

**DYING AT HOME: HOSPITAL AS HOME.
RURAL NURSES' EXPERIENCES PROVIDING END-OF-LIFE CARE**

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Abstract

Few studies explore nurses' experiences providing end-of-life care in the rural hospital setting and the implications of the rural setting on the delivery of care. The purpose of this qualitative study was to begin to address this gap. Two research questions guided this study: (a) What are the experiences of regulated nurses in providing end-of-life care in a rural hospital setting, and (b) How does the rural hospital setting influence regulated nurses' experiences in providing end of life care? Data were collected by conducting individual interviews with rural nurses. Thematic analysis resulted in three themes: (a) end-of-life care as a relational matter, (b) an intimate affair, and (c) dying at home: hospital as home. Providing a description of how home is defined in the rural setting can inform how practical, human and professional resources are allocated and implemented for rural nurses and the communities that they provide care for.

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Chapter 1: Introduction

In the rural hospital setting, you “are it” (MacLeod, 1999, p. 169). Being “it” represents the considerable responsibility and accountability acute care nurses hold in their practice in rural communities (MacLeod, 1999). It also captures the nature of rural hospital nursing practice, which is characterized by providing nursing care in a variety of patient care situations (Scharff, 2013) since rural nurses care for patients of all ages, in a variety of different circumstances, and with a variety of different health challenges. Rural nurses also care for individuals who are already known and familiar; patients are often neighbours, friends, or family members (Long & Weinert, 1989; Wilson et al., 2009).

The choice to remain in a rural hometown to palliate is challenging for individuals and their families who need end-of-life care and also for healthcare providers in rural settings, where typically, there are limited end-of-life care resources (Wilson et al., 2009). The challenges found in the rural hospital setting during the provision of end-of-life care for patients may, in turn, affect nurses’ experiences in providing end-of-life care.

Purpose

The purpose of my descriptive qualitative study was to describe the experiences of regulated nurses during the provision of end-of-life care in the rural hospital settings. The findings of my study contribute to the literature pertaining to nursing practice in rural hospital settings by presenting the experiences and perspectives of nurses who provide end-of-life care in rural hospitals across the southern part of a Western Canadian province, and also by providing a deeper understanding of the realities that nurses face when providing end-of-life care within a rural setting. To more fully understand the realities of providing care in rural settings, I also explored the extent to which rural settings influences nurses’ experience during the provision of end-of-life care

Definitions

For the purposes of my study, *regulated nurses* included registered nurses (RNs) and licensed practical nurses (LPNs). For reasons that will become clear in my methods section of my thesis, my exploration of nurses' experiences providing end-of-life care in rural settings was limited to RNs only.

The concept of *rural* does not have a common, accepted definition (Pitblado et al., 2013). To maintain clarity for my study, I defined rural as any community with a population of less than 10,000 people (Pitblado et al., 2013). Participants were selected from rural hospitals that offered healthcare services 24 hours/day across a southern part of a Western Canadian province.

Last, 'palliative care' encompasses both quality of life and end-of-life care (Canadian Hospice Palliative Care Association, 2002). To help provide focus and direction to my study, I have defined end-of-life care as care that is provided by nurses when death is imminent, and I have outlined imminent death within a matter of days or up to eight weeks. As such, this definition of palliative and end-of-life care was influential and guided which questions I asked during individual participant interviews.

Problem Statement

There is very little information in the literature in regard to nurses' experience of providing end-of-life care within rural hospital settings. This knowledge gap is significant because, although many rural dwellers choose to live out the end of their days in their home community, the nurses who care for them have limited access to specialized healthcare services and resources during the provision of palliative care (Pesut et al., 2015). Therefore, the findings of this study shine light on the experiences of nursing staff providing this type of care within rural hospital settings that are increasingly in demand. Understanding nurses'

experiences in providing end-of-life care within rural hospital settings can help illuminate which resources are relevant, given that the rural population is disproportionately elderly (Bushy, 2013), which may lend itself to a greater need for palliative and end-of-life care.

Significance

There are unique cultures within rural communities that need to be accounted for in the delivery of good nursing care (Pesut, Robinson, & Bottorff, 2014); however, little is known about nurses' experiences in providing end-of-life care in rural hospital settings. This is what makes this study significant. That is, although nurses in rural hospital settings maintain a broad knowledge base to care for the wide variety of needs of the rural population (Scharff, 2013), I believe it is also important to consider the influence of the rural context in the provision of end-of-life care. So, although nurses practicing in rural settings may have unique advantages such as being trusted community members, they must also contend with challenges such as having little separation between personal and professional roles or a shortage of resources compared to their urban counterparts in the provision of high-quality care (Kelley, 2007; Long & Weinert, 1989). It was my assumption that both these advantages and challenges would affect nurses' perspectives and experiences in providing quality end-of-life care within the rural setting. As such, I sought to identify both the advantages and challenges faced by nurses while providing end-of-life care within the rural hospital setting, and this helped illuminate which resources could be most helpful in the provision of contextually relevant care. These resources included things such as policies, educational opportunities, time and opportunity to relate to and support one another.

Research Questions

Consistent with the nature of qualitative research (Creswell, 2014), I sought to understand the experiences of nurses providing end-of-life care within the rural acute care setting and how rural hospital settings influence how that care is provided. My exploration was guided by two research questions:

1. What are the experiences of regulated nurses in providing end-of-life care in rural hospital settings?
2. How do rural hospital settings influence regulated nurses' experiences in providing end of life care?

Overview of Thesis Document

To answer my research questions, I began with a literature review in order to understand the evidence base regarding the experiences of regulated nurses providing end-of-life care in rural settings. Then, I used qualitative methods for primary data collection and analysis.

In chapter two, I explore the existing evidence in the understanding of nurses' experiences in providing end-of-life care in rural hospital settings. Although there is very limited existing literature pertaining to nurses' experiences in providing end-of-life care in rural settings, there is some; there is also literature relating to the experiences of urban nurses who also work in non-specialized settings. In this literature, I discerned some recurring themes: (a) challenges in communication between stakeholders, (b) nature of the acute care environment, (c) perceived competency in skills and knowledge, (d) barriers in the provision of end-of-life care in rural settings, (e) perceived sense of isolation, and (f) the nature of rural relationships.

In chapter three, I present the research methodology of the study. After careful consideration of the weaknesses and gaps in literature, I was able to determine that a descriptive, qualitative design would best answer my research questions. Utilizing a qualitative design allowed me to further explore complex and multi-faceted issues that may not be easily quantifiable (Creswell & Poth, 2018) when describing the experiences of nurses providing end-of-life care.

In chapter four, I present three themes based on my analysis of the data, which are based on my thematic analysis of ten in-depth interviews and reflexive memos. The three themes that became apparent in the experiences of participants providing end-of-life care in the rural hospital setting are (a) end-of-life care as a relational matter; (b) an intimate affair; and (c) dying at home: hospital as home. After reflecting and attending to rigour within the research process, I assessed these three themes as reflective of participant experiences and perspectives in (a) how the provision of end-of-life care within the rural setting is a relational and intimate matter, and (b) how a sense of home is a significant aspect in the care that they provide. As such, findings of my study illuminate what nurses' experiences are like in the provision of end-of-life care within the rural hospital. This may assist healthcare providers and decision makers in highlighting which end-of-life care resources are contextually relevant for the rural setting.

Finally, in chapter five, I suggest that the notion of *dying in place* resonates in the experiences of regulated nurses in providing end-of-life care in rural hospital settings. As such, dying in place may be perceived on both a relational and geographical plane. I also reflected on the potential implications for future nursing practice, which include (a) developing a rural palliative plan of care and (b) enhancing nursing support during the provision of care within the rural setting. Future areas of research include (a) exploring the

perspectives and experiences of rural physicians in the provision of end-of-life care and also (b) illuminating and highlighting how palliative and end-of-life care is provided within the rural setting.

Chapter 2: Literature Review

The purpose of this literature review is to locate my study in the context of the nursing and palliative care literature that pertains to nurses' experiences in the provision of end-of-life care in the rural hospital setting. In my review of the literature, several broad themes emerged that framed the discussion of nursing as related to the provision of care at the end of life: (a) the nature of the acute care environment during the provision of end-of-life care; (b) perceived competency, knowledge, and skill of nurses; and (c) the nature of the communication and relationships among healthcare professionals, patients, and their families during the provision of end-of-life care. Although an abundance of literature existed pertaining to the experiences of the provision of end-of-life care by urban medical-surgical nurses, limited research specifically pertained to the experiences of nurses in the provision of end-of-life care in the rural hospital setting, where nursing care, skills, and knowledge are broad in nature (Scharff, 2013). Further, there was limited evidence pertaining to how the rural context may affect the provision of end-of-life care. The aim of my study is to illuminate the experiences of nurses in the provision of end-of-life care in the rural hospital setting and how the rural context may affect these experiences.

Exploring a palliative approach helped me appreciate what is already understood about the provision of palliative and end-of-life care within the literature. Furthermore, exploring and comparing the non-specialist nature of both urban medical-surgical and rural nurses' experiences in the provision of end-of-life care in the hospital setting helped me appreciate which gaps still exist within the literature. To complete my literature review, I searched the following data bases: CINAHL, Medline, and the Cochrane Collection. I also searched the Initiative for a Palliative Approach in Nursing: Evidence & Leadership (iPanel) website. Articles published between the years of 2000 and 2018 were considered.

As I found no extensive literature specifically pertaining to nurses' experiences in providing end-of-life care in the rural hospital setting within the Canadian setting, both national and international studies were included.

The Palliative Approach

Sawatzky, Porterfield, Lee et al. (2016) suggested a *palliative approach* as a method of end-of-life care delivery for patients and families who do not require specialized services. A palliative approach can be understood as a method of care concerned with emphasising quality of life and can be integrated within the existing context of a healthcare system and is relevant to the work of any healthcare discipline (Sawatzky, Porterfield, Lee et al., 2016; Sawatzky, Porterfield, Roberts et al., 2016). Elements significant in this approach to care include physical, spiritual, psychological, and social dimensions of patients and their families (Canadian Hospice Palliative Care Association, 2002). Although a palliative approach is an upstream approach to care, traditionally, the term *palliative* contextually has varying understandings; that is, use of the term palliative may either be reserved for patients who have been referred to a specialist service, or for patients who have been assigned a status of care by a physician because of a prognosis of short months, weeks, or days to live (Sawatzky, Roberts, Reimer-Kirkham, Stajduhar, & Tayler, 2014). In contrast, the enactment of a palliative approach emphasizes a holistic, upstream approach to care; therapeutic relationships between healthcare providers, patients, and their families; embedding and adapting palliative care knowledge into the pre-existing context; and clear communication throughout the illness trajectory (Sawatzky, Porterfield, Lee et al., 2016). This approach to the delivery of palliative care may be appropriate for the generalist nature of the rural hospital setting, which has unique contextual factors that may present

challenges such as limited access to resources for healthcare providers in providing end-of-life care (Kaasalainen et al., 2011; Kaasalainen et al., 2014; Kaasalainen et al., 2011).

Nurses may perceive that an inpatient practice setting is an inappropriate place for patients to palliate (Stajduhar, 2011). Moreover, nurses working in a non-specialized hospital unit may perceive that palliative patients are better cared for in specialized palliative units, rather than in general acute care settings (Stajduhar, 2011). Similar to a non-specialized hospital unit in an urban setting, rural hospitals share similar characteristics of the generalist nature of healthcare services provided. That is, rural settings also lack specialized units, resources, and healthcare professionals. In a mixed-methods study, describing nurses' palliative approach in British Columbia, RNs, LPNs, and healthcare aides, across urban and rural contexts, described that they frequently have the opportunity to implement a palliative approach (Reimer-Kirkham, Sawatzky, Roberts, Cochrane, & Stajduhar, 2016). However, factors such as lack of role clarity, lack of time, and gaps in knowledge have been described as barriers to their perceived ability to fully and confidently implement a palliative approach into patient care (Reimer-Kirkham et al., 2016; Sawatzky, Porterfield, Roberts et al., 2016). Ambiguity regarding who initiates a palliative approach and poor communication among healthcare providers remain significant issues (Morita et al., 2004; Reimer-Kirkham et al., 2016) and may contribute to late palliative care referrals for patients and their families (Morita et al., 2004). I suspect that these gaps and ambiguities may influence nurses' experiences and perceived abilities to provide adequate end-of-life care in non-specialized settings. Furthermore, I wonder how these gaps and ambiguities manifest in the context of both urban and rural hospital settings and how these contexts may affect how a palliative approach is implemented during the provision of care. As I further explored the experiences of nurses who provide end-of-life care in a non-

specialized setting, such as in an urban medical-surgical setting, I became clearer on similarities and significant differences between urban and rural contexts and how these contexts influence delivery of care. More specifically, I noted three main influences that may affect the provision of end-of-life care, and these are outlined in the following section.

Urban Nurses

Three main influences on the experiences of urban medical-surgical nurses' experiences of providing end-of-life care became evident in the literature: (a) challenges in communication among stakeholders, (b) the treatment-oriented nature of the acute care environment, and (c) differing perspectives among nurses regarding adequacy and proficiency in perceived competency in skills and knowledge in the provision of end-of-life care.

Challenges in communication among stakeholders. The nature of communication among members of the healthcare team appeared to be a significant factor in nurses' experiences in providing end-of-life care in acute care settings. In my review of an ethnographic study and a literature review, I found that due to a lack of communication regarding roles and responsibilities among nurses and the healthcare team, medical-surgical nurses perceived that the transition from curative, aggressive care measures to comfort and palliative care measures was not always initiated in a timely manner (Bergenholtz, Jarlbaek, & Hølge-Hazelton, 2015; Gagnon & Duggleby, 2014). In findings from studies by Bergenholtz et al. (2015) and by Gagnon and Duggleby (2014), the researchers suggested that this delay may have contributed to nurses' sense of being unable to implement appropriate care for patients. Furthermore, a comprehensive literature review conducted by Gagnon and Duggleby found that this perspective of being unable to implement appropriate care for palliative patients was observed and shared among European, Australian, and

Canadian nurses. This may imply that the perception of delaying the transition of care from an aggressive to a palliative approach is shared by nurses internationally. Although there have been challenges in the communication among nurses, physicians, and sometimes with patients and their families, nurses have also reported that they take the opportunity to learn from one another's experiences in an effort to enhance communication skills regarding matters related to death and dying with patients and their families (Clarke & Ross, 2006).

Communication issues identified in the literature extended beyond the healthcare team to patients and families. Qualitative studies with Canadian and European nurses have revealed that nurses believed that patients and their families were either unaware of prognosis or unwilling to accept palliative care (Clarke & Ross, 2006; Oliveria, Fothergill-Bourbonnais, McPherson, & Vanderspank-Wright, 2016). Clarke and Ross (2006) observed that this lack of understanding and acceptance may contribute to a lower level of comfort between healthcare providers and patients and families when communicating during the provision of palliative care. This discomfort may result in difficulty supporting the patient's family (Oliveira et al., 2016). Additionally, research findings from Japan indicated that the degree of comfort in communicating with patients and their families is correlated with the level of education of nurses; that is, the greater knowledge of palliative and end-of-life care of nurses, the fewer number of difficult experiences in communicating with terminally ill patients (Sasahara, Miyashita, Kawa, & Kazuma, 2005). Sasahara et al. (2005) also speculated that additional factors such as level of clinical experience and nurse's age were influential factors in the degree of a nurse's comfort when communicating with terminally ill patients and their families.

Nature of the acute care environment. Clarke and Ross (2006) suggested that in the treatment and cure-oriented structure of the acute care setting, nurses perceived that

they had a limited amount of time to provide care. Due to the structure of the acute care setting, nurses reported that their nursing care became primarily task-oriented around patients and their families; that is, the acute care environment was characterized by a time-saving and curative cultural structure (Bergenholtz et al., 2015). Furthermore, nurses in both Bergenholtz et al.'s (2015) and Thompson, McClement, and Daeninck's (2006) studies identified that this time-saving culture may affect continuity of patient care, thus leaving some patients with unmet palliative and end-of-life care needs.

Despite the perceived lack of time, nurses reported that they prioritized spending time with patients and their families and expressed the importance of *being there* as an important part in the provision of end-of-life care (Bergenholtz et al., 2015; Clarke & Ross, 2006; Thompson et al., 2006). However, in a number of studies, nurses also reported the belief that the acute care environment was unsupportive of palliative care priorities and of the needs of patients, such as having time to communicate with patients and their families or to provide holistic palliative care (Clarke & Ross, 2006). Moreover, nurses also perceived that the impersonal design of the hospital unit presented a significant challenge in being able to provide palliative care. Factors such as the emphasis on aggressive curative interventions, the lack of privacy, and the competing imperatives to simultaneously care for both acute and palliative patients may contribute considerably to nurses' ability to provide quality and timely palliative care (Bergenholtz et al., 2015; Clarke & Ross, 2006; Gagnon & Duggleby, 2014; McCourt, Power, & Glackin, 2013). That is, tensions may be present for nurses when the prioritization of the needs of both palliative and acute patients may become ambiguous, with one model of care spilling into another. Such tensions may emerge and interfere with nurses' ability to simultaneously care for both acute and palliative patients when there are existing expectations that nurses carry out timely curative

interventions (Bergenholtz et al., 2015), conflicting values between nurses and physicians regarding death and dying (Clarke & Ross, 2006; Gagnon & Duggleby, 2014), and a lack of time for care (McCourt et al., 2013).

Additionally, other researchers have also observed that the acute care environment is perceived as being indifferent to the emotional needs and work of nurses during the provision of end-of-life care (Gagnon & Duggleby, 2014). Oliveira et al. (2016) conducted phenomenological research in order to explore the lived experiences of nurses providing end-of-life care on a medical unit and found that nurses reported feeling they were excluded from the inter-professional healthcare team. Moreover, nurses perceived themselves as the agents tasked with carrying out an aggressive curative care plan, which may be perceived by nurses as contributing to a palliative patient's suffering, instead of promoting comfort (Oliveira et al., 2016). In another study, researchers examined nurses' perceptions of end-of-life care and found that acute care nurses' perceptions were that palliative patients were considered *less work* than acutely ill patients by the acute care culture (Kruse, Melhado, Convertine, & Stecher, 2008), despite the broad and complex diagnoses of palliative patients (Oliveira et al., 2016).

Perceived competency in skills and knowledge. In the literature in this area, I discerned that perspectives on perceived competency in relation to the ability to provide end-of-life care differ among nurses. In an ethnographic study, Bergenholtz et al. (2015) found that nurses felt prepared and competent to provide adequate end-of-life care. However, nurses in the same study felt that some of their colleagues did not have sufficient competencies or interests in palliative care. Bergenholtz et al. further suggested that differing care management priorities may deter interest in palliative care among physicians, which may lead to some nurses feeling frustrated and less able to provide timely palliative

care. In contrast, McCourt et al. (2013) suggested that nurses do not have adequate knowledge in palliative or end-of-life care, thus affecting nurses' perceived ability to provide quality care. Furthermore, McCourt et al. noted that nurses experience a tension between the type of care that they want to provide and the type of care that they are able to provide in an acute care setting.

Additionally, Canadian RNs and LPNs surveyed from 28 different medical and/or surgical acute care units across British Columbia (BC) identified that over half of patients cared for could benefit from a palliative approach to care; although, both RNs and LPNs in an acute medical unit are less likely to do so (Sawatzky et al., 2014). The authors, however, noted that further exploration into some of the reasons that a palliative approach in the provision of care is not consistently implemented is needed. These researchers also noted within the same study that both RNs and LPNs reported their perceived competence to be the lowest in the spiritual and social dimensions and highest in managing the physical needs of the patient. More specifically, surveyed respondents identified that confidence in the provision of care for patients' families to be the lowest. In related studies, other researchers observed that influences such as nurses' personal attitudes towards death as well as personal and professional experiences all contributed to a nurse's perceived level of comfort in providing end-of-life care (Gagnon & Duggleby, 2014; McCourt et al., 2013). Although nurses surveyed in Sawatzky et al.'s (2014) study were from a different Canadian province, I speculated that nurses in other Western Canadian provinces may have shared similar end-of-life care perspectives on competency and skills to that of their BC counterparts. Similarities in perspectives among nurses may exist in both the challenges and advantages present in the provision of care within the rural setting.

In summary, urban medical-surgical nurses' end-of-life care experiences are complex and multi-faceted and encompass a variety of perspectives related to factors such as communication; nature of the acute care environment; and perceived competency, knowledge, and skill. Although there are valuable insights in these findings for my study, I was left to wonder how the healthcare contexts in these studies have influenced their findings. How might the rural context affect nurses' experiences in the provision of palliative care differently in a rural Western Canadian province? In the literature review pertaining to rural nurses' experiences in providing end-of-life care, three main factors differed from those of urban nurses: (a) the barriers in the provision of end-of-life care, (b) the sense of isolation experienced, and (c) the nature of relationships in the rural setting.

Rural Nurses

The nature of rural nursing practice can be characterized by the dynamic and broad nature of the knowledge, skills, roles, and responsibilities that are assumed by nurses (Scharff, 2013). Due to the non-specialized nature of the rural setting, rural nurses can be described as "expert generalists" expected to care for a variety of patient situations, including end-of-life (p. 247). From my professional experiences in working in a rural hospital setting, I wondered and questioned whether other nurses who work in the rural setting may face unique challenges and experiences when providing end-of-life care for patients and their families. I turned to the evidence, but found limited literature pertaining to nurses' experiences in providing end-of-life care in the rural hospital setting. Therefore, to provide a fuller description of the unique elements of the rural setting, I explored literature about homecare and emergency nurses' experiences in providing end-of-life care in the rural setting.

Barriers in the provision of rural end-of-life care. The literature in this area included challenges related to experiencing a significant sense of isolation due to the lack of accessibility to resources or regularly needing to take care to extraordinary lengths to provide quality end-of-life care (Pesut et al., 2014).

Navigating and allocating palliative care resources, such as having the ability to consult with another healthcare professional regarding palliative care matters or access to a palliative care multidisciplinary team, are identified as significant barriers in providing end-of-life care in the rural hospital setting (Kaasalainen et al., 2011; Pesut, McLeod, Hole, & Dalhuisen, 2012). These barriers manifest as soon as palliative patients enter the emergency (ER) department (Beckstrand, Giles, Luthy, Callister, & Heaston, 2012). In a questionnaire sent to 52 rural American hospitals, rural ER nurses reported that poor ER department organization is a significant barrier in the provision of end-of-life care for patients and their families. More specifically, factors identified by nurses that are perceived to contribute to poor support for the provision of end-of-life care included inadequate ER staffing, conflicting family decisions regarding direction of patient care (Beckstrand et al., 2012; Beckstrand, Rohwer, Luthy, Macintosh, & Rasmussen, 2017), and being unable to receive adequate palliative care orders outside of regular working hours (Pesut et al., 2012).

Competing priorities and challenges nurses encounter in the ER, as well as the level of acuity of other patients in the hospital, may mean that the needs of palliative patients become a lower priority (Pesut et al., 2014). Furthermore, disagreements regarding the plan of care and perceived inequities in power and authority between rural ER physicians and nurses may significantly affect nurses' perceptions of their ability to provide quality end-of-life care. Factors such as medical dominance in the healthcare hierarchy and dissatisfaction with the limited input by nurses into a patient's end-of-life plan of care may

contribute to rural ER nurses' sense of powerlessness to advocate and intercede on patients' behalf. Thus, these factors may also contribute to nurses' feelings and perceptions of being devalued as members of the healthcare team (Beckstrand, Rohwer et al., 2017).

Like their urban counter parts, nurses in the rural setting have also reported a lack of time in the provision of adequate end-of-life care (Beckstrand, Smith, Luthy, & Macintosh, 2017; Rosenberg & Canning, 2004). Although no contextual information was provided by Rosenberg and Canning (2004) as to why there was a perceived lack of time for nurses in the rural setting, Beckstrand, Smith et al. (2017) identified nursing workload and inadequate staffing to be significant factors that contribute to a perceived lack of time to provide adequate and high-quality end-of-life care in rural ER settings. Although time may be a significant barrier in the provision of end-of-life care for rural nurses, they have also reported a greater sense of being able to work to their full scope when they perceived that they had strong collegial support and the ability to facilitate good care (Rosenberg & Canning, 2004). Additionally, rural homecare nurses reported having a higher sense of self-efficacy and confidence in communicating about issues pertaining to palliative care (Kaasalainen et al., 2011). Moreover, Kaasalainen et al. (2011) observed that rural homecare nurses have reported higher involvement than their urban counter parts in facilitating and supporting psychosocial support and bereavement resources, preparing their clients and families for what to expect during end-of-life care, and participating in palliative care committee work.

Perceived sense of isolation. Attempting to overcome the barriers of limited access to palliative care resources, inadequate hospital staffing, and lack of time may contribute to a sense of professional isolation and ambiguity in roles and responsibilities among nurses and healthcare staff in the rural hospital setting (Pesut et al., 2014; Rosenberg & Canning,

2004). As such, this fluidity of the roles and responsibilities may result in a continuous negotiation among physicians and nurses and, thus, may contribute to power tensions and struggles among nurses and physicians who may not know each other well (Beckstrand, Rohwer et al., 2017; Pesut et al., 2014). Furthermore, nurses in the rural hospital setting may perceive that palliative care is a specialty and may try to relinquish care to other healthcare providers who are perceived to be palliative care specialists. This may be due to a perceived lower level of comfort in competency and knowledge in caring for palliative patients (Pesut et al., 2014). Consequently, the fluidity of roles and responsibilities typically works more favourably if nurses and physicians know and trust one another (Pesut et al., 2014).

A sense of geographic isolation has also been reported among Canadian rural homecare nurses who travel within a large area. Issues such as a lack of physical and practical resources may be experienced by homecare nurses when providing end-of-life care to rural community members who do not desire to be displaced from their home community (Kaasalainen et al., 2011; Kaasalainen et al., 2014; Wilson et al., 2009). More specifically, rural homecare nurses identified that placing greater responsibility on family members to provide care, centralization of homecare services, loss of nursing staff overtime, and increasing nursing workloads are significant factors that contribute to a sense of both professional and physical isolation (Kaasalainen et al., 2014). This sense of isolation related to distance and available resources may be further complicated by the belief held by some rural dwellers that a dignified death can only be achieved by remaining in the patient's home community (Wilson et al., 2009). Rosenberg and Canning (2004) used a questionnaire and open-ended survey questions to explore and evaluate the experiences of nurses providing palliative care in rural communities in Australia. Similar to

their Canadian counterparts, Australian nurses reported similar feelings of isolation related to the lack of available professional resources and palliative educational opportunities (Rosenberg & Canning, 2004), which may contribute to a sense of geographical and professional isolation.

Nature of rural relationships in the provision of care. Rural nurses may develop close and personal relationships with patients and their families and, thus, experience a sense of “personal accountability” for high-quality care (Pesut et al., 2012, p. 293). Furthermore, some have observed that this may culminate in a deep sense of moral obligation by nurses to take measures above and beyond, such as traveling on poor roads and in poor weather conditions to see a client or working beyond their scheduled work hours to provide compassionate and quality end-of-life care (Kaasalainen et al., 2014; Robinson, Pesut, & Bottorff, 2010). It follows that rural nurses may experience emotional difficulty that accompanies personally knowing the patient and his or her family. Although in their study exploring the experiences of rural residential nurses in providing palliative care, Kaasalainen et al. (2014) observed that personally knowing the patient and his/her family may be perceived as an asset due to the trust established among community members, other researchers have suggested that the close-knit nature of the rural hospital setting also presents a challenge in maintaining patient privacy during the provision of end-of-life care (Pesut et al., 2012; Robinson et al., 2010). This lack of privacy was also reflected in American rural nurses’ experiences in providing end-of-life care in the ER department (Beckstrand, Rohwer et al., 2017). Furthermore, rural nurses have also reported having little separation between personal and professional relationships compared to their urban counterparts (Beckstrand et al., 2012; Kaasalainen et al., 2011), which may also considerably add to the emotional burden of nurses in the provision of palliative care.

I discovered only a small number of studies that specifically explored nurses' experiences providing end-of-life care in the rural hospital setting, and there was limited exploration of the implications of the rural setting on the delivery of end-of-life care. Although I have highlighted main ideas and concepts regarding end-of-life care from the perspectives of nurses in rural hospital settings, I have found significant gaps in the literature. In particular, I noted gaps in relation to the specific elements in the delivery of end-of-life care that rural nurses find most rewarding, meaningful, or challenging in the provision of care. Last, I noted that most studies of rural palliative nursing care have been conducted in countries other than Canada, and I was curious about how these insights would compare with findings from my study in a rural Western Canadian province.

In summary, several themes emerged from my review of the literature. First, urban medical-surgical nurses perceived that the acute care setting is a challenging place for patients to palliate. Factors such as time, perceived competency in skills and knowledge, and the nature of the setting itself may either facilitate or hinder nurses' ability to provide end-of-life care. Second, research examining rural hospital nurses' experiences in providing end-of-life care is limited within the Canadian context. Collectively, rural ER, homecare, and acute care nurses, however, report that navigating and allocating practical and physical resources and a perceived sense of both physical and professional isolation are barriers that manifest in the provision of end-of-life care. Additionally, the nature of relationships among nurses, physicians, patients, and their families were significant influential factors in the provision of end-of-life care for rural nurses. However, exploration specifically pertaining to nurses' experiences in providing end-of-life care in the rural hospital setting remains limited. Therefore, the purpose of my study was to explore nurses' experiences in providing end-of-life care in the rural hospital setting. The main research question guiding

my study was: What are the experiences of regulated nurses in providing end-of-life care in the rural hospital setting? Additionally, I explored the influence of the rural setting on the provision of end-of-life care by also asking: How does the rural hospital setting influence regulated nurses' experiences in providing end-of-life care?

Chapter 3: Methodology

My purposes in this chapter are to highlight the underlying philosophical assumptions that guided and informed my research study and to outline methods used in my qualitative study. The main research question guiding my study was: What are the experiences of regulated nurses in providing end-of-life care in the rural hospital setting? A second research question I explored was: How does the rural hospital setting influence regulated nurses' experiences in providing end-of-life care? In this chapter, I will present justification for engaging in a descriptive qualitative design to answer these questions.

I will also explain the research methods I used for my study. I will explain my recruitment and entrée strategies, participant and setting characteristics, as well as sampling processes and data collection and analysis methods used. Lastly, I present a discussion of the trustworthiness and the ethical considerations for my study.

Philosophical Underpinnings

Those whose perspectives align with that of naturalistic inquiry have suggested that there are multiple subjective realities and that knowledge is co-created within the contextual reality of individuals (Morse, 2018). Aligning myself with naturalistic inquiry, it is my assumption that the nature of reality is subjective, and experiences are unique to each individual. Although perceptions of reality are unique for each individual, it is also my belief that there are connections within experiences that may resonate with the experiences of others and, thus, lay the foundation to describe shared understandings within these experiences. Recognizing that both participants and I have professional experiences in providing end-of-life care in the rural hospital setting, it is my understanding that by sharing each other's experiences, new meaning and understanding about the provision of end-of-life care within the rural hospital setting can be co-created.

Qualitative research situates the researcher within the study and involves a naturalistic approach to inquiry (Morse, 2018). It would seem then, that conducting a descriptive qualitative inquiry to describe the experiences of nurses providing end-of-life care in the rural hospital setting in everyday terms (Sandelowski, 2000) is reasonable. Furthermore, exploring the meaning that nurses ascribe to their practice may illuminate multiple perspectives and understandings of providing end-of-life care in a rural setting. My goal with this qualitative descriptive study is to illustrate and describe what is, in fact, *there* for participants in their experiences in providing end-of-life care in the rural hospital setting (Creswell & Poth, 2018; Sandelowski, 2000). By conducting this study, I seek to illuminate and describe participants' multiple perceptions of providing end-of-life care.

Within naturalistic inquiry, the nature of individual realities is perceived to be subjective and co-constructed (Lincoln, Lynham, & Guba, 2018). As such, experiences are subjective in nature; that is, there are multiple perspectives that influence and shape experiences. It is my assumption that exploring and validating reality is not an absolute endeavour; validity is derived from a shared understanding and the meaning that is ascribed to experiences (Lincoln et al., 2018). Utilizing a descriptive qualitative design, I assume that there are specific perspectives and experiences that inform individual experiences. Additionally, I endeavour to describe these perspectives in ways that will resonate with other rural nurses in providing end-of-life care in the rural hospital setting; ultimately, my goal is to encourage reflection and discussion on how these perspectives can inform rural nursing practice (Sandelowski, 2000). I also hope to offer a new perspective and understanding of the phenomenon of rural nurses' experiences in providing end-of-life care by exploring "what else might be there" by asking grounded real-world questions (Thorne, 2016, p. 40).

The assumption that participants come to know and understand knowledge achieved through subjective experiences (Creswell & Poth, 2018) informed my decision to utilize a descriptive qualitative design. From the epistemological perspective of naturalistic inquiry, knowledge is subjective, and is co-created within experiences (Lincoln et al., 2018). Thus, the creation and sharing of knowledge may be individual or collective in nature (Lincoln et al., 2018). My goal is to provide a full account of experiences of nurses providing end-of-life care in a variety of rural hospital settings and how the context of their practice setting informs their provision of end-of-life care.

MacLeod (1999) and Scharff (2013) maintained that nurses in rural hospital settings possess a broad knowledge base to care for the unique needs of the rural population and are viewed as “expert generalists,” which places considerable responsibility on their shoulders (Scharff, 2013, p. 247). I believe that it is important to consider the influence of the rural context in the provision of end-of-life care. Nurses practicing in a rural setting may have unique advantages, such as being trusted community members. They are also presented with challenges such as little separation between personal and professional roles and/or providing care within the context of having a shortage of human and physical resources compared to their urban counterparts (Kelley, 2007; Long & Weinert, 1989). I believe that both the advantages and challenges affect nurses’ perspectives, experiences, and perceptions in providing quality end-of-life care.

Methods

In this section, I describe the specific research methods employed for my qualitative descriptive study, along with descriptions of the work settings and characteristics of participants recruited.

The setting. The geographical settings I selected for my study were rural communities in a southern region across a Western Canadian province. Although there is no one accepted definition of what constitutes rural, Pitblado et al. (2013) defined rural as any community with 10,000 people or less. To maintain clarity and consistency, Pitblado et al.'s definition of rural was used and guided my decision for which rural hospitals I selected for my study. I selected towns with a population that ranged from 892 to slightly over 5,500 people; however, I was careful not to select the rural town in which I worked. Although towns that I selected for data collection were typical of rural by being farming and ranching communities, the landscape surrounding each community was notably different. Rural communities where participants worked and lived were settled in the middle of the prairie grasslands, nestled within the Rocky Mountains, or within a few hours' drive from the distinctive plateaus found in the state of Montana. During my trips to rural communities, I observed that the landscapes and distances from an urban centre of each town contributed to a sense of isolation for me. Driving from town to town deepened my sense of geographical isolation. I wondered if this sense of isolation was also experienced by participants who work and live in these communities and how the role of this sense of isolation may have in the provision of end-of-life care at their hospital.

Sampling. I engaged in purposive sampling of regulated nurses who had at least one experience providing end-of-life care in a rural hospital. I also used snowball sampling (Creswell & Poth, 2018) and asked participants to help identify other individuals who may be interested in participating in my study; I asked the participant to pass along an invitation to contact me.

The specific criteria employed to select from interested participants included that the participant (a) must be fluent in English; (b) have either a professional status of RN or

LPN; and (c) be currently employed at a rural hospital, either casually, full-, or part-time. Also, participants must have had at least one experience of providing end-of-life care during their time in the rural hospital setting. My goal was to provide a holistic account of what it is like for participants to provide end-of-life care in rural hospital settings, recognizing that each participant would have unique experiences in providing care within the rural setting. Participants recruited varied in age, gender, number of years in nursing experience, and places of employment.

Participant recruitment. As I thought about recruitment of participants, I considered location and extent of services offered at each location that participants worked in and wondered how this may affect their end-of-life care experiences. To maximize my opportunity to recruit participants with varying characteristics, participants were also invited through letters of invitation (see Appendix A) and through recruitment posters that were hung in the hospital site (see Appendix B). I also invited nurses to participate in my study at a brief, on-site presentation. In response to the invitation poster, letter, or on-site presentation, interested participants contacted me either in person, via e-mail, or at the participant's request, via text-messaging. It was then that I negotiated with the participant to confirm a mutually convenient time, date, and place for an individual interview. Also, I answered any questions or concerns participants had about my study and encouraged participants to contact me if they had any new questions or concerns at a later time.

The rural hospital sites I selected all offered 24/7 healthcare services (see Table 1 for site inclusion criteria). The type and extent of services, however, varied. Only one community had the availability of community support beds, one site had long-term care beds integrated in with acute care beds, and three hospitals had a long-term care unit attached to the hospital. Given the variability of services offered in these rural communities

and based on my professional experiences working in a rural hospital setting, it was my assumption that the type of healthcare services and resources available to participants would affect the reality of their experiences in the provision of end-of-life care. Thus, my goal was to recruit a sample of participants with varying characteristics from a variety of rural hospital settings so that I could explore multiple perspectives and experiences in the provision of end-of-life care. Following ethical review and approval by the Research Ethics Board of a major university and operational approval from the healthcare organization in the summer of 2017, I started to recruit participants and collect data in the fall of 2017.

Table 1: *Recruitment Site Inclusion Criteria*

Criteria	Rationale
Towns must be within two hours of driving distance from the University.	<ul style="list-style-type: none"> • To maintain a reasonable workload and keep study costs manageable. • To ensure accessibility for the researcher.
Rural hospital must provide 24 hr/7 healthcare services.	<ul style="list-style-type: none"> • To maintain alignment with research question.
The town must have a population of 10,000 people or less.	<ul style="list-style-type: none"> • To maintain consistency of accepted definition of ‘rural’ used in study.

Initially, I anticipated that my goal of gaining a deep and rich understanding of participants’ experiences would be met by recruiting 10 to 15 participants (Loiselle & Profetto-McGrath, 2004). After consultation with my supervisory committee, I set out to recruit participants for my study. Nine nurses responded to the invitation; all nine were recruited and interviewed, and one participant was interviewed twice due to unique constraints in the context for that particular interview. Some challenges faced in participant recruitment included difficulty in contacting nursing managers for permission to conduct

my study at various locations and nursing interest in my study. I suspect that workload and time constraints for staff and managers may have influenced recruitment to the study.

Participants. In total, eight participants were female, and one participant was male. All nine participants identified their professional status as RN. Age of participants ranged from 31 to 50 plus years of age. The average number of years of participants’ nursing experience within the rural hospital setting was approximately 19 years and ranged from eight to 42 years. Participant characteristics are presented in Table 2.

Table 2: *Participant Characteristics*

Hospital	Number of Participants	Age Range	Range of Nursing Years of Experience	Professional Designation	Palliative Care Education
A	4	31-50	8-33 years	RN	Yes
B	2	50 +	8+ years	RN	Yes
C	1	41-45	15+ years	RN	No
D	1	31-35	8+ years	RN	Missing data
E	1	50+	30+ years	RN	No

Data Collection

I collected data by conducting individual, in-depth, semi-structured digitally recorded interviews. My purpose in conducting in-depth interviews was to allow participants to provide rich descriptions of their experiences (Liamputtong, 2013). In total, 10 individual, face-to-face interviews were completed. Reflexive memos also made up the data set, and I analyzed data by using Braun and Clarke’s (2006) first three steps of thematic analysis: (a) immersion, (b) coding, and (c) identify themes and patterns.

Interviewing. Prior to formal participant interviews, I conducted two digitally recorded, individual pilot interviews, which were approximately 30 to 60 minutes in length, as a strategy to assess clarity of questions, structural coherence of the interview, and to identify any existing inconsistencies (Guba, 1981; Loiselle & Profetto-McGrath, 2004). Information discussed during the pilot interviews was not included as data for my study. Each pilot interview was an opportunity to practice and develop my interviewing skills as well as an opportunity to refine my questions and approach with the feedback from my colleagues and also from my supervisor. I conducted both pilot interviews at my place of work; participant permission and written consent was obtained (see Appendix C), and both pilot interviews were completed outside of working hours. Both participants felt that the interview went well and had no additional feedback or suggestions for my interview guide.

Prior to starting each individual participant interview, I introduced myself and revisited the purpose of the interview and also took the opportunity to address any questions or concerns that the participant may have had. In an attempt to mitigate power dynamics between myself in my role as the researcher and the participant I was interviewing, I used icebreakers at the start of the interview (Creswell & Poth, 2018). Icebreaker questions included inquiring where the participant was from and sharing my professional background as a rural nurse. After I reviewed the consent form (Appendix C) and addressed any questions, I acquired written consent and commenced the interview. Participant demographic information collected included (a) age, (b) professional designation, (c) number of rural nursing years of experience, and (d) any formal or informal palliative care education. This was done so I could gather contextual information to provide a full description of my sample of participants (Creswell & Poth, 2018; see also Appendix D). With the participants' permission, I digitally recorded each interview.

The interview guide I followed for all participant interviews had open-ended questions and was used to provide direction for the interview (see Appendix E). I did, however, follow each participant's lead for the exploration of topics. For each interview, I started with a broad question such as: "How did you come to work in a rural hospital?" or "Is palliative care a regular occurrence at your hospital?" Interview guide questions were modified as needed according to preceding participant interviews. For instance, main ideas and concepts that quickly emerged during my interviews and initial stages of coding and analysis were the notions of community and intimacy of the rural setting in the provision of care. In subsequent interviews, I modified my interview guide so that I further explored how the notion of community and the intimacy of the rural setting may have resonated in some of the experiences of other participants. This was done in an effort to illuminate multiple perspectives and provide a holistic account of participant experiences (Creswell, 2014).

Participant interviews lasted approximately 30 to 60 minutes. Fortunately, weather and road conditions were favourable, and I was able to conduct all participant interviews in person. Seven out of the 10 interviews were completed at the participant's place of work. One participant interview was completed at a university in a booked interview room. At the request of the participant, one interview was completed at the participant's home. All but one interview was completed outside of working hours; due to a conflict in the scheduling, one interview was completed during working hours. Interviews completed outside of working hours seemed to have an unhurried quality to them. The interview completed during working hours, however, had a rushed quality. Consequently, I obtained permission to interview the participant a second time so that I could follow up on ideas, thoughts, and insights that I had obtained from the first interview and gain a deeper understanding of the

participant's experience. Permission to follow up with participants for clarification or for member checking was obtained. Each participant had the option of choosing a pseudonym; if the participant did not choose a pseudonym, I assigned a pseudonym on his/her behalf. Lastly, all participants received a \$5.00 Tim Horton's gift card as a token of appreciation for their time.

Reflexive memos. I wrote reflexive memos prior to and immediately following each interview. My intent was to surface, examine, and situate my role within my study by identifying any pre-existing biases, assumptions, and presumptions I had. Furthermore, exploration of how influential the role of my biases may have been throughout my study was illuminated in my reflexive notes (Creswell, 2014). Some questions addressed in my memos were: What were my impressions or assumptions prior to interviewing the participant? How did this affect my perception of the participant and his/her answers? Furthermore, ongoing reflexivity was maintained regarding how my professional experiences in the provision of end-of-life care may have been similar or different to those of participants. More specifically, reflection regarding how my experiences may have shaped how I understood and interpreted the experiences participants described in their interviews was examined. For instance, one participant described emotional withdrawing in one of her experiences in providing end-of-life care during her interview. Shortly after my interview with the participant, I encountered a similar circumstance in my professional practice. It was not until then that I fully appreciated what the participant was describing and the significance of her experience with emotional withdrawing and how this may have influenced her experiences in providing end-of-life care. The use of reflexivity helped me illuminate how some of my professional experiences in providing end-of-life care may intersect with that of the participants' experiences.

Data analysis. Braun and Clarke's (2006) first three steps in thematic data analysis were used; a) immersion in the data; b) identifying codes, and; c) identifying themes. My goal with using only the first three steps of Braun and Clarke's thematic analysis was to be somewhat cautious to not move beyond my data, interpretively speaking, given the limitations of the sample. Instead, the use of the first three steps of thematic analysis allowed me to describe participants' experiences in the provision of end-of-life care within the rural hospital setting in "everyday terms" (Sandelowski, 2000, p. 336) along with presenting participants' experiences in rich detail (Braun & Clarke, 2006). Additionally, I wanted to explore the meaning ascribed by participants to those experiences (Sandelowski, 2000) by describing and representing participants' experiences using their own words as much as possible.

Primary step. My initial step was immersion in the data (Braun & Clarke, 2006). I began data analysis as soon as possible after each interview; analysis was usually started within the same day or the following day, with me transcribing the interview verbatim. I listened to participant interviews several times, so that I could check for accuracy of the transcript as compared to the audio recording and to also familiarize myself with the data. Paralinguistic features such as pauses, laughing, or crying were included in the transcript so that I could maintain an authentic representation of the feel of the interview. To protect participant anonymity as best as possible, I removed identifying information, such as names of people and places from the interview transcript. Once I completed transcribing interviews, I managed the data by importing the interviews into the qualitative research computer software program NVivo v. 11.

I also maintained reflexive notes as I transcribed each interview, which guided me in illuminating significant questions and insights that emerged from each participant

interview. For instance, the notions of relationships, community, and accessibility to resources were frequently discussed during participant interviews, and it became apparent that these were significant elements in the experiences of participants. Additionally, maintaining reflexive notes helped me identify my biases and how they may have shaped my perspective and interpretation of the data, given my professional background as a rural registered nurse. For instance, I learned that the notion of isolation held a different meaning for me. Although I have similar circumstances that may have paralleled that of participants, I also experienced a sense of isolation differently from some participants. For me, a sense of isolation is primarily experienced on a professional plane. That is, my ability to relate to my colleagues in palliative matters may be difficult at times and promote a sense of professional isolation for me. Thus, through the use of reflexivity, a sense of geographic isolation or experiencing a shortage of human and practical resources during the provision of end-of-life care may not be as acutely felt for me as it was for some of the participants in their end-of-life care experiences. Thus, recognizing this pre-existing bias, I was attentive to how isolation may or may not be experienced by participants in the provision of end-of-life care.

Secondary step. After immersion in the data gathered from six participant interviews, I felt I was familiar enough with the data to begin coding. I re-read each interview line-by-line and highlighted components of each interview that appeared to capture the main idea of what the participant was describing in his/her experiences and assigned a code to represent the participant's experience. With each segment of data coded, I created memos to accommodate any thoughts and insights that emerged during coding and data analysis (Sandelowski, 2000). To honour the principle of emergence, I employed an inductive approach to organization of codes into meaningful groups (Braun & Clarke,

2006), and I remained open and attentive to the words and experiences of participants in providing end-of-life care. Additionally, I remained alert to the influence of my pre-existing biases and assumptions.

In the experiences of the nine participants, I was able to discern recurring ideas, patterns, and concepts in the data from the in-depth interviews. Although there is the possibility that more divergent concepts and ideas may have been found with a larger and more diverse sample, I am confident that a varied and resonant description of nurses' experiences in providing end-of-life care in rural hospital settings in a Western Canadian province was captured.

Third step. The last step in my thematic analysis was the identification of themes and patterns in the data (Braun & Clarke, 2006). Themes represented core ideas (Thorne, 2016) of participants' experiences in providing end-of-life care. To illuminate themes and their relationships with one another, I created concept maps (Braun & Clarke, 2006). My purpose was to identify and visualize how ideas, concepts, and themes may be related, yet distinct in nature. In other words, the concept maps allowed me to see the *big picture* of participants' experiences. My purpose was to achieve a near-data, rich description of participants' experiences, recognizing that the participant is the expert in his/her own experience. Consistent with Braun and Clarke's (2006) process, I identified and described semantic themes that captured participants' surface meanings of their experiences and the contexts in which they occurred. I will explore these themes in the following chapter.

Trustworthiness

The criteria used for my study to assess the tenets of rigour were credibility, dependability, confirmability, and transferability of qualitative findings (Guba, 1981; Morse, 2018), as attention to these criteria enhanced my ability to represent credible and

sound qualitative findings (Morse, 2018). These tenets are described in Table 3, along with strategies employed to maintain trustworthiness of my study.

Table 3: *Strategies to Maintain the Tenets of Trustworthiness**

Tenet of Trustworthiness	Strategies Employed
<p>Credibility: <i>Findings are sound and accurately represent participants' experiences.</i></p>	<ul style="list-style-type: none"> - I collected and analyzed the data myself. I transcribed all interviews verbatim to assist me in becoming immersed in the data. As a result, I became familiar with the data and with the experiences of participants in the provision of end-of-life care in rural hospitals in a Western Canadian province. - I completed two pilot interviews to test clarity of interview guide questions. I also did this to test the structural cohesiveness of my interview guide. After inquiring with each pilot interview participant for feedback, both participants confirmed that no further areas of improvement in clarity or nature of interview guide questions was needed. - Where permission was received, I also member checked with the five participants by sending an outline of themes via e-mail to confirm accuracy of interpretations of findings, so that a holistic account of experiences in the provision of end-of-life care can be represented. Participants had no additional feedback regarding my themes, and all felt that they represented their experiences in providing end-of-life care in a rural hospital setting.
<p>Dependability: <i>Processes in research study are described in rich detail and provide a holistic account of participants' experiences.</i></p>	<ul style="list-style-type: none"> - I maintained an audit trail with a clear outline of decisions made along with the rationale. I did this so that my biases were illuminated and accounted for by exploring how they shaped my understanding and perception of participants' experiences during the research process. - I reviewed and negotiated codes and themes generated from the data with my supervisor so that an accurate and holistic account of participants' experiences were interpreted and described. - Also, ongoing review of my work by my supervisor and committee has been maintained.

Table 3 continued

Tenet of Trustworthiness	Strategies Employed
<p>Confirmability: <i>Decisions made throughout the research process are sound and consistent.</i></p>	<ul style="list-style-type: none"> - I maintained researcher reflexivity memos prior and after participant interviews. Memos and reflexive notes were used to illuminate my assumptions, due to my professional background as a rural RN, thoughts, and ideas that emerged during data analysis, including how these may have affected my interpretation and representation of the data. - I also engaged in reflexivity interviews/conversations with my supervisor to identify existing biases, presumptions, and assumptions that I have, including how these may have affected my interpretation of the data. Additionally, discussion of the account of big ideas, themes, and concepts emerging from the data analysis was completed with my supervisor.
<p>Transferability: <i>The extent that interpretations will have meaning in other similar contexts by representing multiple perspectives and worldviews.</i></p>	<ul style="list-style-type: none"> - I recruited a sample of nine participants who varied in age, gender, number of years of nursing experience, and location of work, so that I gained multiple perspectives. Additionally, maintaining variation among participants and rural hospital sites helped to obtain a rich, descriptive account data from participants' experiences.

* Adapted from Morse (2018).

Ethical Considerations

Using the Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences, & Humanities Research Council of Canada's (Tri-Council, 2014) *Tri-Council Policy Statement*, ethical considerations specific to my proposed study included avoiding participant recruitment and data collection at my place of work, protecting participant confidentiality, and remaining aware of the distribution of power between the participants and me. The research ethic guidelines presented by a major university were also followed throughout the research process.

Engaging in participant recruitment and interviewing at my place of work, or “backyard” research (Creswell & Poth, 2018, p. 154), was avoided in order to avoid power imbalances between myself and participants who are known through my work. Although it would certainly have been easier for me to recruit work colleagues, such an approach could have resulted in compromised data quality (Creswell & Poth, 2018). Alternatively, I recruited from other rural locations across the province and, instead, conducted two pilot interviews at my place of work to assess relevancy and clarity of interview questions. Additionally, recruiting participants from a variety of locations allowed for representation of a variety of end-of-life experiences, both similar and different from my place of work.

Due to the close-knit nature of rural communities, full anonymity of participants was not possible, as I knew that participants likely would choose to discuss their interview experience with colleagues. I took every reasonable precaution to protect confidentiality, such as (a) keeping all participant digital recordings and transcriptions of interviews on a password-protected computer and USB flash drive; (b) locking all participant copies of consent and demographic forms in a filing cabinet to which only I had access; (c) altering identifiable information such as names and details of people, places, or events; and (d) in publications and presentations, assuring participants that I would only identify the setting as a rural hospital in a Western Canadian province.

Participants were asked to choose their own pseudonym at the interview. Alternatively, for participants who chose not to assign their own pseudonym, I assigned a name on their behalf. Prior to any of the interviews with participants or any form of data collection, verbal and written consent was obtained. Participants were asked to sign a consent form that clearly identified participant rights, such as ability to withdraw from the study at any time, interview purpose was reviewed, and participants received a copy of the

consent form for their records (see Appendix C). Also, a reminder was provided that the participant could stop the interview at any time, for any reason. Participants were also informed that should the interview process trigger any difficult emotions for participants, I would provide information on counselling resources available through the healthcare organizations' employee assistance. Prior to any engagement of research activities, I obtained ethical approval from the Research Ethics Board from a major university and operational approval from the healthcare organization.

Chapter Summary

In summary, I suggest the significance of this study lies in recognizing that there are unique contexts that need to be accounted for in the delivery of good care in rural settings (Pesut et al., 2014) and in addressing the knowledge gap about nurses' experiences in providing end-of-life care in rural hospital settings. Through my professional experiences in providing end-of-life care in a small rural hospital, I became curious about the experiences of other rural nurses. Limited access to professional end-of-life care resources and caring for those who are known to you have been a part of my reality in providing end-of-life care in a rural setting and have been influential factors in how I provide care.

By learning from participants' experiences in providing end-of-life care in a variety of rural hospital settings, I have had the opportunity to appreciate how some of my experiences aligned or differed from that of participants' experiences. Furthermore, I have come to realize and appreciate how these similarities in experiences and realities co-create new meaning and understanding of the experiences of providing end-of-life care within the rural context. This study contributes to the literature pertaining to nursing in rural hospital settings and illuminates a greater understanding of the experiences of nurses who provide

end-of-life care in the rural setting in a Western Canadian province. The results and findings of this research are detailed in chapter four.

Chapter 4: Results and Findings

Through my review of the literature, it became apparent that little is known about rural hospital nurses' experiences in providing end-of-life care. More specifically, exploration of what rural nurses' find most rewarding, meaningful, or challenging in the provision of care is limited.

In this chapter, I will discuss the results of my descriptive qualitative study. More specifically, I will illuminate and describe the three themes ascertained from the analysis of the data. I have identified these three themes as (a) end-of-life care as a relational matter; (b) end-of-life care as an intimate affair; and (c) dying at home: hospital as home. For the purposes of maintaining anonymity, pseudonyms are assigned to each of the nine participants, which will be used to identify the comments shared in support of the findings presented in this chapter.

Themes

After reflecting on the data pertaining to nurses' experiences in providing end-of-life care, I illuminated three themes from the data analysis. The first over-arching theme was End-of-Life Care as a Relational Matter. This theme encompassed virtually all aspects of participants' experiences in providing end-of-life care in rural hospital setting. Two more themes also became apparent in the data and resonated in participants' experiences: (a) an intimate affair and (b) dying at home: hospital as home. I will discuss and explore these themes in-depth, along with summarizing main categories associated with each theme in the subsequent paragraphs.

Finding 1: End-of-life care as a relational matter. All participants expressed the constant presence and significance of formal and informal relationships during the provision of end-of-life care, and these relationships seemed to be at the core of many of

their experiences during the provision of care. This relational aspect in the provision of end-of-life care manifested itself in several ways for participants, such as through the relationship that they had with physicians and other members of the healthcare team, patients and their families, and the community. Consequently, the landscape of these relationships was influential in the degree of professional isolation experienced and also the degree of involvement during the provision of end-of-life care for participants. These elements will be explored further in the subsequent paragraphs.

Navigating the terrain of rural roles and relationships. The nature and importance of relationships between nurses, other members of the healthcare professional team, and with physicians were discussed by all participants. Due to the interconnectedness of both formal and informal relationships within the rural setting, end-of-life care was identified as a relational process rather than being an episodic occurrence for many participants. This was sustained by the close proximity that participants had with both patients and their families and with members of the healthcare team, along with having a high probability of encountering patient's family members within the community during the provision of care. Navigating roles and relationships within the rural context and environment was an influential factor in the provision of end-of-life care for all participants. For instance, Carol and Christine identified and described a positive relationship with rural physicians, which allowed for effective and timely implementation of the provision of palliative care:

[The] docs are really good with actually brainstorming on rounds and saying, "Hey, what do you think? Do you think this would work, yay or nay?" . . . Because the doc comes in for their five minutes on morning rounds and we're [nursing] here, we see the patient every hour on the hour and do all the hands-on care, so we know the problems. We know what's working and what isn't working. . . . They're really good. They're on board with us. (Carol)

She [the locum physician] knows that I do a lot with palliative care and stay up to date with the current stuff. So, when we have a palliative patient, she values my opinion as a knowledgeable professional. (Christine)

In contrast, some participants described a tense relationship with physicians. In some of Kate's experiences, this tense relationship contributed to Kate's difficulty in trying to provide and implement adequate end-of-life care:

A lot of it is physician-driven, and some are very receptive to you knowing this is working well for this person, and this medication is working really well for this. It may be an off-label. Some are just totally resistant, and you're left, right, you're just left with a suffering person, and there's nothing you can do about it, [and] the constant can I? can we? could we...?

Kate related feelings of frustration related to constantly disputing with physicians during the provision of end-of-life care, which contributed to ongoing tensions and disagreements. Similar experiences in navigating and maintaining professional relationships with physicians during the provision of end-of-life care were also described by Thomas and Christine. Their ability to implement palliative care was influenced by the quality of communication with physicians, which also affected their capacity to advocate for patients and, ultimately, influenced the kind of relationship that existed between physicians and nurses. Both Thomas and Christine described the importance of creating and maintaining an open and trusting relationship between nurses and physicians so that a palliative patient's needs could be met:

I think because we've had these conversations in the past, especially physicians, I think that they are way more accepting. If we're getting into a situation where we're obviously going to be looking at a palliative situation of a patient, there should be certain things we should be—should be in place. Symptom control: pain, nausea, anxiety, and that kind of stuff is basically addressed at that point in time, and because we've talked about this years ago; now, I think they are way more open to that. Before, we'd get—you'd almost have to convince them that that's the right thing to do. (Thomas)

If my patient is in pain or uncomfortable, or if your [the physician's] incompetence or inability . . . or lack of knowledge and unwillingness to improve your knowledge

is actually affecting my patient's comfort level, I won't just not say something.
(Christine)

The quality of communication between rural nurses and physicians set the tone for how end-of-life care was provided within the rural hospital setting. Ultimately, this quality of communication influenced the nature of relationships that many participants have had with physicians and also affected the participant's ability to advocate on behalf of palliative patients. Being able to provide quality end-of-life care was a significant aspect and endeavour for participants.

Interviewer: *What are some of those things that maybe don't go as planned?*

Sally: *Well, you'll have the family member that comes scootin' from wherever and say: "No, no, no, we want to give dad antibiotics..." I think nurses are better than doctors at advocating or having that discussion. I think that we know the doctors that will and the doctors that won't, and we'll say, "Come on, you need to sit down with this patient's family and have this conversation." But I think we will spend some time saying to the family we see this and this happening.*

For some participants, when there was tension within the relationship with physicians, the ability to provide quality end-of-life care may have been compromised and have left some participants frustrated with the kind of care that they could provide for patients. This manifested in the inability to maintain patient comfort, such as management of physical symptoms such as pain, relief of suffering, or being able to provide consistent palliative care for all patients and families. This sense of frustration stemmed from differing perspectives, professional worldviews, or lack of experiential understanding regarding the most appropriate direction of care for a palliative patient:

A lot of them [physicians] have never sat with someone while they died. They have no idea. I think a lot of them really just want to save people, and that's not appropriate at that time. You have your end-of-life patients that some people are still trying to fix, and it's not fixable. (Kate)

They [the physicians] just blindly write orders for things, and they clearly don't understand, but they are also not very receptive when you're trying [to present] resources . . . and sometimes I feel that could be a little bit of a struggle. (Christine)

A few participants also described the significance of relationships with other members of the healthcare team and the role that other members have during the provision of end-of-life care. As such, these relationships were also influential in the kind of care that participants felt that they could provide for a local palliative patient and the patient's family. For instance, homecare and palliative consulting teams were described as important in the coordination of the provision of end-of-life care for local community members:

Homecare's accessed them [palliative patients]; that's another resource. Homecare is in the same building, so they just wander over in the morning, talk about who's here, what's going on, or I'll wander over there. It's real team approach, for sure. (Sally)

Homecare is here all the time. Homecare stopped in today, and they were like: "Ok, how's our guy in this room doing?" 'Cause they look after them when they are actually in the community, before they come back to us. So, it's very much a team thing, where we are involved with a whole bunch of disciplines. (Christine)

Relationship with these extended members of the healthcare team was enhanced by the presence of informal networks and relationships among nursing colleagues. So, having an informal network of support among colleagues also allows for the exchange of information, support, and understanding among one another:

I think that it's mostly bouncing information off each other. . . . I find it to be a very respectful workplace and collaborative; especially among the nurses. (Sally)

Sometimes, the other nurses will call me at home. I had one nurse call me, and she's like: "Are you still up?" It was one thirty in the morning, and I'm like: "I'm actually still up." She's like: "Can I call you really quick? [The] locum doesn't seem to know what he's doing, and this doesn't seem right." So, [I stayed up], just writing on my chalkboard in my kitchen at one thirty in the morning. (Christine)

The presence of an informal network of relationships among healthcare staff then allowed for the provision of timely and effective implementation of end-of-life care that

was contextually relevant and meaningful. This type of care manifested in recommendations in the plan of care, as Christine described in her experiences, or during the provision of everyday care, as Iris described:

We have some really experienced—what are they called—PCA’s that have done a lot of palliative care. So, sometimes you come in [and follow what] the book says best, and they’re [PCAs] like: “No, let’s do it this way” . . . and it works most of the time. (Iris)

Although in some of the experiences of participants tensions existed between physicians and nurses, nearly all participants collectively expressed the importance of having support from other members of the healthcare team. So, relationships in the rural setting seemed to be unique to participants by the fact that they can tap into their own personal and professional knowledge and understanding of a patient’s circumstance in order to provide contextually relevant end-of-life care. Furthermore, participants described their ability to look to one another’s personal and professional experience and knowledge to share information about the best course of action to take during the provision of care for a known local community member.

Maintaining a close relationship with other members of the healthcare team allowed for the provision of timely and appropriate end-of-life care for rural community members. Having the ability to share information about previous approaches to the plan of care with each other allowed participants to prepare for and anticipate the palliative needs of local community members who may be already professionally or personally known to participants:

In my unit, there’s only one RN on shift. So, if I know there’s a homecare RN who knows this client already and has a relationship with them, then I can use them as a resource. I’m dealing with this, has this happened before? We can sort out problems that way. (Lori)

This dates back to my earlier years of working here, and it was sort of before home care really got going, but I do remember one young woman that was dying of ovarian cancer. The nurses took turns going to her home and taking care of her. And if I remember correctly, we were not paid; it was just what we did, because it was her wish to die at home. (Charlottée)

Altogether, participants described the considerable involvement with patients that they experienced as a result of the formation of close relationships with patients and their families. It was evident that having a sense of familiarity and being present during the provision of end-of-life care was an important aspect for participants.

A solitary endeavour. Although the importance of relationships within the rural settings was described by participants, some participants also portrayed how the provision of end-of-life care can also be a solitary endeavour, particularly as related to the absence of resources. That is, a sense of isolation was experienced due to lack of accessibility to physical, human, and palliative educational resources. For participants, a lack of support and relational understanding resonated in some of their experiences in providing end-of-life care in rural settings. For example, a sense of loneliness and seclusion was illustrated by

Lori:

When I first started out there, I felt that I was really missing that. Coming from an area where I worked with other RNs to an area where I'm the only RN, I felt kinda lost, you know? Like, you have no one to turn to, but, now I know I do have people that I can turn to: I've got homecare, I've got palliative, but I don't feel like I should bother them with my problems, but I feel that's something that's an area that's maybe lacking.

This sense of professional isolation was also compounded by the decisions made in the plan of care by other members of the healthcare team. The lack of willingness of other team members to involve other professional human resources in the plan of care for a palliative patient compounded feeling of solitude and professional isolation:

Part of it would be physician-wise as well, 'cause are they comfortable in asking for someone else's advice in this circumstance? (Thomas)

For Thomas, it seemed that the willingness to access and utilize external resources by other healthcare professionals contributed to a sense of professional isolation. Similar feelings of professional isolation were related by other participants and stemmed from a lack of professional support by other healthcare professionals:

I've always felt often unsupported myself in the work that I do. Like, there's no real [pause] debriefing after something. I feel that's just something that we should have. (Lori)

Relationships among members of the healthcare team were at the core of participants' experiences in providing end-of-life care. Due to the visible role that healthcare professionals had in their communities, the importance of relationships that participants had with community members beyond the hospital setting was also evident.

Finding 2: An intimate affair. A sense of intimacy during the provision of end-of-life care was described by participants. The notions of personal accountability, trust, and personally and professionally knowing the patient and her/his family seemed to resonate in the experiences of many participants.

A sense of trust and knowing the patient created a deep sense of personal involvement and investment for participants during the provision of end-of-life care. In turn, this engaged a sense of emotional involvement during the provision of care for participants:

After a while, you get to enjoy being with them [patients] and getting them through their [illness] and learning a lot about their lives, because you spend a lot of time cleaning and washing them, and you know, looking after them. You get to learn a lot about them. (Verna)

I think that's sort of how you go above and beyond in a small community because you know people. So, another thing that I noticed with palliative care, if there's someone who's on and doesn't really know the person, we sort of have a check and balance system. Those who know the person really makes sure the person gets the care. We remind each other that maybe we're checking them every two hours. . . . We tend to know the preferences of people because we know them. (Charlottée)

I think that families appreciate it more when they know 'cause they trust you already, and they already have that bond with you. You see them at a bad time in their life, and you're the one that tries to help them work through the different stages and move along. (Sally)

This level of personal involvement experienced by participants translated into a deep sense of commitment and accountability. This sense of commitment and responsibility was further intensified by the visible role that participants have within the community that they worked in. So, for some participants, there may also have been a sense of accountability that extended beyond the patient and his/her family and to the community:

At the end of the time, where somebody's passed on, you're gonna see them [family] again outside in the community. . . . Of course, people talk outside of the hospital, and so, you still want to do the right things. . . . I think, in a way, you're almost held to higher standards, maybe, 'cause you have extra, I guess stressor on you to live up to that, right? So, you'll either be known as the nurse that did a great job with mom or dad, or whoever, or you're the one that was, you know, the bad one. So, I think that also creates an atmosphere or environment that you feel like you have to live up to their expectations, somewhat. (Thomas)

We have pretty high expectations at this hospital for quality nursing, and especially if you stay with the dying patient. Let them have a good quality of life at the end. (Carol)

Relationships between participants and patients and their families were described as essential for participants in their ability to provide adequate and quality end-of-life care for participants. These relationships allowed for anticipation of needs, appreciation of the patient's circumstances, and provision of quality and supportive care. Inherently, these relationships were dynamic in nature, understood as a journey, and took time to form. That is, participants joined patients and their families during the course of their illness trajectory for a significant period of time and remained constant and active agents in their care. An *up close and personal* feel during the provision of end-of-life care was described by participants and facilitated the formation and maintenance of a tapestry of relationships among patients, their families, and with the community:

I think that end-of-life everybody says, “How can you? How can you work in that environment?” It’s ‘cause we have gone through their process, we’ve gone through their sickness, and when they’re ready to go, we’re ready for them to go as well, and their family is ready for them to go as well. (Verna)

Well, I think there’s more of a sense of community in a small town. People who are just neighbours will come in and [say], “Can I help? Can I sit with this person for a while?” And, they may not be blood family. The family circles can be bigger in a small town. (Lori)

I think that we have a staff that really never likes to see somebody die alone, and I know that on nights, when people are by themselves, we will have staff sitting with that person to make sure—if that’s their wish—that they don’t die alone. So, I think that shows a lot of caring. (Charlottée)

So, a sense of closeness within relationships was influential in the provision of care for participants by establishing a sense of affinity among nurses, patients, and the community, which allowed for the provision of quality end-of-life care for patients and their families.

Although the level of involvement was generally described as a positive characteristic of the rural hospital setting, a level of difficulty and emotional burden also resonated in some of participants’ experiences. That is, participants described how having a relationship with the patient and his/her family, either professionally or personally, contributed to some degree of distress and grief during the provision of end-of-life care, as described by Thomas, Verna, and Lori:

It’s just on a personal level ‘cause you know these people outside of this hospital; you knew them if they were a rancher or whatever in the past and their families. So, it’s—makes it tough. (Thomas)

Lots of the staff know everybody, so there’s just more that personal feel, I think, but that said, it’s tough too. I mean, I don’t know a lot of these people for all the years these girls know, so it’s sometimes a little tougher on them [other colleagues] to see them [patients] going. (Verna)

Well, end-of-life is very stressful. The people are there for a long time, [and] you want to do your best for them. You start to care about them, and then they’re gone. (Lori)

Sharing a close relationship with patients and their families was deeply rewarding, but also had difficult emotional consequences for participants as death approached. This great sense of emotional investment translated into a deep sense of connection and sense of accountability for participants:

You definitely get to know them [at] a way more intimate time, right? It's not just coming into emerg; they're spending days, weeks, and even a couple of months. You just get to know the family that much better. For sure, there's an intimacy about that. (Thomas)

[You're] not just focusing on the client, but, [also] how your care affects every other person who comes in and sees him. [It] makes you do more than you would do in an urban area, where you might only deal with just the client and maybe the immediate family. (Iris)

Participants were aware of the trust and expectation bestowed on them by patients, families, and the community in which they work and live. It seemed that the rapport and relationship that culminated became an important aspect of the provision of end-of-life care and helped nurses see themselves as visible agents within their respective communities.

Finding 3: Dying at home: Hospital as home. The final theme from my analysis of the data was the notion of dying at home. Participants spoke of how the rural hospital setting is a vital link or centre for local rural community members during the provision of end-of-life care.

Rural hospital as a centre for end-of-life care for the community. Participants spoke about how the rural hospital was an essential hub in facilitating accessibility to end-of-life care services for local rural persons. So, the notion of *home* seemed to extend beyond the physical location of a house and to the community that they are from. *Dying at home* represented the importance of the intimacy and closeness that accompanies the decision to remain and receive care in a familiar setting. For participants, being able to

provide and maintain a familiar setting for local members at the time of their death was perceived as a desirable and significant aspect in the provision of care:

So, by the fact we can keep a palliative person here, it saves families having to drive—especially the elderly who possibly shouldn't be driving in the first place—the elderly having to go out in the winter. . . . We're very accessible to them, instead of having to go to [name of city]. (Charloteé)

Most people palliate here if they can. Most of it is because they have family, friends [here]. This is their home for their life and they would rather stay somewhere where their support system can stay with them. (Thomas)

Having the ability to provide end-of-life care services within the local rural hospital was an essential aspect in maintaining the tapestry of relationships and sense of familiarity for both patients and healthcare providers. This sense of familiarity and community was described by participants as an important factor in the provision of end-of-life care. Participants further described how a sense of isolation may be experienced by local people who palliate outside their hometown or in an unfamiliar setting. This sense of familiarity and community during the provision of end-of-life care resonated in the experiences of Lori and Christine:

I think that it enables people to be more comfortable. They're not taken out of their town, or their area. They have neighbours that can come and visit them. (Lori)

I just think that rural is the best place for palliative care, honestly. Who wants to die in a big giant hospital, with thousands of people around you [and] limited amount of time that your family can be there. There's even no good place for it—You have to go to hospice, right? . . . But, yeah, who wants to get shuttled away from their home location to die? I think that's—I dunno, nobody wants that. Show me somebody who wants that. (Christine)

For participants, keeping local community members close to their hometowns allowed for those who matter to be involved and present during a palliative patient's final hours, days, and weeks. The rural hospital facilitated connections or the bringing together

of family, friends, neighbours, and community members, which supported familiarity, connectivity, and closeness in close relationships during the provision of end-of-life care:

I think there's more people that step up at that time and help out family or the patient. Like I know some people make meals for people and that kind of thing. So, I think there's more of that, maybe, in the rural setting. (Thomas)

I think it's [the hospital] a vital link. We become a hospice for lots of people dying, because they don't want to travel those distances to see their loved ones every day. (Carol)

Calling-in resources. In an effort to keep local rural community members within their hometown to palliate, participants often spoke of their ability to call in palliative care resources. That is, participants spoke about bringing specialist resources *to* the patient, instead of sending patients *away* from their communities to receive specialist care:

Well, we have a lot of back-up from the palliative team from [name of city], and they send out one [specialist] to the community. So, the palliative team knows a lot of resources that could be used. (Iris)

The decision and action to call in specialists to assess and provide recommendations for the care of a complex palliative patient contrasted with decisions made in the plan of care for a complex, non-palliative patient. That is, if a non-palliative patient should require specialist services, they are typically sent away from their community into an urban centre to receive care. Keeping local community members in their hometown was expressed as an important value during the provision of end-of-life care. So, the notion of dying at home in a rural setting may include an understanding of the rural hospital setting as a main gathering place so that meaningful end-of-life care can be provided for patients, families, and the community.

Chapter Summary

In summary, I recruited a variety of participants from a variety of rural hospitals across a southern part of a Western Canadian province. Braun and Clarke's (2006) first

three steps to thematic analysis were used in order to gain near-data rich and holistic accounts of nine participants' experiences. It was my goal to describe participants' experiences in the provision of end-of-life care within the rural hospital setting in "everyday terms" (Sandelowski, 2000, p. 336) and to present participants' experiences in rich detail (Braun & Clarke, 2006). I utilized a variety of strategies to maintain the tenets of trustworthiness: credibility, dependability, confirmability, and transferability.

The main, over-arching theme that became apparent in the data was: "end-of-life care as a relational matter." The importance of the nature of relationships encompassed virtually all aspects of the experiences of participants. This notion of the importance of rural relationships supported the existing literature pertaining to the experiences of nurses providing end-of-life care within rural settings. Additionally, I identified two themes of "an intimate affair" and "dying at home: hospital as home," which became apparent within the data. Participants described the intimacy of the rural setting during the provision of end-of-life care and how the rural hospital setting was a vital link in maintaining the tapestry of relationships for the community. Furthermore, the importance of keeping local rural community members in their home towns to palliate was also discussed by participants. The importance of the rural hospital to nurses' ability to facilitate a sense of familiarity during the provision of end-of-life care has not been discussed within the literature and, thus, may extend to a deeper understanding of how the rural context may influence nurses' experiences of providing end-of-life care within a rural setting.

In the following chapter, I will discuss how my findings may support and extend the existing literature pertaining to the experiences of nurses providing end-of-life care within the rural setting. I will also reflect on and discuss my experiences and how they may align

or diverge from my study findings. Lastly, I will discuss the limitations of my study and potential areas of future research.

Chapter 5: Discussion

Findings from my study illuminated the experiences of regulated nurses in the provision of end-of-life care and how the rural hospital setting influenced the provision of care for participants. I will explore how major findings and conclusions of my study aligned, extended, or diverged from the literature. I will also discuss implications for nursing practice and recommendations for future areas of research along with my study's limitations.

Major Findings

Major findings of my study involved three themes and represented core matters of participants' experiences in providing end-of-life care in rural hospital settings. Although some of my findings are consistent with the literature available pertaining to regulated nurses' experiences in providing end-of-life care in rural settings, some of my findings diverge or extend what is already known and understood about nurses' experiences in providing end-of-life care in rural hospital settings. Main findings of my study encompassed the notions of dying in place, both on a geographical and relational plane. Lastly, I will explore how my findings are similar or different than what is understood in the literature.

Dying in place. As I reflected on the importance of the rural hospital setting in the provision of end-of-life care, it became apparent that the notion of *place* is a significant aspect in the provision of care. This sense of place was primarily exemplified by the notion of home and how the rural hospital is an extension of home during the provision of end-of-life care for local rural community members. Participants spoke of the significance of location at the time of death; it seemed that within the rural setting, the hospital is much more than a generic and unfamiliar healthcare facility for rural nurses and community

members. Instead, the rural hospital setting symbolizes the concept of home, when remaining in one's own house to palliate is not a feasible or realistic option. So, *home* within the rural setting may extend beyond the physical location of a house and to the community in which one lives.

As such, it became evident that the notion of *dying-in-place* is a distinctive aspect of the provision of end-of-life care that nurses provide in rural hospital settings and was illuminated within my study findings. Further, I discovered that dying in place may carry different implications and meanings for rural nurses. Specifically, dying in place may encompass both the geographical location of the hospital and the relational space that exists during the provision of care.

Dying in place, geographically. For some nurses, there is a practical significance in the geographical location of the rural hospital during the provision of end-of-life care. This physical location or place is a key element in being able to facilitate accessibility to end-of-life care resources for a rural community. Moreover, having access to a local, rural hospital setting during the provision of end-of-life care avoided the dislocation of family and friends as death approached. Ensuring access to a local rural hospital is instrumental, in that nurses then have the ability to coordinate specialist palliative care resources for patients and their families. Consequently, in some circumstances, when weather and road conditions are favourable, receiving specialist palliative resources becomes a feasible and realistic option in the plan of care. So, for local rural community members requiring palliative care, this may translate into receiving more effective care. It is my assumption that receiving effective end-of-life care could be enhanced by community members having greater control over decisions in the plan of care and symptom management, resulting in an overall sense of well-being in their final hours, days, and weeks of life.

Participants described the importance of keeping local community members within their hometowns to palliate. Having access to a local rural hospital also provided the opportunity and ability of nurses to maintain a sense of familiarity and comfort during the provision of care. That is, rural nurses recognized the importance of keeping members within their hometowns and, thus, saw the rural hospital as an opportunity to achieve a sense of home during the provision of end-of-life care. I believe that this sense of home is a novel finding and extends what is already understood within the palliative literature. Illuminating how the local rural hospital is perceived as part of a sense of “home,” highlights another unique and influential nuance of the rural setting during the provision of end-of-life care. In turn, this sense of home that the rural hospital provides also supports the close relational ties that exist within the rural setting.

In summary, having access to a rural hospital supports the notion of *dying in place* due to the greater degree of ease of access to end-of-life resources closer to the rural community, whereas specialized urban centres may be less accessible and feasible in the plan of care for some rural dwellers. This degree of accessibility may be affected by factors such as weather and road conditions during the year, travel time, and one’s financial circumstance. So, having the ability to die in place geographically may support the perception that a dignified death is more likely achieved by remaining in one’s home community (Wilson et al., 2009).

Dying in place, relationally. Dying in place may also be perceived on a relational plane by some rural nurses. That is, dying in place may also exemplify the importance of community social ties and connections during the provision of end-of-life care. So, for most rural nurses, a local community member’s status within the hospital setting extends beyond the generic label of *patient* and to the status of *family, friend, or neighbour*. Indeed, rural

nurses shared a perception that they feel as though they join patients and their families and friends on their disease trajectory and end-of-life care journey. Consequently, this proximity and shared experience with patients and their families sets the foundation for end-of-life care to be a relational matter. Similar to how family and friends are a constant presence for most people, rural nurses also experience the constant presence of familiar relationships during the provision of care within rural hospital settings.

Indeed, there is a level of intimacy and closeness that accompanies the decision to remain in one's own community to receive palliative care, which may be related to rural perspectives and values on death and dying. Such perspectives include that displacing one from their home community to die is undesirable and having a familiar setting is significant in the palliative plan of care (Wilson et al., 2009). From the perspectives of rural nurses, care provision encompasses a sense of closeness and a deep sense of accountability and even feelings of obligation to take measures above and beyond what is expected in the plan of care. Such examples may include traveling in poor road and weather conditions to see a client or working beyond their scheduled work hours to provide compassionate and quality end-of-life care (Kaasalainen et al., 2014; Robinson et al., 2010). Therefore, the interpersonal closeness that accompanies *knowing* the patient and their families may lay the foundation of feeling morally obliged to provide exceptional care and also influence the degree of emotional involvement experienced by rural nurses during the provision of end-of-life care. Furthermore, this deep sense of obligation is intensified by the visible and trusted role that rural nurses have within their community setting.

Although it is apparent that the provision of end-of-life care is a relational matter as experienced within the rural setting, participants also portrayed how the provision of end-of-life care can be a solitary endeavour. That is, a sense of isolation is experienced due to

lack of accessibility to physical, human, and palliative educational resources. For participants, a lack of support and relational understanding from their colleagues resonated in some of their experiences in providing end-of-life care in rural settings. This lack of support for participants was most acutely experienced when there was a lack of professional support from physicians or a lack of acknowledgment of the palliative expertise and experiences that some nurses have. As a result, a sense of loneliness and seclusion was described by some participants during the provision of end-of-life care. This sense of isolation and seclusion experienced by participants may parallel the experiences of those of urban medical-surgical nurses. In urban settings, medical-surgical nurses have reported feeling excluded from the interdisciplinary team for palliative care matters and that the emotional needs of nurses during the provision of end-of-life care are disregarded (Gagnon & Duggleby, 2014; Oliveira et al., 2016). Additionally, rural nurses in other studies have also reported experiencing a sense of isolation due to ambiguity in the roles and responsibilities during the provision of end-of-life care (Pesut et al., 2014; Rosenberg & Canning, 2004).

I believe that this sense of isolation reported by both urban and rural nurses captures the significance and influence of relationships during the provision of end-of-life care. The tapestry of relationships that exist within the rural hospital setting includes not only the relational ties that exist between nurses, patients, and their family members, but also the ties that rural nurses have with one another, other members of the healthcare team, and also with the community. I see this as another facet in what dying in place, relationally, means for some rural nurses.

In summary, dying in place relationally encompasses the significance of social ties that exist within the rural setting. Indeed, there is a level of intimacy that accompanies the

decision to remain in one's home community to receive end-of-life care. Consequently, in the perceptions and experiences of rural nurses, local rural dwellers are most often viewed as more than anonymous patients; they are seen as neighbours, family members, or friends. As such, this may culminate in a deep sense of personal commitment and loyalty that may lay the foundation of what relationally dying in place means.

Implications for Nursing Practice

The notion of dying at home permeated all participants' experiences and was influential in how end-of-life care was provided in the rural hospital setting. As a result, I believe that there are specific implications for rural nursing practice. These include (a) a rural palliative plan of care and (b) enhancing nursing support within the rural context.

A rural palliative plan of care. A significant aspect for the provision of end-of-life care within rural hospital settings illuminated by participants was the importance of keeping local community members home and within a familiar setting as death approached. Consistent with evidence in the literature that suggested context is influential in every aspect of care (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009), the participants in this study provided specific strategies they felt would be relevant to the provision of palliative care within the rural setting. These strategies include having the ability to bring in specialist palliative resources to the patient and his/her family, having knowledge regarding patient and family preferences and priorities and also having the opportunity to tailor care to these preferences during the provision of end-of-life care. Influential factors that affected this ability included the kind of relationships that existed among members of the healthcare team and the willingness to bring in external human resources into the plan of care. These strategies reflect how rural nurses try to personalize the provision of end-of-life care so that

the needs of local community members are met in ways that respect people's unique insights into what is perceived to be a good and ideal death (Wilson et al., 2009).

In contrast, participants also described how the use of and access to specialized resources that lie within urban centres may not be entirely feasible or realistic within the plan of care in a rural setting. First, there is the belief that displacement away from one's community to receive care is perceived as undesirable (Pesut et al., 2014; Wilson et al., 2009). Second, factors such as unpredictable weather and road conditions can make traveling to urban centres difficult or impossible. Additionally, alternative methods such as public transit may be non-existent or difficult to access for rural community members. Consequently, palliative and end-of-life care is typically provided by general practitioners, instead of palliative care specialists within the rural setting (Kelley, Williams, DeMiglio, & Mettam, 2011). So, recognizing that traveling to urban centres to access specialized palliative resources may be difficult or undesirable, accessing and using a locally available resource, the *Rural Continuing Care Policy and Procedure Manual* (Alberta Health Services, 2017), may help provide direction in the plan of care within the rural hospital setting. This document was developed in 2017 for healthcare professionals working within the continuing care setting. This manual outlines how end-of-life care symptoms and issues can be managed and also provides guidance for healthcare professionals in decisions that are made in the palliative plan of care for a patient. For instance, specific recommendations on how to assess for pain and how to promote comfort are included in the document and are tailored to what resources are realistically available within the rural setting. Ensuring that this policy and procedure manual is easily accessible by nurses and other healthcare providers and also regularly used to inform the plan of care may help with maintaining a contextually relevant rural plan for end-of-life care. More specifically, outlining feasible

and realistic care plan options for symptom and pain control, patient and family resources, and healthcare provider resources that exist within the rural setting may also allow for timely and effective provision of end-of-life care.

Rural nurses are more likely to use local end-of-life care resources, and thus, developing a contextually relevant plan of care is possible. Both rural nurses and other healthcare providers who engage with local community members may help highlight the palliative care needs and priorities of rural community members and healthcare providers alike and help them provide care that respects the unique values held by rural dwellers (Bernal et al., 2009). Moreover, involving local community members within the broad plan of care also acknowledges that *place* is defined differently for different populations and communities. Local community members may be at site level or within the specific healthcare zone. Including staff nurses, facility/organization managers, patients/clients, and their families may be examples of local rural community members who could help inform a contextually relevant palliative plan of care.

Additionally, inviting rural nurses from a variety of communities to meetings where policy creation and review occur may be another strategy in maintaining a contextually relevant plan of care that can be employed. Including rural nurses where decisions are made regarding policy could help ensure that a rural perspective is maintained in the development of palliative and end-of-life care policies, procedures and resources. For example, rural nurses might be invited to review the *Rural Continuing Care Policy and Procedure Manual* (Alberta Health Services, 2017) on a bi-yearly basis so that it remains current and relevant to rural healthcare practitioners.

The provision of end-of-life care is a relational matter for rural nurses, and the notion of familiarity and relationships reflects a meaningful cultural value within a rural

hospital setting during the provision of end-of-life care. For example, ongoing conversations and documentation of conversations and meetings and decisions made regarding the plan of care may be beneficial to illuminate what really matters most for patients and their families during the provision of end-of-life care. This may manifest in regular meetings during the provision of care to assess and re-assess the goals in the plan of care and also help keep all concerned involved and informed in the plan of care. Consequently, ongoing conversations may also help highlight a community's values and preferences within the plan of care and how to best integrate and maintain these values and preferences.

Rural nurses also tend to be highly regarded within a rural community, and local community members often view them as “*their* nurses” (Scharff, 2013, p. 247). With the nurse-patient relationship being central during the provision of care and throughout the continuum of care (Newman, Smith, Pharris, & Jones, 2012), rural nurses have greater access to knowledge about patient circumstances than specialists located outside the rural community. This uniquely situates rural nurses in the provision of end-of-life care as initiators and leaders of conversations regarding how to best provide end-of-life care that highlights patient and family priorities in the plan of care. By highlighting priorities of care, family, hospital, and community needs are kept at the forefront of the conversation. The strengths and limitations of what a local rural hospital can offer can be identified and, thus, lead to appropriate use of local resources and access to tertiary resources.

Moreover, emphasizing the role and relationships that rural nurses have with local community members needing palliative care and their families may also help illuminate how the notion of *place* is perceived and defined by a specific rural community. As such, identifying how the notion of place is defined by a community may help inform a relevant

palliative plan of care. This plan of care can then be tailored to the unique needs of rural community members, allowing for the delivery of effective and quality end-of-life care.

Enhancing nursing support within the rural context. Similar to their urban nursing counterparts where emotional needs are perceived to be disregarded during the provision of palliative care (Gagnon & Duggleby, 2014), the participants in this study described how the provision of end-of-life care may be experienced as a solitary endeavour, despite having the presence of both formal and informal relationships. Since the provision of end-of-life care is a relational matter that resides at the core of the experiences in providing care in rural settings, enhancing nursing support to promote a sense of professional community would be beneficial. Professional solidarity might be supported through having an opportunity to engage in either formal or informal debriefing sessions with colleagues. This may help promote a sense of support, understanding, and camaraderie among nurses, along with the opportunity to develop knowledge (Reierson, Haukedal, Hedeman & Torunn Bjørk, 2017). Furthermore, facilitating a sense of collegial support among members of the healthcare interdisciplinary team may also help address any feelings of discomfort regarding death and dying that may exist (Gagnon & Duggleby, 2014). Including other members of the interdisciplinary team allows the opportunity to share ideas and develop a sense of understanding in their experiences in providing end-of-life care. Sharing of end-of-life experiences may also help illuminate which subjective meanings are ascribed to the provision of palliative care by nurses and also acknowledge one's shared experiences with other healthcare professionals (Watson, 2002). In turn, this may facilitate a deeper sense of connectedness and understanding and the creation of a shared relational space among nurses and healthcare professionals.

Having the opportunity to learn and share their experiences of providing end-of-life care may help promote a sense of understanding and professional community for rural nurses. Such opportunities may be created by (a) advertising and prioritizing palliative care certifications, courses, and educational opportunities for nursing staff; and (b) coordinating on-site palliative educational opportunities for nurses who are unable to travel large distances for educational opportunities if poor weather or road conditions exist. Being more able to obtain and share palliative and end-of-life care resources may also enhance palliative and end-of-life care competencies for rural nurses in a contextually relevant manner. In turn, this may allow for greater confidence in their ability to advocate for patients and provide recommendations to the plan of care for local patients and their families.

Recommendations for Future Research

Although findings from my study have illuminated the experiences of regulated nurses in providing end-of-life care in rural hospital settings, further research focused on the delivery and provision of palliative and end-of-life care in the rural setting is needed. Further questions that became apparent pertain to the experiences of other healthcare professionals in the provision of end-of-life care. More specifically, exploration of future areas of research regarding the experiences of rural physicians may help illuminate differing perspectives on the strengths and challenges the rural setting has to offer during the provision of end-of-life care. Moreover, I wonder how other aspects of the rural setting, such as policies, procedures, and documentation, may also have an impact on how palliative and end-of-life care is provided within the rural setting.

Perspectives of rural physicians in the provision of end-of-life care. A specific element illuminated and consistently discussed during my interviews with participants

pertained to the nature of relationships with physicians and how the tone of this relationship affected the provision of end-of-life care. I wonder how the end-of-life care experiences of rural physicians may align with or diverge from that of nurses' experiences in providing end-of-life care, given that general practitioners tend to have little to no guidance in their education in supporting palliative patients in end-of-life conversations and plan of care (Balaban, 2000).

Although notions such as formal and informal relationships, community, home, and place were significant concepts for participants, further research could explore whether these are also pertinent in the experiences of rural physicians when they are faced with an end-of-life care situation. Would the notions of home and intimacy also resonate in the experiences of physician's providing end-of-life care? Would rural physicians also experience a deep sense of personal accountability and commitment for patients and their families who are already known? These potential questions could guide future inquiry and add another facet to understanding how end-of-life care is experienced in-relationship by providers within rural communities.

Other elements of rural end-of-life care. Although my study has illuminated some elements in the experiences of regulated nurses providing end-of-life care within rural hospital settings, I also wonder about how end-of-life care is reflected in other facets in the delivery of care. That is, how are end-of-life care and a palliative approach to care within rural hospitals carried out or reflected in everyday practices, policies, and procedures?

Gaining a deeper understanding of how the culture of the rural context affects the provision of end-of-life care may also be beneficial in illuminating insights within the nature of care provided. Examining and exploring shared values, perspectives, and language (Creswell & Poth, 2018) used within the rural setting may illuminate another

element of what is already understood in how end-of-life care is delivered. Having the opportunity to gain a deeper understanding of which policies, documents, and reference material that inform and influence the provision of end-of-life within a rural setting may help illuminate what information is meaningful for rural nurses. Are all pieces of information, documents, and policies perceived to be relevant in the rural practice setting? How are end-of-life care matters, information, and educational resources communicated among members of the multidisciplinary healthcare team, and how does this align with or diverge from urban settings? As such, illuminating how resources, documents, and policies may need to be modified so that they are contextually relevant for rural hospitals and communities for the provision of end-of-life care may be beneficial.

Moreover, given there is a strong First Nation presence within rural Western Canada, exploration of how the experiences of rural nurses in the provision of end-of-life care for this population may also extend what is already known and understood. A deeper understanding of how the rural context influences the provision of end-of-life care viewed through the worldviews of First Nation communities may also help inform policy, procedure, and clinical nursing practice.

Lastly, an in-depth exploration of the lived experiences of nurses may also illuminate more about how the rural context influences the provision of end-of-life care. Highlighting the shared meaning that rural nurses ascribe to their practice during the provision of end-of-life care may illuminate patterns of shared understanding in providing end-of-life care in rural hospital settings. Furthermore, exploration of whether differences exist in the experiences of nurses who live within the same community they work in versus nurses who may live in a different city or town could be explored. I wonder if their

perceptions of relationships and home may be perceived differently within the provision of end-of-life care within the rural setting.

As such, the very nature and essence of core ideas, such as relationships, the notion of *home*, and intimacy that were described by participants in my study, could be explored in depth and deepen the understanding of these experiences. The significance of the local rural hospital may contrast with other perceptions that some rural members may try and avoid hospitalization altogether if it meant being able to remain home to die (Wilson et al., 2009). Given that there are varying perspectives on hospitalization during the provision of end-of-life care, I wonder if the perception of home may vary for some rural dwellers and rural nurses. Do other nurses and rural community members perceive their community as home and the hospital as an extension of this concept? Further, I wonder whether a clearer understanding of what constitutes home for rural nurses and community members could inform the palliative plan of care?

Limitations

Although I have been able to deepen my understanding of regulated nurses' experiences providing end-of-life care in rural hospital settings, I understand that my study also has limitations.

First, my study was completed in one geographical area. Although I recognize that there could be some existing commonalities among rural communities and settings, findings of my study reflect the experiences, values, and perceptions of the participants from a small number of rural communities across a southern part of a Canadian Western province. So, not all of my findings will resonate with other nurses who have had experiences of providing end-of-life care in other rural hospital settings, given that the transferability of qualitative findings is context bound (Guba, 1981; Morse, 2018).

Furthermore, no participant recruitment or interviews were completed in any of the First Nations communities that are found across the province. Therefore, the results of my study do not account for a wide variety of cultural perspectives and experiences during the provision of end-of-life care.

Second, there were limitations in my sample, as I was only able to recruit RN volunteers for my study. So, experiences described to me during interviews only reflect the professional worldviews and perspectives of RNs. I am left to wonder if the experiences of LPNs align with or diverge from those of RNs. Is the nature of relationships similar for LPNs? Does professional status play a role in how end-of-life care is provided in rural settings?

Participants within my study were primarily interested volunteers and passionate about providing end-of-life care. Therefore, the perspectives of rural nurses who find the provision of end-of-life care difficult or challenging may be missing, and undoubtedly, there are some facets of the provision of end-of-life care within the rural setting that remain to be further discovered and understood.

Assumptions

When I started this endeavour, I had some assumptions and biases about the provision of end-of-life care in the rural setting. In keeping with qualitative methodology, I kept intensive reflexive notes throughout data collection and analysis, and I found that some of my assumptions on what rural nurses' experiences are in the provision of end-of-life care were confirmed. I also found some findings surprising, which challenged my assumptions.

Confirmed assumptions. Two of my assumptions were confirmed. The first assumption confirmed was the significance and the importance of both formal and informal

relationships during the provision of end-of-life care. When I have provided end-of-life nursing care, I experienced and witnessed how the presence of relationships within the rural setting facilitated and supported the provision of end-of-life care. As a result, I have concluded that the nature of these relationships can and, in fact, do influence the extent of trust and rapport healthcare professionals and patients and their families have with one another. Participants in my study also described the significance of relationships during the provision of end-of-life care and how maintaining the tapestry of relationships within the rural setting was paramount in keeping a sense of familiarity and comfort for palliative rural community members. Although my assumption was supported by the participants' reports, I wondered if the significance in relationships also laid the foundation for the personal responsibility nurses feel that leads them to take measures above and beyond during the provision of *satisfactory* care. Certainly, within my professional experiences in providing end-of-life care within rural hospital settings, the degree of intimacy that exists between me and the patient has influenced the degree of personal responsibility I have felt for the patient and her/his family.

The second assumption confirmed was that there is potential for tense relationships between nurses and physicians during the provision of end-of-life care. Deep reflection on my own experiences in providing end-of-life care and moments when my relationship with physicians were coloured with tension seem to parallel the participants' experiences. I appreciate how perspectives in the goals of care may greatly differ between physicians and nurses. For example, tensions during the provision of end-of-life care may arise when curative, life-prolonging measures versus a comfortable, palliative approach to care exists. As such, these tensions may set the foundation as to whether my experiences in providing end-of-life care are positive or negative in nature. My experiences with the tense

relationships that may arise with physicians in the provision of end-of-life care parallel those of participants. Similar to my experiences, participants also described how navigating the provision of palliative care can be either comfortable or difficult in some cases, due to the nature of relationship that they have with the physician. Consequently, the type of relationships that existed with physicians coloured and influenced the provision of end-of-life care. So, an understanding of the significance of relationships within the rural setting was confirmed.

Surprising findings. Findings that were most surprising to me and which challenged my assumptions were the lack relational understanding that rural nurses experienced during the provision of end-of-life care, and the extent that the rural hospital was perceived as an extension of *home*.

Participants frequently spoke of the significance of the presence of relationships among themselves and how a sense of relational solidarity also existed during their experiences in the provision of end-of-life care. Although both formal and informal relationships were described to be essential and also abundant within the rural setting, there also seemed to be a lack of understanding and acknowledgement of the work and expertise in palliative care of participants by other members of the healthcare team. Thus, this lack of understanding may contribute to a sense of relational isolation for some nurses. Consequently, I wonder if this lack of appreciation is keenly felt and adds to the emotional burden experienced by nurses who place significant value on relational ties during the provision of end-of-life care.

I was also surprised to learn that many participants perceived the rural hospital setting to be an extension of home. Although I have come to appreciate the significance of having access to a local rural hospital, as an employee and someone who commutes to

work, I did not perceive the hospital as an extension of home. It was only by interviewing other rural nurses who live in the community in which they work that I gained a deeper appreciation of the notion of home and the significance of being able to provide end-of-life care within their *home town* or as the participants said, “at home.” As such, my perspective and understanding of home was broadened and deepened. I gained a greater appreciation of the significance of remaining in one’s own community to receive care and the importance of being in a familiar setting in one’s final hours, days, or weeks of life. Reflecting on my professional experiences in providing end-of-life care within the rural hospital setting, it is not uncommon to have local community members transfer back from an urban centre to their rural community to receive palliative care. This allowed the patients and their families greater access to social ties and the ability to maintain relationships during a difficult time. Consequently, my professional practice has changed in the sense that I appreciate the importance of having the ability to provide, create, and maintain a familiar setting during the provision of end-of-life care.

Conclusions

My study began with two research questions focusing on exploring regulated nurses’ experiences in providing end-of-life care and the influence that the rural context has on the provision of care. Main findings from my study illuminated how relationships, whether formal or informal in nature, intimacy, and a sense of home were indeed central to participants’ experiences in providing end-of-life care in rural hospital settings. In fact, the nature of relationships was indeed at the core of all of participants’ experiences in providing end-of-life care. Consequently, the degree of support and relational understanding were influential in participants’ experiences in providing care. The constant presence and significance of relationships within the rural settings was well-supported by

the existing literature. Extending this notion, however, is the significance of dying at home with the perception that the rural hospital is part of what it means to be home for local rural community members.

I believe that my study highlights the importance in maintaining a sense of home for community members who choose to die in their home communities and also supporting relationships among nurses. This work could be better supported by nurses having access to both formal and informal supports to help promote a sense of professional community and understanding among members of the multidisciplinary team. Furthermore, engaging with local community members and healthcare providers may be a way to utilize pre-existing strengths to help allocate contextually relevant palliative resources, such as reference material and easier access to palliative education, and develop a plan of care that is supportive of a rural community's values. Utilizing such resources may also be supportive of the care and work that is completed by nurses within rural communities. In summary, Verna's comment captures the reality that nurses experience when providing end-of-life care in the rural hospital setting:

I think that end-of-life everybody says, "How can you? How can you work in that environment?" It's 'cause we have gone through their process, we've gone through their sickness, and when they're ready to go, we're ready for them to go as well, and their family is ready for them to go as well.

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Appendix A: Participant Letter of Invitation

June 4, 2017

Dear Colleague,

My name is Noëlle Sedgwick. I am a registered nurse, currently completing my Master of Nursing degree through the University of Lethbridge. I am conducting a research study with a focus of exploring the experiences of regulated nurses (registered nurses [RNs] and licensed practical nurses [LPNs]) in providing of end of life care in the rural hospital setting. If you are an RN or LPN with experience(s) in providing end of life care, I would greatly appreciate learning from your experience(s) through an individual digitally recorded interview that will take approximately 45-60 minutes of your time. With your permission, you may also be contacted via e-mail later after your interview to clarify or expand on ideas shared in the first interview.

I do not anticipate any risks participating in this study. A \$5.00 Tim Hortons gift card will be given as a token of appreciation for your time and participation. Anonymity and confidentiality will be maintained during and after the research study. Participation in the study is completely voluntary. Although you will be asked to provide minimal demographic information such as number of practice years and age, personal information will not be used in my dissertation or publications. Pseudonyms will be used in place of actual names.

If you have any questions about my study, you may contact me at [email address]. My thesis supervisor Dr. Shannon Spenceley can be reached at [email address]. If you have any questions regarding research participant rights, you may contact the University of Alberta Health Research Ethics Board at 780-492-2615. This office has no affiliation with the study investigators. This research has received ethics approval from the University of Alberta Research Ethics Office, and operational approval from Alberta Health Services.

Thank you in advance for your participation.

Respectfully,

Noëlle Sedgwick, BN, RN
University of Lethbridge
noelle.sedgwick@uleth.ca

Appendix B: Participant Recruitment Poster

PARTICIPANTS NEEDED FOR

RESEARCH IN End of Life Care in the Rural Hospital Setting

I am looking for volunteers to take part in a study exploring the experiences of registered nurses (RNs) and licensed practical nurses (LPNs) in providing end of life care in the rural hospital setting.

You would be asked to: participate in a 45-60minute individual face-to-face interview

Participation is confidential.

In appreciation for your time, you will receive a \$5 Tim Hortons gift card.

For more information about this study, or to volunteer for this study, please contact:

The logo of the University of Lethbridge, featuring a shield with a sunburst and the motto 'FIAT LUX' below it.

Noëlle Sedgwick, BN, RN
University of Lethbridge
noelle.sedgwick@uleth.ca

This study has received ethics approval from the University of Alberta REB 3: Health Research Ethics Board- Health Panel and operational approval from Alberta Health Services

Email: noelle.sedgwick@uleth.ca
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Email: noelle.sedgwick@uleth.ca

Adapted from: Human Participant Research Forms and Applications. (2017). In *University of Lethbridge*.
Retrieved from: <http://www.uleth.ca/research-services/research-ethics/human-subjects/forms>

Appendix C: Participant Consent Form

End of Life Care in the Rural Setting

Noëlle Sedgwick, BN, RN

noelle.sedgwick@uleth.ca

Shannon Spenceley, PhD, RN

s.spenceley@uleth.ca

Why Are You Being Asked to Participate in this Study?

You are being asked to participate in this study because I believe that you have knowledge, insight, and experience in providing end of life care in the rural hospital setting.

Purpose

I am inviting you to participate in my thesis research study. The intent of my research study is to explore and understand the experiences of nurses providing end of life care in the rural hospital setting. Before you decide, I will go over this consent form with you. You are encouraged to ask any questions if you feel anything needs to be clearer.

What Will You be Asked to Do?

To further my understanding of the topic, I am hoping to interview nurses who currently work in a rural hospital setting. I expect individual interviews will take approximately 45 to 60 minutes. A mutually convenient date, time and place for the interview will be negotiated. With your permission, the interview will be digitally recorded. Alternatively, notes may be taken during the interview. Additionally, with your permission, I may contact you via your preferred e-mail address to clarify or expand on ideas shared in the first interview, or to verify whether my findings accurately describe your experiences.

Risks and Discomforts

It is not possible to know all of the risks that may happen in a study, but the researcher has taken all reasonable safeguards to minimize any known risks to a study participant. I do not anticipate any risks when participating in the interview. There is a small possibility that answering some questions will produce uncomfortable feelings for you. Should this occur, I will refer you to your healthcare organization's counselling services. If you become upset during the interview, I will stop the interview and the recorder until you tell me you are ready to continue with the interview.

You are not expected to get any benefit from being in this research study. That being said, you may find the opportunity to contribute to the nursing body of knowledge rewarding and enjoyable.

Do You Have to Participate in the Study?

Being in this study is your choice. If you decide to be in the study, you can change your mind and stop being in the study at any time, and it will in no way affect your employment at your place(s) of work. You can also stop the interview at any time or choose to not answer any question for any reason. You can also seek clarification of questions that are unclear. If you choose to withdraw, the interview recording will be stopped. The recording and/or notes will be confidentially destroyed and will not be used as data for my

study. I will not be able to withdraw specific individual data once data analysis has begun, which will start approximately three weeks after the interview, because there will be no individual identifiers attached to the data.

Will you be Paid in the Research?

As an appreciation token for your time, a \$5.00 Tim Hortons gift card will be provided to you. If you choose to withdraw from the study at any time, the gift card is yours to keep.

Will Your Information be Kept Private?

Steps will be taken to maintain confidentiality. Names of people, places and events will be changed or removed in the typed-up interviews. You will be assigned a pseudonym. Minimal demographic information (for example number of years working, and age-range) will be collected about you. At no point, will your personal information will be used outside of this study. Sometimes, by law, I may have to release your information with your name so I cannot guarantee absolute privacy. However, I will make every legal effort to make sure that your information is kept private.

Interviews will be transcribed by the researcher. The transcripts and recorded interview will remain in a locked cabinet to which only the researcher has access. The cabinet is in a locked office space. Audio and transcribed interviews will be kept on a password protected computer; only the researcher has knowledge of the password. Only the researcher, thesis supervisor, Dr. Shannon Spenceley, and thesis supervisory committee will see the transcribed interview. All data and research documents will be confidentially destroyed by shredding and permanently deleting documents after five years.

Findings from the study including direct quotes will be used in my analysis and presentation of my thesis. I also plan on presenting my findings at nursing conferences, and submit articles for publication to nursing journals. Your name will not be associated with any direct quote.

If You Have Any Questions

If you wish to follow up regarding the final report, or have any questions, you may contact the researcher with the contact information: noelle.sedgwick@uleth.ca. No actual or potential conflict of interest are realized for this study. Should you have any concerns relating to the conduct of this study, you may also contact my thesis supervisor, Dr. Shannon Spenceley: s.spenceley@uleth.ca.

If you have any questions regarding your rights as a research participant, you may contact the University of Alberta Health Research Ethics Board at 780-492-2615. This office has no affiliation with the study investigator.

Adapted from: REB 3: Health Research Ethics Board- Health Panel (2017). In *University of Alberta*. Retrieved from: <http://www.reo.ualberta.ca/Human-Research-Ethics/Research-Ethics-Boards/REB-3-HREB-HealthPanel.aspx>

End of Life Care in the Rural Setting

Noëlle Sedgwick, BN, RN

Shannon Spenceley, PhD, RN

	Ye s	N o
Do you understand that you have been asked to be in a research study?	<input type="checkbox"/>	<input type="checkbox"/>
Have you read and received a copy of the attached Information Sheet?	<input type="checkbox"/>	<input type="checkbox"/>
Do you understand the benefits and risks involved in taking part in this research study?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had an opportunity to ask questions and discuss this study?	<input type="checkbox"/>	<input type="checkbox"/>
Do you understand that you are free to leave the study at any time, without having to give a reason and without affecting your present and future employment	<input type="checkbox"/>	<input type="checkbox"/>
Has the issue of confidentiality been explained to you?	<input type="checkbox"/>	<input type="checkbox"/>
Do you understand who will have access to your study information?	<input type="checkbox"/>	<input type="checkbox"/>
Who explained this study to you?		

—

A copy of this form will be provided to you for your records.

I agree to take part in this study:

Signature of Research Participant:

Date: _____

(Printed Name)

Signature of Investigator or Designate:

_____ Date:

Adapted from: REB 3: Health Research Ethics Board- Health Panel (2017). In *University of Alberta*.
Retrieved from: <http://www.reo.ualberta.ca/Human-Research-Ethics/Research-Ethics-Boards/REB-3-HREB-HealthPanel.aspx>

Appendix D: Participant Demographic Questionnaire

Date:

Pseudonym Name: _____

Age:

- 20-25
- 26-30
- 31-35
- 36-40
- 41-45
- 50+

Gender:

Professional status (RN or LPN):

Education:

- Diploma
- Undergraduate
- Masters
- Doctorate

Number of years working in this specific rural hospital: _____

Total number of years working in a rural hospital setting: _____

FTE:

- Casual (approximate number of shifts/month):
- Part-time, FTE:
- Full-time

Do you have any extra palliative care or end of life care courses or certifications? (please list)

Do you work, or have you worked in an urban hospital? Y_____ N_____

If yes, please describe:

Appendix E: Interview Guide (*Interview Questions Portion*)

Research Question: What are the experiences of regulated nurses in providing end of life care in the rural hospital setting?

Sub Question: How does the rural hospital setting influence regulated nurses' experiences in providing end of life care?

- How did you come to work in a rural hospital?
- Is providing end of life, or palliative care to patients and their families a regular occurrence at your hospital?
- Can you describe a particularly memorable experience for you, when you have provided end of life or palliative care?
- How do you think that the rural setting itself has influenced how you provide end of life care?
- What are some advantages do you think that your rural hospital has for nurses in providing end of life care?
- Are there any dedicated spaces or rooms for palliative patients in your hospital?
- What are some valuable resources, do you think, that you use during the provision of palliative care? How do you think these resource(s) impact your ability to provide end of life care?
- Are there people you think about as champions for palliative care at your site?
- What about education on palliative care-how does that happen?
- Are there any 'unwritten' or informal things that help support palliative care at your site?
- What do you perceived to be significant challenges in providing end of life care?
- What do you find most meaningful about providing end of life care?

What have I not asked about that you think is important?