

Rural and Remote Nursing Practice: An Updated Documentary Analysis





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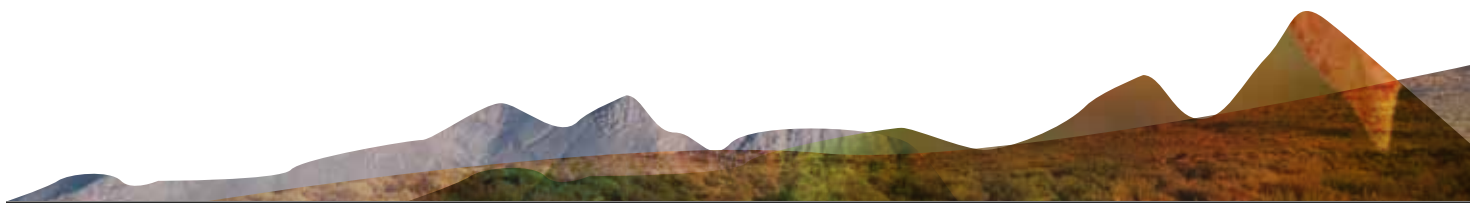
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Key Messages



1. The terms rural and remote continue to lack accepted and universal definitions.
2. There is a paucity of published literature about the contributions of all types of nursing personnel to rural and remote health.
3. The strategies to address issues pertaining to rural and remote health are focused on a deficit rather than a strength-based model.
4. Recruitment and retention of health care professionals including nurses continues to be a challenge in rural and remote settings.
5. There has been a rise in financial supports such as loan forgiveness programs for individual nurses who wish to work in rural and remote settings.
6. Provision of care for Aboriginal peoples continues to need investment to ensure that there are sufficient numbers of Aboriginal nurses and that non-Aboriginal nurses' care for this population within a cultural safety framework.
7. Evaluation of advanced practice in rural and remote settings in Canada is limited.

Executive Summary



This report provides an update of a documentary analysis of relevant reports (grey literature, government documents) regarding rural and remote nursing practice. For this report, nursing practice refers to practice performed by registered nurses, nurse practitioners, licensed practical nurses, and registered psychiatric nurses. Our overall goal was to gain a comprehensive understanding of the current policy environment and determine if, and how, it impacts nursing practice.

The first documentary analysis was conducted within “The Nature of Nursing Practice in Rural and Remote Canada” study (MacLeod, Kulig, Stewart, Pitblado & Knock, 2004) to generate a more comprehensive understanding of nursing practice in rural and remote Canada. The final documentary analysis report focused on issues relevant to rural nursing practice

(Kulig, et al, 2003) which described the practice of registered nurses in rural and remote Canada. The Rural and Small Town definition, i.e., “a population living outside the main commuting zone of larger urban centers (urban centers numbering 10,000 or more)” (du Plessis, Beshiri, Bollman & Clemenson, 2001, p. 7) was adopted for use in this study. This updated documentary analysis helps determine the current state of policy briefs, reports and other relevant documents that relate to rural and remote nursing practice.

Only relevant English language documents were located; a total of 29 reports were retrieved and reviewed based upon Rist’s (1994) policy cycle. Subsequently, full text reviews were completed on 28 documents. Other documents were specifically searched by thematic area to determine if there were any updates or changes since the

first documentary analysis was prepared. In particular, documents related to Canadian frameworks for rural health services and Aboriginal health and Aboriginal nurses were specifically searched for. Documents on Aboriginal health and Aboriginal nurses were specifically searched for on web pages such as Health Canada to determine if there was additional or updated information available. Other reports were located and assessed for specific points—for example, recent publications on the effectiveness of the Aboriginal Health Human Resources Initiative (AHRRI) were useful in understanding educational efforts for Aboriginal peoples. In total, an additional 28 reports or policy statements were located and reviewed. Finally, news releases were also used in the report although they were not reviewed in the same manner. For example, those from provinces or the federal government on scholarships or

loan forgiveness for nurses who choose to work in rural or remote locations were reviewed for specific program details. Telephone calls were made to the personnel affiliated with one of the tuition support programs to enquire about its uptake since this detailed information could not be located in any report.

The overall assessment of the documents revealed that there is a limited use of specific definitions to describe the concepts rural or remote. This lack of precision hampers a comprehensive understanding of the context within which health care professionals, including nurses, work. Furthermore, there is an emphasis on a deficit rather than a strengths-based model in describing rural and remote health status. The analysis of the documents led to the generation of six themes:

- Canadian Frameworks for Rural Health Services. Primary health care is a common framework across Canada and hence is also used in rural and remote contexts. There are examples of health regions applying a rural lens to the development and implementation of their health services delivery. For example, Alberta Health Services has made a concerted effort in ensuring that the delivery of health care services in their rural regions is community-appropriate and incorporates rural community variations.
- Descriptions of Rural Nursing. The characteristics of rural and remote nursing as well as the contextual variables that influence the discipline in these locations have been described in several reports. There is an emphasis on the unique circumstances within which nurses practice and the unique practice setting characteristics including knowing the patients and their families and the dual role of living and working in communities.
- The Context of Aboriginal Health Care. Two major themes arose from

the review of documents about Aboriginal health care: the need to prepare Aboriginal peoples in nursing and the acknowledgement and incorporation of cultural competence and cultural safety by all nurses while caring for Aboriginal peoples.

- Recruitment and Retention of Health Care Professionals for Rural and Remote Areas. Recruitment and retention of health care professionals remains a challenge in rural and remote areas around the globe. There is a greater emphasis on the inclusion of community members in addressing this ongoing challenge.
- Solutions to Recruitment and Retention Issues. To counter the concerns of recruitment and retention, jurisdictions have offered a variety of solutions. One example is improvements to the workplace including providing access to education and virtual connections to urban health care providers as well as improving living conditions for families. In Canada, there has been an increase in loan forgiveness and tuition support programs for those within the nursing field but it is too early to evaluate their effectiveness. There are also specific initiatives to address the shortage of Aboriginal nurses.
- Advanced/Specialized Practice. The meaning and educational preparation of nurses in advanced practice has not been resolved. Even the use of terms: advanced practice, nurse practitioner and clinical nurse specialist can be used interchangeably even though they may have different meanings in different fields.

In conclusion, this updated documentary analysis revealed key issues within the context of rural and remote health that impacts rural and remote nursing practice. Across the country there are isolated initiatives that are attempting to address the need for rural and remote-focused health programming.

Rural and Remote Nursing Practice: An Updated Documentary Analysis



This report provides an update of a documentary analysis of relevant reports (grey literature, government documents) regarding rural and remote nursing practice. For this report, nursing practice refers to practice performed by registered nurses, nurse practitioners, licensed practical nurses and registered psychiatric nurses. Our overall goal was to gain a comprehensive understanding of the current policy environment and determine if, and how, it impacts nursing practice. We also wanted to determine if there had been any recommendations adopted that have positively impacted rural and remote nursing practice. The following section summarizes key findings of the 2003 Rural and Remote Nursing Documentary Analysis Final Report.

RRN1: History of the First Documentary Analysis Report

The first documentary analysis was conducted within “The Nature of

Nursing Practice in Rural and Remote Canada” study (MacLeod, Kulig, Stewart, Pitblado & Knock, 2004) to generate a more comprehensive understanding of nursing practice in rural and remote Canada. The final documentary analysis report focused on issues relevant to rural nursing practice (Kulig, et al, 2003), which described the practice of registered nurses in rural and remote Canada. The Rural and Small Town definition, i.e., “a population living outside the main commuting zone of larger urban centers (urban centers numbering 10,000 or more)” (du Plessis et al., 2001, p. 7) was adopted for use in this study. Relevant English-language documents were analyzed by applying a framework developed from Rist’s (1994) components of the policy cycle (i.e., policy formulation, policy implementation, policy accountability); French-language documents were not located for this review. Five thematic areas were revealed once the analysis

was complete: Advanced Practice; Nursing Practice Issues in Aboriginal Communities; Educational Preparation of Registered Nurses in Rural and Remote Areas; Physician Supply in Rural and Remote Areas; and, Health Care Delivery in Rural and Remote Areas. Seven recommendations were generated based upon the analysis of the policy documents as follows:

1. Develop a national rural health human resource strategy by individuals with expertise in rural health issues
2. Create alternative payment options for nurses and physicians in rural areas
3. Develop scholarships and bursary programs for rural nursing students and rural-based nurses
4. Implement initiatives to enable full scope of practice, including advanced practice in rural areas with process

and outcome evaluation in rural and remote areas

5. Implement educational initiatives and complimentary supports for nurses working with Aboriginal peoples
6. Implement financial and technological support for universities with a rural-focused mission
7. Offer continuing education for nurses who work in rural and remote areas.

It was hoped that these recommendations would positively impact rural nursing practice in Canada. This updated documentary analysis includes documents that address some of these recommendations; however, there is no definitive way to assess the adoption of our recommendations in policy changes.

RRN2: Updating the Documentary Analysis

With the opportunity to conduct an updated version of the study Rural and Remote Nursing Practice II in Canada, a decision was made by the leadership group to update the documentary analysis and determine the current state of policy briefs, reports and other relevant documents that relate to rural and remote nursing practice. A team was developed consisting of the first author of this report, and co-Principal Investigator of the RRNII, and three co-investigators (and three co-authors) to lead the documentary analysis. A student research assistant (RA) was hired to assist in the process of locating documents and managing the materials. The team held several teleconference calls to discuss the creation of a process that would successfully meet the goals of locating and assessing any new documents since the last documentary analysis was completed. Thereafter, the RA was guided to locate relevant grey literature from Canada, the United States, Australia, New Zealand and Europe from 2004 to the present time. Web searches were conducted and when reports were located, searches for the citation of such reports were also conducted in order to locate any other relevant reports. In

addition, the first author held follow-up fact-finding discussions with several individuals to clarify and determine information identified in the analysis of some of the documents. For instance, more information was generated about the tuition support program for nursing students who agreed to work in rural and remote areas of Ontario. In addition, follow-up was conducted in relation to the recommendations and plan of the Rural and Remote Nursing Group in Nova Scotia.

This entire process was undertaken from July 2012 to August 2013 and generated 29 reports in total. A search strategy of the grey literature was updated from RRNI. French and English language documents were identified. The initial screening yielded 23 documents; subsequent searching located another five reports. Titles were reviewed by the first author and a determination made if the report would be reviewed in full. The review form was developed by the first author and each team member independently analyzed two documents in order to provide comparisons in review style and depth. The reviews were posted for all members to appraise before a teleconference meeting was held to discuss the postings completed by each team member. As a consequence of the discussion, the form was revised to include a final statement about strengths and limitations of the document and the concluding statement by the reviewer (see Appendix A). Thereafter, each team member was assigned an equal number of documents reflecting a variety of sub-topics. The individual members of the team independently analyzed the assigned documents and electronically sent them to the RA who then maintained the data base. Under supervision of the first author, the RA then summarized the major review statements of both reviewers onto a comparative sheet outlining each of the documents. Any discrepancies in the document reviews were addressed by the first author who made a determination about the conclusions of the reviews. In addition, the RA also reviewed several of the documents in order to enhance

the inter-rater reliability of the review process. Subsequently, full text reviews were completed on 28 documents.

Other documents were specifically searched by thematic area to determine if there were any updates or changes since the first documentary analysis was prepared. In particular, documents related to Canadian frameworks for rural health services were identified and reviewed. Documents related to Aboriginal health and Aboriginal nurses were specifically searched for on web pages such as Health Canada to determine if there was additional or updated information available. Other reports were located and assessed for specific points—for example, recent publications on the effectiveness of the Aboriginal Health Human Resources Initiative (AHRRI) were useful in understanding educational efforts for Aboriginal peoples. In total, another 28 reports or policy statements were located and reviewed. Finally, news releases were also used in the report although they were not reviewed in the same manner. For example, news releases from the federal or provincial government on scholarships or loan forgiveness for those who choose to work in rural or remote locations were reviewed for details about their specific programs. In addition, telephone calls were made to the personnel affiliated with one of the tuition support programs to specifically enquire about its uptake since this detailed information could not be located in any report.

Results of the Documentary Analysis

The discussion of the context of rural and remote health and the six themes presented here provides a comprehensive understanding of the factors that influence rural and remote nursing practice and ultimately the care of individuals, families and communities in rural settings. This discussion is linked to the identification of policies and programs that have the potential to address the current challenges within rural and remote health practice.

The Context of Rural Health

Several of the documents included a discussion about the issues facing rural and remote communities (Bailey, 2009; Wood, 2004). Despite the geographic area of these reports that span from Canada to the United States, Australia and Scotland, there were similarities that provided the context for understanding the scope of the report. For instance, understanding geographic isolation and demographic changes in the rural population provides a comprehensive understanding of recruiting and retaining health care providers. An American report, *Top Ten Rural Issues for Health Care Reform* (Bailey, 2009), notes that the main issues facing rural communities include an economy that is based on self-employment, workforce shortage in general, an aging population, and inadequate information technologies. These are coupled with a lack of infrastructure in health care organizations, an aging health care workforce and a lack of interest in rural practice. One other American report discussed an evaluation of health information technologies and their use in rural settings (Hook, Grant & Samarth, 2010). There are many positive uses of such technology in rural environments but the authors note a number of challenges including the lack of a reliable internet connection, difficulty of maintaining privacy and confidentiality, and limited staff with training to utilize the health information technology system. Although the report's findings are limited in their direct usefulness in rural and remote nursing practice, it does shed light on a challenge that impacts rural health care delivery in general.

In addition to focusing on a list of general issues within rural environments, a number of the reports discuss health status within a rural or remote setting from a deficit perspective. Thus, health status is reported as a negative (i.e., higher levels of particular disorders with less access to health care providers and facilities) rather than noting the

health benefits of living in rural areas (i.e., extensive community support, independence and resourcefulness). To that end, there are some agencies that provide annual reports on rural health services. For instance, the Annual Report for 2011-12 from Australia (Government of Australia, 2012) provides a comprehensive list of services and program outcomes, which are meant to identify the specific strategies that are used to address the health of rural and remote residents in that country. One example is the number of communities which receive outreach services, the availability of internet- and telephone-based health information and service and multidisciplinary health services for rural and remote residents.

A final document to note is a review of rural health projects meant to address the unique needs of the rural area in the northwest region of the United Kingdom (Wood, 2004). The concept of "rural proofing" is introduced which refers to a policy that has been implemented to ensure that the rural needs are not overlooked. To meet this goal, a list of questions in a checklist is included to assess and determine whether policies are meeting rural needs. However, there is also mention that there are numerous contradictions with the National Health Services not meeting the policies that have been implemented. The report is refreshing because it also includes positive information about rural communities such as the existence of community councils which provide information to residents. In addition, examples are provided regarding how they face their identified issues through the development of unique projects such as the Farmers Health Project which includes mobile health clinics.

International Rural Health Frameworks
There are four reports available that focus on the actual delivery of rural and/or remote health services that help to provide a contextual understanding for rural and remote nursing in general. The Scottish government is one entity that has developed steering groups to review

and develop recommendations in relation to the delivery of care (National Health Service (NHS), 2007). Although the 2007/08 Steering Group, NHS Scotland does not include a specific definition of rural, the information it provides is nonetheless informative. For instance, a Clinical Peripherality Index (CPI) was included which takes into account the population density, practice size and the time required to reach secondary care (p. 9). These criteria are then applied to the map of Scotland, which provides a visualization of the different levels of remote care throughout this country. The document presents their vision for a sustainable health system to help ensure that the changing needs of those in rural and remote areas of Scotland are considered when deploying resources. Additional information in the report focuses on a framework of generic principles including implementing service delivery for primary care in remote settings, the development of a rural education strategy including the development of a virtual School of Rural Health Care and the development of workforce planning which supports the rural and remote agenda. The guiding principle for this work is the belief that all Scottish individuals, regardless of where they live, should receive the same standard of care. Policies were suggested that could meet this goal. This comprehensive document could be applied to other areas of the world that have similar challenges addressing the health care needs of their rural and remote residents.

Themes related to the Policy Analysis

The analysis of the documents led to the generation of the following five themes:

- Canadian Frameworks for Rural Health Services
- Descriptions of Rural Nursing
- The Context of Aboriginal Health Care
- Recruitment and Retention of Health Care Professionals for Rural and Remote Areas

- Solutions to Recruitment and Retention Issues
- Advanced/Specialized Practice.

Each of these will be discussed in detail with specific examples from the reports to offer detailed information based upon our analysis. A number of the reports did not include definitions of rural and remote; more specifically of all of the reports discussed in here only 13 provided a definition of rural or remote (see Table 1). Several of the remaining reports indicated that their goal was not to specifically define or debate this concept. In some of the reports, there is reference to an area that is not urban or metropolitan that is automatically considered rural. The American reports tend to focus the definition based on population density; all three reports we reviewed identified rural in this manner. One of the Australian documents defined rural based upon a point system that included specific criteria to determine if an area is rural or urban while another of the Australian reports used the Australian Standard Geographical Classification Remoteness Area system to determine if the area was rural or remote. Two of the Canadian reports referred to the du Plessis, et al (2001) discussion about rural and in one of the reports, the rural and small town (RST) definition was adopted.

Canadian Frameworks for Rural Health Services

Primary health care (PHC) is one framework within which rural practice, and rural nursing practice, is often placed. For example, a report on continuing care needs in Nova Scotia identified that rural and remote areas would benefit from innovative models and approaches including access to primary health care (Province of Nova Scotia, 2008). A recent synthesis report prepared on behalf of the Canadian Foundation for Healthcare Improvement (CFHI, formerly the Canadian Health Services Research Foundation) on the status of PHC in Canada (Mable & Marriott, 2012) notes that Canada is lagging behind implementing PHC. The

authors reviewed every jurisdiction in Canada to identify PHC policy and programs that are in place. Despite the slow uptake of PHC, this recent report notes that nurse practitioners are increasingly employed as primary care providers. Although the document does not specifically address rural and remote settings, it became apparent through the review of the information, that PHC was mainly developed in areas with the most rural and remote communities. For instance, in Nunavut, PHC services are offered through a multidisciplinary team which includes nurse practitioners, nurses and other health care providers but nurses are the core of this team approach. Telehealth is another service frequently used which also enhances the care that is provided in this territory. The authors conclude that PHC continues to evolve in Canada and that future reviews of this model of care would be able to track the changes.

The Health Workforce Action Plan 2007-2016 (Alberta Health & Wellness, 2007) presents a plan that would include the development of rural health and wellness centres, the creation of a rural health workforce strategy, the development of virtual campuses for rural areas and residents that would include rural mentoring which would also be linked to the rural health and wellness centres and the development of a recruitment strategy for Aboriginal people into health careers. Another report, *Vision 2020: The Future of Health Care in Alberta*, identifies the unique challenges and needs of rural areas in this province (Alberta Health and Wellness, 2008). The document emphasizes a commitment to enhancing access, ensuring there is an adequate workforce and improving coordination to ensure that the identified issues are addressed. Examples of possible solutions include the use of telehealth, increasing the training of Emergency Medical Services (EMS) personnel and reviewing current services to determine what else can be developed and implemented.

Alberta Health Services (AHS) has subsequently released a number

of documents that support rural health planning. For example, in the Community and Rural Health Planning Framework a standardized approach to community and rural health service planning is applied across Alberta. The planning process includes the application of the Community Assessment and Service Response toolkit which begins with the validation of data and ends with specific community health service recommendations. The planning itself is led by the individual Zones with support from AHS provincial strategy teams to ensure standardization across service planning. There are several products developed through this process including: 1) development of a data report based upon local community data that is presented to local AHS leadership; 2) data validation by key stakeholders which includes community members; 3) validation feedback is compiled and integrated into planning documents; 4) the top five community health needs are identified; 5) strategies are identified to address health needs; 6) a three year action plan is developed; and, 7) working groups are formed to implement the plan (AHS, no date). In addition to this work, AHS is also committed to address workforce planning. For instance, environmental scans in AHS rural hospitals, specifically emergency, outpatient, surgical and inpatient services have been completed to identify workforce issues and assist in workforce planning (AHS, 2012a & b).

In addition, the AHS Rural Hospital Clinical Services Capability Framework (2012c) describes and defines the clinical capability and requirements to support rural hospital services (AHS, 2012c). This framework describes the core and support service levels of rural hospitals across Alberta, identifies support service gaps and provides zone planning support for new or enhanced rural hospital services. Environmental scans of rural hospitals are conducted every five years with the completed documents given to relevant Zone leadership.

Clinical service guidelines are currently being developed to inform and guide rural service location determination. *Clinical Service Framework Development* (AHS, 2013a) is guided by a nine-step process to inform planning guidelines for each clinical core service as defined within the Rural Hospital Clinical Service Capability Framework. To further assist with this process, a Literature Review Process Guidebook has been developed by AHS (2013b). The first of these clinical service guidelines is the Rural Service Access Guidelines which focuses on Emergency Departments and Acute Medical Inpatient Service Planning (AHS, 2013c). For example, one of their guidelines is that 95% of rural/remote Albertans shall have access to Emergency Department Service (availability and location) based on a specific population density and travel time. Therefore if an Alberta resident lived in a community of less than or equal to 1000 people per 400 square kilometers the travel time would be 60 minutes to the nearest emergency department. Finally, a Provincial Rural Obstetrical Service Framework is also now in existence within AHS. This framework is based on several principles that align with AHS' strategic direction and includes: a needs assessment, application of rural obstetrical service guidelines (access, quality, sustainability), service gaps and risks identification, service planning, optimization and implementation, and service evaluation and review.

Descriptions of Rural Nursing

Several documents were located that focused on describing the nature of rural nursing practice. Bushy (2006) refers to "frontier" nursing as a descriptor of rural nursing and characterizes rural nursing practice as including the experience of professional isolation, the need to make independent decisions and the need for a wide range of skills. She highlights the challenges of recruitment and retention and lists a number of strategies to create a sustainable rural nursing workforce through education scholarships and loans, retention grants and the availability of advanced nursing education.

This same author also prepared a chapter on the rural contextual attributes to identify how they impact ethical situations that emerge for clinicians providing care in this practice setting (Bushy, 2009). Although the definition was not included, there was clarification that the emphasis was on the population and geographic size of a community relative to population density (i.e., the number of people living in a square mile). The major thrust of the chapter is that a rural context is significantly different from an urban one and hence the ethical dilemmas that are faced are different in rural areas. One example is that there are rural values (i.e., self-reliance, acceptance of illness rather than seeking care) that impact people's outlook on health, illness and care-seeking, overlapping of professional and personal roles in addition inter-related threats to confidentiality and limited availability and access to health services.

Pashen et al. (2007) conducted a systematic review to identify the current and potential components of generalist practice in rural and remote highlighting rural and remote health issues, Indigenous Australian health and mental health workforce issues in rural areas. Their questions revolved around identifying generalists' dimensions in rural and remote areas and how effective this role is in addressing the identified rural health issues. They discovered that Queensland Health has adopted a model of generalist care in rural areas.

An Ontario-based report discussed an initiative to strengthen leadership in rural public health (Kilty, 2007). Several steps were undertaken including: 1) conducting a review of relevant literature which generated a list of issues related to rural public health (i.e., distance and isolation, lack of health care providers, need to identify rural health planning models and services); 2) conducting focus groups with 59 key informants who were staff at the participating health units; 3) examining theoretical models related to rural public health; and, 4) offering recommendations to

assist the participating health units meet their strategic plan. Recommendations focused on programs or initiatives to address rural health needs, and organizational structures and supports for rural public health. Overall the report is useful in informing rural health policy makers and program managers as they continue to improve service delivery and effectiveness.

The Canadian Association for Rural and Remote Nursing (CARRN) (2008) introduced "a framework for practice expectations and practice setting characteristics and to highlight the essential and integral importance of rural and remote nursing" (p. 3). CARRN was granted associate group status within the Canadian Nurses Association (CAN); the objectives of this organization include explicating the roles and functions of rural and remote nurses, collaborating with key stakeholders on the development of health policy for those living in rural and remote Canada and facilitating communication and networking among those who work in rural and remote settings. There is a clear statement that the focus is not to generate a definition of rural and remote nursing practice but to generate a discussion about what is unique about this practice setting. Other available documents were synthesized to present specific characteristics of rural and remote nursing practice setting characteristics (i.e., fewer nurses per capita, knowing patients and their families, being the nurse at work and in the community) and rural and remote nursing practice characteristics (i.e., autonomy of practice and decision making, significant responsibility, ability to adjust nursing care based on community needs and demographics).

There continue to be dedicated nursing education initiatives across the country; there is also an indication that there is an increase in rural-focused nursing education in the last decade. For instance, there have always been opportunities at the University of Lethbridge, University of Northern British Columbia, University

of Saskatchewan and Aurora College for RN students to be placed in clinical rural sites. There is also an increase availability of rural clinical preceptorships at the University of Alberta, Thompson Rivers and The University of Saskatchewan site in Prince Albert, Saskatchewan.

Aboriginal Nursing Practice

The first documentary analysis report emphasized that nursing practice issues in Aboriginal communities included four issues: transfer of health care delivery to local control; the introduction and integration of traditional healing methods; the current and predicted nursing shortage; and, the education of Aboriginal peoples in nursing. The review of reports for this updated documentary analysis report has noted the following themes: the education of Aboriginal peoples in nursing and the acknowledgement and incorporation of cultural competence and cultural safety by all nurses in the care of Aboriginal peoples. However, a brief summary is provided regarding the responsibilities of the First Nations and Inuit Health Branch (FNIHB) in the care of Aboriginal peoples before the two common themes are discussed.

Health care for First Nations and Inuit peoples continues to be provided through FNIHB within Health Canada. Their most recent strategic plan reaffirms the commitment to achieving healthy First Nations and Inuit individuals, families and communities (FNIHB, 2012). This branch is based on the principles of wellness; excellence; reciprocity and trust; fiscal stewardship, flexibility, culture; and finally communications and engagement. There are four strategic goals noted: high quality health services; collaborative planning and relationships; effective and efficient performance; and supportive environment in which employees excel. A systematic process is used to evaluate the progress on meeting these goals. Furthermore, contribution agreements, which clearly specifies the funding that will be provided and the conditions it will be spent within, continue to be the operational

mechanism used within the FNIHB. There are three categories of services: 1) provision of funding for services in lieu of what the department would provide (the contribution agreements would be either a set funding model, flexible funding model, a block funding model or a multi-departmental funding arrangement); 2) inter-departmental partnerships (to help partners address national health priorities such as the National AIDS Strategy); and 3) research projects (research projects that stimulate knowledge development for instance assisting the Canadian Institute of Health Information (CIHI) develop and maintain an integrated, comprehensive health information system).

There remains a concern about the lack of Aboriginal nurses in Canada. In 2007, an update of Aboriginal nurses in Canada was completed (Gregory & Barsky, 2007). The review noted that there was an increase of Aboriginal nursing students in Canada from 237 in 2002 to 730 in 2007. However, this information is based upon surveys with Canadian Association of Schools of Nursing (CASN)–member schools; the response rate was 64.8% (59/91). In addition, the information is only available to the schools where students “self-declare” as Aboriginal. At the time of the survey, several of the provinces have designated seats for Aboriginal students (Saskatchewan for instance has the highest number); Aboriginal faculty continue to be low in numbers across the country with literally no Aboriginal faculty employed east of Ontario. This report concluded that there had been progress in terms of a growth of the actual number of Aboriginal nursing students and in the availability of bridging/transition programs.

In order to address the shortage of Aboriginal peoples in nursing careers, the Aboriginal Health Human Resources Initiative (AHHRI) was made available from Health Canada (2011) from 2005 - 2008. AHHRI had seven principal objectives: increase the number of First Nations Inuit and Métis (FNIM) youth

who are aware of health careers; increase the number of FNIM who enter and are successful in health careers; increase the number of post-secondary educational institutions that are supportive of FNIM in health career studies; identify the conditions that will support the retention of FNIM and non-Aboriginal health care workers in FNIM communities; establish standards of practice and certification processes for FNIM community-based allied health care providers to help ensure a well trained and mobile workforce; establish the foundations for collaboration among partners; and, initiate and establish baseline information about the number of FNIM health care workers, the supply and demand for the same while also identifying best practices to support decisions related to policies, planning and programs. The review concluded that there was a greater awareness among FNIM about the availability of health careers as a choice; innovative bridging programs were developed to help FNIM transition into a health career, best practices have been identified regarding the preparation of FNIM as health providers and curriculum has been developed to increase the number of culturally competent health professionals. Areas for improvement included the need to enhance strategic communications and work to establish sustainable networks, improving ways to share best practices to avoid duplication and streamline the administrative aspect of the projects. The review concluded with seven recommendations: 1) ensure knowledge management and dissemination is established; 2) increase the capacity of the regions; 3) develop human resource strategies that are Inuit specific; 4) improve data gathering mechanisms; 5) ensure that strategies meet the local rural and remote communities’ needs; 6) facilitate the development of community-based health human resources planning tools, and 7) strengthen the roles and responsibilities of governance committees.

In April, 2013 British Columbia’s Practice Education Committee released

their Aboriginal practice guide and toolkit. This AHRRI-funded project, an extension of their previously AHRRI-funded Aboriginal Practice Education Framework project, concentrated on the ongoing development of Aboriginal education in BC. Aboriginal practice education focuses on Aboriginal or non-Aboriginal learners providing health care to Aboriginal peoples in a culturally safe manner. Aboriginal practice sites include intentional exposure to the health needs of Aboriginal peoples as well as the intentional support for the practice education in relation to this group. The report clearly spells out the requirements for quality learning at three levels (introductory, evolving and master), a capacity assessment process for the clinical site to determine their current level of Aboriginal Practice Education and a capacity-building process to enhance their Aboriginal Practice capability. This detailed practice guide and toolkit outlining roles and responsibilities of health regions and educational institutions can be easily reviewed, revised and adopted for other provincial jurisdictions that are dedicated to recruiting and retaining Aboriginal nursing students as well as contributing to Aboriginal health in general (British Columbia Practice Education Committee, 2013).

The concept of cultural safety is increasingly becoming more common within health care delivery and practice. The concept originated in New Zealand where it was developed as a response to address power imbalances between Indigenous peoples and care providers. It is not simply cultural sensitivity or awareness but a full awareness of both the provider's and the Indigenous client's social, economic, political and spiritual worlds (Polaschek, 1999; Williams, 1998). Cultural sensitivity is becoming more common outside of New Zealand including Canada where it has been used in care settings with Aboriginal peoples. For instance, the National Aboriginal Health Organization (NAHO) has produced a guide for health care administrators, providers and educators

to develop and implement care from a cultural safety perspective and to help prepare the next generation of providers who work from this perspective (NAHO, 2008). The document provides examples of "culturally unsafe" education and then provides practical examples of students and nursing educators demonstrating culturally safe behaviors. For instance, not recognizing the values or ways of knowing of First Nations peoples would exemplify culturally unsafe behavior whereas developing and teaching curricula that shows respect for Indigenous knowledge would illustrate culturally safe teaching. The report provides numerous specific examples of how educators can treat students in a culturally safe way that could easily be applied in classrooms.

In 2009, the Aboriginal Nurses Association of Canada (ANAC) in collaboration with CASN released a report that offers a curriculum framework that reflects the principles of cultural safety while developing a curriculum that prepares both Aboriginal and non-Aboriginal nurses for addressing injustices faced by individuals in our society (ANAC/CASN/CNA, 2009). Key definitions of terms such as cultural safety and Indigenous knowledge are provided before the framework is introduced. The visual drawing of the framework illustrates the connections between curriculum, faculty members and students culminating in core competences to achieve cultural safety. Thus, the framework offers guidance to faculty members and the detailed information about the core competencies makes it easy to apply in nursing educational settings.

Following the release of these reports, CASN and the ANAC sponsored a symposium on cultural competence and cultural safety. The symposium included presentations on six cultural competence projects that were developed based upon the national framework on cultural competence discussed in the report noted above. One additional presentation focused on a project developed by Inuit for Inuit nursing students. The final

report highlights all of the projects noting their successes and challenges. For one thing the concepts of cultural safety and cultural competence are difficult concepts that do not easily captivate students in meaningful ways. Based upon participant discussion and responses, the following was offered as future direction for curriculum development. There are two key elements that future nurses need to learn (build respectful relationships and promote social justice and equity when providing care) and two program approaches to facilitate this learning (bring society, culture, history and context alive throughout the program and create a safe and supportive classroom environment for students). Each of these aspects is discussed in-depth and suggestions are offered about how to achieve these goals in a nursing education setting.

Discussing Aboriginal nursing practice would not be complete without noting the issues of health care delivery. For instance, unique in Canada, British Columbia has a tripartite framework on First Nation health governance (Tripartite Committee on First Nations Health Interim Annual Report, 2011/12). The most recent agreement builds on the agreements that were made in 2006 and 2007 to help improve the health and well-being of First Nations peoples in this province. One of their goals is to establish an integrated health system which includes the First Nations Health Council (FNHC) as an advocate for First Nations health in British Columbia. Through a collaborative decision-making process the agreement will avoid parallel but separate health systems for First Nations peoples in this province. A recent positive review of the tripartite agreement noted that there have been several successful activities completed including meeting the timelines for transfers and commitments, making a smooth transition from the FNIHB—BC Region to the First Nations Health Authority and having an ongoing and effective partnership between all listed parties (Tripartite Committee on First Nations Health, 2011/12).

Similar to the BC arrangement, The Federation of Saskatchewan Indian Nations (FSIN), the Government of Canada and the Government of Saskatchewan have developed a Memorandum of Understanding (MOU) on First Nations health and well-being in Saskatchewan (The Federation of Saskatchewan Indian Nations/ Government of Canada, Government of Saskatchewan, 2008). There are five purposes of the agreement including the need to improve the health and well-being while also eliminating the disparity in health status between First Nations and Saskatchewan residents; adapting and effectively integrating health and wellness programs by improving the coordination of health care systems; improving the participating of First Nations in the health system; developing a co-ordinate tripartite partnership for improving First nations health; and, establishing a planning process to develop a 10-year health and wellness plan for First Nations. The roles and responsibilities for the different parties were noted in the MOU; a tripartite Steering Committee was to be established after it was signed which would be responsible for several activities including identifying priorities, producing an annual work plan, identifying performance indicators. Finally, the MOU would be reviewed every two years. However, no additional information could be located regarding the progress of this agreement.

Recruitment and Retention of Health Care Professionals for Rural and Remote Areas

The World Health Organization (WHO) (2010) provides a useful review of global rural and remote health care that are applicable in other countries. The report was aimed at both national policy makers and government leaders across multi sectors (i.e., finance, health, education, labor); specifically the authors discuss areas “not urban” which globally refers to 50% of the world’s population. The authors state that 38% of the nursing workforce cares for 50% of the world’s population which lives in

rural areas and that nurses are less likely than physicians to leave work in rural areas. The overall goal of the report is to “examine existing knowledge and evidence and to provide up-to-date, practical guidance to policy makers on how to design, implement and evaluate strategies to attract and retain health workers in rural and remote area” (p 8). The authors acknowledge that there are issues in the educational preparation of health care professionals to better serve rural and remote populations. The authors suggest recommendations and policies that if implemented could address recruitment and retention issues as discussed below.

A summit on retaining older, experienced rural RNs was held in 2007 in the United States (Minnesota Department of Health, 2007). The nurse leaders were from four states (Iowa, Minnesota, North Dakota and South Dakota) and represented a variety of practice areas. Their discussions focused on several key issues that currently exist in work settings in rural areas including: the need for health care organizations to recognize and support the complexity of rural nursing practice including complementary salary and benefits; the need for continuing education for this group of nurses, use of care models and scheduling that is flexible and meets the needs of rural settings, the actual redesign of the workplace to make it more suitable for older workers and incorporating technology to benefit those that work in the rural environment (i.e., electronic records).

The Centre for Rural and Remote Health Research (CRaNHR) (Pong & Russell, 2003) produced a systematic review regarding the shortage of health care providers in Ontario. The report was one project under the auspices of the Comprehensive Health Human Resources Strategy for Ontario. Pertinent policy and planning documents as well as the strategies and recommendations made by various commissions, task forces and relevant organizations were included. Although rural nursing practice was not specifically defined the information that

was discussed has relevance for nursing practice in rural and remote settings. For instance, there was a pointed discussion about issues relating to both rural physicians and nurses including the lack of sufficient numbers of these two groups as well as a misdistribution of these groups in rural areas. The review did not only focus on issues or problems but on the solutions that were applied; some of these included increasing the number of seats for nursing students, enhancing the quality of the work life and expanding the role of nurses.

A report on the synthesis of relevant policy initiatives with the perspectives of community-based members focused on the experience in Nova Scotia (Osmond, 2004). More specifically, two objectives in its report were particularly relevant: 1) a policy synthesis of initiatives that were implemented across Canada and other international contexts; and 2) report of the findings from interviews with community members to enhance understanding of barriers they face in recruiting and retaining health care providers. Both the policy reviews and the findings generated from the interviews were discussed within five environments (physical, social, administrative, economic and educational environment). The information discussed within these five categories was further broken into subcategories relevant to the rural workforce. For instance, there is a positive link between having a rural background and recruitment and retention in rural areas. Strategies and solutions to address recruitment and retention challenges were also offered; examples include offering rural health practicums as a means to attract the workforce and collaboration between communities and government was essential to be successful in recruitment and retention of health care professionals.

Solutions to Recruitment and Retention Issues

The WHO (2010) report notes that retention of workers through incentives such as educational scholarships and

bursaries would be beneficial and that appropriate infrastructure supportive to health care professionals (i.e., safe working environments, access to education, virtual connections to urban health care providers) and their families (i.e., living conditions) are needed along with supportive networks. The authors suggest recommendations and policies that if implemented could address these issues.

There is one example of an Australian intervention that focuses on recruitment of youth, particularly Indigenous youth, into nursing (Jones, Naden, Ward & Peteron, nd) that warrants discussion and consideration for implementation in other geographic settings. A one-day interactive program called Nursing Academy Project (NAP) was developed in 2007 to gain insight about nursing practice and career pathways available to youth. During the day, tours of health facilities occur and opportunities are provided to speak with health care professionals. NAP is offered on an annual basis allowing further opportunities for the same students to be exposed to the program. The Broken Hill area where the program was carried out had experienced a gradual decline in the number of individuals who choose nursing as a career path. Since NAP's inception, over 100 students from grades 7 through 12 have participated with a 28% Indigenous student participation. One of the major findings is the confirmation that parents play a major role in children's career choices. The evaluations of NAP identified that parents learned about nursing education pathways and positively impacted their confidence and capacity to assist their child make decisions about their career choice. NAP could be implemented in other geographic areas including Canada as one means to educate parents and youth about nursing as a career path in hopes of increasing the numbers of youth entering nursing as a career.

The seven recommendations from the 2007 summit on older rural RN focused on locating and implementing

innovative rural care models; developing a rural nurse certification; creating a new employee benefit group for older RNs; foster a health care delivery system structure that fosters collaboration and engagement with RNs; develop a rural nursing education model that engages with mature rural RNs as preceptors and mentors; examine rural nursing workforce needs through community assessments; and, create accessible continuing education programs that are relevant for rural practice (Minnesota Department of Health, 2007).

In 2003, Nova Scotia created a provincial committee (i.e., Rural and Remote Nursing Working Group) to examine issues and strategies helpful in attracting and retaining nurses in that province's rural communities (Rural and Remote Working Group, 2004). Thereafter, the Rural and Remote Steering Team was developed to implement the recommendations identified by the provincial committee. The steering group represented a variety of nursing groups and professions; it can be viewed as a "watchdog" for ensuring that rural nursing issues are addressed. In addition, the definition of nurses was inclusive with both registered nurses and licensed practical nurses included. The group specifically identified and addressed nurses' quality work life, marketing of rural nursing opportunities and supporting the education as well as the professional development of rural nurses. Specific issues that were addressed therefore include recruitment, retention and the renewal of the rural workforce. Sub-groups were developed to attend to specific issues (i.e., education, marketing, quality practice environments, and a commitment was made to monitor progress and provide ongoing advisement twice a year as well as provide a yearly written review of the overall progress. Each subgroup created their own action plan and held information sessions for nurses, managers and administrators. The report provides the detailed purpose, objective, process and action plan for each subgroup. Examples of successful outcomes were included. For instance,

there was a change in policy regarding bursaries for individuals who chose to work in rural and remote areas i.e., larger bursaries with a longer return-to-service period. Finally, a rural and remote nursing staffing workshop was held in 2005 where challenges and solutions were discussed. The list of this information is included and could be applied to other regional and provincial areas of Canada.

One other document from Nova Scotia focused specifically on recruitment and retention of nurses for that province (Rural and Remote Working Group, 2004). The report provided a comprehensive discussion of the issues facing rural and remote nurses and then forwarded seven recommendations with supporting actions under the categories of recruitment, retention and renewal. Examples include supporting newly recruited graduates as they transition in rural and remote settings (recruitment), supporting employer initiatives that enhance quality work life (retention), and supporting interdisciplinary and other collaboration (renewal).

Nova Scotia has been active in other ways in terms of recruitment and retention of health care providers. A research project conducted by the Atlantic Health Promotion Research Centre and the Coastal Communities Network of Nova Scotia were partners in the Rural Communities Impacting Policy (RCIP) which included examining factors that affect the retention of health care professionals in Yarmouth County in this province (Lombard, 2005). Issues that impact the challenges of both recruitment and retention include community infrastructure (i.e., limited transportation in rural and remote communities, limited options for cultural or entertainment events, geographic isolation), health care system issues (i.e., limited health facilities, resources and equipment, physician resistance to nurse practitioner practice) and social issues (i.e., lack of engagement between community and health care professionals). The findings identified

successful policies and initiatives, which included focusing on financial incentives (i.e., subsidized income, differential fees bonus and alternate payment positions, bonuses, and community scholarships), professional incentives (i.e., encourage the use of nurse practitioners) and social incentives (i.e., welcoming committee in the community, community-based networks for health care professionals). The findings can be used by both provincial and federal government decision makers responsible for health as well as health boards in implementing strategies related to recruitment and retention. The report calls for a national strategy on recruitment of health care professionals in rural settings.

A comprehensive recruitment and retention strategy has been developed by the Government of Nunavut, Department of Health and Social Services to reduce the nursing vacancy rate and to increase the participation of Inuit in nursing careers (Government of Nunavut, 2007). The report integrates Inuit culture and territorial government expectations in its principles and objectives. The four objectives of the strategy including: 1) promoting and supporting the recruitment of motivated and skilled professionals for Nunavut's communities; 2) meeting Article 23 of the Nunavut Land Claims Agreement by recruiting and training Inuit candidates for nursing and other public health careers; 3) increasing retention of Nunavut's front-line nursing professionals; and, 4) obtaining a representative Inuit nursing workforce in their territorial government. There are five principles that guide the above initiatives including: 1) acknowledging the critical need for nurses within the health care decision-making process; 2) successful recruitment and retention initiatives for health care professionals that responds to the challenges of nursing professionals in Nunavut; 3) a focus on community health committees playing an active role in promoting wellness; 4) adhering to the principle of *pinasuaqtavut* (i.e., working to improve the health, prosperity and self-reliance of Nunavummiut); and,

5) incorporating a strategy that will enhance the health and well-being of Nunavummiut by incorporating Inuit *Qaujim ajtuqangit* (i.e., Inuit traditional knowledge) at all levels of service development and implementation. The review of the reasons for recruitment and retention challenges among health care professionals includes issues that parallel other rural and remote locations including housing shortages, few employment opportunities for spouses, inadequate child care facilities, inadequate salary and a belief that their skills will fall behind emerging techniques.

The Department of Health and Social Services had set a goal of 15 – 20% vacancy rate in nursing over the next five years by outlining the following action items: 1) Improving human resource practices affecting nurse recruitment to be met by: assigning a senior member of the nursing workforce to be responsible for coordination of recruitment, retention and training initiatives and orientation of new nursing personnel to assist in their adaptation to the community; maintain ongoing consultation with nursing personnel about evolving issues; development of an aggressive nursing recruitment campaign; and revitalize a Nunavut Nursing Network to coordinate nursing initiatives and be an advocate on nursing issues; 2) Reduce reliance on agency nurses by developing policies setting maximum rates and expenditures for agency nurses while also making them cost-equivalent with full-time nurses in Nunavut; relief nurses will also be expected to work for a minimum of six weeks in each community in order to reduce travel costs; and collaboration with the Department of Education and Nunavut Arctic College to develop long-term education and training initiatives for Inuit to prepare them for nursing program admission; 3) Relief nursing pool to be developed to enhance morale and job satisfaction by: creating 12 additional nursing positions and deploy nurses among Nunavut communities based upon health care needs; 4) Accommodation issues were

recognized and a review of staff housing policies is ongoing; 5) Professional development will be increased for nurses but the details were not provided; and 6) Increased support for nursing students will be enhanced through an increased commitment of funding which will be used toward financial commitment for a specified number of students from each community; development of an RN program in Rankin Inlet and Cambridge Bay commencing in 2008; as well as tutoring support and child care subsidies (Government of Nunavut, 2007).

A follow-up report to the 2007 Nunavut Nursing Recruitment and Retention Strategy included a summary of interviews and focus groups to determine the impacts of nursing shortages on health care for Inuit and the challenges and barriers in recruiting and retaining Inuit into nursing programs (Nunavut Tunngavik Incorporated, 2009). This comprehensive report which was sponsored by AHHRI includes a summary from the literature, the findings from the interviews and then recommendations. The interviews highlighted ongoing barriers including the insufficient skills of Inuit people to enter nursing programs and the ongoing personal challenges they simultaneously content with while attempting their schooling. Some of these challenges include financial problems, family obligations and the attraction of other careers. For currently employed Inuit nurses, there are reports of high stress levels and differences in treatment between themselves and other nurses who relocate to work in Nunavut. The seven recommendations to address these and other issues are to: 1) adapt the Nunavut nursing program to better reflect Inuit culture and values; 2) identify and eliminate systemic barriers to Inuit employment; 3) develop a culture of mentorship; 4) introduce measures to prepare students for success in nursing programs; 5) increase the level of support for Inuit students who are in the Nunavut nursing program; 6) introduce specific measures to support Inuit nurses; and 7) promote nursing as a career for Inuit.

Other jurisdictions also recognize that rural areas are in need of a specific health human resource strategy and initiatives such as funding for college programs in rural and remote communities to help ensure that there will be a successful recruitment of residents. A case in point is the 2009 Ontario health human resource strategy (OHA Strategic Human Resources Provincial Leadership Council, 2009). A Canadian national project—The Nursing Sector Study—examined nursing human resources in Canada and developed a final report on an integrated strategy for nursing human resources (The Nursing Sector Study Corporation, 2006). The authors acknowledge the nursing recruitment and retention challenges faced by rural and remote communities. Several recommendations were offered including: developing innovative approaches to clinical practice in nursing education by expanding and funding clinical rotations in rural and remote areas and providing financial and travel support for rural and remote nurses (i.e., RNs, RPNs, LPNs) who seek ongoing education.

The Alberta Nursing Education Administrators (ANEA) (ANEA, 2006) held a key stakeholder forum to address nursing education in this province. In order to address the shortage in rural areas, a number of suggestions were made including recruiting students from rural areas into nursing and then encouraging them to return to work in rural areas; addressing ongoing issues such as increasing rural clinical placements and addressing issues such as housing for students who wish to complete clinical placements in rural areas, developing a means for educators and employees to work together to support new graduates successfully make the transition to the workplace. Other reports have also strengthening the educational infrastructure to support rural nurses including providing support for certification and specialized continuing education for rural nurses and bursaries for students from rural areas who are committed to these locations after their education is completed

(Baumann, Hunsberger, Blythe & Crea, 2006).

The Ministry of Health and Long Term Care (MoHLTC) in Ontario has designated specific geographic areas as “underserved areas;” this designation is used to assist these communities in the recruitment and retention of health professionals through the Underserved Area Program (UAP) (Olsen, Ardal, Abrahams, Lalani & Kamal, 2007). For example, this program helps by improving access to health care services through integrated initiatives to recruit and retain physicians while simultaneously providing nursing services. In order to be eligible for the UAP, the community must be designated as underserved which includes an ongoing self-assessment process providing the opportunity for communities to identify themselves to the MoHLTC. Examples of factors that are considered for designating a community as underserved include the number of health care professionals that serve the community, population and physician-to-population ratios, history of recruitment efforts, the need for local services and community endorsements. The UAP may designate a community as underserved for general or family practitioners, specialist or rehabilitation professionals. In addition there are three characteristics of the UAP: 1) only Northern Ontario communities can be designated as underserved for specialists; 2) communities across Ontario can be designated as underserved for general/family practitioners; and, 3) underserved areas for general/family practitioners is based on resident population not the catchment area of the hospital. The UAP at one time focused specifically on physicians but has more recently evolved to also include financial supports for nurses. However, even in its earlier iteration, the UAP provided operational funding to nursing stations who provided primary care services within rural and northern communities that did not have a resident physician. In 2000, the UAP provided nurse practitioner positions to improve

access to primary health care services in remote, underserved areas.

The term “underserved” is also being used by other provincial jurisdictions. A case in point is Northern Health in British Columbia which defines an underserved community as any community that is not urban (<https://careers.northernhealth.ca/Portals/0/Careers/documents/BCloanforgiveness-program.pdf>).

Incentive packages have been one commonly used solution to address recruitment and retention of health care professionals in rural and remote geographic areas. The Queensland Government, Australia has offered a Remote Area Nursing Incentive Package (RANIP) for remote area nurses and midwives since 1997, which is routinely reviewed and updated. The 2010 update (Government of Queensland, 2010) included a discussion of how remote locations in this state are determined by an elaborate point system and criteria which included availability of health services (e.g., presence of a medical officer, number of nurses employed on-site) and community infrastructure (e.g., power). The higher total points indicate that the community is remote. Although rural nursing is not defined, there is reference made that nurses and midwives work within an extended scope of practice over long hours in professional isolation and often in a community diverse from their own. For all of these reasons, the conclusion drawn was that individuals working in these conditions would benefit from additional incentives including extended annual leave, annual isolation bonuses depending upon the length of time spent in the community and annual professional development. Details are provided about the application of these incentives based upon employment status (i.e., full-time, part-time, casual, contracted, short-term, and long-term temporary employees). The clear definitions of rural and remote and the detailed incentive plan allows for comparison between health regions in Australia as well as across international borders.

Canada also has tuition support programs. At the national level, commencing in April, 2013, the Government of Canada offered Student Loan Forgiveness to eligible several health care provider groups including nurse practitioners and nurses who work in rural and remote communities (<http://www.canlearn.ca/eng/after/forgiveness/index.shtml>). The nurses could be eligible for a maximum of \$4,000 or a total of \$20,000 over five years. The specific criteria are posted on the website as well as the on-line application. Examples of criteria include being a registered nurse, registered psychiatric nurse, licensed practical nurse or nurse practitioner who has completed one year of service (i.e., one full year and 400 hours) in a designated rural or remote community. The recent roll-out of this program means that its effectiveness in the recruitment and retention of nurses in rural and remote areas are unknown.

One provincial example is the tuition support program within Ontario, specifically the Primary Health Care Team Underserved Area under the auspices of the Ontario Ministry of Long-Term Care (MoHLTC, 2011). The program is within the UAP in Ontario but this specific aspect is geared toward new graduate nurses who have spent at least one year living within rural and remote communities and who wish to work in a rural or remote community (i.e., within 100 km of where they currently live or have gone to high school). In this program, rural and remote communities are defined as those within a score of 40 or greater according to the Rurality Index of Ontario (RIO). The RIO was developed as a fair and consistent way to measure rurality (Krajl, 2000). In Ontario, the MOLTC and the Ontario Medical Association (OMA) use the index as an eligibility criterion for program incentives. The RIO uses a formula to determine the result of the measure of the community population and population density, the time to travel to a basic referral centre and the time to travel to the nearest advanced referral centre. The formula is fixed on

geographic, distance and travel factors resulting in a stable or fixed figure as a result. The end result is a fixed score for each community that is rural or remote and a specific financial incentive that would be paid to the health care provider (Krajl, 2009).

In the NWT, the territorial government offers a loan forgiveness program for nursing students who stay in the north once their nursing education is complete. The Yukon Registered Nurses Association (YRNA) disburses funds for RNs who are pursuing either long-term (i.e., programs such as post-RN baccalaureate, masters or specialty programs), short-term courses (i.e., conferences, certification programs) or re-entry to practice (i.e., refresher programs). Priority is given to applicants who are employed in the Yukon and for programs or courses that are deemed to improve practice and health delivery in the Yukon.

Eligible nurses receive tuition reimbursement for return-of-service (ROS) in an eligible community anywhere within Ontario. The specific terms are clearly outlined in the document and are described as: "For every year of tuition that is reimbursed, the applicant must work a minimum of 1500 hours within a 12 month period when working on a full-time basis, or within 24 months if the applicant is working in a permanent part-time position. If the 1500 hours is attained prior to the end of the 12 or 24 months, the applicant must work to the end of the 12 or 24 months to complete their return of service obligation." This easy-to-read document also provides information about the expectations and answers common questions for those interested in applying for the financial support; each applicant must pay a \$500 administrative fee with their application. In further conversation with the Nursing Secretariat for the Policy Division, in fiscal year 2007/08, there were 537 applications that were received and approved. There is no information that compares the chosen rural and remote communities by First

Nations and non-First Nations status nor is there any ongoing evaluation of the program. However, less than 10% or approximately 25/537 applicants did not honor their contract. Furthermore, one of the main criticisms they hear is that for applicants who work part-time, the hours are not accumulative. For example, in order to reach the 1500 hours, the applicant must work to the end of 2012 and would not receive credit if they had worked all required hours by May of 2012. Despite these concerns, the program managers receive positive comments from the applicants and the community members who relay that assistance with tuition is appreciated and communities appreciate the recruitment of nurses in their locale.

British Columbia also has a loan forgiveness program for registered nurses, licensed practical nurses and other health care providers who were in designated underserved communities (<https://careers.northernhealth.ca/Portals/0/Careers/documents/BCloanforgiveness-program.pdf>). Those working full-time, part-time or casual are eligible to apply; yearly applications are accepted with the Province of BC forgiving 33% of the loan per year. The program was implemented in 2013. Thus, it is too new to determine its success in recruiting and retaining nurses in rural and remote communities.

An announcement in July, 2013 from the Manitoba government illustrated the commitment of recruiting nurse practitioners to rural communities. Under this new program (the Nurse Practitioner Education Grant), students would be eligible for up to \$10,000 to cover tuition in exchange for one year of service working as a nurse practitioner in designated rural communities once they have graduated. In this province, northern is more often used rather than remote to describe this kind of geographic setting. In this province, rural and northern communities are defined as all Manitoba communities except Winnipeg and Brandon. "Bundling" of provincial and federal grants by nursing personnel is encouraged to increase the

likelihood of nurses staying beyond their agreement of service. For example, Manitoba Health offers conditional grants for recent nursing graduates (i.e., within six months of initial registration) from RN, RPN, LPN or Registered Nurse Extended Practice (RNEP) programs. In order to receive the grant, the applicant must be willing to provide 12 months of continual nursing employment in a rural or northern location within Manitoba. This program commenced in 2004 and is funded from the Manitoba Nursing Recruitment and Retention Fund (NRRF). Any individuals who receive a conditional grant is allowed to accept other grants that assist recruitment and retention of nurses in rural or northern locations; if this is the case, the individual is required to meet a consecutive return for service agreement in the rural or northern location.

Advanced/Specialized Practice

Advanced practice roles for nurses, particularly those who work in rural and remote areas, has been a topic of debate for some time. The Australian Education/Practice Subgroup of the International Nursing Practitioner/Advanced Practice Network (Duffy, 2001) prepared a report on nurse practitioner/advance practice nursing roles in Australia. The main thrust of the document was to discuss the evolution of this role in Australia; this particular role is seen as a way to address access, quality and cost of rural health care. One of the conclusions is that nurses themselves should drive the nurse practitioner debate and movement in Australia. Finally, the Australian Nursing Federation's creation of competency standards for the Advanced Nurse Practitioner will be implemented across the entire country leading to consistent practice expectations and roles. However, political will to support this role varied by individual state within Australia. In addition, at the time of the report, the Australian Medical Association remained non-supportive of this advanced role for nursing leading to challenges in jurisdictional issues (e.g., prescriptions, referral). The report provides a comprehensive overview of

the NP movement in Australia but given the dynamics of change in health care, the conclusions it draws may be out-of-date and the information is to be used with caution.

The Continuing Care Strategy Report from Nova Scotia notes the importance of clarifying the role of nurse practitioners in continuing care in rural areas (Province of Nova Scotia, 2008). A needs assessment was conducted in northern Ontario to identify the continuing education needs of nurse practitioners who work in First Nations communities (Coty, Tilleczek, Pong, Michel & Lemieux, n.d.). The study was commissioned by the Council of Ontario University Programs in Nursing (COUPN) to aid in the design and pilot of a continuing education program for Nurse Practitioners (NP) in northern Ontario. However, the sample size was expanded to include nurse practitioners from both northern and southern Ontario. All NPs in northern Ontario were included while those who lived in the RST areas of southern Ontario comprised that part of the sample. The final sample size included 145 NPs (75% northern and 25% southern). The findings noted that there were specific learning needs among this group of NPs including: focus-specific (i.e., health promotion and disease prevention, women's reproductive health, assessment and diagnosis, and psycho-social health issues), client-focused content (i.e., assessment, drug prescriptions and interactions) and profession-focused content (i.e., program planning, evidence-based practice, program evaluation). In addition, the preferred modality methods for continuing education were noted as face-to-face (i.e., seminars, workshops, conferences) that would be planned during regular working hours. A suggestion from the researchers was to evaluate the NP continuing education pilot project to track the process and any regional differences in the implementation as well as the determinants of success of the different delivery methods.

Certified practice is one other area that has been implemented in some jurisdictions to prepare nurses for rural and remote practice. For example, RN First Call was developed in British Columbia to prepare rural RNs to provide primary care through the implementation of decision support tools (CRNBC, 2010). Another example is rural and remote certification programs which provide additional education for RNs to practice in these environments (CRNBC, 2010). Interestingly the document does not use the terms rural or remote but instead refers to care in small acute hospitals, diagnostic and treatment centres and other settings where physicians or nurse practitioner services are available. Regardless of this oversight, British Columbia initiated the rural and remote certification program with Nova Scotia following its lead.

Discussion

The publications discussed in this report enhance our understanding of the policy environment and its impacts on rural nursing practice. There are several key points generated from our review and analysis of the reports: 1) the majority of the reports do not specifically identify the meaning of rural and remote; 2) there remains a paucity of information about the health status of rural and remote residents; 3) descriptions of nursing practice tend to focus on rural rather than remote locations; 4) there remains a great need for Aboriginal nurses; 5) there is an increased emphasis on the importance of cultural safety in preparing future nurses and in applying this concept in practice; 6) recruitment and retention of health care providers, including nurses, in rural and remote areas continues to be a high priority but the difference is that tangible solutions have been offered to address the identified concerns; 7) policies and programs that enhance the recruitment and retention of nurses in rural and remote locations have been slow to move forward but there are some jurisdictions that have been very proactive; and, 8) lack of nursing voice in the publications.

Unclear definitions of Rural and Remote. Defining rural and remote is a perennial issue that is no closer in being resolved. The majority of reports did not provide a clear definition of either term. Several of the reports stated that they did not want to debate the definition but this in turn continues to make it difficult to discern the meanings used when discussing rural and remote contexts.

Paucity of Information about Rural and Remote Health Status. Specific data about the health status of rural and remote residents in Canada continues to be lacking. The example of the Annual Report for 2011-12 from Australia (Australia, 2012) which prepares annual reports that discuss the health status of rural and remote residents including programs and initiatives that are implemented could be used as an example in Canada to provide information about its rural and remote residents.

Descriptions of Nursing in Rural Contexts. The documents that were reviewed range in their discussion about rural and remote as two separate entities within which nurses' practice. For example, Bushy's (2009) chapter on rural ethics pays little attention to remote areas and does not differentiate if there are any differences in ethical issues between rural and remote sites. Both of Bushy's publications focus on a deficit health status model in rural settings; despite this issue, the document on rural ethics would be useful in the orientation of newly recruited health care professionals in rural and remote areas and in preparing a rural health practice course. The CARRN document can be used to compare rural and remote nursing practice in Canada to other countries including Australia, New Zealand and the United States. The lists of characteristics and issues can be used to launch a research program about rural health and nursing while also guide policy development. Their statement that they are referring to anything that is not urban does hinder clarity on what is really rural given the changing face of this dynamic context. In addition, although there have been some new reports prepared in the last decade

since the first documentary analysis was completed, there remains a paucity of information regarding the rural and remote nursing workforce. For instance, the systematic review by Pashen et al (2007) focuses on the medical workforce and is therefore more limited in its usefulness in application to other health care providers.

Shortage of Aboriginal nurses. The updated report on Aboriginal nurses showed that there have been significant strides in the numbers of Aboriginal nursing students across the country (Gregory & Barsky, 2007). The availability of accurate statistics continues to hamper a true understanding of this situation. In addition, the report was conducted before the Aboriginal Health Human Resources Initiatives (AHHRI) money was available and thus the numbers and initiatives regarding increasing Aboriginal nurses are likely outdated.

Other reports have noted that the severe shortage of Aboriginal and Inuit nurses needs to be addressed (Nunavut Tunngavik Incorporated, 2009). The Nunavut Recruitment and Retention Strategy is a case in point; one of the action items was to offer two other sites (Cambridge Bay and Rankin Inlet) for an RN program by 2008. In 2010, the first year of the nursing program was made available at these sites but the program was discontinued because of low student enrollment.

Acknowledging the Importance of Cultural Safety. A number of reports and initiatives have been spearheaded in order to address the significance of cultural safety in the preparation of future nurses and in current practice settings. Workshops, reports with relevant frameworks and specific examples of suggestions for curriculum change are available to nurse educators.

Ongoing Issues with Recruitment and Retention. Recruitment and retention of health care providers remains an ongoing issue in rural and remote areas. There have been recent reports that

focus on this issue such as the Ontario-based Comprehensive Health Human Resources Strategy but the solutions noted in this report need to be considered with caution given they have been used in both rural and urban settings. Despite this caution, this report acknowledges that health workforce planning is complex and multi-layered and that rural issues may vary depending upon the health discipline.

The 2004 Nova-Scotia (Rural and Remote Working Group, 2004) based report on recruitment and retention adds an additional layer of understanding of this issue but specific details about the recruitment and retention strategies were lacking and would have added a more comprehensive understanding. Although the report is now dated, it offers an excellent backdrop into the challenges and initiatives in one specific area of Canada that can be useful for other similar geographic areas in our country.

Solutions to Recruitment and Retention of the Nursing Workforce. Even though the nursing workforce is the largest of the health care provider groups and is often the only group represented in rural and remote communities, less time and effort has been spent on developing and implementing initiatives to recruit and retain nurses in those communities. The UAP within the Province of Ontario originally focused its attention on the recruitment and retention of physicians and specialists. In 2011, the Nursing Tuition Support Program within the UAP was announced. Other provincial geographic areas have recently followed suit with the BC Government announcing a loan forgiveness program in 2013; the Manitoba NP funding program was also announced in July 2013. The Canadian Federal government announced a loan forgiveness program for all newly recruited health care professionals who work in rural and remote communities in April, 2013. Evaluation of these initiatives and their effects on recruitment and retention of nurses in rural and remote communities would be an important step.

Key Messages

1. The terms rural and remote continue to lack accepted and universal definitions.
2. There is a paucity of published literature about the contributions of all types of nursing personnel to rural and health.
3. The strategies to address issues pertaining to rural and remote health are focused on a deficit rather than a strength-based model.
4. Recruitment and retention of health care professionals including nurses continues to be a challenge in rural and remote settings.
5. There has been a rise in financial supports such as loan forgiveness programs for individual nurses who wish to work in rural and remote settings.
6. Provision of care for Aboriginal peoples continues to need investment to ensure that there are sufficient numbers of Aboriginal nurses and that non-Aboriginal nurses' care for this population within a cultural safety framework.
7. Evaluation of advanced practice in rural and remote settings in Canada is limited.

Based upon our documentary analysis, we propose the following recommendations:

1. Identify initiatives used by all nursing personnel to prepare and support registered nurses, registered psychiatric nurses, practical nurses, and nurse practitioners to work in rural and remote settings.
2. Initiate forums including webinars with nurse educators and administrators to discuss lessons learned related to nursing education rural-focused initiatives.
3. Identify the number of Aboriginal nursing students and practicing nurses planning to work or working in rural and remote settings on a yearly basis to help determine the success of preparing and retaining this specific group of nurses.
4. Track the use of scholarships, bursaries and loan forgiveness programs on recruitment and retention of nurses in rural and remote locations.
5. Initiate an evaluation of nursing practice in rural and remote settings that will focus on outcomes such as health status and patient satisfaction.
6. Initiate an evaluation of advanced practice in rural and remote settings that focuses on outcomes such as health status and patient satisfaction.

Conclusions

This updated documentary analysis revealed that there are ongoing key issues within the context of rural and remote health that impacts rural and remote nursing practice. The recruitment and retention of nurses continues to be an issue but our analysis revealed that there are an increased number of incentives and programs to address the shortfall. The evaluations of these initiatives over the next few years will be informative for their renewal or for the development of other ways of addressing the lack of health providers in rural and remote contexts. There are also concerted, although isolated, initiatives across the country that are attempting to address the need for rural and remote-focused health programming. Finally, the context of Aboriginal health care continues to be a priority with a number of new agreements reflecting the principles of collaboration to address the health disparities experienced by this group.

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Appendix A

Documentary Analysis Review Form (adapted from Rist, 1994)	
Document Title and Author	Document Date
Geographic Area:	Intended Audience:
Type of Document (Policy, Standards, Management, Government Regulations, Other—specify)	
Based upon the document, identify:	
1. What level of government prepared the document? (provincial/state, federal, local government? Or provincial or federal nursing association or union? Or a specific institution such as a centre for rural health research or a centre for rural health)	
2. Their definition of rural and remote.	
3. Their definition of rural and remote nursing practice.	
4. What was the main purpose of the document?	
5. Did they identify specific objectives and if so, what are they?.	
6. What they identify as the major issues (for rural nursing/rural health care—identify both if applicable).	
7. What programs or projects were developed to address the above issue?	
8. Are these programs/projects ongoing?	
9. What were the outcomes of the programs/projects?	
10. Were there any other impacts as a result of these programs/projects?	
11. Is there any evidence of ongoing support for rural/remote nursing practice based upon what they discussed in the document?	
12. Have interest groups been develop as a result of the issues identified in relation to rural nursing practice?	
Were there specific policies developed as a result of the issues identified and/or the programs/projects that were implemented? If so, what are they and how effective have they been.	
1. Were there any other health-related policies put into place to address rural health issues?	
2. Is there evidence of strengths or weakness of the organizational structure that was used to implement the policy or program/project? Identify them.	
3. If it is a standard document, how successful have they been at matching their standards and regulations (competencies) to rural/remote nursing practice needs?	
4. Is there any indication of transformation of the government/regulatory agency/or institution as a result of identifying and addressing the issue?	
5. Were there any social changes as a result of the implemented policy or program?	
6. Were there any changes in relation to the issue as a result of the policies/programs/projects?	
7. What were the strengths of this document?	
8. What were the limitations?	
9. What would be your concluding statement about the document?	

Availability of Rural and Remote Definitions within Reviewed Reports	
Author	Rural and Remote Definition
Alberta Health and Wellness (2007).	Not defined.
Alberta Health and Wellness (2008).	Not defined.
Alberta Health Services (2013c).	Rural Alberta is any geographical area outside the two large tertiary centres (Calgary & Edmonton) and five regional centres (Fort McMurray, Grande Prairie, Red Deer, Medicine Hat & Lethbridge).
Alberta Nursing Education Administrators (ANEA) (2006).	Not defined.
Bailey (2009).	Non urban. "The rural economy is unique in its composition, making issues of uninsurance and underinsurance more prominent in rural areas. Since the late 1990s, rural areas have witnessed a significant decline in manufacturing jobs and a rise in sector employment, losing jobs with higher rates of employer-sponsored health insurance while gaining jobs with much lower rates of employer-sponsored coverage." P. 1.
Baumann, A., Hunsberger, M., Blythe, J. & Crea, M. (2006).	The authors that no standard definition of rural exists, no adoption of any definition in the report.
Bushy (2006).	U.S. regions with "ninety-nine or fewer people per square mile."
Bushy (2009).	Focus on population and the geographic size of a community relative to population density. Rural "regions having ninety-nine or fewer people per square mile" (p. 17). Frontier "regions having fewer than six persons per square mile" (p.18).
CARRN (2008).	Broad inclusive definition for rural and remote locations for practice is essentially ... rural and remote is what is not classified as urban.
Caty et al (n.d.).	Southern Ontario: communities of less than 10,000. All of Northern On included in study (n=145 respondents).
CRNBC, 2010	Not defined.
Duffy (2001).	Not defined.
Government of Australia (2012).	Classified using the Australian Standard Geographical Classification Remoteness Areas (ASGC-RA) based on geography, access to services and population. See www.health.gov.au/internet/otd/Publishing.nsf/Content/RA-intro for further information.
Government of Nunavut (2007).	Not defined.
Government of Queensland (2010).	There are criteria for defining remote areas in Queensland. Some criteria merit 5 points, some 3 points and some 1 point. If a community gets a total of 16 points then it is deemed remote. For example, if there is no medical officer in residence in the community, and a medical office visits less than once a week (5 points), if there is no medical office in residence in the community, but a medical officer does visit the community at least once a week (3 points) or a medical officer is in residence but is not replaced on days off (1 point). As well, there is an establishment of one or two registered nurses (5 points), the nurse is operating in a predominantly different culture (3 points) or the community does not have social and cultural facilities available to the nurse, and the public entertainment is rarely available (1 point). The list goes on with defining criteria in this manner.
Hook et al (2010).	Rural populations are defined as: "...we define rural population as those residing within a county or area not designated by the Office of Management and Budget as a Metropolitan Statistical Area (MSA), which has at least one city with 50,000 or more inhabitants and a total population of at least 100,000" (page 2). Underserved populations are defined as: "...groups whose demographic, geographic, or economic characteristics impede or prevent their access to health care services, such as low-income individuals, the uninsured, immigrants, racial and ethnic minorities, and the elderly" (page 2).

Jones et al (2010).	Not defined.
Kilty (2007).	<p>"du Plessis, Beshiri, Bollman and Clemenson (2002) explored the prevailing formal definitions of rural, but suggested that "rural" can refer to a geographical concept, a location of boundaries on a map, a social representation, a community interest, a culture or a way of life (p. 6). The continuum from rural to urban can also be defined by the functional relationships that develop between people and the space and place they live in. Six definitions of rural were explored by these authors and they suggested that different definitions generate a slightly different and variable number of rural people in a locale. They suggest that researchers consider the scale of the rural issue and whether it is of a local, community or regional scope and that they "consider which geographic dimensions are most relevant to the issue at hand - population size, population density, labour market or settlement context - and then choose a definition that incorporates those dimensions" (p. 1). Other options they suggest are to assign "degrees of rurality" to each territorial unit or to cross-classify two definitions of rural in order to focus on a specific sub-sector of the rural population" (p 1).</p> <p>The focus group discussion in response to asking the questions, 'do you work in a rural area? How do you know?' add to health professionals' idea of rural. The following themes were identified: geographically rural, transportation issues and distances to travel, self-definition, philosophy of life, community relationships, lack of access to services and resources.</p>
Lombard (2005).	Not defined.
Mable & Marriott (2012).	Not defined.
MoHLTC (2011).	Not defined.
Minnesota Department of Health (2007).	Not defined.
NHS (2007).	Not defined.
Nunavut Tunngavik Incorporated (2009).	Not defined.
Ontario Hospital Association (OHA) (2009).	Not defined.
Osmond (2004).	<p>No standard definition of rural is used in research, policy or planning (Adams et. al., 2003 MacLeod, 1999). The most common approach is that all territory not classified as 'urban' is considered 'rural.' Based on the 2001 Census data, Statistics Canada's rural and small town definition classified 21 percent of the Canadian population as rural, while the Organization for Economic Co-operation and Development (OECD) predominantly rural regions definition classified 30 percent of the Canadian population as rural. These differences in definition in turn affect decisions on policies, programs, funding and service delivery (Ministerial Advisory Council on Rural Health, 2002). To reflect the unique diversity of communities commonly referred to as rural; a recent Canadian Ministerial Advisory Council on Rural Health used the terminology "rural, remote and northern". Page 1. It is not the mandate of this discussion paper to make recommendations on the definition of 'rural.'</p>
Pashen et al (2007).	<p>Non-metropolitan location.</p> <p>Practice functionally distant from major tertiary centres of healthcare without ready access to the full range of specialist medical supports. P. 13.</p>
Pong & Russell (2003).	<p>Generally speaking and for the purpose of this review and synthesis report, rural, remote, northern, isolated, and underserved areas refer to areas, regions, or communities that are far from major urban centres and have a small or widely dispersed population.</p>
Province of Nova Scotia (2008).	RST definition.
Rural and Remote Nursing Group (2004).	<p>Extensive discussion about definitions of rural and RST as well as a discussion about the intersection between geography and statistical definitions. They conclude with a definition that is based on geographic boundaries, include variables and indicators to reflect the specific question at hand and coordinate their use of the term with groups (i.e., physicians, nurses) that have already established a definition. They also recommend using a term other than rural or remote to avoid ambiguity.</p>

Rural and Remote Steering Team (2006).	Not defined.
The Nursing Sector Study Corporation (2006).	Not defined.
Wood (2004).	Talks about factors that are considered i.e., pop density, remoteness from urban, but then indicate the def depends upon the project. No specific definition is therefore included. They describe their districts by population density and proximity to urban/services available.
World Health Organization (2010).	Defined as areas that are not urban.

Summary

Rural definition included in 16 reports.

Rural definitions not included in 16 reports.



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