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What does quality care mean to nurses in rural hospitals?

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Abstract

Aim—This paper is a report of a study conducted to answer the question: ‘How do rural nurses and their chief nursing officers define quality care?’

Background—Established indicators of quality care were developed primarily in urban hospitals. Rural hospitals and their environments differ from urban settings, suggesting that there might be differences in how quality care is defined. This has measurement implications.

Methods—Focus groups with staff nurses and interviews with chief nursing officers were conducted in 2006 at four rural hospitals in the South-Eastern United States of America. Data were analysed using conventional content analysis.

Findings—The staff nurse and chief nursing officer data were analysed separately and then compared, exposing two major themes: ‘Patients are what matter most’ and ‘Community connectedness is both a help and a hindrance’. Along with conveying that patients were the utmost priority and all care was patient-focused, the first theme included established indicators of quality such as falls, pressure ulcers, infection rates, readmission rates, and lengths of stay. A new discovery in this theme was a need for an indicator relevant for rural settings: transfer time to larger hospitals. The second theme, Community Connectedness, is unique to rural settings, exemplifying the rural culture. The community and hospital converge into a family of sorts, creating expectations for quality care by both patients and staff that are not typically found in urban settings and larger hospitals.

Conclusion—Established quality indicators are appropriate for rural hospitals, but additional indicators need to be developed. These must include transfer times to larger facilities and the culture of the community.

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Conflict of interest

No conflict of interest has been declared by the authors.

Author contributions

MB, BJ and EM were responsible for the study conception and design. MB, BJ, EM and DT performed the data collection. MB and BJ performed the data analysis. MB and BJ were responsible for the drafting of the manuscript. MB, BJ, EM and ET made critical revisions to the paper for important intellectual content. BJ provided expertise in qualitative analysis. MB and EM obtained funding.

Keywords

chief nursing officers; community nurses; quality care; rural culture; rural hospitals

Introduction

Quality care is receiving increased global attention because it is part of measures to document health system performance (Kruk & Freedman 2008). Several global and regional groups have been formed to develop and evaluate the presence of quality care, for example the World Health Organization (WHO) Health Metrics Network, which assists countries in setting up systems that provide accurate, reliable health information and measures (WHO 2009), and the European Pressure Ulcer Advisory Board, which focuses on the measurement and prevention of pressure ulcer incidents (Shahin *et al.* 2009). These groups help delineate how to measure quality care, but the influence of location on quality care has not been considered. Established quality care measures were developed and studied primarily in developed countries and urban hospitals (Shaw 2003, Casey *et al.* 2006, Bates *et al.* 2009). However, rural hospitals and the environments in which they function are different from their urban counterparts, suggesting that how quality care is measured might need to be adjusted for location (IOM 2005). Improving the conceptual understanding of what constitutes quality care in rural hospitals is a required first step towards developing measures that are locally relevant, valid and reliable.

Background

Because of the importance of quality care measures for global public performance ratings and, in some countries, linkages to reimbursement (Kruk & Freedman 2008), these measures must be relevant for all hospitals, including those in rural settings. Indicators of quality care are delineated in the literature (Kruk & Freedman 2008), but it is not clear that they cover all features that constitute quality. Some of the more common indicators are rates of falls, pressure ulcers, infections, readmissions and length of stay.

A review of more than 300 United States of America (USA) quality measures by an expert panel on rural health showed that only 20 of the indicators were appropriate for rural hospitals (Moscovice *et al.* 2004). These 20 indicators included aspects of quality related to emergency care, medication management, diagnosis-specific conditions and infection control. None of them reflect the special circumstances of rural hospitals or the particular concerns of people living in rural communities.

Globally, there are national differences in how 'rural' is defined. According to the United Nations (UN), the distinction between urban and rural populations is not amenable to a single definition (UN 1998). For most countries, rural areas are defined as 'what is not urban' (UN 1998, 2004). This broad definition places about half of the world's population in rural areas (UNFPA 2008). In the USA, rural hospitals are frequently the only healthcare facilities available for the one in five citizens who live in rural communities (Moscovice & Stensland 2002). Most rural hospitals have fewer than 100 beds; they also have fewer nurses per patient, less technology, and nurses with less education than those in urban hospitals (Bushy 2000, IOM 2005). Moreover, because they are often the major employer in the region, rural hospitals play an essential part in the economic and social identity of the community (Moscovice & Stensland 2002). Rural communities also tend to have high proportions of people who are both sick and poor (Hartley 2004, Merchant *et al.* 2006). The different characteristics and environments of rural hospitals should be reflected in measures of quality. At present, it is not clear whether comparisons of quality care should be made

across all hospitals, or if rural hospitals are a unique subset where comparisons and benchmarking should occur independent of their urban counterparts.

For people living in rural areas, nurses are often the first, if not the only, point of contact with the healthcare system (ICN 2009a). Examining nurses' perceptions of quality care was therefore deemed an appropriate first step toward developing a better understanding of quality care in rural hospitals.

The study

Aim

The aim of the study was to answer the question: 'How do rural nurses and their Chief Nursing Officers (CNOs) define quality care?'

Methodology

We used a qualitative descriptive design, as described by Sandelowski (2000). Of the various qualitative designs, this approach has the least pre-existing theoretical and philosophical commitments and therefore is especially useful for describing a phenomenon about which little is known. It also allowed us to use a combination of research techniques to achieve an understanding of what quality care meant to rural nurses. These included sampling both staff nurses and CNOs, individual and group interviews, and conventional content analysis.

Participants

We approached CNOs in five rural hospitals in the South-Eastern USA with ties to the university where the study was conducted. Four CNOs agreed to participate in interviews and to allow recruitment of staff nurses. The four hospitals were within 1–2 hours of another hospital and varied in size, with 25, 37, 56 and 132 beds. They met the definition of USA rural hospitals as each was located in a non-metropolitan geographical area and had a population of fewer than 50,000 (AHA 2005).

In each hospital the CNO was interviewed and a single focus group was held for staff nurses, defined as Licensed Practical Nurses (LPNs) and Registered Nurses (RNs) with no management responsibilities. Staff nurses were recruited using flyers and participation was voluntary. The four focus groups comprised two, five, seven and nine participants. All groups included nurses who were on duty as well as nurses who came in on a day off. Refreshments were served and each participant received \$25.

Data collection

Data were collected over a 6-month period in 2006. The same open-ended, semi-structured questions were used in both the focus groups and individual interviews. The questions were developed using advice from methods and contents experts. The interviews began with the question: What is quality care in rural hospitals? Additional questions requested an example of quality care and features that reflect quality, one or two measures that are indicators of quality, and ideas about differences in quality between rural and urban hospitals. In addition, participants' perspectives were sought on transfers to larger facilities. Probes were used to clarify information and to seek additional information.

All focus groups and interviews were led by the first author. A second author was present at each hospital to take field notes and, on occasion, ask clarifying questions. Immediately after an interview, the participant(s) was asked to complete a demographic information

sheet. Each interview, group or individual, lasted about 1½ hours. All interviews were audiotaped and transcribed verbatim.

Ethical considerations

The study was approved by a university institutional review board and participants signed a consent form. No identifying information such as names or work unit was collected.

Data analysis

The transcribed data were analysed using conventional content analysis (Hsieh & Shannon 2005). No pre-existing codes or theoretical structures were used. Rather, the codes were derived from the data word-by-word and segment-by-segment to capture key concepts about rural nurses' perceptions of quality care. Through an iterative process, related codes were grouped into categories; the categories were then clustered into themes based on a shared idea. Although this approach does not yield a complex structure delineating the nature of the relationships, it was well-suited to the goal of describing quality care from the viewpoint of nurses working in rural hospitals.

Because CNOs and staff nurses might have differed in their perceptions of quality care, the data were initially analysed in two separate groups, following the same process for each group. The CNO interviews were analysed first. After a 2-month lapse, the staff nurse data were analysed. This lapse allowed identification of the ideas expressed by each group with minimal influence from the other group. Once the analysis was completed for both groups, the findings were compared. Although the naming convention for the categories differed between the groups, suggesting that there was minimal influence of the analysis of the first group on the second, the themes were strikingly similar, indicating a shared view between staff nurses and CNOs. This similarity supported combining the groups to reflect two major themes.

When the groups' categories were compared, the only difference between them was a nuanced difference related to hospital resources. Staff nurses spent more time talking about their preference for improved technology and economic resources and the challenge of transferring patients to other facilities. CNOs, by contrast, were more matter-of-fact about resource limitations and did not articulate details about technology and patient transfers. This did not represent a difference between the two groups' perceptions of quality.

Rigour

The transcripts were read independently several times by two of the authors to gain a solid sense of the data. Key ideas were identified and considered in relation to the context of the comments. Detailed notes were kept throughout the analysis to enhance the auditability of the work.

After these independent reviews, the two authors worked collaboratively to synthesize the codes into categories and then themes. During this process, they frequently returned to the transcripts to ensure that the analysis remained true to the sentiments expressed by the participants. The categories were examined across hospitals to determine whether they were evident in all hospitals. Although the density of each category varied, all categories were addressed across all four hospitals, supporting their presence in all sites.

Reactions to and comments about the findings were sought from a qualitative researcher not associated with the project and from two nurses involved with rural hospitals in the Western USA: a county Public Health Director and a CNO at a critical access hospital, one of approximately 1400 rural hospitals with 25 beds or less in a special USA federal programme

aimed at keeping health care available in all rural communities (Gale *et al.* 2007). They each considered that the findings were valid and applicable to rural hospitals, providing an indication of their transferability.

Findings

The demographic characteristics of the 23 staff nurses and 4 CNOs are presented in Table 1. Most staff nurses were female (91%) and on average were 42 years old; 39% were Registered Nurses with an associate degree. They had an average of 15 years of experience in nursing, almost 10 years of experience in their present institution, and just over 7 years of experience on their current unit. A majority worked rotating shifts (57%). The CNOs were all female. On average, they were 56 years of age, had more education, and typically had more years in nursing and at their institution.

There were two overarching themes: 'Patients are what matter most' and 'Community connectedness is both a help and a hindrance'. Based on frequency counts, data relevant to the first theme dominated both groups, representing 65% of the comments in the staff nurse data and 60% of the comments in the CNO data. Although textual data were expressed less frequently for the second theme, the comments were clearly linked to the rural setting and perceptions of quality care. That link was not obvious to us prior to this study and therefore not addressed explicitly in the questions guiding the interviews, a factor that might have affected the frequency counts.

Patients are what matter most

The first theme reflected how the work and purpose of the CNOs and staff nurses were 'all about the patient'. Quality care was much more than collecting information about established quality measures. A paramount feature was treating the whole person and helping people overcome barriers to get needed care. Participants also reported keeping their knowledge and competencies up-to-date as part of quality care.

Quality care is our goal—Established quality indicators such as rates of falls, pressure ulcers, infections, readmission rates and length of stay were part of the rural nurses' everyday language. Yet both staff nurses and CNOs said that patient satisfaction was the most important quality indicator. Patient satisfaction was defined broadly to include whether family members were treated well, along with whether patients felt well-informed and safe. The staff nurses believed that patient satisfaction scores were 'coming from a true and important source and that is the patient'. These sentiments were echoed in the CNO comments. One CNO was 'on cloud nine' when an unannounced Joint Commission survey found that every patient they interviewed in the hospital said that '[the staff] made you feel like you were home, the nurses cared about me'.

Participants made distinctions between larger urban hospitals and rural hospitals regarding quality care. They noted that specialty care is the hallmark of urban hospitals. In contrast, the hallmark of rural hospitals is their individualized care, noted in patient satisfaction scores and word-of-mouth comments in their small communities. A staff nurse who had worked in a larger hospital was emphatic in conveying that patients were not sent to bigger hospitals for better care; they were sent to have access to treatments that were beyond the scope of smaller rural hospitals.

The goal of quality care was shared by the four hospitals' leadership. The staff nurses were very conversant about quality scores and other patient feedback, indicating communication to bedside staff from the hospital leadership. If reports reflecting various quality indicators, including patient satisfaction, were not at the desired levels, then all personnel worked

together to make them better, taking seriously the need to improve. Likewise, staff knew that CNOs would not ignore problem areas identified in the surveys, nor would they sweep mistakes under the carpet. Rather, together with staff, CNOs used errors as learning experiences and corrected care processes that contributed to problems.

Going beyond the basics to treat the whole person—Rural nurses expressed a strong commitment to individualized care for patients. They rarely mentioned tasks or meeting patients' physical needs without also mentioning their responsibility to treat the whole person by preserving patients' dignity while also showing compassion, respect and concern. Staff nurses believed strongly that patients should be made to 'feel at home'. Patients needed to have confidence that nurses would be there for them, willing to 'go the extra mile' if needed.

The CNOs encouraged this philosophy. They expected nurses to go beyond the basics to meet their patients' needs and to personalize care. They expected staff to take time to sit down with patients, because to a patient 'three minutes equals an hour'. They wanted every patient to have a good experience, one that would leave them at ease if they needed care at the facility in the future.

The focus on the whole person was something that made work in rural hospitals enjoyable for staff nurses. They commented that personalized care was often not seen in bigger hospitals. One said: 'I am not originally from here. I've been here three years – [I came] from a much larger facility and I find that the treatment here [is] definitely more compassionate and more empathetic... much more holistic'.

Getting patients the care they need—All participants acknowledged that for patients to get the care they needed, it was important to consider how to address acute problems as well as long-term illnesses and prevention. The former required care in the hospital or transfers if treatment was not available, whereas the latter required considerations that extended beyond the hospital into the community. Getting patients the hospital care they needed concerned hospital resources. It was this area where nuanced differences were detected between staff nurses and CNOs. Staff nurses repeatedly mentioned that better technology, including automated communication and documentation systems, would make it easier to provide care in a timely and efficient way. CNOs were aware of resource issues, as illustrated by one who described how financial constraints made it 'a struggle every day'; however, they were more likely to touch upon these points and move on.

The more prevalent issue with hospital resources related to transferring patients to other facilities for services not provided at the rural hospitals. Transfer times varied according to a patient's disease, time of day, and day of the week. For example, a patient with mental health concerns admitted on a weekend might have to wait several days to be transferred to an inpatient psychiatric facility. In contrast, transfers of patients with acute medical conditions usually happened quickly. Here too, there were subtle differences between CNOs and staff nurses. Again, CNOs were aware of the issues but did not elaborate on them. Staff nurses, who were intimately involved in 'transfer battles', described the considerable paperwork and numerous contacts with physicians, the receiving facility, the ambulance service, and the family.

Nurses expressed awareness of their communities' needs. They mentioned concern about lack of preventive services, and wanted to take care into the community by providing prenatal classes, mental health services and screening for chronic illnesses. They thought that these initiatives might fail because of barriers such as lack of health insurance, poverty and unhealthy lifestyles. Many patients had no insurance, and those who did often had

difficulty paying the co-payments. Even when health care was provided without charge, many patients still did not get the care they needed because they had no transport to get to the clinic or class. Nurses further commented that poverty was why ‘the four favourites of the South, sugar, salt, fat and alcohol’, along with fast food, were a nutritional mainstay instead of more expensive food such as vegetables and fruit.

Nurses who care stay on top of their clinical game—Staff believed that quality care required them to stay up-to-date in competencies, skills and education for all areas of their work. This could be challenging because rural nurses often practise as generalists rather than specialists; for example, they routinely ‘float’ to other care areas in need. In addition, ‘nurses do everything’ because rural hospitals lack support services such as intravenous teams and 24-hour pharmacists, usually available in urban hospitals. These staff nurses, therefore, needed proficiencies in multiple areas. Continuing education offerings, however, were rare. Consequently, the nurses depended on manuals, the experience of other nurses, and an occasional skills day to keep them up-to-date with the knowledge they needed to stay at the top of their clinical game.

The CNOs also reported that quality care depended on nurses who were good at their jobs. They recognized that their hospitals would be nothing without nurses who were safe, up-to-date practitioners, knew their limitations, and wanted to give the best care they could to all their patients. One CNO said, ‘They [the staff nurses] have a commitment to making sure that things get done right’.

Community connectedness is both a help and a hindrance

The second theme conveyed the deep sense of community that pervaded all interactions in rural hospitals. People knew one another. Community connectedness made a difference in how patients and staff interacted, as well as in how staff related to each other at work.

Patients and nurses know each other—A sense of community left staff feeling highly accountable to patients; it also laid the foundation for patients being able to trust their nurses. This trust came from the sense of being one big family where ‘everybody knows everybody’. ‘They know you by name’ was a two-way street: nurses knew patients by name and *vice versa*. Patients and staff went to the same churches, their children played together, and it was common for staff and patients to meet at the one grocery store in town. The shared history and its positive effects on trust were strongly noted. As one staff nurse said, ‘You know the people, you see them out in the street, you see them in here, they trust you and that trust is a big thing with patient care’.

The interconnectedness of the people in the community also meant that when patients were admitted the nurses knew their personal and medical history as soon as they heard their names. They could therefore start a plan of care immediately. However, nurses’ intimate knowledge of patients could also be a challenge. Because churches play a dominant role in rural communities, nurses were sometimes placed in awkward positions when well-meaning members of their congregation inquired about people who were hospitalized. The nurses had to balance being polite and maintaining patients’ privacy. Alternately, intimate knowledge of patients and their family histories was an advantage when nurses attempted to break through unhealthy family histories, such as obesity-related diabetes or teenage pregnancy.

Working in our small town—There were clear indications of a unique rural culture that had to be considered when delivering care. Participants mentioned words such as ‘natives’ to indicate individuals who had lived in these communities for generations. They also noted how, compared to newcomers from urban areas, many residents in these communities spoke

with very thick accents and used slower speech patterns. Staff nurses said that new nurses had to learn the 'local language' because patients would not listen to a nurse who did not speak as they did.

The rural culture also included norms for approaching and interviewing patients. If patients perceived any arrogance or superiority, they would 'put up that brick wall' and ask for someone they knew. If they were in the emergency room, they might even ask to be seen another day. Newcomers had to learn accepted interviewing practices. They could not start by directly asking about a health problem. Instead, they first had to establish the patient's connection to people and events in the community. Only then could the nurse tackle the problem. A nurse who relocated to one of these rural communities said that, as an outsider, she had to learn to work in her new community: 'I know I've had difficulty not being from here. I've had difficulty communicating with some of my patients, but [as you] work closely with the nurses that are from here, you're able to learn what the best way is to go about educating the patients'.

What enables us to work well together—The nurses were connected to one another and other staff through the same community venues that connected them with their patients. These connections outside the hospital spilled into the work environment, leaving staff with a feeling that the rural hospital was their second home and that staff were a second family. The work environment was described as warm and welcoming. All staff took pride in creating this environment where 'anyone entering the hospital is met with a smile and offerings of help and information'.

There was a team spirit among all staff. Just as they cared for their patients, staff cared for one another. Teams were defined in broad terms, including housekeeping staff, who not only cleaned but also kept nurses apprised of 'things going on with patients'. This eagerness to work together was also reflected in nurses' willingness to float to help on other units. When on their assigned units, assistance was often offered before nurses needed to ask, indicating an awareness of one another and unit activities. As one staff nurse described:

If one patient needs extra time, we make time for that patient. The other patients aren't neglected. Somebody else just steps in and takes over... That probably goes back to the nurses themselves working well together. It's more of a family atmosphere here; this is my second home.

Discussion

Through individual and group interviews, we were able to get a beginning glimpse of how CNOs and staff nurses working in rural hospitals perceive quality care. They were aware of established quality indicators, such as rates of falls, pressure ulcers, and infections and used these to evaluate and improve quality. They also thought that the most important quality indicator was patient satisfaction.

An unexpected finding was the way in which the interpersonal connections common in smaller towns affected quality care. This discovery warrants more penetrating exploration as it appears to have a powerful effect on quality, allowing patients to feel cared for and staff to exhibit caring for patients and one another.

Features of quality care as perceived by nurses in rural hospitals

The nurses in our sample believed that the most important aspect of quality is patient-focused care, such that all healthcare interactions are individually tailored, delivered with compassion and concern, and build trust. These concepts are similar to aspects of care rated

as important by patients in Japan, Jordan, Finland, and the USA (Larabee & Bolden 2001, Tokunaga *et al.* 2002, Suhonen *et al.* 2005, Bikker & Thompson 2006, Mrayyan 2006, Lynn *et al.* 2007). The similarities between rural nurses' and patients' beliefs as to what constitutes quality care are notable as previous studies have shown differences in nurses' and patients' perceptions of quality care (Shannon *et al.* 2002). Compared to nurses, patients felt that how care was delivered was more important for quality care (Lynn & McMillen 1999). However, existing measures of patients' ratings of quality do not include questions that tap into the quality dimensions found in our and previous studies (Lynn *et al.* 2007). Measures of quality care are needed that reflect aspects of care that matter most to patients; these aspects align with how rural nurses envision quality care.

These nurses had a high level of knowledge about quality structures and indicators. Together with their CNOs, staff nurses acted upon their institutions' quality indicators. These discoveries are indicative that these organizations had components necessary to improve quality care: good communication between leaders and staff, and non-punitive environments where nurses are able to learn from others' mistakes (Cook *et al.* 2004, Dayton & Henriksen 2007). The WHO reports that economic and cultural barriers can hinder the development of such organizational quality structures (Bates *et al.* 2009). Clearly, structures and measures of quality care need to have local relevance.

Along with established quality indicators, our participants believed that rural hospitals needed quality measures tailored to their unique situation. Consistent with previous reports (Moscovice *et al.* 2004, IOM 2005), they believed that it is important to develop a quality indicator of patient transfer time to other institutions, because transfers are such a common occurrence in rural hospitals. At present, no standards exist for measuring this. Guidance in creating such an indicator might be found in recent initiatives to create benchmarks for transferring patients from the emergency department to an assigned unit (Eitel *et al.* 2010).

Although sustaining competency and keeping knowledge up-to-date were regarded as important features of quality care, nurses in rural areas have limited access to continuing education. The major continuing education challenges faced by them have been identified previously (Bushy 2004, Newhouse 2005). Challenges remain, however, regarding how to help rural nurses continue their education. Previously suggested solutions include telehealth, online or distance-based education, international list serves and blogs (IOM 2005, ICN Rural and Remote Nursing Network 2009b). The feasibility of these solutions is uncertain because of limited technology resources in rural communities.

Importance of community and culture

Community connectedness as a feature of quality care is unique to rural hospitals. Rural nurses' work environment is different from that in urban hospitals because patients and staff are so well known to each other. This relationship, often familial in nature, translates into a deep commitment to deliver high quality care. Nurses see their patients throughout their community and therefore want patients' care experiences to be good. In addition, the connectedness among staff creates a collaborative atmosphere and working conditions that support giving high quality care. These features are not present in existing instruments and international studies that link nurses' work environment to quality care (Aiken *et al.* 2001, Kanai-Pak *et al.* 2008, Bruyneel *et al.* 2009). Ways to measure community connectedness are needed to capture factors in the work environment that are important for quality care in rural hospitals.

Knowledge of the rural cultural is a basic requirement for working effectively in small towns. According to Hofstede (2001), culture is a specific set of beliefs and attributes in a group, region or nation. Culture determines how a group thinks, feels and acts. Nurses'

awareness of their rural cultures was reflected in their understanding of obstacles to quality care, such as arranging for patients to have transport to health programmes. Care consistent with local customs and beliefs was also practised and taught to newcomers. The importance of rural culture to individuals' health has been identified in other studies (Pierce 2001, Leipert & George 2008).

Study limitations

Our study took place in a specific region of one state in the South-Eastern part of the USA. Although the findings may not apply to all rural areas, nurses working in these areas in another part of the USA thought that they accurately portrayed their circumstances. The consistency across hospitals further suggests that the findings are trustworthy. The findings need to be used cautiously, however, until views from additional areas of the USA and other countries are examined to determine if these perspectives remain constant.

Conclusion

Examining how rural nurses perceive quality broadens our understanding of what constitutes quality and how it should be measured. Our results demonstrate that USA rural nurses perceive as essential for quality care, patient-focused approaches including building trust and providing individualized care. More importantly, this study opened uncovered aspects of quality that have not been previously explored. Questions in the interviews were quite specific to established quality care indicators, but the importance of community emerged as a dynamic in quality care delivery in rural hospitals. This knowledge now creates a platform for future investigations.

Interventions are needed that incorporate the rural context and have local relevance. Future research should include development of ways to measure quality care that accounts for a community's culture as well as an indicator for transfer time to other facilities.

Participants believed that to provide and assess quality care, rural nurses need opportunities to sustain their skills and knowledge. Rural nurses need venues for continuing education. Interventions using new technology would increase rural nurses' ability to stay current and connected, but only if the technology is available to them.

Nurses are the largest component of the healthcare workforce worldwide. Quality measures therefore should incorporate those aspects of care perceived by nurses as important, which includes cultural relevance. We need a more complete picture of what constitutes quality care.

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What is already known about this topic

- Quality care is receiving global attention because it is part of measures of healthcare system performance and in some countries quality care measures are linked to reimbursement.
- Established measures of quality care were developed in large urban hospitals but differences between rural and urban hospitals suggest that measures of quality care may vary depending on location.
- Examples of established measures of quality care include complications, falls, infection rates, and lengths of stay, but currently no measures specifically address quality care issues unique to rural hospitals.

What this paper adds

- Established measures of quality care are used in rural hospitals, but most important for quality care is that patients are treated with respect and compassion from up-to-date and competent nurses.
- The sense of community in rural settings contributes to quality care: because people know each other outside the hospital, commitments exist to assure all patient experiences are optimal.
- New measures of quality care are needed that capture the unique features of rural hospitals, including the need for transfers to larger facilities and the culture of the community.

Implications for practice and/or policy

- Rural nurses' knowledge of their communities should be used when examining healthcare needs and planning interventions to improve quality care.
- Quality care in rural hospitals should be evaluated with measures appropriate for their setting, for example transfer time, and these measures should also assess whether care is sensitive to rural culture.
- Instruments are needed for practice and research to capture the connectedness found in rural communities, and its influence on quality care needs to be explored in order to improve quality.

Table 1

Participant demographics

	Staff nurses (<i>n</i> = 23)		Chief nursing officers (<i>n</i> = 4)	
	<i>f</i> (<i>p</i>)	<i>M</i> (<i>SD</i>)	<i>f</i> (<i>p</i>)	<i>M</i> (<i>SD</i>)
Gender				
Female	21 (91%)		4 (100%)	
Male	2 (9%)		0	
Age		41.6 (10.6)		55.5 (7.2)
Highest degree obtained				
LPN	4 (17%)			
Diploma	3 (13%)			
AD	10 (43%)			
BSN	6 (26%)		1 (25%)	
MSN	0		1 (25%)	
Other	0		2 (50%)	
Years in nursing		15 (11.2)		32.8 (2.5)
Years in institution		9.7 (8.3)		14.3 (11.8)
Years on unit		7.2 (6.1)		
Work hours				
Days	8 (35%)			
Evenings	0			
Nights	2 (9%)			
Rotations	13 (57%)			

AD, Associate degree; BSN, Bachelor of Science in Nursing; LPN, Licensed Practical Nurse; MSN, Master of Science in Nursing; 'Other', Master of Public Administration, Bachelor of Health Care Management.