

ORIGINAL RESEARCH

Labouring to nurse: the work of rural nurses who provide maternity care

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ABSTRACT

Introduction: This research takes up the standpoint of nurses who provide maternity care to women and families in six different communities of one geographically isolated area of British Columbia, Canada. This first report (phase one of the study) focuses on describing the complexities of rural nursing work and identifies some possibilities for change that would better support nurses in their work.

Methods: This study was guided by institutional ethnography and included both observations of nursing work and interviews with expert informants about nurses' work of providing maternity care in rural communities and geographically isolated small towns. Nurses were asked to describe their work in as much detail as possible, and chronological accounts were constructed. Analysis focused on painting a complex picture of the work of rural nurses and identifying traces of social organization for further investigation.

Results: Overall, the work of nurses who provide maternity care was characterized as broad in scope, as requiring complex knowledge and skills, with a significant amount of professional responsibility in an environment with limited resources. Rural nursing work was also grounded in nurses knowing their community. An adequate number of skilled nurses was consistently identified by all participants as essential for the safe provision of maternity care. Since opportunities to learn the skills needed to



provide maternity care were difficult to obtain in small rural settings, nurses also identified affordable and accessible continuing professional education as the most important strategy for recruiting and retaining rural nurses.

Conclusions: Phase one of this study has confirmed the complex and contextual nature of rural nursing work. Phase two, which is currently underway, is exploring the institutional discourses, structures and work processes that obscure this complexity and regulate, rather than support, rural nurses' work of providing maternity care.

Key words: experiences, institutional ethnography, maternity care, rural nurses' work.

Introduction

This research takes up the standpoint of nurses who provide maternity care to women and families in six different communities of one geographically isolated area of British Columbia (BC). Nurses were asked to describe their work in as much detail as possible. This first report focuses on the complexities of nursing practice and what it is like for nurses to provide maternity care in rural settings. The overall aim of this research was to explore rural nurses' experiences with the provision of maternity care in their communities and to identify possibilities for changes in health policy and nursing education/ practice that would better support nurses in their work.

Background and significance

Lack of access to local maternity services in rural settings increases childbearing women's stress and vulnerability^{1,2}. Local provision of maternity care depends on the availability of health service resources and skilled healthcare providers. However, recent trends have documented an impending crisis in the provision of maternity care for Canadian women^{3,4} because there is a shortage of healthcare providers, including nurses^{5,6}. Addressing this shortage of skilled maternity care providers will require the exploration of new models of collaborative practice⁷⁻⁹ and better ways to support healthcare providers, including nurses, in their provision of maternity care to rural childbearing women in Canada.

Previous research has identified that skilled nurses working in rural and remote locations are crucial for the provision of maternity care to rural parturient women^{10,11}. However, little is known about the experiences of the registered nurses (RNs) who are providing this care¹². Researchers have reported that it is difficult for nurses working in these settings to obtain/ maintain the nursing practice knowledge and skills they need to provide nursing care for childbearing women and their families¹³. This study considered the experiences of rural nurses and their contributions to maternity care in rural and remote settings (and in the small towns where women might be referred for care surrounding childbirth).

Review of the literature

This study is grounded in a deep sense of respect for the work that nurses do and has been influenced by and builds upon the ethnographic work of feminist researchers^{14,15}. Nelson and Gordon¹⁶ have questioned the caring discourse so prominent in nursing that tends to obscure the knowledge and skills needed for nursing work both in hospital and community settings. Rural nurses have consistently told researchers that the complexity of their work is vastly underestimated¹⁷.

Rural nurses work in a variety of settings across Canada and their nursing work reflects this diversity. Nurses work as 'expert generalists' in both hospital and community settings^{18,19}. Rural nurses are also expected to do the work of both non-professionals (such as housekeepers) and other professionals (such as physiotherapists or pharmacists)



particularly on night shifts and/ or weekends when these other workers are not available^{20,21}. The characteristics of the local community, including local demographics, available resources/amenities/people, and community needs directly influence nursing work in these settings¹⁷.

Rural nurses have also described the centrality of developing, promoting and maintaining relationships in the work they do²². Feminist researchers²³ have described 'relationship work' as a form of important, yet invisible work done by women in our society. Vudik and Keddy²⁴ have also described the invisible aspects of rural nursing work such as 'integrating into an indigenous setting'. Nurses working in small rural communities also need to be skilled in maintaining professional boundaries between their home and their work responsibilities^{25,26}.

Our recent pilot study²⁷ focusing on the experiences of nurses working in two coastal rural communities revealed that rural nursing is rewarding work (this unpublished study allowed us to describe nurses' experiences in providing maternity care and identify areas for further exploration in this larger study). Rural nurses were proud of the work they do and revealed passion, commitment and creativity in their everyday work. This commitment can lead to an increased sense of responsibility for ensuring that people living in their communities have access to the health resources they need²⁷. However, to date there has been very little published research on rural nurses' work of providing maternity care. This article attempts to address this gap in our knowledge about rural nursing.

The study: goals and objectives

The overall aim of this research was to explore the social organization of nursing work and identify possibilities for changes in health policy, nursing education and practice environments. Specific objectives include: (i) to describe the work nurses do when providing maternity care in rural/remote settings, including the local context for their work and the competencies required for rural maternity nursing practice; (ii) to explore how interactions with

women, healthcare providers, administrators, and the rural community influence nursing work in rural settings; (iii) to identify the institutional structures, resources and (textually mediated) work processes that affect nursing work; and (iv) to identify possibilities for change at the local and institutional level that would better support nurses in their work of providing maternity nursing care to women and families.

Methods

Institutional ethnography

The approach guiding this study was institutional ethnography (IE), a methodology developed by a Canadian sociologist, Dorothy Smith^{15,28,29}. Institutional ethnography begins from the standpoint of a group of people, such as nurses, and explores how their experiences are socially organized. Institutional ethnographers examine texts and institutional practices to uncover the work texts do in constructing the objects of institutional action. The goal is to map out social processes, creating a tool for more effectively navigating or changing complex social systems. This study also draws on Dorothy Smith's understanding of work as something that requires effort and skill¹⁵. Institutional ethnographers take up work as anchored in material conditions and done in real time.

Institutional ethnography has been taken up by a number of researchers investigating the social organization of health services. Campbell^{30,31} and Rankin³² studied how healthcare reforms have restructured nurses' work. Mykhalovskiy³³ showed how a standardized care pathway text was used to decrease the duration and amount of nursing care provided to heart attack patients. Beginning from the standpoint of front-line healthcare workers, other institutional ethnographers have studied nursing homes³⁴ and a psychiatric day program³⁵. Institutional ethnography has also been used to examine healthcare and home care services from the standpoint of patients and clients^{36,37}.



In this study, interviews and observations with these front-line nurses focused on their work activities. Rather than conceptualizing nursing work (focusing on what nurses should do), these interviews focused on what nurses actually do, on the particulars of their everyday interactions with childbearing women and their families, with physicians and other healthcare providers, and with a variety of hospital and community service workers. It is not always possible to directly observe nursing work in small settings where births may not be an everyday occurrence. We also interviewed nurses as experts in their work, and chronological accounts of what they do were constructed.

This study was undertaken in two phases: (i) an exploration of the everyday experiences and work of rural nurses; and (ii) an investigation of the social and institutional factors organizing nurses' experiences. Phase two is still in process and will be reported in more detail later. Data collection methods included: (i) observations/ interviews with nurses; (ii) textual analysis; and (iii) follow-up interviews with childbearing women, healthcare planners and/or other providers. Institutional ethnography requires some flexibility in the research process because the initial interviews/ observations (in this case with nurses) can identify directions for further study³⁸.

The local context for maternity nursing work

The East Kootenay region in BC's southern interior is mountainous and geographically isolated. Forestry, mining, manufacturing, tourism, trade, service and transportation form the backbone of the region's economy. The East Kootenay Health Service Area (EKHSA), one of 6 health service areas within the Interior Health Authority has a total population of 78 133 people spread out over a large geographic area of 45 085 km².³⁹ The regional hospital in Cranbrook provides core medical and surgical specialty services (including obstetrics) to patients throughout the service area. We interviewed some nurses working in Cranbrook but most were from small towns (<10 000 people) and/ or their surrounding rural communities.

Investigative methods

After ethical approval was obtained from the university and the health region, participants were recruited through a poster/ information sheet sent to all maternity care settings in this BC health region. We also invited other healthcare providers, local decision-makers and women living in the community to talk to us about the work of rural nurses (although not the focus of this article, 10 women from one rural community participated in a focus group that affirmed the importance of both local maternity services and the personalized care they received from rural nurses). Participants were volunteers and a written informed consent process was undertaken before they were observed or interviewed.

Data collection

After informed consent was obtained from the nurses, the study began with observations of nursing work in the hospital setting. Observations focused on the nurses' work activities, who they interacted with, and the resources (including people and texts) they used to accomplish their work. Here we began to identify institutional policies, guidelines and work processes for further exploration.

Following these observations, individual interviews or small focus groups were conducted with nurses that further explored the organization of rural maternity nursing work. Initial questions included: What is involved in your work? What kind of knowledge and skills are required? What is it like for you to do this work?⁴⁰ Any RN who provided care for childbearing women was eligible to participate. To further understand the complexities of rural nursing work, we also talked with nine other healthcare providers (including physicians, a physiotherapist, two community-based midwives, practical nurses or licensed practical nurses; LPNs) and seven decision-makers or local hospital administrators.



Expert informants: the nurses

The RN group included 48 RNs working in 6 communities. In this group, 35 nurses worked in the hospital setting as staff nurses, five were clinical coordinators or RNs who provide front-line leadership on the nursing units but remain within the union bargaining unit ('in scope'), and eight nurses worked in the community as public health nurses (PHNs). The nursing work experience of nurses participating in this study ranged from new graduates ($n = 12$) to nurses with more than 30 years experience. Most nurses who participated were diploma prepared and had been working as a nurse for more than 15 years.

Analytic methods

Analysis focused on painting a more complex picture of the work of rural nurses and identifying traces of social organization in their talk. We have drawn on the work of Liza McCoy for this analysis of the nurses' work activities and experiences⁴⁰. The questions asked during analysis were:

1. What is the work that these rural nurses are describing or alluding to? What does it involve for them?
2. What particular skills or knowledge seem to be required?
3. What does it feel like to do this work? What troubles or successes arise for the nurses?
4. How does the rural community and practice setting affect maternity nursing work?
5. What evokes the work? How is their work connected to the work of other people?
6. How is the work articulated to institutional work processes and institutional order?

This article focuses on the complexities of rural nurses' work of providing maternity care, but also formed the basis for further exploration into the social organization of nursing work. In phase two of the study we are currently performing an analysis of field notes, texts and interview transcripts focused on explicating the effects of coordinated

and intersecting work processes taking place in multiple settings. This approach is one important technique for identifying how power is exercised in ways that influence the everyday experiences of nurses or other groups of people⁴¹.

Reflections on the research team

The nurses and care providers interviewed and observed were also a very important part of the research team and this study would not have been possible without their active participation and support. Nurses seemed to enjoy the opportunity to engage in a detailed discussion about their work with a respectful listener which resulted in some very animated conversations. We would like to acknowledge the conversational nature of these interviews and remind the reader that the findings from this study were co-created between the researcher and participants.

Reflections on the research process

One of the limitations to this kind of research results from the limited opportunities to remain in the communities for an extended period of time. We tried to compensate by making several trips through the health region and by including periods of observation and informal conversation in addition to more formal interviews and focus groups. If someone was missed, the opportunity to participate in a telephone interview was provided. The importance of prolonged engagement in the community was made particularly salient by one front-line nurse who remarked on our second trip through the area that we were 'the first researchers who had ever come back'. On reflection, this comment is a reminder that researchers need to make a commitment to their participants and respect their contributions to health service research.

The integrity of the study⁴², including the potential for researcher 'bias', was addressed by making the decision-making process as transparent as possible through the use of field notes and reflective journals. Preliminary findings were taken back to participants for feedback, and community



information sheets were created to encourage ongoing discussion (these community information sheets can be obtained from 'Working Papers' at <http://nursing.uvic.ca/people/KarenMcKinnon.php>).

Results

The context for rural nursing work: work grounded in knowing their community

Rural nurses described needing to know who lives in their community, what their skills are and whether they are available to address local health needs or respond in emergency situations. Although privacy concerns were acknowledged by rural nurses, rural nurses consistently described knowing the people in the community as a way to enhance local health services.

If I phone [PHNs name], who I know in [rural community], and say, 'This person is coming home, she does not have a breast pump. She needs one'. I mean, she will get it, pick it up, take it to her home. It doesn't matter what time. You know, really, if she's there she'll do it. And it's that connection you have with these people... (RN 34)

Both hospital and community health nurses described the importance of knowing their community and recognized the need to utilize the skills of all healthcare providers available including LPNs. Public health nurses were also observed to take a leadership role in developing, importing and adapting health programs that addressed the needs of people in their communities. Their work also requires the very complex skills of building and maintaining interprofessional relationships and promoting intersectoral collaboration.

Responsibility, commitment and creativity

Knowing their community contributed to the nurses' tremendous sense of responsibility for providing care to local women.

I think in a small community, the people you care for in the hospital are people you're going to see on the street. And you know, you do. You do want to do a really good job for them. (LPN 3)

Well, I mean, you care more, I think about what your community needs. And you know, Interior Health provides sort of a standard service, and we kind of have to make it work for the extra things that we think are important. (PHN 5)

Many rural communities also demonstrated considerable creativity ensuring that a skilled nurse was always available and sometimes this commitment went as far as 'volunteer call' for the nurses (including nurses with operating room [OR] training for emergency caesarean birth). Many nurses also demonstrated significant creativity, such as collaborating with other people from their community to ensure that essential health services were available.

Public health nurses working in rural communities were observed to provide leadership for developing local programs and promoting intersectoral collaboration to address local health needs. One of the PHNs we interviewed identified a colleague who (with three others) had developed a creative program for young women called 'Girls Night Out'⁴³. We later interviewed this PHN to find out more about the factors that enabled and constrained program development in a rural setting. She shared that smaller centres have more 'maneuverability', are less constrained by bureaucracy, have better relationships established across sectors, and have people who are very committed to their local community. She also identified the need to compete for funding as a significant barrier in rural settings where a small group of professionals are available to do all the work.

The complexities of rural nursing work

This research report attempts to make visible some of the complexities of rural nurses' work of providing maternity care. We observed nurses in their work settings, sometimes providing maternity care but often caring for a greater



variety of patients and families with complex healthcare needs. Both hospital nurses and PHNs were observed and interviewed about their work. Although their work differed in emphasis we were continuously surprised at the level of knowledge and skill required for rural nursing practice.

That's the thing about being over at the hospital, is you're everything. You are the person that, you know, cardiac patients come through. You're the person that's dealing with everyone that's there on the floor for whatever medical or whatever. And you're also doing non-stress tests, you know... And you know, if something progresses to a labour, some times there are people that, regardless of their maternity experience, need to take on that role. (RN 7)

In addition to the skills needed to provide immunizations, public health nursing work also required skills in sexual health counseling, communicable disease follow up, and designing or delivering a complex array of health promotion/health education programs. This study has confirmed the complexity of rural nursing work and the difficulties of being an 'expert generalist' both in the community and in the hospital setting.

Rural nurses' work of providing maternity care

What is the work these nurses are describing and what knowledge and skills are required?

The work of hospital nurses: Rural nurses are an important resource for childbearing women and work closely with physicians and midwives. In rural hospitals they are the only healthcare provider who is immediately available, therefore they need to be skilled at assisting women during childbirth, as well as mobilizing the resources needed for emergency situations. For example, rural hospital nurses may be called upon to care for a critically ill newborn for several hours until the 'transport team' arrives from a larger centre. Hospital nurses identified the knowledge and skills required for their maternity nursing work as including:

- assessing the childbearing woman to identify risk factors and progress of labour
- supporting the woman in labour and caring for her family by knowing about them
- delivering the baby in the absence of the primary care provider
- anticipating the possible need for transfer of mother and/ or baby and mobilizing community resources as needed in emergencies
- stabilizing the sick newborn and assisting the 'transport team' and other healthcare providers
- assessing the newborn and assisting with breastfeeding
- ensuring that the woman was aware of community resources prior to hospital discharge
- completing the many chart forms required for childbirth by hospital management
- a variety of housekeeping and other duties when support staff were not available (particularly on weekends and at night).

The amount of time required to complete provincial chart forms was identified as more time-consuming in settings where birth was less frequent because there were fewer opportunities to develop the knowledge and experience needed to do this work quickly.

In this study nurses clearly identified maternity care as a specialized area of nursing knowledge. Rural nurses identified maternity care or perinatal nursing (perinatal nursing has been a recognized specialty of nursing in Canada since 2000; Canadian Nurses Association, 2008; available http://www.cna-nurses.ca/CNA/nursing/certification/default_e.aspx) along with emergency and mental health nursing as specialty areas of nursing practice that are very important for nurses working in rural hospitals.

The maternity care work of community nurses: Public health nurses identified skills with maternal, newborn and family assessment and assisting with breastfeeding as most central to their maternity nursing work. Public health nurses



were very concerned about the lack of resources and/ or health services for local childbearing women.

What I find difficult is not having all the services. I am from [a big city] and I know what it was like to have everything... You know, when a family was having extra trouble we had the social worker in the building, or we had the psychologist in the building, or we had whatever we needed. We had the lactation consultant in the building. And [here] you kind of have to be everything to everybody, or try. (RN 33)

Here the PHN has articulated how difficult it is to provide a high level of service across many programs. The PHNs also described providing perinatal education, counseling women with postpartum depression, and working with women/ families with few resources and/ or living in complex social situations as part of their maternity care work. They described needing to build on what they learned in their undergraduate nursing education programs and through experience by enrolling in continuing professional education programs.

Well, in the beginning I really didn't have any preparation and I found myself in a situation where I was teaching a breastfeeding course, but really I would honestly say I knew basically nothing about it. So I worked very hard at preparing myself and took a course through distance education. (RN 48)

Both hospital- and community-based nurses highly valued opportunities for continuing professional education.

Safeguarding work: Knowing their community contributed to the nurses' tremendous sense of responsibility for providing care to local women. Because of the devastating impact of losing a baby and the increased visibility of the nurse in small communities, the nurses we interviewed described being particularly concerned with safeguarding childbearing women and anticipating the possibility of obstetrical emergencies.

Nurses were also aware if the local ambulance was available and were able to describe in great detail the work processes and time involved for arranging an emergency transfer to a larger centre. Part of the nurses' safeguarding work was knowing what was happening in 'Emerg', knowing the skill level of the nurse coming on to night shift, and knowing how to mobilize the OR team quickly should an emergency arise. The nurses' gaze differed from that of the physician or midwife in that they were always aware of what else was happening in the hospital.

Rural nurses were very concerned when a skilled maternity nurse was not available at the local hospital.

There are a few nurses, maybe three or four that we have on the casual list that have very minimal mat. experience. And the understanding just is if you're working with them and a maternity comes in, they take whatever you were doing and you go with the maternity. So, yeah.... It's tough, and because sometimes there'll be two like that on one shift at night, so there has to be kind of a backup plan. And there isn't always a backup plan. (RN 31)

In several communities nurses told us that their work of providing maternity care sometimes conflicted with their ability to provide safe care to other patients. Here the nurse is referring to a national guideline (Family-Centred Maternity and Newborn Care National Guidelines are available at <http://www.phac-aspc.gc.ca/dca-dea/publications/fcm02-eng.php>) that recommends one-to-one nursing care for women once they are in active labour.

That's the other thing. I mean they always say, 'Yes, you'll have one-to-one nursing when they're in active labour'. We don't. And they say, 'Well I can't staff for what ifs.' And this is my thought, if you can't staff for one-to-one, then you can't deliver. You can't have a labouring patient and four or six other patients. (RN 36, focus group)



In a small rural hospital these nurses may not care for a woman in labour very often. So for them to provide safe care they it is likely to be more important that recommendations for safe staffing are followed. In one of the communities we visited these nurses rallied together to ensure adequate nursing staffing levels (and skilled maternity nurses) were maintained for their local community hospital.

Knowing their community also affected the nurses' willingness to keep babies whose condition they considered 'borderline' and some nurses acknowledged that their work of safeguarding babies sometimes strained relationships with other healthcare providers (RN focus groups, May 2007).

Promoting good working relationships with all healthcare providers was another important yet invisible part of the rural nurses' work.

Public health nurses working with women and newborns in the community also described their safeguarding work.

My experience is in the hospital you leave and you're passing off your responsibilities to another nurse. Here [in the community] you're never passing off. And I know it's not as acute, but you still have in the back of your head... that family, how are they coping? I've gone in on weekends before and just said, 'Okay, so just to check, I'm coming over'. Just to make sure everything's OK and the feeding's going well. (RN 08)

Knowing women in their community seemed to foster commitment to working extra hours to address identified needs in the absence of formal community follow-up programs. The PHNs voiced concerns that this 'extra work' was not formally recognized in the 'core deliverables' for public health nursing.

Rural nurses told us many stories where they had experienced 'moral distress'. Some inexperienced nurses we interviewed said they were 'scared to death' when a labouring woman walked into the hospital. Some of these

new nurses also described how difficult it was for them to get the education and experience that they felt they needed to be comfortable providing maternity care.

I graduated and went to [a remote community]. And talk about throwing me in...I had six orientation shifts...and during those six orientation shifts there were no babies. Now my university orientation of maternity was not stellar. ...we did a lot of scenarios, but we didn't have to have an in-hospital maternity placement. (RN 08)

The comfort/skill level of new RNs was understood as influenced by changes in nursing education, increased expectations regarding post-registration specialty education, concerns about legal liability, and by the lack of mentorship opportunities in rural hospitals with low birth numbers. Several experienced nurses told us that new nurses needed opportunities to learn maternity care skills in larger centres.

I think they [new nurses] should do a mentorship in a larger centre. ... And I really wish that as full time [nurses] we would have the opportunity to do that [for a refresher]. ... I'd like to see a trade. Like so many times we've encountered nurses... and you know, I'll be perfectly honest, I didn't know what was really in store for me. I came from a larger acute care hospital...and you get very good at what you're doing because you work on a specific unit. And here it was like, 'Holy Diana, we do what?' And I firmly believe that a lot of the bigger centres, the nursing staff who work in emergency or ICU or wherever, whatever unit they're on, if they haven't done rural nursing, they've got no idea. (RN32)

In addition to the need for 'refresher' experiences for experienced nurses, this nurse is suggesting that nurses working in larger centres might also learn something important by changing places with a rural nurse. Some rural nurses told us that they had experienced a 'cold' or 'judgmental' response from nurses working in larger settings when they transferred women to larger hospitals.



More experienced rural nurses experienced distress when their concerns about needing to rehearse infrequently used maternity skills or having adequate staffing levels to ensure that ensure safe care for childbearing women and their other patients not been acted upon. One nurse shared the distress she experienced when a woman whose baby had died following transfer to a larger centre received the ambulance bill three times despite her efforts to ensure this routine practice did not happen for this devastated family.

Exploring generalist/specialist tensions

Nurses working in the hospital were clear that they understood maternity care as requiring a high level of specialty ‘perinatal nursing skills’ yet they also talked about needing to ensure that everyone working was able to help out in some way.

I think education is such a key component. I personally felt a thousand times better delivering babies after I had neonatal resusc[itation], which I'd never had because I ...hadn't delivered babies in 20 years, and having that just...that makes me know that I can care for a baby as well as I could care for an MI [myocardial infarction]. (RN 29)

Building skilled teams of nurses with different areas of ‘expertise’ was one model that worked well in some communities. The LPNs sometimes received additional education in providing postpartum care and assisting with breastfeeding and so were able to care for the more stable women and their newborns. All nurses felt that NRP (neonatal resuscitation) was important as they might be called upon to assist during birth even though their expertise might be in emergency or medical-surgical nursing.

Discussion

Maternity care is part of primary healthcare services and women want care as close to home as possible^{1,2}. But what level of care is appropriate to provide in different sized

communities?⁹ Some people feel that care for healthy women in normal childbirth is most appropriate for small towns and rural settings. And yet there is no clear understanding of what ‘normal’ entails, and small communities vary considerably in the availability of skilled maternity care providers. Recently researchers have identified some of the personal ‘risks’ that healthcare professionals experience when providing maternity care in rural and remote communities^{44,45}.

Staffing levels

An adequate number of skilled nurses was consistently identified by all participants as essential for patient safety. Community health nurses also described having large caseloads that did not reflect the time needed for home visiting at great distances and in differing weather conditions, which has been confirmed by other research⁴⁶. Varcoe and Rodney⁴⁷ drew on critical and feminist perspectives in their studies of nurses’ work and found wide discrepancies between the care nurses valued and the care many nurses were able to provide. These discrepancies can result in moral distress for nurses and can affect nurses’ willingness to provide maternity care in rural settings.

Continuing professional development

Recognizing the complexity of nursing work is essential for ensuring that funding is allocated for rural nurses’ continued learning⁴⁸. All of the nurses we spoke to felt that investing in continuing professional education benefited nurses and enhanced both patient safety and the health services available in their local community. Nurses working in smaller hospital settings, where birth was a less frequent experience, noted that ‘refresher’ practice experiences were also helpful for more experienced nursing staff. Both hospital and community health nurses emphasized the importance of continuing professional development, yet also told us how difficult it was to get away from their local community for educational sessions. Barriers to continuing professional education for rural and remote nurses have been identified by other researchers⁴⁹.



Distance learning coupled with new educational technologies (such as the Rural Nursing Program offered by UNBC; for more information on the new rural acute care nursing certificate program see <http://www.unbc.ca/calendar/certificates/nursing.html>) should make it easier to deliver educational sessions from afar. However distance education cannot entirely replace 'hands on' practice opportunities in local settings for infrequently used emergency skills. Opportunities to rehearse infrequently used emergency skills with an interprofessional team of healthcare providers was identified by many nurses as critical for ensuring safety for women and babies. Programs such as ALARM ((Advances in Labour and Risk Management; for more information on the ALARM program see www.sogc.org/alarm2005/english/index.shtml) and MORE^{OB} (Managing Obstetrical Risk Efficiently; for more information on the MORE^{OB} program see http://www.sogc.org/more/index_e.asp) warrant further consideration.

Local solutions with centralized support

Policies and practice guidelines developed in larger centres also have the potential to negatively impact on rural nursing practice¹⁷. For example, nurses working in one small hospital had taken the initiative to develop a policy for inductions that required local physicians to first consult with the nurse in charge (this might be the clinical coordinator or the most experienced maternity nurse) who would be aware of the implications for nursing staffing. They next heard from the central administrative office for their health region that they were not to develop any more policies or procedures. This rule concerned these nurses greatly as they recognized the need for policies that reflect the local context of rural nursing.

Rural nurses may be able to provide leadership for new models of interprofessional and intersectoral collaboration and need support for their creativity and commitment. The possibilities for nurse practitioners to complement RNs, LPNs, PHNs, physicians and midwives working in rural communities warrants further exploration.

Limitations

Although the selection criteria for study sites included isolation, distance and access to referral services, the diversity of rural communities cannot be represented by studying one health service area in one Canadian province. The importance of local context in rural health care reminds us to be cautious when transferring findings to other rural and remote communities.

Conclusions and recommendations

Rural nurses make a significant contribution to the provision of maternity care in BC, Canada. An adequate number of skilled nurses was consistently identified by all participants as essential for patient safety. This study has confirmed the complexity of rural nursing work and, by listening to nurses talk about their work, has identified a number of ways to better support rural nurses. These include:

1. Funding for continuing professional development for all rural nurses. Despite the limitations of nursing turnover in some settings, rural nurses identified the need to enhance the skills of all nurses (including LPNs) and other healthcare providers working in rural hospitals and communities.
2. Continuing education programs that are offered locally and/ or by distance technologies and include the opportunity to rehearse infrequently used emergency skills. Rural nurses identified affordable and accessible continuing professional education as the most important strategy for recruiting and retaining rural nurses.
3. A careful review is required of the effects of policies and guidelines developed in urban and suburban settings for how these texts impact rural nursing work. Providing templates that can be adapted to reflect the local context for care, and supporting rural nurses to make these adaptations was identified as helpful.



4. Competing for program funding and grant writing were identified as barriers for nurses who wanted to develop programs to address community needs. Nurses working in small rural communities need support for local program development, implementation and evaluation.

Negative experiences with the provision of maternity care can have serious implications for the retention of skilled nurses and other healthcare providers working in rural communities. It is important that we learn to listen to rural nurses when they express their concerns about unsafe 'staffing levels' or unsafe practices.

The following traces of social organization in rural nursing work have been identified as possibilities for further exploration and research.

1. Decisions about the level/type of maternity care offered locally seemed to be structured by something other than the needs of local women and the availability of skilled maternity nurses and other care providers. Further research about how decision-makers can better support local solutions would seem warranted.
2. Decisions about the allocation of resources for nurses' continuing professional development seemed to be structured by something other than the learning needs of rural nurses. Further investigation focusing on how to improve access to continuing education opportunities and learning resources is warranted.
3. The comfort/skill level of new RNs was understood as influenced by changes in nursing education, increased expectations regarding post-registration specialty education, concerns about legal liability, and by the lack of mentorship opportunities in rural hospitals. Further investigation of appropriate learning experiences for nursing students and new graduates would seem warranted.

4. Further exploration of moral distress experienced by rural nurses who provide maternity care is warranted.

Knowing their community and mobilizing community resources through skillful collaboration were identified as important components of rural nursing work. The rural nurses who participated in this study voiced a deep sense of commitment to and responsibility for childbearing women (and their families) living in their communities. The complex and contextual nature of rural nursing work was also documented. In phase two of this study we are currently investigating a number of institutional discourses, structures and work processes that obscure this complexity and attempt to regulate, rather than support, rural nurses in their work of providing maternity care.

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