FACTORS EFFECTING ENGAGEMENT OR DISENGAGEMENT FOR RURAL NURSES
Acknowledgement
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CRANaplus Professional Services
October 2016
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EXECUTIVE SUMMARY

Is the rural nursing and midwifery workforce in Australia engaged or disengaged?

CRANAplus recognised there has been a void in professional representation within the health industry for rural nursing and commissioned the Rural Nursing Project, with the aim to identify opportunities for CRANAplus to be more relevant for Nursing working in rural context of practice. Contemporary professional practice clearly recognizes the respective nursing and midwifery professions, this paper draws on the parallels between nursing and midwifery. The project commenced in July 2016 with the undertaking of a narrative literature review. The literature review has explored the factors of engagement and disengagement of rural nurses, in both Australia and the developed countries, namely, New Zealand, Canada, United States, Great Britain and Scandinavia.

In the narrative literature review undertaken for CRANAplus, 700 abstracts and 59 articles were examined. These papers indicated that the bedrock of our rural health services, nursing, had been suffering from the gradual withdrawal of structural supports for over twenty years. A change in public policy from one of social welfare to a market economy caused the regionalisation and rationalisation of health services. Consequently having a negative impact on the Health Services of smaller communities, and significantly deskilling of the local rural specialist and generalist nurse and midwife. Thus resulting in a disengagement of both the nursing and midwifery professions with rural Australia.

The reviewed literature acknowledged that the rural nurse’s skills encompasses a broad knowledge and expertise base = generalist approach. Graduate nurses who had begun their careers in the rural areas, reported that they felt poorly prepared through their undergraduate studies, and were not able to meet the required breadth of skills as novice nurses. The rural nurse simultaneously struggled with role creep as a result of competing demands of the health service. There was a clear lack of recognition and acknowledgement by the employer of the extended roles of the rural nurse and midwife.

The withdrawal of speciality care, including mental health and midwifery, has seen the slow deskilling of practitioners and, subsequently, the erosion of vital and essential services. Nurses have expressed their loss of autonomy within their practice. This was paradoxical, considering the more recent legislative changes to endorse the roles of the nurse practitioner and midwife. These practitioners were a means to address the decline in rural health services, particularly in the smaller communities that were unable to recruit procedural medical officers. Inflexibility within workplace
practices, was also a feature of the literature. Nurses sought a work life balance but with the changes in roles and the demands of work, family and lifestyle were compromised.

Another demand, which had been made on the nursing and midwifery professions by the Nursing and Midwifery Board of Australia, was the requirement to provide evidence for undertaking continuous professional development to maintain registrations. Rural nurses reported that their preference for Continuing Professional Development (CPD) education was for onsite, face-to-face training. Inhibitive financial and social and family impacts to attend training, was highlighted along with the need to gain management support to be released from work.

Significant advances in information technology for training have included web-based training, webinars, online resources and high fidelity simulation has been acknowledged as improving access to ongoing education, however unreliable internet connections impacted on the usefulness of this form of training. Acceptance of this delivery mode was variable amongst the generational workforce.

A recognised strength of the rural areas was the vibrant relationships and informal networks, which were deeply embedded within the local culture. This provided a means to integrate and support the new graduate entering the workforce and those who had been recently recruited from overseas. This also led to positive methods of collaboration with community members and was extended to multidisciplinary health teams to ensure that a breadth of services was available to the rural communities in Australia.
INTRODUCTION

CRANAplus, commissioned the Rural Nursing Project with the aim to identify opportunities for CRANAplus to be more relevant to Nurses working in the rural context of practice, including recruitment, retention, professional development opportunities and rural pathway for Rural Nursing.

A narrative literature review was undertaken to explore the means of engagement and disengagement of rural nurses and midwives in the developed countries of Australia, New Zealand, Canada, United States, Great Britain and Scandinavia. The context of this study we acknowledge the role of the duel qualified Registered Nurse and Registered Midwife who have traditionally provided maternity care in the rural setting. This paper principally refers to Nursing roles unless Midwifery was specifically included in the articles identified in the Literature Review. The engagement of nurses in the rural sector may have occurred when career options were introduced to them as high school students. This continued throughout their career continuum to retirement and included the opportunity to be re-engaged back into the workplace. (Voit & Carson, 2014) Enrolled Nurses were included in this review however there is a dearth of literature regarding their role in the rural setting.

There is a plethora of research, studies and commentaries published on rural nursing and midwifery both internationally and in Australia this is evident by the number of articles accessed and subsequently reviewed. The literature clearly described the continued struggle by an ageing rural workforce that is disadvantaged through having fewer resources to serve across vast geographical distances. (K. L. Francis & Mills, 2011; McCool, Guidera, Reale, Smith, & Koucoi, 2013; Nowrouzi et al., 2015; Welfare, 2014, 2015; Yates, Usher, & Kelly, 2011).

Historically the rural nursing and midwifery workforce have, utilised advanced clinical practices and have been responsible for initiating interventions and treatments. Currently many of these procedures require credentialing or endorsements by local health services or nationally by the Nurses and Midwifery Board of Australia (NMBA). Bish et al (2015) describes and defines the rural nurse as specialist generalist who uses the ‘knowledge of the community [that] they reside in combined with advanced clinical skills to provide a nurse led service that responds to the health needs of their community in a contextual way’. (Bish, Kenny, & Nay, 2015) p 382

This paper focuses on the 49 articles retrieved within the review. Through a thematic analysis, five main themes presented themselves, which included education, recruitment, retention, organisational and government policies that support neoliberalism and corporatisation. Within
these main themes, multiple sub groups were then identified and have been described within this paper. These are presented in Diagram 1 page 8. Within the themes an overview and detailed examples are provided for the reader to consider the current position for nurses and midwives working in the rural sector. To provide a context for the review, data on the current rural nursing and midwifery workforce (2015) is introduced, following a presentation on the methodology utilised for this review.

METHODOLOGY

A narrative literature review was undertaken to investigate factors, which engages or disengages nurses working in the rural areas in developed countries of Australia, New Zealand, United States of America, Canada, Scandinavia and Great Britain. Each county shared similar professional, social, political and environmental settings.

Inclusion criteria for the review included both qualitative and quantitative publications in print between January 2014 and August 2016. The Griffith University Library catalogue was utilised and included the Science Direct, ProQuest, Scopus and CINAHL databases for the literature search.

To achieve a broad perspective and understanding of rural nursing, the keywords selected included the terms: professional identity, collegiality, motivation, career, membership, professional development, professional needs and graduate programs. These were then matched against the primary search terms of rural and nursing and midwifery.

The literature search included a total of 748 publications with a final 49 articles accepted that met all the inclusion criteria. A thematic analysis was then undertaken of these articles to identify what engages or disengages the rural nurse or midwife. (Braun & Clarke, 2006) Five main themes became evident within the research and these included: professional development, recruitment, retention, organisational and government policies that support neoliberalism and corporatisation. These themes were then further explored and sub groups were identified which described the existing context of rural nursing and midwifery, which is embedded within the national political, social, environmental and industrial milieu of the twenty-first century. To further develop the presentation, within the thematic sub groups, examples have been provided of the extensive research undertaken as identified within this literature review.

To contextualise and gain an understanding of the Australian rural nursing workforce a brief overview is provided as a means of introduction to the study and is as follows.
THE RURAL NURSING AND MIDWIFERY WORKFORCE IN AUSTRALIA

The rural and regional areas represent 27% of the total Australian population. These areas are known to have higher rates of illness and mortality. They also experience greater barriers in accessing services through geographical distances and reduced access to health services. (Welfare, 2014) Nurses and midwives make up the largest workforce in rural and remote Australia. (Bish et al., 2015; Mills, Francis, McLeod, & Al-Motlaq, 2015) These professions in Australia continue to be challenged by an ageing workforce. (Pugh, Twigg, Martin, & Rai, 2013).

Data and Definitions
The Australian Institute for Health and Welfare (AIHW), publish the ‘National Health and Workforce Series’ included within the annual publication of the ‘Nursing and Midwifery Workforce’ Report. This publication utilises the Australian Standard Geographical Classification (ASGC) employed by the Australian Bureau of Statistics (ABS) to classify five major geographic regions; Major cities, Inner regional, Outer regional, Remote and Very remote. (Pink, 2011). For the purposes of this paper we have used the classifications: Inner and Outer Regions, to define the rural areas in Australia.

The AIHW uses data obtained from the workforce survey provided annually by the Nurses and Midwifery Board of Australia (NMBA) of all nurses and midwives at the time of their renewal of registration. The data has been utilised in this study to describe current rural workforce for nurses.

The table below is adapted from the AIHW publication, ‘Nursing and Midwifery Workforce 2012’ and the 2015 workforce data sets published online. There is evidence of a small increase in the rural workforce since 2012 and also a 7.55% increase in the fifty plus age group. The average total weekly hours worked remained similar from 2008 to 2015 which was also comparable to the hours worked by nurses and midwives in the major cities. (Welfare, 2013, 2015)

<table>
<thead>
<tr>
<th>Number</th>
<th>Inner &amp; Outer Regional</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>79,414</td>
</tr>
<tr>
<td>2012</td>
<td>77,742</td>
</tr>
<tr>
<td>2015</td>
<td>80,445</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Average Age (Years)</th>
<th>Inner &amp; Outer Regional</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>45.50</td>
</tr>
<tr>
<td>2012</td>
<td>46.35</td>
</tr>
<tr>
<td>2015</td>
<td>46.35</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age 50 and over (%)</th>
<th>Inner &amp; Outer Regional</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>38.55</td>
</tr>
<tr>
<td>2012</td>
<td>45.35</td>
</tr>
<tr>
<td>2015</td>
<td>46.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Average weekly hours worked</th>
<th>Inner &amp; Outer Regional</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>33.15</td>
</tr>
<tr>
<td>2012</td>
<td>33.00</td>
</tr>
<tr>
<td>2015</td>
<td>33.1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FTE rate (per 1,000 population)</th>
<th>Inner &amp; Outer Regional</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>1,148.55</td>
</tr>
<tr>
<td>2012</td>
<td>1,101.03</td>
</tr>
<tr>
<td>2015</td>
<td>1,093.75</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Population (total)</th>
<th>Inner &amp; Outer Regional</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>6,347,479</td>
</tr>
</tbody>
</table>

Table 1: Employed Nurses and Midwives for rural areas (Inner and Outer Regional) selected characteristics 2008 – 2012 Adapted from Nursing and Midwifery Workforce 2012 (Welfare, 2013) page 31 and the National Health Workforce Data Set 2015 Detailed Supplementary Tables (Welfare, 2015)
Enrolled Nurses constitute 29.06% of the rural nursing workforce and work similar hours to the
Registered Nurse. This is described through data adapted from the 2014 National Health Workforce
Data Set (AIHW) as provided in the table below. (Welfare, 2015)

<table>
<thead>
<tr>
<th></th>
<th>Inner Regional</th>
<th>Outer Regional</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurses</td>
<td>42,925</td>
<td>19,402</td>
<td>62,327</td>
</tr>
<tr>
<td>Enrolled Nurses</td>
<td>12,122</td>
<td>5,996</td>
<td>18,118</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Average</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurses</td>
<td>32.9</td>
<td>34.3</td>
<td>33.6</td>
</tr>
<tr>
<td>Enrolled Nurses</td>
<td>31.1</td>
<td>31.9</td>
<td>31.5</td>
</tr>
</tbody>
</table>

Table 2: Employed Rural Nurses and Midwives 2015 as adapted from the National Health Workforce
Data Set 2015 Detailed Supplementary Tables (Welfare, 2015)

The ageing and contracting of the rural workforce has been reflected internationally in countries as
the United States of America and Canada (K. L. Francis & Mills, 2011; McCool et al., 2013; Medves,
Edge, Bisonette, & Stansfield, 2015; Nowrouzi et al., 2015; Yates et al., 2011).

Extensive research has been undertaken over the past twenty years to address these ongoing
changes in the health workforce in an attempt to meet the demands of those living within the rural
areas. The following discourse represents a thematic analysis of what engages or disengages nurses
working in the rural areas of Australia, USA, Canada, New Zealand, Great Britain and Scandinavia
within the past five years (2011 to 2016). The diagram as follows represents the thematic analysis of
the literature with the presenting themes of engagement and disengagement, which focuses on the
elements of education, recruitment, retention, government policy and corporatisation.
Diagram One: Engagement and disengagement of the rural nursing and midwifery workforce

- **Education**
  - Postgraduate Education
  - Orientation
  - High School Programs
  - Undergraduate student placements
  - Immersion (students & academics)
  - Transitional Programs
  - Mentoring & Preceptorship
  - Continuous Professional Development

- **Recruitment**
  - Overseas Recruitment
  - Post Retirement

- **Retention**
  - Professional recognition
  - Empowerment
  - Autonomy
  - Advanced Practice (Nurse Practitioner)
  - Networking
  - Multi-disciplinary Collaboration
  - Cultural Integration
  - Flexible Workforce

- **Inadequate Education**
  - Undergraduate student placements
  - Postgraduate education and transitional programs
  - Continuous Professional Development

- **Inadequate Retention Strategies**
  - Inadequate Professional Recognition
  - Disempowerment
  - Lack of Autonomy

- **Government Policy**
  - Neoliberalism

- **Corporatisation**
ENGAGEMENT FACTORS FOR RURAL NURSES

ENGAGEMENT THROUGH EDUCATION

An overview

Engagement factors for the nursing and midwifery workforce, includes both an international and Australian perspective for a breadth educational opportunities. This begins with the introduction of nursing and midwifery to local high school student to promote these professions as well as being a process for potential recruitment to undergraduate university education. (Benavides-Vaello et al., 2014)

The placement and support for undergraduate students is also a means to recruit nurses and midwives back into the country. It requires strong supports through a clinical facilitator embedding the student into a welcoming community and recognising the social qualities of both professional and personal relationships, which are the cornerstone of a rural community.(Smith, Lloyd, Lobzin, Bartel, & Medlicott, 2015)

The provision of a transitional and post graduate training that utilises different forms of media to support development, such as high fidelity equipment, but prioritises opportunities for local face to face education.(Missen, Sparkes, Porter, Cooper, & McConnell-Henry, 2013).

Strong orientation programs facilitate a means to provide an overview of the workplace but also introduce the nurse and midwife to the community. This includes cultural orientation for entering indigenous communities but also for overseas workers who require clarity in communication protocols and social etiquette.(Dywili, Bonner, Anderson, & O’ Brien, 2012; Yonge, Myrick, Ferguson, & Grundy, 2013)

Preceptorship and the role of clinical facilitators were viewed as the preferred means to support students and employees for undergraduate, transitional and orientation programs. Mentoring created extra demands on the mentor who also had demanding clinical roles. It was the responsibility of the University to employ clinical facilitators, this strategy was promoted by the students and hosting rural hospital. Both graduates and undergraduates sought to receive regular constructive feedback on performance as a means to achieving their set goals.(Gray & Brown, 2016; Mbemba, Gagnon, Paré, & Côté, 2013; Pront, Kelton, Munt, & Hutton, 2013)

Further more the provision of transitional and post graduate training that utilised different forms of media, such as high fidelity equipment, to support development, did not negate the importance for local face-to-face education.(Missen, Sparkes, Porter, Cooper, & McConnell-Henry, 2013).
To provide a purview of rural life and prospective work for students and employees, the use of immersion through bush camps or study days was exercised. Immersion activities were an instrument for academics seeking to improve their understanding and involvement in student rural placements, (Deutchman, Nearing, Baumgarten, & Westfall, 2012; Page et al., 2016; K. P. Sutton, Patrick, Maybery, & Eaton, 2015)

All nurses and midwives are required to complete mandated professional development hours to gain renewal of their registration with the Nurses and Midwifery Board of Australia. To achieve this nurses indicated their preference for local learning activities with face to face in multidisciplinary teams with clinical placements as opportunities for skill and knowledge development.(Phillips, Piza, & Ingham, 2012)

**High School Programs**

A successful photovoice project was undertaken in a two-week summer residential program with Hispanic and Native American high school students. This was included in local pipelines programs, which had been established, to increase and diversify applicants from high schools to apply for local nursing undergraduate programs. (Benavides-Vaello et al., 2014)

**Placement for Undergraduate Students**

Placements for undergraduate students in the rural areas provided a means for promoting future recruiting opportunities whilst introducing the students to generalist nursing and the rural community. In the United Kingdom a study was undertaken where three phases were identified for a nurse’s placement. This included the initial transitional phase where a dislocation from peers, and clinical staff occurred. The second phase was one of negotiation where the student sought the support, guidance and protection of a senior student or mentor. The final phase was relocation (engagement) when the student was enabled to address any negative external attitudes and resume their role as a student, despite incivility within the workforce. (Thomas, Jinks, & Jack, 2015)

**A South Australian Experience**

A study conducted in a regional hospital in South Australia, acknowledged the impact the rural environment had on the undergraduate student and his / her placement and their learning experiences. This included both professional and social relationships shared when working and living in the country and some confounding of boundaries.(Pront et al., 2013)
Smith et al (2015) included five small hospitals and a regional community health service in a South Australian study. The aim was to increase the number of university student placements by the enhancement of the clinical facilitator’s role. An increase in undergraduate placements was undertaken in direct response to an anticipated shortfall in the rural nursing and midwifery workforce. (Smith et al., 2015)

A Queensland Experience
A midwifery continuity of care student placement, in a rural Queensland Midwifery Group Practice, afforded high levels of satisfaction. This was linked to a close mentorship and positive clinical learning culture built with the caseload midwives. Funding from Departmental scholarships freed the student to focus on the placement, without the need to financially support themselves. (20%) of participants indicated they would seek future employment in a regional hospital and 25% indicated they would work within a hospital based MGP. (Carter, Wilkes, Gamble, Sidebotham, & Creedy, 2015)

POST GRADUATE EDUCATION AND TRANSITIONAL PROGRAM

Photovoice & Cultural Awareness
A photovoice study was conducted with graduates and their preceptors in Western Canada, in Alberta and Saskatchewan. (Crow, Conger, & Knoki-Wilson, 2011) This was reported as a very positive means for new graduates to record, with their preceptors, their journey of learning based in a rural health setting. Feedback within this research from the graduates included the importance for them to be an accepted as valued team members, which enabled the graduate, to develop trust and confidence with their preceptors through this process.

An experience from Ontario, Canada
A study undertaken in rural southern Ontario, Canada, included nurses who were interviewed in five small community hospitals (10 to 53 beds). The study incorporated eight interventions in response to the recommendations derived from the report. The nursing workforce in rural Ontario included 58% of staff working full time (eight or twelve hour shifts) with only 2.5% of staff working casually. This may reflect the current practices for both 48% of urban and rural nurses who choose to work part-time in Australia. (Welfare, 2013).

Other aspects of this study worth noting were the interventions undertaken within the study, that were derived from nursing feedback and included mainly educational strategies. The education
strategies incorporated various courses; two day mock trauma, critical care education and an orientation course. External funding was sought for continuing staff development, an investigation for a potential library service and an application for academic and certificate development. Two further recommendations included staff appreciation events and a preceptor recognition program. (Medves et al., 2015) These were also reflected, but in less detail, in the Australian literature with nursing responses for methods to improve retention of nurses through education. (K. L. Francis & Mills, 2011)

**Post Graduate Programs**

Learning needs identified for new graduates included the requirement for a definitively structured program, extending to two years as one suggested option. Graduates also needed structural empowerment, with resources, to enable them to achieve their goals within the first year. Clinical scenarios with high-fidelity simulation was also recommended to enable a positive learning environment and to develop confidence in clinical care. (Missen, McKenna, Beauchamp, & Larkins, 2016) A focus on time management, prioritising clinical duties and develop communication skills to support difficult conversations with medical officers were also identified as key areas for development. Graduates also needed to learn how to provide a comprehensive handover and these learning experiences were all required to be undertaken within the first twelve months. The graduates also needed to be rostered appropriately with their preceptor, receive regular feedback and reflect on their performance. These were essential to achieve a positive and safe learning environment. (Mellor & Greenhill, 2014) Ultimately a collaborative approach between health service management, clinical staff, educators and academics was vital to support a successful transitional graduate program. (Bennett, Barlow, Brown, & Jones, 2012; Lea & Cruickshank, 2015).

Research undertaken by Stewart et al (2012) on an 2008 online post graduate mental health program for Griffith University (Queensland) rural and remote interprofessional students, included nurses, social work / human services and psychology. This study indicated that the online environment provided flexibility but the lack of face-to-face environment inhibited learning. There was a need for work base placements and assessments to ensure the development and consolidation of skills and knowledge. Whilst the interdisciplinary approach was appreciated, the need for discipline specific training was also acknowledged. (Stewart, Fielden, Harris, & Wheeler, 2012)
Simulation Training

The use of simulation training in an Australian rural health service was reported as a means to provide local on site education to nurses in emergency management. Included were three researchers as observers and an assessor, two actors to play the role of three patients, and a video recording for the three cases managing a deteriorating patient. Feedback was provided to each of the response groups through replaying the video, debriefing and evaluating the program. (Missen et al., 2013)

ORIENTATION

Orientation for all students, graduates and new staff was critical for the introduction to the workplace and procedures, including systems for communication and safety. Orientation into the rural area was also reputed to be a means to introduce the community to the nurse and midwife and embed the employee into the culture. This included those nurses and midwives recruited from overseas to meet the increased work demands of a contracting workforce. (Bourgeault, Neiterman, & LeBrun, 2011; Pugh et al., 2013).

A literature review was undertaken by Dywili et al (2012), on the experience of overseas trained health professionals (OTHP) in rural and remote areas of Australia, Canada, New Zealand, UK and USA. The researchers screened 1,652 documents between the years 2004 - 2011 with the final inclusion of 17 documents of which 2 focused specifically on nursing. (Dywili et al., 2012) These authors emphasised that the orientation program and integration into the local community was crucial to the success of employee appointments. Included within the orientation an introduction to local communication protocols was seen as essential to support safe practice. Cross-cultural communication was also perceived as a challenge for both staff and overseas trained health professional. These professionals may have had a different worldview and so can present with different professional values, which may have created a sense of 'cultural separateness and otherness'. (Bourgeault et al., 2011) (p179)

Rural communities were perceived as welcoming and accepting, but they also possessed a strong desire to see that their culture was respected. The new nurses and midwives need to be supported, to integrate both into the workplace and the local community. Some nurses and midwives felt very isolated from their own families and friends when relocating to a rural area. Specialist nurses may also be challenged through the change to generalist care and require additional support through orientation. Offering onsite education and access to professional development and support as a
means to embed the overseas nurse within the workplace and ensure continuity of service. (Dywili et al., 2012)

Cultural Orientation
An emphasis on the community ethos was also the fulcrum for the attraction of nurses to the country with the Navajo American Indians. A cultural orientation program was provided for urban nurses and utilised a mentor to culturally connect the nurse to the community. This assisted with the socialisation required between the traditional (Navajo) and western nursing worldviews. (Yonge et al., 2013)

MENTORING & PRECEPTORSHIP
The need to mentor new nurses and midwives was highlighted, not only for the undergraduate placements, but also for new appointments, including those who undertook transitional postgraduate training. The new graduate appointed to a rural health facility also required a broader scope of practice than what was provided through their undergraduate program. Graduates expressed that they felt overwhelmed and abandoned if a comprehensive orientation and buddying system had not been provided at commencement.

An Umbrella Review of Mentorship, Preceptorship & Clinical Supervision
Mbemba et al (2013) undertook an umbrella review of 5 articles from 517 publications. These articles identified four main themes that included supportive relationships in nursing as mentoring, preceptorship and clinical supervision. Preceptorship involved clinical staff whilst mentoring included faculty staff, which were able to provide one to one support for the student nurse. A vital resource is the mentor for rural nursing staff, contrary to Gray and Brown (2016) who reported that regional nurse mentors did not have the resources or time whilst working in a busy rural hospital. (Gray & Brown, 2016; Mbemba et al., 2013; Pront et al., 2013)

FINANCIAL & NON-FINANCIAL INCENTIVES
Mbemba et al identified that financial incentives were the most commonly reported incentives for recruitment and short-term retention. Non-financial incentives included improved working and housing conditions may have a greater impact on retention of rural nurses than financial incentives. (Mbemba et al., 2013)

IMMERSION (Students & Academics)
The use of immersion weeks or study days for undergraduate students and academics gave a purview of rural life and work. These strategies have supported future recruitment and placements for undergraduate nurses.
A means to support interdisciplinary relationships included an immersion week held by the University of Colorado Debver (USA), for students in selected rural communities. This enhanced their understanding and involvement in the cultural, economic and environmental aspects of life and work in the country. It provided opportunities for students to consider future employment and addressed rural recruitment demands (Deutchman et al., 2012).

**An Australian experience - Gippsland**

A similar model was used in Gippsland to promote future employment opportunities. A pilot program to attract undergraduates from rural areas undertaking their allied health and nursing studies in Melbourne, within their vacation periods, to participate in a five-day rural mental health program in Gippsland was undertaken. The five-day program included seminars, workplace visits, plenary discussions and social outings. Two courses were provided in 2010 and a longitudinal study was also undertaken. Pre and post participant evaluation surveys were conducted and indicated a strong effect on student attitudes and intentions in working in rural mental health(K. Sutton, Maybery, & Moore, 2012). Local stakeholder involvement was also very positive. The final outcomes of this study was published by Sutton et al (2015) and provided two findings. Firstly, a short-term recruitment intervention can affect attitudes towards pursuing a rural career in mental health. Secondly, an emersion experience for students, can change their knowledge and understanding of a future career and work available in the rural mental health sector(K. P. Sutton et al., 2015).

**Immersion for Academics; a Western Australia Experience**

An example of an academic emersion model in the rural areas was undertaken by the Western Australian Centre for Rural Health (WACRH), who invited nurses, allied health academics and clinical placement coordinators to an Academic Bush Camp. The camp modelled student programs with the purpose to increase rural student placements. The program consisted of visiting rural and remote learning sites, walking tours and presentations by the WACRH. (Page et al., 2016)

**CONTINUOUS PROFESSIONAL DEVELOPMENT**

**Palliative Care**

A rural palliative care program was researched through an integrative literature review and included an international perspective by encompassing Canada, UK, America and Australia. The authors sought to address five questions, which included; the impact of CPD on improving patient care, learning formats that best suited the needs of rural nurses, the use of technology, and the barriers and facilitators for training.
The outcomes of this study highlighted the inadequacy of research undertaken to measure the impact of CPD on patient care. Stakeholders also needed to be included within the planning and development phase of the training, which was underpinned by adult learning principles. There was a dearth of information available on the use of information technology (IT) for rural palliative care training. A recommendation from this report was to include IT competencies within the rural palliative care program. The challenges and barriers to providing CPD for rural palliative care, mirrors the rural sector. There was limited means of access because of geographical distances. The costs for accommodation and travel and the inability to roster relief staff to provide cover were barriers. Preferences were for local learning activities, with face to face and multi disciplinary approaches to support effective networking whilst training. Clinical placements with specialist services to support the development of skills and knowledge were also seen as a priority. (Phillips et al., 2012)

**An Overseas Example – Norway**

One overseas study conducted in Norway was able to describe, quite a different context to rural Australia. Similarities though did include barriers for nurses and midwives in the rural sector seeking to access CPD whilst being geographical isolated. Norway however did not require nurses or midwives to complete CPD for ongoing licensure. Nurses who were seeking to specialise in anaesthetics, operating theatre or intensive care for university hospital employment however, were then required to attend appropriate education.

In the rural or municipal areas in Norway, nursing care included gerontic, public health and mental health care. Midwifery practice was also declining in the rural areas, similar to other developing countries, as birthing moved towards the University hospitals or regional cities. In this study, a survey was conducted with 233 former graduates of the Artic University of Norway, between the years of 1990 – 2011 with 56% of these graduates who completed their Continuous Professional Education (CPD) within 186 programs. This was seen as a positive outcome as CPD was seen as a means to network and retain nurses in the Artic areas whilst also achieving diversification in health care. (Skaalvik, Gaski, & Norbye, 2014)

**ENGAGEMENT THROUGH RECRUITMENT**

**An Overview:**

Recruitment has been an ongoing challenge for the rural sector. Opportunities to recruit begin with students in high school, through immersion projects, inviting students and prospective employees to attended workshops located in rural communities. This principle
was sustained through undergraduate placements and by attracting nurses and midwives into the country for their graduate transitional programs. All of these are potential recruiting opportunities and need to be appropriately resourced with well researched programs that include face to face local services, clinical facilitators funded through universities and regular feedback and support for professional development plans.

Another means to consider is the opportunity for inviting those who have chosen to retire or leave their professions by offering incentives that are attractive and relevant. Rural areas are attractive and provide a means to welcome back nurses and midwives into the local workforce. (Voit & Carson, 2014)

**POST RETIREMENT**

A study into retirement intentions and post retirement employment opportunities was undertaken through a voluntary survey with nurses employed in the Northern Territory (NT). This was not a rural project but included respondents who were either urban based (53.8%) or remote (46.2%). The study identified 8 post retirement options that could be transferrable to rural nursing & midwifery. Two cohorts of nurses were surveyed; those who intended to retire and not seek re-employment and those who were considering post retirement opportunities. The opportunities for post retirement included; financial incentives for re-employment, opportunities to mentor, undertaking seasonal employment, gradual reduction in work hours, act as a NT representative, be involved in research and policy development or job share. Barriers identified within the study, included current policies in the Northern Territory that required full time appointment and the selection of recently qualified nurses and midwives. The compulsory legislated retirement in the Northern Territory is 65 years of age and currently there are no policies for continuing the engagement of the older person. (Voit & Carson, 2014)

**ENGAGEMENT THROUGH WORKFORCE RETENTION**

*An Overview*

Retention of staff is dependent on a web of interlaced factors which includes the need for both midwives and nurses to be recognised for their work and standing in the community. The Nurse Generalist has a breadth of skills and knowledge that exceeds the generalist role in the urban setting. There is a clear need by the nurse and midwife to be recognised and to function autonomously, with the underlying support of managers and government policy makers (Hildingsson et al., 2016).
The role of nurse practitioners, nurse led clinics and midwifery case managers is a means to ensure that health services remain in the smaller rural communities. (K. Francis et al., 2014).

Informal and formal networking and working collaboratively in interdisciplinary teams has been strength in the rural and remote areas. This is part of being community and is an incentive to living in the country as it professionally, personally and culturally embeds the worker into the local workplace and town. (Cox, 2003; Crotty, Henderson, & Fuller, 2012; Jesse & Kirkpatrick, 2013)

Flexibility inclusive of openness of management, funders and policy makers to support alternative models in nursing and midwifery led care is a valued requirement by rural nurses and midwives. Recognising the generalist roles of the nurse as well as identifying that changes in workloads with increased responsibilities needs to be shared or redistributed.(K. L. Francis & Mills, 2011; Pugh et al., 2013)

**PROFESSIONAL RECOGNITION**

Research was undertaken to survey midwives in New Zealand, Sweden and Australia to measure the degree of autonomy, managerial and professional support, skills and resources. The study revealed that New Zealand and Sweden provided a stronger professional identity as the midwife worked more autonomously compared to the Australian midwife, who was based in a more fragmented, medical model within a hospital environment. Australian midwives had retained an 'industrial approach' to their professional development whilst having a formal career pathway when employed by the public sector. However these midwives were firmly enmeshed within a nursing hierarchy and this impacted on their promotional opportunities.

New Zealand midwives were provided with supportive mentoring in their pre-registration and transitional programmes. These midwives have a large workforce of self-employed midwifery models that encompassed a full scope of practice with significant opportunities for development. However Sweden midwives, though autonomous in their practice, work in a fragmented prenatal and birthing model and have low opportunities for education post registration to re-enter the workforce. The midwifery employer in Sweden does provide further education but there is no registration requirement for ongoing education as regulated in Australia.(Hildingsson et al., 2016)

**ADVANCED PRACTICE (NURSE PRACTITIONER)**

The literature review highlighted the need for both nurses and midwives to be able to be recognised for their roles as practitioners and to be able to perform autonomously. The role of the nurse practitioner and midwifery caseload manager enable the retention of vital services to the smaller
rural communities in the absence of procedural medical officers being recruited to the country. Disempowerment was identified as a means to undervalue the nurse. This was in response to the fragmentation of the specialist mental health role. A sense of ‘abandonment’ by management and policy makers, to the profession was interpreted by the mental health nurses. The need to ensure sustainability and strength of the practitioner role was by improving undergraduate and postgraduate education thus ensuring a better understanding of the role by other disciplines.

Midwives and nurses in the country are often recognised for both their generalist and specialist skills and knowledge. However the breadth of the generalist role, and greater workload created greater stress. (K. L. Francis & Mills, 2011; McCool et al., 2013; Pugh et al., 2013) The role of sole practitioners for nursing and midwifery, including nurse practitioners, midwifery caseload managers, nurse-led clinics, has also been a means to enhance work satisfaction. The advanced enrolled nurse role has also supported professional advancement and provides recognition for rural practice.

Obstacles and barriers to achieving recognition and support for advanced nursing and midwifery practice are not confined to the Obstetric or Medical Colleges and Associations. State and Federal governments with the required legislative changes, public sector managers and executives are needed to provide leadership and funding in the advancement of these roles.

The provision of postgraduate studies for rural nurses to qualify as nurse practitioners is a means to address the inequality of access to local health services. Nurse Practitioners are able to diagnose, treat, refer and prescribe medications and this is a welcomed resource for those communities who are experiencing difficulties in attracting and retaining general practitioners and allied health. (K. Francis et al., 2014) These can include practitioners who have provided a breadth of specialist services including aged care, emergency, mental health, community health and chronic disease management.

DECISION MAKING

An Ontario, Canada Experience

The College of Nurses of Ontario, Canada, undertook a self-administered questionnaire with 45 Registered Practice Nurses (RPN) who held a 2-year Diploma and worked in 5 community hospitals. The RPN reported to the Registered Nurse, and was similar to the role of the Australian Enrolled Nurse. The Canadian rural workforce was experiencing similar conditions to Australia: staff shortages, high turnover, ageing staff approaching retirement, and with fewer graduates entering the labour force. This study was able to identify that those having worked nine to eighteen years
were more likely to remain within the workforce. The RPN’s with more than thirty years of work experience were more likely to retire or leave because of increasing workloads. RPN’s also indicated their desire to be included in the decision making process which led to a higher job satisfaction and a lower level of work stress. (Nowrouzi et al., 2015)

**NETWORKING**

Networking was also a key strategy used by both urban and rural health workers. A qualitative research study, conducted in a country region in South Australia, highlighted the importance of informal social networks for mental health practitioners. (Crotty et al., 2012) Practitioners that were interviewed included mental health nurses. They identified informal networking to be a means to develop strong ties between professionals and to socially imbed themselves into the local community, this strengthened and sustained the local workforce. Conversely, rural networks have diffuse role boundaries with less separation between the professional and personal identity. This diffusion makes the health worker more visible and easily accessible to the community. Networking has a downside for new workers entering the rural sector, as the experience of acceptance by their peers could be perceived as more difficult, initially therefore leading to the inability to share their own experiences and perspectives easily.

Newcastle University developed a research protocol to facilitate effective interprofessional relationships through defining a framework for an acute or community setting. This protocol included a functional role for clinicians, management and policy maker providers. The protocol was located in a centre or practice based location with nursing, allied health, medical or non-professionals. The protocol used individual interviews, focus groups and document analysis to support collaborative professional relationships to improve communication and functions across the disciplines. It was proposed that this research would support the function and cohesion of the team and so subsequently improve job satisfaction through minimising interprofessional conflict. It would also reduce healthcare costs by reducing future admissions and the turnover of staff. (Mitchell et al., 2013)

**MULTI-DISCIPLINARY COLLABORATION**

Providing strong collaborative multidisciplinary relationships was achieved through: formal professional networking, informal social communication, and contacts by the nurse living in the rural areas. Rural townships are renowned for their kinship and support for integrating new health workers into their communities. The collaborative role, within multidisciplinary teams was well
embedded in the fabric of each rural community. This has been heralded as the means to address not only the health needs for the rural areas but also the workforce maldistribution and shortage. (Mitchell et al., 2013)

The need for intragroup and intergroup collaboration and communication between multidisciplinary or interdisciplinary teams was an issue shared by both urban and rural practitioners. (Cox, 2003) This was described by two teams of urban and rural midwives in Scotland who related differences in their understanding of risk assessment and decision making for the transfer of a woman in labour to an urban tertiary hospital. (Harris et al., 2011) Intradisciplinary or interdisciplinary collaboration also required an understanding of the complexities by each health provider and a means to deliver and provide care to the client, patient or woman.

**CULTURAL ENGAGEMENT**

Cultural engagement has been provided through comprehensive orientation programs to embed new nurses into the community and provide frameworks to guide and assist the new workers. The training can also be enhanced by being placed, directly within a cultural community or using alternative education mediums to support learning. The use of photovoice was a means to record the journey for the nurse beginning in a new role and how this was shared this with the mentor. The recruitment of overseas nurses and midwives also required, the orientation to include local communication protocols to identify professional values and worldviews, which may not be similar to that of the rural community.

The midwifery and nursing care provided to the Hispanic and Native American communities, included the Cherokee and Lumbee Indians, was done within a diverse cross cultural environment. This was done to prepare through education the nurses and midwives entering this cross-cultural workforce. This was undertaken for student midwives in the East Carolina University and was a 4-pronged course, which included a cultural competency course, Spanish language training, traditional healing practices and an opportunity to undertake global awareness within an international project. The cultural competency course was embedded in the midwifery course and included cultural immersion experiences in Mexico and Haiti. (Jesse & Kirkpatrick, 2013).

**Cultural Engagement – By Native American Nurses**

In the Eleventh Annual Indian Nursing Education Conference, a plenary session was conducted with participant focus groups to consider the Native American Culture Conceptual Framework and how it applied to their nursing practice and research. The Framework included 7 important dimensions;
caring, tradition, respect, connection, holism, trust and spirituality all embedded within nursing practice. Outcomes from these group focus sessions were set against the framework and used to integrate the cultural framework into practice. Nursing research supported the means to investigate and explore the Native American health related phenomena and the means to develop a culturally appropriate service within available health resources. (Lowe & Anne Nichols, 2013)

**FLEXIBLE WORKFORCE**

There is a need for a flexible rural workforce, open to considering alternative models of care and break with the traditional biomedical (illness) model. Models for community based and client centred care also meets with the philosophy of indigenous and non-indigenous rural communities. The need to recognise the generalist roles for the rural nurse but also recognise the demands of increasing workloads and the distribution of work. This includes the role the nurse being mentor for undergraduate students in addition to their clinical loading. The use of University funded preceptors for undergraduate placements in rural hospitals is the preferred model to remove the demand on busy clinical staff to provide the required coaching. (Dywili et al., 2012; K. L. Francis & Mills, 2011; Pugh et al., 2013)
DISENGAGEMENT FACTORS FOR THE RURAL NURSING WORKFORCE

EDUCATIONAL CHALLENGES

An Overview:

Disengagement for rural nursing and midwifery is well represented in the literature and this includes identification of barriers, which inhibit a rewarding learning and working environment. As well as the means to engage undergraduates in the workforce, there still remains barriers to supporting students in rural placements when resourcing is stretched and clinical workloads demanding, as was the experience for some Tasmanian nurse preceptors. (Zournazis & Marlow, 2015)

Postgraduate transitional programs also experience challenges in resourcing regions that are impacted through restructuring and diminishing infrastructure. (Lea & Cruickshank, 2015) The graduate also has demands placed on them to have a broader scope of practice and responsibilities than prepared by university training leaving graduates overwhelmed with a feeling of being abandoned. (Bennett et al., 2012; Mellor & Greenhill, 2014) This was further aggravated by senior nurses expectations for work readiness which was beyond the graduates skill level, which in turn, became a barrier to the learning environment and negatively impacted on their adjustment to rural living. (Bennett et al., 2012; Ostini & Bonner, 2012)

The requirement to meet mandated hours of continuous professional development is a statutory requirement for renewal of registration by the Nurses and Midwifery Board of Australia. It is also fraught with challenges for those living and working in the rural sector. Distances, costs for travel and accommodation, seeking leave approval and having access to specialist courses are challenges that continue for the rural nurse and midwife. Understanding the requirements for developing a professional development plan and using reflective practice were also concerns that need to be met by the professions working in the rural sector. (Brideson, Glover, & Button, 2012)
UNDERGRADUATE STUDENT PLACEMENTS

A Tasmania Experience
Preceptors, similar to the mainland, predominantly provided the Tasmanian experience for rural nursing support. The nurse preceptors were also under pressure with extended clinical workloads whilst they provided educational assistance. The University of Tasmania School of Nursing and Midwifery had provided monthly video conferencing and a website to facilitate networking and information sharing prior to student placements. It was acknowledged that some sites did not have the technological aptitude for this equipment. The preceptors stated that clinical pressures negatively impacted on them being able to attend the video conferences. (Zournazis & Marlow, 2015)

POST GRADUATE EDUCATION & TRANSITIONAL PROGRAM
Postgraduate transitional programs provided in rural areas were the focus of four studies undertaken in three states of Australia: New South Wales, South Australia and Victoria. The studies included focus groups and interviews with graduate nurses and preceptors. (Lea & Cruickshank, 2015; Mellor & Greenhill, 2014; Ostini & Bonner, 2012). This research acknowledged the distinct challenges and resources required to provide rural graduate programs, often in regions suffering from diminishing infrastructure and experiencing significant restructuring within their local rural health services. (Lea & Cruickshank, 2015)

The vocational demands on graduates who chose to relocate to the country following the completion of their degree, could be difficult as they were often required to have a broader scope of practice than their urban based colleagues. The broader scope of practice was the undertaking of concurrent multiple nursing roles within an acute, aged care or emergency setting often without the supporting skill mix. Coupled with the expectations to fulfil these roles, whilst only having access to an on call medical officer was deemed stressful. The graduates reported that they were generally underprepared for practice and often felt overwhelmed and abandoned without being afforded the required clinical supervision. They often received only adhoc education, because of busy clinical settings and inadequate available time for training. (Bennett et al., 2012; Mellor & Greenhill, 2014).

Senior nursing staff also expected a work readiness beyond the graduates’ level of education and experience. This was particularly difficult for the graduate nurse to address within the first three to six months of employment as they had only begun to consolidate their practice. (Ostini & Bonner, 2012) The presence of negativity by older, experienced hospital trained nurses was harmful to the
graduate’s learning environment. The negativity towards them acted as a barrier to socialise and be included within the fabric of the workplace and rural community. (Bennett et al., 2012; Ostini & Bonner, 2012)

**CONTINUOUS PROFESSIONAL DEVELOPMENT**

Continuous professional development (CPD) was also a means to engage and retain rural nurses and midwives. CPD is a statutory requirement by the Nurses and Midwifery Board of Australia (NMBA) to maintain registration. Rural nurses and midwives experienced barriers to accessing CPD, including geographical distances, costs of accommodation, ability to be released from work, particularly if backfill for rosters was required. Gaining resource support by management was and is an ongoing challenge.

The advancement of electronic and web based education has improved access for rural staff to education but this was dependent on good internet connections and the ability for these nurses and midwives to work with technology. Resistance to this form of education by older nurses, who were unfamiliar with technology, preferred face-to-face education as a superior form of training. Provision of local training was seen as the best option when the alternative included travelling great distances and being separated from their families.

**Flight Nurses Experiences**

In a case study conducted by the Flinders University in 2009, flight nurses (FN) employed by the aero medical organisations were surveyed. This study identified barriers and variances in achieving the required mandated twenty hours of CPD by the Nurses and Midwifery Board of Australia (Brideson et al., 2012). The barriers flight nurses experienced were reported as similar challenges faced by rural nurses; being released from their rosters, travelling significant distances required to attend the training and inadequate financial support. Flight nurses indicated there was minimal specialist education available on aero medical midwifery.

The study also highlighted the differences between what the researchers called a ‘worker attitude’ and a ‘professional attitude’ when some flight nurses did not incorporate reflective practice within their learning. It was also identified that there was poor motivation to meet CPD requirements as 80% of the participants did not have a professional development plan and they considered such training as optional. The scope of practice for the flight nurse is to work autonomously. The flight nurse was required to provide emergency care for women during the flight. They were not afforded the professional support from a second midwife. However respondents did volunteer some
suggestions that could improve their access to training which included accessing electronic formats such as e-learning and use of simulation equipment (Brideson et al., 2012).

**RETENTION CHALLENGES**

*An Overview:*

Rural nurses and midwives felt undervalued with imposed changes to their generalist and specialists roles. This has created a sense of abandonment felt by nurses and midwives from other health disciplines, management, funders and policy makers. This was experienced in the milieu of a sector, which continued to place increasing demands and expectations on a contracting and ageing workforce. There was an expectation for the practitioner to meet multiple demands whilst acknowledging the loss of roles and no means to address the inequities in service provision. This was described by both mental health workers and midwives, and divisive when urban and rural sectors competed for the same resources and funding. This was particularly the case for the growing nursing specialities and midwifery led models (Crowther & Ragusa, 2011; Yates, Kelly, Lindsay, & Usher, 2013; Yates et al., 2011).

These experiences created a sense of dissatisfaction in the workplace. Increasing work demands with minimal management support, lead to work-life imbalance, particularly when family demands also increased. (K. L. Francis & Mills, 2011; McCool et al., 2013; Pugh et al., 2013)
INADEQUATE PROFESSIONAL RECOGNITION

Studies undertaken with rural midwives and nurses have shown that, with poor work changes, role ambiguity, intra and interprofessional conflict, inadequate performance feedback and insufficient recognition by management, all leads to dissatisfaction with working conditions. (Yates et al., 2013; Yates et al., 2011)

DISEMPOWERMENT

A Mental Health Example
This was exemplified through the grounded research undertaken in Wagga Wagga, New South Wales with mental health nurses who were interviewed and expressed that they felt undervalued. This was attributed to being multifactorial and was pre-empted with the closure of the NSW Mental Health Nursing Register in early 1990’s. The loss of the mental health specialist-nursing role to generalist undergraduate training, and the change from hospital to community care, were perceived as great losses to the profession. The ongoing natural attrition of the specialist mental health nurse, lead to the absence of suitably qualified replacements. Instead, allied health workers subsumed these roles. This produced a feeling of abandonment from government policy makers, line managers and the allied discipline. Management, however still expected the mental health nurse to do the 'grunt' of the work. With a caseload, which had increased in acuity in the rural areas, many clients were also being assessed with dual diagnoses.

The mental health nurses also considered that, in comparison with the urban areas, they were unable to access as many support services in psychology and drug and alcohol. They were often heavily involved in responding to crises at the cost of providing therapeutic intervention to local clients. This increased their sense of being undervalued as a professional and as a valued community member. (Crowther & Ragusa, 2011) A means to address this inequity by the Universities was to include a more comprehensive content to the undergraduate mental health subjects as well as increase the number of postgraduate courses in the relevant areas of mental health practice.
A Midwifery Example

Rural midwives also felt undervalued in their work environment when the birthing services were shifted to the regional facilities. Those who were qualified in both nursing and midwifery became deskilled, as they no longer supported women through their pregnancy and birth. Midwives experienced conflict at times when required to provide care for both the acute patient and the woman in labour. As this was resource and time intensive and only added further stress to the work environment. (Yates et al., 2013; Yates et al., 2011)

This was also the experience for international midwives located in the rural areas of the United Kingdom, United States of America and Canada. Global maternity reform was to support continuity of care for the woman within these countries and to promote this model of care, with some solutions being provided to support their midwives. The support included access to professional development, provision of regular feedback from senior professionals (management, administrators and obstetricians), and opportunities to work within the models. (K. L. Francis & Mills, 2011; McCool et al., 2013)

The Western Australian Experience

The Nurses and Midwifery Office undertook a survey with midwives employed in Western Australia. 23% of all respondents lived in the rural, regional or remote areas. 50% of all respondents indicated their intention of leaving work within five years because of a work-life imbalance, career change or family commitments. Midwives were also seeking a workforce that was flexible, provided reasonable caseload work and provided locally based, professional development to negate the high costs in travel and disruption to their family life. Web based learning however was not the preferred form of choice by senior midwives and the younger, less experienced midwives, preferred to work in midwifery led models. (Pugh et al., 2013)

LACK OF AUTONOMY

Lack of professional autonomy was also reflected in a midwifery pilot study undertaken by the University of Pennsylvania School of Nursing at an International Confederation of Midwives Conference (2010). 30% of midwifery participants, who were based in the rural areas, sought both recognition and autonomy in their workload from their managers and local doctors. A barrier identified in achieving this was the clear lack of administrative and political support. The authors also highlighted a significant shift to a defensive, medical approach by midwives because of the pervasive fear of litigation and subsequent loss of licensure and livelihoods. (McCool et al., 2013)
DISENGAGEMENT THROUGH CORPORITISATION & ECONOMIC RATIONALISATION

An Overview;

The role of neoliberalism and the rationalisation of government supported services to the rural areas, continues to impact on the retention and recruitment of rural nurses and midwives (West, 2013). Changes in Government public policy has lead to centralisation and regionalisation with the rationalisation of health services and the subsequent withdrawal of services being available for the smaller rural communities. This had negative implications for the nursing and midwifery workforce, having experienced changes in their own workplaces and roles. Through inadequate resourcing, significant gaps in education, and inadequate workforce retention strategies, the professions have suffered disengagement.

An International Experience - Appalachian Mountains, West Kentucky

West (2013) described, from a historical perspective, the changes in an organisational culture within a poor, undeveloped rural area in the Appalachian Mountains of Eastern Kentucky. (West, 2013) A community based nursing and midwifery service, initially founded and funded by one woman in the early 1900’s, experienced changes to become a corporatized, fiscally based service. The rural nurses and midwives who were initially employed, were autonomous and utilised their advanced clinical skills with a small-centralised service. This grew to one hospital with six nursing outposts. Changes occurred when interventions by the United States government, to address poverty in the Appalachian area, were managed remotely by Washington economists. The interventions implemented were without an understanding of the isolated areas and led to a service, which became fragmented, medicalised and changed through economic rationalisation. The author interviewed both the former nurses and midwives employed under the previous benefactor and the new corporate structure. The former nurses acknowledged the changes to the organisation and their disempowerment with the loss of autonomy and ability to provide advanced practices (West, 2013).
CONCLUSION
The developed countries share similar factors, which has contributed to the engagement and disengagement of rural nurses. The mix of government and employer policy and funding models, recruitment and retention incentives and educational resourcing determines the extent of engagement by nurses and midwives within their professional practice and rural communities. Given that, it is important to recognised there were limitations within this literature review on the extent of specific rural government policies and initiatives, which have effected the engagement of rural nurses.

Contemporary professional practice clearly recognises the respective nursing and midwifery professions, this paper draws on the parallels between nursing and midwifery. However this paper has principally referred to nursing roles unless midwifery was specifically included in the identified articles in the literature review. When nurses and midwives are recognised as health practitioners in their own right, who are empowered to fulfil their generalist or specialist roles, engagement then happens. When Universities appropriately resource and employ clinical facilitators to support undergraduate student placements, the future rural workforce is strengthened. When transitional graduate programs offer comprehensive; and supportive mentors, who also assist to embed the nurse or midwife into the local community; retention of staff is a likely outcome and engagement happens. With the use of immersion, photovoice, cultural integration and other innovative means to attract and retain staff, the rural workforce becomes truly engaged.

There is a great strength that emanates from rural communities being open and relational. Rural health services attract, support and also embed their nurses and midwives within their local communities. The health services who provide flexible working conditions and a supportive, learning environment; attract, actively engage and retain staff. Provision of educational programs tailored to the needs of the practitioner, which are provided locally is a means to further develop and mature the workforce.

Employers, government policy makers, funders, educational bodies and leaders within the nursing and midwifery professions will determine the future of the rural workforce. There is always a need for strong nursing leaders who are prepared to advocate for the professions and ensure they are appropriately resourced to meet future demands.
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