Orientation Report

Prepared for CARRN Executive

By

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Orientation of Rural and Remote Nurses in Canada

Orientation for rural and remote nurses is considered to be an important aspect of retention as well as a contributor to quality work life (Hunsberger, Baumann, Blythe & Crea, 2009; Keahey, 2008; MacLeod, Kulig, Stewart, & Pitblado, 2004). Rural and remote nurses are particularly disadvantaged given the reported isolation, limited resources, shortage and age of practicing nurses, and turnover of nursing staff (MacLeod, Kulig, Stewart, & Pitblado, 2004; Priest, 2004). These obstacles intensify the need for effective orientation. Orientation introduces and guides nurses in their adjustment and transition to new surroundings, philosophies, employment, roles, and competencies required in their positions, whether they are new graduates or seasoned nurses.

The Canadian Association for Rural and Remote Nursing (CARRN) identified orientation for nurses working in rural and remote practice as a focus within the 2009/2010 strategic work plan. To that end, a committee was struck, a survey was developed and posted on the web-site, and circulated at local sites. This report will provide a background document to begin dialogue amongst CARRN members with the intention of developing recommendations for a national standard and a position statement.

Literature Review

Professional development is a lifetime pursuit for registered nurses. Along with a provincial/territorial requirement to develop individual professional development plans for yearly registration as a nurse, registered nurses must demonstrate their competence in the workplace. Employers are required to provide tangible and explicit support for nurse competency within the accreditation process in Canada. Orientation programs have the ability to

provide the support, tools and resources that are required to initiate and foster sustainable professional development of nurses and nurse competency, individually and collectively, within an organization.

Competency Based Orientation

Competency based orientation has been reported in the literature since the 1980s (Alspach, 1984; Chesnutt & Everhart, 2007; CRNNS, 2007;delBueno, Barker & Christmyer, 1981; Harvey, Novicevic & Speier, 2000; Strasser, 2005;Whelan, 2006). Whelan (2006) states that the components of a competency-based orientation are competency statements (performance outcomes), critical behaviours (specific actions), and learning options for individual nurses. She describes phases of orientation from general knowledge about the facility to a specific unit orientation. Keahey (2008) identifies the components as didactic instruction, core competencies, and evaluation. She suggests that comprehensive skills checklists are required to both assess and monitor progress. As well, orientation must occur in a nurturing and caring environment with an experienced preceptor and management involvement and support. Priest (2004) describes a program in rural BC where nurse educators are working with RNs to develop a framework of continuing education that enhances competencies of registered nurses.

Critical Pathways and Orientation

Many educators have realized that orientation is the beginning steps in a lifelong journey or learning pathway (Notarianni, Curry-Laurenco, Barham& Palmer, 2009). Notarianni et al. developed the Progressive Professional Development Model (PPDM) that combines virtual education, simulation, standardized patient and clinical practice to establish and promote lifelong

learning. Their model considers the generational diversity of nurses working today and individualizes each nurse's learning.

Simulation

Simulation is a means of acting out or mimicking nursing situations or events "making it real" (Campbell & Daley, 2009). Educators have described simulation as a knowledge tool that incorporates assessment and practice in a safe place, increases critical thinking, clinical judgment, teamwork and ultimately self-confidence for clinical practice (Stefanski & Rossler, 2009). Simulation in nursing occurs both with low and high fidelity models and live actors. Bosek, Li and Hicks (2007) describe using standardized patients with actors to facilitate learning. Institutions are utilizing simulation in professional development activities including orientation (Morris, Pfeifer, Catalano et.al., 2007). Simulation can be used both as a way of assessing learning and also as a continuing education modality.

There are a few examples of simulation for rural and remote settings provided through medical schools (Halaas, Zink, Brooks & Miller, 2007; Wilkinson, Smith, Margolis, Gupta & Prideaux, 2008) In rural US, medical students are prepared for a rural placement by reviewing case scenarios to decipher urgent from non-urgent, heighten decision-making skills, review communication in stressful events, and enhance clinical learning and action (Halaas et al). In rural settings in Australia, research was conducted on an assessment tool that used multiple patient scenarios by videoconference (Wilkinson, Smith, Margolis, Gupta & Prideaux, 2008). The researchers concluded that the tool facilitated "resourcefulness and flexibility in thinking" through content reflective of rural and remote medical practice (Wilkinson, Smith, Margolis,

Gupta & Prideaux, p. 480). Although there is a dearth of evidence, there is an indication that simulation would strengthen orientation for rural and remote nurses.

Method

A small ad hoc committee was struck amongst the executive of CARRN to investigate the role that orientation has within recruitment and retention of rural and remote nurses. A survey was developed that consisted of 12 questions that were both open-ended and closed. The survey was posted on the CARRN website for three weeks. It was also downloaded and a hard copy was circulated to nurses working in rural and remote locations by committee members.

Sixteen participants (n=16) responded to the survey. Ten (n=10) indicated their practice was in a remote setting while six (n=6) identified their practice to be in a rural setting. The remote practice nurses identified community (n=6) or nursing station (n=1) as the area[1] of nursing. Three did not respond to this question. The rural nurses acknowledged acute care hospital (n=6) as their area of nursing.

Sampling was purposive and a snowball technique was used, but the number of respondents is not representative. Our purpose was to gather some data so that we can develop a set of recommendations for a national standard for rural and remote nurses and to develop a position statement. The data were grouped using the questions as a framework and then analyzed for themes.

Findings

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[1] "Area" of nursing may have been a poor choice of words in the survey. The terms specialty, or focus of practice, may have generated more explicit responses. We were trying to capture broad categories and had listed the choices as acute care, hospital, community and other.

Orientation to rural settings and to remote settings was contextual. Rural nurse participants worked in small acute care hospitals, while remote nurses worked in community health centres (nursing stations). Responses between rural and remote nurses, as cohorts, were similar within the cohort and yet different between the cohorts. All of the rural nurses completed an orientation to their job and all but one of the remote nurses had an orientation to their job.

Only one rural nurse checked "yes" to an orientation to her community, while three nurses (30%) of the remote nurses checked "yes" to a community orientation. One rural nurse indicated that the length of community orientation was "years". One other rural nurse responded with a "4" that was inferred to be hours, since the subsequent question was answered in hours. The length of the community orientation for remote nurses had varied responses from 1 hour to 3 months to *on own* to *ongoing*. The rural nurses also indicated that the length of their orientation to the acute care hospital positions (described as their area of work) occurred from 72 hours to eight 12 hour shifts. Remote nurses had a variety of responses as well, from none to 3 months, to the length of orientation to their position.

Fifteen of the sixteen participants indicated that they believed that a formal orientation would assist with both recruitment and retention of rural and remote nurses. The one nurse who responded "no" wrote that there are "far too many other issues [influencing recruitment and retention], but there should be orientation" (Participant 011).

Topics Covered in Orientation

Participants were asked to list the topics covered in their orientation. There was a distinct difference between the rural and remote nurses' responses that were geared to the differences in

the setting where they worked. The rural nurses were mostly placed in small acute care hospitals, while the remote nurses were in health centers in remote communities. One nurse indicated she was the only Registered Nurse in her rural setting. The overarching themes of topics covered were general knowledge required for the facility and unit, specific topics required for the position, and processes of orientation.

*General knowledge required for the facility and unit.*A rural nurse stated she was provided "WHIMIS, CPR, etc. then basic orientation to the unit" (Participant 01). Other rural nurses listed the following topics; "safety, union, human resources, fire alarm, finances, work on the floor and NIC [nurse in charge] duties" (Participant 04), "multisystem topics and cultural [information]" (Participant 07), and "program goals and intent" (Participant 014). One rural nurse stated that there were no nursing topics[2]covered in her/his orientation rather "I was oriented to the ward routine and the nursing job" (Participant 016).

The remote nurses identified a "general orientation to the clinic" (Participant 08), "transportation of dangerous goods, everything I needed to know" (Participant 09), "Peoplesoft-HR" (Participant 011), "general organizational structure [place]" (Participant o12), and "back care/lifing, fire drill, introduction to "mother hospital", departments and personnel (Participant 015). The remote nurses included a community orientation. For example, one remote nurse stated she was introduced to the "community lay-out" (Participant 012), while another remote nurse stated she learned the "basic geography of the area (Participant 013).

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[2] The words "nursing topics" were used in this question. Please refer to the section on limitations.

Specific topics required for the position. Rural nurses for the most part did not include specific topics required for their position that were covered in orientation. One rural nurse indicated that "assessments and family violence/abuse" (Participant 07).

Remote nurses, on the other hand, referred to assessments and medical evacuations as topics frequently encountered in orientation. Responses included "different assessments (well women, well men, pediatric)" (Participant 06), "assessments of family systems and diagnoses, emergencies and medevacs" (Participant 08), "assessment, immunization, pharmacology, medivac" (Participant 08), and "immunizations, x-ray, labs, casting, suturing, ambulance, medevac, meds" (Participant 010).

One remote nurse described orientation to "delegated nursing" in the way she listed the topics of orientation. She reported "laboratory/x-rays-delegated nursing, pharmacy-delegated nursing", and "clinical guidelines-nursing" (Participant 011). One remote nurse requested extra Emergency room shifts as part of her orientation because in her position she is by herself on shift. She reported

> *I requested some ER shifts at [place]as this is the biggest and closest hospital and was granted three shifts to help me feel better equipped to be in [place of work], where I am the only RN on duty at any given time* (Participant 01).

One remote nurse reported that she was given "everything I needed to know" (Participant 09).

Processes of orientation. From the participant responses it was apparent that when orientation occurred, it was delivered in a variety of ways. One rural nurse reported that in 2001 when she started her job, orientation was "not formally developed at this time" (Participant 02). Another rural nurse reiterated that

> *It was purely buddy shifts. No specific classroom teaching.Its purpose was to become familiar with routines, and where to find things. I was also shown how to use the equipment needed for my job (i.e. infusion pumps, cardiac monitors, glucometer). I did have previous experience with these types of equipment; it was more to become familiar with the model used here* (Participant 03)

A remote nurse indicated that she learned "all aspects of the job…in a three month mentorship" (Participant 010). Still another remote nurse indicated that the process of orientation was geared to her individual nursing experience when she reported "…had worked for [place] before so aware of what job entailed. Received orientation to the organization and programs that was two days long, but this was done in the organization office not in the local community" (Participant 013). Some nurses identified that their learning was self-directed.

Competencies

Participants were asked if they were made aware of the competencies required for their job. Fifty percent of the rural cohort (n=3) responded yes, while seventy percent of the remote nurses (n=7) responded yes. Some of the nurses identified that competencies required for their job were identified in the job description. Although nurses indicated that competencies were identified within the job description, one remote nurse made the following comment:

> *Yes* [I was made aware of competencies]*, outlined in job description, not in detail though. There really should be continuing education related to community nursing+++ topics/areas to know. No amount of experience can really prepare a nurse for this nursing specialty and that maybe that is because there are so many non-nursing jobs expected of a CHN [Community Health Nurse]* (Participant)

Rural nurses provided a variety of responses to the competencies question. One rural nurse stated that she was made aware of competencies and that this was "clear with verbal and written information" (Participant 01). A second rural nurse reflected that "I think some of the competencies were outlined in a general orientation manual, but I wasn't given a copy and asked

to review" (Participant 03). Another rural nurse indicated that competencies were not identified

and went on to share the following:

> *No, I was not* [informed about competencies]. *There was no clear orientation plan, they did not seem to do it very often and it was disjointed. The nurse I buddied with for each shift was different and gave me what she thought I would need. No one asked me what I wanted* (Participant 016).

Supports for gaining and maintaining competencies were grouped under four themes;

peers and colleagues, courses and professional development information, certification processes

and simulation. These themes overlap and are reported by both rural and remote nurses. For

example, a rural nurse listed the following as her supports:

> *Local nurse educator; Mandated courses are available and fairly regularly-CPR, ACLS, TNCC, NRP, FHS, etc. Simulator training occasionally offered for the emergency staff; On-line resources available (library, policy/procedure manuals); Pre-printed orders/protocols available for some patient presentations. These are updated regularly* (Participant 03).

Both rural and remote nurses mentioned that the nurse educator was a support to gain and

maintain competency. A remote nurse described her supports as follows

> *[nursing credentialing body] is now doing certified practice. Support from other RNs working in similar situations. Basically responsible for finding own programs, resources for competency under current employer. Initial employer [names] had conferences to help maintain competency. Am not up to date on what is happening in that area now* (Participant 013).

Several rural and remote nurses noted "I maintain TNCC and ACLS and NRP on my own, no

rural employer yet has contributed much to keeping those certifications current" (Participant

016) and "personally chosen courses" (Participant 015). Another nurse shared that she completed

"self-directed learning on the internet" (Participant 011).

Gaps in Orientation

Fourteen of the participants identified gaps in their orientation that were as diverse as their individual experiences and learning needs. Some of the identified gaps included no formal orientation to the emergency room, labour and delivery, paediatrics, scope of practice, leadership role and topics like conflict resolution. It was apparent from the comments of both rural and remote nurses responding to this survey that they were not fully satisfied with the orientation they received. One rural nurse put it this way:

> *Orientation has in my opinion been breezed over in the past jobs that I have worked in. It is often assumed that because I have years of experience that I must know what is required. But this change from a Medical Nurse with a full crew of professionals working along side to being the only RN on shift has been a huge adjustment that at times I have felt abandoned. I could only imagine what a new grad feels*(Participant 01).

Another nurse referred to the incivility of colleagues as so destructive that she plans to leave nursing. She wrote the following:

> *First impressions go a long way, and that works for the employer as well as the newbie. If rural and remote employers put more thought and effort into orientation, they just might save a few new hires. Me, I am in the job till I can get enough education to get out. I do not feel I have been treated respectfully and this is not just rural and remote issue, it has to do with age old , we eat our young, whether they are young or not. I am embarrassed to call them colleagues* (Participant 016).

One rural nurse referred to the generalist aspect of her work that makes orientation to specifics difficult, when she responded that in her…"very small hospital ,only a 2 bed ER so having patients present with the variety of illnesses and crisis that are required to keep skills current, is impossible" (Participant 01). Another remote nurse described her orientation as "self-taught" (Participant 012).

Discussion

Orientation is integral to the recruitment and retention of rural and remote nurses. Both the literature and this survey, demonstrate that nurses' desire and require formal orientation to assess, develop and maintain competencies; acquire job satisfaction; and to create healthy and supportive work environments. The participants of this survey found that although they were receiving orientation it was incomplete and/or inadequate and the majority identified areas that needed improvement.

An orientation to community is particular to rural and remote nurses. Jensen and Boyeen (2002) suggest that best practice occurs when connections, community, and culture are all integrated. Connections occur by effective communication between all of the stakeholders, building trust that is congruent with the mission of the community, and by working with both of these principles, authenticity occurs. Nurses need to be flexible and respond to community needs in a proactive way that builds community capacity and utilizes advocacy. Professional socialization with community members is accessed through immersion and identity formation with the community. This is a transformative process that creates social responsibility. Jensen and Boyeen (2002) demonstrated through this integrated model improved access to care. The actualization of this model conceptualizes principles significant to orientation.

Although this was a small sample, nurses' spoke of "abandonment" and exposure to lateral violence in the workplace, which directs us to consider the recent literature on workplace behaviours of incivility (Laschinger, Finegan, & Wilk, 2009) and cynicism (Leiter & Maslach, 2009) that are associated with stress, burnout and unhealthy work environments. Laschinger,

Finegan and Wilk (2009) found that new graduates must be supported with the professional practice standards they learn in their education settings. They also found that leadership through effective management will enable an empowered workforce. Incivility was related in this study to an unsupportive work environment. Similarly, cynicism was found to be a key burnout dimension in nurses in Atlantic Canada that led to nursing turnover (Leiter & Maslach, 2009).It is crucial that administrations create positive and healthy work environments that must begin when new employees are introduced to an institution and continue throughout the working life of that particular nurse at that facility.

Limitations

Within this survey, we did not collect demographics about the participants. This data would be helpful to describe the gender, age, years of experience and geographical location of the participants and the potential impact that this may have on the findings. Some of the terminology used in the survey may have limited the scope of the answers received, for example, question five asks what "nursing" topics were covered in your orientation. The answers may have been more comprehensive or different if the question had not included the word nursing, although the participants did list more than nursing topics. Similarly, the question asking what 'area' of nursing elicited a geographical description and could be revised to ask what focus of nursing or what nursing specialty. A broad survey target audience of rural acute hospital nurses and remote community nurses in the one survey helps us to reveal the uniqueness of each practice area as well as the overlapping similarities. Though this provides insight in content and structure of shared learning opportunities, it may have limited our data in that the questions were generalized to fit both contexts. Further studies targeting rural and remote nursing practice separately, may flush out important details specific to the rural or remote context.

Conclusion

Our data reveals, the uniqueness of rural and remote practice and the challenges related to 1) nurses obtaining and sustaining competency; and, 2) organizations supporting competency in isolated comprehensive generalized practice context. Workplace literature reveals that anxiety often stems from the unknown and inexplicit role expectations. In the current healthcare environment with rapid change, and staffing challenges the importance of inter-professional collaboration to support safe quality care is obvious. Recent legislation (Health Professional Act) in British Columbia recognizes the overlapping scopes of healthcare professions. Provincial licensing bodies recognizing the overlapping scopes, emphasize that contextual factors often determine the role and responsibilities of the healthcare provider (CRNBC, 2010, p.10). These bodies emphasize the importance of role clarity within the healthcare team with employers explicitly stating the competency expectations in practice. Our data supports role clarity when for example nurses describe that anxiety can be daunting, and may lead to nurses leaving rural practice. As one respondent states, "First impressions go a long way and that works for the employer as well as the newbie. If rural and remote employers put more thought and effort into orientation, they just might save a few new hires". We hypothesize that by emphasizing the positive aspects that attract nurses, and providing supports to diminish the anxiety-provoking aspects, these proactive steps will assist in recruitment and retention of nurses. A rural and remote orientation program which states explicitly the role expectations and supports nurses in obtaining clearly defined competencies, would not only provide a message of mutual respect and value to the new employee, but may also decrease or alleviate unnecessary anxiety in this very demanding role.

This paper is preliminary and a first attempt by CARRN to address a practice- specific issue on a national basis. The impetus for this study stemmed from anecdotal stories that abound in the rural and remote nursing and management circles. There is limited data on this topic related to nurse orientation in the Canadian rural context.   Our data is limited, but the ensuing themes may help form a basis for future studies.

References

Alspach, J.G. (1984). Designing a competency-based orientation for critical care nurses. *HeartLung 13*(6), 655-662.

Bosek,M.S., Li, S., & Hicks, F.D. (2007). Working with standardized patients: a primer. *International Journal of Nursing Education Scholarship, 4,* article16

Campbell, S.H. & Daley, K.M. (Eds.) (2009). *Scenarios for nurse educators: making it real.* New York: Springer Publishing Company.

Chesnutt, B.M. & Everhart, B. (2007). Meeting the needs of graduate nurses in critical care orientation. Staged orientation program in surgical intensive care. *Critical Care Nurse, 27*(3), Available from http://ccn.aacnjournals.org

College of Registered Nurses of British Columbia, (CRNBC) (2010). Scope of practice for registered nurses, standards, limits, conditions. Vancouver, BC: Author.

College of Registered Nurses of Nova Scotia (CRNNS) (2007). *Position statement orientation of Registered Nurses to the workplace. Halifax,* NS: Author. Retrieved fromhttp://www.crnns.ca/documents/PositionStatementOrientationofRNstotheWorkplace 2007.pdf

delBueno, D., Barker, F., & Christmyer, C. (1981). Implementing a competency-based orientation program. Journal of Nursing Administration, 11(12)

Halaas GW, Zink T, Brooks KD, Miller J.(2007). Clinical skills day: preparing third year medical students for their rural rotation. *Rural and Remote Health* 7. Available from: http://www.rrh.org.au

Harvey, M.G., Novicevic, M.M. & Speier, S. (2000). An innovative global management staffing system: a competrency-based perspective. *Human Resource Management, 39*(4), 381-394.

Hunsberger, M., Baumann, A., Blythe, J. &Crea. M. (2009).Sustaining the rural workforce: nursing perspectives on worklife challenges. *The Journal of Rural Health, 25*, 17-25.

Jensen, G.M. &Boyeen, C.B. (2002). Improved rural access to care: dimensions of best practice. *Journal of Interprofessional Care, 16(*2).Retrieved from http://www.nurseone.cadoi: 10.1080/1356182020124139.

Keahey, S. (2008). Against the odds: orienting and retaining rural nurses. *Journal for Nurses in Staff Development, 24*(2), E15-E20.

Laschinger, H.K.S., Finegan, J., &Wilk, R. (2009). New graduate burnout: the impact of professional practice environment, workplace civility and empowerment. *Nursing Economics, 27*(6), 377-383.

Leiter, M.P. &Maslach, C. (2009). Nurse turnover: the mediating role of burnout. *Journal of Nursing Mangement, 17*, 331-339.

MacLeod, M.L.P., Kulig, J.C., Stewart, N.J., &Pitblado, J.R.(2004). The nature of nursing practice in rural and remote Canada. Retrieved from http://www.chsrf.ca/final_research/ogc/pdf/macleod_final.pdf

Morris, L.L., Pfeifer, P.B., Catalano, R., Fortney, R., Hilton, E.L., Mclaughlin, J….Glodstein, L. (2007). Designing a comprehensive model for critical care orientation. *Critical Care Nurse, 27*(6)Available from http://ccn.aacnjournals.org

Notarianni, M.A., Curry-Lourenco, K., Barham, P. & Palmer, K. (2009). Engaging learners across generations: the progressive professional development model. *The Journal of Continuing Education in Nursing, 40*(6), 261- 266.

Priest, A. (2004). Setting the bar for rural nursing practice. *Nursing BC,* 7-10.

Stefanski, R. & Rossler, K.L. (2009). Preparing the novice critical care nurse: a community wide collaboration using the benefits of simulation. *The Journal of Continuing Education in Nursing, 40*(10) 443-452. Doi:10.3928/00220/24-20090923-03

Strasser, P.B. (2005). Competency-based occupational health nurse orientation. *AAOHN Journal, 53*(8), 338-339.

Whelan, L. (2006). Competency assessment of nursing staff.Orthopaedic Nursing, 25(3), 198-202.

Wilkinson, T.J., Smith, J.D., Margolis, S.A., Gupta, T.S.& Prideaux, D.J. (2008). Structured assessment using multiple patient scenarios by videoconference in rural settings. *Medical Education, 42*, 480-487 doi:10.1111/j.1365-2923.2008.03011.x