Rural generalist : community based nursing
by Linda Elisabeth Troyer

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Nursing
Montana State University

Abstract:
The purposes of this thesis were to examine whether the concept of rural generalist could be extended more broadly to the practice of community based nurses and how community based nurses perceived themselves in terms of rural generalist nursing.

Studies on the characteristics of rural nurses in hospital settings have described rural nursing as a unique specialty area of generalist practice. Presently the concept of rural generalist nursing is based on studies of rural hospital nurses.

This study was qualitative in design utilizing a convenience sample of community based registered nurses in rural eastern Montana. Three home health, three public health, and one tribal nurse made up the sample. A demographic questionnaire and semi-structured interview schedule were used after obtaining informed written consent. Data were coded for emergent categories in the grounded theory tradition. Generic codes derived from the 1980 ANA Social Pohcy Statement were used to describe their scope of practice.

A continuum emerged from the grounded theory analysis based on autonomy, job variety, and job satisfaction which co-varied among the nurses. In contrast to the tribal and public health nurses the three home health nurses had the least autonomy, job variety, and job satisfaction due to constraints from home health regulations and paperwork requirements.

The nurses' descriptions of their practice reflected similarities to Scharff's (1998) definition of rural nurse generalist. The sample incorporated different roles and worked in different areas of nursing within the same work day which, is a key characteristic of the rural generalist reported in the literature. The nature of the rural environment enhanced their ability to give holistic nursing care.

Further research is needed in other regions to verify or refute the concepts presented in the grounded theory analysis. Replication of this study in other regions of Montana and other regions of the country is recommended. Replication should include similar and different comparison groups of home health, public health, and tribal nurses.

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APPROVAL

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Linda Elisabeth Troyer

This thesis has been read by each member of the thesis committee and has been found to be satisfactory regarding content, English usage, format, citations, bibliographic style, and consistency, and is ready for submission to the College of Graduate Studies.

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Date May 4, 2000

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ABSTRACT

The purposes of this thesis were to examine whether the concept of rural generalist could be extended more broadly to the practice of community based nurses and how community based nurses perceived themselves in terms of rural generalist nursing.

Studies on the characteristics of rural nurses in hospital settings have described rural nursing as a unique specialty area of generalist practice. Presently the concept of rural generalist nursing is based on studies of rural hospital nurses.

This study was qualitative in design utilizing a convenience sample of community based registered nurses in rural eastern Montana. Three home health, three public health, and one tribal nurse made up the sample. A demographic questionnaire and semi-structured interview schedule were used after obtaining informed written consent. Data were coded for emergent categories in the grounded theory tradition. Generic codes derived from the 1980 ANA Social Policy Statement were used to describe their scope of practice.

A continuum emerged from the grounded theory analysis based on autonomy, job variety, and job satisfaction which co-varied among the nurses. In contrast to the tribal and public health nurses the three home health nurses had the least autonomy, job variety, and job satisfaction due to constraints from home health regulations and paperwork requirements.

The nurses' descriptions of their practice reflected similarities to Scharff's (1998) definition of rural nurse generalist. The sample incorporated different roles and worked in different areas of nursing within the same work day which is a key characteristic of the rural generalist reported in the literature. The nature of the rural environment enhanced their ability to give holistic nursing care.

Further research is needed in other regions to verify or refute the concepts presented in the grounded theory analysis. Replication of this study in other regions of Montana and other regions of the country is recommended. Replication should include similar and different comparison groups of home health, public health, and tribal nurses.

CHAPTER 1

INTRODUCTION

Background and Significance of Study

Almost one fourth of the United States (US) population lives in rural communities. Of the 50 states, 31 have over 60% of their counties designated as rural (US General Accounting Office, 1989). A majority of indicators (per capita income, health status, access to health care, level of education, & employment opportunities) show that US residents in non-metropolitan areas have less than their metropolitan counterparts (Bushy, 1998). Due to these discrepancies, many of these non-metropolitan or rural dwellers are more likely to need help from human services and health professionals than their urban counterparts.

Looking at this information, it is disturbing to consider the nursing shortage that exists in rural areas. For example, the mean registered nurse (RN)-to-population ratio is twice as large in metropolitan areas compared to non-metropolitan areas (Stratton, Dunkin, Juhl, & Geller, 1995). And yet a higher percentage of rural nurses work in community health nursing, 11.8% compared to 7% in the overall RN population (Dunkin, Stratton, Movassaghi, & Kindig, 1994). As our health care delivery system has shifted from acute care delivery in hospitals to community based settings, more complex, ill patients return to rural settings. More community based nurses are needed to provide care for these patients.

While this need increases, barriers to recruiting and retaining community based nurses exist. Results of quantitative studies have shown that nonmetropolitan community based nurses make $5,000/year less in annual salary than their metropolitan counterparts (Dunkin et al., 1994). With scarce financial resources, the community nurse positions are often part-time. In addition, the isolation of community rural practice often is overwhelming to new nurse graduates who have not developed confidence in their abilities and a broad knowledge base to help make nurse-practice decisions (Davis & Droes, 1993).

Studies on the characteristics of rural nurses in hospital settings have described rural nursing as a unique specialty area of generalist practice (Davis, 1991). The generalist orientation of rural nursing is a key concept found repeatedly in the literature (Bigbee 1993; Bushy, 1991; Lee, 1998; Weinert & Long, 1991). Scharff's (1987) literature review described distinctive characteristics in the nature and scope of rural nursing. This literature consistently reported the multiple specialty practice of rural hospital nursing. However, Scharff did not find empirical literature to confirm the generalist nature of rural nursing practice prior to her qualitative study on rural hospital nurses.

The generalist nature of rural hospital nursing has also been described as creating role diffusion where nurses feel that they must be all things to all people (Bigbee, 1993). Scharff (1987) reported that rural hospital nurses must be "jacks of all trades" who often practice within many health care disciplines. Rural hospital nurses may not be assigned to one specific unit of the hospital but may have to function in multiple roles in different areas of the hospital during the same work shift.

Rural hospital nursing also has other distinguishing characteristics, such as high community visibility, greater autonomy, greater independence, and greater cohesiveness among staff (Scharff, 1987). High community visibility increased respect and influence of rural nurses but contributed to burn-out because of lack of personal anonymity. Increased autonomy and independence led to increased job satisfaction in many cases but also increased the potential for professional isolation. Increased cohesiveness was seen as decreasing burn-out in rural nursing (Bigbee, 1993).

In a review of the state of the science of rural nursing Weinert (1994) concluded that rural nursing research was limited and had theoretical and methodological problems. For example rural nursing practice was described as having a multiplicity of functions and a diversity of clinical situations. This description is based on rural hospital nursing research; however, the description has been extrapolated to apply to non-hospital settings as well. Recommendations for research included replications of studies with nurses serving varied populations in sparsely populated areas, while exploring key concepts to provide more in-depth understanding of rural concepts. Weinert also expressed a need to address negative aspects of rural nursing.

The paper written by the American Nurses Association's Rural/Frontier Health Care Task Force (1996) emphasized a need for cross-validation of key concepts across the diverse spectrum of rural populations. Public health, community, and home health nurses were mentioned as needing to function independently and make on-site decisions in practice settings a long distance from adequate resources and support. The need for these nurses to be familiar with available community resources was essential. Distance and isolation presented problems for rural community based nurses. Innovative and creative responses were constantly needed to meet the preventative and treatment needs of a population that is relatively older, poorer, and less likely to be insured.

The generalist orientation of the rural hospital nurse has been described by the two qualitative studies previously cited (Scharff, 1987; Davis, 1991). Davis (1991) included one community based nurse in her study. Because of the increasingly vital nature of community health nurses in rural settings, an increased understanding of the nature of their nursing practice was needed. No qualitative studies were found which had been done exclusively on the characteristics of community based nurses working in the rural setting. By obtaining a description of the nature of community based nurses practicing in rural settings, one can better address the challenges in their practice.

Research Questions/Statement of Purpose

Can the concept of rural generalist be extended more broadly to the practice of community based nurses? How do community based nurses perceive themselves in terms of rural generalist nursing? Presently, the concept of rural generalist nursing is based on studies of rural hospital nurses. This concept needed to be explored with community based nurses.

Definition of Terms

Nurse: Registered nurse licensed in Montana.

Rural: a nonmetropolitan county not having a city of 50,000 population within its boundaries.

Community based nurse: a registered nurse who practices outside of the hospital setting. This includes public health, tribal health, and home health nursing.

Public health nursing: the practice of promoting and protecting the health of populations using knowledge from nursing, social, and public health sciences (American Public Health Association, 1996).

Home health nursing: a subspecialty of community health nursing in which the primary focus is health restoration with the segment of the population that is ill in their homes (Association of Community Health Nurse Educators, 1990).

Rural generalist nursing: "a type of nursing practiced in rural hospitals in which the nurse must have a wide range of advanced knowledge and ability, in combination with commitment, to practice proficiently in multiple clinical areas simultaneously along the career trajectory" (Scharff, 1998, p.37).

CHAPTER 2

REVIEW OF LITERATURE

Introduction

Literature on rural nursing has increased since the late 1980's. Currently four texts focus exclusively on rural nursing (Bushy, Vols. 1 & 2, 1991; Lee, 1998; Winstead-Fry, Tiffany & Shippee-Rice, 1992). In addition, various community health nursing text books devote at least one chapter to the discussion of aspects of nursing in a rural environment (Clark, 1999; Smith & Maurer, 1995; Swanson & Albrecht, 1993). The vast majority of literature describing the characteristics of rural nurses is based on descriptions of rural hospital nurses. In describing rural hospital nursing, Rosenblatt and Moscovice (1982) stated that "nurses are called upon to accept responsibility for obstetrics, new-born care, and intensive care, either sequentially or, at times, concurrently" (p. 273). Moscovice (1989) stated that as generalists, physicians, nurses, and allied health professionals must form the foundation for the health care system at all levels in the rural setting.

The origins and development of the concept of "rural nurse generalist" were discussed in several articles. Benson, Sweeney, and Nicholls (1982) surveyed 41 rural RN's in northern Arizona to determine the skills and abilities necessary in rural nursing. The surveys were followed by small group discussions to support the survey data obtained. Eighty-five percent of the survey respondents stated that RNs were expected to work in diverse areas. This included working in all clinical areas of the agency in which the nurses were employed. Most of those surveyed worked in hospital settings.

Biegel (1983) surveyed 25 rural hospital nurses to determine if the skills needed by the rural nurse were perceived to be different than those of urban nurses. The questionnaire responses were clustered according to frequency. The highest frequency response to the question, "What characteristics do you feel are important for a rural nurse?" was ability to function as a generalist. Additional characteristics were flexibility, versatility, and adaptability.

Faculty from Humboldt State University in Northern California interviewed 24 rural hospital nurses to validate the generalist nature of rural nursing (Thobaden & Weingard, 1983). They found that the skills and characteristics most needed were flexibility and the ability to work in a number of different clinical areas in a rural hospital. In addition, they surveyed a combination of rural (N=23) and urban (N=32) nurses using Schwirian's "Six dimension scale of nursing performance" to identify differences between the two groups. A nonparametric, median statistical test was used to compare the two groups. No significant differences were seen in the areas of leadership, critical care, planning and evaluation, interpersonal relations and communication, or professional development ($p=0.01$). In the area of teaching and collaboration, urban nurses were significantly more proficient. Thobaden and Weingard questioned whether Schwirian's tool was sensitive enough to measure the uniqueness of rural nursing.

Diversity in Rural Nursing Textbooks

Rural nursing textbooks reflect the diversity of functions and roles existing in rural nursing. Bushy edited two volumes on rural nursing in 1991. These volumes provide a review of a wide range of topics in regards to the national rural health care agenda. Problems in rural health care highlighted in these texts were high infant mortality, adolescent health issues, a large and growing elderly population, dangers associated with the agriculture industry, a breakdown in the rural emergency medical system, an unequal geographic distribution of nurses and physicians, and chronic shortages of professionals and programs dealing with mental health problems and substance abuse. She noted that obstetrical (OB) services were decreasing in rural areas, and many rural hospitals were closing. Bushy considered these volumes introductory texts on rural nursing as they cover the background, definitions, theories, vulnerable populations, health care delivery, interdisciplinary collaboration, and pertinent health care issues that affect rural nursing practice.

Another text on rural nursing (Winstead-Fry et al., 1992) presented many pictures of rural nursing in Vermont, New Hampshire, and Maine. The first chapter described generalist nursing on Swans Island, Maine from 1938-1975 where one nurse was the only health care provider. The characteristics of rural nursing stressed throughout this book were autonomy and creativity. A shortage of RN's existed due to inadequate and inequitable salaries. In addition, a fear of professional isolation, lack of modern facilities, and an inability for spouses to find suitable employment were concerns. They related that knowledge and skills differ between metropolitan and nonmetropolitan areas. In nonmetropolitan areas nurses made decisions without input and assumed responsibility for a wide variety of skills and procedures normally performed by physicians or allied health professionals.

Rural Nursing Theory Development

Montana State University's rural nursing theory development is described in Lee's (1998) textbook on rural nursing. The theory development included the qualitative gathering of descriptive data about rural health care needs from the perspective rural dwellers. Ethnographic data were categorized using the nursing theory paradigm refined by Fawcett (1984). Constructs were organized under the dimensions of person, health, environment, and nursing. Quantitative data were collected to validate the concepts of health status, health beliefs, distance and isolation, self-reliance, and informal health care systems. Several key concepts for rural nursing theory were identified, such as "health as ability to work". Other concepts identified as common themes in rural nursing, were outsider/insider and old-timer/newcomer. These are closely linked to gaining the acceptance and trust of local people, a distinctive challenge of rural nursing.

Two relational statements regarding nursing were derived from the data base of research on rural nursing at Montana State University (Weinert & Long, 1991). First, nurses in rural areas face much greater role diffusion than their counterparts in urban settings. Second, rural nursing is significantly affected by a lack of anonymity. Weinert and Long described how social network theory could provide a framework for understanding how rural nurses provide vital links between formal and informal health care. A nurse may serve as both the operating room nurse at the local hospital and the church volunteer who teaches first aid. The generalist role was identified as the appropriate role for the rural health provider and is suited to nurses as they use principles of physiologic and psychologic nursing care.

Nurses in rural Montana are traditionally relied upon to meet diverse health care needs and function in a variety of roles; therefore, a rural generalist master's program was developed at Montana State University-Bozeman College of Nursing. This program emphasized rural health. In one course, students were required to do ethnographic interviews with rural dwellers to learn first-hand how rural dwellers view health and their needs and preferences (Long, Scharff, & Weinert, 1998).

Rural Nurse Generalist

Scharff's (1987) thesis findings were the seminal work on the concept of rural nurse generalist. Scharff conducted an ethnographic study of 34 rural hospital nurses employed in eastern Washington, Idaho, and western Montana. Her conceptual framework described rural nursing as it fits into the 1980 ANA Social Policy Statement description of nursing. In describing the intersections of rural hospital nurses, she found that rural hospital nurses consistently practiced in other allied health areas. The most distinctive finding of her study was that rural hospital nurses do not specialize but rather expand the scope of their practice.

Lee's book (1998) includes a chapter written by Scharff on the philosophical basis behind the distinctive nature and scope of rural nursing practice. Long (1998) described this chapter as a "thorough and clear discussion of the distinctiveness of rural nursing" (p. 481). Ten years after writing her thesis, Scharff (1998) claimed that not only is rural nursing distinctive in its nature and scope from the practice of nursing in urban settings, "it is distinctive in its boundaries, intersections, dimensions, and even in its core" (p. 19). She reiterated that the nature of rural nursing was generalist and described rural nursing's distinctive scope. Scharff stated the dimensions, boundaries, and core were distinctive whether rural nursing is practiced in the hospital or the community setting.

Other distinctive characteristics of rural hospital nursing practice were the lack of anonymity and the need to provide nursing care to persons known in a social and personal context. Scharff (1998) emphasized how the rural setting causes the nurse's practice to be "thoroughly and integrally a constant factor in a nurse's life" (p. 37). Rural nurses cannot separate their private lives from their professional lives because of lack of anonymity. Little literature exists describing community based nurses' experience with lack of anonymity when practicing in the rural setting.

<u>Rural Nurse Generalist and Community Based Nursing</u>

Lassiter (1985) described the distinctions of rural nursing and related these distinctions to community based nursing. She stated that "it (rural nursing), requires a wide range of knowledge, skills, and appropriate attitudes for successful practice" (p. 23). Lassiter believed that rural nursing requires advanced skills and knowledge beyond basic

RN education because of the diversity of knowledge needed and the isolation of rural practice; therefore, she was instrumental in developing the content for a master's program in rural community health nursing in Virginia. The rural nurse needed to be aware of the unique rural culture and community setting in which care was given. The rural nursing practice was distinctive because of the unavailability and often unacceptability of health services, isolation, transportation hardships, environmental risks from waste and toxin pollution, farming accidents, family violence, and kin and friendship networks that vary from the urban practice.

Lassiter (1985) outlined areas for advanced training for the rural nurse. Included were the ability to do community health assessment, the need for expanded knowledge of family and group dynamics, a sensitivity to rural cultural factors, knowledge and skill in leadership, and an appreciation of the dynamics of planned change. Although she did not use the rural generalist term, she addressed the fact that rural nurses need advanced education because of the diversity of knowledge required in isolated practice.

The generalist nature of hospital nursing found in Scharff's (1987) work was validated by Davis' (1991) study of rural nurses in Nevada. She included one community based nurse in her study. Regarding community based nursing, Davis stated,

> Although urban community health/home health nurses see a far more diverse practice, it is not to the extreme of a rural area where the nurse may be the <u>only</u> nurse in the community providing services of any kind. Also, in a rural area, there is not as large of a distinction between hospital and other sites for nursing practice. The diversity of practice is not just within the confines of a practice site, but extends to the community in all areas. The hospital nurse provides home health nursing, the community health nurse does both school health and T.B. testing, the childbirth educator teaches AIDS education in the schools and works as the social services director at the hospital. (p. 119)

Since this analysis was based on the experience of one community based nurse there is a need to verify if other community based nurses in the rural setting have the same experience in their practice.

In a chapter in the Winstead-Fry et al. (1992) rural nursing text, Tiffany & Hourigan shared observations of community health based nurses regarding family caregivers and their relationship to community based nurses. Several areas of concern were described, including difficulty developing rural home health services because of the great distances between the patient and provider's home. Nurses could devote the greater part of a day to see one patient who lived several hours from the health care agency and required extensive care. Nurses in a rural setting became more involved in patients' lives because they lived in the same small community. Issues regarding the trend for high-tech care delivered in the home were discussed. Is there staffing for home care of patients with high-tech treatments in the rural setting? Is the staff trained, and is there enough staff for 24-hour coverage? Is there different reimbursement for the long driving distances between clients? Is there enough family support? Is the home environment suitable, and how far away is the home from emergency services? Looking at these issues in, one could not assume that home care in rural areas would be less expensive than hospitalization.

Gaps in the Literature

As seen from this literature review, the majority of the rural nurse generalist references were based on research with hospital based nurses. Only one community based nurse was specifically asked to describe the generalist nature of her work (Davis, 1991).

That description showed an extremely broad scope of practice within the community as one person fulfills a variety of roles. More exploration of this role was needed.

CHAPTER 3

METHODOLOGY

Introduction

The research method was discussed in this chapter. Included were a description of the design, sample selection, data collection, analysis using generic codes from the 1980 ANA social policy statement, analysis using grounded theory, and human rights protection.

Design

This study sought to fill a gap in nursing knowledge related to how community based nurses perceived themselves in terms of rural generalist nursing. This study was qualitative in design and used interviews with rural community based nurses as the source of data from which to perform a grounded theory analysis. Results from this analysis were compared with the results of Scharff's (1987) ethnographical study of hospital nurses.

Sample

A convenience sample of seven community based nurses working only in non-metropolitan areas was selected. These nurses were practicing in rural community based settings in central and eastern Montana. The community based nurses were selected by networking with nurses at Montana State University-Bozeman College of Nursing and other nurses east of the continental divide. Three were exclusively public health nurses and three were home health nurses. One nurse was both a public health and home health nurse. The sample had nurses, both with and without previous urban work experience. All the sample had at least one year of experience in community based nursing, and worked twenty or more hours per week on average. Community based nurses with lengthy service in rural areas were included to provide data on changes occurring over time.

Data Collection

Data were collected using focused interviews. The interviews were audio taped with the informants' permission and then transcribed verbatim. First, demographic information was obtained (see Appendix A). Next, questions pertaining to the scope of practice as well as their experience of nursing were used (see Appendix B). The first questions were general, such as "tell me what you do." Then prompts were used to have the RN describe the variety of her job responsibilities, such as "describe a typical and atypical work-day." The RN was asked about her responsibilities in areas of allied health such as physical therapy, occupational therapy, nutritional therapy, laboratory, financial/insurance and social services, mental health, pharmacy, and medicine. Questions were included regarding the clients she cared for and advantages and disadvantages of working as a community based nurse in a rural setting. A lengthy description of a wide variety of nursing activities was obtained from each of the nurses. They also discussed the number of counties they served and typical driving distances. The amount of autonomy these nurses have was elicited by asking to whom they were responsible, how supervisors and physicians affected their practice, and what they would change if they had complete control of their job. Finally, informants were asked if they matched the following definition of a rural nurse generalist as defined by Scharff (1998), "a type of nursing in which the nurse must have a wide range of advanced knowledge and ability, in combination with commitment, to practice proficiently in multiple clinical areas simultaneously along the career trajectory" (p. 37).

Data Analysis

The data analysis occurred in two stages. First all data were coded for emergent categories in the grounded theory tradition. Second, the generic codes Scharff (1987) derived from the 1980 ANA Social Policy Statement were used.

Stage I Analysis

Grounded theory was the qualitative, systematic research method used in this study. The interview data were examined using grounded theory analysis to determine common themes regarding the scope of practice of rural community based nurses and characteristics of their practice. According to Strauss and Corbin (1990), "the purpose of grounded theory method is to build theory that is faithful to and illuminates the area under study" (p. 24). The grounded theory approach identifies concepts and the relationship between these concepts in an inductive manner. Open coding is done initially to find tentative categories and their properties from the interview data. These categories are developed by the researcher after reading the transcribed data and selecting data that tell "what is going on" (Buehler & Lee, 1998, p. 303).

After examination of the transcribed interviews, categories emerged such as "liking variety in their job," "being called at home as a common occurrence they've had to grow accustomed to," limited or no cell phone coverage, and constraints in home health with reimbursement issues and homebound regulations limiting the amount of care that can be provided. Categories emerged regarding the clients that were seen by the nurses such as "making do," "hesitant to ask for help with mental health issues," clients falling "through the cracks" due to lack of resources in the rural setting, and the majority of the home health nurses clients being elderly. A constant comparative method was used to compare datum to datum and category to category. Uniformity of the data under varying conditions was noted and led to identifying relationships between categories. Recoding and constant comparison was continued and major themes and core variables were identified, leading to concept/theory development (Glaser & Strauss, 1967). This analysis resulted in a continuum showing how autonomy, job variety, and job satisfaction co-varied among these nurses. Each nurse was placed on the continuum based on the amount of autonomy, job variety, and job satisfaction they had experienced. A nurse with a high level of autonomy also had a high level of job variety and job satisfaction.

Stage II Analysis

The 1980 ANA Social Policy Statement used four constructs to describe nursing. These constructs were intersections, dimensions, boundary, and core. They have what

Glaser (1978) would call a "useful fit" in terms of their utility in describing the totality of nursing. These four constructs formed a set of generic codes which conceptualize nursing and offer a way to summarize the raw data obtained from the rural community based nurses. Just as Scharff (1987) used them to describe the uniqueness of hospital rural nursing, these four constructs were used to describe rural community health nursing as related by the sample.

Human Rights Protection

The study was approved by the Human Subjects Review Committee of Montana State University, Bozeman, Montana (see Appendix C). Prior to being interviewed, the informants read, signed, and dated the consent form (Appendix D). The consent form indicated pertinent information about the study. This allowed the potential participant to make an informed decision about participating in the interview. Due to the sparse population of eastern Montana and the small number of nurses in certain locations, no specific locations were mentioned in order to protect the identities of the informants.

CHAPTER 4

RESULTS

Introduction

This chapter provided a summary of the results of the study. The sample was described. Then, a more detailed description of rural community based nursing practice was given based on the in-depth interviews with the nurses. This description was organized around the generic codes derived from the 1980 American Nurses Association (ANA) Social Policy Statement. The emergence of a continuum from the grounded theory analysis was then explained. The perceptions of the sample in terms of fitting the rural generalist definition were presented.

Description of the Sample

The nurses were all female. They ranged in age from 27 to 56. Their years of experience working in nursing ranged from three to twenty-four. Three of the nurses had worked more than twenty years in nursing. Their years of experience in rural community based nursing ranged from two to fourteen. Three nurses had more than ten years experience in rural community based nursing. Three nurses had bachelors of science degrees in nursing. The other four had associate degrees in nursing although one these nurses had a bachelors of arts degree. Four nurses worked full-time and three were part-time, working twenty to thirty-two hours per week. All full-time nurses reported working overtime, varying from a few hours a month to twenty hours per week. Four nurses took call; the greatest amount reported was twenty nights of the month. One question from the questionnaire asked what percentage of time nurses spent doing general activities such as driving and making phone calls. Table 1 depicts how each nurse spends time among general nursing responsibilities.

Table 1. Percentage of Time Spent on General Job Responsibilities

	Driving	Client Contact	Paper-work	Meetings	Phone calls	Computer Work	Other
HHN #1	10-20%	50%	10-20%	<5%	10%	10%	other reports, PR*
Tribal RN	30%	50%	8%	10%	2%	0	coordination of care
PHN #1	25%	35%	15%	10%	10%	5%	
HHN#2	10%	30%	50%	2%	10%	2%	
PHN#2	20%	50%	15%	5%	5%	5%	
PHN#3	5%	45%	40%	5%	2%		CNE**, workshops
HHN#3	6%	15%	33%	15%	12%	15%	Inservices, PR*

*Public relations, **Continuing nursing education

The majority of time was spent with client contact and/or paperwork. Driving took up a significant amount of time for most of the nurses in the sample. The nurses, whether tribal, public health, or home health, had a unique way of dividing their time and no clear cut differences could be seen between the different type of nurses.

The tribal nurse summarized the purpose of the majority of time she spent on paperwork, meetings, and phone calls as “coordination of client care.” This included getting clients set up to see other health providers, arranging transportation, arranging for care of clients in the home, and following up on clients after hospitalization. This was time-consuming and, if any part of the plan fell through, she often risked losing the trust of that client.

Public relations was a responsibility of two home health nurses who were also the nurse administrators of their home health agencies. This involved public speaking regarding the services of the agency for various groups in the community and was done in order to promote the use of their services.

Description of Rural Community Based Nursing Using Generic Codes

Intersections

The intersections of nursing are points where nursing meets, interfaces, and extends its practice into areas of other professions. The interview data showed that rural community based nursing intersected or subsumed the practice of several other professions. The amount of extension into other professions' varied with the degree of rurality of the county in which the nurse was located. With increasing rurality, allied health services were located longer distances away, often in a metropolitan area.

Intersections occurred between rural community based nurses and respiratory therapy. Examples included monitoring patients on oxygen, trouble-shooting respiratory therapy equipment, coordinating home oxygen set-up, coordinating apnea monitor set-up and usage, patient education on respiratory therapy, and performance of chest physiotherapy and nebulizer treatments.

Intersections between rural community based nurses and physical therapy included the performance of physical therapy by the nurse or a nurse aide, personal care attendant, or family member who had been instructed by the RN in the physical therapy exercises to be done with the client. A few locations had a physical therapist who would do home visits. However, if clients lived more than twenty miles away, physical therapists would not drive that far and the nurses coordinated the performance of physical therapy for those clients.

There were no occupational therapists in any of these rural areas. Nurses would follow-up with any occupational therapy program started while a client was in a rehabilitation program and continued this program in the home setting.

Intersections between rural community based nurses and nutritional counseling were many. Registered dieticians were available in the communities at least one day a week and were available for consultation by phone. However, they rarely did home visits with clients. Frequently the tribal nurse did diabetic diet teaching because of the high incidence of diabetes in the population she served. This tribe has a full-time nutritionist serving the reservation but as the tribal nurse stated, “she couldn’t even touch what it takes for diabetic education.” All the public health nurses did counseling regarding the proper diet for pregnant women, breast-feeding mothers, and infant and children’s nutrition. Much of this counseling was done with the Women’s, Infant, and Children Nutrition program (WIC) and during well child care (WCC) visits. One public health nurse covering two isolated counties was the “competent professional authority” who took the place of the registered dietician for the WIC program in these remote counties. Many home health nurses counseled their clients on low-sodium, diabetic, or other diets as indicated.

There were several examples of intersections between rural community based nurses and social work. All community based nurses dealt with concerns regarding whether clients had food, shelter, or a proper road to their home. The public health nurses were on child/elder protective service teams to deal with abuse problems. All the nurses frequently identified problems that were referred to a social worker. Children were identified with developmental delays and referred to special programs. Home health nurses often were caught in the middle of elder abuse situations that they would monitor during their visits.

Because of the frequent and wide variety of contact, the public health nurses kept track of the welfare of their clients and their families. For example, they saw pregnant women, infants, and children during WIC appointments. They saw children and parents during well-child care appointments. They saw children for sports physicals. They saw people of childbearing age for family planning. They saw grandparents in elder-care programs for flu-shots, foot care, blood-pressure screenings, and other programs. They followed up on clients needing substance abuse treatment, child-protective service referrals, and sexually transmitted infection treatment. They knew whether the client was following up on referrals to other programs because they were involved with most of the programs in that county.

Part of social work involved dealing with the finances and health insurance coverage of the client. Public health services often were provided on a sliding scale fee basis. Clients were referred for Medicaid or other health insurance programs as indicated. The tribal nurse did not charge for services but knew whether her clients had Medicaid or Medicare and what other resources they had. The tribal nurse attended meetings where decisions were made about which client would get money for health care services, and advocated for the needs of clients. Home health nurses especially had to keep abreast of what services and durable medical equipment were covered by insurance for their client. Home health nurses were constrained by the home health care eligibility regulations and financial limitations of their clients. These constraints limited the services they could provide to their home health clients. One nurse stated,

> Cutbacks in Medicare are affecting the elderly so bad that the ones who need care the most, such as the cancer patients, can't get service provided because they went over their allotted amount. These are clients that can't afford any other supplemental coverage and only have Medicare.

Usually, the home health nurse worked closely with a social worker or a financial case manager regarding finances and the insurance coverage of their client. The nurse provided input and documentation so clients could continue to receive home health services.

Nurses were always dealing with the psychological needs of their clients. If nurses saw a mental health need, they referred the client for mental health services. The home health nurses saw many depressed elderly clients and spent time talking with them and giving them support. Many psychological needs were seen by the home health nurses when providing hospice care. Nurses were also monitoring for the therapeutic action and side effects of psychiatric medications and providing follow-up with psychiatrists or other physicians as indicated.

Overlap with medicine was described by some nurses. One nurse reported having physicians talk her through medical procedures over the phone while she was at the home of clients. Or they would write instructions for procedures for her to carry out in client homes. She stated, "You end up acting like a doctor in a lot of situations." In comparison with rural hospital nursing, none of the community based nurses performed any tasks associated with radiology. All community based nurses did phlebotomies and client teaching on the implications of the lab results.

There was less overlap with pharmacy compared to rural hospital nursing. Most nurses did education on the medications clients received. Both home health and public health nurses set up weekly medications in pill boxes for their clients. The community nurses cultivated close connections with pharmacists to keep informed of side effects and other vital information regarding new medications used by their clients.

The overlap of the practice of community based nursing and other allied health fields lent itself to role diffusion. This was described by a home health nurse who stated, "You name it, we do it," and "We're a jack-of-all-trades, we have to be." A public health nurse said, "We wear many hats instead of having a distinctive job." The community based nurses were consistently required to have knowledge in other disciplines outside of nursing. These nurses had to function in the realm of other disciplines when there was no one from that discipline in their rural setting. One nurse said, "You get so used to doing different things, that you may do more in the scope of another discipline than you realize." In public health nursing the greatest overlap with other allied health areas was with nutrition and social work. In home health nursing the greatest overlap was with mental health and the social work issues of finances and insurance coverage. All rural community based nurses had expanded their scope of practice by increasing their knowledge base in other allied health fields.

Dimensions

The dimensions of nursing are the roles, responsibilities, and skills that a nurse has in practice. The dimensions of nursing provided further description of the scope of nursing. These dimensions were influenced by the nurses' philosophy, ethics, and authority. This was an area where the practice of the rural community based nurse distinguished itself. Table 2 summarizes the responsibilities and areas of practice of the seven community based nurses.

In the rural setting public health nurses conducted a wide variety of programs for all ages whereas the public health nurse in the urban setting is often responsible for just one program. The rural home health nurses were simultaneously the administrator of the various home services their program provided and staff nurses seeing clients in the home. In contrast, these services are done by different people in the urban setting. Furthermore, some services are specialized, such as in hospice care or ostomy care. When urban nurses come to work in a rural setting they continue to use their specialized knowledge; however, since there are fewer clients in their specialty, they see other types of clients and expand their scope of practice.

Table 2. Responsibilities of Community Based Nurses

	home health nurses (n=3)	public health nurses (n=3)	tribal nurse (n=1)
Administration	3 of three (3/3)	3/3	yes
Allied health tasks	3/3	3/3	yes
Assessment	3/3	3/3	yes
Continuing ed for self and staff	3/3	3/3	yes
Coordination of care	3/3	3/3	yes
Family planning	0/3	2/3	yes
Gap-filling	0/3	3/3	yes
Head start	0/3	3/3	yes
Home visits	3/3	2/3	yes
Hospice	3/3	0/3	yes
Immunizations	0/3	3/3	yes
Maternal-child health	0/3	3/3	yes
On call	3/3	0/3	yes
Patient education	3/3	3/3	yes
Prison	0/3	1/3	yes
Reimbursement forms	3/3	1/3	no
Satellite clinics	0/3	2/3	yes
School nursing	0/3	3/3	yes
Supervise nurse aides	3/3	1/3	yes
Travel to >1 county	3/3	3/3	no
Well child care	0/3	3/3	no
WIC nutrition prog.	0/3	3/3	no

Gap-filling was a theme that emerged from the grounded theory analysis. The home health nurses filled the gap in terms of providing allied health services in the home.

They provided services in lieu of a physical therapist, nutritionist, or social worker that the client required for health maintenance and restoration. They often assumed different roles from nurse aide to nurse administrator depending on client need and the staffing situation they were in. The public health nurses played a large role in filling gaps with the health needs of their communities. They added services based on the needs of individuals and agencies in the community. For example, if the community hospital staff stopped teaching childbirth classes, the public health nurses would start childbirth classes. They had the flexibility to make home visits as individual or family needs developed, without having to consider eligibility regulations or the payer source as the home health nurses do prior to home visits. If home health programs were being discontinued, the public health nurses took over some of the home health clients' care either temporarily or permanently.

All the nurses had poor or no cell phone coverage in the areas where they had their office and where they traveled to see clients. Coordination of care between all allied health services was often the responsibility of the nurse.

<u>Similarities Among Home Health Nurses</u>. All the home health nurses were concerned with cuts in Medicare reimbursement for home health care especially for clients who lived long driving distances from the home health office. They spent hours completing the long Outcome And Assessment Information Set (OASIS) forms (Center for Health Services and Policy Research, 1998) required for their home health clients upon admission, follow-up, transfer to an inpatient facility, and discharge from their home health program.

The clients they served were mostly elderly persons but they occasionally had adult and pediatric clients. They all supervised home health aides and personal care attendants. They were on-call periodically and were called at home by clients and their families. They all spent a great deal of time with clients and families dealing with emotional issues. These issues were time consuming but were of high priority. They verbalized that they often felt overwhelmed by the amount of responsibility they had in their job. All the home health nurses saw a need for continuing education to keep up with new technology and equipment.

Differences Among Home Health Nurses. Two home health nurses were in combined administrative and staff positions. One office handled five different home health based programs. These were home health, hospice, personal care attendants, homemaker services, and a lifeline program. Although the two home health nurses were administrators, they also did home visits with clients.

One home health nurse who previously worked in urban settings could compare between her rural and urban practice. When working in Washington DC she feared more for her personal safety. She saw that poverty existed in both urban and rural settings. She noted more access to services in the urban setting and more networking to facilitate the use of these services. She thought seeing clients and their families more often in the rural setting, both during patient visits and informally such as at the gas station, led to better follow-through and continuity of care.

One home health nurse did not have a hospice program in the counties where she worked. She thought her cancer patients did not get the amount of visits they required because of Medicare reimbursement issues. She made unpaid visits to these clients; she ultimately quit her home health job because of this issue.

<u>Similarities Among Public Health Nurses</u>. The public health nurses conducted many mandated programs such as WCC, WIC, immunizations, maternal-child health, and Head Start developmental and health screening. The county commissioners approved the public health nurses' budget but otherwise the public health nurses were in charge of administering and carrying out their job duties. They all liked the variety in their job.

They did nursing administration tasks such as creating and updating their own policy and procedure manuals and creating their own job descriptions. They kept records of the services provided to justify funding of programs. Often the paperwork needed to justify a program took more time than the actual program itself.

<u>Differences Among Public Health Nurses</u>. One public health nurse did primarily school nursing for all the schools in her county and kept her involvement in the public health office more limited by not doing elder programs sponsored by the county's Council on Aging. Despite being the only public health nurse in her county, she did not do any family planning programs, sexually transmitted infection follow-up, and very little maternal-child health in that she only had done home visits for two teenage moms since starting her job.

The other two public health nurses had maternal child health programs, did prenatal classes, did home visits for clients with needs that did not meet home health agency guidelines, and traveled to satellite public health clinics within their county. One public health nurse set up medications for the prison in her county.

Tribal Nurse: Both a Public Health and Home Health Nurse. One nurse worked for a tribe and developed her own job description to include public health and home health duties. She did public health programs such as immunizations, maternal-child health, sexually transmitted infection follow-up, and Head Start developmental and health screening. She did not do WCC or WIC. She had the school nurse responsibilities for one of the outlying schools on the reservation. She did elder care and hospice nursing and worked in conjunction with a home health agency to take call for their home health clients on the reservation. For clients requiring daily or twice daily visits, she coordinated with the home health agency to do part of these visits. This was because the home health agency is located sixty miles from the largest town on the reservation and did not have resources to provide for frequent visits. She provided care to those who did not meet home health care guidelines or who did not have a payer source.

As an employee of the tribe she developed her own job description because she was the first nurse hired by the tribe. Before that time, the public health nurses were employed by the federal government/Indian Health Service, a separate entity from the tribal government. Since elders are very important to the tribe, she saw elderly clients who were homebound and needed nursing services such as the set up of weekly medications and dressing changes. She ensured the continuity of care after a client was released from the hospital. She provided acute home health coverage when she was flagged down to see a client at their home. Because of the lack of phones in homes and lack of cell phone coverage on the reservation, she often had to decide whether or not to drive clients to the emergency room. Eighty percent of those living on the reservation did not have a phone and they may live 10-20 miles from a phone and 10-40 miles from the emergency room. She also did hospice care and stated,

> Now many more tribal members are allowing their loved ones to die at home, where before it was unheard of. There's been a lot of education on how dying at home works. What equipment is needed, how to order hospital beds, overnight tables, commodes, we coordinate all of that, lots of times ordering it ourselves. One family had worked hard for two to three months to keep their mom at home to die, and at the last they were panicked. And so I said, "I'll come over and be with you." And just by example they were able to work through it. And now this family is helping other families who have loved ones dying at home.

She believed she was willing to take on challenges that others could easily rationalize not doing. For example, a diabetic client with a grossly infected leg ulcer containing maggots refused to leave her home for hospitalization and wound care. Many Native American diabetic clients with ulcers avoided going to the hospital because they were afraid of having an extremity amputated (which often was what did occur). The tribal nurse easily could have rationalized that "since the client is refusing the proper treatment, why should I try to help her wound heal at home?" But she was able to get screens for the doors and windows, have the house cleaned, perform appropriate wound care in the home, make sure the client got antibiotics for the wound infection and her diabetes under control, and obtain a high protein diet for her client. The wound healed.

Because of the lack of resources in her remote setting, the tribal nurse has learned to utilize what or who is available. It may be family or volunteers who were doing the dressing changes or who sat with the dying client. She planed ahead, was prepared, and was not afraid to drive on bad roads. She stated, "It's really important to have good skills and have confidence in your assessment skills. You really need to know your client and think ahead. In the rural setting it's not like you have a clinic every three blocks." She has been in this position for ten years and believes she has made a difference. She does not mind the lack of set job hours or job tasks or personal intrusions as she remains flexible to meet the needs of her clients. She stated

> I wouldn't trade this experience for the world. I love this tribe. They are so humorous in spite of all their poverty and what they don't have and in spite of a lot of ignorance and they really have been good to me. I feel so loved. I feel that they have a respect that comes from reaching out to them in the right way. I don't think there's another discipline you could really achieve that in besides nursing. You get to be involved.

<u>Summary of the Dimension of Rural Community Based Nurses</u>. Looking at the dimensions of practice of the seven community health nurses, the home health nurses had the most similar tasks in that the majority of their clients are elderly with more acute health care needs requiring skilled nursing care in the home. The public health nurses had more variety in the ages of their clients and the many different programs with which they were involved. The public health nurses conducted many similar mandated programs. Public health nurses did home visits but the home health nurses did not conduct public health programs. The tribal nurse had the greatest amount of variety in her practice doing both public health and home health nursing.

<u>Core</u>

The core of nursing dealt with human responses to health/illness issues. As Scharff (1998) stated,

> Nursing exists to deal with human response to health issues, and human response can be equated to human need with respect to health. The patients' *needs* and their *responses* are outgrowths of whom they are as human *beings*. The nursing care we provide is an outgrowth of whom we are as human beings. The core of nursing is the dynamic of nursing care juxtaposed with human response. (p. 23)

In a rural setting many clients viewed health as being able to work, to be productive, and/or to do usual tasks (Long & Weinert, 1989). Rural nurses needed to keep this in mind as well as the characteristic of self-sufficiency of rural clients. One rural home health nurse reported that many rural elders were very independent and wanted to do everything themselves. Clients who could qualify for hospice care waited too long, exhausting themselves and their family before getting hospice care; they died soon after hospice care was initiated. Also they showed much pride and valued privacy; this made them hesitant to have "strangers" in their home.

Public health nurses saw various populations that viewed WIC as welfare. These groups had members who would qualify for these programs but would not use them. Rural poverty existed but not as visibly as urban poverty because of the rural norms of "taking care of our own," or making do with less. The homeless and hungry often go to a larger city where there are shelters and services for them (Wenger, 1998).

Boundary

The boundary of rural community based nursing is a combination of the intersections, dimensions, and core of nursing. As with rural hospital nursing, rural community based nursing's boundary of practice changed continually as the nurse moved between nursing activities. These excerpts portray the variety of rural community based practice, showing the wide boundary of their practice.

I saw a client at 6 a.m. and then came to the office. I have lots of paperwork and meetings at the hospital to go to. There's a staff conflict that I have to work to resolve. I had a nurse aide resign this morning and I don't have staff to cover so I'm looking at having registered nurses doing nurse aide visits. Then, the client I saw at 6 a.m. fell again at 12:30 p.m. So I worked on getting him admitted to the hospital, making the transition, and his children are coming from out of state to make a decision about whether they can help him stay at home. If not, then we're looking at a nursing home placement. That is a very emotional issue with the family that I'll have to deal with. And I've got to do payroll and review recommendations from a consultant before we're reviewed by the joint commission.

I walked in the office at 7 a.m. and the phone was ringing off the hook. My client fifty miles away pulled out his central intravenous line. The closest ambulance couldn't make it to his place because it was broken down. I called the ambulance here but I beat them out there and applied pressure until they got there. When I got back, a client thirty miles away in another direction was having cardiac problems. I went out there and had to call the ambulance because he was in third degree heart block. And cell phones don't work out here so I can't get things done while I'm driving.

On my way to work, I was flagged down and informed that someone had been sick all night. I haven't got a telephone in the car because cell phones don't work out here. That client needed to go to the emergency room. I always follow up and go to the emergency room with a client. You're always breaking rules. So you have to have good common sense on when to break the rules. Then there was a sick baby somewhere where the child had a positive blood culture and they want me to find the baby so the parents can bring the child in. Then I got a report on children somebody was neglecting. I got an anonymous call to check on them because they were left alone. So I had to go out and check if they were left alone and then call social services. Our social service department is overwhelmed. If there is medical neglect, the public health nurses deal with that too. Then a school called to say that five kids have head lice. They're brought to my office and we treat the head lice and contact the parents and educate the parents on the treatment of head lice. Then the clinic called me to say there's a lady in labor and she's 17 and she's scared, can you come over and give her a crash course on some breathing exercises? How can you say no? So you throw down all your paperwork and run over to the clinic and start demonstrating the blowing and puffing. It's just too wild sometimes. You have to be very flexible.

At the core of these rural community based nurses was the enjoyment of variety, the ability to be flexible in adapting to the needs of the individual and the community, and the ability to be comfortable with lack of anonymity. One nurse stated:

> Sometimes I forget I'm working. I work when I buy my groceries. Because there are people that I know in the store and they're talking to me and ask, " Is this what I should be eating?" as a newly diagnosed diabetic. So you stop and tell them what they should eat. You're educating, you know. It's incorporated into your life.

Nurses were approached in public and were called at home. They all said they did not mind these interruptions of their personal time, as this came with the job. Clients told one home health nurse, "We just know you're the nurse, that's why we ask for your advice." They said they enjoyed and took pride in caregiving and providing comfort to clients.

Grounded Theory Findings

As the interviews were coded and categorized using grounded theory analysis, a continuum emerged based on autonomy, job variety, and job satisfaction (see Figure 1). The seven nurses were placed on the continuum starting from left to right, from less to more job autonomy, job variety, and job satisfaction which co-varied among the nurses. The following paragraphs describe their placement on the continuum.

Figure 1. Continuum of Autonomy, Job Variety, and Job Satisfaction

⇐ Less AUTONOMY More ⇒

JOB VARIETY

JOB SATISFACTION

Home health RNs, PHN (new grad), PHN (new-comer), PHN (old-timer), tribal HHN/PHN

The three home health RNs had the least autonomy, job variety, and job satisfaction due to constraints from home health regulations and concerns regarding insurance coverage. Home-bound status regulations limited their flexibility in providing care. Medicare/insurance coverage limitations strictly structured the home health visits and dictated whether there could be home visits, and the number and length of the visits. Additionally, the vast amount of paperwork involved in home health care took time away from patient care and decreased job satisfaction. For example, Medicare has started a data collection system using OASIS forms. When admitting a client to home health, an admission OASIS form, fourteen pages long, must be completed. A home health nurse stated,

> Admissions were lengthy with paperwork taking 2½ hours and now it takes 4 hours to do with the OASIS form. If you transfer a patient to the hospital there's more paperwork. If they go home you have to do the OASIS all over again even if you haven't had them off services for a week yet. There's another form to do when a patient gets discharged. There's just a lot of paperwork. And starting July 1, 1999 they passed a fifteen minute increment billing deal, where now you have to track all the time in the home. You don't start counting until you've been in the home eight minutes. If there's any interruptions greater than three minutes, you're supposed to subtract time if they're in the bathroom or on the phone or whatever. It's an asinine regulation. I think all the staff feels bogged down with paperwork requirements.

Another home health nurse stated,

> My supervisors tie my hands. They won't cover this, and say if I see this patient, they won't cover that. There are a lot of things I do on my own time when I know I should be spending time with my own family but you know you haven't done your job good enough until it's done.

The public health nurse who was a new graduate thought she had a lot of autonomy but felt uncomfortable with the lack of set priorities in her job description. She mainly focused on school nursing, immunizations, and WCC. As time progressed she stated she became more comfortable in starting new programs in the community.

A second public health nurse was labeled a newcomer because she was new to her community and had only recently started her public health job. She previously worked for a home health agency in an adjacent county and felt comfortable in seeing clients in their homes as a PHN. She and her co-PHN were developing policies and procedures for their office and had the freedom to develop programs based on the needs of the community. As a newcomer to public health nursing she felt she was still growing in the role but was very pleased with the variety and flexibility she had to do what was needed to promote positive health outcomes in her county.

The third public health nurse had worked for a long time in public health and lived most of her life in her community. The county tried to combine the public health and home health nursing offices a few years ago. She was able to structure her position so that it would not be combined with home health; she did not want to learn all of the home health regulations and paperwork guidelines. She structured her job to meet the needs of the community. She mentioned feeling high satisfaction in seeing the effect of her practice on all age levels in the community. As she lived a long distance from a major health center, she filled gaps and was a safety net, providing care to clients who otherwise would not qualify for home health or other programs.

The widest variety in roles and tasks was seen with the tribal public health/home health nurse. She developed her job to best meet the needs of the tribe she serves. She did classic public health activities as well as coordination of home health/hospice care for