A case study of new nurses' transition from education to rural practice in times of adversity

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Abstract

The transition of new nurses from training to employment in rural practice can be difficult in the best of times. The COVID-19 pandemic amplified challenges in supporting new nurses transitioning from education to employment. Drawing together Benner's novice-to-expert model and the concept of human flourishing, this article reports on research that explored new nurses' experiences transitioning from training to employment in rural nursing during the initial years of the COVID-19 pandemic, using case study methodology combining an online recruitment survey and in-depth semi-structured interviews. Participants identified a lack of on-the-job training and mentorship, feeling unprepared for the acuity of patients and concerns about patient safety, feeling unprepared for leadership roles, feeling unsupported by management, feeling fatigued and anxious, and a lack of optimism about the future of rural health care. On the positive side, participants reported valuing social connections and teamwork, gratitude from patients, and a sense of community, as well as increasing competency at work. Their stories and self-rated flourishing revealed both strengths and challenges in transitioning to practice in rural settings during times of adversity. This research can inform theories of nursing development as well as policies and practices that support new nurses to thrive in rural contexts.

Keywords

rural, new nurses, nurse development, flourishing, mental health

Implications for Practice and Research

- Nursing development requires time, structure, and supportive feedback to attain competence and confidence.
- The concept of flourishing despite challenging work conditions provides a unique perspective on the complex problem of transitioning to practice in times of adversity, and offers information about the environment and resources required to support the growth of resilient nurses and health-care systems.
- Benner's work on skill acquisition was done in tertiary care settings; more research is needed about how new nurses develop competence in rural practice where there are fewer resources and supports.
- New nurses often experience transition to rural practice as stressful, draining, and physically and emotionally demanding, with a lack of support from physicians, pharmacists, clinical nurse educators, and more experienced nurses that compounds these negative experiences.

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Background and Purpose

For new nurses (those who graduated and completed their registration exams in the past year), the transition to rural practice can be difficult for a multitude of reasons. Because nurse education is often situated in urban centres, students lack exposure to rural clinical settings; there is an absence of rural-specific education and curriculum, and minimal mentorship within rural practice (Edwards et al., 2004; Kulig et al., 2015). New nurses often experience transition to rural practice as stressful, draining, and physically and emotionally demanding (Heslop et al., 2001; Parker et al., 2014). They report a lack of support from other individuals within nursing and allied health professions that compounds these negative experiences (Parker et al., 2014), including heightened expectations to have extensive general knowledge in comparison to those practicing in urban settings, and working without the direct support of physicians, pharmacists, clinical nurse educators, and more experienced nurses (Smith & Vandall-Walker, 2017). More research is needed to explore what conditions and resources could support nurses transitioning to practice in rural settings to thrive in these challenging contexts.

Recent studies have indicated the COVID-19 pandemic had a detrimental effect on the nursing workforce globally. Hall (2020) found nurses reported added stress due to shortages of personal protective equipment, fears of bringing illness home to family and friends, fears of the unknown, and the death of patients and colleagues from the virus. New nurses transitioning into practice reported fear of caring for high acuity patients with limited or no training, a lack of professional skills, and being responsible for leadership roles too early in their careers because of staffing shortages (Ji & Lee, 2021; Naylor et al., 2021). Some new nurses found that being pushed into professional practice shortened orientation programs, increased workload, and challenged what they thought being a nurse was like (Crimson et al., 2021). Notably, most of the research on new nurses' experiences during COVID-19 has taken place in urban settings. More research is needed that considers the broader contextual factors that influence the transition to practice, including the practice environment, in the wake of COVID-19.

Learning from nurses whose transition into practice took place in rural settings during the COVID-19 pandemic may provide insights into how nurse managers, experienced nurses, and nurse educators may assist with the transition to practice in the coming years. In this article, we draw together Benner's (2004) novice-to-expert model and the concept of flourishing (Agenor et al., 2017: Willen et al., 2022) to consider the following research questions:

- What are new nurses' experiences transitioning from training to employment in rural nursing during the initial years of the COVID-19 pandemic?
- How does the concept of flourishing advance the understanding of new nurses' work experiences in the context of challenging work conditions?

For the purposes of this article, we define flourishing as the active process of pursuing a meaningful and engaged life (Agenor et al., 2017: Willen et al., 2022). The concept of flourishing despite challenging work conditions provides a unique perspective on the complex problem of transitioning to practice in times of adversity. It offers information about the environment and resources required to support the growth of resilient nurses and health-care systems.

Understanding nursing development and supporting flourishing

Skill acquisition and the novice-to-expert model

Nursing theorists have developed several models to explain the challenges and growth that accompany the transition to practice and to provide a framework for potential interventions to retain nurses (Graf et al., 2020). Patricia Benner (2004) used the Dreyfus model of skill acquisition (Dreyfus & Dreyfus, 1980) within a feminist tradition, to explain how nurses evolve from novice (e.g., student, new orientee) to expert through experiential learning (Benner, 2004). Nursing development requires time, structure, and supportive feedback to develop competence and confidence. In the first stage of learning, students require structure and protocol to develop their competencies (Benner, 2004), and reassurance from instructors and experienced nurses. In the second stage, new graduates, with additional scope of practice, experience heightened responsibility, which may be accompanied by an anxious state (Benner, 2004), and they frequently look to other nurses for feedback on their critical reasoning. This stage of transition is fatiguing because new graduates find it challenging to perform nursing tasks in constantly unfamiliar situations (Benner, 2004).

Benner suggests that within one to two years, nurses build upon further learning opportunities and gain competence that reduces the anxiety experienced as a new graduate. At this stage, nurses practice with prediction and planned execution, and can critically reflect on what constitutes good practice versus suboptimal practice (Benner, 2004). They have not achieved complete proficiency, as they are refining their situational adaptation and finding their sense of agency (Benner, 2001; Benner, 2004), but they have a comfortable blend of theoretical knowledge and flexible response to varying clinical situations as a proficient learner. As nurses refine their practice, recognition of opportunities for teaching and learning become more apparent. At the expert level, the nurse achieves what Benner calls *phronesis* or practical wisdom (Benner, 2001). Not all nurses reach this phase within a career; it is marked by leadership and integration

of experience, to create proficiency and an appreciation for the dynamic situations required for expert-level care.

Critiques of Benner's Model. Benner's model of skill acquisition is accepted by the nursing profession and educators with some critiques (Cash, 1995; English, 1993). While a full review of these critiques is not within the scope of this article, there have been significant changes in both nursing theory and practice since Benner developed this model. It is important to note that the nurses in Benner's research were baccalaureate degree-prepared and working in a tertiary care setting, making it difficult to generalize to other practise areas (Padgett, 2000). More research is needed about how new nurses develop competence in rural practice where there are fewer resources and supports. Additionally, Benner paid little attention to the links between competence and well-being, which are critical to sustaining a rural health workforce.

Supporting flourishing

To understanding nursing development in a more holistic sense, we draw on the concept of human flourishing, which has been used in the fields of philosophy (Seligman, 2011), psychology (Diener et al., 2010), and other social sciences (Willen, 2021), but has received less attention in nursing research. Recent reviews of the concept have revealed significant variation in the ways flourishing is defined and operationalized (Willen et al., 2022) leading Agenor and colleagues (2017) to describe the concept as "immature" (p. 915). In general, the term is used to describe the process of living a meaningful and engaged life; it is often associated with maintaining an optimal state of well-being even in the face of significant challenges. Scholars have used the concept of flourishing to shift from deficit models of mental health and disability to exploring how people can live good lives (Keyes, 2002). Research in nursing has begun to explore the evolution of the concept of flourishing (Agenor et al., 2017), its utility in mental health nursing and ethical decision-making (Hewitt, 2019), and the relationship between supportive leadership and flourishing (El-Gazar & Zoromba, 2021). In many studies, especially in positive psychology, flourishing has been examined quantitatively; however, a growing body of research advocates for the need for more qualitative and mixed-methods approaches to deepen understanding of the everyday challenges, contingencies, and strategies involved in flourishing (Willen et al., 2022).

Conceptually, human flourishing centres on the relational, social, and emotional features of a person's environment and life that support well-being even in sickness and adversity. Central elements of human flourishing include positive relationships (e.g., supportive relationships, opportunities to contribute to the happiness of others), engagement and interest in one's activities, meaning and purpose in life, and positive emotions (e.g., feeling respected) (Diener et al., 2010; Oberholzer, 2019; Seligman, 2011). Importantly, flourishing is not just an outcome; it is a dynamic process that is shaped by the social and structural conditions that people live and work (Willen et al., 2022). Applying theories of human flourishing in the context of transitioning from nursing education to working as a nurse can enrich understandings of the contexts and relationships required to help new nurses not only develop competency, but also actively pursue purposeful and meaningful careers in the midst of periods of significant adversity and throughout their lives.

The case of rural Manitoba

The Canadian Province of Manitoba provides an interesting case study for exploring nurses' experiences of transitioning to rural practice. The province covers an area of 552,371 km^2, including many rural and remote communities with low population densities and significant distances to urban centres. In 2021, 62% of the population lived in one census metropolitan area, the city of Winnipeg, and the rest of the population resided is smaller cities and rural areas (Statistics Canada, 2021). Demographically, rural Manitoba includes a large Indigenous population, European settlers, and a growing number of newcomers who each have diverse health, social, and cultural needs that new nurses must learn about. Decades of health and social service restructuring prior to the COVID-19 pandemic have produced an uneven geography of service provision, with many small communities fighting to retain health services and professionals, with varying degrees of success (Ramsey & Beesly, 2012). This context of continual change and the more recent pandemic state of emergency provide the backdrop for our case study.

Methods and procedures

A case study approach was used to explore new nurses' experiences transitioning from training to employment in rural Manitoba during the initial years of the COVID-19 pandemic. Case study research is defined by Gerring (2004) as "an intensive study of a single unit for the purpose of understanding a larger class of (similar) units" (p. 342). The unit of analysis may be an event (COVID-19), a process (transitioning from training to employment), a place (rural Manitoba), or an individual (new nurse). In our case, the smallest unit of analysis is the individual new nurse. Comparing each case enables us to explore multiple influences and explanations of the phenomenon of transitioning to practice, in context, over time, and through intensive analysis of data (Flyvbjerg, 2011).

Case studies are characterized by the collection of multiple data sources, often combining a mixture of qualitative and quantitative data (Baxter, 2016). This case study of three individual nurses is drawn from a larger research project (Doell et al., 2021) in which data was collected using an online survey and remote in-depth interviews with health-care workers in rural and non-metropolitan Manitoba.

The online survey was used to collect descriptive information about health-care workers' mental health experiences and resource needs, and also served as a recruitment tool for a second phase of the research, in-depth qualitative interviews. The interviews were developed to empower participants to tell the stories about their pandemic experiences that were most significant to them as well as to reflect on why these stories were important not only for themselves, but also for others to hear. For the purposes of this article, we focused on a sub-sample of three participants who self-identified as new nurses who had graduated and completed their registration exams in the past year.

Sampling/recruitment

Following Brandon University Research Ethics approval (approval number 22654), survey participants were recruited over a one-month period from late May to June 2021 using advertisements on social media and through various professional listservs, each of which contained a link to the survey. Health-care organizations, professional organizations, and unions in Manitoba were contacted with the survey information and a request to distribute it among their membership. The researchers also conducted recruitment through their own professional networks. A total of 220 completed surveys were received. All survey participants who answered yes to a question asking them if they wished to participate in an interview were contacted for a follow up interview by phone, and 32 interviews were conducted between July and September 2021 until no new professionals responded to the invitation to participate.

Data collection tools

We drew on the survey data to situate the new nurses' experiences during their transition.

Personal Information Questionnaire. Participants were asked a series of closed questions about their background, mental health, well-being, and work environment.

The Generalized Anxiety Disorder 7 (GAD-7) (Spitzer et al., 2006, used with permission), a standardized measure for generalized anxiety symptoms, includes seven items measuring symptoms of anxiety, using a four-point Likert scale from 0 to 3; higher scores indicate more severe symptoms of anxiety. The measure has a high degree of reliability and construct validity (Spitzer et al., 2006).

The Flourishing Scale (Diener et al., 2010, used with permission) is a short, valid measure of overall well-being that includes 8 items about respondents' perceptions of their own success and well-being, on a seven-point Likert scale with responses ranging from strongly disagree to strongly agree.

These tools provided some baseline information about new nurses' experiences transitioning to work, that were then explored further through qualitative interviews.

Interview Guide. Interviews followed a guide developed by an interdisciplinary research team, including a nurse practitioner, a registered psychiatric nurse, a health geographer, and a certified clinical counsellor. The guide began with an open-ended prompt asking participants about their role, to provide a qualitative, descriptive account of the job they identified in the survey. Then the participant was asked: What is the story you need to share about being a rural health-care worker during COVID-19? A series of follow-up prompts were used to explore the feelings, beliefs, values, and underlying meanings of these stories as well as to elicit a rich description of the events (Younas et al., 2023). Interviews typically lasted about one hour. All interviews were digitally recorded and transcribed verbatim following a transcription protocol to enhance the confirmability of data analysis.

Data analysis

During the development of a coding protocol, the experiences and challenges of new nurses emerged as a specific area of interest. A subset of three participants self-identified as new nurses and the research team began a separate in-depth analysis of these cases. They began by looking at descriptive information from the survey and generating in-depth summaries of each interview transcript to retain the context of the new graduates' experiences. This initial within-case analysis focused on describing each of the three participants (e.g., how they described themselves in their role); how they described their working conditions (e.g., social interactions and feedback); what was their story; and what emotions they experienced. The research team used the summaries to develop analytic codes within each case and then compared codes across the three cases. The findings of this article are presented as individual cases, integrating the results from the survey and interviews for each participant first, to provide context and rich detail about each case, and then analytic themes that were found across the three cases are discussed (Ayres et al., 2003).

Case studies

Each of the cases in this study illustrated the importance of strong relationships and social connection to supporting new nurses practicing in rural settings through times of adversity. The cases also highlighted the anxiety, fatigue, fear, and sadness that the new nurses experienced in relation to lack of staff, time, and mentorship as well as lack of preparation, training, and resources for the acuity of patients for whom they cared. This left the new nurses in the study with less optimism for the future of rural health care. Each participant has been given a pseudonym to protect their anonymity.

Amanda

Amanda identified as a Caucasian woman in her 20 s. Her responses on The Flourishing Scale indicated that she had

supportive and rewarding social relationships: she felt she was actively contributing to the happiness and well-being of others; she felt competent in the activities that she valued; and she believed she was a good person with a good life. Amanda indicated little optimism for her future. Her responses to the GAD-7 indicated she was experiencing moderate anxiety symptoms during the past two weeks (e.g., feeling nervous, anxious, or on edge and not able to stop or control worrying).

Amanda identified herself as a new graduate. When she was applying for a job, there were "lots of lines open" and many new nurses were hired. She completed her senior practicum in a small rural hospital and was hired for a full-time position on a medical ward immediately after graduating. People who tested positive for COVID were sent to this ward.

Amanda described her experience as "awful," and she laughed, as if to deflect from this negative experience. She continued, "This is the hardest and worst thing I have ever done and experienced." As a new graduate, "I felt like I couldn't speak up at the time." Her voice was shaky. Several times during the interview she talked about a sense of powerlessness and voicelessness in relation to aspects of safe work. She described her experience as a "rough start" and said, "I was getting put into situations that I shouldn't have, necessarily as a new grad, but was forced to because of COVID and staffing and [this] influx of really more acute patients than we're used to." She was placed in the charge nurse role, with no orientation, two months into her position, and "felt like she had no idea what she was doing." Throughout the interview, she mentioned feeling unprepared and unsupported in ways that challenged both her confidence and competence at work. She described herself as "overwhelmed" and "constantly extra on edge overnight" when there were few staff and patients could deteriorate quickly. The night shift staffing was composed of four "brand-new nurses," and she felt there was a lack of leadership and mentorship on this shift.

Amanda described the stress of the constant possibility of working short or being mandated to work overtime. On their own, 12-h shifts were already very demanding:

> I work only 12 s and I'm full time, so I come home from a shift, a horrible day. I'd cry, after a shower, and then go to bed, wake up the next day, go to work, come back. Literally, that was a lot of my days in the fall. … Every day in the last month or more, we all come into work just a little more stressed than [before; we're] already really stressed, because we actually don't know when we're going to leave work.

She described a time when she felt unsafe working mandated overtime, comparing her state of fatigue to a state of impairment. Very aware of her state, she was slower and kept double-checking things to make sure they were correct.

Despite the stresses, Amanda identified supportive relationships at work as a critical resource. She described herself as having a "work wife," and felt "close" to the co-workers she started with because of their shared experience. She also explained the importance of asking questions in times of uncertainty, and how that can bring people "closer." In contrast, she felt a lack of support from management. "I'm not expecting, 'How are you doing?'" She felt it was obvious she was not doing well. She wanted management to acknowledge her situation rather than turn a blind eye to it, as they seemed to be doing.

At times she also identified relational aggression and unfair treatment from more senior nursing staff. For example, she was always assigned patients who tested positive for COVID. Then management decided to keep track of "who's having the front." She was assigned "the front" two days in a row and another nurse noticed and advocated for a change. Amanda did not feel she could say anything, but she felt the other "seasoned nurse" who was assigned her original task "lost it. … she literally treated me like garbage all day." She expressed a sense of exasperation about this instance saying, "We're supposed to be a team."

She spoke with a sense of defeat about the acuity of patients and the lack of time to provide the quality of care they needed. "You feel like a horrible person [and] nurse." She also described low morale at work; no one was picking up shifts. "More days than not lately, you're not feeling satisfied," because she was too rushed to provide quality care. Although her patients did not get mad at her, she felt they should.

Looking to the future, sometimes she questioned, "Why am I doing this." She cited a strong sense of place as part of the reason; she was working near her hometown and had always seen herself working there. "It used to be a really fun environment. … I hope it is going to get back to that someday. … I feel like Manitoba's just the wrong place to work right now as a nurse." She said that she wanted to leave but she had no plan.

June

June identified as a Caucasian woman in her 20 s. Her responses on The Flourishing Scale indicated that she had supportive and rewarding social relationships; she was actively contributing to the happiness and well-being of others; she felt competent in completing activities that she valued; she believed she was a good person with a good life; and she felt people respected her. In contrast, she indicated little engagement and interest in daily activities as well as little optimism about her future. Her scores on the GAD-7 indicated she was experiencing symptoms of severe anxiety. During the interview, June reiterated these feelings, saying, "This past year, I really suffered with anxiety and depression and suicidal ideation because of the pandemic and because of my job, and feeling helpless."

She was working in two different rural hospitals and described herself as "very new," having graduated in 2020

"right in time for the pandemic." June loved working in the rural environment and found a lot of meaning in providing care to people she knew. "That part of rural nursing, it's just beautiful and it is so amazing and something that you don't get in the city."

June vividly described how a lack of staffing and time shaped her work experiences. She described working in COVID-19 as "a war zone." "I missed every single one of my breaks, I've missed my coffee break, my lunch break, and my supper break. People are still waiting 10 min for [someone to answer] a call bell." Lack of staff led her to feel guilty when she took days off:

> I think part of the problem is, we're burnt out and there is no one to replace us. Even to take a mental health day isn't taking a mental health day. You know you're phoning in sick and you know that every co-worker that you were supposed to work with is now having a terrible day because they're working short, because you know really there is no one coming in.

Fatigue, frustration, and disappointment were evident in June's voice as she described her experience. Lack of preparation and resources affected her ability to care for patients and her well-being. "We didn't have N95 masks for the longest time, we only had one ventilator." She noted that this went against best practice. She also described herself experiencing "overwhelming fear for weeks" because "we do not have the equipment. We do not have staff that is properly trained to look after patients who are sedated and intubated for extended periods of time."

June identified resources she valued that helped her through the more difficult times. She talked about the strong relationships and social connections she experienced in the workplace. She described herself as working with

> . . . a really great team of nurses and doctors. So, part of it is the team aspect of where I work is wonderful. You walk in and you feel like part of a team and everyone's working together. …This pandemic has brought a huge sense of community to health-care workers. I think that we are very much more united as a whole and it's not as segregated.

A sense of team and camaraderie was helpful to June because there was a sense of shared struggle and emotional challenges that helped normalize her feelings. Additionally, June felt that the team was unified by mistreatment. "All of us have been mistreated by the government or employers, so all of us are kind of bonding together." Finally, June talked about her religion, and how that helped her to see her calling as a nurse and feel a sense of purpose in what she was doing.

June described the hospital's employee assistance plan (EAP) as a valued resource; the service was quick and she was able to speak to someone who was qualified. Contrarily, she had a very negative experience when trying to access mental health services in the community to gain extra support within the pandemic; "The mental health system is very broken."

Although June did not speak directly about her plans for the future, she did talk more broadly about the future of the health-care system in Manitoba. "If the health-care system continues the way it is, it won't continue because there simply won't be staff to work it. I think that after this pandemic we are burnt out and we need help." In making this statement, June revealed some of the reasons she had less optimism about her future in health care.

Nicole

Nicole, who identified as a Caucasian woman in her 20 s, was a nursing student at the start of the pandemic, and she was also pregnant. Her responses on The Flourishing Scale indicated that she had good supportive and rewarding social relationships and felt she was a good person with a good life. Conversely, she felt less strongly that she was leading a purposeful and meaningful life, had little engagement with daily activities, felt little competence in activities she valued, was not optimistic about her future, and did not feel that people respected her. Her scores on the GAD-7 indicated severe anxiety, and she was struggling with her mental health at the time of the interview. The medical unit where she worked as a registered nurse after graduation was overwhelmed by the third wave of the pandemic. There were more acute patients on her unit that normally would have been transferred elsewhere. She reported not having the necessary training to safely do her job such as caring for patients that should be in the intensive care unit.

Nicole's story was one of ethical dilemmas in relation to patient safety. She could not observe patients as frequently or carefully as they should have been, because there was "just no staff, or there was no resources for that." Nicole became tearful when she discussed an incident that involved being instructed to stop CPR on a patient due to resource limitations. She felt that was not "what the patient wanted" and the family was angry, which she "completely understood and agreed with." She expressed helplessness and anger about this situation.

Nicole also reported feeling fearful and hopeless about the future of the health-care system. She expressed concern and discomfort when describing how she coped. "I feel more detached at the end of this year [from] my patients, which I feel like is a coping mechanism. But I feel like it doesn't make me a good nurse, which is unfortunate." She was particularly troubled not only by systemic resource limitations but also by her own response to these limitations.

Nicole reflected on the lack of time to rest and recover from her work. She recalled having a scheduled week off from work, during which time she realized that she did not have antepartum depression, a condition she thought she might have been experiencing. She realized that she was "burnt out, and that. … I got enough time to relax, and

kind of at least reflect. I think the problem is that we don't have any time to reflect on anything."

Despite her struggles, Nicole reported feeling thankful and lucky for the teamwork on her unit. She had chosen to work on her unit because it required teamwork. She felt that she experienced and benefited from more teamwork than most of her classmates. She was particularly thankful for the "good leaders" she worked with, which she felt smaller facilities may not have had.

Nicole was considering pursuing a master's degree to leave bedside nursing. She wanted to be more present, focus on social relationships outside of work, and be a good mom. When she returns from maternity leave, she wanted to remember the importance of relationships, and to step back when necessary. She wanted to have a strong foundation for her own well-being and to support others in her social network. She believed that stepping away from work would help her to become a better nurse.

Discussion

In this article, we explore three new nurses' experiences transitioning from nursing school to employment in rural environments during the initial years of the COVID-19 pandemic. Analytically, we drew together Benner's theory of nursing development (Benner, 2004) and the concept of flourishing (Diener et al., 2010; Willen et al., 2022), to understand these experiences of transition in a more holistic sense, considering the social and contextual resources that enable new nurses to work through adversity. The contents of these three case studies indicate that there were some features of rural practice during this period that were supportive of processes of development and flourishing; however, there were many other features that undermined both these processes.

Looking at the measures collected during the online survey, all three nurses identified some supportive resources that enabled them to flourish to some degree–in particular, supportive and rewarding social relationships in their lives and at work. They emphasized the importance of feeling they were part of a team at work; two nurses suggested that the pandemic produced a greater sense of cohesiveness among health-care workers in general–a greater sense of unity as they all shared certain fears, anxieties, and challenges. One nurse explained that she started with a cohort of new nurses who provided an essential source of support, even outside of work.

One new nurse reported experiencing relational aggression from more experienced nurses, and all three reported a lack of support from management. While incivility and lateral aggression toward new nurses is well-documented in the nursing literature (Mammen et al., 2023, Chachula & Varley, 2022), it is interesting to note that the three new nurses generally felt part of a team and spoke more about positive relationships at work than they did about negative interactions. In addition, and consistent with research on rural nurse recruitment and retention (Kulig et al., 2015), having previous relationships to the rural community in which they worked contributed to some positive and rewarding relationships at work when being able to help and care for people they knew. These new nurses felt their relationships with their patients could be rewarding, but this was limited by time constraints.

Lack of staffing and time for rest and recovery were central to these new nurses' experiences. While working short-staffed and overtime are challenges that affect all nurses, particularly in the wake of the COVID-19 pandemic (Labrague, 2021), they have particular implications for new nurses transitioning from education to employment, influencing the time and staff available to provide orientation, role modeling, and supportive feedback. For example, Amanda received no orientation because she completed her final practicum in the setting where she worked. Lack of staffing and time also exacerbated fatigue among the new nurses. Without time to rest and recover, new nurses may struggle to process new learning because they have neither the time nor support to affirm their learning. Time and mentorship, critical to new nurses' self-efficacy, were often lacking in rural contexts during the COVID-19 pandemic.

These new nurses felt unprepared for the acuity of patients they were treating in rural settings. They reported not being trained or properly resourced to do some procedures within their hospitals. In some cases, they lacked personal protective equipment and struggled with resource rationing that went against the best practices they learned during their education.

Consistent with studies of health-care workers during the initial stages of the pandemic (Crowe et al., 2021; Havaei et al., 2021), these new nurses experienced anxiety in relation to their work and the pandemic. In Benner's model (2004), symptoms of anxiety and fatigue are common among new graduates because they are not yet able to apply their learning in constantly unfamiliar situations. Two of the nurses reported experiencing severe symptoms of anxiety, and the other experienced moderate symptoms of anxiety, highlighting the persistence of unfamiliar and changing situations inside and outside of work during that period as well as many fears about the safety of patients and themselves.

All three new nurses struggled to be optimistic about their futures, and two struggled with engagement and interest in their daily activities. The interview data reveals some reasons why these new nurses felt hopeless about their future in health care. Although they had managed to function well for the time being, they were not optimistic about their futures in rural health care. Each shared a sense that the system they worked in did not enable them to provide quality care and to be the "good nurse" they expected to be, coming out of their education. Consistent with Crimson and colleagues (2021), their experiences challenged their expectations and their beliefs about what it means to be a

good nurse. Two of the nurses expressed wanting to leave nursing, and the other was going on maternity leave.

Limitations

This case study is not without limitations. Three new nurses is a small sample; more research is needed to explore whether larger samples might generate different cases and patterns. Small homogenous samples can, however, yield transferable results. Future research should include a larger, more diverse sample of nurses transitioning to practice, considering their age, race, and other intersectional determinants influencing their experience.

Additional research on new nurses' experiences should apply The Flourishing Scale to explore the extent to which other work environments support new nurses' flourishing (Diener et al., 2010). A strength of the research is that it provides a transparent description (i.e., audit trail) of the steps, measures, questions, and process used to explore and analyze new nurses' experiences, for replication in future studies. It also offers an in-depth descriptive understanding of three new nurses' experiences transitioning from education to employment during a period of significant adversity using data from multiple points in time and theories of nurse development and human flourishing.

Implications for nursing practice

We view this case study as offering rich description and contributing to the nascent development of research into flourishing, focused on new nurses transitioning to practice during COVID-19. More large-scale research on nurses transitioning to practice in other times of adversity is needed. Nonetheless, the case study provides important information about the resources available and those needed to support nurses' development and maintain their well-being as they transition into practice in rural settings. In the context of a global nursing shortage, developing peer support may be one strategy that can offer new nurse cohorts positive and rewarding relationships at work. While these peer relationships can offer social and emotional support, they cannot offer the leadership and mentorship that new nurses require to become nurse experts themselves. Benner (2004) recommended formalized mentorship, reduced patient loads, and strong relationships with nursing leaders to support nursing development. These recommendations need to be acted on and resourced, now more than ever. Incentivizing experts in nursing in rural areas to continue to practice and mentor in those settings may provide more support for new nurses. In addition, mandatory breaks and limits on overtime are critical. Safe staffing levels and adequate leadership would also ensure that new nurses do not need to take on leadership roles before they are ready. Outside the workplace, new nurses need access to supportive employee assistance programs (EAPs) and other mental health supports to process the challenges they face at work. EAPs may be particularly critical for new nurses in rural settings because of the lack of other services available in those communities.

Conclusion

As we work to build our global health-care workforce that is critically under-resourced, we must provide the conditions for new nurses to develop and flourish. In rural health-care settings, there may be opportunities to leverage strong relational resources to enhance a sense of camaraderie, teamwork, and community that makes work rewarding; however, these resources alone will not sustain new nurses. New nurses need consistent on-the-job mentorship and training, strong relationships with nurse leaders, time for rest and recovery, and the resources and support to provide the quality of care they came into the profession wanting to provide.

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