage participants to share further information regarding their experiences. The researcher did not feel the method (whether phone, video meeting, or in-person) in which the interviews was carried out made a difference in the depth and quality of the responses; rather, the adjustments were made to the questioning process as the interviews continued to strive for depth and clarity. Colaizzi's (1978) seven-step process was used for this phenomenological inquiry to extract important statements related to the description of the phenomenon and to sort data into categories, clusters, and larger themes (Abalos, Rivera, Locsin, & Schoenhofer, 2016; Giorgi, 1997). The following summary of Colaizzi's steps guided the data analysis:

1. The researcher read through the transcripts of interviews several times to "extract from them phrases or sentences that directly pertain to the investigated phenomenon" (Colaizzi, 1978, p. 59).
2. While reading the transcripts, the researcher identified and highlighted a large number of significant statements from the participants. These areas

were shared with the research advisor and then color-coded more specifically by the researcher to delineate related areas further in the manual coding process.

3. The researcher considered all significant statements and formulated their interpretive meanings, visited transcripts as needed to check the original description, and looked for any hidden meanings that applied to the context of the participants. Open coding continued throughout this step.
4. The researcher arranged the interpretative meanings into clusters and themes to describe the meaning of the new graduate nurses' experiences.
5. Findings were used to write an exhaustive description organized by theme clusters and with the identification of an overarching theme discovered through data saturation.
6. A concise statement of identification was created to reference the overall essence of the phenomenon relating back to the overarching theme.
7. To validate the exhaustive description, forms of member checking were used throughout these steps with the participants to assess for accuracy in the descriptions of the experiences.

Determination of data saturation was an ongoing assessment throughout data collection with the expertise of a research advisor assisting the researcher in the process of this dissertation and validating progress in developing the narrative. As interviews were completed, transcribed, and reviewed, key areas were noted in the initial process of open coding; assessments were also made to ensure the questions were appropriately helping participants expand on their responses. Utilizing constant comparison, categories

of data were grouped throughout the interview transcripts. When more information was needed or clarification was necessary, participants were contacted to revisit their responses in a form of member checking. This also helped tie together some of the initial interviews and the final interviews in terms of depth; by the 12<sup>th</sup> and 13<sup>th</sup> interviews, both the researcher and the research advisor were already in conversation about general themes with the realization that no new data were forthcoming in the responses received from those final participants. The recruitment goal was to interview as many participants as needed to achieve data saturation (Creswell, 2014). A total of 13 participants shared their experiences to achieve this goal. A descriptive narrative was developed for the study findings, showcasing theme clusters and associated statements from the participants. Themes were organized with direct quotes from participants and ties to findings in previous literature to support the findings of the completed study and capture the essence of being a new graduate nurse in a critical access hospital. The results section is rich with direct quotes to best portray the natural responses of the participants as they shared their lived experiences.

### **Summary**

Chapter III provided a discussion of the qualitative, phenomenological research design, methods for data collection and analysis, and examined trustworthiness and rigor. Upon approval by the IRB, data collection and analyses were completed. Chapter IV discusses the findings of the research study.

## CHAPTER IV

### RESULTS

#### Introduction

The purpose of this descriptive, phenomenological study was to explore the lived experiences of new nurse graduates in the first year of employment in CAHs. Insight gained from interviewing these participants highlighted the unique experiences of rural nurses, especially the resources and support needed for the newest nurses joining staff in CAHs. This study was designed to examine the meaning of the experiences of new nurses as they began their practice in rural areas. One central research question guided the study:

- Q1 What are the lived experiences of new nurse graduates in their first year of employment in critical access hospitals?

Following each interview, the researcher transcribed the recordings, repeatedly read through transcripts, and discussed the process and theme development ideas with her research advisor. The researcher continued to follow Colaizzi's (1978) seven-step process in the manual coding process to reveal theme clusters and final themes with significant statements, creating a detailed description. The analysis process and themes identified in the study follow in addition to a description of the participants.

## Study Participants

One-on-one interviews were completed with 13 participants who were all working regular hours within their first year as registered nurses in CAHs with differing backgrounds. Participants represented rural nurses from all three states: Iowa, Kansas, and Nebraska. While most of the participants (nine) reported they were raised in a rural area, four reported they were not. Of those who grew up in a rural area, four were working in the same community in which they were raised. The group was split fairly evenly between working in small rural or small-town communities and isolated rural communities per RUCA guidelines (Hart & Cromartie, 2014). Eight of the participants had some kind of previous work experience within the same hospital setting, either as a volunteer, nursing assistant, licensed practical nurse (LPN), or with an internship. Three of the participants graduated with a BSN degree and nine of the participants had an ADN (see Table 1).

Two males and 11 females participated in this study with ages ranging from 22- to 49-years-old. The mean age of the group of participants was 30.7 years old. Months employed as an RN ranged from 2 to 10 for the group with 7.5 months as the mean. All participants labeled themselves primarily as “White” or “Caucasian” when asked about race/ethnicity. Although in years past, the U.S. nursing workforce has been predominately White and female, the demographics are changing. White female nurses under the age of 40 comprise 65% of the U.S. nursing workforce, a number that is continuing to change as new nurses enter the profession (McMenamin, 2015). For older female nurses, that percentage is higher—about 77%. While about 15% of this small

sample was male, the national percentage of males in the U.S. nursing workforce is still just over 9% (McMenamin, 2015).

Table 1

*Participant Demographic Information*

Participant pseudonym	Gender Stated	Age	Race/Ethnicity as Stated	Months Employed as an RN	Nursing Degree	Hospital Community Size
Abbie	Female	22	White	7	ADN	2,500 to 9,999 Small town
Alicia	Female	24	White	9	ADN	2,500 to 9,999 Small town
Jennifer	Female	31	White	7	ADN	Isolated rural
Jim	Male	49	White	2	BSN	2,500 to 9,999 Small town
Laura	Female	34	White/European	6	ADN	2,500 to 9,999 Small town
Leah	Female	23	White	10	BSN	Isolated rural
Madelyn	Female	32	Caucasian/Non-Hispanic	5	ADN	2,500 to 9,999 Small town
Marie	Female	26	Caucasian	9	BSN	Isolated rural
Mary	Female	35	White/Hispanic	10	ADN	Isolated rural
Michelle	Female	26	White	10	BSN	Isolated rural
Phoebe	Female	32	Caucasian	9	ADN	Isolated rural
Sally	Female	36	White	7	ADN	Isolated rural
Wayne	Male	29	Caucasian	7	ADN	10,000 to 49,999 Large rural

$N = 13$

### **Analysis Summary**

Colaizzi's (1978) steps were used for analysis as described in the previous chapter. The process of coordinating and conducting the one-on-one interviews and transcribing the data allowed the researcher to work intimately in this phenomenological exploration with immersion in the data. Before and after interviews, journaling was used to bracket the researcher's personal feelings about the phenomenon, the participants, and ideas about participants' statements. Field notes were also completed on each interviewing experience.

After verifying the interviews were accurately transcribed, the transcripts were read for content and the depth in which they addressed the intended questions; the transcribed interviews were also read by the research advisor in a form of peer debriefing to guide additional interviews and their structure. While analysis steps one through four were visited recurrently, the remaining steps followed in a linear fashion to produce the following six themes: (a) Always a Professional, (b) Personal Connections, (c) Pride in Work and Community, (d) Always on Your Toes, (e) Everyone Works as a Team, and (f) Essential Preparation Experiences. Sub-categories of each theme are described within the narrative and displayed within Table 2 (see Appendix I for themes and selected statements as exemplars).



Table 2

*Themes and Sub-Categories of Themes*

Theme Number	Theme	Sub-Categories of Theme
1	Always a Professional	Respected in the community
2	Personal Connections	Knowing patients Accountability for confidentiality Need for emotional support
3	Pride in Work and Community	A rewarding job Contributions to community
4	Always on Your Toes	Readiness for whatever comes in the door Switching roles On the job training
5	Everyone Works as a Team	Nurses lean on one another Interpersonal working relationships Personal investment in coworkers
6	Essential Preparation Experiences	Orientation adequacy Organizational culture Curriculum gaps

**Themes****Theme One: Always a Professional**

The overarching theme that emerged in data analysis and data saturation was these nurse participants saw their identity and their role as Always a Professional. Regardless of whether or not the nurses were “on the clock” or within their hospitals at work, each participant was universally identified as a nurse. This was often accompanied by the perception of respect as described in the sub-category of Respected in the

Community. In *Always a Professional*, the participants described how this identity in the rural setting was complex; both positive and negative sentiments were shared on how this perception might feel in their everyday lives.

Although nurses work in numerous settings, nurses can often identify with one another through similar journeys through nursing school or in the focus of providing holistic patient care. More narrowly, within more rural areas where nursing opportunities might be more limited to cornerstone hospitals in the communities or area agencies, the tendency to share common work experiences becomes even more likely. Thus, in the context of introductions in the social setting, the question of “What do you do?” might be asked or a friend doing the introductions might even offer “They’re a nurse,” creating a generalized perception about the person. One participant, Wayne, mentioned how this commonly happened with introductions: “Because that’s the quickest way they know to introduce someone in the community is, ‘Hey, I work with this person at the hospital, they’re a nurse’ and then all of a sudden that’s what they want to talk about.”

Jennifer agreed: “It’s kind of like, now, people—they’re like, ‘Oh, you’re a nurse’, like that’s kind of how I’m seen now out in the community.” This carried over sometimes into how they felt about presenting themselves—what they said, what opinions they shared, how they expressed themselves, and whether or not they appeared approachable or seemed confrontational in their personal public identity in the event they cared for others and were remembered in the future as well. On this note, Phoebe added, “I think it doesn’t hinder your life, but I’m so paranoid of how I am outside of work...and I think it’s probably like that anywhere, so it’s such a small community, so before you even do anything everyone’s already talking about what you do or don’t do.” This could

be difficult and “hard” when in a rural community, as explained by another participant, as nurses are likely to be recognized by their former patients. Abbie summarized the thoughts of some participants by describing social situations:

When I first started working here I didn't think I would know anyone. But then you start taking care of all these people and the people that you see frequently, and then you see them out in the community and they wave at you, and so then, just I don't know, it sounds kind of weird but whenever I go to Walmart, and people like see me, I'm really conscious of like, if I'm going to buy alcohol, you know, things like just cause I'm like...hmm? What are they going to think? I don't necessarily feel guilty for drinking in public if I am out and about but do feel a little shy if I run into someone and have alcohol in my cart at Walmart! I never would have thought that I would run into people that I know from taking care of them in the hospital or that they would even remember me, but they sure do. I definitely think that it just comes with the territory of working in a small community at a small hospital.

Another participant, Madelyn, shared that personal presentation out in public also seemed to come with the territory in her community: “I think you have a little more...anonymity in a bigger city. You know, you can go to a different part of the city if you wanted to go see a concert and have some drinks but out here, you're pretty limited.” Leah agreed the professional identity is carried wherever one goes and shared:

I think being in a rural setting, a lot of people know your face, know your name, know your family, and so I think that carries...a high hope. Versus in an urban (facility), you're kind of like...You go up to your job, you do your job, and when

you leave it you're just like a regular normal person, whereas in a rural hospital, you kind of carry that identity wherever you go.

Do nurses in a rural community feel a greater sense of responsibility to role model in their communities compared to urban nurses? Several participants seemed to think so. Some of the participants felt more comfortable with this deduction than others as many of the nurse participants were also new to the communities in which they were working. As Abbie put it,

I definitely think it is different working in a rural community vs. urban. I can say I probably see a lot less people than a med surg nurse working in a larger hospital, and they would be less likely to run into one of them at a store somewhere, so they probably would not have to be very worried about running into someone somewhere and worry about what they are buying and whatnot. I even feel a little self-conscious when I go to Walmart looking terrible and run into someone I have taken care of before.

Similarly, Madelyn summarized the pressure to present herself in a certain way when you are a nurse in the community but carrying on with an everyday, personal life:

Yeah, I definitely think that as a nurse in a rural community, it's important in how you present yourself in your everyday life. Like, I would never go to a bar in the town I work in, I don't go to the bar anyway, but um, you know, I would never do anything like that because I feel like the public perception would be negative on you as a health professional. As far as posting on social media, those kind of things, too, some things I see co-workers post and I just cringe and, you know, I

think that's really important to present yourself in a professional manner at all times, really.

**Respected in the community.** Several participants commented that as they were recognized as registered nurses in their community or in surrounding communities, they felt respected and recognized by others in the community. One participant, Sally, agreed that being respected in the community because of her professional job felt very meaningful. Mary did not grow up personally in the community in which she worked but had a connection to the area through her spouse; she felt respected simply because of her registered nurse identity:

You know, like everyone around here, they...well they, everyone knows everyone (laughs heartily). You can't escape that, but I, feel like people look at me with more respect 'cause I'm an RN. I think the average person doesn't realize, or they think that oh my gosh, RNs, they go through so much school they're the smartest people around, you know, so...and at the hospital, like RNs I feel like are kind of put on that pedestal, too. Which I'm okay with! It's nice to be in a community that, I didn't grow up here, so I'm just kind of a stranger but it's nice to come into a community where I'm applauded at where I am at.

For those nurses who might have been previously known in their community under a different occupation, the public recognition of the journey through nursing education was meaningful. "You get a lot of respect and I think I got a lot of respect being a nurse and going back to school because I'm older and have kids," Phoebe added. "I think I had respect before, but then I think working as a nurse you, you definitely have a lot more respect in our community. Um, people are always talking about how great our

hospital is or the nurses and stuff like that, so that is something I take pride in.” The situation was similar for Jennifer:

I have four kids and I went to school kind of as a non-traditional student, so um, it’s been I guess...It’s been really rewarding for me when people are like, “Oh, you know, that’s great, you did so good”, and “Congratulations” and, but like now, when I’m out, it’s like, “Oh, she’s a nurse,” “You’re a nurse,” “*I’m* a nurse.” (smiles, proudly)

At times, nurses must discern how to carefully answer questions regarding health advice and information within their scope of practice. As community members reach out in interest and in trust, a nurse must decide about the safe extent of answering a question. Marie laughed and shared, “I would say there’s a lot of people that come to ask me questions.” When on the job, documentation and workplace protocols are a clear part of this communication in a formal nurse and patient relationship. When approached randomly in a grocery store on the other hand, this dialogue might not be carefully captured in the same manner using the same resources. This ability to think carefully, even deciding what to acknowledge, must be exhibited all times when always seen as a professional. To this effect, Leah claimed,

It has its perks and it has its downfalls also, because, um, being somewhere you hear, “Well, I’m having this problem, what do you think it is? Do I need to go somewhere?” And it’s kind of nice if you can give some information, but also, kind of a detriment because you don’t want to give them too much information or lead them in the wrong way.

Overall, the participants recognized that nurses in general seem to take on a constant form of identity as a professional upon becoming a registered nurse. This can cause both a sense of satisfaction from respect shown by other members of the community and also a sense of uncertainty about public perceptions at times. Michelle summarized that especially when she felt known in the community, she felt accountable for always looking the part of Always a Professional:

I have to really focus on being sure that I'm representing my hospital and myself in a really good way just because they do know me personally anyway? So I feel like it kind of holds me accountable, I guess, to really provide excellent care and compassion and all that.

In summary, all participants expressed in some way the fact that they were known as nurses wherever they went and while they might or might not be asked for healthcare information when someone had a concern or signs and symptoms, most felt their presence was something that was being observed. Their behaviors and choices in their personal lives reflected on their identity as a nursing professional when they provided care in the workplace. Personal identity and professional identity can be one and the same in rural communities, especially for these new graduate nurses acclimating to their role in the profession in CAHs.

### **Theme Two: Personal Connections**

Proximity and location are often draws for new graduate nurses employed in CAHs, especially when there is a previous tie to the community. Some CAHs might still be a considerable commute for those who live on farms and acreages although they are truly the closest possibilities for available acute care nursing opportunities. Nine

participants grew up in rural communities. Of those participants, four were working in the communities in which they were raised. “I think my background in the small town absolutely influenced my job choice,” said Alicia. Michelle stated, “And it is all about convenience, and it’s just working in the town I grew up in also is just wonderful, because you know your patients and that’s...awesome, I think.” Phoebe shared a similar perspective:

We’ve grown up around here...so for us it was never a question of moving somewhere bigger while we had kids, until I went to school and realized that there were more options. But again, it just isn’t...safety-wise and you know the community feeling, the family feeling in a small community. And I could drive to bigger locations if I wanted to, but it’s convenient and like I said, you feel like you become a family at the hospital that you work at, here, even though it’s smaller. So, I do think that does play a part in staying here. That’s where I was raised. That’s kind of how I wanted our kids to be raised too.

This connection to staying in or returning to the same community was something that was recognized early and was a source of spirit and enthusiasm for new nurses. Michelle commented, “I just love the fact that yes I’m close to work and then just the whole aspect of being in a rural setting is just cool.” On the other hand, having a prior tie to any rural community might very well have been a considerable factor as to why nurses stayed in CAHs even if not the same rural community they were raised in previously.

Wayne said,

If maybe I had grown up in a more urban setting I wouldn’t like the small town feel? But the majority of my life has been spent in this kind of setting. I do enjoy



it, and I'm not looking to get out of the hospital for bigger things, right away, like somebody who might miss that urban setting would be.

For some participants, a spouse or partner from a rural community might have brought them to the area. This might have been a comfortable move or perceived as a new change or challenge by the participants. "You know when I first was applying for jobs, I was applying in [larger cities] and I was really reluctant to apply here. But, I really, I love the people that I work with," commented Mary. She went on to describe the average patient age was typically an older adult but she enjoyed working with that population more than she thought she might. For some participants, having experienced work or even just a rotation in a rural or CAH setting provided a more accurate picture of the everyday work environment in a CAH. In his interview, Jim reflected on a change in his perception about working in a CAH that came about as a result of spending time there during a rotation in nursing school. Not knowing what to expect and thinking it might not be very exciting, he and other students had been assured by faculty they would like it better than they thought. Jim shared that in this experience, his eyes were opened to the rural nursing environment. This had implications for the preparation of new nurses discussed in a later theme.

**Knowing patients.** Participants commented that knowing patients from the community or local area made the work experience as a registered nurse more meaningful in the midst of the small-town feel. As described in the interviews, patients often came back to recognize their caregivers or send correspondence around holidays or special times of year. Nurses appreciate the times patients recognize their care. Laura noted, "The best experiences was like, uh, people from my patients that they...told that,

um, I do, like, a good job and I really, like, helped them, make difference in their life. Uh, so this was like the best experience was for me.”

Several participants thought rural care setting provided a greater opportunity for continuity of care over the long term when nurses are familiar with treatments, routines, and support systems. While some patients might spend a brief amount of time within the walls of the hospital for a diagnostic procedure or emergency room visit, others might have an extended stay requiring more time spent with nursing staff. This might lead to efficiency and improved quality of care, Laura concluded. When known patients are cared for in the hospital, the initial sense of rapport is already established and the nurse and patient can continue their dialogue forward in the nurse-patient relationship.

When the relationship exists outside the nurse-patient domain, this experience can impact future encounters and the dynamics of that existing relationship. Jennifer shared, “I think it may be different in an urban area in the sense that its larger community and the likelihood of community members outside of your own family/friends circle aren’t going to know you that intimately.” For Michelle, developing relationships while patients are hospitalized and later discharged was important and something more unique to the rural setting: “You really get to know them, and they almost become family, too, you know? You almost miss them when they’re gone.” Knowing the patients and having personal connections could ease difficult conversations and create trust. According to Sally,

In a rural hospital, I know a lot of my patients personally, so it was easier for me to connect with them. Health things are very personal, so I thought that with, especially with the older people I know here in my community, they have a lot of

trust in me and it's easier for us to connect and easier for us to talk about like, what is going on with them.

Similarly, Wayne spoke of the rapport that is developed and the important role nurses play in helping maintain the health status of community members:

You see obviously being the critical access hospital, a lot of the same people kind of come through, you get kind of a rapport with them, which is kind of nice, get the same patients back, but at the same time, you get to see their disease processes, how they progress on, and then a lot of different things itself throughout the community because you are one of the only hospitals they have access to.

That element of knowing you are on a team of healthcare professionals aiding in the health of the community could be interwoven both with the previous theme and additional themes related to pride and service. Michelle described how family connections and the fact she was raised in the community tied everything together in her experience as a CAH nurse:

I'm honored to work there and I feel like, um, a lot of my patients know me, or know at least my parents or grandparents or they know someone in my family just because all of us have been around, you know, in growing up there. So I just—I feel honored and proud, because, you know, it makes, I feel like I—because I know a majority of my patients on a personal level, like, outside of my care for them, um, I feel like that I have to like step up my game that much more to be...and not that I wouldn't be kind and caring and all that anyway, but just, I like, I have to really focus on being sure that I'm representing my hospital and

myself in a really good way just because they do know me personally anyway?

So I just feel like it kind of holds me accountable I guess to really provide excellent care and compassion and all that. Um, and then I just also am proud to, to represent my town and my hospital.

Critical access hospitals might give nurses more time to get to know their patients during the occasions when the census is lower or when the emergency room and acute events are not in the forefront of shift assignments. Leah also spoke about the need to continue to coach returning patients and assess for their holistic needs, sometimes with tough love:

I think especially in critical access hospitals, you have a lot more time with the patient and you get to know them on a personal level, and so being open about um, yourself can kind of relate to the patient and then from there, they'll have more of an open relationship with you, so that you can provide that better care for the patients. Um, also doing the critical access hospital care on the floor and in ER, you kind of have that, you need to have that empathetic part of you, but know when you need to, can have that backbone, too. Otherwise, I don't think you'll really get into the problems of the patient and what they're really there for. Um, I think, all around, you just kind of have to have that feel of loving your people and your small town communities, 'cause that's what you provided the care for in the long run is those people in your community.

Even when the nurse participants in this study reported they did not live in the same community in which they were working, they recognized a difference in observing the interactions of nurses and patients who did. Madelyn commented,

Something I've kind of figured out, too, is that being in a critical access hospital and in a rural community a lot of, you know, I'm not from the community I work in, I don't live in the community I work in, but a lot of the nurses there do. And so they all know the patients on a pretty personal level, too, which can be good and bad at the same time.

Similarly, Jim recognized that as a nurse who did not live in the community in which he worked, some type of mutual recognition (whether it was through family connections or the nurse and patient themselves) could be something that helped with small talk and rapport. However, that difference or boundary could insulate him from emotional difficulty or changing relationship dynamics from crisis situations where nurses are in the midst of negative news or poor prognosis with well-known patients.

Not always are encounters outside of the hospital comfortable and pleasant as nurses are sometimes remembered as being connected to difficult or painful situations for former patients or family members. Marie shared a story of being recognized by a child in the community within the public context; the child cried seeing Marie in recognition of the memory of frequent emergency room visits. This could be similar for adults who have been cared for in the community, which leads into the next sub-category of Accountability for Confidentiality.

**Accountability for confidentiality.** All nurses abide by a nursing code of ethics and must follow federal law for protected health information through guidance such as the Health Insurance Portability and Accountability Act (HIPAA). While the public is generally aware of laws to protect disclosure of protected health information, nurses might feel challenged or even experience some moral distress in protecting privacy and

maintaining confidentiality. Nurses know and understand the implications of following the law and ethical guidance. However, it seems news of acute events in rural communities can travel quickly and there might be opportunities to encounter individuals asking for more information. Acquaintances or family members might push for more information, knowing a nurse was working at the time of an event. Or they might assume a nurse is aware of all situations with hospitalized patients. Human curiosity from others often presents nurses with the dilemma of even being in the position where they have to choose whether or not to acknowledge any awareness of an event at all. They must continually assess where all or any publicly-known information is coming from and not overstep boundaries in the acknowledgement of further details. According to the participants, that pressure from others and deciding quickly in how to respond can be difficult. Alicia spoke to this:

So that's what's hard, is that you actually do know those people and you have those connections. I know things in rural communities are different, versus like in town, like HIPAA—it will eventually get out. You will be able to...like you know, someone's gonna say, "Oh I heard that my uncle was in the hospital," and that thing.

Sometimes, it may not be outsiders who want to learn more about an event or a patient status in a community. Instead, former patients comment or see their nurse for the first time since their hospital encounter and acknowledge the experience. Sally mentioned her experience with this type of situation:

Then you see them outside the community so I feel like here, like HIPAA is a big thing...they don't want to feel like, out, if you see them outside the hospital, that

you're judging them...and I have had some people be like, "Ohhh, she's my nurse" you know, and I kind of ignore them and I don't want them to think, "Ohhh, she told them [other people]," you know what I mean? Like, "Oh you took such good care of me," and I always just say thank you and I leave it at that because I don't want anybody ever to feel uncomfortable.

Leah also shared that it is difficult not to say anything about her former patients in an encounter, "especially if they say 'Oh, hey, thanks for being my nurse for my mom or my dad or me' and it's kind of like, I can't really say anything so it's kind of like 'Yup, you're welcome' like I really can't go into depth and ask 'em how they are, how they're doing.'" In discussing some of these examples shared by the participants, a structural question was posed to some nurses, asking if they thought the familiarity of being known in the rural community brought with it extra expectations of maintaining confidentiality due to knowing patients and their personal connections. Alicia responded:

I absolutely do. When something serious come into our ER, the whole town will know about it before we even have the room cleaned. And everyone will be asking if we know anything or if we were working. It is so hard to just let the insane rumors fly around when you know the story. Even for our patients on the floor, almost everyone is going to know you or your family member. You always have to be conscious of what you do or say, more so than if you were treating a stranger, because they can tell your whole family what you did.

In the same regard, Jennifer shared her thoughts as well, reflecting on the responsibility that came with personal connections within a rural or small-town community:

It is a big responsibility especially in a small rural community, it's important that my community members know and understand that I will not discuss their healthcare with others outside the healthcare team. I have already had situations where I've had to care for a neighbor or close friend in my community and they may feel uncomfortable with me outside the hospital setting knowing that I've been involved with their healthcare/illness. So I try to assure my patients that outside of this setting they are my neighbor/friend etc. and not my patient and that their privacy is important to me. I also think it's important even more so in this setting to not be judgmental, as nurses we should always be non-judgmental but when we are working with people we know on a personal level it becomes even more important, I feel.

**Need for emotional support.** Recognizing that personal connections are prevalent for CAH nurses and newly graduated nurses are seeking sources of support, this sub-category unfolded while these nurses were sharing their stories of patient encounters in public and other personal connections with their patients. While not all participants commented on this specifically, it seemed to have been implied when they spoke of other difficult situations. Participants expressed that having close personal connections with people in the community and seeing them through the best and worst times, especially tragic events requiring healthcare intervention, could be difficult, prompting the need for further emotional support. With confidentiality laws in place, this meant it was especially important for other healthcare professionals understanding these obligations to fulfill this need in the workplace as discussed in theme five. Nine months into her job as



a new nurse, Alicia shared she was growing confident in practicing her skills and finding resources to manage her patient loads but this was one area that might be overlooked:

I do feel, however, that I was not prepared emotionally for this job. I feel like being in a small hospital, in a small community, can really have its toll on a person, especially as you learn to know more people. I was not prepared to have classmates in our ER, or to have family members as patients, and especially not prepared for everyone who knows you were working to ask questions that you can't answer.

This sentiment was recognized by other participants as well in terms of code situations, abuse, or suicide with awareness of the other healthcare providers involved and again recognizing personal connections within the community. In the context of a suicide, for example, Alicia explained, "...and then to know that the family doesn't know what we know. That's hard." As the conversation continued with participants sharing some of these examples, the meaning of these situations as experienced by them took on the importance of having a safe place to acknowledge the obligation for confidentiality and to be able to debrief about some patient encounters and events.

Participants were asked about any incidents, events, or experiences that really stood out or represented the feeling of being a new nurse within the first year. Leah spoke of a situation where she was within her first week of the job and she witnessed a trauma case with a code/cardiopulmonary resuscitation (CPR) situation where the patient did not survive. The next week, she witnessed another highly acute situation where CPR had been involved and the patient did survive. Although she felt her needs for emotional

support as a nurse were met, the loss was something that would stay with her forever.

She also reflected on the positive experience:

Kind of the different opposite spectrum that you get to see a person in that critical of a stage, and see how they come out of it, and are so thankful for having a small town critical access hospital. So, I think those are two stories that will kind of stick with me for a long time because they're so intense and they're something that is kind of unique to critical access hospitals.

In summary, the second theme of Personal Connections and its subcategories of Knowing Patients, Accountability for Confidentiality, and Need for Emotional Support branched off participants' discussions on what it was like to be a new graduate nurse in a CAH as they reflected on stories of acute experiences, patient encounters, and what it meant to care for patients encountered both in the workplace and in their everyday lives. Keeping in mind that they carried their nursing identity with them always, as mentioned with the first theme, the participants continued to share expectations of their role within the community and described how they addressed those expectations.

### **Theme Three: Pride in Work and Community**

Several participants commented about feeling great pride in their roles in both the hospital and in the community due to both their sense of identity and the importance of their service, especially when they were the few on staff or roster to meet the healthcare needs of community members. Amongst this theme of Pride in Work and Community, the sub-categories of A Rewarding Job and Contributions to the Community emerged in this area of conversation. Michelle commented about the implications of her role amongst other healthcare professionals as representatives in their small town:

It's amazing because we are such a small town that the people around us really, um, cherish what we have, because it is so convenient, um, and that just makes you feel as working there and being a nurse for those people, just like honored, I guess? Just because...if we weren't there, um, they would, you know, their, they would have to go so much further, and that could...inevitably change the outcome of what's going on with them.

**A rewarding job.** Amongst the statements from the participants, the words “exciting” and “rewarding” were often used within some of the opening comments when asked what it was like to be a new graduate nurse in a CAH. This often led to descriptions of some of the diagnoses encountered, opportunities to draw on certifications and specialized skills, and descriptions of which cases were kept for continued care or recovery or which were “shipped” to larger hospitals in acknowledging the role of a CAH in triage and stabilization. Others talked about good benefits, education assistance, and again, the convenience of location as part of the reward for their work.

Is nursing a rewarding career choice in itself? Most of the participants would likely acknowledge this outside of the context of their job in a CAH as well but the rewarding feeling was mentioned most commonly in association with personal connection and identity of being a nurse within the community or rural area specifically. Amongst similar participant comments, Madelyn shared proudly, “It's really exciting and I feel honored to be part of the team up there.” For Phoebe, the feeling of pride as a nurse in the community did not seem to be overshadowed by the feeling of being paranoid sometimes in being seen or judged out in the community. As these conversations began

with the sentiment that the participants had a rewarding job, the discussion quickly moved onto the “why” of these statements including service to their rural communities.

**Contributions to community.** In this sub-category, participants commented that having a personal connection to family or the environment, such as growing up in the area, influenced the sense that they wanted to give back and continue to provide for those they cared about in their communities. Leah talked about the love and support she felt from her community growing up and affirmed that she “really wanted to give back to them.” When asked about why she stayed in her job, Madelyn also expressed, “I just think the sense of pride and accomplishment you get from helping people in your community, that’s the biggest thing for me that’s gonna keep me going...probably really serving my community is the biggest thing.”

Not only did nurses feel this intrinsic motivation to “give back” in a general sense but sometimes they were asked to do additional volunteer work or provide service in related areas because of their professional training and expertise. Marie commented that since the emergency medical technician squads were all volunteer-based in their rural area, she had often been asked to join their efforts as “they see you in that, you know, professional way and they kind of want you to volunteer more of your time to help others in the community. You know?” For others, being asked questions as a nurse was a way to carefully help meet the needs of community members and was a source of pride.

Madelyn noted:

Well, really, I feel proud. Um, I feel proud that, you know, the people around me know I’m a nurse, and they know they can come to me if they have a question, I’ll

refer them to the appropriate place, get their questions answered if I can't answer the question for them.

Others commuted to communities in which they worked and did not have the same personal connections with seeing members of the community outside of their work hours. They were drawn to nursing care in CAHs for other reasons such as the schedule, pace, or other benefits, and still they felt they were making a difference. Jim mentioned:

In that setting both the...uh, your coworkers and the patients as well as the families all just seem to be a little bit more laid back, and more friendly, and...uh, I think it alleviates a lot of fear that you have with that whole, something that we've studied in college about old nurses eating the young and that sort of thing, and I don't see any of that.

Despite not having that personal connection discussed previously due to not growing up or living in the same community, it was clear during the interview that Jim perceived this as an opportunity to share his nursing skills. This was also a meaningful challenge to build rapport with patients quickly in service to his patients due to the positive culture of his workplace. The small-town feel was still present right within the hospital. As Mary did not grow up in the same community and noted she had otherwise been looking for nursing positions in an urban setting, she also commented she had a lot to give to her rural area as a nurse professional: "I just feel like I have a lot to contribute to this community so I'm gonna, I'm going on, I'm getting my Bachelor's (degree) now. Going on to something else, you know, that I feel like I still want to stay here."

#### **Theme Four: Always on Your Toes**

Participants commented that the daily workload of a nurse in a CAH could change rather quickly as soon as a trauma came in or during peak emergency room hours. “You need to be able to roll with the punches,” said Mary. Participants described other characteristics they felt new graduate nurses should have such as being open to asking questions, being open to new experiences, being trustworthy, being open-minded, being willing to advocate for patients, as well as just following the golden rule—treating others how you would want to be treated.

Jennifer and Alicia described work as new graduates in a CAH as “exciting.” Michelle was torn between the feelings that this situation was “both scary and amazing” and agreed with the conclusion that you need the ability to flex your skills and feel like you have to be an expert generalist in this setting. “I have been here almost a year and still get something new every week,” commented Alicia. Several of the participants thought a CAH was a great way to continue to learn nursing skills and readiness for many types of situations. Jennifer felt it was “a really good experience to kind of get to do a little bit of everything, as opposed to, you know, specializing in just one certain area.” Similarly, Abbie remarked:

You get to see everything (smiles). I’m not technically specialized in anything, so we do anything med surg, we get to have like OBs, I’ve had a little bit of OB experience, not a whole lot. But, we’ve done some critical care... A lot of learning experiences there...I feel comfortable pretty much with doing anything just in any kind of setting.

Comments differed on the pace and the learning experiences, which depended on (a) the time the participants had been in their position, and (b) whether or not their hospital was large enough to have different departments. For some hospitals, a different department might be literally across the hall but was considered another department with varied staffing guidelines. In times of acute need and volume, this formal distinction did not prevent the possibility of need for service by other staff nurses in the facility. Wayne discussed this type of structure in his facility while working on night shifts in the medical surgical department: “Being on med surg, I’ve enjoyed getting the taste of a lot of different little...a lot of different things.” Mary worked in a CAH with fewer beds overall and thought the pace was just right:

This is probably the best setting for a brand new nurse, because the pace is really good. We have enough time to get to know our patients, really get to know what we’re doing, and I have time to prepare what I need to do before I actually do it. So that’s what I love about working at this hospital. [The reason] Is just, I have the time to gather all my thoughts to do something that I need to do.

Others such as Phoebe preferred a faster pace than what was typically seen on the night shift when caring for inpatients; however, she acknowledged the times emergency room admissions and traumas could dramatically change the pace of a situation.

**Switching roles.** Most participants commented they did not have separate departments within the nursing department; rather, there were rooms or areas of differing levels of care such as rooms used for medical patients, emergency room (ER) patients, surgery cases, obstetrical patients, or swing bed patients. Some of the role changes might depend on the bed size of facilities such as a 25-bed or less setup common of CAHs. A

nurse might be caring for a medical surgical patient for most of a shift, assisting with the delivery of a newborn later, only to end the shift in the emergency room as patients walked in. As Leah put it,

Being a nurse in a critical access hospital is something very different from being a nurse in a bigger hospital because in a critical access hospital, like where I work, we do acute care, um, skilled care, observation, plus we have an ER that's open 24/7 that we work with. Um, we do have some nursing home residents and um, we do a lot of outpatient treatments, we also have an outpatient clinic that comes around and we do surgeries. Um, so, getting to be diverse in all of that is really unique for being a critical access hospital. Um, some of the things that I've kind of got to learn from being in a critical access hospital is getting to be diverse in being on the floor and then having to transition over to ER when we have an ER come in, which that's kind of different. Um, I have got to see really unique ERs for being in a critical access hospital. Um, just because we have a wide area that we have patients come from, since we are rural. I have got to experience traumas that we have lost and saved, so that's something...different, especially being a new nurse.

For many new nurses in these CAHs, they recognized they would be asked to help out at some point in the emergency room--whether planned through a formal orientation and staffing assignment or unplanned due to an acute need for staffing. Laura stated, "Working in a small, rural hospital gives me an opportunity to practice different nursing skills in different units because as a shift nurse, I do both ER and med surg care." To some, it was exciting and to others, it was scary. For Sally, who worked in her hospital in



previous roles, becoming an RN was something that made her nervous due to the expectations for those situations. Michelle also discussed her role in assisting as a nurse in the emergency room:

More times than not we are...one of us is pulled to the ER to help, and that gives me anxiety just because, not only did I have to train on my unit, but then, um, I get pulled over there, so I'm new to both areas, which, you know, I can kind of figure out, but even though...it's...we're literally across the hall from each other, we're so different. Even with the just the...how you, medication and where it's located, their supplies and where it's located, you know, how they do things, how they chart.

**Readiness for whatever comes in the door.** This subcategory revealed that since nurses often spend some time working in a triage role or in the emergency room, they truly must be ready for literally whatever or whomever comes in the door. While some nurses felt uneasy and this was an area where they could benefit from the most extra training, others felt it was an area of interest. Alicia commented, "I feel like I'm always on my toes. Like, learning new things. I've never had the same patient twice, and...you never know what's going to walk in the door, and it's kind of terrifying, but also exciting." Jennifer acknowledged this often happened: "We do so many different things...you really have to be flexible, and you have to be able to adjust your settings." Flexibility was a characteristic shared by many of the participants as something important for new graduate nurses in CAH settings. Others acknowledged the responsibility that came with autonomy in their assessments and triage skills. Marie mentioned the intuition she was building as a new registered nurse in the critical access environment:

I'm the first eye so that's a big thing. The providers have to trust my, you know, intuition, how I feel about things, and you know, like the other night we had a chest pain come in. And, you know, the provider had to trust in me that I was ok to make the judgment to start the tests we needed until she could get there, you know, they have 30 minutes to get there. So, being it was just a, you know...um... nothing I was used to, but everything, obviously [went okay]-- I've never had a problem yet, but I feel like it's a good learning experience.

Feeling an extent of readiness for whatever might come in the door is something developed with more experience and often far beyond the time of new nurse orientation or even the first year. However, an awareness of resources could help new nurses as they encounter these experiences. Some nurses were able to share the progression of their confidence in their first year of working as registered nurses. For Madelyn, nervousness transitioned into an attitude to always be learning:

So at the very beginning I was really nervous, especially for the ER, because I just wanted to make sure my school had prepared me completely for anything I might see, and what I'm learning is a lot--a lot of what you pick up is on the job. So, ...I mean, it's... it's been great so far, but, I was definitely very nervous at first and still am working on developing that confidence.

**On the job training.** Participants commented that (as discussed related to the emergency room) some of the learning in the first year was on the job training. While three participants mentioned having a preceptorship in an intensive care unit (ICU) or ER area during their schooling, most did not. Since Marie reported an internship, she was asked whether she would have felt prepped for the ER during school otherwise if it had

not been for her 10-week ER internship. Her response was “no.” As a new graduate nurse, she acknowledged she was still adapting to differences in staffing resources between shifts as well. As she reflected on a recent critical incident and how she would have handled the situation had she been working, she commented, “I just think to myself if that was, if I was there that night how I would have handled it, you know? ‘Cause there are only three nurses on staff, and one has to stay on the floor if there’s patients.”

Being a new nurse in a CAH was “difficult and stressful at the very beginning” for Laura: “‘cause you cannot know everything at your school.” Other areas of care and protocols for on the job training were needs for specialty care within the scope of a CAH such as obstetrical deliveries (if the hospital provided those services) but possibly not seen at a frequency as in urban communities. Participants were well aware of which types of cases they triaged, stabilized, and transferred to larger hospitals for higher-acuity care. Participants wondered though, what if they saw some of these cases and they no longer offered some services such as childbirth services? Concern was expressed about the need to stay competent and be aware of how to care for patients who might not be able to be transferred once they arrived such as women in active labor. As long as training was available for services provided, the ability to cross-train was often seen as a benefit to new nurses. Madelyn saw the variety of experiences and cross-training in a CAH as a great selling point in an interview or a very marketable experience as did Jim. They welcomed additional courses and certifications as they were made available for additional training. Madelyn added:

But as far as the people I work with, it’s been great, and what I *love* about the critical access hospital is that I’m able to be trained in so many different areas,

whereas in a larger hospital, I would have one specialized area I'm in. But in the hospital I work at, I'm able to work, I'm getting trained in OB, I've been trained in OR, to circulate and scrub. I've been trained in ER, um...and then eventually I'd like to get into some chemo. Um, you know, administration—there's a whole big certification that comes with that though (laughs gently).

One difference participants found was in some facilities the certification courses were taken immediately while in others they were eased into the first year of training. Participants had mixed feelings on when these courses should be offered to new hires. While some preferred to be able to complete training right away in the mindset of preparedness, others felt as if they did not remember some of the content due to the newness of everything in starting their job. This was Alicia's sentiment: "I do feel like I'm constantly having a class that I have to go to, and that is hard. Like, the first one they threw me into was ACLS (Advanced Cardiac Life Support) and I feel like I don't even remember it because I was still trying to be a nurse then."

Overall, communication seemed to be a key factor in promoting success in On the Job Training and being Always on Your Toes to accept whatever came in the door. When new nurses are in need of information or resources, they should feel comfortable in requesting further assistance or in trying to be as proactive as possible. Marie reflected:

I think the ability to say that you don't know something is huge. Like I said, there's not a lot of resources to pull from and sometimes they just kind of throw you into it and just expect you to know everything...Another big thing is, you need to be able to accept different positions. I never thought I would do OB ever in my life either, (laughs) and I've been thrown in to that as well.

In summary, critical access nurses work in settings that might have fewer resources at given times and nurses must be called upon to utilize different areas of skill on demand, requiring competency and confidence. Perhaps the ever-changing workload and need for competency of a rural nurse was best summarized by Phoebe: “In a rural hospital, you kinda get good at...a little bit of everything.” Michelle distinguished some of the differences she noticed in her previous experience in larger hospitals in comparison to her current job in a CAH:

Because I’m in a rural setting, I’m needed not just on my unit, so I just feel like, um...you know, it’s gonna take me some time to get comfortable with not only being new to the unit I’m on, but having to help out other units, um, and being able to just be universal, with everything and now things are done and you know something might happen and I’m going to need to be there for it and we don’t have the staff, so I guess just being comfortable with that ‘cause I feel like, and I have worked in larger hospitals, you know, I was on the floor and I was comfortable with it because I knew what would happen, I knew the routine. Like, obviously unexpected things could happen, all, you don’t know what a night can be like, because you don’t know what will happen. So, which is fine, but it’s just getting comfortable since I am new at everything and all that.

#### **Theme Five: Everyone Works as a Team**

Participants were asked what it was like to be “a team member of the healthcare team in a rural hospital” so it remained fitting to label this overarching area as Everyone Works as a Team with sub-categories of Nurses Lean on One Another, Interpersonal Working Relationships, and Personal Investment in Coworkers. Although the nurses

shared a special connection as nursing colleagues, it was not uncommon to find the attitude that amongst the entire hospital, the staff is still all a team. Marie agreed about the teamwork atmosphere in her hospital and commented about feeling supported especially by the other new graduates working with her in her hospital:

Everybody is a team. It's a teamwork atmosphere. There's another grad that started around the same time that I did. We actually went to the same college [name omitted] but she went to a different campus, so we kind of had the same education, but I feel like when we work on the floor together for their, um...we kind of take each other's patients on, both together, you know? And we help each other with each other's patients as well as everybody else on the floor. There may be, like, one or two nurses that don't like to play nice, you know? Um, other than that, it has to be teamwork or otherwise, people are gonna drown.

In addition to new graduate nurses working together, a connectedness was shared amongst various levels of expertise in nursing for most of the participants in the study as well as rapport with administrators. Some of the differing opinions are discussed in the final theme. Alicia highlighted the feeling of widespread support and teamwork amongst her coworkers:

I feel supported from all of my fellow nurses, experienced and new. The older nurses are there to teach me, show me and guide me through every task, and the newer ones--we just get through it together. I never have to worry about someone stepping in the room to help me out. And the other office workers who are RN's, our DON (Director of Nursing) and really everyone from lab technicians to

pharmacists are supportive. I have felt welcome and like everyone works as a team, no matter what your position.

Relating back to the need to switch roles and work together to cover needs, Michelle also talked about the teamwork, ability to count on one another, and mentoring from other older nurses:

Um, it's pretty awesome 'cause a lot of the people I work with are older than me and I knew them growing up and I knew them all through my life. Um, so there's that aspect, you know, I know them, already before I came there, but um...it's the team aspect in a rural hospital is very important because for instance, um, on my shift I work weekend package nights, so there's two of us in inpatient and then usually one nurse, the doctor and like a tech in the ER. Um, so that's really like all we have—for caring for let's say we have 10 patients in inpatient and the ER is full with six. So being a team, you know, usually one of us will float to the ER to help, so you really have to know your team members and like know your strengths and weaknesses with each of them and just really work together because you have to be. You have to just because you know you're so short you can't pull from other floors, you can't pull from like a resource pool, you can't say "hey we need help," it's just who you have, what you have. So um, team, the team aspect is really important and um, you know, it makes me feel good cause I know that others can count on me and I can count on others and, um, you know your times that it doesn't always work seamlessly but usually, usually it does.

One of the more innovative resources within the domain of teamwork becoming more readily available to rural nurses was telemedicine resources if the hospital was part

of a network that might utilize these services. Madelyn described the ability to press a button and gain assistance through distance-based personnel, which could provide easy access to verification of pharmacological and dosing information, location-specific inventory, and other needs. She commented that it's "been a lifesaver" during times of need or the desire to verify information for a safety check.

**Nurses lean on one another.** Participants commented that especially when working a weekend shift together, which tended to be in a pattern or a form of rotation, they got to work often with some of the same nurses and developed a rapport. "I feel like the nurses all kind of come together and work together to try to help each other," commented Phoebe in her interview. New nurse hires, including new graduate nurses, usually partnered with a designated nurse for a period of time in their orientation period but they continued to rely on one another for advice, for assistance with tasks, and for support. Leah described this as "just kind of being there for each other, and I think that's really unique about a critical access hospital, because everyone is so close, that um, we can really lean on each other in those times of hard."

Resource nurses, mentor nurses, and charge nurses were described as key individuals who took the time to enhance learning and answer questions. As Michelle described her resource nurse, she talked about the ease of asking questions, stating, "She's just like an open book. I could ask her anything and she knew." Wayne described a general sense of great rapport with the charge nurses and particularly pointed out a great charge nurse who was stepping into her role at the same time but still made time to assist the new hires: "She had a lot to learn on her plate at the same time, but she was *great*. Really helpin', helping both me and the other new hire get our feet under us and



keep ‘em that way.” Sally shared how her nurse mentor anticipated her needs upon change of shift before leaving, and told Sally, “Let’s go look at this PCA pump. Let’s clear it together, let’s load it together, let’s start your shift out knowing what you’re going to do throughout the day with this pump.” Reflecting on that experience, Sally stated, “That was one thing that, you know, I didn’t even have to go to her. She just knew right away that you know, ‘this [is] something new for her, let’s get it going right away’.” In other situations, participants described that some of the older, more experienced nurses continued to provide support and enhanced their learning. Abbie and Alicia both discussed that it was nice to have the experienced nurses around to guide them. Alicia commented,

I feel very supported, um...especially by the other nurses. There’s some, you know like there’s the ones that are close to retirement and there’s the ones in between. Not so much by the ones in between cause they are like “well I was new once too, you can do it” but the older nurses, gosh, they pretty much walk you through everything. I do love that. And then, some of us younger ones, too, we all just go into the new rooms together and we figure it out, which is, that’s nice. It’s not...you’re not on your own, ever.

Leah felt it was a benefit to have one-on-one time with the experienced nurses at the hospital to learn from their techniques; it was a great learning environment for new nurses. Phoebe also felt the older, more experienced nurses were willing to teach:

In our hospital, you have so many that are older, that have been there forever, and then the same community that they grew up in, so they, they know everybody or whatever, but they’re very good about teaching. Um, so it’s nice that they’ll take

the time to say, “Hey, have you seen this yet? Is this something that you want to come get in on, so that you can get the experience?”

Leah and Madelyn commented specifically about the support of their supervisors or directors in addition to the other nursing staff. Leah felt her director of nursing was very good about asking how things were going or with explanations and providing support: “I think just kind of as a whole, everyone in there is very good, in knowing when I need some help and support.” Madelyn also commented about the ability to have monthly meetings with her supervisor to touch base on how things were going and improve the experience: “And so those times do really help to sit down and process what you’ve gone through and how you can improve yourself.”

Nurse participants in this study were asked who they felt was their greatest source of support in the workplace. All participants named their fellow coworkers in a general sense and some named specifically charge nurses or the licensed practical nurses (LPNs) and nurse aides who had been in the facility the longest. In an acute situation or a situation where staffing was low, the participants shared how important it was to identify whom you had available for support. Mary described a hypothetical scenario of having to rely on your resources on a Saturday evening or a Saturday at 2 a.m. when teamwork was essential. When asked what it was like to be a new nurse in a CAH, Marie commented:

I never thought I was going to do it, personally I was, thought I was going to work in an ICU. Um, I think it’s actually more challenging to work in a critical access hospital just because, like, where I work we only, like at night we only have three-three nurses on staff and maybe an aide? And when things go down, like, there’s

not a lot of people to get...you know, there's not a hat of resources to pull from, or, there's not even a provider in the house at all times, either.

**Interpersonal working relationships.** As participants explained the different scenarios that could take place when the hospital was short staffed or they were on the same weekend rotation, for example, with a couple coworkers, they eluded to the fact that they must work together and get to know one another to develop strong Interpersonal Working Relationships. Jim summarized that he observed everyone pull together when there was a need and Mary commented about the ability to work alongside anyone and use resources. She mentioned nursing was her second career; in comparing to a previous career, Mary said, "They value my opinion and my knowledge more than I've ever experienced, so it's more of like a camaraderie, more of a...a community."

The fact that few were on staff during a given shift prompted the need for being able to work together. Laura enjoyed the camaraderie along with the emotional support it provided, noting, "I do enjoy working in a small community hospital because it's much easier to know all the staff I work with and this makes me feel more comfortable and less stressful at work." Michelle commented on this as well: "I know the people, I...we're just, because we're small and we're, we don't have those resources I just feel like a really good, if I had to pick a word, we're just tight knit." Wayne related his perception of close-knit relationships with the local providers as well as being part of the healthcare team that strove to figure out the best care for the patients; he pointed out his working relationship with providers and all ancillary staff was a positive one. If working relationships were not developed, outcomes could be poor.

I think especially on my floor that it is, that it is great to be a part of the whole team. We are very good about working together. On the overnights, you know, you kinda get that skeleton staff, and so, if you get a big rush, if you guys don't have each other back then the whole night can fall apart rather quickly. (Wayne)

As a new nurse on the job for 10 months, Leah emphasized how important the development of interpersonal working relationships could be in adapting to a new job in a CAH:

And so, being a team member and kind of working together and knowing um, the scopes of each person, they, we can all really work together and get things done that we need to, and um, I think being able especially as a new nurse, being able to kind of know what you're capable of and what things that you need to kind of wave, wave your hand and say "hey I need help" and having that team member role, that somebody can come and help you with, is kind of nice...So right now I'm feeling more confident, uh, because like good, um, emotional support from my staff, and like all trainings that they give me. So I feel like, that um, like I'm emotional protected, and I gained a lot of knowledge, even for the six months that I work as an RN at the hospital.

**Personal investment in coworkers.** As this sub-category emerged throughout the interviews, participants commented that the amount of time they spent together in the workplace created a family feel. Therefore, it was not uncommon to support one another in covering shifts for activities for one another or perhaps even going to coworkers' children's sporting events to show support and fellowship. "You become a family," said

Phoebe, when referring to how many hours nurses spend at work outside of the home and their own families.

It's nice to have an environment where everyone cares about everyone, and I feel like where we work, everyone is a family, you know, everyone will ask about my kids or some will come to my kids' sporting events and watch them and, I mean it's just a big family and to me that's important because you do spend so many hours there it's nice that you don't feel like, "Uh, I have to go to work with these people that I don't know and that I don't enjoy" but then on top of that it's working together. I mean, everybody pitches in, it's a great teamwork aspect, and to me that's important instead of, "Well that's your patient, you need to do that," or you know, "I'm only, I'm only in surgery" or, "I'm only OB. That's not my job." I don't hear any of that and I really like that about the rural communities.

Laura discussed how in a rural hospital the employees relate to one another better as they know about personal lives and that creates more emotional support and a friendly environment. She felt comfortable enough to ask for help when she needed it and appreciated the closeness of the small-town feel. Some of the participants anticipated this and desired it as they searched for their first job. Alicia attested to this: "All throughout school I was determined to work in a hospital in a small town. I was not a fan of my clinical rotations in large hospitals where you hardly know your coworkers. I feel like I am already a part of the 'family'."

### **Theme Six: Essential Preparation Experiences**

This final theme encompassed participants' experiences in their orientation (Orientation Adequacy) as well as the Organizational Culture of their workplace and any

identified Curriculum Gaps that could be improved upon in nursing education. A couple of the participants also commented it was important to try to provide the opportunities to change the perception about CAHs as Marie felt bigger hospitals might look down on them sometimes, such as in the instance of giving a report for transferred patients. Jim also described in his interview that nursing students might have a differing perception of CAHs than reality and how his rural rotation opened his eyes to the opportunity he now had in working in a CAH.

**Orientation adequacy.** All participants were asked about their feelings on the adequacy of their orientation to their new RN position. The length and structure of reported orientation experiences varied greatly, ranging from a couple weeks to a few months. For about one-fourth of the participants, it was three months. Six weeks was a common response as well. Two of the participants could not easily quantify their time and mentioned they essentially jumped in and just started working.

When participants reported their orientation as adequate, this often occurred when they had been working in the facility prior to their hire in the RN role. All participants were asked about previous volunteer work, nursing assistant/tech, or licensed practical nurse work within the same facility in which they were currently working. A couple participants reported they completed an internship or preceptorship prior to hire so that was counted in the yes/no response for that question as well. Others did not have prior experience but still felt it was a positive experience. Jennifer had already worked in her facility and had about a month of orientation, mostly going over policy and procedure:

For me I felt it was adequate, I am a hands on learner so I was anxious to just get in there and get started. The fact that I had already been employed with the

hospital was an advantage to me as well. I did not need a lot of the basic facility orientation that brand new employees get.

Michelle felt similarly about her six-week orientation.

On the other hand, some nurses who had been working in different roles within the facility felt like assumptions might have been made or could not easily identify the transition between roles with any formal structure to an orientation. In Abbie's case, she could not identify much formal orientation between her transition from LPN in the facility to the RN role but discussed plans for training as a charge nurse in her future. Throughout her interview, however, she described her comfort in encountering a variety of patients without concern for an inadequate orientation. She seemed content with the situation of "learning as I go."

Sally recalls her orientation was six to eight weeks and she had previously worked in the facility. She thought it was adequate "to a point" but sometimes felt like assumptions were made that she knew things just because she had been a familiar face within the facility:

I thought it was ok, I mean I jumped in pretty quickly and I felt comfortable when I was on my own. Granted the first couple days I was very, very nervous and I asked, and I guess it kind of helped me that I worked at the hospital beforehand as a CNA and everything because I did get to start to know the RNs more so I felt comfortable asking them questions. You know, if I hadn't worked at the hospital beforehand and just started working there I would have probably felt very nervous just asking all the questions I asked, but, I have worked there beforehand, you know, as a CNA while I was going to school, which was very beneficial to me

because then I was able to get to know the RNS on a personal level and then I was comfortable asking them questions.

Wayne went through a preceptored experience in his facility prior to hire and then another six weeks of official orientation. He declined an offer for additional time, voiced needs as they arose, and overall thought the facility did a great job. He felt comfortable with his role in caring for primarily medical surgical patients but shared,

One of the things I said they should push harder was um, supply location. And, kind of giving new, expecting the new nurses to kind of spend time in the supply closets and things like that. Because if an emergency ... situation does arise, we need to know exactly where to go to get what things.

Madelyn had heard from classmates hired prior to her time that they received half a day orientation. She expressed her concerns upon hire and was provided a three month orientation with an improved process. Most of her orientation process involved a checkoff process with a nurse mentor. Madelyn was confident when asked if she felt her orientation was adequate:

Yeah, I really do. I felt like, um, by the end of it I had a lot more confidence in what I was doing, it started where I followed my mentor around, and watched her for the first couple days, and she had been my clinical instructor previously so she kind of knew me, so she was pretty comfortable with me, so pretty quickly I took over doing the tasks, and she was pretty much sitting in the nurses station and I was doing everything and just coming to her for any backup that I needed (smiles).



Leah concluded her orientation was about two to three months--progressing from observation to more hands-on support and working one-on-one with a nurse. She voiced that having more time to orient in the emergency room would have been helpful since it was not touched on well in nursing school. When Leah was asked about an adequate orientation, she responded:

Um, somewhat. There's some things, especially, um, being a night shift nurse that you don't really get to see when you're orientated on day shift. And, so I think a little bit more orientation into the different kind of shifts and what's expected in those would be great. Um, especially being a new nurse right out of nursing school, I think it kind of takes a little bit more time and more practice to understand what the roles of a nurse in the real world are like, versus, you know, what you learn in nursing school, 'cause it's totally different. So I think just a few more months just of kind of getting comfortable in the nursing role would have been nice.

Laura described her experience as a time that helped her learn new practical nursing skills specific to ER and OB; the support of her fellow nurses helped contribute to the feeling of confidence or competence. She did not have any further suggestions to improve upon her experience:

Well I'm a night shift nurse, but the orientation was mostly at day shifts, because we have more experience, like more critical things experienced during day shift. Um, so uh, all staff was very supportive, we just went to ER, like OB, inpatient was like super busy, busier than at night, so I got a lot of...everything was important. Like especially like ER because it's very acute and very stressful. So

I think those three months like helped me a lot to be more confident to work with like difficult situations and to gain knowledge so when I work at night then we have maybe, usually less acute case but still, (inhales) I gained that knowledge and it helps me to apply my knowledge, I could to every patient.

Although Alicia reported her orientation was about three weeks, she felt it was adequate and was comfortable with the fact that she would always be learning and taking in new experiences:

I feel like my orientation was as adequate as it could be. I was shown the basics of where things are and how things are done, but being in a small critical access hospital, I wasn't going to see every type of case in those three weeks. We just don't have a big enough population to get a specific orientation, like on cardiac or respiratory or even surgery. I have been here almost a year and still get something new every week...As long as I feel like I have a more experienced nurse close that I can ask questions, I feel relatively comfortable being on my own on the floor. No matter how long the schooling or orientation is, you still aren't prepared, because every patient is different. And you will always be learning more, and getting more qualified!

Mary described her orientation experience as approximately two weeks; it was “really laid back, and there’s nothing set in stone... would say it was like a two week ‘here’s the hospital, here’s where things are, here’s a checklist” and then, we just kind of got, I felt like I just kind of got thrown out there.” As the conversation continued, she reported she was paired with another nurse for about two months while taking her own patients and felt like the structure of the orientation was lacking in her facility: “So we’re

left alone pretty early on. Um, so like I think I would have liked to take, like your specialized classes like your TNCC (Trauma Nursing Core Course) and your ACLS (Advanced Cardiac Life Support) kinds of classes earlier” in feeling more prepared for code situations or incidents that might still be encountered early on the job. She spoke with classmates who took the courses earlier for their jobs in urban hospitals and felt that would have been better for her needs.

Overall, Marie did not feel her orientation was adequate. Sometimes one preceptor made the difference; for Marie, her second preceptor was not engaged in the learning and mentoring process due to outside personal issues brought into the workplace and was usually unavailable for support. She also felt like it would have helped to get grounded in one area first before moving into specialized areas but recognized she particularly liked the emergency room, which was sometimes a fear for others:

Um, I feel like they should start out in one position first before making us go into every other position. Um, like I didn't want to do OB. I wanted to wait at least a year before I worked, for being a nurse, before I even dipped my foot in the water with that one. And I think, like a month after I was on my own I had to do a delivery. That was like terrifying (laughing gasp). But as far as like ER, that. ER is my comfort spot, personally. Um, I felt more comfortable there than I did on the floor 'cause I had done ICU and I had done a 10 week ER internship and that's just, I do well in those types of situations better than like having slower environment on the floor.

Jim described he was told his orientation was a 90-day timeframe with a preceptor but he was technically off of orientation shifts by that time. He appreciated the move

from days to nights, commenting the shift felt more laid back: “I think it’s still going to be well if you have a question about which button in the computer or stuff just ask the person next to you, which is what orientation was.” Jim did appreciate an expedited orientation tailored to his needs, especially in anticipating that he would be completing certifications such as Pediatric Advanced Life Support (PALS) and ACLS quicker than some of his colleagues in urban hospitals. He explained that after orienting to the floor, those with special interests in OB or ER shifts would be oriented to those roles.

In summary, participants shared a variety of thoughts about their orientation experiences and these experiences varied both in time and structure. No participants reported they were part of a nursing transition program or a nurse residency program. In fact, Jim voiced he preferred not to have that type of arrangement:

Sure like any other new hire at any place you have to watch the videos and all that type of thing. It’s nothing like a city residency program like at [larger city hospital] which did not appeal to me. I mean, you can quote me on that after four years of college I don’t want to go through another six months of college.

Participants had some recommendations for improvement, e.g., moving paper protocols, policies, and procedures from paper to electronic or online files would be helpful and less cumbersome as would the scheduling system. Jim reported more days of training on software systems and electronic charting processes would be helpful over general human resources types of training and time spent viewing videos on morale and workplace culture. Jennifer thought taking certification courses like ACLS, NRP (Neonatal Resuscitation Program), PALS, and TNCC in a different setting or in a facility more practiced in those areas might be of greater benefit to new nurses and, as noted

previously, the timing of these classes was a varying discussion point amongst participants.

Phoebe felt her orientation experience could be improved:

In orientation they had a big packet of papers that you have to have someone sign off that you have been orientated on, but...which some things, they would show you, but it wasn't like you're really taught. And then you didn't really follow anybody. You just kind of got patients right away and were just kinda thrown in there. That's something that I've told our DON that our orientation is really bad.

She acknowledged that sometimes nurses just learn as they go but it would be helpful to feel more prepared.

**Organizational culture.** A lesser thread but a subcategory of importance, Organizational Culture emerged as an area of discussion when it came to facilitating Essential Preparation Experiences and feeling supported in the workplace. Recognizing unique differences in resources and building confidence is important so the perception of a friendly environment is part of the growth that happens in the first year of experience for new graduate nurses in a CAH setting. Phoebe and Wayne both appreciated that their hospital brought in many seminars for continuing education--both from a convenience standpoint of not having to travel and also to show continuing education was valued.

When asked why new nurses stayed, some participants said it was the tie to the local community as discussed previously. For others, culture and benefits played a part. Jim mentioned,

It's the most-friendly environment, it's much less stressful in terms of rules and regulations and that sort of things. The commute is probably shorter for them.

Even for me, it's a less stressful commute. It takes the same amount of time as driving across the city, and ....at least this hospital is doing, I think a good job of trying to stay on par with the pay in the city.

New nursing graduates come in with their experiences from school, expecting to often have rigid guidelines, policies, procedures, and theories to guide their nursing practice. Some participants reported that in their facilities, the ability to refer to policy and procedure was cumbersome amidst its current access or they began to recognize critical thinking and availability of resources also guided their action and decision-making in a given moment. If new nurses do not come in with a mindset of flexibility, it is a characteristic that might have to be further fostered.

I'm pretty sure just in doing your clinicals in the later years, you know that on the hospital floor in the big cities do everything by the book, but in a rural hospital, you, you really can't, um. And the policies and procedures are...many of them aren't even, um, written in book or in a computer somewhere. They don't have a policy and procedures, or our policy is to refer to Lippincott. So, there's a lot of flying by the seat of your pants. (Jim)

Leadership and administrators make an impact on new nurses working in the CAH setting. If they are perceived as welcoming, supportive, and willing to pitch in, they increase the perception of teamwork throughout the hospital. Wayne stated,

Even the administration, you see them passing in the day, they stop and chat with you a little while, education manager is uh, particularly good about asking how things are going, and, answers anything that we need to bring up with them on the floor with issues, so I think my hospital personally does a great job with it.

On the other hand, some of the participants were more critical and felt the support of their administrators or supervisors was lacking. Nurses desire to have a voice and witness follow-through.

Sometimes our supervisors aren't always the best at...helping? Um, like they always say that you know, if something happens we can call them but every time that I've had that situations happen and then I needed somebody to come in, they'd never answer their phone...I feel like the supervisors need to spend more time on the floor and see what we're doing instead of just being in an office. It's hard to implement and get respect at new changes when you're not one to be there, having to do it? That's a big thing. My supervisors have not been...as, as good as we would need it to be. We have, they put up, like obviously the nursing shortage is, very, you know, very bad, especially in rural communities, and I feel like sometimes they put, it takes a lot to get someone fired, I'll just say that (laughs). And we're having to deal with the consequences of it. (Marie)

Similarly, Phoebe explained that working night shift is a very common situation for new graduate nurses and one that does not often change very quickly amongst experienced staff working days. While night shift staff generally accept they will not have as many resources around, recognition of their work/sleep hours in scheduling other events as well as feeling supported and remembered by administration were areas that left more to be desired.

Yeah. I can tell you that working nights, never once did we see any of our administration people, and he did not, we did get a new administrator within the last, um, six months. Never once has he, um, introduced himself to us or come in

there, so we, we don't--especially working nights don't feel like we have the support of those people. Um, so that makes it tough and I think that's why night shift and our nursing staff are so close is cause everyone has to work together, especially on nights cause there's limited amount of people there and you just don't have the support that you do during the day when all departments are there. But also, I don't know if it's just night shift or what, but you kind of get the brunt of everything, 'cause, um, like charge nurse meetings and stuff like that, they schedule during the day at like 4 [p.m.]. Well, most people work the night before and night of, so I don't know, it just seems like they don't really take into consideration your night shift people. (Phoebe)

**Curriculum gaps.** In the final interview question regarding possible curriculum gaps, participants were asked what they would want nursing schools to know about the preparation of new graduate nurses in a CAH. Responses ranged from suggestions about concept-based curriculum, i.e., starting content from infancy in the beginning of the lifespan all the way to aging adults in the later part of the lifespan, to advice for students. Most participants emphasized that the more hands-on learning experiences and clinical hours in school the better, especially if the clinical hours could actually be completed in a rural hospital setting. Madelyn was one of these participants:

First of all give them as many clinical experiences as possible because they're going to be...I don't know how most critical access hospitals work but at least in the ones around here, they're going to be several different departments. Um, and so I think it's important to have a range of clinical experiences, as much clinical time as possible, because once you get out there on the floor you realize there are



some things that you have to do very textbook, but there is a lot that is on the fly and coming out of the box with ideas, and interventions, and so I think it's important that nurses be prepared for that and not be too focused on the textbook knowledge, which definitely, I mean, don't get me wrong, is very important (smiles).

Madelyn also reflected on an experience early in her time as a new graduate nurse when she felt like her preparation was not enough for what she encountered on the job:

Well there was like one instance that I can think of right now, was, we had a patient present to the ER and she was having seizure-like activity, and we got her into the trauma room and we were trying to get her airway stabilized, and we had to get her into CT. And then in the CT room, the suction, we needed suction, and it was not hooked up properly (tone raises, as if asking a question). I guess the radiology tech had hooked it up wrong. Well, being a new graduate nurse, I did not have experience with suctioning in our clinicals. I felt like our clinical experiences were pretty limited, because we're in a rural area. And, so I did not know how to properly connect that suctioning. And the tubing wasn't long enough, and I felt like there should have been longer tubing available. So it really stuck out to me and after we did a debriefing, I asked for training on the suction so that that would never happen again. But I just kind of felt like as a new nurse, "I should know this," you know, "why don't I know this?" and so part of it just goes back to the, you know, the clinical experiences that you're able to get and the orientation that's provided by the facility.

Participants such as Michelle thought just the mere exposure to the clinical in a rural setting could help show students the differences in available resources in nursing practice:

I definitely think that there needs to be like a lot more hands on, um. So, I think that there would be cool if nursing schools could you know you have all your basic clinicals, but if you could almost just, offer even like a short clinical if you could find like let's say, I know not all nursing schools are close to like a rural hospital but I think it would be really cool for nursing students to have some sort of, um, experience whether it be a day or shift or, a weekend or whatever in a rural setting just to be like, "Wow, this is what you have? This is what you...", you know? Like, "Oh you -can't you just call pharmacy?" "No, you can't do..."—just to get a taste so they're like, "wow", cause I feel like all my training was in very large hospitals and then you come to this and it's like, "Oh yeah, you can't" ...it's not just at our fingertips, it's not just like a call or it's not just, "Hey, someone go do this"--it's you. You know? And so I really think it would be cool just to do some sort of rotation in smaller hospital even if it's like, I feel like even if it's a 40-bed unit, you know. I mean we only have 20 is our--somewhere around there, but even if it's somewhat smaller you know just cause you don't have those resources and I think it would be eye opening for them to see like, "No, I can't, I have to rely on myself and my coworkers, I don't have those resources," you know? It kind of makes you a better nurse really 'cause you have to think of all those things and know how to do them for yourselves versus having someone else do them for you or whatever.

Abbie said all she had was education in CAHs for her clinical hours, which was very helpful for her post-graduation plans although she acknowledged not everyone would work there: “So I feel like definitely any school needs to have some sort of rotation to a critical access hospital”. Leah also had regular exposure to rural care settings in the curriculum of her nursing education and thought that showing what CAHs had to offer was important:

I got to kind of stay around all of the rural areas and I got to do a lot of clinicals in the rural settings, but I think something that maybe needs to be kind of touched on more in schools is the critical access kind of hospitals and what they all are to offer? Because they're not just little hospitals. We do a lot of things in critical access hospitals, especially for communities. Um, especially with the ER. Our, ... you don't really get that touched on when you go to clinicals in bigger hospitals because they're all broken apart (in units), um, and I think some more time with skills and techniques to kind of master those in nursing school would be great (smiles), so then when you get to the real world, you're more apt to um, be more competent, in those skills and techniques. And, um, I think just more kind of learning about the communities where critical access hospitals have to offer, so that more students know what is really beneficial to working in a critical access hospital, because, I know um, a lot of my classmates wanted to go to [names of two area bigger cities] because they're just bigger, they have more to offer, but critical access hospitals they also have a lot to offer. Um, they just kind of offer it in a different way.

Jim felt similarly that helping students know what it is really like to be a nurse in a CAH could be an eye-opening experience as was in his case. He felt rural nursing might get “kind of a bad rap” in the midst of other considerations for job placement and plans for starting nursing careers:

I came away feeling like if I was, a hiring manager at a hospital, a larger hospital in the city, I wouldn't be shying away from hiring a nurse that had previous experience in a critical access hospital, because if you work in that, uh, setting, you've seen a big variety of things, more than you're ever going to see on one specific floor in a larger hospital, and typically working with less resources. So, I don't see how that's a bad thing. So anything that a nursing school could do to kind of promote the idea, because they're needed; those nurses are needed. Yeah, I think, I don't know if other nursing schools, go, you know, make a point to give rural experience like [his school did], but they should.

Mary did not have a CAH rotation at her school and really wished they would implement something like this to give variety to their clinical experiences:

I think there should be more clinical in rural settings. My program did not have it as a requirement. Um, but I know some like [named program] I know they do require at least one, like two, like a weekend shift, and I think that kind of helps open up eyes a little bit. Um, I think it'd be good for...them to realize like you're not gonna have many staff to pull resources from so like learning how to define resources other than other nurses like Lippincott's or stuff like that.

Again, the mention of flexibility was brought forth as well if not mentioned previously by participants in a response about important characteristics for a new

graduate nurse in a CAH. Jim reflected, “I would say that would be the number one thing just because, when you are a new grad you really try to, well you, you’ve been conditioned for a long time to do everything exactly by the book.” Wayne also shared a comment about these differences: “There is straight from the book learning and how things go and then there’s the real world. And kind of knowing a little bit more what to expect when you get out there.” Participants such as Phoebe concluded that nurses would never stop learning:

When you go to nursing school and you learn the abundance of information that you learn, you will never stop learning and I don’t think that they can preach that enough...When I was going to school I was so focused on, I need to learn this, I need to know everything. I need to, I want to be the best nurse I can be, you know, I graduated with a 4.0, and even though, really no employer’s gonna ask you what your GPA was, to me it meant a lot. But still, I came out and I was like, “I don’t know *anything*”. You learn as you go, so to know that, you’re not going to be great at everything I guess, is probably the most important thing I learned.

Madelyn’s comments were made on a similar note, confirming new graduate nurses in a critical hospital setting need to balance humility and carry themselves with confidence. She also commented that a customer service attitude was always important in nursing and in reflecting positively on the hospital:

The first biggest thing I think that is important is to realize you don’t know everything and be willing to ask questions and learn. Um, I feel like there are some nurses that come out of nursing school feeling like they’re on top of the world and they know what they need to know. I was kind of the opposite. I feel

like I'm smart enough to know, I know just barely the tip of the iceberg, of what all is involved in nursing. Um, so I think that's important is to be humble and to be willing to ask questions. You also do want to have a sense of confidence in yourself. I do think that's important because the patients are going to feel that when you walk into a room. So even if you have to fake it, y-- it's important that you radiate that confidence.

Laura summarized that in any experience or any department in nursing school or training, it is important to seek out learning experiences and be engaged as much as possible to help promote success in the future. Jennifer shared similar sentiments, encouraging new grads to be open to different aspects of nursing as sometimes nurses think they know what they want to do and later end up not doing that at all. Michelle also encouraged an open mind, especially creativity for those nurses working in a rural setting:

Just because you know you might not have, like, you know, I can't call pharmacy and be like, 'Hey bring me this.' I need to be able to go figure out how to get that and make it happen, you know so, or like if we don't have...I can't think of an example off the top of my head, but if we don't have a certain tool or whatever that the doctor may order even if he knows that we don't have it we have to kind of, I guess troubleshoot and think of something so being creative is, you kind of have to be.

Wayne reflected on his experience and acknowledged the role transition from a nursing graduate completing coursework and passing the licensure exam but beginning again as a novice nurse: "Just know that, school is done and your boards are over,

congratulations, but the learning hasn't stopped, and never will." These participants all seemed to reflect on the fact they had embraced the expert generalist expectations of new nurses in CAHs but at the same time, embraced the fact that lifelong learning was a part of the nursing profession. Critical access hospitals could be a great environment for new nursing graduates if graduates gave them a chance. Leah encouraged an open mind and reinforced that individualized learning opportunities were available:

We are just like, bigger hospitals, we can still do surgeries, um, we do hernias and gallbladders and scopes, there's just so much to offer in a small town hospital and definitely being around the community is a great benefit and stepping stones being at a critical access hospital.

### **Summary**

This chapter described the findings of the study in terms of the six primary themes and their subcategories. A description of the participants was provided in a table with demographic data and participants' responses were illustrated through use of direct quotations and conclusions as they were asked about their experiences in interview questions from the semi-structured interview guide. Chapter V discusses the findings as they were interpreted by the researcher in comparing and contrasting them with existing literature. Recommendations for research and practice are also discussed.

## CHAPTER V

### DISCUSSION AND CONCLUSION

#### Introduction

This study sought to explore the lived experiences of new nurse graduates in their first year of employment in CAHs within the Midwest region of the United States. This research involved 13 nurses working regularly as new RNs in CAHs within 1 to 12 months of experience. One-on-one interviews were used to encourage participants to share their stories and suggestions to support the role transition of new graduate nurses in rural hospitals.

The significance of this study lies in the dearth of literature available regarding new nurses in rural and CAH settings. As the researcher corresponded initially with nurse administrators to disseminate recruitment flyers in facilities, positivity and support were conveyed for the development of new literature on rural nurses and their needs. Directors and managers were very interested in hearing the outcome of this qualitative research. Most studies were focused on the experiences of new nurse graduates in urban facilities. It was necessary to add to the body of knowledge to guide the support of nurses and their professional development in rural care settings as well in the effort to maintain quality nurses on staff. Since the volume of new hires and the availability of resources could be different amongst urban and rural settings, it was important to gain knowledge of the meaning of these first-year experiences as well as what the participants



voiced as concerns or additional needs in rural nursing. The diversity of skills and competencies needing to be maintained was also important as CAHs often care for a variety of needs and diagnoses rather than staffing nurses in a single specialty department such as in an urban hospital. As one participant stated,

Being a nurse in a critical access hospital is something very different from being a nurse in a bigger hospital because in a critical access hospital, like where I work, we do acute care, um, skilled care, observation, plus we have an ER that's open 24/7 that we work with...we do have some nursing home residents and, um, we do a lot of outpatient treatments. We also have an outpatient clinic that comes around and we do surgeries. Um, so, getting to be diverse in all of that is really unique for being a critical access hospital.

The results of this qualitative, phenomenological study might help to create a change in some practices lacking structure or to reinforce those practices that are working well in orienting new graduates in CAHs. In the educational setting, these findings might help guide curriculum decisions about clinical hours and prospective learning sites as well. While the first chapter of this dissertation discussed the background and issues supporting the need for this research, the second chapter presented available literature on new nursing graduates and factors such as recruitment and retention that tied into rural nursing needs. Chapter III provided details on the methodology of the study and Chapter IV shared the findings. This chapter summarizes the study findings with discussion and conclusions with implications for practice and recommendations for future research.

## Summary and Interpretation of Findings

### Theme One: Always a Professional

As the Always a Professional theme was discussed in the previous chapter, the discovery that participants felt universally identified and accountable as nurses emerged amongst all conversations in some manner. This could be a complex situation, requiring some nurses to spend considerable time and effort in adapting in this role transition, especially if they were not anticipating this identity element upon accepting a position in a CAH. For other nurses more familiar with their community of employment, their introduction to the new identity might have been more incremental and gradual based upon their understanding and familiarity with small-town culture. This was often the case for those working within the hospital setting in another healthcare role or in the LPN position prior to obtaining their registered nursing license.

To some of the participants, the expectation of constant role-modeling for the public's perception of professional behaviors seemed overwhelming and uncomfortable. This was communicated especially as they shared stories about being nervous or paranoid about what might be in their shopping cart for personal items or how they might be perceived when they are in a social setting with friends, possibly involving a setting such as a bar. As Phoebe shared, she did not see it as a hindrance but rather something that always crossed her mind in being aware of the culture of small-town environments. Other participants spoke of trying to avoid certain settings or situations altogether in an effort to not encounter patients they might have cared for in the past. Although it only arose in discussion with one participant (Madelyn), the issue of posting information on social media and seeing colleagues posting was something that could also be

uncomfortable. Although no HIPAA or privacy violations might be made in these types of posts, nurses must give thought to the potential for information to be seen by friends of friends or others in the community, providing a window into personal lives that occurs online versus out while running errands in the community.

Taking into account that these nurses felt they were always “on guard” as professionals, it would be important to continue to assess the perception of an acceptable work-life balance and self-care as perceptions of these might be tied to their new positions in CAHs. This key concept would be a comfortable acceptance of the new professional identity and role and not necessarily the number of hours on the clock as typically comes to mind in a discussion of work-life balance.

As nurses are recognized in their communities as a professional registered nurse, they feel respect and reverence from others for the work they do. This can be very meaningful to CAH nurses as Sally agreed in her interview. Mary expressed awe in feeling like she was put on a pedestal in joining a community (or local area) where her spouse had connections but in which she was a newcomer. Phoebe had strong ties to her local community as it was where she wanted to stay and raise her family. She discussed the respect she and her fellow nurses had in her community as well. The feeling of being respected likely tied into thoughts about job satisfaction and job embeddedness for these nurses.

In other literature, support and respect perceived by rural nurses impacted choices to stay in nursing jobs. Smith and Vandall-Walker (2017) conducted a qualitative study amongst 14 rural communities across the Alberta, Canada province with 12 new nurse participants ranging from one month to less than two years’ experience. The primary

questions the study sought to address were “What are the experiences of new RNs transitioning into the rural acute care environment” and “How do these experiences influence recruitment and retention?” (Smith & Vandall-Walker, 2017, p. 3). Similar to this current study, their 12 participants cited their reasons for choosing a rural hospital for employment as (a) growing up rurally, (b) their partner’s work, (c) current rural residence, (d) a lack of urban jobs, and/or (e) the draw of autonomy. Those nurses who chose to stay in their job often cited the feelings of support in the workplace, the people and the small-town feeling, work schedules, and a preference for rural living as influences.

Smith and Vandall-Walker’s (2017) participants referred to their role transition as a “huge learning curve” and “emotional roller coaster” with fluctuations often dependent upon the support from their peers on the healthcare team (p. 4). In the current study, the participants spoke less about the learning curve but did voice need for emotional support. In a different approach than the current study, Smith and Vandall-Walker used an explanatory model of a “double whammy,” which consisted of the combined considerations for “I’m a generalist” and “I’m it” (p. 5). “I’m it” referred to the sense of responsibility acknowledged by the participants but they spoke less about their sense of identity amongst those two intersecting areas of the model. The participants in the current study seemed to acknowledge the need to be an expert generalist and situations where autonomy and responsibility could be great.

In the book, *The Rural Nurse: Transition to Practice*, Bushy (2012) compiled a list of the characteristics of rural nursing gleaned from past scholarly work citing Bushy (2009), Hurme (2009), Nelson (2009), and Winters and Lee (2010). The “lack of

anonymity” and nurses being “viewed as a professional role model” were two characteristics that closely matched the findings from the 13 participants in this current study (Bushy, 2012, p. 7). Bushy (2012) went on to describe how nurses are highly esteemed in rural communities and often viewed as local experts for health-related questions, which also corresponded with the current study’s theme of Personal Connections and statements shared by participants such as Marie and Leah regarding being approached for health advice. Bushy (2012) described the enjoyment some rural nurses had in the quality of life in rural communities and the enjoyment of the social status and recognition of being a nurse in a small community. This might create the perception of satisfaction and job embeddedness for rural nurses.

Reitz et al. (2010) discussed the importance of nurses’ perceptions in relationship to their satisfaction level, job embeddedness, and contributions. In their article, they reported the intent to stay in a position tended to be greater amongst nurses as their ages increased, which could parallel years of experience in the position as well (Reitz et al., 2010). The participants in the current study were not asked directly about the concept of job embeddedness but discussion on the recognition of the immediate and constant identity as a professional registered nurse might connect them into their workplace culture more instantly as a new graduate nurse versus nurses in urban settings. This might leave room for further exploration of the concept of job embeddedness specifically in CAHs and rural communities.

### **Theme Two: Personal Connections**

Participants in this study spoke of the personal connections that resulted naturally from living in the same area or community as their patients and families. For most of the

participants, this could be described as a lifestyle preference wherein they chose to accept a job and reside in that area. Some returned to communities they were raised in and others chose nearby or similar communities. Others did not anticipate finding a job in a CAH, such as Leah or Mary, but reflected on how they felt it was just the right fit. In some situations such as Michelle's, she spoke of being known first in the community as someone's family member—a child and a grandchild of other residents. She felt this pre-established personal connection held her accountable for providing excellent care now as she worked as a nurse, prompting her to “step up my game that much more.”

Some participants described how they commuted into the rural community in which they worked. They might not feel the strength of the connection with their patients as did those nurses residing amongst them locally. They might commute from a nearby small town without a hospital, might reside on a farm, or even live in a nearby larger community but sought out the facility due to personal reasons or preferences such as prior experiences. In speaking with Jim, a commuter, the difference in residence created a boundary that lessened the weight of some of the hard situations or high expectations out in the community when nurses were seen by former patients. It could also mitigate some of the difficult situations nurses encountered when they were asked directly about trauma cases or their presence in caring for known individuals or family members as protected health information and HIPAA laws must be followed.

Participants who spoke about the ability to filter information, especially as a small-town or rural area nurse, demonstrated a level of integrity they recognized as essential to their professional role. This also linked back to the theme of Always a Professional identity as a nurse. Jennifer shared how important it was to her that

community members knew she was not going to share their personal information. This was part of the complexity of the professional social identity that emerged from conversations with participants. Similarly, the participants in the Smith and Vandall-Walker (2017) study discussed being guarded in what was shared in terms of news traveling fast in the community and in challenging attempts to maintain client-nurse boundaries.

Observations of nurse behaviors on personal or social time might be perceived by the general public as a question of straying from the standards of confidentiality or code of ethics upheld by nurses. These nurses might feel they have always internalized responsibility in their work regardless of where they are or what they are doing but a disconnect could exist. For this reason, the participants felt they needed to always be aware of their surroundings and make choices accordingly--to not project an image outside of being professional at all times and losing trust in the public for future care.

The sub-category of Need for Emotional Support arose as participants discussed that helping known people in their community so intimately required a form of debriefing or an opportunity to feel their colleagues were with them in support and in shared experiences. Caring for loved ones, neighbors, or former classmates on a routine basis and not always observing closure or progression to wellness could be difficult and might require a degree of mental and emotional strength. This was recognized in talking with participants such as Alicia as she shared her experiences.

However, even if CAH nurses do not live down the street or in the same community of the hospital in which they work, opportunities still exist to develop a unique rapport for patients and nurses in CAHs. Diagnoses and care situations that

require ongoing treatments or visits help to naturally develop a rapport and a continued nurse-patient relationship over time that can also enhance any new personal connections built in CAH nursing. Further, this provides an opportunity for all critical access nurses to assess for new areas of coaching and education throughout the care provision such as Leah discussed when she reflected on having both empathy and a “backbone” in caring for her emergency room patients. This sense of purpose was gleaned from the stories of the participants who desired to improve the overall health and wellness of community members and avoid problem-based return visits and readmissions. These nurses were aware of the livelihood and lifestyles of their fellow residents who often valued functionality and work ethic to support sustained, independent residence in a rural area. Thus, this awareness could help improve outcomes for return to productivity and mobility with a shared mission for holistic wellness amongst CAH nurses.

### **Theme Three: Pride in Work and Community**

As participants shared their experiences regarding their role and service to others, the words “proud,” “honored,” and “rewarding” were frequently associated with prevalent personal connections and recognition in the community. As nursing is a service profession, it was not unusual to hear participants discuss the importance of service in their nursing role. In CAH settings, this seemed to carry very special meaning as a result of the intimate connections and relationships developed throughout the communities. This standard of excellence and trust must be maintained in staff within one of the only care facilities in these areas. In turn, registered nurses reach the humble realization that the autonomy of critical access nurses facilitates a special opportunity to provide leadership in care and improve outcomes within their scope of practice. Participants and



citizens alike are aware of the importance of CAHs within their communities. The loss of services or the threat of CAHs closing around the United States related to funding issues could have ripple effects on the local economy as well as the ability to retain other professionals in the area and the overall health of the community (Bushy, 2012).

Although hospitals are structures themselves, the skilled providers, nurses, and ancillary staff are representative of an integral service provided to the community.

These nurses take pride in maintaining competencies and desiring to learn more, even within their first year of practice, to be ready to care for all patients. Participants often cited serving their local community as a reason to stay in the job or as a reason to persevere through new challenges or learning situations. “Giving back” was so important for those participants familiar with the area and working in their hometowns. For example, Leah and Madelyn enjoyed being able to demonstrate their professional identity as nurses in the workplace while balancing the identity of being another community member’s loved one. It created a special acknowledgement of their progress in their careers and their willingness to return and serve.

#### **Theme Four: Always on Your Toes**

The statements of study participants’ experiences aligned with another Midwestern nursing research study acknowledging that nurses in rural facilities must be skilled and ready for a variety of situations including the ability to triage and stabilize patients for transfer (McCafferty et al., 2017). It is not uncommon for nurses in the smallest CAHs to “do it all” in the course of a single shift--from medical-surgical or post-operative nursing care to monitoring a laboring patient to covering the emergency room or assisting a coworker there. Some CAHs are just large enough to consider the

emergency room as a separate department where cross training is an option and the need for staffing or floating might be more deliberate. Regardless, these nurses know versatility and switching roles are parts of their everyday workload as a new nurse. They expected their confidence level to increase over time but they acknowledged they did their best at times where it was necessary to just jump into a situation and provide care. On the job training was something expected and was acknowledged by the participants as they commented that nurses are lifelong learners. In a similar study by Smith and Vandall-Walker (2017), the findings of “learn on the fly” and “change hats” tied into this area of readiness and on the job training discussed by current study participants.

Despite the feeling of sometimes being nervous about whatever came through the door, such as in the emergency room or with a laboring patient, participants seemed diplomatic and accepting of their roles and in acknowledging they were comfortable calling on available resources. An understanding existed that these resources might be one or two other individuals on shift, or perhaps a manager or provider on-call, but they made the best choices they could in times of need. Participants remarked it was both exciting and scary but with greater exposure, these instances of acute need did not seem so daunting. The participants did not particularly discuss their stress levels or becoming stressed in these instances, which was a bias the researcher held originally prior to beginning the study. The researcher felt these participants might discuss more stress and role insufficiency in their experiences than what was shared in reality. In fact, the word “stressful” was only mentioned by one of the participants (Laura) in describing the beginning of her experience but she was quick to advocate for the emotional support provided by her coworkers to diminish her initial stress.

Bratt et al. (2014) also showed that in a quantitative longitudinal study, rural nurses had lower job stress and higher satisfaction rates than did urban nurses. The Bratt et al. study was quantitative with sampling from only one state (Wisconsin) so the methodology and sampling differed from the current study but a parallel existed in looking at the subjective statements of the 13 participants from three states. A quantitative or mixed-method measurement in a larger group of rural nurses might be able to further validate the findings of both of these studies.

### **Theme Five: Everyone Works as a Team**

As participants described their lived experiences in working as a team, words like “family,” “close-knit,” “tight-knit,” and “awesome” were utilized. Michelle acknowledged that knowing the strengths and weaknesses of team members was an important point, which allowed the nurses to make the best judgments about delegation and resources in times of need. Alicia stated, “You’re not on your own, ever” though the fact that CAHs might be staffed with only two to three nurses at times might be daunting to others. Michelle enjoyed reflecting on her cross-training and the need for rural nurses to be creative and resourceful. She shared how creativity and teamwork might be needed to carry out a particular physician’s order with limited resources or how the nurses worked together to obtain, titrate, and verify dosing on appropriate treatments from the hospital pharmacy area in times of need. She commented on how urban hospitals differed in that manner with a complete reliance on other departments.

In the current study, participants had between 2 and 10 months’ experience and on average 7.5 months of work in their registered nurse position. The value of peer or coworker support was discussed by nearly every participant. In a different Australian

study that tracked nursing students from pre-employment to six months on the job, themes such as peer support, confidence, feelings of a lack of support, and “being thrown in at the deep end” were major findings from the interviews conducted by Kelly and McAllister (2013, p. 172). Those participants perceived the more experienced nurses to be less available for support, creating the feeling of being “thrown in at the deep end” (p. 172). While three of the current study’s participants mentioned feeling “thrown in” or similar sentiments, explanation was usually given in relation to length of the orientation process or trying new areas such as obstetrical care rather than feeling a lack of support from experienced nurses. In fact, Abbie, Alicia, Phoebe, and Wayne each often praised the support of the more experienced, older nurses and reported they were highly approachable. As a backup source of support, newer nurses used a team-based approach to get through difficult situations if experienced nurses were not available. The value of peer support was an area that was similarly discussed in both research studies.

In comparing the findings of this study to themes from Martin and Wilson (2011), *Adapting to the Culture of Nursing and Reality Shock: The Journey Toward Adaptation* were not as widely discussed as the theme of *Everyone Works as a Team*. This would align best with their theme of *The Significance of Relationships to Adaptation*. Interpersonal relationships and the family feeling in the CAH setting can be so important to the care team. The participants in this study acknowledged the importance of working together and leaning on one another; Wayne reported that without having one another’s backs, “then the whole night can fall apart rather quickly.” In the mixed-methods cross-sectional study from Parker et al. (2014), their participants felt their highest level of support came from other nurses, which was similar to these new findings with the least

support from other professions in the workplace. While few other professions were mentioned from the participants in this study, all participants named their fellow nurses as sources of support and two discussed the lack of support or perceived support from administrators as well.

As Marie described her frustrations with not always being able to contact the administrative nurse or director when they had previously stated they would be available, this created tension and mistrust. Wayne enjoyed acknowledgement in the hallways by hospital administrators and the opportunity to share feedback in his initial months but Phoebe expressed that in working on the night shift, she and her coworkers rarely had an opportunity to hear from or be acknowledged by administrators. The timing of other scheduled work-related activities for all registered nurses on staff, such as staff meetings, was not ideal for their night shift work and sleep hours. In an Australian qualitative case study, Lea and Cruickshank (2017) reviewed the findings of rural new graduate nurses at three, six, and nine months into the job and suggested nurse managers should be prepared to provide more support and role modeling. As Marie discussed, role modeling and follow-through in times of staffing need can be so important in creating perceptions of trust and approachability. No stories of horizontal violence were shared by any of the participants in this study, contrasting with those reported in another Australian study from Parker et al. (2014) that explored new nurse graduates' perceived levels of support through focus groups and online survey data. Parker et al. utilized mixed methods as the focus groups enriched the data from the 282 online nurse graduate respondents. Although the Parker et al.'s study respondents also reported their peer nurses to be the greatest source of support, such as in this study, it included both urban and rural nurses in

the sampling procedures. The study from Smith and Vandall-Walker (2017) also made mention of the value of support amongst peers but highlighted that one participant had already left her position in a CAH to move to another due to the experience of being bullied by more experienced or senior nurses.

The feeling of connectedness seemed to be a factor that influenced first-year retention. While several of the participants discussed what made them stay in terms of location or pride in serving their communities, no mention was made of a desire to leave this type of nursing work or the current positions. Interpersonal Working Relationships and Personal Investment in Coworkers emerged as sub-categories of this fifth theme. This finding was similar to findings in a cross-sectional survey by Laschinger (2012) who revealed for both first and second-year nurses, there were low intentions to leave the current position and high satisfaction levels with choice in nursing career. The random sample from the Laschinger study was from an Ontario, Canada nursing registry. It is unknown if rural nurses were represented in the sample but we do know retention in first-year nurses is still reported as a widespread issue and the loss of nurses in rural settings could result in dire situations (Kovner et al., 2014). It was refreshing to see it was not a concern amongst the 13 participants from the rural hospitals in this study. The Laschinger study found when nurses were more satisfied with their initial orientation, they were less likely to leave their jobs. As a result, this researcher asked the participants about their perceptions of the adequacy of their orientation as well, which is discussed in the sixth and final theme.

## **Theme Six: Essential Preparation Experiences**

In beginning this research study, the researcher did not expect CAH nurses to report being part of a nurse residency program as those are largely developed for urban facilities with a high volume of new graduate nurses. However, all hospitals are targeting strategies toward some of the same issues—recruitment and retention of nurses. One article in the literature review showed that out of the nurse executive survey respondents in the study, 15% of those reporting a nurse residency program in place were identified as rural hospitals (Pittman et al., 2013). However, none of the participants in this study referenced their orientation process as a “transition program” or “nurse residency program.” In fact, one participant (Jim) voiced his preference for not participating in a long-term residency program in his first year of practice in the CAH setting as he was familiar with peers in a structured orientation in a larger, urban hospital. He desired the independence of being mentored at a quicker pace as an individual and was comfortable with any on the job training he encountered. He was excited about the fact that he might be able to take some additional certification courses needed for his position more quickly than some of his peers in an urban setting.

Prion et al. (2015) discussed that creating structure in new graduate orientation is especially of benefit to nurses but Sedgwick and Pijl-Zieber (2015) noted this type of support might be lacking in rural facilities or CAHs. Lack of structure seemed to be the case in the conversations with participants of this study. The responses from the participants when asked about the adequacy of their orientation resulted in both “yes” and “no” with suggestions to follow. Those nurses with experience in the facilities might have felt more comfortable with supply

locations and workplace culture but did not want to be overlooked in the introduction to how their workload or scope would be different as a licensed registered nurse.

They reported that assumptions were often made about their knowledge and comfort in everyday registered nurse workflow and processes. Some of the participants who were brand new to their facility acknowledged a previous preceptored or intern experience through their nursing education made all the difference and practically doubled their “orientation” time as they counted it as an element of their orientation in reflecting on the experience overall. Yet for others, weaknesses could be found in reporting that two to three weeks might not have been enough considering time was spent in general orientation processes or classroom time. They shared the true need rested in the time working hand in hand with other nurses before feeling they were ready to be on their own.

What is the ideal orientation length for a new CAH nurse? The results of this single qualitative research study could not be considered conclusive; however, most nurses voiced that around three months was both average and adequate so this is something for hospitals to examine. Within the three months, what occurs as “orientation” could in fact be very different in content and structure. What is important is the perception that it *is* structured in some manner. Sometimes the act of signing off on a particular skill or process was not as meaningful as intended if the emphasis was more about timely completion of a checklist rather than true assessment of the new nurse’s confidence or a partial overview of a process or competency. Recognition of learning styles could be important to note as well as many of the nurses commented they were more hands-on learners. Although meant for and



generated from an urban hospital, Maryniak, Markantes, and Murphy (2017) offered some guidelines for hospitals to consider during the first weeks of new nurse orientation. They acknowledged orientation might begin naturally with getting accustomed to the care of inpatient medical-surgical patients and the flow of a care shift for those patients without adding in some of the extra needs requiring switching roles and versatility. Maryniak et al. (2017) began with new nurses being placed on a New Employee Training Unit before being transferred to their “home” unit of hire, which was helpful due to standardization and familiarity of environment for the new nurses. In rural hospitals, this would not be possible but the timing of introduction to other opportunities such as surgery, emergency room, outpatient treatments/clinics, and OB services might vary greatly within hospital sizes that all meet criteria for CAHs. This area requires some individualization but one important point taken from Maryniak et al. (2017) was the value of regular check-ins with nursing leadership and online follow-up evaluation opportunities at 30, 60, and 90 days.

While it might seem like an investment to prolong orientation or provide additional face-to-face time, nurse administrators might consider the implications on patient outcomes. If administrators feel confident in the retention of their nurses, what other factors might be impacted by listening to the needs of new nurses and structuring orientation differently? Does the placement of additional training such as Advanced Cardiac Life Support (ACLS), Neonatal Resuscitation Program (NRP), and Trauma Nursing Core Course (TNCC) make a difference in how prepared nurses feel when there might be few on shift and a trauma comes in? It might be an investment of time and budget up front but the dividends might result in a smooth workflow and

optimal staff communication during critical situations within the first year of employment for these new graduate nurses. Either way, a timely assessment of readiness might help with scaffolding learning experiences as new nurses feel ready to take on more. Some of the participants in this study also mentioned that gaining awareness of facility policies and procedures was a concern as most of them were coming from an extremely structured nursing education experience where a review of policies and procedures was a regular step in preparing for any intervention or anticipated skill in nursing care. In rural facilities, these resources might not be as readily available or are indexed within large binders that were said to be cumbersome or incomplete. A discussion of expectations would be helpful to alleviate concern or streamline processes the participants named as needing improvement.

Statements from participants in this study aligned with findings of knowledge, skills, and environment as major themes from new graduate nurses in rural Florida within the phenomenological study by McCalla-Graham and De Gagne (2015) whose participants were employed in two major healthcare corporations, differing from those in rural healthcare facilities. Participants in their study did not feel fully prepared for the demands of their new nursing position and wanted to feel better prepared for “worst case scenarios” (McCalla-Graham & De Gagne, 2015).

Likewise, the participants in this study desired the same level of preparation but they also acknowledged they might never know what comes in the door and they would have to be ready to rely upon resources and do their best. This ability to switch roles echoed findings previously mentioned by Bushy (2012).

One difference between the current study and that of McCalla-Graham and De Gagne (2015) was McCalla-Graham and De Gagne's participants emphasized inadequate staffing issues amongst the discussion for their environment theme. Participants in the current study seemed to accept the gravity of their responsibility in their ability to quickly grow comfortable with a different staffing structure and the need to be versatile in skills and competencies by helping wherever needed in times of acute need. Participants in this study did not discuss staffing in terms of a temporary problem but instead seemed to have an understanding that in the midst of teamwork and careful scheduling, their needs were met. No participants spoke of existing vacancies causing concern but one participant thought some nurses' behaviors were more tolerated than they should be in order to retain all nurses on staff as vacancies could be hard to fill.

The findings of this study differed from those in Parker et al. (2014) stating that development opportunities were lacking. When professional development opportunities did arise in discussion under the theme of Essential Experiences, participants such as Abbie and Wayne discussed employer support for continuing education. In addition, Phoebe was appreciative of opportunities and speakers brought in-house for professional development and training. This might validate that their administrators, as members of a rural community themselves, are in touch with the needs for nurses in terms of convenience and timing as employer support of travel to professional development opportunities could require staff to be away from the bedside and other considerations for staffing needs.

In answering a final interview question about suggestions for nursing programs on the development of nurses for the rural care setting, participants voiced their ideas about possible curriculum gaps. In some nursing programs, the majority of clinical experiences are provided through CAHs, such as in Abbie's case, but for several programs, urban facilities are the primary location for clinical experiences in order to accommodate the volume of students. Especially in urban communities with more than one nursing school, programs and colleges must work together to coordinate clinical experiences and also create clinical learning experiences through simulation. Some schools found the opportunity to provide a brief experience designed especially for exposure to a rural facility. Others did not include this opportunity at all, which was a strong suggestion by most participants in the study. They felt stereotypes and stigma about rural facilities could be lessened and more graduates might be open to CAHs if they were just able to experience the nuances and see what the hospitals had to offer. While not every new graduate would choose to work in a CAH, especially if it requires relocation away from loved ones, they might appreciate the pace, the support, or the feel of "family" amongst their coworkers. In all, they received a global perspective on access to resources--both from a patient-based lens and a nursing workflow lens.

Simulation might be an answer to providing further hands-on experiences as many participants recommended (as many clinical hours as possible); however, simulation activities are usually scenario-based and it is difficult to recreate the experience of being in the actual setting of a CAH without considerable planning and a lengthy simulation scenario. This was not something that came to mind in

suggestions for nursing schools from the participants. They felt strongly that being in the CAHs themselves could be eye-opening for nursing students. As they realized upon beginning their careers that not everything in practice was “by the book” as learned in school, this experience could also give students a preview of “real life” with the ability to test out autonomy and critical thinking under the wing of rural nurse preceptors.

### **Essence of the Phenomenon: Always a Professional**

The essence of the participants’ experiences evolved from each one-on-one interview and was revealed through several comments about identity, pride, a rewarding job, and the universal perception that within their communities, they were viewed as Always a Professional. This could be interpreted as either empowering, limiting, or a recognition of both depending on the way participants chose to answer interview questions about what it was like to be a new nurse in a CAH and how being an RN in a rural community impacted their personal identity. However this identity might be perceived, it represented a type of accountability for excellence as an individual even in the social environment. All participants in this study shared their own feelings about personal identity in the community and how the perception of others influenced social encounters, introductions, and even participants’ feelings about their own behaviors. For these CAH nurses, personal identity and professional identity coincided in their everyday lives.

### **Theoretical Implications and Interpretations**

This phenomenological study was grounded in Husserl’s (1931) ideas on the focus of description in learning about the meaning of these new nurses’ experiences and

identifying the essence of the phenomenon (Crotty, 2013; Giorgi, 1997; Norlyk & Harder, 2010). The methods were explained in detail within Chapter III. Interpretations of data through the selected nursing theories are now discussed.

In revisiting the theoretical framework for the study, Benner's (1982) novice to expert theory is well-known in framing the process of skill acquisition for new nurses. Nursing students and newly-licensed graduates move from *novice* into *advanced beginner* and then to *competent*, *proficient*, and *expert* in their skill acquisition. The implications of this study might indicate rural nurses perceive they are expected to progress through these five levels of proficiency at a quicker pace than other new graduate nurses. This might be due to the fact that staffing levels could be minimal at times or providers are not in-house but "on call." This leaves rural nurses to draw on their assessment skills to properly triage and begin orders and treatments for patients, especially in emergent situations or in the transfer process inherent to CAHs. One of the nurse participants in this study discussed using her intuition, which is described typically with the progression to Benner's *expert* stage.

A primary question asked participants what it was like to be a new graduate nurse in a critical hospital setting. Although some of the participants chose to mostly describe the types of patients they saw or the skills they had practiced, the majority of participants provided a global view that connected many of the themes identified in this study. They discussed their orientation process and some of the necessary components such as policy and procedure review and general orientation procedures as something to get past but with true interest in getting a feel for their care environment with familiarity for supplies and resources so they were ready to launch on their own. The autonomy of CAH nurses

was something these participants were well aware of upon beginning the job but something they felt might be overlooked by nursing students in exploring career options after graduation.

The Meleis (2010) transition theory was selected to frame the research study and interview questions related to role transition from nursing student/graduate to professional identity and employment as a registered nurse. Some nurse participants, such as Abbie, who were already LPNs and working within the same facilities, felt comfortable that they continued to learn on the job without a structured, formal orientation. Other participants, such as Sally and Phoebe, voiced suggestions to improve their experience and add more depth to their learning in the transition from LPN to RN within the familiar setting.

Many of the participants, however, were not already in nursing roles prior to their hires as registered nurses and instead were figuring out their identities and professional roles all within the timing of their hiring and orientation. As the Meleis (2010) transition theory was developed to help facilitate the transition of patients and families in the health and illness cycle, a goal in application was the assessment of any barriers or concerns in the statements of the participants. It was anticipated that participants might report their transitions in a rural hospital setting to be more difficult, translating to concerns about role insufficiency, but participants such as Laura were careful to offer that in comparison to a larger facility, she felt comfortable with the experience and was very supported emotionally. Overall, the tone was very positive in terms of the attitude of the nurses, especially with Readiness for Whatever Comes in the Door. Conditions of the work environment could also be a major influencing factor in the role transition for a new

nurse; all nurses reported their coworkers as sources of support in their everyday work-- whether they found the most support in peers with the same level of experience or those who were more seasoned nurses.

In the progression to reach role mastery as Meleis (2010) described in her theory, these participants were on target with reporting they had already found meaning in their work as CAH nurses being valued members of the team. This occurred especially in knowing their patients and serving their communities. This meaning might have been something that drew them to their CAH position in the first place. A major theme in the findings of an integrative review from Morrison and Symes (2011) was “knowing the patient,” which aligned with a finding from this study. In their integrated review, Morrison and Symes asked the question, “How is expert nursing practice of experienced staff nurse clinicians characterized across a variety of clinical settings or specialties?” This comparison of the two studies highlighted that perhaps the engagement and rapport with the patient, inherent to a small-town atmosphere, promoted expedited progression to expert. This might lead to quantitative research opportunities using observations and clinical performance rubrics, additional instruments, or mixed-methods studies to evaluate the progression in the Benner (1982) competency stages from novice to expert.

### **Limitations**

The final number of participants was 13, which was consistent with Creswell’s (2014) guidelines on phenomenological research. Careful reflections and bracketing supported the data collection process during analysis and the decision that data saturation was achieved. While in qualitative research the goal is not generalizability but rather transferability under trustworthiness (Creswell, 2014; Lincoln & Guba, 1985), the



findings of this study could be considered as meaningful and valid for the group of 13 participants sharing their lived experiences. In some of the Australian studies discussed, the mixed-method approaches provided opportunities to measure data and variables objectively as well so further testing of hypotheses about new nurses might progress in the development of research. This phenomenological study built the foundation for further research or theory development involving themes that emerged from interviewing the participants.

This was a rather homogenous sample in terms of race/ethnicity as all participants mentioned being “white” or “Caucasian” as all or part of their identities. One participant identified as “Caucasian/Hispanic” and another as “Caucasian European.” Therefore, it was not as easy to compare these findings to interviews conducted by Esther Morales (2013) who explored the experiences of seven Hispanic nurses in their first year. In that study, the assumptions of the general public and patients in the nurses’ care were discussed in a different way but there were still parallels in the mention of the opportunity to serve their communities and the perceptions created by previous employment.

The sample in this study, however, was not limited to just women in nursing as it also included two male nurses within the group of participants. Since participants volunteered and also fit study criteria with purposive sampling, a degree of self-selection bias was a known possibility. This might suggest participants who felt passionate about their experiences were ones interested in participating in this study. However, the strategy of recruiting through 230 CAHs provided an opportunity for a variety of participants to respond and share their experiences to make up the group of participants

used in this sample. Researchers do strive for recruiting participants who fully understand the research protocol and are willing to share rich descriptions about their experiences in qualitative methodologies. The experiences of these participants were subjective and they were their own as expected with descriptive, phenomenological methodology.

### **Implications for Practice and Research**

#### **Overview**

This study was designed to explore the lived experiences of new nurse graduates in their first year of employment in CAHs with the intent to disseminate findings to improve new nurse preparation and assist nurse administrators with valuable information to use for their new hires. With an open attitude and the use of bracketing, the researcher strove to capture the participants' own stories as they were naturally shared in order to communicate the true meaning of this group's experiences. As a result of this research, six themes were discovered that might help to create further professional development opportunities for nurses or to enhance orientation experiences lacking structure and opportunities for feedback and evaluation. These ideas are discussed further throughout this section.

These results provided information that could be helpful to both hospital administration and nursing schools in both the processes of preparation of new graduates and the orientation and retention of newly-licensed registered nurses. The participants communicated a degree of comfort with their role identity, which is important for both self-assessment and fit to an organization. They also shared recommendations for

improving orientation structure and timing and reinforced the importance of nursing administrator presence as well as preparation and clinical hours in nursing education.

A theory on rural nursing itself is still under development (Lee & McDonagh, 2013) but Long and Weinert (1989) acknowledged the differences between rural and urban settings and named isolation and distance, self-reliance, lack of anonymity, outsider/insider, old-timer/newcomer, and work beliefs/health beliefs as core concepts in their theory on rural health (Schlairet, 2017). By using the Meleis (2010) and Benner (1982) theories to frame this study, discussions with the nurse participants resulted in statements that expressed the meaning of relationships, connections, professionalism, and versatility that all tied uniquely to the nursing role transition itself. The professional identity recognized by participants in their role transitions was who they were in their communities as well as both inside and outside of the work environment. It shaped perceptions, sometimes altered behaviors, and was threaded into conversations and interactions with community members on a regular basis. Since many of the other studies mentioned in the review of literature only addressed urban nurses' experiences as new graduates, the current study is one of a few studies (Clark & Springer, 2012; Martin & Wilson, 2011; McCalla-Graham & De Gagne, 2015; Phillips et al., 2015) that addressed the niche of rural nursing and could begin a program of additional research for this researcher.

## **Research**

Phenomenological research was the best way to truly share the subjective realities of the everyday experiences of new nurses in CAH settings, whereas a quantitative research study would objectively measure variables that might be identified as priorities

in moving forward with the results of this study. Additional studies could use quantitative methods such as surveys to examine organizational culture, further quantify orientation procedures and timelines, and possibly piloting shared or structured orientation programs between facilities. It might be useful to plan a study that assessed nurses' attitudes and job embeddedness after completion of their first year of study. A mixed-methods design might allow for reflection that highlights experiences and also quantifies organizational variables of interest such as satisfaction or embeddedness. Or, with continued focus on rural settings, a comparison between perceived competencies in urban nurses and rural nurses could be performed that examined the first five years of practice and explored the rate of perceived or observed progression through novice to expert competency stages.

Further research could also be explored on shared governance or leadership styles in CAH settings as facilitated by administrators or how nurses perceived their opportunities for growth within these settings. A recommendation for this avenue would be to explore the extent with which hospitals "grow their own" in terms of fostering continuing education for LPNs desiring to return to school for an RN degree. Along a similar thread, a researcher could explore possibilities for those RNs who desire to further their education for bachelor's or master's degrees and still hope to utilize graduate degrees within rural care settings. One of the participants, Abbie, spoke of the financial support her employer provided in her transition from LPN to RN with an expected work agreement to follow; yet she did not convey that she planned to leave the facility after having received this benefit. She was positive about the opportunities to come in her career within the facility. When young nurses or families think about relocating or

returning to a familiar community, the consideration of “settling” and an examination of the outcomes of a long-term commitment or investment might be an important factor in planning the future. Growth opportunities are important or the longevity of the nursing career could seem overwhelming. For some nurses, the potential for growth could also be balanced by a preference for a specific lifestyle outside of work. These are important considerations to be aware of when new graduate nurses make decisions about where to accept nursing employment.

### **Nursing Practice and Education**

In nursing practice, it is suggested that administrators examine both the structure and duration of orientation in place for the scope of RN practice even in transition of those LPNs who might be familiar with their surroundings in-house. New graduate nurses need a bit of time to explore their environment and take a good look at where supplies and resources are housed to avoid future workflow issues. It is likely a tour and staff introductions are some of the first agenda items for a new hire but it is also likely the brand-new staff nurse might forget some of those details if they are not revisited until later or only during a time of need. It is suggested that sufficient time be spent on learning computer systems that might include documentation for general charting purposes, for medication administration, as not all systems are intuitive, or at least some components might need extra reinforcement to follow correct procedures.

In the study, participants such as Phoebe referred to orientation checklists as if their function was more about going through the motions with an emphasis on getting through the list quickly rather than in a meaningful manner. Findings from this study could be used to refine learning objectives in a new nurse orientation process. Responses

from study participants could help facilities further examine their orientation checklists and evaluation of nurse competencies. Rather than an emphasis on the timely completion of tasks or skills, a goal-based orientation might individualize the experience while also acknowledging that skills practice remains important for ensuring various competencies in nursing. In discussion with the participants, exposure to different acute scenarios or particular staffing situations enhanced learning the most.

In practice, facilities should strive for clearly-defined functions and responsibilities with the identification of preceptors as staff leaders who are enthusiastic about the mentoring role (Morales, 2013; Parker et al., 2014). In a grounded theory study involving nine rural Australian nurses, Mills, Francis, and Bonner (2007) found supportive mentoring relationships between experienced and novice nurses were helpful in demonstrating to new nurses how to transition into their role into a rural community where the professional nurse identity always exists. In their study, this concept was termed “live my work” (Mills et al., 2007, p. 585). As the experienced nurses discussed how they had grown to manage living and working in the same community, they believed the mentoring of novice nurses was important for confidence development. As Wayne shared his example of a charge nurse who was willing to balance both a shift in her own job responsibilities and the mentoring of two new hires, Marie shared another experience. One of her preceptors was not engaged in the opportunity due to outside circumstances and that impacted the quality of her learning experience, perception of support, as well as patient care.

Additionally, it would be beneficial to introduce 30-, 60-, and 90-day check-ins with managers or nurse leaders if a process is not already intact. Participants such as

Wayne, Madelyn, and Leah spoke of the value in these opportunities. Managers could network with one another to share success stories and strategies to better understand the stages of role transition in a rural setting. This was also recommended by Lea and Cruickshank (2017) as they discussed their findings from their qualitative interviews with new nurses in rural settings. This opportunity might also provide a conduit for the dissemination of continuing education opportunities for nurses, especially topic areas targeted for registered nurses in their first year of practice. Another recommendation for nurse leaders in rural facilities would be to engage in continuing education on leadership facilitation to address issues and growth initiatives in the nursing work environment. All participants desired recognition and assistance from their leaders when requested but participants such as Marie and Phoebe mentioned their leaders were not always available and ready to lead by example.

In nursing education, programs offering rural clinical rotations could feel confident their offerings were valued and often coveted by other programs or nursing graduates who did not complete such an experience. If at all possible, pre-licensure programs should strive to offer, at least as an option through an individualized practicum or internship, rural locations amongst contract locations or student choices. As the participants mentioned, not all graduates will desire to work in a CAH; however, a brief experience could be eye-opening and provide greater insight about both autonomy and teamwork in the professional nursing role. As the attitude of all participants was quite positive about the experiences, this opportunity could be presented as a beneficial learning environment where nurses feel meaning in their daily work and are contributors to the health of the surrounding community.

Participants voiced the need for as many clinical hours as possible in practicing skills and preparing for the variety of situations they would see in rural nursing. As one participant had a suggestion about the sequencing for nursing education coursework, she felt it was most logical to implement courses in a birth-to-aging, lifespan-based, concept-based curriculum. This would be something to consider for programs that vary the timing of their experiences, especially with exposure to specialty nursing areas.

In summary, the above recommendations could both improve workplace culture perceptions of new graduate nurses in the CAH setting and reinforce clinical education curriculum practices in nursing programs. Suggestions for future research in this area were also shared. Although growing, the area of rural nursing still remains ripe for further research as CAHs work to maintain a steady, quality workforce as the healthcare industry changes and no two rural facilities are exactly alike. Thus, a qualitative study such as this was able to take an in-depth look at the realities shared, extracting important themes that could be built upon with further research.

### **Conclusion**

Interviews with the 13 participants revealed the lived experiences of a group that met the criteria as new graduate nurses working within their first 12 months. Findings included six themes related to the focal research question: (a) Always a Professional, (b) Personal Connections, (c) Pride in Work and Community, (d) Always on Your Toes, (e) Everyone Works as a Team, and (f) Essential Preparation Experiences.

This research study filled a gap in knowledge related to the needs of new nurses in rural hospital settings as a dearth of literature exists for American-based nursing literature on new nurse graduates or new registered nurses in rural hospitals. This study



built upon previous nursing literature that was limited largely to nurses in urban hospitals or rural nurses in Australia (Bushy, 2012; Laschinger, 2012; Laschinger et al., 2013; Lea & Cruickshank, 2017; Parker et al., 2014). By allowing the participants to voice their experiences and reflect on their orientation period as well as the meaning of being a new registered nurse in this setting, this study helped fill a gap that could drive future research in quantitative methodology.

As the essence of Always a Professional emerged as a primary theme, the other five themes allowed for a discussion of the unique environment of the workplace in a rural hospital setting as well as the importance of meaningful relationships and community ties for these nurse participants. Throughout this study, it became clear the participants were cognizant of the impact their behaviors might have on public perceptions of their nursing identity if they lived in the community or local area; if they did not, they observed this through peers in their approach to rapport and encounters in sensitive situations. As hospitals examine their market base for new nurses, their ability to welcome spouses, partners, and family members with an inviting culture might be a key to helping families “settle” in a community without feeling the need to move on to a larger community. In acknowledging that the participants in this study identified universally as Always a Professional, administrators could keep in mind that even beyond the walls of the hospital, messages are conveyed and sent about identity and roles as community citizens and in personal lives. A comfortable connectedness is valued and important for finding the meaning in the work that makes nurses stay in their rural workplace. The final two themes were extracted through a review of dialogue that focused on the orientation process of the new graduate nurses as well as their suggestions

for changes in practice or for reinforcement of helpful resources. They were a foundation for future recommendations shared for nursing practice and education.

In summary, new graduate nurses in CAHs are seeking support from peers and leaders just as any other new graduates in their first nursing job. However, the themes in this study spoke to the statements and expressions of this particular group of rural participants in terms of the nuances of a rural hospital care setting, e.g., the autonomy and readiness for whatever comes in the door. Pride and perceived respect seemed to balance out the lack of anonymity for these nurses as the public recognition of skill and status as Always a Professional could act as a motivator in continuing the daily work of contributing to the health of rural communities. While the majority of participants in this study were raised in rural communities, some participants were drawn to their rural facility for the team-based environment or previous exposure, creating an immediate sense of belonging and contribution. Within their first year experiences, these new graduate nurses were thriving in their work, anchored in personal connections with both coworkers and community members, supporting their desire to stay and give back to the community as a professional nurse.

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**APPENDIX A**  
**SEMI-STRUCTURED INTERVIEW GUIDE**

### Semi-Structured Interview Guide

Thank you for your willingness to participate. This interview is designed to explore the experiences of new graduate nurses in their first year of employment in critical access hospitals.

The interview will be recorded as part of a qualitative design for doctoral dissertation work, and your statements will be described word for word before they are prepared for analysis. You may choose a fictitious name now to disguise your responses to protect your identity in the research findings. I will also not identify your hometown or your employer name. The information that I gather may be used to design additional studies on the preparation or orientation of new graduates.

Pseudonym:

I have several general questions to begin with:

1. Tell me what it's like to be a new nurse in a critical access hospital.  
  
(Any experiences, incidents, events that really stand out?)
2. Describe how being a registered nurse in a rural community impacts your personal identity.
3. What are important characteristics for a new graduate nurse in a rural setting to have? Why are these important to you?  
  
(What is it like being a team member of the healthcare team in a rural hospital?)  
(Who provides the most support to you in your workplace?)
4. Did you have an orientation in your workplace? How long was it? What was included?  
  
(Do you feel like it was an adequate orientation? Anything more?)  
(What makes you stay in your job?)
5. Given everything you have shared, if you had the opportunity to talk with several nursing schools about how to continue to develop students for practice in a rural setting, what is something that you would want them to know?

Thank you for your time today. It may be necessary to contact you once more by phone to verify that I am accurately representing what you intended to say. If so, would you please share the best phone number to do so? I will not use this phone number for any other purposes other than to clarify a statement. It will not be shared with others. Upon completion of the interview, I will distribute or mail out your Amazon giftcard, if you can also provide a current mailing address. I will not send any additional information to your home other than the mailing address.

**APPENDIX B**  
**ADMINISTRATOR RECRUITMENT LETTER**

Greetings (hospital administrator name)!

My name is Lesa Hoppe, MSN, RN and I am a doctoral student in nursing at the University of Northern Colorado (UNC) located in Greeley, Colorado. I live and teach nursing in Lincoln, Nebraska.

I am currently focused on my dissertation effort in continuing to improve the preparation of new nurse graduates and improve retention of nurses in rural communities while I serve as nursing faculty in a local nursing program. My dissertation explores the experiences of new nurse graduates employed in a critical access hospital setting (CAH), as I believe this is a unique group with different needs than those supported by growing nurse residency programs in urban settings. Your hospital is one of several possible sites throughout Nebraska, Iowa, and Kansas where I hope to find nurses willing to participate in an interview. I will begin this exciting data collection journey with your assistance. I need your help! Please forward the attached email to any potential participants working in their first year as a registered nurse.

I will be working under the guidelines approved through the UNC Human Subjects Institutional Review Board and am dedicated to the confidentiality and well-being of the participants. As some critical access hospitals may have only 1-2 new graduates in their staff roster, it is very important that once the nurses receive the recruitment information, they feel they can choose to participate or decline from the opportunity without consequence in their workplace, as the identity of study participants will be replaced with pseudonyms and the hospital names and communities will not be disclosed in the study findings.

I am seeking nurses who:

- will be within the range of 1-12 months of employment as a registered nurse in a CAH
- age 19 or older with current registered nurse licensure
- are scheduled to work on average 24-32 hours a week or greater in a CAH

With as busy as nurses are, my goal is to make the participant experience as convenient as possible and will coordinate with the nurse to complete a one-time interview outside of work hours and the work setting via phone, Skype, or face-to-face.

Participants will be asked to:

- complete one interview in late fall/winter (approximately 45-60 minutes) and a demographic questionnaire
- review the interview transcripts for accuracy and further comment (sent through email)

I know how busy your schedule is and greatly appreciate your help. Please forward the attached flyer in this e-mail to potential participants. If at any point you have questions please contact me through email or at (402) 239-4824. Thank you for your assistance.

Appreciatively,

Lesla Hoppe

[Hopp6990@bears.unco.edu](mailto:Hopp6990@bears.unco.edu)



**APPENDIX C**  
**RECRUITMENT FLYERS**

## Are you a new RN graduate working in your first nursing job?

- Do you work in a critical access hospital?
- Are you in your first year of employment?
- You're invited to share your experiences in a confidential, one-time interview.
- If eligible, you will receive compensation for your participation

Please contact Lesa at [hopp6990@bears.unco.edu](mailto:hopp6990@bears.unco.edu)  
or (402) 239-4824 (call or text) for details about  
this confidential research study.  
UNC IRB # \_\_\_\_\_



UNIVERSITY OF  
NORTHERN  
COLORADO



DO YOU KNOW A NEW RN  
GRADUATE WORKING IN  
A CRITICAL ACCESS HOSPITAL?

I'M INTERESTED  
IN HEARING ABOUT 1ST  
YEAR EXPERIENCES IN  
MY RESEARCH STUDY!

PLEASE REFER  
INTERESTED CANDIDATES  
TO LESA AT  
HOPP6990@BEARS.UNCO.EDU

THANK YOU! -LESA HOPPE

**APPENDIX D**  
**INSTITUTIONAL REVIEW BOARD**  
**APPROVAL LETTER**



*Institutional Review Board*

DATE: January 16, 2018

TO: Lesa Hoppe

FROM: University of Northern Colorado (UNCO) IRB

PROJECT TITLE: [1174241-1] LIVED EXPERIENCES OF NEW NURSE GRADUATES IN CRITICAL ACCESS HOSPITALS

SUBMISSION TYPE: New Project

ACTION: APPROVAL/VERIFICATION OF EXEMPT STATUS

DECISION DATE: January 2, 2018

EXPIRATION DATE: January 2, 2022

Thank you for your submission of New Project materials for this project. The University of Northern Colorado (UNCO) IRB approves this project and verifies its status as EXEMPT according to federal IRB regulations.

Lesla -

**Thank you for your patience with the UNC IRB process. Your application is thorough and your materials are clear and comprehensive. There are no requests for amendments or additions. You may begin participant recruitment and data collection using the verified/approved exempt category materials and protocols.**

**Best wishes with this research.**

**Sincerely,**

**Dr. Megan Stellino, UNC IRB Co-Chair**

We will retain a copy of this correspondence within our records for a duration of 4 years.

If you have any questions, please contact Sherry May at 970-351-1910 or [Sherry.May@unco.edu](mailto:Sherry.May@unco.edu). Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within University of Northern Colorado (UNCO) IRB's records.

**APPENDIX E**  
**CONSENT FORM FOR HUMAN PARTICIPANTS**  
**IN RESEARCH**



UNIVERSITY OF  
NORTHERN COLORADO

CONSENT FORM FOR HUMAN PARTICIPANTS IN RESEARCH  
UNIVERSITY OF NORTHERN COLORADO

Project Title: Lived Experiences of New Nurse Graduates in Critical Access Hospitals

Researcher: Lesa Hoppe, MSN, RN, Doctoral Student

Research Advisor: Lory Clukey, Ph.D., PsyD, RN, CNS, School of Nursing, College of Natural and Health Sciences Phone: (970) 351-2648; lory.clukey@unco.edu

Purpose and Description: The purpose of this descriptive, phenomenological study is to explore the lived experiences of new nurse graduates in the first year of employment in critical access hospitals.

Through the approach of one-on-one interviews, participants will be invited to share their experiences and perceptions. These experiences will be audio-recorded, transcribed, and analyzed to develop several core themes or paradigms describing this phenomenon. It is estimated that each of these interview sessions will take 45-60 minutes. Participants may be contacted as a follow-up to confirm the accuracy of interview transcripts. Audio-recordings will be erased and deleted after transcription. A pseudonym will be assigned to replace the participant name, and only the investigator will know the name connected with a pseudonym. Data collected and analyzed for this study will be kept in a locked file in the investigator's office and in a password-protected computer file, which is only accessible by the researcher. The research advisor will also provide input during data analysis. The transcripts and consent forms will be kept for a period of three years following the study and then destroyed. Only pseudonyms will be used to report data.

The cost for participating in this study is the time invested to participate in the interview and for transportation related to the event. Compensation of a \$10 Amazon gift card will be provided to all participants in this study upon its completion. Foreseeable risks are not greater than those that might be encountered in a classroom environment or a conversation with a colleague about one's employment.

Participation is voluntary. You may decide not to participate in this study and if you begin participation you may still decide to stop and withdraw at any time. Your decision will be respected and will not result in loss of benefits to which you are otherwise entitled. Having read the above and having had an opportunity to ask any questions, please sign below if you would like to participate in this research. A copy of this form will be given to you to retain for future reference. If you have any concerns about your selection or treatment as a research participant, please contact the Office of Research, Kepner Hall, University of Northern Colorado Greeley, CO 80639; 970-351-1910.

Participant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Researcher's Signature \_\_\_\_\_ Date \_\_\_\_\_

**APPENDIX F**  
**RECRUITMENT LETTER**



Greetings!

My name is Lesa Hoppe, MSN, RN and I am a doctoral student at the University of Northern Colorado (UNC). I live in Lincoln, Nebraska.

I am interested in hearing your stories and experiences about life as a new graduate nurse working in a rural hospital! I believe this information can help improve the experiences of new nurses and also better-prepare nursing students for practice in this unique care environment.

I am conducting a research study for my dissertation in continuing to improve the preparation of new nurse graduates and improve retention of nurses in rural communities while I serve as nursing faculty in a local nursing program. Your hospital is one of several possible sites throughout Nebraska, Iowa, and Kansas where I hope to find nurses interested in participating in an interview. I will begin this exciting data collection journey with your assistance. I need your help! Please feel free to forward this letter or email to any other individuals working in their first year as a registered nurse in a critical access hospital (CAH).

I will be working under the guidelines approved through the UNC Human Subjects Institutional Review Board and am dedicated to the confidentiality and well-being of the participants. As some critical access hospitals may have only 1-2 new graduates in their staff roster, it is very important as you consider this opportunity, you feel you can choose to participate or decline from the opportunity without consequence in their workplace, as the identity of study participants will be replaced with pseudonyms and the hospital names and communities will not be disclosed in the study findings. You may have received this information from an administrator at the hospital, but they will not be involved in the study in any way other than posting flyers and informing potential participants of the opportunity.

I am seeking nurses who:

- will be within the range of 1-12 months of employment as a registered nurse in a CAH
- are age 19 or older with current registered nurse licensure
- are scheduled to work on average 24-32 hours a week or greater at a CAH

With as busy as nurses are, my goal is to make the participant experience as convenient as possible and will coordinate with you to complete a one-time interview outside of work hours and the work setting via phone, Skype, or face-to-face.

You will be asked to:

- complete one interview in late fall/winter in-person or via distance (approximately 45-60 minutes) and a demographic questionnaire
- review the interview transcripts for accuracy and further comment if needed (sent through email)

I know how busy your schedule is and greatly appreciate your help. Please contact me through email ([hopp6990@bears.unco.edu](mailto:hopp6990@bears.unco.edu)) or at (402) 239-4824. Thank you for your assistance.

Appreciatively,

Lesla Hoppe, RN, MSN

**APPENDIX G**  
**DEMOGRAPHIC QUESTIONNAIRE**

### Demographic questionnaire

Pseudonym name \_\_\_\_\_

Gender \_\_\_\_\_

How many months have you been employed in this RN position? \_\_\_\_\_

Do you have previous experience in this setting (CNA, LPN, volunteer)? Y or N

Age \_\_\_\_\_

Race/ethnicity \_\_\_\_\_

Zip code of residence (used to classify community size): \_\_\_\_\_

Zip code of employer: \_\_\_\_\_

Type of RN nursing degree (please circle):

RN diploma

ADN

BSN

Were you raised in a rural community? Y or N (circle)

Were you raised in the same community you are working in? Y or N (circle)

Do you feel you have job mobility (are able to move to a different location for a different job)? Yes No

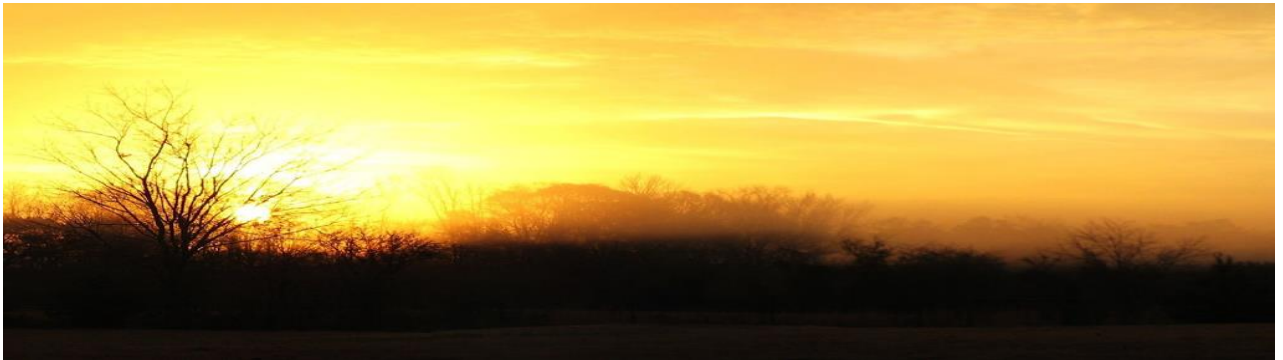
\*No town names or facilities will be reported. The above data will be shared for comparisons and descriptive data to describe the sample.

**APPENDIX H**  
**PARTICIPANT STUDY BRIEF**

## Participant Briefing

### *Thank You!*

Thank you for your time! My sincere thanks for your time and participation for the interview and questions to follow while taking part in this research study. I truly appreciate your meaningful contributions. You will receive a \$10 Amazon gift card upon completion of the interview.



Swanson, 2017

Image: Creative Commons, Flickr, Doug

### *Counseling Resources*

If, following the interview, your reflection or response to questions has created a need to talk with anyone about a distressing issue or concern, please feel free to phone one of the following toll-free resources for further direction to support:

All callers--United Way: Phone 2-1-1 or visit 221.org

Iowa: Call or text the Iowa Helpline 1-855-800-1239 to connect to counseling services 24/7

Nebraska: Nebraska Family Helpline 1-888-866-8660 24/7

Kansas: Compassionate Ear Warmline 1-866-927-6327 7 days a week/4-10 p.m.

### *How Will Study Data be Used?*

The results of this study will add to the body of knowledge in nursing and nursing education concerning the experiences of new graduate rural nurses and the needs for support, professional development, and even undergraduate nursing program curriculum updates. By examining these experiences, nurse educators and administrators can structure services to best-support new graduates in the rural care setting, and also impact the retention of quality nurses. The results of this study will be published as part of doctoral dissertation work and a manuscript may later be published in a journal. No personal identifiers will be shared. Study information will be available upon request once completed. Study participants who have further questions may contact the researcher Lesa Hoppe via e-mail at [hopp6990@bears.unco.edu](mailto:hopp6990@bears.unco.edu).

**APPENDIX I**  
**THEMES AND EXEMPLARS**

## Themes and Exemplars

Theme Number	Theme	Selected Statements as Exemplars
1	Always a Professional	“I think being in a rural setting, a lot of people know your face, know your name, know your family, and so I think that carries a, a high hope. Versus in an urban (facility), you’re kind of like... You go up to your job, you do your job, and when you leave it you’re just like a regular normal person, whereas in a rural hospital, you kind of carry that identity wherever you go.” (Leah)
2	Personal Connections	“I’m honored to work there and I feel like um, a lot of my patients know me, or know at least my parents or grandparents or they know someone in my family just because all of us have been around, you know, in growing up there. So I just—I feel honored and proud, because, you know, it makes, I feel like I—because I know a majority of my patients on a personal level like outside of my care for them, um, I feel like that I have to like step up my game that much more.” (Michelle)
3	Pride in Work and Community	“I just think the sense of pride and accomplishment you get from helping people in your community, that’s the biggest thing for me that’s gonna keep me going... probably really serving my community is the biggest thing.” (Madelyn)
4	Always on Your Toes	“I feel like I’m always on my toes. Like learning new things. I’ve never had the same patient twice, and... you never know what’s going to walk in the door, and it’s kind of terrifying, but also exciting.” (Alicia)
5	Everyone Works as a Team	“I feel supported from all of my fellow nurses, experienced and new. The older nurses are there to teach me, show me and guide me through every task, and the newer ones--we just get through it together. I never have to worry about someone stepping in the room to help me out. And the other office workers who are RN’s, our DON and really everyone from lab technicians to pharmacists are supportive. I have felt welcome and like everyone works as a team, no matter what your position.” (Alicia)

Theme Number	Theme	Selected Statements as Exemplars
6	Essential Preparation Experiences	<p>“First of all give them as many clinical experiences as possible because they’re going to be...I don’t know how most critical access hospitals work but at least in the ones around here, they’re going to be several different departments. Um, and so I think it’s important to have a range of clinical experiences, as much clinical time as possible, because once you get out there on the floor you realize there are some things that you have to do very textbook, but there is a lot that is on the fly and coming out of the box with ideas, and interventions, and so I think it’s important that nurses be prepared for that...” (Madelyn)</p>